STATE OF MICHIGAN
EXECUTIVE OFFICE
LANSING

RICK SNYDER
GOVERNOR

BRIAN CALLEY
LT. GOVERNOR

December 6, 2017

The Honorable Eric D. Hargan
Acting Secretary
U.S. Department of Health & Human Services
200 Independence Ave, SW
Washington, D.C. 20201

Dear Acting Secretary Hargan:

On behalf of the residents of the State of Michigan, I am pleased to submit the State's extension application for the Healthy Michigan Plan (HMP) §1115 Demonstration Waiver (Project No. 11-W-00245/5). HMP was implemented in April 2014 to provide healthcare access to low-income, uninsured and underinsured Michigan residents. This demonstration project introduced cost-sharing initiatives and a Healthy Behavior Incentive Program that promotes beneficiary engagement in healthy behaviors and conscientious utilization of healthcare services.

Through HMP, the Michigan Department of Health and Human Services has extended healthcare coverage to approximately 650,000 eligible low-income Michigan residents. Since its inception, HMP has demonstrated success in meeting several key State goals. In comparing data from 2013 to 2015, it has been demonstrated that, for the average hospital, annual uncompensated care expenses fell from $7.21 million to $3.77 million. Additionally, within the first year of their enrollment in the program, 82 percent of HMP beneficiaries had an ambulatory or preventive care visit.

The HMP program has made a significant impact on the health and well-being of Michigan residents and the proposed waiver extension will enable the State to continue these efforts. Given its demonstrated successes and the desire to continue evaluating its unique components, the State is requesting an extension of the current waiver.

The State looks forward to its ongoing work with federal partners at the Centers for Medicare & Medicaid Services to ensure that HMP enrollees continue to have access to quality benefits that improve health outcomes.

Sincerely,

[redacted]

Rick Snyder
Governor

cc: Jennifer Kostesich, Project Manager, CMS
Ruth Hughes, Regional Administrator, CMS
Andrea Casart, Director, Division of Medicaid Expansion Demonstrations, CMS

Section 1115 Demonstration Extension Application

Healthy Michigan Plan
Project No. 11-W-00245/5

Submission Date: December 6, 2017

State of Michigan
Rick Snyder, Governor

Nick Lyon, Director
Michigan Department of Health and Human Services
333 S. Grand Avenue
Lansing, MI 48913

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Section I – Executive Summary

The Michigan Department of Health and Human Services respectfully requests approval to extend its highly successful Healthy Michigan Plan demonstration waiver. Michigan has a proven record of efficiently managing health care costs and improving the State's Medicaid program. As part of these efforts, the Michigan Department of Health and Human Services (MDHHS) implemented the Michigan Medicaid expansion program, known as the Healthy Michigan Plan (HMP) administered under the §1115 Demonstration Waiver authority (Project No. 11-W-00245/5) on April 1, 2014. Through HMP, MDHHS has extended health care coverage to over 650,000 low-income Michigan residents who were previously either uninsured or underinsured. HMP is built upon systemic innovations that improve quality and stabilize health care costs. Other key program elements include: (a) the advancement of health information technology, (b) structural incentives for healthy behaviors and personal responsibility, (c) encouraging use of high value services, and (d) promoting the overall health and well-being of Michigan residents.

HMP is predicated on the establishment of the Healthy Behaviors Incentives Program and the MI Health Account (MIHA) which support beneficiary participation in healthy behaviors and awareness of personal health care utilization costs. The Healthy Behaviors Incentives Program encourages beneficiaries to achieve and maintain healthy behaviors in collaboration with their primary care providers, primarily through completion of a standardized Health Risk Assessment (HRA) and attesting to a healthy behavior. All HMP beneficiaries enrolled in Medicaid Health Plans (MHPs) have the opportunity to earn program incentives which are applied consistently across the participating plans.

HMP also implements innovative approaches to beneficiary cost-sharing and financial responsibility for health care expenses. For the subset of HMP beneficiaries with incomes above 100% of the federal poverty level (FPL), there is a requirement to pay monthly contributions toward the cost of their health care. The MIHA is a vehicle to collect cost sharing and also serves to increase beneficiaries' awareness of health care costs and promote engagement in their health service utilization.

On December 17, 2015, the Centers for Medicare & Medicaid Services (CMS) approved an amendment to the HMP Demonstration Waiver which is referred to as the "Marketplace Option." Beneficiaries who are impacted by this amendment are those:

- With incomes above 100% of the FPL,
- Enrolled in a Medicaid Health Plan (MHP) for twelve (12) consecutive months or more,
- Who did not complete a healthy behavior,
- Who are not medically frail in accordance with 42 CFR 440.315, and
- Who are not exempt from premiums and cost-sharing pursuant to 42 CFR 447.56

These beneficiaries will be transferred to the Marketplace Option beginning April 1, 2018. Marketplace Option enrolled beneficiaries will be receiving their health coverage through the Marketplace issuers.

At this time, MDHHS is not seeking any additional program changes with this demonstration renewal application request. With the approval of an extension of the HMP waiver, which is currently set to expire on December 31, 2018, MDHHS seeks to continue to build on program successes.

Section II – Program History and Overview

A. HMP Program History

In January 2004, the State of Michigan's Adult Benefits Waiver (ABW) was approved by CMS as a §1115 Demonstration Waiver. The ABW program provided a limited ambulatory benefit package to low-income, childless adults between the ages of 19-64, with incomes at or below 35% FPL and who were not otherwise eligible for Medicaid. The programmatic goals for the ABW demonstration were to improve the access and quality of appropriate healthcare services.

The Michigan legislature passed Public Act 107 of 2013, which permitted MDHHS to augment its ABW program by expanding the eligibility criteria for this adult population overall, from 35% to 133% of the FPL, utilizing the Modified Adjusted Gross Income Methodology. Concurrently, program benefits were expanded to include all federally mandated Essential Health Benefits (EHBs) under an Alternative Benefit Plan (ABP) State Plan Amendment. In December 2013, CMS approved the state's request to amend the ABW waiver, which was subsequently renamed HMP. HMP was implemented on April 1, 2014.

In September 2015, MDHHS sought CMS approval of a second HMP waiver amendment to implement additional directives contained in the state law (Public Act 107 of 2013). The request was made to continue the provision of affordable and accessible health care coverage for approximately 600,000 Michigan residents receiving HMP benefits at that time. CMS approved the second waiver amendment on December 17, 2015, which effectuates the Marketplace Option program updates.

The Marketplace Option amendment provides that beneficiaries with incomes greater than 100% of the FPL who have been enrolled in an HMP health plan for 12 consecutive months may be required to receive their health benefits through the Marketplace Option if they have not completed a healthy behavior. As required by state law, individuals who are determined medically frail in accordance with 42 CFR 440.315 are not eligible for the Marketplace Option. Details on MDHHS' three-pronged strategy for the identification of these individuals are detailed in the HMP Marketplace Option Protocol included in the HMP §1115 Demonstration Waiver Special Terms and Conditions. Additionally, individuals exempt from premiums and cost-sharing pursuant to 42 CFR 447.56 are exempt from the Marketplace Option.

The transition of the HMP beneficiaries who qualify for the Marketplace Option will begin on April 1, 2018. Beneficiaries enrolled in the Marketplace Option will receive the health benefits in accordance with the Marketplace Option ABP. Beneficiaries who do not qualify for the Marketplace Option will continue to receive their health benefits through HMP managed care.

B. HMP Goals & Objectives

The overarching goals of the HMP Demonstration are to increase access to quality health care, encourage the utilization of high-value services, promote beneficiary adoption of healthy behaviors, and implement evidence-based practice initiatives. Organized service delivery systems are utilized to improve coherence and overall program efficiency.

MDHHS' initial and continued goals for HMP include:

- Improving access to healthcare for uninsured or underinsured low-income Michigan residents;
- Improving the quality of healthcare services delivered;
- Reducing uncompensated care;
- Encouraging individuals to seek preventive care and encourage the adoption of healthy behaviors;
- Helping uninsured or underinsured individuals manage their health care issues;
- Encouraging quality, continuity, and appropriate medical care; and
- Studying 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 HMP has a positive impact on personal health outcomes and financial well-being.

C. HMP Program Overview

1. Eligibility

HMP targets individuals who are eligible in the new adult group under the State Plan.

Table 1: Eligibility				
Medicaid State Plan Group Description	**Federal Poverty Level and/or Other Qualifying Criteria**	**Funding Stream**	**Expenditure Group Reporting Name**	**Demonstration Specific Name**
Adults 19 through 64 described in §1902(a)(10((A)(i)(VIII), except as specifically excluded.	Income up to 133% FPL receiving ABP benefits, not disabled and not pregnant.	Title XIX	Healthy MI Adults	Healthy Michigan Plan (Project No. 11-W-00245/5)

2. Benefits

All beneficiaries covered by HMP are eligible for comprehensive services consistent with the ABP as described in the Medicaid State Plan. These benefits include the federally mandated 10 EHBs and many additional services which align with state plan services, such as dental, hearing aids, and vision services.

The Marketplace Option enrollees will also have access to the 10 EHBs in accordance with the Affordable Care Act and its implementing regulations. Enrollees will receive coverage of these EHBs from the defined Marketplace issuer provider network. All participating issuers must meet the network and service area requirements as required by the Michigan Department of Insurance and Financial Services (DIFS), including all essential community provider requirements specified by CMS.

3. Cost-Sharing

All HMP beneficiaries are required to adhere to the cost-sharing requirements outlined in the MIHA and HMP Marketplace Option Operational Protocols. The HMP has a unique MIHA vehicle where beneficiary cost-sharing requirements are satisfied, monitored and communicated to the beneficiary. Moreover, HMP incorporates the Healthy Behaviors Incentives Program which was created to reward beneficiaries for their conscientious use of health care services. Incentives, which are defined in the waiver protocol, include both reductions in cost-sharing responsibilities and select financial rewards. Participating HMP beneficiaries who are enrolled in a health plan may earn incentives on the basis of their active, appropriate participation in the health care delivery system.

The HMP program has undergone some positive changes based on stakeholder and evaluator input over the course of MDHHS' experience with HMP. Some changes, such as revisions to the MIHA statement, have been implemented to improve beneficiary understanding of cost-sharing responsibilities. Other changes, such as revisions to the program HRA tool and submission process, seek to increase the promotion of beneficiary engagement in the Healthy Behavior Incentive Program. The program has also expanded the scope of services and medications associated with chronic medical condition which are deemed exempt from cost-sharing as a way to reduce any potential financial barriers to important primary care.

4. Delivery Systems

Services for HMP are provided through a managed care delivery system. After April 1, 2018, when HMP has been operational for 48 months, beneficiaries with incomes above 100% of the FPL will receive services through either an HMP Medicaid Health Plan (MHP) or the Marketplace Option.

a. Healthy Michigan Plan

All HMP eligible beneficiaries are initially mandatorily enrolled into a MHP, with the exception of those few beneficiaries who meet the MHP enrollment exemption criteria or those beneficiaries who meet the voluntary enrollment criteria.

MDHHS utilizes two different types of managed care plans to provide the HMP ABP for the HMP demonstration population:

- Comprehensive Health Plans: The State's contracted MHPs provide acute care, physical health services and most pharmacy benefits.

- Behavioral Health Plans: Prepaid Inpatient Health Plans (PIHPs) provide inpatient and outpatient mental health, substance use disorder, and developmental disability services statewide to all enrollees in the demonstration.

Individuals who are enrolled in HMP on or after April 1, 2018, or who come into the higher income level (above 100% of the FPL) on or after April 1, 2018, will have one year of enrollment in HMP in order to allow time for completion of healthy behaviors before alternative contributions and cost sharing are applicable.

b. Marketplace Option

The Marketplace Option will be effective as of April 1, 2018, with monthly rolling enrollment thereafter. HMP beneficiaries who have incomes above 100% of the FPL and have not completed the healthy behavior requirements of the Healthy Behaviors Incentive Program must transition to the Marketplace Option, absent an applicable exception such as medical frailty, as outlined in the Marketplace protocol.

MDHHS will also provide or arrange for wrap-around benefits that are included in the Marketplace ABP but not covered by the Marketplace issuers. These benefits, covered as Fee-For-Service, are non-emergency medical transportation (NEMT); family planning services and supplies including access to out-of-network family planning providers; and access to Federally Qualified Health Center (FQHC) and Rural Health Center (RHC) services.

Section III – Waivers and Expenditure Authorities

A. Waiver Authorities

MDHHS requests the continuation of the following waivers of state plan requirements contained in §1902 of the Social Security Act, subject to the Special Terms & Conditions for the HMP §1115 Demonstration:

- *Premiums, § 1092(a)(14), insofar as it incorporates §§ 1916 and 1916A* - To the extent necessary to enable the state to require monthly premiums for individuals eligible in the adult population described in section 1902(a)(10)(A)(i)(VIII) of the Act, who have incomes between 100 and 133 percent of the federal poverty level (FPL).
- *State-wideness § 1902(a)(1)* - To the extent necessary to enable the state to require enrollment in managed care plans only in certain geographical areas for those eligible in the adult population described in section 1902(a)(10)(A)(i)(VIII) of the Act.
- *Freedom of Choice § 1902(a)(23)(A)* - To the extent necessary to enable the state to restrict freedom of choice of provider for those eligible in the adult population described in section 1902(a)(10)(A)(i)(VIII) of the Act. No waiver of freedom of choice is authorized for family planning providers.
- *Proper and Efficient Administration § 1902(a)(4)* - To enable the State to limit beneficiaries to enrollment in a single prepaid inpatient health plan or prepaid ambulatory health plan in a region or region(s) and restrict disenrollment from them.
- *Comparability § 1902(a)(17)* - To the extent necessary to enable the state to vary the premiums, cost-sharing and healthy behavior reduction options as described in these terms and conditions.
- *Payment of Providers §§ 1902(a)(13) and 1902 (a)(30)* - To the extent necessary to permit the state to limit payment to providers for individuals enrolled in the Marketplace Option to amounts equal to the market-based rates determined by the Qualified Health Plan providing primary coverage for services under the Marketplace Option.
- *Prior Authorization § 1902(a)(54), as it incorporates §1927(d)(5*) - To permit the state to require that requests for prior authorization for drugs in the Marketplace Option be addressed within 72 hours, rather than 24 hours. A 72-hour supply of the requested medication will be provided in the event of an emergency.

B. Expenditure Authorities

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- Expenditures for Healthy Behaviors Program incentives that offset beneficiary cost sharing liability.
- Expenditures for part or all of the cost of private insurance premiums, and for payments to reduce cost sharing, for individuals enrolled in a Marketplace issuer health plan through the Marketplace Option, to the extent that such expenditures do not meet cost effectiveness requirements or include amounts for benefits that are not otherwise covered under the approved state plan (but are incidental to coverage of state plan benefits).
- To the extent necessary to permit the state to offer premium assistance and cost sharing reduction payments that are determined to be cost effective using state developed tests of cost effectiveness that differ from otherwise permissible tests for cost effectiveness.

Section IV – Reporting

MDHHS has routinely documented the progress of HMP since its inception in 2014 and submits quarterly and annual reports to CMS. These reports can be found at www.medicaid.gov.

MDHHS also contracts with Health Services Advisory Group, Inc. (HSAG), an external quality review organization (EQRO), to aggregate and analyze MHP data and prepare annual technical reports on the quality and timeliness of, and access to, care furnished by the state's MHPs. The quality and performance reports can be found at: http://www.michigan.gov/mdhhs/0,5885,7-339-71547_4860---,00.html.

MDHHS completes Performance Monitoring Reports (PMR) for all MHPs that were licensed and approved to provide coverage to Michigan's Medicaid beneficiaries during reporting periods. These reports are based on data submitted by the health plans and include the following items: grievance and appeal reporting, a log of beneficiary contacts; financial reports, encounter data; pharmacy encounter data; provider rosters; primary care provider-to-member ratio reports; and access to care reports.

MDHHS developed HMP Performance Monitoring Specifications beginning with the initiation of the program in 2014. Many of the measures for fiscal year (FY) 2015 were informational as MDHHS refined its data collection and analysis process. Performance standards were set for these measures in FY 2016 and will continue in FY 2017 and beyond. Performance areas include Adult Access to Ambulatory Health Services, Outreach and Engagement to Facilitate Entry to Primary Care, Adults' Generic Drug Utilization, Plan All-Cause Acute 30-Day Readmissions, and Timely Completion of Initial Health Risk Assessment. Please see Attachment A for the full PMR and EQRO reports.

Section V – Program Financing

Historical HMP demonstration expenditures for all 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. Total 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. HMP demonstration expenditures have historically remained under per-member-per-month (PMPM) budget neutrality limits as defined by the demonstration special terms and conditions. The following table includes expenditures and member months by demonstration year (DY) starting April 1, 2014 through June 30, 2017.

Table 2: Healthy Michigan Demonstration Budget Neutrality Monitoring				
	DY 5 - 2014	**DY 6 - 2015**	**DY 7 - 2016**	**DY 8 - 2017**
Approved HMP PMPM	$667.36	$602.21	$569.80	$598.86
Actual HMP PMPM (YTD)	$475.72	$480.41	$492.93	$446.22
Total Expenditures (YTD)	$1,776,995,398.00	$3,492,109,239.00	$3,824,569,481.00	$1,839,545,788.00
Total Member Months (YTD)	3,735,411	7,269,012	7,758,811	4,122,536

Healthy Michigan demonstration expenditure and enrollment projections developed by Milliman, Inc., an MDHHS actuarial contractor, are detailed in the following table:

Table 3: Healthy Michigan Demonstration Budget Neutrality Projections					
	DY 9 -2018	**DY 10 - 2019**	**DY 11 - 2020**	**DY 12 - 2021**	**DY 13 - 2022**
Approved HMP PMPM	$629.40	TBD	TBD	TBD	TBD
Projected HMP PMPM	$550.55	$569.30	$588.87	$609.30	$630.64
Projected Expenditures	$4,438,896,588.00	$4,604,748,464.56	$4,778,374,610.65	$4,960,115,373.92	$5,150,547,789.10
Projected Enrollment	8,062,644	8,088,468	8,114,496	8,140,716	8,167,140

Section VI – Evaluation Report

Demonstration Evaluation Activities

The HMP Demonstration Waiver is being independently evaluated by The Institute for Healthcare Policy & Innovation (IHPI) at the University of Michigan. This evaluation began in mid-2014 and will be completed in 2020. A final report will be available in mid-2020. For more information about evaluation activities, timelines, and deliverables, please see Attachment B for the §1115 Demonstration Waiver Amendment Evaluation Proposal. This interim evaluation summary provides an overview of the evaluation, presents highlights from work completed to date, and describes the timeline for upcoming reports.

A. Overview

The HMP Demonstration's program objectives and hypotheses, as identified in the waiver Special Terms and Conditions, are being assessed consistent with the CMS-approved evaluation plan. The evaluation examines multiple hypotheses associated with the following seven specific domains:

1. The extent to which the increased availability of health insurance reduces the costs of uncompensated care borne by hospitals;

2. The extent to which availability of affordable health insurance results in a reduction in the number of uninsured/underinsured individuals who reside in Michigan;
3. 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;
4. The extent to which beneficiaries believe that HMP has a positive impact on personal health outcomes and financial well-being;
5. Whether requiring beneficiaries to make contributions toward the cost of their health care has an impact on the continuity of their coverage, and whether collecting an average co-pay from beneficiaries in lieu of copayments at the point of service, and increasing communication to beneficiaries about their required contributions (through quarterly statements) affects beneficiaries' propensity to use services;
6. Whether providing an MIHA into which beneficiaries' contributions are deposited, that provides quarterly statements that include explanation of benefits (EOB) information and details utilization and contributions, and allows for reductions in future contribution requirements, deters beneficiaries from receiving needed health services or encourages beneficiaries to be more cost-conscious; and
7. Whether the preponderance of the evidence about the costs and effectiveness of the Marketplace Option when considered in its totality demonstrates cost effectiveness taking into account both initial and longer-term costs and other impacts such as improvements in service delivery and health outcomes.

B. Overview of Evaluation Methods

As described below, the evaluation uses a wide variety of data sources, including: hospital cost reports; Medicaid enrollment, utilization, and cost data from the Michigan Department of Health and Human Services Data Warehouse; provider survey data; enrollee survey data (the annual Healthy Michigan Voices survey); and interviews with enrollees and providers.

C. Primary Care Practitioners' Views of the Impact of the Healthy Michigan Plan

Methods

IHPI conducted 19 semi-structured telephone interviews with PCPs caring for HMP patients in five Michigan regions selected to provide racial/ethnic diversity and a mix of urban and rural communities. Interviews informed the development of survey items and guided the interpretation of survey findings. The evaluation team also surveyed all PCPs in Michigan with ≥12 HMP patients about practice changes and their experiences caring for patients with HMP. The final response rate was 56% with 2,104 respondents.

IHPI calculated descriptive statistics without survey weighting because the cohort included all PCPs with ≥12 HMP patients. Bivariate and multivariable logistic regression analyses assessed the association of personal, professional and practice characteristics with practice changes reported since Medicaid expansion. Multivariable models and chi-square goodness-of-fit tests calculated. Quotes from PCP interviews have been used to expand upon key survey findings.

Key Findings

Key findings from the Interim Report on Primary Care Practitioners' Views of the Impact of the Healthy Michigan Plan (Attachment C.1) are highlighted below.

Providers expressed varying degrees of familiarity with features of HMP.

- 71% were very/somewhat familiar with completing HRA.
- 25% reported being very/somewhat familiar with enrollee cost-sharing.
- 36% reported being very/somewhat familiar with healthy behavior incentives for patients.

Most providers reported accepting new Medicaid/HMP patients.

- 78% reported accepting new Medicaid/HMP patients. PCPs who are female, racial minorities, or non-physician PCPs, internal medicine specialists, have salaried income, report a Medicaid predominant payer mix, or previously provided care to the underserved were more likely to report accepting new Medicaid/HMP patients.
- 73% felt a responsibility to care for patients regardless of their ability to pay.
- 72% agreed all providers should care for Medicaid/HMP patients.
- 52% reported an increase in new patients to a great or to some extent.
- 57% reported an increase in new patients who had not seen a PCP in many years.
- 51% reported established patients who had been uninsured gained insurance.
- Most practices hired new clinicians (53%) and/or staff (58%) in the past year.
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Most providers reported completing Health Risk Assessments.

- 79% completed at least one HRA with a patient; most of those completed >10.
- 65% did not know if they or their practice has received a bonus for completing HRAs.
- 58% reported that financial incentives for patients and 55% reported financial incentives for practices had at least a little influence on completing HRAs.
- Most PCPs found HRAs useful for identifying and discussing health risks, persuading patients to address important health risks, and documenting behavior change goals.

Providers felt responsibility to decrease non-urgent ER use and identified facilitators and barriers to doing so.

- 30% felt that they could influence non-urgent emergency room (ER) use by their patients a great deal.
- 88% accepted major or some responsibility as a PCP to decrease non-urgent ER use.
- Many reported offering services to avoid non-urgent ER use, such as walk-in appointments, 24-hour telephone triage, weekend and evening appointments, and care coordinators or social work assistance for patients with complex issues.

Providers described positive benefits in terms of access though access challenges remain.

- PCPs with previously uninsured HMP patients reported some or great impact on health, health behavior, health care and function for those patients, particularly for control of chronic conditions, early detection of illness, and improved medication adherence.

- PCPs reported that HMP enrollees, compared to those with private insurance, more often had difficulty accessing specialists, medications, mental health care, dental care, and treatment for substance use and counseling for behavior change.

Providers expressed the many ways HMP had an impact on their patients.

- PCPs noted HMP has allowed patients to get much needed care, improved financial stability, provided a sense of dignity, improved mental health, increased accessibility to care and compliance (especially medications), and helped people engage in healthy behaviors such as quitting smoking.

Limitations

Survey responses were self-reported and may be prone to social desirability bias. The sample included only PCPs who cared for at least 12 HMP enrollees. Decision making regarding acceptance of new patients, practice changes, and experiences of the impact of HMP may differ for PCPs with fewer or no Medicaid patients or for specialists. IHPI developed a new set of survey items not used in previous studies to assess PCP attitudes toward various factors related to their Medicaid acceptance decision. These items were developed based on prior literature and the evaluation team's qualitative interviews with PCPs caring for HMP patients, and were cognitively tested with physician and non-physician PCPs serving HMP patients to ensure understanding and accuracy of responses. Performance of these items (e.g. whether they predict actual acceptance of HMP/Medicaid patients) should be validated in future studies. Finally, the qualitative interviews were limited to 19 PCPs in select regions of the state.

Conclusions

PCPs shared experiences from within the health system and thus provided valuable information about how Medicaid expansion is playing out for patients and providers. PCPs reported improved detection and management of chronic conditions such as diabetes and hypertension in patients who gained coverage due to Medicaid expansion, and better adherence to medical and medication regimens as well as improvements in health behaviors, better ability to work or attend school, and improved emotional well-being.

PCPs reported an increase in new patients, including some who had not sought primary care in many years. They reported hiring clinicians and staff; changing workflow for new patients; co-locating mental health services in primary care; and consulting with care coordinators, case managers, and community health workers.

Coverage for dental services, prescription drugs, and mental health services were specifically noted as previously unmet needs being addressed by HMP. Access to these services were described as "a lifesaver." Yet access to some services remains challenging for enrollees and lags behind access for those with private insurance.

PCPs varied substantially in their understanding of HMP features and, therefore, their ability to navigate or help patients obtain services. PCPs reported general familiarity with HRAs, but less familiarity with enrollee cost-sharing and rewards. Most surveyed PCPs felt they could, and should, influence ER utilization trends for their Medicaid patients.

IHPI survey results and interviews indicate that PCPs believe HMP has improved access to care; detection of serious health conditions; medication adherence; and management of chronic conditions and healthy behaviors – especially for previously uninsured patients.

D. 2016 Healthy Michigan Voices Enrollee Survey

Methods

Sampling for the Healthy Michigan Voices (HMV) enrollee survey was conducted 2016. At the time of sample selection, inclusion criteria for enrollees included: at least 12 months total HMP enrollment in fee-for-service or managed care including enrollment in 10 of past 12 months and managed care enrollment in 9 of the past 12 months, age 19-64, complete Michigan contact information and income level in the MDHHS Data Warehouse, and preferred language of English, Arabic, or Spanish. The sampling plan was based on four state regions (Upper Peninsula/North West/North East; West/East Central/East; South Central/South West/South East; Detroit) and three income categories (0-35%, 36-99%, ≥100% of the Federal Poverty Level). In total, 4,099 HMP enrollees participated in the 2016 HMV survey, and the weighted response rate was 53.7%.

Many survey items were drawn from large national surveys. Items specific to HMP (e.g. about HRAs, understanding of HMP) were developed by the evaluation team based on 67 semi-structured interviews with HMP enrollees. New items underwent cognitive testing and pre-testing before being included in the survey instrument. Responses were recorded in a computer-assisted telephone interviewing (CATI) system. Descriptive statistics with weights were calculated to adjust for selection and nonresponse bias. Bivariate and multivariate analyses were performed.

Key Findings

Key findings from the Interim Report of the 2016 Healthy Michigan Voices Enrollee Survey (Attachment C.2) are highlighted below.

Many enrollees did not have insurance prior to HMP.

- 57.9% did not have insurance at any time in the year before enrolling in HMP. About half of those who did have health insurance reported having Medicaid or other state insurance.

Enrollees reported improvements in their health status with HMP.

- 47.8% said their physical health had improved, 38.2% said their mental health had improved, and 39.5% said their dental health had improved since enrolling in HMP.

Many enrollees have chronic health conditions.

- 69.2% reported they had a chronic health condition, with 60.8% reporting at least one physical health condition and 32.1% reporting at least one mental health condition.
- 30.6% reported they had a chronic health condition that was newly diagnosed since enrolling in HMP.

Enrollees expressed their perspectives on HRAs.

- 45.9% of those who said they completed an HRA did so because a PCP suggested it; 33% did so because they received a mailed form; 12.6% completed it by phone at enrollment.
- Most of those who reported completing the HRA felt it was valuable for improving their health (83.7%) and was helpful for their PCP to understand their health needs (89.7%). 80.7% of those who said they completed an HRA chose to work on a health behavior.

Some enrollees reported working on cutting back or quitting tobacco use after HMP.

- 37.7% reported smoking or using tobacco in the last 30 days, and 75.2% of them said they wanted to quit. Of these, 90.7% were working on cutting back or quitting now.

Enrollees were more likely to report a regular source of care after HMP, and less likely to report the ER as their regular source of care.

- 20.6% had not had a primary care visit in five or more years before enrolling in HMP.
- 73.8% said that in the year before enrolling in HMP they had a place they usually went for health care. Of those, 16.8% used an urgent care center, 16.2% used an ER, and 65.1% used a doctor's office or clinic.
- 92.2% reported that in the year since enrolling in HMP they had a place they usually went for health care. Of those, 5.8% said that place was an urgent care center and 1.7% reported the emergency room, while 75.2% reported a doctor's office or clinic.
- 85.2% of those who reported having a PCP had a visit with their PCP in the last year.
- Those who reported seeing a PCP were more likely to note improved access to preventive care, completing an HRA, health behavior counseling and new diagnoses of a chronic condition since enrollment.

Enrollees reported a reduction in foregone care.

- 33% of enrollees reported not getting care they needed in the year before enrollment in HMP; 77.5% attributed this to cost concerns. Since enrolling in HMP, 5.6% reported foregone care; 25.4% attributed this to cost concerns.
- 83.3% strongly agreed/agreed that without HMP they would not be able to go to a doctor.

Enrollees reported on their experiences using the ER for care.

- 28.0% of those who visited the ER in the past year said they called their usual provider's office first. 64% said they were more likely to contact their usual doctor's office before going to the ER than before they had HMP.
- Respondents who used the ER were more likely than those who did not use the ER to report their health as fair/poor (40.1% vs. 23.2%) and to report chronic physical or mental health conditions (79.4% vs. 62.8%).

Enrollees reported on the impact of HMP on employment, education and ability to work.

- 48.9% reported they were employed/self-employed, 27.6% were out of work, 11.3% were unable to work, and 2.5% were retired.
- HMP enrollees were more likely to be employed if their health status was excellent, very good, or good vs. fair or poor (56.1% vs. 32.3%) or if they had no chronic conditions (59.8% vs. 44.1%).
- Among employed respondents, over two-thirds (69.4%) reported that HMP insurance helped them to do a better job at work.
- For the 27.6% of respondents who were out of work, 54.5% strongly agreed or agreed that HMP made them better able to look for a job.
- For the 12.8% of respondents who had changed jobs in the past 12 months, 36.9% strongly agreed or agreed that having HMP insurance helped them get a better job.

Some enrollees were knowledgeable about HMP program features but gaps in knowledge exist.

- The majority of respondents knew that HMP covers routine dental visits (77.2%), eyeglasses (60.4%), and counseling for mental or emotional problems (56%). Only one-fifth (21.2%) knew that HMP covers brand-name as well as generic medications.

Few enrollees reported challenges using their HMP coverage.

- Few (15.5%) survey respondents reported that they had questions or problems using their HMP coverage. Among those who did, about half (47.7%) reported getting help or advice, and most (74.2%) of those said that they got an answer or solution.

Many enrollees reported that problems paying medical bills improved with HMP.

- 44.7% said they had problems paying medical bills in the year before HMP.
- 85.9% said that since enrolling in HMP their problems paying medical bills got better.

Enrollees shared their perspectives on and knowledge about HMP cost-sharing requirements and the MIHA statement.

- 87.6% strongly agreed or agreed that the amount they pay overall for HMP seems fair.
- 88.8% strongly agreed or agreed that the amount they pay for HMP is affordable.
- 68.2% said they received a MIHA statement. 88.3% strongly agreed or agreed they carefully review each statement to see how much they owe. 88.4% strongly agreed or agreed the statements help them be more aware of the cost of health care.
- 75.6% of respondents knew some visits, tests, and medicines have no copays. Only14.4% were aware they could not be disenrolled from HMP for not paying their bill. Only 28.1% were aware they could reduce the amount they owed by completing an HRA.

Limitations

HMV survey responses may be prone to social desirability bias. While the survey was available in three languages, it was not available in all languages spoken by enrollees. While many measures were based on those used in large national surveys, some questions were developed specifically to assess enrollee perspectives on key features of the HMP program.

Conclusions

Three-fifths of respondents did not have insurance at any time in the year before enrolling in HMP and half of those who did were covered by Medicaid or another state program. HMP does not appear to have substantially replaced employer-sponsored insurance.

Most respondents said that without HMP they would not be able to see a doctor. Foregone care, usually due to cost, lessened considerably after enrollment. The percentage of enrollees who had a place they usually went for health care increased significantly with HMP whereas the percentage naming the ER as a regular source of care declined after enrolling in HMP (from 16.2% to 1.7%). There were some areas in which enrollee understanding of coverage (e.g., dental, vision and family planning) and cost-sharing requirements could be improved.

Many HMP enrollees reported improved functioning, ability to work, and job seeking after enrolling in HMP. Chronic health conditions were common among enrollees even though most enrollees were under 50 years old. Almost half of these conditions were newly diagnosed after enrolling in HMP. Overall, HMP enrollees expressed improved access to care, improved health behaviors, better management of chronic conditions, fewer financial barriers to care, and a sense that the amount they pay for HMP seems fair and affordable.

E. Public Act 107 of 2013 §105d(8) 2015 Report on Uncompensated Care

Methods

Each year, Michigan hospitals submit cost reports to the State Medicaid program. Based on data elements contained in these reports, the cost of uncompensated care provided by each hospital can be assessed. The cost reports for state FY 2015 include data on 142 hospitals.

Key Findings

The amount of uncompensated care provided by Michigan hospitals fell substantially after the implementation of HMP. Comparing 2013 and 2015 for a consistent set of hospitals, uncompensated care costs decreased by almost 50%. For the average hospital, annual uncompensated care expenses fell from $7.21 million to $3.77 million. As a percentage of total hospital expenses, uncompensated care decreased from 5.2% to 2.9%. Over 90% of hospitals saw a decline in uncompensated care between FY 2013 and FY 2015 (Attachment C.3).

Limitations

FY 2015 is the first fiscal year that began after the HMP was in place. Thus, the impact of the HMP is more readily seen by focusing on the 88 hospitals that reported data for 2013 and 2015. In future years, changes in uncompensated care will be examined for all Michigan hospitals.

The full evaluation reports are available at www.michigan.gov/healthymichiganplan.

F. Lessons Learned from IHPI's Evaluation of HMP to Date

Lessons from conducting outreach to HMP enrollees through recruitment for the Healthy Michigan Voices survey:

- To meet the needs of enrollees who are more comfortable speaking Spanish or Arabic, sampling lists were reviewed for names that suggest Hispanic or Arabic ethnicity so that bilingual interviewers could place those calls. This helped put enrollees at ease about the project (e.g. "I only did the survey because you speak Arabic.")
- In the initial HMV survey, many enrollees offered descriptions and anecdotes not captured by fixed-choice or brief response items used with the computer-assisted telephone interview system. For subsequent waves, the evaluation team has asked enrollees if their interview could be recorded and nearly all have agreed, provided additional details about the enrollee experience.

G. Future Evaluation Reports

Domain I: Uncompensated Care
This report will be available in the fall of 2018.

Domain II: Insurance Coverage
Preliminary results from analyses completed thus far:

- The number of uninsured Michigan residents dropped sharply between 2013 and 2015.
- According to data from the U.S. Census Bureau's American Community Survey, the fraction of Michigan's total population that was uninsured was 11.3% in 2013 and 6.7% in 2015. The fraction with Medicaid increased from 19.9% to 23.1% over this period.
- Among non-elderly adults in Michigan (ages 19 through 64), the fraction uninsured dropped from 16.6% in 2013 to 9.0% in 2015, while the fraction with Medicaid increased from 13.9% to 19.2%.

The full report from this domain will be available in the fall of 2018.

Domain III: Utilization
Interim results will be available in the fall of 2017.

Domain IV: Provider and Enrollee Perspectives
Final interim reports for the 2016 Healthy Michigan Voices survey and Primary Care Provider survey will be available by the end of 2017. Reports based on subsequent annual Healthy Michigan Voices surveys will be available in 2018, 2019, and 2020. The report based on interviews with those who are eligible but unenrolled for HMP will be available at the end of 2017 and a second report will be completed at the end of 2018.

Domain V/VI: Consumer Behavior
This report will be available in the spring of 2018.

Domain VII: Marketplace Option
This report will be available in the spring of 2020.

Evaluation Plan for Extension Period

During the extension period, IHPI will continue to field and analyze the data from the Annual HMV Survey. Further, IHPI will conduct the Domain VII – Cost-Effectiveness Analysis of the Marketplace Option. For Domain III, IHPI will continue to examine the impact the Healthy Behavior Program's expansion on utilization. Finally, should IHPI continue to provide the Uncompensated Care Analysis as required in PA 107 of 2013, it will contribute to the future assessment of Domain I analysis.

Section VII - Public Notice Process

A. Public Notice, Comment and Hearings Process

MDHHS has been engaged in ongoing discussions with various stakeholders regarding HMP. MDHHS has provided regular updates on the progress of HMP to the Medical Care Advisory Council (MCAC) since the inception of the program. MDHHS began its discussions on the proposed demonstration waiver extension at the MCAC meetings which took place on June 26, 2017 and August 30, 2017. MDHHS extended its public engagement on September 26, 2017 by posting the proposed demonstration waiver extension request on the MDHHS dedicated HMP webpage available at www.michigan.gov/healthymichiganplan. On this webpage, the public was informed about the demonstration waiver renewal process, which included public notice and hearing information and provided opportunities for and instructions on how to submit comments. This is in addition to publishing a public notice in selected newspapers throughout the state on September 29, 2017, which included, among other information, details regarding the proposed demonstration waiver extension, as well as the website, hearing and public comment information. A copy of the notice is included as Attachment D.

A public hearing regarding the proposed demonstration waiver extension will be held on October 19, 2017, from 2:00 p.m. – 3:00 p.m. at the Michigan Public Health Institute located at 2436 Woodlake Circle, Suite 380, Okemos, MI 48864. In addition to the notice procedures described above, MDHHS sent email notifications of this event to providers, stakeholders and the media. This public hearing had telephone, webinar and in-person capability (with sign interpretation available for those present). Comments were accepted until October 30, 2017. As required by the existing Special Terms and Conditions, the MDHHS is including a summary of the comments received, with notes of any changes to the proposal, as a result, as Attachment E.

B. Tribal Consultation

Consistent with the State Plan, MDHHS issued a letter on August 16, 2017 notifying the Tribal Chairs and Health Directors of the plan to submit the proposed Demonstration Waiver extension. A copy of the notice is included as Attachment F.

Additional Tribal Consultation has occurred on the following dates.

- *July 12, 2017 - In person meeting -MI Tribal Health Director's Association Meeting*
- *August 28, 2017 - Quarterly Tribal Health Directors conference call*
- *September 15, 2017 – Pokagon Band of Potawatomi Director of Health Services*
- *October 11, 2017 – Tribal Health Directors Meeting*
- *October 18, 2017 – Tribal Health Directors Conference Call*

C. Post-Award Forums

In accordance with the HMP Waiver Special Terms & Conditions, MDHHS provides continuous updates to the program's MCAC at regularly scheduled meetings. These meetings provide an opportunity for attendees to provide program comments or suggestions. A copy of the meeting minutes for the 2016 and 2017 meetings are included as Attachment G.

D. Additional Stakeholder Engagement

MDHHS has also discussed the proposed demonstration waiver extension in additional venues as part of its ongoing outreach and engagement with its stakeholders. The following is a listing of locations and events at which MDHHS addressed the proposed demonstration waiver extension:

- Michigan Association of Local Public Health Administrative Forum, on June 10, 2017, in Lansing, MI
- MDHHS/MHPs Operations Annual Conference, on July 19, 2017, in Acme, MI
- 2017 Michigan Primary Care Association Annual Conference, on July 24, 2017, in Acme, MI
- Michigan Association of Health Plans Meetings, on June 23, 2017 and August 4, 2017, in Lansing, MI
- Durable Medical Equipment Liaison Meeting, on September 11, 2017, in Lansing, MI
- Michigan State Medical Society/Medicaid Quarterly Meeting, September 12, 2017, in Lansing, MI
- Pharmacy Liaison Meeting on September 21, 2017 in Lansing, MI
- Michigan Association of Health Plans on September 29, 2017 in Lansing, MI
- Orthotics and Prosthetics Medicaid Provider Liaison Meeting on October 25, 2017 in Lansing, MI
- MI Marketplace Option Provider Training Webinar on November 7, 2017.

Attachments:

Attachment A: Monitoring Reports

Attachment B: Healthy Michigan Plan Evaluation Plan

Attachment C: Healthy Michigan Plan Evaluation Reports

1. Primary Care Practitioners' Views of the Impact of the Healthy Michigan Plan
2. 2016 Healthy Michigan Voices Enrollee Survey
3. Public Act 107 of 2013 §105d(8) 2015 Report on Uncompensated Care

Attachment D: Public Notice

Attachment E: Public Comment Summary

Attachment F: Tribal Notice

Attachment G: Medical Care Advisory Council Meeting Minutes

Medical Services Administration
Bureau of Medicaid Care Management and Quality Assurance

PERFORMANCE MONITORING REPORT

ANNUAL HEDIS MEASURES

Composite – All Plans

January 2017

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

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HEDIS

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Executive Summary

This Performance Monitoring Report is produced by the Quality Improvement and Program Development (QIPD) Section of the Managed Care Plan Division (MCPD) to track quality, access, and utilization in the Michigan Medicaid program to better support high quality care for beneficiaries.

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

HEDIS				
Timeliness of Prenatal Care	*Postpartum Care*	*Childhood Immunizations*	*Well-Child Visits 0-15 Months*	*Well-Child Visits 3 to 6 Years*
Adolescent Well Care Visits	*Appropriate Testing for Children with Pharyngitis*	*Child Access to Care 12 to 24 Months*	*Child Access to Care 7 to 11 Years*	*Comprehensive Diabetes Care: Hemoglobin A1c Testing*
Comprehensive Diabetes Care: Eye Exam	*Breast Cancer Screening*	*Chlamydia Screening in Women (Total)*		

Data for these 13 HEDIS measures are represented on an annual basis. The body of the report contains a cross-plan analysis of the most current data available for each of these measures. A composite summary of plan performance for all standards is displayed in Appendix A. Appendix B contains specific three letter codes identifying each of the MHPs. Appendix C contains the one-year plan specific analysis for each measure.

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 fiscal year 2017 unless otherwise noted.

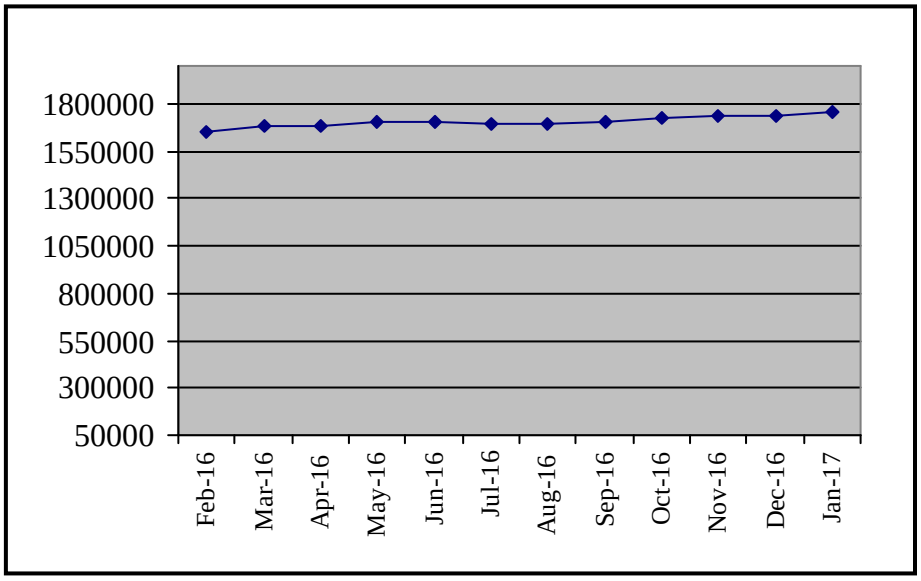
Table 1: Fiscal Year 2017[1]

Annually Reported Measures	Results
Timeliness of Prenatal Care	2/11
Postpartum Care	0/11
Childhood Immunizations	1/11
Well-Child Visits 0 – 15 Months	2/10
Well-Child Visits 3 to 6 Years	2/11
Adolescent Well Care Visits	1/11
Appropriate Testing for Children with Pharyngitis	Informational Only
Child Access to Care 12 to 24 Months	3/11
Child Access to Care 7 to 11 Years	2/11
Comprehensive Diabetes Care: HbA1c Testing	3/11
Comprehensive Diabetes Care: Eye Exam	Informational Only
Breast Cancer Screening	9/11
Chlamydia Screening in Women (Total)	8/11

Managed Care Enrollment

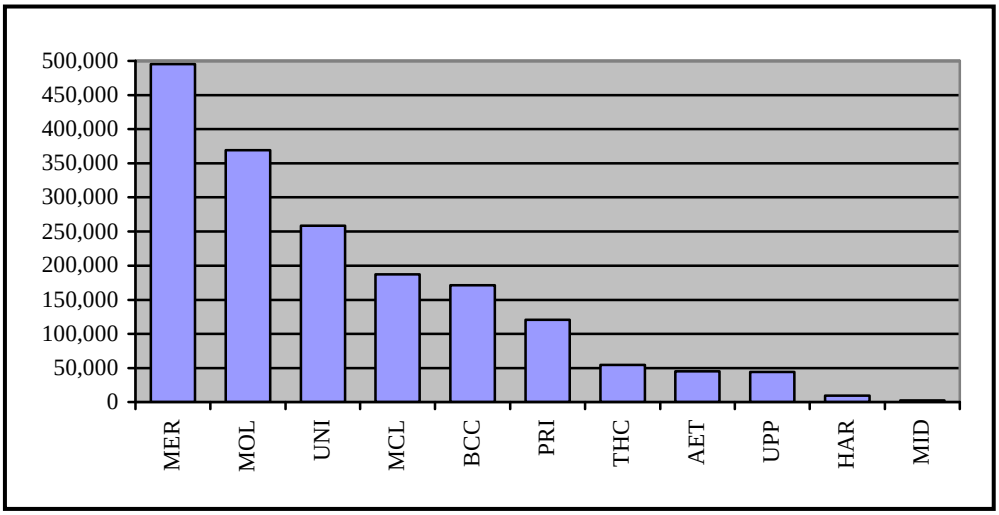
Michigan Medicaid Managed Care (MA-MC) enrollment has remained steady over the past year. In January 2017, enrollment was 1,757,652, up 103,154 enrollees (6.2%) from February 2016. An increase of 16,775 enrollees (1.0%) was realized between December 2016 and January 2017.

Figure 1: Medicaid Managed Care Enrollment, February 2016 – January 2017



[1] Plans with a numerator under 5 or a denominator under 30 are not included in denominators less than 11 in this table.

Figure 2: Medicaid Managed Care Enrollment by Health Plan, January 2017



Medicaid Health Plan News

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

Cross-Plan Performance Monitoring Analyses

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

Timeliness of Prenatal Care

Measure
Percentage of pregnant women who delivered a live birth and received an initial prenatal care visit in the first trimester or within 42 days of enrollment into the health plan, according to HEDIS prenatal care specifications.

Minimum Standard
At or above 86%

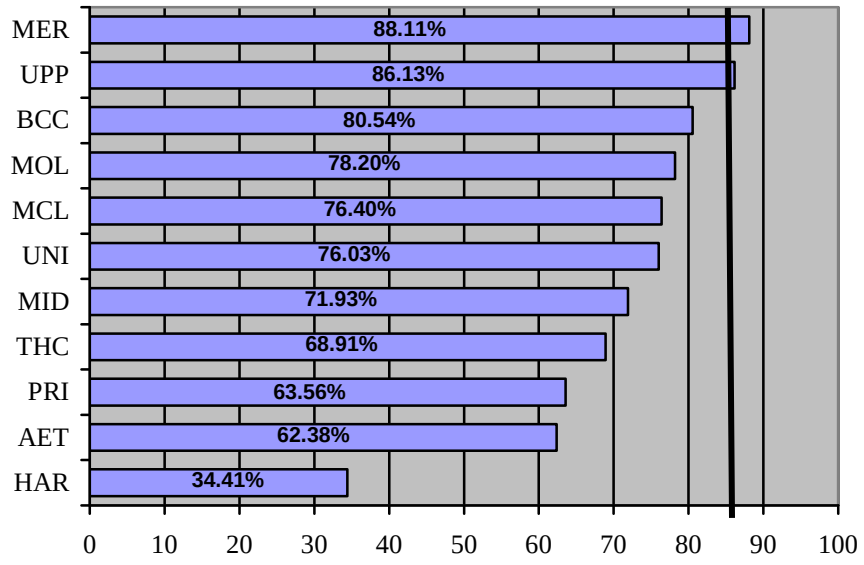
Measurement Period
Calendar Year 2015

Data Source
HEDIS 2016

Measurement Frequency
Annually

Summary: Two plans met or exceeded the standard, while nine plans (AET, BCC, HAR, MCL, MID, MOL, PRI, THC, and UNI) did not. Results ranged from 34.41% to 88.11%

Figure 3: Timeliness of Prenatal Care



Postpartum Care

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

Minimum Standard
At or above 72%

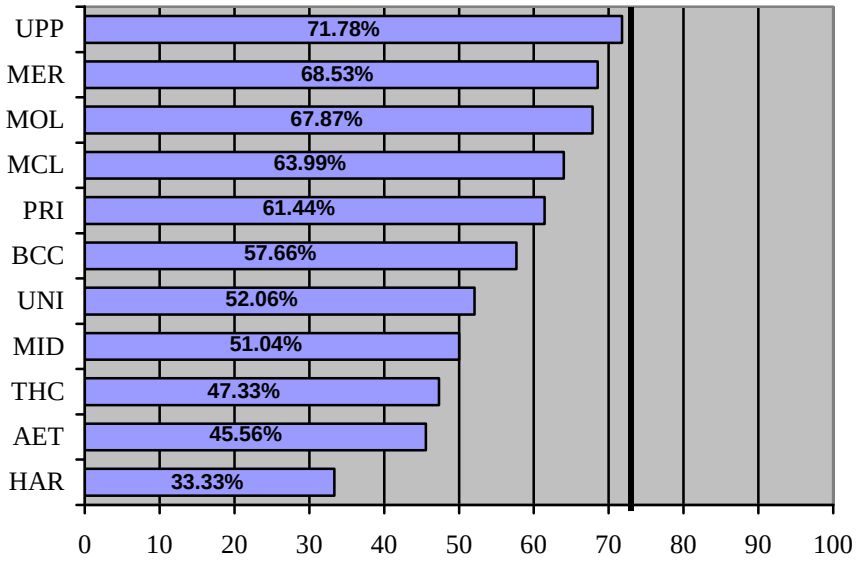
Measurement Period
Calendar Year 2015

Data Source
HEDIS 2016

Measurement Frequency
Annually

Summary: Summary: None of the plans met or exceeded the performance standard. Results ranged from 33.33% to 71.78%.

Figure 4: Postpartum Care



Postpartum Care Percentages

Childhood Immunizations

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

Minimum Standard
At or above 75%

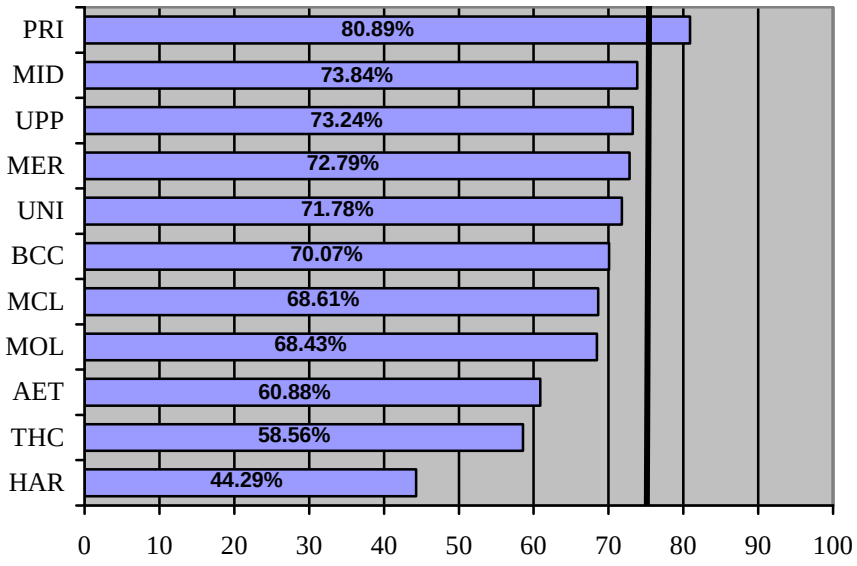
Measurement Period
Calendar Year 2015

Data Source
HEDIS 2016

Measurement Frequency
Annually

Summary: One plan met or exceeded the standard, while ten plans (AET, BCC, HAR, MCL, MER, MID, MOL, THC, UNI, and UPP) did not. Results ranged from 44.29% to 80.89%

Figure 5: Childhood Immunizations



Well-Child Visits First 15 Months

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

Minimum Standard
At or above 71%

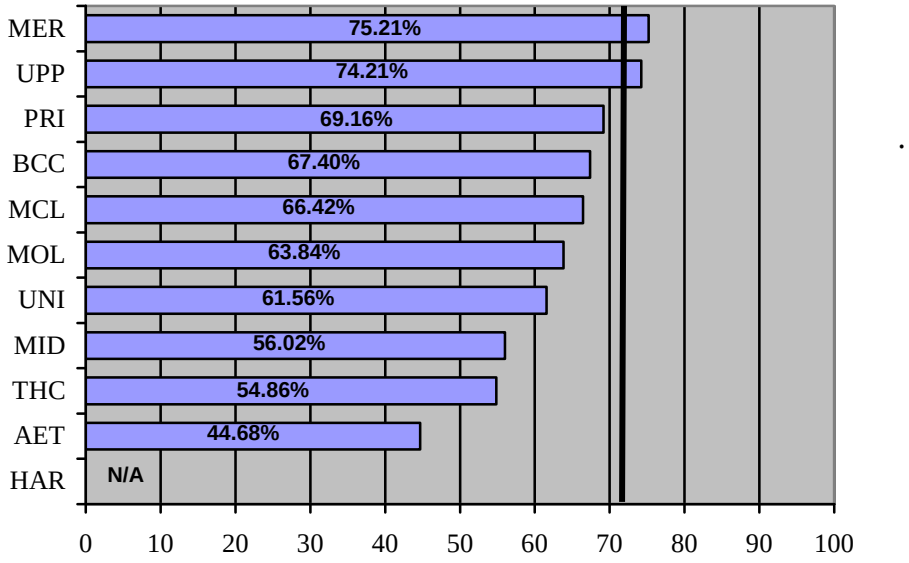
Measurement Period
Calendar Year 2015

Data Source
HEDIS 2016

Measurement Frequency
Annually

Summary: Two plans met or exceeded the standard, while eight plans (AET, BCC, MCL, MID, MOL, PRI, THC, and UNI) did not. Results ranged from 44.68% to 75.21%

Figure 6: Well-Child Visits 0-15 Months[2]



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

Well-Child Visits 3-6 Years Old

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

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

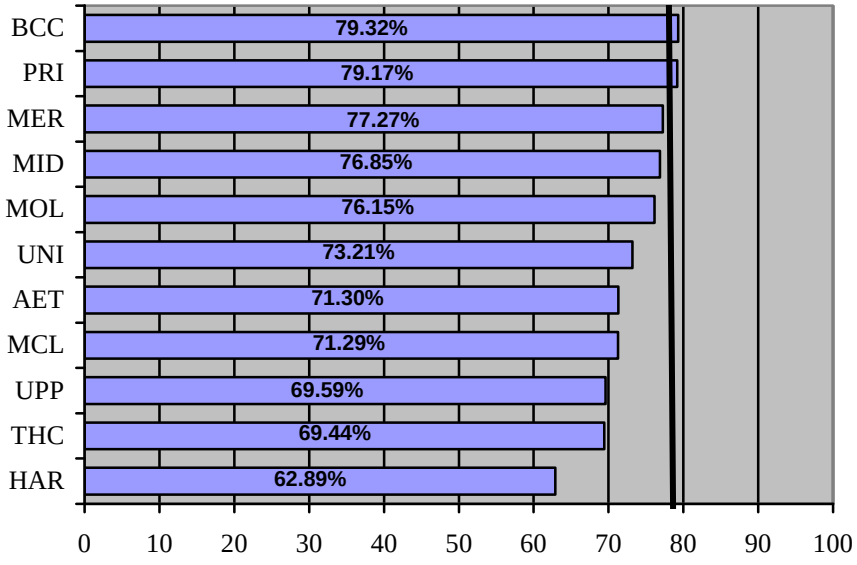
Measurement Period
Calendar Year 2015

Data Source
HEDIS 2016

Measurement Frequency
Annually

Summary: Two plans met or exceeded the standard, while nine plans (AET, HAR, MCL, MER, MID, MOL, THC, UNI, and UPP) did not. Results ranged from 62.89% to 79.32%

Figure 7: Well-Child Visits 3-6 Years



Adolescent Well Care Visits

Measure
Percentage of members ages 12 to 21, who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year.

Minimum Standard
At or above 60% (as shown on bar graph below)

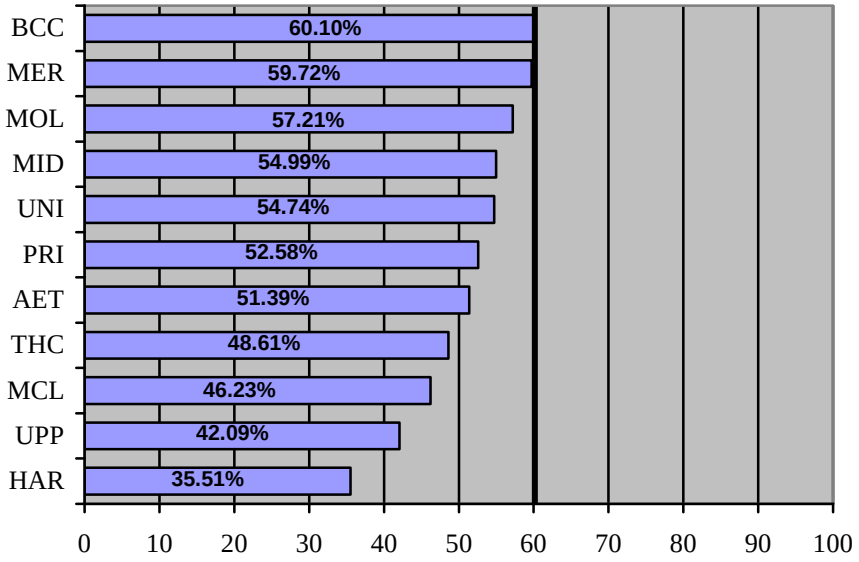
Measurement Period
Calendar Year 2015

Data Source
HEDIS 2016

Measurement Frequency
Annually

Summary: One plan met or exceeded the standard, while ten plans (AET, HAR, MCL, MER, MID, MOL, PRI, THC, UNI, and UPP) did not. Results ranged from 35.51% to 60.10%.

Figure 8: Adolescent Well Care Visits



Adolescent Well Care Visits Years Percentage

Appropriate Testing for Children with Pharyngitis

Measure
Percentage of children ages two (2) to 18 years of age, who were diagnosed with pharyngitis, dispensed an antibiotic, and received a group A streptococcus (strep) test for the episode.

Minimum Standard
N/A –Informational Only
.

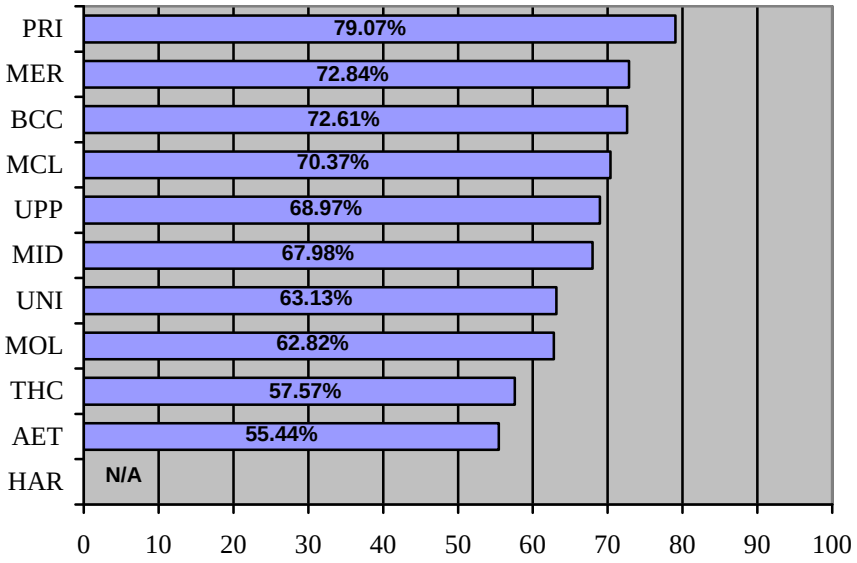
Measurement Period
Calendar Year 2015

Data Source
HEDIS 2016

Measurement Frequency
Annually

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

Figure 9: Appropriate Testing for Children with Pharyngitis[3]



Appropriate Testing for Children with Pharyngitis Percentage

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

Child Access to Care 12 to 24 Months

Measure
Percentage of children ages 12 to 24 months, who had a visit with a PCP during the measurement year.

Minimum Standard
At or above 97% (as shown on bar graph below)

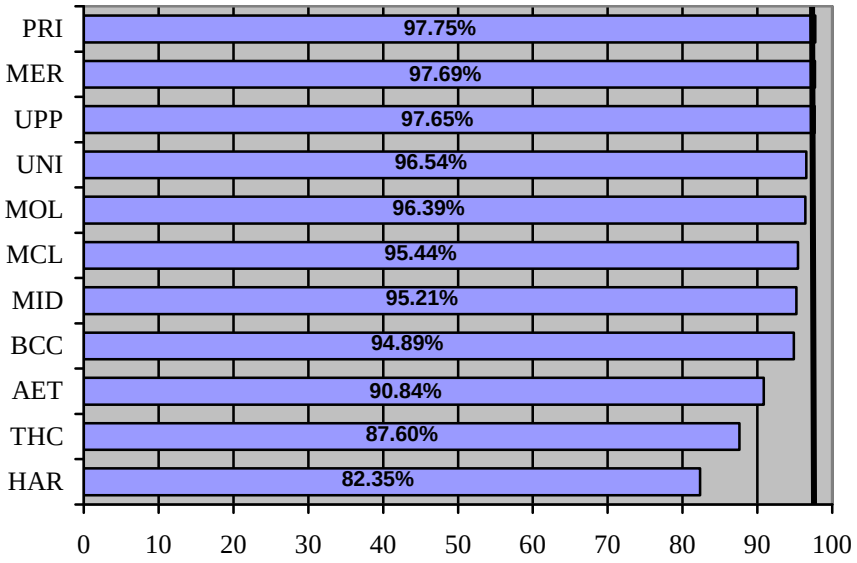
Measurement Period
Calendar Year 2015

Data Source
HEDIS 2016

Measurement Frequency
Annually

Summary: Three plans met or exceeded the standard, while eight plans (AET, BCC, HAR, MCL, MID, MOL, THC, and UNI) did not. Results ranged from 82.35 to 97.75%.

Figure 10: Child Access to Care 12 to 24 Months



Child Access to Care 12 to 24 Months Percentage

Child Access to Care 7 to 11 Years

Measure
Percentage of children ages seven (7) to 11 years, who had a visit with a PCP during the measurement year.

Minimum Standard
At or above 92% (as shown on bar graph below)

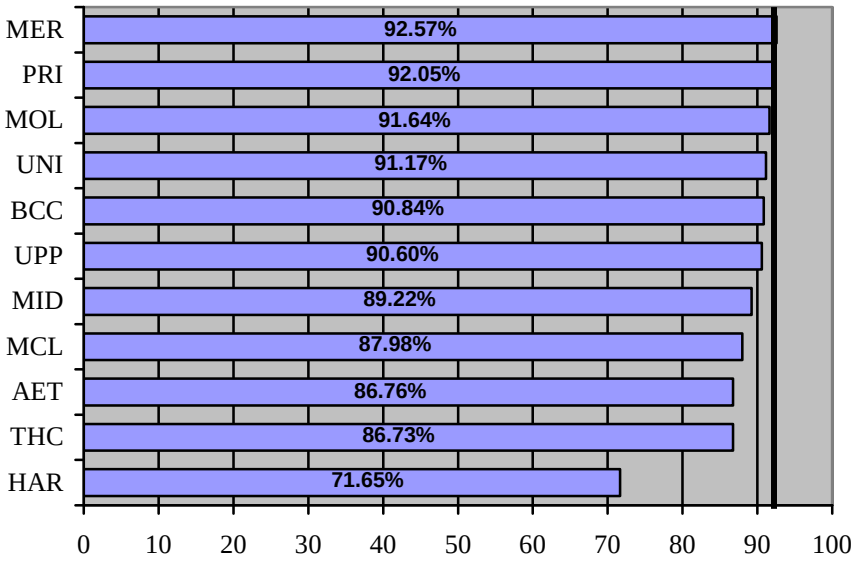
Measurement Period
Calendar Year 2015

Data Source
HEDIS 2016

Measurement Frequency
Annually

Summary: Two plans met or exceeded the standard, while nine plans (AET, BCC, HAR, MCL, MID, MOL, THC, UNI, and UPP) did not. Results ranged from 71.65% to 92.57%.

Figure 11: Child Access to Care 7 to 11 Years



Child Access to Care 7 to 11 Years Percentage

Comprehensive Diabetes Care: Hemoglobin A1c Testing

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

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

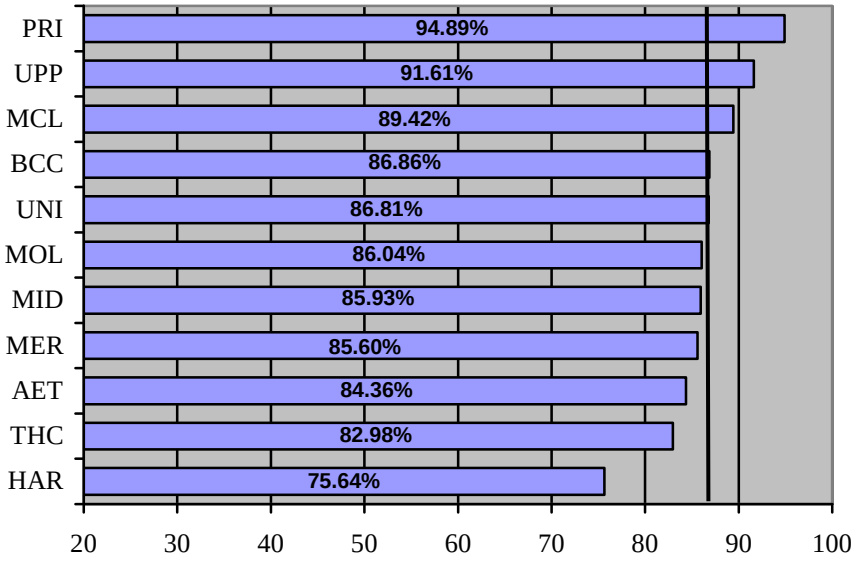
Measurement Period
Calendar Year 2015

Data Source
HEDIS 2016

Measurement Frequency
Annually

Summary: Three plans met or exceeded the standard, while eight plans (AET, BCC, HAR, MID, MER, MOL, THC, and UNI) did not. Results ranged from 75.64% to 94.89%.

Figure 12: Comprehensive Diabetes Care: Hemoglobin A1c Testing



Comprehensive Diabetes Care: Hemoglobin A1c Testing Percentages

Comprehensive Diabetes Care: Eye Exam

Measure
Percentage of adults enrolled in a health plan between the ages of 18 and 75 with type 1 or type 2 diabetes who had a retinal eye exam performed during the measurement year.

Standard
N/A – Informational Only

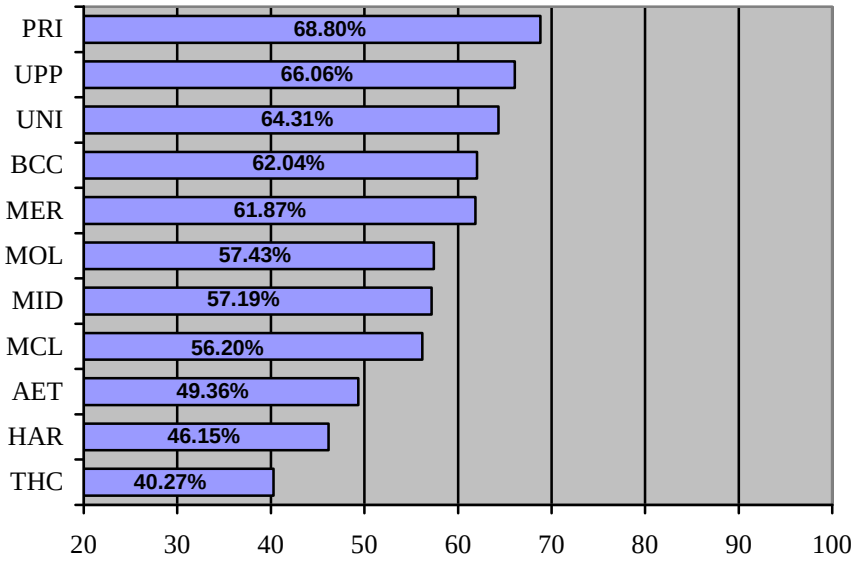
Measurement Period
Calendar Year 2015

Data Source
HEDIS 2016

Measurement Frequency
Annually

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

Figure 13: Comprehensive Diabetes Care: Eye Exam



Comprehensive Diabetes Care: Eye Exam Percentages

Breast Cancer Screening

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

Standard
At or above 58% (as shown on bar graph below)

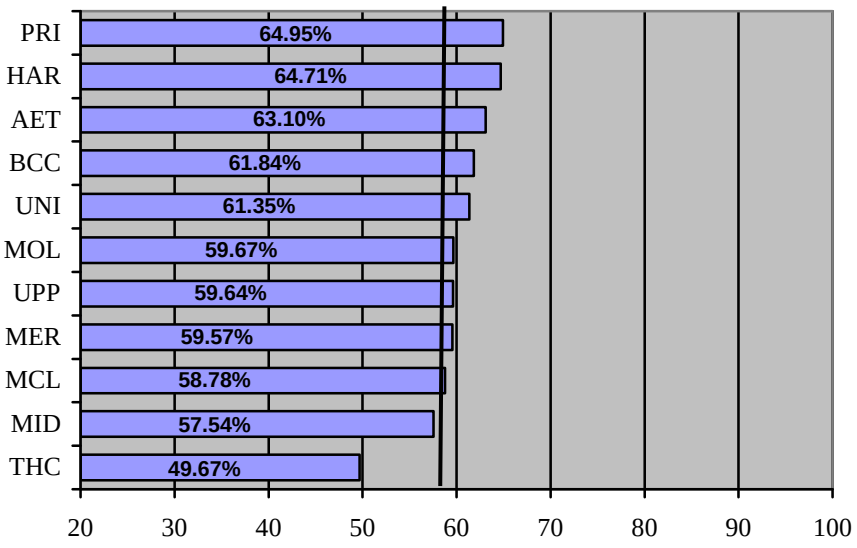
Measurement Period
Calendar Year 2015

Data Source
HEDIS 2016

Measurement Frequency
Annually

Summary: Nine plans met or exceeded the standard, while two plans (MID and THC) did not. Results ranged from 49.67% to 64.95%.

Figure 14: Breast Cancer Screening



Breast Cancer Screening Percentages

Chlamydia Screening in Woman - Total

Measure
The percentage of women enrolled in a health plan between the ages of 16 and 24 who were identified as sexually active and who had at least one (1) test for chlamydia during the measurement period.

Standard
At or above 62% (as shown on bar graph below)

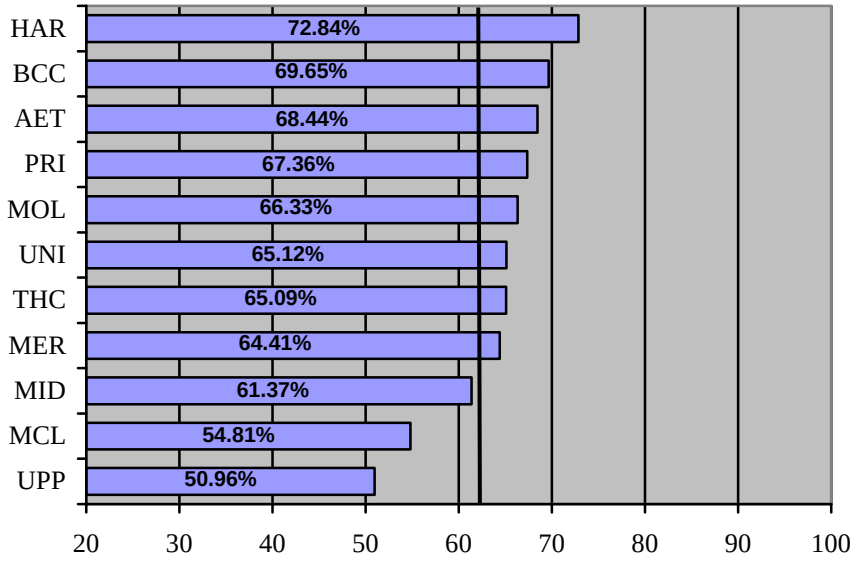
Measurement Period
Calendar Year 2015

Data Source
HEDIS 2016

Measurement Frequency
Annually

Summary: Eight plans met or exceeded the standard, while three plans (MCL, MID, and UPP) did not. Results ranged from 50.96% to 72.84%

Figure 15: Chlamydia Screening in Women - Total



Chlamydia Screening in Women-Total Percentages

Appendix A: Composite Performance Monitoring Summary[4]

January 2017

	AET	BCC	HAR	MCL	MER	MID	MOL	PRI	THC	UNI	UPP	Total
Timeliness Prenatal Care	**N**	**N**	**N**	**N**	Y	**N**	**N**	**N**	**N**	**N**	Y	**2 / 11**
Postpartum Care	**N**	**N**	**N**	**N**	**N**	**N**	**N**	**N**	**N**	**N**	**N**	**0 / 11**
Childhood Immunizations	**N**	**N**	**N**	**N**	**N**	**N**	**N**	Y	**N**	**N**	**N**	**1 / 11**
Well-Child 0 to 15 months	**N**	**N**	N/A	**N**	Y	**N**	**N**	**N**	**N**	**N**	Y	**2 / 10**
Well-Child 3 to 6 years	**N**	Y	**N**	**N**	**N**	**N**	**N**	Y	**N**	**N**	**N**	**2 / 11**
Adolescent Well-Care	**N**	Y	**N**	**N**	**N**	**N**	**N**	**N**	**N**	**N**	**N**	**1 / 11**
Pharyngitis Testing	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Child-Access 12 to 24 months	**N**	**N**	**N**	**N**	Y	**N**	**N**	Y	**N**	**N**	Y	**3 / 11**
Child-Access 7 to11years	**N**	**N**	**N**	**N**	Y	**N**	**N**	Y	**N**	**N**	**N**	**2 / 11**
Comp. Diabetes Care: HbA1c	**N**	**N**	**N**	Y	**N**	**N**	**N**	Y	**N**	**N**	Y	**3 / 11**
Comp. Diabetes Care: Eye Exam	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Breast Cancer Screening	Y	Y	Y	Y	Y	**N**	Y	Y	**N**	Y	Y	**9 / 11**
Chlamydia Screening	Y	Y	Y	**N**	Y	**N**	Y	Y	Y	Y	**N**	**8 / 11**
Total Standards Achieved	**2**	**4**	**2**	**2**	**6**	**0**	**2**	**7**	**1**	**2**	**5**	

[4] "N/A" in the Well-Child Visits 0 to 15 months row represents plans who had a denominator under 5 or a numerator under 30. "N/A" for Pharyngitis Testing and Comprehensive Diabetes Care: Eye Exam

Appendix B: Three Letter MHP Codes

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

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

Appendix C: One Year Plan-Specific Analysis

Aetna Better Health of Michigan – AET

HEDIS:

Performance Measure	Measurement Period	Standard	Plan Result	Standard Achieved
Timeliness of Prenatal Care	Calendar Year 2015	86%	62.38%	No
Postpartum Care	Calendar Year 2015	72%	45.56%	No
Childhood Immunization	Calendar Year 2015	75%	60.88%	No
Well-Child 0 to 15 Months	Calendar Year 2015	71%	44.68%	No
Well-Child 3 to 6 Years	Calendar Year 2015	79%	71.30%	No
Adolescent Well-Care Visits	Calendar Year 2015	60%	51.39%	No
Appropriate Testing for Children with Pharyngitis	Calendar Year 2015	N/A	55.44%	N/A
Child Access to Care 12 to 24 Months	Calendar Year 2015	97%	90.84%	No
Child Access to Care 7 to 11 Years	Calendar Year 2015	92%	86.76%	No
Diabetes Care: Hemoglobin A1c Testing	Calendar Year 2015	87%	84.36%	No
Diabetes Care: Eye Exam	Calendar Year 2015	N/A	49.36%	NA
Breast Cancer Screening	Calendar Year 2015	58%	63.10%	Yes
Chlamydia Screening	Calendar Year 2015	62%	68.44%	Yes

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

Appendix C: One Year Plan-Specific Analysis

Blue Cross Complete of Michigan, Inc. – BCC

HEDIS:

Performance Measure	Measurement Period	Standard	Plan Result	Standard Achieved
Timeliness of Prenatal Care	Calendar Year 2015	86%	80.54%	No
Postpartum Care	Calendar Year 2015	72%	57.66%	No
Childhood Immunization	Calendar Year 2015	75%	70.07%	No
Well-Child 0 to 15 Months	Calendar Year 2015	71%	67.40%	No
Well-Child 3 to 6 Years	Calendar Year 2015	79%	79.32%	Yes
Adolescent Well-Care Visits	Calendar Year 2015	60%	60.10%	Yes
Appropriate Testing for Children with Pharyngitis	Calendar Year 2015	N/A	72.61%	N/A
Child Access to Care 12 to 24 Months	Calendar Year 2015	97%	94.89%	No
Child Access to Care 7 to 11 Years	Calendar Year 2015	92%	90.84%	No
Diabetes Care: Hemoglobin A1c Testing	Calendar Year 2015	87%	86.86%	No
Diabetes Care: Eye Exam	Calendar Year 2015	N/A	62.04%	NA
Breast Cancer Screening	Calendar Year 2015	58%	61.84%	Yes
Chlamydia Screening	Calendar Year 2015	62%	69.65%	Yes

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

Appendix C: One Year Plan-Specific Analysis

Harbor Health Plan, Inc. – HAR

HEDIS:

Performance Measure	Measurement Period	Standard	Plan Result	Standard Achieved
Timeliness of Prenatal Care	**Calendar Year 2015**	**86%**	**34.41%**	**No**
Postpartum Care	**Calendar Year 2015**	**72%**	**33.33%**	**No**
Childhood Immunization	**Calendar Year 2015**	**75%**	**44.29%**	**No**
Well-Child 0 to 15 Months	**Calendar Year 2015**	**71%**	**N/A**	**N/A**
*****A rate was not calculated for plans with a numerator under 5 or a denominator under 30.				
Well-Child 3 to 6 Years	**Calendar Year 2015**	**79%**	**62.89%**	**No**
Adolescent Well-Care Visits	**Calendar Year 2015**	**60%**	**35.51%**	**No**
Appropriate Testing for Children with Pharyngitis	**Calendar Year 2015**	**N/A**	**N/A**	**N/A**
*****A rate was not calculated for plans with a numerator under 5 or a denominator under 30.				
Child Access to Care 12 to 24 Months	**Calendar Year 2015**	**97%**	**82.35%**	**No**
Child Access to Care 7 to 11 Years	**Calendar Year 2015**	**92%**	**71.65%**	**No**
Diabetes Care: Hemoglobin A1c Testing	**Calendar Year 2015**	**87%**	**75.64%**	**No**
Diabetes Care: Eye Exam	**Calendar Year 2015**	**N/A**	**46.15%**	**NA**
Breast Cancer Screening	**Calendar Year 2015**	**58%**	**64.71%**	**Yes**
Chlamydia Screening	**Calendar Year 2015**	**62%**	**72.84%**	**Yes**

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

Appendix C: One Year Plan-Specific Analysis

McLaren Health Plan – MCL

HEDIS:

Performance Measure	Measurement Period	Standard	Plan Result	Standard Achieved
Timeliness of Prenatal Care	Calendar Year 2015	86%	76.40%	No
Postpartum Care	Calendar Year 2015	72%	63.99%	No
Childhood Immunization	Calendar Year 2015	75%	68.61%	No
Well-Child 0 to 15 Months	Calendar Year 2015	71%	66.42%	No
Well-Child 3 to 6 Years	Calendar Year 2015	79%	71.29%	No
Adolescent Well-Care Visits	Calendar Year 2015	60%	46.23%	No
Appropriate Testing for Children with Pharyngitis	Calendar Year 2015	N/A	70.37%	N/A
Child Access to Care 12 to 24 Months	Calendar Year 2015	97%	95.44%	No
Child Access to Care 7 to 11 Years	Calendar Year 2015	92%	87.98%	No
Diabetes Care: Hemoglobin A1c Testing	Calendar Year 2015	87%	89.42%	Yes
Diabetes Care: Eye Exam	Calendar Year 2015	N/A	56.20%	N/A
Breast Cancer Screening	Calendar Year 2015	58%	58.78%	Yes
Chlamydia Screening	Calendar Year 2015	62%	54.81%	Yes

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

Appendix C: One Year Plan-Specific Analysis

Meridian Health Plan – MER

HEDIS:

Performance Measure	Measurement Period	Standard	Plan Result	Standard Achieved
Timeliness of Prenatal Care	Calendar Year 2015	86%	88.11%	Yes
Postpartum Care	Calendar Year 2015	72%	68.53%	No
Childhood Immunization	Calendar Year 2015	75%	72.79%	No
Well-Child 0 to 15 Months	Calendar Year 2015	71%	75.21%	Yes
Well-Child 3 to 6 Years	Calendar Year 2015	79%	77.27%	No
Adolescent Well-Care Visits	Calendar Year 2015	60%	59.72%	No
Appropriate Testing for Children with Pharyngitis	Calendar Year 2015	N/A	72.84%	N/A
Child Access to Care 12 to 24 Months	Calendar Year 2015	97%	97.69%	Yes
Child Access to Care 7 to 11 Years	Calendar Year 2015	92%	92.57%	Yes
Diabetes Care: Hemoglobin A1c Testing	Calendar Year 2015	87%	85.60%	No
Diabetes Care: Eye Exam	Calendar Year 2015	N/A	61.87%	NA
Breast Cancer Screening	Calendar Year 2015	58%	59.57%	Yes
Chlamydia Screening	Calendar Year 2015	62%	64.41%	Yes

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

Appendix C: One Year Plan-Specific Analysis

HAP Midwest Health Plan, Inc. – MID

HEDIS:

Performance Measure	Measurement Period	Standard	Plan Result	Standard Achieved
Timeliness of Prenatal Care	Calendar Year 2015	86%	71.93%	No
Postpartum Care	Calendar Year 2015	72%	51.04%	No
Childhood Immunization	Calendar Year 2015	75%	73.84%	No
Well-Child 0 to 15 Months	Calendar Year 2015	71%	56.02%	No
Well-Child 3 to 6 Years	Calendar Year 2015	79%	76.85%	No
Adolescent Well-Care Visits	Calendar Year 2015	60%	54.99%	No
Appropriate Testing for Children with Pharyngitis	Calendar Year 2015	N/A	67.98%	N/A
Child Access to Care 12 to 24 Months	Calendar Year 2015	97%	95.21%	No
Child Access to Care 7 to 11 Years	Calendar Year 2015	92%	89.22%	No
Diabetes Care: Hemoglobin A1c Testing	Calendar Year 2015	87%	85.93%	No
Diabetes Care: Eye Exam	Calendar Year 2015	N/A	57.19%	NA
Breast Cancer Screening	Calendar Year 2015	58%	57.54%	No
Chlamydia Screening	Calendar Year 2015	62%	61.37%	No

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

Appendix C: One Year Plan-Specific Analysis

Molina Healthcare of Michigan – MOL

HEDIS:

Performance Measure	Measurement Period	Standard	Plan Result	Standard Achieved
Timeliness of Prenatal Care	**Calendar Year 2015**	**86%**	**78.20%**	**No**
Postpartum Care	**Calendar Year 2015**	**72%**	**67.87%**	**No**
Childhood Immunization	**Calendar Year 2015**	**75%**	**68.43%**	**No**
Well-Child 0 to 15 Months	**Calendar Year 2015**	**71%**	**63.84%**	**No**
Well-Child 3 to 6 Years	**Calendar Year 2015**	**79%**	**76.15%**	**No**
Adolescent Well-Care Visits	**Calendar Year 2015**	**60%**	**57.21%**	**No**
Appropriate Testing for Children with Pharyngitis	**Calendar Year 2015**	**N/A**	**62.82%**	**N/A**
Child Access to Care 12 to 24 Months	**Calendar Year 2015**	**97%**	**96.39%**	**No**
Child Access to Care 7 to 11 Years	**Calendar Year 2015**	**92%**	**91.64%**	**No**
Diabetes Care: Hemoglobin A1c Testing	**Calendar Year 2015**	**87%**	**86.04%**	**No**
Diabetes Care: Eye Exam	**Calendar Year 2015**	**N/A**	**57.43%**	**NA**
Breast Cancer Screening	**Calendar Year 2015**	**58%**	**59.67%**	**Yes**
Chlamydia Screening	**Calendar Year 2015**	**62%**	**66.33%**	**Yes**

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

Appendix C: One Year Plan-Specific Analysis

Priority Health Choice – PRI

HEDIS:

Performance Measure	Measurement Period	Standard	Plan Result	Standard Achieved
Timeliness of Prenatal Care	Calendar Year 2015	86%	63.56%	No
Postpartum Care	Calendar Year 2015	72%	61.44%	No
Childhood Immunization	Calendar Year 2015	75%	80.89%	Yes
Well-Child 0 to 15 Months	Calendar Year 2015	71%	69.16%	No
Well-Child 3 to 6 Years	Calendar Year 2015	79%	79.17%	Yes
Adolescent Well-Care Visits	Calendar Year 2015	60%	52.58%	No
Appropriate Testing for Children with Pharyngitis	Calendar Year 2015	N/A	79.07%	N/A
Child Access to Care 12 to 24 Months	Calendar Year 2015	97%	97.75%	Yes
Child Access to Care 7 to 11 Years	Calendar Year 2015	92%	92.05%	Yes
Diabetes Care: Hemoglobin A1c Testing	Calendar Year 2015	87%	94.89%	Yes
Diabetes Care: Eye Exam	Calendar Year 2015	N/A	68.80%	NA
Breast Cancer Screening	Calendar Year 2015	58%	64.95%	Yes
Chlamydia Screening	Calendar Year 2015	62%	67.36%	Yes

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

Appendix C: One Year Plan-Specific Analysis

Total Health Care – THC

HEDIS:

Performance Measure	Measurement Period	Standard	Plan Result	Standard Achieved
Timeliness of Prenatal Care	Calendar Year 2015	86%	68.91%	No
Postpartum Care	Calendar Year 2015	72%	47.33%	No
Childhood Immunization	Calendar Year 2015	75%	58.56%	No
Well-Child 0 to 15 Months	Calendar Year 2015	71%	54.86%	No
Well-Child 3 to 6 Years	Calendar Year 2015	79%	69.44%	No
Adolescent Well-Care Visits	Calendar Year 2015	60%	48.61%	No
Appropriate Testing for Children with Pharyngitis	Calendar Year 2015	N/A	57.57%	N/A
Child Access to Care 12 to 24 Months	Calendar Year 2015	97%	87.60%	No
Child Access to Care 7 to 11 Years	Calendar Year 2015	92%	86.73%	No
Diabetes Care: Hemoglobin A1c Testing	Calendar Year 2015	87%	82.98%	No
Diabetes Care: Eye Exam	Calendar Year 2015	N/A	40.27%	NA
Breast Cancer Screening	Calendar Year 2015	58%	49.67%	No
Chlamydia Screening	Calendar Year 2015	62%	65.09%	Yes

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

Appendix C: One Year Plan-Specific Analysis

UnitedHealthcare Community Plan – UNI

HEDIS:

Performance Measure	Measurement Period	Standard	Plan Result	Standard Achieved
Timeliness of Prenatal Care	**Calendar Year 2015**	**86%**	**76.03%**	**No**
Postpartum Care	**Calendar Year 2015**	**72%**	**52.06%**	**No**
Childhood Immunization	**Calendar Year 2015**	**75%**	**71.78%**	**No**
Well-Child 0 to 15 Months	**Calendar Year 2015**	**71%**	**61.56%**	**No**
Well-Child 3 to 6 Years	**Calendar Year 2015**	**79%**	**73.21%**	**No**
Adolescent Well-Care Visits	**Calendar Year 2015**	**60%**	**54.74%**	**No**
Appropriate Testing for Children with Pharyngitis	**Calendar Year 2015**	**N/A**	**63.13%**	**N/A**
Child Access to Care 12 to 24 Months	**Calendar Year 2015**	**97%**	**96.54%**	**No**
Child Access to Care 7 to 11 Years	**Calendar Year 2015**	**92%**	**91.17%**	**No**
Diabetes Care: Hemoglobin A1c Testing	**Calendar Year 2015**	**87%**	**86.81%**	**No**
Diabetes Care: Eye Exam	**Calendar Year 2015**	**N/A**	**64.31%**	**NA**
Breast Cancer Screening	**Calendar Year 2015**	**58%**	**61.35%**	**Yes**
Chlamydia Screening	**Calendar Year 2015**	**62%**	**65.12%**	**Yes**

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

Appendix C: One Year Plan-Specific Analysis

Upper Peninsula Health Plan – UPP

HEDIS:

Performance Measure	Measurement Period	Standard	Plan Result	Standard Achieved
Timeliness of Prenatal Care	Calendar Year 2015	86%	86.13%	Yes
Postpartum Care	Calendar Year 2015	72%	71.78%	No
Childhood Immunization	Calendar Year 2015	75%	73.24%	No
Well-Child 0 to 15 Months	Calendar Year 2015	71%	74.21%	Yes
Well-Child 3 to 6 Years	Calendar Year 2015	79%	69.59%	No
Adolescent Well-Care Visits	Calendar Year 2015	60%	42.09%	No
Appropriate Testing for Children with Pharyngitis	Calendar Year 2015	N/A	68.97%	N/A
Child Access to Care 12 to 24 Months	Calendar Year 2015	97%	97.65%	Yes
Child Access to Care 7 to 11 Years	Calendar Year 2015	92%	90.60%	No
Diabetes Care: Hemoglobin A1c Testing	Calendar Year 2015	87%	91.61%	Yes
Diabetes Care: Eye Exam	Calendar Year 2015	N/A	66.06%	NA
Breast Cancer Screening	Calendar Year 2015	58%	59.64%	Yes
Chlamydia Screening	Calendar Year 2015	62%	50.96%	No

- 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

Composite – All Plans

April 2017

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

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

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

Measurement Frequency

The data for each performance measure in this report will be run and represented on a quarterly basis. Measurement Periods may vary and are based on the specifications for that individual measure. In addition to this, Figures 3 through 7 depict only Managed Care Plan data, and not Fee-For-Service (FFS) data.

MHPs are contractually obligated to achieve specified standards for most measures. The following table displays the number of MHPs meeting or exceeding the standards for the performance measure versus total MHPs, as reported in the Performance Monitoring Report, during the listed quarter for fiscal year 2017 unless otherwise noted.

Table 1: Fiscal Year 2017

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

Managed Care Enrollment

The Healthy Michigan Plan (HMP-MC) enrollment has increased slightly over the past year. In April 2017. Unfortunately May 2016 HMP-MC enrollment data is unavailable. An increase of 16,923 enrollees (3.2%) was realized between March 2017 and April 2017.

Figure 1: HMP-MC Enrollment, May 2016 – April 2017[1]

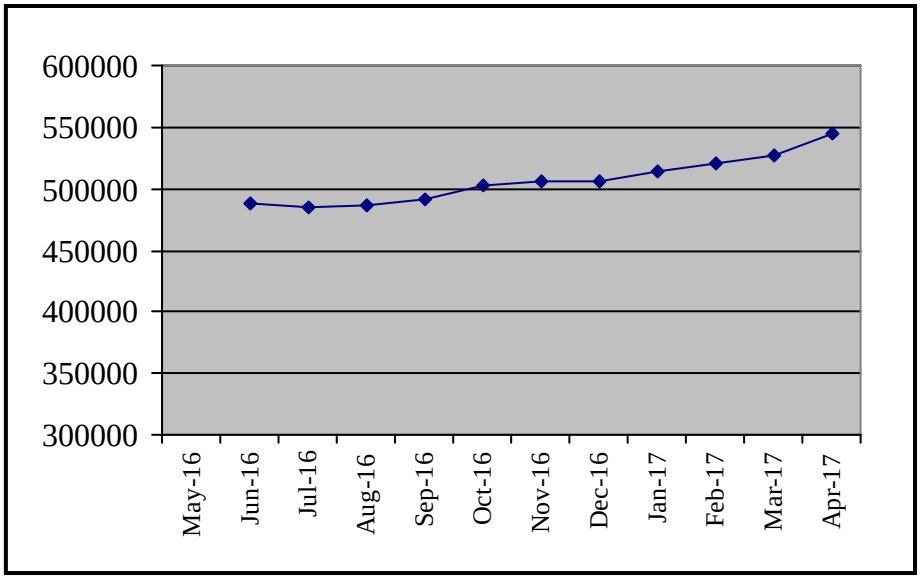
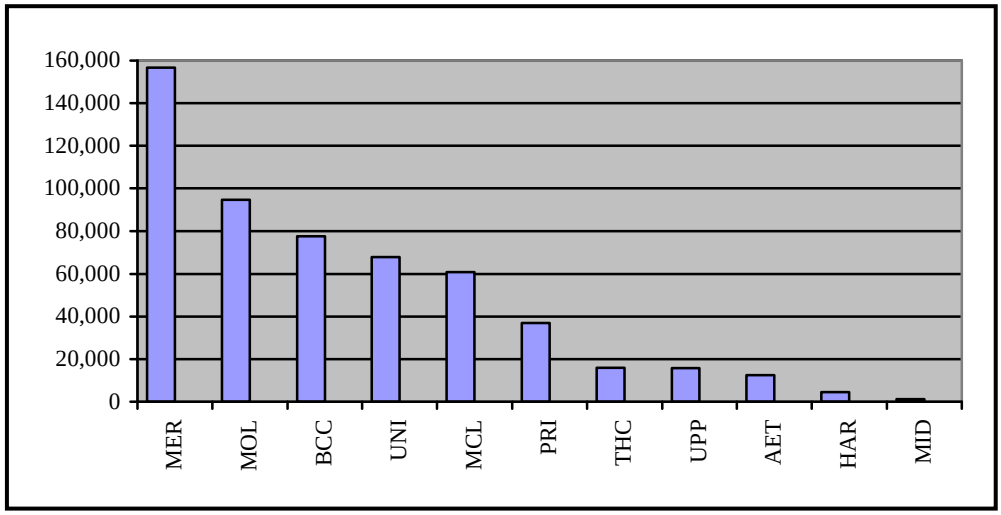


Figure 2: HMP-MC Enrollment by Medicaid Health Plan, April 2017



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

Medicaid Health Plan News

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

Cross-Plan Performance Monitoring Analyses

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

Adults' Generic Drug Utilization

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

Standard
At or above 80% (as shown on bar graph below)

Measurement Period
July 2016 –September 2016

Data Source
MDHHS Data Warehouse

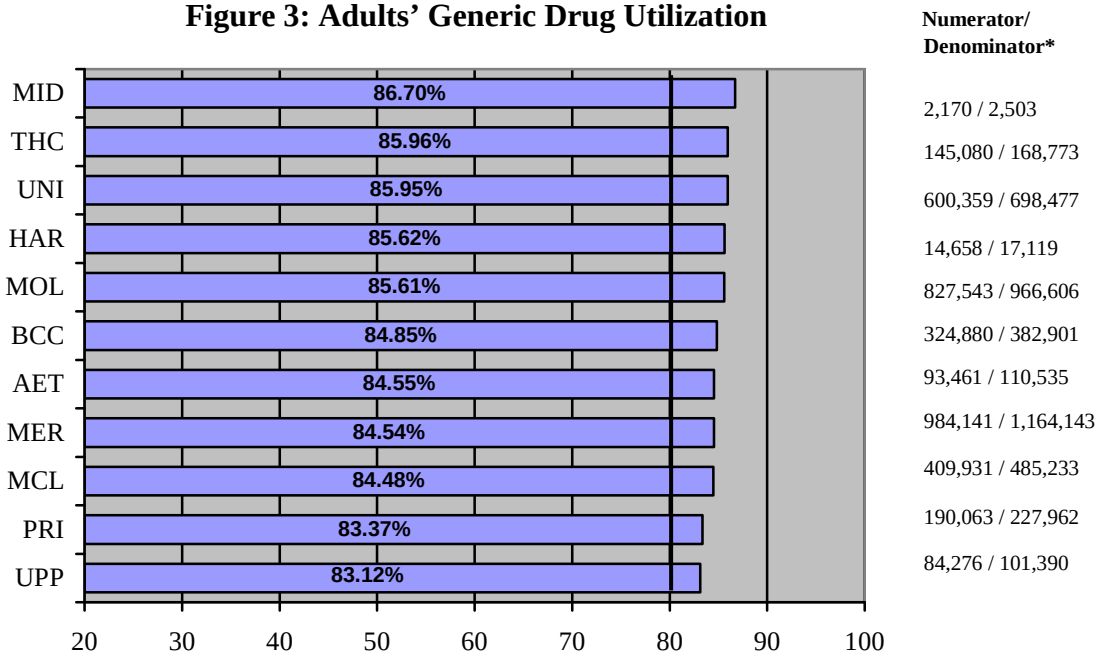
Measurement Frequency
Quarterly

Summary: All of the plans met or exceeded the standard. Results ranged from 83.12% to 86.70%.

Table 2: Comparison across Medicaid Programs

Medicaid Program	Numerator	Denominator	Percentage
Michigan Medicaid All	3,771,541	4,465,372	84.46%
Fee For Service (FFS) only	22,561	49,488	45.59%
Managed Care only	3,691,634	4,343,424	84.99%
MA-MC	1,958,394	2,314,991	84.60%
HMP-MC	1,694,296	1,982,902	85.45%

Figure 3: Adults' Generic Drug Utilization



Adult's Generic Drug Utilization Percentages

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

Timely Completion of Initial Health Risk Assessment

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

Standard
At or above 15% (as shown on bar graph below)

Enrollment Dates
April 2016 – June 2016

Data Source
MDHHS Data Warehouse

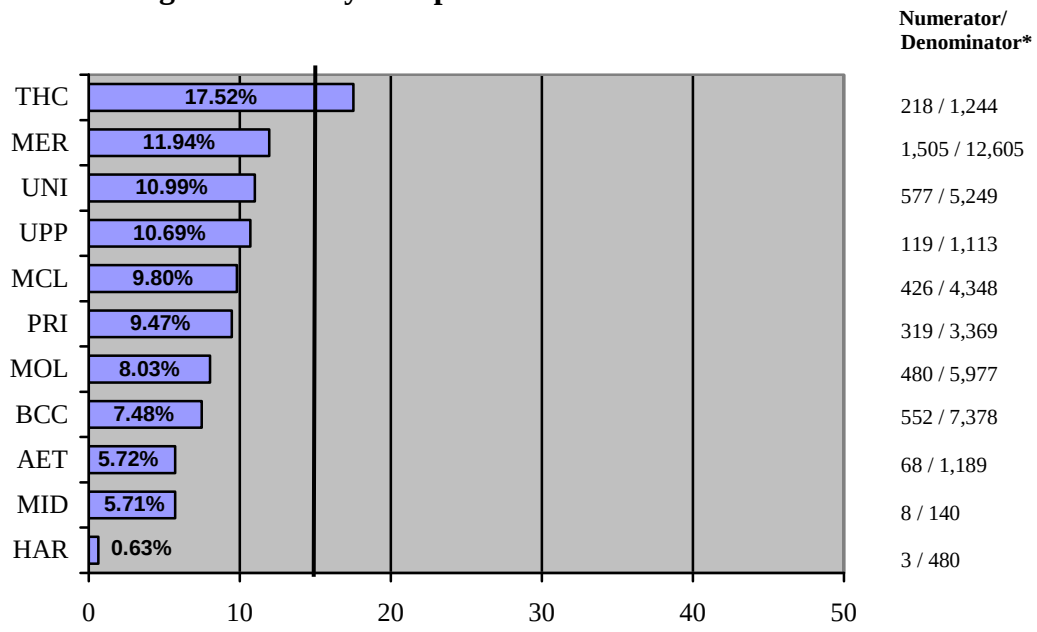
Measurement Frequency
Quarterly

Summary: One plan met or exceeded the standard, while ten plans (AET, BCC, HAR, MCL, MER, MID, MOL, PRI, UNI, and UPP). Results ranged from 0.63% to 17.52%.

Table 3: Program Total[2]

Medicaid Program	Numerator	Denominator	Percentage
HMP-MC	4,275	43,092	9.92%

Figure 4: Timely Completion of Initial HRA



Timely Completion of Initial HRA Percentages

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

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

Outreach and Engagement to Facilitate Entry to Primary Care

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

Standard
At or above 60% (as shown on bar graph below)

Enrollment Dates
April 2016 – June 2016

Data Source
MDHHS Data Warehouse

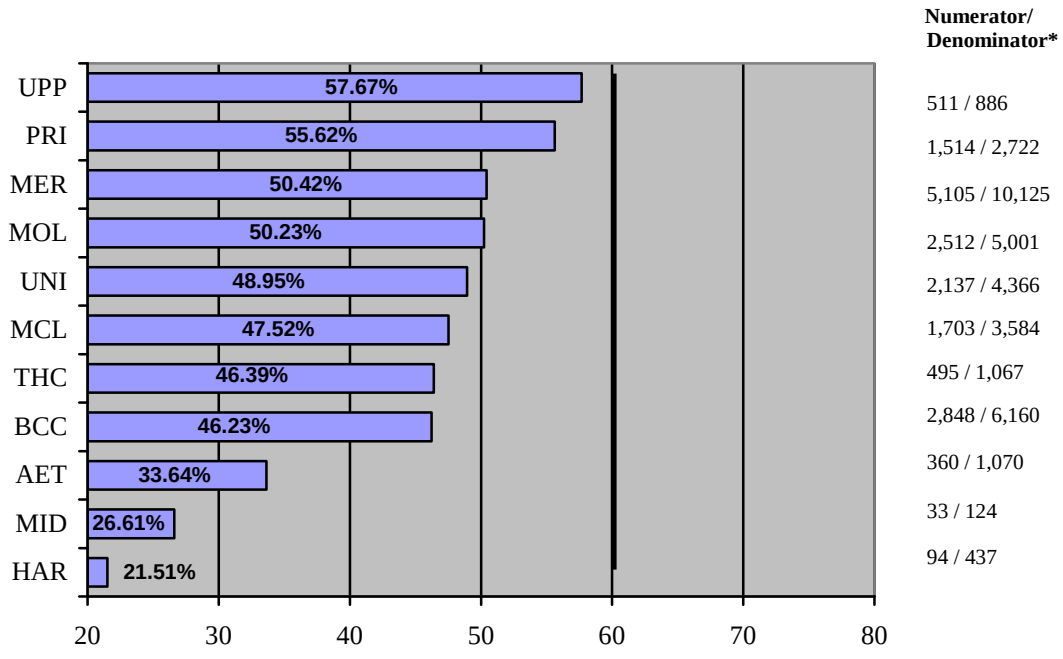
Measurement Frequency
Quarterly

Summary: None of the plans met or exceeded the standard. Results ranged from 21.51% to 57.67%.

Table 4: Program Total[3]

Medicaid Program	Numerator	Denominator	Percentage
HMP-MC	24,862	43,092	57.70%

Figure 5: Outreach & Engagement to Facilitate Entry to Primary Care



Outreach & Engagement to Facilitate Entry to Primary Care Percentages

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

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

Plan All-Cause Acute 30-Day Readmissions

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

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

Enrollment Dates
October 2015 –September 2016

Data Source
MDHHS Data Warehouse

Measurement Frequency
Quarterly

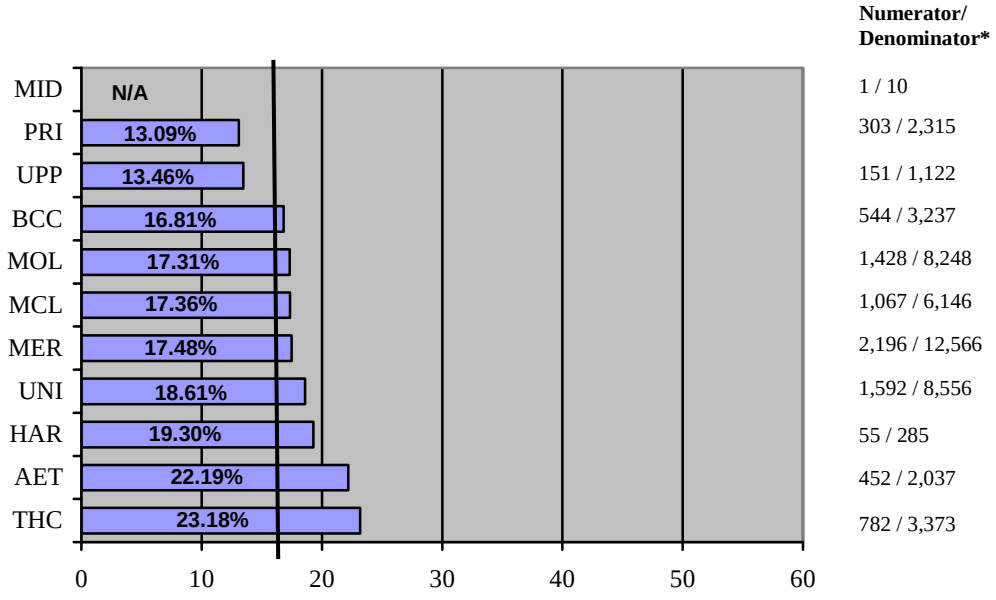
Summary: Two of the plans met or exceeded the standard, while eight plans (AET, BCC, HAR, MCL, MER, MOL, THC, and UNI) did not. Results ranged from 13.09% to 23.18%.

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

Table 5: Comparison across Medicaid Programs

Medicaid Program	Numerator	Denominator	Percentage
Michigan Medicaid All	13,889	77,348	17.96%
Fee For Service (FFS) only	631	2,843	22.19%
Managed Care only	10,207	56,486	18.07%
MA-MC	7,602	36,787	20.66%
HMP-MC	1,998	15,918	12.55%

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



Plan All-Cause Acute 30-Day Readmissions Percentages

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

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

Adults' Access to Ambulatory Health Services

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

Standard
At or above 83% (as shown on bar graph below)

Measurement Period
October 2015 – September 2016

Data Source
MDHHS Data Warehouse

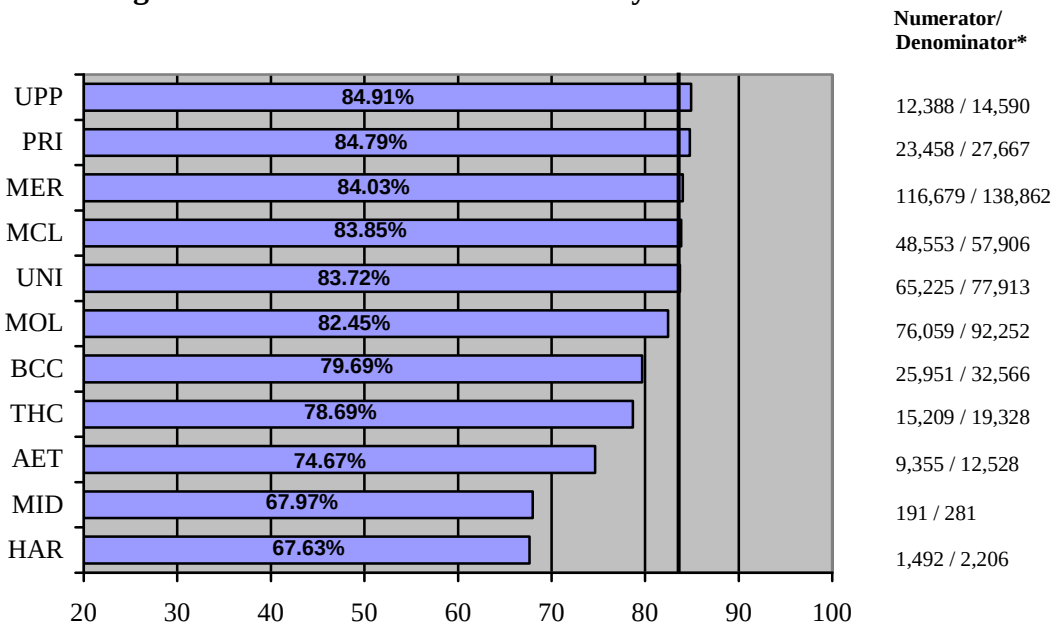
Measurement Frequency
Quarterly

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

Table 6: Comparison across Medicaid Programs

Medicaid Program	Numerator	Denominator	Percentage
Michigan Medicaid All	576,031	708,180	81.34%
Fee For Service (FFS) only	9,354	14,541	64.33%
Managed Care only	442,967	533,158	83.08%
MA-MC	215,581	257,970	83.57%
HMP-MC	182,047	221,924	82.03%

Figure 7: Adults' Access to Ambulatory Health Services



Adult's Access to Ambulatory Health Services Percentages

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

Appendix A: Composite Performance Monitoring Summary[5]

April 2017

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

Appendix B: Three Letter Medicaid Health Plan Codes

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

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

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

Appendix C: One Year Plan-Specific Analysis

Aetna Better Health of Michigan – AET

HEALTHY MICHIGAN PLAN:

Performance Measure	Measurement Period	Standard	Plan Result	Standard Achieved
Adults' Generic Drug Utilization	Apr 16 – Jun 16	80%	84.66%	Yes
	Jul 16 – Sep 16	**80%**	**84.55%**	**Yes**
Timely Completion of HRA	Jan 16 – Mar 16	15%	4.14%	**No**
	Apr 16 – Jun 16	**15%**	**5.72**	**No**
Outreach/Engagement to Facilitate Entry to Primary Care	Jan 16 – Mar 16	60%	35.59%	**No**
	Apr 16 – Jun 16	**60%**	**33.64%**	**No**
Plan All-Cause Acute 30-Day Readmissions	Jul 15 – Jun 16	16%	22.55%	**No**
	Oct 15 – Sep 16	**16%**	**22.19%**	**No**
Adults' Access to Ambulatory Health Services	Jul 15 – Jun 16	83%	75.38%	**No**
	Oct 15 – Sep 16	**83%**	**74.67%**	**No**

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

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

Appendix C: One Year Plan-Specific Analysis

Blue Cross Complete of Michigan – BCC

HEALTHY MICHIGAN PLAN:

Performance Measure	Measurement Period	Standard	Plan Result	Standard Achieved
Adults' Generic Drug Utilization	Apr 16 – Jun 16	80%	84.47%	Yes
	Jul 16 – Sep 16	**80%**	**84.85%**	**Yes**
Timely Completion of HRA	Jan 16 – Mar 16	15%	9.68%	**No**
	Apr 16 – Jun 16	**15%**	**7.48%**	**No**
Outreach/Engagement to Facilitate Entry to Primary Care	Jan 16 – Mar 16	60%	50.64%	**No**
	Apr 16 – Jun 16	**60%**	**46.23%**	**No**
Plan All-Cause Acute 30-Day Readmissions	Jul 15 – Jun 16	16%	16.68%	**No**
	Oct 15 – Sep 16	**16%**	**16.81%**	**No**
Adults' Access to Ambulatory Health Services	Jul 15 – Jun 16	83%	79.32%	**No**
	Oct 15 – Sep 16	**83%**	**79.69%**	**No**

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

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

Appendix C: One Year Plan-Specific Analysis

Harbor Health Plan, Inc. – HAR

HEALTHY MICHIGAN PLAN:

Performance Measure	Measurement Period	Standard	Plan Result	Standard Achieved
Adults' Generic Drug Utilization	Apr 16 – Jun 16	80%	85.37%	Yes
	Jul 16 – Sep 16	**80%**	**85.62%**	**Yes**
Timely Completion of HRA	Jan 16 – Mar 16	15%	1.12%	**No**
	Apr 16 – Jun 16	**15%**	**0.63%**	**No**
Outreach/Engagement to Facilitate Entry to Primary Care	Jan 16 – Mar 16	60%	27.18%	**No**
	Apr 16 – Jun 16	**60%**	**21.51%**	**No**
Plan All-Cause Acute 30-Day Readmissions	Jul 15 – Jun 16	16%	22.08%	**No**
	Oct 15 – Sep 16	**16%**	**19.30%**	**No**
Adults' Access to Ambulatory Health Services	Jul 15 – Jun 16	83%	66.95%	**No**
	Oct 15 – Sep 16	**83%**	**67.63%**	**No**

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

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

Appendix C: One Year Plan-Specific Analysis

McLaren Health Plan – MCL

HEALTHY MICHIGAN PLAN:

Performance Measure	Measurement Period	Standard	Plan Result	Standard Achieved
Adults' Generic Drug Utilization	Apr 16 – Jun 16	80%	84.33%	Yes
	Jul 16 – Sep 16	**80%**	**84.48%**	**Yes**
Timely Completion of HRA	Jan 16 – Mar 16	15%	10.34%	**No**
	Apr 16 – Jun 16	**15%**	**9.80%**	**No**
Outreach/Engagement to Facilitate Entry to Primary Care	Jan 16 – Mar 16	60%	50.77%	**No**
	Apr 16 – Jun 16	**60%**	**47.52%**	**No**
Plan All-Cause Acute 30-Day Readmissions	Jul 15 – Jun 16	16%	16.22%	**No**
	Oct 15 – Sep 16	**16%**	**17.36%**	**No**
Adults' Access to Ambulatory Health Services	Jul 15 – Jun 16	83%	83.86%	Yes
	Oct 15 – Sep 16	**83%**	**83.85%**	**Yes**

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

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

Appendix C: One Year Plan-Specific Analysis

Meridian Health Plan – MER

HEALTHY MICHIGAN PLAN:

Performance Measure	Measurement Period	Standard	Plan Result	Standard Achieved
Adults' Generic Drug Utilization	Apr 16 – Jun 16	80%	83.55%	Yes
	Jul 16 – Sep 16	**80%**	**84.54%**	**Yes**
Timely Completion of HRA	Jan 16 – Mar 16	15%	14.04%	**No**
	Apr 16 – Jun 16	**15%**	**11.94%**	**No**
Outreach/Engagement to Facilitate Entry to Primary Care	Jan 16 – Mar 16	60%	54.45%	**No**
	Apr 16 – Jun 16	**60%**	**50.42%**	**No**
Plan All-Cause Acute 30-Day Readmissions	Jul 15 – Jun 16	16%	16.01%	**No**
	Oct 15 – Sep 16	**16%**	**17.48%**	**No**
Adults' Access to Ambulatory Health Services	Jul 15 – Jun 16	83%	84.31%	Yes
	Oct 15 – Sep 16	**83%**	**84.03%**	**Yes**

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

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

Appendix C: One Year Plan-Specific Analysis

HAP Midwest Health Plan, Inc. – MID

HEALTHY MICHIGAN PLAN:

Performance Measure	Measurement Period	Standard	Plan Result	Standard Achieved
Adults' Generic Drug Utilization	Apr 16 – Jun 16	80%	87.76%	Yes
	Jul 16 – Sep 16	**80%**	**86.70%**	**Yes**
Timely Completion of HRA	Jan 16 – Mar 16	15%	5.60%	**No**
	Apr 16 – Jun 16	**15%**	**5.71%**	**No**
Outreach/Engagement to Facilitate Entry to Primary Care	Jan 16 – Mar 16	60%	29.46%	**No**
	Apr 16 – Jun 16	**60%**	**26.61%**	**No**
Plan All-Cause Acute 30-Day Readmissions	Jul 15 – Jun 16	16%	N/A	N/A
	Oct 15 – Sep 16	**16%**	**N/A**	**N/A**

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

Adults' Access to Ambulatory Health Services	Jul 15 – Jun 16	83%	69.97%	**No**
	Oct 15 – Sep 16	**83%**	**67.97%**	**No**

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

Appendix C: One Year Plan-Specific Analysis

Molina Healthcare of Michigan – MOL

HEALTHY MICHIGAN PLAN:

Performance Measure	Measurement Period	Standard	Plan Result	Standard Achieved
Adults' Generic Drug Utilization	Apr 16 – Jun 16	80%	85.75%	Yes
	Jul 16 – Sep 16	**80%**	**85.61%**	**Yes**
Timely Completion of HRA	Jan 16 – Mar 16	15%	8.75%	**No**
	Apr 16 – Jun 16	**15%**	**8.03%**	**No**
Outreach/Engagement to Facilitate Entry to Primary Care	Jan 16 – Mar 16	60%	50.52%	**No**
	Apr 16 – Jun 16	**60%**	**50.23%**	**No**
Plan All-Cause Acute 30-Day Readmissions	Jul 15 – Jun 16	16%	17.18%	**No**
	Oct 15 – Sep 16	**16%**	**17.31%**	**No**
Adults' Access to Ambulatory Health Services	Jul 15 – Jun 16	83%	82.07%	**No**
	Oct 15 – Sep 16	**83%**	**82.45%**	**No**

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

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

Appendix C: One Year Plan-Specific Analysis

Priority Health Choice – PRI

HEALTHY MICHIGAN PLAN:

Performance Measure	Measurement Period	Standard	Plan Result	Standard Achieved
Adults' Generic Drug Utilization	Apr 16 – Jun 16	80%	83.11%	Yes
	Jul 16 – Sep 16	**80%**	**83.37%**	**Yes**
Timely Completion of HRA	Jan 16 – Mar 16	15%	7.60%	**No**
	Apr 16 – Jun 16	**15%**	**9.47**	**No**
Outreach/Engagement to Facilitate Entry to Primary Care	Jan 16 – Mar 16	60%	55.92%	**No**
	Apr 16 – Jun 16	**60%**	**55.62%**	**No**
Plan All-Cause Acute 30-Day Readmissions	Jul 15 – Jun 16	16%	13.65%	Yes
	Oct 15 – Sep 16	**16%**	**13.09%**	**Yes**
Adults' Access to Ambulatory Health Services	Jul 15 – Jun 16	83%	83.55%	Yes
	Oct 15 – Sep 16	**83%**	**84.79%**	**Yes**

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

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

Appendix C: One Year Plan-Specific Analysis

Total Health Care – THC

HEALTHY MICHIGAN PLAN:

Performance Measure	Measurement Period	Standard	Plan Result	Standard Achieved
Adults' Generic Drug Utilization	Apr 16 – Jun 16	80%	86.53%	Yes
	Jul 16 – Sep 16	**80%**	**85.96%**	**Yes**
Timely Completion of HRA	Jan 16 – Mar 16	15%	15.25%	Yes
	Apr 16 – Jun 16	**15%**	**17.52%**	**Yes**
Outreach/Engagement to Facilitate Entry to Primary Care	Jan 16 – Mar 16	60%	46.74%	**No**
	Apr 16 – Jun 16	**60%**	**46.39%**	**No**
Plan All-Cause Acute 30-Day Readmissions	Jul 15 – Jun 16	16%	22.26%	**No**
	Oct 15 – Sep 16	**16%**	**23.18%**	**No**
Adults' Access to Ambulatory Health Services	Jul 15 – Jun 16	83%	79.01%	**No**
	Oct 15 – Sep 16	**83%**	**78.69%**	**No**

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

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

Appendix C: One Year Plan-Specific Analysis

UnitedHealthcare Community Plan – UNI

HEALTHY MICHIGAN PLAN:

Performance Measure	Measurement Period	Standard	Plan Result	Standard Achieved
Adults' Generic Drug Utilization	Apr 16 – Jun 16	80%	84.29%	Yes
	Jul 16 – Sep 16	**80%**	**85.95%**	**Yes**
Timely Completion of HRA	Jan 16 – Mar 16	15%	15.45%	Yes
	Apr 16 – Jun 16	**15%**	**10.99%**	**No**
Outreach/Engagement to Facilitate Entry to Primary Care	Jan 16 – Mar 16	60%	50.23%	**No**
	Apr 16 – Jun 16	**60%**	**48.95%**	**No**
Plan All-Cause Acute 30-Day Readmissions	Jul 15 – Jun 16	16%	18.70%	**No**
	Oct 15 – Sep 16	**16%**	**18.61%**	**No**
Adults' Access to Ambulatory Health Services	Jul 15 – Jun 16	83%	83.85%	Yes
	Oct 15 – Sep 16	**83%**	**83.72%**	**Yes**

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

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

Appendix C: One Year Plan-Specific Analysis

Upper Peninsula Health Plan – UPP

HEALTHY MICHIGAN PLAN:

Performance Measure	Measurement Period	Standard	Plan Result	Standard Achieved
Adults' Generic Drug Utilization	Apr 16 – Jun 16	80%	83.09%	Yes
	Jul 16 – Sep 16	**80%**	**83.12%**	**Yes**
Timely Completion of HRA	Jan 16 – Mar 16	15%	12.12%	**No**
	Apr 16 – Jun 16	**15%**	**10.69%**	**No**
Outreach/Engagement to Facilitate Entry to Primary Care	Jan 16 – Mar 16	60%	53.64%	**No**
	Apr 16 – Jun 16	**60%**	**57.67%**	**No**
Plan All-Cause Acute 30-Day Readmissions	Jul 15 – Jun 16	16%	13.53%	Yes
	Oct 15 – Sep 16	**16%**	**13.46%**	**Yes**
Adults' Access to Ambulatory Health Services	Jul 15 – Jun 16	83%	85.16%	Yes
	Oct 15 – Sep 16	**83%**	**84.91%**	**Yes**

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

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

Medical Services Administration
Bureau of Medicaid Care Management and Quality Assurance

PERFORMANCE MONITORING REPORT

Medicaid Managed Care

Composite – All Plans

April 2017

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

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Medicaid Managed Care

Appendixes

Figures

Tables

Executive Summary

This Performance Monitoring Report is produced by the Quality Improvement and Program Development (QIPD) Section of the Managed Care Plan Division (MCPD) to track quality, access, and utilization in the Michigan Medicaid program to better support high quality care for beneficiaries.

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

MEDICAID MANAGED CARE			
Blood Lead Testing for 2 Year Olds	*Developmental Screening*	*Complaints*	*Claims Processing*
Encounter Data Reporting	*Pharmacy Encounter Data Reporting*	*NEMT Encounter Submissions*	*Provider File*

Data for these eight 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. 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 months for fiscal year 2017 unless otherwise noted.

Table 1: Fiscal Year 2017[1].

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

Quarterly Reported Measures	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter
Complaints	11/11	11/11		

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

Managed Care Enrollment

Michigan Medicaid Managed Care (MA-MC) enrollment has remained steady over the past year. In April 2017, enrollment was 1,807,526, up 103,748 enrollees (6.1%) from May 2016. An increase of 30,286 enrollees (1.7%) was realized between March 2017 and April 2017.

Figure 1: Medicaid Managed Care Enrollment, May 2016 – April 2017

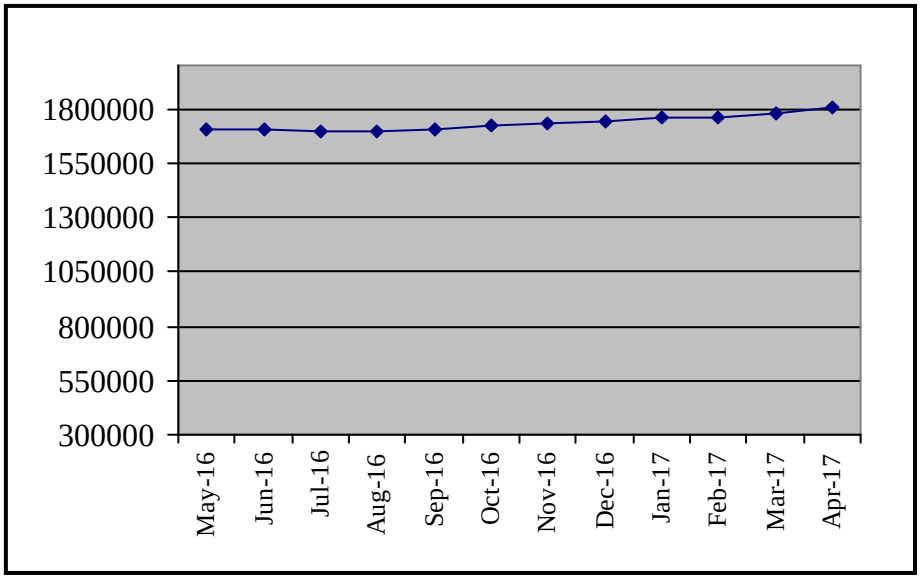
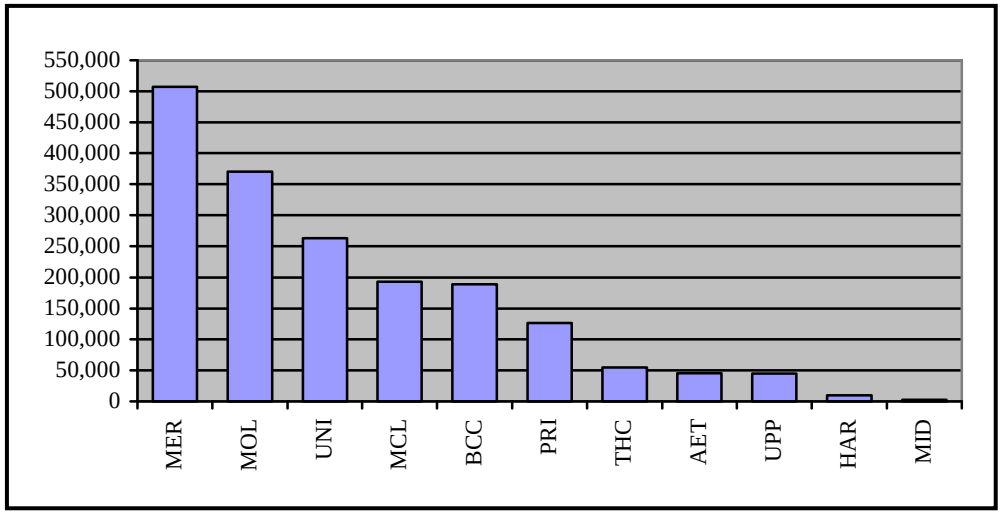


Figure 2: Medicaid Managed Care Enrollment by Health Plan, April 2017



Medicaid Health Plan News

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

Cross-Plan Performance Monitoring Analyses

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

Blood Lead Testing for Two Year Olds

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

Minimum Standard
At or above 81% for continuously enrolled children

Measurement Period
October 2016 –December 2016

Data Source
MDHHS Data Warehouse

Measurement Frequency
Monthly

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

Table 2: Blood Lead Testing for Two Year Olds

MHP	Standard	Cont. Enrolled Result			Standard Achieved		
		Oct	Nov	Dec	Oct	Nov	Dec
AET	81%	**70%**	**70%**	**72%**	**No**	**No**	**No**
BCC	81%	**71%**	**71%**	**71%**	**No**	**No**	**No**
HAR	81%	**61%**	**63%**	**65%**	**No**	**No**	**No**
MCL	81%	85%	85%	85%	Yes	Yes	Yes
MER	81%	**77%**	**77%**	**78%**	**No**	**No**	**No**
MID	81%	**71%**	**78%**	**75%**	**No**	**No**	**No**
MOL	81%	**71%**	**73%**	**73%**	**No**	**No**	**No**
PRI	81%	82%	81%	81%	Yes	Yes	Yes
THC	81%	**63%**	**65%**	**64%**	**No**	**No**	**No**
UNI	81%	**76%**	**75%**	**75%**	**No**	**No**	**No**
UPP	81%	84%	85%	84%	Yes	Yes	Yes

Developmental Screening

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

Minimum Standard
At or above 22% - First year of Life
At or above 25% - Second Year of Life
At or above 20% - Third Year of Life

Measurement Period
January 2017 – March 2017

Data Source
MDHHS Data Warehouse

Measurement Frequency
Monthly

Summary: For the ***first year of life***, nine plans met or exceeded the standard for January, February and March, while two plans (AET and UPP) did not.
For the ***second year of life***, nine plans met or exceeded the standard for January, February, and March, while two plans (HAR, and UPP) did not;
For the ***third year of life***, nine plans met or exceeded the standard for January, February, and March, while two plans (HAR, and UPP) did not;

Table 3: Developmental Screening First Year of Life

MHP	Standard	Plan Result			Standard Achieved		
		Jan	Feb	Mar	Jan	Feb	Mar
AET	22%	**21.50%**	**21.30%**	**21.88%**	**No**	**No**	**No**
BCC	22%	33.36%	31.91%	30.12%	Yes	Yes	Yes
HAR	22%	31.43%	30.56%	27.40%	Yes	Yes	Yes
MCL	22%	27.02%	27.81%	28.29%	Yes	Yes	Yes
MER	22%	25.06%	25.63%	25.51%	Yes	Yes	Yes
MID	22%	30.34%	30.23%	55.56%	Yes	Yes	Yes
MOL	22%	27.92%	28.31%	28.25%	Yes	Yes	Yes
PRI	22%	23.00%	23.27%	23.94%	Yes	Yes	Yes
THC	22%	23.06%	22.66%	22.12%	Yes	Yes	Yes
UNI	22%	25.77%	26.29%	27.12%	Yes	Yes	Yes
UPP	22%	**9.13%**	**9.02%**	**10.29%**	**No**	**No**	**No**

Table 4: Developmental Screening Second Year of Life

MHP	Standard	Plan Result			Standard Achieved		
		Jan	Feb	Mar	Jan	Feb	Mar
AET	25%	26.37%	27.49%	26.99%	Yes	Yes	Yes
BCC	25%	45.34%	43.85%	42.99%	Yes	Yes	Yes
HAR	25%	**11.90%**	**11.43%**	**16.67%**	**No**	**No**	**No**
MCL	25%	33.45%	34.96%	35.62%	Yes	Yes	Yes
MER	25%	32.43%	32.34%	32.70%	Yes	Yes	Yes
MID	25%	41.90%	42.42%	66.67%	Yes	Yes	Yes
MOL	25%	33.30%	34.25%	33.96%	Yes	Yes	Yes
PRI	25%	37.53%	37.03%	35.27%	Yes	Yes	Yes
THC	25%	26.64%	27.22%	25.96%	Yes	Yes	Yes
UNI	25%	33.27%	33.54%	34.57%	Yes	Yes	Yes
UPP	25%	**11.67%**	**11.73%**	**12.88%**	**No**	**No**	**No**

Table 5: Developmental Screening Third Year of Life

MHP	Standard	Plan Result			Standard Achieved		
		Jan	Feb	Mar	Jan	Feb	Mar
AET	20%	20.58%	21.90%	21.64%	Yes	Yes	Yes
BCC	20%	34.17%	32.60%	32.54%	Yes	Yes	Yes
HAR	20%	**6.35%**	**11.48%**	**10.53%**	**No**	**No**	**No**
MCL	20%	24.10%	24.21%	25.43%	Yes	Yes	Yes
MER	20%	26.23%	26.10%	27.21%	Yes	Yes	Yes
MID	20%	30.53%	25.89%	25.00%	Yes	Yes	Yes
MOL	20%	25.45%	26.31%	25.93%	Yes	Yes	Yes
PRI	20%	33.44%	32.71%	32.31%	Yes	Yes	Yes
THC	20%	23.76%	25.45%	26.06%	Yes	Yes	Yes
UNI	20%	25.91%	25.97%	26.50%	Yes	Yes	Yes
UPP	20%	**12.13%**	**12.80%**	**12.84%**	**No**	**No**	**No**

Complaints

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

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

Measurement Period
October 2016 –December 2016

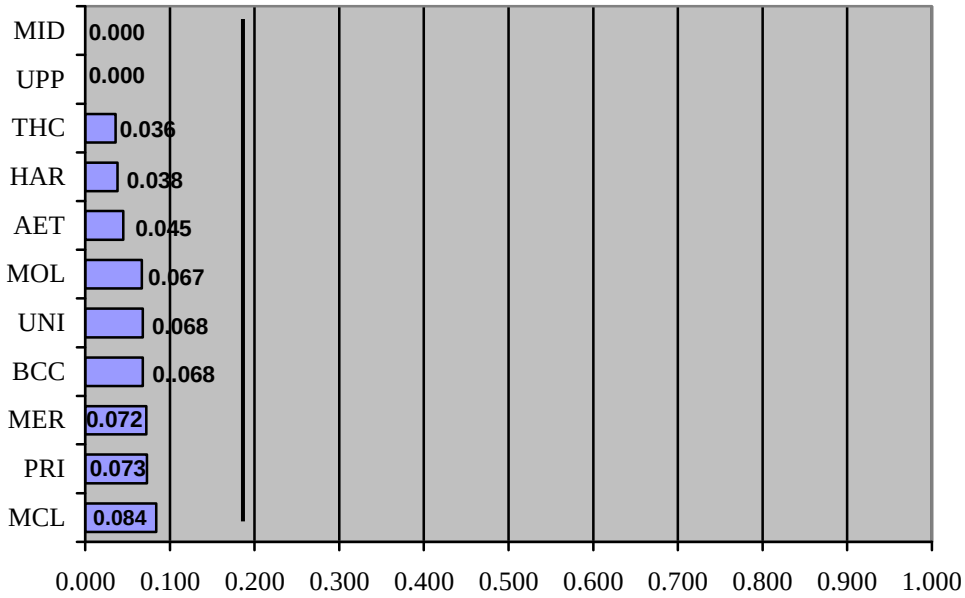
Data Source
Customer Relations System (CRM)

Measurement Frequency
Quarterly

Summary: All of the plans met or exceeded the standard. The results ranged from 0.000 to 0.084 complaints per 1,000 member months.

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

Figure 3: Complaints



Claims Processing

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

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

Measurement Period
November 2016 –January 2017

Data Source
Claims report submitted by health plan

Measurement Frequency
Monthly

Summary: Eight plans met or exceeded the standard in November 2016, while three plans (AET, MID, and MOL) did not. Ten plans met or exceeded the standard in December 2016 and January 2017, while one plan (AET) did not.

Table 6: Claims Processing November 2016

MHP	Timely	Accurate	≥95%	≤12%	≤1%	Standard Achieved
AET	Yes	**No**	**92%**	4%	0.68%	**No**
BCC	Yes	Yes	100%	11%	0.01%	Yes
HAR	Yes	Yes	100%	0%	0.26%	Yes
MCL	Yes	Yes	100%	3%	0.09%	Yes
MER	Yes	Yes	99%	5%	0.00%	Yes
MID	Yes	**No**	100%	**17%**	0.00%	**No**
MOL	Yes	**No**	100%	2%	**3.21%**	**No**
PRI	Yes	Yes	99%	4%	0.03%	Yes
THC	Yes	Yes	100%	2%	0.00%	Yes
UNI	Yes	Yes	100%	6%	0.02%	Yes
UPP	Yes	Yes	100%	8%	0.00%	Yes

Table 7: Claims Processing December 2016

MHP	Timely	Accurate	≥95%	≤12%	≤1%	Standard Achieved
AET	Yes	**No**	**93%**	4%	**1.87%**	**No**
BCC	Yes	Yes	100%	8%	0.00%	Yes
HAR	Yes	Yes	100%	0%	0.21%	Yes
MCL	Yes	Yes	98%	4%	0.37%	Yes
MER	Yes	Yes	96%	9%	0.00%	Yes
MID	Yes	Yes	100%	8%	0.00%	Yes
MOL	Yes	Yes	100%	2%	0.08%	Yes
PRI	Yes	Yes	99%	5%	0.01%	Yes
THC	Yes	Yes	100%	2%	0.00%	Yes
UNI	Yes	Yes	100%	8%	0.11%	Yes
UPP	Yes	Yes	100%	8%	0.00%	Yes

Table 8: Claims Processing January 2017

MHP	Timely	Accurate	≥95%	≤12%	≤1%	Standard Achieved
AET	Yes	**No**	**94%**	9%	0.92%	**No**
BCC	Yes	Yes	100%	9%	0.00%	Yes
HAR	Yes	Yes	96%	0%	0.35%	Yes
MCL	Yes	Yes	100%	4%	0.26%	Yes
MER	Yes	Yes	97%	8%	0.00%	Yes
MID	Yes	Yes	100%	9%	0.00%	Yes
MOL	Yes	Yes	100%	2%	0.14%	Yes
PRI	Yes	Yes	99%	6%	0.01%	Yes
THC	Yes	Yes	100%	2%	0.00%	Yes
UNI	Yes	Yes	100%	7%	0.05%	Yes
UPP	Yes	Yes	100%	9%	0.00%	Yes

Encounter Data Reporting

Measure
Timely and complete encounter data submission

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

Measurement Period
January 2017 – March 2017

Data Source
MDHHS Data Exchange Gateway, MDHHS Data Warehouse

Measurement Frequency
Monthly

Summary: Nine plans met the standard of submitting a minimum volume of professional and institutional encounters paid in December 2016, by the 15th of January 2017, while two plans (HAR and MER) did not.
Nine plans met the standard of submitting a minimum volume of professional and institutional encounters paid in January 2017, by the 15th of February 2017, while two plans (HAR and MER) did not.
All plans met the standard of submitting a minimum volume of professional and institutional encounters paid in February 2017, by the 15th of March 2017.

Table 9: Encounter Data Reporting January 2017

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

Table 10: Encounter Data Reporting February 2017

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

Table 11: Encounter Data Reporting March 2017

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

Pharmacy Encounter Data Reporting

Measure
Timely and complete pharmacy encounter data submission

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

Measurement Period
January 2017 – March 2017

Data Source
MDHHS Data Exchange Gateway, Encounter Data

Measurement Frequency
Monthly

Summary: Ten plans met the standard of submitting a minimum volume of pharmacy encounters paid in December 2016, by the 15th of January 2017, while one plan (UPP) did not.
All plans met the standard of submitting a minimum volume of pharmacy encounters paid in January 2017, by the 15th of February 2017.
All plans met the standard of submitting a minimum volume of pharmacy encounters paid in February 2017, by the 15th of March 2017.

Table 12: Pharmacy Encounter Data Reporting January 2017

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

Table 13: Pharmacy Encounter Data Reporting February 2017

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

Table 14: Pharmacy Encounter Data Reporting March 2017

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

Non-Emergent Medical Transportation (NEMT) Encounter Submissions

Measure
Data submission using appropriate NEMT codes and appropriate Provider IDs for MA-MC, HMP-MC, and CSHCS-MC.

Standard
N/A – Informational Only

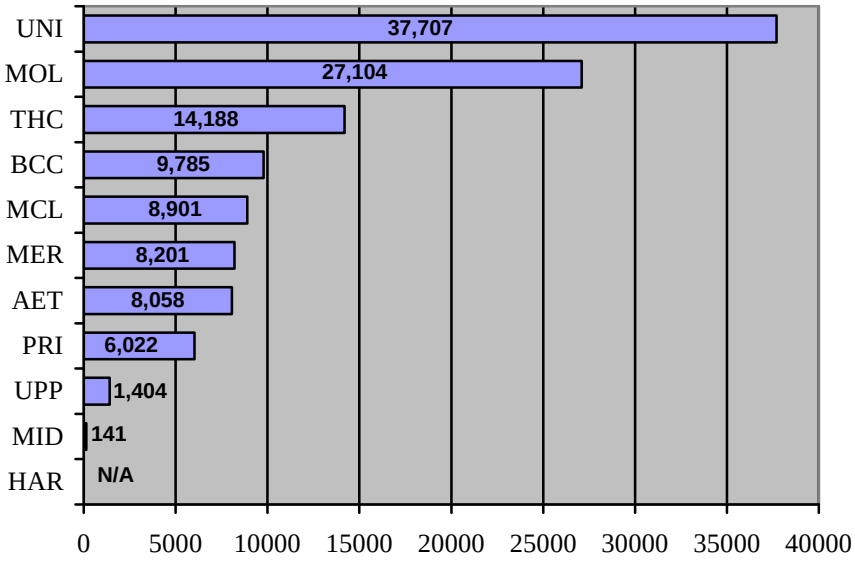
Measurement Period
January 2017 – March 2017

Data Source
MDHHS Data Exchange Gateway, Encounter Data

Measurement Frequency
Quarterly

Summary: The results shown are informational only. For MA-MC results ranged from 141 to 39,107. For HMP results ranged from 20 to 11,878. For CSHCS results ranged from 11 to 1,417.

Figure 4: NEMT MA-MC Encounter Submissions[2]



[2] Results showing "N/A" are for plans who did not submit transportation encounters for this measurement period.

Figure 5: NEMT HMP-MC Encounter Submissions

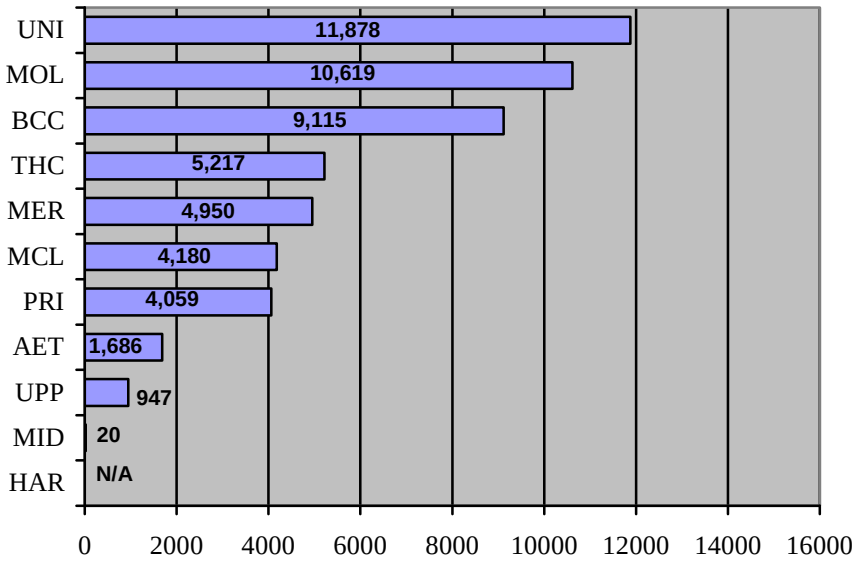
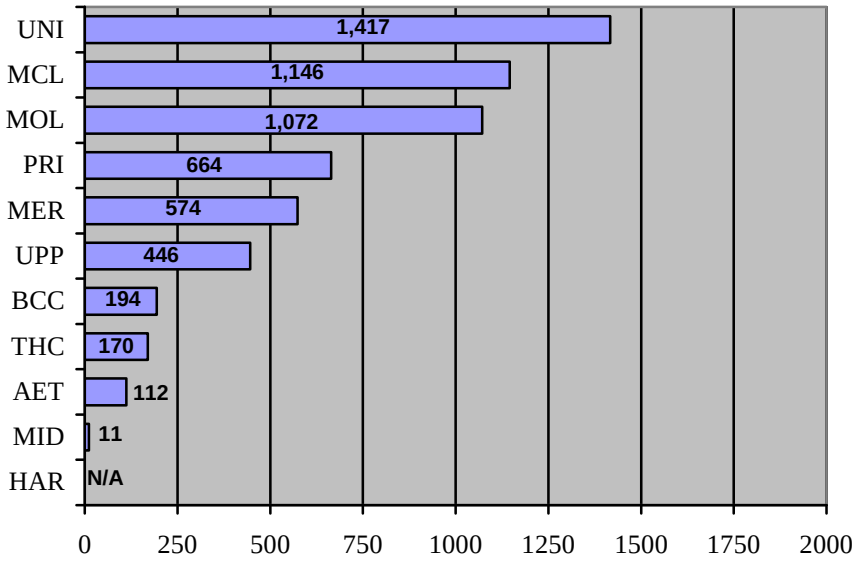


Figure 6: NEMT CSHCS-MC Encounter Submissions



Provider File Reporting

Measure
Monthly provider file submission.

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

Measurement Period
January 2017 – March 2017

Data Source
MDHHS Data Exchange Gateway, Encounter Data

Measurement Frequency
Monthly

Summary: In January and March all plans met the standard of submitting an error free provider file to Michigan ENROLLS by the last Thursday of the month.
In February nine plans met the standard of submitting an error free provider file to Michigan ENROLLS by the last Thursday of the month, while two plans (PRI and UPP) did not.

Table 15: Provider File Reporting

MHP	Standard	Timely			Accurate			Standard Achieved		
		Jan	Feb	Mar	Jan	Feb	Mar	Jan	Feb	Mar
AET	Timely, Complete	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
BCC	Timely, Complete	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
HAR	Timely, Complete	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
MCL	Timely, Complete	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
MER	Timely, Complete	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
MID	Timely, Complete	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
MOL	Timely, Complete	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
PRI	Timely, Complete	Yes	**No**	Yes	Yes	**No**	Yes	Yes	**No**	Yes
THC	Timely, Complete	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
UNI	Timely, Complete	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
UPP	Timely, Complete	Yes	**No**	Yes	Yes	**No**	Yes	Yes	**No**	Yes

Appendix A: Three Letter MHP Codes

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

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

Appendix B: One Year Plan-Specific Analysis

Aetna Better Health of Michigan – AET

Performance Measure	Measurement Period	Standard	Plan Result	Standard Achieved
Blood Lead Testing	Jul 16	81%	72%	**No**
	Aug 16	81%	70%	**No**
	Sep 16	81%	71%	**No**
	Oct 16	**81%**	**70%**	**No**
	Nov 16	**81%**	**70%**	**No**
	Dec 16	**81%**	**72%**	**No**

		Year 1	Result	Standard Achieved	Year 2	Result	Standard Achieved	Year 3	Result	Standard Achieved
Developmental Screening	Oct 16	22%	20.42%	**No**	25%	24.23%	**No**	20%	21.06%	Yes
	Nov 16	22%	21.55%	**No**	25%	25.00%	Yes	20%	21.06%	Yes
	Dec 16	22%	21.38%	**No**	25%	25.55%	Yes	20%	20.68%	Yes
	Jan 17	**22%**	**21.50%**	**No**	**25%**	**26.37%**	**Yes**	**20%**	**20.58%**	**Yes**
	Feb 17	**22%**	**21.30%**	**No**	**25%**	**27.49%**	**Yes**	**20%**	**21.90%**	**Yes**
	Mar 17	**22%**	**21.88%**	**No**	**25%**	**26.99%**	**Yes**	**20%**	**21.64%**	**Yes**

Complaints	Jul 16 – Sep 16	≤.15/1000 MM	0.149	Yes
	Oct 16 – Dec 16	**≤.15/1000 MM**	**0.045**	**Yes**

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

Claims Processing	Aug 16	T/A, ≥95%, ≤12%, ≤1.0%	T/NA, 94%, 5%, 1.15%	**No**
	Sep 16	T/A, ≥95%, ≤12%, ≤1.0%	T/NA, 95% 8%, 2.23%	**No**
	Oct 16	T/A, ≥95%, ≤12%, ≤1.0%	T/NA, 90%, 5%, 1.12%	**No**
	Nov 16	**T/A, ≥95%, ≤12%, ≤1.0%**	**T/NA, 92%, 4%, 0.68%**	**No**
	Dec 16	**T/A, ≥95%, ≤12%, ≤1.0%**	**T/NA, 93%, 4%, 1.87%**	**No**
	Jan 17	**T/A, ≥95%, ≤12%, ≤1.0%**	**T/NA, 94%, 9%, 0.92%**	**No**

Encounter Data	Oct 16	Timely, Complete	T, C	Yes
	Nov 16	Timely, Complete	T, C	Yes
	Dec 16	Timely, Complete	T, C	Yes
	Jan 17	**Timely, Complete**	**T,C**	**Yes**
	Feb 17	**Timely, Complete**	**T,C**	**Yes**
	Mar 17	**Timely, Complete**	**T,C**	**Yes**

Pharmacy Encounter Data	Oct 16	Timely, Complete	T, C	Yes
	Nov 16	Timely, Complete	T, C	Yes
	Dec 16	Timely, Complete	T, C	Yes
	Jan 17	**Timely, Complete**	**T,C**	**Yes**
	Feb 17	**Timely, Complete**	**T,C**	**Yes**
	Mar 17	**Timely, Complete**	**T,C**	**Yes**

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

Aetna Better Health of Michigan – AET

Performance Measure	Measurement	Standard			Plan Result		Standard Achieved		
		MA-MC Standard	MA-MC Result	Standard Achieved	HMP Standard	HMP Result	Standard Achieved	CSHCS Standard	CSHCS Result	Standard Achieved
NEMT Encounter Submission	Jul 16 – Sep 16	N/A	7,356	N/A	N/A	1,543	N/A	N/A	100	N/A
	Oct 16 – Dec 16	**N/A**	**8,058**	**N/A**	**N/A**	**1,686**	**N/A**	**N/A**	**112**	**N/A**

Provider File Reporting	Oct 16	Timely, Accurate	T, A	Yes
	Nov 16	Timely, Accurate	T, A	Yes
	Dec 16	Timely, Accurate	T, A	Yes
	Jan 17	**Timely, Accurate**	**T, A**	**Yes**
	Feb 17	**Timely, Accurate**	**T, A**	**Yes**
	Mar 17	**Timely, Accurate**	**T, A**	**Yes**

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

Appendix B: One Year Plan-Specific Analysis

Blue Cross Complete of Michigan, Inc. – BCC

Performance Measure	Measurement Period	Standard	Plan Result	Standard Achieved
Blood Lead Testing	Jul 16	81%	70%	**No**
	Aug 16	81%	71%	**No**
	Sep 16	81%	71%	**No**
	Oct 16	**81%**	**71%**	**No**
	Nov 16	**81%**	**71%**	**No**
	Dec 16	**81%**	**71%**	**No**

		Year 1	Result	Standard Achieved	Year 2	Result	Standard Achieved	Year 3	Result	Standard Achieved
Developmental Screening	Oct 16	22%	36.60%	Yes	25%	46.05%	Yes	20%	36.40%	Yes
	Nov 16	22%	35.46%	Yes	25%	46.23%	Yes	20%	36.78%	Yes
	Dec 16	22%	33.49%	Yes	25%	46.24%	Yes	20%	35.50%	Yes
	Jan 17	**22%**	**33.36%**	**Yes**	**25%**	**45.34%**	**Yes**	**20%**	**34.17%**	**Yes**
	Feb 17	**22%**	**31.91%**	**Yes**	**25%**	**43.85%**	**Yes**	**20%**	**32.60%**	**Yes**
	Mar 17	**22%**	**30.12%**	**Yes**	**25%**	**42.99%**	**Yes**	**20%**	**32.54%**	**Yes**

Complaints	Jul 16 – Sep 16	<.15/1000 MM	0.037	Yes
	Oct 16 – Dec 16	**<.15/1000 MM**	**0.068**	**Yes**

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

Claims Processing	Aug 16	T/A, ≥95%, ≤12%, ≤1.0%	T/A, 98%, 8%, 0.01%	Yes
	Sep 16	T/A, ≥95%, ≤12%, ≤1.0%	T/A, 100%, 9%, 0.01%	Yes
	Oct 16	T/A, ≥95%, ≤12%, ≤1.0%	T/A, 100%, 10%, 0.00%	Yes
	Nov 16	**T/A, ≥95%, ≤12%, ≤1.0%**	**T/A, 100%, 11%, 0.01%**	**Yes**
	Dec 16	**T/A, ≥95%, ≤12%, ≤1.0%**	**T/A, 100%, 8%, 0.00%**	**Yes**
	Jan 17	**T/A, ≥95%, ≤12%, ≤1.0%**	**T/A, 100%, 9%, 0.00%**	**Yes**

Encounter Data	Oct 16	Timely, Complete	T,C	Yes
	Nov 16	Timely, Complete	T,C	Yes
	Dec 16	Timely, Complete	T,C	Yes
	Jan 17	**Timely, Complete**	**T,C**	**Yes**
	Feb 17	**Timely, Complete**	**T,C**	**Yes**
	Mar 17	**Timely, Complete**	**T,C**	**Yes**

Pharmacy Encounter Data	Oct 16	Timely, Complete	T,C	Yes
	Nov 16	Timely, Complete	T,C	Yes
	Dec 16	Timely, Complete	T,C	Yes
	Jan 17	**Timely, Complete**	**T,C**	**Yes**
	Feb 17	**Timely, Complete**	**T,C**	**Yes**
	Mar 17	**Timely, Complete**	**T,C**	**Yes**

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

Blue Cross Complete of Michigan, Inc. – BCC

Performance Measure	Measurement Period	Standard			Plan Result		Standard		Standard Achieved
		MA-MC Standard	MA-MC Result	Standard Achieved	HMP Standard	HMP Result	Standard Achieved	CSHCS Standard	CSHCS Result	Standard Achieved
NEMT Encounter Submission	Jul 16 – Sep 16	N/A	9,286	N/A	N/A	8,300	N/A	N/A	211	N/A
	Oct 16 – Dec 16	**N/A**	**9,785**	**N/A**	**N/A**	**9,115**	**N/A**	**N/A**	**194**	**N/A**

Provider File Reporting	Oct 16	Timely, Accurate	T, A	Yes
	Nov 16	Timely, Accurate	T, A	Yes
	Dec 16	Timely, Accurate	T, A	Yes
	Jan 17	**Timely, Accurate**	**T, A**	**Yes**
	Feb 17	**Timely, Accurate**	**T, A**	**Yes**
	Mar 17	**Timely, Accurate**	**T, A**	**Yes**

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

Appendix B: One Year Plan-Specific Analysis

Harbor Health Plan, Inc. – HAR

Performance Measure	Measurement Period	Standard	Plan Result	Standard Achieved
Blood Lead Testing	Jul 16	81%	67%	**No**
	Aug 16	81%	66%	**No**
	Aug 16	81%	65%	**No**
	Oct 16	**81%**	**61%**	**No**
	Nov 16	**81%**	**63%**	**No**
	Dec 16	**81%**	**65%**	**No**

		Year 1	Result	Standard Achieved	Year 2	Result	Standard Achieved	Year 3	Result	Standard Achieved
Developmental Screening	Oct 16	22%	27.69%	Yes	25%	14.89%	**No**	20%	5.45%	**No**
	Nov 16	22%	21.55%	**No**	25%	25.00%	Yes	20%	21.06%	Yes
	Dec 16	22%	21.38%	**No**	25%	25.55%	Yes	20%	20.68%	Yes
	Jan 17	**22%**	**31.43%**	**Yes**	**25%**	**11.90%**	**No**	**20%**	**6.35%**	**No**
	Feb 17	**22%**	**30.56%**	**Yes**	**25%**	**11.43%**	**No**	**20%**	**11.48%**	**No**
	Mar 17	**22%**	**27.40%**	**Yes**	**25%**	**16.67%**	**No**	**20%**	**10.53%**	**No**

Complaints	Jul 16 – Sep 16	<.15/1000 MM	0.000	Yes
	Oct 16 – Dec 16	**<.15/1000 MM**	**0.038**	**Yes**

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

Claims Processing	Aug 16	T/A, ≥95%, ≤12%, ≤1.0%	T/NA, 100%, 0%, 1.44%	**No**
	Sep 16	T/A, ≥95%, ≤12%, ≤1.0%	T/A, 100%, 0%, 0.26%	Yes
	Oct 16	T/A, ≥95%, ≤12%, ≤1.0%	T/A, 100%, 0%, 0.25%	Yes
	Nov 16	**T/A, ≥95%, ≤12%, ≤1.0%**	**T/A, 100%, 0%, 0.26%**	**Yes**
	Dec 16	**T/A, ≥95%, ≤12%, ≤1.0%**	**T/A, 100%, 0%, 0.21%**	**Yes**
	Jan 17	**T/A, ≥95%, ≤12%, ≤1.0%**	**T/A, 96%, 0%, 0.35%**	**Yes**

Encounter Data	Oct 16	Timely, Complete	T,C	Yes
	Nov 16	Timely, Complete	T,C	Yes
	Dec 16	Timely, Complete	T,C	Yes
	Jan 17	**Timely, Complete**	**T,NC**	**No**
	Feb 17	**Timely, Complete**	**T,NC**	**No**
	Mar 17	**Timely, Complete**	**T,C**	**Yes**

Pharmacy Encounter Data	Oct 16	Timely, Complete	T,NC	**No**
	Nov 16	Timely, Complete	T,C	Yes
	Dec 16	Timely, Complete	T,C	Yes
	Jan 17	**Timely, Complete**	**T,C**	**Yes**
	Feb 17	**Timely, Complete**	**T,C**	**Yes**
	Mar 17	**Timely, Complete**	**T,C**	**Yes**

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

Harbor Health Plan, Inc. – HAR

Performance Measure	Measurement Period	Standard			Plan Result		Standard Achieved		
		MA-MC Standard	MA-MC Result	Standard Achieved	HMP Standard	HMP Result	Standard Achieved	CSHCS Standard	CSHCS Result	CSHCS Standard Achieved
NEMT Encounter Submission	Jul 16 – Sep 16	N/A	6	N/A	N/A	4	N/A	N/A	0	N/A
	Oct 16 – Dec 16	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**

Provider File Reporting	Oct 16	Timely, Accurate	T, A	Yes
	Nov 16	Timely, Accurate	T, A	Yes
	Dec 16	Timely, Accurate	T, A	Yes
	Jan 17	**Timely, Accurate**	**T, A**	**Yes**
	Feb 17	**Timely, Accurate**	**T, A**	**Yes**
	Mar 17	**Timely, Accurate**	**T, A**	**Yes**

- 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

Performance Measure	Measurement Period	Standard	Plan Result	Standard Achieved
Blood Lead Testing	Jul 16	81%	83%	Yes
	Aug 16	81%	84%	Yes
	Aug 16	81%	84%	Yes
	Oct 16	**81%**	**85%**	**Yes**
	Nov 16	**81%**	**85%**	**Yes**
	Dec 16	**81%**	**85%**	**Yes**

		Year 1	Result	Standard Achieved	Year 2	Result	Standard Achieved	Year 3	Result	Standard Achieved
Developmental Screening	Oct 16	22%	25.52%	Yes	25%	30.64%	Yes	20%	23.11%	Yes
	Nov 16	22%	25.44%	Yes	25%	32.45%	Yes	20%	23.40%	Yes
	Dec 16	22%	25.80%	Yes	25%	33.35%	Yes	20%	23.52%	Yes
	Jan 17	**22%**	**27.02%**	**Yes**	**25%**	**33.45%**	**Yes**	**20%**	**24.10%**	**Yes**
	Feb 17	**22%**	**27.81%**	**Yes**	**25%**	**34.96%**	**Yes**	**20%**	**24.21%**	**Yes**
	Mar 17	**22%**	**28.29%**	**Yes**	**25%**	**35.62%**	**Yes**	**20%**	**25.43%**	**Yes**

Complaints	Jul 16 – Sep 16	<.15/1000 MM	0.032	Yes
	Oct 16 – Dec 16	**<.15/1000 MM**	**0.084**	**Yes**

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

Claims Processing	Aug 16	T/A, ≥95%, ≤12%, ≤1.0%	T/A, 100%, 3%, 0.07%	Yes
	Sep 16	T/A, ≥95%, ≤12%, ≤1.0%	T/A, 100%, 4%, 0.06%	Yes
	Oct 16	T/A, ≥95%, ≤12%, ≤1.0%	T/A, 100%, 3%, 0.09%	Yes
	Nov 16	**T/A, ≥95%, ≤12%, ≤1.0%**	**T/A, 100%, 3%, 0.09%**	**Yes**
	Dec 16	**T/A, ≥95%, ≤12%, ≤1.0%**	**T/A, 98%, 4%, 0.37%**	**Yes**
	Jan 17	**T/A, ≥95%, ≤12%, ≤1.0%**	**T/A, 100%, 4%, 0.26%**	**Yes**

Encounter Data	Oct 16	Timely, Complete	T,C	Yes
	Nov 16	Timely, Complete	T,C	Yes
	Dec 16	Timely, Complete	T,C	Yes
	Jan 17	**Timely, Complete**	**T,C**	**Yes**
	Feb 17	**Timely, Complete**	**T,C**	**Yes**
	Mar 17	**Timely, Complete**	**T,C**	**Yes**

Pharmacy Encounter Data	Oct 16	Timely, Complete	T,C	Yes
	Nov 16	Timely, Complete	T,C	Yes
	Dec 16	Timely, Complete	T,C	Yes
	Jan 17	**Timely, Complete**	**T,C**	**Yes**
	Feb 17	**Timely, Complete**	**T,C**	**Yes**
	Mar 17	**Timely, Complete**	**T,C**	**Yes**

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

McLaren Health Plan – MCL

Performance Measure	Measurement Period	Standard			Plan Result		Standard Achieved		
		MA-MC Standard	MA-MC Result	Standard Achieved	HMP Standard	HMP Result	Standard Achieved	CSHCS Standard	CSHCS Result	Standard Achieved
NEMT Encounter Submission	Jul 16 – Sep 16	N/A	8,678	N/A	N/A	4,492	N/A	N/A	705	N/A
	Oct 16 – Dec 16	**N/A**	**8,901**	**N/A**	**N/A**	**4,180**	**N/A**	**N/A**	**1,146**	**N/A**

Provider File Reporting	Oct 16	Timely, Accurate	T, A	Yes
	Nov 16	Timely, Accurate	T, A	Yes
	Dec 16	Timely, Accurate	T, A	Yes
	Jan 17	**Timely, Accurate**	**T, A**	**Yes**
	Feb 17	**Timely, Accurate**	**T, A**	**Yes**
	Mar 17	**Timely, Accurate**	**T, A**	**Yes**

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

Appendix B: One Year Plan-Specific Analysis

Meridian Health Plan – MER

Performance Measure	Measurement Period	Standard	Plan Result	Standard Achieved
Blood Lead Testing	Jul 16	81%	77%	**No**
	Aug 16	81%	77%	**No**
	Aug 16	81%	77%	**No**
	Oct 16	**81%**	**77%**	**No**
	Nov 16	**81%**	**77%**	**No**
	Dec 16	**81%**	**78%**	**No**

		Year 1	Result	Standard Achieved	Year 2	Result	Standard Achieved	Year 3	Result	Standard Achieved
Developmental Screening	Oct 16	22%	24.26%	Yes	25%	31.58%	Yes	20%	24.63%	Yes
	Nov 16	22%	24.64%	Yes	25%	32.16%	Yes	20%	25.09%	Yes
	Dec 16	22%	25.02%	Yes	25%	31.97%	Yes	20%	25.62%	Yes
	Jan 17	**22%**	**25.06%**	**Yes**	**25%**	**32.43%**	**Yes**	**20%**	**26.23%**	**Yes**
	Feb 17	**22%**	**25.63%**	**Yes**	**25%**	**32.34%**	**Yes**	**20%**	**26.10%**	**Yes**
	Mar 17	**22%**	**25.51%**	**Yes**	**25%**	**32.70%**	**Yes**	**20%**	**27.21%**	**Yes**

Complaints	Jul 16 – Sep 16	<.15/1000 MM	0.059	Yes
	Oct 16 – Dec 16	**<.15/1000 MM**	**0.072**	**Yes**

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

Claims Processing	Aug 16	T/A, ≥95%, ≤12%, ≤1.0%	T/A, 98%, 7%, 0.00%	Yes
	Sep 16	T/A, ≥95%, ≤12%, ≤1.0%	T/A, 99%, 7%, 0.00%	Yes
	Oct 16	T/A, ≥95%, ≤12%, ≤1.0%	T/A, 100%, 6%, 0.00%	Yes
	Nov 16	**T/A, ≥95%, ≤12%, ≤1.0%**	**T/A, 99%, 5%, 0.00%**	**Yes**
	Dec 16	**T/A, ≥95%, ≤12%, ≤1.0%**	**T/A, 96%, 9%, 0.00%**	**Yes**
	Jan 17	**T/A, ≥95%, ≤12%, ≤1.0%**	**T/A, 97%, 8%, 0.00%**	**Yes**

Encounter Data	Oct 16	Timely, Complete	T,C	Yes
	Nov 16	Timely, Complete	T,C	Yes
	Dec 16	Timely, Complete	T,C	Yes
	Jan 17	**Timely, Complete**	**T,NC**	**No**
	Feb 17	**Timely, Complete**	**T, NC**	**No**
	Mar 17	**Timely, Complete**	**T,C**	**Yes**

Pharmacy Encounter Data	Oct 16	Timely, Complete	T,C	Yes
	Nov 16	Timely, Complete	T,NC	**No**
	Dec 16	Timely, Complete	NT, NC	**No**
	Jan 17	**Timely, Complete**	**T,C**	**Yes**
	Feb 17	**Timely, Complete**	**T,C**	**Yes**
	Mar 17	**Timely, Complete**	**T,C**	**Yes**

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

Meridian Health Plan – MER

Performance Measure	Measurement Period	Standard			Plan Result		Standard Achieved		
		MA-MC Standard	MA-MC Result	Standard Achieved	HMP Standard	HMP Result	Standard Achieved	CSHCS Standard	CSHCS Result	Standard Achieved
NEMT Encounter Submission	Jul 16 – Sep 16	N/A	24,077	N/A	N/A	15,172	N/A	N/A	1,643	N/A
	Oct 16 – Dec 16	**N/A**	**8,201**	**N/A**	**N/A**	**4,950**	**N/A**	**N/A**	**574**	**N/A**

Provider File Reporting	Oct 16	Timely, Accurate	T, A	Yes
	Nov 16	Timely, Accurate	T, A	Yes
	Dec 16	Timely, Accurate	T, A	Yes
	Jan 17	**Timely, Accurate**	**T, A**	**Yes**
	Feb 17	**Timely, Accurate**	**T, A**	**Yes**
	Mar 17	**Timely, Accurate**	**T, A**	**Yes**

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

Appendix B: One Year Plan-Specific Analysis

HAP Midwest Health Plan, Inc. – MID

Performance Measure	Measurement Period	Standard	Plan Result	Standard Achieved
Blood Lead Testing	Jul 16	81%	67%	**No**
	Aug 16	81%	67%	**No**
	Aug 16	81%	67%	**No**
	Oct 16	**81%**	**71%**	**No**
	Nov 16	**81%**	**78%**	**No**
	Dec 16	**81%**	**75%**	**No**

		Year 1	Result	Standard Achieved	Year 2	Result	Standard Achieved	Year 3	Result	Standard Achieved
Developmental Screening	Oct 16	22%	30.22%	Yes	25%	37.81%	Yes	20%	31.25%	Yes
	Nov 16	22%	28.92%	Yes	25%	40.96%	Yes	20%	31.63%	Yes
	Dec 16	22%	28.42%	Yes	25%	40.96%	Yes	20%	32.16%	Yes
	Jan 17	**22%**	**30.34%**	**Yes**	**25%**	**41.90%**	**Yes**	**20%**	**30.53%**	**Yes**
	Feb 17	**22%**	**30.23%**	**Yes**	**25%**	**42.42%**	**Yes**	**20%**	**25.89%**	**Yes**
	Mar 17	**22%**	**55.56%**	**Yes**	**25%**	**66.67%**	**Yes**	**20%**	**25.00%**	**Yes**

Complaints	Jul 16 – Sep 16	<.15/1000 MM	0.000	Yes
	Oct 16 – Dec 16	**≤.15/1000 MM**	**0.000**	**Yes**

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

Claims Processing	Aug 16	T/A, ≥95%, ≤12%, ≤1.0%	T/A, 100%, 8%, 0.00%	Yes
	Sep 16	T/A, ≥95%, ≤12%, ≤1.0%	T/A, 100%, 12%, 0.00%	Yes
	Oct 16	T/A, ≥95%, ≤12%, ≤1.0%	T/NA, 100%, 16%, 0.00%	**No**
	Nov 16	**T/A, ≥95%, ≤12%, ≤1.0%**	**T/NA, 100%, 17%, 0.00%**	**No**
	Dec 16	**T/A, ≥95%, ≤12%, ≤1.0%**	**T/A, 100%, 8%, 0.00%**	**Yes**
	Jan 17	**T/A, ≥95%, ≤12%, ≤1.0%**	**T/A, 100%, 9%, 0.00%**	**Yes**

Encounter Data	Oct 16	Timely, Complete	T,C	Yes
	Nov 16	Timely, Complete	T,C	Yes
	Dec 16	Timely, Complete	T,C	Yes
	Jan 17	**Timely, Complete**	**T,C**	**Yes**
	Feb 17	**Timely, Complete**	**T,C**	**Yes**
	Mar 17	**Timely, Complete**	**T,C**	**Yes**

Pharmacy Encounter Data	Oct 16	Timely, Complete	T,C	Yes
	Nov 16	Timely, Complete	T,C	Yes
	Dec 16	Timely, Complete	T,C	Yes
	Jan 17	**Timely, Complete**	**T,C**	**Yes**
	Feb 17	**Timely, Complete**	**T,C**	**Yes**
	Mar 17	**Timely, Complete**	**T,C**	**Yes**

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

HAP Midwest Health Plan, Inc. – MID

Performance Measure	Measurement Period	Standard			Plan Result		Standard Achieved		
		MA-MC Standard	MA-MC Result	Standard Achieved	HMP Standard	HMP Result	Standard Achieved	CSHCS Standard	CSHCS Result	Standard Achieved
NEMT Encounter Submission	Jul 16 – Sep 16	N/A	81	N/A	N/A	40	N/A	N/A	24	N/A
	Oct 16 – Dec 16	**N/A**	**141**	**N/A**	**N/A**	**20**	**N/A**	**N/A**	**11**	**N/A**

Provider File Reporting	Oct 16	Timely, Accurate	T, A	Yes
	Nov 16	Timely, Accurate	T, A	Yes
	Dec 16	Timely, Accurate	T, A	Yes
	Jan 17	**Timely, Accurate**	**T, A**	**Yes**
	Feb 17	**Timely, Accurate**	**T, A**	**Yes**
	Mar 17	**Timely, Accurate**	**T, A**	**Yes**

- 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

Performance Measure	Measurement Period	Standard	Plan Result	Standard Achieved
Blood Lead Testing	Jul 16	81%	70%	**No**
	Aug 16	81%	71%	**No**
	Aug 16	81%	71%	**No**
	Oct 16	**81%**	**71%**	**No**
	Nov 16	**81%**	**73%**	**No**
	Dec 16	**81%**	**73%**	**No**

		Year 1	Result	Standard Achieved	Year 2	Result	Standard Achieved	Year 3	Result	Standard Achieved
Developmental Screening	Oct 16	22%	26.25%	Yes	25%	30.89%	Yes	20%	23.64%	Yes
	Nov 16	22%	26.62%	Yes	25%	31.89%	Yes	20%	24.50%	Yes
	Dec 16	22%	27.24%	Yes	25%	33.13%	Yes	20%	24.86%	Yes
	Jan 17	**22%**	**27.92%**	**Yes**	**25%**	**33.30%**	**Yes**	**20%**	**25.45%**	**Yes**
	Feb 17	**22%**	**28.31%**	**Yes**	**25%**	**34.25%**	**Yes**	**20%**	**26.31%**	**Yes**
	Mar 17	**22%**	**28.25%**	**Yes**	**25%**	**33.96%**	**Yes**	**20%**	**25.93%**	**Yes**

Complaints	Jul 16 – Sep 16	<.15/1000 MM	0.038	Yes
	Oct 16 – Dec 16	**<.15/1000 MM**	**0.067**	**Yes**

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

Claims Processing	Aug 16	T/A, ≥95%, ≤12%, ≤1.0%	T/A, 100%, 2%, 0.31%	Yes
	Sep 16	T/A, ≥95%, ≤12%, ≤1.0%	T/A, 100%, 0%, 1.44%	**No**
	Oct 16	T/A, ≥95%, ≤12%, ≤1.0%	T/A, 100%, 2%, 3.28%	**No**
	Nov 16	**T/A, ≥95%, ≤12%, ≤1.0%**	**T/NA, 100%, 2%,3.21%**	**No**
	Dec 16	**T/A, ≥95%, ≤12%, ≤1.0%**	**T/A, 100%, 2%, 0.08%**	**Yes**
	Jan 17	**T/A, ≥95%, ≤12%, ≤1.0%**	**T/A, 100%, 2%, 0.14%**	**Yes**

Encounter Data	Oct 16	Timely, Complete	T,C	Yes
	Nov 16	Timely, Complete	T,C	Yes
	Dec 16	Timely, Complete	T,C	Yes
	Jan 17	**Timely, Complete**	**T,C**	**Yes**
	Feb 17	**Timely, Complete**	**T,C**	**Yes**
	Mar 17	**Timely, Complete**	**T,C**	**Yes**

Pharmacy Encounter Data	Oct 16	Timely, Complete	T,C	Yes
	Nov 16	Timely, Complete	T,C	Yes
	Dec 16	Timely, Complete	T,C	Yes
	Jan 17	**Timely, Complete**	**T,C**	**Yes**
	Feb 17	**Timely, Complete**	**T,C**	**Yes**
	Mar 17	**Timely, Complete**	**T,C**	**Yes**

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

Molina Healthcare of Michigan – MOL

Performance Measure	Measurement Period	Standard			Plan Result		Standard Achieved		
		MA-MC Standard	MA-MC Result	Standard Achieved	HMP Standard	HMP Result	Standard Achieved	CSHCS Standard	CSHCS Result	Standard Achieved
NEMT Encounter Submission	Jul 16 – Sep 16	N/A	27,213	N/A	N/A	10,482	N/A	N/A	1392	N/A
	Oct 16 – Dec 16	**N/A**	**27,104**	**N/A**	**N/A**	**10,619**	**N/A**	**N/A**	**1,072**	**N/A**

Provider File Reporting	Oct 16	Timely, Accurate	T, A	Yes
	Nov 16	Timely, Accurate	T, A	Yes
	Dec 16	Timely, Accurate	T, A	Yes
	Jan 17	**Timely, Accurate**	**T, A**	**Yes**
	Feb 17	**Timely, Accurate**	**T, A**	**Yes**
	Mar 17	**Timely, Accurate**	**T, A**	**Yes**

- 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

Performance Measure	Measurement Period	Standard	Plan Result	Standard Achieved
Blood Lead Testing	Jul 16	81%	82%	Yes
	Aug 16	81%	82%	Yes
	Aug 16	81%	82%	Yes
	Oct 16	**81%**	**82%**	**Yes**
	Nov 16	**81%**	**81%**	**Yes**
	Dec 16	**81%**	**81%**	**Yes**

		Year 1	Result	Standard Achieved	Year 2	Result	Standard Achieved	Year 3	Result	Standard Achieved
Developmental Screening	Oct 16	22%	22.01%	Yes	25%	38.07%	Yes	20%	34.15%	Yes
	Nov 16	22%	22.26%	Yes	25%	37.36%	Yes	20%	34.07%	Yes
	Dec 16	22%	22.46%	Yes	25%	38.12%	Yes	20%	33.52%	Yes
	Jan 17	**22%**	**23.00%**	**Yes**	**25%**	**37.53%**	**Yes**	**20%**	**33.44%**	**Yes**
	Feb 17	**22%**	**23.27%**	**Yes**	**25%**	**37.03%**	**Yes**	**20%**	**32.71%**	**Yes**
	Mar 17	**22%**	**23.94%**	**Yes**	**25%**	**35.27%**	**Yes**	**20%**	**32.31%**	**Yes**

Complaints	Jul 16 – Sep 16	<.15/1000 MM	0.035	Yes
	Oct 16 – Dec 16	**<.15/1000 MM**	**0.073**	**Yes**

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

Claims Processing	Aug 16	T/A, ≥95%, ≤12%, ≤1.0%	T/A, 99%, 6%, 0.07%	Yes
	Sep 16	T/A, ≥95%, ≤12%, ≤1.0%	T/A, 99%, 5%, 0.02%	Yes
	Oct 16	T/A, ≥95%, ≤12%, ≤1.0%	T/A, 99%, 5%, 0.09%	Yes
	Nov 16	**T/A, ≥95%, ≤12%, ≤1.0%**	**T/A, 99%, 4%, 0.03%**	**Yes**
	Dec 16	**T/A, ≥95%, ≤12%, ≤1.0%**	**T/A, 99%, 5%, 0.01%**	**Yes**
	Jan 17	**T/A, ≥95%, ≤12%, ≤1.0%**	**T/A, 99%, 6%, 0.01%**	**Yes**

Encounter Data	Oct 16	Timely, Complete	T,C	Yes
	Nov 16	Timely, Complete	T,C	Yes
	Dec 16	Timely, Complete	T,C	Yes
	Jan 17	**Timely, Complete**	**T,C**	**Yes**
	Feb 17	**Timely, Complete**	**T,C**	**Yes**
	Mar 17	**Timely, Complete**	**T,C**	**Yes**

Pharmacy Encounter Data	Oct 16	Timely, Complete	T,C	Yes
	Nov 16	Timely, Complete	T,C	Yes
	Dec 16	Timely, Complete	T,C	Yes
	Jan 17	**Timely, Complete**	**T,C**	**Yes**
	Feb 17	**Timely, Complete**	**T,C**	**Yes**
	Mar 17	**Timely, Complete**	**T,C**	**Yes**

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

Priority Health Choice – PRI

Performance Measure	Measurement Period	Standard			Plan Result		Standard Achieved		
		MA-MC Standard	MA-MC Result	Standard Achieved	HMP Standard	HMP Result	Standard Achieved	CSHCS Standard	CSHCS Result	Standard Achieved
NEMT Encounter Submission	Jul 16 – Sep 16	N/A	5,569	N/A	N/A	3,827	N/A	N/A	672	N/A
	Oct 16 – Dec 16	**N/A**	**6,022**	**N/A**	**N/A**	**4,059**	**N/A**	**N/A**	**664**	**N/A**

Provider File Reporting	Oct 16	Timely, Accurate	T, A	Yes
	Nov 16	Timely, Accurate	T, A	Yes
	Dec 16	Timely, Accurate	T, A	Yes
	Jan 17	**Timely, Accurate**	**T, A**	**Yes**
	Feb 17	**Timely, Accurate**	**NT, NA**	**No**
	Mar 17	**Timely, Accurate**	**T, A**	**Yes**

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- For questions regarding measurement periods or standards, see the Performance Monitoring Specifications

Appendix B: One Year Plan-Specific Analysis

Total Health Care – THC

Performance Measure	Measurement Period	Standard	Plan Result	Standard Achieved
Blood Lead Testing	Jul 16	81%	66%	**No**
	Aug 16	81%	65%	**No**
	Aug 16	81%	64%	**No**
	Oct 16	**81%**	**63%**	**No**
	Nov 16	**81%**	**65%**	**No**
	Dec 16	**81%**	**64%**	**No**

		Year 1	Result	Standard Achieved	Year 2	Result	Standard Achieved	Year 3	Result	Standard Achieved
Developmental Screening	Oct 16	22%	Yes	22.39%	25%	Yes	27.22%	20%	21.20%	Yes
	Nov 16	22%	Yes	23.53%	25%	Yes	26.72%	20%	22.22%	Yes
	Dec 16	22%	Yes	22.58%	25%	Yes	26.41%	20%	23.51%	Yes
	Jan 17	**22%**	**23.06%**	**Yes**	**25%**	**26.64%**	**Yes**	**20%**	**23.76%**	**Yes**
	Feb 17	**22%**	**22.66%**	**Yes**	**25%**	**27.22%**	**Yes**	**20%**	**25.45%**	**Yes**
	Mar 17	**22%**	**22.12%**	**Yes**	**25%**	**25.96%**	**Yes**	**20%**	**26.06%**	**Yes**

Complaints	Jul 16 – Sep 16	<.15/1000 MM	0.090	Yes
	Oct 16 – Dec 16	**≤.15/1000 MM**	**0.036**	**Yes**

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

Claims Processing	Aug 16	T/A, ≥95%, ≤12%, ≤1.0%	T/A, 100%, 3%, 0.00%	Yes
	Sep 16	T/A, ≥95%, ≤12%, ≤1.0%	T/A, 100%, 2%, 0.00%	Yes
	Oct 16	T/A, ≥95%, ≤12%, ≤1.0%	T/A, 100%, 2%, 0.00%	Yes
	Nov 16	**T/A, ≥95%, ≤12%, ≤1.0%**	**T/A, 100%, 2%, 0.00%**	**Yes**
	Dec 16	**T/A, ≥95%, ≤12%, ≤1.0%**	**T/A, 100%, 2%, 0.00%**	**Yes**
	Jan 17	**T/A, ≥95%, ≤12%, ≤1.0%**	**T/A, 100%, 2%, 0.00%**	**Yes**

Encounter Data	Oct 16	Timely, Complete	T,C	Yes
	Nov 16	Timely, Complete	T,C	Yes
	Dec 16	Timely, Complete	T,C	Yes
	Jan 17	**Timely, Complete**	**T,C**	**Yes**
	Feb 17	**Timely, Complete**	**T,C**	**Yes**
	Mar 17	**Timely, Complete**	**T,C**	**Yes**

Pharmacy Encounter Data	Oct 16	Timely, Complete	T,C	Yes
	Nov 16	Timely, Complete	T,C	Yes
	Dec 16	Timely, Complete	T,C	Yes
	Jan 17	**Timely, Complete**	**T,C**	**Yes**
	Feb 17	**Timely, Complete**	**T,C**	**Yes**
	Mar 17	**Timely, Complete**	**T,C**	**Yes**

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- For questions regarding measurement periods or standards, see the Performance Monitoring Specifications

Total Health Care – THC

Performance Measure	Measurement Period	Standard			Plan Result		Standard Achieved		
		MA-MC Standard	MA-MC Result	Standard Achieved	HMP Standard	HMP Result	Standard Achieved	CSHCS Standard	CSHCS Result	Standard Achieved
NEMT Encounter Submission	Jul 16 – Sep 16	N/A	8,758	N/A	N/A	3,116	N/A	N/A	109	N/A
	Oct 16 – Dec 16	**N/A**	**14,188**	**N/A**	**N/A**	**5,217**	**N/A**	**N/A**	**170**	**N/A**

Provider File Reporting	Oct 16	Timely, Accurate	T, A	Yes
	Nov 16	Timely, Accurate	T, A	Yes
	Dec 16	Timely, Accurate	T, A	Yes
	Jan 17	**Timely, Accurate**	**T, A**	**Yes**
	Feb 17	**Timely, Accurate**	**T, A**	**Yes**
	Mar 17	**Timely, Accurate**	**T, A**	**Yes**

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- For questions regarding measurement periods or standards, see the Performance Monitoring Specifications

Appendix B: One Year Plan-Specific Analysis

UnitedHealthcare Community Plan – UNI

Performance Measure	Measurement Period	Standard	Plan Result	Standard Achieved
Blood Lead Testing	Jul 16	81%	76%	**No**
	Aug 16	81%	76%	**No**
	Aug 16	81%	76%	**No**
	Oct 16	**81%**	**76%**	**No**
	Nov 16	**81%**	**75%**	**No**
	Dec 16	**81%**	**75%**	**No**

		Year 1	Result	Standard Achieved	Year 2	Result	Standard Achieved	Year 3	Result	Standard Achieved
Developmental Screening	Oct 16	22%	25.20%	Yes	25%	31.50%	Yes	20%	25.32%	Yes
	Nov 16	22%	25.35%	Yes	25%	32.25%	Yes	20%	25.78%	Yes
	Dec 16	22%	25.47%	Yes	25%	33.40%	Yes	20%	25.55%	Yes
	Jan 17	**22%**	**25.77%**	**Yes**	**25%**	**33.27%**	**Yes**	**20%**	**25.91%**	**Yes**
	Feb 17	**22%**	**26.29%**	**Yes**	**25%**	**33.54%**	**Yes**	**20%**	**25.97%**	**Yes**
	Mar 17	**22%**	**27.12%**	**Yes**	**25%**	**34.57%**	**Yes**	**20%**	**26.50%**	**Yes**

Complaints	Jul 16 – Sep 16	<.15/1000 MM	0.143	Yes
	Oct 16 – Dec 16	**≤.15/1000 MM**	**0.068**	**Yes**

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

Claims Processing	Aug 16	T/A, ≥95%, ≤12%, ≤1.0%	T/A, 100%, 7%, 0.02%	Yes
	Sep 16	T/A, ≥95%, ≤12%, ≤1.0%	T/A, 100%, 7%, 0.02%	Yes
	Oct 16	T/A, ≥95%, ≤12%, ≤1.0%	T/A, 100%, 7%, 0.03%	Yes
	Nov 16	**T/A, ≥95%, ≤12%, ≤1.0%**	**T/A, 100%, 6%, 0.02%**	**Yes**
	Dec 16	**T/A, ≥95%, ≤12%, ≤1.0%**	**T/A, 100%, 8%, 0.11%**	**Yes**
	Jan 17	**T/A, ≥95%, ≤12%, ≤1.0%**	**T/A, 100%, 7%, 0.05%**	**Yes**

Encounter Data	Oct 16	Timely, Complete	T,C	Yes
	Nov 16	Timely, Complete	T,C	Yes
	Dec 16	Timely, Complete	T,C	Yes
	Jan 17	**Timely, Complete**	**T,C**	**Yes**
	Feb 17	**Timely, Complete**	**T,C**	**Yes**
	Mar 17	**Timely, Complete**	**T,C**	**Yes**

Pharmacy Encounter Data	Oct 16	Timely, Complete	T,C	Yes
	Nov 16	Timely, Complete	T,C	Yes
	Dec 16	Timely, Complete	T,C	Yes
	Jan 17	**Timely, Complete**	**T,C**	**Yes**
	Feb 17	**Timely, Complete**	**T,C**	**Yes**
	Mar 17	**Timely, Complete**	**T,C**	**Yes**

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

UnitedHealthcare Community Plan – UNI

Performance Measure	Measurement Period	Standard			Plan Result		Standard Achieved		
		MA-MC Standard	MA-MC Result	Standard Achieved	HMP Standard	HMP Result	Standard Achieved	CSHCS Standard	CSHCS Result	Standard Achieved
NEMT Encounter Submission	Jul 16 – Sep 16	N/A	39,107	N/A	N/A	12,574	N/A	N/A	1,827	N/A
	Oct 16 – Dec 16	**N/A**	**37,707**	**N/A**	**N/A**	**11,878**	**N/A**	**N/A**	**1,417**	**N/A**

Provider File Reporting	Oct 16	Timely, Accurate	T, A	Yes
	Nov 16	Timely, Accurate	T, A	Yes
	Dec 16	Timely, Accurate	T, A	Yes
	Jan 17	**Timely, Accurate**	**T, A**	**Yes**
	Feb 17	**Timely, Accurate**	**T, A**	**Yes**
	Mar 17	**Timely, Accurate**	**T, A**	**Yes**

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- For questions regarding measurement periods or standards, see the Performance Monitoring Specifications

Appendix B: One Year Plan-Specific Analysis

Upper Peninsula Health Plan – UPP

Performance Measure	Measurement Period	Standard	Plan Result	Standard Achieved
Blood Lead Testing	Jul 16	81%	85%	Yes
	Aug 16	81%	84%	Yes
	Aug 16	81%	84%	Yes
	Oct 16	**81%**	**84%**	**Yes**
	Nov 16	**81%**	**85%**	**Yes**
	Dec 16	**81%**	**84%**	**Yes**

		Year 1	Result	Standard Achieved	Year 2	Result	Standard Achieved	Year 3	Result	Standard Achieved
Developmental Screening	Oct 16	22%	9.70%	**No**	25%	10.23%	**No**	20%	11.99%	**No**
	Nov 16	22%	8.98%	**No**	25%	10.56%	**No**	20%	11.53%	**No**
	Dec 16	22%	8.66%	**No**	25%	10.53%	**No**	20%	12.32%	**No**
	Jan 17	**22%**	**9.13%**	**No**	**25%**	**11.67%**	**No**	**20%**	**12.13%**	**No**
	Feb 17	**22%**	**9.02%**	**No**	**25%**	**11.73%**	**No**	**20%**	**12.80%**	**No**
	Mar 17	**22%**	**10.29%**	**No**	**25%**	**12.88%**	**No**	**20%**	**12.84%**	**No**

Complaints	Jul 16 – Sep 16	<.15/1000 MM	0.031	Yes
	Oct 16 – Dec 16	**<.15/1000 MM**	**0.000**	**Yes**

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

Claims Processing	Aug 16	T/A, ≥95%, ≤12%, ≤1.0%	T/A, 99%, 9%, 0.00%	Yes
	Sep 16	T/A, ≥95%, ≤12%, ≤1.0%	T/A, 100%, 8%, 0.00%	Yes
	Oct 16	T/A, ≥95%, ≤12%, ≤1.0%	T/A, 100%, 8%, 0.00%	Yes
	Nov 16	**T/A, ≥95%, ≤12%, ≤1.0%**	**T/A, 100%, 8%, 0.00%**	**Yes**
	Dec 16	**T/A, ≥95%, ≤12%, ≤1.0%**	**T/A, 100%, 8%, 0.00%**	**Yes**
	Jan 17	**T/A, ≥95%, ≤12%, ≤1.0%**	**T/A, 100%, 9%, 0.00%**	**Yes**

Encounter Data	Oct 16	Timely, Complete	T,C	Yes
	Nov 16	Timely, Complete	T,C	Yes
	Dec 16	Timely, Complete	T,C	Yes
	Jan 17	**Timely, Complete**	**T,C**	**Yes**
	Feb 17	**Timely, Complete**	**T,C**	**Yes**
	Mar 17	**Timely, Complete**	**T,C**	**Yes**

Pharmacy Encounter Data	Oct 16	Timely, Complete	T,C	Yes
	Nov 16	Timely, Complete	T,C	Yes
	Dec 16	Timely, Complete	T,C	Yes
	Jan 17	**Timely, Complete**	**NT,NC**	**No**
	Feb 17	**Timely, Complete**	**T,C**	**Yes**
	Mar 17	**Timely, Complete**	**T,C**	**Yes**

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Upper Peninsula Health Plan – UPP

Performance Measure	Measurement Period	Standard			Plan Result		Standard Achieved		
		MA-MC Standard	MA-MC Result	Standard Achieved	HMP Standard	HMP Result	Standard Achieved	CSHCS Standard	CSHCS Result	Standard Achieved
NEMT Encounter Submission	Jul 16 – Sep 16	N/A	1,032	N/A	N/A	584	N/A	N/A	324	N/A
	Oct 16 Dec 16	**N/A**	**1,404**	**N/A**	**N/A**	**947**	**N/A**	**N/A**	**446**	**N/A**

Provider File Reporting	Oct 16	Timely, Accurate	T, A	Yes
	Nov 16	Timely, Accurate	T, A	Yes
	Dec 16	Timely, Accurate	T, A	Yes
	Jan 17	**Timely, Accurate**	**T, A**	**Yes**
	Feb 17	**Timely, Accurate**	**NT, NA**	**No**
	Mar 17	**Timely, Accurate**	**T, A**	**Yes**

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- For questions regarding measurement periods or standards, see the Performance Monitoring Specifications

RICK SNYDER, GOVERNOR | NICK LYON, DIRECTOR

2015–2016 External Quality Review Technical Report for Medicaid Health Plans

April 2017

Table of Contents

Acknowledgements and Copyrights

1. Executive Summary

Purpose of Report

The Balanced Budget Act of 1997 (BBA), Public Law 105-33, requires states to prepare an annual technical report that describes the manner in which data from activities conducted in accordance with the Code of Federal Regulations (CFR), 42 CFR 438.358, were aggregated and analyzed. The report must describe how conclusions were drawn as to the quality and timeliness of, and access to, care furnished by the states' managed care organizations, called Medicaid Health Plans (MHPs) in Michigan. The report of results must also contain an assessment of the strengths and opportunities for improvement for the MHPs regarding healthcare quality, timeliness, and access to care. Finally, the report must assess the degree to which the MHPs addressed any previous recommendations. To meet this requirement, the State of Michigan Department of Health and Human Services (MDHHS) contracted with Health Services Advisory Group, Inc. (HSAG), an external quality review organization (EQRO), to aggregate and analyze MHP data and prepare the annual technical report.

The State of Michigan contracted with the following MHPs for the provision of Medicaid services:

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

Scope of External Quality Review (EQR) Activities Conducted

This EQR technical report analyzes and aggregates data from three mandatory EQR activities:

- **Compliance Monitoring**: MDHHS evaluated the MHPs' compliance with federal Medicaid managed care regulations using a compliance review process. HSAG examined, compiled, and analyzed the results as presented in the MHP compliance review documentation provided by MDHHS.
- **Validation of Performance Measures**: Each MHP underwent a National Committee for Quality Assurance (NCQA) Healthcare Effectiveness Data and Information Set (HEDIS®) Compliance Audit™ conducted by an NCQA-licensed audit organization. HSAG performed an independent audit of the audit findings to determine the validity of each performance measure.
- **Validation of Performance Improvement Projects (PIPs)**: HSAG reviewed one PIP for each MHP to ensure that the projects were designed, conducted, and reported in a methodologically sound manner, allowing real improvements in care and giving confidence in the reported improvements.

Summary of Findings

The following is a statewide summary of the findings drawn regarding the MHPs' general performance and compliance in 2015–2016. Appendices A–K contain detailed, MHP-specific findings, while Section 3 presents detailed statewide findings with year-to-year comparisons.

In 2015–2016, 11 Medicaid Health Plans were contracted with the State of Michigan to provide comprehensive healthcare services. As of September 1, 2015, HealthPlus Partners, Inc. (HPP) was no longer an active Medicaid Health Plan; and as of January 1, 2016, Sparrow PHP (PHP) was no longer an active Medicaid Health Plan. **Aetna Better Health of Michigan** (**AET**) acquired CoventryCares (COV); therefore, this report includes findings for **AET**.

Compliance Review

MDHHS completed its assessment of the MHPs' compliance with the requirements in the six standards shown in the table below through the 2015–2016 annual compliance review process. Table 1-1 shows the statewide results for each standard.

Table 1-1—Summary of Data From the Annual Compliance Reviews

Standard	Range of MHP Scores	MHPs in Full Compliance*	Statewide Compliance Score
Standard 1—*Administrative*	90%–100%	9	98%
Standard 2—*Providers*	92%–100%	9	99%
Standard 3—*Members*	81%–100%	6	95%
Standard 4—*Quality*	89%–94%	0	91%
Standard 5—*MIS*	50%–100%	7	89%
Standard 6—*Program Integrity*	78%–100%	7	96%
Overall Score	**86%–99%**	**0**	**96%**

* The terms "full compliance" and "100 percent compliance" are used interchangeably in this report.

The statewide average across all standards and all 11 MHPs was 96 percent, reflecting continued strong performance.

The *Administrative* standard was a statewide strength with a statewide score of 98 percent, and nine of the 11 MHPs achieving 100 percent compliance. All MHPs had organizational charts that met contractual requirements as well as final, approved policies for the election of Board members that included the required provisions for vacancies, election procedures, and Board composition. All MHPs demonstrated compliance with the requirement to have health plan representatives present at all mandatory administrative meetings hosted by the State's Managed Care Plan Division.

Performance on the *Providers* standard was also strong, with a statewide score of 99 percent, and with most MHPs in full compliance with all requirements. All MHPs met the requirements for standard provider contract provisions, agreements with the community mental health centers, availability of covered services, primary care medical home (PCMH) expansion, communication with contracted providers, and provider appeal processes.

For the *Members* standard, with a statewide score of 95 percent and six MHPs achieving 100 percent compliance, all MHPs demonstrated compliance with the requirements for the member handbooks, member newsletters, website maintenance, and the Benefits Monitoring Program (BMP). Timely mailing of new member ID cards and handbooks continued to be an opportunity for improvement for some of the MHPs.

Performance on the *Program Integrity* standard resulted in a statewide score of 96 percent, with seven MHPs achieving 100 percent compliance. The 2015–2016 annual review identified opportunities for improvement across almost all criteria on this standard. For this year's review, the State required that MHPs report on overpayments recovered as well as on the comprehensive program integrity plan and provider enrollment and screening criteria.

Seven MHPs had compliance scores of 100 percent on the *Management Information System (MIS)* standard, resulting in a statewide average score of 89 percent. For the 2015–2016 annual review, no criterion on this standard was met by all MHPs. The results for the *MIS* standard, at 89 percent, represent the lowest statewide score when compared to all other standards.

The *Quality* standard continued to represent an opportunity for improvement, with a statewide average score of 91 percent and no MHP meeting all requirements. Opportunities for improvement were identified primarily in the MHPs' Quality Improvement Program (QIP) Evaluations and work plans and the performance measure review (PMR). All MHPs were required to implement corrective actions for failing to meet contractually required minimum standards for key performance measures. Statewide strengths on the *Quality* standard included HEDIS submissions and final audit reports as well as policies and procedures for practice guidelines, quality improvement (QI), utilization management (UM), and accreditation status.

Overall, MDHHS is maintaining and ensuring the MHPs' compliance with both State and federal provisions through a robust compliance review program. The State had developed a tool inclusive of the required elements for a comprehensive compliance review of its MHPs. Similarly, the MHPs demonstrated continued strong performance on the compliance monitoring reviews, with statewide percentages ranging in the 90s.

Validation of Performance Measures

Table 1-2 displays the 2016 Michigan Medicaid statewide HEDIS averages and performance levels. The performance levels are a comparison of the 2016 Michigan Medicaid statewide average to the NCQA Quality Compass® national HEDIS 2015 Medicaid percentiles.[1-1] For all measures except those under the Utilization domain, the Michigan Medicaid weighted average (MWA) rates were used to represent Michigan Medicaid statewide performance. For measures in the Utilization domain, an unweighted statewide average rate was calculated. For most measures, a display of ★★★★★ indicates performance at or above the national Medicaid 90th percentile. Performance levels displayed as ★★★★ represent performance at or above the national Medicaid 75th percentile but below the national Medicaid 90th percentile. A ★★★ performance level indicates performance at or above the national Medicaid 50th percentile but below the national Medicaid 75th percentile. Performance levels displayed as ★★ represent performance at or above the national Medicaid 25th percentile but below the national Medicaid 50th percentile. Finally, performance levels displayed as ★ indicate that the statewide performance was below the national Medicaid 25th percentile.

For certain measures, such as *Comprehensive Diabetes Care—Poor HbA1c Control,* where lower rates indicate better performance, the national Medicaid 10th percentile (rather than the national Medicaid 90th percentile) represents excellent performance and the national Medicaid 75th percentile (rather than the national Medicaid 25th percentile) represents below-average performance.

Of note, measures in the Health Plan Diversity and Utilization domains are provided within this section for information purposes only as they assess the MHPs' use of services and/or describe health plan characteristics and are not related to performance. Therefore, most of the rates within these domains were not evaluated in comparison to national benchmarks.

For the current measurement year, no issues related to HEDIS reporting were identified by the auditors and all 11 MHPs were fully compliant with six information systems (IS) standards (Medical Service Data [IS 1.0], Enrollment Data [IS 2.0], Practitioner Data [IS 3.0], Medical Record Review Process [IS 4.0], Supplemental Data [IS 5.0], and Data Integration [IS 7.0]). The IS standard related to Member Call Center Data (IS 6.0) was not applicable to the measures required to be reported by the MHPs.

[1-1] 2016 performance levels were based on comparisons to national Medicaid HMO Quality Compass HEDIS 2015 benchmarks, with the exception of the *Medication Management for People With Asthma—Medication Compliance 50%—Total* indicator, which was compared to national Medicaid HMO NCQA Audit Means and Percentiles HEDIS 2015 benchmarks.

Table 1-2—Overall Statewide Averages for Performance Measures

Measure	HEDIS 2016	Performance Level for 2016
Child & Adolescent Care		
Childhood Immunization Status		
Combination 2	76.15%	★★★
Combination 3	71.05%	★★
Combination 4	67.50%	★★
Combination 5	58.78%	★★★
Combination 6	40.45%	★★
Combination 7	56.15%	★★★
Combination 8	39.27%	★★
Combination 9	34.97%	★★
Combination 10	33.92%	★★
Well-Child Visits in the First 15 Months of Life		
Six or More Visits	66.22%	★★★
Lead Screening in Children		
Lead Screening in Children	79.55%	★★★
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life		
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	75.11%	★★★
Adolescent Well-Care Visits		
Adolescent Well-Care Visits	54.74%	★★★
Immunizations for Adolescents		
Combination 1	86.99%	★★★★
Appropriate Treatment for Children With Upper Respiratory Infection		
Appropriate Treatment for Children With Upper Respiratory Infection	89.09%	★★★
Appropriate Testing for Children With Pharyngitis		
Appropriate Testing for Children With Pharyngitis	68.41%	★★
Follow-Up Care for Children Prescribed ADHD Medication		
Initiation Phase	42.58%	★★★
Continuation and Maintenance Phase	53.96%	★★★

2016 performance levels represent the following percentile comparisons:

★★★★★ = 90th percentile and above
★★★★ = 75th to 89th percentile
★★★ = 50th to 74th percentile
★★ = 25th to 49th percentile
★ = Below 25th percentile

Measure	HEDIS 2016	Performance Level for 2016
Women—Adult Care		
Breast Cancer Screening		
Breast Cancer Screening	59.58%	★★★
Cervical Cancer Screening		
Cervical Cancer Screening	63.79%	★★★
Chlamydia Screening in Women		
Ages 16 to 20 Years	60.75%	★★★★
Ages 21 to 24 Years	67.85%	★★★★
Total	63.86%	★★★★
Access to Care		
Children and Adolescents' Access to Primary Care Practitioners		
Ages 12 to 24 Months	96.20%	★★
Ages 25 Months to 6 Years	88.79%	★★★
Ages 7 to 11 Years	90.85%	★★
Ages 12 to 19 Years	89.86%	★★
Adults' Access to Preventive/Ambulatory Health Services		
Ages 20 to 44 Years	82.76%	★★★
Ages 45 to 64 Years	89.81%	★★★
Ages 65+ Years	91.15%	★★★★
Total	85.62%	★★★
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis		
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	26.94%	★★★
Obesity		
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents		
BMI Percentile—Total	74.93%	★★★
Counseling for Nutrition—Total	65.77%	★★★
Counseling for Physical Activity—Total[†]	57.88%	★★★
Adult BMI Assessment		
Adult BMI Assessment	89.92%	★★★★

[†] Due to technical specification changes, caution should be exercised when comparing HEDIS 2016 rates to national HEDIS 2015 Medicaid benchmarks.

2016 performance levels represent the following percentile comparisons:

★★★★★ = 90th percentile and above
★★★★ = 75th to 89th percentile
★★★ = 50th to 74th percentile
★★ = 25th to 49th percentile
★ = Below 25th percentile

Measure	HEDIS 2016	Performance Level for 2016
Pregnancy Care		
Prenatal and Postpartum Care		
Timeliness of Prenatal Care	78.63%	★★
Postpartum Care	61.73%	★★
Frequency of Ongoing Prenatal Care		
≥81 Percent of Expected Visits	56.40%	★★
Weeks of Pregnancy at Time of Enrollment		
Prior to 0 Weeks	32.63%	—
1–12 Weeks	11.40%	—
13–27 Weeks	31.45%	—
28 or More Weeks	20.82%	—
Unknown	3.70%	—
Living With Illness		
Comprehensive Diabetes Care†		
Hemoglobin A1c (HbA1c) Testing	86.89%	★★★
*HbA1c Poor Control (>9.0%)**	39.30%	★★★
HbA1c Control (<8.0%)	50.91%	★★★
Eye Exam (Retinal) Performed	59.61%	★★★
Medical Attention for Nephropathy	91.28%	★★★★★
Blood Pressure Control (<140/90 mm Hg)	59.38%	★★
Medication Management for People With Asthma		
Medication Compliance 50%—Total	67.13%	★★★★
Medication Compliance 75%—Total	43.79%	★★★★★
Asthma Medication Ratio		
Total	62.18%	★★★
Controlling High Blood Pressure		
Controlling High Blood Pressure	55.54%	★★

† Due to technical specification changes, caution should be exercised when comparing HEDIS 2016 rates to national HEDIS 2015 Medicaid benchmarks.

* For this indicator, a lower rate indicates better performance.

— indicates that the 2016 performance levels were not determined because the measure did not have an applicable benchmark.

2016 performance levels represent the following percentile comparisons:

★★★★★ = 90th percentile and above
★★★★ = 75th to 89th percentile
★★★ = 50th to 74th percentile
★★ = 25th to 49th percentile
★ = Below 25th percentile

Measure	HEDIS 2016	Performance Level for 2016
Living With Illness (continued)		
Medical Assistance With Smoking and Tobacco Use Cessation^		
Advising Smokers and Tobacco Users to Quit	79.75%	★★★★
Discussing Cessation Medications	55.04%	★★★★
Discussing Cessation Strategies	45.20%	★★★
Antidepressant Medication Management		
Effective Acute Phase Treatment	60.36%	★★★★
Effective Continuation Phase Treatment	42.21%	★★★★
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications		
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	82.61%	★★★
Diabetes Monitoring for People With Diabetes and Schizophrenia		
Diabetes Monitoring for People With Diabetes and Schizophrenia	69.98%	★★★
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia		
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia	74.46%	★★
Adherence to Antipsychotic Medications for Individuals With Schizophrenia†		
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	58.76%	★★
Annual Monitoring for Patients on Persistent Medications		
ACE Inhibitors or ARBs	87.20%	★★
Digoxin	52.47%	★★
Diuretics	86.88%	★★
Total	86.84%	★★

^ The weighted averages for this measure were based on the eligible population for the survey rather than only the number of people who responded to the survey as being smokers.

† Due to technical specification changes, caution should be exercised when comparing HEDIS 2016 rates to national HEDIS 2015 Medicaid benchmarks.

2016 performance levels represent the following percentile comparisons:

★★★★★ = 90th percentile and above
★★★★ = 75th to 89th percentile
★★★ = 50th to 74th percentile
★★ = 25th to 49th percentile
★ = Below 25th percentile

Measure	HEDIS 2016	Performance Level for 2016
Health Plan Diversity		
Race/Ethnicity Diversity of Membership		
Total—White	54.01%	—
Total—Black or African American	28.00%	—
Total—American-Indian and Alaska Native	0.49%	—
Total—Asian	1.09%	—
Total—Native Hawaiian and Other Pacific Islander	0.05%	—
Total—Some Other Race	1.23%	—
Total—Two or More Races	0.00%	—
Total—Unknown	12.23%	—
Total—Declined	2.89%	—
Language Diversity of Membership		
Spoken Language Preferred for Health Care—English	88.26%	—
Spoken Language Preferred for Health Care—Non-English	1.11%	—
Spoken Language Preferred for Health Care—Unknown	10.63%	—
Spoken Language Preferred for Health Care—Declined	0.00%	—
Preferred Language for Written Materials—English	70.13%	—
Preferred Language for Written Materials—Non-English	1.08%	—
Preferred Language for Written Materials—Unknown	28.79%	—
Preferred Language for Written Materials—Declined	0.00%	—
Other Language Needs—English	52.71%	—
Other Language Needs—Non-English	0.51%	—
Other Language Needs—Unknown	46.78%	—
Other Language Needs—Declined	0.00%	—

— indicates that the 2016 performance levels were not determined because the measure did not have an applicable benchmark.

2016 performance levels represent the following percentile comparisons:

★★★★★ = 90th percentile and above
★★★★ = 75th to 89th percentile
★★★ = 50th to 74th percentile
★★ = 25th to 49th percentile
★ = Below 25th percentile

Measure	HEDIS 2016	Performance Level for 2016
Utilization		
Ambulatory Care—Total (Per 1,000 Member Months)		
ED Visits—Total‡,*	74.00	★
Outpatient Visits—Total	373.49	—
Inpatient Utilization—General Hospital/Acute Care—Total		
Total Inpatient—Discharges per 1,000 Member Months—Total	8.27	—
Total Inpatient—Average Length of Stay—Total	3.98	—
Maternity—Discharges per 1,000 Member Months—Total	2.59	—
Maternity—Average Length of Stay—Total	2.63	—
Surgery—Discharges per 1,000 Member Months—Total	1.83	—
Surgery—Average Length of Stay—Total	6.18	—
Medicine—Discharges per 1,000 Member Months—Total	4.52	—
Medicine—Average Length of Stay—Total	3.64	—

‡ Performance levels provided for this measure are for information purposes only.

* For this indicator, a lower rate indicates better performance.

— indicates that the 2016 performance levels were not determined because the measure did not have an applicable benchmark.

2016 performance levels represent the following percentile comparisons:

★★★★★ = 90th percentile and above
★★★★ = 75th to 89th percentile
★★★ = 50th to 74th percentile
★★ = 25th to 49th percentile
★ = Below 25th percentile

Of the 63 measure rates with national benchmarks available and appropriate for comparison, 41 statewide rates performed at or above the national Medicaid 50th percentile, with 11 rates performing at or above the national Medicaid 75th percentile but below the national Medicaid 90th percentile. Further, two rates (*Comprehensive Diabetes Care—Medical Attention for Nephropathy* and *Medication Management for People With Asthma—Medication Compliance 75%—Total*) met or exceeded the national Medicaid 90th percentile, demonstrating a strength statewide. However, due to changes in the technical specifications for the *Comprehensive Diabetes Care* measure indicators, caution should be used when comparing HEDIS 2016 rates to benchmarks derived from the previous year's results.

Statewide performance at or above the national Medicaid 75th percentile but below the national Medicaid 90th spanned multiple domains including Child & Adolescent Care (*Immunizations for Adolescents—Combination 1*), Women—Adult Care (all three *Chlamydia Screening in Women* indicators), Access to Care (*Adults' Access to Preventive/Ambulatory Health Services—Ages 65+ Years*), Obesity (*Adult BMI Assessment*), and Living With Illness (*Medication Management for People With Asthma—Medication Compliance 50%—Total*, two of the three *Medical Assistance With Smoking and Tobacco Use Cessation* indicators, and both *Antidepressant Medication Management* indicators).

Conversely, 22 statewide rates fell below the national Medicaid 50th percentile, with one rate (*Ambulatory Care—Total [Per 1,000 Member Months]—ED Visits—Total*) falling below the national Medicaid 25th percentile. Opportunities for statewide improvement spanned multiple domains including Child & Adolescent Care (six of nine *Childhood Immunization Status* indicators and *Appropriate Testing for Children With Pharyngitis*), Access to Care (three of four *Children and Adolescents' Access to Primary Care Practitioners* indicators), Pregnancy Care (both *Prenatal and Postpartum Care* indicators and *Frequency of Ongoing Prenatal Care—≥81 Percent of Expected Visits*), and Living With Illness (*Comprehensive Diabetes Care—Blood Pressure Control [<140/90 mm Hg]*, *Controlling High Blood Pressure*, *Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia*, *Adherence to Antipsychotic Medications for Individuals With Schizophrenia*, and all four *Annual Monitoring for Patients on Persistent Medications* indicators).

Performance Improvement Projects (PIPs)

For the 2015–2016 validation cycle, the MHPs provided third-year submissions on PIPs that focused on special groups or unique subpopulations of enrollees. With the implementation of the outcomes-focused scoring methodology, MHPs were required to achieve statistically significant improvement over the baseline rate across all study indicators to receive an overall *Met* validation status. Of the 11 MHPs, five received a validation status of *Met* for their PIPs and six had a validation status of *Not Met*, as shown in Table 1-3.

Table 1-3—MHPs' 2015–2016 PIP Validation Status

Validation Status	Number of MHPs
Met	5
Partially Met	0
Not Met	6

Table 1-4 presents a summary of the statewide 2015–2016 results for the activities of the protocol for validating PIPs.

Table 1-4—Summary of Results From the 2015–2016 Validation of PIPs

Review Activities		Number of PIPs Meeting All Evaluation Elements/ Number Reviewed	Number of PIPs Meeting All Critical Elements/ Number Reviewed
I.	Select the Study Topic	11/11	11/11
II.	Define the Study Question(s)	11/11	11/11
III.	Use a Representative and Generalizable Study Population	11/11	11/11
IV.	Select the Study Indicator(s)	11/11	11/11
V.	Use Sound Sampling Techniques*	3/3	3/3
VI.	Reliably Collect Data	11/11	11/11
VII.	Analyze Data and Interpret Study Results	7/11	11/11
VIII.	Implement Interventions and Improvement Strategies	9/11	11/11
IX.	Assess for Real Improvement	4/11	5/11
X.	Assess for Sustained Improvement**	3/4	3/4

* This activity is assessed only for PIPs that conduct sampling.

** This activity was assessed only for PIPs that achieved statistically significant improvement in the 2014–2015 cycle.

HSAG validated Activities I through IX for all 2015–2016 PIP submissions and Activity X for four PIPs that achieved statistically significant improvement in 2014–2015. The MHPs demonstrated both strong performance related to the quality of their PIPs and thorough application of the requirements for Activities I through VI of the Centers for Medicare & Medicaid Services (CMS) protocol for conducting PIPs.

All PIPs completed the Design (Activities I through VI) and Implementation and Evaluation (Activities VII and VIII) phases of the study and progressed to the Outcomes (Activities IX and X) phase.

All 11 PIPs received *Met* scores for all applicable evaluation elements in Activities I through VI and all critical elements in Activities VII and VIII. Only five of the 11 PIPs met the critical element in Activity IX regarding achieving a statistically significant improvement over baseline. Three of the four PIPs achieved sustained improvement and each received a *Met* score for the evaluation element in Activity X.

The PIPs submitted for the 2015–2016 validation reflected statewide strength in the Design and the Implementation and Evaluation phases of the study and opportunities for improvement in the Outcomes phase. Each MHP provided its third-year submission on a previously selected topic, advanced to the Outcomes phase of the study, and reported Remeasurement 2 data from calendar year (CY) 2015. The

MHPs conducted appropriate causal/barrier analyses and implemented interventions with the potential to impact healthcare outcomes. While eight MHPs documented improvement in the outcomes of care, only five of those eight MHPs demonstrated statistically significant improvement over the baseline rates. Additionally, three MHPs documented a statistically significant improvement over baseline for two consecutive years and hence demonstrated a sustained improvement in their study indicator rates.

To address the lack of statistically significant improvement in the study indicator rates—or, in some cases, a decline in the rate—the MHPs should use quality improvement tools such as process mapping or failure modes and effects analysis to determine barriers and weaknesses within processes that may prevent them from achieving desired outcomes. The MHPs should continue to evaluate the effectiveness of each implemented intervention and use the findings from this analysis to make decisions regarding continuing, revising, or abandoning interventions.

Quality, Timeliness, and Access

The annual compliance review of the MHPs showed continued strong performance across the areas of **quality**, **timeliness**, and **access**. Combined, the areas with the highest level of compliance—the *Administrative* and *Providers* standards—addressed the **quality** and **timeliness** of, as well as **access** to, services provided to beneficiaries. The compliance reviews identified opportunities for improvement primarily in the **quality** and **access** areas.

Results for the validated performance measures reflected statewide strengths across the areas of **quality**, **timeliness**, and **access**. Statewide rates for 63 of the 98 performance measure indicators were compared to the available national HEDIS 2015 Medicaid percentiles. Forty-one rates demonstrated average to above-average performance and ranked at or above the national Medicaid 50th percentile, with 11 of these rates ranking above the national Medicaid 75th percentile but below the national Medicaid 90th percentile. Two rates ranked above the national Medicaid 90th percentile. The 22 rates that fell below the national Medicaid 50th percentile represented opportunities for improvement.

The validation of the MHPs' PIPs reflected strong performance in the studies that addressed the **quality**, **timeliness**, and **access** areas. All projects reflected a thorough application of the PIP Design and Implementation and Evaluation phases. The MHPs should continue to implement, evaluate, and, if necessary, revise or replace interventions to achieve desired outcomes.

Table 1-5 shows HSAG's assignment of the compliance review standards, performance measures, and PIPs into the areas of **quality**, **timeliness**, and **access**.

Table 1-5—Assignment of Activities to Performance Areas

Compliance Review Standards	Quality	Timeliness	Access
Standard 1—*Administrative*	✓		
Standard 2—*Providers*	✓	✓	✓
Standard 3—*Members*	✓	✓	✓
Standard 4—*Quality*	✓		✓
Standard 5—*MIS*	✓	✓	
Standard 6—*Program Integrity*	✓	✓	✓
Performance Measures[1-2]	**Quality**	**Timeliness**	**Access**
Childhood Immunization Status—Combinations 2–10	✓	✓	
Well-Child Visits in the First 15 Months of Life—Six or More Visits	✓		
Lead Screening in Children	✓	✓	
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	✓		
Adolescent Well-Care Visits	✓		
Immunizations for Adolescents—Combination 1	✓	✓	
Appropriate Treatment for Children With Upper Respiratory Infection	✓		
Appropriate Testing for Children With Pharyngitis	✓		
Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase and *Continuation and Maintenance Phase*	✓	✓	✓
Breast Cancer Screening	✓		
Cervical Cancer Screening	✓		
Chlamydia Screening in Women—Ages 16 to 20 Years, Ages 21 to 24 Years, and *Total*	✓		
Children and Adolescents' Access to Primary Care Practitioners—Ages 12 to 24 Months, Ages 25 Months to 6 Years, Ages 7 to 11 Years, and *Ages 12 to 19 Years*			✓
Adults' Access to Preventive/Ambulatory Health Services—Ages 20 to 44 Years, Ages 45 to 64 Years, Ages 65 Years and Older, and *Total*			✓
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	✓		

[1-2] *Race/Ethnicity Diversity of Membership, Language Diversity of Membership, Weeks of Pregnancy at Time of Enrollment, Ambulatory Care—Total (Per 1,000 Member Months)—Outpatient Visits—Total* and *Inpatient Utilization* were not included in Table 1-5 because they cannot be categorized into any performance areas.

Performance Measures	Quality	Timeliness	Access
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile—Total, *Counseling for Nutrition—Total*, and *Counseling for Physical Activity—Total*	✓		
Adult BMI Assessment	✓		
Prenatal and Postpartum Care—Timeliness of Prenatal Care and *Postpartum Care*		✓	✓
Frequency of Ongoing Prenatal Care—≥81 Percent of Expected Visits	✓		✓
Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Testing, *HbA1c Poor Control (>9.0%)*, *HbA1c Control (<8.0%)*, *Eye Exam (Retinal) Performed*, *Medical Attention for Nephropathy*, and *Blood Pressure Control (<140/90 mm Hg)*	✓		
Medication Management for People With Asthma—Medication Compliance 50%—Total and *Medication Compliance 75%—Total*	✓		
Asthma Medication Ratio—Total	✓		
Controlling High Blood Pressure	✓		
Medical Assistance With Smoking and Tobacco Use Cessation—Advising Smokers and Tobacco Users to Quit, *Discussing Cessation Medications*, and *Discussing Cessation Strategies*	✓		
Antidepressant Medication Management—Effective Acute Phase Treatment and *Effective Continuation Phase Treatment*	✓		
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	✓		
Diabetes Monitoring for People With Diabetes and Schizophrenia	✓		
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia	✓		
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	✓		
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs, *Digoxin*, *Diuretics*, and *Total*	✓		
Ambulatory Care—Total (Per 1,000 Member Months)—Emergency Department Visits—Total			✓
PIPs	**Quality**	**Timeliness**	**Access**
One PIP for each MHP	✓	✓	✓

2. External Quality Review Activities

Introduction

This section of the report describes the manner in which data from the activities conducted in accordance with 42 CFR 438.358 were aggregated and analyzed.

Compliance Monitoring

Objectives

According to 42 CFR 438.358, a state or its EQRO must conduct a review within a three-year period to determine the Medicaid managed care organizations' compliance with standards established by the state for access to care, structure and operations, and quality measurement and improvement. To meet this requirement, MDHHS performed annual compliance reviews of its contracted MHPs.

The objectives of conducting compliance reviews are to ensure performance and adherence to contractual provisions as well as compliance with federal Medicaid managed care regulations. The reviews also aid in identifying areas of noncompliance and assist MHPs in developing corrective actions to achieve compliance with State and federal requirements.

Technical Methods of Data Collection

MDHHS is responsible for conducting compliance activities that assess MHPs' conformity with State requirements and federal Medicaid managed care regulations. This technical report presents the results of the compliance reviews performed during the 2015–2016 contract year. MDHHS conducted a compliance review of six standards as listed below:

1. *Administrative* (5 criteria)
2. *Providers* (11 criteria)
3. *Members* (8 criteria)
4. *Quality* (9 criteria)
5. *MIS* (3 criteria)
6. *Program Integrity* (16 criteria)

Description of Data Obtained

To assess the MHPs' compliance with federal and State requirements, MDHHS obtained information from a wide range of written documents produced by the MHPs, including the following:

- Policies and procedures
- Quality assessment and performance improvement (QAPI) programs
- Minutes of meetings of the governing body, QI committee, compliance committee, UM committee, credentialing committee, and peer review committee
- QI work plans, utilization reports, provider and member profiling reports, and QI effectiveness reports
- Internal auditing/monitoring plans, auditing/monitoring findings, and accreditation status
- Claims review reports, prior-authorization reports, complaint logs, grievance logs, telephone contact logs, disenrollment logs, MDHHS hearing requests, and medical record review reports
- Provider service and delegation agreements and contracts
- Provider files, disclosure statements, and current sanctioned/suspended provider lists
- Organizational charts
- Program integrity forms and reports
- Employee handbooks, fliers, employee newsletters, provider manuals, provider newsletters, websites, educational/training materials, and sign-in sheets
- Member materials, including welcome letters, member handbooks, member newsletters, provider directories, and certificates of coverage

For the 2015–2016 compliance reviews, MDHHS continued using the review tool and process from the previous review cycle. Two factors may affect the comparability of findings from the 2014–2015 and 2015–2016 review cycles:

- The number of contracted MHPs changed from 13 to 11.
- While the standards reviewed remained the same, MDHHS added criteria to the *Administrative*, *Providers*, *Members*, and *Program Integrity* standards, increasing the total number of criteria assessed from 48 in the prior year to 53 in the 2015–2016 review cycle.

For the *Quality* standard, MDHHS reviewed MHPs' reported rates for 12 of the performance measures (*Childhood Immunizations, Elective Delivery, Postpartum Care, Blood Lead Testing for 2 Year Olds, Developmental Screening, Well-Child Visits 0–15 Months, Well-Child Visits 3–6 Years, Complaints, Claims Processing, Encounter Data Reporting, Pharmacy Encounter Data Reporting,* and *Provider File Reporting).*[2-1]

[2-1] Medical Services Administration Bureau of Medicaid Care Management and Quality Assurance—Performance Monitoring Report—Medicaid Managed Care Healthy Michigan Plan, Revised November 7, 2016. These measures were taken from this report verbatim.

Throughout the fiscal year, MHPs submitted documentation of their compliance with a specified subset of the criteria in the review tool. The assessment of compliance with the standards was spread over multiple months or repeated at multiple points during the fiscal year. Following each month's submissions, MDHHS determined the MHPs' levels of compliance with the criteria assessed and provided feedback to the MHPs about their performance. For criteria with less than full compliance, MDHHS also specified its findings and requirements for a corrective action plan. MHPs then detailed the proposed corrective action, which was reviewed and—when acceptable—approved by MDHHS prior to implementation. MDHHS conducted an annual site visit with each MHP.

Data Aggregation, Analysis, and How Conclusions Were Drawn

MDHHS reviewers used the compliance review tool for each MHP to document their findings and to identify, when applicable, specific action(s) required of the MHP to address any areas of noncompliance with contractual requirements.

For each criterion reviewed, MDHHS assigned one of the following scores:

- *Pass*—The MHP demonstrated full compliance with the requirement(s).
- *Incomplete*—The MHP demonstrated partial compliance with the requirement(s).
- *Fail*—The MHP failed to demonstrate compliance with the requirement(s).
- *Not Applicable (N/A)*—The requirement was not applicable to the MHP.

HSAG calculated a total compliance score for each standard, reflecting the degree of compliance with contractual requirements related to that area, and an overall score for each MHP across all six standards. The total compliance scores were obtained by adding the weighted number of criteria that received a score of *Pass* (value: 1 point) to the weighted number of criteria that received a score of *Incomplete* (0.5 points), *Fail* (0 points), or *N/A* (0 points), then dividing this total by the total number of applicable criteria reviewed. Statewide averages were calculated by summing the individual MHP scores, then dividing that sum by the total number of applicable criteria reviewed across all MHPs.

To draw conclusions *and make overall assessments about the* **quality** *and* **timeliness** *of, and* **access** *to, care provided by the MHPs using findings from the compliance reviews, the standards were categorized to evaluate each of these three* areas. Using this framework, Table 1-5 (page 1-15) shows HSAG's assignment of standards to the three areas of performance.

Validation of Performance Measures

Objectives

As set forth in 42 CFR 438.358, validation of performance measures is one of the mandatory EQR activities. The primary objectives of the performance measure validation process are to:

- Evaluate the accuracy of the performance measure data collected by the MHP.
- Determine the extent to which the specific performance measures calculated by the MHP (or on behalf of the MHP) followed the specifications established for each performance measure.

To meet the two primary objectives of the validation activity, a measure-specific review of all reported measures was performed, as well as a thorough information system evaluation, to assess each MHP's support system available to report accurate HEDIS measures.

Technical Methods of Data Collection and Analysis

MDHHS required each MHP to collect and report a set of Medicaid HEDIS measures. Developed and maintained by NCQA, HEDIS is a set of performance measures broadly accepted in the managed care environment as an industry standard.

Each MHP underwent an NCQA HEDIS Compliance Audit conducted by an NCQA-licensed audit organization. The NCQA HEDIS Compliance Audit followed NCQA audit methodology as set out in NCQA's 2016 *Volume 5, HEDIS Compliance Audit™: Standards, Policies and Procedures.*[2-2] The NCQA HEDIS Compliance Audit encompasses an in-depth examination of the health plans' processes consistent with CMS' protocols for validation of performance measures. To complete the validation of performance measures process according to the CMS protocols, HSAG performed an independent evaluation of the audit results and findings to determine the validity of each performance measure.

Each NCQA HEDIS Compliance Audit was conducted by a licensed audit organization and included the following activities:

Pre-review Activities: Each MHP was required to complete the NCQA Record of Administration, Data Management, and Processes (Roadmap), which is comparable to the Information Systems Capabilities Assessment Tool, Appendix V of the CMS protocols. Pre-on-site conference calls were held to follow up on any outstanding questions. The audit team conducted a thorough review of the Roadmap and supporting documentation, including an evaluation of processes used for collecting, storing, validating, and reporting the performance measure data.

[2-2] National Committee for Quality Assurance. *Volume 5, HEDIS Compliance Audit™: Standards, Policies and Procedures*. Washington D.C; 2016.

On-site Review: The on-site reviews, which typically lasted one to two day(s), included:

- An evaluation of system compliance, focusing on the processing of claims and encounters.
- An overview of data integration and control procedures, including discussion and observation.
- A review of how all data sources were combined and the method used to produce the performance measures.
- Interviews with MHP staff members involved with any aspect of performance measure reporting.
- A closing conference at which the audit team summarized preliminary findings and recommendations.

Post-on-site Review Activities: For each performance measure calculated and reported by the MHPs, the audit teams aggregated the findings from the pre-on-site and on-site activities to determine whether the reported measures were valid, based on an allowable bias. The audit teams assigned each measure one of seven audit findings: (1) *Reportable* (the MHP followed the specifications and produced a reportable rate or result for the measure), (2) *Not Applicable* (the MHP followed the specifications, but the denominator was too small [<30] to report a valid rate), (3) *No Benefit* (the MHP did not offer the health benefits required by the measure), (4) *Not Reportable* (the MHP chose not to report the measure), (5) *Not Required* (the MHP was not required to report the measure), (6) *Biased Rate* (the calculated rate was materially biased), or (7) *Un-Audited* (the MHP chose to report a measure not required to be audited).

Description of Data Obtained

As identified in the CMS protocol, the following key types of data were obtained and reviewed as part of the validation of performance measures. Table 2-1 shows the data sources used in the validation of performance measures and the time period to which the data applied.

Table 2-1—Description of Data Sources

Data Obtained	Time Period to Which the Data Applied
NCQA HEDIS Compliance Audit reports were obtained for each MHP, which included a description of the audit process, the results of the information systems findings, and the final audit designations for each performance measure.	Calendar Year (CY) 2015 (HEDIS 2016)
Performance measure reports, submitted by the MHPs using NCQA's Interactive Data Submission System (IDSS), were analyzed and subsequently validated by HSAG.	CY 2015 (HEDIS 2016)
Previous performance measure reports were reviewed to assess trending patterns and the reasonability of rates.	CY 2014 (HEDIS 2015)

Data Aggregation, Analysis, and How Conclusions Were Drawn

HSAG performed a comprehensive review and analysis of the MHPs' IDSS results, data submission tools, and MHP-specific NCQA HEDIS Compliance Audit reports and performance measure reports.

HSAG ensured that the following criteria were met prior to accepting any validation results:

- An NCQA-licensed audit organization completed the audit.
- An NCQA-certified HEDIS compliance auditor led the audit.
- The audit scope included all MDHHS-selected HEDIS measures.
- The audit scope focused on the Medicaid product line.
- Data were submitted via an auditor-locked NCQA IDSS.
- A final audit opinion, signed by the lead auditor and responsible officer within the licensed organization, was produced.

To draw conclusions and make overall assessments about the **quality**, **timeliness** of, and **access** to care provided by the MHPs using findings from the validation of performance measures, measures were categorized to evaluate one or more of the three areas. Table 1-5 shows HSAG's assignment of performance measures to these areas of performance.

Several measures did not fit into these areas since they are collected and reported as health plan descriptive measures or because the measure results could not be tied to any of the dimensions. These measures included *Weeks of Pregnancy at Time of Enrollment, Race/Ethnicity Diversity of Membership, Language Diversity of Membership, Ambulatory Care—Total (Per 1,000 Member Months)—Outpatient Visits—Total,* and *Inpatient Utilization*. Additionally, while national benchmarks were available for these measures, they were not included in the report as it was not appropriate to use them for benchmarking the MHPs' performance. Rates for these measures were not linked to performance as lower or higher rates did not necessarily indicate better or worse performance. Further, the first three measures are considered health plan descriptive measures; therefore, performance on these measures cannot be directly impacted by improvement efforts. The last two measures cannot be assigned to performance areas due to the inability to directly correlate measure performance to **quality**, **timeliness**, or **access** to care. For these reasons, these measures were not included in Table 1-5.

Validation of Performance Improvement Projects (PIPs)

Objectives

As part of its quality assessment and performance improvement (QAPI) program, each MHP is required by MDHHS to conduct PIPs in accordance with 42 CFR 438.240. MDHHS contracted with HSAG, as its EQRO, to assess the PIPs conducted by MHPs. MDHHS requires that the MHP conduct and submit PIPs annually to meet the requirements of the BBA, Public Law 105-33. According to the BBA, the quality of healthcare delivered to Medicaid enrollees in MHPs must be tracked, analyzed, and reported annually. PIPs provide a structured method of assessing and improving the processes, and thereby the outcomes, of care for the population that an MHP serves. By assessing PIPs, HSAG assesses each MHP's "strengths and weaknesses with respect to the quality, timeliness, and access to health care services furnished to Medicaid recipients," according to 42 CFR 438.364(a)(2).

The purpose of the PIPs is to achieve, through ongoing measurements and interventions, significant improvement sustained over time in clinical and nonclinical areas. The primary objective of PIP validation is to determine the MHP's compliance with the requirements of 42 CFR 438.240(b)(1). HSAG's evaluation of the PIP includes two key components of the quality improvement process:

1. HSAG evaluates the technical structure of the PIP to ensure that the MHP designs, conducts, and reports the PIP in a methodologically sound manner, meeting all State and federal requirements. HSAG's review determines whether or not the PIP design (e.g., study question, population, indicator[s], sampling techniques, and data collection methodology) is based on sound methodological principles and could reliably measure outcomes. Successful execution of this component ensures that reported PIP results are accurate and capable of measuring sustained improvement.
2. HSAG evaluates the implementation of the PIP. Once designed, a PIP's effectiveness in improving outcomes depends on the systematic data collection process, analysis of data, identification of causes and barriers, and subsequent development of relevant interventions. Through this component, HSAG evaluates how well the MHP improves its rates through implementation of effective processes (i.e., barrier analyses, intervention design, and evaluation of results).

The goal of HSAG's PIP validation is to ensure that MDHHS and key stakeholders can have confidence that any reported improvement is related and can be directly linked to the quality improvement strategies and activities conducted by the MHP during the life of the PIP.

MDHHS required that each MHP conduct one PIP subject to validation by HSAG. For the 2015–2016 validation cycle, each MHP continued with its study topic that focused on a special group or unique subpopulation of enrollees for the third-year submission.

Technical Methods of Data Collection and Analysis

The HSAG PIP Review Team consisted of, at a minimum, an analyst with expertise in statistics and study design and a clinician with expertise in performance improvement processes. The methodology used to validate PIPs was based on the CMS guidelines as outlined in *EQR Protocol 3: Validating Performance Improvement Projects (PI Ps): A Mandatory Protocol for External Quality Review (EQR),* Version 2.0, September 2012.[2-3] Using this protocol, HSAG, in collaboration with MDHHS, developed the PIP Summary Form. Each MHP completed this form and submitted it to HSAG for review. The PIP Summary Form standardized the process for submitting information regarding the PIPs and ensured that all CMS PIP protocol requirements were addressed.

HSAG, with MDHHS' input and approval, developed a PIP Validation Tool to ensure uniform validation of PIPs. Using this tool, HSAG evaluated each of the PIPs according to the CMS protocols. The CMS protocols identify ten activities that should be validated for each PIP, although in some cases the PIP may not have progressed to the point at which all of the activities can be validated.

These activities are:

- Activity I. Appropriate Study Topic
- Activity II. Clearly Defined, Answerable Study Question(s)
- Activity III. Correctly Identified Study Population
- Activity IV. Clearly Defined Study Indicator(s)
- Activity V. Valid Sampling Techniques (if sampling was used)
- Activity VI. Accurate/Complete Data Collection
- Activity VII. Sufficient Data Analysis and Interpretation
- Activity VIII. Appropriate Improvement Strategies
- Activity IX. Real Improvement Achieved
- Activity X. Sustained Improvement Achieved

Description of Data Obtained

HSAG obtained the data needed to conduct the PIP validations from the MHPs' PIP Summary Form. This form provided detailed information about each MHP's PIP as it related to the ten activities reviewed and evaluated for the 2015–2016 validation cycle.

[2-3] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *EQR Protocol 3: Validating Performance Improvement Projects (PIPs): A Mandatory Protocol for External Quality Review (EQR),* Version 2.0, September 2012. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/eqr-protocol-3.pdf Accessed on: Jan 31, 2017.

Data Aggregation, Analysis, and How Conclusions Were Drawn

HSAG used the following methodology to evaluate PIPs conducted by the MHPs to determine whether or not a PIP was valid and the percentage of compliance with CMS' protocol for conducting PIPs.

Each required activity is evaluated on one or more elements that form a valid PIP. The HSAG PIP Review Team scores each evaluation element within a given activity as *Met*, *Partially Met*, *Not Met*, *Not Applicable*, or *Not Assessed*. HSAG designates evaluation elements pivotal to the PIP process as critical elements. For a PIP to produce valid and reliable results, all critical elements must be *Met*. Given the importance of critical elements to the scoring methodology, any critical element that receives a *Not Met* score results in an overall validation rating for the PIP of *Not Met*. The MHP is assigned a *Partially Met* score if 60 percent to 79 percent of all evaluation elements are *Met* or one or more critical elements are *Partially Met*. HSAG provides a *Point of Clarification* when enhanced documentation would have demonstrated a stronger understanding and application of the PIP activities and evaluation elements.

In addition to the validation status (e.g., *Met*) HSAG assigns the PIP an overall percentage score for all evaluation elements (including critical elements). HSAG calculates the overall percentage score by dividing the total number of elements scored as *Met* by the total number of elements scored as *Met*, *Partially Met*, and *Not Met*. HSAG also calculates a critical element percentage score by dividing the total number of critical elements scored as *Met* by the sum of the critical elements scored as *Met*, *Partially Met*, and *Not Met*.

HSAG assessed the implications of the study's findings on the likely validity and reliability of the results as follows:

- *Met*: High confidence/confidence in reported PIP results. All critical evaluation elements were *Met*, and 80 to 100 percent of all evaluation elements were *Met* across all activities.
- *Partially Met*: Low confidence in reported PIP results. All critical evaluation elements were *Met*, and 60 to 79 percent of all evaluation elements were *Met* across all activities; or one or more critical evaluation elements were *Partially Met*.
- *Not Met*: All critical evaluation elements were *Met*, and less than 60 percent of all evaluation elements were *Met* across all activities; or one or more critical evaluation elements were *Not Met*.

The MHPs had an opportunity to resubmit revised PIP Summary Forms and additional information in response to any *Partially Met* or *Not Met* evaluation scores, regardless of whether the evaluation element was critical or noncritical. HSAG re-reviewed the resubmitted documents and rescored each PIP before determining a final validation score and status. With MDHHS' approval, HSAG offered technical guidance to any MHP that requested an opportunity to review the scoring of the evaluation elements prior to a resubmission. Four MHPs requested and received technical assistance from HSAG. HSAG conducted conference calls or responded to emails to answer questions regarding the MHPs' PIPs or to discuss areas of deficiency. HSAG encouraged MHPs to use the PIP Summary Form Completion Instructions as they completed their PIPs. These instructions outlined each evaluation element and provided documentation resources to support CMS PIP protocol requirements.

HSAG followed the preceding methodology for validating the PIPs for all MHPs to assess the degree to which the MHPs designed, conducted, and reported their projects in a methodologically sound manner.

After completing the validation review, HSAG prepared a report of its findings and recommendations for each validated PIP. These reports, which complied with 42 CFR 438.364, were forwarded to MDHHS and the appropriate MHPs.

The EQR activities related to PIPs were designed to evaluate the validity and reliability of the MHP's processes in conducting the PIPs and to draw conclusions about the MHP's performance in the areas of quality, timeliness of, and access to care and services. With the MDHHS requirement that each MHP's PIP topic be targeted to a special group or unique subpopulation of enrollees, the topics varied across the MHPs, covering all three areas of **quality** and **timeliness** of—and **access** to—care, as illustrated in Table 1-5.

3. Statewide Findings

The following section presents findings for the two reporting periods of 2014–2015 and 2015–2016 from the annual compliance reviews, the validation of performance measures, and the validation of PIPs. Appendices A–K present additional details about the 2015–2016 MHP-specific results of the activities.

Annual Compliance Review

MDHHS conducted annual compliance reviews of the MHPs, assessing their compliance with State and federal requirements on six standards: *Administrative*, *Providers*, *Members*, *Quality*, *MIS*, and *Program Integrity*. MDHHS completed the full review of all standards over the course of the 2015–2016 State fiscal year. Due to changes to the compliance monitoring tool, as described in Section 2 of this report, results from the 2015–2016 review cycle are not fully comparable to previous results.

Table 3-1 presents—for each standard and overall across all standards—the statewide compliance score, the number of corrective actions required, and the number and percentage of MHPs that achieved 100 percent compliance for the 2014–2015 and 2015–2016 compliance reviews.

Table 3-1—Comparison of Results From the Compliance Reviews: Previous Results for 2014–2015 (P) and Current Results for 2015–2016 (C)

		Statewide Compliance Score		Number of Corrective Actions Required		MHPs in Full Compliance (Number)		MHPs in Full Compliance (Percentage)	
		P	C	P	C	P	C	P	C
1	*Administrative*	99%	98%	1	2	12	9	92%	82%
2	*Providers*	98%	99%	4	3	9	9	69%	82%
3	*Members*	95%	95%	9	8	7	6	54%	55%
4	*Quality*	92%	91%	19	18	1	0	8%	0%
5	*MIS*	94%	89%	5	7	8	7	62%	64%
6	*Program Integrity*	96%	96%	15	13	6	7	46%	64%
Overall Score/Total		**96%**	**96%**	**53**	**51**	**0**	**0**	**0%**	**0%**

Please note that the total number of contracted MHPs changed from 13 in 2014–2015 to 11 in 2015–2016.

Overall, the MHPs demonstrated continued strong performance related to compliance with State and federal requirements assessed during the annual compliance reviews. The current-year statewide overall compliance score across all standards and all MHPs was 96 percent, the same as the prior-year score. While no MHP achieved a 100 percent overall compliance score, three of the MHPs each received a 99 percent overall score across all standards. The total number of CAPs across all standards and MHPs

decreased from 53 to 51, and the percentage of MHPs in full compliance with all requirements increased for most standards, most markedly for the *Program Integrity* and *Providers* standards.

The *Administrative* standard continued to be a statewide strength. However, this standard saw a small decrease in in the statewide score—from 99 percent in the prior year to 98 percent in the current review cycle—and in the percentage of MHPs in full compliance.

The *Providers* standard was the area of strongest performance for this review period, with a 2015–2016 statewide score of 99 percent and nine of the 11 MHPs demonstrating full compliance with all requirements in this area. Compared to the 2014–2015 review cycle, performance on this standard reflected improvement, with fewer corrective actions required and an increase in the percentage of MHPs meeting all requirements.

Performance on the *Members* standard resulted in a statewide score of 95 percent, remaining the same as achieved in the previous year's review. All MHPs demonstrated full compliance with the new requirement related to the Benefits Monitoring Program (BMP). The total number of corrective actions required for this standard decreased to eight CAPs. The most frequent recommendation on this standard, given to three MHPs, was related to requirements for tobacco cessation programs.

For the *Quality* standard, the statewide average score decreased by 1 percentage point to 91 percent. The number of MHPs that demonstrated full compliance on this standard remained the lowest among all standards, with no MHPs achieving a score of 100 percent. For this review period, 18 CAPs were required compared to the 19 CAPs required in the previous year. The highest scores were obtained by four MHPs, each with a 94 percent compliance score, resulting in only one CAP per MHP. The seven remaining MHPs all obtained scores of 89 percent, resulting in two CAPS each. The criterion that requires an annual evaluation of the quality improvement (QI) program and work plan was the second-highest noncompliant element, resulting in four CAPs. Compliance with MDHHS-specified minimum standards for performance measures remains a statewide opportunity for improvement, with CAPs required for all MHPs.

Statewide performance on the *MIS* standard was lower than in the previous cycle as the statewide average score declined from 94 percent to 89 percent. The number of corrective actions increased by two. Three CAPs were necessary for the requirement that MHPs maintain information systems that collect, analyze, integrate, and report data as required by MDHHS.

Performance on the *Program Integrity* standard reflected improvement over the prior-year results. While the statewide compliance score for this standard remained at 96 percent, the percentage of MHPs found to be in compliance with all elements reviewed showed a marked increase and the number of required CAPs decreased. The compliance review findings reflected continued challenges for some MHPs to provide complete and accurate reports on their activities related to the identification and reporting of fraud, waste, and abuse to the MDHHS Office of Inspector General (OIG).

Performance Measures

As set forth in 42 CFR 438.358, the primary objectives of the performance measure validation process were to evaluate the accuracy of the performance measure data collected by the MHPs and determine the extent to which the specific performance measures calculated by the MHPs (or on behalf of the MHPs) followed the specifications established for each performance measure. To meet the two primary objectives of the validation activity, a thorough information system evaluation was performed to assess the ability of each MHP's data system to report accurate HEDIS measures and a measure-specific review of all reported measures was conducted.

Results from the validation of performance measures activities showed that all 11 MHPs received findings of *Reportable* (i.e., appropriate processes, procedures, and corresponding documentation) for all assessed performance measures. The performance measure data were collected accurately from a wide variety of sources statewide. All MHPs demonstrated the ability to calculate and accurately report performance measures that complied with HEDIS specifications. These findings suggest that the information systems for reporting HEDIS measures were strengths statewide.

Table 3-2 displays the Michigan Medicaid 2016 HEDIS weighted averages and performance levels.[3-6] The performance levels compare the 2016 Michigan Medicaid weighted average and the NCQA Quality Compass national Medicaid HMO percentiles for HEDIS 2015.[3-7] For most measures, a display of ★★★★★ indicates performance at or above the national Medicaid 90th percentile. Performance levels displayed as ★★★★ represent performance at or above the national Medicaid 75th percentile but below the national Medicaid 90th percentile. A ★★★ performance level indicates performance at or above the national Medicaid 50th percentile but below the national Medicaid 75th percentile. Performance levels displayed as ★★ represent performance at or above the national Medicaid 25th percentile but below the national Medicaid 50th percentile. Finally, performance levels displayed as ★ indicate that the weighted average performance was below the national Medicaid 25th percentile.

For certain measures such as *Comprehensive Diabetes Care—Poor HbA1c Control*, where lower rates indicate better performance, the national Medicaid 10th percentile (rather than the national Medicaid 90th percentile) represents excellent performance and the national Medicaid 75th percentile (rather than the national Medicaid 25th percentile) represents below-average performance.

Of note, measures in the Health Plan Diversity and Utilization domains are provided within this section for information purposes only as they assess the MHPs' use of services and/or describe health plan characteristics and are not related to performance. Therefore, most of these rates were not evaluated in comparison to national benchmarks and were not analyzed for statistical significance.

[3-6] Weighted averages were calculated and compared from HEDIS 2015 to HEDIS 2016, and comparisons were based on a Chi-square test of statistical significance with a p value of <0.01 due to large denominators. Of note, 2015–2016 comparison values are based on comparisons of the exact HEDIS 2015 and HEDIS 2016 statewide weighted averages rather than on rounded values.

[3-7] 2016 performance levels were based on comparisons to national Medicaid HMO Quality Compass HEDIS 2015 benchmarks, with the exception of the *Medication Management for People With Asthma—Medication Compliance 50%—Total* indicator, which was compared to national Medicaid HMO NCQA Audit Means and Percentiles HEDIS 2015 benchmarks.

Table 3-2—Overall Statewide Averages for Performance Measures

Measure	HEDIS 2015	HEDIS 2016	2015–2016 Comparison	Performance Level for 2016
Child & Adolescent Care				
Childhood Immunization Status				
Combination 2	77.16%	76.15%	**-1.01^{++}**	★★★
Combination 3	72.90%	71.05%	**-1.85^{++}**	★★
Combination 4	67.78%	67.50%	-0.27	★★
Combination 5	60.52%	58.78%	**-1.74^{++}**	★★★
Combination 6	44.76%	40.45%	**-4.31^{++}**	★★
Combination 7	56.97%	56.15%	-0.82	★★★
Combination 8	42.69%	39.27%	**-3.42^{++}**	★★
Combination 9	38.43%	34.97%	**-3.47^{++}**	★★
Combination 10	36.92%	33.92%	**-3.00^{++}**	★★
Well-Child Visits in the First 15 Months of Life				
Six or More Visits	64.76%	66.22%	**+1.45^{+}**	★★★
Lead Screening in Children				
Lead Screening in Children	80.37%	79.55%	-0.82	★★★
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life				
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	75.76%	75.11%	**-0.65^{++}**	★★★
Adolescent Well-Care Visits				
Adolescent Well-Care Visits	54.02%	54.74%	**+0.72^{+}**	★★★
Immunizations for Adolescents				
Combination 1	88.94%	86.99%	**-1.95^{++}**	★★★★

Green Shading^{+} Indicates that the HEDIS 2016 MWA demonstrated a statistically significant improvement from the HEDIS 2015 MWA.

Red Shading^{++} Indicates that the HEDIS 2016 MWA demonstrated a statistically significant decline from the HEDIS 2015 MWA.

2016 performance levels represent the following percentile comparisons:

★★★★★ = 90th percentile and above
★★★★ = 75th to 89th percentile
★★★ = 50th to 74th percentile
★★ = 25th to 49th percentile
★ = Below 25th percentile

Measure	HEDIS 2015	HEDIS 2016	2015–2016 Comparison	Performance Level for 2016
Child & Adolescent Care (continued)				
Appropriate Treatment for Children With Upper Respiratory Infection				
Appropriate Treatment for Children With Upper Respiratory Infection	88.00%	89.09%	**+1.09⁺**	★★★
Appropriate Testing for Children With Pharyngitis				
Appropriate Testing for Children With Pharyngitis	67.25%	68.41%	**+1.15⁺**	★★
Follow-Up Care for Children Prescribed ADHD Medication				
Initiation Phase	38.87%	42.58%	**+3.71⁺**	★★★
Continuation and Maintenance Phase	44.35%	53.96%	**+9.61⁺**	★★★
Women—Adult Care				
Breast Cancer Screening				
Breast Cancer Screening	59.65%	59.58%	-0.06	★★★
Cervical Cancer Screening				
Cervical Cancer Screening	68.46%	63.79%	**-4.67⁺⁺**	★★★
Chlamydia Screening in Women				
Ages 16 to 20 Years	59.08%	60.75%	**+1.67⁺**	★★★★
Ages 21 to 24 Years	67.58%	67.85%	+0.28	★★★★
Total	62.20%	63.86%	**+1.65⁺**	★★★★
Access to Care				
Children and Adolescents' Access to Primary Care Practitioners				
Ages 12 to 24 Months	96.32%	96.20%	-0.12	★★
Ages 25 Months to 6 Years	88.73%	88.79%	+0.06	★★★
Ages 7 to 11 Years	91.14%	90.85%	-0.29	★★
Ages 12 to 19 Years	90.21%	89.86%	**-0.35⁺⁺**	★★
Adults' Access to Preventive/Ambulatory Health Services				
Ages 20 to 44 Years	83.42%	82.76%	**-0.65⁺⁺**	★★★
Ages 45 to 64 Years	90.77%	89.81%	**-0.96⁺⁺**	★★★
Ages 65+ Years	88.60%	91.15%	**+2.55⁺**	★★★★
Total	86.11%	85.62%	**-0.49⁺⁺**	★★★

Green Shading⁺ Indicates that the HEDIS 2016 MWA demonstrated a statistically significant improvement from the HEDIS 2015 MWA.

Red Shading⁺⁺ Indicates that the HEDIS 2016 MWA demonstrated a statistically significant decline from the HEDIS 2015 MWA.

2016 performance levels represent the following percentile comparisons:

★★★★★ = 90th percentile and above
★★★★ = 75th to 89th percentile
★★★ = 50th to 74th percentile
★★ = 25th to 49th percentile
★ = Below 25th percentile

Measure	HEDIS 2015	HEDIS 2016	2015–2016 Comparison	Performance Level for 2016
Access to Care (continued)				
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis				
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	—	26.94%	—	★★★
Obesity				
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents				
BMI Percentile—Total	78.34%	74.93%	**-3.41**$^{++}$	★★★
Counseling for Nutrition—Total	67.95%	65.77%	**-2.19**$^{++}$	★★★
Counseling for Physical Activity—Total†	58.07%	57.88%	-0.19	★★★
Adult BMI Assessment				
Adult BMI Assessment	90.31%	89.92%	**-0.39**$^{++}$	★★★★
Pregnancy Care				
Prenatal and Postpartum Care				
Timeliness of Prenatal Care	84.45%	78.63%	**-5.81**$^{++}$	★★
Postpartum Care	66.69%	61.73%	**-4.96**$^{++}$	★★
Frequency of Ongoing Prenatal Care				
≥81 Percent of Expected Visits	63.43%	56.40%	**-7.03**$^{++}$	★★
Weeks of Pregnancy at Time of Enrollment[1]				
Prior to 0 Weeks	30.34%	32.63%	+2.29	—
1–12 Weeks	9.55%	11.40%	+1.85	—
13–27 Weeks	39.34%	31.45%	-7.89	—
28 or More Weeks	17.35%	20.82%	+3.47	—
Unknown	3.42%	3.70%	+0.28	—

Green Shading^{+} Indicates that the HEDIS 2016 MWA demonstrated a statistically significant improvement from the HEDIS 2015 MWA.

Red Shading^{++} Indicates that the HEDIS 2016 MWA demonstrated a statistically significant decline from the HEDIS 2015 MWA.

† Due to changes in the technical specifications for this measure, exercise caution when trending rates between 2016 and prior years.

[1] Significance testing was not performed for utilization-based measure indicator rates or any performance levels for 2016 or 2015–2016. Comparisons provided for these measures are for information purposes only.

— indicates that the measure indicator was not presented in the HEDIS 2015 deliverables; therefore, the HEDIS 2015 rate and 2015–2016 comparison values are not presented in this report. This symbol may also indicate that the performance levels for 2016 were not determined because the measure did not have an applicable benchmark.

2016 performance levels represent the following percentile comparisons:

★★★★★ = 90th percentile and above
★★★★ = 75th to 89th percentile
★★★ = 50th to 74th percentile
★★ = 25th to 49th percentile
★ = Below 25th percentile

Measure	HEDIS 2015	HEDIS 2016	2015–2016 Comparison	Performance Level for 2016
Living With Illness				
Comprehensive Diabetes Care†				
Hemoglobin A1c (HbA1c) Testing	85.99%	86.89%	**+0.90**+	★★★
*HbA1c Poor Control (>9.0%)**	35.83%	39.30%	**3.48**++	★★★
HbA1c Control (<8.0%)	53.78%	50.91%	**-2.87**++	★★★
Eye Exam (Retinal) Performed	59.48%	59.61%	+0.13	★★★
Medical Attention for Nephropathy	83.73%	91.28%	**+7.55**+	★★★★★
Blood Pressure Control (<140/90 mm Hg)	65.90%	59.38%	**-6.52**++	★★
Medication Management for People With Asthma				
Medication Compliance 50%—Total	—	67.13%	—	★★★★
Medication Compliance 75%—Total	—	43.79%	—	★★★★★
Asthma Medication Ratio				
Total	—	62.18%	—	★★★
Controlling High Blood Pressure				
Controlling High Blood Pressure	62.06%	55.54%	**-6.53**++	★★
Medical Assistance With Smoking and Tobacco Use Cessation^				
Advising Smokers and Tobacco Users to Quit	79.90%	79.75%	**-0.15**++	★★★★
Discussing Cessation Medications	54.26%	55.04%	**+0.79**+	★★★★
Discussing Cessation Strategies	45.73%	45.20%	**-0.53**++	★★★
Antidepressant Medication Management				
Effective Acute Phase Treatment	—	60.36%	—	★★★★
Effective Continuation Phase Treatment	—	42.21%	—	★★★★

Green Shading+ Indicates that the HEDIS 2016 MWA demonstrated a statistically significant improvement from the HEDIS 2015 MWA.

Red Shading++ Indicates that the HEDIS 2016 MWA demonstrated a statistically significant decline from the HEDIS 2015 MWA.

† Due to changes in the technical specifications for this measure, exercise caution when trending rates between 2016 and prior years.

^ The weighted averages for this measure were based on the eligible population for the survey rather than only the number of people who responded to the survey as being smokers.

* For this indicator, a lower rate indicates better performance.

— indicates that the measure indicator was not presented in the HEDIS 2015 deliverables; therefore, the HEDIS 2015 rate and 2015–2016 comparison values are not presented in this report. This symbol may also indicate that the performance levels for 2016 were not determined because the measure did not have an applicable benchmark.

2016 performance levels represent the following percentile comparisons:

★★★★★ = 90th percentile and above
★★★★ = 75th to 89th percentile
★★★ = 50th to 74th percentile
★★ = 25th to 49th percentile
★ = Below 25th percentile

Measure	HEDIS 2015	HEDIS 2016	2015–2016 Comparison	Performance Level for 2016
Living With Illness (continued)				
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications				
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	83.75%	82.61%	-1.14	★★★
Diabetes Monitoring for People With Diabetes and Schizophrenia				
Diabetes Monitoring for People With Diabetes and Schizophrenia	72.73%	69.98%	-2.74	★★★
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia				
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia	60.10%	74.46%	**+14.36⁺**	★★
Adherence to Antipsychotic Medications for Individuals With Schizophrenia†				
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	59.22%	58.76%	-0.46	★★
Annual Monitoring for Patients on Persistent Medications				
ACE Inhibitors or ARBs	—	87.20%	—	★★
Digoxin	—	52.47%	—	★★
Diuretics	—	86.88%	—	★★
Total	—	86.84%	—	★★

Green Shading⁺ Indicates that the HEDIS 2016 MWA demonstrated a statistically significant improvement from the HEDIS 2015 MWA.

Red Shading⁺⁺ Indicates that the HEDIS 2016 MWA demonstrated a statistically significant decline from the HEDIS 2015 MWA.

† Due to changes in the technical specifications for this measure, exercise caution when trending rates between 2016 and prior years.

* For this indicator, a lower rate indicates better performance.

— indicates that the measure indicator was not presented in the HEDIS 2015 deliverables; therefore, the HEDIS 2015 rate and 2015–2016 comparison values are not presented in this report. This symbol may also indicate that the performance levels for 2016 were not determined because the measure did not have an applicable benchmark.

2016 performance levels represent the following percentile comparisons:

★★★★★ = 90th percentile and above
★★★★ = 75th to 89th percentile
★★★ = 50th to 74th percentile
★★ = 25th to 49th percentile
★ = Below 25th percentile

Measure	HEDIS 2015	HEDIS 2016	2015–2016 Comparison	Performance Level for 2016
Health Plan Diversity‡				
Race/Ethnicity Diversity of Membership				
Total—White	53.44%	54.01%	0.57%	—
Total—Black or African American	29.35%	28.00%	-1.35%	—
Total—American-Indian and Alaska Native	0.33%	0.49%	0.16%	—
Total—Asian	1.24%	1.09%	-0.15%	—
Total—Native Hawaiian and Other Pacific Islander	0.06%	0.05%	-0.01%	—
Total—Some Other Race	0.44%	1.23%	0.79%	—
Total—Two or More Races	0.00%	0.00%	0.00%	—
Total—Unknown	12.40%	12.23%	-0.17%	—
Total—Declined	2.74%	2.89%	0.15%	—
Language Diversity of Membership				
Spoken Language Preferred for Health Care—English	92.88%	88.26%	-4.62%	—
Spoken Language Preferred for Health Care—Non-English	1.34%	1.11%	-0.23%	—
Spoken Language Preferred for Health Care—Unknown	5.71%	10.63%	4.92%	—
Spoken Language Preferred for Health Care—Declined	0.07%	0.00%	-0.07%	—
Preferred Language for Written Materials—English	70.40%	70.13%	-0.27%	—
Preferred Language for Written Materials—Non-English	1.27%	1.08%	-0.19%	—
Preferred Language for Written Materials—Unknown	28.34%	28.79%	0.45%	—
Preferred Language for Written Materials—Declined	0.00%	0.00%	0.00%	—
Other Language Needs—English	42.69%	52.71%	10.02%	—
Other Language Needs—Non-English	0.51%	0.51%	0.00%	—
Other Language Needs—Unknown	56.80%	46.78%	-10.02%	—
Other Language Needs—Declined	0.00%	0.00%	0.00%	—

‡ Significance testing was not performed for health plan characteristics measure indicator rates or any performance levels for 2016 or 2015–2016. Comparisons provided for these measures are for information purposes only.

— indicates that the measure indicator was not presented in the HEDIS 2015 deliverables; therefore, the HEDIS 2015 rate and 2015–2016 comparison values are not presented in this report. This symbol may also indicate that the performance levels for 2016 were not determined because the measure did not have an applicable benchmark.

Measure	HEDIS 2015	HEDIS 2016	2015–2016 Comparison	Performance Level for 2016
Utilization‡				
Ambulatory Care—Total (Per 1,000 Member Months)				
*ED Visits—Total**	70.20	74.00	+3.80	★
Outpatient Visits—Total	340.77	373.49	+32.72	—
Inpatient Utilization—General Hospital/Acute Care—Total				
Total Inpatient—Discharges per 1,000 Member Months—Total	8.02	8.27	+0.25	—
Total Inpatient—Average Length of Stay—Total	3.99	3.98	-0.01	—
Maternity—Discharges per 1,000 Member Months—Total	3.62	2.59	-1.03	—
Maternity—Average Length of Stay—Total	2.65	2.63	-0.02	—
Surgery—Discharges per 1,000 Member Months—Total	1.62	1.83	+0.21	—
Surgery—Average Length of Stay—Total	6.50	6.18	-0.32	—
Medicine—Discharges per 1,000 Member Months—Total	4.02	4.52	+0.50	—
Medicine—Average Length of Stay—Total	3.77	3.64	-0.13	—

‡ Significance testing was not performed for utilization-based measure indicator rates and any performance levels for 2016 or 2015–2016. Comparisons provided for these measures are for information purposes only.

* For this indicator, a lower rate indicates better performance.

— indicates that the measure indicator was not presented in the HEDIS 2015 deliverables; therefore, the HEDIS 2015 rate and 2015–2016 comparison values are not presented in this report. This symbol may also indicate that the performance levels for 2016 were not determined because the measure did not have an applicable benchmark.

2016 performance levels represent the following percentile comparisons:
★★★★★ = 90th percentile and above
★★★★ = 75th to 89th percentile
★★★ = 50th to 74th percentile
★★ = 25th to 49th percentile
★ = Below 25th percentile

Overall, 41 statewide rates performed at or above the national Medicaid 50th percentile, with 11 rates performing at or above the national Medicaid 75th percentile but below the national Medicaid 90th percentile. Further, two rates (*Comprehensive Diabetes Care—Medical Attention for Nephropathy* and *Medication Management for People With Asthma—Medication Compliance 75%—Total*) met or exceeded the national Medicaid 90th percentile, demonstrating a strength statewide. However, due to changes in the technical specifications for the *Comprehensive Diabetes Care* measure indicators, caution should be used when comparing HEDIS 2016 rates to benchmarks derived from the previous year's results.

Statewide performance at or above the national Medicaid 75th percentile but below the national Medicaid 90th percentile spanned multiple domains including Child & Adolescent Care (*Immunizations*

for Adolescents—Combination 1), Women—Adult Care (all three *Chlamydia Screening in Women* indicators), Access to Care (*Adults' Access to Preventive/Ambulatory Health Services—Ages 65+ Years*), Obesity (*Adult BMI Assessment*), and Living With Illness (*Medication Management for People With Asthma—Medication Compliance 50%—Total*, two of the three *Medical Assistance With Smoking and Tobacco Use Cessation* indicators, and both *Antidepressant Medication Management* indicators).

Conversely, 22 statewide rates fell below the national Medicaid 50th percentile, with one rate (*Ambulatory Care—Total [Per 1,000 Member Months]—ED Visits—Total*) falling below the national Medicaid 25th percentile. Opportunities for statewide improvement spanned multiple domains including Child & Adolescent Care (six of nine *Childhood Immunization Status* indicators and *Appropriate Testing for Children With Pharyngitis*), Access to Care (three of four *Children and Adolescents' Access to Primary Care Practitioners* indicators), Pregnancy Care (both *Prenatal and Postpartum Care* indicators and *Frequency of Ongoing Prenatal Care—≥81 Percent of Expected Visits*), and Living With Illness (*Comprehensive Diabetes Care—Blood Pressure Control [<140/90 mm Hg]*, *Controlling High Blood Pressure*, *Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia*, *Adherence to Antipsychotic Medications for Individuals With Schizophrenia*, and all four *Annual Monitoring for Patients on Persistent Medications* indicators).

Table 3-3 presents, by measure, the number of MHPs that performed at each performance level. The counts include only measures with a valid, reportable rate that could be compared to national Medicaid benchmarks. Therefore, not all rows will add up to all 11 MHPs.

Table 3-3—Count of MHPs by Performance Level

Measure	Number of Stars				
	★	★★	★★★	★★★★	★★★★★
Child & Adolescent Care					
Childhood Immunization Status					
Combination 2	3	2	4	1	1
Combination 3	3	3	4	1	0
Combination 4	3	4	3	0	1
Combination 5	3	3	4	0	1
Combination 6	3	7	0	1	0
Combination 7	3	3	4	0	1
Combination 8	3	6	1	0	1
Combination 9	3	5	2	0	1
Combination 10	3	5	2	0	1

2016 performance levels represent the following percentile comparisons:

★★★★★ = 90th percentile and above
★★★★ = 75th to 89th percentile
★★★ = 50th to 74th percentile
★★ = 25th to 49th percentile
★ = Below 25th percentile

Measure	Number of Stars				
	★	★★	★★★	★★★★	★★★★★
Child & Adolescent Care (continued)					
Well-Child Visits in the First 15 Months of Life					
Six or More Visits	1	2	2	4	1
Lead Screening in Children					
Lead Screening in Children	0	1	6	2	2
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life					
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	1	4	4	2	0
Adolescent Well-Care Visits					
Adolescent Well-Care Visits	1	3	6	1	0
Immunizations for Adolescents					
Combination 1	1	0	0	6	4
Appropriate Treatment for Children With Upper Respiratory Infection					
Appropriate Treatment for Children With Upper Respiratory Infection	0	3	5	2	1
Appropriate Testing for Children With Pharyngitis					
Appropriate Testing for Children With Pharyngitis	3	4	3	0	0
Follow-Up Care for Children Prescribed ADHD Medication					
Initiation Phase	2	3	3	2	0
Continuation and Maintenance Phase	1	3	4	1	1
Women—Adult Care					
Breast Cancer Screening					
Breast Cancer Screening	1	1	9	0	0
Cervical Cancer Screening					
Cervical Cancer Screening	1	2	8	0	0
Chlamydia Screening in Women					
Ages 16 to 20 Years	0	1	1	6	3
Ages 21 to 24 Years	0	2	1	6	2
Total	0	1	2	6	2

2016 performance levels represent the following percentile comparisons:

★★★★★ = 90th percentile and above
★★★★ = 75th to 89th percentile
★★★ = 50th to 74th percentile
★★ = 25th to 49th percentile
★ = Below 25th percentile

Measure	Number of Stars				
	★	★★	★★★	★★★★	★★★★★
Access to Care					
Children and Adolescents' Access to Primary Care Practitioners					
Ages 12 to 24 Months	3	3	2	3	0
Ages 25 Months to 6 Years	3	3	4	1	0
Ages 7 to 11 Years	4	4	3	0	0
Ages 12 to 19 Years	4	2	4	1	0
Adults' Access to Preventive/Ambulatory Health Services					
Ages 20 to 44 Years	1	4	3	3	0
Ages 45 to 64 Years	1	3	4	3	0
Ages 65+ Years	2	1	2	2	2
Total	1	4	3	3	0
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis					
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	0	3	3	4	1
Obesity					
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents					
BMI Percentile—Total	0	1	7	1	2
Counseling for Nutrition—Total	1	1	8	1	0
Counseling for Physical Activity—Total	0	1	9	1	0
Adult BMI Assessment					
Adult BMI Assessment	1	1	4	3	2
Pregnancy Care					
Prenatal and Postpartum Care					
Timeliness of Prenatal Care	7	2	2	0	0
Postpartum Care	5	2	3	1	0
Frequency of Ongoing Prenatal Care					
≥81 Percent of Expected Visits	8	1	0	1	1

2016 performance levels represent the following percentile comparisons:

★★★★★ = 90th percentile and above
★★★★ = 75th to 89th percentile
★★★ = 50th to 74th percentile
★★ = 25th to 49th percentile
★ = Below 25th percentile

Measure	Number of Stars				
	★	★★	★★★	★★★★	★★★★★
Living With Illness					
Comprehensive Diabetes Care					
Hemoglobin A1c (HbA1c) Testing	2	4	3	1	1
*HbA1c Poor Control (>9.0%)**	2	2	4	1	2
HbA1c Control (<8.0%)	2	2	4	2	1
Eye Exam (Retinal) Performed	2	1	5	2	1
Medical Attention for Nephropathy	0	0	0	0	11
Blood Pressure Control (<140/90 mm Hg)	6	2	2	1	0
Medication Management for People With Asthma					
Medication Compliance 50%—Total	0	1	1	3	5
Medication Compliance 75%—Total	1	0	1	3	5
Asthma Medication Ratio					
Total	3	1	3	2	1
Controlling High Blood Pressure					
Controlling High Blood Pressure	4	5	1	1	0
Medical Assistance With Smoking and Tobacco Use Cessation					
Advising Smokers and Tobacco Users to Quit	0	0	6	4	1
Discussing Cessation Medications	0	0	3	7	1
Discussing Cessation Strategies	0	2	8	1	0
Antidepressant Medication Management					
Effective Acute Phase Treatment	2	1	1	3	3
Effective Continuation Phase Treatment	2	1	3	1	3
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications					
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	0	1	3	4	2

* For this indicator, a lower rate indicates better performance.

2016 performance levels represent the following percentile comparisons:

★★★★★ = 90th percentile and above
★★★★ = 75th to 89th percentile
★★★ = 50th to 74th percentile
★★ = 25th to 49th percentile
★ = Below 25th percentile

Measure	Number of Stars				
	★	★★	★★★	★★★★	★★★★★
Living With Illness (continued)					
Diabetes Monitoring for People With Diabetes and Schizophrenia					
Diabetes Monitoring for People With Diabetes and Schizophrenia	3	3	3	0	0
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia					
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia	1	0	2	0	0
Adherence to Antipsychotic Medications for Individuals With Schizophrenia					
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	3	4	3	0	0
Annual Monitoring for Patients on Persistent Medications					
ACE Inhibitors or ARBs	1	8	2	0	0
Digoxin	1	2	4	0	0
Diuretics	1	6	4	0	0
Total	1	6	4	0	0
Utilization					
Ambulatory Care—Total (Per 1,000 Member Months)					
ED Visits—Total‡,*	7	4	0	0	0
Total	**124**	**160**	**209**	**105**	**68**

‡ Performance levels provided for this measure are for information purposes only.

* For this indicator, a lower rate indicates better performance.

2016 performance levels represent the following percentile comparisons:

★★★★★ = 90th percentile and above
★★★★ = 75th to 89th percentile
★★★ = 50th to 74th percentile
★★ = 25th to 49th percentile
★ = Below 25th percentile

Table 3-3 shows that 31.38 percent of all performance measure rates (209 of 666) reported by the MHPs fell into the average (★★★) range relative to national Medicaid results. While 25.98 percent of all performance measure rates (173 of 666) ranked at or above the national Medicaid 75th percentile (★★★★), 42.64 percent of all performance measure rates (284 of 666) fell below the national Medicaid 50th percentile, suggesting opportunities for improvement.

Performance Improvement Projects (PIPs)

Table 3-4 presents a summary of the MHPs' PIP validation status results. For the 2015–2016 validation, the MHPs provided their third-year submissions on a PIP topic they had previously selected to focus on a specific group or unique subpopulation of enrollees. With the implementation of the outcome-focused scoring methodology, there were fewer MHPs with an overall *Met* validation status, as this scoring methodology requires the MHPs to achieve statistically significant improvement over the baseline rate across all study indicators to receive an overall *Met* validation status. The percentage of PIPs receiving a validation status of *Met* improved for the third-year submissions to 45 percent.

Table 3-4—MHPs' PIP Validation Status

Validation Status	Percentage of PIPs	
	2014–2015	2015–2016
Met	31%	45%
Partially Met	0%	0%
Not Met	69%	55%

The following presents a summary of the validation results for the MHPs for the activities from the CMS PIP protocol. For the 2015–2016 cycle, HSAG validated all third-year PIP submissions for Activity I—Select the Study Topic through Activity IX—Assess for Real Improvement. Only those PIPs that had demonstrated significant improvement in the 2014–2015 cycle were assessed on Activity X—Assess for Sustained Improvement.

Table 3-5 shows the percentage of MHPs that met all applicable evaluation or critical elements within each of the ten activities.

Table 3-5—Summary of Data From Validation of Performance Improvement Projects

Review Activities		Percentage Meeting All Elements/ Percentage Meeting All Critical Elements	
		2014–2015	2015–2016
I.	Select the Study Topic	100%/100%	100%/100%
II.	Define the Study Question(s)	100%/100%	100%/100%
III.	Use a Representative and Generalizable Study Population	100%/100%	100%/100%
IV.	Select the Study Indicator(s)	100%/100%	100%/100%
V.	Use Sound Sampling Techniques*	67%/67%	100%/100%
VI.	Reliably Collect Data	85%/100%	100%/100%
VII.	Analyze Data and Interpret Study Results	92%/92%	64%/100%

Review Activities		Percentage Meeting All Elements/ Percentage Meeting All Critical Elements	
		2014–2015	2015–2016
VIII.	Implement Interventions and Improvement Strategies	77%/92%	82%/100%
IX.	Assess for Real Improvement	31%/31%	45%/36%
X.	Assess for Sustained Improvement**	Not Assessed	75%/75%

* This activity is assessed only for PIPs that conduct sampling.

** This activity was assessed only for PIPs that demonstrated significant improvement in the 2014–2015 cycle.

The results from the 2015–2016 validation continued to reflect strong performance in the Design phase (Activities I through VI) of the PIPs. All 11 MHPs received scores of *Met* for each applicable evaluation element in Activities I through VI. The MHPs designed scientifically sound projects supported by the use of key research principles. The PIP topics included improving rates of well-child visits; adolescent well-care visits; childhood immunizations; prenatal and postpartum care; access to care; and prevention or management of chronic health conditions for members living in certain areas of the State, members of specific age groups or race/ethnicity, or members having specific medical diagnoses.

Validation of Activities VII through X resulted in the following number of MHPs achieving *Met* scores for all applicable evaluation elements in each activity: seven MHPs for Activity VII, nine MHPs for Activity VIII, four MHPs for Activity IX, and three MHPs for Activity X. The MHPs collected, reported, and interpreted second remeasurement data accurately; used appropriate quality improvement tools to conduct causal/barrier analyses; and implemented interventions that had the potential to have a positive impact on the study indicator outcomes.

Activity IX—Assess for Real Improvement represented the largest opportunity for improvement, with recommendations identified for seven MHPs. All MHPs reflected compliance with the requirement to apply the same measurement methodology to the remeasurement data as was used for the baseline data. While eight MHPs documented improvement in the outcomes of care, only five MHPs demonstrated a statistically significant improvement over the respective baseline rates in the second remeasurement. Additionally, three MHPs documented statistically significant improvement over baseline for two consecutive years, hence demonstrating sustained improvement in study indicator rates.

As the PIPs progress, MHPs should revisit causal/barrier analyses at least annually to assess whether or not the barriers identified continue to be barriers and to determine whether any new barriers exist that require the development of interventions. Additionally, MHPs should continue to evaluate the effectiveness of each implemented intervention and make decisions about continuing, revising, or abandoning interventions to achieve the desired outcomes.

Conclusions/Summary

The review of the MHPs showed both strengths and opportunities for improvement statewide.

Results of the 2015–2016 annual compliance reviews conducted by MDHHS reflected continued strong performance by the MHPs, which—with statewide compliance score percentages ranging in the 90s—demonstrated high levels of compliance with State and federal requirements in all areas assessed. The *Administrative* and *Providers* standards represented statewide strengths. Compliance with MDHHS-specified minimum performance standards—assessed in the *Quality* standard—remained a statewide opportunity for improvement.

Michigan's statewide HEDIS 2016 performance showed both strengths and opportunities for improvement. Of the 83 comparable measure rates, 32 measure rates (38.55 percent) reflected improved performance from 2015–2016, with statistically significant improvements observed related to 13 of these measure indicators. Statistically significant improvements were concentrated in the Child & Adolescent Care and Living With Illness domains. One statewide weighted average rate, *Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia*, demonstrated statistically significant improvement, with an increase of 14.36 percentage points; however, the rate continued to fall below the national Medicaid 50th percentile. Despite these improvements, more rates declined than last year. Overall, 52 measure rates showed performance declines from the prior year, 26 (31.33 percent) of which were statistically significant declines. The most significant declines were concentrated in the Pregnancy Care and Living With Illness domains.

The 2015–2016 validation of the PIPs reflected high levels of compliance with the requirements for Activities I–VI of the CMS PIP protocol and the critical evaluation elements in Activities VII and VIII. The MHPs provided their third-year submission of the PIP on improving quality outcomes—specifically, the quality, timeliness, and accessibility of care and services for a selected subpopulation of enrollees. The MHPs designed methodologically sound projects with a foundation on which to progress to subsequent PIP activities; implemented interventions logically linked to identified barriers; and collected, reported, and analyzed their second remeasurement data. However, most PIPs received a *Not Met* validation status due to lack of statistically significant improvement in the study indicator rates. While eight MHPs documented improvement in outcomes of care, only five of those demonstrated statistically significant improvement over the baseline rates. Three MHPs documented statistically significant improvement over baseline for two consecutive years, hence demonstrating sustained improvement in study indicator rates. To strengthen improvement efforts, the MHPs should continue using performance improvement tools to evaluate the effectiveness of the implemented interventions and make needed changes to overcome barriers that prevent them from achieving the desired outcomes.

State of Michigan
Department of Health and Human Services

2016 Michigan Department of Health and Human Services Child Medicaid Health Plan CAHPS® Report

September 2016

HSAG HEALTH SERVICES ADVISORY GROUP

TABLE OF CONTENTS

Introduction

The Michigan Department of Health and Human Services (MDHHS) periodically assesses the perceptions and experiences of members enrolled in the MDHHS Medicaid health plans (MHPs) and the Fee-for-Service (FFS) program as part of its process for evaluating the quality of health care services provided to child members in the MDHHS Medicaid Program. MDHHS contracted with Health Services Advisory Group, Inc. (HSAG) to administer and report the results of the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Health Plan Survey for the MDHHS Medicaid Program.[1-1] The goal of the CAHPS Health Plan Survey is to provide performance feedback that is actionable and that will aid in improving overall member satisfaction.

This report presents the 2016 child Medicaid CAHPS results based on responses of parents or caretakers who completed the survey on behalf of child members enrolled in an MHP or FFS.[1-2] The surveys were completed from February to May 2016. The standardized survey instrument selected was the CAHPS 5.0 Child Medicaid Health Plan Survey with the Healthcare Effectiveness Data and Information Set (HEDIS®) supplemental item set.[1-3]

Report Overview

A sample of at least 1,650 child members was selected from the FFS population and each MHP, with two exceptions. HAP Midwest Health Plan and Harbor Health Plan did not have enough eligible members to meet the sampling goal of 1,650 members; therefore, the sample sizes for HAP Midwest Health Plan and Harbor Health Plan were 172 and 1,094, respectively.

Results presented in this report include four global ratings: Rating of Health Plan, Rating of All Health Care, Rating of Personal Doctor, and Rating of Specialist Seen Most Often. Additionally, five composite measures are reported: Getting Needed Care, Getting Care Quickly, How Well Doctors Communicate, Customer Service, and Shared Decision Making.

HSAG presents aggregate statewide results and compares them to national Medicaid data and the prior year's results, where appropriate. Throughout this report, two statewide aggregate results are presented for comparative purposes:

- MDHHS Medicaid Program – Combined results for FFS and the MHPs.
- MDHHS Medicaid Managed Care Program – Combined results for the MHPs.

[1-1] CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).
[1-2] The health plan name for one of the MHPs changed since the child MHP population was surveyed in 2015. Aetna Better Health of Michigan was previously referred to as CoventryCares.
[1-3] HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

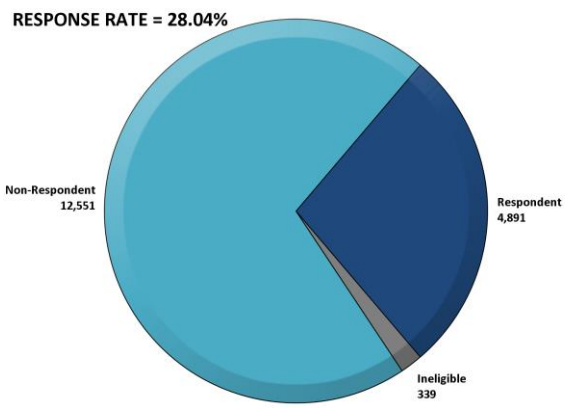
Key Findings

Survey Dispositions and Demographics

Figure 1-1 provides an overview of the MDHHS Medicaid Program survey dispositions and child member demographics.

Figure 1-1: Survey Dispositions and Member Demographics

Survey Dispositions



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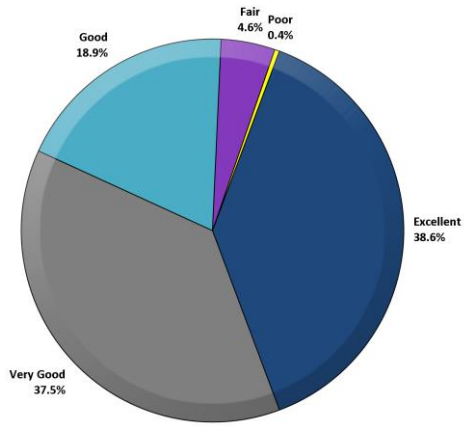

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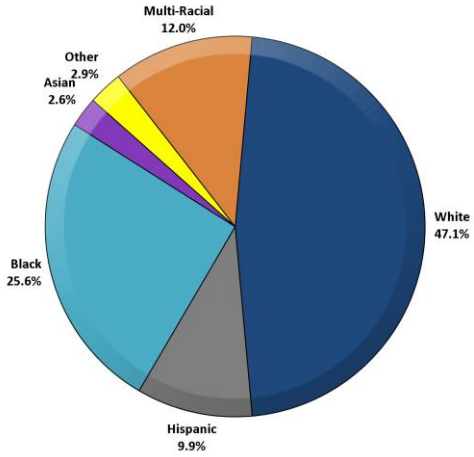
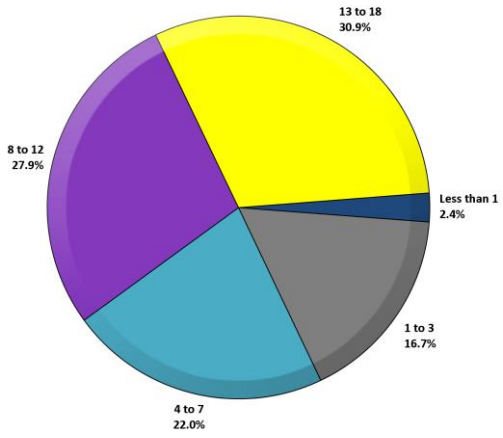


Age



Please note, percentages may not total 100.0% due to rounding.

National Comparisons and Trend Analysis

A three-point mean score was determined for the four CAHPS global ratings and four CAHPS composite measures. The resulting three-point mean scores were compared to the National Committee for Quality Assurance's (NCQA's) 2016 HEDIS Benchmarks and Thresholds for Accreditation to derive the overall member satisfaction ratings (i.e., star ratings) for each CAHPS

measure.[1-4,1-5] In addition, a trend analysis was performed that compared the 2016 CAHPS results to their corresponding 2015 CAHPS results, where appropriate. Table 1-1 provides highlights of the National Comparisons and Trend Analysis findings for the MDHHS Medicaid Program. The numbers presented below represent the three-point mean score for each measure, while the stars represent overall member satisfaction ratings when the three-point means were compared to NCQA HEDIS Benchmarks and Thresholds for Accreditation.

Table 1-1: National Comparisons and Trend Analysis MDHHS Medicaid Program

Measure	National Comparisons	Trend Analysis
Global Rating		
Rating of Health Plan	★★ 2.54	—
Rating of All Health Care	★★★ 2.55	▼
Rating of Personal Doctor	★★★ 2.64	—
Rating of Specialist Seen Most Often	★★★ 2.59	—
Composite Measure		
Getting Needed Care	★★ 2.44	▼
Getting Care Quickly	★★★ 2.64	—
How Well Doctors Communicate	★★★★ 2.73	—
Customer Service	★★★ 2.57	—

Star Assignments Based on Percentiles

★★★★★ 90th or Above ★★★★ 75th-89th ★★★ 50th-74th ★★ 25th-49th ★ Below 25th

▲ statistically significantly higher in 2016 than in 2015.

▼ statistically significantly lower in 2016 than in 2015.

— indicates the 2016 score is not statistically significantly different than the 2015 score.

The National Comparisons results indicated three global ratings and two composite measures scored at or between the 50th and 74th percentiles: Rating of All Health Care, Rating of Personal Doctor, Rating of Specialist Seen Most Often, Getting Care Quickly, and Customer Service. Further, one composite measure scored at or between the 75th and 89th percentiles: How Well Doctors Communicate.

Results from the trend analysis showed that the MDHHS Medicaid Program scored significantly *lower* in 2016 than in 2015 on two measures: Rating of All Health Care and Getting Needed Care.

[1-4] National Committee for Quality Assurance. *HEDIS Benchmarks and Thresholds for Accreditation 2016*. Washington, DC: NCQA; January 21, 2016.

[1-5] NCQA does not publish national benchmarks and thresholds for the Shared Decision Making composite measure; therefore, this CAHPS measure was excluded from the National Comparisons analysis.

Statewide Comparisons

HSAG calculated top-box rates (i.e., rates of satisfaction) for each global rating and composite measure. HSAG compared the MHP and FFS results to the MDHHS Medicaid Managed Care Program average to determine if plan or program results were statistically significantly different than the MDHHS Medicaid Managed Care Program average. Table 1-2 and Table 1-3 show the results of this analysis for the global ratings and composite measures, respectively.

Table 1-2: Statewide Comparisons—Global Ratings

Plan Name	Rating of Health Plan	Rating of All Health Care	Rating of Personal Doctor	Rating of Specialist Seen Most Often
Fee-for-Service	↓	—	—	—+
Aetna Better Health of Michigan	↓	—	—	—+
Blue Cross Complete of Michigan	—	—	—	—+
HAP Midwest Health Plan	—+	—+	—+	—+
Harbor Health Plan	↓	—	—	—+
McLaren Health Plan	—	—	—	—
Meridian Health Plan of Michigan	—	—	—	—
Molina Healthcare of Michigan	—	—	—	—+
Priority Health Choice, Inc.	↑	—	—	—+
Total Health Care, Inc.	—	—	—	—+
UnitedHealthcare Community Plan	—	—	—	—+
Upper Peninsula Health Plan	—	—	—	—+

\+ indicates fewer than 100 responses. Caution should be exercised when evaluating these results.
↑ indicates the plan's score is statistically significantly higher than the MDHHS Medicaid Managed Care Program average
↓ indicates the plan's score is statistically significantly lower than the MDHHS Medicaid Managed Care Program average
— indicates the plan's score is not statistically significantly different than the MDHHS Medicaid Managed Care Program average

Table 1-3: Statewide Comparisons—Composite Measures					
Plan Name	**Getting Needed Care**	**Getting Care Quickly**	**How Well Doctors Communicate**	**Customer Service**	**Shared Decision Making**
Fee-for-Service	—	—	↑	—+	—+
Aetna Better Health of Michigan	—	—	—	—	—+
Blue Cross Complete of Michigan	—	—	—	—	—
HAP Midwest Health Plan	—+	—+	—+	—+	—+
Harbor Health Plan	—+	—+	—+	—+	—+
McLaren Health Plan	—	—	—	—	—
Meridian Health Plan of Michigan	—	—	—	—	—
Molina Healthcare of Michigan	—	—	—	—	—+
Priority Health Choice, Inc.	—	—	—	—+	—
Total Health Care, Inc.	—	—	—	—	—+
UnitedHealthcare Community Plan	—	—	—	—	—+
Upper Peninsula Health Plan	—	—	—	—+	—

\+ indicates fewer than 100 responses. Caution should be exercised when evaluating these results.
↑ indicates the plan's score is statistically significantly higher than the MDHHS Medicaid Managed Care Program average
↓ indicates the plan's score is statistically significantly lower than the MDHHS Medicaid Managed Care Program average
— indicates the plan's score is not statistically significantly different than the MDHHS Medicaid Managed Care Program average

The results from the Statewide Comparisons presented in Table 1-2 and Table 1-3 revealed that FFS had one measure that was significantly *higher* than the MDHHS Medicaid Managed Care Program. Additionally, Priority Health Choice, Inc. had one measure that was signficantly *higher* than the MDHHS Medicaid Managed Care Program average.

Conversely, FFS, Aetna Better Health of Michigan, and Harbor Health Plan had one measure that was significantly *lower* than the MDHHS Medicaid Managed Care Program average.

Key Drivers of Satisfaction

HSAG focused the key drivers of satisfaction analysis on three measures: Rating of Health Plan, Rating of All Health Care, and Rating of Personal Doctor. HSAG evaluated each of these measures to determine if particular CAHPS items (i.e., questions) strongly correlated with these measures, which HSAG refers to as "key drivers." These individual CAHPS items are driving levels of satisfaction with each of the three measures. Table 1-4 provides a summary of the key drivers identified for the MDHHS Medicaid Program.

Table 1-4: MDHHS Medicaid Program Key Drivers of Satisfaction
Rating of Health Plan
Respondents reported that when their child did not need care right away, they did not obtain an appointment for health care as soon as they thought they needed.
Respondents reported that it was not always easy to get the care, tests, or treatment they thought their child needed through his/her health plan.
Respondents reported that their child's health plan's customer service did not always give them the information or help they needed.
Respondents reported that their child's personal doctor did not always seem informed and up-to-date about the care their child received from other doctors or health providers.
Respondents reported that forms from their child's health plan were often not easy to fill out.
Respondents reported that it was often not easy for their child to obtain appointments with specialists.
Rating of All Health Care
Respondents reported that when their child did not need care right away, they did not obtain an appointment for health care as soon as they thought they needed.
Respondents reported that it was not always easy to get the care, tests, or treatment they thought their child needed through his/her health plan.
Respondents reported that their child's personal doctor did not always seem informed and up-to-date about the care their child received from other doctors or health providers.
Respondents reported that it was often not easy for their child to obtain appointments with specialists.
Rating of Personal Doctor
Respondents reported that their child's personal doctor did not always seem informed and up-to-date about the care their child received from other doctors or health providers.
Respondents reported that their child's personal doctor did not always spend enough time with them.
Respondents reported that their child's personal doctor did not talk with them about how their child is feeling, growing, or behaving.

2016 CAHPS Performance Measures

The CAHPS 5.0 Child Medicaid Health Plan Survey with the HEDIS supplemental item set includes 48 core questions that yield 9 measures of satisfaction. These measures include four global rating questions and five composite measures. The global measures (also referred to as global ratings) reflect overall satisfaction with the health plan, health care, personal doctors, and specialists. The composite measures are sets of questions grouped together to address different aspects of care (e.g., "Getting Needed Care" or "Getting Care Quickly").

Table 2-1 lists the measures included in the CAHPS 5.0 Child Medicaid Health Plan Survey with the HEDIS supplemental item set.

Table 2-1: CAHPS Measures

Global Ratings	Composite Measures
Rating of Health Plan	Getting Needed Care
Rating of All Health Care	Getting Care Quickly
Rating of Personal Doctor	How Well Doctors Communicate
Rating of Specialist Seen Most Often	Customer Service
	Shared Decision Making

How CAHPS Results Were Collected

NCQA mandates a specific HEDIS survey methodology to ensure the collection of CAHPS data is consistent throughout all plans to allow for comparison. In accordance with NCQA requirements, HSAG adhered to the sampling procedures and survey protocol described below.

Sampling Procedures

MDHHS provided HSAG with a list of all eligible members for the sampling frame, per HEDIS specifications. HSAG inspected a sample of the file records to check for any apparent problems with the files, such as missing address elements. Following HEDIS requirements, HSAG sampled members who met the following criteria:

- Were 17 years of age or younger as of December 31, 2015.
- Were currently enrolled in an MHP or FFS.
- Had been continuously enrolled in the plan or program for at least five of the last six months (July through December) of 2015.
- Had Medicaid as a payer.

Next, a systematic sample of members was selected for inclusion in the survey. For each MHP, no more than one member per household was selected as part of the survey samples. A sample of at least 1,650 child members was selected from the FFS population and each MHP, with two exceptions. HAP Midwest Health Plan and Harbor Health Plan did not have enough eligible members to meet the sampling goal of 1,650 members; therefore, the sample sizes for HAP Midwest Health Plan and Harbor Health Plan were 172 and 1,094, respectively. Table 3-1 in the Results section provides an overview of the sample sizes for each plan and program.

Survey Protocol

The CAHPS 5.0 Health Plan Survey process allows for two methods by which parents or caretakers of child members could complete a survey. The first, or mail phase, consisted of sampled members receiving a survey via mail. HSAG tried to obtain new addresses for members selected for the sample by processing sampled members' addresses through the United States Postal Service's National Change of Address (NCOA) system. All sampled parents or caretakers of child members received an English version of the survey, with the option of completing the survey in Spanish. Non-respondents received a reminder postcard, followed by a second survey mailing and postcard reminder.

The second phase, or telephone phase, consisted of Computer Assisted Telephone Interviewing (CATI) of parents or caretakers of child members who did not mail in a completed survey. At least three CATI calls to each non-respondent were attempted.[2-1] It has been shown that the addition of the telephone phase aids in the reduction of non-response bias by increasing the number of respondents who are more demographically representative of a plan's population.[2-2]

[2-1] National Committee for Quality Assurance. *Quality Assurance Plan for HEDIS 2016 Survey Measures.* Washington, DC: NCQA; 2015.

[2-2] Fowler FJ Jr., Gallagher PM, Stringfellow VL, et al. "Using Telephone Interviews to Reduce Nonresponse Bias to Mail Surveys of Health Plan Members." *Medical Care*. 2002; 40(3): 190-200.

Table 2-2 shows the standard mixed-mode (i.e., mail followed by telephone follow-up) CAHPS 5.0 timeline used in the administration of the CAHPS surveys.

Table 2-2: CAHPS 5.0 Mixed-Mode Methodology Survey Timeline

Task	Timeline
Send first questionnaire with cover letter to the parent or caretaker of child member.	0 days
Send a postcard reminder to non-respondents 4-10 days after mailing the first questionnaire.	4-10 days
Send a second questionnaire (and letter) to non-respondents approximately 35 days after mailing the first questionnaire.	35 days
Send a second postcard reminder to non-respondents 4-10 days after mailing the second questionnaire.	39-45 days
Initiate CATI interviews for non-respondents approximately 21 days after mailing the second questionnaire.	56 days
Initiate systematic contact for all non-respondents such that at least three telephone calls are attempted at different times of the day, on different days of the week, and in different weeks.	56 – 70 days
Telephone follow-up sequence completed (i.e., completed interviews obtained or maximum calls reached for all non-respondents) approximately 14 days after initiation.	70 days

How CAHPS Results Were Calculated and Displayed

HSAG used the CAHPS scoring approach recommended by NCQA in Volume 3 of HEDIS Specifications for Survey Measures. Based on NCQA's recommendations and HSAG's extensive experience evaluating CAHPS data, HSAG performed a number of analyses to comprehensively assess member satisfaction. In addition to individual plan results, HSAG calculated an MDHHS Medicaid Program average and an MDHHS Medicaid Managed Care Program average. HSAG combined results from FFS and the MHPs to calculate the MDHHS Medicaid Program average. HSAG combined results from the MHPs to calculate the MDHHS Medicaid Managed Care Program average. This section provides an overview of each analysis.

Who Responded to the Survey

The administration of the CAHPS survey is comprehensive and is designed to achieve the highest possible response rate. NCQA defines the response rate as the total number of completed surveys divided by all eligible members of the sample.[2-3] HSAG considered a survey completed if members answered at least three of the following five questions: questions 3, 15, 27, 31, and 36. Eligible members included the entire sample minus ineligible members. Ineligible members met at least one of the following criteria: they were deceased, were invalid (did not meet the eligible criteria), were removed from the sample during deduplication, or had a language barrier.

$$\textit{Response Rate} = \frac{\textit{Number of Completed Surveys}}{\textit{Sample - Ineligibles}}$$

Demographics of Child Members

The demographics analysis evaluated demographic information of child members. MDHHS should exercise caution when extrapolating the CAHPS results to the entire population if the respondent population differs significantly from the actual population of the plan or program.

National Comparisons

HSAG conducted an analysis of the CAHPS survey results using NCQA HEDIS Specifications for Survey Measures. Although NCQA requires a minimum of 100 responses on each item in order to report the item as a valid CAHPS Survey result, HSAG presented results with less than 100 responses. Therefore, caution should be exercised when evaluating measures' results with less than 100 responses, which are denoted with a cross (+).

[2-3] National Committee for Quality Assurance. *HEDIS® 2016, Volume 3: Specifications for Survey Measures.* Washington, DC: NCQA; 2015.

Table 2-3 shows the percentiles that were used to determine star ratings for each CAHPS measure.

Table 2-3: Star Ratings	
Stars	**Child Percentiles**
★★★★★ Excellent	At or above the 90th percentile
★★★★ Very Good	At or between the 75th and 89th percentiles
★★★ Good	At or between the 50th and 74th percentiles
★★ Fair	At or between the 25th and 49th percentiles
★ Poor	Below the 25th percentile

In order to perform the National Comparisons, a three-point mean score was determined for each CAHPS measure. HSAG compared the resulting three-point mean scores to published NCQA HEDIS Benchmarks and Thresholds for Accreditation to derive the overall member satisfaction ratings for each CAHPS measure.[2-4]

Table 2-4 shows the NCQA HEDIS Benchmarks and Thresholds for Accreditation used to derive the overall child Medicaid member satisfaction ratings on each CAHPS measure.[2-5] NCQA does not publish national benchmarks and thresholds for Shared Decision Making; therefore, this CAHPS measure was excluded from the National Comparisons analysis.

Table 2-4: Overall Child Medicaid Member Satisfaction Ratings Crosswalk				
Measure	**90th Percentile**	**75th Percentile**	**50th Percentile**	**25th Percentile**
Rating of Health Plan	2.67	2.62	2.57	2.51
Rating of All Health Care	2.59	2.57	2.52	2.49
Rating of Personal Doctor	2.69	2.65	2.62	2.58
Rating of Specialist Seen Most Often	2.66	2.62	2.59	2.53
Getting Needed Care	2.58	2.53	2.47	2.39
Getting Care Quickly	2.69	2.66	2.61	2.54
How Well Doctors Communicate	2.75	2.72	2.68	2.63
Customer Service	2.63	2.58	2.53	2.50

[2-4] For detailed information on the derivation of three-point mean scores, please refer to *HEDIS® 2016, Volume 3: Specifications for Survey Measures.*

[2-5] National Committee for Quality Assurance. *HEDIS Benchmarks and Thresholds for Accreditation 2016.* Washington, DC: NCQA; January 21, 2016.

Statewide Comparisons

For purposes of the Statewide Comparisons analysis, HSAG calculated question summary rates for each global rating and global proportions for each composite measure, following NCQA HEDIS Specifications for Survey Measures.[2-6] The scoring of the global ratings and composite measures involved assigning top-box responses a score of one, with all other responses receiving a score of zero. A "top-box" response was defined as follows:

- "9" or "10" for the global ratings;
- "Usually" or "Always" for the Getting Needed Care, Getting Care Quickly, How Well Doctors Communicate, and Customer Service composites;
- "Yes" for the Shared Decision Making composite.

Weighting

Both a weighted MDHHS Medicaid Program rate and a weighted MDHHS Medicaid Managed Care Program rate were calculated. Results were weighted based on the total eligible population for each plan's or program's child population. The MDHHS Medicaid Program average includes results from both the MHPs and the FFS population. The MDHHS Medicaid Managed Care Program average is limited to the results of the MHPs (i.e., the FFS population is not included). For the Statewide Comparisons, no threshold number of responses was required for the results to be reported. Measures with less than 100 responses are denoted with a cross (+). Caution should be used when evaluating rates derived from fewer than 100 respondents.

MHP Comparisons

The results of the MHPs were compared to the MDHHS Medicaid Managed Care Program average. Two types of hypothesis tests were applied to these results. First, a global F test was calculated, which determined whether the difference between MHP means was significant. If the F test demonstrated MHP-level differences (i.e., p value ≤ 0.05), then a t-test was performed for each MHP. The t-test determined whether each MHP's mean was significantly different from the MDHHS Medicaid Managed Care Program average. This analytic approach follows the Agency for Healthcare Research and Quality's (AHRQ's) recommended methodology for identifying significant plan-level performance differences.

Fee-for-Service Comparisons

The results of the FFS population were compared to the MDHHS Medicaid Managed Care Program average. One type of hypothesis test was applied to these results. A F test was performed to determine whether the results of the FFS population were significantly different (i.e., p value ≤ 0.05) from the MDHHS Medicaid Managed Care Program average results.

[2-6] National Committee for Quality Assurance. *HEDIS® 2016, Volume 3: Specifications for Survey Measures.* Washington, DC: NCQA; 2015.

Trend Analysis

A trend analysis was performed that compared the 2016 CAHPS scores to the corresponding 2015 CAHPS scores, where appropriate, to determine whether there were significant differences. A *t*-test was performed to determine whether results in 2015 were significantly different from results in 2016. A difference was considered significant if the two-sided *p* value of the *t*-test was less than or equal to 0.05. The two-sided *p* value of the *t*-test is the probability of observing a test statistic as extreme as or more extreme than the one actually observed by chance. Measures with less than 100 responses are denoted with a cross (+). Caution should be used when evaluating rates derived from fewer than 100 respondents.

Key Drivers of Satisfaction Analysis

HSAG performed an analysis of key drivers of satisfaction for the following measures: Rating of Health Plan, Rating of All Health Care, and Rating of Personal Doctor. The purpose of the key drivers of satisfaction analysis is to help decision makers identify specific aspects of care that will most benefit from quality improvement (QI) activities. The analysis provides information on: 1) how ***well*** the MDHHS Medicaid Program is performing on the survey item and 2) how ***important*** that item is to overall satisfaction.

The performance on a survey item was measured by calculating a problem score, in which a negative experience with care was defined as a problem and assigned a "1," and a positive experience with care (i.e., non-negative) was assigned a "0." The higher the problem score, the lower the member satisfaction with the aspect of service measured by that question. The problem score could range from 0 to 1.

For each item evaluated, the relationship between the item's problem score and performance on each of the three measures was calculated using a Pearson product moment correlation, which is defined as the covariance of the two scores divided by the product of their standard deviations. Items were then prioritized based on their overall problem score and their correlation to each measure. Key drivers of satisfaction were defined as those items that:

- Had a problem score that was greater than or equal to the median problem score for all items examined.
- Had a correlation that was greater than or equal to the median correlation for all items examined.

Limitations and Cautions

The findings presented in this CAHPS report are subject to some limitations in the survey design, analysis, and interpretation. MDHHS should consider these limitations when interpreting or generalizing the findings.

Case-Mix Adjustment

The demographics of a response group may impact member satisfaction. Therefore, differences in the demographics of the response group may impact CAHPS results. NCQA does not recommend case-mix adjusting CAHPS results to account for these differences; therefore, no case-mix adjusting was performed on these CAHPS results.[2-7]

Non-Response Bias

The experiences of the survey respondent population may be different than that of non-respondents with respect to their health care services and may vary by plan or program. Therefore, MDHHS should consider the potential for non-response bias when interpreting CAHPS results.

Causal Inferences

Although this report examines whether respondents report differences in satisfaction with various aspects of their health care experiences, these differences may not be completely attributable to an MHP or the FFS program. These analyses identify whether respondents give different ratings of satisfaction with their child's MHP or the FFS program. The survey by itself does not necessarily reveal the exact cause of these differences.

Missing Phone Numbers

The volume of missing telephone numbers may impact the response rates and the validity of the survey results. For instance, a certain segment of the population may be more likely to have missing phone information than other segments.

[2-7] Agency for Healthcare Research and Quality. *CAHPS Health Plan Survey and Reporting Kit 2008*. Rockville, MD: US Department of Health and Human Services; 2008.

Who Responded to the Survey

A total of 17,781 child surveys were distributed to parents or caretakers of child members. A total of 4,891 child surveys were completed. The CAHPS Survey response rate is the total number of completed surveys divided by all eligible members of the sample. A survey was considered complete if members answered at least three of the following five questions on the survey: questions 3, 15, 27, 31, and 36. Eligible members included the entire sample minus ineligible members. Ineligible members met at least one of the following criteria: they were deceased, were invalid (did not meet the eligible criteria), were removed from sample during deduplication, or had a language barrier.

Table 3-1 shows the total number of members sampled, the number of surveys completed, the number of ineligible members, and the response rates.

Table 3-1: Total Number of Respondents and Response Rates

Plan Name	Sample Size	Completes	Ineligibles	Response Rates
MDHHS Medicaid Program	**17,781**	**4,891**	**339**	**28.04%**
Fee-for-Service	1,650	439	62	27.64%
MDHHS Medicaid Managed Care Program	**16,131**	**4,452**	**277**	**28.08%**
Aetna Better Health of Michigan	1,651	369	28	22.74%
Blue Cross Complete of Michigan	1,654	517	19	31.62%
HAP Midwest Health Plan	172	26	2	15.29%
Harbor Health Plan	1,094	154	46	14.69%
McLaren Health Plan	1,651	508	18	31.11%
Meridian Health Plan of Michigan	1,653	503	24	30.88%
Molina Healthcare of Michigan	1,652	424	30	26.14%
Priority Health Choice, Inc.	1,652	472	14	28.82%
Total Health Care, Inc.	1,652	458	27	28.18%
UnitedHealthcare Community Plan	1,650	480	53	30.06%
Upper Peninsula Health Plan	1,650	541	16	33.11%

Demographics of Child Members

Table 3-2 depicts the ages of children for whom a parent or caretaker completed a CAHPS survey.

Table 3-2: Child Member Demographics—Age					
Plan Name	**Less than 1**	**1 to 3**	**4 to 7**	**8 to 12**	**13 to 18***
MDHHS Medicaid Program	**2.4%**	**16.7%**	**22.0%**	**27.9%**	**30.9%**
Fee-for-Service	1.2%	10.2%	20.0%	32.1%	36.5%
MDHHS Medicaid Managed Care Program	**2.5%**	**17.4%**	**22.2%**	**27.5%**	**30.4%**
Aetna Better Health of Michigan	2.0%	10.4%	22.3%	30.7%	34.6%
Blue Cross Complete of Michigan	3.3%	22.1%	22.3%	26.2%	26.2%
HAP Midwest Health Plan	3.8%	15.4%	23.1%	30.8%	26.9%
Harbor Health Plan	5.3%	29.8%	29.1%	17.2%	18.5%
McLaren Health Plan	2.8%	16.7%	22.0%	27.8%	30.8%
Meridian Health Plan of Michigan	1.2%	18.6%	22.8%	28.6%	28.8%
Molina Healthcare of Michigan	2.9%	14.4%	20.6%	31.3%	30.9%
Priority Health Choice, Inc.	2.8%	18.0%	20.1%	30.5%	28.6%
Total Health Care, Inc.	2.0%	13.4%	20.9%	21.8%	41.9%
UnitedHealthcare Community Plan	0.8%	17.8%	22.6%	28.5%	30.2%
Upper Peninsula Health Plan	3.7%	18.4%	23.6%	26.4%	27.7%

Please note, percentages may not total 100.0% due to rounding.

**Children are eligible for inclusion in CAHPS if they are age 17 or younger as of December 31, 2015. Some children eligible for the CAHPS Survey turned age 18 between January 1, 2016, and the time of survey administration.*

Table 3-3 depicts the gender of children for whom a parent or caretaker completed a CAHPS survey.

Table 3-3: Child Member Demographics—Gender		
Plan Name	**Male**	**Female**
MDHHS Medicaid Program	**51.6%**	**48.4%**
Fee-for-Service	50.5%	49.5%
MDHHS Medicaid Managed Care Program	**51.7%**	**48.3%**
Aetna Better Health of Michigan	47.9%	52.1%
Blue Cross Complete of Michigan	50.4%	49.6%
HAP Midwest Health Plan	50.0%	50.0%
Harbor Health Plan	55.3%	44.7%
McLaren Health Plan	56.0%	44.0%
Meridian Health Plan of Michigan	50.7%	49.3%
Molina Healthcare of Michigan	52.5%	47.5%
Priority Health Choice, Inc.	51.7%	48.3%
Total Health Care, Inc.	53.0%	47.0%
UnitedHealthcare Community Plan	49.0%	51.0%
Upper Peninsula Health Plan	52.2%	47.8%
Please note, percentages may not total 100.0% due to rounding.		

Table 3-4 depicts the race and ethnicity of children for whom a parent or caretaker completed a CAHPS survey.

Table 3-4: Child Member Demographics—Race/Ethnicity						
Plan Name	**White**	**Hispanic**	**Black**	**Asian**	**Other**	**Multi-Racial**
MDHHS Medicaid Program	**47.1%**	**9.9%**	**25.6%**	**2.6%**	**2.9%**	**12.0%**
Fee-for-Service	58.5%	10.9%	10.9%	2.8%	3.9%	13.0%
MDHHS Medicaid Managed Care Program	**46.0%**	**9.8%**	**27.0%**	**2.5%**	**2.8%**	**11.9%**
Aetna Better Health of Michigan	6.8%	3.1%	83.0%	0.3%	1.4%	5.4%
Blue Cross Complete of Michigan	36.2%	8.1%	30.2%	3.2%	5.9%	16.4%
HAP Midwest Health Plan	60.0%	4.0%	20.0%	0.0%	0.0%	16.0%
Harbor Health Plan	15.9%	9.3%	57.6%	2.0%	2.6%	12.6%
McLaren Health Plan	62.3%	9.8%	9.2%	3.0%	1.6%	14.0%
Meridian Health Plan of Michigan	59.1%	12.1%	11.3%	2.6%	2.8%	12.1%
Molina Healthcare of Michigan	40.5%	16.0%	27.7%	2.4%	2.4%	10.9%
Priority Health Choice, Inc.	51.5%	20.4%	10.7%	2.1%	0.9%	14.4%
Total Health Care, Inc.	23.7%	3.6%	56.8%	4.3%	2.9%	8.7%
UnitedHealthcare Community Plan	42.8%	12.7%	25.0%	4.0%	4.0%	11.4%
Upper Peninsula Health Plan	82.3%	2.4%	0.6%	0.9%	2.8%	11.0%
Please note, percentages may not total 100.0% due to rounding.						

Table 3-5 depicts the general health status of children for whom a parent or caretaker completed a CAHPS survey.

Table 3-5: Child Member Demographics—General Health Status					
Plan Name	**Excellent**	**Very Good**	**Good**	**Fair**	**Poor**
MDHHS Medicaid Program	**38.6%**	**37.5%**	**18.9%**	**4.6%**	**0.4%**
Fee-for-Service	38.9%	35.0%	21.9%	3.9%	0.2%
MDHHS Medicaid Managed Care Program	**38.6%**	**37.8%**	**18.6%**	**4.6%**	**0.4%**
Aetna Better Health of Michigan	35.0%	30.6%	24.7%	9.4%	0.3%
Blue Cross Complete of Michigan	42.8%	39.6%	15.0%	2.3%	0.2%
HAP Midwest Health Plan	50.0%	34.6%	11.5%	3.8%	0.0%
Harbor Health Plan	40.4%	35.1%	19.9%	3.3%	1.3%
McLaren Health Plan	39.6%	39.3%	17.6%	3.4%	0.2%
Meridian Health Plan of Michigan	36.3%	39.7%	17.1%	5.8%	1.0%
Molina Healthcare of Michigan	39.4%	30.5%	23.2%	6.4%	0.5%
Priority Health Choice, Inc.	37.3%	38.6%	18.0%	5.8%	0.2%
Total Health Care, Inc.	34.6%	38.2%	22.4%	3.9%	0.9%
UnitedHealthcare Community Plan	38.8%	39.0%	17.4%	4.7%	0.2%
Upper Peninsula Health Plan	40.7%	41.9%	15.1%	2.1%	0.2%
Please note, percentages may not total 100.0% due to rounding.					

National Comparisons

In order to assess the overall performance of the MDHHS Medicaid Program, HSAG scored each CAHPS measure on a three-point scale using an NCQA-approved scoring methodology. HSAG compared the plans' and programs' three-point mean scores to NCQA HEDIS Benchmarks and Thresholds for Accreditation.[3-1]

Based on this comparison, ratings of one (★) to five (★★★★★) stars were determined for each CAHPS measure, where one is the lowest possible rating (i.e., Poor) and five is the highest possible rating (i.e., Excellent), as shown in Table 3-6.

Table 3-6: Star Ratings

Stars	Child Percentiles
★★★★★ Excellent	At or above the 90th percentile
★★★★ Very Good	At or between the 75th and 89th percentiles
★★★ Good	At or between the 50th and 74th percentiles
★★ Fair	At or between the 25th and 49th percentiles
★ Poor	Below the 25th percentile

The results presented in the following two tables represent the three-point mean scores for each measure, while the stars represent overall member satisfaction ratings with the three-point means when compared to NCQA HEDIS Benchmarks and Thresholds for Accreditation.

[3-1] National Committee for Quality Assurance. *HEDIS® Benchmarks and Thresholds for Accreditation 2016.* Washington, DC: NCQA; January 21, 2016.

Table 3-7 shows the overall member satisfaction ratings on each of the four global ratings.

Table 3-7: National Comparisons—Global Ratings				
Plan Name	**Rating of Health Plan**	**Rating of All Health Care**	**Rating of Personal Doctor**	**Rating of Specialist Seen Most Often**
MDHHS Medicaid Program	★★ 2.54	★★★ 2.55	★★★ 2.64	★★★ 2.59
Fee-for-Service	★ 2.36	★★★ 2.52	★★★★ 2.68	★★+ 2.57
MDHHS Medicaid Managed Care Program	★★ 2.56	★★★ 2.55	★★★ 2.64	★★★ 2.60
Aetna Better Health of Michigan	★ 2.37	★ 2.46	★★★ 2.62	★★★★+ 2.64
Blue Cross Complete of Michigan	★★★ 2.60	★★★ 2.54	★★★★ 2.67	★★+ 2.58
HAP Midwest Health Plan	★+ 2.32	★★+ 2.50	★★+ 2.58	★★★★★+ 2.71
Harbor Health Plan	★ 2.36	★★★ 2.52	★ 2.52	★+ 2.50
McLaren Health Plan	★★★ 2.58	★★★ 2.54	★★ 2.60	★ 2.51
Meridian Health Plan of Michigan	★★ 2.56	★★★ 2.53	★★★ 2.62	★★★★ 2.63
Molina Healthcare of Michigan	★★★ 2.60	★★★★★ 2.62	★★★★ 2.65	★★★★★+ 2.68
Priority Health Choice, Inc.	★★★★ 2.66	★★★★★ 2.60	★★★★ 2.65	★★+ 2.55
Total Health Care, Inc.	★ 2.50	★★★★ 2.57	★★★ 2.63	★★★★★+ 2.73
UnitedHealthcare Community Plan	★★★ 2.60	★★★ 2.54	★★ 2.61	★★★+ 2.59
Upper Peninsula Health Plan	★★★ 2.60	★★★ 2.53	★★★★★ 2.69	★+ 2.51

+ Indicates fewer than 100 responses. Caution should be exercised when evaluating these results.

The MDHHS Medicaid Program and MDHHS Medicaid Managed Care Program scored at or between the 50th and 74th percentiles for three global ratings: Rating of All Health Care, Rating of Personal Doctor, and Rating of Specialist Seen Most Often. In addition, the MDHHS Medicaid Program and the MDHHS Medicaid Managed Care Program scored at or between the 25th and 49th percentiles for the Rating of Health Plan global rating. The MDHHS Medicaid Program and MDHHS Medicaid Managed Care Program did not score at or below the 25th percentile for any of the global ratings.

Table 3-8 shows the overall satisfaction ratings on four of the composite measures.[3-2]

Table 3-8: National Comparisons—Composite Measures				
Plan Name	**Getting Needed Care**	**Getting Care Quickly**	**How Well Doctors Communicate**	**Customer Service**
MDHHS Medicaid Program	★★ 2.44	★★★ 2.64	★★★★ 2.73	★★★ 2.57
Fee-for-Service	★★ 2.45	★★★★ 2.66	★★★★★ 2.80	★★★+ 2.55
MDHHS Medicaid Managed Care Program	★★ 2.44	★★★ 2.64	★★★★ 2.73	★★★ 2.57
Aetna Better Health of Michigan	★★★★ 2.53	★★★ 2.61	★★★★★ 2.76	★★★ 2.56
Blue Cross Complete of Michigan	★★ 2.42	★★★ 2.64	★★★★★ 2.76	★★★★ 2.59
HAP Midwest Health Plan	★+ 2.25	★★★★+ 2.66	★★★★★+ 2.76	★+ 2.25
Harbor Health Plan	★+ 2.19	★★★★★+ 2.73	★★+ 2.65	★+ 2.36
McLaren Health Plan	★★★ 2.50	★★★ 2.64	★★★★ 2.72	★★ 2.52
Meridian Health Plan of Michigan	★★ 2.46	★★★ 2.65	★★★ 2.68	★★★★★ 2.68
Molina Healthcare of Michigan	★★ 2.45	★★ 2.57	★★★★ 2.72	★ 2.48
Priority Health Choice, Inc.	★★ 2.41	★★★ 2.63	★★★★★ 2.75	★★★★+ 2.60
Total Health Care, Inc.	★★ 2.45	★★ 2.59	★★★★★ 2.76	★★★★★ 2.64
UnitedHealthcare Community Plan	★ 2.32	★★★★ 2.66	★★ 2.67	★★ 2.52
Upper Peninsula Health Plan	★★★ 2.47	★★★★ 2.67	★★★★ 2.73	★★★★★+ 2.67
+ Indicates fewer than 100 responses. Caution should be exercised when evaluating these results.				

The MDHHS Medicaid Program and the MDHHS Medicaid Managed Care Program scored at or between the 75th and 89th percentiles for one composite measure, How Well Doctors Communicate. The MDHHS Medicaid Program and the MDHHS Medicaid Managed Care Program scored at or between the 50th and 74th percentiles for two composite measures: Getting Care Quickly and Customer Service. The MDHHS Medicaid Program and the MDHHS Medicaid Managed Care Program scored at or between the 25th and 49th percentiles for the Getting Needed Care composite measure. The MDHHS Medicaid Program and MDHHS Medicaid Managed Care Program did not score at or below the 25th percentile for any of the composite measures.

[3-2] NCQA does not publish national benchmarks and thresholds for Shared Decision Making; therefore, this CAHPS measure was excluded from the National Comparisons analysis.

Statewide Comparisons

For purposes of the Statewide Comparisons analysis, HSAG calculated top-box rates (i.e., rates of satisfaction) for each global rating and composite measure. A "top-box" response was defined as follows:

- "9" or "10" for the global ratings;
- "Usually" or "Always" for the Getting Needed Care, Getting Care Quickly, How Well Doctors Communicate, and Customer Service composites;
- "Yes" for the Shared Decision Making composite.

The MDHHS Medicaid Program and MDHHS Medicaid Managed Care Program results were weighted based on the eligible population for each child population (i.e., FFS and/or MHPs). HSAG compared the MHP results to the MDHHS Medicaid Managed Care Program average to determine if the MHP results were significantly different than the MDHHS Medicaid Managed Care Program average. Additionally, HSAG compared the FFS results to the MDHHS Medicaid Managed Care Program results to determine if the FFS results were significantly different than the MDHHS Medicaid Managed Care Program results. The NCQA child Medicaid national averages also are presented for comparison.[3-3] Colors in the figures note significant differences. Green indicates a top-box rate that was significantly higher than the MDHHS Medicaid Managed Care Program average. Conversely, red indicates a top-box rate that was significantly lower than the MDHHS Medicaid Managed Care Program average. Blue represents top-box rates that were not significantly different from the MDHHS Medicaid Managed Care Program average. Health plan/program rates with fewer than 100 respondents are denoted with a cross (+). Caution should be used when evaluating rates derived from fewer than 100 respondents.

In some instances, the top-box rates presented for two plans were similar, but one was statistically different from the MDHHS Medicaid Managed Care Program average and the other was not. In these instances, it was the difference in the number of respondents between the two plans that explains the different statistical results. It is more likely that a significant result will be found in a plan with a larger number of respondents.

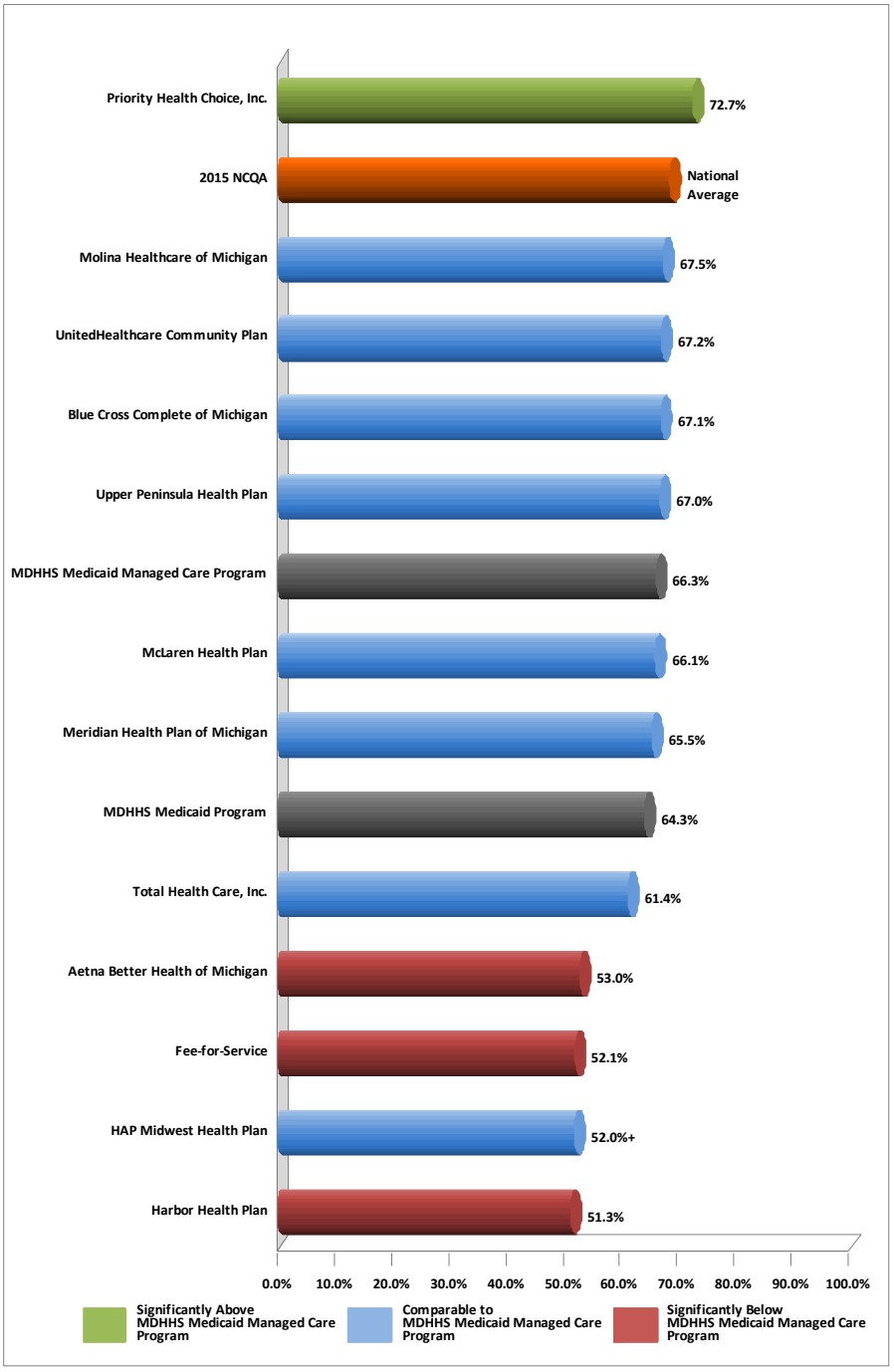
[3-3] The source for the national data contained in this publication is Quality Compass® 2015 and is used with the permission of the National Committee for Quality Assurance (NCQA). Quality Compass 2015 includes certain CAHPS data. Any data display, analysis, interpretation, or conclusion based on these data is solely that of the authors, and NCQA specifically disclaims responsibility for any such display, analysis, interpretation, or conclusion. Quality Compass is a registered trademark of NCQA. CAHPS® is a registered trademark of AHRQ.

Global Ratings

Rating of Health Plan

Parents or caretakers of child members were asked to rate their child's health plan on a scale of 0 to 10, with 0 being the "worst health plan possible" and 10 being the "best health plan possible." Figure 3-1 shows the Rating of Health Plan top-box rates.

Figure 3-1: Rating of Health Plan Top-Box Rates

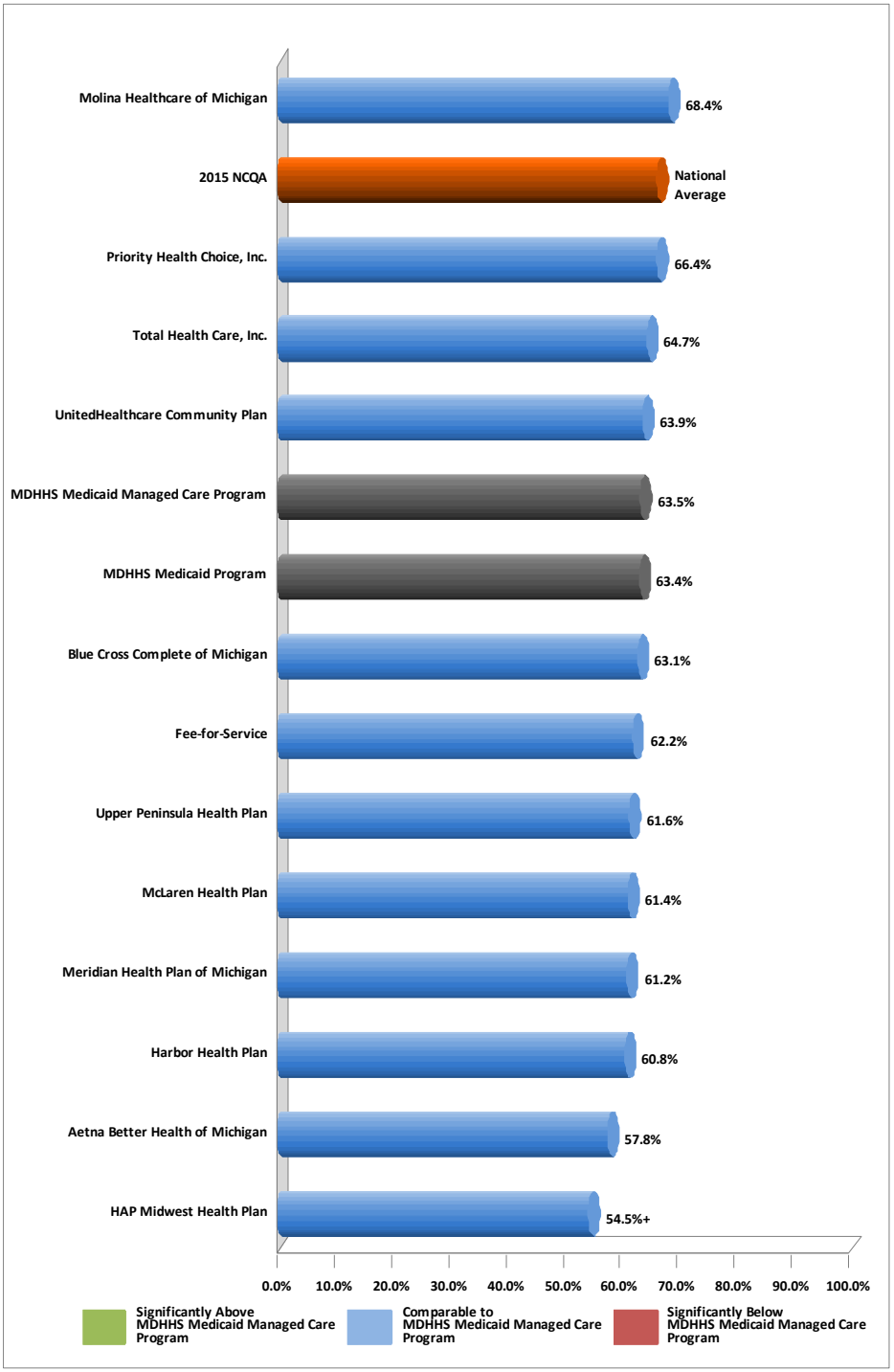


Note: + indicates fewer than 100 responses

Rating of All Health Care

Parents or caretakers of child members were asked to rate their child's health care on a scale of 0 to 10, with 0 being the "worst health care possible" and 10 being the "best health care possible." Figure 3-2 shows the Rating of All Health Care top-box rates.

Figure 3-2: Rating of All Health Care Top-Box Rates

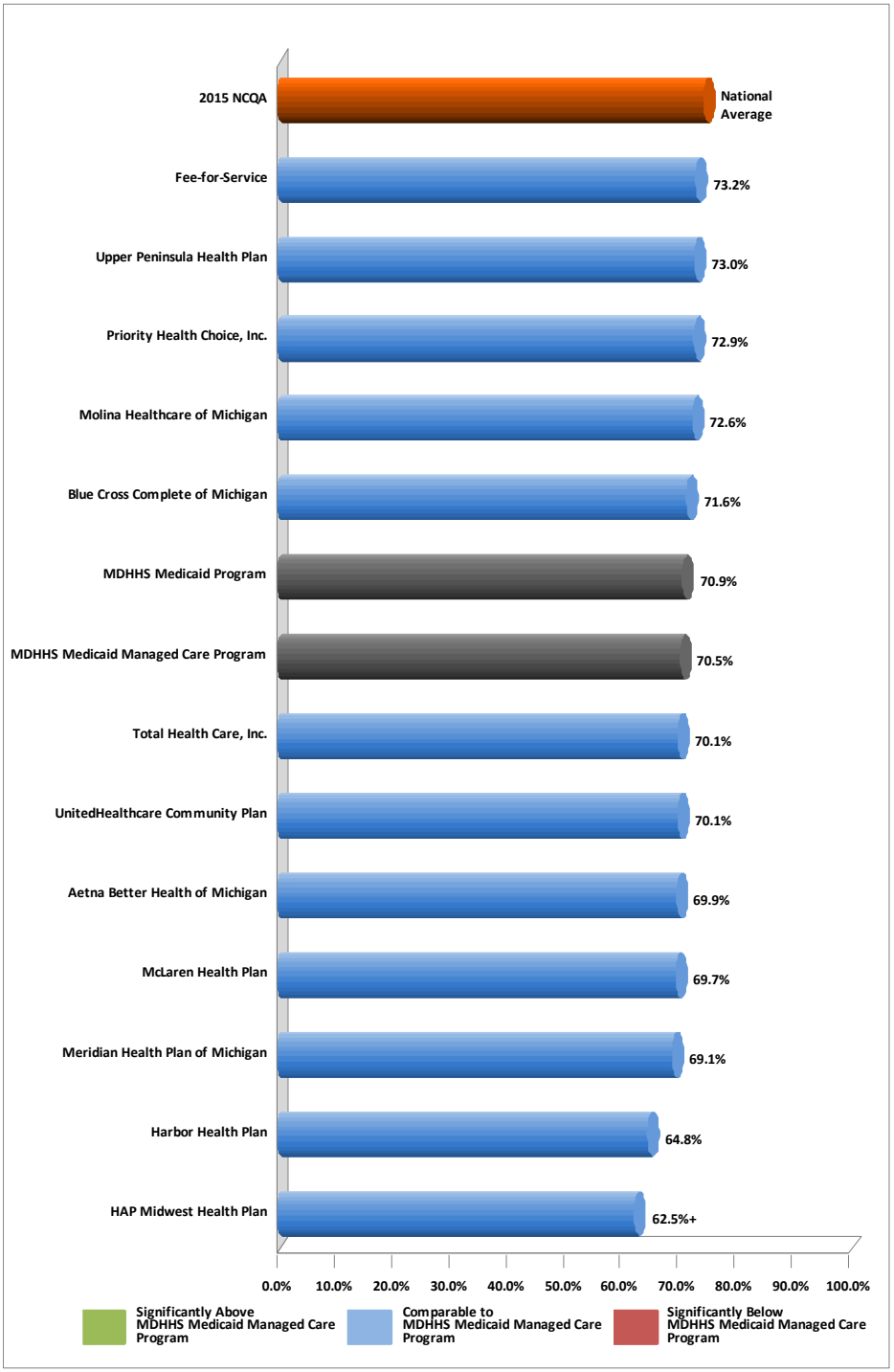


Note: + indicates fewer than 100 responses

Rating of Personal Doctor

Parents or caretakers of child members were asked to rate their child's personal doctor on a scale of 0 to 10, with 0 being the "worst personal doctor possible" and 10 being the "best personal doctor possible." Figure 3-3 shows the Rating of Personal Doctor top-box rates.

Figure 3-3: Rating of Personal Doctor Top-Box Rates

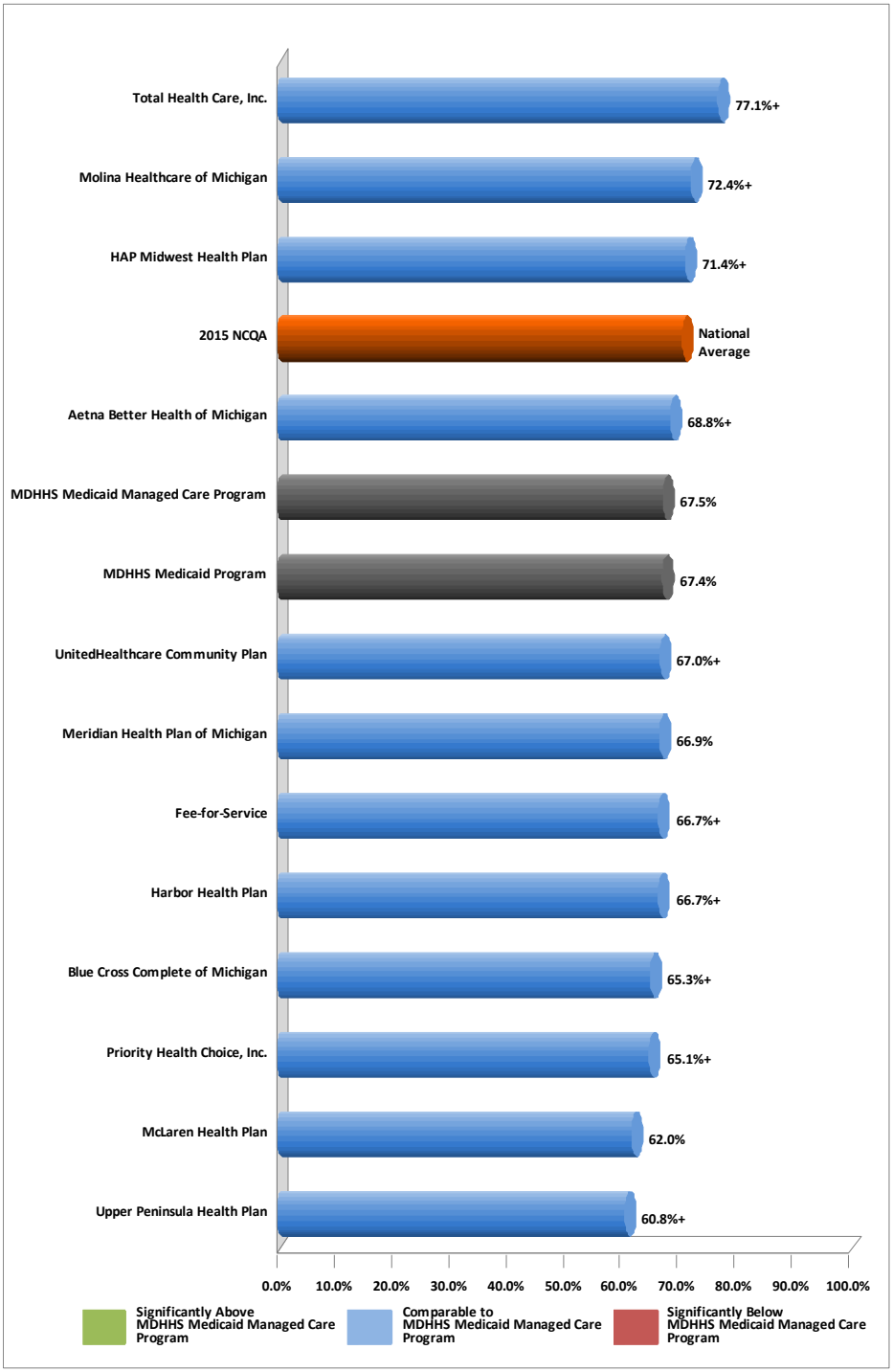


Note: + indicates fewer than 100 responses

Rating of Specialist Seen Most Often

Parents or caretakers of child members were asked to rate their child's specialist on a scale of 0 to 10, with 0 being the "worst specialist possible" and 10 being the "best specialist possible." Figure 3-4 shows the Rating of Specialist Seen Most Often top-box rates.

Figure 3-4: Rating of Specialist Seen Most Often Top-Box Rates



Note: + indicates fewer than 100 responses

Composite Measures

Getting Needed Care

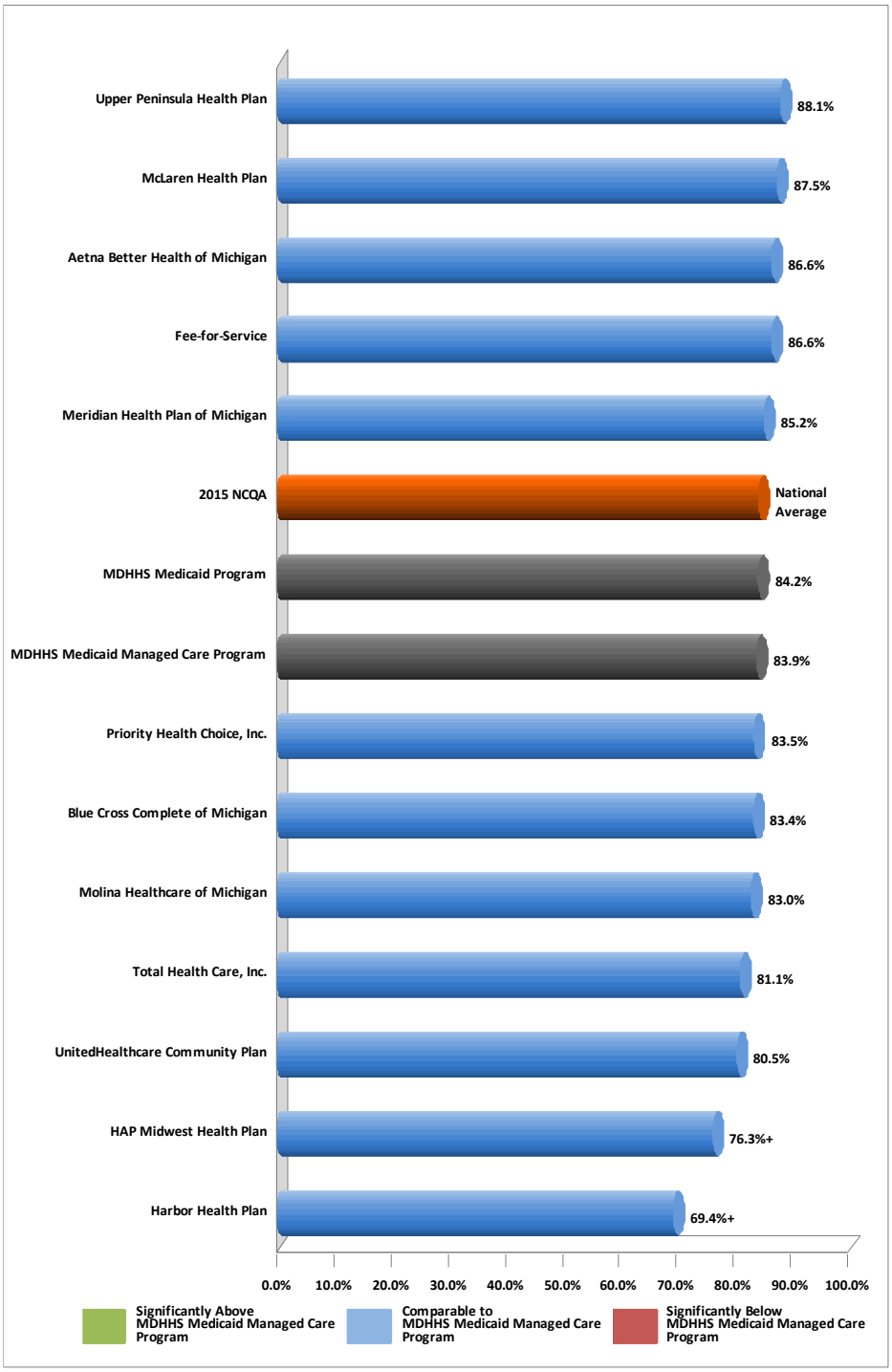
Two questions (Questions 14 and 28 in the CAHPS Child Medicaid Health Plan Survey) were asked to assess how often it was easy to get needed care:

- **Question 14**. In the last 6 months, how often was it easy to get the care, tests, or treatment your child needed?
  - Never
  - Sometimes
  - Usually
  - Always
- **Question 28**. In the last 6 months, how often did you get an appointment for your child to see a specialist as soon as you needed?
  - Never
  - Sometimes
  - Usually
  - Always

For purposes of the Statewide Comparisons analysis, HSAG calculated top-box rates for the Getting Needed Care composite measure, which was defined as a response of "Usually" or "Always."

Figure 3-5 shows the Getting Needed Care top-box rates.

Figure 3-5: Getting Needed Care Top-Box Rates



Note: + indicates fewer than 100 responses

Getting Care Quickly

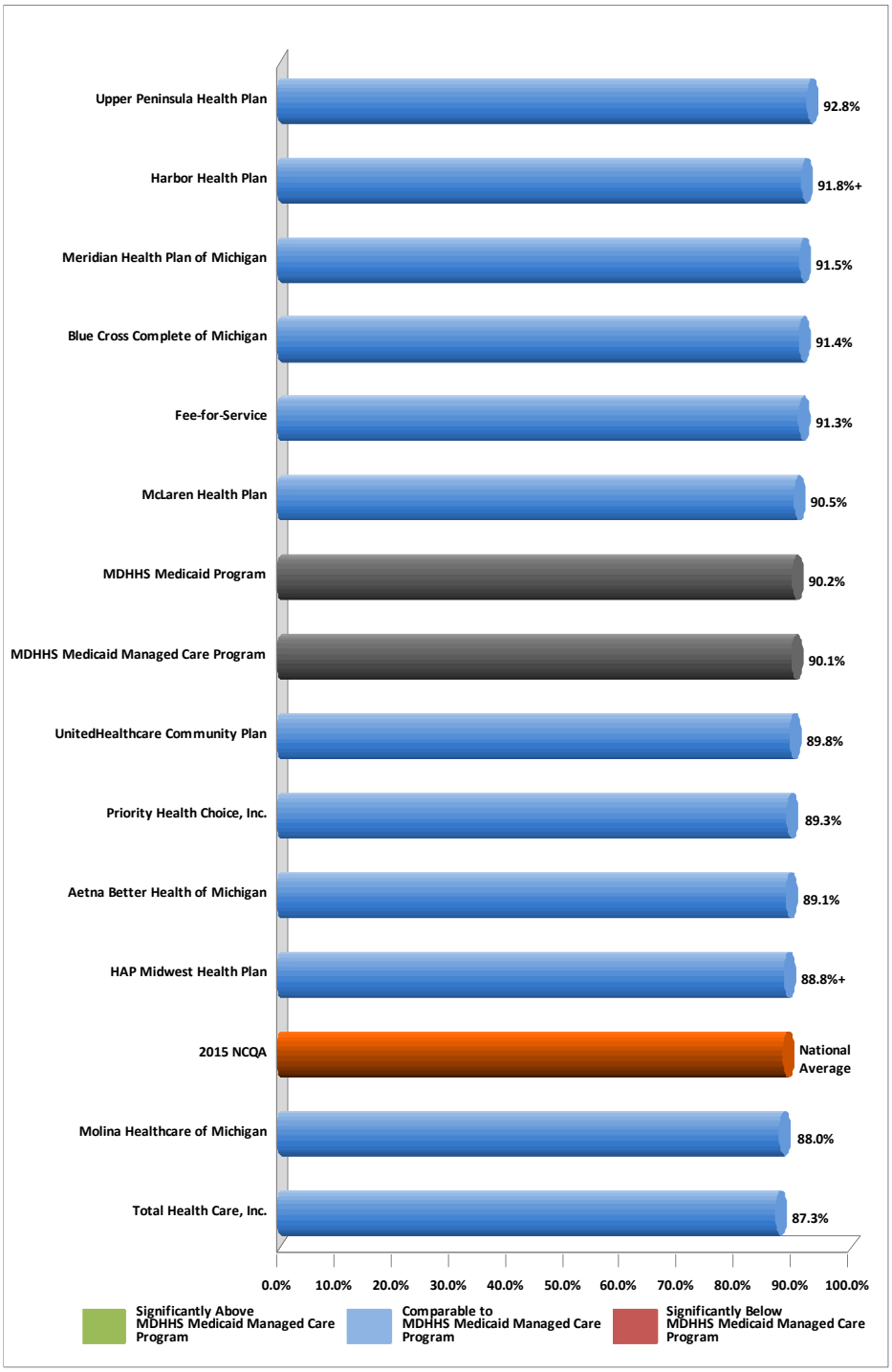
Two questions (Questions 4 and 6 in the CAHPS Child Medicaid Health Plan Survey) were asked to assess how often child members received care quickly:

- **Question 4**. In the last 6 months, when your child needed care right away, how often did your child get care as soon as he or she needed?
  - Never
  - Sometimes
  - Usually
  - Always
- **Question 6**. In the last 6 months, when you made an appointment for a check-up or routine care for your child at a doctor's office or clinic, how often did you get an appointment as soon as your child needed?
  - Never
  - Sometimes
  - Usually
  - Always

For purposes of the Statewide Comparisons analysis, HSAG calculated top-box rates for the Getting Care Quickly composite measure, which was defined as a response of "Usually" or "Always."

Figure 3-6 shows the Getting Care Quickly top-box rates.

Figure 3-6: Getting Care Quickly Top-Box Rates



Note: + indicates fewer than 100 responses

How Well Doctors Communicate

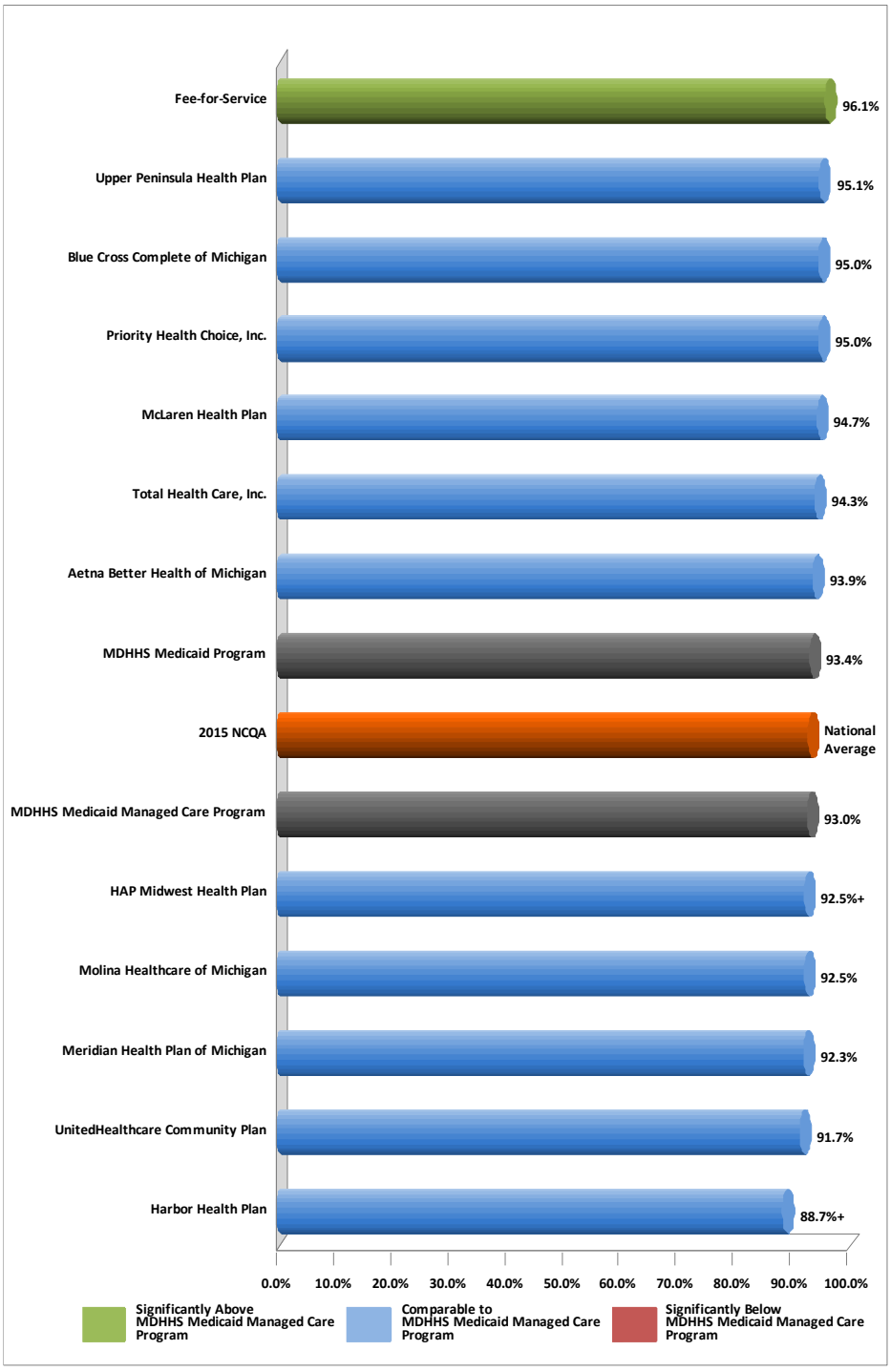
A series of four questions (Questions 17, 18, 19, and 22 in the CAHPS Child Medicaid Health Plan Survey) was asked to assess how often doctors communicated well:

- **Question 17**. In the last 6 months, how often did your child's personal doctor explain things about your child's health in a way that was easy to understand?
  - Never
  - Sometimes
  - Usually
  - Always
- **Question 18**. In the last 6 months, how often did your child's personal doctor listen carefully to you?
  - Never
  - Sometimes
  - Usually
  - Always
- **Question 19**. In the last 6 months, how often did your child's personal doctor show respect for what you had to say?
  - Never
  - Sometimes
  - Usually
  - Always
- **Question 22**. In the last 6 months, how often did your child's personal doctor spend enough time with your child?
  - Never
  - Sometimes
  - Usually
  - Always

For purposes of the Statewide Comparisons analysis, HSAG calculated top-box rates for the How Well Doctors Communicate composite measure, which was defined as a response of "Usually" or "Always."

Figure 3-7 shows the How Well Doctors Communicate top-box rates.

Figure 3-7: How Well Doctors Communicate Top-Box Rates



Note: + indicates fewer than 100 responses

Customer Service

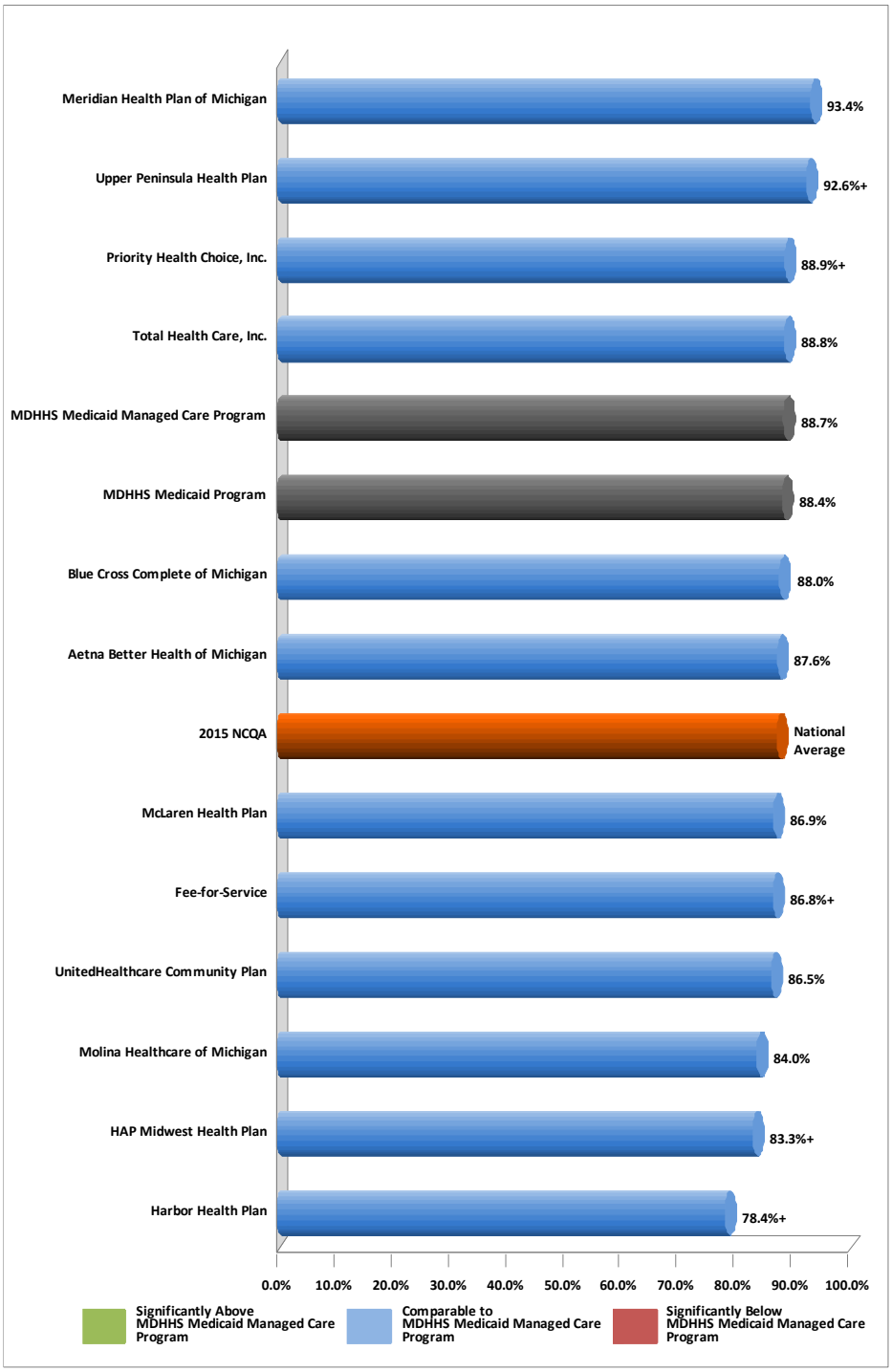
Two questions (Questions 32 and 33 in the CAHPS Child Medicaid Health Plan Survey) were asked to assess how often parents or caretakers were satisfied with customer service:

- **Question 32**. In the last 6 months, how often did customer service at your child's health plan give you the information or help you needed?
  - Never
  - Sometimes
  - Usually
  - Always
- **Question 33**. In the last 6 months, how often did customer service staff at your child's health plan treat you with courtesy and respect?
  - Never
  - Sometimes
  - Usually
  - Always

For purposes of the Statewide Comparisons analysis, HSAG calculated top-box rates for the Customer Service composite measure, which was defined as a response of "Usually" or "Always."

Figure 3-8 shows the Customer Service top-box rates.

Figure 3-8: Customer Service Top-Box Rates



Note: + indicates fewer than 100 responses

Shared Decision Making

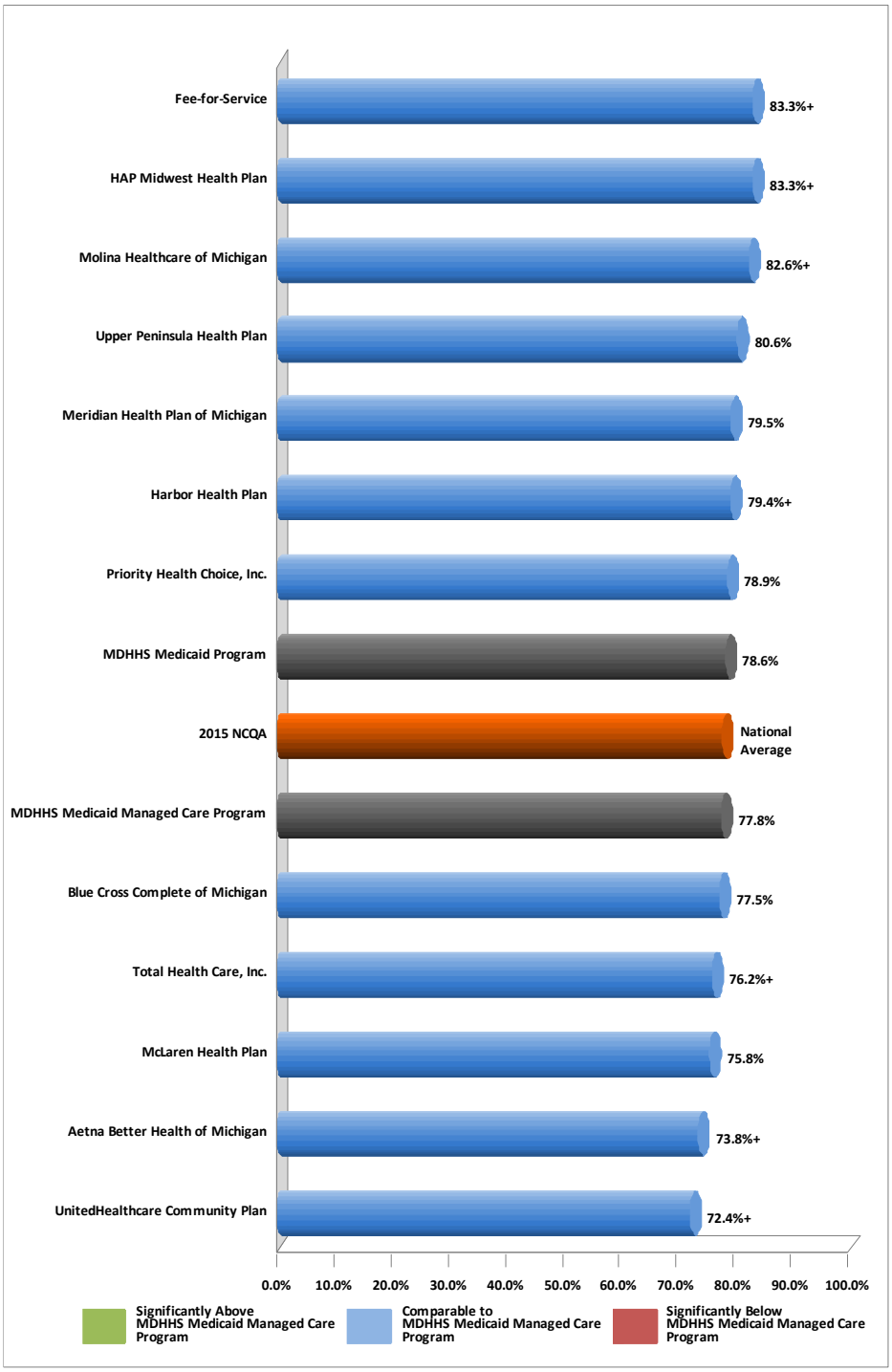
Three questions (Questions 10, 11, and 12 in the CAHPS Child Medicaid Health Plan Survey) were asked regarding the involvement of parents or caretakers in decision making when starting or stopping a prescription medicine for their child:

- **Question 10**. Did you and a doctor or other health provider talk about the reasons you might want your child to take a medicine?
  - Yes
  - No
- **Question 11**. Did you and a doctor or other health provider talk about the reasons you might not want your child to take a medicine?
  - Yes
  - No
- **Question 12**. When you talked about your child starting or stopping a prescription medicine, did a doctor or other health provider ask you what you thought was best for your child?
  - Yes
  - No

For purposes of the Statewide Comparisons analysis, HSAG calculated top-box rates for the Shared Decision Making composite measure, which was defined as a response of "Yes."

Figure 3-9 shows the Shared Decision Making top-box rates.

Figure 3-9: Shared Decision Making Top-Box Rates



Note: + indicates fewer than 100 responses

Summary of Results

Table 3-9 provides a summary of the Statewide Comparisons results for the global ratings.

Table 3-9: Statewide Comparisons—Global Ratings

Plan Name	Rating of Health Plan	Rating of All Health Care	Rating of Personal Doctor	Rating of Specialist Seen Most Often
Fee-for-Service	↓	—	—	—+
Aetna Better Health of Michigan	↓	—	—	—+
Blue Cross Complete of Michigan	—	—	—	—+
HAP Midwest Health Plan	—+	—+	—+	—+
Harbor Health Plan	↓	—	—	—+
McLaren Health Plan	—	—	—	—
Meridian Health Plan of Michigan	—	—	—	—
Molina Healthcare of Michigan	—	—	—	—+
Priority Health Choice, Inc.	↑	—	—	—+
Total Health Care, Inc.	—	—	—	—+
UnitedHealthcare Community Plan	—	—	—	—+
Upper Peninsula Health Plan	—	—	—	—+

\+ indicates fewer than 100 responses. Caution should be exercised when evaluating these results.
↑ indicates the plan's score is statistically significantly higher than the MDHHS Medicaid Managed Care Program average
↓ indicates the plan's score is statistically significantly lower than the MDHHS Medicaid Managed Care Program average
— indicates the plan's score is not statistically significantly different than the MDHHS Medicaid Managed Care Program average

Table 3-10 provides a summary of the Statewide Comparisons results for the composite measures.

Table 3-10: Statewide Comparisons—Composite Measures					
Plan Name	**Getting Needed Care**	**Getting Care Quickly**	**How Well Doctors Communicate**	**Customer Service**	**Shared Decision Making**
Fee-for-Service	—	—	↑	—+	—+
Aetna Better Health of Michigan	—	—	—	—	—+
Blue Cross Complete of Michigan	—	—	—	—	—
HAP Midwest Health Plan	—+	—+	—+	—+	—+
Harbor Health Plan	—+	—+	—+	—+	—+
McLaren Health Plan	—	—	—	—	—
Meridian Health Plan of Michigan	—	—	—	—	—
Molina Healthcare of Michigan	—	—	—	—	—+
Priority Health Choice, Inc.	—	—	—	—+	—
Total Health Care, Inc.	—	—	—	—	—+
UnitedHealthcare Community Plan	—	—	—	—	—+
Upper Peninsula Health Plan	—	—	—	—+	—

\+ indicates fewer than 100 responses. Caution should be exercised when evaluating these results.
↑ indicates the plan's score is statistically significantly higher than the MDHHS Medicaid Managed Care Program average
↓ indicates the plan's score is statistically significantly lower than the MDHHS Medicaid Managed Care Program average
— indicates the plan's score is not statistically significantly different than the MDHHS Medicaid Managed Care Program average

Trend Analysis

The completed surveys from the 2016 and 2015 CAHPS results were used to perform the trend analysis presented in this section. The 2016 CAHPS scores were compared to the 2015 CAHPS scores to determine whether there were statistically significant differences. Statistically significant differences between 2016 scores and 2015 scores are noted with triangles. Scores that were statistically significantly higher in 2016 than in 2015 are noted with upward triangles (▲). Scores that were statistically significantly lower in 2016 than in 2015 are noted with downward triangles (▼). Scores in 2016 that were not statistically significantly different from scores in 2015 are noted with a dash (–). Measures that did not meet the minimum number of 100 responses required by NCQA are denoted with a cross (+). Caution should be used when evaluating rates derived from fewer than 100 respondents.

Global Ratings

Rating of Health Plan

Parents or caretakers of child members were asked to rate their child's health plan on a scale of 0 to 10, with 0 being the "worst health plan possible" and 10 being the "best health plan possible." Table 4-1 shows the 2015 and 2016 top-box responses and the trend results for Rating of Health Plan.[4-1]

Table 4-1: Rating of Health Plan Trend Analysis

Plan Name	2015	2016	Trend Results
MDHHS Medicaid Program	**63.9%***	**64.3%**	—
Fee-for-Service	56.1%	52.1%	—
MDHHS Medicaid Managed Care Program	**65.1%****	**66.3%**	—
Aetna Better Health of Michigan	61.6%	53.0%	▼
Blue Cross Complete of Michigan	69.8%	67.1%	—
HAP Midwest Health Plan	63.3%	52.0%+	—
Harbor Health Plan	47.9%	51.3%	—
McLaren Health Plan	59.6%	66.1%	▲
Meridian Health Plan of Michigan	66.0%	65.5%	—
Molina Healthcare of Michigan	63.4%	67.5%	—
Priority Health Choice, Inc.	72.8%	72.7%	—
Total Health Care, Inc.	64.4%	61.4%	—
UnitedHealthcare Community Plan	64.4%	67.2%	—
Upper Peninsula Health Plan	69.6%	67.0%	—

+ indicates fewer than 100 responses. Caution should be exercised when evaluating these results.

▲ *statistically significantly higher in 2016 than in 2015.*

▼ *statistically significantly lower in 2016 than in 2015.*

— *not statistically significantly different in 2016 than in 2015.*

**The MDHHS Medicaid Program 2015 average includes two MHPs that were not active in 2016. There is no plan specific trend analysis for these two MHPs. An adjusted 2015 rate, which excludes these plans, would be 63.6%.*

*** The MDHHS Medicaid Managed Care Program 2015 average includes 2 MHPs that were not active in 2016. There is no plan specific trend analysis for these two MHPs. An adjusted 2015 rate, which excludes these plans, would be 64.9%.*

There were two statistically significant differences between scores in 2016 and scores in 2015 for this measure.

The following scored statistically significantly *higher* in 2016 than in 2015:

- McLaren Health Plan

The following scored statistically significantly *lower* in 2016 than in 2015:

- Aetna Better Health of Michigan

[4-1] Due to the removal of two MHPs in 2016 (HealthPlus Partners and Sparrow PHP), the 2015 MDHHS Medicaid Program and MDHHS Medicaid Managed Care Program top-box responses presented in the 2016 Child Medicaid Health Plan CAHPS Report will be different from the top-box responses presented in the 2015 Child Medicaid Health Plan CAHPS Report.

Rating of All Health Care

Parents or caretakers of child members were asked to rate their child's health care on a scale of 0 to 10, with 0 being the "worst health care possible" and 10 being the "best health care possible." Table 4-2 shows the 2015 and 2016 top-box responses and the trend results for Rating of All Health Care.

Table 4-2: Rating of All Health Care Trend Analysis

Plan Name	2015	2016	Trend Results
MDHHS Medicaid Program	**66.3%***	**63.4%**	▼
Fee-for-Service	72.6%	62.2%	▼
MDHHS Medicaid Managed Care Program	**65.3%****	**63.5%**	—
Aetna Better Health of Michigan	62.5%	57.8%	—
Blue Cross Complete of Michigan	67.6%	63.1%	—
HAP Midwest Health Plan	60.7%	54.5%+	—
Harbor Health Plan	46.2%+	60.8%	▲
McLaren Health Plan	64.0%	61.4%	—
Meridian Health Plan of Michigan	68.0%	61.2%	—
Molina Healthcare of Michigan	63.9%	68.4%	—
Priority Health Choice, Inc.	71.9%	66.4%	—
Total Health Care, Inc.	65.1%	64.7%	—
UnitedHealthcare Community Plan	63.9%	63.9%	—
Upper Peninsula Health Plan	61.3%	61.6%	—

+ indicates fewer than 100 responses. Caution should be exercised when evaluating these results.

▲ *statistically significantly higher in 2016 than in 2015.*

▼ *statistically significantly lower in 2016 than in 2015.*

— *not statistically significantly different in 2016 than in 2015.*

**The MDHHS Medicaid Program 2015 average includes two MHPs that were not active in 2016. There is no plan specific trend analysis for these two MHPs. An adjusted 2015 rate, which excludes these plans, would be 66.5%.*

*** The MDHHS Medicaid Managed Care Program 2015 average includes 2 MHPs that were not active in 2016. There is no plan specific trend analysis for these two MHPs. An adjusted 2015 rate, which excludes these plans, would be 65.4%.*

There were three statistically significant differences between scores in 2016 and scores in 2015 for this measure.

The following scored statistically significantly *higher* in 2016 than in 2015:

- Harbor Health Plan

The following scored statistically significantly *lower* in 2016 than in 2015:

- MDHHS Medicaid Program
- FFS

Rating of Personal Doctor

Parents or caretakers of child members were asked to rate their child's personal doctor on a scale of 0 to 10, with 0 being the "worst personal doctor possible" and 10 being the "best personal doctor possible." Table 4-3 shows the 2015 and 2016 top-box responses and the trend results for Rating of Personal Doctor.

Table 4-3: Rating of Personal Doctor Trend Analysis

Plan Name	2015	2016	Trend Results
MDHHS Medicaid Program	**72.6%***	**70.9%**	**—**
Fee-for-Service	74.3%	73.2%	—
MDHHS Medicaid Managed Care Program	**72.3%****	**70.5%**	**—**
Aetna Better Health of Michigan	70.1%	69.9%	—
Blue Cross Complete of Michigan	72.6%	71.6%	—
HAP Midwest Health Plan	72.1%	62.5%+	—
Harbor Health Plan	64.1%	64.8%	—
McLaren Health Plan	70.9%	69.7%	—
Meridian Health Plan of Michigan	74.4%	69.1%	—
Molina Healthcare of Michigan	71.4%	72.6%	—
Priority Health Choice, Inc.	79.4%	72.9%	▼
Total Health Care, Inc.	69.8%	70.1%	—
UnitedHealthcare Community Plan	70.3%	70.1%	—
Upper Peninsula Health Plan	73.1%	73.0%	—

+ indicates fewer than 100 responses. Caution should be exercised when evaluating these results.

▲ *statistically significantly higher in 2016 than in 2015.*

▼ *statistically significantly lower in 2016 than in 2015.*

— *not statistically significantly different in 2016 than in 2015.*

**The MDHHS Medicaid Program 2015 average includes two MHPs that were not active in 2016. There is no plan specific trend analysis for these two MHPs. An adjusted 2015 rate, which excludes these plans, would be 72.8%.*

*** The MDHHS Medicaid Managed Care Program 2015 average includes 2 MHPs that were not active in 2016. There is no plan specific trend analysis for these two MHPs. An adjusted 2015 rate, which excludes these plans, would be 72.5%.*

There was one statistically significant difference between scores in 2016 and scores in 2015 for this measure.

The following scored statistically significantly *lower* in 2016 than in 2015:

- Priority Health Choice, Inc.

Rating of Specialist Seen Most Often

Parents or caretakers of child members were asked to rate their child's specialist on a scale of 0 to 10, with 0 being the "worst specialist possible" and 10 being the "best specialist possible." Table 4-4 shows the 2015 and 2016 top-box responses and the trend results for Rating of Specialist Seen Most Often.

Table 4-4: Rating of Specialist Seen Most Often Trend Analysis

Plan Name	2015	2016	Trend Results
MDHHS Medicaid Program	**68.3%***	**67.4%**	**—**
Fee-for-Service	66.7%+	66.7%+	—
MDHHS Medicaid Managed Care Program	**68.6%****	**67.5%**	**—**
Aetna Better Health of Michigan	60.5%+	68.8%+	—
Blue Cross Complete of Michigan	63.7%	65.3%+	—
HAP Midwest Health Plan	70.3%+	71.4%+	—
Harbor Health Plan	68.8%+	66.7%+	—
McLaren Health Plan	61.4%	62.0%	—
Meridian Health Plan of Michigan	74.0%	66.9%	—
Molina Healthcare of Michigan	71.0%	72.4%+	—
Priority Health Choice, Inc.	74.4%+	65.1%+	—
Total Health Care, Inc.	68.3%+	77.1%+	—
UnitedHealthcare Community Plan	65.3%+	67.0%+	—
Upper Peninsula Health Plan	63.2%+	60.8%+	—

+ indicates fewer than 100 responses. Caution should be exercised when evaluating these results.

▲ *statistically significantly higher in 2016 than in 2015.*

▼ *statistically significantly lower in 2016 than in 2015.*

— *not statistically significantly different in 2016 than in 2015.*

**The MDHHS Medicaid Program 2015 average includes two MHPs that were not active in 2016. There is no plan specific trend analysis for these two MHPs. An adjusted 2015 rate, which excludes these plans, would be 68.6%.*

*** The MDHHS Medicaid Managed Care Program 2015 average includes 2 MHPs that were not active in 2016. There is no plan specific trend analysis for these two MHPs. An adjusted 2015 rate, which excludes these plans, would be 68.9%.*

There were no statistically significant differences between scores in 2016 and scores in 2015 for this measure.

Composite Measures

Getting Needed Care

Two questions (Questions 14 and 28 in the CAHPS Child Medicaid Health Plan Survey) were asked to assess how often it was easy to get needed care. Table 4-5 shows the 2015 and 2016 top-box responses and trend results for the Getting Needed Care composite measure.

Table 4-5: Getting Needed Care Composite Trend Analysis

Plan Name	2015	2016	Trend Results
MDHHS Medicaid Program	**86.7%***	**84.2%**	▼
Fee-for-Service	93.6%	86.6%	▼
MDHHS Medicaid Managed Care Program	**85.6%****	**83.9%**	—
Aetna Better Health of Michigan	84.8%	86.6%	—
Blue Cross Complete of Michigan	85.5%	83.4%	—
HAP Midwest Health Plan	81.4%	76.3%+	—
Harbor Health Plan	74.0%+	69.4%+	—
McLaren Health Plan	85.1%	87.5%	—
Meridian Health Plan of Michigan	87.9%	85.2%	—
Molina Healthcare of Michigan	83.7%	83.0%	—
Priority Health Choice, Inc.	88.1%	83.5%	—
Total Health Care, Inc.	83.5%	81.1%	—
UnitedHealthcare Community Plan	85.0%	80.5%	—
Upper Peninsula Health Plan	86.1%	88.1%	—

+ indicates fewer than 100 responses. Caution should be exercised when evaluating these results.

▲ *statistically significantly higher in 2016 than in 2015.*

▼ *statistically significantly lower in 2016 than in 2015.*

— *not statistically significantly different in 2016 than in 2015.*

**The MDHHS Medicaid Program 2015 average includes two MHPs that were not active in 2016. There is no plan specific trend analysis for these two MHPs. An adjusted 2015 rate, which excludes these plans, would be 86.7%.*

*** The MDHHS Medicaid Managed Care Program 2015 average includes 2 MHPs that were not active in 2016. There is no plan specific trend analysis for these two MHPs. An adjusted 2015 rate, which excludes these plans, would be 85.5%.*

There were two statistically significant differences between scores in 2016 and scores in 2015 for this measure.

The following scored statistically significantly *lower* in 2016 than in 2015:

- MDHHS Medicaid Program
- FFS

Getting Care Quickly

Two questions (Questions 4 and 6 in the CAHPS Child Medicaid Health Plan Survey) were asked to assess how often child members received care quickly. Table 4-6 shows the 2015 and 2016 top-box responses and trend results for the Getting Care Quickly composite measure.

Table 4-6: Getting Care Quickly Composite Trend Analysis

Plan Name	2015	2016	Trend Results
MDHHS Medicaid Program	**90.8%***	**90.2%**	**—**
Fee-for-Service	95.7%	91.3%	▼
MDHHS Medicaid Managed Care Program	**89.9%****	**90.1%**	**—**
Aetna Better Health of Michigan	85.2%	89.1%	—
Blue Cross Complete of Michigan	89.4%	91.4%	—
HAP Midwest Health Plan	88.5%	88.8%+	—
Harbor Health Plan	84.9%+	91.8%+	—
McLaren Health Plan	90.3%	90.5%	—
Meridian Health Plan of Michigan	93.5%	91.5%	—
Molina Healthcare of Michigan	87.1%	88.0%	—
Priority Health Choice, Inc.	90.3%	89.3%	—
Total Health Care, Inc.	91.5%	87.3%	—
UnitedHealthcare Community Plan	87.0%	89.8%	—
Upper Peninsula Health Plan	93.6%	92.8%	—

+ indicates fewer than 100 responses. Caution should be exercised when evaluating these results.

▲ *statistically significantly higher in 2016 than in 2015.*

▼ *statistically significantly lower in 2016 than in 2015.*

— *not statistically significantly different in 2016 than in 2015.*

**The MDHHS Medicaid Program 2015 average includes two MHPs that were not active in 2016. There is no plan specific trend analysis for these two MHPs. An adjusted 2015 rate, which excludes these plans, would be 90.6%.*

*** The MDHHS Medicaid Managed Care Program 2015 average includes 2 MHPs that were not active in 2016. There is no plan specific trend analysis for these two MHPs. An adjusted 2015 rate, which excludes these plans, would be 89.7%.*

There was one statistically significant difference between scores in 2016 and scores in 2015 for this measure.

The following scored statistically significantly *lower* in 2016 than in 2015:

- FFS

How Well Doctors Communicate

A series of four questions (Questions 17, 18, 19, and 22 in the CAHPS Child Medicaid Health Plan Survey) was asked to assess how often doctors communicated well. Table 4-7 shows the 2015 and 2016 top-box responses and trend results for the How Well Doctors Communicate composite measure.

Table 4-7: How Well Doctors Communicate Composite Trend Analysis

Plan Name	2015	2016	Trend Results
MDHHS Medicaid Program	**94.0%***	**93.4%**	**—**
Fee-for-Service	97.1%	96.1%	—
MDHHS Medicaid Managed Care Program	**93.5%****	**93.0%**	**—**
Aetna Better Health of Michigan	91.0%	93.9%	—
Blue Cross Complete of Michigan	93.4%	95.0%	—
HAP Midwest Health Plan	94.6%	92.5%+	—
Harbor Health Plan	90.2%+	88.7%+	—
McLaren Health Plan	92.3%	94.7%	—
Meridian Health Plan of Michigan	95.1%	92.3%	▼
Molina Healthcare of Michigan	92.8%	92.5%	—
Priority Health Choice, Inc.	95.8%	95.0%	—
Total Health Care, Inc.	92.6%	94.3%	—
UnitedHealthcare Community Plan	92.1%	91.7%	—
Upper Peninsula Health Plan	95.1%	95.1%	—

+ indicates fewer than 100 responses. Caution should be exercised when evaluating these results.

▲ *statistically significantly higher in 2016 than in 2015.*

▼ *statistically significantly lower in 2016 than in 2015.*

— *not statistically significantly different in 2016 than in 2015.*

**The MDHHS Medicaid Program 2015 average includes two MHPs that were not active in 2016. There is no plan specific trend analysis for these two MHPs. An adjusted 2015 rate, which excludes these plans, would be 94.1%.*

*** The MDHHS Medicaid Managed Care Program 2015 average includes 2 MHPs that were not active in 2016. There is no plan specific trend analysis for these two MHPs. An adjusted 2015 rate, which excludes these plans, would be 93.5%.*

There was one statistically significant difference between scores in 2016 and scores in 2015 for this measure.

The following scored statistically significantly *lower* in 2016 than in 2015:

- Meridian Health Plan of Michigan

Customer Service

Two questions (Questions 32 and 33 in the CAHPS Child Medicaid Health Plan Survey) were asked to assess how often parents and caretakers were satisfied with customer service. Table 4-8 shows the 2015 and 2016 top-box responses and trend results for the Customer Service composite measure.

Table 4-8: Customer Service Composite Trend Analysis

Plan Name	2015	2016	Trend Results
MDHHS Medicaid Program	**88.0%***	**88.4%**	**—**
Fee-for-Service	85.8%+	86.8%+	—
MDHHS Medicaid Managed Care Program	**88.4%****	**88.7%**	**—**
Aetna Better Health of Michigan	84.4%	87.6%	—
Blue Cross Complete of Michigan	91.5%	88.0%	—
HAP Midwest Health Plan	86.8%	83.3%+	—
Harbor Health Plan	74.1%+	78.4%+	—
McLaren Health Plan	88.3%+	86.9%	—
Meridian Health Plan of Michigan	89.6%	93.4%	—
Molina Healthcare of Michigan	89.0%	84.0%	—
Priority Health Choice, Inc.	88.3%+	88.9%+	—
Total Health Care, Inc.	83.5%+	88.8%	—
UnitedHealthcare Community Plan	87.6%	86.5%	—
Upper Peninsula Health Plan	89.9%+	92.6%+	—

+ indicates fewer than 100 responses. Caution should be exercised when evaluating these results.

▲ *statistically significantly higher in 2016 than in 2015.*

▼ *statistically significantly lower in 2016 than in 2015.*

— *not statistically significantly different in 2016 than in 2015.*

**The MDHHS Medicaid Program 2015 average includes two MHPs that were not active in 2016. There is no plan specific trend analysis for these two MHPs. An adjusted 2015 rate, which excludes these plans, would be 87.9%.*

*** The MDHHS Medicaid Managed Care Program 2015 average includes 2 MHPs that were not active in 2016. There is no plan specific trend analysis for these two MHPs. An adjusted 2015 rate, which excludes these plans, would be 88.3%.*

There were no statistically significant differences between scores in 2016 and scores in 2015 for this measure.

Shared Decision Making

Three questions (Questions 10, 11, and 12 in the CAHPS Child Medicaid Health Plan Survey) were asked regarding the involvement of parents or caretakers in decision making when starting or stopping a prescription medicine for their child. Table 4-9 shows the 2015 and 2016 top-box responses and trend results for the Shared Decision Making composite measure.

Table 4-9: Shared Decision Making Composite Trend Analysis

Plan Name	2015	2016	Trend Results
MDHHS Medicaid Program	**78.5%***	**78.6%**	**—**
Fee-for-Service	84.2%+	83.3%+	—
MDHHS Medicaid Managed Care Program	**77.6%****	**77.8%**	**—**
Aetna Better Health of Michigan	79.0%+	73.8%+	—
Blue Cross Complete of Michigan	78.8%	77.5%	—
HAP Midwest Health Plan	79.0%+	83.3%+	—
Harbor Health Plan	76.4%+	79.4%+	—
McLaren Health Plan	77.2%	75.8%	—
Meridian Health Plan of Michigan	75.8%	79.5%	—
Molina Healthcare of Michigan	79.3%	82.6%+	—
Priority Health Choice, Inc.	81.1%	78.9%	—
Total Health Care, Inc.	76.5%+	76.2%+	—
UnitedHealthcare Community Plan	77.2%	72.4%+	—
Upper Peninsula Health Plan	79.0%	80.6%	—

+ indicates fewer than 100 responses. Caution should be exercised when evaluating these results.

▲ *statistically significantly higher in 2016 than in 2015.*

▼ *statistically significantly lower in 2016 than in 2015.*

— *not statistically significantly different in 2016 than in 2015.*

**The MDHHS Medicaid Program 2015 average includes two MHPs that were not active in 2016. There is no plan specific trend analysis for these two MHPs. An adjusted 2015 rate, which excludes these plans, would be 78.7%.*

*** The MDHHS Medicaid Managed Care Program 2015 average includes 2 MHPs that were not active in 2016. There is no plan specific trend analysis for these two MHPs. An adjusted 2015 rate, which excludes these plans, would be 77.8%.*

There were no statistically significant differences between scores in 2016 and scores in 2015 for this measure.

Key Drivers of Satisfaction

HSAG performed an analysis of key drivers for three measures: Rating of Health Plan, Rating of All Health Care, and Rating of Personal Doctor. The analysis provides information on: 1) how well the MDHHS Medicaid Program is performing on the survey item (i.e., question), and 2) how important the item is to overall satisfaction.

Key drivers of satisfaction are defined as those items that (1) have a problem score that is greater than or equal to the program's median problem score for all items examined, and (2) have a correlation that is greater than or equal to the program's median correlation for all items examined. For additional information on the assignment of problem scores, please refer to the Reader's Guide section. Table 5-1 lists those items identified for each of the three measures as being key drivers of satisfaction for the MDHHS Medicaid Program.

Table 5-1: MDHHS Medicaid Program Key Drivers of Satisfaction
Rating of Health Plan
Respondents reported that when their child did not need care right away, they did not obtain an appointment for health care as soon as they thought they needed.
Respondents reported that it was not always easy to get the care, tests, or treatment they thought their child needed through his/her health plan.
Respondents reported that their child's health plan's customer service did not always give them the information or help they needed.
Respondents reported that their child's personal doctor did not always seem informed and up-to-date about the care their child received from other doctors or health providers.
Respondents reported that forms from their child's health plan were often not easy to fill out.
Respondents reported that it was often not easy for their child to obtain appointments with specialists.
Rating of All Health Care
Respondents reported that when their child did not need care right away, they did not obtain an appointment for health care as soon as they thought they needed.
Respondents reported that it was not always easy to get the care, tests, or treatment they thought their child needed through his/her health plan.
Respondents reported that their child's personal doctor did not always seem informed and up-to-date about the care their child received from other doctors or health providers.
Respondents reported that it was often not easy for their child to obtain appointments with specialists.
Rating of Personal Doctor
Respondents reported that their child's personal doctor did not always seem informed and up-to-date about the care their child received from other doctors or health providers.
Respondents reported that their child's personal doctor did not always spend enough time with them.
Respondents reported that their child's personal doctor did not talk with them about how their child is feeling, growing, or behaving.

Survey Instrument

The survey instrument selected was the CAHPS 5.0 Child Medicaid Health Plan Survey with the HEDIS supplemental item set. This section provides a copy of the survey instrument.

MDHHS
Michigan Department of Health & Human Services
RICK SNYDER, GOVERNOR | NICK LYON, DIRECTOR

DataStat

Your privacy is protected. The research staff will not share your personal information with anyone without your OK. Personally identifiable information will not be made public and will only be released in accordance with federal laws and regulations.

You may choose to answer this survey or not. If you choose not to, this will not affect the benefits your child gets. You may notice a number on the cover of this survey. This number is ONLY used to let us know if you returned your survey so we don't have to send you reminders.

If you want to know more about this study, please call 1-888-506-5134.

SURVEY INSTRUCTIONS

- **Please be sure to fill the response circle <u>completely</u>. Use only <u>black or blue ink</u> or <u>dark pencil</u> to complete the survey.**

Correct Mark ●

Incorrect Marks 

- **You are sometimes told to skip over some questions in the survey. When this happens you will see an arrow with a note that tells you what question to answer next, like this:**

● **Yes** ➔ ***Go to Question 1***
○ **No**

⬇ START HERE ⬇

Please answer the questions for the child listed on the envelope. Please do not answer for any other children.

1. **Our records show that your child is now in [HEALTH PLAN NAME/STATE MEDICAID PROGRAM NAME]. Is that right?**

○ Yes ➔ ***Go to Question 3***
○ No

2. **What is the name of your child's health plan? (Please print)**

_____

YOUR CHILD'S HEALTH CARE IN THE LAST 6 MONTHS

These questions ask about your child's health care. Do not include care your child got when he or she stayed overnight in a hospital. Do not include the times your child went for dental care visits.

3. In the last 6 months, did your child have an illness, injury, or condition that needed care right away in a clinic, emergency room, or doctor's office?

- ○ Yes
- ○ No ➔ ***Go to Question 5***

4. In the last 6 months, when your child needed care right away, how often did your child get care as soon as he or she needed?

- ○ Never
- ○ Sometimes
- ○ Usually
- ○ Always

5. In the last 6 months, did you make any appointments for a check-up or routine care for your child at a doctor's office or clinic?

- ○ Yes
- ○ No ➔ ***Go to Question 7***

6. In the last 6 months, when you made an appointment for a check-up or routine care for your child at a doctor's office or clinic, how often did you get an appointment as soon as your child needed?

- ○ Never
- ○ Sometimes
- ○ Usually
- ○ Always

7. In the last 6 months, not counting the times your child went to an emergency room, how many times did he or she go to a doctor's office or clinic to get health care?

- ○ None ➔ ***Go to Question 15***
- ○ 1 time
- ○ 2
- ○ 3
- ○ 4
- ○ 5 to 9
- ○ 10 or more times

8. In the last 6 months, did you and your child's doctor or other health provider talk about specific things you could do to prevent illness in your child?

- ○ Yes
- ○ No

9. In the last 6 months, did you and your child's doctor or other health provider talk about starting or stopping a prescription medicine for your child?

- ○ Yes
- ○ No ➔ ***Go to Question 13***

10. Did you and a doctor or other health provider talk about the reasons you might want your child to take a medicine?

- ○ Yes
- ○ No

11. Did you and a doctor or other health provider talk about the reasons you might not want your child to take a medicine?

- ○ Yes
- ○ No

12. When you talked about your child starting or stopping a prescription medicine, did a doctor or other health provider ask you what you thought was best for your child?

- ○ Yes
- ○ No

13. Using any number from 0 to 10, where 0 is the worst health care possible and 10 is the best health care possible, what number would you use to rate all your child's health care in the last 6 months?

○	○	○	○	○	○	○	○	○	○	○
0	1	2	3	4	5	6	7	8	9	10
Worst Health Care Possible										Best Health Care Possible

14. In the last 6 months, how often was it easy to get the care, tests, or treatment your child needed?

- ○ Never
- ○ Sometimes
- ○ Usually
- ○ Always

YOUR CHILD'S PERSONAL DOCTOR

15. A personal doctor is the one your child would see if he or she needs a checkup, has a health problem or gets sick or hurt. Does your child have a personal doctor?

- ○ Yes
- ○ No ➔ ***Go to Question 27***

16. In the last 6 months, how many times did your child visit his or her personal doctor for care?

- ○ None ➔ ***Go to Question 26***
- ○ 1 time
- ○ 2
- ○ 3
- ○ 4
- ○ 5 to 9
- ○ 10 or more times

17. In the last 6 months, how often did your child's personal doctor explain things about your child's health in a way that was easy to understand?

- ○ Never
- ○ Sometimes
- ○ Usually
- ○ Always

18. In the last 6 months, how often did your child's personal doctor listen carefully to you?

- ○ Never
- ○ Sometimes
- ○ Usually
- ○ Always

19. In the last 6 months, how often did your child's personal doctor show respect for what you had to say?

- ○ Never
- ○ Sometimes
- ○ Usually
- ○ Always

20. Is your child able to talk with doctors about his or her health care?

- ○ Yes
- ○ No ➔ ***Go to Question 22***

21. In the last 6 months, how often did your child's personal doctor explain things in a way that was easy for <u>your child</u> to understand?

- ○ Never
- ○ Sometimes
- ○ Usually
- ○ Always

22. In the last 6 months, how often did your child's personal doctor spend enough time with your child?

- ○ Never
- ○ Sometimes
- ○ Usually
- ○ Always

23. In the last 6 months, did your child's personal doctor talk with you about how your child is feeling, growing, or behaving?

- ○ Yes
- ○ No

24. In the last 6 months, did your child get care from a doctor or other health provider besides his or her personal doctor?

- ○ Yes
- ○ No ➔ ***Go to Question 26***

25. In the last 6 months, how often did your child's personal doctor seem informed and up-to-date about the care your child got from these doctors or other health providers?

- ○ Never
- ○ Sometimes
- ○ Usually
- ○ Always

26. Using any number from 0 to 10, where 0 is the worst personal doctor possible and 10 is the best personal doctor possible, what number would you use to rate your child's personal doctor?

○	○	○	○	○	○	○	○	○	○	○
0	1	2	3	4	5	6	7	8	9	10

Worst Personal Doctor Possible — Best Personal Doctor Possible

GETTING HEALTH CARE FROM SPECIALISTS

When you answer the next questions, do <u>not</u> include dental visits or care your child got when he or she stayed overnight in a hospital.

27. Specialists are doctors like surgeons, heart doctors, allergy doctors, skin doctors, and other doctors who specialize in one area of health care.

In the last 6 months, did you make any appointments for your child to see a specialist?

- ○ Yes
- ○ No ➔ ***Go to Question 31***

28. In the last 6 months, how often did you get an appointment for your child to see a specialist as soon as you needed?

- ○ Never
- ○ Sometimes
- ○ Usually
- ○ Always

29. How many specialists has your child seen in the last 6 months?

- ○ None ➔ ***Go to Question 31***
- ○ 1 specialist
- ○ 2
- ○ 3
- ○ 4
- ○ 5 or more specialists

30. We want to know your rating of the specialist your child saw most often in the last 6 months. Using any number from 0 to 10, where 0 is the worst specialist possible and 10 is the best specialist possible, what number would you use to rate that specialist?

○	○	○	○	○	○	○	○	○	○	○
0	1	2	3	4	5	6	7	8	9	10

Worst Specialist Possible — Best Specialist Possible

YOUR CHILD'S HEALTH PLAN

The next questions ask about your experience with your child's health plan.

31. In the last 6 months, did you get information or help from customer service at your child's health plan?

- ○ Yes
- ○ No ➔ ***Go to Question 34***

32. In the last 6 months, how often did customer service at your child's health plan give you the information or help you needed?

- ○ Never
- ○ Sometimes
- ○ Usually
- ○ Always

33. In the last 6 months, how often did customer service staff at your child's health plan treat you with courtesy and respect?

- ○ Never
- ○ Sometimes
- ○ Usually
- ○ Always

34. In the last 6 months, did your child's health plan give you any forms to fill out?

- ○ Yes
- ○ No ➔ ***Go to Question 36***

35. In the last 6 months, how often were the forms from your child's health plan easy to fill out?

- ○ Never
- ○ Sometimes
- ○ Usually
- ○ Always

36. Using any number from 0 to 10, where 0 is the worst health plan possible and 10 is the best health plan possible, what number would you use to rate your child's health plan?

○	○	○	○	○	○	○	○	○	○	○
0	1	2	3	4	5	6	7	8	9	10

Worst Health Plan Possible — Best Health Plan Possible

ABOUT YOUR CHILD AND YOU

37. In general, how would you rate your child's overall health?

- ○ Excellent
- ○ Very good
- ○ Good
- ○ Fair
- ○ Poor

38. In general, how would you rate your child's overall mental or emotional health?

- ○ Excellent
- ○ Very good
- ○ Good
- ○ Fair
- ○ Poor

39. What is your child's age?

- ○ Less than 1 year old

☐☐ YEARS OLD (write in)

40. Is your child male or female?

- ○ Male
- ○ Female

41. Is your child of Hispanic or Latino origin or descent?

- ○ Yes, Hispanic or Latino
- ○ No, Not Hispanic or Latino

42. What is your child's race? Mark one or more.

- ○ White
- ○ Black or African-American
- ○ Asian
- ○ Native Hawaiian or other Pacific Islander
- ○ American Indian or Alaska Native
- ○ Other

43. What is your age?

- ○ Under 18
- ○ 18 to 24
- ○ 25 to 34
- ○ 35 to 44
- ○ 45 to 54
- ○ 55 to 64
- ○ 65 to 74
- ○ 75 or older

44. Are you male or female?

- ○ Male
- ○ Female

45. What is the highest grade or level of school that you have completed?

- ○ 8th grade or less
- ○ Some high school, but did not graduate
- ○ High school graduate or GED
- ○ Some college or 2-year degree
- ○ 4-year college graduate
- ○ More than 4-year college degree

46. How are you related to the child?

- ○ Mother or father
- ○ Grandparent
- ○ Aunt or uncle
- ○ Older brother or sister
- ○ Other relative
- ○ Legal guardian
- ○ Someone else

47. Did someone help you complete this survey?

- ○ Yes ➔ ***Go to Question 48***
- ○ No ➔ ***Thank you. Please return the completed survey in the postage-paid envelope.***

48. How did that person help you? Mark one or more.

- ○ Read the questions to me
- ○ Wrote down the answers I gave
- ○ Answered the questions for me
- ○ Translated the questions into my language
- ○ Helped in some other way

Thanks again for taking the time to complete this survey! Your answers are greatly appreciated.

When you are done, please use the enclosed prepaid envelope to mail the survey to:

DataStat, 3975 Research Park Drive, Ann Arbor, MI 48108

CD Contents

The accompanying CD includes all of the information from the Executive Summary, Reader's Guide, Results, Trend Analysis, Key Drivers of Satisfaction, and Survey Instrument sections of this report. The CD also contains electronic copies of comprehensive crosstabulations that show responses to each survey question stratified by select categories. The following content is included in the CD:

- 2016 Michigan Child Medicaid CAHPS Report
- MDHHS Child Medicaid Program Crosstabulations
- MDHHS Child Medicaid Plan-level Crosstabulations

State of Michigan
Department of Health and Human Services

2016 Michigan Department of Health and Human Services Adult Medicaid Health Plan CAHPS® Report

November 2016

HSAG HEALTH SERVICES ADVISORY GROUP

TABLE OF CONTENTS

Introduction

The Michigan Department of Health and Human Services (MDHHS) periodically assesses the perceptions and experiences of members enrolled in the MDHHS Medicaid health plans (MHPs) and the Fee-for-Service (FFS) program as part of its process for evaluating the quality of health care services provided to adult members in the MDHHS Medicaid Program. MDHHS contracted with Health Services Advisory Group, Inc. (HSAG) to administer and report the results of the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Health Plan Survey for the MDHHS Medicaid Program.[1-1,1-2] The goal of the CAHPS Health Plan Survey is to provide performance feedback that is actionable and that will aid in improving overall member satisfaction.

This report presents the 2016 CAHPS results of adult members enrolled in an MHP or FFS.[1-3] The surveys were completed in the spring of 2016. The standardized survey instrument selected was the CAHPS 5.0 Adult Medicaid Health Plan Survey with the Healthcare Effectiveness Data and Information Set (HEDIS®) supplemental item set.[1-4]

Report Overview

A sample of at least 1,350 adult members was selected from the FFS population and each MHP.[1-5] Results presented in this report include four global ratings: Rating of Health Plan, Rating of All Health Care, Rating of Personal Doctor, and Rating of Specialist Seen Most Often. Five composite measures are reported: Getting Needed Care, Getting Care Quickly, How Well Doctors Communicate, Customer Service, and Shared Decision Making. Additionally, overall rates for five Effectiveness of Care measures are reported: Advising Smokers and Tobacco Users to Quit, Discussing Cessation Medications, Discussing Cessation Strategies, Aspirin Use, and Discussing Aspirin Risks and Benefits.

HSAG presents aggregate statewide results and compares them to national Medicaid data and the prior year's results, where appropriate. Throughout this report, two statewide aggregate results are presented for comparative purposes:

- MDHHS Medicaid Program – Combined results for FFS and the MHPs.
- MDHHS Medicaid Managed Care Program – Combined results for the MHPs.

1-1 CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).
1-2 HSAG surveyed the FFS Medicaid population. The 11 MHPs contracted with various survey vendors to administer the CAHPS survey.
1-3 The health plan name for one of the MHPs changed since the adult MHP population was surveyed in 2015. Aetna Better Health of Michigan was previously referred to as CoventryCares.
1-4 HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).
1-5 Some MHPs elected to oversample their population.

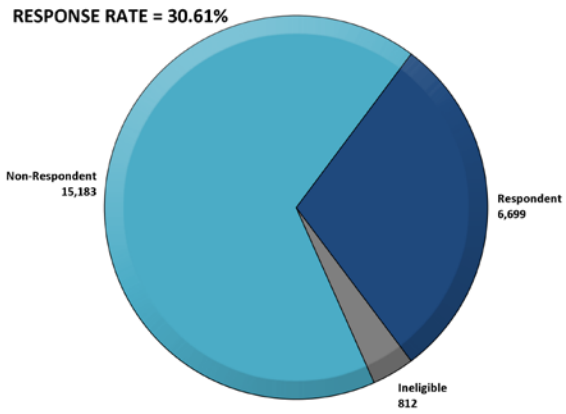
Key Findings

Survey Dispositions and Demographics

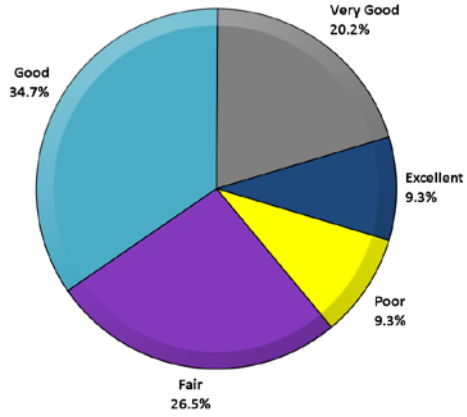
Figure 1-1 provides an overview of the MDHHS Medicaid Program survey dispositions and adult member demographics.

Figure 1-1: Survey Dispositions and Member Demographics

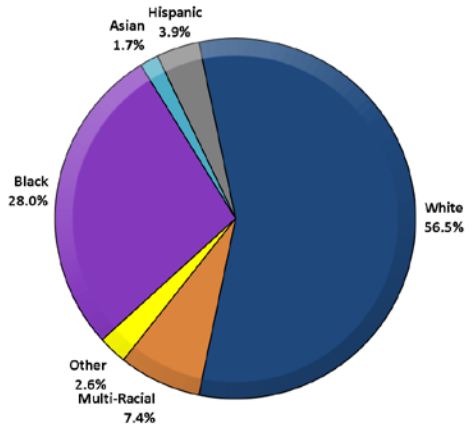
Survey Dispositions



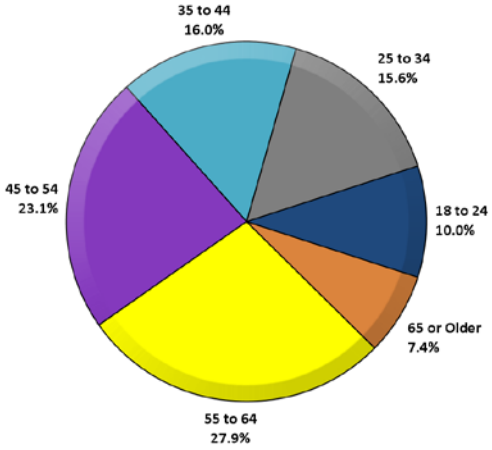
General Health Status



Race/Ethnicity



Age



Please note, percentages may not total 100.0% due to rounding.

National Comparisons and Trend Analysis

A three-point mean score was determined for the four CAHPS global ratings and four CAHPS composite measures. The resulting three-point mean scores were compared to the National Committee for Quality Assurance's (NCQA's) 2016 HEDIS Benchmarks and Thresholds for Accreditation to derive the overall member satisfaction ratings (i.e., star ratings) for each CAHPS measure.[1-6,1-7] In addition, a trend analysis was performed that compared the 2016 CAHPS results to their corresponding 2015 CAHPS results**.** Table 1-1 provides highlights of the National Comparisons and Trend Analysis findings for the MDHHS Medicaid Program. The numbers presented below represent the three-point mean score for each measure, while the stars represent overall member satisfaction ratings when the three-point means were compared to NCQA HEDIS Benchmarks and Thresholds for Accreditation.

Table 1-1: National Comparisons and Trend Analysis MDHHS Medicaid Program

Measure	National Comparisons	Trend Analysis
Global Rating		
Rating of Health Plan	★★★ 2.48	—
Rating of All Health Care	★★★ 2.37	—
Rating of Personal Doctor	★★★ 2.50	—
Rating of Specialist Seen Most Often	★★★ 2.52	—
Composite Measure		
Getting Needed Care	★★★ 2.40	—
Getting Care Quickly	★★★ 2.45	—
How Well Doctors Communicate	★★★★★ 2.64	—
Customer Service	★★★★ 2.59	—

Star Assignments Based on Percentiles

★★★★★ 90th or Above ★★★★ 75th-89th ★★★ 50th-74th ★★ 25th-49th ★ Below 25th

▲ statistically significantly higher in 2016 than in 2015.

▼ statistically significantly lower in 2016 than in 2015.

— indicates the 2016 score is not statistically significantly different than the 2015 score.

1-6 National Committee for Quality Assurance. *HEDIS® Benchmarks and Thresholds for Accreditation 2016*. Washington, DC: NCQA; January 21, 2016.

1-7 NCQA does not publish national benchmarks and thresholds for the Shared Decision Making composite measure; therefore, this CAHPS measure was excluded from the National Comparisons analysis.

The National Comparisons results on the previous page indicated the Rating of Health Plan, Rating of All Health Care, Rating of Personal Doctor, and Rating of Specialist Seen Most Often global ratings, and the Getting Needed Care and Getting Care Quickly composite measures scored at or between the 50th and 74th percentiles. The How Well Doctors Communicate composite measure scored at or above the 90th percentile, and the Customer Service composite measure scored at or between the 75th and 89th percentiles.

Results from the trend analysis showed that the MDHHS Medicaid Program did not score significantly *higher* or *lower* in 2016 than in 2015 on any of the measures.

Statewide Comparisons

HSAG calculated top-box rates (i.e., rates of satisfaction) for each global rating and composite measure and overall rates for the Effectiveness of Care measures. HSAG compared the MHP and FFS results to the MDHHS Medicaid Managed Care Program average to determine if plan or program results were statistically significantly different than the MDHHS Medicaid Managed Care Program average. Table 1-2 through Table 1-4 show the results of this analysis for the global ratings, composite measures, and Effectiveness of Care measures, respectively.

Table 1-2: Statewide Comparisons—Global Ratings

Plan Name	Rating of Health Plan	Rating of All Health Care	Rating of Personal Doctor	Rating of Specialist Seen Most Often
Fee-for-Service	—	—	—	—
Aetna Better Health of Michigan	↓	—	—	—
Blue Cross Complete of Michigan	↑	—	—	—
HAP Midwest Health Plan	↓	—	—	—
Harbor Health Plan	↓	—	—	—
McLaren Health Plan	—	—	—	—
Meridian Health Plan of Michigan	—	—	—	—
Molina Healthcare of Michigan	—	—	—	—
Priority Health Choice, Inc.	↑	—	—	—
Total Health Care, Inc.	—	—	—	—
UnitedHealthcare Community Plan	—	—	—	—
Upper Peninsula Health Plan	—	—	—	—

\+ indicates fewer than 100 responses. Caution should be exercised when evaluating these results.
↑ indicates the plan's score is statistically significantly higher than the MDHHS Medicaid Managed Care Program average.
↓ indicates the plan's score is statistically significantly lower than the MDHHS Medicaid Managed Care Program average.
— indicates the plan's score is not statistically significantly different than the MDHHS Medicaid Managed Care Program average.

Table 1-3: Statewide Comparisons—Composite Measures					
Plan Name	Getting Needed Care	Getting Care Quickly	How Well Doctors Communicate	Customer Service	Shared Decision Making
Fee-for-Service	—	↑	—	—+	—
Aetna Better Health of Michigan	↓	—	—	—	↓
Blue Cross Complete of Michigan	—	—	—	—	—
HAP Midwest Health Plan	—	—	—	—	—
Harbor Health Plan	—	—	—	—	↓
McLaren Health Plan	—	—	—	—	↑
Meridian Health Plan of Michigan	—	—	—	—	—
Molina Healthcare of Michigan	—	—	—	—	—
Priority Health Choice, Inc.	↑	—	—	—	—
Total Health Care, Inc.	—	↑	—	—	—
UnitedHealthcare Community Plan	—	—	—	—	—
Upper Peninsula Health Plan	↑	↑	—	—	↑

\+ indicates fewer than 100 responses. Caution should be exercised when evaluating these results.
↑ indicates the plan's score is statistically significantly higher than the MDHHS Medicaid Managed Care Program average.
↓ indicates the plan's score is statistically significantly lower than the MDHHS Medicaid Managed Care Program average.
— indicates the plan's score is not statistically significantly different than the MDHHS Medicaid Managed Care Program average.

Table 1-4: Statewide Comparisons—Effectiveness of Care Measures					
Plan Name	Advising Smokers and Tobacco Users to Quit	Discussing Cessation Medications	Discussing Cessation Strategies	Aspirin Use	Discussing Aspirin Risks and Benefits
Fee-for-Service	—	—	—	↑+	↑
Aetna Better Health of Michigan	—	—	—	—+	—
Blue Cross Complete of Michigan	—	—	—	—	—
HAP Midwest Health Plan	—	—	—	—	↑
Harbor Health Plan	—	—	—	—	—
McLaren Health Plan	—	—	—	—	—
Meridian Health Plan of Michigan	—	—	—	—	—
Molina Healthcare of Michigan	—	—	—	—	↑
Priority Health Choice, Inc.	—	—	—	—	—
Total Health Care, Inc.	—	—	—	—	—
UnitedHealthcare Community Plan	—	—	—	—+	—
Upper Peninsula Health Plan	—	—	—	—	↓

\+ indicates fewer than 100 responses. Caution should be exercised when evaluating these results.
↑ indicates the plan's score is statistically significantly higher than the MDHHS Medicaid Managed Care Program average.
↓ indicates the plan's score is statistically significantly lower than the MDHHS Medicaid Managed Care Program average.
— indicates the plan's score is not statistically significantly different than the MDHHS Medicaid Managed Care Program average.

The following plans scored statistically significantly *higher* than the MDHHS Medicaid Managed Care Program average on at least one measure:

- Blue Cross Complete of Michigan
- Fee-for-Service
- HAP Midwest Health Plan
- McLaren Health Plan
- Molina Healthcare of Michigan
- Priority Health Choice, Inc.
- Total Health Care, Inc.
- Upper Peninsula Health Plan

Conversely, the following plans scored statistically significantly *lower* than the MDHHS Medicaid Managed Care Program average on at least one measure:

- Aetna Better Health of Michigan
- HAP Midwest Health Plan
- Harbor Health Plan
- Upper Peninsula Health Plan

Key Drivers of Satisfaction

HSAG focused the key drivers of satisfaction analysis on three measures: Rating of Health Plan, Rating of All Health Care, and Rating of Personal Doctor. HSAG evaluated each of these measures to determine if particular CAHPS items (i.e., questions) strongly correlated with these measures, which HSAG refers to as "key drivers." These individual CAHPS items are driving levels of satisfaction with each of the three measures. Table 1-5 provides a summary of the key drivers identified for the MDHHS Medicaid Program.

Table 1-5: MDHHS Medicaid Program Key Drivers of Satisfaction
Rating of Health Plan
Respondents reported that their health plan's customer service did not always give them the information or help they needed.
Respondents reported that their personal doctor did not always seem informed and up-to-date about the care they received from other doctors or health providers.
Respondents reported that information in written materials or on the Internet about how the health plan works did not always provide the information they needed.
Respondents reported that forms from their health plan were often not easy to fill out.
Respondents reported that it was often not easy to obtain appointments with specialists.
Rating of All Health Care
Respondents reported that when they talked about starting or stopping a prescription medicine, a doctor or other health provider did not ask what they thought was best for them.
Respondents reported that their personal doctor did not always seem informed and up-to-date about the care they received from other doctors or health providers.
Respondents reported that it was often not easy to obtain appointments with specialists.
Rating of Personal Doctor
Respondents reported that it was not always easy to get the care, tests, or treatment they thought they needed through their health plan.
Respondents reported that their personal doctor did not always seem informed and up-to-date about the care they received from other doctors or health providers.

2016 CAHPS Performance Measures

The CAHPS 5.0 Adult Medicaid Health Plan Survey with the HEDIS supplemental item set includes 58 core questions that yield 14 measures. These measures include four global rating questions, five composite measures, and five Effectiveness of Care measures. The global measures (also referred to as global ratings) reflect overall satisfaction with the health plan, health care, personal doctors, and specialists. The composite measures are sets of questions grouped together to address different aspects of care (e.g., "Getting Needed Care" or "Getting Care Quickly"). The Effectiveness of Care measures assess the various aspects of providing medical assistance with smoking and tobacco use cessation and managing aspirin use for the primary prevention of cardiovascular disease.

Table 2-1 lists the measures included in the CAHPS 5.0 Adult Medicaid Health Plan Survey with the HEDIS supplemental item set.

Table 2-1: CAHPS Measures

Global Ratings	Composite Measures	Effectiveness of Care Measures
Rating of Health Plan	Getting Needed Care	Advising Smokers and Tobacco Users to Quit
Rating of All Health Care	Getting Care Quickly	Discussing Cessation Medications
Rating of Personal Doctor	How Well Doctors Communicate	Discussing Cessation Strategies
Rating of Specialist Seen Most Often	Customer Service	Aspirin Use
	Shared Decision Making	Discussing Aspirin Risks and Benefits

How CAHPS Results Were Collected

NCQA mandates a specific HEDIS survey methodology to ensure the collection of CAHPS data is consistent throughout all plans to allow for comparisons. In accordance with NCQA requirements, the sampling procedures and survey protocol were adhered to as described below.

Sampling Procedures

MDHHS provided HSAG with a list of all eligible members in the FFS population for the sampling frame, per HEDIS specifications. HSAG inspected a sample of the file records to check for any apparent problems with the files, such as missing address elements. The MHPs contracted with separate survey vendors to perform sampling. Following HEDIS requirements, members were sampled who met the following criteria:

- Were 18 years of age or older as of December 31, 2015.
- Were currently enrolled in an MHP or FFS.
- Had been continuously enrolled in the plan or program for at least five of the last six months (July through December) of 2015.
- Had Medicaid as a payer.

Next, a sample of members was selected for inclusion in the survey. For each MHP, no more than one member per household was selected as part of the survey samples. A sample of at least 1,350 adult members was selected from the FFS population and each MHP.[2-1] Table 3-1 in the Results section provides an overview of the sample sizes for each plan and program.

[2-1] Some MHPs elected to oversample their population.

Survey Protocol

The survey administration protocol employed by all of the MHPs and FFS, with the exception of Aetna Better Health of Michigan, McLaren Health Plan, Total Health Care, Inc., and Upper Peninsula Health Plan, was a mixed-mode methodology, which allowed for two methods by which members could complete a survey.[2-2] The first, or mail phase, consisted of sampled members receiving a survey via mail. Non-respondents received a reminder postcard, followed by a second survey mailing and reminder postcard.

The second phase, or telephone phase, consisted of Computer Assisted Telephone Interviewing (CATI) of members who did not mail in a completed survey. At least three CATI calls to each non-respondent were attempted.[2-3] It has been shown that the addition of the telephone phase aids in the reduction of non-response bias by increasing the number of respondents who are more demographically representative of a plan's population.[2-4] The survey administration protocol employed by Aetna Better Health of Michigan, McLaren Health Plan, Total Health Care, Inc., and Upper Peninsula Health Plan was a mixed-mode methodology with an Internet option, which allowed sampled members the option to complete the survey via mail, telephone, or Internet.

Table 2-2 shows the standard mixed-mode (i.e., mail followed by telephone follow-up) CAHPS timeline used in the administration of the CAHPS surveys.

Table 2-2: CAHPS 5.0 Mixed-Mode Methodology Survey Timeline

Task	Timeline
Send first questionnaire with cover letter to the adult member.	0 days
Send a postcard reminder to non-respondents four to 10 days after mailing the first questionnaire.	4 – 10 days
Send a second questionnaire (and letter) to non-respondents approximately 35 days after mailing the first questionnaire.	35 days
Send a second postcard reminder to non-respondents four to 10 days after mailing the second questionnaire.	39 – 45 days
Initiate CATI interviews for non-respondents approximately 21 days after mailing the second questionnaire.	56 days
Initiate systematic contact for all non-respondents such that at least three telephone calls are attempted at different times of the day, on different days of the week, and in different weeks.	56 – 70 days
Telephone follow-up sequence completed (i.e., completed interviews obtained or maximum calls reached for all non-respondents) approximately 14 days after initiation.	70 days

2-2 Blue Cross Complete of Michigan, Meridian Health Plan of Michigan, and Molina Healthcare of Michigan utilized an enhanced mixed-mode survey methodology pre-approved by NCQA.

2-3 National Committee for Quality Assurance. *Quality Assurance Plan for HEDIS 2016 Survey Measures.* Washington, DC: NCQA; 2015.

2-4 Fowler FJ Jr., Gallagher PM, Stringfellow VL, et al. "Using Telephone Interviews to Reduce Nonresponse Bias to Mail Surveys of Health Plan Members." *Medical Care*. 2002; 40(3): 190-200.

How CAHPS Results Were Calculated and Displayed

HSAG used the CAHPS scoring approach recommended by NCQA in Volume 3 of HEDIS Specifications for Survey Measures. Based on NCQA's recommendations and HSAG's extensive experience evaluating CAHPS data, HSAG performed a number of analyses to comprehensively assess member satisfaction. In addition to individual plan results, HSAG calculated an MDHHS Medicaid Program average and an MDHHS Medicaid Managed Care Program average. HSAG combined results from FFS and the MHPs to form the MDHHS Medicaid Program average. HSAG combined results from the MHPs to form the MDHHS Medicaid Managed Care Program average. This section provides an overview of each analysis.

Who Responded to the Survey

The administration of the CAHPS survey is comprehensive and is designed to achieve the highest possible response rate. NCQA defines the response rate as the total number of completed surveys divided by all eligible members of the sample.[2-5] HSAG considered a survey completed if members answered at least three of the following five questions: 3, 15, 24, 28, and 35. Eligible members included the entire sample minus ineligible members. Ineligible members met at least one of the following criteria: they were deceased, were invalid (did not meet the eligible criteria), were mentally or physically incapacitated, were removed from the sample during deduplication, or had a language barrier.

$$Response\ Rate = \frac{Number\ of\ Completed\ Surveys}{Sample - Ineligibles}$$

Demographics of Adult Members

The demographics analysis evaluated demographic information of adult members. MDHHS should exercise caution when extrapolating the CAHPS results to the entire population if the respondent population differs significantly from the actual population of the plan or program.

National Comparisons

HSAG conducted an analysis of the CAHPS survey results using NCQA HEDIS Specifications for Survey Measures. Although NCQA requires a minimum of 100 responses on each item in order to report the item as a valid CAHPS Survey result, HSAG presented results with less than 100 responses. Therefore, caution should be exercised when evaluating measures' results with less than 100 responses, which are denoted with a cross (+).

[2-5] National Committee for Quality Assurance. *HEDIS® 2016, Volume 3: Specifications for Survey Measures.* Washington, DC: NCQA; 2015.

Table 2-3 shows the percentiles that were used to determine star ratings for each CAHPS measure.

Table 2-3: Star Ratings	
Stars	**Percentiles**
★★★★★ Excellent	At or above the 90th percentile
★★★★ Very Good	At or between the 75th and 89th percentiles
★★★ Good	At or between the 50th and 74th percentiles
★★ Fair	At or between the 25th and 49th percentiles
★ Poor	Below the 25th percentile

In order to perform the National Comparisons, a three-point mean score was determined for each CAHPS measure. HSAG compared the resulting three-point mean scores to published NCQA HEDIS Benchmarks and Thresholds for Accreditation to derive the overall member satisfaction ratings for each CAHPS measure.[2-6]

Table 2-4 shows the NCQA HEDIS Benchmarks and Thresholds for Accreditation used to derive the overall adult Medicaid member satisfaction ratings on each CAHPS measure.[2-7] NCQA does not publish national benchmarks and thresholds for Shared Decision Making; therefore, this CAHPS measure was excluded from the National Comparisons analysis.

Table 2-4: Overall Adult Medicaid Member Satisfaction Ratings Crosswalk				
Measure	**90th Percentile**	**75th Percentile**	**50th Percentile**	**25th Percentile**
Rating of Health Plan	2.55	2.49	2.43	2.37
Rating of All Health Care	2.45	2.42	2.36	2.31
Rating of Personal Doctor	2.57	2.53	2.50	2.43
Rating of Specialist Seen Most Often	2.59	2.56	2.51	2.48
Getting Needed Care	2.45	2.42	2.37	2.31
Getting Care Quickly	2.49	2.46	2.42	2.36
How Well Doctors Communicate	2.64	2.58	2.54	2.48
Customer Service	2.61	2.58	2.54	2.48

2-6 For detailed information on the derivation of three-point mean scores, please refer to *HEDIS® 2016, Volume 3: Specifications for Survey Measures.*

2-7 National Committee for Quality Assurance. *HEDIS® Benchmarks and Thresholds for Accreditation 2016.* Washington, DC: NCQA; January 21, 2016.

Statewide Comparisons

Global Ratings and Composite Measures

For purposes of the Statewide Comparisons analysis, HSAG calculated question summary rates for each global rating and global proportions for each composite measure, following NCQA HEDIS Specifications for Survey Measures.[2-8] The scoring of the global ratings and composite measures involved assigning top-box responses a score of one, with all other responses receiving a score of zero. A "top-box" response was defined as follows:

- "9" or "10" for the global ratings.
- "Usually" or "Always" for the Getting Needed Care, Getting Care Quickly, How Well Doctors Communicate, and Customer Service composites.
- "Yes" for the Shared Decision Making composite.

Medical Assistance with Smoking and Tobacco Use Cessation

HSAG calculated three rates that assess different facets of providing medical assistance with smoking and tobacco use cessation:

- Advising Smokers and Tobacco Users to Quit
- Discussing Cessation Medications
- Discussing Cessation Strategies

These rates assess the percentage of smokers or tobacco users who were advised to quit, were recommended cessation medications, and were provided cessation methods or strategies, respectively. Responses of "Sometimes," "Usually," and "Always" were used to determine if the member qualified for inclusion in the numerator. The rates presented follow NCQA's methodology of calculating a rolling average using the current and prior year's results.

Aspirin Use and Discussion

HSAG calculated two rates that assess different facets of managing aspirin use for the primary prevention of cardiovascular disease:

- Aspirin Use
- Discussing Aspirin Risks and Benefits

[2-8] National Committee for Quality Assurance. *HEDIS® 2016, Volume 3: Specifications for Survey Measures.* Washington, DC: NCQA; 2015.

The Aspirin Use measure assesses the percentage of members at risk for cardiovascular disease who are currently taking aspirin. The Discussing Aspirin Risks and Benefits measure assesses the percentage of members who discussed the risks and benefits of using aspirin with a doctor or other health provider. Responses of "Yes" were used to determine if the member qualified for inclusion in the numerator. The rates presented follow NCQA's methodology of calculating a rolling average using the current and prior year's results.

Weighting

Both a weighted MDHHS Medicaid Program rate and a weighted MDHHS Medicaid Managed Care Program rate were calculated. Results were weighted based on the total eligible population for each plan's or program's adult population. The MDHHS Medicaid Program average includes results from both the MHPs and the FFS population. The MDHHS Medicaid Managed Care Program average is limited to the results of the MHPs (i.e., the FFS population is not included). For the Statewide Comparisons, no threshold number of responses was required for the results to be reported. Measures with less than 100 responses are denoted with a cross (+). Caution should be used when evaluating rates derived from fewer than 100 respondents.

MHP Comparisons

The results of the MHPs were compared to the MDHHS Medicaid Managed Care Program average. Two types of hypothesis tests were applied to these results. First, a global F test was calculated, which determined whether the difference between MHP means was significant. If the F test demonstrated MHP-level differences (i.e., p value ≤ 0.05), then a t-test was performed for each MHP. The t-test determined whether each MHP's mean was significantly different from the MDHHS Medicaid Managed Care Program average. This analytic approach follows the Agency for Healthcare Research and Quality's (AHRQ's) recommended methodology for identifying significant plan-level performance differences.

FFS Comparisons

The results of the FFS population were compared to the MDHHS Medicaid Managed Care Program average. One type of hypothesis test was applied to these results. A F test was performed to determine whether the results of the FFS population were significantly different (i.e., p value ≤ 0.05) from the MDHHS Medicaid Managed Care Program average results.

Trend Analysis

A trend analysis was performed that compared the 2016 CAHPS scores to the corresponding 2015 CAHPS scores to determine whether there were significant differences. A *t*-test was performed to determine whether results in 2015 were significantly different from results in 2016. A difference was considered significant if the two-sided *p* value of the *t*-test was less than or equal to 0.05. The two-sided *p* value of the *t*-test is the probability of observing a test statistic as extreme as or more extreme than the one actually observed. Measures with less than 100 responses are denoted with a cross (+). Caution should be used when evaluating rates derived from fewer than 100 respondents.

Key Drivers of Satisfaction Analysis

HSAG performed an analysis of key drivers of satisfaction for the following measures: Rating of Health Plan, Rating of All Health Care, and Rating of Personal Doctor. The purpose of the key drivers of satisfaction analysis is to help decision makers identify specific aspects of care that will most benefit from quality improvement (QI) activities. The analysis provides information on: 1) how ***well*** the MDHHS Medicaid Program is performing on the survey item and 2) how ***important*** that item is to overall satisfaction.

The performance on a survey item was measured by calculating a problem score, in which a negative experience with care was defined as a problem and assigned a "1," and a positive experience with care (i.e., non-negative) was assigned a "0." The higher the problem score, the lower the member satisfaction with the aspect of service measured by that question. The problem score could range from 0 to 1.

For each item evaluated, the relationship between the item's problem score and performance on each of the three measures was calculated using a Pearson product moment correlation, which is defined as the covariance of the two scores divided by the product of their standard deviations. Items were then prioritized based on their overall problem score and their correlation to each measure. Key drivers of satisfaction were defined as those items that:

- Had a problem score that was greater than or equal to the median problem score for all items examined.
- Had a correlation that was greater than or equal to the median correlation for all items examined.

Limitations and Cautions

The findings presented in this CAHPS report are subject to some limitations in the survey design, analysis, and interpretation. MDHHS should consider these limitations when interpreting or generalizing the findings.

Case-Mix Adjustment

The demographics of a response group may impact member satisfaction. Therefore, differences in the demographics of the response group may impact CAHPS results. NCQA does not recommend case-mix adjusting CAHPS results to account for these differences; therefore, no case-mix adjusting was performed on these CAHPS results.[2-9]

Non-Response Bias

The experiences of the survey respondent population may be different than that of non-respondents with respect to their health care services and may vary by plan or program. Therefore, MDHHS should consider the potential for non-response bias when interpreting CAHPS results.

Causal Inferences

Although this report examines whether respondents report differences in satisfaction with various aspects of their health care experiences, these differences may not be completely attributable to an MHP or the FFS program. These analyses identify whether respondents give different ratings of satisfaction with their MHP or the FFS program. The survey by itself does not necessarily reveal the exact cause of these differences.

Missing Phone Numbers

The volume of missing telephone numbers may impact the response rates and the validity of the survey results. For instance, a certain segment of the population may be more likely to have missing phone information than other segments.

[2-9] Agency for Healthcare Research and Quality. *CAHPS Health Plan Survey and Reporting Kit 2008*. Rockville, MD: US Department of Health and Human Services; 2008.

Mode Effects

The CAHPS survey was administered via standard or enhanced mixed-mode (FFS and all MHPs except Aetna Better Health of Michigan, McLaren Health Plan, Total Health Care, Inc., and Upper Peninsula Health Plan) and mixed-mode with Internet enhancement (Aetna Better Health of Michigan, McLaren Health Plan, Total Health Care, Inc., and Upper Peninsula Health Plan) methodologies. The mode in which a survey is administered may have an impact on respondents' assessments of their health care experiences. Therefore, mode effects should be considered when interpreting the CAHPS results.

Survey Vendor Effects

The CAHPS survey was administered by multiple survey vendors. NCQA developed its Survey Vendor Certification Program to ensure standardization of data collection and the comparability of results across health plans. However, due to the different processes employed by the survey vendors, there is still the small potential for vendor effects. Therefore, survey vendor effects should be considered when interpreting the CAHPS results.

Priority Health Choice, Inc. Survey Results

Priority Health Choice, Inc.'s 2016 CAHPS results were calculated using adult Medicaid and Healthy Michigan Plan data.[2-10] Caution should be taken when interpreting and comparing Priority Health Choice, Inc.'s 2016 CAHPS results to other MHPs and previous year's CAHPS results.

[2-10] The 2016 CAHPS results for Priority Health Choice, Inc. are based on the data file submitted in June 2016, which combined adult Medicaid and Healthy Michigan Plan data, instead of adult Medicaid data only.

Who Responded to the Survey

A total of 22,694 surveys were distributed to adult members. A total of 6,699 surveys were completed. The CAHPS Survey response rate is the total number of completed surveys divided by all eligible members of the sample. A survey was considered complete if members answered at least three of the following five questions on the survey: 3, 15, 24, 28, and 35. Eligible members included the entire sample minus ineligible members. Ineligible members met at least one of the following criteria: they were deceased, were invalid (did not meet the eligible criteria), were mentally or physically incapacitated, were removed from the sample during deduplication, or had a language barrier.

Table 3-1 shows the total number of members sampled, the number of surveys completed, the number of ineligible members, and the response rates.

Table 3-1: Total Number of Respondents and Response Rates

Plan Name	Sample Size	Completes	Ineligibles	Response Rates
MDHHS Medicaid Program	**22,694**	**6,699**	**812**	**30.61%**
Fee-for-Service	1,350	444	113	35.89%
MDHHS Medicaid Managed Care Program	**21,344**	**6,255**	**699**	**30.30%**
Aetna Better Health of Michigan	1,499	301	26	20.43%
Blue Cross Complete of Michigan	1,830	513	36	28.60%
HAP Midwest Health Plan	1,355	436	118	35.25%
Harbor Health Plan	1,426	365	82	27.16%
McLaren Health Plan	1,350	417	43	31.91%
Meridian Health Plan of Michigan	1,893	641	51	34.80%
Molina Healthcare of Michigan	2,768	803	102	30.12%
Priority Health Choice, Inc.	3,200	1,007	71	32.18%
Total Health Care, Inc.	2,160	491	48	23.25%
UnitedHealthcare Community Plan	1,703	491	80	30.25%
Upper Peninsula Health Plan	2,160	790	42	37.30%

Demographics of Adult Members

Table 3-2 depicts the ages of members who completed a CAHPS survey.

Table 3-2: Adult Member Demographics—Age						
Plan Name	**18 to 24**	**25 to 34**	**35 to 44**	**45 to 54**	**55 to 64**	**65 and older**
MDHHS Medicaid Program	**10.0%**	**15.6%**	**16.0%**	**23.1%**	**27.9%**	**7.4%**
Fee-for-Service	5.9%	8.0%	9.8%	13.9%	20.8%	41.6%
MDHHS Medicaid Managed Care Program	**10.3%**	**16.1%**	**16.5%**	**23.8%**	**28.4%**	**4.9%**
Aetna Better Health of Michigan	9.5%	16.3%	21.4%	23.1%	26.4%	3.4%
Blue Cross Complete of Michigan	11.6%	15.5%	15.3%	27.1%	29.0%	1.6%
HAP Midwest Health Plan	1.4%	4.6%	9.3%	18.8%	21.8%	44.1%
Harbor Health Plan	3.7%	12.1%	16.7%	28.8%	37.8%	0.9%
McLaren Health Plan	9.9%	14.1%	24.0%	22.5%	25.7%	3.7%
Meridian Health Plan of Michigan	14.2%	19.2%	18.1%	21.9%	22.5%	4.1%
Molina Healthcare of Michigan	13.3%	16.9%	15.0%	24.7%	28.9%	1.3%
Priority Health Choice, Inc.	10.8%	20.3%	14.6%	23.3%	30.0%	1.0%
Total Health Care, Inc.	7.6%	15.0%	18.9%	24.8%	30.7%	3.0%
UnitedHealthcare Community Plan	14.0%	16.7%	17.6%	24.4%	25.6%	1.7%
Upper Peninsula Health Plan	10.2%	17.2%	15.9%	23.5%	32.1%	1.0%
Please note, percentages may not total 100% due to rounding.						

Table 3-3 depicts the gender of members who completed a CAHPS survey.

Table 3-3: Adult Member Demographics—Gender		
Plan Name	**Male**	**Female**
MDHHS Medicaid Program	**42.0%**	**58.0%**
Fee-for-Service	39.0%	61.0%
MDHHS Medicaid Managed Care Program	**42.2%**	**57.8%**
Aetna Better Health of Michigan	40.5%	59.5%
Blue Cross Complete of Michigan	46.7%	53.3%
HAP Midwest Health Plan	39.8%	60.2%
Harbor Health Plan	59.1%	40.9%
McLaren Health Plan	41.6%	58.4%
Meridian Health Plan of Michigan	37.8%	62.2%
Molina Healthcare of Michigan	42.3%	57.7%
Priority Health Choice, Inc.	37.7%	62.3%
Total Health Care, Inc.	42.8%	57.2%
UnitedHealthcare Community Plan	42.1%	57.9%
Upper Peninsula Health Plan	42.8%	57.2%
Please note, percentages may not total 100% due to rounding.		

Table 3-4 depicts the race and ethnicity of members who completed a CAHPS survey.

Table 3-4: Adult Member Demographics—Race/Ethnicity						
Plan Name	**White**	**Hispanic**	**Black**	**Asian**	**Other**	**Multi-Racial**
MDHHS Medicaid Program	**56.5%**	**3.9%**	**28.0%**	**1.7%**	**2.6%**	**7.4%**
Fee-for-Service	67.8%	4.6%	17.8%	2.1%	3.0%	4.6%
MDHHS Medicaid Managed Care Program	**55.6%**	**3.9%**	**28.7%**	**1.6%**	**2.6%**	**7.6%**
Aetna Better Health of Michigan	17.8%	2.8%	70.0%	0.7%	2.1%	6.6%
Blue Cross Complete of Michigan	38.2%	5.3%	45.3%	2.8%	2.4%	5.9%
HAP Midwest Health Plan	39.8%	2.6%	42.9%	3.3%	4.0%	7.5%
Harbor Health Plan	12.6%	1.5%	75.7%	1.5%	1.5%	7.2%
McLaren Health Plan	74.6%	2.5%	10.8%	1.3%	1.5%	9.3%
Meridian Health Plan of Michigan	68.3%	3.3%	18.1%	0.3%	2.7%	7.3%
Molina Healthcare of Michigan	51.0%	4.3%	29.9%	1.7%	3.0%	10.1%
Priority Health Choice, Inc.	72.4%	7.1%	9.5%	2.4%	1.1%	7.6%
Total Health Care, Inc.	34.3%	3.1%	50.0%	1.3%	3.1%	8.3%
UnitedHealthcare Community Plan	49.6%	3.5%	31.6%	2.3%	6.2%	6.8%
Upper Peninsula Health Plan	88.2%	2.3%	0.6%	0.5%	1.9%	6.3%
Please note, percentages may not total 100% due to rounding.						

Table 3-5 depicts the general health status of members who completed a CAHPS survey.

Table 3-5: Adult Member Demographics—General Health Status					
Plan Name	**Excellent**	**Very Good**	**Good**	**Fair**	**Poor**
MDHHS Medicaid Program	**9.3%**	**20.2%**	**34.7%**	**26.5%**	**9.3%**
Fee-for-Service	5.5%	12.6%	32.2%	32.4%	17.4%
MDHHS Medicaid Managed Care Program	**9.6%**	**20.8%**	**34.9%**	**26.0%**	**8.7%**
Aetna Better Health of Michigan	8.1%	21.4%	28.8%	29.5%	12.2%
Blue Cross Complete of Michigan	12.0%	23.4%	34.1%	23.2%	7.3%
HAP Midwest Health Plan	4.7%	11.0%	34.9%	35.8%	13.6%
Harbor Health Plan	8.1%	18.8%	32.9%	30.6%	9.5%
McLaren Health Plan	8.3%	21.6%	37.0%	25.5%	7.6%
Meridian Health Plan of Michigan	11.4%	22.4%	36.0%	23.9%	6.3%
Molina Healthcare of Michigan	9.6%	18.5%	33.0%	29.5%	9.4%
Priority Health Choice, Inc.	10.6%	23.8%	35.6%	23.0%	6.9%
Total Health Care, Inc.	7.4%	17.2%	35.7%	28.9%	10.8%
UnitedHealthcare Community Plan	12.3%	20.8%	32.6%	24.1%	10.2%
Upper Peninsula Health Plan	9.4%	23.8%	38.6%	21.0%	7.2%
Please note, percentages may not total 100% due to rounding.					

National Comparisons

In order to assess the overall performance of the MDHHS Medicaid Program, HSAG scored the four global ratings (Rating of Health Plan, Rating of All Health Care, Rating of Personal Doctor, and Rating of Specialist Seen Most Often) and four composite measures (Getting Needed Care, Getting Care Quickly, How Well Doctors Communicate, and Customer Service) on a three-point scale using an NCQA-approved scoring methodology. HSAG compared the plans' and programs' three-point mean scores to NCQA HEDIS Benchmarks and Thresholds for Accreditation.[3-1]

Based on this comparison, ratings of one (★) to five (★★★★★) stars were determined for each CAHPS measure, where one is the lowest possible rating (i.e., Poor) and five is the highest possible rating (i.e., Excellent), as shown in Table 3-6.

Table 3-6: Star Ratings

Stars	Percentiles
★★★★★ Excellent	At or above the 90th percentile
★★★★ Very Good	At or between the 75th and 89th percentiles
★★★ Good	At or between the 50th and 74th percentiles
★★ Fair	At or between the 25th and 49th percentiles
★ Poor	Below the 25th percentile

The results presented in the following two tables represent the three-point mean scores for each measure, while the stars represent overall member satisfaction ratings when the three-point means were compared to NCQA HEDIS Benchmarks and Thresholds for Accreditation.

[3-1] National Committee for Quality Assurance. *HEDIS® Benchmarks and Thresholds for Accreditation 2016*. Washington, DC: NCQA; January 21, 2016.

Table 3-7 shows the overall member satisfaction ratings on each of the four global ratings.

Table 3-7: National Comparisons—Global Ratings				
Plan Name	**Rating of Health Plan**	**Rating of All Health Care**	**Rating of Personal Doctor**	**Rating of Specialist Seen Most Often**
MDHHS Medicaid Program	★★★ 2.48	★★★ 2.37	★★★ 2.50	★★★ 2.52
Fee-for-Service	★★ 2.41	★★★ 2.38	★★★★ 2.54	★★★ 2.51
MDHHS Medicaid Managed Care Program	★★★ 2.48	★★★ 2.37	★★★ 2.50	★★★ 2.53
Aetna Better Health of Michigan	★ 2.32	★ 2.20	★★ 2.45	★ 2.37
Blue Cross Complete of Michigan	★★★★★ 2.58	★★★★ 2.43	★★★★ 2.56	★★ 2.49
HAP Midwest Health Plan	★★ 2.37	★★ 2.33	★★ 2.48	★★★ 2.54
Harbor Health Plan	★ 2.30	★ 2.28	★★ 2.43	★★★★ 2.56
McLaren Health Plan	★★★ 2.47	★★ 2.35	★★ 2.48	★★★ 2.51
Meridian Health Plan of Michigan	★★★★ 2.52	★★★ 2.39	★★★ 2.52	★★★★ 2.57
Molina Healthcare of Michigan	★★★ 2.46	★★★ 2.39	★★ 2.49	★★★ 2.53
Priority Health Choice, Inc.	★★★★★ 2.56	★★★ 2.38	★★★ 2.50	★★★★ 2.56
Total Health Care, Inc.	★★★★ 2.49	★★★ 2.40	★★★ 2.52	★★ 2.50
UnitedHealthcare Community Plan	★★★ 2.48	★★★ 2.38	★★ 2.48	★★★ 2.52
Upper Peninsula Health Plan	★★★★ 2.50	★★★★ 2.42	★★★★ 2.53	★★★ 2.52
+ Indicates fewer than 100 responses. Caution should be exercised when evaluating these results.				

The MDHHS Medicaid Program and the MDHHS Medicaid Managed Care Program scored at or between the 50th and 74th percentiles for all global ratings.

Table 3-8 shows the overall member satisfaction ratings on four of the composite measures.[3-2]

Table 3-8: National Comparisons—Composite Measures				
Plan Name	**Getting Needed Care**	**Getting Care Quickly**	**How Well Doctors Communicate**	**Customer Service**
MDHHS Medicaid Program	★★★ 2.40	★★★ 2.45	★★★★★ 2.64	★★★★ 2.59
Fee-for-Service	★★★★ 2.44	★★★★★ 2.51	★★★★ 2.63	★+ 2.47
MDHHS Medicaid Managed Care Program	★★★ 2.39	★★★ 2.45	★★★★★ 2.64	★★★★ 2.60
Aetna Better Health of Michigan	★ 2.28	★ 2.34	★★★★ 2.61	★★★ 2.54
Blue Cross Complete of Michigan	★★★★ 2.42	★★★★ 2.46	★★★★★ 2.67	★★★★★ 2.61
HAP Midwest Health Plan	★★ 2.35	★★★ 2.42	★★★★ 2.61	★★★★ 2.59
Harbor Health Plan	★★ 2.35	★★ 2.40	★★★★★ 2.65	★★ 2.53
McLaren Health Plan	★★★ 2.40	★★ 2.39	★★★★ 2.62	★★★ 2.54
Meridian Health Plan of Michigan	★★★ 2.40	★★★ 2.45	★★★★★ 2.68	★★★★★ 2.64
Molina Healthcare of Michigan	★★ 2.35	★★★ 2.43	★★★★ 2.59	★★★★★ 2.61
Priority Health Choice, Inc.	★★★★ 2.43	★★★ 2.45	★★★★★ 2.64	★★★★★ 2.64
Total Health Care, Inc.	★★★ 2.41	★★★★★ 2.52	★★★★★ 2.67	★★★ 2.54
UnitedHealthcare Community Plan	★★★ 2.39	★★★★ 2.48	★★★★★ 2.64	★★★★ 2.60
Upper Peninsula Health Plan	★★★★★ 2.45	★★★★ 2.48	★★★★★ 2.67	★★★★★ 2.63
+ Indicates fewer than 100 responses. Caution should be exercised when evaluating these results.				

The MDHHS Medicaid Program and the MDHHS Medicaid Managed Care Program both scored at or above the 90th percentile for the How Well Doctors Communicate composite measure, and scored at or between the 75th and 89th percentiles for the Customer Service composite measure. In addition, the MDHHS Medicaid Program and the MDHHS Medicaid Managed Care Program both scored at or between the 50th and 74th percentiles for the Getting Needed Care and Getting Care Quickly composite measures. The MDHHS Medicaid Program and MDHHS Medicaid Managed Care Program did not score below the 50th percentile for any of the composite measures.

[3-2] NCQA does not publish national benchmarks and thresholds for Shared Decision Making; therefore, this CAHPS measure was excluded from the National Comparisons analysis.

Statewide Comparisons

For purposes of the Statewide Comparisons analysis, HSAG calculated top-box rates (i.e., rates of satisfaction) for each global rating and composite measure. A "top-box" response was defined as follows:

- "9" or "10" for the global ratings.
- "Usually" or "Always" for the Getting Needed Care, Getting Care Quickly, How Well Doctors Communicate, and Customer Service composites.
- "Yes" for the Shared Decision Making composite.

HSAG also calculated overall rates for the Effectiveness of Care measures: 1) Medical Assistance with Smoking and Tobacco Use Cessation and 2) Aspirin Use and Discussion. Refer to the Reader's Guide section for more detailed information regarding the calculation of these measures.

The MDHHS Medicaid Program and MDHHS Medicaid Managed Care Program results were weighted based on the eligible population for each adult population (i.e., FFS and/or MHPs). HSAG compared the MHP results to the MDHHS Medicaid Managed Care Program average to determine if the MHP results were significantly different than the MDHHS Medicaid Managed Care Program average. Additionally, HSAG compared the FFS results to the MDHHS Medicaid Managed Care Program average to determine if the FFS results were significantly different than the MDHHS Medicaid Managed Care Program average. The NCQA adult Medicaid national averages also are presented for comparison.[3-3] Colors in the figures note significant differences. Green indicates a top-box rate that was significantly higher than the MDHHS Medicaid Managed Care Program average. Conversely, red indicates a top-box rate that was significantly lower than the MDHHS Medicaid Managed Care Program average. Blue represents top-box rates that were not significantly different from the MDHHS Medicaid Managed Care Program average. Health plan/program rates with fewer than 100 respondents are denoted with a cross (+). Caution should be used when evaluating rates derived from fewer than 100 respondents.

In some instances, the top-box rates presented for two plans were similar, but one was statistically different from the MDHHS Medicaid Managed Care Program average, and the other was not. In these instances, it was the difference in the number of respondents between the two plans that explains the different statistical results. It is more likely that a significant result will be found in a plan with a larger number of respondents.

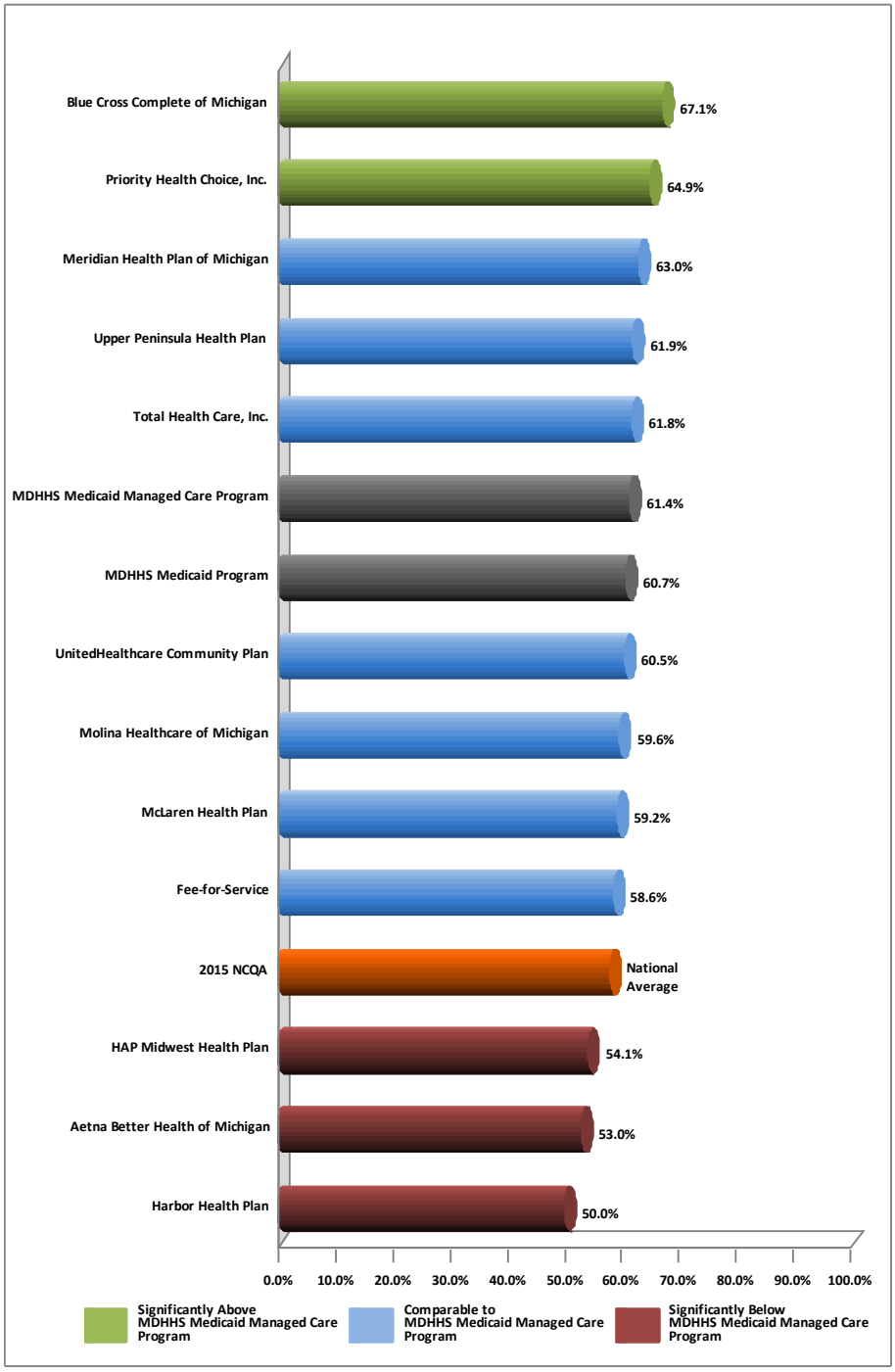
[3-3] The source for the national data contained in this publication is Quality Compass® 2015 and is used with the permission of the National Committee for Quality Assurance (NCQA). Quality Compass 2015 includes certain CAHPS data. Any data display, analysis, interpretation, or conclusion based on these data is solely that of the authors, and NCQA specifically disclaims responsibility for any such display, analysis, interpretation, or conclusion. Quality Compass is a registered trademark of NCQA. CAHPS® is a registered trademark of AHRQ.

Global Ratings

Rating of Health Plan

Adult members were asked to rate their health plan on a scale of 0 to 10, with 0 being the "worst health plan possible" and 10 being the "best health plan possible." Figure 3-1 shows the Rating of Health Plan top-box rates.

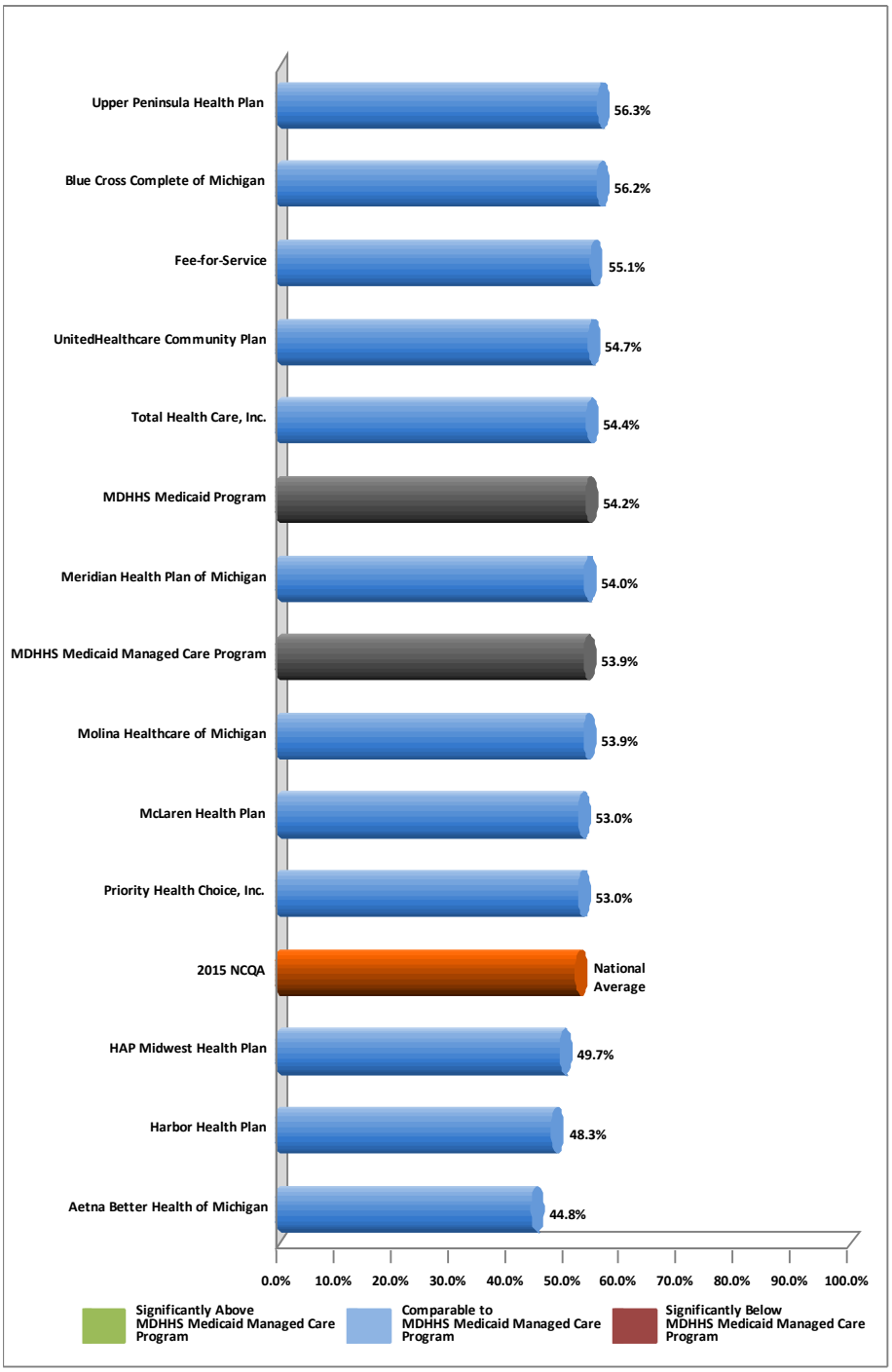
Figure 3-1: Rating of Health Plan Top-Box Rates



Rating of All Health Care

Adult members were asked to rate all their health care on a scale of 0 to 10, with 0 being the "worst health care possible" and 10 being the "best health care possible." Figure 3-2 shows the Rating of All Health Care top-box rates.

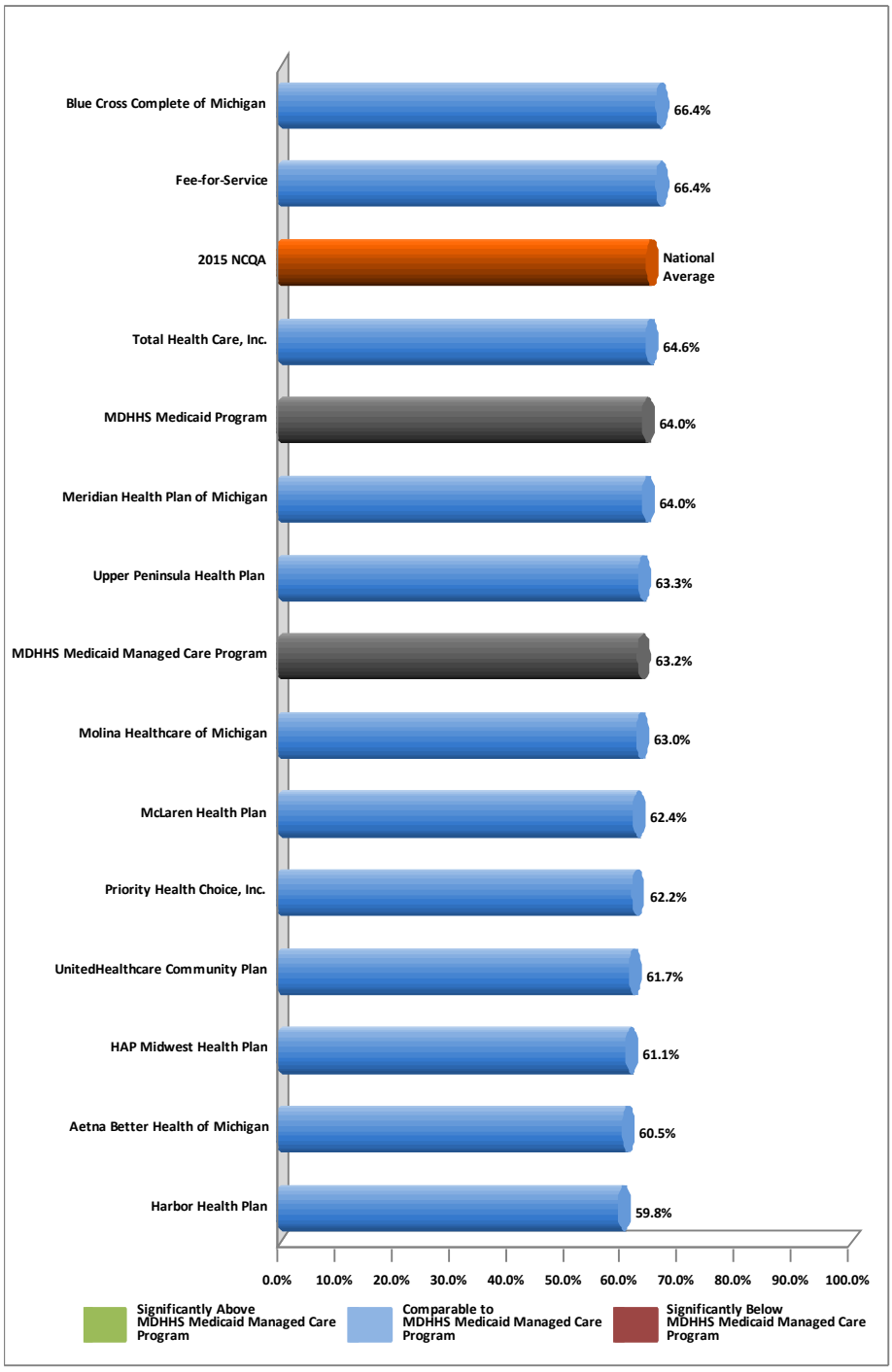
Figure 3-2: Rating of All Health Care Top-Box Rates



Rating of Personal Doctor

Adult members were asked to rate their personal doctor on a scale of 0 to 10, with 0 being the "worst personal doctor possible" and 10 being the "best personal doctor possible." Figure 3-3 shows the Rating of Personal Doctor top-box rates.

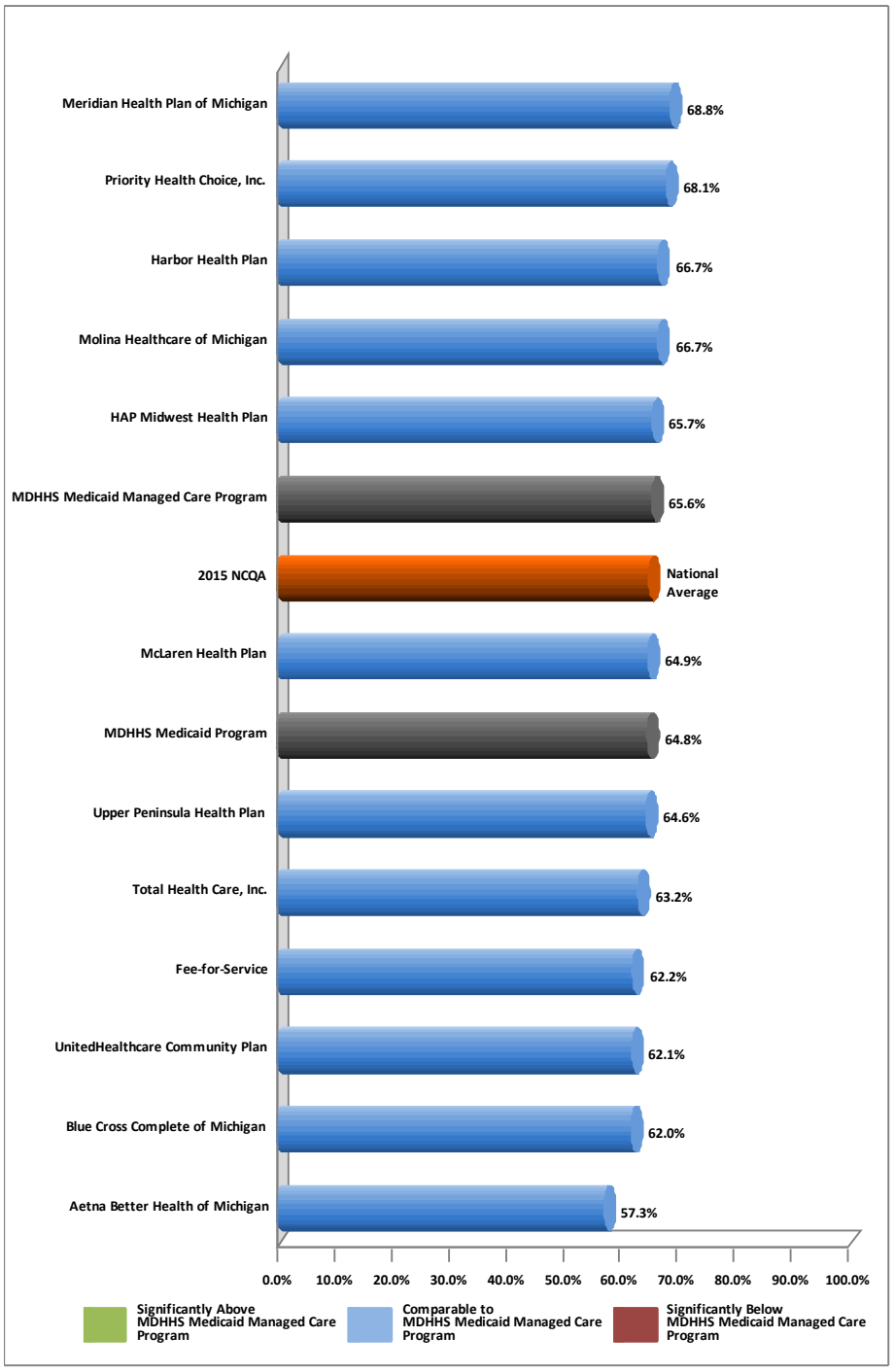
Figure 3-3: Rating of Personal Doctor Top-Box Rates



Rating of Specialist Seen Most Often

Adult members were asked to rate their specialist on a scale of 0 to 10, with 0 being the "worst specialist possible" and 10 being the "best specialist possible." Figure 3-4 shows the Rating of Specialist Seen Most Often top-box rates.

Figure 3-4: Rating of Specialist Seen Most Often Top-Box Rates



Composite Measures

Getting Needed Care

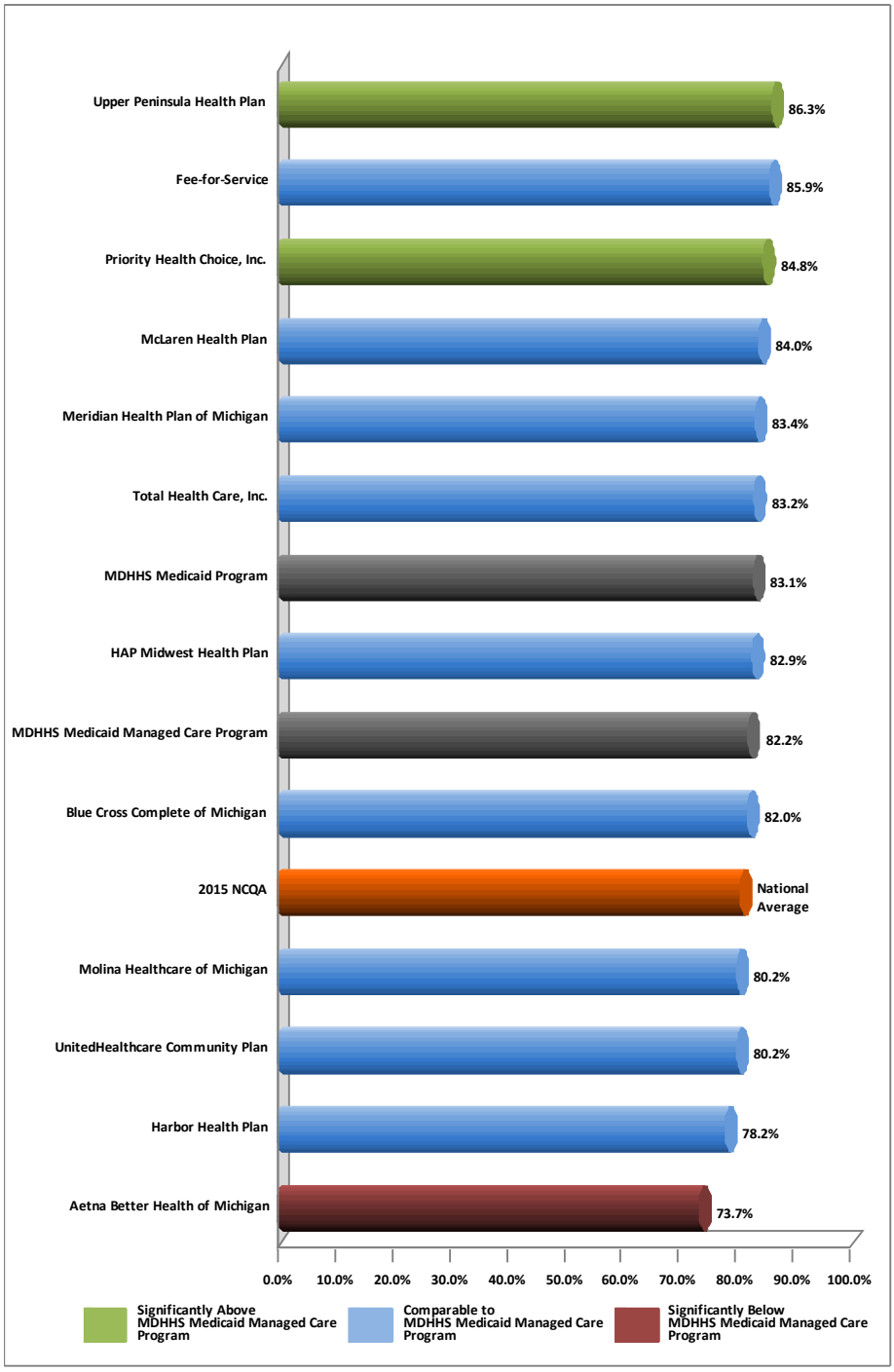
Two questions (Questions 14 and 25 in the CAHPS Adult Medicaid Health Plan Survey) were asked to assess how often it was easy to get needed care:

- **Question 14**. In the last 6 months, how often was it easy to get the care, tests, or treatment you needed?
    - Never
    - Sometimes
    - Usually
    - Always
- **Question 25.** In the last 6 months, how often did you get an appointment to see a specialist as soon as you needed?
    - Never
    - Sometimes
    - Usually
    - Always

For purposes of the Statewide Comparisons analysis, HSAG calculated top-box rates for the Getting Needed Care composite measure, which was defined as a response of "Usually" or "Always."

Figure 3-5 shows the Getting Needed Care top-box rates.

Figure 3-5: Getting Needed Care Top-Box Rates



Getting Care Quickly

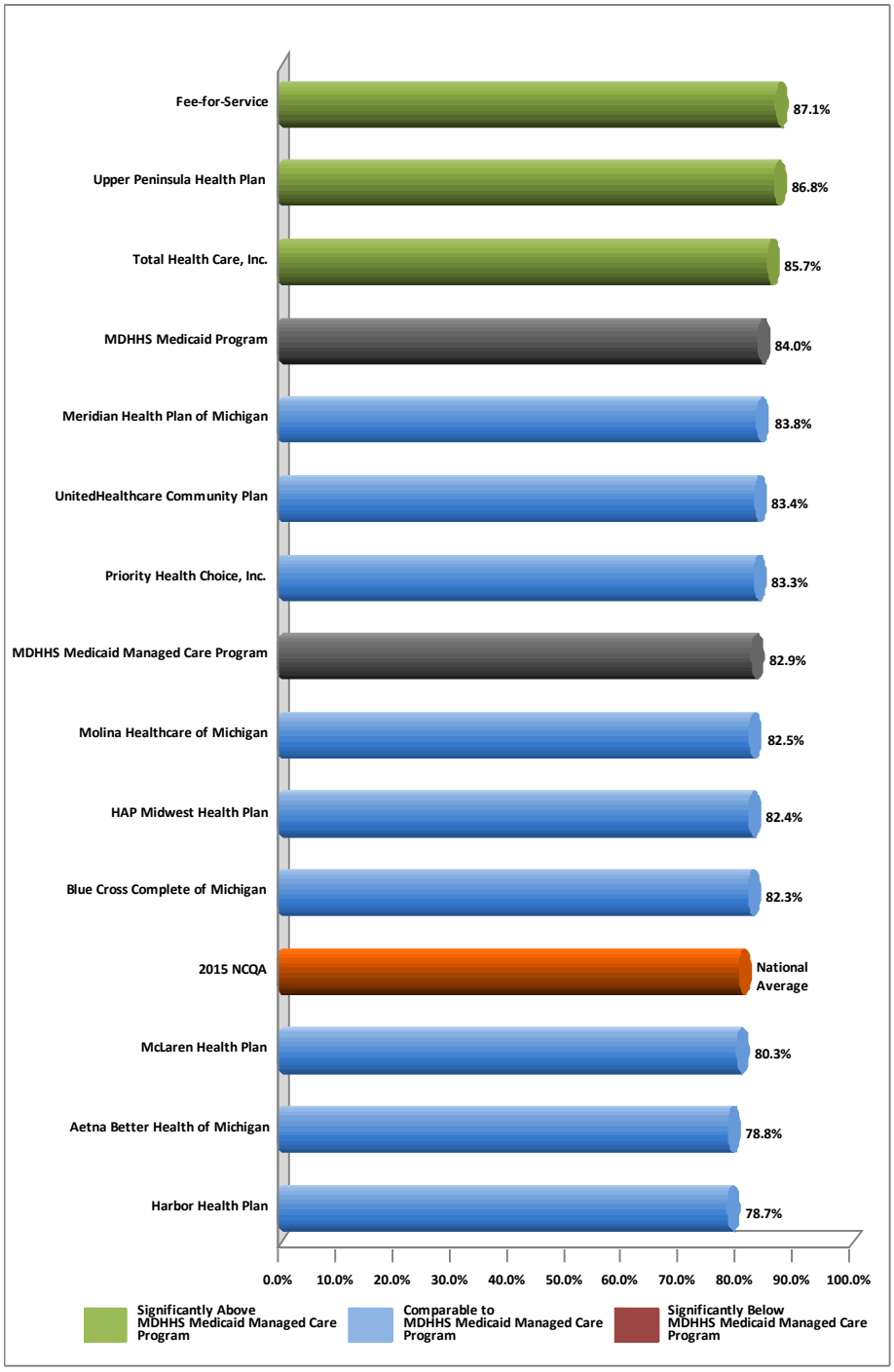
Two questions (Questions 4 and 6 in the CAHPS Adult Medicaid Health Plan Survey) were asked to assess how often adult members received care quickly:

- **Question 4**. In the last 6 months, when you needed care right away, how often did you get care as soon as you needed?
  - Never
  - Sometimes
  - Usually
  - Always
- **Question 6**. In the last 6 months, how often did you get an appointment for a check-up or routine care at a doctor's office or clinic as soon as you needed?
  - Never
  - Sometimes
  - Usually
  - Always

For purposes of the Statewide Comparisons analysis, HSAG calculated top-box rates for the Getting Care Quickly composite measure, which was defined as a response of "Usually" or "Always."

Figure 3-6 shows the Getting Care Quickly top-box rates.

Figure 3-6: Getting Care Quickly Top-Box Rates



How Well Doctors Communicate

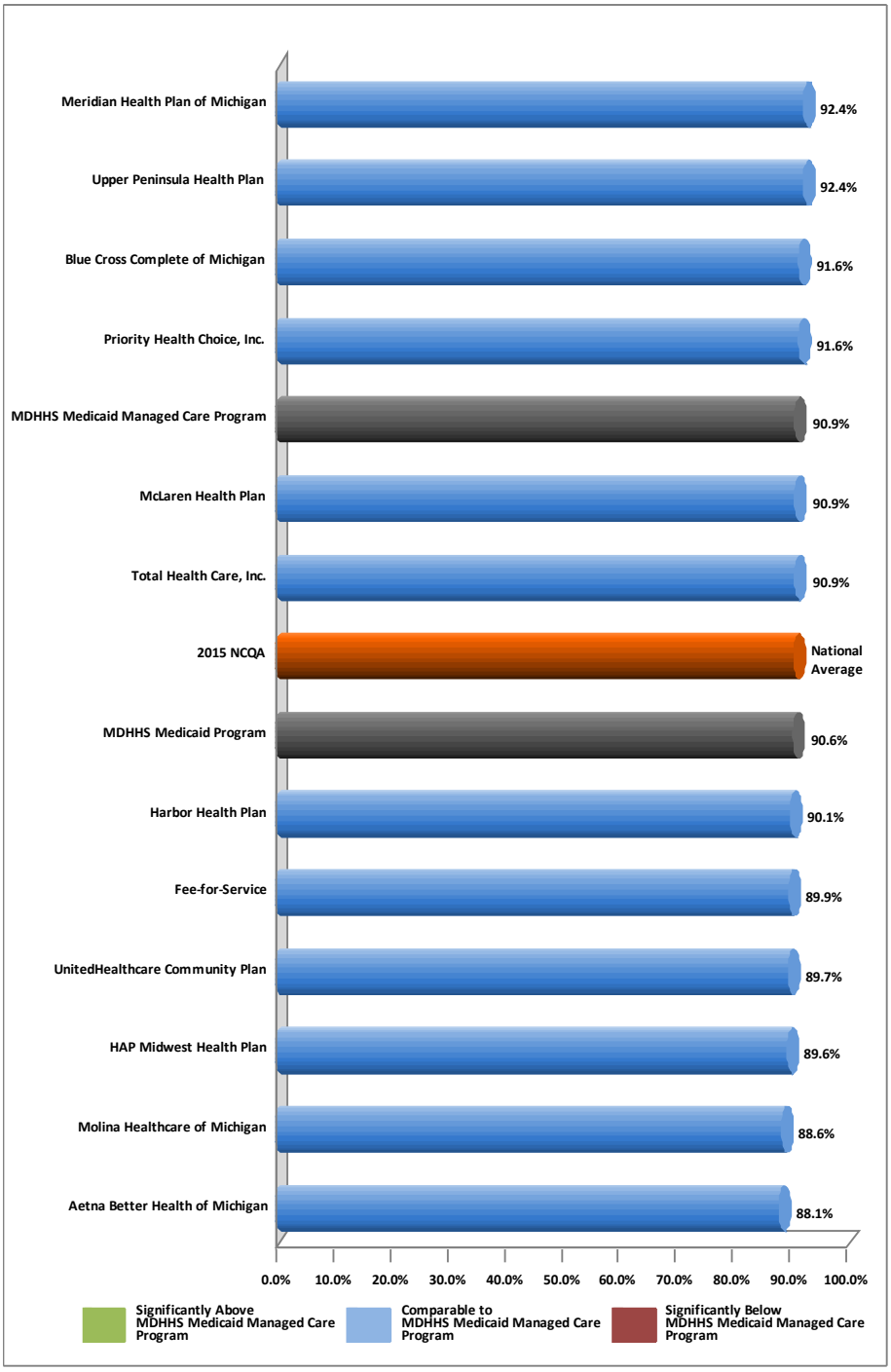
A series of four questions (Questions 17, 18, 19, and 20 in the CAHPS Adult Medicaid Health Plan Survey) was asked to assess how often doctors communicated well:

- **Question 17**. In the last 6 months, how often did your personal doctor explain things in a way that was easy to understand?
    - Never
    - Sometimes
    - Usually
    - Always
- **Question 18**. In the last 6 months, how often did your personal doctor listen carefully to you?
    - Never
    - Sometimes
    - Usually
    - Always
- **Question 19**. In the last 6 months, how often did your personal doctor show respect for what you had to say?
    - Never
    - Sometimes
    - Usually
    - Always
- **Question 20**. In the last 6 months, how often did your personal doctor spend enough time with you?
    - Never
    - Sometimes
    - Usually
    - Always

For purposes of the Statewide Comparisons analysis, HSAG calculated top-box rates for the How Well Doctors Communicate composite measure, which was defined as a response of "Usually" or "Always."

Figure 3-7 shows the How Well Doctors Communicate top-box rates.

Figure 3-7: How Well Doctors Communicate Top-Box Rates



Customer Service

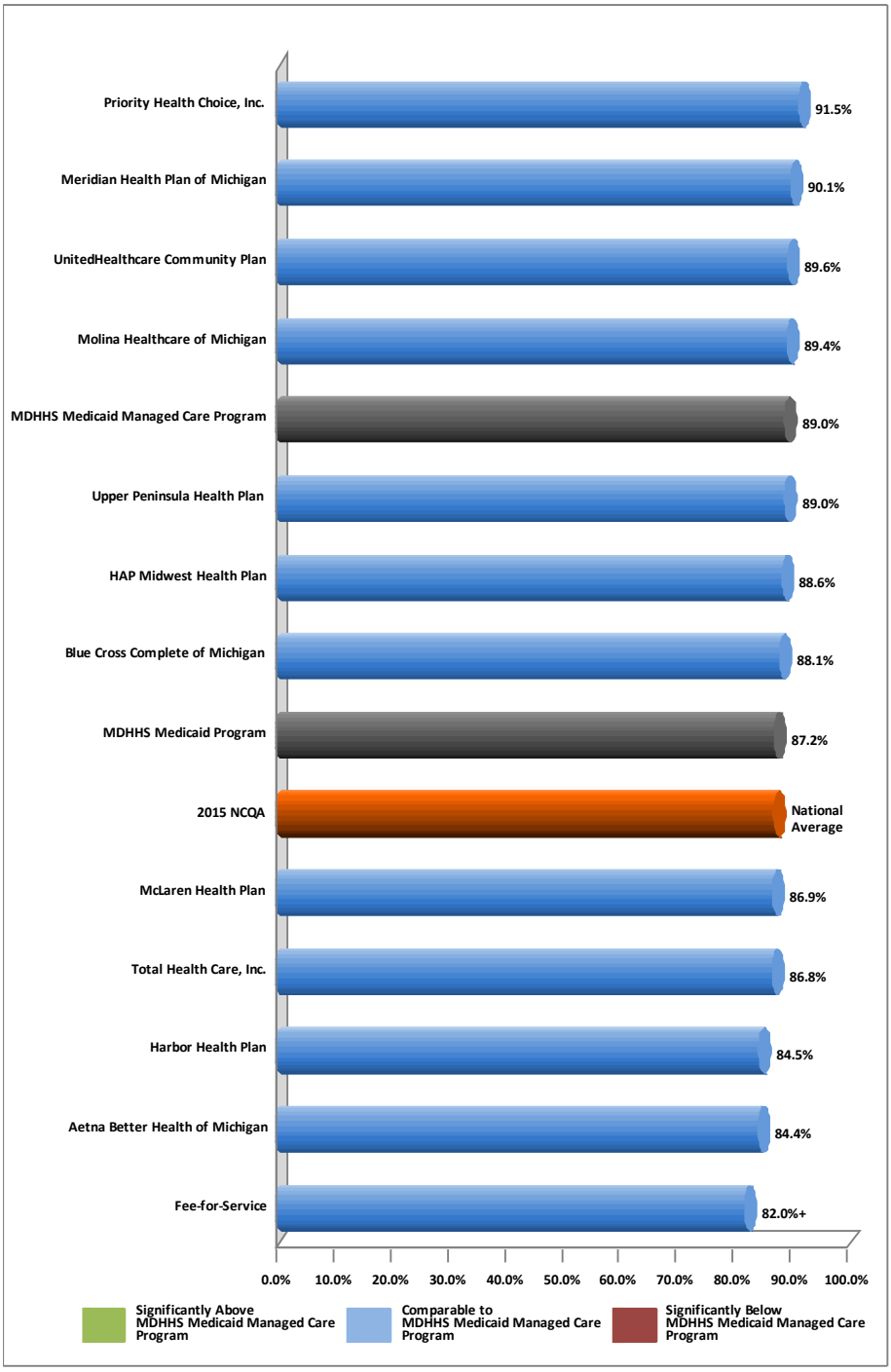
Two questions (Questions 31 and 32 in the CAHPS Adult Medicaid Health Plan Survey) were asked to assess how often adult members were satisfied with customer service:

- **Question 31**. In the last 6 months, how often did your health plan's customer service give you the information or help you needed?
    - Never
    - Sometimes
    - Usually
    - Always
- **Question 32**. In the last 6 months, how often did your health plan's customer service staff treat you with courtesy and respect?
    - Never
    - Sometimes
    - Usually
    - Always

For purposes of the Statewide Comparisons analysis, HSAG calculated top-box rates for the Customer Service composite measure, which was defined as a response of "Usually" or "Always."

Figure 3-8 shows the Customer Service top-box rates.

Figure 3-8: Customer Service Top-Box Rates



Note: + indicates fewer than 100 responses

Shared Decision Making

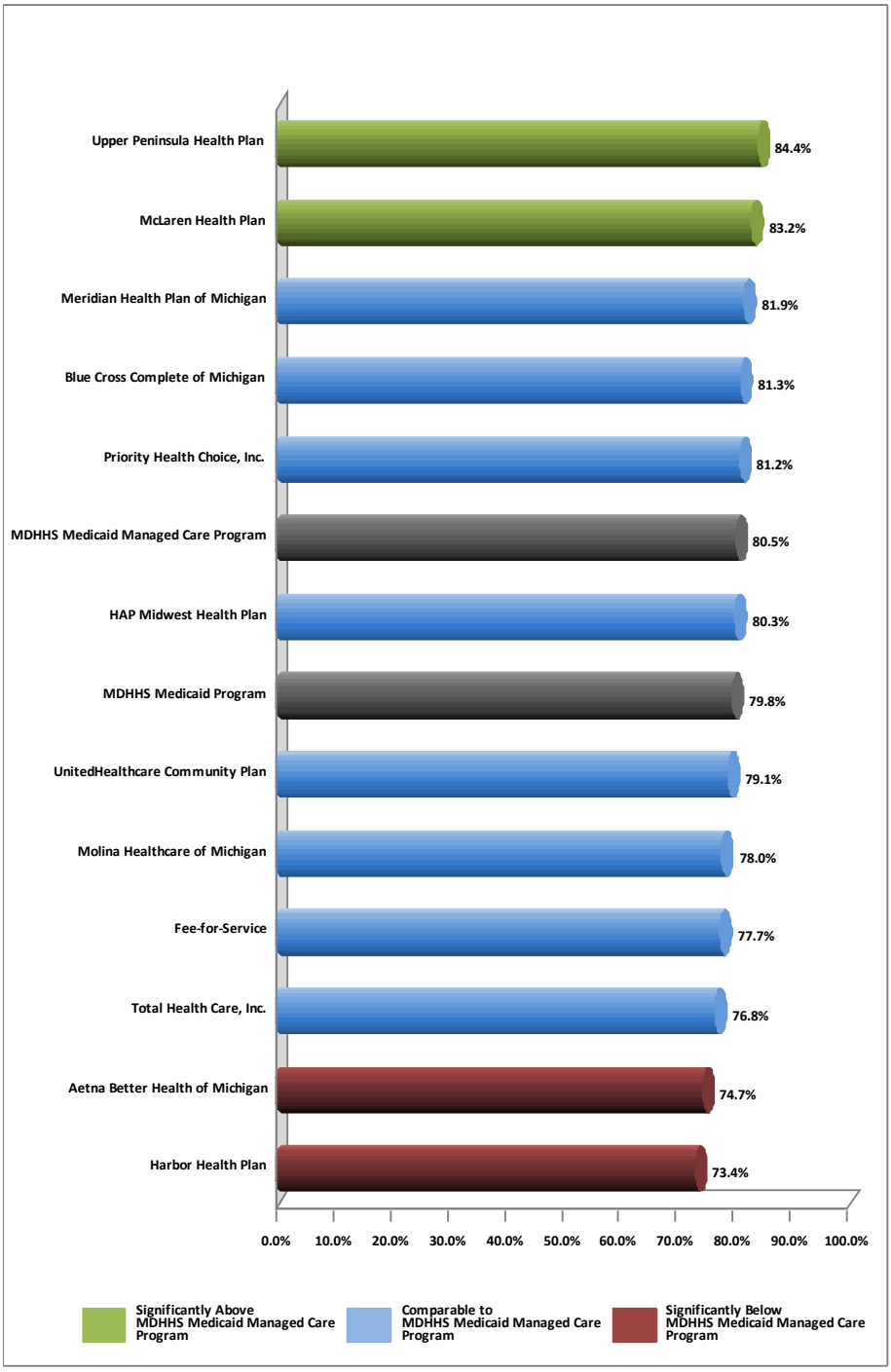
Three questions (Questions 10, 11, and 12 in the CAHPS Adult Medicaid Health Plan Survey) were asked regarding the involvement of adult members in decision making when starting or stopping a prescription medicine:

- **Question 10**. Did you and a doctor or other health provider talk about the reasons you might want to take a medicine?
  - Yes
  - No
- **Question 11**. Did you and a doctor or other health provider talk about the reasons you might not want to take a medicine?
  - Yes
  - No
- **Question 12**. When you talked about starting or stopping a prescription medicine, did a doctor or other health provider ask you what you thought was best for you?
  - Yes
  - No

For purposes of the Statewide Comparisons analysis, HSAG calculated top-box rates for the Shared Decision Making composite measure, which was defined as a response of "Yes."

Figure 3-9 shows the Shared Decision Making top-box rates.

Figure 3-9: Shared Decision Making Top-Box Rates



Note: + indicates fewer than 100 responses

Effectiveness of Care Measures

Medical Assistance with Smoking and Tobacco Use Cessation

Advising Smokers and Tobacco Users to Quit

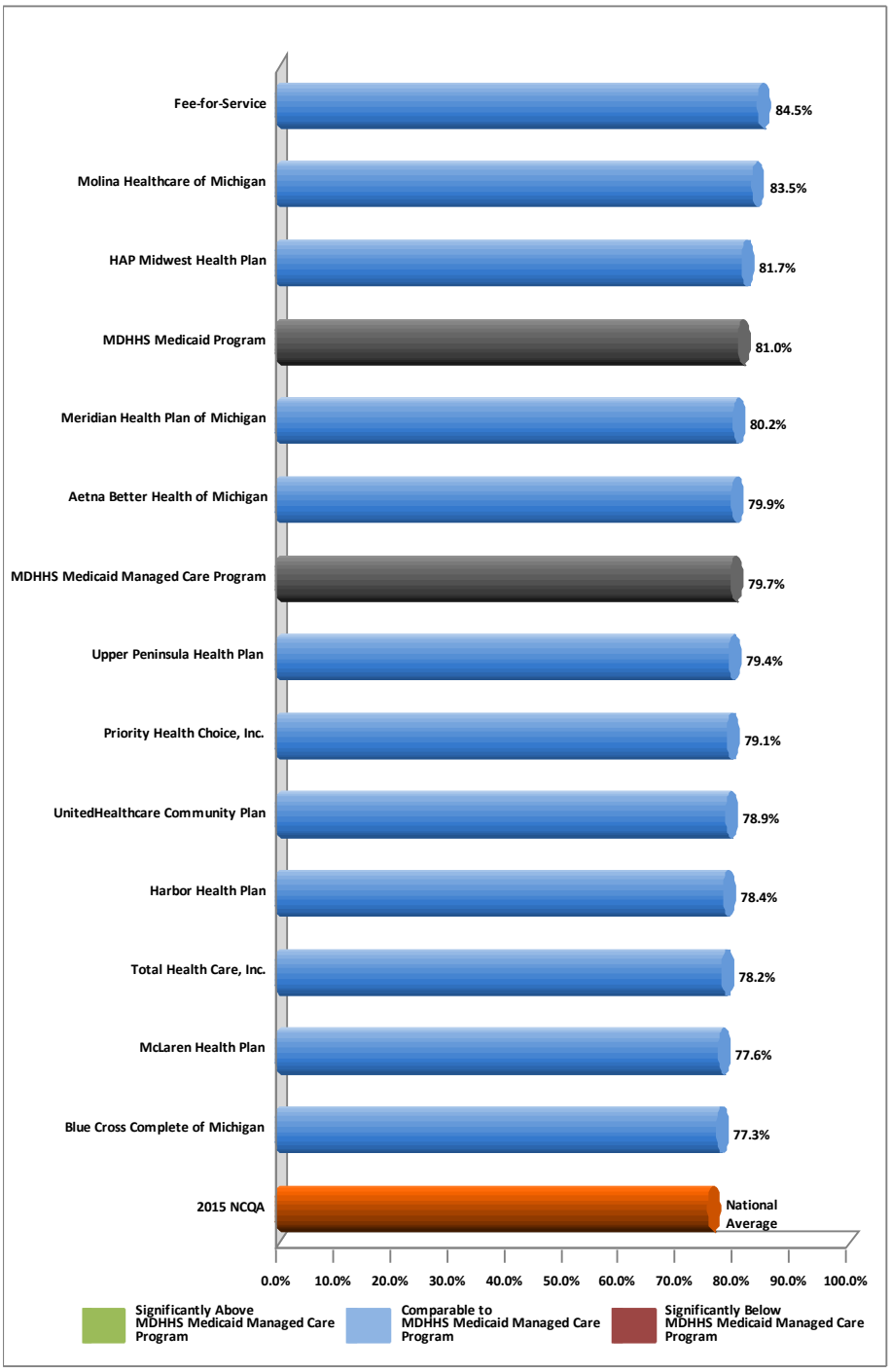
Adult members were asked how often they were advised to quit smoking or using tobacco by a doctor or other health provider (Question 40 in the CAHPS Adult Medicaid Health Plan Survey):

- **Question 40**. In the last 6 months, how often were you advised to quit smoking or using tobacco by a doctor or other health provider in your plan?
    - Never
    - Sometimes
    - Usually
    - Always

The results of this measure represent the percentage of smokers/tobacco users who answered "Sometimes," "Usually," or "Always" to this question. The rates presented follow NCQA's methodology of calculating a rolling average using the current and prior year's results.

Figure 3-10 shows the Advising Smokers and Tobacco Users to Quit rates.

Figure 3-10: Advising Smokers and Tobacco Users to Quit Rates



Discussing Cessation Medications

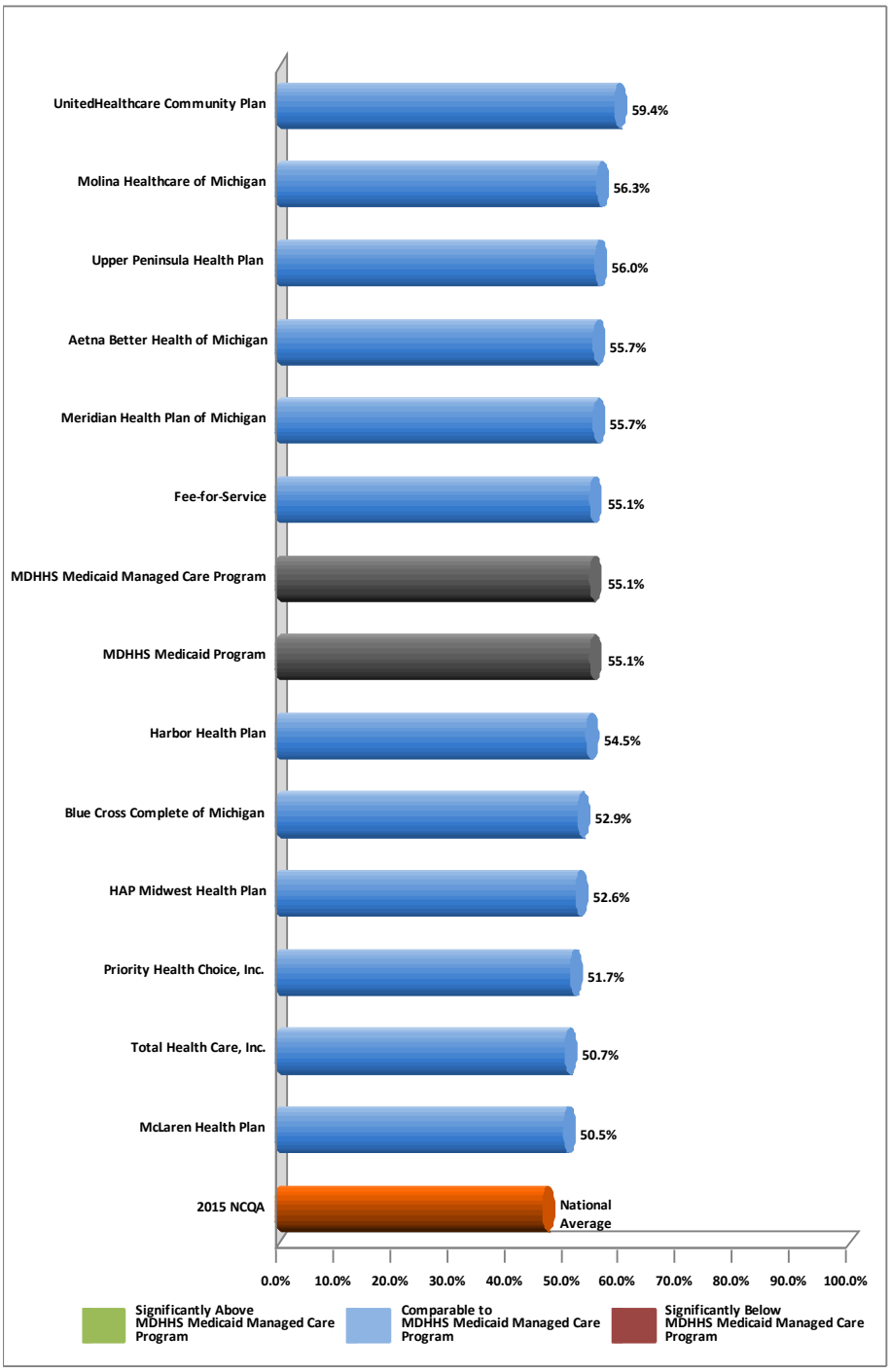
Adult members were asked how often medication was recommended or discussed by a doctor or other health provider to assist them with quitting smoking or using tobacco (Question 41 in the CAHPS Adult Medicaid Health Plan Survey):

- **Question 41**. In the last 6 months, how often was medication recommended or discussed by a doctor or health provider to assist you with quitting smoking or using tobacco? Examples of medication are: nicotine gum, patch, nasal spray, inhaler, or prescription medication.
    - Never
    - Sometimes
    - Usually
    - Always

The results of this measure represent the percentage of smokers/tobacco users who answered "Sometimes," "Usually," or "Always" to this question. The rates presented follow NCQA's methodology of calculating a rolling average using the current and prior year's results.

Figure 3-11 shows the Discussing Cessation Medications rates.

Figure 3-11: Discussing Cessation Medications Rates



Discussing Cessation Strategies

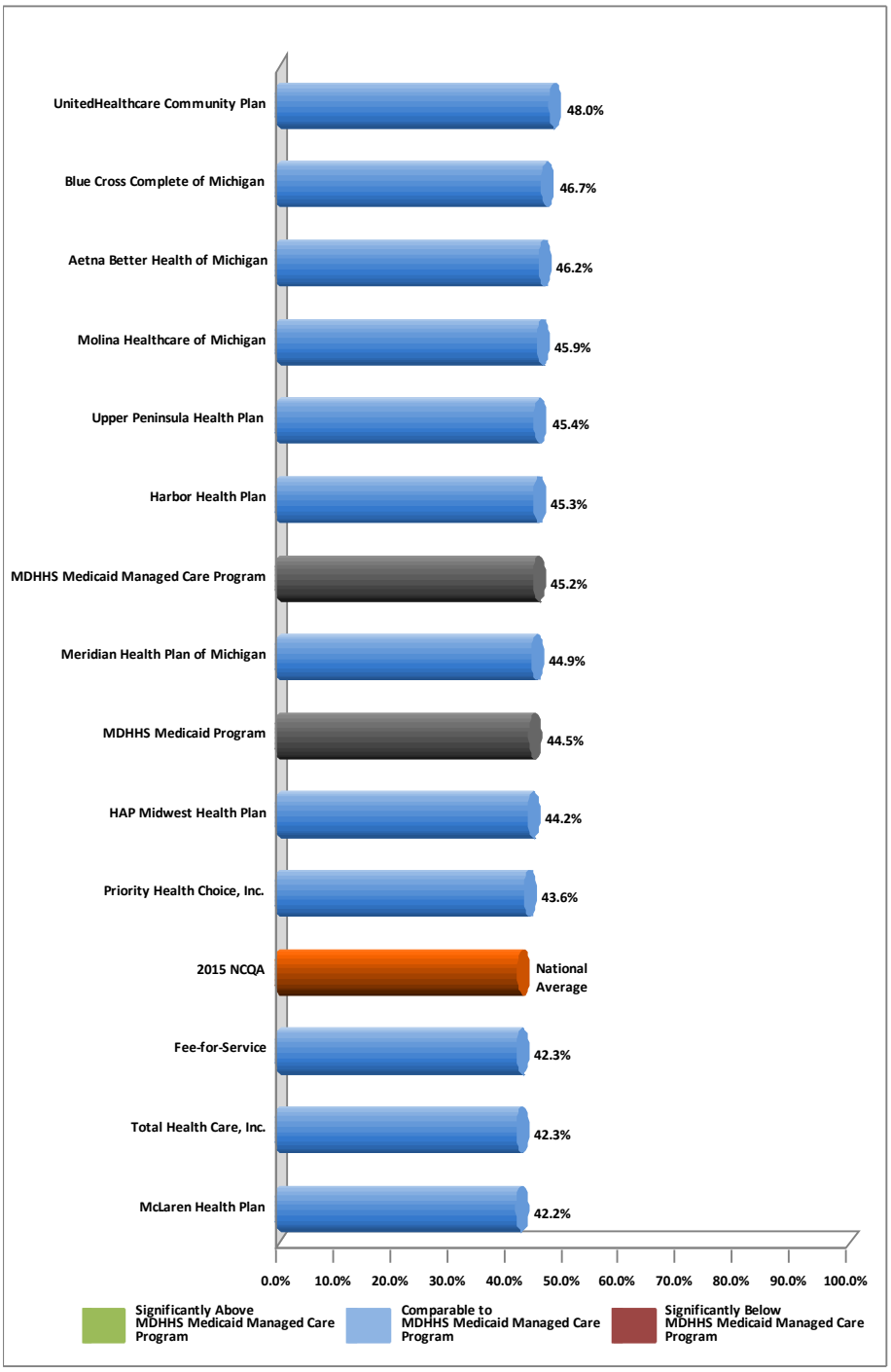
Adult members were asked how often their doctor or health provider discussed or provided methods and strategies other than medication to assist them with quitting smoking or using tobacco (Question 42 in the CAHPS Adult Medicaid Health Plan Survey):

- **Question 42**. In the last 6 months, how often did your doctor or health provider discuss or provide methods and strategies other than medication to assist you with quitting smoking or using tobacco? Examples of methods and strategies are: telephone helpline, individual or group counseling, or cessation program.
    - Never
    - Sometimes
    - Usually
    - Always

The results of this measure represent the percentage of smokers/tobacco users who answered "Sometimes," "Usually," or "Always" to this question. The rates presented follow NCQA's methodology of calculating a rolling average using the current and prior year's results.

Figure 3-12 shows the Discussing Cessation Strategies rates.

Figure 3-12: Discussing Cessation Strategies Rates



Aspirin Use and Discussion[3-4]

Aspirin Use

Adult members were asked if they currently take aspirin daily or every other day (Question 43 in the CAHPS Adult Medicaid Health Plan Survey):

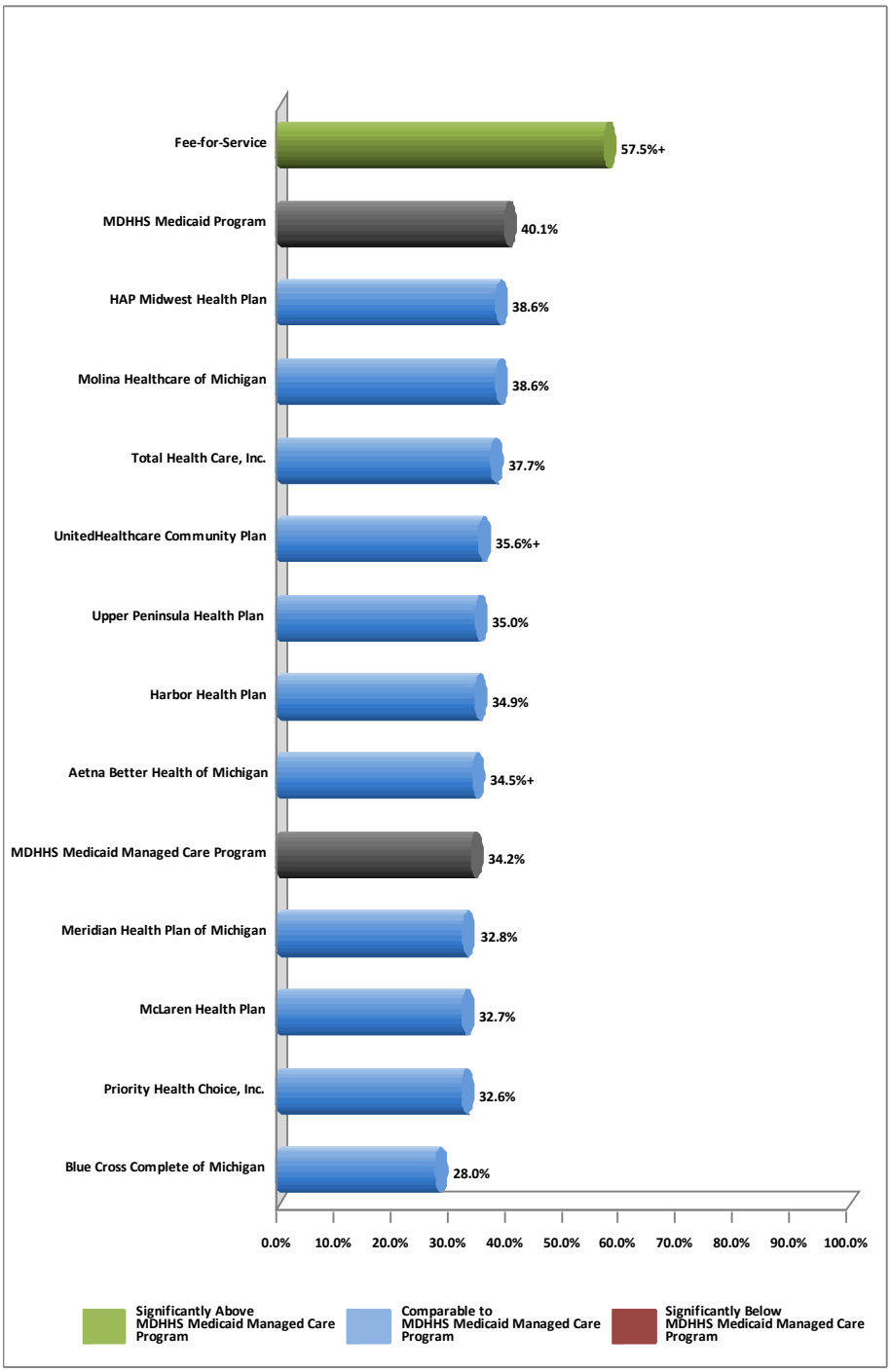
- **Question 43.** Do you take aspirin daily or every other day?
  - Yes
  - No
  - Don't know

The results of this measure represent the percentage of respondents who answered "Yes" to this question. The rates presented follow NCQA's methodology of calculating a rolling average using the current and prior year's results.

[3-4] NCQA does not publish national averages for the Aspirin Use and Discussion measures.

Figure 3-13 shows the Aspirin Use rates.

Figure 3-13: Aspirin Use Rates



Note: + indicates fewer than 100 responses

Discussing Aspirin Risks and Benefits

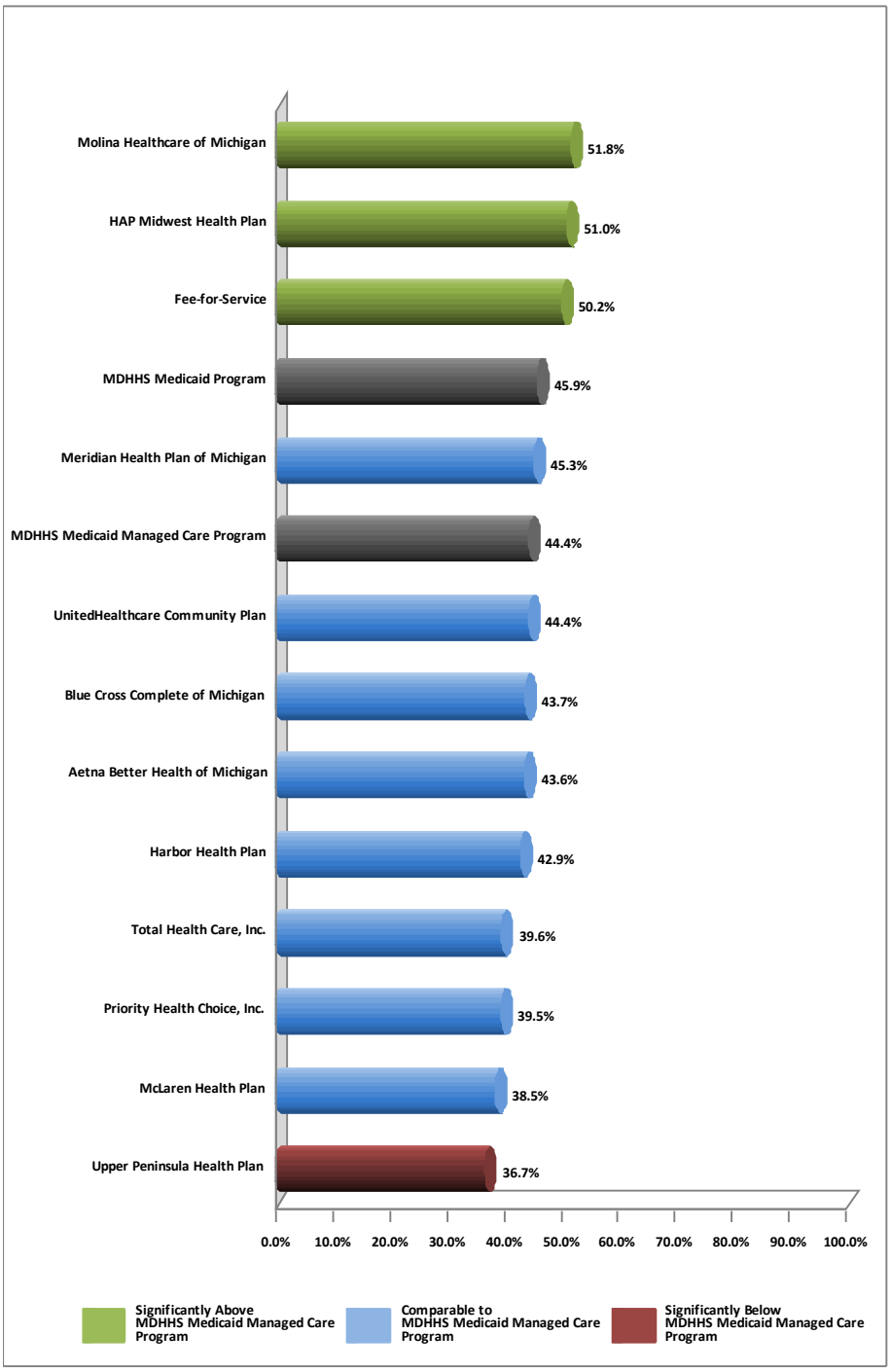
Adult members were asked if a doctor or health provider discussed with them the risks and benefits of aspirin to prevent a heart attack or stroke (Question 45 in the CAHPS Adult Medicaid Health Plan Survey):

- **Question 45**. Has a doctor or health provider ever discussed with you the risks and benefits of aspirin to prevent heart attack or stroke?
  - Yes
  - No

The results of this measure represent the percentage of respondents who answered "Yes" to this question. The rates presented follow NCQA's methodology of calculating a rolling average using the current and prior year's results.

Figure 3-14 shows the Discussing Aspirin Risks and Benefits rates.

Figure 3-14: Discussing Aspirin Risks and Benefits Rates



Summary of Results

Table 3-9 provides a summary of the Statewide Comparisons results for the global ratings.

Table 3-9: Statewide Comparisons—Global Ratings

Plan Name	Rating of Health Plan	Rating of All Health Care	Rating of Personal Doctor	Rating of Specialist Seen Most Often
Fee-for-Service	—	—	—	—
Aetna Better Health of Michigan	↓	—	—	—
Blue Cross Complete of Michigan	↑	—	—	—
HAP Midwest Health Plan	↓	—	—	—
Harbor Health Plan	↓	—	—	—
McLaren Health Plan	—	—	—	—
Meridian Health Plan of Michigan	—	—	—	—
Molina Healthcare of Michigan	—	—	—	—
Priority Health Choice, Inc.	↑	—	—	—
Total Health Care, Inc.	—	—	—	—
UnitedHealthcare Community Plan	—	—	—	—
Upper Peninsula Health Plan	—	—	—	—

\+ indicates fewer than 100 responses. Caution should be exercised when evaluating these results.
↑ indicates the plan's score is statistically significantly higher than the MDHHS Medicaid Managed Care Program average.
↓ indicates the plan's score is statistically significantly lower than the MDHHS Medicaid Managed Care Program average.
— indicates the plan's score is not statistically significantly different than the MDHHS Medicaid Managed Care Program average.

Table 3-10 provides a summary of the Statewide Comparisons for the composite measures.

Table 3-10: Statewide Comparisons—Composite Measures					
Plan Name	**Getting Needed Care**	**Getting Care Quickly**	**How Well Doctors Communicate**	**Customer Service**	**Shared Decision Making**
Fee-for-Service	—	↑	—	—+	—
Aetna Better Health of Michigan	↓	—	—	—	↓
Blue Cross Complete of Michigan	—	—	—	—	—
HAP Midwest Health Plan	—	—	—	—	—
Harbor Health Plan	—	—	—	—	↓
McLaren Health Plan	—	—	—	—	↑
Meridian Health Plan of Michigan	—	—	—	—	—
Molina Healthcare of Michigan	—	—	—	—	—
Priority Health Choice, Inc.	↑	—	—	—	—
Total Health Care, Inc.	—	↑	—	—	—
UnitedHealthcare Community Plan	—	—	—	—	—
Upper Peninsula Health Plan	↑	↑	—	—	↑

\+ indicates fewer than 100 responses. Caution should be exercised when evaluating these results.
↑ indicates the plan's score is statistically significantly higher than the MDHHS Medicaid Managed Care Program average.
↓ indicates the plan's score is statistically significantly lower than the MDHHS Medicaid Managed Care Program average.
— indicates the plan's score is not statistically significantly different than the MDHHS Medicaid Managed Care Program average.

Table 3-11 provides a summary of the Statewide Comparisons for the Effectiveness of Care measures.

Table 3-11: Statewide Comparisons—Effectiveness of Care Measures

Plan Name	Advising Smokers and Tobacco Users to Quit	Discussing Cessation Medications	Discussing Cessation Strategies	Aspirin Use	Discussing Aspirin Risks and Benefits
Fee-for-Service	—	—	—	↑+	↑
Aetna Better Health of Michigan	—	—	—	—+	—
Blue Cross Complete of Michigan	—	—	—	—	—
HAP Midwest Health Plan	—	—	—	—	↑
Harbor Health Plan	—	—	—	—	—
McLaren Health Plan	—	—	—	—	—
Meridian Health Plan of Michigan	—	—	—	—	—
Molina Healthcare of Michigan	—	—	—	—	↑
Priority Health Choice, Inc.	—	—	—	—	—
Total Health Care, Inc.	—	—	—	—	—
UnitedHealthcare Community Plan	—	—	—	—+	—
Upper Peninsula Health Plan	—	—	—	—	↓

\+ indicates fewer than 100 responses. Caution should be exercised when evaluating these results.
↑ indicates the plan's score is statistically significantly higher than the MDHHS Medicaid Managed Care Program average.
↓ indicates the plan's score is statistically significantly lower than the MDHHS Medicaid Managed Care Program average.
— indicates the plan's score is not statistically significantly different than the MDHHS Medicaid Managed Care Program average.

Trend Analysis

The completed surveys from the 2016 and 2015 CAHPS results were used to perform the trend analysis presented in this section. The 2016 CAHPS scores were compared to the 2015 CAHPS scores to determine whether there were statistically significant differences. Statistically significant differences between 2016 scores and 2015 scores are noted with triangles. Scores that were statistically significantly higher in 2016 than in 2015 are noted with upward triangles (▲). Scores that were statistically significantly lower in 2016 than in 2015 are noted with downward triangles (▼). Scores in 2016 that were not statistically significantly different from scores in 2015 are noted with a dash (–). Measures that did not meet the minimum number of 100 responses required by NCQA are denoted with a cross (+). Caution should be used when evaluating rates derived from fewer than 100 respondents.

Global Ratings

Rating of Health Plan

Adult members were asked to rate their health plan on a scale of 0 to 10, with 0 being the "worst health plan possible" and 10 being the "best health plan possible." Table 4-1 shows the 2015 and 2016 top-box responses and the trend results for Rating of Health Plan.

Table 4-1: Rating of Health Plan Trend Analysis

Plan Name	2015	2016	Trend Results
MDHHS Medicaid Program	**60.9%***	**60.7%**	**—**
Fee-for-Service	57.6%	58.6%	—
MDHHS Medicaid Managed Care Program	**61.3%****	**61.4%**	**—**
Aetna Better Health of Michigan	54.0%	53.0%	—
Blue Cross Complete of Michigan	63.0%	67.1%	—
HAP Midwest Health Plan	58.2%	54.1%	—
Harbor Health Plan	56.3%	50.0%	—
McLaren Health Plan	59.4%	59.2%	—
Meridian Health Plan of Michigan	60.7%	63.0%	—
Molina Healthcare of Michigan	61.5%	59.6%	—
Priority Health Choice, Inc.	62.4%	64.9%	—
Total Health Care, Inc.	59.4%	61.8%	—
UnitedHealthcare Community Plan	63.9%	60.5%	—
Upper Peninsula Health Plan	59.8%	61.9%	—

+ indicates fewer than 100 responses. Caution should be exercised when evaluating these results.

▲ *statistically significantly higher in 2016 than in 2015.*

▼ *statistically significantly lower in 2016 than in 2015.*

— *not statistically significantly different in 2016 than in 2015.*

**The MDHHS Medicaid Program 2015 average includes two MHPs that were not active in 2016. There is no plan specific trend analysis for these two MHPs. An adjusted 2015 rate, which excludes these plans, would be 60.6%.*

***The MDHHS Medicaid Managed Care Program 2015 average includes two MHPs that were not active in 2016. There is no plan specific trend analysis for these two MHPs. An adjusted 2015 rate, which excludes these plans, would be 60.9%.*

There were no statistically significant differences between scores in 2016 and scores in 2015 for this measure.

Rating of All Health Care

Adult members were asked to rate all their health care on a scale of 0 to 10, with 0 being the "worst health care possible" and 10 being the "best health care possible." Table 4-2 shows the 2015 and 2016 top-box responses and the trend results for Rating of All Health Care.

Table 4-2: Rating of All Health Care Trend Analysis

Plan Name	2015	2016	Trend Results
MDHHS Medicaid Program	**52.2%***	**54.2%**	**—**
Fee-for-Service	56.9%	55.1%	—
MDHHS Medicaid Managed Care Program	**51.7%****	**53.9%**	**—**
Aetna Better Health of Michigan	43.8%	44.8%	—
Blue Cross Complete of Michigan	53.7%	56.2%	—
HAP Midwest Health Plan	50.5%	49.7%	—
Harbor Health Plan	46.7%	48.3%	—
McLaren Health Plan	50.6%	53.0%	—
Meridian Health Plan of Michigan	50.3%	54.0%	—
Molina Healthcare of Michigan	55.4%	53.9%	—
Priority Health Choice, Inc.	56.1%	53.0%	—
Total Health Care, Inc.	51.4%	54.4%	—
UnitedHealthcare Community Plan	51.9%	54.7%	—
Upper Peninsula Health Plan	55.4%	56.3%	—

+ indicates fewer than 100 responses. Caution should be exercised when evaluating these results.

▲ *statistically significantly higher in 2016 than in 2015.*

▼ *statistically significantly lower in 2016 than in 2015.*

— *not statistically significantly different in 2016 than in 2015.*

**The MDHHS Medicaid Program 2015 average includes two MHPs that were not active in 2016. There is no plan specific trend analysis for these two MHPs. An adjusted 2015 rate, which excludes these plans, would be 52.3%.*

***The MDHHS Medicaid Managed Care Program 2015 average includes two MHPs that were not active in 2016. There is no plan specific trend analysis for these two MHPs. An adjusted 2015 rate, which excludes these plans, would be 51.7%.*

There were no statistically significant differences between scores in 2016 and scores in 2015 for this measure.

Rating of Personal Doctor

Adult members were asked to rate their personal doctor on a scale of 0 to 10, with 0 being the "worst personal doctor possible" and 10 being the "best personal doctor possible." Table 4-3 shows the 2015 and 2016 top-box responses and the trend results for Rating of Personal Doctor.

Table 4-3: Rating of Personal Doctor Trend Analysis

Plan Name	2015	2016	Trend Results
MDHHS Medicaid Program	**63.3%***	**64.0%**	**—**
Fee-for-Service	69.7%	66.4%	—
MDHHS Medicaid Managed Care Program	**62.6%****	**63.2%**	**—**
Aetna Better Health of Michigan	60.0%	60.5%	—
Blue Cross Complete of Michigan	63.7%	66.4%	—
HAP Midwest Health Plan	64.1%	61.1%	—
Harbor Health Plan	63.5%	59.8%	—
McLaren Health Plan	56.6%	62.4%	—
Meridian Health Plan of Michigan	62.5%	64.0%	—
Molina Healthcare of Michigan	68.1%	63.0%	—
Priority Health Choice, Inc.	68.5%	62.2%	▼
Total Health Care, Inc.	62.4%	64.6%	—
UnitedHealthcare Community Plan	62.7%	61.7%	—
Upper Peninsula Health Plan	64.7%	63.3%	—

+ indicates fewer than 100 responses. Caution should be exercised when evaluating these results.

▲ *statistically significantly higher in 2016 than in 2015.*

▼ *statistically significantly lower in 2016 than in 2015.*

— *not statistically significantly different in 2016 than in 2015.*

**The MDHHS Medicaid Program 2015 average includes two MHPs that were not active in 2016. There is no plan specific trend analysis for these two MHPs. An adjusted 2015 rate, which excludes these plans, would be 63.6%.*

***The MDHHS Medicaid Managed Care Program 2015 average includes two MHPs that were not active in 2016. There is no plan specific trend analysis for these two MHPs. An adjusted 2015 rate, which excludes these plans, would be 62.8%.*

There was one statistically significant difference between scores in 2016 and scores in 2015 for this measure.

The following scored statistically significantly *lower* in 2016 than in 2015:

- Priority Health Choice, Inc.

Rating of Specialist Seen Most Often

Adult members were asked to rate their specialist on a scale of 0 to 10, with 0 being the "worst specialist possible" and 10 being the "best specialist possible." Table 4-4 shows the 2015 and 2016 top-box responses and the trend results for Rating of Specialist Seen Most Often.

Table 4-4: Rating of Specialist Seen Most Often Trend Analysis

Plan Name	2015	2016	Trend Results
MDHHS Medicaid Program	**65.4%***	**64.8%**	**—**
Fee-for-Service	69.4%	62.2%	—
MDHHS Medicaid Managed Care Program	**64.9%****	**65.6%**	**—**
Aetna Better Health of Michigan	61.0%	57.3%	—
Blue Cross Complete of Michigan	62.1%	62.0%	—
HAP Midwest Health Plan	61.1%	65.7%	—
Harbor Health Plan	62.5%+	66.7%	—
McLaren Health Plan	62.0%	64.9%	—
Meridian Health Plan of Michigan	68.2%	68.8%	—
Molina Healthcare of Michigan	66.8%	66.7%	—
Priority Health Choice, Inc.	70.7%	68.1%	—
Total Health Care, Inc.	64.2%	63.2%	—
UnitedHealthcare Community Plan	64.9%	62.1%	—
Upper Peninsula Health Plan	65.4%	64.6%	—

+ indicates fewer than 100 responses. Caution should be exercised when evaluating these results.

▲ *statistically significantly higher in 2016 than in 2015.*

▼ *statistically significantly lower in 2016 than in 2015.*

— *not statistically significantly different in 2016 than in 2015.*

**The MDHHS Medicaid Program 2015 average includes two MHPs that were not active in 2016. There is no plan specific trend analysis for these two MHPs. An adjusted 2015 rate, which excludes these plans, would be 65.8%.*

***The MDHHS Medicaid Managed Care Program 2015 average includes two MHPs that were not active in 2016. There is no plan specific trend analysis for these two MHPs. An adjusted 2015 rate, which excludes these plans, would be 65.3%.*

There were no statistically significant differences between scores in 2016 and scores in 2015 for this measure.

Composite Measures

Getting Needed Care

Two questions (Questions 14 and 25 in the CAHPS Adult Medicaid Health Plan Survey) were asked to assess how often it was easy to get needed care. Table 4-5 shows the 2015 and 2016 top-box responses and trend results for the Getting Needed Care composite measure.

Table 4-5: Getting Needed Care Composite Trend Analysis

Plan Name	2015	2016	Trend Results
MDHHS Medicaid Program	**83.5%***	**83.1%**	**—**
Fee-for-Service	89.8%	85.9%	—
MDHHS Medicaid Managed Care Program	**82.8%****	**82.2%**	**—**
Aetna Better Health of Michigan	79.0%	73.7%	—
Blue Cross Complete of Michigan	82.9%	82.0%	—
HAP Midwest Health Plan	80.1%	82.9%	—
Harbor Health Plan	87.6%	78.2%	▼
McLaren Health Plan	84.2%	84.0%	—
Meridian Health Plan of Michigan	83.3%	83.4%	—
Molina Healthcare of Michigan	82.9%	80.2%	—
Priority Health Choice, Inc.	84.0%	84.8%	—
Total Health Care, Inc.	82.6%	83.2%	—
UnitedHealthcare Community Plan	81.4%	80.2%	—
Upper Peninsula Health Plan	86.5%	86.3%	—

+ indicates fewer than 100 responses. Caution should be exercised when evaluating these results.

▲ *statistically significantly higher in 2016 than in 2015.*

▼ *statistically significantly lower in 2016 than in 2015.*

— *not statistically significantly different in 2016 than in 2015.*

**The MDHHS Medicaid Program 2015 average includes two MHPs that were not active in 2016. There is no plan specific trend analysis for these two MHPs. An adjusted 2015 rate, which excludes these plans, would be 83.5%.*

***The MDHHS Medicaid Managed Care Program 2015 average includes two MHPs that were not active in 2016. There is no plan specific trend analysis for these two MHPs. An adjusted 2015 rate, which excludes these plans, would be 82.7%.*

There was one statistically significant difference between scores in 2016 and scores in 2015 for this measure.

The following scored statistically significantly *lower* in 2016 than in 2015:

- Harbor Health Plan

Getting Care Quickly

Two questions (Questions 4 and 6 in the CAHPS Adult Medicaid Health Plan Survey) were asked to assess how often adult members received care quickly. Table 4-6 shows the 2015 and 2016 top-box responses and trend results for the Getting Care Quickly composite measure.

Table 4-6: Getting Care Quickly Composite Trend Analysis

Plan Name	2015	2016	Trend Results
MDHHS Medicaid Program	**83.5%***	**84.0%**	**—**
Fee-for-Service	90.0%	87.1%	—
MDHHS Medicaid Managed Care Program	**82.8%****	**82.9%**	**—**
Aetna Better Health of Michigan	85.1%	78.8%	▼
Blue Cross Complete of Michigan	82.9%	82.3%	—
HAP Midwest Health Plan	81.0%	82.4%	—
Harbor Health Plan	80.1%	78.7%	—
McLaren Health Plan	79.4%	80.3%	—
Meridian Health Plan of Michigan	83.1%	83.8%	—
Molina Healthcare of Michigan	83.3%	82.5%	—
Priority Health Choice, Inc.	86.6%	83.3%	—
Total Health Care, Inc.	81.9%	85.7%	—
UnitedHealthcare Community Plan	82.5%	83.4%	—
Upper Peninsula Health Plan	85.9%	86.8%	—

+ indicates fewer than 100 responses. Caution should be exercised when evaluating these results.

▲ *statistically significantly higher in 2016 than in 2015.*

▼ *statistically significantly lower in 2016 than in 2015.*

— *not statistically significantly different in 2016 than in 2015.*

**The MDHHS Medicaid Program 2015 average includes two MHPs that were not active in 2016. There is no plan specific trend analysis for these two MHPs. An adjusted 2015 rate, which excludes these plans, would be 83.4%.*

***The MDHHS Medicaid Managed Care Program 2015 average includes two MHPs that were not active in 2016. There is no plan specific trend analysis for these two MHPs. An adjusted 2015 rate, which excludes these plans, would be 82.6%.*

There was one statistically significant difference between scores in 2016 and scores in 2015 for this measure.

The following scored statistically significantly *lower* in 2016 than in 2015:

- Aetna Better Health of Michigan

How Well Doctors Communicate

A series of four questions (Questions 17, 18, 19, and 20 in the CAHPS Adult Medicaid Health Plan Survey) was asked to assess how often doctors communicated well. Table 4-7 shows the 2015 and 2016 top-box responses and trend results for the How Well Doctors Communicate composite measure.

Table 4-7: How Well Doctors Communicate Composite Trend Analysis

Plan Name	2015	2016	Trend Results
MDHHS Medicaid Program	**90.0%***	**90.6%**	—
Fee-for-Service	95.3%	89.9%	▼
MDHHS Medicaid Managed Care Program	**89.4%****	**90.9%**	—
Aetna Better Health of Michigan	89.6%	88.1%	—
Blue Cross Complete of Michigan	91.1%	91.6%	—
HAP Midwest Health Plan	88.2%	89.6%	—
Harbor Health Plan	91.3%	90.1%	—
McLaren Health Plan	89.4%	90.9%	—
Meridian Health Plan of Michigan	89.2%	92.4%	▲
Molina Healthcare of Michigan	90.0%	88.6%	—
Priority Health Choice, Inc.	90.1%	91.6%	—
Total Health Care, Inc.	86.4%	90.9%	▲
UnitedHealthcare Community Plan	89.9%	89.7%	—
Upper Peninsula Health Plan	92.4%	92.4%	—

+ indicates fewer than 100 responses. Caution should be exercised when evaluating these results.

▲ *statistically significantly higher in 2016 than in 2015.*

▼ *statistically significantly lower in 2016 than in 2015.*

— *not statistically significantly different in 2016 than in 2015.*

**The MDHHS Medicaid Program 2015 average includes two MHPs that were not active in 2016. There is no plan specific trend analysis for these two MHPs. An adjusted 2015 rate, which excludes these plans, would be 90.2%.*

***The MDHHS Medicaid Managed Care Program 2015 average includes two MHPs that were not active in 2016. There is no plan specific trend analysis for these two MHPs. An adjusted 2015 rate, which excludes these plans, would be 89.5%.*

There were three statistically significant differences between scores in 2016 and scores in 2015 for this measure.

The following scored statistically significantly *lower* in 2016 than in 2015:

- FFS

The following scored statistically significantly *higher* in 2016 than in 2015:

- Meridian Health Plan of Michigan
- Total Health Care, Inc.

Customer Service

Two questions (Questions 31 and 32 in the CAHPS Adult Medicaid Health Plan Survey) were asked to assess how often adult members were satisfied with customer service. Table 4-8 shows the 2015 and 2016 top-box responses and trend results for the Customer Service composite measure.

Table 4-8: Customer Service Composite Trend Analysis

Plan Name	2015	2016	Trend Results
MDHHS Medicaid Program	**87.3%***	**87.2%**	—
Fee-for-Service	86.6%+	82.0%+	—
MDHHS Medicaid Managed Care Program	**87.4%****	**89.0%**	—
Aetna Better Health of Michigan	88.1%	84.4%	—
Blue Cross Complete of Michigan	90.2%	88.1%	—
HAP Midwest Health Plan	84.8%	88.6%	—
Harbor Health Plan	93.8%+	84.5%	▼
McLaren Health Plan	86.7%	86.9%	—
Meridian Health Plan of Michigan	86.9%	90.1%	—
Molina Healthcare of Michigan	88.7%	89.4%	—
Priority Health Choice, Inc.	88.9%	91.5%	—
Total Health Care, Inc.	88.0%	86.8%	—
UnitedHealthcare Community Plan	86.0%	89.6%	—
Upper Peninsula Health Plan	91.0%	89.0%	—

+ indicates fewer than 100 responses. Caution should be exercised when evaluating these results.

▲ *statistically significantly higher in 2016 than in 2015.*

▼ *statistically significantly lower in 2016 than in 2015.*

— *not statistically significantly different in 2016 than in 2015.*

**The MDHHS Medicaid Program 2015 average includes two MHPs that were not active in 2016. There is no plan specific trend analysis for these two MHPs. An adjusted 2015 rate, which excludes these plans, would be 87.3%.*

***The MDHHS Medicaid Managed Care Program 2015 average includes two MHPs that were not active in 2016. There is no plan specific trend analysis for these two MHPs. An adjusted 2015 rate, which excludes these plans, would be 87.3%.*

There was one statistically significant difference between scores in 2016 and scores in 2015 for this measure.

The following scored statistically significantly *lower* in 2016 than in 2015:

- Harbor Health Plan

Shared Decision Making

Three questions (Questions 10, 11, and 12 in the CAHPS Adult Medicaid Health Plan Survey) were asked regarding the involvement of adult members in decision making when starting or stopping a prescription medicine. Table 4-9 shows the 2015 and 2016 top-box responses and trend results for the Shared Decision composite measure.

Table 4-9: Shared Decision Making Composite Trend Analysis

Plan Name	2015	2016	Trend Results
MDHHS Medicaid Program	**79.6%***	**79.8%**	**—**
Fee-for-Service	80.2%	77.7%	—
MDHHS Medicaid Managed Care Program	**79.5%****	**80.5%**	**—**
Aetna Better Health of Michigan	74.9%	74.7%	—
Blue Cross Complete of Michigan	81.2%	81.3%	—
HAP Midwest Health Plan	80.2%	80.3%	—
Harbor Health Plan	77.1%+	73.4%	—
McLaren Health Plan	78.0%	83.2%	—
Meridian Health Plan of Michigan	80.1%	81.9%	—
Molina Healthcare of Michigan	80.2%	78.0%	—
Priority Health Choice, Inc.	79.3%	81.2%	—
Total Health Care, Inc.	73.7%	76.8%	—
UnitedHealthcare Community Plan	80.4%	79.1%	—
Upper Peninsula Health Plan	83.0%	84.4%	—

+ indicates fewer than 100 responses. Caution should be exercised when evaluating these results.

▲ *statistically significantly higher in 2016 than in 2015.*

▼ *statistically significantly lower in 2016 than in 2015.*

— *not statistically significantly different in 2016 than in 2015.*

**The MDHHS Medicaid Program 2015 average includes two MHPs that were not active in 2016. There is no plan specific trend analysis for these two MHPs. An adjusted 2015 rate, which excludes these plans, would be 79.6%.*

***The MDHHS Medicaid Managed Care Program 2015 average includes two MHPs that were not active in 2016. There is no plan specific trend analysis for these two MHPs. An adjusted 2015 rate, which excludes these plans, would be 79.5%.*

There were no statistically significant differences between scores in 2016 and scores in 2015 for this measure.

Effectiveness of Care Measures

Medical Assistance with Smoking and Tobacco Use Cessation

Advising Smokers and Tobacco Users to Quit

One question (Question 40 in the CAHPS Adult Medicaid Health Plan Survey) was asked to determine how often adult members were advised to quit smoking or using tobacco by a doctor or other health provider. Table 4-10 shows the 2015 and 2016 rates and trend results for the Advising Smokers and Tobacco Users to Quit measure.

Table 4-10: Advising Smokers and Tobacco Users to Quit Trend Analysis

Plan Name	2015	2016	Trend Results
MDHHS Medicaid Program	**80.5%***	**81.0%**	**—**
Fee-for-Service	87.4%	84.5%	—
MDHHS Medicaid Managed Care Program	**79.8%****	**79.7%**	**—**
Aetna Better Health of Michigan	81.5%	79.9%	—
Blue Cross Complete of Michigan	77.4%	77.3%	—
HAP Midwest Health Plan	81.3%	81.7%	—
Harbor Health Plan	80.8%	78.4%	—
McLaren Health Plan	75.7%	77.6%	—
Meridian Health Plan of Michigan	80.8%	80.2%	—
Molina Healthcare of Michigan	84.2%	83.5%	—
Priority Health Choice, Inc.	83.2%	79.1%	—
Total Health Care, Inc.	78.7%	78.2%	—
UnitedHealthcare Community Plan	77.2%	78.9%	—
Upper Peninsula Health Plan	80.0%	79.4%	—

+ indicates fewer than 100 responses. Caution should be exercised when evaluating these results.

▲ *statistically significantly higher in 2016 than in 2015.*

▼ *statistically significantly lower in 2016 than in 2015.*

— *not statistically significantly different in 2016 than in 2015.*

**The MDHHS Medicaid Program 2015 average includes two MHPs that were not active in 2016. There is no plan specific trend analysis for these two MHPs. An adjusted 2015 rate, which excludes these plans, would be 80.5%.*

***The MDHHS Medicaid Managed Care Program 2015 average includes two MHPs that were not active in 2016. There is no plan specific trend analysis for these two MHPs. An adjusted 2015 rate, which excludes these plans, would be 79.7%.*

There were no statistically significant differences between scores in 2016 and scores in 2015 for this measure.

Discussing Cessation Medications

One question (Question 41 in the CAHPS Adult Medicaid Health Plan Survey) was asked to ascertain how often medication was recommended or discussed by their doctor or health provider to assist adult members with quitting smoking or using tobacco. Table 4-11 shows the 2015 and 2016 rates and trend results for the Discussing Cessation Medications measure.

Table 4-11: Discussing Cessation Medications Trend Analysis

Plan Name	2015	2016	Trend Results
MDHHS Medicaid Program	**54.4%***	**55.1%**	**—**
Fee-for-Service	56.8%	55.1%	—
MDHHS Medicaid Managed Care Program	**54.1%****	**55.1%**	**—**
Aetna Better Health of Michigan	58.0%	55.7%	—
Blue Cross Complete of Michigan	53.2%	52.9%	—
HAP Midwest Health Plan	50.5%	52.6%	—
Harbor Health Plan	63.1%	54.5%	—
McLaren Health Plan	43.0%	50.5%	▲
Meridian Health Plan of Michigan	58.6%	55.7%	—
Molina Healthcare of Michigan	55.3%	56.3%	—
Priority Health Choice, Inc.	53.0%	51.7%	—
Total Health Care, Inc.	51.9%	50.7%	—
UnitedHealthcare Community Plan	55.7%	59.4%	—
Upper Peninsula Health Plan	54.9%	56.0%	—

+ indicates fewer than 100 responses. Caution should be exercised when evaluating these results.

▲ *statistically significantly higher in 2016 than in 2015.*

▼ *statistically significantly lower in 2016 than in 2015.*

— *not statistically significantly different in 2016 than in 2015.*

**The MDHHS Medicaid Program 2015 average includes two MHPs that were not active in 2016. There is no plan specific trend analysis for these two MHPs. An adjusted 2015 rate, which excludes these plans, would be 54.3%.*

***The MDHHS Medicaid Managed Care Program 2015 average includes two MHPs that were not active in 2016. There is no plan specific trend analysis for these two MHPs. An adjusted 2015 rate, which excludes these plans, would be 54.0%.*

There was one statistically significant difference between scores in 2016 and scores in 2015 for this measure.

The following scored statistically significantly *higher* in 2016 than in 2015:

- McLaren Health Plan

Discussing Cessation Strategies

One question (Question 42 in the CAHPS Adult Medicaid Health Plan Survey) was asked to ascertain how often methods or strategies other than medication were discussed or provided by their doctor or health provider to assist adult members with quitting smoking or using tobacco. Table 4-12 shows the 2015 and 2016 rates and trend results for the Discussing Cessation Strategies measure.

Table 4-12: Discussing Cessation Strategies Trend Analysis

Plan Name	2015	2016	Trend Results
MDHHS Medicaid Program	**45.5%***	**44.5%**	**—**
Fee-for-Service	43.5%	42.3%	—
MDHHS Medicaid Managed Care Program	**45.7%****	**45.2%**	**—**
Aetna Better Health of Michigan	44.8%	46.2%	—
Blue Cross Complete of Michigan	44.2%	46.7%	—
HAP Midwest Health Plan	45.8%	44.2%	—
Harbor Health Plan	49.2%	45.3%	—
McLaren Health Plan	39.9%	42.2%	—
Meridian Health Plan of Michigan	48.0%	44.9%	—
Molina Healthcare of Michigan	48.8%	45.9%	—
Priority Health Choice, Inc.	43.0%	43.6%	—
Total Health Care, Inc.	42.1%	42.3%	—
UnitedHealthcare Community Plan	43.6%	48.0%	—
Upper Peninsula Health Plan	46.8%	45.4%	—

+ indicates fewer than 100 responses. Caution should be exercised when evaluating these results.

▲ *statistically significantly higher in 2016 than in 2015.*

▼ *statistically significantly lower in 2016 than in 2015.*

— *not statistically significantly different in 2016 than in 2015.*

**The MDHHS Medicaid Program 2015 average includes two MHPs that were not active in 2016. There is no plan specific trend analysis for these two MHPs. An adjusted 2015 rate, which excludes these plans, would be 45.0%.*

***The MDHHS Medicaid Managed Care Program 2015 average includes two MHPs that were not active in 2016. There is no plan specific trend analysis for these two MHPs. An adjusted 2015 rate, which excludes these plans, would be 45.2%.*

There were no statistically significant differences between scores in 2016 and scores in 2015 for this measure.

Aspirin Use and Discussion

Aspirin Use

One question (Question 43 in the CAHPS Adult Medicaid Health Plan Survey) was asked to determine if adult members take aspirin daily or every other day. Table 4-13 shows the 2015 and 2016 rates and trend results for the Aspirin Use measure.

Table 4-13: Aspirin Use Trend Analysis

Plan Name	2015	2016	Trend Results
MDHHS Medicaid Program	**38.1%***	**40.1%**	**—**
Fee-for-Service	60.0%+	57.5%+	—
MDHHS Medicaid Managed Care Program	**35.6%****	**34.2%**	**—**
Aetna Better Health of Michigan	36.6%+	34.5%+	—
Blue Cross Complete of Michigan	29.2%	28.0%	—
HAP Midwest Health Plan	42.9%+	38.6%	—
Harbor Health Plan	32.5%+	34.9%	—
McLaren Health Plan	23.9%+	32.7%	—
Meridian Health Plan of Michigan	37.4%	32.8%	—
Molina Healthcare of Michigan	33.6%	38.6%	—
Priority Health Choice, Inc.	31.4%+	32.6%	—
Total Health Care, Inc.	41.7%	37.7%	—
UnitedHealthcare Community Plan	41.2%	35.6%+	—
Upper Peninsula Health Plan	42.9%	35.0%	—

+ indicates fewer than 100 responses. Caution should be exercised when evaluating these results.

▲ *statistically significantly higher in 2016 than in 2015.*

▼ *statistically significantly lower in 2016 than in 2015.*

— *not statistically significantly different in 2016 than in 2015.*

**The MDHHS Medicaid Program 2015 average includes two MHPs that were not active in 2016. There is no plan specific trend analysis for these two MHPs. An adjusted 2015 rate, which excludes these plans, would be 38.3%.*

***The MDHHS Medicaid Managed Care Program 2015 average includes two MHPs that were not active in 2016. There is no plan specific trend analysis for these two MHPs. An adjusted 2015 rate, which excludes these plans, would be 35.7%.*

There were no statistically significant differences between scores in 2016 and scores in 2015 for this measure.

Discussing Aspirin Risks and Benefits

One question (Question 45 in the CAHPS Adult Medicaid Health Plan Survey) was asked to determine if a doctor or health provider discussed with adult members the risks and benefits of aspirin to prevent a heart attack or stroke. Table 4-14 shows the 2015 and 2016 rates and trend results for the Discussing Aspirin Risks and Benefits measure.

Table 4-14: Discussing Aspirin Risks and Benefits Trend Analysis

Plan Name	2015	2016	Trend Results
MDHHS Medicaid Program	**48.0%***	**45.9%**	**—**
Fee-for-Service	51.4%	50.2%	—
MDHHS Medicaid Managed Care Program	**47.6%****	**44.4%**	**—**
Aetna Better Health of Michigan	46.8%	43.6%	—
Blue Cross Complete of Michigan	47.2%	43.7%	—
HAP Midwest Health Plan	55.4%	51.0%	—
Harbor Health Plan	41.7%+	42.9%	—
McLaren Health Plan	38.8%	38.5%	—
Meridian Health Plan of Michigan	47.9%	45.3%	—
Molina Healthcare of Michigan	50.8%	51.8%	—
Priority Health Choice, Inc.	43.9%	39.5%	—
Total Health Care, Inc.	44.6%	39.6%	—
UnitedHealthcare Community Plan	52.4%	44.4%	—
Upper Peninsula Health Plan	44.5%	36.7%	▼

+ indicates fewer than 100 responses. Caution should be exercised when evaluating these results.

▲ *statistically significantly higher in 2016 than in 2015.*

▼ *statistically significantly lower in 2016 than in 2015.*

— *not statistically significantly different in 2016 than in 2015.*

**The MDHHS Medicaid Program 2015 average includes two MHPs that were not active in 2016. There is no plan specific trend analysis for these two MHPs. An adjusted 2015 rate, which excludes these plans, would be 48.2%.*

***The MDHHS Medicaid Managed Care Program 2015 average includes two MHPs that were not active in 2016. There is no plan specific trend analysis for these two MHPs. An adjusted 2015 rate, which excludes these plans, would be 47.8%.*

There was one statistically significant difference between scores in 2016 and scores in 2015 for this measure.

The following scored statistically significantly *lower* in 2016 than in 2015:

- Upper Peninsula Health Plan

Key Drivers of Satisfaction

HSAG performed an analysis of key drivers for three measures: Rating of Health Plan, Rating of All Health Care, and Rating of Personal Doctor. The analysis provides information on: 1) how well the MDHHS Medicaid Program is performing on the survey item (i.e., question), and 2) how important the item is to overall satisfaction.

Key drivers of satisfaction are defined as those items that (1) have a problem score that is greater than or equal to the program's median problem score for all items examined, and (2) have a correlation that is greater than or equal to the program's median correlation for all items examined. For additional information on the assignment of problem scores, please refer to the Reader's Guide section. Table 5-1 depicts those items identified for each of the three measures as being key drivers of satisfaction for the MDHHS Medicaid Program.

Table 5-1: MDHHS Medicaid Program Key Drivers of Satisfaction
Rating of Health Plan
Respondents reported that their health plan's customer service did not always give them the information or help they needed.
Respondents reported that their personal doctor did not always seem informed and up-to-date about the care they received from other doctors or health providers.
Respondents reported that information in written materials or on the Internet about how the health plan works did not always provide the information they needed.
Respondents reported that forms from their health plan were often not easy to fill out.
Respondents reported that it was often not easy to obtain appointments with specialists.
Rating of All Health Care
Respondents reported that when they talked about starting or stopping a prescription medicine, a doctor or other health provider did not ask what they thought was best for them.
Respondents reported that their personal doctor did not always seem informed and up-to-date about the care they received from other doctors or health providers.
Respondents reported that it was often not easy to obtain appointments with specialists.
Rating of Personal Doctor
Respondents reported that it was not always easy to get the care, tests, or treatment they thought they needed through their health plan.
Respondents reported that their personal doctor did not always seem informed and up-to-date about the care they received from other doctors or health providers.

Survey Instrument

The survey instrument selected was the CAHPS 5.0 Adult Medicaid Survey with the HEDIS supplemental item set. This section provides a copy of the survey instrument.

Michigan Department of Health & Human Services
RICK SNYDER, GOVERNOR | NICK LYON, DIRECTOR

DataStat

Your privacy is protected. The research staff will not share your personal information with anyone without your OK. Personally identifiable information will not be made public and will only be released in accordance with federal laws and regulations.

You may choose to answer this survey or not. If you choose not to, this will not affect the benefits you get. You may notice a number on the cover of this survey. This number is ONLY used to let us know if you returned your survey so we don't have to send you reminders.

If you want to know more about this study, please call 1-888-506-5134.

SURVEY INSTRUCTIONS

- **Please be sure to fill the response circle <u>completely</u>. Use only <u>black or blue ink</u> or <u>dark pencil</u> to complete the survey.**

Correct Mark ● **Incorrect Marks** 

- **You are sometimes told to skip over some questions in the survey. When this happens you will see an arrow with a note that tells you what question to answer next, like this:**

● **Yes** ➔ ***Go to Question 1***
○ **No**

START HERE

1. **Our records show that you are now in Michigan Medicaid Fee-For-Service. Is that right?**

○ Yes ➔ ***Go to Question 3***
○ No

2. **What is the name of your health plan? (Please print)**

_____

YOUR HEALTH CARE IN THE LAST 6 MONTHS

These questions ask about your own health care. Do not include care you got when you stayed overnight in a hospital. Do not include the times you went for dental care visits.

3. In the last 6 months, did you have an illness, injury, or condition that needed care right away in a clinic, emergency room, or doctor's office?

- ○ Yes
- ○ No ➔ ***Go to Question 5***

4. In the last 6 months, when you needed care right away, how often did you get care as soon as you needed?

- ○ Never
- ○ Sometimes
- ○ Usually
- ○ Always

5. In the last 6 months, did you make any appointments for a check-up or routine care at a doctor's office or clinic?

- ○ Yes
- ○ No ➔ ***Go to Question 7***

6. In the last 6 months, how often did you get an appointment for a check-up or routine care at a doctor's office or clinic as soon as you needed?

- ○ Never
- ○ Sometimes
- ○ Usually
- ○ Always

7. In the last 6 months, not counting the times you went to an emergency room, how many times did you go to a doctor's office or clinic to get health care for yourself?

- ○ None ➔ ***Go to Question 15***
- ○ 1 time
- ○ 2
- ○ 3
- ○ 4
- ○ 5 to 9
- ○ 10 or more times

8. In the last 6 months, did you and a doctor or other health provider talk about specific things you could do to prevent illness?

- ○ Yes
- ○ No

9. In the last 6 months, did you and a doctor or other health provider talk about starting or stopping a prescription medicine?

- ○ Yes
- ○ No ➔ ***Go to Question 13***

10. Did you and a doctor or other health provider talk about the reasons you might want to take a medicine?

- ○ Yes
- ○ No

11. Did you and a doctor or other health provider talk about the reasons you might not want to take a medicine?

- ○ Yes
- ○ No

12. When you talked about starting or stopping a prescription medicine, did a doctor or other health provider ask you what you thought was best for you?

- ○ Yes
- ○ No

13. Using any number from 0 to 10, where 0 is the worst health care possible and 10 is the best health care possible, what number would you use to rate all your health care in the last 6 months?

○	○	○	○	○	○	○	○	○	○	○
0	1	2	3	4	5	6	7	8	9	10
Worst Health Care Possible										Best Health Care Possible

14. In the last 6 months, how often was it easy to get the care, tests, or treatment you needed?

- ○ Never
- ○ Sometimes
- ○ Usually
- ○ Always

YOUR PERSONAL DOCTOR

15. A personal doctor is the one you would see if you need a check-up, want advice about a health problem, or get sick or hurt. Do you have a personal doctor?

- ○ Yes
- ○ No ➔ ***Go to Question 24***

16. In the last 6 months, how many times did you visit your personal doctor to get care for yourself?

- ○ None ➔ ***Go to Question 23***
- ○ 1 time
- ○ 2
- ○ 3
- ○ 4
- ○ 5 to 9
- ○ 10 or more times

17. In the last 6 months, how often did your personal doctor explain things in a way that was easy to understand?

- ○ Never
- ○ Sometimes
- ○ Usually
- ○ Always

18. In the last 6 months, how often did your personal doctor listen carefully to you?

- ○ Never
- ○ Sometimes
- ○ Usually
- ○ Always

19. In the last 6 months, how often did your personal doctor show respect for what you had to say?

- ○ Never
- ○ Sometimes
- ○ Usually
- ○ Always

20. In the last 6 months, how often did your personal doctor spend enough time with you?

- ○ Never
- ○ Sometimes
- ○ Usually
- ○ Always

21. In the last 6 months, did you get care from a doctor or other health provider besides your personal doctor?

- ○ Yes
- ○ No ➔ ***Go to Question 23***

22. In the last 6 months, how often did your personal doctor seem informed and up-to-date about the care you got from these doctors or other health providers?

- ○ Never
- ○ Sometimes
- ○ Usually
- ○ Always

23. Using any number from 0 to 10, where 0 is the worst personal doctor possible and 10 is the best personal doctor possible, what number would you use to rate your personal doctor?

○ ○ ○ ○ ○ ○ ○ ○ ○ ○ ○
0 1 2 3 4 5 6 7 8 9 10
Worst Personal Doctor Possible — Best Personal Doctor Possible

GETTING HEALTH CARE FROM SPECIALISTS

When you answer the next questions, do <u>not</u> include dental visits or care you got when you stayed overnight in a hospital.

24. Specialists are doctors like surgeons, heart doctors, allergy doctors, skin doctors, and other doctors who specialize in one area of health care.

In the last 6 months, did you make any appointments to see a specialist?

- ○ Yes
- ○ No ➔ ***Go to Question 28***

25. In the last 6 months, how often did you get an appointment to see a specialist as soon as you needed?

- ○ Never
- ○ Sometimes
- ○ Usually
- ○ Always

26. How many specialists have you seen in the last 6 months?

- ○ None ➔ ***Go to Question 28***
- ○ 1 specialist
- ○ 2
- ○ 3
- ○ 4
- ○ 5 or more specialists

27. We want to know your rating of the specialist you saw most often in the last 6 months. Using any number from 0 to 10, where 0 is the worst specialist possible and 10 is the best specialist possible, what number would you use to rate that specialist?

○ ○ ○ ○ ○ ○ ○ ○ ○ ○ ○
0 1 2 3 4 5 6 7 8 9 10
Worst Specialist Possible — Best Specialist Possible

YOUR HEALTH PLAN

The next questions ask about your experience with your health plan.

28. In the last 6 months, did you look for any information in written materials or on the Internet about how your health plan works?

- ○ Yes
- ○ No ➔ ***Go to Question 30***

29. In the last 6 months, how often did the written materials or the Internet provide the information you needed about how your health plan works?

- ○ Never
- ○ Sometimes
- ○ Usually
- ○ Always

30. In the last 6 months, did you get information or help from your health plan's customer service?

- ○ Yes
- ○ No ➔ ***Go to Question 33***

31. In the last 6 months, how often did your health plan's customer service give you the information or help you needed?

- ○ Never
- ○ Sometimes
- ○ Usually
- ○ Always

32. In the last 6 months, how often did your health plan's customer service staff treat you with courtesy and respect?

- ○ Never
- ○ Sometimes
- ○ Usually
- ○ Always

33. In the last 6 months, did your health plan give you any forms to fill out?

- ○ Yes
- ○ No ➔ ***Go to Question 35***

34. In the last 6 months, how often were the forms from your health plan easy to fill out?

- ○ Never
- ○ Sometimes
- ○ Usually
- ○ Always

35. Using any number from 0 to 10, where 0 is the worst health plan possible and 10 is the best health plan possible, what number would you use to rate your health plan?

○	○	○	○	○	○	○	○	○	○	○
0	1	2	3	4	5	6	7	8	9	10

Worst Health Plan Possible — Best Health Plan Possible

ABOUT YOU

36. In general, how would you rate your overall health?

- ○ Excellent
- ○ Very Good
- ○ Good
- ○ Fair
- ○ Poor

37. In general, how would you rate your overall <u>mental or emotional</u> health?

- ○ Excellent
- ○ Very Good
- ○ Good
- ○ Fair
- ○ Poor

38. Have you had either a flu shot or flu spray in the nose since July 1, 2015?

- ○ Yes
- ○ No
- ○ Don't know

39. Do you now smoke cigarettes or use tobacco every day, some days, or not at all?

- ○ Every day
- ○ Some days
- ○ Not at all ➔ ***Go to Question 43***
- ○ Don't know ➔ ***Go to Question 43***

40. In the last 6 months, how often were you advised to quit smoking or using tobacco by a doctor or other health provider in your plan?

- ○ Never
- ○ Sometimes
- ○ Usually
- ○ Always

41. In the last 6 months, how often was medication recommended or discussed by a doctor or health provider to assist you with quitting smoking or using tobacco? Examples of medication are: nicotine gum, patch, nasal spray, inhaler, or prescription medication.

- ○ Never
- ○ Sometimes
- ○ Usually
- ○ Always

42. In the last 6 months, how often did your doctor or health provider discuss or provide methods and strategies other than medication to assist you with quitting smoking or using tobacco? Examples of methods and strategies are: telephone helpline, individual or group counseling, or cessation program.

- ○ Never
- ○ Sometimes
- ○ Usually
- ○ Always

43. Do you take aspirin daily or every other day?

- ○ Yes
- ○ No
- ○ Don't know

44. Do you have a health problem or take medication that makes taking aspirin unsafe for you?

- ○ Yes
- ○ No
- ○ Don't know

45. Has a doctor or health provider ever discussed with you the risks and benefits of aspirin to prevent heart attack or stroke?

- ○ Yes
- ○ No

46. Are you aware that you have any of the following conditions? Mark one or more.

- ○ High cholesterol
- ○ High blood pressure
- ○ Parent or sibling with heart attack before the age of 60

47. Has a doctor ever told you that you have any of the following conditions? Mark one or more.

- ○ A heart attack
- ○ Angina or coronary heart disease
- ○ A stroke
- ○ Any kind of diabetes or high blood sugar

48. In the last 6 months, did you get health care 3 or more times for the same condition or problem?

- ○ Yes
- ○ No ➔ ***Go to Question 50***

49. Is this a condition or problem that has lasted for at least 3 months? Do <u>not</u> include pregnancy or menopause.

- ○ Yes
- ○ No

50. Do you now need or take medicine prescribed by a doctor? Do <u>not</u> include birth control.

- ○ Yes
- ○ No ➔ ***Go to Question 52***

51. Is this medicine to treat a condition that has lasted for at least 3 months? Do <u>not</u> include pregnancy or menopause.

- ○ Yes
- ○ No

52. What is your age?

- ○ 18 to 24
- ○ 25 to 34
- ○ 35 to 44
- ○ 45 to 54
- ○ 55 to 64
- ○ 65 to 74
- ○ 75 or older

53. Are you male or female?

- ○ Male
- ○ Female

54. What is the highest grade or level of school that you have completed?

- ○ 8th grade or less
- ○ Some high school, but did not graduate
- ○ High school graduate or GED
- ○ Some college or 2-year degree
- ○ 4-year college graduate
- ○ More than 4-year college degree

55. Are you of Hispanic or Latino origin or descent?

- ○ Yes, Hispanic or Latino
- ○ No, Not Hispanic or Latino

56. What is your race? Mark one or more.

- ○ White
- ○ Black or African-American
- ○ Asian
- ○ Native Hawaiian or other Pacific Islander
- ○ American Indian or Alaska Native
- ○ Other

57. Did someone help you complete this survey?

- ○ Yes ➔ ***Go to Question 58***
- ○ No ➔ ***Thank you. Please return the completed survey in the postage-paid envelope.***

58. How did that person help you? Mark one or more.

- ○ Read the questions to me
- ○ Wrote down the answers I gave
- ○ Answered the questions for me
- ○ Translated the questions into my language
- ○ Helped in some other way

Thanks again for taking the time to complete this survey! Your answers are greatly appreciated.

When you are done, please use the enclosed prepaid envelope to mail the survey to:

DataStat, 3975 Research Park Drive, Ann Arbor, MI 48108

CD Contents

The accompanying CD includes all of the information from the Executive Summary, Reader's Guide, Results, Trend Analysis, Key Drivers of Satisfaction, and Survey Instrument sections of this report. The CD also contains electronic copies of comprehensive crosstabulations that show responses to each survey question stratified by select categories. The following content is included in the CD:

- 2016 Michigan Adult Medicaid CAHPS Report
- MDHHS Adult Medicaid Program Crosstabulations
- MDHHS Adult Medicaid Plan-level Crosstabulations

2016 Michigan Department of Health and Human Services Healthy Michigan Plan CAHPS® Report

February 2017

Table of Contents

1. Executive Summary

Introduction

The Michigan Department of Health and Human Services (MDHHS) assesses the perceptions and experiences of members enrolled in the MDHHS Healthy Michigan Plan (HMP) health plans as part of its process for evaluating the quality of health care services provided to eligible adult members in the HMP Program. MDHHS contracted with Health Services Advisory Group, Inc. (HSAG) to administer and report the results of the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Health Plan Survey for the HMP Program.[1-1] The goal of the CAHPS Health Plan Survey is to provide performance feedback that is actionable and that will aid in improving overall member satisfaction.

This report presents the 2016 CAHPS results of adult members enrolled in an HMP health plan. The survey instrument selected was the CAHPS 5.0 Adult Medicaid Health Plan Survey with the Healthcare Effectiveness Data and Information Set (HEDIS®) supplemental item set.[1-2] The surveys were completed by adult members from August to November 2016.

Report Overview

A sample of 1,350 adult members was selected from each HMP health plan. There were less than 1,350 adult members eligible for inclusion in the survey for HAP Midwest Health Plan; therefore, each member from HAP Midwest Health Plan's eligible population was included in the sample. Results presented in this report include four global ratings: Rating of Health Plan, Rating of All Health Care, Rating of Personal Doctor, and Rating of Specialist Seen Most Often. Five composite measures are reported: Getting Needed Care, Getting Care Quickly, How Well Doctors Communicate, Customer Service, and Shared Decision Making. Overall rates for five Effectiveness of Care measures are reported: Advising Smokers and Tobacco Users to Quit, Discussing Cessation Medications, Discussing Cessation Strategies, Aspirin Use, and Discussing Aspirin Risks and Benefits. HSAG presents aggregate statewide results (i.e., the MDHHS HMP Program) and compares them to national Medicaid data.

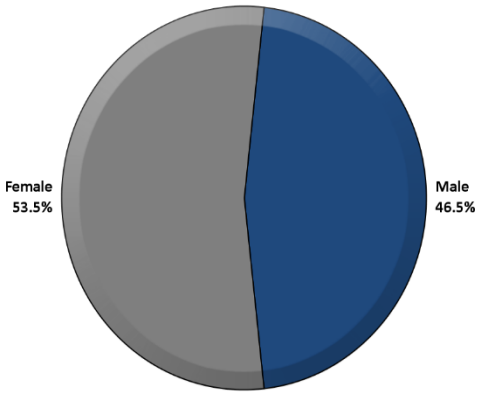
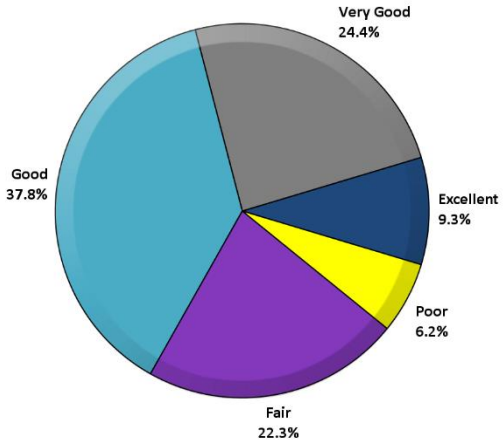
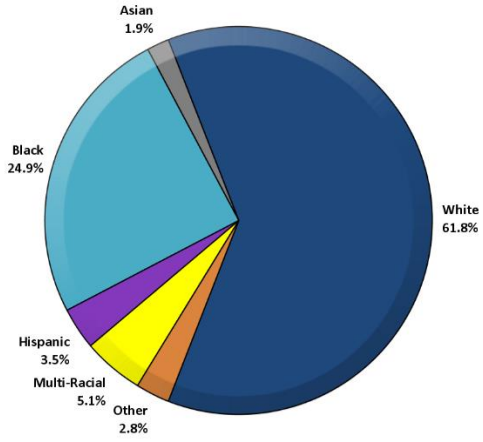
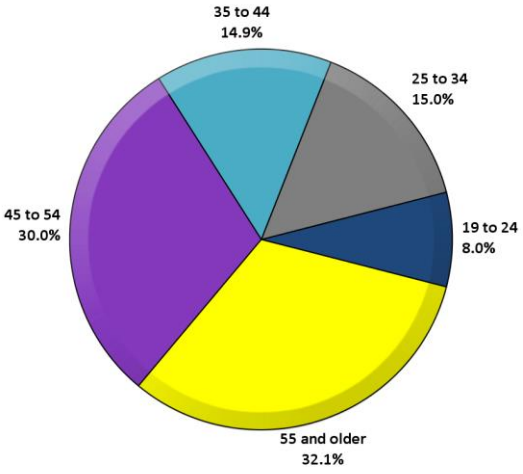
[1-1] CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).
[1-2] HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

Key Findings

Survey Demographics and Dispositions

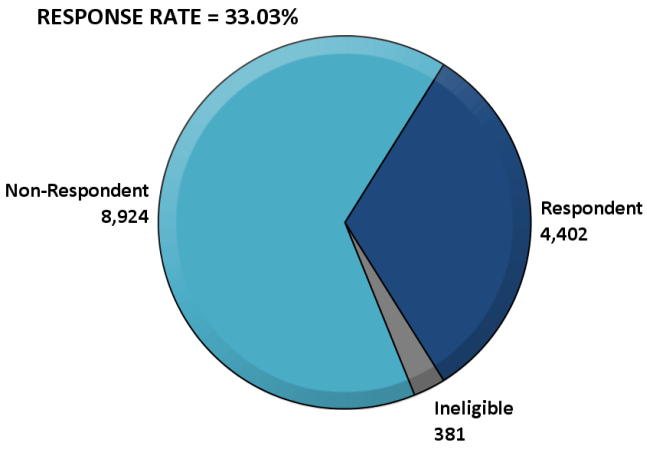
Table 1-1 provides an overview of the adult member demographics and survey dispositions for the MDHHS HMP Program.

Table 1-1 – Survey Demographics and Dispositions

Gender	General Health Status
	
Race/Ethnicity	**Age**
	

Please note, percentages may not total 100.0% due to rounding.

Survey Dispositions



National Comparisons

A three-point mean score was determined for the four CAHPS global ratings and four CAHPS composite measures. The resulting three-point means scores were compared to the National Committee for Quality Assurance's (NCQA's) 2016 HEDIS Benchmarks and Thresholds for Accreditation to derive the overall member satisfaction ratings (i.e., star ratings) for each CAHPS measure.[1-3,1-4] Table 1-2 provides highlights of the National Comparisons findings for the MDHHS HMP Program. The numbers presented below represent the three-point mean score for each measure, while the stars represent overall member satisfaction ratings when the three-point means were compared to NCQA HEDIS Benchmarks and Thresholds for Accreditation.[1-5]

Table 1-2 – National Comparisons MDHHS HMP Program

Measure	National Comparisons
Global Rating	
Rating of Health Plan	★★★ 2.43
Rating of All Health Care	★★★ 2.37
Rating of Personal Doctor	★★ 2.49
Rating of Specialist Seen Most Often	★★★ 2.52
Composite Measure	
Getting Needed Care	★★★ 2.39
Getting Care Quickly	★★ 2.40
How Well Doctors Communicate	★★★★★ 2.66
Customer Service	★★★★ 2.59
Star Assignments Based on Percentiles ★★★★★ 90th or Above ★★★★ 75th-89th ★★★ 50th-74th ★★ 25th-49th ★ Below 25th	

1-3 National Committee for Quality Assurance. *HEDIS® Benchmarks and Thresholds for Accreditation 2016*. Washington, DC: NCQA; January 21, 2016.

1-4 NCQA does not publish national benchmarks and thresholds for the Shared Decision Making composite measure; therefore, this CAHPS measure was excluded from the National Comparisons analysis.

1-5 Given the potential differences in demographic make-up of the HMP population and services received from the HMP health plans compared to the adult Medicaid population, caution should be exercised when interpreting the comparisons to Adult Medicaid NCQA HEDIS Benchmarks and Thresholds for Accreditation.

The National Comparisons results on the previous page indicated that the How Well Doctors Communicate composite measure scored at or above the 90th percentile. The Customer Service composite measure scored at or between the 75th and 89th percentiles. The Rating of Health Plan, Rating of All Health Care, and Rating of Specialist Seen Most Often global ratings, and the Getting Needed Care composite measure scored at or between the 50th and 74th percentiles. The Rating of Personal Doctor global rating and the Getting Care Quickly composite measure scored at or between the 25th and 49th percentiles.

Statewide Comparisons

HSAG calculated top-box rates (i.e., rates of satisfaction) for each global rating, composite measure, and Effectiveness of Care measure. HSAG compared the HMP health plan results to the MDHHS HMP Program average to determine if plan results were statistically significantly different than the MDHHS HMP Program average.

Table 1-3 through 1-5 show the results of this analysis for the global ratings, composite measures, and Effectiveness of Care measures, respectively.

Table 1-3 – Statewide Comparisons – Global Ratings

Plan Name	Rating of Health Plan	Rating of All Health Care	Rating of Personal Doctor	Rating of Specialist Seen Most Often
Aetna Better Health of Michigan	↓	↓	—	—
Blue Cross Complete of Michigan	—	—	↑	—
HAP Midwest Health Plan	—+	—+	↓+	—+
Harbor Health Plan	—	↓	↓	—
McLaren Health Plan	—	↑	↑	—
Meridian Health Plan of Michigan	—	—	—	↓
Molina Healthcare of Michigan	—	—	—	—
Priority Health Choice, Inc.	↑	—	—	—
Total Health Care, Inc.	—	↑	—	—
UnitedHealthcare Community Plan	—	—	—	↓
Upper Peninsula Health Plan	—	—	↑	—

\+ indicates fewer than 100 responses. Caution should be exercised when evaluating these results.
↑ indicates the plan's score is statistically significantly higher than the MDHHS HMP Program average.
↓ indicates the plan's score is statistically significantly lower than the MDHHS HMP Program average.
— indicates the plan's score is not statistically significantly different than the MDHHS HMP Program average.

Table 1-4 – Statewide Comparisons – Composite Measures

Plan Name	Getting Needed Care	Getting Care Quickly	How Well Doctors Communicate	Customer Service	Shared Decision Making
Aetna Better Health of Michigan	↓	—	—	—	—
Blue Cross Complete of Michigan	—	—	—	—	—
HAP Midwest Health Plan	—+	—+	—+	—+	NA
Harbor Health Plan	↓	—	—	—	↓
McLaren Health Plan	—	—	—	—+	—
Meridian Health Plan of Michigan	—	—	—	—	—
Molina Healthcare of Michigan	—	—	—	—	—
Priority Health Choice, Inc.	—	—	—	—	—
Total Health Care, Inc.	—	—	—	—	↓
UnitedHealthcare Community Plan	—	—	—	—	—
Upper Peninsula Health Plan	—	—	—	—+	↑

+ indicates fewer than 100 responses. Caution should be exercised when evaluating these results.
↑ indicates the plan's score is statistically significantly higher than the MDHHS HMP Program average.
↓ indicates the plan's score is statistically significantly lower than the MDHHS HMP Program average.
— indicates the plan's score is not statistically significantly different than the MDHHS HMP Program average.
NA indicates that results for this measure are not displayed because too few members responded to the questions.

Table 1-5 – Statewide Comparisons – Effectiveness of Care Measures

Plan Name	Advising Smokers and Tobacco Users to Quit	Discussing Cessation Medications	Discussing Cessation Strategies	Aspirin Use	Discussing Aspirin Risks and Benefits
Aetna Better Health of Michigan	—	—	—	—+	—+
Blue Cross Complete of Michigan	—	—	—	—+	—
HAP Midwest Health Plan	—+	—+	—+	NA	—+
Harbor Health Plan	—	—	—	—+	—
McLaren Health Plan	—	—	—	—+	—
Meridian Health Plan of Michigan	—	—	—	—+	—
Molina Healthcare of Michigan	—	—	—	—+	—
Priority Health Choice, Inc.	—	—	—	—+	—
Total Health Care, Inc.	—	—	—	—+	—
UnitedHealthcare Community Plan	—	—	—	—+	—+
Upper Peninsula Health Plan	—	—	—	—+	—

+ indicates fewer than 100 responses. Caution should be exercised when evaluating these results.
↑ indicates the plan's score is statistically significantly higher than the MDHHS HMP Program average.
↓ indicates the plan's score is statistically significantly lower than the MDHHS HMP Program average.
— indicates the plan's score is not statistically significantly different than the MDHHS HMP Program average.
NA indicates that results for this measure are not displayed because too few members responded to the questions.

The following plans scored statistically significantly *higher* than the MDHHS HMP Program average on at least one measure:

Blue Cross Complete of Michigan

- Rating of Personal Doctor

McLaren Health Plan

- Rating of All Health Care
- Rating of Personal Doctor

Priority Health Choice, Inc.

- Rating of Health Plan

Total Health Care, Inc.

- Rating of All Health Care

Upper Peninsula Health Plan

- Rating of Personal Doctor
- Shared Decision Making

Conversely, the following plans scored statistically significantly *lower* than the MDHHS HMP Program average on at least one measure:

Aetna Better Health of Michigan

- Rating of Health Plan
- Rating of All Health Care
- Getting Needed Care

HAP Midwest Health Plan

- Rating of Personal Doctor

Harbor Health Plan

- Rating of All Health Care
- Rating of Personal Doctor
- Getting Needed Care
- Shared Decision Making

Meridian Health Plan of Michigan

- Rating of Specialist Seen Most Often

Total Health Care, Inc.

- Shared Decision Making

UnitedHealthcare Community Plan

- Rating of Specialist Seen Most Often

Key Drivers of Satisfaction

HSAG focused the key drivers of satisfaction analysis on three measures: Rating of Health Plan, Rating of All Health Care, and Rating of Personal Doctor. HSAG evaluated each of these measures to determine if particular CAHPS items (i.e., questions) strongly correlated with these measures, which HSAG refers to as "key drivers." These individual survey items are driving levels of satisfaction with each of the three measures.

Table 1-6 provides a summary of the key drivers identified for the MDHHS HMP Program.

Table 1-6 – MDHHS HMP Program Key Drivers of Satisfaction

Rating of Health Plan
Respondents reported that their health plan's customer service did not always give them the information or help they needed.
Respondents reported that information in written materials or on the Internet about how the health plan works did not always provide the information they needed.
Respondents reported that forms from their health plan were often not easy to fill out.
Respondents reported that it was often not easy to obtain appointments with specialists.
Rating of All Health Care
Respondents reported that when they talked about starting or stopping a prescription medicine, a doctor or other health provider did not ask what they thought was best for them.
Respondents reported that their personal doctor did not always seem informed and up-to-date about the care they received from other doctors or health providers.
Respondents reported that it was often not easy to obtain appointments with specialists.
Rating of Personal Doctor
Respondents reported that their personal doctor did not always seem informed and up-to-date about the care they received from other doctors or health providers.

2. Reader's Guide

2016 CAHPS Performance Measures

The CAHPS 5.0 Adult Medicaid Health Plan Survey with the HEDIS supplemental item set includes 58 core questions that yield 14 measures. These measures include four global rating questions, five composite measures, and five Effectiveness of Care measures. The global measures (also referred to as global ratings) reflect overall satisfaction with health plan, health care, personal doctors, and specialists. The composite measures are sets of questions grouped together to address different aspects of care (e.g., "Getting Needed Care" or "Getting Care Quickly"). The Effectiveness of Care measures assess the various aspects of providing medical assistance with smoking and tobacco use cessation and managing aspirin use for the primary prevention of cardiovascular disease.

Table 2-1 lists the measures included in the CAHPS 5.0 Adult Medicaid Health Plan Survey with the HEDIS supplemental item set.

Table 2-1 – CAHPS Measures

Global Ratings	Composite Measures	Effectiveness of Care Measures
Rating of Health Plan	Getting Needed Care	Advising Smokers and Tobacco Users to Quit
Rating of All Health Care	Getting Care Quickly	Discussing Cessation Medications
Rating of Personal Doctor	How Well Doctors Communicate	Discussing Cessation Strategies
Rating of Specialist Seen Most Often	Customer Service	Aspirin Use
	Shared Decision Making	Discussing Aspirin Risks and Benefits

How CAHPS Results Were Collected

Sampling Procedures

MDHHS provided HSAG with a list of all eligible adult members in the HMP Program for the sampling frame. HSAG inspected a sample of the file records to check for any apparent problems with the files, such as missing address elements. HSAG sampled adult members who met the following criteria:

- Were 19 years of age or older as of June 30, 2016.
- Were currently enrolled in an HMP health plan.
- Had been continuously enrolled in the plan for at least five of the first six months of the measurement year (January 1, 2016 through June 30, 2016).

Next, a sample of members was selected for inclusion in the survey. For each HMP health plan, no more than one member per household was selected as part of the survey samples. A sample of 1,350 adult members was selected from each HMP health plan. HAP Midwest Health Plan had less than 1,350 adult members who were eligible for inclusion in the survey; therefore, each member from HAP Midwest Health Plan's eligible population was included in the sample. Table 3-1 in the Results section provides an overview of the sample sizes for each plan.

Survey Protocol

The HMP CAHPS survey process allowed for two methods by which members could complete a survey. The first, or mail phase, consisted of sampled members receiving a survey via mail. HSAG tried to obtain new addresses for members selected for the sample by processing sampled members' addresses through the United States Postal Service's National Change of Address (NCOA) system. All sampled members received an English version of the survey, with the option of completing the survey in Spanish. Non-respondents received a reminder postcard, followed by a second survey mailing and postcard reminder.

The second phase, or telephone phase, consisted of Computer Assisted Telephone Interviewing (CATI) of members who did not mail in a completed survey. At least three CATI calls to each non-respondent were attempted. It has been shown that the addition of the telephone phase aids in the reduction of non-response bias by increasing the number of respondents who are more demographically representative of a plan's population.[2-1]

[2-1] Fowler FJ Jr., Gallagher PM, Stringfellow VL, et al. "Using Telephone Interviews to Reduce Nonresponse Bias to Mail Surveys of Health Plan Members." *Medical Care*. 2002; 40(3): 190-200.

Table 2-2 shows the standard mixed-mode (i.e., mail followed by telephone follow-up) CAHPS timeline used in the administration of the HMP CAHPS survey.

Table 2-2 – CAHPS 5.0 Mixed-Mode Methodology Survey Timeline

Task	Timeline
Send first questionnaire with cover letter to the adult member.	0 days
Send a postcard reminder to non-respondents 4-10 days after mailing the first questionnaire.	4-10 days
Send a second questionnaire (and letter) to non-respondents approximately 35 days after mailing the first questionnaire.	35 days
Send a second postcard reminder to non-respondents 4-10 days after mailing the second questionnaire.	39-45 days
Initiate CATI interviews for non-respondents approximately 21 days after mailing the second questionnaire.	56 days
Initiate systematic contact for all non-respondents such that at least three telephone calls are attempted at different times of the day, on different days of the week, and in different weeks.	56 – 70 days
Telephone follow-up sequence completed (i.e., completed interviews obtained or maximum calls reached for all non-respondents) approximately 14 days after initiation.	70 days

How CAHPS Results Were Calculated and Displayed

HSAG used the CAHPS scoring approach recommended by NCQA in Volume 3 of HEDIS Specifications for Survey Measures. Based on NCQA's recommendations and HSAG's extensive experience evaluating CAHPS data, HSAG performed a number of analyses to comprehensively assess member satisfaction. In addition to individual plan results, HSAG calculated an MDHHS HMP Program average. HSAG combined results from the HMP health plans to form the HMP Program average. This section provides an overview of each analysis.

Who Responded to the Survey

The response rate was defined as the total number of completed surveys divided by all eligible members of the sample. HSAG considered a survey completed if members answered at least three of the following five questions: 3, 15, 24, 28, and 35. Eligible members included the entire random sample minus ineligible members. Ineligible members met at least one of the following criteria: they were deceased, were invalid (did not meet the eligible criteria), were mentally or physically incapacitated, or had a language barrier.

$$\textit{Response Rate} = \frac{\textit{Number of Completed Surveys}}{\textit{Random Sample - Ineligibles}}$$

Demographics of Adult Members

The demographics analysis evaluated demographic information of adult members. MDHHS should exercise caution when extrapolating the CAHPS results to the entire population if the respondent population differs significantly from the actual population of the plan or program.

National Comparisons

HSAG conducted an analysis of the CAHPS survey results using NCQA HEDIS Specifications for Survey Measures. Although NCQA requires a minimum of 100 responses on each item in order to report the item as a reportable CAHPS Survey result, HSAG presented results with fewer than 100 responses. Results with fewer than 11 responses are denoted as "Not Applicable." Therefore, caution should be exercised when evaluating measures' results with fewer than 100 responses, which are denoted with a cross (+).

Table 2-3 shows the percentiles that were used to determine star ratings for each CAHPS measure.

Table 2-3 – Star Ratings

Stars	Percentiles
★★★★★ Excellent	At or above the 90th percentile
★★★★ Very Good	At or between the 75th and 89th percentiles
★★★ Good	At or between the 50th and 74th percentiles
★★ Fair	At or between the 25th and 49th percentiles
★ Poor	Below the 25th percentile

In order to perform the National Comparisons, a three-point mean score was determined for each CAHPS measure. HSAG compared the resulting three-point mean scores to published NCQA HEDIS Benchmarks and Thresholds for Accreditation to derive the overall member satisfaction ratings for each CAHPS measure.[2-2]

Table 2-4 shows the NCQA HEDIS Benchmarks and Thresholds for Accreditation used to derive the overall member satisfaction ratings on each CAHPS measure.[2-3] NCQA does not publish national benchmarks and thresholds for Shared Decision Making; therefore, this CAHPS measure was excluded from the National Comparisons analysis. In addition, there are no national benchmarks available for this population; therefore, national adult Medicaid data were used for comparative purposes.[2-4]

Table 2-4 – Overall Member Satisfaction Ratings Crosswalk

Measure	90th Percentile	75th Percentile	50th Percentile	25th Percentile
Rating of Health Plan	2.55	2.49	2.43	2.37
Rating of All Health Care	2.45	2.42	2.36	2.31
Rating of Personal Doctor	2.57	2.53	2.50	2.43
Rating of Specialist Seen Most Often	2.59	2.56	2.51	2.48
Getting Needed Care	2.45	2.42	2.37	2.31
Getting Care Quickly	2.49	2.46	2.42	2.36
How Well Doctors Communicate	2.64	2.58	2.54	2.48
Customer Service	2.61	2.58	2.54	2.48

2-2 For detailed information on the derivation of three-point mean scores, please refer to *HEDIS® 2016, Volume 3: Specifications for Survey Measures.*

2-3 National Committee for Quality Assurance. *HEDIS® Benchmarks and Thresholds for Accreditation 2016*. Washington, DC: NCQA; January 21, 2016.

2-4 Given the potential differences in demographic make-up of the HMP population and services received from the HMP health plans compared to the adult Medicaid population, caution should be exercised when interpreting the comparisons to Adult Medicaid NCQA HEDIS Benchmarks and Thresholds for Accreditation.

Global Ratings and Composite Measures

Statewide Comparisons

For purposes of the Statewide Comparisons analysis, HSAG calculated question summary rates for each global rating and global proportions for each composite measure, following NCQA HEDIS Specifications for Survey Measures.[2-5] The scoring of the global ratings and composite measures involved assigning top-box responses a score of one, with all other responses receiving a score of zero. A "top-box" response was defined as follows:

- "9" or "10" for the global ratings.
- "Usually" or "Always" for the Getting Needed Care, Getting Care Quickly, How Well Doctors Communicate, and Customer Service composites.
- "Yes" for the Shared Decision Making composite.

Medical Assistance with Smoking and Tobacco Use Cessation

HSAG calculated three rates that assess different facets of providing medical assistance with smoking and tobacco use cessation:

- Advising Smokers and Tobacco Users to Quit
- Discussing Cessation Medications
- Discussing Cessation Strategies

These rates assess the percentage of smokers or tobacco users who were advised to quit, were recommended cessation medications, and were provided cessation methods or strategies, respectively. Responses of "Sometimes," "Usually," and "Always" were used to determine if the member qualified for inclusion in the numerator. The rates presented do not follow NCQA's methodology of calculating a rolling average using the current and prior year's results. HSAG calculated these rates using one year of data (i.e., baseline year data).

[2-5] National Committee for Quality Assurance. *HEDIS® 2016, Volume 3: Specifications for Survey Measures.* Washington, DC: NCQA; 2015.

Aspirin Use and Discussion

HSAG calculated two rates that assess different facets of managing aspirin use for the primary prevention of cardiovascular disease:

- Aspirin Use
- Discussing Aspirin Risks and Benefits

The Aspirin Use measure assesses the percentage of members at risk for cardiovascular disease who are currently taking aspirin. The Discussing Aspirin Risks and Benefits measure assesses the percentage of members who discussed the risks and benefits of using aspirin with a doctor or other health provider. Responses of "Yes" were used to determine if the member qualified for inclusion in the numerator. The rates presented do not follow NCQA's methodology of calculating a rolling average using the current and prior year's results. HSAG calculated these rates using one year of data (i.e., baseline year data).

Weighting

A weighted MDHHS HMP Program average was calculated. Results were weighted based on the total eligible population for each plan's adult HMP population. Measures with fewer than 100 responses are denoted with a cross (+). Results with fewer than 11 responses are denoted as "Not Applicable." Caution should be used when evaluating rates derived from fewer than 100 respondents.

HMP Health Plan Comparisons

The results of the HMP health plans were compared to the MDHHS HMP Program average. Two types of hypothesis tests were applied to these results. First, a global *F* test was calculated, which determined whether the difference between HMP health plans' means was significant. If the *F* test demonstrated plan-level differences (i.e., p value < 0.05), then a *t* test was performed for each HMP health plan. The *t* test determined whether each HMP health plan's mean was significantly different from the MDHHS HMP Program average. This analytic approach follows the Agency for Healthcare Research and Quality's (AHRQ's) recommended methodology for identifying significant plan-level performance differences.

Key Drivers of Satisfaction Analysis

HSAG performed an analysis of key drivers of satisfaction for the following measures: Rating of Health Plan, Rating of All Health Care, and Rating of Personal Doctor. The purpose of the key drivers of satisfaction analysis is to help decision makers identify specific aspects of care that will most benefit from quality improvement (QI) activities. The analysis provides information on: 1) how ***well*** the MDHHS Medicaid Program is performing on the survey item and 2) how ***important*** that item is to overall satisfaction.

The performance on a survey item was measured by calculating a problem score, in which a negative experience with care was defined as a problem and assigned a "1," and a positive experience with care (i.e., non-negative) was assigned a "0." The higher the problem score, the lower the member satisfaction with the aspect of service measured by that question. The problem score could range from 0 to 1.

For each item evaluated, the relationship between the item's problem score and performance on each of the three measures was calculated using a Pearson product moment correlation, which is defined as the covariance of the two scores divided by the product of their standard deviations. Items were then prioritized based on their overall problem score and their correlation to each measure. Key drivers of satisfaction were defined as those items that:

- Had a problem score that was greater than or equal to the median problem score for all items examined.
- Had a correlation that was greater than or equal to the median correlation for all items examined.

Limitations and Cautions

The findings presented in this CAHPS report are subject to some limitations in the survey design, analysis, and interpretation. MDHHS should consider these limitations when interpreting or generalizing the findings.

Case-Mix Adjustment

The demographics of a response group may impact member satisfaction. Therefore, differences in the demographics of the response group may impact CAHPS results. NCQA does not recommend case-mix adjusting CAHPS results to account for these differences; therefore, no case-mix adjusting was performed on these CAHPS results.[2-6]

Non-Response Bias

The experiences of the survey respondent population may be different than that of non-respondents with respect to their health care services and may vary by plan or program. Therefore, MDHHS should consider the potential for non-response bias when interpreting CAHPS results.

Causal Inferences

Although this report examines whether respondents report differences in satisfaction with various aspects of their health care experiences, these differences may not be completely attributable to the plan. These analyses identify whether respondents give different ratings of satisfaction with their plan. The survey by itself does not necessarily reveal the exact cause of these differences.

Missing Phone Numbers

The volume of missing telephone numbers may impact the response rates and the validity of the survey results. For instance, a certain segment of the population may be more likely to have missing phone information than other segments.

[2-6] Agency for Healthcare Research and Quality. *CAHPS Health Plan Survey and Reporting Kit 2008*. Rockville, MD: US Department of Health and Human Services; 2008.

National Data for Comparisons

While comparisons to national data were performed for the survey measures, it is important to note that the survey instrument utilized for the 2016 survey administration was the standard CAHPS 5.0 Adult Medicaid Health Plan Survey with the HEDIS supplemental item set; however, the population being surveyed was not a standard adult Medicaid population. There are currently no available benchmarks for this population; therefore, caution should be exercised when interpreting the comparisons to NCQA national data.

3. Results

Who Responded to the Survey

A total of 13,707 surveys were distributed to adult members. A total of 4,402 surveys were completed. The CAHPS Survey response rate is the total number of completed surveys divided by all eligible members of the sample. A survey was considered complete if members answered at least three of the following five questions on the survey: 3, 15, 24, 28, and 35. Eligible members included the entire sample minus ineligible members. Ineligible members met at least one of the following criteria: they were deceased, were invalid (did not meet the eligible criteria), were mentally or physically incapacitated, or had a language barrier.

Table 3-1 shows the total number of members sampled, the number of surveys completed, the number of ineligible members, and the response rates.

Table 3-1 – Total Number of Respondents and Response Rates

Plan Name	Sample Size	Completes	Ineligibles	Response Rates
MDHHS HMP Program	**13,707**	**4,402**	**381**	**33.03%**
Aetna Better Health of Michigan	1,350	368	28	27.84%
Blue Cross Complete of Michigan	1,350	412	35	31.33%
HAP Midwest Health Plan	207	40	4	19.70%
Harbor Health Plan	1,350	379	48	29.11%
McLaren Health Plan	1,350	494	37	37.62%
Meridian Health Plan of Michigan	1,350	437	40	33.36%
Molina Healthcare of Michigan	1,350	435	44	33.31%
Priority Health Choice, Inc.	1,350	475	28	35.93%
Total Health Care, Inc.	1,350	405	32	30.73%
UnitedHealthcare Community Plan	1,350	422	52	32.51%
Upper Peninsula Health Plan	1,350	535	33	40.62%

Demographics of Adult Members

Table 3-2 depicts the ages of members who completed a CAHPS survey.

Table 3-2 – Adult Member Demographics: Age

Plan Name	19 to 24	25 to 34	35 to 44	45 to 54	55 and Older
MDHHS HMP Program	**8.0%**	**15.0%**	**14.9%**	**30.0%**	**32.1%**
Aetna Better Health of Michigan	10.6%	16.7%	16.7%	30.3%	25.8%
Blue Cross Complete of Michigan	6.0%	14.5%	17.7%	29.9%	31.9%
HAP Midwest Health Plan	7.7%	17.9%	23.1%	20.5%	30.8%
Harbor Health Plan	4.1%	10.6%	13.6%	38.5%	33.3%
McLaren Health Plan	6.9%	15.8%	13.4%	29.2%	34.7%
Meridian Health Plan of Michigan	9.5%	17.1%	13.7%	28.0%	31.7%
Molina Healthcare of Michigan	9.8%	16.6%	16.6%	29.2%	27.8%
Priority Health Choice, Inc.	5.7%	15.3%	14.0%	29.8%	35.1%
Total Health Care, Inc.	6.8%	12.6%	14.6%	33.8%	32.2%
UnitedHealthcare Community Plan	13.5%	15.9%	15.9%	28.3%	26.3%
Upper Peninsula Health Plan	7.2%	14.5%	13.4%	26.4%	38.6%
Please note, percentages may not total 100.0% due to rounding.					

Table 3-3 depicts the gender of members who completed a CAHPS survey.

Table 3-3 – Adult Member Demographics: Gender

Plan Name	Male	Female
MDHHS HMP Program	**46.5%**	**53.5%**
Aetna Better Health of Michigan	47.8%	52.2%
Blue Cross Complete of Michigan	54.0%	46.0%
HAP Midwest Health Plan	60.5%	39.5%
Harbor Health Plan	61.4%	38.6%
McLaren Health Plan	45.6%	54.4%
Meridian Health Plan of Michigan	38.9%	61.1%
Molina Healthcare of Michigan	44.4%	55.6%
Priority Health Choice, Inc.	40.9%	59.1%
Total Health Care, Inc.	44.6%	55.4%
UnitedHealthcare Community Plan	45.1%	54.9%
Upper Peninsula Health Plan	44.9%	55.1%
Please note, percentages may not total 100.0% due to rounding.		

Table 3-4 depicts the race and ethnicity of members who completed a CAHPS survey.

Table 3-4 – Adult Member Demographics: Race/Ethnicity

Plan Name	White	Hispanic	Black	Asian	Other	Multi-Racial
MDHHS HMP Program	**61.8%**	**3.5%**	**24.9%**	**1.9%**	**2.8%**	**5.1%**
Aetna Better Health of Michigan	43.4%	3.1%	47.0%	1.1%	0.6%	4.8%
Blue Cross Complete of Michigan	43.4%	4.5%	38.2%	4.2%	4.5%	5.2%
HAP Midwest Health Plan	79.5%	2.6%	10.3%	0.0%	0.0%	7.7%
Harbor Health Plan	16.6%	2.7%	72.2%	1.6%	1.9%	4.9%
McLaren Health Plan	79.3%	4.5%	7.6%	1.8%	2.1%	4.7%
Meridian Health Plan of Michigan	73.1%	3.5%	14.3%	1.2%	2.8%	5.1%
Molina Healthcare of Michigan	56.6%	4.9%	25.6%	1.2%	5.2%	6.6%
Priority Health Choice, Inc.	81.5%	5.2%	6.0%	1.7%	1.1%	4.5%
Total Health Care, Inc.	46.9%	1.5%	42.0%	1.5%	3.4%	4.6%
UnitedHealthcare Community Plan	60.0%	4.2%	19.6%	4.2%	4.2%	7.8%
Upper Peninsula Health Plan	92.1%	0.9%	0.6%	0.6%	3.0%	2.8%
Please note, percentages may not total 100.0% due to rounding.						

Table 3-5 depicts the general health status of members who completed a CAHPS survey.

Table 3-5 – Adult Member Demographics: General Health Status

Plan Name	Excellent	Very Good	Good	Fair	Poor
MDHHS HMP Program	**9.3%**	**24.4%**	**37.8%**	**22.3%**	**6.2%**
Aetna Better Health of Michigan	11.1%	22.2%	33.5%	27.4%	5.8%
Blue Cross Complete of Michigan	12.8%	28.3%	32.5%	22.4%	3.9%
HAP Midwest Health Plan	5.0%	27.5%	42.5%	20.0%	5.0%
Harbor Health Plan	7.0%	21.0%	38.2%	25.8%	8.1%
McLaren Health Plan	8.6%	23.1%	40.6%	21.6%	6.1%
Meridian Health Plan of Michigan	7.4%	24.5%	37.4%	22.2%	8.5%
Molina Healthcare of Michigan	8.6%	24.2%	39.8%	23.0%	4.4%
Priority Health Choice, Inc.	8.1%	27.0%	38.9%	19.3%	6.8%
Total Health Care, Inc.	11.1%	22.2%	34.3%	24.7%	7.6%
UnitedHealthcare Community Plan	11.0%	22.2%	41.4%	19.4%	6.0%
Upper Peninsula Health Plan	8.3%	27.4%	39.4%	19.7%	5.3%
Please note, percentages may not total 100.0% due to rounding.					

National Comparisons

In order to assess the overall performance of the MDHHS HMP Program, HSAG scored the four global ratings (Rating of Health Plan, Rating of All Health Care, Rating of Personal Doctor, and Rating of Specialist Seen Most Often) and four composite measures (Getting Needed Care, Getting Care Quickly, How Well Doctors Communicate, and Customer Service) on a three-point scale using an NCQA-approved scoring methodology. HSAG compared the plans' and program's three-point mean scores to NCQA HEDIS Benchmarks and Thresholds for Accreditation.[3-1]

Based on this comparison, ratings of one (★) to five (★★★★★) stars were determined for each CAHPS measure, where one is the lowest possible rating (i.e., Poor) and five is the highest possible rating (i.e., Excellent), as shown in Table 3-6.

Table 3-6 – Star Ratings

Stars	Percentiles
★★★★★ Excellent	At or above the 90th percentile
★★★★ Very Good	At or between the 75th and 89th percentiles
★★★ Good	At or between the 50th and 74th percentiles
★★ Fair	At or between the 25th and 49th percentiles
★ Poor	Below the 25th percentile

The results presented in the following two tables represent the three-point mean scores for each measure, while the stars represent the overall member satisfaction ratings when the three-point means were compared to NCQA HEDIS Benchmarks and Thresholds for Accreditation.[3-2]

[3-1] National Committee for Quality Assurance. *HEDIS® Benchmarks and Thresholds for Accreditation 2016*. Washington, DC: NCQA; January 21, 2016.

[3-2] Given the potential differences in demographic make-up of the HMP population and services received from the HMP health plans compared to the adult Medicaid population, caution should be exercised when interpreting the comparisons to Adult Medicaid NCQA HEDIS Benchmarks and Thresholds for Accreditation.

Table 3-7 shows the overall member satisfaction ratings on each of the four global ratings.

Table 3-7 – National Comparisons – Global Ratings

Plan Name	Rating of Health Plan	Rating of All Health Care	Rating of Personal Doctor	Rating of Specialist Seen Most Often
MDHHS HMP Program	★★★ 2.43	★★★ 2.37	★★ 2.49	★★★ 2.52
Aetna Better Health of Michigan	★ 2.27	★ 2.25	★★ 2.43	★★★ 2.53
Blue Cross Complete of Michigan	★★★ 2.44	★★★ 2.41	★★★★ 2.53	★★★★★ 2.62
HAP Midwest Health Plan	★★+ 2.37	★★★★+ 2.43	★+ 2.22	★★★★★+ 2.73
Harbor Health Plan	★★ 2.37	★ 2.21	★ 2.35	★ 2.47
McLaren Health Plan	★★★ 2.48	★★★★★ 2.47	★★★★ 2.56	★★★★★ 2.63
Meridian Health Plan of Michigan	★★ 2.41	★★★ 2.36	★★ 2.43	★ 2.43
Molina Healthcare of Michigan	★★ 2.38	★★★ 2.36	★★ 2.47	★★ 2.50
Priority Health Choice, Inc.	★★★★★ 2.55	★★★★ 2.43	★★★ 2.50	★★★★ 2.58
Total Health Care, Inc.	★★★ 2.46	★★★★ 2.44	★★★★ 2.53	★★★ 2.52
UnitedHealthcare Community Plan	★★★ 2.44	★★ 2.31	★★ 2.46	★ 2.45
Upper Peninsula Health Plan	★★★ 2.46	★★★ 2.37	★★★★ 2.56	★ 2.46

+ Indicates fewer than 100 responses. Caution should be exercised when evaluating these results.

The MDHHS HMP Program scored at or between the 50th and 74th percentiles for the Rating of Health Plan, Rating of All Health Care, and Rating of Specialist Seen Most Often global ratings. In addition, the MDHHS HMP Program scored at or between the 25th and 49th percentile for the Rating of Personal Doctor global rating. The MDHHS HMP Program did not score at or above the 75th percentile nor below the 25th percentile for any of the global ratings.

Table 3-8 shows the overall member satisfaction ratings on four of the composite measures.[3-3]

Table 3-8 – National Comparisons – Composite Measures

Plan Name	Getting Needed Care	Getting Care Quickly	How Well Doctors Communicate	Customer Service
MDHHS HMP Program	★★★ 2.39	★★ 2.40	★★★★★ 2.66	★★★★ 2.59
Aetna Better Health of Michigan	★ 2.27	★ 2.34	★★★★★ 2.64	★★★★★ 2.66
Blue Cross Complete of Michigan	★★★★★ 2.45	★★★ 2.45	★★★★★ 2.71	★★★★★ 2.68
HAP Midwest Health Plan	★★★★★+ 2.47	★★★+ 2.42	★★★+ 2.56	★★★★★+ 2.79
Harbor Health Plan	★ 2.28	★ 2.29	★★★★★ 2.70	★★★★ 2.58
McLaren Health Plan	★★★★★ 2.48	★★★ 2.43	★★★★★ 2.71	★★★+ 2.54
Meridian Health Plan of Michigan	★★★★ 2.43	★★ 2.41	★★★★ 2.62	★★★★ 2.58
Molina Healthcare of Michigan	★★★ 2.39	★★ 2.41	★★★ 2.57	★★ 2.52
Priority Health Choice, Inc.	★★★★★ 2.46	★★★ 2.42	★★★★★ 2.64	★★★★★ 2.61
Total Health Care, Inc.	★★★★ 2.42	★★★★★ 2.51	★★★★★ 2.72	★★★★ 2.59
UnitedHealthcare Community Plan	★ 2.27	★★ 2.36	★★★★ 2.59	★★ 2.51
Upper Peninsula Health Plan	★★★ 2.41	★★ 2.38	★★★★★ 2.72	★★★★+ 2.58

+ Indicates fewer than 100 responses. Caution should be exercised when evaluating these results.

The MDHHS HMP Program scored at or above the 90th percentile for the How Well Doctors Communicate composite measure, and scored at or between the 75th and 89th percentiles for the Customer Service composite measure. In addition, the MDHHS HMP Program scored at or between the 50th and 74th percentiles for the Getting Needed Care composite measure, and scored at or between the 25th and 49th percentiles for the Getting Care Quickly composite measure. The MDHHS HMP Program did not score below the 25th percentile for any of the composite measures.

[3-3] NCQA does not publish national benchmarks and thresholds for Shared Decision Making; therefore, this CAHPS measure was excluded from the National Comparisons analysis.

Statewide Comparisons

For purposes of the Statewide Comparisons analysis, HSAG calculated top-box rates (i.e., rates of satisfaction) for each global rating and composite measure. A "top-box" response was defined as follows:

- "9" or "10" for the global ratings.
- "Usually" or "Always" for the Getting Needed Care, Getting Care Quickly, How Well Doctors Communicate, and Customer Service composites.
- "Yes" for the Shared Decision Making composite.

HSAG also calculated overall rates for the Effectiveness of Care measures: 1) Medical Assistance with Smoking and Tobacco Use Cessation and 2) Aspirin Use and Discussion. Refer to the Reader's Guide section for more detailed information regarding the calculation of these measures.

The MDHHS HMP Program results were weighted based on the eligible population for each adult population (i.e., HMP health plans). HSAG compared the HMP health plan results to the MDHHS HMP Program average to determine if the HMP health plan results were significantly different than the MDHHS HMP Program average. The NCQA adult Medicaid national averages also are presented for comparison.[3-4,3-5] Colors in the figures note statistically significant differences. Green indicates a top-box rate that was statistically significantly higher than the MDHHS HMP Program average. Conversely, red indicates a top-box rate that was statistically significantly lower than the MDHHS HMP Program average. Blue represents top-box rates that were not statistically significantly different from the MDHHS HMP Program average. Health plan/program rates with fewer than 100 respondents are denoted with a cross (+). Results with fewer than 11 responses are denoted as "Not Applicable." Caution should be used when evaluating rates derived from fewer than 100 respondents.

In some instances, the top-box rates presented for two plans may be similar, but one was statistically different from the MDHHS HMP Program average, and the other was not. In these instances, it was the difference in the number of respondents between the two plans that explains the different statistical results. It is more likely that a significant result will be found in a plan with a larger number of respondents.

[3-4] Given the potential differences in demographic make-up of the HMP population and services received from the HMP health plans compared to the adult Medicaid population, caution should be exercised when interpreting the comparisons to Adult Medicaid national averages.

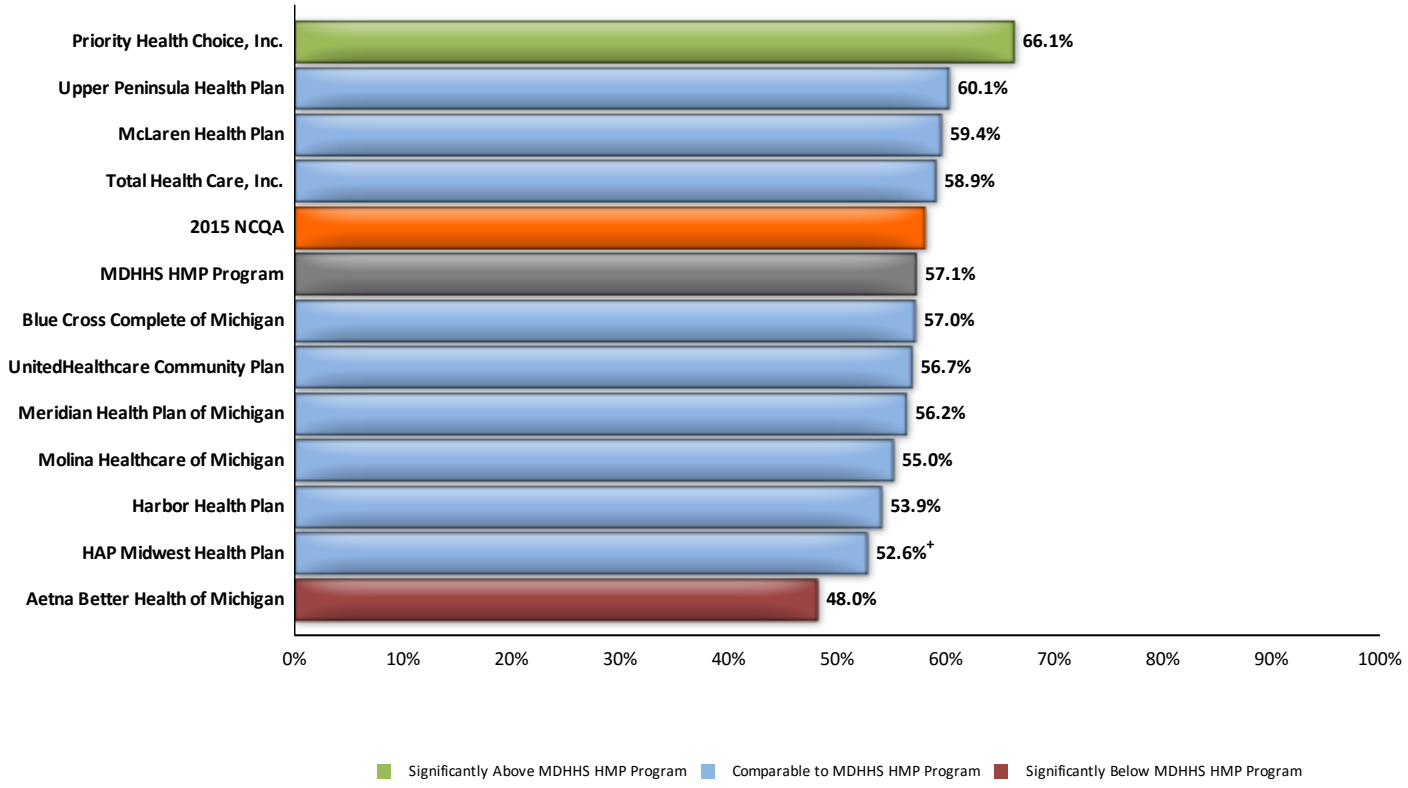
[3-5] The source for the national data contained in this publication is Quality Compass® 2015 and is used with the permission of the National Committee for Quality Assurance (NCQA). Quality Compass 2015 includes certain CAHPS data. Any data display, analysis, interpretation, or conclusion based on these data is solely that of the authors, and NCQA specifically disclaims responsibility for any such display, analysis, interpretation, or conclusion. Quality Compass is a registered trademark of NCQA. CAHPS® is a registered trademark of AHRQ.

Global Ratings

Rating of Health Plan

Adult members were asked to rate their health plan on a scale of 0 to 10, with 0 being the "worst health plan possible" and 10 being the "best health plan possible." Figure 3-1 shows the Rating of Health Plan top-box rates.

Figure 3-1 – Rating of Health Plan Top-Box Rates

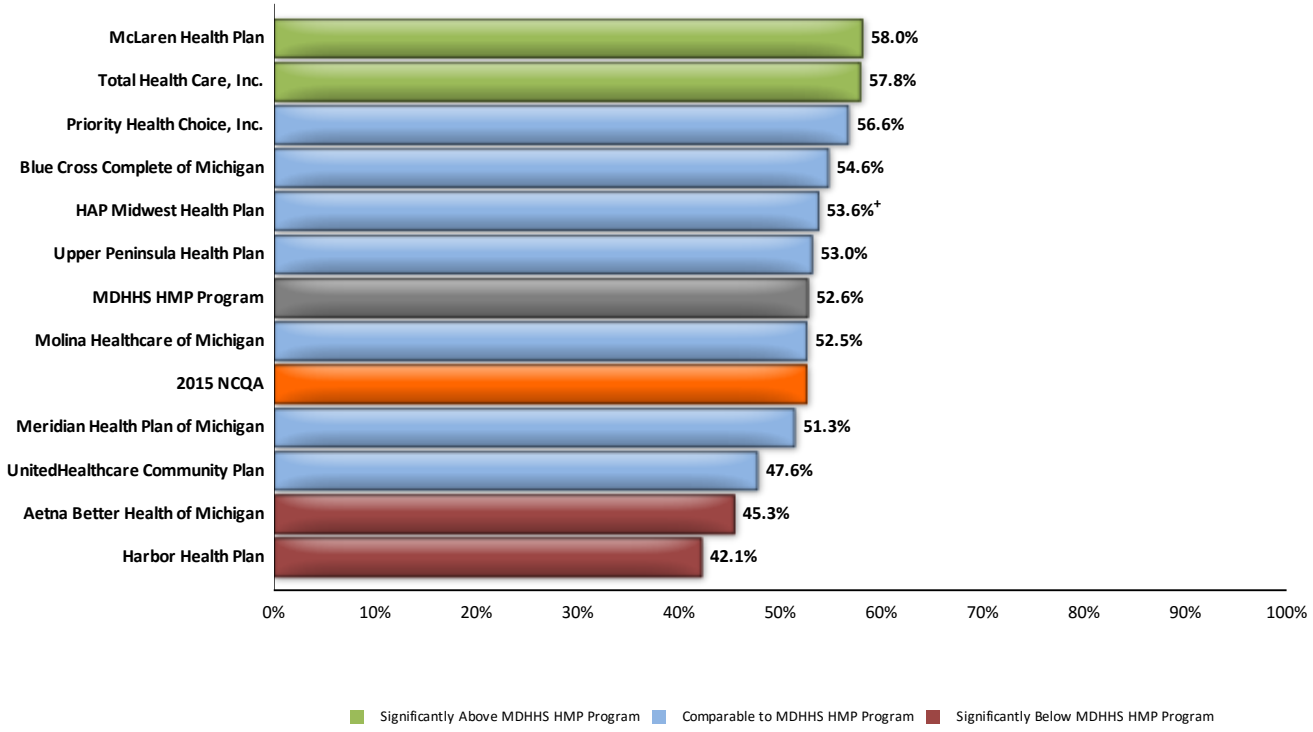


Note: + indicates fewer than 100 responses

Rating of All Health Care

Adult members were asked to rate all their health care on a scale of 0 to 10, with 0 being the "worst health care possible" and 10 being the "best health care possible." Figure 3-2 shows the Rating of All Health Care top-box rates.

Figure 3-2 – Rating of All Health Care Top-Box Rates

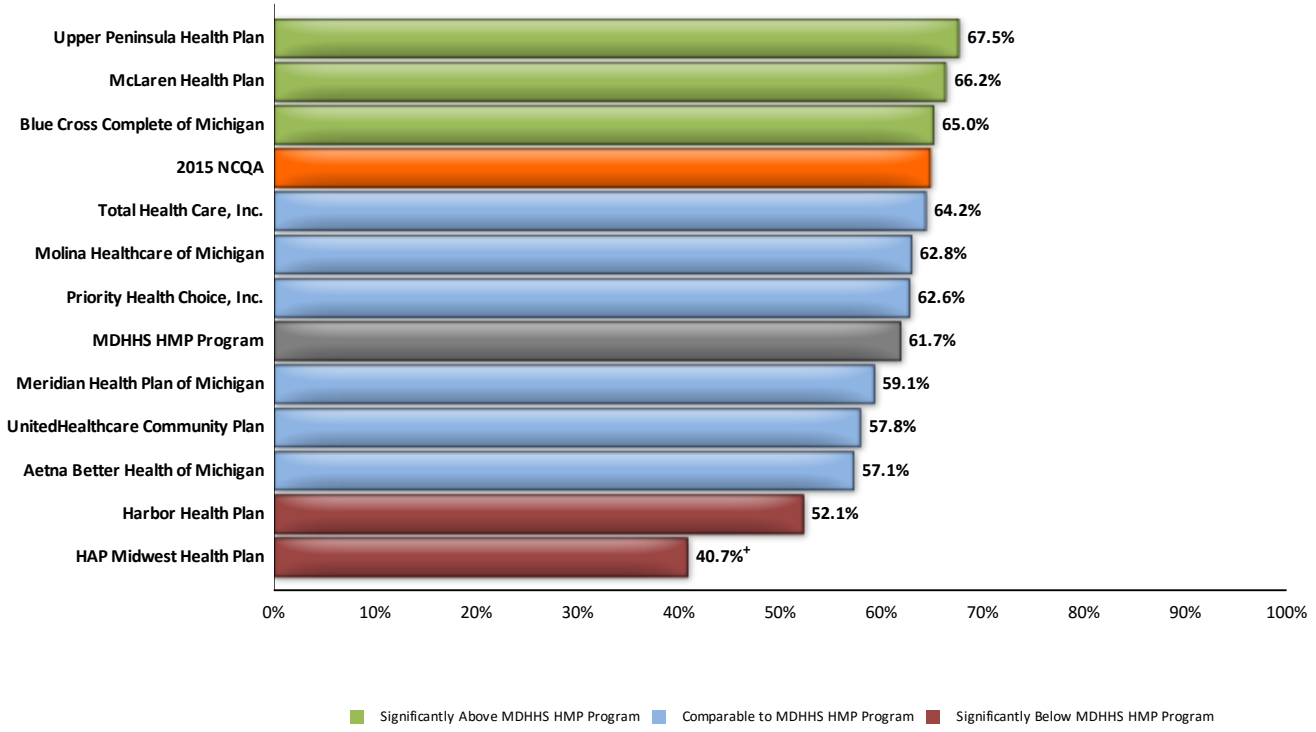


Note: + indicates fewer than 100 responses

Rating of Personal Doctor

Adult members were asked to rate their personal doctor on a scale of 0 to 10, with 0 being the "worst personal doctor possible" and 10 being the "best personal doctor possible." Figure 3-3 shows the Rating of Personal Doctor top-box rates.

Figure 3-3 – Rating of Personal Doctor Top-Box Rates

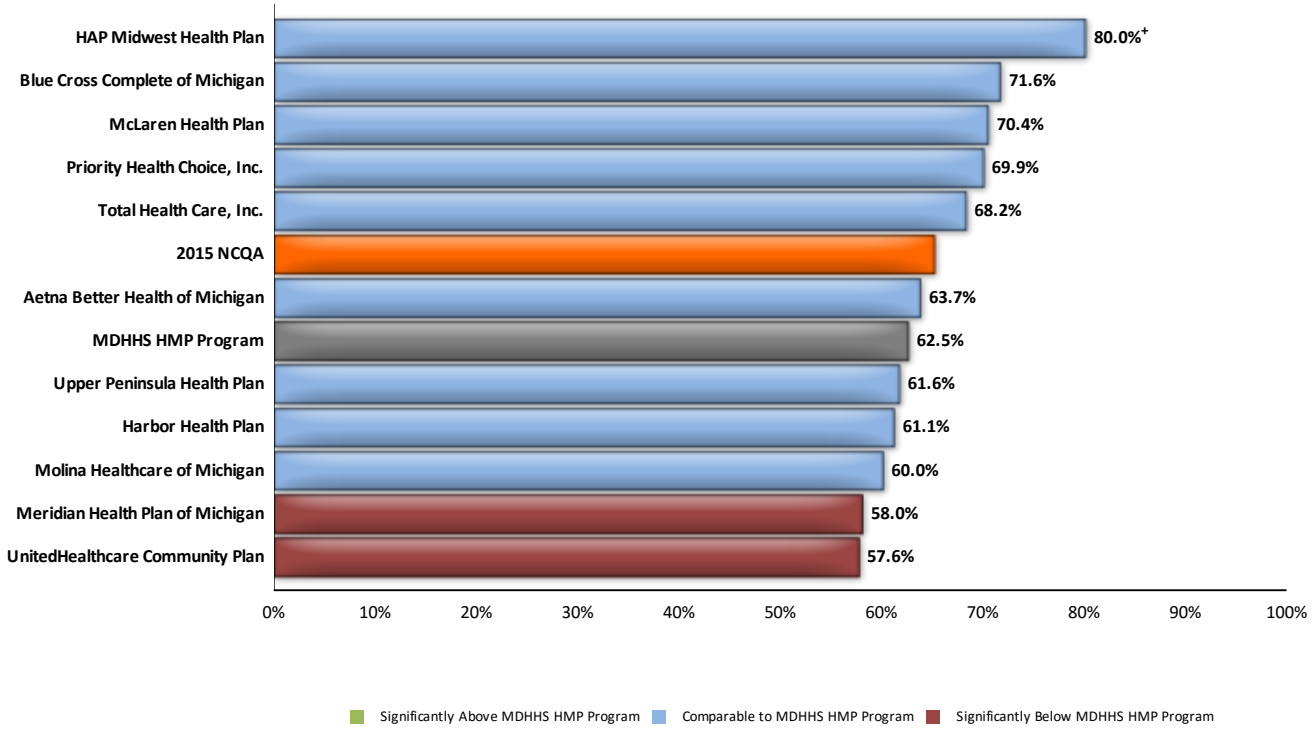


Note: + indicates fewer than 100 responses

Rating of Specialist Seen Most Often

Adult members were asked to rate their specialist on a scale of 0 to 10, with 0 being the "worst specialist possible" and 10 being the "best specialist possible." Figure 3-4 shows the Rating of Specialist Seen Most Often top-box rates.

Figure 3-4 – Rating of Specialist Seen Most Often Top-Box Rates



Note: + indicates fewer than 100 responses

Composite Measures

Getting Needed Care

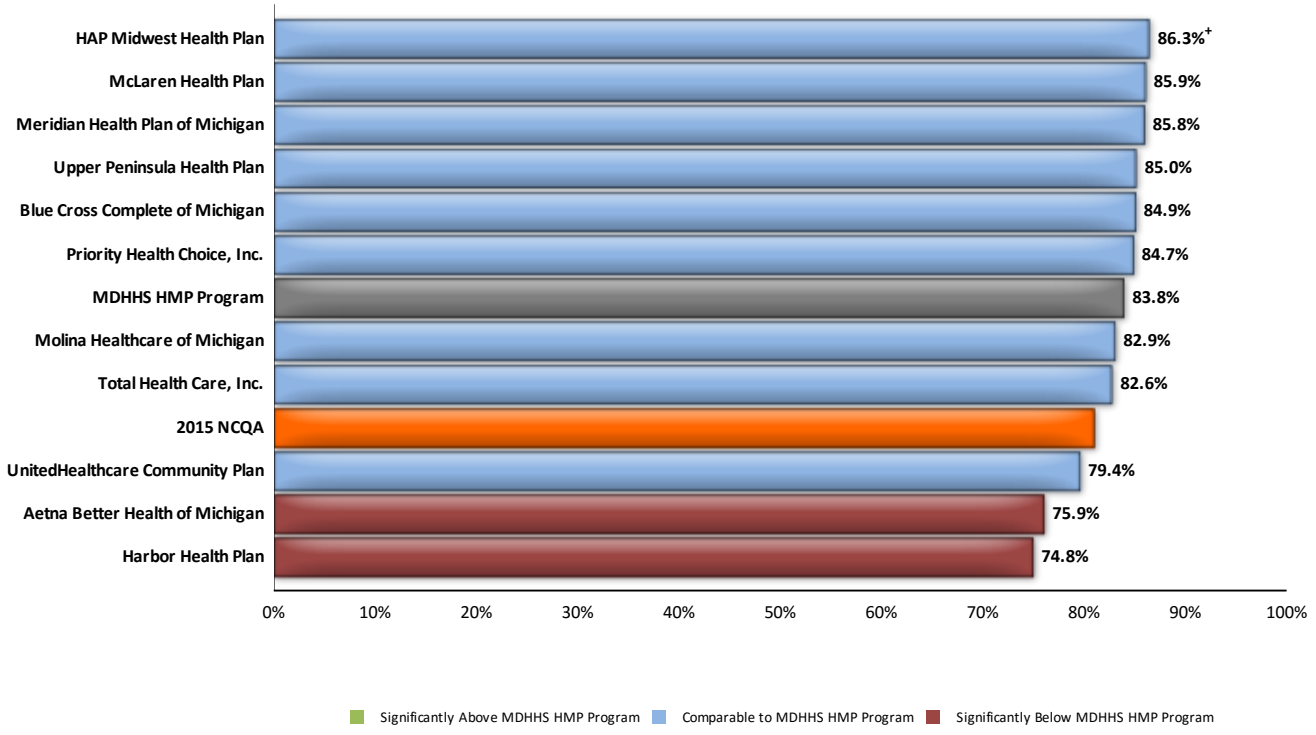
Two questions (Questions 14 and 25 in the CAHPS Adult Medicaid Health Plan Survey) were asked to assess how often it was easy to get needed care:

- **Question 14**. In the last 6 months, how often was it easy to get the care, tests, or treatment you needed?
  - Never
  - Sometimes
  - Usually
  - Always
- **Question 25**. In the last 6 months, how often did you get an appointment to see a specialist as soon as you needed?
  - Never
  - Sometimes
  - Usually
  - Always

For purposes of the Statewide Comparisons analysis, HSAG calculated top-box rates for the Getting Needed Care composite measure, which was defined as a response of "Usually" or "Always."

Figure 3-5 shows the Getting Needed Care top-box rates.

Figure 3-5 – Getting Needed Care Top-Box Rates



Note: + indicates fewer than 100 responses

Getting Care Quickly

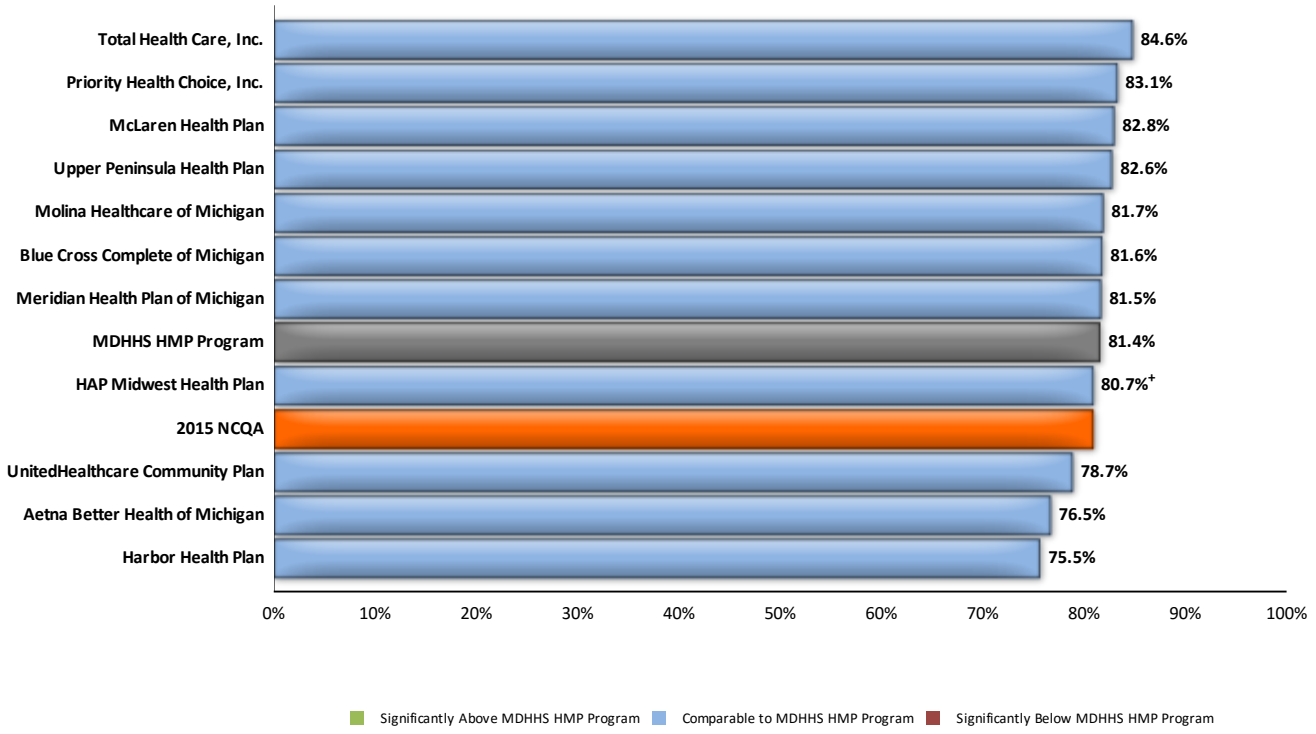
Two questions (Questions 4 and 6 in the CAHPS Adult Medicaid Health Plan Survey) were asked to assess how often adult members received care quickly:

- **Question 4**. In the last 6 months, when you needed care right away, how often did you get care as soon as you needed?
  - Never
  - Sometimes
  - Usually
  - Always
- **Question 6**. In the last 6 months, how often did you get an appointment for a check-up or routine care at a doctor's office or clinic as soon as you needed?
  - Never
  - Sometimes
  - Usually
  - Always

For purposes of the Statewide Comparisons analysis, HSAG calculated top-box rates for the Getting Care Quickly composite measure, which was defined as a response of "Usually" or "Always.

Figure 3-6 shows the Getting Care Quickly top-box rates.

Figure 3-6 – Getting Care Quickly Top-Box Rates



Note: + indicates fewer than 100 responses

How Well Doctors Communicate

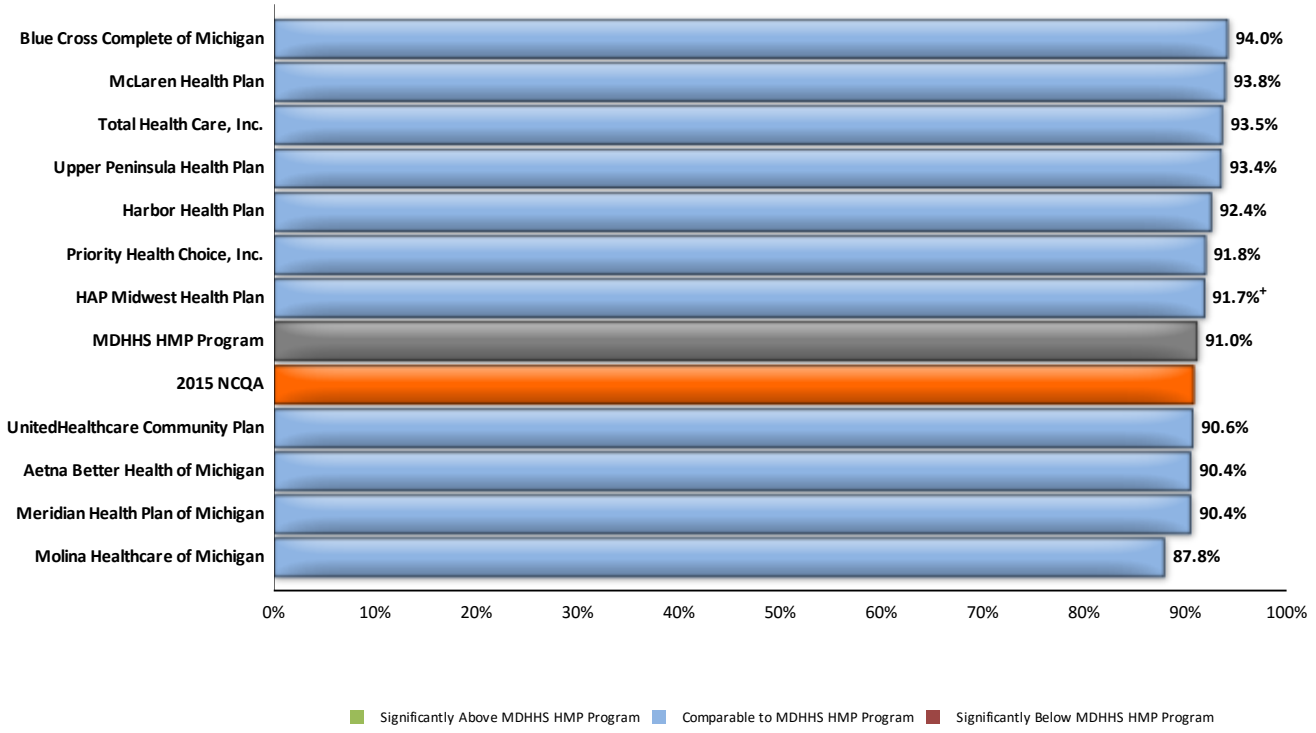
A series of four questions (Questions 17, 18, 19, and 20 in the CAHPS Adult Medicaid Health Plan Survey) was asked to assess how often doctors communicated well:

- **Question 17**. In the last 6 months, how often did your personal doctor explain things in a way that was easy to understand?
  - Never
  - Sometimes
  - Usually
  - Always
- **Question 18**. In the last 6 months, how often did your personal doctor listen carefully to you?
  - Never
  - Sometimes
  - Usually
  - Always
- **Question 19**. In the last 6 months, how often did your personal doctor show respect for what you had to say?
  - Never
  - Sometimes
  - Usually
  - Always
- **Question 20**. In the last 6 months, how often did your personal doctor spend enough time with you?
  - Never
  - Sometimes
  - Usually
  - Always

For purposes of the Statewide Comparisons analysis, HSAG calculated top-box rates for the How Well Doctors Communicate composite measure, which was defined as a response of "Usually" or "Always."

Figure 3-7 shows the How Well Doctors Communicate top-box rates.

Figure 3-7 – How Well Doctors Communicate Top-Box Rates



Note: + indicates fewer than 100 responses

Customer Service

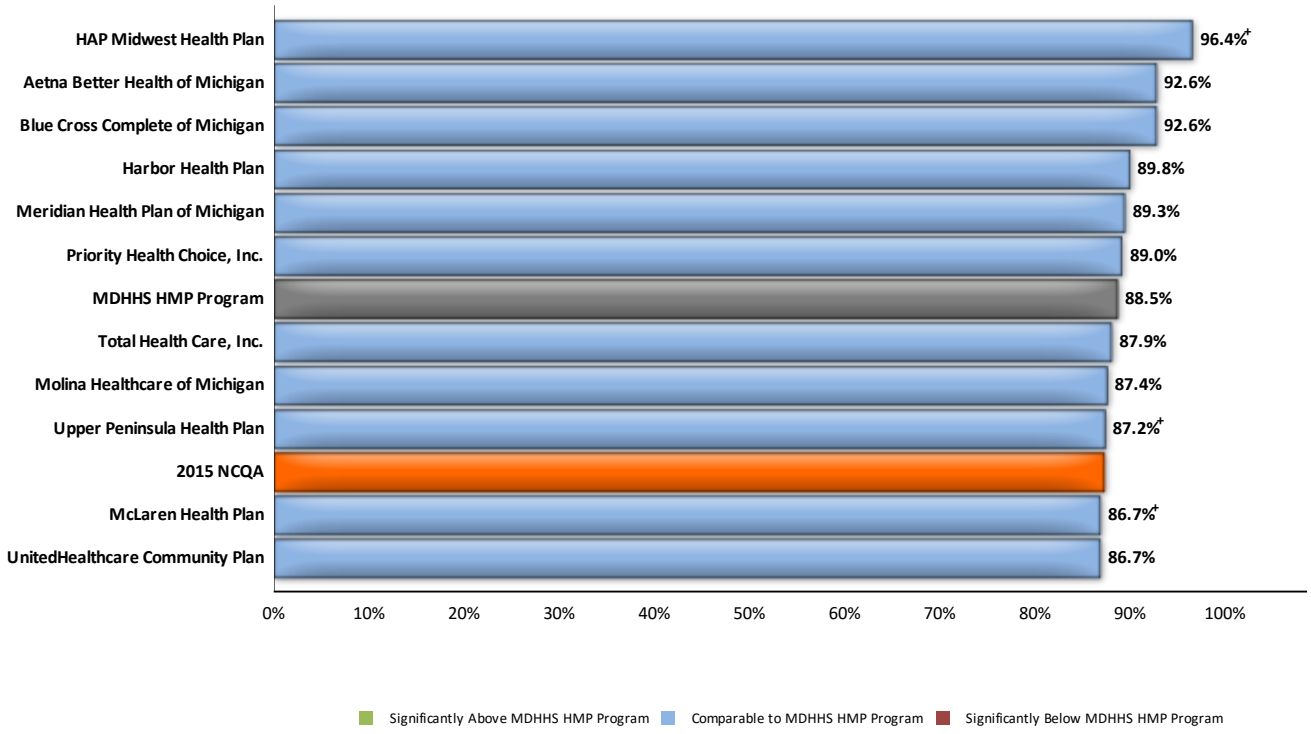
Two questions (Questions 31 and 32 in the CAHPS Adult Medicaid Health Plan Survey) were asked to assess how often adult members were satisfied with customer service:

- **Question 31**. In the last 6 months, how often did your health plan's customer service give you the information or help you needed?
  - Never
  - Sometimes
  - Usually
  - Always
- **Question 32**. In the last 6 months, how often did your health plan's customer service staff treat you with courtesy and respect?
  - Never
  - Sometimes
  - Usually
  - Always

For purposes of the Statewide Comparisons analysis, HSAG calculated top-box rates for the Customer Service composite measure, which was defined as a response of "Usually" or "Always."

Figure 3-8 shows the Customer Service top-box rates.

Figure 3-8 – Customer Service Top-Box Rates



Note: + indicates fewer than 100 responses

Shared Decision Making

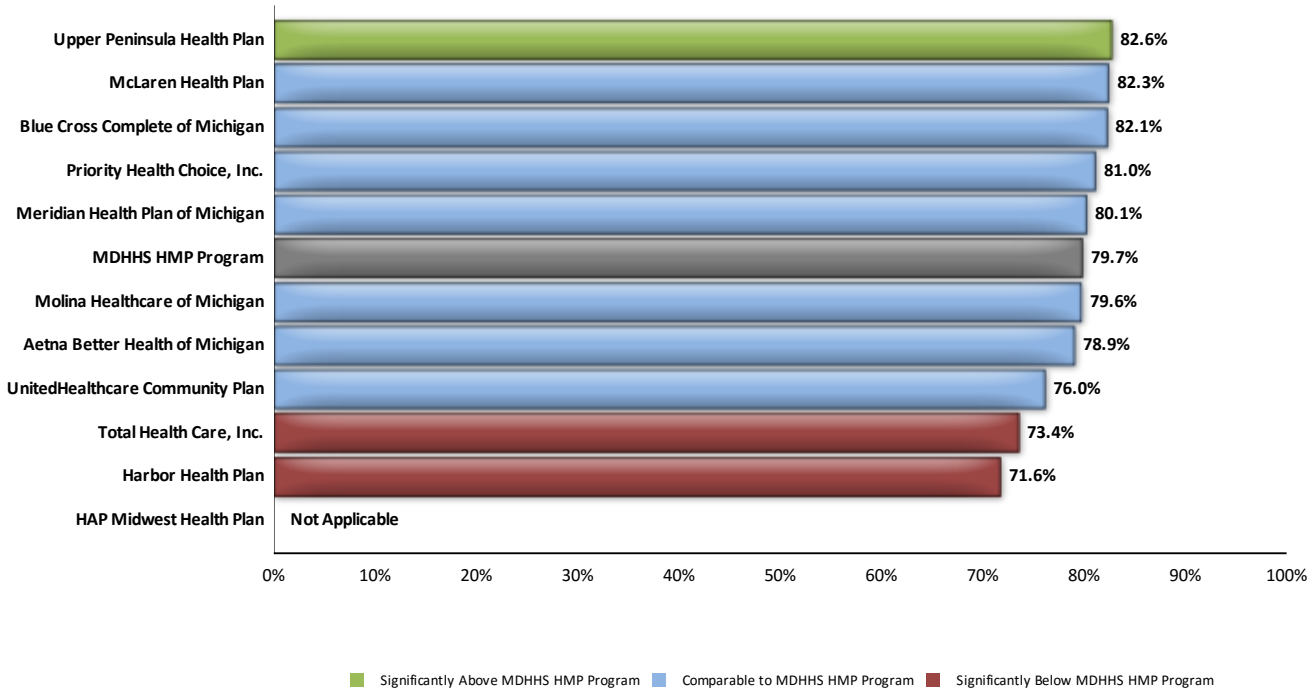
Three questions (Questions 10, 11, and 12 in the CAHPS Adult Medicaid Health Plan Survey) were asked regarding the involvement of adult members in decision making when starting or stopping a prescription medicine:

- **Question 10**. Did you and a doctor or other health provider talk about the reasons you might want to take a medicine?
  - Yes
  - No
- **Question 11**. Did you and a doctor or other health provider talk about the reasons you might not want to take a medicine?
  - Yes
  - No
- **Question 12**. When you talked about starting or stopping a prescription medicine, did a doctor or other health provider ask you what you thought was best for you?
  - Yes
  - No

For purposes of the Statewide Comparisons analysis, HSAG calculated top-box rates for the Shared Decision Making composite measure, which was defined as a response of "Yes."

Figure 3-9 shows the Shared Decision Making top-box rates.

Figure 3-9 – Shared Decision Making Top-Box Rates[3-6]



3-6 In some instances, HMP health plans had fewer than 11 respondents to a survey question. HAP Midwest Health Plan had fewer than 11 respondents to the Shared Decision Making Composite Measure; therefore, a top-box rate could not be presented for this HMP health plan, which is indicated as "Not Applicable" in the figure.

Effectiveness of Care Measures

Medical Assistance with Smoking and Tobacco Use Cessation

Advising Smokers and Tobacco Users to Quit

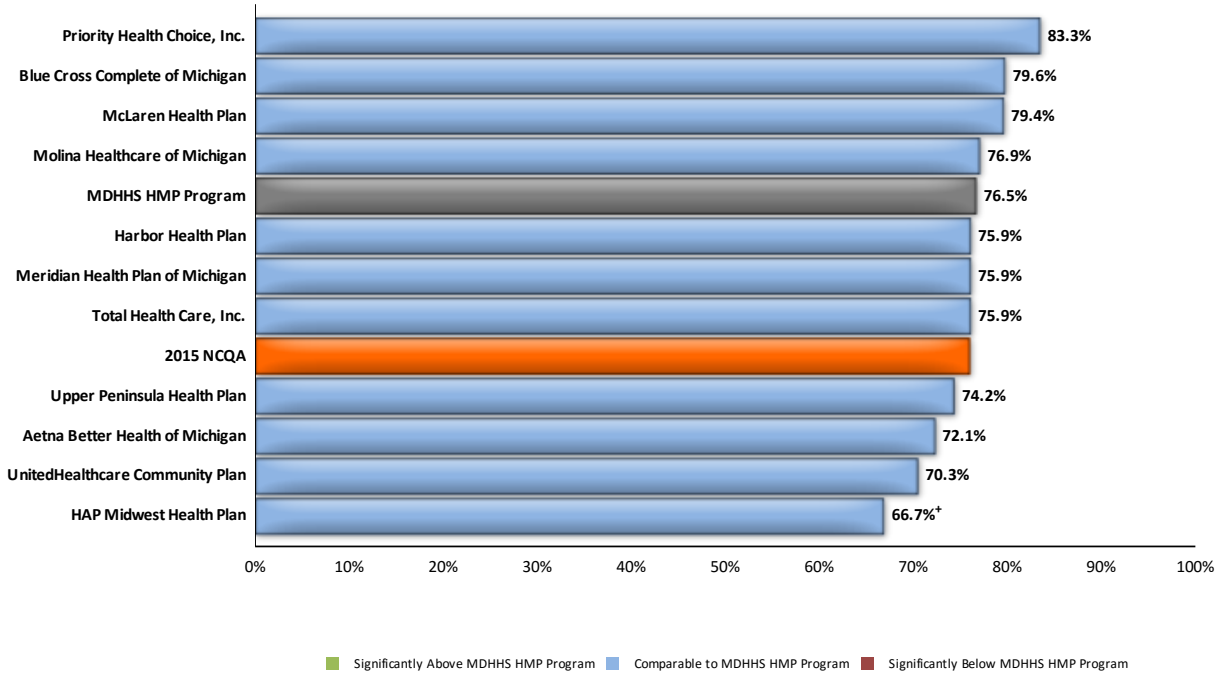
Adult members were asked how often they were advised to quit smoking or using tobacco by a doctor or other health provider (Question 40 in the CAHPS Adult Medicaid Health Plan Survey):

- **Question 40**. In the last 6 months, how often were you advised to quit smoking or using tobacco by a doctor or other health provider in your plan?
  - Never
  - Sometimes
  - Usually
  - Always

The results of this measure represent the percentage of smokers/tobacco users who answered "Sometimes," "Usually," or "Always" to this question.

Figure 3-10 shows the Advising Smokers and Tobacco Users to Quit rates.

Figure 3-10 – Advising Smokers and Tobacco Users to Quit Top-Box Rates



Note: + indicates fewer than 100 responses

Discussing Cessation Medications

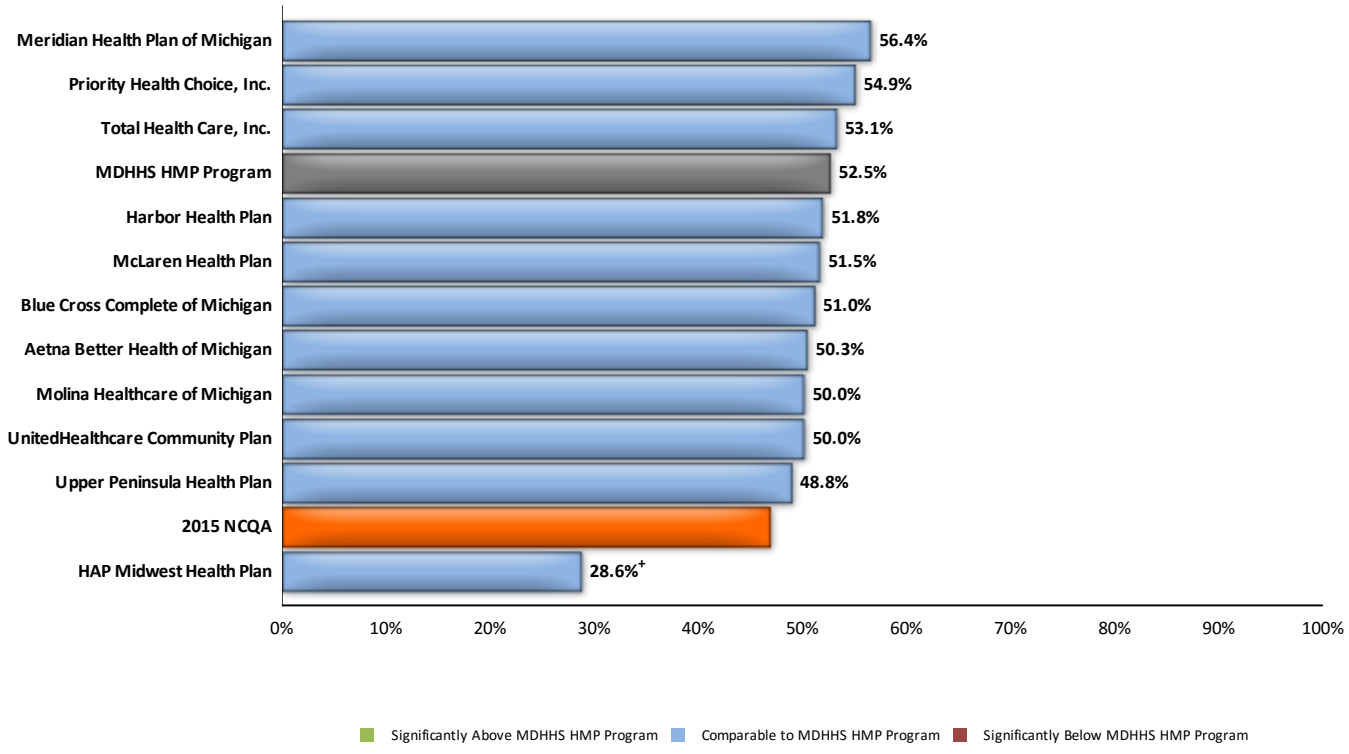
Adult members were asked how often medication was recommended or discussed by a doctor or other health provider to assist them with quitting smoking or using tobacco (Question 41 in the CAHPS Adult Medicaid Health Plan Survey):

- **Question 41**. In the last 6 months, how often was medication recommended or discussed by a doctor or health provider to assist you with quitting smoking or using tobacco? Examples of medication are: nicotine gum, patch, nasal spray, inhaler, or prescription medication.
  - Never
  - Sometimes
  - Usually
  - Always

The results of this measure represent the percentage of smokers/tobacco users who answered "Sometimes," "Usually," or "Always" to this question.

Figure 3-11 shows the Discussing Cessation Medications rates.

Figure 3-11 – Discussing Cessation Medications Top-Box Rates



Note: + indicates fewer than 100 responses

Discussing Cessation Strategies

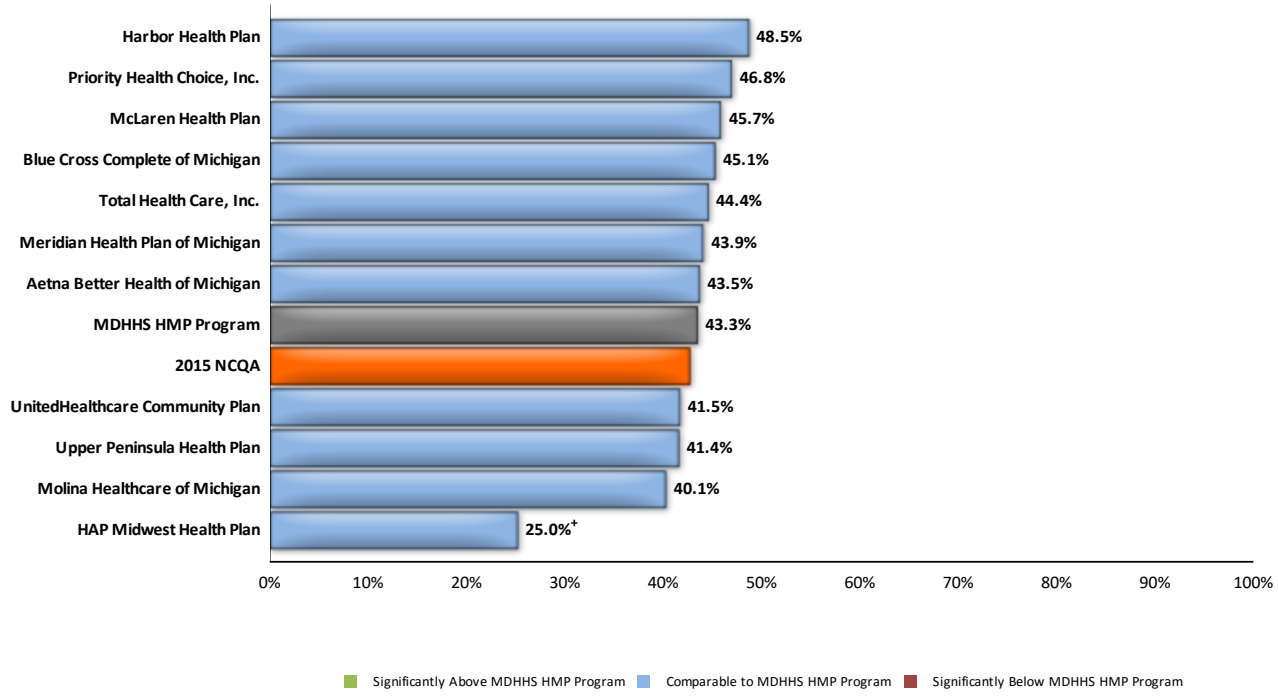
Adult members were asked how often their doctor or health provider discussed or provided methods and strategies other than medication to assist them with quitting smoking or using tobacco (Question 42 in the CAHPS Adult Medicaid Health Plan Survey):

- **Question 42**. In the last 6 months, how often did your doctor or health provider discuss or provide methods and strategies other than medication to assist you with quitting smoking or using tobacco? Examples of methods and strategies are: telephone helpline, individual or group counseling, or cessation program.
  - Never
  - Sometimes
  - Usually
  - Always

The results of this measure represent the percentage of smokers/tobacco users who answered "Sometimes," "Usually," or "Always" to this question.

Figure 3-12 shows the Discussing Cessation Strategies rates.

Figure 3-12 – Discussing Cessation Strategies Top-Box Rates



Note: + indicates fewer than 100 responses

Aspirin Use and Discussion[3-7]

Aspirin Use

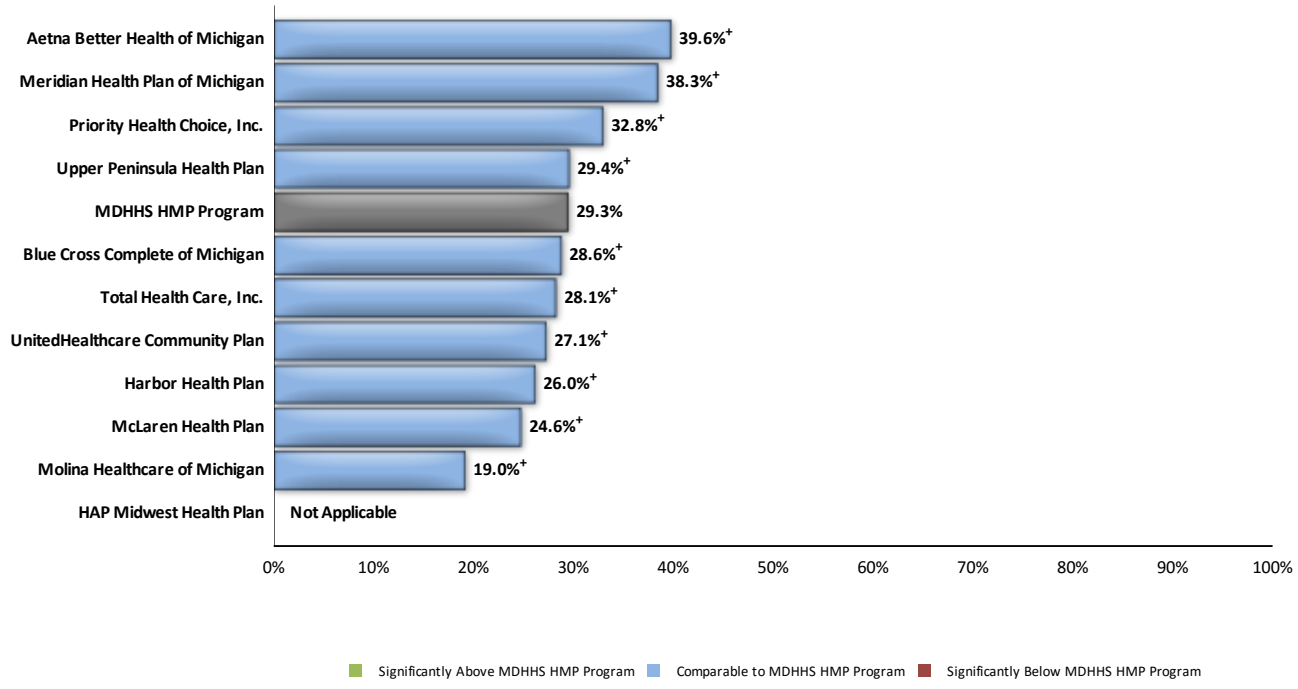
Adult members were asked if they currently take aspirin daily or every other day (Question 43 in the CAHPS Adult Medicaid Health Plan Survey):

- **Question 43.** Do you take aspirin daily or every other day?
  - Yes
  - No
  - Don't know

The results of this measure represent the percentage of respondents who answered "Yes" to this question.

Figure 3-13 shows the Aspirin Use rates.

Figure 3-13 – Aspirin Use Top-Box Rates[3-8]



Note: + indicates fewer than 100 responses

3-7 NCQA does not publish national averages for the Aspirin Use and Discussion measures.

3-8 In some instances, HMP health plans had fewer than 11 respondents to a survey question. HAP Midwest Health Plan had fewer than 11 respondents to the Aspirin Use Effectiveness of Care measure; therefore, a top-box rate could not be presented for this HMP health plan, which is indicated as "Not Applicable" in the figure.

Discussing Aspirin Risks and Benefits

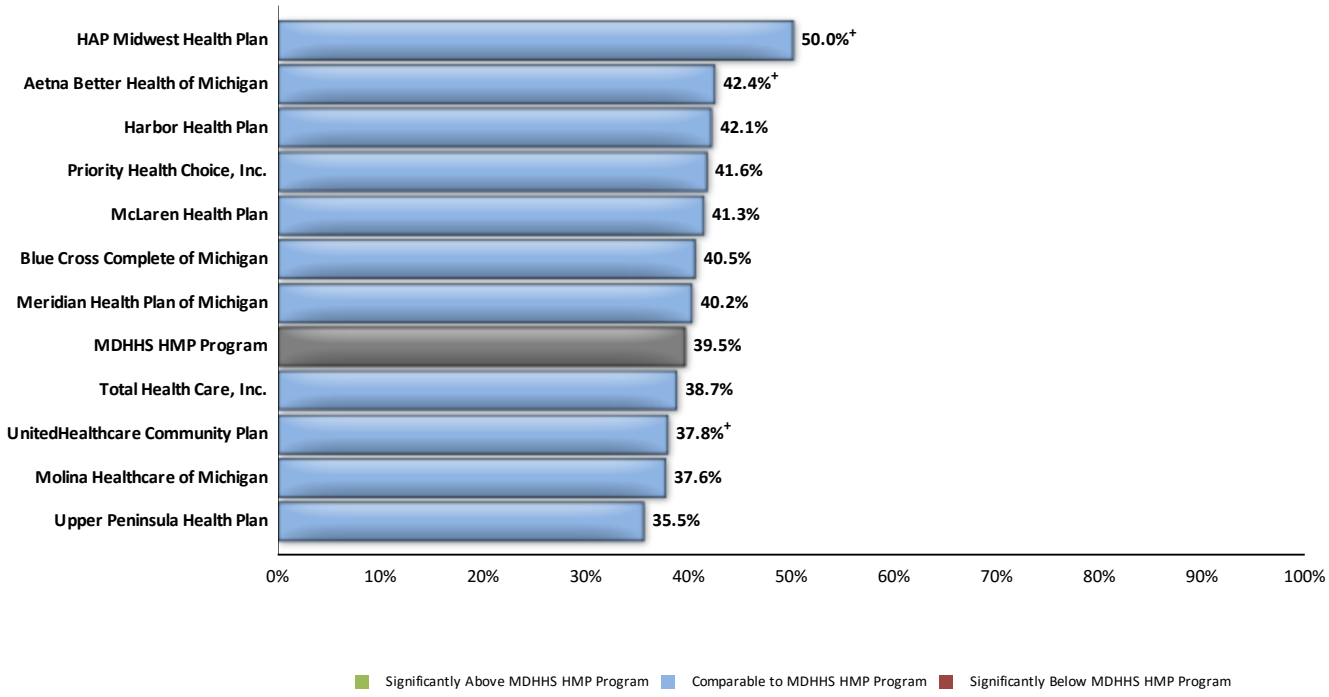
Adult members were asked if a doctor or health provider discussed with them the risks and benefits of aspirin to prevent a heart attack or stroke (Question 45 in the CAHPS Adult Medicaid Health Plan Survey):

- **Question 45**. Has a doctor or health provider ever discussed with you the risks and benefits of aspirin to prevent heart attack or stroke?
  - Yes
  - No

The results of this measure represent the percentage of respondents who answered "Yes" to this question.

Figure 3-14 shows the Discussing Aspirin Risks and Benefits rates.

Figure 3-14 – Discussing Aspirin Risks and Benefits Top-Box Rates



Note: + indicates fewer than 100 responses

Summary of Results

Table 3-9 provides a summary of the Statewide Comparisons results for the global ratings.

Table 3-9 – Statewide Comparisons: Global Ratings

Plan Name	Rating of Health Plan	Rating of All Health Care	Rating of Personal Doctor	Rating of Specialist Seen Most Often
Aetna Better Health of Michigan	↓	↓	—	—
Blue Cross Complete of Michigan	—	—	↑	—
HAP Midwest Health Plan	—+	—+	↓+	—+
Harbor Health Plan	—	↓	↓	—
McLaren Health Plan	—	↑	↑	—
Meridian Health Plan of Michigan	—	—	—	↓
Molina Healthcare of Michigan	—	—	—	—
Priority Health Choice, Inc.	↑	—	—	—
Total Health Care, Inc.	—	↑	—	—
UnitedHealthcare Community Plan	—	—	—	↓
Upper Peninsula Health Plan	—	—	↑	—

\+ indicates fewer than 100 responses. Caution should be exercised when evaluating these results.
↑ indicates the plan's score is statistically significantly higher than the MDHHS HMP Program average.
↓ indicates the plan's score is statistically significantly lower than the MDHHS HMP Program average.
— indicates the plan's score is not statistically significantly different than the MDHHS HMP Program average.

Table 3-10 provides a summary of the Statewide Comparisons for the composite measures.

Table 3-10 – Statewide Comparisons: Composite Measures

Plan Name	Getting Needed Care	Getting Care Quickly	How Well Doctors Communicate	Customer Service	Shared Decision Making
Aetna Better Health of Michigan	↓	—	—	—	—
Blue Cross Complete of Michigan	—	—	—	—	—
HAP Midwest Health Plan	—+	—+	—+	—+	NA
Harbor Health Plan	↓	—	—	—	↓
McLaren Health Plan	—	—	—	—+	—
Meridian Health Plan of Michigan	—	—	—	—	—
Molina Healthcare of Michigan	—	—	—	—	—
Priority Health Choice, Inc.	—	—	—	—	—
Total Health Care, Inc.	—	—	—	—	↓
UnitedHealthcare Community Plan	—	—	—	—	—
Upper Peninsula Health Plan	—	—	—	—+	↑

\+ indicates fewer than 100 responses. Caution should be exercised when evaluating these results.
↑ indicates the plan's score is statistically significantly higher than the MDHHS HMP Program average.
↓ indicates the plan's score is statistically significantly lower than the MDHHS HMP Program average.
— indicates the plan's score is not statistically significantly different than the MDHHS HMP Program average.
NA indicates that results for this measure are not displayed because too few members responded to the questions.

Table 3-11 provides a summary of the Statewide Comparisons for the Effectiveness of Care measures.

Table 3-11 – Statewide Comparisons: Effectiveness of Care Measures

Plan Name	Advising Smokers and Tobacco Users to Quit	Discussing Cessation Medications	Discussing Cessation Strategies	Aspirin Use	Discussing Aspirin Risks and Benefits
Aetna Better Health of Michigan	—	—	—	—+	—+
Blue Cross Complete of Michigan	—	—	—	—+	—
HAP Midwest Health Plan	—+	—+	—+	NA	—+
Harbor Health Plan	—	—	—	—+	—
McLaren Health Plan	—	—	—	—+	—
Meridian Health Plan of Michigan	—	—	—	—+	—
Molina Healthcare of Michigan	—	—	—	—+	—
Priority Health Choice, Inc.	—	—	—	—+	—
Total Health Care, Inc.	—	—	—	—+	—
UnitedHealthcare Community Plan	—	—	—	—+	—+
Upper Peninsula Health Plan	—	—	—	—+	—

\+ indicates fewer than 100 responses. Caution should be exercised when evaluating these results.
↑ indicates the plan's score is statistically significantly higher than the MDHHS HMP Program average.
↓ indicates the plan's score is statistically significantly lower than the MDHHS HMP Program average.
— indicates the plan's score is not statistically significantly different than the MDHHS HMP Program average.
NA indicates that results for this measure are not displayed because too few members responded to the questions.

4. Key Drivers of Satisfaction

Key Drivers of Satisfaction

HSAG performed an analysis of key drivers for three measures: Rating of Health Plan, Rating of All Health Care, and Rating of Personal Doctor. The analysis provides information on: 1) how well the MDHHS HMP Program is performing on the survey item (i.e., question), and 2) how important the item is to overall satisfaction.

Key drivers of satisfaction are defined as those items that (1) have a problem score that is greater than or equal to the program's median problem score for all items examined, and (2) have a correlation that is greater than or equal to the program's median correlation for all items examined. For additional information on the assignment of problem scores, please refer to the Reader's Guide section.

Table 4-1 depicts those items identified for each of the three measures as being key drivers of satisfaction for the MDHHS HMP Program.

Table 4-1 – MDHHS HMP Program Key Drivers of Satisfaction

Rating of Health Plan
Respondents reported that their health plan's customer service did not always give them the information or help they needed.
Respondents reported that information in written materials or on the Internet about how the health plan works did not always provide the information they needed.
Respondents reported that forms from their health plan were often not easy to fill out.
Respondents reported that it was often not easy to obtain appointments with specialists.
Rating of All Health Care
Respondents reported that when they talked about starting or stopping a prescription medicine, a doctor or other health provider did not ask what they thought was best for them.
Respondents reported that their personal doctor did not always seem informed and up-to-date about the care they received from other doctors or health providers.
Respondents reported that it was often not easy to obtain appointments with specialists.
Rating of Personal Doctor
Respondents reported that their personal doctor did not always seem informed and up-to-date about the care they received from other doctors or health providers.

5. Survey Instrument

Survey Instrument

The survey instrument selected was the CAHPS 5.0 Adult Medicaid Health Plan Survey with the HEDIS supplemental item set. This section provides a copy of the survey instrument.

MDHHS
Michigan Department of Health & Human Services
RICK SNYDER, GOVERNOR | NICK LYON, DIRECTOR

DataStat

Your privacy is protected. The research staff will not share your personal information with anyone without your OK. Personally identifiable information will not be made public and will only be released in accordance with federal laws and regulations.

You may choose to answer this survey or not. If you choose not to, this will not affect the benefits you get. You may notice a number on the cover of this survey. This number is ONLY used to let us know if you returned your survey so we don't have to send you reminders.

If you want to know more about this study, please call 1-800-839-3455.

SURVEY INSTRUCTIONS

- **Please be sure to fill the response circle <u>completely</u>. Use only <u>black or blue ink</u> or <u>dark pencil</u> to complete the survey.**

Correct Mark ● **Incorrect Marks** 

- **You are sometimes told to skip over some questions in the survey. When this happens you will see an arrow with a note that tells you what question to answer next, like this:**

● **Yes** ➔ ***Go to Question 1***
○ **No**

START HERE

1. **Our records show that you are now in [HEALTH PLAN NAME]. Is that right?**

○ Yes ➔ ***Go to Question 3***
○ No

2. **What is the name of your health plan? (Please print)**

_____

YOUR HEALTH CARE IN THE LAST 6 MONTHS

These questions ask about your own health care. Do not include care you got when you stayed overnight in a hospital. Do not include the times you went for dental care visits.

3. In the last 6 months, did you have an illness, injury, or condition that needed care right away in a clinic, emergency room, or doctor's office?

- ○ Yes
- ○ No ➔ ***Go to Question 5***

4. In the last 6 months, when you needed care right away, how often did you get care as soon as you needed?

- ○ Never
- ○ Sometimes
- ○ Usually
- ○ Always

5. In the last 6 months, did you make any appointments for a check-up or routine care at a doctor's office or clinic?

- ○ Yes
- ○ No ➔ ***Go to Question 7***

6. In the last 6 months, how often did you get an appointment for a check-up or routine care at a doctor's office or clinic as soon as you needed?

- ○ Never
- ○ Sometimes
- ○ Usually
- ○ Always

7. In the last 6 months, not counting the times you went to an emergency room, how many times did you go to a doctor's office or clinic to get health care for yourself?

- ○ None ➔ ***Go to Question 15***
- ○ 1 time
- ○ 2
- ○ 3
- ○ 4
- ○ 5 to 9
- ○ 10 or more times

8. In the last 6 months, did you and a doctor or other health provider talk about specific things you could do to prevent illness?

- ○ Yes
- ○ No

9. In the last 6 months, did you and a doctor or other health provider talk about starting or stopping a prescription medicine?

- ○ Yes
- ○ No ➔ ***Go to Question 13***

10. Did you and a doctor or other health provider talk about the reasons you might want to take a medicine?

- ○ Yes
- ○ No

11. Did you and a doctor or other health provider talk about the reasons you might not want to take a medicine?

- ○ Yes
- ○ No

12. When you talked about starting or stopping a prescription medicine, did a doctor or other health provider ask you what you thought was best for you?

- ○ Yes
- ○ No

13. Using any number from 0 to 10, where 0 is the worst health care possible and 10 is the best health care possible, what number would you use to rate all your health care in the last 6 months?

○	○	○	○	○	○	○	○	○	○	○
0	1	2	3	4	5	6	7	8	9	10

Worst Health Care Possible — Best Health Care Possible

14. In the last 6 months, how often was it easy to get the care, tests, or treatment you needed?

- ○ Never
- ○ Sometimes
- ○ Usually
- ○ Always

YOUR PERSONAL DOCTOR

15. A personal doctor is the one you would see if you need a check-up, want advice about a health problem, or get sick or hurt. Do you have a personal doctor?

- ○ Yes
- ○ No ➔ ***Go to Question 24***

16. In the last 6 months, how many times did you visit your personal doctor to get care for yourself?

- ○ None ➔ ***Go to Question 23***
- ○ 1 time
- ○ 2
- ○ 3
- ○ 4
- ○ 5 to 9
- ○ 10 or more times

17. In the last 6 months, how often did your personal doctor explain things in a way that was easy to understand?

- ○ Never
- ○ Sometimes
- ○ Usually
- ○ Always

18. In the last 6 months, how often did your personal doctor listen carefully to you?

- ○ Never
- ○ Sometimes
- ○ Usually
- ○ Always

19. In the last 6 months, how often did your personal doctor show respect for what you had to say?

- ○ Never
- ○ Sometimes
- ○ Usually
- ○ Always

20. In the last 6 months, how often did your personal doctor spend enough time with you?

- ○ Never
- ○ Sometimes
- ○ Usually
- ○ Always

21. In the last 6 months, did you get care from a doctor or other health provider besides your personal doctor?

- ○ Yes
- ○ No ➔ ***Go to Question 23***

22. In the last 6 months, how often did your personal doctor seem informed and up-to-date about the care you got from these doctors or other health providers?

- ○ Never
- ○ Sometimes
- ○ Usually
- ○ Always

23. Using any number from 0 to 10, where 0 is the worst personal doctor possible and 10 is the best personal doctor possible, what number would you use to rate your personal doctor?

○	○	○	○	○	○	○	○	○	○	○
0	1	2	3	4	5	6	7	8	9	10
Worst Personal Doctor Possible										Best Personal Doctor Possible

GETTING HEALTH CARE FROM SPECIALISTS

When you answer the next questions, do <u>not</u> include dental visits or care you got when you stayed overnight in a hospital.

24. Specialists are doctors like surgeons, heart doctors, allergy doctors, skin doctors, and other doctors who specialize in one area of health care.

In the last 6 months, did you make any appointments to see a specialist?

- ○ Yes
- ○ No ➔ ***Go to Question 28***

25. In the last 6 months, how often did you get an appointment to see a specialist as soon as you needed?

- ○ Never
- ○ Sometimes
- ○ Usually
- ○ Always

26. How many specialists have you seen in the last 6 months?

- ○ None ➔ ***Go to Question 28***
- ○ 1 specialist
- ○ 2
- ○ 3
- ○ 4
- ○ 5 or more specialists

27. We want to know your rating of the specialist you saw most often in the last 6 months. Using any number from 0 to 10, where 0 is the worst specialist possible and 10 is the best specialist possible, what number would you use to rate that specialist?

○	○	○	○	○	○	○	○	○	○	○
0	1	2	3	4	5	6	7	8	9	10
Worst Specialist Possible										Best Specialist Possible

YOUR HEALTH PLAN

The next questions ask about your experience with your health plan.

28. In the last 6 months, did you look for any information in written materials or on the Internet about how your health plan works?

- ○ Yes
- ○ No ➔ ***Go to Question 30***

29. In the last 6 months, how often did the written materials or the Internet provide the information you needed about how your health plan works?

- ○ Never
- ○ Sometimes
- ○ Usually
- ○ Always

30. In the last 6 months, did you get information or help from your health plan's customer service?

- ○ Yes
- ○ No ➔ ***Go to Question 33***

31. In the last 6 months, how often did your health plan's customer service give you the information or help you needed?

- ○ Never
- ○ Sometimes
- ○ Usually
- ○ Always

32. In the last 6 months, how often did your health plan's customer service staff treat you with courtesy and respect?

- ○ Never
- ○ Sometimes
- ○ Usually
- ○ Always

33. In the last 6 months, did your health plan give you any forms to fill out?

- ○ Yes
- ○ No ➔ ***Go to Question 35***

34. In the last 6 months, how often were the forms from your health plan easy to fill out?

- ○ Never
- ○ Sometimes
- ○ Usually
- ○ Always

35. Using any number from 0 to 10, where 0 is the worst health plan possible and 10 is the best health plan possible, what number would you use to rate your health plan?

○	○	○	○	○	○	○	○	○	○	○
0	1	2	3	4	5	6	7	8	9	10

Worst Health Plan Possible — Best Health Plan Possible

ABOUT YOU

36. In general, how would you rate your overall health?

- ○ Excellent
- ○ Very Good
- ○ Good
- ○ Fair
- ○ Poor

37. In general, how would you rate your overall <u>mental or emotional</u> health?

- ○ Excellent
- ○ Very Good
- ○ Good
- ○ Fair
- ○ Poor

38. Have you had either a flu shot or flu spray in the nose since July 1, 2015?

- ○ Yes
- ○ No
- ○ Don't know

39. Do you now smoke cigarettes or use tobacco every day, some days, or not at all?

- ○ Every day
- ○ Some days
- ○ Not at all ➔ ***Go to Question 43***
- ○ Don't know ➔ ***Go to Question 43***

40. In the last 6 months, how often were you advised to quit smoking or using tobacco by a doctor or other health provider in your plan?

- ○ Never
- ○ Sometimes
- ○ Usually
- ○ Always

41. In the last 6 months, how often was medication recommended or discussed by a doctor or health provider to assist you with quitting smoking or using tobacco? Examples of medication are: nicotine gum, patch, nasal spray, inhaler, or prescription medication.

- ○ Never
- ○ Sometimes
- ○ Usually
- ○ Always

42. In the last 6 months, how often did your doctor or health provider discuss or provide methods and strategies other than medication to assist you with quitting smoking or using tobacco? Examples of methods and strategies are: telephone helpline, individual or group counseling, or cessation program.

- ○ Never
- ○ Sometimes
- ○ Usually
- ○ Always

43. Do you take aspirin daily or every other day?

- ○ Yes
- ○ No
- ○ Don't know

44. Do you have a health problem or take medication that makes taking aspirin unsafe for you?

- ○ Yes
- ○ No
- ○ Don't know

45. Has a doctor or health provider ever discussed with you the risks and benefits of aspirin to prevent heart attack or stroke?

- ○ Yes
- ○ No

46. Are you aware that you have any of the following conditions? Mark one or more.

- ○ High cholesterol
- ○ High blood pressure
- ○ Parent or sibling with heart attack before the age of 60

47. Has a doctor ever told you that you have any of the following conditions? Mark one or more.

- ○ A heart attack
- ○ Angina or coronary heart disease
- ○ A stroke
- ○ Any kind of diabetes or high blood sugar

48. In the last 6 months, did you get health care 3 or more times for the same condition or problem?

- ○ Yes
- ○ No ➔ ***Go to Question 50***

49. Is this a condition or problem that has lasted for at least 3 months? Do <u>not</u> include pregnancy or menopause.

- ○ Yes
- ○ No

50. Do you now need or take medicine prescribed by a doctor? Do <u>not</u> include birth control.

- ○ Yes
- ○ No ➔ ***Go to Question 52***

51. Is this medicine to treat a condition that has lasted for at least 3 months? Do <u>not</u> include pregnancy or menopause.

- ○ Yes
- ○ No

52. What is your age?

- ○ 18 to 24
- ○ 25 to 34
- ○ 35 to 44
- ○ 45 to 54
- ○ 55 to 64
- ○ 65 to 74
- ○ 75 or older

53. Are you male or female?

- ○ Male
- ○ Female

54. What is the highest grade or level of school that you have completed?

- ○ 8th grade or less
- ○ Some high school, but did not graduate
- ○ High school graduate or GED
- ○ Some college or 2-year degree
- ○ 4-year college graduate
- ○ More than 4-year college degree

55. Are you of Hispanic or Latino origin or descent?

- ○ Yes, Hispanic or Latino
- ○ No, Not Hispanic or Latino

56. What is your race? Mark one or more.

- ○ White
- ○ Black or African-American
- ○ Asian
- ○ Native Hawaiian or other Pacific Islander
- ○ American Indian or Alaska Native
- ○ Other

57. Did someone help you complete this survey?

- ○ Yes ➔ ***Go to Question 58***
- ○ No ➔ ***Thank you. Please return the completed survey in the postage-paid envelope.***

58. How did that person help you? Mark one or more.

- ○ Read the questions to me
- ○ Wrote down the answers I gave
- ○ Answered the questions for me
- ○ Translated the questions into my language
- ○ Helped in some other way

Thanks again for taking the time to complete this survey! Your answers are greatly appreciated.

When you are done, please use the enclosed prepaid envelope to mail the survey to:

DataStat, 3975 Research Park Drive, Ann Arbor, MI 48108

ATTACHMENT B
Demonstration Evaluation Plan

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Section 1115 Demonstration Waiver Amendment
Evaluation Proposal

Evaluation Proposal Prepared by
The Institute for Healthcare Policy & Innovation
University of Michigan

October 20, 2014

Centers for Medicare & Medicaid Services
Evaluation Design

ATTACHMENT B
Demonstration Evaluation Plan

Table of Contents

ATTACHMENT B
Demonstration Evaluation Plan

Evaluation start date: June 1, 2014
Evaluation end date: September 30, 2019

I. Brief Overview and History of the Demonstration

On December 30, 2013, the Centers for Medicare & Medicaid Services approved amendments to Michigan's existing Section 1115 Demonstration, which had been known as the Adult Benefits Waiver. These amendments to the Section 1115 Demonstration authorize the creation of a new program known as the Healthy Michigan Plan, enacted by the Michigan legislature and signed by Governor Snyder in Public Act 107 of 2013. The Centers for Medicare & Medicaid Services' approval of this plan allows the State to make comprehensive health care coverage available to eligible adults ages 19-64 with incomes at or below 133% of the Federal Poverty Level, who are not currently eligible for Medicare or existing Medicaid programs. An anticipated 300,000-500,000 people are eligible for the Healthy Michigan Plan, including an estimated 60,000 adults previously covered by the Adult Benefits Waiver.

Since 2004, the Adult Benefits Waiver program has provided a limited ambulatory benefit package to previously uninsured, low-income non-pregnant adults ages 19-64, with incomes at or below 35% of the Federal Poverty Level. Adult Benefits Waiver services are provided to beneficiaries primarily through a managed health care delivery system utilizing a network of county-administered health plans and Community Mental Health Services Programs.

The new Healthy Michigan Plan is designed to provide comprehensive health insurance coverage for low-income residents and thereby improve their access to primary care and specialty care when appropriate. Proponents of this plan also anticipate that it will improve the health outcomes and healthy behaviors of newly covered adults and also reduce levels of uncompensated care in the state. Benefits will be provided through existing contracted health plans in the state and will meet the federal benchmark coverage standards, including the 10 essential health benefits. The Healthy Michigan Plan also introduces a number of reforms, including cost-sharing for individuals with incomes above the Federal Poverty Level, the creation of an individual's MI Health Account to record health care expenses and cost-sharing contributions, and opportunities for beneficiaries to reduce their cost-sharing by completing health risk assessments and engaging in healthy behaviors.

This new program became effective April 1, 2014. The transition of current Adult Benefits Waiver beneficiaries and identification and enrollment of newly eligible beneficiaries into the Healthy Michigan Plan is of great importance to the State.

Population groups affected by demonstration

Current Adult Benefits Waiver beneficiaries: Low-income, non-pregnant adults ages 19-64 with income below 35% of the Federal Poverty Level currently enrolled in the Adult Benefits Waiver Program were transitioned into the Healthy Michigan Plan effective April 1, 2014. As approved

by the Centers for Medicare & Medicaid Services, no eligibility redetermination was necessary at the time of transition, though enrollees will need to re-determine eligibility at a later time.

New Healthy Michigan Plan enrollees: Adults ages 19-64 with incomes at or below 133% of the Federal Poverty Level under the Modified Adjusted Gross Income methodology, who do not qualify for existing Medicare or Medicaid programs, are residents of the State of Michigan, and are not pregnant at the time of application will be eligible to receive comprehensive health care coverage through the Healthy Michigan Plan.

II. Objectives & Goals of the Demonstration

The central objective of this demonstration is to improve the health and well-being of Michigan residents by extending health care coverage to low-income individuals who are uninsured or underinsured, and to implement systemic innovations to improve quality and stabilize health care costs.

As approved by the Centers for Medicare & Medicaid Services in the December 30, 2013 Healthy Michigan Plan Section 1115 Demonstration Waiver, the policy goals of the Healthy Michigan Plan are to:

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

Under this demonstration model, the State aims to evaluate the implementation of market-driven principles into a public healthcare insurance program. This evaluation will examine the following six specific domains, as outlined in the Healthy Michigan Plan Section 1115 Demonstration Waiver:

1. "The extent to which the increased availability of health insurance reduces the costs of uncompensated care borne by hospitals;
2. The extent to which availability of affordable health insurance results in a reduction in the number of uninsured/underinsured individuals who reside in Michigan;
3. 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;
4. The extent to which beneficiaries feel that the Healthy Michigan Plan has a positive impact on personal health outcomes and financial well-being;
5. Whether requiring beneficiaries to make contributions toward the cost of their health care has no impact on the continuity of their coverage, and whether collecting an average co-pay from beneficiaries in lieu of copayments at the point of service, and increasing

communication to beneficiaries about their required contributions (through quarterly statements) affects beneficiaries' propensity to use services; and

6. Whether providing a MI Health Account into which beneficiaries' contributions are deposited, that provides quarterly statements that include explanation of benefits (EOB) information and details utilization and contributions, and allows for reductions in future contribution requirements, deters beneficiaries from receiving needed health services or encourages beneficiaries to be more cost-conscious."[4]

III. Demonstration Hypotheses

A. Domain I: Uncompensated Care Analysis

Hypothesis I.1: Uncompensated care in Michigan will decrease significantly.

- Hypothesis I.1A: Uncompensated care in Michigan will decrease significantly *relative to the existing trend in Michigan.*
- Hypothesis I.1B: Uncompensated care will decrease more by percentage *for Michigan hospitals with baseline levels of uncompensated care that are above the average for the state than for hospitals with levels that are below the average for the state.*
- Hypothesis I.1C: Uncompensated care will decrease more by percentage *for Michigan hospitals in areas with above average baseline rates of uninsurance in the state than for hospitals with below state average levels.*
- Hypothesis I.1D: Uncompensated care in Michigan will decrease significantly *relative to states that did not expand their Medicaid programs.*
- Hypothesis I.1E: Trends in uncompensated care in Michigan will not differ significantly *relative to other states that did expand their Medicaid programs.*

B. Domain II: Reduction in the Number of Uninsured

Hypothesis II.1: The uninsured population in Michigan will decrease significantly.

- Hypothesis II.1A: The uninsured population in Michigan will decrease significantly *relative to the existing trend within Michigan.*
- Hypothesis II.1B: The uninsured population in Michigan will decrease *more by percentage for subgroups with higher than average baseline rates of uninsurance in the state than for subgroups with lower than state average baseline rates.*
- Hypothesis II.1C: The uninsured population in Michigan will decrease significantly *relative to states that did not expand their Medicaid programs.*
- Hypothesis II.1D: The uninsured population in Michigan will decrease to a similar degree *relative to states that did expand their Medicaid programs.*

Hypothesis II.2: Medicaid coverage in Michigan will increase significantly.

- Hypothesis II.2A: The Medicaid population in Michigan will increase significantly *relative to the existing trend in Michigan.*

[4] CMS Waiver Approval, December 30, 2013.

- Hypothesis II.2B: The Medicaid population in Michigan will increase significantly *more by percentage for subgroups with rates of uninsurance higher than state average baseline than for subgroups with baseline rate lower than the state average.*
- Hypothesis II.2C: The Medicaid population in Michigan will increase significantly *relative to states that did not expand their Medicaid programs.*
- Hypothesis II.2D: The Medicaid population in Michigan will increase to a similar degree *relative to states that did expand their Medicaid programs.*

C. Domain III: Impact on Healthy Behaviors and Health Outcomes

1. Hypothesis III.1: Emergency Department Utilization
    a. Emergency department utilization among the Healthy Michigan beneficiaries will decrease from the Year 1 baseline;
    b. Healthy Michigan Plan beneficiaries who make regular primary care visits (at least once per year) will have lower adjusted rates of emergency department utilization compared to beneficiaries who do not have primary care visits; and
    c. Healthy Michigan Plan beneficiaries who agree to address at least one behavior change will have lower adjusted rates of emergency department utilization compared to beneficiaries who do not agree to address behavior change.
2. Hypothesis III.2: Healthy Behaviors
    a. Receipt of preventive health services among the Healthy Michigan Plan population will increase from the Year 1 baseline;
    b. Healthy Michigan Plan beneficiaries who make regular primary care visits (at least once per year) will have higher rates of general preventive services compared to beneficiaries who do not have primary care visits;
    c. Healthy Michigan Plan beneficiaries who complete an annual health risk assessment will have higher rates of preventive services compared to beneficiaries who do not complete a health risk assessment;
    d. Healthy Michigan Plan beneficiaries who agree to address at least one behavior change will demonstrate improvement in self-reported health status compared to beneficiaries who do not agree to address behavior change; and
    e. Healthy Michigan Plan beneficiaries who receive incentives for healthy behaviors will have higher rates of preventive services compared to beneficiaries who do not receive such incentives.
3. Hypothesis III.3: Hospital Admissions
    a. Adjusted hospital admission rates for Healthy Michigan Plan beneficiaries will decrease from the Year 1 baseline;
    b. Healthy Michigan Plan beneficiaries who make regular primary care visits (at least once per year) will have lower adjusted rates of hospital admissions compared to beneficiaries who do not have primary care visits; and
    c. Healthy Michigan Plan beneficiaries who agree to address at least one behavior change will have lower adjusted rates of hospital admission compared to beneficiaries who do not agree to address behavior change.

D. Domain IV: Participant Beneficiary Views of the Healthy Michigan Plan

1. Aim IV.1: Describe Healthy Michigan Plan enrollees' consumer behaviors and health

insurance literacy, including knowledge and understanding about the Healthy Michigan Plan, their health plan, benefit coverage, and cost-sharing aspects of their plan.
2. Aim IV.2: Describe Healthy Michigan Plan enrollees' self-reported changes in health status, health behaviors (including medication use), and facilitators and barriers to healthy behaviors (e.g. knowledge about health and health risks, engaged participation in care), and strategies that facilitate or challenge improvements in health behaviors.
3. Aim IV.3: Understand enrollee decisions about when, where and how to seek care, including decisions about emergency department utilization.
4. Aim IV.4: Describe primary care practitioners' experiences with Healthy Michigan Plan beneficiaries, practice approaches and innovation adopted or planned in response to the Healthy Michigan Plan, and future plans regarding care of Healthy Michigan Plan patients.

E. Domains V & VI: Impact of Contribution Requirements & MI Health Accounts

1. **Hypothesis V/VI.1:** Cost-sharing implemented through the MI Health Account framework will be associated with beneficiaries making more efficient use of health care services, as measured by total costs of care over time relative to their initial year of enrollment, and relative to trends in the Healthy Michigan Plan's population below 100% of the Federal Poverty Level that face similar service-specific cost-sharing requirements but not additional contributions towards the cost of their care.
2. **Hypothesis V/VI.2:** Cost-sharing implemented through the MI Health Account framework will be associated with beneficiaries making more effective use of health care services relative to their initial year of enrollment, as indicated by a change in the mix of services from low-value (e.g., non-urgent emergency department visits, low priority office visits) to higher-value categories (e.g., emergency-only emergency department visits, high priority office visits), and relative to trends in the Healthy Michigan Plan's population below 100% of the Federal Poverty Level that face similar service-specific cost-sharing requirements but not additional contributions towards the cost of their care. Several questions on the Healthy Michigan Voices Survey also address this hypothesis.
3. **Hypothesis V/VI.3:** Cost-sharing and contributions implemented through the MI Health Account framework will not be associated with beneficiaries dropping their coverage through the Healthy Michigan Plan.
4. **Hypothesis V/VI.4a:** Exemptions from cost-sharing for specified services for chronic illnesses and rewards implemented through the MI Health Account framework for completing a health risk assessment with a primary care provider and agreeing to behavior changes will be associated with beneficiaries increasing their healthy behaviors and their engagement with healthcare decision-making relative to their initial year of enrollment. Several questions on the Healthy Michigan Voices Survey also address this hypothesis.

   Hypothesis V/VI.4b: This increase in healthy behaviors and engagement will be associated with an improvement in enrollees' health status over time, as measured by changes in elements of their health risk assessments and changes in receipt of recommended preventive care (e.g., flu shots, cancer screening) and adherence to prescribed medications for chronic disease (e.g., asthma controller medications).

IV. Information about Evaluation Entity

The University of Michigan Institute for Healthcare Policy and Innovation is an interdisciplinary institute at a premier public research university. The mission of the Institute is to enhance the health and well-being of local, national, and global populations through innovative health services research that effectively informs public and private efforts to optimize the quality, safety, equity, and affordability of health care. The Institute includes more than 400 health services researchers from 14 schools and colleges across the university, as well as 4 nonprofit private-sector partners and the Veterans Health Administration. Institute faculty members participating in the proposed Healthy Michigan Plan evaluation represent the Medical School, School of Public Health, Institute for Social Research, Ross School of Business, Ford School of Public Policy, and School of Social Work.

V. Timeline

Fiscal Year	Deliverable/Milestone	Domain
2015	Initial Baseline Estimate of the Rate of Uninsurance	II
2016	Interim Report: Primary Care Physician Survey (select measures)	IV
2016	Interim Report: Healthy Michigan Voices Survey (select measures)	IV
2017	Interim Report: Healthy Behaviors and Health Outcomes (select measures)	III
2017	Interim Report: Impact of Cost-Sharing/MI Health Accounts (select measures)	V, VI
2018	Interim Report: Uncompensated Care Analysis	I
2018	Interim Report: Rate of Uninsurance	II
2019	Final Evaluation Report	All

ATTACHMENT B
Demonstration Evaluation Plan

Special Terms and Conditions Requirements

The federal approval of the Healthy Michigan Plan Demonstration is conditioned upon compliance with a set of Special Terms and Conditions. Specific to program evaluation, the Special Terms and Conditions outlined six Domains of Focus that the State must investigate, around which Institute for Healthcare Policy and Innovation faculty leads have developed multiple testable hypotheses (listed above). The evaluation design includes a discussion of these goals, objectives, and specific testable hypotheses, including those that focus specifically on target populations for the demonstration, and more generally on beneficiaries, providers, plans, market areas, and public expenditures.

While some members of the University of Michigan evaluation team are practicing clinicians at the University of Michigan, this team will function independently from the system-level clinical operations of the University of Michigan Health System and those who interact with Department officials around Medicaid reimbursement and clinical policies. The University of Michigan research team will continue to maintain this separation throughout the demonstration evaluation to avoid potential conflicts of interest.

A. Scientific Rigor & Academic Standards

The Centers for Medicare & Medicaid Services approval of the Section 1115 waiver for the Healthy Michigan Plan requires that the evaluation be designed and conducted by researchers who will meet the scientific rigor and research standards of leading academic institutions and academic journal peer review. As detailed throughout this proposed evaluation plan, the faculty members and staff of the University of Michigan Institute for Healthcare Policy and Innovation are national leaders in the fields of health services research, health economics, and population health with substantial experience conducting rigorous evaluations of access to care, quality of care, costs of care, and health outcomes.

As further required by the Centers for Medicare & Medicaid Services, the design of the proposed evaluation includes a discussion of the goals, objectives and specific testable hypotheses, including those that focus specifically on target populations for the demonstration, and more generally on beneficiaries, providers, plans, market areas and public expenditures. The analysis plan addresses all six domains specified in paragraph 69 of the waiver approval with a scientifically rigorous data strategy and evaluation plan. The University of Michigan evaluation team will make careful use of the best available data in each of the six required domains; control for and report limitations of these data and their effects on results; and characterize the generalizability of results.

B. Measures Summary

Outcome measures are described in detail in each specific Domain design and reflect key hypotheses. Importantly, because the design of the Healthy Michigan Plan goes beyond the organization of health care to address the personal health behaviors and choices of enrollees, the selected measures are based on established indicators for both clinical care and personal health-

related behaviors. The evaluation team will utilize its significant expertise to refine existing indicators to better match the goals of the Healthy Michigan Plan.

Because most Healthy Michigan Plan enrollees will not have prior Medicaid coverage, there are limitations around baseline values for the selected measures. The University of Michigan evaluation team will take a dual approach to this limitation: 1) Year 1 of the Healthy Michigan Plan will serve as a baseline from which to measure changes over the course of the demonstration project; and 2) comparison data from comparable populations will be gleaned from national data sources when feasible.

C. Data Handling and Management

The evaluation will use a wide variety of data sources (summarized in Appendix B and detailed in specific Domain designs, as noted), including Medicaid enrollment, utilization, encounter and cost data from the Michigan Department of Community Health Data Warehouse, enrollee survey data (the newly-designed Healthy Michigan Voices Survey), hospital cost reports and filings, and provider survey data.

D. Recognition of other initiatives occurring in the state

A fundamental challenge associated with this evaluation is the fact that the Healthy Michigan Plan is being implemented in the context of broader changes to health insurance markets in Michigan and in other states. In particular, the health insurance exchange, the associated premium tax credits, and the individual mandate all affect consumer and firm behavior. An increase in private insurance coverage as people enroll in plans through the newly established health insurance exchange should reduce the amount of uncompensated care provided to uninsured patients. At the same time, the longer-term trend toward private plans with high deductibles will mean more privately insured patients may not be able to pay large out-of- pocket obligations when they are hospitalized, thereby increasing uncompensated care provided to privately insured patients.

In order to address these challenges, our analysis in Domains I and II will compare Michigan to a "control group" of states that are and are not expanding their Medicaid programs, in order to help isolate the impact of the Healthy Michigan Plan on policy problems like uncompensated care, rates of uninsurance, access to appropriate medical services, and trends in health care utilization and health outcomes.

ATTACHMENT B
Demonstration Evaluation Plan

Domain I: Reduction in Uncompensated Care

Uncompensated Care Analysis *– This evaluation project will examine the impact of reducing the number of uninsured individuals on uncompensated care costs to hospitals in Michigan through the expansion of subsidized insurance.*

I. Hypotheses

Hypothesis I.1: Uncompensated care in Michigan will decrease significantly.

- Hypothesis I.1A: Uncompensated care in Michigan will decrease significantly *relative to the existing trend in Michigan.*
- Hypothesis I.1B: Uncompensated care will decrease more by percentage *for Michigan hospitals with baseline levels of uncompensated care that are above the average for the state than for hospitals with levels that are below the average for the state.*
- Hypothesis I.1C: Uncompensated care will decrease more by percentage *for Michigan hospitals in areas with above average baseline rates of uninsurance in the state than for hospitals with below state average levels.*
- Hypothesis I.1D: Uncompensated care in Michigan will decrease significantly *relative to states that did not expand their Medicaid programs.*
- Hypothesis I.1E: Trends in uncompensated care in Michigan will not differ significantly *relative to other states that did expand their Medicaid programs.*

II. Management/Coordination of Evaluation

A. Evaluation Team

The work on Domains I and II of the evaluation will be conducted by a team of researchers led by two University of Michigan faculty members, Thomas Buchmueller Ph.D. and Helen Levy Ph.D. Buchmueller's primary appointment is in the Ross School of Business, where he holds the Waldo O. Hildebrand Endowed Chair in Risk Management and Insurance and currently serves as the Chair of the Business Economics Area. He has a secondary appointment in the Department of Health Management and Policy in the School of Public Health. Levy is a tenured Research Associate Professor, with appointments in the Institute for Social Research, the Ford School of Public Policy and the Department of Health Management and Policy. She is a Co-Investigator on the Health and Retirement Survey, a longitudinal survey supported by the National Institute on Aging. Buchmueller and Levy are experts on the economics of health insurance and health reform. In 2010-2011, Levy served as the Senior Health Economist at the White House Council of Economic Advisers. Buchmueller succeeded her in this position in 2011-2012.

Additional faculty and staff working on this domain are described in Appendix A.

III. Timeline

A. Overview

Initially, our main activities will be related to background research to improve our understanding of the data and to sharpen our hypotheses, the preparation of analytic data files, and an analysis of baseline measures using those files. Once we have sufficient data from the post-Healthy Michigan Plan period, our main focus will be on evaluating trends in uncompensated care and analyses aimed at disentangling the effect of the Healthy Michigan Plan from other factors affecting hospitals and their provision of uncompensated care.

B. Specific Activities: 6/14 to 10/15

The main data sources for this domain are hospital cost reports and Internal Revenue Service filings (see below). Because these data sources were not created for the purposes of research or evaluation, creating data files that can be used for the analysis will require substantial effort. In order to ensure that we are on track to deliver a rigorous evaluation in state fiscal year 2018, it will be important to develop these files well before then. (If it turns out that the cost report and Internal Revenue Service data are not suitable for our purposes, this will give us time to develop other strategies.)

An important part of this process will involve comparing baseline results from the different sources with the goal of representing the distribution of uncompensated care in the state in a clear and consistent fashion. We will also analyze the baseline data from Michigan and other states to identify appropriate comparison groups for the cross-state components of the analysis. This process will involve merging the hospital level data with state and county level data on measures such as the baseline rate of insurance coverage and population demographics.

Another important initial activity will be to review the relevant academic literature on hospital uncompensated care. This review will build on prior reviews conducted by Drs. Lee and Singh who have conducted substantial research on hospital uncompensated care and community benefit.

C. Specific Activities: 10/15 to 10/19

We will conduct most of the analysis in state fiscal year 2018. By December 2017, we expect to have more than a full year of post-implementation data for all hospitals in Michigan and up to two years of post-implementation data for some.

IV. Performance Measures

A. Specific measures and rationale

A number of indicators of uncompensated care will be used to test the research hypotheses outlined above. Our primary indicators will include measures of uncompensated care from hospitals' Medicare and Medicaid cost reports. In particular, we will focus on hospitals' expenditures on charity care and bad debt, measured in terms of cost rather than full charges. Data from Medicare cost reports on these indicators are available for all Medicare-certified hospitals in the U.S. In the Medicare cost report, we will focus on Schedule S-10, which

provides detailed information on hospital uncompensated care and indigent care. Specifically, we will measure charity care costs using the information in line 23 on Schedule S-10. This number represents the cost of care provided to charity and self-pay patients. To distinguish between charity care and self-pay patients, we will further refine our analysis for Michigan hospitals by using data from the Medicaid cost report. In particular, we will estimate true charity care costs by using information on indigent volume and charges reported by Michigan hospitals on their Medicaid cost report. Data from Medicaid cost reports on these indicators are available for all Michigan hospitals. In addition to charity care, we will examine hospitals' bad debt expense. Specifically, we will measure charity care costs using the information in line 29 on Schedule S-10. This number represents a hospital's bad debt expenditures – measured at cost – after accounting for any Medicare bad debt reimbursement.

We will supplement data from the Medicare and Medicaid cost reports with information on community benefits provided from the hospitals' Internal Revenue Service filings. In particular, we will focus on the amount of charity care and bad debt reported by hospitals on their Internal Revenue Service Form 990 Schedule H. In this form, hospitals are required to report their charity care costs net of any direct offsetting revenue. Hospitals are also required to report their bad debt expenses, at cost. We will compare these to the levels of uncompensated care reported in hospitals' Medicare cost reports to validate our primary estimates. Data from the Form 990 is only available for a subset of hospitals, however. More specifically, only federally tax-exempt hospitals that are either free-standing or system-affiliated but report their community benefit at the individual hospital level are required to file Form 990 with the Internal Revenue Service. These data sources are described in more detail below.

B. Methodology and specifications

i. Eligible/target population

The analysis will focus on uncompensated care provided by acute care hospitals. According to Medicare.gov, there are 130 non-Federal hospitals in Michigan.[5] Of these, 85 are federally tax-exempt hospitals that file Form 990 with the Internal Revenue Service at the individual hospital level.[6] As discussed below, hospitals in neighboring states and other states not expanding their Medicaid programs will be used as comparison groups.

ii. Time period of study

The time period of the analysis will vary according to the data used. Data from Schedule H of Form 990 are not available before 2009. Additionally, the Medicare cost report underwent substantial change in data elements reported in 2010. Therefore, for any analyses using these data for the pre-Healthy Michigan Plan period will be 2009/2010 to 2013.

C. Measure steward

[5] https://data.medicare.gov/Hospital-Compare/Michigan-hospitals-April-2011/xmzb-hgc8
[6] Although most hospitals in Michigan are tax-exempt, not all file a Form 990 at the facility level.

As described below, our main data sources are Centers for Medicare & Medicaid Services cost reports, Michigan Medicaid cost reports, and Internal Revenue Service filings.

D. Baseline values for measures

The most recent Medicare cost report data we have is for 2009. Our calculations using those data indicate that the mean level of uncompensated care provided by Michigan hospitals was $8.6 million. This is slightly lower than the mean of $10.3 million for hospitals nationwide. Median amounts for Michigan and the U.S. are more similar: $4.4 million and $4.1 million, respectively. According to the American Hospital Association, in aggregate the cost of uncompensated care provided by community hospitals nationwide was nearly $46 billion in 2012, or 6 percent of total expenses.[7]

The most recent Form 990 data we have is also from 2009. That year non-profit hospitals nationwide reported an average of $3.4 million in charity care costs and an average of $4.3 million in bad debt expense. Non-profit hospitals in Michigan reported an average of $1.3 million in charity care costs and an average of $3.8 million in bad debt expenses. According to the Michigan Hospital Association, in 2011 Michigan hospitals provided a total of more than $882 million in bad debt and charity care.[8]

E. Data Sources

There are several sources of data on hospital uncompensated care, each with particular strengths and weaknesses with respect to this evaluation.

Our primary data source will be Medicare cost reports, which Medicare-certified hospitals are required to submit annually to a Medicare Administrative Contractor. The cost report contains provider information such as facility characteristics, utilization data, cost and charges by cost center (in total and for Medicare), Medicare settlement data, and financial data. As part of the financial data, hospitals are required to provide detailed data on uncompensated care and indigent care provided. These include charity care and bad debt (both in terms of full charges and cost) as well as the unreimbursed cost for care provided to patients covered under Medicaid, the State Children's Health Insurance Program, and state and local indigent care programs. Medicare cost reports (Form CMS-2552-10) for hospitals in Michigan and other states will be obtained from the Centers for Medicare & Medicaid Services website.

We will also use Medicaid cost reports as well as supplementary forms compiled by the Michigan Department of Community Health. These reports have the advantage of providing

[7] American Hospital Association. 2014. Uncompensated Hospital Care Cost Fact Sheet, http://www.aha.org/research/policy/finfactsheets.shtml

[8] Michigan Health & Hospital Association. 2013. Michigan Community Hospitals, A Healthy Dose of the Facts. http://www.hnjh.org/MHAfactsheet.pdf

more detail than the Centers for Medicare & Medicaid Services reports, but are only available for Michigan hospitals.

A third data source will be the Schedule H of Form 990. Since 2009, federally tax-exempt hospitals have been required to complete the revised Form 990 Schedule H, which requires hospitals to annually report their expenditures for activities and services that the Internal Revenue Service has classified as community benefits. These include charity care (i.e., subsidized care for persons who meet the criteria for charity care established by a hospital), unreimbursed costs for means-tested government programs (such as Medicaid), subsidized health services (i.e., clinical services provided at a financial loss), community health improvement services and community-benefit operations (i.e., activities carried out or supported for the express purpose of improving community health), research, health professions education, and financial and in-kind contributions to community groups. In addition to community benefits, Schedule H asks hospitals to report on their bad debt expenditures.

Hospitals' Internal Revenue Service filings will be obtained from GuideStar, a company that obtains, digitizes, and sells data that organizations report on Form 990 and related Schedules. Data will be obtained for all hospitals that file Form 990 with the Internal Revenue Service at the individual hospital-level. (For 2009 to 2011, Form 990 Schedule H is available for 85 federally tax-exempt hospitals in Michigan.) Members of our research team have previous experience working with these data.[9]

V. Plan for Analysis

A. Evaluation of performance

Our evaluation of the impact of the Healthy Michigan Plan on uncompensated care relies on three types of comparisons: (1) across time; (2) within state; (3) across states.

Comparisons over time

Our initial comparison, looking at changes in Michigan over time, analyzes whether by increasing insurance coverage the Healthy Michigan Plan will reduce the amount of uncompensated care provided by hospitals in Michigan. In technical terms, we will estimate interrupted time series regression models to test for a break in the trend in aggregate uncompensated care amounts at the time the demonstration was implemented.

Comparisons within the state

We expect that the baseline level of uncompensated care to be distributed unevenly across hospitals in Michigan. Some hospitals located in areas with high rates of uninsurance are likely to have high levels of uncompensated care, while other hospitals in areas with lower rates of

[9] Young, G.J., Chou, C, Alexander, J, Lee, S.D. and Raver, E. 2013. "Provision of Community Benefits by Tax-Exempt U.S. Hospitals, *New England Journal of Medicine*, 368(16): 1519-1527.

uninsurance are likely to provide less uncompensated care. To account for these differences we will stratify the analysis by hospital characteristics, including baseline measures of the provision of uncompensated care, size, for-profit status, etc. In doing so, we will test the hypothesis that hospitals that had previously faced a large burden of uncompensated care experienced larger reductions in this burden compared with hospitals that provided less uncompensated care at baseline.

Comparisons across states

We will also compare trends in uncompensated care in Michigan to trends in other states. Cross-state comparisons are useful for two reasons. First, comparisons with trends in neighboring expansion states (Ohio and Illinois) put the effects of the Healthy Michigan Plan in meaningful context. This comparison will provide a sense of whether Michigan's approach to the Medicaid expansion is living up to its potential, gauged relative to what other expansion states are achieving. Second, comparing Michigan with selected states that have not chosen to expand their Medicaid programs allows us to isolate the effect of the Healthy Michigan Plan on uncompensated care outcomes.

In conducting the cross-state analysis, we will also be able to leverage the within-state differences just described. Essentially, we will compare hospitals in Michigan to hospitals in other states that prior to the implementation of the Healthy Michigan Plan provided similar amounts of uncompensated care. This component of the evaluation will use multivariate statistical models that are designed to minimize the impact of other potentially confounding differences between hospitals in Michigan and hospitals in comparison states.

Increased insurance coverage is the primary mechanism by which the Healthy Michigan Plan and other aspects of the Affordable Care Act are expected to reduce uncompensated care. Some cross-state comparisons will directly examine the link between changes in insurance coverage and changes in uncompensated care. As part of the analysis of insurance coverage (Domain II, described below) we will estimate annual rates of uninsurance by sub-state geographic regions (in most cases, counties) for a period spanning several years before the implementation of the Affordable Care Act and the first few years after. We will use these estimates as an independent variable in statistical models that estimate the relationship between changes in market-level rates of insurance coverage and changes in hospital uncompensated care.

B. Outcomes (expected)

We expect total uncompensated care in Michigan to decline as a result of the Healthy Michigan Plan as many currently uninsured individuals gain coverage through Medicaid. Additional currently uninsured individuals will gain coverage through health insurance exchanges. We expect that these gains in coverage will drive declines in uncompensated care that more than offset any increase in uncompensated care that arises as some patients shift from generous employer-sponsored coverage to exchange plans with higher cost-sharing. We expect to observe larger declines in uncompensated care in areas with baseline levels of uncompensated care that are above the state average than in area with levels below the state average. We expect this

pattern to hold for both the within-Michigan analysis and the analysis that uses non-expanding states as a comparison group.

C. Limitations/challenges/opportunities

A fundamental challenge associated with this analysis is the fact that the Healthy Michigan Plan is being implemented in the context of broader changes to health insurance markets in Michigan and in other states. The largest changes will be the result of other provisions of the Affordable Care Act. An increase in private insurance coverage as people enroll in plans through the newly established health insurance exchange should reduce the amount of uncompensated care provided to uninsured patients. In addition, new limits on out-of-pocket payments mean that fewer privately insured patients have large hospital bills that they cannot pay. At the same time, the longer-term trend toward private plans with high deductibles will mean more privately insured patients with large out of pocket obligations.

In order to address this challenge, our cross-state analysis comparing Michigan to a "control group" of states that are and are not expanding their Medicaid programs will help to isolate the impact of the Healthy Michigan Plan on uncompensated care. Still, it will be difficult to precisely isolate the impact of the Healthy Michigan Plan from these other confounding factors.

D. Interpretations/conclusions

The main way that the Healthy Michigan Plan will reduce uncompensated care provided by hospitals is by reducing the number of uninsured patients. Therefore, the results from this analysis will be best interpreted in light of the results concerning the effect of the Healthy Michigan Plan on insurance coverage (Domain II).

ATTACHMENT B
Demonstration Evaluation Plan

Domain II: Reduction in the Number of Uninsured

Reduction in the Number of Uninsured *– The Healthy Michigan Program will test the hypothesis that, when affordable health insurance is made available and the application for insurance is simplified (through both an exchange and the state's existing eligibility process), the uninsured population will decrease significantly. This evaluation will examine the insured/uninsured rates in general and more specifically by select population groups (e.g., income levels, geographic areas, age, gender, and race/ethnicity).*

I. Hypotheses

Hypothesis II.1: The uninsured population in Michigan will decrease significantly.

- Hypothesis II.1A: The uninsured population in Michigan will decrease significantly *relative to the existing trend within Michigan.*
- Hypothesis II.1B: The uninsured population in Michigan will decrease *more by percentage for subgroups with higher than average baseline rates of uninsurance in the state than for subgroups with lower than state average baseline rates.*
- Hypothesis II.1C: The uninsured population in Michigan will decrease significantly *relative to states that did not expand their Medicaid programs.*
- Hypothesis II.1D: The uninsured population in Michigan will decrease to a similar degree *relative to states that did expand their Medicaid programs.*

Hypothesis II.2: Medicaid coverage in Michigan will increase significantly.

- Hypothesis II.2A: The Medicaid population in Michigan will increase significantly *relative to the existing trend in Michigan.*
- Hypothesis II.2B: The Medicaid population in Michigan will increase significantly *more by percentage for subgroups with rates of uninsurance higher than baseline state average than for subgroups with baseline rate lower than state average.*
- Hypothesis II.2C: The Medicaid population in Michigan will increase significantly *relative to states that did not expand their Medicaid programs.*
- Hypothesis II.2D: The Medicaid population in Michigan will increase to a similar degree *relative to states that did expand their Medicaid programs.*

II. Management/Coordination of Evaluation

A. Evaluation Team

The work on Domains I and II of the evaluation will be conducted by a team of researchers led by two University of Michigan faculty members, Thomas Buchmueller Ph.D. and Helen Levy Ph.D. Buchmueller's primary appointment is in the Ross School of Business, where he holds the Waldo O. Hildebrand Endowed Chair in Risk Management and Insurance and currently serves as the Chair of the Business Economics Area. He has a secondary appointment in the Department of Health Management and Policy in the School of Public Health. Levy is a tenured Research Associate Professor, with appointments in the Institute for Social Research, the Ford School of Public Policy and the Department of Health Management and Policy. She is a Co-Investigator

on the Health and Retirement Survey, a longitudinal survey supported by the National Institute on Aging. Buchmueller and Levy are experts on the economics of health insurance and health reform. In 2010-2011, Levy served as the Senior Health Economist at the White House Council of Economic Advisers. Buchmueller succeeded her in this position in 2011-2012.

Additional faculty and staff working on this domain are described in Appendix A.

III. Timeline

A. Overview

The evaluation timeline for this domain is determined by when the necessary data are released by the Census Bureau. Data for both of the main sources used in evaluating insurance coverage—the Current Population Survey (CPS) and the American Community Survey (ACS)—are released annually in September, although the reference periods for the two surveys differ (see below). The data released each fall describe insurance coverage in the prior calendar year. For example, in September 2014 the Census Bureau will release data from the March 2014 Current Population Survey and from the 2013 American Community Survey; both of these sources describe coverage in calendar year 2013. Therefore, we expect to produce the first quantitative estimates of the overall effect of the Healthy Michigan Plan on insurance coverage in fall 2015. In subsequent years, as additional data from both surveys are released, we will update the analysis to evaluate longer-term impacts of the Healthy Michigan Plan on insurance coverage.

B. Specific Activities: 10/15 to 10/19

The report on insurance coverage will be prepared during state fiscal year 2018. The most recent Census data available from that point will provide estimates of coverage in 2016. These data will become available in September 2017. In order to make timely use of these data, it will be important to undertake a number of preliminary tasks in the latter half of state fiscal year 2017.

The two Census Bureau surveys have slightly different questions about health insurance and it will be important to investigate and understand any differences in the estimated coverage rates that each produces. For example, does one survey consistently produce higher rates of insurance coverage than the other? Do the two surveys produce similar differences in insurance coverage across demographic groups?

We will also analyze baseline data in order to determine which states offer the most relevant comparison to Michigan's experience. To understand how the Healthy Michigan Plan affected coverage relative to what would have happened if the state had not expanded Medicaid at all, we will want to compare Michigan to states that did not expand their Medicaid programs. We will therefore need to establish which states are similar to Michigan before 2014, in terms of health insurance, population, and other characteristics such as unemployment rates, as well as monitoring ongoing implementation activities in other states. Our approach for this domain will be similar to the one we will use for Domain I.

IV. Performance Measures:

A. Specific measures and rationale

The outcomes analyzed will be various measures of insurance coverage based on questions in the Current Population Survey and the American Community Survey. The Current Population Survey asks a detailed battery of health insurance questions referring to the respondent's coverage in the prior calendar year; for example, the March 2015 Current Population Survey asks respondents to report coverage during calendar year 2014. These questions make it possible to construct measures of the fraction of the population with Medicaid and the fraction of the population with no coverage – our two main outcome measures. We also plan to look at changes in rates of coverage from other source, such as employer-sponsored coverage and individually-purchased private coverage, since health reform will likely affect those too. The Census Bureau is implementing new health insurance questions in March 2014[10]; we have communicated with Census Bureau staff to get more information about these new measures and will carefully evaluate their usefulness as data become available.

The changes to the Current Population Survey are one rationale for also using data from American Community Survey; another is that the American Community Survey sample is approximately 20 times larger than Current Population Survey (see tables 1 and 2 below) and allows reliable analysis of smaller geographic areas within Michigan.

B. Methodology and specifications

i. Eligible/target population

The population that will gain Medicaid eligibility as a result of the Healthy Michigan Plan consists of non-elderly adults with incomes less than or equal to 133 percent of the Federal Poverty Level. We expect coverage to increase for higher income adults because of other components of the Affordable Care Act, most importantly the availability of premium tax credits for insurance purchased through the new health insurance marketplace and the individual mandate. Therefore, it is important to analyze changes in coverage for non-elderly adults at all income levels. The implementation of the Healthy Michigan Plan is expected to increase Medicaid take-up among people who were eligible for coverage under pre-Affordable Care Act rules (the "welcome mat effect"). Since children make up a large percentage of this group, we will also analyze coverage changes for children.

ii. Time period of study

The Healthy Michigan Plan's implementation date is April 1, 2014. Data covering the years 2006 to 2013 (for the Current Population Survey) and 2010 to 2013 (for the American

[10] Pascale, Joanne, et al. "Preparing to Measure Health Coverage in Federal Surveys Post-Reform: Lessons from Massachusetts." INQUIRY: The Journal of Health Care Organization, Provision, and Financing 50.2 (2013): 106-123.

Community Survey) will be used to establish baseline levels and prior trends in Michigan and other states. The post-implementation period will be defined as 2014 to 2016.

C. Measure steward

The Census Bureau is the measure steward.

D. Baseline values for measures

Please see Tables 1 and 2, which present rates of Medicaid coverage and uninsurance in Michigan and in neighboring states using data from both surveys. We also calculate these rates for respondents in Michigan broken into groups based on race/ethnicity, income, and age. Note that the poverty categories in the Current Population Survey require us to use categories of income relative to poverty of <125%, 125-399%, 400%+ since the underlying continuous measure of income/poverty is not provided on the public use file. In the American Community Survey, in contrast, income/poverty is measured continuously and so our categories better match the Affordable Care Act eligibility categories.

E. Data Sources

The analysis will be based on data from two annual national surveys conducted by the Census Bureau: the Current Population Survey and the American Community Survey. Each survey has specific strengths related to this evaluation. The Current Population Survey is the most commonly cited data source for state-level estimates of insurance coverage. It provides a detailed breakdown by source of coverage. The American Community Survey provides less detail on source of coverage but with a much larger sample size than the Current Population Survey, it provides for precise estimates, even for subgroups defined by geography or demographic characteristics. In each case, our analysis will be based on public use files disseminated by Census.

Each data source is publicly available at no cost from the Census Bureau.

V. Plan for Analysis

A. Evaluation of performance

Our evaluation of the impact of the Healthy Michigan Plan on uninsurance relies on three types of comparisons: (1) across time; (2) within state; (3) across states.

Comparisons across time

Our initial comparison, looking at changes in Michigan over time, analyzes whether the Healthy Michigan Plan reduced the numbers of uninsured both in an absolute sense and relative to the pre-existing trend. In technical terms, we will estimate interrupted time series regression models to test for a break in coverage trends at the time the demonstration was implemented.

Comparisons within the state

As shown in Tables 1 and 2, baseline rates of uninsurance were much higher for some groups within Michigan than for others. We will examine whether the Healthy Michigan Plan effectively reached the groups most in need, reducing disparities in insurance coverage. We will investigate the impact of the Healthy Michigan Plan on disparities within the state across groups defined by income, age, race/ethnicity, sex and geographic location.

Comparisons across states

We will also compare trends in Michigan to trends in other states. Cross-state comparisons are useful for two reasons. First, comparisons with trends in neighboring expansion states (Ohio and Illinois) put the effects of the Healthy Michigan Plan in meaningful context. This comparison will provide a sense of whether Michigan's approach to the Medicaid expansion is living up to its potential, gauged relative to what other expansion states are achieving. Second, comparing Michigan with selected states that have not chosen to expand their Medicaid programs allows us to isolate the effect of the Healthy Michigan Plan on insurance outcomes. This component of the evaluation will use multivariate statistical models that are designed to minimize the impact of other potentially confounding differences between Michigan and comparison states, following current best practices in the program evaluation literature.[11,12]

B. Outcomes (expected)

Our primary outcome measures are uninsurance and health care coverage through the Healthy Michigan Plan. As described above, we hypothesize that uninsurance will decline and Healthy Michigan Plan coverage will increase. We measure uninsurance and Healthy Michigan Plan using the variables described above in both surveys. We are also interested in the interplay between Healthy Michigan Plan and other types of insurance. In particular, some new enrollees in the Healthy Michigan Plan or in Michigan's health insurance exchange will have been uninsured at baseline, while others will have had coverage from another source, such as employer-sponsored coverage or individually purchased private coverage. In order to paint a complete picture of how health reform in Michigan is affecting insurance coverage, we will also analyze coverage from other sources. Both surveys include information on employer-sponsored coverage; other private coverage; and other public coverage (for example, Medicare and Veterans Affairs). We will use these data to analyze how much of the decline in uninsurance can be attributed to increased numbers of Medicaid enrollees and how much to increases in coverage through the exchange or other private sources. We expect to observe larger declines in uninsurance for population subgroups with above average baseline levels of uninsurance, such as racial/ethnic minorities, young adults and low-income families. We will also explore potential

[11] Sommers, Benjamin D., Katherine Baicker, and Arnold M. Epstein. "Mortality and access to care among adults after state Medicaid expansions." New England Journal of Medicine 367.11 (2012): 1025-1034.

[12] Abadie, Alberto, Alexis Diamond, and Jens Hainmueller. "Synthetic control methods for comparative case studies: Estimating the effect of California's tobacco control program." Journal of the American Statistical Association 105.490 (2010).

differences by gender, though currently rates of uninsurance are similar for men and women. We expect this pattern to hold for both the within-Michigan analysis and the analysis that uses non-expanding states as a comparison group.

C. Limitations/challenges/opportunities

A fundamental challenge associated with this analysis is the fact that the Healthy Michigan Plan is being implemented in the context of broader changes to the health insurance market in Michigan associated with the Affordable Care Act. In particular, the health insurance exchange, the associated premium tax credits, and the individual mandate all affect consumer and firm behavior. In order to address this challenge, our cross-state analysis comparing Michigan to a "control group" of states that are not expanding their Medicaid programs will help to isolate the impact of the Healthy Michigan Plan and uninsurance.

D. Interpretations/conclusions

The outcomes associated with this domain of the Healthy Michigan Plan evaluation are fundamental to understanding the demonstration's impact. Without increases in Healthy Michigan Plan enrollment and commensurate reductions in uninsurance, the demonstration cannot achieve the goals of reducing uncompensated care, enhancing access to appropriate medical services, and improving health. Therefore, the conclusions of this domain of the evaluation help to inform the interpretation of other domains of the evaluation.

Table 1
American Community Survey, 2010 - 2012
Baseline measures - Fraction uninsured and fraction with Medicaid
Estimates are weighted using samples weights provided by the Census Bureau

	Uninsured			Medicaid			Unweighted sample size		
	2010	2011	2012	2010	2011	2012	2010	2011	2012
State									
MI	14.6 %	14.1 %	13.8 %	20.3 %	20.9 %	20.6 %	82,340	81,618	80,570
OH	14.4 %	14.2 %	13.8 %	17.4 %	17.7 %	18.4 %	97,998	97,476	95,969
IN	17.5 %	17.1 %	17.1 %	15.8 %	16.2 %	16.2 %	55,381	55,020	55,046
IL	16.0 %	14.7 %	15.0 %	17.8 %	19.1 %	18.7 %	107,140	106,436	106,264
WI	11.4 %	11.0 %	10.9 %	17.9 %	19.1 %	17.7 %	48,554	48,962	47,704
Race/ethnicity (Michigan only)									
White	13.4 %	12.5 %	12.4 %	15.4 %	15.8 %	15.9 %	66,820	65,459	64,526
Black	18.4 %	19.5 %	18.8 %	40.0 %	41.0 %	39.1 %	7,924	8,597	8,427
Other race	13.5 %	14.5 %	14.1 %	22.5 %	25.2 %	23.7 %	4,377	4,176	4,313
Hispanic	23.6 %	21.0 %	20.3 %	33.0 %	33.6 %	33.8 %	3,219	3,386	3,304
Income/poverty (Michigan only)									

<125% FPL	24.8 %	24.1 %	23.6 %	53.0 %	53.7 %	52.2 %	18,071	18,813	18,492
125-399% FPL	15.2 %	14.6 %	14.0 %	13.8 %	14.6 %	14.3 %	35,001	33,874	33,455
>400% FPL	5.1%	4.4%	4.6%	2.5%	2.5%	3.1%	27,504	26,027	25,984
Age (Michigan only)									
0-18	4.6%	4.2%	4.5%	37.7 %	38.7 %	39.3 %	23,412	22,347	22,033
19-34	27.6 %	24.9 %	23.5 %	16.5 %	17.0 %	16.4 %	16,847	17,135	16,895
35-64	14.4 %	14.7 %	14.5 %	11.4 %	12.1 %	11.5 %	42,081	42,136	41,642

Table 2
Current Population Survey, Annual Social and Economic Supplement (March survey), 2010 - 2013
Baseline measures - Fraction uninsured and fraction with Medicaid
Estimates are weighted using samples weights provided by the Census Bureau

	Uninsured				Medicaid				Unweighted sample size			
	2010	2011	2012	2013	2010	2011	2012	2013	2010	2011	2012	2013
State												
MI	15.5 %	14.9 %	14.1 %	12.7 %	16.2 %	18.9 %	19.3 %	18.8 %	4,324	4,134	4,063	3,830
OH	16.4 %	15.5 %	15.9 %	14.4 %	15.3 %	15.5 %	18.3 %	17.9 %	4,981	4,788	4,239	4,485
IN	16.3 %	15.3 %	13.9 %	15.6 %	18.1 %	17.9 %	18.5 %	18.2 %	2,636	2,712	2,681	2,671
IL	16.6 %	16.6 %	16.7 %	15.5 %	17.2 %	18.2 %	19.2 %	17.6 %	5,846	5,651	5,802	5,399
WI	10.9 %	10.9 %	12.0 %	11.2 %	16.8 %	16.8 %	18.5 %	19.7 %	3,398	3,322	3,251	3,330
Race/ethnicity (Michigan only)												
White	15.1 %	13.2 %	13.5 %	11.3 %	12.2 %	14.6 %	13.8 %	14.5 %	3,171	3,000	2,995	2,875
Black	18.8 %	20.8 %	13.4 %	17.7 %	33.5 %	34.5 %	39.0 %	34.7 %	624	584	599	481
Other race	11.3 %	21.0 %	14.4 %	6.5%	19.7 %	17.2 %	24.7 %	25.5 %	291	262	236	266
Hispanic	17.3 %	16.6 %	26.1 %	28.6 %	22.1 %	38.6 %	42.1 %	31.4 %	238	288	233	208
Income/poverty (Michigan only)												
<125% FPL	30.6 %	28.4 %	25.2 %	22.7 %	48.1 %	51.7 %	52.9 %	52.2 %	850	884	874	754

125-399% FPL	16.6%	14.7%	15.6%	15.2%	13.0%	16.2%	16.8%	16.0%	1,945	1,809	1,734	1,663
>400% FPL	6.1%	7.2%	6.2%	4.8%	2.8%	2.6%	3.1%	4.4%	1,529	1,441	1,455	1,413
Age (Michigan only)												
0-18	6.0%	5.2%	5.5%	4.0%	31.1%	35.6%	34.9%	35.8%	1,482	1,419	1,406	1,313
19-34	28.7%	25.5%	24.4%	22.1%	13.0%	16.5%	16.8%	14.1%	931	866	841	797
35-64	14.8%	15.7%	14.3%	13.5%	8.4%	9.6%	11.0%	10.5%	1,911	1,849	1,816	1,720

ATTACHMENT B
Demonstration Evaluation Plan

Domain III: Evaluation of Health Behaviors, Utilization & Health Outcomes

Impact on Healthy Behaviors and Health Outcomes *– The Healthy Michigan Program will evaluate what impact incentives for healthy behavior and the completion of an annual risk assessment have on increasing healthy behaviors and health outcomes. This evaluation will analyze selected indicators, such as emergency room utilization rates, inpatient hospitalization rates, use of preventive services and health and wellness programs, and the extent to which beneficiaries report an increase in their overall health status. Clear milestone reporting on the Healthy Behavior Incentives initiative must be summarized and provided to CMS once per year."*

I. Hypotheses

1. Hypothesis III.1: Emergency Department Utilization
    a. Emergency department utilization among the Healthy Michigan beneficiaries will decrease from the Year 1 baseline;
    b. Healthy Michigan Plan beneficiaries who make regular primary care visits (at least once per year) will have lower adjusted rates of emergency department utilization compared to beneficiaries who do not have primary care visits; and
    c. Healthy Michigan Plan beneficiaries who agree to address at least one behavior change will have lower adjusted rates of emergency department utilization compared to beneficiaries who do not agree to address behavior change.
2. Hypothesis III.2: Healthy Behaviors
    a. Receipt of preventive health services among the Healthy Michigan Plan population will increase over time, from the Year 1 baseline;
    b. Healthy Michigan Plan beneficiaries who make regular primary care visits (at least once per year) will have higher rates of general preventive services compared to beneficiaries who do not have primary care visits;
    c. Healthy Michigan Plan beneficiaries who complete an annual health risk assessment will have higher rates of preventive services compared to beneficiaries who do not complete a health risk assessment;
    d. Healthy Michigan Plan beneficiaries who agree to address at least one behavior change will demonstrate improvement in self-reported health status compared to beneficiaries who do not agree to address behavior change; and
    e. Healthy Michigan Plan beneficiaries who receive incentives for healthy behaviors will have higher rates of preventive services compared to beneficiaries who do not receive such incentives.
3. Hypothesis III.3: Hospital Admissions
    a. Adjusted hospital admission rates for Healthy Michigan Plan beneficiaries will decrease from the Year 1 baseline;
    b. Healthy Michigan Plan beneficiaries who make regular primary care visits (at least once per year) will have lower adjusted rates of hospital admissions compared to beneficiaries who do not have primary care visits; and

c. Healthy Michigan Plan beneficiaries who agree to address at least one behavior change will have lower adjusted rates of hospital admission compared to beneficiaries who do not agree to address behavior change.

II. Management/Coordination of Evaluation

A. Faculty Team

The analysis of administrative data will be led by an existing research team within the Child Health Evaluation and Research (CHEAR) Unit, whose faculty are active members of the Institute for Healthcare Policy and Innovation (IHPI). The core of this team has worked together for over ten years, in collaboration with Michigan Department of Community Health officials, on analyses of administrative data. The team includes Sarah Clark, faculty lead, and Lisa Cohn, lead data analyst. Along with this core analysis team, John Ayanian (General Medicine) and other clinical content experts as needed, will participate in refining data protocols and interpreting results.

III. Timeline

Administrative data will be analyzed throughout the Healthy Michigan Plan demonstration project. Data will be analyzed for baseline measurement, for identification of subpopulations to sample for the Domain IV beneficiary survey, for evaluation of changes related to cost-sharing requirements, and for overall evaluation of changes in health care utilization and other healthy behaviors.

June 1 – September 30, 2014: Development of final data extraction, storage and security protocols; analysis of Adult Benefit Waiver data from state fiscal years 2011-2013 to ascertain potential use as baseline data.

October 1, 2014 – September 30, 2015: Assess rate of primary care visits and health risk assessment completion for persons enrolled in state fiscal year 2014. Analyze early utilization patterns to develop targeted sample for Domain IV beneficiary survey. Provide assistance to the Department in summarizing Healthy Behaviors Incentives initiative.

October 1, 2015 – September 30, 2016: Assess rate of primary care visits and health risk assessment completion for persons enrolled in state fiscal year 2015. Analyze utilization data to support analysis of Domain IV beneficiary survey. Provide assistance to the Department in summarizing Healthy Behaviors Incentives initiative.

October 1, 2016 – September 30, 2017: Calculate measures on emergency department utilization, healthy behaviors/preventive health services, and hospital admissions. Analyze trends over time, and summarize in report to the Centers for Medicare & Medicaid Services. Provide assistance to the Department in summarizing Healthy Behaviors Incentives initiative.

October 1, 2017 – September 30, 2018: Calculate measures on emergency department utilization, healthy behaviors/preventive health services, and hospital admissions for final year of demonstration project. Analyze trends over time, and summarize in final evaluation report to the Centers for Medicare & Medicaid Services.

IV. Performance Measures/Data Sources

A. Overview: Using Medicaid Enrollment & Utilization Data

The Michigan Department of Community Health's Data Warehouse offers an unusually rich data environment for evaluation. For Michigan Medicaid enrollees, the Data Warehouse contains individual-specific information, refreshed daily, on demographic characteristics, enrollment, and health care utilization (including inpatient, outpatient, emergency department, pharmacy, durable medical equipment, immunization, dental and mental health). Data elements unique to the Healthy Michigan Plan will include self-reported health status and other individual-specific data on health risk assessments, incentives for healthy behaviors, and cost-sharing requirements.

The University of Michigan has a longstanding history of collaborating with the Michigan Medicaid program within the Department of Community Health to analyze information from the Data Warehouse to evaluate Medicaid programs and policies. This experience positions the University evaluation team to analyze information in the Data Warehouse to:

- Document trends in key health care utilization (e.g., emergency department use, preventive care services) and Medicaid adult quality measures over time within the Healthy Michigan Plan population, using the first year of implementation as baseline rates and measuring annual changes. This type of analysis addresses federal evaluation requirements.
- Explore associations of health care utilization and Medicaid adult quality measures with major features of the Healthy Michigan Plan, such as receipt of annual visit to a primary care provider, completion of annual health risk assessment, and cost-sharing.
- Identify subgroups of beneficiaries, providers or geographic areas with higher- or lower-than-average utilization, to enable targeted sampling for Domain IV activities exploring beneficiary and provider perspectives.

B. Data Sources

The data source will be the Michigan Department of Community Health Data Warehouse. Under the authority of a Business Associates' Agreement between the Department of Community Health and the University of Michigan, individual-level data for Healthy Michigan Plan enrollees will be extracted from the Data Warehouse, to include enrollment and demographic characteristics; all utilization (encounters in primary care, inpatient, emergency, urgent care; pharmacy); completion of health risk assessments; beneficiary co-pay charges; and vaccine administration data from all providers (including pharmacies). Data will be extracted from the Data Warehouse via an existing secure line, and stored in encrypted files on a secure network with multiple layers of password protection.

The eligible population will include all Healthy Michigan Plan enrollees.

C. Measures

A broad range of measures will be generated each year of the demonstration project, and are noted below for specific focus areas. Measures include established indicators for clinical care (e.g., Healthcare Effectiveness Data and Information Set measures, Adult Core Quality Indicators) with identified measure stewards (e.g., National Quality Forum). Importantly, health plan-based measures offer useful but limited information, as they exclude enrollees who change health plans and do not allow a full assessment of outcomes for the entire population or for a target geographic area with multiple plans; moreover, some measures require a period of identification prior to measurement outcomes, which will be problematic with the Healthy Michigan population. HEDIS criteria for measures of chronic disease populations (Diabetes HbA1c, LDL testing, admission rate; COPD admission rate; CHF admission rate; asthma admission rate) require a year for identification of members who meet the chronic disease definition (i.e., the denominator), followed by a measurement year to assess utilization (i.e., the numerator). However, most HMP enrollees were not covered by Medicaid coverage prior to their HMP start date, and so the MDCH data warehouse will not provide pre-HMP data for identification of chronic disease status. To follow HEDIS criteria strictly, we would need to use the first full year of HMP as the identification year, followed by the second full year of HMP as the measurement year – delaying any results on these key outcome measures until midway through the third year of the demonstration project. Therefore, the evaluation plan will modify identification criteria where necessary, and will go beyond the plan-specific HEDIS measures by generating not only plan-level results, but also results across plans for key subgroups (e.g., by geographic region, urban v. rural, by race/ethnicity, by gender, by age group, and by chronic disease status).

Because most Healthy Michigan Plan enrollees will not have prior Medicaid coverage, baseline values for the selected measures will not be available for most new enrollees. Therefore, Year 1 (April 1, 2014-March 31, 2015) of the Healthy Michigan Plan will serve as a baseline from which to measure changes over the course of the demonstration project; in addition, comparison data from comparable populations will be gleaned from national data sources.

V. Plan for Analysis

Over the 5-year waiver period we will assess a targeted set of performance measures detailed below. Measure stewards are noted, as appropriate. In addition to the performance measures, we will generate annual data on the proportion of Healthy Michigan Plan enrollees who agree to address a behavior change, and the proportion who make at least one primary care visit.

A. Emergency Department (ED) Utilization

We hypothesize that:

1) Emergency department utilization among the Healthy Michigan Plan population will decrease from the Year 1 baseline;

2) Healthy Michigan Plan beneficiaries who make regular primary care visits (at least once per year) will have lower adjusted rates of emergency department utilization compared to beneficiaries who do not make primary care visits; and
3) Healthy Michigan Plan beneficiaries who agree to address at least one behavior change will have lower adjusted rates of emergency department utilization compared to beneficiaries who do not agree to address behavior change.

To evaluate these hypotheses, we will calculate the following measures for the overall Healthy Michigan Plan population, by plan, by gender (where appropriate), by race/ethnicity, by county/geographic region, by chronic disease subgroups (diabetes, COPD, CHF, asthma), for beneficiaries who do vs. do not make regular primary care visits, for those who do vs. do not complete a health risk assessment, and for those who do vs. do not agree to address at least one behavior change. We will calculate measures for each year of the Healthy Michigan Plan demonstration period, and analyze trends over time. In addition, data from these analyses will be used to evaluate the association between emergency department utilization and the presence of cost-sharing requirements (Domain V/VI).

- **Healthcare Effectiveness Data and Information Set (HEDIS) Emergency Department Measure**: We will calculate the rate of emergency department visits per 1000 member months, and will calculate incidence rate ratios to assess the relative magnitude of emergency department utilization rates for subgroup comparisons. To provide additional information, we will calculate subgroup rates for key chronic disease populations (e.g., asthma, COPD, diabetes, CHF) at the plan level and by geographic region; this information will help the state to evaluate disease management programs and other services intended to encourage outpatient visits over emergency department use.
- **Emergency Department High-Utilizer Measure**: We will calculate the proportion of Healthy Michigan Plan beneficiaries who demonstrate high emergency department utilization (e.g., ≥5 emergency department visits within a 12-month period).

B. Healthy Behaviors/Preventive Health Services

We hypothesize that:
1) Receipt of preventive health services among the Healthy Michigan Plan population will increase from the Year 1 baseline;
2) Healthy Michigan Plan beneficiaries who make regular primary care visits (at least once per year) will have higher rates of general preventive services compared to beneficiaries who do not have primary care visits; and that
3) Healthy Michigan Plan beneficiaries who complete an annual health risk assessment will have higher rates of preventive services compared to beneficiaries who do not complete a health risk assessment.
4) Healthy Michigan Plan beneficiaries who agree to address at least one behavior change will demonstrate improvement in self-reported health status compared to beneficiaries who do not agree to address behavior change.

5) Healthy Michigan Plan beneficiaries who are eligible to receive incentives for healthy behaviors will have higher rates of preventive services compared to beneficiaries who are not eligible to receive such incentives.

To evaluate these hypotheses, we will calculate the following measures for the overall Healthy Michigan Plan population, by plan, by gender (where appropriate), by race/ethnicity, by county/geographic region, for beneficiaries who do vs. do not make regular primary care visits for those who do vs. do not complete a health risk assessment, and for those who do vs. do not receive healthy behavior incentives. We will calculate measures for each year of the Healthy Michigan demonstration period, and analyze trends over time. In addition, data from these analyses will be used to evaluate the association between healthy behaviors and the presence of cost-sharing requirements (Domain V/VI).

- **Flu Shots for Adults**: We will calculate the proportion of beneficiaries aged 50-64 and aged 18-49 who received an influenza vaccine between July 1 and April 30. To supplement Consumer Assessment of Healthcare Providers and Systems self-reported data from a small sample of beneficiaries (NQF 0039), we will take advantage of Michigan's unique data environment by combining Medicaid utilization data with information found in the statewide immunization registry (Michigan Care Improvement Registry) to document rates of influenza vaccine receipt for the Healthy Michigan Plan population, and for individuals at high risk for influenza-related complications, such as those with diabetes, COPD, CHF, or asthma.
- **Colon Cancer Screening** (NQF 0034, measure steward NCQA): We will calculate the proportion of beneficiaries aged 50-64 who received colon cancer screening by high-sensitivity fecal occult blood test, sigmoidoscopy with FOBT, or colonoscopy (recommendation USPSTF).
- **Hemoglobin A1c Testing** (NQF 0057; measure steward NCQA): We will calculate the proportion of beneficiaries aged 18-64 with type 1 or type 2 diabetes who had hemoglobin a1c testing at least once during the measurement year.
- **LDL-C Screening** (NQF 0063; measure steward NCQA): We will calculate the proportion of beneficiaries aged 18-64 with type 1 or type 2 diabetes who had an LDL-C screening performed at least once during the measurement year.
- **Breast Cancer Screening** (modified NQF 0031; measure steward NCQA): We will calculate the proportion of women 40-64 who had a mammogram to screen for breast cancer. Modifications from the NQF standard include **age range** (NQF includes 40-69 years; we will use 40-64 years, to be consistent with Healthy Michigan Plan eligibility); **measurement time period** (NQF includes two years; initially, we will calculate this measure for a one-year period, to allow for early results, rather than wait until enrollees have 2 years of data, and then subsequently will use both a one-year and two-year measurement period).
- **Cervical Cancer Screening** (NQF 0032; measure steward NCQA): Among those women who have 3 or more years of continuous enrollment in the Healthy Michigan Plan, we will calculate the proportion of women 21-64 years of age who received a Pap test to screen for cervical cancer.

- **Smoking and Tobacco Use Cessation, Medical Assistance** (NQF 0037; measure steward NCQA): Among beneficiaries who report on smoking or tobacco use on their Health Risk Assessment (HRA), we will calculate the proportion who received tobacco cessation counseling or assistance.
- **Self-Reported Health Status:** As part of the Health Risk Assessment (HRA) to be completed annually, beneficiaries will rate their health status using a commonly used and validated tool. We will calculate the proportion of beneficiaries who rate their health status as Excellent or Very Good vs. Good or Fair or Poor. In addition, we will analyze each beneficiary's change in self-reported health status over time.

C. Hospital Admissions

We hypothesize that:
1) Adjusted hospital admission rates for Healthy Michigan Plan beneficiaries will decrease from the Year 1 baseline.
2) Healthy Michigan Plan beneficiaries who make regular primary care visits (at least once per year) will have lower adjusted rates of hospital admissions compared to beneficiaries who do not have primary care visits.
3) Healthy Michigan Plan beneficiaries who agree to address at least one behavior change will have lower adjusted rates of hospital admission compared to beneficiaries who do not agree to address behavior change.

To evaluate these hypotheses, we will calculate the following measures for the overall Healthy Michigan Plan population, by plan, by gender, by race/ethnicity, by county/geographic region, urban/rural, for beneficiaries who do vs. do not make regular primary care visits, and for those who are vs. are not eligible to receive healthy behavior incentives. We will calculate measures for each year of the Healthy Michigan demonstration period, and analyze trends over time. In addition, data from these analyses will be used to evaluate the association between hospital admission and the presence of cost-sharing requirements (Domain V/VI).

- **Overall Admission Rate**: We will calculate the proportion of enrollees with any inpatient admission, as well as the rate of inpatient admissions per 1000 member months. We will make the same calculations for medical admissions and surgical admissions.
- **Diabetes, Short-term Complications Admission Rate** (NQF 0272; measure steward AHRQ): We will calculate the number of discharges for diabetes short-term complications per 100,000 Healthy Michigan Plan enrollees age 18-64.
- **Chronic Obstructive Pulmonary Disease (COPD) Admission Rate** (NQF 0275; measure steward AHRQ): We will calculate the number of discharges for COPD per 100,000 Healthy Michigan Plan enrollees age 18-64.
- **Congestive Heart Failure Admission Rate** (NQF 0277; measure steward AHRQ): We will calculate the number of discharges for CHF per 100,000 Healthy Michigan Plan enrollees age 18-64.
- **Adult Asthma Admission Rate** (NQF 0283; measure steward AHRQ): We will calculate the number of discharges for asthma per 100,000 Healthy Michigan Plan enrollees age 18-64.

D. Baseline Data

Baseline data on prior healthcare utilization for Healthy Michigan Plan enrollees are not available except for those who were previously enrolled in the Adult Benefits Waiver (state fiscal years 2011-2013); therefore, direct comparison of performance measures pre- and post-implementation will not be possible for most Healthy Michigan Plan enrollees. Rather, Year 1 of the Healthy Michigan Plan will largely serve as baseline data, setting up an evaluation of changes over time.

References

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3. Dombkowski K.J., Costello L., Dong S., Clark S.J. (2014). Using administrative claims to identify children with high risk conditions in a statewide immunization registry. *American Journal of Managed Care.* In press.

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ATTACHMENT B
Demonstration Evaluation Plan

Domain IV: Participant Beneficiary Views of the Healthy Michigan Program

Participant Beneficiary Views on the Impact of the Healthy Michigan Program *– The Healthy Michigan Program will evaluate whether access to a low-cost (modest co- payments, etc.) primary and preventive health insurance benefit will encourage beneficiaries to maintain their health through the use of more basic health care services in order to avoid more costly acute care services.*

I. Aims

1) Aim IV.1: Describe Healthy Michigan Plan enrollees' consumer behaviors and health insurance literacy, including knowledge and understanding about the Healthy Michigan Plan, their health plan, benefit coverage, and cost-sharing aspects of their plan.
2) Aim IV.2: Describe Healthy Michigan Plan enrollees' self-reported changes in health status, health behaviors (including medication use), and facilitators and barriers to healthy behaviors (e.g. knowledge about health and health risks, engaged participation in care), and strategies that facilitate or challenge improvements in health behaviors.
3) Aim IV.3: Understand enrollee decisions about when, where and how to seek care, including decisions about emergency department utilization.
4) Aim IV.4: Describe primary care practitioners' experiences with Healthy Michigan Plan beneficiaries, practice approaches and innovation adopted or planned in response to the Healthy Michigan Plan, and future plans regarding care of Healthy Michigan Plan patients.

II. Management/Coordination of Evaluation

Domain IV will be led by Susan Dorr Goold, Professor of Internal Medicine and Health Management and Policy, with community co-director Zachary Rowe, Executive Director, Friends of Parkside and Founding Member of the board of Detroit Urban Research Center and the MICH-R Community Engagement Coordinating Council. Dr. Goold and Mr. Rowe co-direct two projects that engage members of underserved and minority communities in deliberations about health research priorities, including a statewide project funded by the National Institute on Aging and led by a Steering Committee of community leaders from throughout the state (decidersproject.org).

Additional faculty members working on this domain are described in Appendix A.

III. Performance Measures:

A. Specific measures and rationale

1. *Healthy Michigan Voices Survey of Healthy Michigan Plan enrollees (HMV)* (Goold, Clark, Kullgren, Kieffer, Haggins, Rosland and Tipirneni)

Evaluation of the Impact of the Healthy Michigan Plan requires understanding the experience of those who enroll: Do they establish primary care? Do they access care appropriately? Do they understand their cost-sharing parameters, their MI Health Account, and the incentives they have for particular behaviors? Do they gain knowledge about health risks and healthy behaviors? Do their health behaviors improve?

Understanding the overall health and economic impact of the Healthy Michigan Plan at a personal level requires learning about the experiences of participant beneficiaries. Tools typically used to track population experiences generally do not include a comprehensive list of items necessary for the purposes of this evaluation. The Medicaid Consumer Assessment of Healthcare Providers and Systems (CAHPS) and Behavioral Risk Factor Surveillance System (BRFSS) do not query respondents about specific knowledge, attitudes and experiences that relate to the impact of the Healthy Michigan Plan, such as incentives for healthy behaviors and an emphasis on primary care, and may not capture a sufficient number of respondents enrolled in the Healthy Michigan Plan to draw valid conclusions. We propose the **Healthy Michigan Voices** telephone survey of Healthy Michigan Plan beneficiaries on key topics related to the Healthy Michigan Plan.

Primary Care Practitioner Survey (PCPS) (Goold, Campbell, Tipirneni)

Evaluating the impact of the Healthy Michigan Plan will benefit greatly from the insights and experiences of primary care practitioners. We propose a survey of primary care practitioners to obtain empirically valid and timely data from a representative sample of primary care practitioners who have Healthy Michigan Plan enrollees assigned to their care. We plan to measure:

- Experiences caring for Healthy Michigan Plan beneficiaries, including access to and decision making about preventive health, basic health care services, specialty services and costly acute care services
- New practice approaches and innovations adopted or planned in response to the Healthy Michigan Plan
- Future plans regarding care of Healthy Michigan Plan patients

IV. Healthy Michigan Voices Survey (HMV)

1) *Sample*

The Healthy Michigan Voices survey sample will be limited to individuals who enrolled in the Healthy Michigan Plan between April 1, 2014 and March 31, 2016. Selection for the sample will be based on:

- Income level, proportionally selected across 4 bands of Healthy Michigan Plan eligibility (Federal Poverty Levels 0-35%, 36-75%, 76-99%, and ≥100%);
- County of residence, to ensure adequate representation of rural and urban beneficiaries; and
- Enrollment status – at least 10% of the sample will comprise early enrollees who disenrolled or failed to reenroll.

Age, gender and race/ethnicity will not be used as a selection variable, but are expected to be proportional to enrollment. The recruitment samples will be selected using Medicaid enrollment files in the Michigan Department of Community Health Data Warehouse. University of Michigan analysts approved to access the Data Warehouse will create unique sampling files that contain encrypted beneficiary identification numbers and required sampling variables, to enable selection of the recruitment sample by algorithm. The analysts will then generate mailing labels and a telephone contact file for selected beneficiaries. Recruitment staff will not have access to other beneficiary information.

With an estimated 50% recruitment rate, we will need to select and recruit 9000 Healthy Michigan Plan beneficiaries to achieve our target of 4500 Healthy Michigan Voices respondents. We plan to administer the survey using a method similar to a telephone survey of Medicaid parents conducted by CHEAR in 2005-6. (Dombkowski et al, 2012) In that survey, parents were mailed packets inviting participation and containing a stamped postcard indicating whether they wished to participate or opt out of the study. Those who indicated their willingness to participate had the option of providing a preferred telephone number and calling time. Parents acknowledging interest in participating were contacted first, followed by parents of eligible children who did not explicitly opt out. A working telephone number from Medicaid administrative data or parent response postcards was required for eligibility; consecutive phone calls were placed until the targeted number of interviews was completed. Of 523 parents who returned postcards, 127 (24%) did not have a working phone number or could not be reached and 3 refused participation when reached by phone; the remaining 393 (75%) had completed parent interviews. Of the 3279 parents who did not return postcards, 115 calls were randomly attempted until interview targets were reached; 58% had a nonworking number or could not be reached and were excluded; 47 interviews were completed from this group of parents (41%) for a total of 440 total completed interviews. The sample closely mirrored the eligible population by age and gender. However, participants were more frequently of white race ($P < .0001$). Since this survey was conducted, beneficiary contact information in the MDCH Data Warehouse has improved; however, increasing use of cellphones among lower income and young adults poses a challenge for response rates. Of the first 328,000 Healthy Michigan beneficiaries, 42% were 19-34 and 20% were 35-44.

If recruitment rates are lower than 50%, we will select and recruit more beneficiaries in order to achieve our target number of participants (e.g., with a 40% recruitment rate, we will need to select and recruit approximately 11,000 beneficiaries).

Recruitment will incorporate multiple contact methods. An invitation packet will be mailed to the selected beneficiaries, describing the Healthy Michigan Voices initiative and allowing them to indicate a desire to participate in Healthy Michigan Voices or opt out by either returning a postage-paid reply card or calling a toll-free number. In addition, 10 days after invitation packets are mailed, telephone calls will be placed to beneficiaries who have not yet responded, offering to answer any questions about Healthy Michigan Voices and asking people to participate. If they agree, the survey will preferentially take place during that telephone call or a future time will be scheduled to complete the telephone survey.

To avoid interfering with the Healthy Michigan Plan processes for enrollment, selecting a plan and provider, and completing the health risk assessment, no Healthy Michigan Voices recruitment will occur for 90 days after a person's enrollment, except for beneficiaries with documented plan and primary care practitioner selection and completion of a health risk assessment.

2) *Data Sources*

When possible, the Healthy Michigan Voices Survey will use existing items and scales. For example, questions about consumer behaviors will be drawn from the Employee Benefit Research Institute Consumer Engagement in Healthcare Survey. Questions about health behaviors will be drawn from the Behavioral Risk Factor Surveillance System and National Health and Nutrition Examination Survey questionnaires. Questions about access to care will be drawn from the Medical Expenditure Panel Survey and National Health Interview Survey questionnaires. To measure domains where existing items/scales are not available, or where the domain is specific to the Healthy Michigan Plan, new survey items and scales will be developed.. Survey measures will:

Aim 1: Describe Healthy Michigan Plan enrollees' consumer behaviors and health insurance literacy, including knowledge and understanding about the Healthy Michigan Plan, their health plan, benefit coverage, and cost-sharing aspects of their plan. Including:

- Knowledge and understanding of health insurance, the Healthy Michigan Plan, cost-sharing, incentives for healthy behaviors, MI Health accounts and value-based insurance design
- Health care spending, financial and nonfinancial obstacles to care
- Consumer Behaviors, including:
    - Checking cost-sharing before seeking care
    - Checking MI Health Account balance before seeking care
    - Talking with doctor about treatment options and costs
    - Seeking out and using quality information in health care decisions
    - Budgeting for health care expenses
    - Reasons for health risk assessment completion and non-completion
- Work ability, medical debt and other measures of economic impact of Healthy Michigan Plan
- Reason for failure to re-enroll, when applicable

Aim 2: Describe Healthy Michigan Plan enrollees' self-reported changes in health status, health behaviors (including medication use), and facilitators and barriers to healthy behaviors (e.g. knowledge about health and health risks, engaged participation in care), and strategies that facilitate or challenge improvements in health behaviors.

- Health status, including physical and mental health, physical function, and the presence of chronic health conditions
- Health behaviors and knowledge about healthy behaviors and health risks

- Medical self-management behaviors (e.g. medication adherence, self-monitoring when appropriate) and receipt of preventive care
- Patient activation and self-efficacy in managing health care and making healthy changes
- Strategies that facilitate healthy behaviors, including contact with community health workers and other community resources

Aim 3: Understand enrollee decisions about when, where and how to seek care, including decisions about emergency department utilization.

A unique feature of Healthy Michigan Voices is the ability to link to participants' Medicaid utilization and enrollment data. Data analysts working on the analysis of Medicaid utilization data (Domain III) will maintain the file of Healthy Michigan Voices participants and will query enrollment files to identify Healthy Michigan Voices participants who have left or failed to reenroll in the Healthy Michigan Plan. We will attempt to identify this group using contact information (address/telephone) stored in the MDCH Data Warehouse, and will supplement with other program information as needed. Categories of questions targeted to this group may include: enrollment in private insurance, cost barriers, and other areas identified in our survey development work.

Healthy Michigan Voices survey questions may be targeted to some important subgroups, including:

- Low utilizers of health care (e.g., those who have not had a primary care visit in the preceding 12 months) will be targeted to assess:
    - Financial and non-financial barriers to care
    - Views about health care providers and the health care system
    - Health insurance literacy
- High utilizers of health care (e.g., those with 5 or more ER visits in the preceding 12 months) will be targeted to assess:
    - Beneficiary decision-making about when, where and how to seek care
    - Contact with community health workers or other community resources
    - Views about and experiences with health care providers (especially primary care practitioners)
    - Financial and non-financial barriers to care
- Beneficiaries with mental and behavioral health conditions and substance use disorders
    - Beneficiary decision-making about when, where and how to seek care
    - Contact with community health workers or other community resources
    - Views about and experiences with health care providers (especially primary care practitioners)
- Beneficiaries with complex chronic conditions. These cases can be ascertained with inpatient or outpatient ICD-9 diagnosis codes and other claims information, or health risk assessment results when the full content of items assessed is known. Examples using the ICD-9/claims method are given below for 2 conditions:
    - *Diabetes*: At least 1 inpatient encounter or 2 outpatient encounters on separate days in the previous 2 years with a diabetes ICD-9 code (250.X, 357.2, 362.01-362.07, 366.41, 962.3, E932.3) or one outpatient fill of a diabetes prescription

(except metformin) with a day supply of 31 or greater or two outpatient fills with a day supply of 30 or less
- *Asthma*: At least 1 inpatient encounter or 2 outpatient encounters with ICD-9 code 493.x

3) *Measure stewards*

When possible, the Healthy Michigan Voices Survey will use existing items and scales from, among others, the Behavioral Risk Factor Surveillance System; Consumer Assessment of Healthcare Providers and Systems; Medical Expenditure Panel System; Employee Benefit Research Institute; Consumer Engagement in Healthcare Survey; National Health and Nutrition Examination Survey. When new measures are developed, the University of Michigan will serve as the measure steward.

4) *Baseline value for measures*

Although there is no true baseline to which results can be compared, results can be interpreted in light of results reported about those of similar income strata from the Behavioral Risk Factor Surveillance System in Michigan and other states, and Medicaid-specific Consumer Assessment of Healthcare Providers and Systems survey results.

5) *Analysis*

We will obtain descriptive statistics related to health insurance/health plan literacy, such as the proportion of Healthy Michigan Plan enrollees who understand use of their MI Health Accounts, and self-reported health status and healthy behaviors (e.g., current smoking, level of physical activity). We will link participants' survey data to Medicaid utilization and enrollment data available through the Michigan Department of Community Health Data Warehouse, as well as other existing secondary data on the characteristics of their communities through use of geocodes. Data analysts from Domain III will query enrollment and utilization files to identify important beneficiary sub-groups of interest (e.g., low utilizers of health care, high utilizers of health care, those with mental/behavioral health conditions and substance use disorders, and those with other complex chronic conditions). We will then use mixed effects regression to identify individual and community factors associated with Healthy Michigan Plan enrollees':

- Health insurance literacy, and knowledge and understanding about the Healthy Michigan Plan
- Knowledge about health and health risks, health behaviors, and engaged participation in care
- Decision making about when, where and how to seek care

V. Primary Care Practitioner Survey (PCPS)

1) *Sample*

Practitioners listed as the primary care provider of record for a minimum number of Healthy Michigan Plan enrollees (minimum number to be determined, based on the range and quartiles of numbers of Healthy Michigan Plan enrollees per practitioner) will be identified using the Michigan Department of Community Health Data Warehouse. From that frame we will draw a random sample of 2400 practitioners, anticipating we can obtain agreement from at least 1000 primary care practitioners to participate in the Survey. Sampling will be stratified by:

- Region as defined and used in the State Health Assessment and Improvement Plan. Regional sampling assures inclusion of primary care practitioners caring for patients in urban, suburban, rural and remote rural locations.
- Number of Healthy Michigan Plan enrollees for whom the practitioner is the primary care provider of record (by quartile). This will permit examination of whether primary care practitioners with greater and lesser experience caring for Healthy Michigan Plan enrollees report different experiences, innovations adaptations and future plans.
- Practice size

2) *Data Sources*

Surveys will include measures of primary care practitioner and practice characteristics, and measures related to the Healthy Michigan Plan such as, but not limited to:

- Plans to accept new Medicaid patients
- Anticipated, predicted barriers to care for the Healthy Michigan Plan patients (including barriers to specialty care)
- Experiences with Healthy Michigan Plan enrollees regarding decision making about emergency department use
- Experiences of caring for newly insured Medicaid patients, including ability to access non-primary care (specialty care, equipment, medication, dental care, mental health care)
- Experiences with care of special populations of newly insured Medicaid patients. Special populations (as reference in Domain III, Section V.A) include those that are a risk for overuse, under use, or inappropriate use of health care such as:
    - Key chronic disease populations (e.g., asthma, COPD, diabetes, CHF)
    - Beneficiaries who demonstrate high emergency department utilization (e.g., ≥5 emergency department visits within a 12-month period).
- New practice approaches adopted as a result of the newly insured Medicaid patients
- Future plans regarding care of Medicaid patients

Drs. Goold, Campbell and Tipirneni will develop the survey questions in collaboration with other members of the research team, informed by analysis of data collected in individual and group interviews. The development process will begin by identifying the key survey domains through an iterative process with the members of the evaluation team. Once the domains are identified we will scan the research literature to find existing survey items measuring the domains of interest (e.g., Backus *et al* 2001).

To develop and test measures for the Primary Care Practitioner Survey and the Healthy Michigan Voices Survey, we will conduct a set of individual and focus group interviews in 4 communities

(see below for selection criteria). Within each community, we plan to conduct 2 focus groups with ~10 Healthy Michigan Plan beneficiaries in each group; and individual or group interviews with 20 providers of medical, dental, mental health and substance use disorder care (including emergency department providers), community health workers, social service providers and key informants from health systems and community-based organizations serving Healthy Michigan Plan and other low-income clientele. Focus group interviews will be used more frequently in larger communities and individual interviews more frequently in rural areas and with some specific key health system, health provider and community organization informants. Individual interviews and focus groups will be conducted by trained interviewers and facilitators.
We will conduct all interviews during year 1, with development beginning in early fall 2014, first interviews by late fall and expected conclusion by early summer 2015. Analysis of results will be ongoing, aiming to first inform the development and testing of the Primary Care Practitioner Survey and, subsequently, the Healthy Michigan Voices Survey.

We will purposefully select four communities to assure inclusion of:

a) Medically underserved counties or populations,
b) Communities with a large proportion of high-utilizing beneficiaries,
c) Communities that have instituted innovations in care delivery or financing, for example the Michigan Pathways to Better Health initiative,
d) Racial and ethnic diversity,
e) A mix of urban, suburban and rural.

Dr. Campbell will take the lead in developing new survey items for the Practitioner Survey, which will be vetted thoroughly with members of the research team.

It is essential that newly developed survey instruments be tested extensively prior to use. We will pre-test the practitioner instrument using cognitive interviews with 5-10 primary care practitioners (including a variety of types of clinicians and specialties), and pretest the beneficiaries survey with 5-10 adult low-income Michigan residents balanced in age, gender and educational attainment. The goals of the cognitive testing are to ensure that: 1) respondents understand the questions in the manner in which the researcher intends; and 2) that the questions are written in a manner answerable for respondents. Through cognitive interviewing, we can determine whether the respondents understand the questions and can identify problems in two specific areas: potential response errors and errors in question interpretation associated with vague wording, use of technical terms, inappropriate assumptions, sensitive content and item wording. (Fowler, 2002) We will use the interview results to ensure that our survey items are as free from error as possible.

The surveys will be administered by the University of Michigan Child Health Evaluation and Research Unit, which has extensive experience in physician studies. All data will be stored in secure, password-protected files.

3) *Measure stewards and baseline*

Although direct comparisons cannot be made, results can be compared to those from the Michigan Primary Care Physician Survey conducted by the University of Michigan Child Health Evaluation and Research Unit and the Center for Healthcare Research and Transformation (Davis *et al*, 2012), the Michigan Survey of Physicians from 2012, and studies of physicians nationally (e.g., Strouse *et* al 2009, Tilburt *et al* 2013, Decker 2013) and in other states (e.g., Long 2013, Yen and Mounts 2012, Bruen *et al* 2013).

4) *Analysis*

We will obtain various descriptive statistics such as proportion of primary care practitioners reporting difficulty accessing specialty care for Healthy Michigan Plan enrollees or experiences related to emergency department decision making. We will examine differences between primary care practitioners by rural vs. urban practice, gender, specialty, years in practice, size of practice, number of Healthy Michigan Plan enrollees (by quartile) and proportion of assigned enrollees with a primary care visit and/or emergency department visit in the preceding 12 months.

VI. Timeline

June 1 – September 30, 2014: Identify key domains for primary care practitioner survey and gaps in existing measures. Create sampling frame and finalize sampling strategy for primary care practitioner survey.

October 1, 2014 – September 30, 2015: Cognitive testing for primary care practitioner survey. Primary care practitioner survey fielded and data collection completed. Key domains identified for Healthy Michigan Voices survey and gaps in existing measures. New measures developed and tested for Healthy Michigan Voices survey. Finalize sampling strategy for Healthy Michigan Voices survey. Begin analysis of primary care practitioner survey data.

October 1, 2015 – September 30, 2016: Continue and complete analysis of primary care practitioner survey data and prepare interim reports. Healthy Michigan Voices survey fielded and data collection completed. Begin descriptive analysis and prepare interim report.

October 1, 2016 – September 30, 2017 Prepare Healthy Michigan Voices survey data for analysis, complete descriptive analyses and interim reporting. Begin subgroup analyses, analyses of relationships (e.g., individual and community factors associated with care-seeking) and multivariate analyses.

October 1, 2017 – September 30, 2018. Complete analysis of Healthy Michigan Voices survey and prepare reports.

VII. Outcomes (expected)

	porting Quarters	**ta Source**

ATTACHMENT B
Demonstration Evaluation Plan

	(state fiscal years)	
Key domains and existing measures identified for Primary Care Practitioner Survey	2015	ploratory interviews, literature review
Primary care practitioners' experiences caring for Healthy Michigan Plan patients including: • Experiences with Healthy Michigan Plan enrollees regarding decision making about emergency room use • Experiences of caring for Healthy Michigan Plan enrollees, including ability to access non-primary care (specialty care, equipment, medication, dental care, mental health care) • Experiences caring for special populations of Healthy Michigan Plan enrollees • New practice approaches adopted as a result of the newly insured Medicaid patients • Future plans regarding care of Medicaid patients	-Q4 2016	mary Care Practitioner Survey
Beneficiaries' Experiences and Views: • Health insurance literacy, knowledge and understanding about the Healthy Michigan Plan, their health plan, benefit coverage, cost-sharing, and consumer behaviors. • Health status, including physical and mental health and the presence of chronic health conditions • Knowledge about health, health risks and health behaviors; their reported changes in health status, health behaviors, and engaged participation in care; facilitators and barriers to healthy behaviors, and strategies that facilitate or challenge improvements in health behaviors • Decisions about when, where, and how to seek care, including decisions about emergency department utilization	2017 - Q4 2018	althy Michigan Voices Survey
lividual and Community factors associated with: o Knowledge and understanding or health insurance, Healthy Michigan Plan, health risks and health behaviors o Health behaviors, activation and engaged participation in care o Experiences of health plan enrollment and use; decision making about when, where, and how to seek care; consumer behaviors ctors associated with Healthy Michigan Plan beneficiaries' health behaviors and patient activation	2018	althy Michigan Voices Survey

VIII. Limitations/challenges/opportunities

This multi-faceted evaluation of the Healthy Michigan Plan from the perspective of beneficiaries provides an opportunity to understand the impact of insurance coverage for low-income adults in Michigan, and whether and how cost-sharing and incentives for healthy behavior and the use of high-value care affect their decisions and behavior. Although we will not be able to compare the impact of the Healthy Michigan Plan on enrollees to a control group without Healthy Michigan Plan, we will explore insights that could be gained from comparisons to historical data and to information from neighboring states, if available.

The primary challenge related to surveys of physicians is getting physicians to respond. The standard approaches that are essential to overcoming this challenge include:

1. Making the survey short (no-more than 10 to 15 minutes to complete),
2. Making the topic relevant to physicians personally,
3. Convincing subjects that their responses will be used to change policy or practice,
4. Providing the survey in a format that can be easily completed and returned,
5. Providing an incentive for participation,
6. Doing extensive follow-up.

These approaches have been shown over time to be associated with high response rates. Below are examples of surveys in which Dr. Campbell has used these techniques with physicians and other professionals (including Dr. Goold) in order to achieve high response rates:

Grant Title	Study Population	# (pages)	Response Rate
Data Withholding in Genetics, 2000	2,893 life scientists	15	64%
Medical Professionalism, 2004	3,000 physicians	7	58%
Academic Industry Relationships, 2006	2,941 life scientists	8	74%
IRB Industry Relationships, 2005	893 IRB members	8	67%
Government Industry Relationships, 2008	567 NIH scientists	8	70%
Physician Professionalism 2009	3,500 physicians	8	69%
IRB Members and Conflicts of Interest 2014	1,016 IRB members	6	68%

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ATTACHMENT B
Demonstration Evaluation Plan

Domains V & VI: Impact of Contribution Requirements & Impact of MI Health Accounts

Impact of Contribution Requirements *– The Healthy Michigan Program will evaluate whether requiring beneficiaries to make contributions toward the cost of their health care results in individuals dropping their coverage, and whether collecting an average utilization component from beneficiaries in lieu of copayments at point of service affects beneficiaries' propensity to use services.*

Impact of MI Health Accounts *– The Healthy Michigan Program will evaluate whether providing a MI Health Account into which beneficiaries' contributions are deposited, that provides quarterly statements detailing account contributions and health care utilization, and that allows for reductions in future contribution requirements when funds roll over, deters beneficiaries from receiving needed health care services, or encourages beneficiaries to be more cost conscious.*

I. Hypotheses

- **Hypothesis V/VI.1:** Cost-sharing implemented through the MI Health Account framework will be associated with beneficiaries making more efficient use of health care services, as measured by total costs of care over time relative to their initial year of enrollment, and relative to trends in the Healthy Michigan Plan's population below 100% of the Federal Poverty Level that face similar service-specific cost-sharing requirements but not additional contributions towards the cost of their care.
- **Hypothesis V/VI.2:** Cost-sharing implemented through the MI Health Account framework will be associated with beneficiaries making more effective use of health care services relative to their initial year of enrollment, as indicated by a change in the mix of services from low-value (e.g., non-urgent emergency department visits, low priority office visits) to higher-value categories (e.g., emergency-only emergency department visits, high priority office visits), and relative to trends in the Healthy Michigan Plan's population below 100% of the Federal Poverty Level that face similar service-specific cost-sharing requirements but not additional contributions towards the cost of their care. Several questions on the Healthy Michigan Voices Survey address this hypothesis.
- **Hypothesis V/VI.3:** Cost-sharing and contributions implemented through the MI Health Account framework will not be associated with beneficiaries dropping their coverage through the Healthy Michigan Plan.
    - Beneficiaries above 100% of FPL who have few health care needs may consider dropping coverage due to the required contributions. However, those contributions do not begin until 6 months after enrollment, and can be reduced by 50% based on healthy behaviors. Therefore, we expect most beneficiaries will have little incentive to let their enrollment lapse, despite continued eligibility. To determine the prevalence of coverage drops due to cost-sharing, we will monitor compliance with contribution requirements and use the Healthy Michigan Voices survey to assess reasons for failure to re-enroll.
- **Hypothesis V/VI.4:**
    A. Exemptions from cost-sharing for specified services for chronic illnesses and rewards implemented through the MI Health Account framework for completing a health risk assessment with a primary care provider and agreeing to behavior changes will be

associated with beneficiaries increasing their healthy behaviors and their engagement with healthcare decision-making relative to their initial year of enrollment. Several questions on the Healthy Michigan Voices Survey also address this hypothesis.

B. This increase in healthy behaviors and engagement will be associated with an improvement in enrollees' health status over time, as measured by changes in elements of their health risk assessments and changes in receipt of recommended preventive care (e.g., flu shots, cancer screening) and adherence to prescribed medications for chronic disease (e.g., asthma controller medications).

II. Management/Coordination of Evaluation

The evaluation will be conducted by a team of researchers led by University of Michigan faculty member Richard Hirth, Ph.D. Dr. Hirth is Professor and Associate Chair of Health Management and Policy and Professor of Internal Medicine. His expertise includes health insurance and healthcare costs. He recently received the 2014 AcademyHealth Health Services Research Impact Award for his work on designing the renal dialysis bundled payment system adopted by Medicare in 2011. He serves as Deputy Editor of *Medical Care*, Research Director of the Center for Value-Based Insurance Design, and Associate Director of the Kidney Epidemiology and Cost Center.

Additional faculty members working on this domain are described in Appendix A.

III. Timeline

Administrative data will be analyzed throughout the Healthy Michigan Plan demonstration project, in conjunction with timeline activities described in Domains III and IV.

Planning: 6/1/14 – 12/31/16: Work with Domain III leads to analyze administrative data for baseline measurement and to establish a control population. Work with Domain IV leads to establish baseline, identify gaps in existing measures to develop new Healthy Michigan Voices survey measures specific to Domains V/VI.

Pilot Testing: 1/1/15 – 8/31/15: Work with Domain IV to test Healthy Michigan Voices survey measures specific to Domains V/VI, analyze early utilization patterns and cost-sharing experiences.

Data Collection: 9/1/15 – 5/31/16: Healthy Michigan Voices survey field and data collection completed (domain IV). Work with Domain IV to begin analysis of Healthy Michigan Voices survey data. Continue to analyze trends over time in MI Health Account and cost-sharing experiences.

Data Analysis: 6/1/16 – 5/31/17: Continue and complete analysis of administrative data and Healthy Michigan Voices survey data specific to Domains V/VI. Analyze administrative data for evaluation of changes related to cost sharing requirements.

Reporting: 6/1/17 – 12/31/17: Complete analysis of administrative data and Healthy Michigan Voices survey data specific to Domains V/VI and prepare reports.

A. Development

During the initial phase of the project, we will focus on the acquisition of baseline data on the treatment and control populations. In addition, we will work with the other domains to incorporate questions into the Healthy Michigan Voices survey.

B. Implementation

Data acquisition, updating and analysis will be ongoing throughout the project. This will facilitate the provision of timely interim and final reports on the outcomes of the Healthy Michigan Plan and allow for informed decisions regarding modification of the program.

C. Reporting

Interim reporting will be completed during state fiscal year 2017, with final reporting occurring at the end of the demonstration period.

IV. Performance Measures

A. Specific measures and rationale

Cost, utilization, and outcome measures will come from Medicaid claims, health risk assessments, and the responses on the Healthy Michigan Voices Survey, as described in more detail in Domain III. Survey questions specific to the hypotheses in this domain will focus on two main areas: knowledge of program features and consumer behaviors. For each of these areas, it will be important to describe baseline levels and examine changes over time (i.e., with more experience in the Healthy Michigan Plan).

The survey questions developed to assess beneficiary knowledge of cost-sharing requirements will seek to evaluate the impact of the increased communication on behavior. We will design survey questions aimed at assessing beneficiary recall of cost-sharing information shared at the point of service as well as in the MI Health Account quarterly statements. Specifically, we will incorporate survey questions to understand whether and how this increased communication leads to beneficiaries becoming more aware of these program features, and whether there is an impact on behavior.

Beneficiary Knowledge of Specific Program Features

- Cost-Sharing:
    - Co-pays for different types of services, in particular services that are exempt from cost-sharing (such as preventive services, which has been a key area of confusion

in high deductible health plans) and services that cost-sharing aims to discourage (e.g., non-emergency emergency department visits)
    - How co-pays are paid, in light of the waiver specification that co-pays will not be collected at the point of service so as not to discourage needed care
    - If/how cost-sharing can be reduced (i.e., by health risk assessment completion and engagement in healthy behaviors)
- MI Health Accounts:
    - Purpose of account
    - Required beneficiary contributions
    - Whether account balances can be rolled over

Consumer Behaviors

- Checking cost-sharing before seeking care
- Checking MI Health Account balance before seeking care
- Talking with doctor about treatment options and costs
- Budgeting for health care expenses

B. Statistical reliability and validity

We will utilize standard descriptive and adjusted statistical techniques with appropriate attention to confounding and consideration of temporal trends through use of concurrent control groups.

C. Methodology and specifications

i. Eligible/target population

The target population is Healthy Michigan Plan enrollees on or after April 1, 2014. We expect 300,000-500,000 persons to be eligible for the Healthy Michigan Plan, all of whom will be subject to copay requirements. Only those with incomes between 100%-133% of the Federal Poverty Level will be subject to contribution requirements.

ii. Time period of study

Enrollees will be followed from the initiation of the Healthy Michigan Plan on April 1, 2014 and run through the most recent available data at the end of 2017. We anticipate following and evaluating enrollees until at least the end of 2016 and possibly through mid-2017.

iii. Measure steward

The Department of Community Health is the steward of Medicaid data on utilization, MI Health Accounts, and cost-sharing. We will assess how MI Health Accounts and cost-sharing are associated with specified measures from the Centers for Medicare & Medicaid Services' Core Set of Health Care Quality Measures for Medicaid Eligible Adults, as detailed in Domain III.

iv. Data Handling, Storage, and Confidentiality

Please refer to Domain III for information on the handling, storage and confidentiality of data on utilization, MI Health Accounts, and cost-sharing data from the Data Warehouse, and to Domain IV for comparable information on the Healthy Michigan Voices survey.

v. Rationale for approach

See Plan for Analysis below.

vi. Sampling methodology

Claims-based utilization and cost measures, MI Health Accounts, and cost-sharing data will be available for all Healthy Michigan Plan enrollees, so no sampling will be required for these data. Please refer to Domain IV for info on sampling strategy for Healthy Michigan Voices survey.

V. Plan for Analysis

A. Evaluation of performance

We propose to address the four study hypotheses by using Medicaid claims and MI Health Account statements to track resource utilization, both in terms of total spending (Medicaid spending plus patient obligations) and in terms of specific services (e.g., emergency department use, use of preventive services). This tracking will incorporate the first full 3 years of the Healthy Michigan Plan (4/1/2014 – 4/1/2017). Two populations will be tracked over this timeframe:

- The Healthy Michigan Plan population with incomes between 100% and 133% of the Federal Poverty Level,
- The Healthy Michigan Plan population with incomes less than 100% of the Federal Poverty Level,

The primary comparisons described in the hypotheses involve relative changes over time in different parts of the Healthy Michigan Plan population. These analyses will use a "differences in differences" model, comparing trends in the treatment group to trends in the control group(-s). Please see the limitations section below for further details.

For the Healthy Michigan Plan enrollees with incomes between 100% and 133% of the Federal Poverty Level, we will also assess changes in health and health risks over time based on the completed health risk assessments. Primary analyses of the health risk assessments data will occur under Domain III; that information will be integrated with Domains V and VI in order to support testing the hypotheses under these Domains.

In addition to tracking utilization for the entire population, we propose using the Healthy Michigan Voices to survey to provide supporting information regarding consumers' responses to cost-sharing and contribution requirements. The purpose of that survey will be to assess

enrollees' understanding of the program and their obligations and their engagement in health and healthcare decisions.

B. Outcomes (expected)

We expect the trend in total costs per enrollee to be no greater, or possibly lower, among those with higher contribution requirements. Underlying the total cost of care, we expect to see a shift in the composition of services from low value towards high-value uses among those in the MI Health Account program relative to the control populations. We also expect to see improvements on health risks, understanding of the program and engagement in health decisions over time in the MI Health Account enrollees.

C. Limitations/challenges/opportunities

There are four primary analytic challenges:

1) **Ensuring appropriate control populations against which to judge the trends observed among MI Health Account enrollees is necessary to draw compelling conclusions about the program's success.** The primary control populations will be different eligibility groups within the Healthy Michigan Plan (e.g., <100% of the Federal Poverty Level). Because those groups differ systematically from those who are eligible for the program, the levels of the outcome variables may be different but it is plausible that many of the factors causing changes over time are common to the control and treatment populations. One approach to limiting the effects of any residual differences in populations would be to focus on comparisons between narrower (and presumably more similar) subpopulations (e.g., 100-120% of the Federal Poverty Level vs. 80-100% of the Federal Poverty Level) rather than using the entire range of incomes

2) **Lack of data for population prior to their enrollment on or after April 1, 2014.** The initial data on enrollees with contribution requirements will come from their first six months to one year in the program rather than from a pre-program baseline period. We expect that the program's effects will take time to develop (e.g., MI Health Account contributions do not occur in the first six months of the program, learning how to use the program and better engage with the health system and changes in health behaviors subsequent to the initial health risk assessment will not be immediate). Therefore, using the first program year as the baseline may not be a substantial limitation.

3) **Given the relatively small incentives in an absolute sense (though not necessarily trivial to a low income population), the magnitude of behavior change may not be substantial across all outcome dimensions.** However, we expect the expected enrollment of 300,000 to 500,000 individuals to be sufficient to detect statistically significant changes even if their absolute magnitudes are not large.

4) **Changing program eligibility over time may result in households "churning" into and out of the Healthy Michigan program.** We anticipate that most, but not all, program

eligibility determinations will be on an annual basis, limiting the amount of month-to-month turnover. In addition, to the extent that incomes dropped below 100% of the Federal Poverty Level, we would be able to continue to track individuals who move below the income range required to make additional contributions to their MI Health Accounts.

Domain VII: Cost-effectiveness

I. Hypotheses

Hypothesis VII.1: Marketplace Option enrollees will not differ significantly from Healthy Michigan Plan enrollees in access to primary care providers.

Hypothesis VII.2: Marketplace Option enrollees will not differ significantly from Healthy Michigan Plan enrollees in access to specialty care providers.

Hypothesis VII.3: The quality of care and utilization of emergency department and hospital services will not differ significantly for Marketplace Option beneficiaries relative to enrollees in the same income range who remain in the Healthy Michigan Plan.

Hypothesis VII.4: The cost of covering Marketplace Option beneficiaries will not differ significantly from the cost of covering enrollees in the same income range who remain in the Healthy Michigan Plan.

II. Management/Coordination of Evaluation

A. Evaluation Team

The work on Domain VII of the evaluation will be conducted by John Ayanian, Sarah Clark, and Renu Tipirneni.

III. Timeline

The timeline will be adjusted depending on the availability of claims data for the analyses.

- *July 2018 - October 2018*: Conduct analyses of quality measures from HMP claims data from the prior year of HMP enrollment (April 1, 2017 to March 31, 2018) as the identification year/pre condition.

- *April 2019 - June 2019*: Field Healthy Michigan Voices survey of Marketplace Option enrollees.

- *July 2019 – December 2019:* Conduct analyses of primary care and specialist availability (Hypotheses VII.1 and VII.2) and quality and utilization measures (Hypothesis VII.3) from HMP and Marketplace Option utilization data for the first 12 months (April 1, 2018 through March 31, 2019) as the measurement period if the Marketplace Option data are available in a timely manner. Conduct analysis of overall cost data from HMP and Marketplace Option (Hypothesis VII.4). Conduct geo-mapping analysis.

- *December 2019*: Prepare summary of Domain VII findings for final evaluation report, to be submitted by February 1, 2020.

IV. Performance Measures/Data Sources

A. Specific measures and rationale

1. Hypothesis VII.1. Access to Primary Care Providers

To assess access to primary care for enrollees in the Healthy Michigan Plan and those who enroll in the Marketplace Option, we will use three measures. First, we will assess the overlap in primary care provider networks between the Healthy Michigan Plan and the Marketplace Option. Using provider NPI numbers, we will compare the list of available primary care providers for the Marketplace Option with the primary care network lists for plans of comparable region and size participating in the Healthy Michigan Plan.

Second, to assess geographic access of Healthy Michigan Plan and Marketplace Option enrollees to in-network providers and enable analytic comparisons between groups, we will use GIS mapping techniques to calculate travel distances from enrollees' residence to one of the following three options: (1) the primary care providers (PCPs) enrollees have actually seen for their care, (2) their selected or assigned PCP, or (3) the nearest in-network PCP – based on the data available to the evaluation team.

Another source of data for exploring this hypothesis is the Healthy Michigan Voices Survey. A portion of the sample of the Healthy Michigan Voices survey in 2019 will include beneficiaries enrolled in the Marketplace Option (either by choice or through state transfer because they did not meet the criteria to remain in a Medicaid Health Plan). The survey will include questions that address perceptions of access to primary care, including whether individuals were able to keep their primary care provider if they chose to do so, or were required to find a new PCP that was in network, after making the transition.

For beneficiaries who transition to the Marketplace Option, we will also compare primary care utilization in the final year of HMP to the first year in the Marketplace Option, assess changes in primary care provider, compare a measure of primary care utilization-vs-emergency department utilization in the final year of HMP to the first year in the Marketplace Option, and describe the characteristics of those who have a drop in primary care utilization after transitioning to the Marketplace Option. We will consider these analyses in light of changes in health plan carriers that occur for beneficiaries during the transition to the Marketplace Option.

2. Hypothesis VII.2. Access to Specialty Care Providers

We recognize that provider network lists may overstate the number of providers willing to see Medicaid patients (U.S. Department of Health and Human Services Office of the Inspector General, 2014). As a result, we will use three measures to assess access to specialty care for enrollees in the Healthy Michigan Plan and those who enroll in the Marketplace Option. First, we will assess the overlap in specialty care provider networks between the Healthy Michigan Plan and the Marketplace Option, Second, we will modify an existing measure designed to assess

the availability of specialty care for Medicaid-enrolled children. This measure focuses on specialists who have claims evidence of providing outpatient visits to enrollees. Using this method, we will assess the respective rates of participating cardiologists, dermatologists, endocrinologists, gastroenterologists, hematologists/oncologists, nephrologists, neurologists, otolaryngologists, pulmonologists, rheumatologists, general surgeons, orthopedic surgeons, and obstetrician-gynecologists who have seen at least one enrolled adult in the measurement year for at least one outpatient visit. Specialist physicians are identified using taxonomy codes linked to a National Provider Identifier (NPI) using the National Plan & Provider Enumeration System (NPPES) registry (https://npiregistry.cms.hhs.gov). These measures are implemented with administrative claims data. They are adapted from a comparable set of measures recently developed by members of our HMP evaluation team and approved by the National Quality Measures Clearinghouse for assessing outpatient specialty care for children (Clark et al., 2016). To address concerns that this measure may partly reflect provider-patient relationships that pre-exist enrollment in either program, we will conduct a secondary analysis to look at rates of specialist visits among individuals newly enrolling in HMP (between April and December 2018) with incomes at or above 100 percent FPL and compare to utilization among Marketplace Option enrollees.

Second, to assess geographic access of Healthy Michigan Plan and Marketplace Option enrollees to in-network specialist providers in a variety of categories (e.g. cardiologist, endocrinologist, obstetrician/gynecologist, ophthalmologist, rheumatologist, pulmonologist) and enable analytic comparisons between groups, we will use GIS mapping techniques to calculate travel distances from enrollees' residence to one of the following two options: (1) the specialists enrollees have actually seen for their care, or (2) the nearest in-network specialists – based on the data available to the evaluation team.

Another source of data for exploring this hypothesis is the Healthy Michigan Voices Survey. A portion of the sample of the Healthy Michigan Voices survey in 2019 will include beneficiaries enrolled in the Marketplace Option (either by choice or through state transfer because they did not complete the Health Risk Assessment and agree to a healthy behavior). The survey will include questions that address perceptions of access to specialty care.

For beneficiaries who transition to the Marketplace Option, we will also compare specialty care utilization in the final year of HMP to the first year in the Marketplace Option, assess changes in specialty care providers, and describe the characteristics of those who have a drop in specialty care utilization after transitioning to the Marketplace Option. This analysis will be focused on key chronic disease populations (asthma, CHF, COPD, diabetes). We will consider these analyses in light of changes in health plan carriers that occur for beneficiaries during the transition to the Marketplace Option.

3. Hypothesis VII.3. Quality of Care & Health Care Utilization

If the Michigan Department of Health and Human Services (MDHHS) can obtain claims data from Marketplace Option plans for HMP enrollees who switch to these plans in 2018, we will compare claims-based quality and utilization measures between HMP and Marketplace Option

enrollees. If information is available on reasons for transitioning to the Marketplace Option, we will conduct a subgroup analysis of enrollees who chose the Marketplace Option as compared to those who were transferred by the state because they did not meet the criteria to remain in a Medicaid Health Plan. To address this hypothesis in our final evaluation report to be submitted by November 1, 2019, we will analyze HMP and Marketplace Option claims data for health services delivered during the first 12 months after the Marketplace Option becomes active (April 1, 2018 through March 31, 2019), anticipating that >90% of claims will be adjudicated and available in the data warehouse by the expected start date for this analysis in July 2019. We will re-run analyses in September 2019 to verify that claims with delayed adjudication do not affect the results. It should be noted that this analysis is of realized utilization via claims analysis, and as a result, it is not possible to draw conclusions about those who do not utilize care during this period.

Additionally, a portion of the sample of the Healthy Michigan Voices survey in 2019 will include beneficiaries enrolled in the Marketplace Option (either by choice or through state transfer because they did not meet the criteria to remain in a Medicaid Health Plan) and will include questions that address perceptions of quality of care and health care utilization.

As outlined in Domain III of our HMP evaluation plan approved by CMS on October 21, 2014, a broad range of measures will be generated for each year of the evaluation project. These measures include established indicators for clinical care (e.g., Healthcare Effectiveness Data and Information Set measures, Adult Core Quality Indicators) with identified measure stewards (e.g., National Quality Forum). Importantly, health plan-based measures offer useful but limited information, as they exclude enrollees who change health plans and do not allow a full assessment of outcomes for the entire population or for a target geographic area with multiple plans; moreover, some measures require a period of identification prior to measurement outcomes. HEDIS criteria for measures of chronic disease populations (Diabetes HbA1c, LDL testing, admission rate; COPD admission rate; CHF admission rate; asthma admission rate) require a year for identification of members who meet the chronic disease definition (i.e., the denominator), followed by a measurement year to assess utilization (i.e., the numerator).

To follow HEDIS or NQF criteria for such measures among Marketplace Option enrollees, we will use the prior year of HMP enrollment (April 1, 2017 – March 31, 2018) as the identification year, followed by the ensuing 12 months of HMP or Marketplace Option enrollment as the measurement period. Assuming these claims data are available, we will complete this analysis during July through October of 2019. While we did consider modifications to established measures to accommodate a shortened time period and/or the use of claims-based utilization measures that do not require a pre-period, this approach would not offer a fruitful subgroup analysis, as the groups may not be subject to the same requirements, such as having an early primary care visit, so their results would not be comparable.

As outlined on pages 79-81 of our original evaluation plan, we will focus on the following claims-based quality and utilization measures that can be feasibly measured during a 12-month observation period (for which Marketplace Option claims data could become available) rather than a full-year measurement period (as needed for cancer screening, for example):

- **Healthcare Effectiveness Data and Information Set (HEDIS) Emergency Department Measure**: We will calculate the rate of emergency department visits per 1000 member months, and will calculate incidence rate ratios to assess the relative magnitude of emergency department utilization rates for subgroup comparisons. To provide additional information, we will calculate subgroup rates for key chronic disease populations (e.g., asthma, COPD, diabetes, CHF) at the plan level and by geographic region; this information will help the state to evaluate disease management programs and other services intended to encourage outpatient visits over emergency department use.

- **Emergency Department High-Utilizer Measure**: We will calculate the proportion of Healthy Michigan Plan beneficiaries who demonstrate high emergency department utilization (e.g., ≥5 emergency department visits within a 12-month period).
    - We will also account for clustering of visits among frequent users to examine the degree to which a small number of frequent emergency department users drive observed utilization rates among HMP and Marketplace Option enrollees including sensitivity tests to examine the probability of having any emergency room visit at all.

- **Hemoglobin A1c Testing** (NQF 0057; measure steward NCQA): We will calculate the proportion of beneficiaries aged 18-64 with type 1 or type 2 diabetes who had hemoglobin a1c testing at least once during the measurement year.

- **LDL-C Screening** (NQF 0063; measure steward NCQA): We will calculate the proportion of beneficiaries aged 18-64 with type 1 or type 2 diabetes who had an LDL-C screening performed at least once during the measurement year.

- **Overall Admission Rate**: We will calculate the proportion of enrollees with any inpatient admission, as well as the rate of inpatient admissions per 1000 member months. We will make the same calculations for medical admissions and surgical admissions.

- **Diabetes, Short-term Complications Admission Rate** (NQF 0272; measure steward AHRQ): We will calculate the number of discharges for diabetes short-term complications per 100,000 Healthy Michigan Plan enrollees age 18-64.

- **Chronic Obstructive Pulmonary Disease (COPD) Admission Rate** (NQF 0275; measure steward AHRQ): We will calculate the number of discharges for COPD per 100,000 Healthy Michigan Plan enrollees age 18-64.

- **Congestive Heart Failure Admission Rate** (NQF 0277; measure steward AHRQ): We will calculate the number of discharges for CHF per 100,000 Healthy Michigan Plan enrollees age 18-64.

- **Adult Asthma Admission Rate** (NQF 0283; measure steward AHRQ): We will calculate the number of discharges for asthma per 100,000 Healthy Michigan Plan enrollees age 18-64.

- **Flu Shots for Adults:** We will calculate the proportion of beneficiaries aged 50-64 and aged 18-49 who received an influenza vaccine between July 1 and March 31. To supplement Consumer Assessment of Healthcare Providers and Systems self-reported data from a small sample of beneficiaries (NQF 0039), we will take advantage of Michigan's unique data environment by combining Medicaid utilization data with information found in the statewide immunization registry (Michigan Care Improvement Registry) to document rates of influenza vaccine receipt for the HMP and Marketplace Option enrollees, and for individuals at high risk for influenza-related complications, such as those with diabetes, COPD, CHF, or asthma.

4. Hypothesis VII.4. Costs of Care

For this hypothesis we will assess the total state and federal costs of Marketplace Option coverage on a per-member-per-month basis for former HMP enrollees who move to a Qualified Health Plan (QHP). These costs include four main components:

1. Costs of Marketplace Option premiums
2. MDHHS costs of Medicaid wraparound coverage
3. MDHHS administrative costs to oversee the Marketplace Option

The total of these four components will be compared to the capitated payments and costs outside the cap made for an age/sex/comorbidity matched group of enrollees with incomes above 100% of the Federal poverty level (FPL) who remain in HMP health plans. This analysis assumes that MDHHS can provide the University of Michigan evaluation team with the four components of Marketplace Option cost data listed above by June 30, 2019, thereby enabling the cost analyses to be conducted during July through October 2019. For this analysis, we will conduct a subgroup analysis to minimize the influence of selection bias by separately examining costs for those Marketplace Option enrollees who willingly switched from HMP and those that the state transferred because they did not meet the criteria to stay in a Medicaid Health Plan controlled for age and sex.

Given the limited 12-month time period of data that we expect to be available for analysis of Marketplace Option enrollees in Michigan during April 2018 through March 2019, we propose the following measures of incremental cost-effectiveness ratios (ICER) that employ the utilization and cost data described above for this time period:

Overall emergency department (ED) use

$$\frac{\text{Total Cost (Marketplace Option) - Total Cost(HMP)}}{\text{ED Use (Marketplace Option) - ED Use(HMP)}}$$

Overall admission rates

Total Cost (Marketplace Option) - Total Cost(HMP)
Admission Rate (Marketplace Option) - Admission Rate(HMP)

Admission rates for COPD, diabetes short-term complications, CHF and asthma

Total Cost (Marketplace Option) - Total Cost(HMP)
Admission Rate (Marketplace Option) - Admission Rate(HMP)

Breast Cancer Screening

Total Cost (Marketplace Option) - Total Cost(HMP)
Breast Cancer Screening (Marketplace Option) - Breast Cancer Screening(HMP)

LDL-C Screening

Total Cost (Marketplace Option) - Total Cost(HMP)
LDL-C Screening (Marketplace Option) - LDL-C Screening(HMP)

Hemoglobin A1c Testing

Total Cost (Marketplace Option) - Total Cost(HMP)
Hemoglobin A1c Testing (Marketplace Option) - Hemoglobin A1c Testing(HMP)

We will also incorporate select measures from HMV survey data in our analysis of the ICERs in order to understand how the relative costs relate to perceptions of access to care.

B. Methodology and specifications

i. Eligible/target population

The eligible population will include all Marketplace Option and Healthy Michigan Plan beneficiaries with incomes above 100% FPL and who are not deemed medically frail by MDHHS. The Healthy Michigan Plan participants who move to the Marketplace Option beginning in April 2018 will include enrollees in this income range who have not completed a Health Risk Assessment and agreed to a healthy behavior, as well as some enrollees who may choose the Marketplace Option because of a preference for private insurance coverage. Relative to Healthy Michigan Plan enrollees who complete the Health Risk Assessment, the former group may be less interested pursuing healthy behaviors and thus be less healthy, which could be associated with greater medical needs and higher costs. We will account for these differences as described in Section V below.

ii. Time period of study

The main period of study will begin April 1, 2018, after the Marketplace Option is implemented and extend for 12 months through March 31, 2019. Baseline data on prior health care use and costs will be collected during April 1, 2017 through March 31, 2018. The Healthy Michigan Voices survey of Marketplace Option enrollees will be conducted April through June 2019.

C. Measure steward

The Michigan Department of Health and Human Services is the measure steward.

D. Baseline values for measures

Information available at baseline includes primary care and specialist availability, healthcare utilization and cost data from the Healthy Michigan Plan available through the Michigan Department of Health and Human Services Data Warehouse.

E. Data Sources

The data source for information on utilization within the Healthy Michigan Plan will be the MDHHS Data Warehouse. Under the authority of a Business Associates' Agreement between the Department of Health and Human Services and the University of Michigan, individual-level data for Healthy Michigan Plan enrollees will be extracted from the Data Warehouse, to include enrollment and demographic characteristics, as well as all utilization (encounters in primary care, inpatient, emergency, urgent care; pharmacy). Data will be extracted from the Data Warehouse via an existing secure line, and stored in encrypted files on a secure network with multiple layers of password protection.

Healthy Michigan Plan and Marketplace Option provider and enrollee address data are the minimum necessary to perform the GIS mapping, Therefore, this component of the evaluation is contingent on access to accurate and timely electronic data on provider network lists, including practice location, and information about the beneficiaries enrolled in the Marketplace Option through Qualified Health Plans (QHPs). Because geographic access does not equate to realized access, we favor analyzing claims data to ascertain the distance traveled by beneficiaries for actual visits with PCPs, if these data from the QHPs can be provided to our evaluation team in a timely manner. The secondary preference is to use PCP of record, and the default plan will be to use the nearest in-network PCP. For the analysis of access to specialists, our preference is to use actual visits to specialty care providers and focus on high-volume specialty areas. Alternatively, depending on the volume of specialty care during the evaluation period (April 1, 2018-March 31, 2019), we would use the nearest in-network specialists.

We anticipate the data source for information on utilization and quality of care in Marketplace Option plans will come from data reporting by QHPs in Michigan to MDHHS. *The details of these new data reporting systems remain to be determined, so we will revisit the feasibility of these analyses with MDHHS in 2018 when we expect further information about the Marketplace Option plans and their data reporting to MDHHS will become available*.

The data source for information on costs of the Healthy Michigan Plan and Marketplace Option will be MDHHS. This information will include the capitated payments made to HMP health plans, the state payments made to Marketplace Option health plans for former HMP enrollees, the costs of wraparound Medicaid coverage for these enrollees, and the administrative costs associated with state oversight of the Marketplace Option for former HMP enrollees.

V. Plan for Analysis

Our evaluation of the cost effectiveness of the Marketplace Option as compared to the Healthy Michigan Plan will employ several types of analyses. To understand demographic and clinical characteristics of enrollees in these categories, we will compare the characteristics of Marketplace Option enrollees with those who have incomes above 100% FPL who remain in the Healthy Michigan Plan. These analyses will be based on HMP enrollment and encounter data during the year prior to the start of the Marketplace Option (April 1, 2017-March 31, 2018).

For the analysis of primary care access in Hypothesis VII.1, we will assess the overlap in primary care provider networks for HMP and the Marketplace Option. Using provider NPI numbers, we will compare the list of available primary care providers for the Marketplace Option with the primary care network lists for plans of comparable region and size participating in the Healthy Michigan Plan. For each Healthy Michigan Plan network assessed, we will calculate the proportion of primary care providers from the HMP network that appear on the Marketplace Option primary care provider network, to yield the percent overlap. We will also quantify the number of providers listed on the Healthy Michigan Plan network only and the number listed on the Marketplace Option network only. Finally, we will calculate the number of total primary care providers listed for each network and the ratio of primary care providers to enrolled members.

For the analysis of specialist availability in Hypothesis VII.2, we will compare the provider networks for Marketplace Option and comparable HMP plans for key specialties, specifically cardiologists, dermatologists, endocrinologists, gastroenterologists, hematologists/oncologists, nephrologists, neurologists, otolaryngologists, pulmonologists, rheumatologists, general surgeons, orthopedic surgeons, and obstetrician-gynecologists. As described above, we will calculate the overlap in specialists, as well as those unique to the Marketplace Option and those unique to the HMP plan network.

In addition, we will use administrative claims to calculate the respective rates of participating cardiologists, dermatologists, endocrinologists, gastroenterologists, hematologists/oncologists, nephrologists, neurologists, otolaryngologists, pulmonologists, rheumatologists, general surgeons, orthopedic surgeons, and obstetrician-gynecologists who have seen at least one enrolled adult in the measurement year for at least one outpatient visit will be expressed in terms of the numbers of participating specialists in each category per 1,000 eligible enrollees (number of providers/1,000 eligible enrollees), where the eligible population includes adults 18 years of age and older who have been enrolled in the Healthy Michigan Plan or the Marketplace Option for at least one 90-day period (or 3 consecutive months) within the measurement year.

For the analysis of quality and utilization measures for Hypothesis VII.3, we will compare the measures for Healthy Michigan Plan enrollees and Marketplace Option enrollees with incomes above 100% of FPL by gender, by race/ethnicity, and by urban/rural areas. For each of these measures, we will be building on analyses conducted for 2014 through 2017 as part of our original HMP evaluation. With risk-adjustment to account for baseline demographic and health status differences between these two groups prior to April 2018, we will use difference-in-difference methods to compare overall changes in quality and utilization measures for Marketplace Option enrollees with changes in these measures for comparable enrollees who remain in the Healthy Michigan Plan. This difference-in-difference approach will account for potential inherent differences between these two groups.

For Hypothesis VII.4, costs per-enrollee-per-month in HMP and the Marketplace Option during April 1, 2018 through March 31, 2019 will be compared after risk-adjustment based on enrollees' demographic characteristics and on their comorbid conditions and utilization using HMP data for the year prior to April 1, 2018. Incremental cost-effectiveness ratios will be calculated based on cost and utilization data as detailed above. We will also use difference-in-difference methods for these cost analyses. We will incorporate data from the high-utilizer ED measure to assess the extent to which ED costs are driven by high utilizers. Similarly, we will incorporate data from the inpatient quality measures to estimate the proportion of inpatient care attributable to the four chronic disease groups.

Geomapping Analysis Plan

Before conducting the geomapping, we will randomly select a sample of age- and sex-matched Healthy Michigan Plan enrollees who meet the same criteria as those enrolled in the Marketplace Option (income >100% FPL and not deemed medically frail) in equal number to the Marketplace Option enrollees within each prosperity region in the state.

To assess geographic access of Healthy Michigan Plan and Marketplace Option enrollees to in-network providers and enable analytic comparisons between groups, we will use GIS mapping techniques to calculate travel distances from enrollees' residence to one of the following three options: (1) the primary care providers (PCPs) enrollees have actually seen for their care, (2) their selected or assigned PCP, or (3) the nearest in-network PCP – based on the data available to the evaluation team.

The geographic method we choose to assess distance/travel time to provider will depend on the data source available. For options 1 and 2 above (last PCP seen based on claims data or PCP of record), we will use existing street centerline networks to compute miles traveled. For this method, each enrollee will have a two pairs of geographic coordinates (home and health care provider office), and distance/travel time will involve a single calculation using minimum distance methods available. If information about enrollees' unique PCP is not available, we will replicate the method described in Appendix 1 of Arkansas Health Care Independence Program ("Private Option") Section 1115 Demonstration Waiver Interim Report (Arkansas Center for Health Improvement, 2016), in which we will define incremental "ringed" polygons for each network PCP, and we will also use this approach to assess access to specialists. These polygons

will define regions based on the number of miles from the PCP or specialist (0-5, 5-10, 10-15, etc.). Similar polygons will also be constructed based on travel time in in 15-minute intervals rather than miles. For each enrollee in the dataset, we will find the closest PCP or specialist, and assign the distance value of that ring to the participant (e.g. if the smallest ring overlapping with that individual in a rural area is 15-20 miles, they will be assigned that value).

We will conduct statistical analyses to examine whether the level of access differs for enrollees in the Healthy Michigan Plan and those with a Marketplace Option. We will compare Marketplace enrollees with their matched counterparts enrolled in HMP based on the following:

1. Distance/travel time to PCP
2. Distance/travel time to specialist

We will use logistic regression to calculate p-values for differences in access by enrollment type. Because Healthy Michigan Plan and Marketplace Option enrollees will be matched on income, age, sex, and prosperity region within Michigan, we do not anticipate needing to adjust these analyses for additional covariates.

Results for the full analysis of access in the state of Michigan will be presented in tabular form. We will also conduct sub-analyses of each of the 10 prosperity regions within the state, producing map-based graphics to illustrate the differences in levels of access between the regions, if differences are present.

References

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ATTACHMENT B
Demonstration Evaluation Plan

Appendix A: Researcher Bios

I. Faculty Leadership Profiles

Project Director: John Z. Ayanian, M.D., M.P.P.

John Z. Ayanian, M.D., M.P.P., Director of the University of Michigan Institute for Healthcare Policy & Innovation, will lead the interdisciplinary team of faculty members and staff conducting the Healthy Michigan Plan evaluation. In addition to serving as the Institute's director, Dr. Ayanian is the Alice Hamilton professor of medicine in the University of Michigan Medical School, professor of health management and policy in the School of Public Health, and professor of public policy in the Gerald R. Ford School of Public Policy. Dr. Ayanian's research focuses on the effects of race, ethnicity, gender, and insurance coverage on access to care and clinical outcomes, and the impact of physician specialty and organizational characteristics on the quality of care for cardiovascular disease, cancer, diabetes, and other major health conditions. He has published over 200 studies and over 50 editorials and chapters assessing access to care, quality of care, and health care disparities.

Dr. Ayanian joined the University of Michigan in 2013 from Harvard Medical School, where he served as professor of medicine and of health care policy. He also was a professor in health policy and management at the Harvard School of Public Health, and a practicing primary care physician at Brigham and Women's Hospital in Boston. From 2008-2013, he directed the Health Disparities Research Program of Harvard Catalyst (Harvard's National Institutes of Health-funded Clinical and Translational Sciences Center), Outcomes Research Program of the Dana-Farber/Harvard Cancer Center, and Harvard Medical School Fellowship in General Medicine and Primary Care.

Elected to the Institute of Medicine, the American Society for Clinical Investigation and the Association of American Physicians, he is also a Fellow of the American College of Physicians. In 2012, he received the John M. Eisenberg Award for Career Achievement in Research from the Society of General Internal Medicine, and his past honors include the Generalist Physician Faculty Scholar Award from the Robert Wood Johnson Foundation, Alice Hersch Young Investigator Award from AcademyHealth, and Best Published Research Article of the Year from the Society of General Internal Medicine in 2000 and in 2008.

Project Co-Director: Sarah J. Clark, M.P.H.

Sarah J. Clark, M.P.H., is Associate Research Scientist in the Department of Pediatrics, and Associate Director of the Child Health Evaluation and Research (CHEAR) Unit at the University of Michigan. She also serves as Associate Director of the C.S. Mott Children's Hospital National Poll on Children's Health.

Since joining the University of Michigan faculty in 1998, Ms. Clark has worked closely with Michigan Medicaid Program Staff on projects evaluating Medicaid programs and policies, utilizing both the analysis of Medicaid administrative data and/or primary data collection

involving Medicaid beneficiaries and providers. Areas of inquiry have included trends in emergency department visits after implementation of Medicaid managed care; trends in dental visits associated with expansion of a dental demonstration project; availability of appointments with medical specialists for Medicaid-enrolled children; and the impact of auto-assignment on children's receipt of primary care services. Under her leadership, the Child Health Evaluation and Research Unit researchers have published more than 30 manuscripts related to the Michigan Medicaid program and more than 25 reports to Department of Community Health officials.

II. Faculty Leads, Domains I & II: Thomas Buchmueller, Ph.D. and Helen Levy, Ph.D.

The work on Domains I and II of the evaluation will be conducted by a team of researchers co-led by two University of Michigan faculty members, Thomas Buchmueller Ph.D. and Helen Levy Ph.D. Buchmueller's primary appointment is in the Ross School of Business, where he holds the Waldo O. Hildebrand Endowed Chair in Risk Management and Insurance and currently serves as the Chair of the Business Economics Area. He has a secondary appointment in the Department of Health Management and Policy in the School of Public Health. Levy is a tenured Research Associate Professor with appointments in the Institute for Social Research, Ford School of Public Policy and Department of Health Management and Policy at the School of Public Health. She is a co-investigator on the Health and Retirement Survey, a national longitudinal survey supported by the National Institute on Aging. Buchmueller and Levy are experts on the economics of health insurance and health reform. In 2010-2011, Levy served as the Senior Health Economist at the White House Council of Economic Advisers. Buchmueller succeeded her in this position in 2011-2012.

Domains I & II: Sayeh Nikpay (M.P.H; Ph.D. expected 2014), a Research Investigator at the UM Institute for Healthcare Policy and Innovation (IHPI), will serve as evaluation manager and lead data analyst for Domains I and II. In 2010-2011, Nikpay served as a Staff Economist at the White House Council of Economic Advisers (Levy was her supervisor). In addition to collaborating with Buchmueller and Levy on the design of the evaluation analysis, her responsibilities will include managing the acquisition and maintenance of large data sets, conducting periodic interim analyses and generating reports based on these analyses, and coordinating activities among team members.

Domain I: Professors Daniel Lee, Ph.D. and Simone Singh, Ph.D. from the Department of Health Management and Policy in the University of Michigan School of Public Health will participate in the evaluation activities related to Domain I. Professors Lee and Singh are experts in hospital organization and finance and have conducted research on the determinants of uncompensated care. Their expertise will be essential for compiling the necessary data resources and designing the analysis.

A graduate student researcher will also assist the faculty team.

III. Faculty Leads, Domain III: Sarah Clark, John Ayanian

The work on Domain III will be led by Sarah Clark, M.P.H., and John Ayanian, M.D., M.P.P.as described in Section I of Appendix A above.

IV. Faculty Lead, Domain IV: Susan Goold, M.D., M.H.S.A., M.A.

The work on Domain IV will be led by Susan Dorr Goold, M.D., M.H.S.A., M.A., Professor of Internal Medicine and Health Management and Policy at the University of Michigan. Dr. Goold studies the allocation of scarce healthcare resources, especially the perspectives of patients and citizens. The results from projects using the CHAT (Choosing Healthplans All Together) allocation game, which she pioneered, have been published and presented in national and international venues. CHAT won the 2003 Paul Ellwood Award, and Dr. Goold's research using CHAT received the 2002 Mark S. Ehrenreich Prize for Research in Healthcare Ethics. CHAT has been used by educators, community-based organizations, employer groups, and others in over 20 U.S. states and several countries to engage the public in deliberations on health spending priorities. Dr. Goold serves on several editorial boards and as Chair of the American Medical Association Council on Ethical and Judicial Affairs. She has also held leadership positions in the American Society for Bioethics and Humanities and the International society on Healthcare Priority Setting.

Edith Kieffer (Social Work) brings extensive experience using longitudinal epidemiological studies, qualitative formative research, intervention research, CBPR and CHW-led approaches to design, conduct and evaluate programs addressing health disparities.

Jeffrey Kullgren (Internal Medicine) brings expertise in behavioral economics and experience conducting research on decision making, cost-related access barriers, financial incentives for patients and cost transparency.

Adrianne Haggins (Emergency Medicine) brings knowledge and experience related to patient decision-making about when and where to seek care. She has experience analyzing national data on the impact of expansion of insurance coverage on use of emergency department and non-emergency outpatient services and has completed a review of the state-level effects of healthcare reform initiatives on utilization of outpatient services.

Renuka Tipirneni (Internal Medicine) studies the impact of health care reform on access to and quality of care for low-income and other vulnerable populations, and is currently conducting a study of access to primary care practices for Medicaid enrollees in the state of Michigan.

Ann-Marie Rosland (Internal Medicine) brings experience studying self-management and organization of clinical care for chronic diseases.

Eric Campbell (Mongan Institute for Health Policy), will consult on the project, and will bring extensive experience and expertise with high-profile surveys of physicians on health policy topics.

V. Faculty Lead, Domains V & VI: Richard Hirth, Ph.D.

Richard Hirth, Ph.D. will lead a team of researchers on the work of Domains V and VI. Dr. Hirth is Professor and Associate Chair of Health Management and Policy at the School of Public Health and Professor of Internal Medicine. His expertise includes health insurance and healthcare costs, and his research interests include the role of not-for-profit providers in health care markets, health insurance, the relationship between managed care and the adoption and utilization of medical technologies, long-term care, and the economics of end stage renal disease care.

Dr. Hirth has received several awards, including the Kenneth J. Arrow Award in Health Economics, awarded annually by the American Public Health Association and the International Health Economics Association to the best paper in health economics (1993); the Excellence in Research Award in Health Policy from the Blue Cross/Blue Shield of Michigan Foundation (1998 and 2009); and the Thompson Prize for Young Investigators from the Association of University Programs in Health Administration (1999); Listing in Top 20 Most Read Articles of 2009, Health Affairs (2010); Outstanding abstract (consumer decision-making theme), AcademyHealth Annual Meeting (2007); and Outstanding abstract (long-term care theme), Academy for Health Services Research and Health Policy Annual Meeting (2001).

Most recently, Dr. Hirth received the 2014 AcademyHealth Health Services Research Impact Award for his work on designing the renal dialysis bundled payment system adopted by Medicare for the End-Stage Renal Disease Program in 2011.

Jeff Kullgren, M.D., M.S., M.P.H., is an Assistant Professor of Internal Medicine at the University of Michigan Medical School and a Research Scientist in the VA Ann Arbor HSR&D Center for Clinical Management Research. His research aims to improve patient decisions about healthcare utilization and health behaviors. Most recently his work has examined decision-making and cost-related access barriers among families enrolled in high-deductible health plans as well as the growth of state-based initiatives to publicly report health care prices to consumers. He currently leads a project examining the potential value of state prescription drug price comparison tools for patients who take commonly prescribed prescription drugs and face high levels of out-of-pocket expenditures. In another study, he is testing a provider-focused intervention to decrease overuse of low-value health care services that can often trigger high out-of-pocket expenditures for patients. He has studied the effects of community-based programs to improve access for low-income uninsured adults and the relationship between financial and nonfinancial access barriers, and studies the effects of financial incentives for healthy behaviors such as weight loss, physical activity, and colorectal cancer screening.

A. Mark Fendrick, M.D. is a Professor of Internal Medicine and Professor of Health Management and Policy at the University of Michigan. He directs the Center for Value-Based Insurance Design at the University of Michigan [www.vbidcenter.org], the leading advocate for development, implementation, and evaluation of innovative health benefit plans. Dr. Fendrick's research focuses on how financial incentives impact care-seeking behavior, clinical outcomes and health care costs. Dr. Fendrick is the Co-editor in chief of the *American Journal of Managed Care*. He serves on the Medicare Coverage Advisory Committee and has won numerous awards

for his role for the creation and implementation of value-based insurance design. Dr. Fendrick remains clinically active in the practice of general internal medicine.

Additional staff will include a part time programmer/analyst and a 0.5 FTE Graduate Student Research Assistant, to be identified.

ATTACHMENT B
Demonstration Evaluation Plan

Appendix B: Description of Data Sources

1. Michigan Department of Community Health Data Warehouse

A key data source for the Healthy Michigan Plan evaluation will be the Michigan Department of Community Health Data Warehouse. Components of the data warehouse that will contain data for the Healthy Michigan Plan population include Medicaid beneficiary eligibility, enrollment and demographic characteristics; Medicaid provider enrollment; managed care encounters, payments and provider networks; Medicaid fee-for-service claims; pharmacy claims, including National Drug Codes; community mental health, including managed mental health plans; substance abuse; immunizations; third-party liability; and vital records. A unique client identifier links person-level records across Department of Community Health program areas. The Data Warehouse also links to the statewide Enterprise Data Warehouse, which contains records for human services, corrections, treasury, secretary of state, federal-state programs, and other program areas. The Enterprise Data Warehouse is the nation's most sophisticated and highly utilized state government data warehouse, supporting evaluation of state policies across programmatic lines.

For nearly 15 years, the University of Michigan's Child Health Evaluation and Research (CHEAR) Unit has utilized the Data Warehouse for numerous collaborative projects with Department officials. A Business Associates' Agreement between the Department and the University was enacted to allow CHEAR to extract and analyze information from the Data Warehouse in response to requests from MDCH officials; for other project types, specific Data Use Agreements are prepared and approved by the MDCH Privacy Office, as well as the MDCH Institutional Review Board. CHEAR data analysts participate in training and educational sessions related to the Data Warehouse, and communicate frequently with MDCH staff on data quality issues.

As part of the University's Institute for Healthcare Policy and Innovation (IHPI), the CHEAR Unit will play a central role in the Healthy Michigan Plan evaluation, bringing its experience in extracting and analyzing Medicaid data from the MDCH Data Warehouse. Data extraction will be conducted via VPN connection using a RSA SecurID password token. Using a second password, CHEAR analysts will access data models using Open Text BI-Query, writing specific queries to download demographic, eligibility, health care utilization and provider information records. To protect enrollee confidentiality, CHEAR analysts encrypt the beneficiary IDs using SAS, and use the encrypted datasets for data analysis. The analytic datasets are stored on password protected external hard drives, which are stored in locked cabinets at night. Office doors are locked when unoccupied during the day. The raw data and final analytic files are backed up to a server location that is only accessible to CHEAR analysts and specific faculty leads through secured network sign-on. The server folders are reviewed periodically and data files not accessed in over 5 years are removed unless a longer storage timeframe is requested by MDCH officials.

2. Public Use Data Sets

Hospital Cost Reports & Filings (Domain I)

We intend to use Medicare cost reports, which Medicare-certified hospitals are required to submit annually to a Medicare Administrative Contractor. The cost report contains provider information such as facility characteristics, utilization data, cost and charges by cost center (in total and for Medicare), Medicare settlement data, and financial data. As part of the financial data, hospitals are required to provide detailed data on uncompensated care and indigent care provided. These include charity care and bad debt (both in terms of full charges and cost) as well as the unreimbursed cost for care provided to patients covered under Medicaid, SCHIP, and state and local indigent care programs. Medicare cost reports (Form CMS-2552-10) for hospitals in Michigan and other states will be obtained from the CMS website.

We will also use Medicaid cost reports as well as supplementary forms compiled by the Michigan Department of Community Health. These reports have the advantage of providing more detail than the CMS reports, but are only available for Michigan hospitals.

We also plan to use Schedule H of IRS Form 990. Since 2009, federally tax-exempt hospitals have been required to complete the revised IRS Form 990 Schedule H, which requires hospitals to annually report their expenditures for activities and services that the IRS has classified as community benefits. These include charity care (i.e., subsidized care for persons who meet the criteria for charity care established by a hospital), unreimbursed costs for means-tested government programs (such as Medicaid), subsidized health services (i.e., clinical services provided at a financial loss), community health improvement services and community-benefit operations (i.e., activities carried out or supported for the express purpose of improving community health), research, health professions education, and financial and in-kind contributions to community groups. In addition to community benefits, Schedule H asks hospitals to report on their bad debt expenditures.

Hospitals' IRS filings will be obtained from GuideStar, a company that obtains, digitizes, and sells data that organizations report on IRS Form 990 and related Schedules. Data will be obtained for all hospitals that file Form 990 with the IRS at the individual hospital-level. (For 2009 to 2011, Form 990 Schedule H is available for 85 federally tax-exempt hospitals in Michigan.) Members of our research team have extensive experience working with these data.[13]

US Census Bureau Surveys (Domain II)

The analysis of insurance coverage will be based on data from two annual national surveys conducted by the Census Bureau: the Current Population Survey (CPS) and the American Community Survey (ACS). Each survey has specific strengths related to this evaluation. The CPS is the most commonly cited data source for state-level estimates of insurance coverage. It provides a detailed breakdown by source of coverage. The ACS provides less detail on source of coverage but with a much larger sample size than the CPS. The larger sample size means it is possible to make estimates for subgroups not supported by the CPS, such as geographic areas

[13] Young, G.J., Chou, C, Alexander, J, Lee, S.D. and Raver, E. 2013. "Provision of Community Benefits by Tax-Exempt U.S. Hospitals, *New England Journal of Medicine*, 368(16): 1519-1527.

within a state. In each case, our analysis will be based on public use files disseminated by Census.

3. Primary Data Collection

Healthy Michigan Voices Survey (Domains II, III, IV, V, VI)

Evaluation of the impact of the Healthy Michigan Plan requires tracking the experience of those who enroll: Do they establish primary care? Do they access care appropriately? Do they gain knowledge about health risks and healthy behaviors? Do their health behaviors improve? Identifying trends, assessing the impact of strategies to overcome barriers, and understanding the overall health and economic impact of the Healthy Michigan Plan at a personal level requires learning about the experiences of participant beneficiaries. Tools typically used to track population experiences generally do not include a comprehensive list of items necessary to measure for the purposes of this evaluation.

Researchers at the University of Michigan have established that measuring public experiences, attitudes, and actions through longitudinal population surveys is a timely and informative way to track progress and identify challenges. Such efforts provide objective evaluations of the impact of health programs, and offer timely results that enable stakeholders to identify the need for targeted action. We propose the **Healthy Michigan Voices** (HMV) project, a survey of Healthy Michigan enrollees on key topics related to the Healthy Michigan program.

The Healthy Michigan Voices survey will be limited to those enrolled in the Healthy Michigan Plan, and will include one cohort of approximately 4500 participants, recruited at strategic intervals after enrollment opens in April 2014. The survey will be fielded during state fiscal year 2016, administered by telephone. The survey methodology and specifications are described in greater detail in Domain IV.

Primary Care Practitioner Survey (Domain IV)

To measure primary care practitioners' expectations, experiences, and innovative responses for caring for the Healthy Michigan Plan population, we propose the Primary Care Practitioner Survey (PCPS) to obtain empirically valid and timely data from a small, but generalizable sample of primary care practitioners in Michigan. This will be accomplished through the use of multiple, short surveys (10 items or less) administered during state fiscal year 2015, asking relevant questions about the Healthy Michigan Plan. The surveys will be self-administered and distributed via Priority Mail (with an option to complete online).

As described in greater detail in Domain IV, we will identify primary care practitioners using the Michigan Department of Community Health Data Warehouse, drawing a random sample of 2400 practitioners actively engaging in primary care in Michigan, anticipating we can obtain agreement from at least 1000 primary care practitioners for participation. The surveys will be administered by CHEAR, which has extensive experience in physician studies. All data will be stored in secure, password-protected files.

Domain VII Cost Effectiveness
Draft Demonstration Evaluation Plan for FY17-FY19

Draft Evaluation Proposal Prepared by
The Institute for Healthcare Policy & Innovation
University of Michigan

June 2017

Centers for Medicare & Medicaid Services
Evaluation Design

INSTITUTE FOR HEALTHCARE POLICY & INNOVATION
UNIVERSITY OF MICHIGAN

MDHHS
Michigan Department of Health & Human Services
RICK SNYDER, GOVERNOR | NICK LYON, DIRECTOR

I. Hypotheses

Hypothesis VII.1: Marketplace Option enrollees will not differ significantly from Healthy Michigan Plan enrollees in access to primary care providers.

Hypothesis VII.2: Marketplace Option enrollees will not differ significantly from Healthy Michigan Plan enrollees in access to specialty care providers.

Hypothesis VII.3: The quality of care and utilization of emergency department and hospital services will not differ significantly for Marketplace Option beneficiaries relative to enrollees in the same income range who remain in the Healthy Michigan Plan.

Hypothesis VII.4: The cost of covering Marketplace Option beneficiaries will not differ significantly from the cost of covering enrollees in the same income range who remain in the Healthy Michigan Plan.

II. Management/Coordination of Evaluation

A. Evaluation Team

The work on Domain VII of the evaluation will be conducted by John Ayanian, Sarah Clark, and Renu Tipirneni.

III. Timeline

The timeline will be adjusted depending on the availability of claims data for the analyses.

- *July 2018 - October 2018*: Conduct analyses of quality measures from HMP claims data from the prior year of HMP enrollment (April 1, 2017 to March 31, 2018) as the identification year/pre condition.

- *April 2019 - June 2019*: Field Healthy Michigan Voices survey of Marketplace Option enrollees.

- *July 2019 – December 2019:* Conduct analyses of primary care and specialist availability (Hypotheses VII.1 and VII.2) and quality and utilization measures (Hypothesis VII.3) from HMP and Marketplace Option utilization data for the first 12 months (April 1, 2018 through March 31, 2019) as the measurement period if the Marketplace Option data are available in a timely manner. Conduct analysis of overall cost data from HMP and Marketplace Option (Hypothesis VII.4). Conduct geo-mapping analysis.

- *December 2019*: Prepare summary of Domain VII findings for final evaluation report, to be submitted by February 1, 2020.

IV. Performance Measures/Data Sources

A. Specific measures and rationale

1. Hypothesis VII.1. Access to Primary Care Providers

To assess access to primary care for enrollees in the Healthy Michigan Plan and those who enroll in the Marketplace Option, we will use three measures. First, we will assess the overlap in primary care provider networks between the Healthy Michigan Plan and the Marketplace Option. Using provider NPI numbers, we will compare the list of available primary care providers for the Marketplace Option with the primary care network lists for plans of comparable region and size participating in the Healthy Michigan Plan.

Second, to assess geographic access of Healthy Michigan Plan and Marketplace Option enrollees to in-network providers and enable analytic comparisons between groups, we will use GIS mapping techniques to calculate travel distances from enrollees' residence to one of the following three options: (1) the primary care providers (PCPs) enrollees have actually seen for their care, (2) their selected or assigned PCP, or (3) the nearest in-network PCP – based on the data available to the evaluation team.

Another source of data for exploring this hypothesis is the Healthy Michigan Voices Survey. A portion of the sample of the Healthy Michigan Voices survey in 2019 will include beneficiaries enrolled in the Marketplace Option (either by choice or through state transfer because they did not meet the criteria to remain in a Medicaid Health Plan). The survey will include questions that address perceptions of access to primary care, including whether individuals were able to keep their primary care provider if they chose to do so, or were required to find a new PCP that was in network, after making the transition.

For beneficiaries who transition to the Marketplace Option, we will also compare primary care utilization in the final year of HMP to the first year in the Marketplace Option, assess changes in primary care provider, compare a measure of primary care utilization-vs-emergency department utilization in the final year of HMP to the first year in the Marketplace Option, and describe the characteristics of those who have a drop in primary care utilization after transitioning to the Marketplace Option. We will consider these analyses in light of changes in health plan carriers that occur for beneficiaries during the transition to the Marketplace Option.

2. Hypothesis VII.2. Access to Specialty Care Providers

We recognize that provider network lists may overstate the number of providers willing to see Medicaid patients (U.S. Department of Health and Human Services Office of the Inspector General, 2014). As a result, we will use three measures to assess access to specialty care for enrollees in the Healthy Michigan Plan and those who enroll in the Marketplace Option. First, we will assess the overlap in specialty care provider networks between the Healthy Michigan Plan and the Marketplace Option, Second, we will modify an existing measure designed to assess the availability of specialty care for Medicaid-enrolled children. This measure focuses on specialists who have claims evidence of providing outpatient visits to enrollees. Using this method, we will assess the respective rates of participating cardiologists, dermatologists, endocrinologists, gastroenterologists, hematologists/oncologists, nephrologists, neurologists,

otolaryngologists, pulmonologists, rheumatologists, general surgeons, orthopedic surgeons, and obstetrician-gynecologists who have seen at least one enrolled adult in the measurement year for at least one outpatient visit. Specialist physicians are identified using taxonomy codes linked to a National Provider Identifier (NPI) using the National Plan & Provider Enumeration System (NPPES) registry (https://npiregistry.cms.hhs.gov). These measures are implemented with administrative claims data. They are adapted from a comparable set of measures recently developed by members of our HMP evaluation team and approved by the National Quality Measures Clearinghouse for assessing outpatient specialty care for children (Clark et al., 2016). To address concerns that this measure may partly reflect provider-patient relationships that pre-exist enrollment in either program, we will conduct a secondary analysis to look at rates of specialist visits among individuals newly enrolling in HMP (between April and December 2018) with incomes at or above 100 percent FPL and compare to utilization among Marketplace Option enrollees.

Second, to assess geographic access of Healthy Michigan Plan and Marketplace Option enrollees to in-network specialist providers in a variety of categories (e.g. cardiologist, endocrinologist, obstetrician/gynecologist, ophthalmologist, rheumatologist, pulmonologist) and enable analytic comparisons between groups, we will use GIS mapping techniques to calculate travel distances from enrollees' residence to one of the following two options: (1) the specialists enrollees have actually seen for their care, or (2) the nearest in-network specialists – based on the data available to the evaluation team.

Another source of data for exploring this hypothesis is the Healthy Michigan Voices Survey. A portion of the sample of the Healthy Michigan Voices survey in 2019 will include beneficiaries enrolled in the Marketplace Option (either by choice or through state transfer because they did not complete the Health Risk Assessment and agree to a healthy behavior). The survey will include questions that address perceptions of access to specialty care.

For beneficiaries who transition to the Marketplace Option, we will also compare specialty care utilization in the final year of HMP to the first year in the Marketplace Option, assess changes in specialty care providers, and describe the characteristics of those who have a drop in specialty care utilization after transitioning to the Marketplace Option. This analysis will be focused on key chronic disease populations (asthma, CHF, COPD, diabetes). We will consider these analyses in light of changes in health plan carriers that occur for beneficiaries during the transition to the Marketplace Option.

3. Hypothesis VII.3. Quality of Care & Health Care Utilization

If the Michigan Department of Health and Human Services (MDHHS) can obtain claims data from Marketplace Option plans for HMP enrollees who switch to these plans in 2018, we will compare claims-based quality and utilization measures between HMP and Marketplace Option enrollees. If information is available on reasons for transitioning to the Marketplace Option, we will conduct a subgroup analysis of enrollees who chose the Marketplace Option as compared to those who were transferred by the state because they did not meet the criteria to remain in a Medicaid Health Plan. To address this hypothesis in our final evaluation report to be submitted by November 1, 2019, we will analyze HMP and Marketplace Option claims data for health

services delivered during the first 12 months after the Marketplace Option becomes active (April 1, 2018 through March 31, 2019), anticipating that >90% of claims will be adjudicated and available in the data warehouse by the expected start date for this analysis in July 2019. We will re-run analyses in September 2019 to verify that claims with delayed adjudication do not affect the results. It should be noted that this analysis is of realized utilization via claims analysis, and as a result, it is not possible to draw conclusions about those who do not utilize care during this period.

Additionally, a portion of the sample of the Healthy Michigan Voices survey in 2019 will include beneficiaries enrolled in the Marketplace Option (either by choice or through state transfer because they did not meet the criteria to remain in a Medicaid Health Plan) and will include questions that address perceptions of quality of care and health care utilization.

As outlined in Domain III of our HMP evaluation plan approved by CMS on October 21, 2014, a broad range of measures will be generated for each year of the evaluation project. These measures include established indicators for clinical care (e.g., Healthcare Effectiveness Data and Information Set measures, Adult Core Quality Indicators) with identified measure stewards (e.g., National Quality Forum). Importantly, health plan-based measures offer useful but limited information, as they exclude enrollees who change health plans and do not allow a full assessment of outcomes for the entire population or for a target geographic area with multiple plans; moreover, some measures require a period of identification prior to measurement outcomes. HEDIS criteria for measures of chronic disease populations (Diabetes HbA1c, LDL testing, admission rate; COPD admission rate; CHF admission rate; asthma admission rate) require a year for identification of members who meet the chronic disease definition (i.e., the denominator), followed by a measurement year to assess utilization (i.e., the numerator).

To follow HEDIS or NQF criteria for such measures among Marketplace Option enrollees, we will use the prior year of HMP enrollment (April 1, 2017 – March 31, 2018) as the identification year, followed by the ensuing 12 months of HMP or Marketplace Option enrollment as the measurement period. Assuming these claims data are available, we will complete this analysis during July through October of 2019. While we did consider modifications to established measures to accommodate a shortened time period and/or the use of claims-based utilization measures that do not require a pre-period, this approach would not offer a fruitful subgroup analysis, as the groups may not be subject to the same requirements, such as having an early primary care visit, so their results would not be comparable.

As outlined on pages 79-81 of our original evaluation plan, we will focus on the following claims-based quality and utilization measures that can be feasibly measured during a 12-month observation period (for which Marketplace Option claims data could become available) rather than a full-year measurement period (as needed for cancer screening, for example):

- **Healthcare Effectiveness Data and Information Set (HEDIS) Emergency Department Measure**: We will calculate the rate of emergency department visits per 1000 member months, and will calculate incidence rate ratios to assess the relative magnitude of emergency department utilization rates for subgroup comparisons. To provide additional information, we will calculate subgroup rates for key chronic disease

populations (e.g., asthma, COPD, diabetes, CHF) at the plan level and by geographic region; this information will help the state to evaluate disease management programs and other services intended to encourage outpatient visits over emergency department use.

- **Emergency Department High-Utilizer Measure**: We will calculate the proportion of Healthy Michigan Plan beneficiaries who demonstrate high emergency department utilization (e.g., ≥5 emergency department visits within a 12-month period).
    - We will also account for clustering of visits among frequent users to examine the degree to which a small number of frequent emergency department users drive observed utilization rates among HMP and Marketplace Option enrollees including sensitivity tests to examine the probability of having any emergency room visit at all.

- **Hemoglobin A1c Testing** (NQF 0057; measure steward NCQA): We will calculate the proportion of beneficiaries aged 18-64 with type 1 or type 2 diabetes who had hemoglobin a1c testing at least once during the measurement year.

- **LDL-C Screening** (NQF 0063; measure steward NCQA): We will calculate the proportion of beneficiaries aged 18-64 with type 1 or type 2 diabetes who had an LDL-C screening performed at least once during the measurement year.

- **Overall Admission Rate**: We will calculate the proportion of enrollees with any inpatient admission, as well as the rate of inpatient admissions per 1000 member months. We will make the same calculations for medical admissions and surgical admissions.

- **Diabetes, Short-term Complications Admission Rate** (NQF 0272; measure steward AHRQ): We will calculate the number of discharges for diabetes short-term complications per 100,000 Healthy Michigan Plan enrollees age 18-64.

- **Chronic Obstructive Pulmonary Disease (COPD) Admission Rate** (NQF 0275; measure steward AHRQ): We will calculate the number of discharges for COPD per 100,000 Healthy Michigan Plan enrollees age 18-64.

- **Congestive Heart Failure Admission Rate** (NQF 0277; measure steward AHRQ): We will calculate the number of discharges for CHF per 100,000 Healthy Michigan Plan enrollees age 18-64.

- **Adult Asthma Admission Rate** (NQF 0283; measure steward AHRQ): We will calculate the number of discharges for asthma per 100,000 Healthy Michigan Plan enrollees age 18-64.

- **Flu Shots for Adults:** We will calculate the proportion of beneficiaries aged 50-64 and aged 18-49 who received an influenza vaccine between July 1 and March 31. To supplement Consumer Assessment of Healthcare Providers and Systems self-reported data from a small sample of beneficiaries (NQF 0039), we will take advantage of Michigan's unique data environment by combining Medicaid utilization data with

information found in the statewide immunization registry (Michigan Care Improvement Registry) to document rates of influenza vaccine receipt for the HMP and Marketplace Option enrollees, and for individuals at high risk for influenza-related complications, such as those with diabetes, COPD, CHF, or asthma.

4. Hypothesis VII.4. Costs of Care

For this hypothesis we will assess the total state and federal costs of Marketplace Option coverage on a per-member-per-month basis for former HMP enrollees who move to a Qualified Health Plan (QHP). These costs include four main components:

1. Costs of Marketplace Option premiums
2. MDHHS costs of Medicaid wraparound coverage
3. MDHHS administrative costs to oversee the Marketplace Option

The total of these four components will be compared to the capitated payments and costs outside the cap made for an age/sex/comorbidity matched group of enrollees with incomes above 100% of the Federal poverty level (FPL) who remain in HMP health plans. This analysis assumes that MDHHS can provide the University of Michigan evaluation team with the four components of Marketplace Option cost data listed above by June 30, 2019, thereby enabling the cost analyses to be conducted during July through October 2019. For this analysis, we will conduct a subgroup analysis to minimize the influence of selection bias by separately examining costs for those Marketplace Option enrollees who willingly switched from HMP and those that the state transferred because they did not meet the criteria to stay in a Medicaid Health Plan controlled for age and sex.

Given the limited 12-month time period of data that we expect to be available for analysis of Marketplace Option enrollees in Michigan during April 2018 through March 2019, we propose the following measures of incremental cost-effectiveness ratios (ICER) that employ the utilization and cost data described above for this time period:

Overall emergency department (ED) use

$$\frac{\text{Total Cost (Marketplace Option) - Total Cost(HMP)}}{\text{ED Use (Marketplace Option) - ED Use(HMP)}}$$

Overall admission rates

$$\frac{\text{Total Cost (Marketplace Option) - Total Cost(HMP)}}{\text{Admission Rate (Marketplace Option) - Admission Rate(HMP)}}$$

Admission rates for COPD, diabetes short-term complications, CHF and asthma

$$\frac{\text{Total Cost (Marketplace Option) - Total Cost(HMP)}}{\text{Admission Rate (Marketplace Option) - Admission Rate(HMP)}}$$

Breast Cancer Screening

Total Cost (Marketplace Option) - Total Cost(HMP)
Breast Cancer Screening (Marketplace Option) - Breast Cancer Screening(HMP)

LDL-C Screening

Total Cost (Marketplace Option) - Total Cost(HMP)
LDL-C Screening (Marketplace Option) - LDL-C Screening(HMP)

Hemoglobin A1c Testing

Total Cost (Marketplace Option) - Total Cost(HMP)
Hemoglobin A1c Testing (Marketplace Option) - Hemoglobin A1c Testing(HMP)

We will also incorporate select measures from HMV survey data in our analysis of the ICERs in order to understand how the relative costs relate to perceptions of access to care.

B. Methodology and specifications

i. Eligible/target population

The eligible population will include all Marketplace Option and Healthy Michigan Plan beneficiaries with incomes above 100% FPL and who are not deemed medically frail by MDHHS. The Healthy Michigan Plan participants who move to the Marketplace Option beginning in April 2018 will include enrollees in this income range who have not completed a Health Risk Assessment and agreed to a healthy behavior, as well as some enrollees who may choose the Marketplace Option because of a preference for private insurance coverage. Relative to Healthy Michigan Plan enrollees who complete the Health Risk Assessment, the former group may be less interested pursuing healthy behaviors and thus be less healthy, which could be associated with greater medical needs and higher costs. We will account for these differences as described in Section V below.

ii. Time period of study

The main period of study will begin April 1, 2018, after the Marketplace Option is implemented and extend for 12 months through March 31, 2019. Baseline data on prior health care use and costs will be collected during April 1, 2017 through March 31, 2018. The Healthy Michigan Voices survey of Marketplace Option enrollees will be conducted April through June 2019.

C. Measure steward

The Michigan Department of Health and Human Services is the measure steward.

D. Baseline values for measures

Information available at baseline includes primary care and specialist availability, healthcare utilization and cost data from the Healthy Michigan Plan available through the Michigan Department of Health and Human Services Data Warehouse.

E. Data Sources

The data source for information on utilization within the Healthy Michigan Plan will be the MDHHS Data Warehouse. Under the authority of a Business Associates' Agreement between the Department of Health and Human Services and the University of Michigan, individual-level data for Healthy Michigan Plan enrollees will be extracted from the Data Warehouse, to include enrollment and demographic characteristics, as well as all utilization (encounters in primary care, inpatient, emergency, urgent care; pharmacy). Data will be extracted from the Data Warehouse via an existing secure line, and stored in encrypted files on a secure network with multiple layers of password protection.

Healthy Michigan Plan and Marketplace Option provider and enrollee address data are the minimum necessary to perform the GIS mapping, Therefore, this component of the evaluation is contingent on access to accurate and timely electronic data on provider network lists, including practice location, and information about the beneficiaries enrolled in the Marketplace Option through Qualified Health Plans (QHPs). Because geographic access does not equate to realized access, we favor analyzing claims data to ascertain the distance traveled by beneficiaries for actual visits with PCPs, if these data from the QHPs can be provided to our evaluation team in a timely manner. The secondary preference is to use PCP of record, and the default plan will be to use the nearest in-network PCP. For the analysis of access to specialists, our preference is to use actual visits to specialty care providers and focus on high-volume specialty areas. Alternatively, depending on the volume of specialty care during the evaluation period (April 1, 2018-March 31, 2019), we would use the nearest in-network specialists.

We anticipate the data source for information on utilization and quality of care in Marketplace Option plans will come from data reporting by QHPs in Michigan to MDHHS. *The details of these new data reporting systems remain to be determined, so we will revisit the feasibility of these analyses with MDHHS in 2018 when we expect further information about the Marketplace Option plans and their data reporting to MDHHS will become available*.

The data source for information on costs of the Healthy Michigan Plan and Marketplace Option will be MDHHS. This information will include the capitated payments made to HMP health plans, the state payments made to Marketplace Option health plans for former HMP enrollees, the costs of wraparound Medicaid coverage for these enrollees, and the administrative costs associated with state oversight of the Marketplace Option for former HMP enrollees.

V. Plan for Analysis

Our evaluation of the cost effectiveness of the Marketplace Option as compared to the Healthy Michigan Plan will employ several types of analyses. To understand demographic and clinical characteristics of enrollees in these categories, we will compare the characteristics of Marketplace Option enrollees with those who have incomes above 100% FPL who remain in the

Healthy Michigan Plan. These analyses will be based on HMP enrollment and encounter data during the year prior to the start of the Marketplace Option (April 1, 2017-March 31, 2018).

For the analysis of primary care access in Hypothesis VII.1, we will assess the overlap in primary care provider networks for HMP and the Marketplace Option. Using provider NPI numbers, we will compare the list of available primary care providers for the Marketplace Option with the primary care network lists for plans of comparable region and size participating in the Healthy Michigan Plan. For each Healthy Michigan Plan network assessed, we will calculate the proportion of primary care providers from the HMP network that appear on the Marketplace Option primary care provider network, to yield the percent overlap. We will also quantify the number of providers listed on the Healthy Michigan Plan network only and the number listed on the Marketplace Option network only. Finally, we will calculate the number of total primary care providers listed for each network and the ratio of primary care providers to enrolled members.

For the analysis of specialist availability in Hypothesis VII.2, we will compare the provider networks for Marketplace Option and comparable HMP plans for key specialties, specifically cardiologists, dermatologists, endocrinologists, gastroenterologists, hematologists/oncologists, nephrologists, neurologists, otolaryngologists, pulmonologists, rheumatologists, general surgeons, orthopedic surgeons, and obstetrician-gynecologists. As described above, we will calculate the overlap in specialists, as well as those unique to the Marketplace Option and those unique to the HMP plan network.

In addition, we will use administrative claims to calculate the respective rates of participating cardiologists, dermatologists, endocrinologists, gastroenterologists, hematologists/oncologists, nephrologists, neurologists, otolaryngologists, pulmonologists, rheumatologists, general surgeons, orthopedic surgeons, and obstetrician-gynecologists who have seen at least one enrolled adult in the measurement year for at least one outpatient visit will be expressed in terms of the numbers of participating specialists in each category per 1,000 eligible enrollees (number of providers/1,000 eligible enrollees), where the eligible population includes adults 18 years of age and older who have been enrolled in the Healthy Michigan Plan or the Marketplace Option for at least one 90-day period (or 3 consecutive months) within the measurement year.

For the analysis of quality and utilization measures for Hypothesis VII.3, we will compare the measures for Healthy Michigan Plan enrollees and Marketplace Option enrollees with incomes above 100% of FPL by gender, by race/ethnicity, and by urban/rural areas. For each of these measures, we will be building on analyses conducted for 2014 through 2017 as part of our original HMP evaluation. With risk-adjustment to account for baseline demographic and health status differences between these two groups prior to April 2018, we will use difference-in-difference methods to compare overall changes in quality and utilization measures for Marketplace Option enrollees with changes in these measures for comparable enrollees who remain in the Healthy Michigan Plan. This difference-in-difference approach will account for potential inherent differences between these two groups.

For Hypothesis VII.4, costs per-enrollee-per-month in HMP and the Marketplace Option during April 1, 2018 through March 31, 2019 will be compared after risk-adjustment based on

enrollees' demographic characteristics and on their comorbid conditions and utilization using HMP data for the year prior to April 1, 2018. Incremental cost-effectiveness ratios will be calculated based on cost and utilization data as detailed above. We will also use difference-in-difference methods for these cost analyses. We will incorporate data from the high-utilizer ED measure to assess the extent to which ED costs are driven by high utilizers. Similarly, we will incorporate data from the inpatient quality measures to estimate the proportion of inpatient care attributable to the four chronic disease groups.

Geomapping Analysis Plan

Before conducting the geomapping, we will randomly select a sample of age- and sex-matched Healthy Michigan Plan enrollees who meet the same criteria as those enrolled in the Marketplace Option (income >100% FPL and not deemed medically frail) in equal number to the Marketplace Option enrollees within each prosperity region in the state.

To assess geographic access of Healthy Michigan Plan and Marketplace Option enrollees to in-network providers and enable analytic comparisons between groups, we will use GIS mapping techniques to calculate travel distances from enrollees' residence to one of the following three options: (1) the primary care providers (PCPs) enrollees have actually seen for their care, (2) their selected or assigned PCP, or (3) the nearest in-network PCP – based on the data available to the evaluation team.

The geographic method we choose to assess distance/travel time to provider will depend on the data source available. For options 1 and 2 above (last PCP seen based on claims data or PCP of record), we will use existing street centerline networks to compute miles traveled. For this method, each enrollee will have a two pairs of geographic coordinates (home and health care provider office), and distance/travel time will involve a single calculation using minimum distance methods available. If information about enrollees' unique PCP is not available, we will replicate the method described in Appendix 1 of Arkansas Health Care Independence Program ("Private Option") Section 1115 Demonstration Waiver Interim Report (Arkansas Center for Health Improvement, 2016), in which we will define incremental "ringed" polygons for each network PCP, and we will also use this approach to assess access to specialists. These polygons will define regions based on the number of miles from the PCP or specialist (0-5, 5-10, 10-15, etc.). Similar polygons will also be constructed based on travel time in in 15-minute intervals rather than miles. For each enrollee in the dataset, we will find the closest PCP or specialist, and assign the distance value of that ring to the participant (e.g. if the smallest ring overlapping with that individual in a rural area is 15-20 miles, they will be assigned that value).

We will conduct statistical analyses to examine whether the level of access differs for enrollees in the Healthy Michigan Plan and those with a Marketplace Option. We will compare Marketplace enrollees with their matched counterparts enrolled in HMP based on the following:

1. Distance/travel time to PCP
2. Distance/travel time to specialist

We will use logistic regression to calculate p-values for differences in access by enrollment type. Because Healthy Michigan Plan and Marketplace Option enrollees will be matched on income,

age, sex, and prosperity region within Michigan, we do not anticipate needing to adjust these analyses for additional covariates.

Results for the full analysis of access in the state of Michigan will be presented in tabular form. We will also conduct sub-analyses of each of the 10 prosperity regions within the state, producing map-based graphics to illustrate the differences in levels of access between the regions, if differences are present.

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Primary Care Practitioners' Views of the Impact of the Healthy Michigan Plan

June 29, 2017

University of Michigan
Institute for Healthcare Policy & Innovation

Evaluation team: Susan Dorr Goold, Renuka Tipirneni, Adrianne Haggins, Eric Campbell, Cengiz Salman, Edith Kieffer, Erica Solway, Lisa Szymecko, Sarah Clark, Sunghee Lee

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EXECUTIVE SUMMARY

The University of Michigan Institute for Healthcare Policy and Innovation (IHPI) is conducting the evaluation required by the Centers for Medicare and Medicaid Services (CMS) of the Healthy Michigan Plan (HMP) under contract with the Michigan Department of Health and Human Services (MDHHS). The fourth aim of Domain IV of the evaluation is to describe primary care practitioners' experiences with Healthy Michigan Plan beneficiaries, practice approaches and innovation adopted or planned in response to the Healthy Michigan Plan, and future plans regarding care of Healthy Michigan Plan patients.

Methods

We conducted 19 semi-structured telephone interviews with primary care practitioners caring for Healthy Michigan Plan patients in five Michigan regions selected to include racial/ethnic diversity and a mix of urban and rural communities. Interviews informed survey items and measures and enhanced the interpretation of survey findings.

We then surveyed all primary care practitioners in Michigan with at least 12 assigned Healthy Michigan Plan patients about practice changes and innovations since April 2014 and their experiences caring for patients with the Healthy Michigan Plan.

Results

The final response rate was 56% resulting in 2,104 respondents.

Knowledge of Patient Insurance

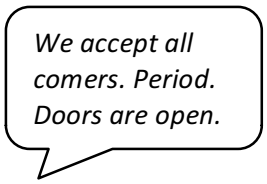
- 53% report knowing a patient's insurance at the beginning of an appointment
- 91% report that it is easy to find out a patient's insurance status
- 35% report intentionally ignoring a patient's insurance status

Familiarity with HMP

- 71% very or somewhat familiar with how to complete a Health Risk Assessment
- 25% very/somewhat familiar with beneficiary cost-sharing
- 36% very/somewhat familiar with healthy behavior incentives for patients
- PCPs working in small, non-academic, non-hospital-based and FQHC practices and those with predominantly Medicaid or uninsured patients reported more familiarity with HMP

Acceptance of Medicaid and HMP

- 78% report accepting <u>new</u> Medicaid/HMP patients – more likely if:
  - Female, racial minorities or non-physician PCPs
  - Internal medicine specialty
  - Salary payment
  - Medicaid predominant payer mix
  - Previously provided care to underserved
  - Stronger commitment to caring for underserved
- 73% felt a responsibility to care for patients regardless of their ability to pay
- 72% agreed all providers should care for Medicaid/HMP patients



Changes in Practice

- 52% report an increase in new patients to a great or to some extent
- 57% report an increase in the number of new patients who hadn't seen a PCP in many years
- 51% report established patients who had been uninsured gained insurance
- Most practices hired clinicians (53%) and/or staff (58%) in the past year
- 56% report consulting with care coordinators, case managers and/or community health workers
- 41% said that almost all established patients who request a same or next day appointment can get one; 34% said the proportion getting those appointments had increased over the past year
- FQHCs, those with predominately uninsured, Medicaid and mixed payer mixes and suburban practices were more likely to report an increase in new patients. FQHCs, and those with predominately Medicaid payer mix, were more likely to report existing patients who had been uninsured gained insurance, and an increase in the number of patients who hadn't seen a PCP in many years.
- Large and FQHC practices were more likely to have hired new clinicians in the past year. Small, non-FQHC, academic and suburban practices and were less likely to report hiring additional staff.
- Large and FQHC practices and those with predominantly private or uninsured payer mixes were all more likely to report consulting with care coordinators, case managers and/or community health workers in the past year.

Your working poor people who just were in between the cracks, didn't have anything, and now they've got something, which is great.

Experiences caring for HMP Beneficiaries - Health Risk Assessments

- 79% completed at least one HRA with a patient; most of those completed >10
- 65% don't know if they or their practice has received a bonus for completing HRAs
- PCPs reported completing more HRAs if they
  - Were located in Northern regions
  - Were paid by capitation or salary compared to fee-for-service
  - Reported receiving a financial incentive for completing HRAs
  - Were in a smaller practice (5 or fewer) size
- 58% reported that financial incentives for patients and 55% reported financial incentives for practices had at least a little influence on completing HRAs
- 52% said patients' interest in addressing health risks had at least as much influence
- Most PCPs found HRAs useful for identifying and discussing health risks, persuading patients to address their most important health risks, and documenting behavior change goals

What I've heard people say is "I just want to stay healthy or find out if I'm healthy."

ER Use and Decision Making

- 30% felt that they could influence non-urgent ER use by their patients a great deal (and 44% some)
- 88% accepted major or some responsibility as a PCP to decrease non-urgent ER use
- Many reported offering services to avoid non-urgent ER use, such as walk-in appointments, 24-hour telephone triage, weekend and evening appointments, and care coordinators or social work assistance for patients with complex problems
- PCPs identified care without an appointment, being the place patients are used to getting care and access to pain medicine as major influences for non-urgent ER use

People who work day shift…It's easier for them to go to the ER or something for a minor thing because they don't have to take time off work. That's a big deal.

- PCPs recommended PCP practice changes, ER practice changes, patient educational initiatives, and patient penalties/incentives when asked about strategies to reduce non-urgent ER use

Access

- PCPs with HMP patients who were previously uninsured reported some or great impact on health, health behavior, health care and function for those patients. The greatest impact was for control of chronic conditions, early detection of serious illness, and improved medication adherence
- PCPs reported that HMP enrollees, compared to those with private insurance, more often had difficulty accessing specialists, medications, mental health care, dental care, treatment for substance use and counseling for behavior change

I learned a long time ago if the patient doesn't take the medicine, they don't get better…if they don't have insurance to cover it and they don't ever pick it up, then they're not going to take it.

It can still take up to six months to see a psychiatrist unless you get admitted to the hospital.

Discussing Costs with Patients

- 22% of PCPs reported discussing out-of-pocket costs with an HMP patient. The patient was the most likely one to bring up the topic
- 56% of the time, such a discussion resulted in a change of management plans
- PCPs who were white, Hispanic/Latino, non-physician practitioners and with Medicaid or uninsured predominant payer mixes were more likely to have cost conversations with patients
- PCPs who were younger and in rural practices were more likely to report a change in management due to cost conversations with patients

Impact and Suggestions to Improve the Healthy Michigan Plan

We provided PCPs open-ended opportunities in the survey to provide additional information. We asked about the impact of HMP:

- PCPs noted HMP has allowed patients to get much needed care, improved financial stability, provided a sense of dignity, improved mental health, increased accessibility to care and compliance (especially medications), helped people engage in healthy behaviors like quitting smoking and saved lives

And also about suggestions to improve HMP:

- Educating patients about health insurance, health behaviors, when and where to get care, medication adherence and greater patient responsibility
- Improving accessibility to other providers, especially mental health and other specialists, and improve reimbursement
- Educating providers and providing up-to-date information about coverage, formularies, administrative processes and costs faced by patients
- Better coverage for some services (e.g., physical therapy)
- Formularies should be less limited, more transparent and streamlined across plans
- Decrease patient churn on/off insurance

Primary Care Practitioners' Views of the Impact of the Healthy Michigan Plan

Susan Dorr Goold, MD, MHSA, MA
Professor of Internal Medicine and Health Management and Policy, University of Michigan
Renuka Tipirneni, MD, MSc
Clinical Lecturer in the Department of Internal Medicine, University of Michigan
Adrianne Haggins, MD
Clinical Lecturer in the Department of Emergency Medicine, University of Michigan
Eric Campbell, PhD
Professor of Medicine and Director of Research, Mongan Institute for Health Policy, Harvard Medical School
Cengiz Salman, MA
Research Associate at the Center for Bioethics & Social Sciences in Medicine (CBSSM), University of Michigan
Edith Kieffer, MPH, PhD
Professor of Social Work, University of Michigan
Erica Solway, PhD, MSW, MPH
Project Manager at the Institute for Healthcare Policy and Innovation, University of Michigan
Lisa Szymecko, PhD, JD
Project Manager and Research Area Specialist Intermediate at CBSSM, University of Michigan
Sarah Clark, MPH
Associate Research Scientist in the Department of Pediatrics, University of Michigan
Sunghee Lee, PhD
Assistant Research Scientist at the Institute for Social Research, University of Michigan

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METHODS

IN-DEPTH INTERVIEWS WITH PRIMARY CARE PRACTITIONERS

Sample: To develop PCP survey items and measures, and to enhance the interpretation of survey findings, we conducted 19 semi-structured interviews with primary care practitioners caring for Medicaid/Healthy Michigan Plan patients between December 2014 and April 2015. These interviews were conducted in five Michigan regions: Detroit, Kent County, Midland/Bay/Saginaw Counties, Alcona/Alpena/Oscoda Counties, and Marquette/Baraga/Iron Counties. These regions were purposefully selected to include racial/ethnic diversity and a mix of urban and rural communities. Interviewees were both physicians and non-physician practitioners who worked at small private practices, Federally Qualified Health Centers (FQHCs), free/low-cost clinics, hospital-based practices, or rural practices.

Interview Topics: Topics included: provider knowledge/awareness of patient insurance and experiences caring for HMP patients, including facilitators and challenges of accessing needed care; changes in practice, due to or to meet the needs of HMP patients; how decisions were made about whether to accept Medicaid/HMP patients and what might change PCPs' acceptance of new Medicaid/HMP patients in the future; provider and patient decision-making about ER use; experience with Health Risk Assessments (HRAs), and any knowledge or conversation with patients about out of pocket costs.

Analysis: Interviews were audio recorded, transcribed and coded iteratively using grounded theory and standard qualitative analysis techniques.[1,2] Quotations that illustrate key findings included in this report were drawn from these interviews.

SURVEY OF PRIMARY CARE PRACTITIONERS

To evaluate the impact of the Healthy Michigan Plan, we surveyed primary care practitioners about their experiences caring for Healthy Michigan Plan beneficiaries, new practice approaches and innovations, and future plans.

Sample: The sample was drawn from the 7,360 National Provider Identifier (NPI) numbers assigned in the MDHHS Data Warehouse as the primary care provider for at least one Healthy Michigan Plan managed care member as of April 2015. Eligible for the survey were those with at least 12 assigned members (an average of one per month); 2,813 practitioners were excluded based on <12 assigned members. Of the remaining 4,547 NPIs, 25 were excluded because the NPI entity code did not reflect an individual physician (20 were organizational NPIs, 4 were deactivated, and 1 was invalid). Also excluded were 161 physicians with only pediatric specialty; 4 University of Michigan physicians involved in the Healthy Michigan Plan evaluation; and 35 physicians with out-of-state addresses >30 miles from the Michigan border. After exclusions, 4,322 primary care practitioners (3686 physicians and 636 nurse practitioners/physician assistants) remained as the survey sampling frame.

Survey Design: The survey included measures of primary care practitioner and practice characteristic derived from published surveys and reports,[3,4,5,6,7] and measures related to the Healthy Michigan Plan on a variety of topics, including:

- Plans to accept new Medicaid patients[8]
- Perceptions of difficulty accessing care for Healthy Michigan Plan beneficiaries with parallel questions about difficulty accessing care for privately insured patients
- Experiences with Healthy Michigan Plan beneficiaries regarding decision making about emergency department use
- Perceptions of influences on non-urgent ER use by Healthy Michigan Plan beneficiaries
- Practice approaches in place to prevent non-urgent ER use
- Experiences of caring for newly insured Medicaid patients, including ability to access non-primary care (specialty care, equipment, medication, dental care, mental health care)[6,7]
- New practice approaches adopted within the previous year
- Future plans regarding care of Medicaid patients

Drs. Goold, Campbell and Tipirneni developed the survey questions in collaboration with other members of the research team. The development process began by identifying the key survey domains through an iterative process with the members of the evaluation team. Then, literature searches identified survey items and scales measuring the domains of interest.[3-8] For domains without existing valid measures, items were developed from data collected from the 19 semi-structured individual interviews with PCPs. New items were cognitively pretested with two primary care practitioners who serve Healthy Michigan Plan patients, one MD from a low-cost clinic and one PA from a private practice. Both practitioners were asked about their understanding of each original survey item, their capacity to answer these questions, and how they would answer said items. The final survey itself was pretested with one PCP for timing and flow.

Survey Administration: Primary care provider addresses were identified from the MDHHS data warehouse Network Provider Location table, the MDHHS Provider Enrollment Location Address table, and the National Plan & Provider Enumeration System (NPPES) registry detail table linked to NPI. Research assistants reviewed situations where primary care practitioners had multiple addresses, and selected (a) the address with more detail (e.g., street address + suite number, rather than street alone), (b) the address that occurred in multiple databases, or (c) the address that matched an internet search for that physician.

The initial survey mailing occurred in June 2015 and included a personalized cover letter describing the project, a Fact Sheet about the Healthy Michigan Plan, a hard copy of the survey, a $20 bill, and a postage-paid return envelope. The cover letter gave information on how to complete the survey via Qualtrics, rather than hard copy. Two additional mailings were sent to nonrespondents in August and September 2015. Data from mail surveys returned by November 1, 2015, were entered in an excel spreadsheet, reviewed for accuracy, and subsequently merged with data from Qualtrics surveys.

Survey Response Characteristics: Of the original sample of 4,322 primary care practitioners in the initial sample, 501 envelopes were returned as undeliverable. Of the 2,131 primary care practitioners who responded, 1,986 completed a mailed survey, 118 completed a Qualtrics survey, and 27 were ineligible (e.g., retired, moved out of state). The final response rate was 56% (54% for physicians, 65% for nurse practitioners/physician assistants).

Comparison of the 2,104 eligible respondents and the 1,690 nonrespondents revealed no differences in gender, birth year, number of affiliated Medicaid managed care plans, and FQHC designation. More nonrespondents had internal medicine specialty.

Table 1. Comparison of Respondents to Nonrespondents

	Respondents N=2104	Nonrespondents N=1690	p
Gender			
Female	44.6	43.7	0.55
Male	55.4	56.3	
Birth Year			
1970 or earlier	71.0	69.5	0.32
1971 or later	29.0	30.5	
Medicaid Managed Care Plans			
1 plan	20.5	20.1	0.48
2 plans	27.2	25.7	
3 or more plans	52.3	54.2	
Practice setting			
FQHC	14.9	14.7	0.86
Not FQHC	85.1	85.3	
Specialty			
Family/general practice	54.5	51.0	<.0001
Internal medicine	27.3	36.3	
Nurse practitioner/physician assistant	17.0	11.3	
Ob-gyn/other	1.2	1.4	

Analysis: We calculated descriptive statistics such as proportion of primary care practitioners reporting difficulty accessing specialty care for Healthy Michigan Plan beneficiaries or experiences related to emergency department decision making. No survey weighting was necessary, as the sample included the full census of PCPs with ≥12 HMP patients. Bivariate and multivariable logistic regression analysis was used to assess the association of independent variables (personal, professional and practice characteristics) with dependent variables - practice changes reported since Medicaid expansion. Multivariable models were run with and without interaction variables (Ownership*Practice size and FQHC*predominant payer type), and chi-square goodness-of-fit tests calculated. All analyses were performed using STATA version 14 (Stata Corp, College Station, TX. Quotes from practitioner interviews have been used to expound upon some key findings from our analysis of survey data.

SURVEY OF PRIMARY CARE PRACTITIONERS
RESULTS

Survey results are presented in the following format:

Topic

Key findings
Illustrative quote(s) from PCP interviews
Tables of Results
Results of analysis of relationships (e.g., chi-square, multivariable logistic regression)

Respondents' Personal, Professional and Practice Characteristics

Just over half of respondents were men. About 80% self-identified as white. Eleven percent identified as Asian/Pacific Islander, with small numbers in other racial and ethnic groups. More than 80% of respondents were physicians, although nearly three-quarters had nonphysician providers in their practice. About half identified their specialty as family medicine and a quarter as internal medicine. More than half were in practices with 5 or fewer providers; 15% practiced in FQHCs. Three-quarters of PCP respondents practiced in urban settings, 31% in Detroit. Their self-reported payer mix varied; about one-third had Medicaid/HMP as the predominant payer.

Table 2. Personal, Professional and Practice Characteristics of PCP Respondents (N=2104)

Personal characteristics		
Gender	N	%
Male	1165	55
Female	939	45
Race		
White	1583	79
Black/African-American	93	5
Asian/Pacific Islander	224	11
American Indian/Alaska Native	10	<1
Other	86	4
Ethnicity		
Hispanic/Latino	46	2
Non-Hispanic/Latino	1978	98
Professional characteristics		
Provider type	N	%
Physician	1750	83
Non-Physician (NP/PA)	357	17
Specialty		
Family medicine	1123	53
Internal medicine	507	24
Medicine-Pediatrics	67	3
General practice (GP)	24	1
Obstetrics/Gynecology (OB/Gyn)	12	<1
Nurse practitioner (NP)	192	9
Physician's Assistant (PA)	165	8
Other	14	<1
Board/Specialty certification	N	%
Yes	1695	82
No	383	18

Table 2 (continued). Personal, Professional and Practice Characteristics of PCP Respondents

Years in practice		
<10 years	520	26
10-20 years	676	34
>20 years	810	40
Provider ownership of practice		
Full-owner	446	22
Partner/part-owner	232	11
Employee	1352	1352
Practice characteristics		
Practice size (mean, median, SD)	7.5, 5, 16.5	
Small (≤5 practitioners)[a]	1157	57.5
Large (≥6 practitioners)	855	42.5
Presence of non-physician practitioners in practice[b]	1275 (72%)	72
Federally qualified health center (FQHC)	311 (15%)	15
University/teaching hospital practice	276 (13%)	13
Hospital-based practice (non-teaching)	643 (31%)	31
Payer mix (current % of patients with insurance type)	Mean %	SD
Private	32.8%	19.8
Medicaid	23.3%	18.3
Healthy Michigan Plan	10.9%	11.8
Medicare	30.2%	16.7
Uninsured	5.8%	7.1
Predominant payer mix[c]	N	%
Private	661	35
Medicaid/Healthy Michigan Plan	677	35
Medicare	421	22
Uninsured	12	1
Mixed	141	7
Payment arrangement		
Fee-for-service	784	38
Salary	946	45
Capitation	44	2
Mixed	275	13
Other	40	2
Urbanicity[d]		
Urban	1584	75
Suburban	193	9
Rural	327	16

[a] Dichotomized at sample median

[b] >5% missing

[c] Composite variable of all current payers: payer is considered predominant for the practice if >30% of physician's patients have this payer type and <30% of patients have any other payer type. "Mixed" includes practices with more than one payer representing >30% of patients, or practices with <30% of patients for each payer type.

[d] Zip codes and county codes were linked to the U.S. Department of Agriculture Economic Research Service 2013 Urban Influence Codes to classify regions into urban (codes 1-2), suburban (codes 3-7) and rural (codes 8-12) designations.

Knowledge of Patient Insurance

Because we relied on PCPs to report their experiences caring for patients with Healthy Michigan Plan coverage we asked them questions about their knowledge of patients' insurance status.

Key findings: About half report knowing what kind of insurance a patient has at the beginning of an encounter. Nearly all report that it is easy to find out a patient's insurance status. About a third report intentionally ignoring a patient's insurance status.

Table 3. Knowledge of Patients' Insurance Status

	Strongly agree	Agree	Neither	Disagree	Strongly disagree
If I need to know a patient's insurance status it is easy to find out (N=2081)	904 (43.4%)	982 (47.2%)	131 (6.3%)	57 (2.7%)	7 (0.3%)
I know what kind of insurance a patient has at the beginning of an encounter (N=2081)	442 (21.2%)	671 (32.2%)	342 (16.4%)	427 (20.5%)	199 (9.6%)
I ignore a patient's insurance status on purpose so it doesn't affect my recommendations (N=2078)	294 (14.1%)	433 (20.8%)	549 (26.4%)	577 (27.8%)	225 (10.8%)
I only find out about a patient's insurance coverage if they have trouble getting something I recommend (N=2071)	281 (13.6%)	551 (26.6%)	393 (19.0%)	649 (31.3%)	197 (9.5%)

Familiarity with Healthy Michigan Plan

Key findings: PCPs report familiarity with how to complete and submit a Health Risk Assessment. They report less familiarity with beneficiary cost-sharing and rewards, and the availability of specialists and mental health services. PCPs working in small, non-academic, non-hospital-based and FQHC practices reported more familiarity with Healthy Michigan Plan.

> *[O]ne of our challenges…from an FQHC standpoint, when we have patients that do have Medicaid, we do get an increased reimbursement. So that number…being aware of that is, I think, very important for all of the providers in the clinic and probably all of the staff as well.*
>
> – Urban physician, FQHC

In general, how familiar are you with the Healthy Michigan Plan? (N=2031)

Very familiar	Somewhat familiar	A little familiar	Not at all familiar
307 (15.1%)	776 (38.2%)	557 (27.4%)	391 (19.3%)

Table 4. Familiarity with Healthy Michigan Plan

How familiar are you with the following:	Very familiar	Somewhat familiar	A little familiar	Not at all familiar
How to complete a Health Risk Assessment	966 (47.6%)	472 (23.3%)	276 (13.6%)	314 (15.5%)
How to submit a Health Risk Assessment	700 (34.6%)	469 (23.2%)	355 (17.5%)	501 (24.7%)

Table 4 (continued). Familiarity with Healthy Michigan Plan

How familiar are you with the following:	Very familiar	Somewhat familiar	A little familiar	Not at all familiar
Healthy behavior incentives that Healthy Michigan Plan Patients can receive	257 (12.6%)	481 (23.7%)	548 (27.0%)	746 (36.7%)
Specialists available for Healthy Michigan Plan patients	189 (9.3%)	553 (27.3%)	533 (26.3%)	752 (37.1%)
Mental health services available for Healthy Michigan Plan patients	156 (7.7%)	369 (18.2%)	564 (27.8%)	943 (46.4%)
Out-of-pocket expenses Healthy Michigan Plan Patients have to pay	137 (6.7%)	377 (18.6%)	577 (28.4%)	940 (46.3%)
Dental coverage in the Healthy Michigan Plan	89 (4.4%)	274 (13.5%)	415 (20.4%)	1,254 (61.7%)

We hypothesized that PCPs in different practice settings would differ in their familiarity with Healthy Michigan Plan. We found that PCPs working in **small**, **non-academic**, **non-hospital-based** and **FQHC** practices, as well as practices with **predominantly Medicaid or uninsured payer mixes**, reported greater familiarity with Healthy Michigan Plan. Differences in familiarity based on practice size, academic or hospital-based status were relatively modest.

Acceptance of Medicaid and Healthy Michigan Plan

Key findings:

About 4 in 5 survey respondents reported accepting <u>new</u> Medicaid/Healthy Michigan Plan patients. Most PCPs reported having at least some influence on that decision. Capacity to accept any new patients was rated as a very important factor in decisions to accept Medicaid/Healthy Michigan Plan patients.

> *We accept all comers. Period. Doors are open. Come on in. But I have to add a comment to that or a clarification…a qualification to that. My nurse manager…The site manager just came to me on Monday of this week and said, "You know, [name], if a person wants a new appointment with you, we're scheduling…It's like the end of April. There are so many patients now that are in the system that even for routine follow-up stuff, we can't get them in."*
>
> – Urban physician, FQHC

In multivariable analyses PCPs were more likely to accept new Medicaid/Healthy Michigan Plan patients if female, racial minorities, non-physician providers, specializing in internal medicine, paid by salary vs. fee-for service, with prior history of care to the underserved, or working in practices with Medicaid predominant payer mixes. PCPs were less likely to accept new Medicaid/Healthy Michigan Plan patients if they considered their practice's overall capacity to accept new patients important.

> *[A]s long as the rural health center plans still pay me adequately, I don't foresee making any changes. If they were to all of a sudden say, "Okay, we're only going to reimburse 40% or 50% of what we used to," that would be enough to put me out of business. So I would think twice about seeing those patients then, but as long as they continue the way they have been for the last six years that I've owned the clinic, I don't see making any changes. It works just fine.*
>
> – Rural nurse practitioner, Rural health center

PCPs in the Detroit area were more likely to accept new Medicaid/Healthy Michigan Plan patients than PCPs in other regions of the state. Of PCPs' <u>established patients</u>, an average of 11% had

Healthy Michigan Plan and 23% had Medicaid as their primary source of coverage (see demographics table, pg. 4-5).

Most PCPs reported providing care in a setting that serves poor and underserved patients with no anticipation of being paid in the past three years, and nearly three-quarters felt a responsibility to care for patients regardless of their ability to pay. Nearly three-quarters agreed all practitioners should care for Medicaid/Healthy Michigan Plan patients.

We asked PCPs whether they were currently accepting new patients with Healthy Michigan Plan and other types of insurance:

Table 5. Acceptance of New Patients by Insurance Type[5]

Accepting *new* patients, by type of insurance	N (%)
Private	1774 (87%)
Medicaid*	1517 (75%)
Healthy Michigan Plan*	1461 (73%)
Medicare	1717 (84%)
No insurance (i.e., self-pay)	1541 (76%)
*Combined, 1575 (78%) of PCP respondents reported accepting new patients with either Healthy Michigan Plan or Medicaid.	

How much influence do you have in making the decision to accept or not accept Medicaid or Healthy Michigan Plan patients in your practice?

The decision is entirely mine	I have a lot of influence	I have some influence	I have no influence
459 (23%)	275 (14%)	425 (21%)	866 (43%)

Table 6. Importance for Accepting New Medicaid or Healthy Michigan Plan Patients

Please indicate the importance of each of the following for your practice's decision to accept new Medicaid or Healthy Michigan Plan patients:	Very important	Moderately important	Not very important	Not at all important	Don't know
Capacity to accept new patients with any type of insurance	774 (38%)	638 (31%)	187 (9%)	177 (9%)	273 (13%)
Reimbursement amount	532 (26%)	613 (30%)	274 (13%)	310 (15%)	327 (16%)
Availability of specialists who see Medicaid or Healthy Michigan Plan patients	528 (26%)	617 (30%)	310 (15%)	284 (14%)	313 (15%)
Psychosocial needs of Medicaid or Healthy Michigan Plan patients	404 (20%)	623 (30%)	376 (18%)	344 (17%)	304 (15%)
Illness burden of Medicaid or Healthy Michigan Plan patients	370 (18%)	574 (28%)	442 (22%)	370 (18%)	296 (14%)

We asked PCPs about their prior experience and attitudes toward caring for poor or underserved patients. A majority reported providing care in a setting that serves poor and underserved patients with no anticipation of being paid.

In the past three years, have you provided are in a setting that serves poor and underserved patients with no anticipation of being paid?

Yes	No
1,153 (57.0%)	871 (43.0%)

Table 7. Attitudes About Caring for Poor or Underserved Patients

	Strongly Agree	Agree	Neither	Disagree	Strongly disagree
All practitioners should care for some Medicaid/Healthy Michigan Plan patients	941 (45%)	555 (27%)	346 (17%)	150 (7%)	81 (4%)
It is my responsibility to provide care for patients regardless of their ability to pay	874 (42%)	642 (31%)	282 (14%)	190 (9%)	78 (4%)
Caring for Medicaid/Healthy Michigan Plan patients enriches my clinical practice	418 (20%)	590 (29%)	746 (36%)	246 (12%)	67 (3%)
Caring for Medicaid/Healthy Michigan Plan patients increases my professional satisfaction	379 (18%)	543 (26%)	794 (39%)	260 (13%)	88 (4%)

We hypothesized that acceptance of new Medicaid/Healthy Michigan Plan patients would vary by PCPs' personal, professional and practice characteristics. In multivariable analyses, **we found that PCPs were more likely to accept new Medicaid/Healthy Michigan Plan patients if female, racial minorities, non-physician providers, specializing in internal medicine, paid by salary vs. fee-for service, with prior history of care to the underserved, or working in practices with Medicaid predominant payer mixes. PCPs were less likely to accept new Medicaid/Healthy Michigan Plan patients if they considered their practice's overall capacity to accept new patients important.**

Table 8. Multivariable Analysis of Association of PCP and Practice Characteristics with Medicaid Acceptance

	Unadjusted Odds of Medicaid Acceptance (OR, 95% CI)	Adjusted[a] Odds of Medicaid Acceptance (aOR, 95% CI)
Personal and Professional characteristics		
Female Gender	1.59 (1.28-1.98)**	1.32 (1.01-1.72)*
Race		
White	[ref]	[ref]
Black/African American	3.93 (1.80-8.57)*	3.46 (1.45-8.25)*
Asian/Pacific Islander	1.76 (1.20-2.58)*	1.84 (1.21-2.80)*
Other	1.94 (1.04-3.62)*	1.79 (0.84-3.80)
Ethnicity, Hispanic	1.88 (0.79-4.48)	1.54 (0.56-4.22)
Years in Practice		
<10 years	[ref]	[ref]
10-20 years	0.69 (0.51-0.93)*	0.87 (0.62-1.22)
>20 years	0.51 (0.38-0.68)**	0.82 (0.58-1.15)
Non-physician provider (vs. physician provider)	4.78 (3.09-7.40)**	2.21 (1.32-3.71)*

Table 8 (continued). Multivariable Analysis of Association of PCP and Practice Characteristics with Medicaid Acceptance

	Unadjusted Odds of Medicaid Acceptance (OR, 95% CI)	Adjusted[a] Odds of Medicaid Acceptance (aOR, 95% CI)
Specialty		
Family medicine	[ref]	[ref]
Internal medicine	1.43 (1.12-1.83)*	1.47 (1.09-1.97)*
Nurse practitioner (NP)	7.81 (3.95-15.45)**	3.53 (1.64-7.61)*
Physician Assistant (PA)	4.07 (2.32-7.16)**	1.83 (0.94-3.56)
Other	2.86 (1.21-6.79)*	2.02 (0.75-5.45)
Board Certified	0.57 (0.42-0.77)**	0.92 (0.64-1.32)
Personal and Professional characteristics		
Payment arrangement		
Fee-for-service	[ref]	[ref]
Salary predominant	3.02 (2.36-3.85)**	2.09 (1.58-2.77)**
Mixed payment	1.34 (0.98-1.84)	1.43 (0.99-2.07)
Other payment arrangements	2.44 (1.01-5.93)*	1.33 (0.51-3.49)
PCP attitudes		
Capacity very/moderately important	0.53 (0.41-0.68)**	0.59 (0.44-0.79)**
Reimbursement very/moderately important	0.64 (0.51-0.79)**	0.86 (0.67-1.10)
Specialist availability very/moderately important	0.95 (0.76-1.17)	1.11 (0.86-1.42)
Illness burden of patients very/moderately important	1.02 (0.83-1.27)	1.03 (0.81-1.32)
Psychosocial needs of patients very/moderately important	1.10 (0.89-1.37)	1.14 (0.89-1.45)
Provided care to the underserved in past 3 years	1.64 (1.33-2.03)**	1.35 (1.05-1.73)*
Expressed commitment to caring for underserved	1.16 (1.13-1.19)**	1.14 (1.11-1.18)**
Practice characteristics		
Small practice with ≤5 providers (vs. large practice)	1.18 (0.95-1.47)	1.27 (0.99-1.63)
Urban (vs. rural/suburban)	0.69 (0.53-0.89)*	0.97 (0.72-1.31)
Federally qualified health center (FQHC)	2.40 (1.66-3.47)**	1.08 (0.70-1.65)
Mental health co-location	1.99 (1.42-2.79)**	1.16 (0.79-1.71)
Predominant payer mix		
Private insurance	[ref]	[ref]
Medicaid/HMP	8.64 (6.14-12.15)**	7.31 (5.05-10.57)**
Medicare	1.94 (1.47-2.55)**	2.04 (1.52-2.73)**
Mixed	3.32 (2.05-5.37)**	3.76 (2.24-6.30)**

[a] Adjusted for covariates of gender, years in training, physician vs. non-physician provider, board certification, urbanicity, FQHC status, predominant payer mix, except for when independent variable included in list.
* $p < 0.05$
** $p < 0.001$
Note: Each cell represents a separate bivariate or multivariable logistic regression model. Bivariate and multivariable logistic regression analysis was used to assess the association of the independent variables of PCP personal, professional and practice characteristics, as well as attitudes, with the dependent variable of PCP Medicaid acceptance.

Changes in Practice

Key findings:

Most PCPs reported an increase in new patients and in the number of new patients who hadn't seen a PCP in many years.

Really the only thing I know about the expansion is in early 2014 we started getting a way lot more requests for a new patient visit than we've ever had before. I was just like, "what is going on? We don't get 25 requests for new patients/month." So when it started really climbing, that's when I figured out, "Okay. It's probably due to the Obamacare Medicaid expansion."

– Urban physician; Small, private practice

Most reported established patients who had been uninsured gained insurance. Fewer reported patients changing from other insurance to Healthy Michigan Plan.

Your working poor people who just were in between the cracks, didn't have anything, and now they've got something, which is great.

– Urban physician, FQHC

Most practices hired clinicians and/or staff in the past year. Most reported consulting with care coordinators, case managers and/or community health workers.

About a third of PCPs reported that the portion of established patients able to obtain a same- or next-day appointment had increased over the previous year.

FQHCs, those with predominately uninsured, Medicaid and mixed payer mixes and suburban practices were more likely to report an increase in new patients. FQHCs, and those with predominately Medicaid payer mix, were more likely to report existing patients who had been uninsured gained insurance, and an increase in the number of patients who hadn't seen a PCP in many years.

Large and FQHC practices were more likely to have hired new clinicians in the past year. Small, non-FQHC, academic and suburban practices and were less likely to report hiring additional staff.

Large and FQHC practices and those with predominantly private or uninsured payer mixes were all more likely to report consulting with care coordinators, case managers and/or community health workers in the past year.

Table 9. Experiences of Practices Since April 2014

To what extent has your practice experienced the following since Healthy Michigan Plan began in April 2014?	To a great extent	To some extent	To a little extent	Not at all	Don't know
Increase in the number of new patients who haven't seen a primary care practitioner in many years (N=2020)	496 (24.6%)	638 (31.6%)	407 (20.1%)	130 (6.4%)	349 (17.3%)
Increase in number of new patients (N=2021)	351 (17.4%)	706 (34.9%)	389 (19.2%)	195 (9.6%)	380 (18.8%)
Existing patients who had been uninsured or self-pay gained insurance (N=2019)	321 (15.9%)	701 (34.7%)	502 (24.9%)	108 (5.3%)	387 (19.2%)
Existing patients changed from other insurance to Healthy Michigan Plan (N=2019)	110 (5.4%)	529 (26.2%)	576 (28.5%)	176 (8.7%)	628 (31.1%)

Table 10. Changes Made to PCP Practices Within the Past Year

Has your practice made any of the following changes in the past year? (check all that apply)	Checked	Not Checked‡
Hired additional clinicians	1120 (53.2%)	984 (46.8%)
Hired additional office staff	1209 (57.5%)	895 (42.5%)
Consulted with care coordinators, case managers, community health workers	1174 (55.8%)	930 (44.2%)
Changed workflow processes for new patients	878 (41.7%)	1226 (58.3%)
Co-located mental health within primary care	325 (15.4%)	1779 (84.6%)

‡288 (13.7%) participants did not check any boxes indicating that their practice had made changes in the previous year. This data was factored into the "Not Checked" category for each potential response.

What proportion of your established patients who request a same- or next-day appointment at your primary practice can get one? (N=2033)[7]

Almost all (>80%)	Most (60-80%)	About half (~50%)	Some (20-40%)	Few (<20%)	Don't know
826 (40.6%)	527 (25.9%)	237 (11.7%)	287 (14.1%)	122 (6.0%)	34 (1.7%)

Over the past year, this proportion has:

Increased	Decreased	Stayed the same	Don't know
682 (34.0%)	316 (15.8%)	883 (44.1%)	123 (6.1%)

Table 11. Multivariable Analysis of Association of Practice Characteristics with Changes Made in PCP Practices Within the Past Year

Has your practice made the following changes in the past year?	Hired additional clinicians	Hired additional office staff	Consulted with care coordinator, case manager, or community health worker	Changed workflow processes for new patients	Co-located mental health within primary care
Practice size:					
Large (ref)	71.8%	67.8%	71.1%	49.4%	19.5%
Small	40.0%§	52.4%§	49.0%§	38.3%§	11.4%§
Practice Type:					
FQHC (ref)	61.8%	68.0%	72.7%	43.0%	31.9%
Non-FQHC	52.3%†	57.5%‡	56.0%§	43.0%	11.5%§
Academic (ref)	48.5%	47.8%	57.1%	38.3%	17.3%
Non-Academic	54.4%	60.7%‡	58.4%	43.8%	14.9%
Hospital-based (ref)	51.6%	56.7%	57.6%	42.0%	12.7%
Not hospital-based	54.6%	60.0%	58.6%	43.5%	16.6%
Predominant payer mix:					
Private (ref)	54.6%	60.7%	65.0%	41.4%	11.5%
Medicare	51.3%	58.9%	54.5%‡	48.5%†	13.1%
Medicaid	53.2%	59.4%	53.0%§	43.4%	19.3%§
Uninsured	39.4%	33.5%	64.3%	39.7%	26.4%
Mixed	57.9%	51.5%†	58.3%†	35.1%	14.2%
Urbanicity:					
Urban (ref)	53.6%	59.9%	58.1%	41.6%	13.4%
Suburban	53.1%	50.9%†	53.3%	45.1%	15.2%
Rural	54.0%	59.1%	62.2%	48.8%†	23.8%§

Table 12. Multivariable Analysis of Association of Practice Characteristics with Experiences of Practices Since April 2014

*To what extent has your practice experienced the following since the Healthy Michigan Plan began in April 2014?***	Increase number of new patients	Existing patients who had been uninsured or self-pay gained insurance	Existing patients changed from other insurance to Healthy Michigan Plan	Increase in the number of new patients who have not seen a primary care practitioner in many years
All	52.3%	50.6%	31.6%	56.2%
Practice size:				
Large (ref)	51.4%	50.0%	28.9%	54.0%
Small	51.7%	51.2%	31.9%	57.8%
Practice Type:				
FQHC (ref)	58.8%	64.9%	32.6%	63.7%
Non-FQHC	50.5%†	48.5%§	30.3%	55.1%†
Academic (ref)	52.9%	53.5%	29.9%	59.2%
Non-Academic	51.3%	50.2%	30.8%	55.7%
Hospital-based (ref)	51.5%	49.5%	28.3%	56.9%
Not hospital-based	51.6%	51.3%	31.7%	55.8%
Predominant payer mix:				
Private (ref)	39.4%	41.5%	22.4%	46.2%
Medicare	43.8%	44.8%	25.0%	50.5%
Medicaid	69.7%§	64.7%§	43.0%§	72.4%§
Uninsured	79.4%†	59.1%	14.4%	61.5%
Mixed	49.9%†	50.4%	29.2%	49.7%
Urbanicity:				
Urban (ref)	51.0%	49.5%	28.6%	56.7%
Suburban	59.8%†	55.6%	33.1%	60.3%
Rural	49.1%	53.7%	38.8%‡	51.3%

*Proportions are the predictive margins from logistic regression models adjusted for each practice characteristic in the table, as well as PCP gender, specialty, ownership of practice, and years in practice.
**Analyses based on sum of those who responded "to a great extent" or "to some extent" for the items below.
All p-values are based on logistic regression analysis
†p<0.05
‡p<.01
§p<0.001

Experiences Caring for Healthy Michigan Plan Beneficiaries

Health Risk Assessments

Key findings:

About four-fifths of PCPs who responded to the survey have completed at least one HRA with a patient; over half of those have completed more than 10.

Most PCPs reported their practice has a process in place for submitting HRAs, but not for identifying patients who needed HRAs completed. Some PCPSs reported having been contacted by a health plan about a patient who needed to complete an HRA. Most don't know whether they or their practice has received a financial incentive for completing HRAs. PCPs reported completing more HRAs if they were located in Northern regions, reported a Medicaid or uninsured

predominant payer mix, payment by capitation or salary, compared to fee-for-service, receiving a financial incentive for completing HRAs, smaller practice size, and co-location of mental health in primary care.

Most PCPs reported that financial incentives for patients and practices had at least a little influence on completing HRAs. According to PCPs, patients' interest in addressing health risks had at least as much influence.

> *We finally get the chance to do prevention because if someone doesn't have insurance and doesn't see a doctor, then there's no way we can do any kind of prevention. We're just kind of dealing with the end-stage results of whatever's been going on and hasn't been treated. So I mean what I've heard people say is "I just want to stay healthy or find out if I'm healthy," and to me that says a lot. We can at least find out where they stand in terms of chronic illness or if they have any or if they are healthy, how can we make sure that they stay that way?*
>
> – Urban physician; Large, hospital-based practice

Most PCPs found HRAs useful for identifying and discussing health risks, persuading patients to address their most important health risks, and documenting behavior change goals. Most found them at least a little useful for getting patients to change behavior.

> *I recently… In the last month, I've signed up two people [for Weight Watchers…two or three people to that, and one of them is really sticking to it. She's already lost 10 pounds.*
>
> – Urban physician; Small, private practice

Approximately how many Health Risk Assessments have you completed with Healthy Michigan Plan patients? (N=2032)

None	1-2	3-10	More than 10
420 (20.7%)	235 (11. 6%)	503 (24.8%)	874 (43.0%)

How often do your Healthy Michigan Plan patients bring in their Health Risk Assessment to complete at their initial office visit? (N=1923)

Almost always	Often	Sometimes	Rarely/never
215 (11.2%)	416 (21.6%)	720 (37.4%)	572 (29.7%)

Table 13. Experience with Health Risk Assessments

Please report your experience with the following:	Yes	No	Don't know
My practice has a process to submit completed HRAs to the patient's Medicaid Health Plan. (N=2041)	1250 (61.2%)	176 (8.6%)	615 (30.1%)
My practice has a process to identify Healthy Michigan Plan patients who need to complete an HRA. (N=2042)	697 (34.1%)	514 (25.2%)	831 (40.7%)
Please report your experience with the following:	Yes	No	Don't know
I/my practice have been contacted by a Medicaid Health Plan about a patient who needs to complete an HRA. (N=2040)	678 (33.2%)	438 (21.5%)	924 (45.3%)
I/my practice have received a financial bonus from a Medicaid Health Plan for helping patients complete HRAs. (N=2033)	367 (18.1%)	339 (16.7%)	1327 (65.3%)

Table 14. Influence on Completing HRA

How much influence do the following have on completion and submission of the Health Risk Assessment?	A great deal	Some	A little	No	Don't know
Financial incentives for patients (N=2046)	549 (26.8%)	486 (23.8%)	155 (7.6%)	294 (14.4%)	562 (27.5%)
Patients' interest in addressing health risks (N=2046)	437 (21.4%)	618 (30.2%)	374 (18.3%)	181 (8.8%)	436 (21.3%)
Financial incentives for practices (N=2044)	374 (18.3%)	502 (24.6%)	258 (12.6%)	353 (17.3%)	557 (27.3%)

Table 15. Usefulness of HRA

For Healthy Michigan Plan patients who have completed their HRA, how useful has this been for each of the following?	Very useful	Somewhat useful	A little useful	Not at all useful
Discussing health risks with patients (N=1828)	601 (32.9%)	733 (40.1%)	311 (17.0%)	183 (10.0%)
Persuading patients to address their most important health risks (N=1828)	484 (26.5%)	712 (38.9%)	415 (22.7%)	217 (11.9%)
Identifying health risks (N=1833)	471 (25.7%)	769 (42.0%)	369 (20.1%)	224 (12.2%)
Documenting patient behavior change goals (N=1826)	409 (22.4%)	716 (39.2%)	449 (24.6%)	252 (13.8%)
Getting patients to change health behaviors (N=1821)	277 (15.2%)	582 (32.0%)	652 (35.8%)	310 (17.0%)

We hypothesized that PCPs who identify a process in place at their practice for identifying patients who need to complete an HRA, and a process in place for submitting an HRA, would report completing more HRAs and that was confirmed. PCPs reporting greater familiarity with healthy behavior incentives and out of pocket expenses faced by patients also reported completing more HRAs.

PCPs were more likely to report their practice had a process for submitting HRAs if they reported:

- Smaller practice size
- They or their practice consulted with care coordinators, case managers, or community health workers
- They or their practice changed workflow processes for new patients
- Co-location of mental health within primary care
- Medicaid or uninsured predominant payer mix
- They or their practice had received an incentive for completing an HRA
- Their practice was located in Northern, Mid-state, or Detroit regions, compared with the Southern region

PCPs were more likely to report a practice to identify patients who needed to complete an HRA if they reported:

- Co-location of mental health within primary care
- Medicaid or uninsured predominant payer mix
- They or their practice had received an incentive for completing an HRA
- Their practice was located in Northern, Mid-state, or Detroit regions, compared with the Southern region

PCPs reported completing more HRAs if they reported:

- Smaller practice size
- Co-location of mental health within primary care
- Medicaid or uninsured predominant payer mix
- Payment by capitation or salary, compared with fee-for-service
- They or their practice had received an incentive for completing an HRA
- Their practice was located in Northern regions of the state compared with other regions

ER Use and Decision Making

Key findings:

The majority of PCPs surveyed felt that they could influence ER utilization trends for their Medicaid patient population and nearly all accepted responsibility for playing a role in reducing non-urgent ER use. Many reported offering services to avoid non-urgent ER use, such as walk-in appointments, 24-hour telephone triage, weekend and evening appointments, and care coordinators or social work assistance for patients with complex problems, but were less likely to offer transportation services.

PCPs reported that accessibility to pain medication and evaluations without appointments are major drivers of ER use, along with patients' comfort with accessing ER services.

> *People who work day shift… It's easier for them to go to the ER or something for a minor thing because they don't have to take time off work. That's a big deal.*
>
> – Rural physician; Small, private practice

> *I think that a lot of it is cultural. I don't mean ethnic culture. I mean just culture… There are some people who that is just what they understand, and that is how they operate. They've seen people do it for years, and they've done it and they just feel comfortable with that.*
>
> – Urban physician assistant, FQHC

PCPs recommended PCP practice changes, ER practice changes, patient educational initiatives, and patient penalties/incentives when asked about strategies to reduce non-urgent ER use.

How much can PCPs influence non-urgent ER use by their patients?

A great deal	Some	A little	Not at all
608 (29.9%)	886(43.6%)	460(22.6%)	80(3.9%)

To what extent do you think it is your responsibility as a PCP to decrease non-urgent ER use?

Major Responsibility	Some Responsibility	Minimal responsibility	No responsibility
740 (36.5%)	1035 (51.0%)	212 (10.4%)	43 (2.1%)

Table 16. PCP Practice Offerings to Avoid Non-Urgent ER Use

Does your practice offer any of the following to help Healthy Michigan Plan patients avoid non-urgent ER use?	Yes	No	Don't know
Walk-in appointments	1336 (66.5%)	607 (30.2%)	67 (3.3%)
Assistance with arranging transportation to appointments	615(30.6%)	1144 (57.0%)	249 (12.4%)
24-hour telephone triage	1492 (74.0%)	438 (21.7%)	85 (4.2%)
Appointments during evenings and weekends	1122(55.8%)	819(40.7%)	71 (3.5%)
Care coordination/social work assistance for	1134 (56.5%)	672 (33.5%)	202(10.1%)

patients with complex problems			

Table 17. Influence on Non-Urgent ER Use

In your opinion, to what extent do the following factors influence non-urgent ER use?	Major influence	Minor influence	Little or no influence
The ER will provide care without an appointment	1679 (82.7%)	273 (13.4%)	78 (3.8%)
Patients believe the ER provides better quality of care	341 (16.8%)	798 (39.4%)	887 (43.8%)
The ER offers quicker access to specialists	614 (30.3%)	723 (35.7%)	691 (34.1%)
Hospitals encourage use of the ER	377 (18.7%)	577 (28.7%)	1058 (52.6%)
The ER offers access to medications for patients with chronic pain	1030 (50.7%)	646 (31.8%)	355 17.5%)
The ER is where patients are used to getting care	1204 (59.5%)	633 (31.3%)	186 (9.2%)

Nearly three-quarters of PCPs felt that they could have "a great deal/some" influence on non-urgent ER use. This finding was associated with **fewer years in practice** and an **increased number of practice changes,** of which **changing workflow for new patients** and **care coordination or social work assistance** for complex problems seemed to be the more significant drivers of that trend.

Nearly nine-tenths of PCPs surveyed felt that they had "a major/some" responsibility to decrease non-urgent ER use. This sense of responsibility was associated with **fewer years in practice**, and a **greater number of practice changes**. More specifically, **having care coordinators/case managers/community health workers** seemed to drive that trend. **Increasing familiarity with specialists or mental health services available for Healthy Michigan Plan patients** was also associated with increased responsibility to decrease non-urgent ER use.

When asked how to reduce non-urgent ER use (open-ended, write-in question), many respondent suggestions addressed **PCP availability** (e.g., increases in the workforce) and changes in **PCP practice** (e.g., extended hours, same-day appointments, improved follow-up). They also recommended gatekeeper strategies, non-primary care options (e.g., urgent care clinics) and greater use of care coordinators and case managers.

Some PCPs suggested **modifications to ER practice**, such as diversion to PCPs, nearby urgent care sites or reducing payment to hospitals/ER practitioners. Others recommended **limiting pain medication** prescriptions in the ER. A few PCPs suggested that the Emergency Medical Treatment and Labor Act (EMTALA) be changed to allow ER practitioners to more readily divert patients to other settings, along with altering the "litigation culture."

Patient educational initiatives were also recommended, for example to clarify "when to seek care," awareness of available alternative services, enhancing patient "coping" and self-management skills, as well as increased transparency on the costs associated with ER care.

Most commonly, PCPs recommended **patient penalties**. Financial penalties were overwhelmingly co-pays, or point-of care payment for ER visits, particularly for visits that do not result in a hospital admission or for patients deemed "high utilizers." Non-financial penalties included having the patient dismissed from the practice panel, or by the insurer.

Others suggested instituting **financial incentives to encourage patients to contact their PCP** prior to seeking ER care, or suggested both increasing out of pocket costs for ER visits while lowering or eliminating costs for visits to primary or urgent care.

Access

Key findings:

PCPs with Healthy Michigan Plan patients who were previously uninsured reported some or great impact on health, health behavior, health care and function for those patients. The greatest impact was reported for control of chronic conditions, early detection of serious illness, and improved medication adherence.

> *One patient…a 64-year-old gentleman who has lived in Michigan or at least lived in the United States for 40 years and had never pursued primary care. Upon receiving health insurance and upon his daughter's recommendation, he pursued care and that was his first…according to him, his first physical evaluation of any sort in 40 years, and he has just….It wasn't a full health maintenance exam. It was a new patient evaluation, and in the time in that initial evaluation he was found to be hypertensive. Upon subsequent labs, you know, ordered on that visit, he was found to be diabetic and upon routine referral at that initial visit for an eye exam, given his hypertension, he was found to have had…hemianopia, which later was determined to be caused by a prior stroke.*
>
> – Urban physician assistant, FQHC

> *Well, I learned a long time ago if the patient doesn't take the medicine, they don't get better. There are a lot of different reasons they don't take it, but the easy one is that if they don't have insurance to cover it and they don't ever pick it up, then they're not going to take it.…if they have financial barriers to getting that done, they're not going to get it done. So I'd say it has a humungous effect.*
>
> – Rural physician, FQHC

PCPs reported that Healthy Michigan Plan patients, compared to those with private insurance, more often had difficulty accessing specialists, medications, mental health care, dental care, treatment for substance use and counseling for behavior change (all, p<.001).

> *It can still take up to six months to see a psychiatrist unless you get admitted to the hospital… the ones that work for the hospital that don't take Medicaid or Medicare. And then at discharge, you really aren't going to see the other psychiatrist any quicker. It's kind of a mess. But I don't blame Medicaid expansion for that. It was a mess before then.*
>
> – Urban physician; Small, private practice

> *He has a job that I think he gets paid $9/hour to work, and he's like a super hard-working guy….I think his son has like…is 14 years old with…mental disabilities,…..So now we're talking about a man that needs to get a super expensive medication….Although I feel like I'm a great primary care doc, sometimes, you know, those medications and the follow-up need to probably…There needs to be a team….some teamwork between the rheumatologist and the primary care doctor, and we couldn't get him back in*.
>
> – Urban physician, FQHC

Table 18. Impact of Healthy Michigan Plan on Previously Uninsured Patients

Please think about what has changed for your patients who were previously uninsured and are now covered by the Healthy Michigan Plan. Rate the extent to which you think HMP has had an impact on each of the following for these patients:	Great impact	Some impact	Little impact	No impact	Don't know
Better control of chronic conditions	701 (35%)	789 (39.4%)	139 (6.9%)	30 (1.5%)	346 (17.3%)
Early detection of serious illness	674 (33.7%)	748 (37.4%)	153 (7.6%)	40 (2%)	387 (19.3%)
Improved medication adherence	568 (28.3%)	817 (40.8%)	215 (10.7%)	54 (2.7%)	350 (17.5%)
Improved health behaviors	323 (16.1%)	811 (40.4%)	378 (18.9%)	106 (5.3%)	387 (19.3%)
Better ability to work or attend school	263 (13.1%)	661 (33%)	399 (19.9%)	114 (5.7%)	566 (28.3%)
Improved emotional wellbeing	328 (16.4%)	813 (40.6%)	348 (17.4%)	76 (3.8%)	439 (21.9%)
Improved ability to live independently	239 (11.9%)	593 (29.6%)	438 (21.9%)	141 (7%)	591 (29.5%)

Table 19. Reported Frequency of Access Difficulty – Healthy Michigan Plan Patients

	Often	Sometimes	Rarely	Never	Don't know
How often do Healthy Michigan Plan patients have difficulty accessing the following?					
Specialists **+	644 (31.3%)	729 (35.4%)	137 (6.7%)	19 (.9%)	530 (25.7%)
Medications **+	322 (15.6%)	886 (43.1%)	330 (16.0%)	37 (1.8%)	483 (23.5%)
Mental Health Care **+	711 (34.5%)	523 (25.4%)	193 (9.4%)	35 (1.7%)	597 (29.0%)
Dental/Oral Health Care **+	623 (30.2%)	361 (17.5%)	131 (6.4%)	23 (1.1%)	923 (44.8%)
Treatment for substance use disorder **+	594 (28.9%)	446 (21.7%)	151 (7.3%)	31 (1.5%)	836 (40.6%)
Counseling and support for health behavior change **+	536 (26.0%)	543 (26.4)	218 (10.6%)	55 (2.7%)	708 (34.4%)
How often do your privately insured patients have difficulty accessing the following?					
Specialists **+	71 (3.4%)	650 (31.3%)	1009 (48.6%)	273 (13.2%)	71 (3.4%)
Medications **+	137 (6.6%)	1053 (50.8%)	719 (34.7%)	97 (4.6%)	68 (3.3%)
Mental Health Care **+	367 (17.7%)	893 (43.1%)	551 (26.6%)	125 (6.0%)	136 (6.6%)
Dental/Oral Health Care **+	156 (7.5%)	632 (30.5%)	624 (30.1%)	132 (6.4%)	528 (25.5%)
Treatment for substance use disorder **+	305 (14.7%)	799 (38.6%)	525 (25.4%)	98 (4.7%)	344 (16.6%)
Counseling and support for health behavior change **+	256 (12.4%)	802 (38.7%)	649 (31.3%)	144 (6.9%)	221 (10.7%)

**p<.001 paired t-test comparing don't know responses for HMP and privately insured patients

+p<.001 Wilcoxon signed-rank test comparing responses for HMP and privately insured patients

Discussing Costs with Patients

Given the cost-sharing features of Healthy Michigan Plan, we asked PCPs about conversations they may have had with patients about out-of-pocket costs.

Key findings:

About one-fifth of PCPs reported discussing out-of-pocket costs with a Healthy Michigan Plan patient. The patient was more likely than the PCP to bring up the topic. About half the time the discussion resulted in a change of management plans.

> *They don't have that stigma any longer of not being insured and there's not that barrier between us about them worrying about the money, even though we really never made a big deal of it, but they could feel that. I don't know. I think they feel more worth.*
>
> – Rural physician; Small, private practice

Have you ever discussed out-of-pocket medical costs with a Healthy Michigan Plan patient? (N=1988)

Yes	No
445(22.4%)	1543 (77.6%)

Thinking of the most recent time you discussed out-of-pocket medical expenses with a Healthy Michigan Plan patient, who brought up the topic? (N=440)

The Patient	Me	Somebody Else in the Practice	Other
247 (56.1%)	171 (38.9%)	16 (3.6%)	6 (1.4%)

Thinking of the most recent time you discussed out-of-pocket medical expenses with a Healthy Michigan Plan patient, did the conversation result in a change in the management plan for the patient? (N=440)

Yes	No	Don't remember	Blank
248 (55.7)(56.4%)	131 (29.4)(29.8%)	61 (13.7)(13.9%)	5 (1.1)

We hypothesized that PCPs' likelihood of having cost conversations would vary by their PCPs' personal, professional and practice characteristics:

Table 20. Association of PCP personal, professional and practice characteristics with Frequency of Cost Conversations and Change in Clinical Management due to Cost Conversations

	N (%)	
	Cost Conversations†	Change in Management due to Cost Conversation‡
Personal characteristics		
Gender		
Male	227 (20.5%)*	118 (52.7%)
Female	218 (24.7%)	130 (60.2%)
Race		
White	367 (24.3%)**	204 (56.0%)
Black/African American	14 (15.4%)	8 (57.1%)
Asian/Pacific Islander	25 (12.3%)	14 (60.9%)

Other/More than one	18 (17.5%)	10 (55.6%)

Table 20 (continued). Association of PCP personal, professional and practice characteristics with Frequency of Cost Conversations and Change in Clinical Management due to Cost Conversations

	N (%)	
	Cost Conversations†	Change in Management due to Cost Conversation‡
Ethnicity		
Hispanic/Latino	15 (33.3%)	8 (53.3%)
Not Hispanic/Latino	416 (22.0%)	234 (56.9%)
Professional characteristics		
Provider type		
Physician	337 (20.4%)**	180 (54.1%)
Non-physician (NP or PA)	108 (32.2%)	68 (63.6%)
Specialty		
Family medicine	230 (21.6%)**	119 (52.2%)*
Internal medicine	96 (17.8%)	58 (61.7%)
Other physician specialty	11 (21.6%)	3 (27.3%)
Non-physician (NP or PA)	108 (32.2%)	68 (63.6%)
Years in practice		
<10 years	126 (25.1%)	87 (69.6%)*
10-20 years	134 (20.8%)	72 (54.1%)
>20 years	172 (22.8%)	84 (49.7%)
Prior care for underserved patients		
Yes	284 (25.8%)**	161 (57.1%)
No	151 (18.1%)	82 (55.4%)
Practice characteristics		
Practice size		
Small (≤5 providers)	252 (23.2%)	141 (56.4%)
Large (>5 providers)	181 (22.1%)	103 (57.9%)
FQHC practice		
Yes	94 (31.4%)**	58 (61.7%)
No	347 (20.8%)	188 (54.8%)
University/teaching hospital practice		
Yes	48 (18.3%)	27 (57.5%)
No	388 (23.0%)	217 (56.5%)
Hospital-based practice (non-teaching)		
Yes	134 (22.0%)	82 (62.1%)
No	302 (22.5%)	162 (54.2%)
Payer mix		
Medicaid/Uninsured predominant	177 (26.4%)*	104 (58.8%)
Private/Medicare/Other predominant	232 (20.0%)	128 (55.7%)
Practice characteristics		
Urbanicity		
Urban	312 (20.9%)*	168 (54.4%)*
Suburban	42 (22.7%)	20 (47.6%)
Rural	91 (29.3%)	60 (67.4%)
Total	445 (22.4%)	248 (56.4%)

†Percent among total respondents
‡Percent among those respondents who had a cost conversation
*p<0.05
**p<0.001

In multivariable analyses, **we found that PCPs who were white, Hispanic/Latino, non-physician practitioners and with Medicaid or uninsured predominant payer mixes were more likely to have cost conversations with patients. We also found that PCPs who were younger and in rural practices were more likely to report a change in management due to cost conversations with patients.**

Table 21. Multivariable Association of PCP personal, professional and practice characteristics with Likelihood of Cost Conversations, and Likelihood of Change in Clinical Management due to Cost Conversations

	Adjusted Odds Ratio† (95% CI)	
	Odds of Cost Conversation	Odds of Change in Management due to Cost Conversation
Personal characteristics		
Male gender	0.82 (0.63-1.05)	0.91 (0.58-1.41)
Race		
White	[ref]	[ref]
Black/African American	0.52 (0.28-0.96)*	0.92 (0.29-2.93)
Asian/Pacific Islander	0.43 (0.27-0.70)*	1.37 (0.54-3.46)
Other/More than one	0.65 (0.36-1.17)	1.60 (0.52-4.94)
Ethnicity, Hispanic/Latino	2.11 (1.08-4.12)*	0.93 (0.31-2.77)
Professional characteristics		
Provider type, physician (ref=non-physician)	0.71 (0.51-0.99)*	0.96 (0.54-1.73)
Years in practice		
<10 years	[ref]	[ref]
10-20 years	0.81 (0.60-1.09)	0.52 (0.30-0.89)*
>20 years	1.04 (0.77-1.42)	0.47 (0.27-0.82)*
Practice Characteristics		
Payer Mix		
Medicaid/Uninsured predominant	1.31 (1.02-1.69)*	0.95 (0.60-1.51)
Private/Medicare/Other predominant	[ref]	[ref]

Table 21 (continued). Multivariable Association of PCP personal, professional and practice characteristics with Likelihood of Cost Conversations, and Likelihood of Change in Clinical Management due to Cost Conversations

	Adjusted Odds Ratio† (95% CI)	
	Odds of Cost Conversation	Odds of Change in Management due to Cost Conversation
Practice characteristics		
Urbanicity		
Urban	0.82 (0.60-1.11)	0.62 (0.35-1.11)
Suburban	0.70 (0.45-1.11)	0.41 (0.18-0.95)*
Rural	[ref]	[ref]

†Each column represents a different multivariable model
*p<0.05
**p<0.001

Suggestions for Improvement and Impact of the Healthy Michigan Plan

We provided PCPs open-ended opportunities in the survey to provide additional information, including asking them for suggestions to improve and impact of the Healthy Michigan Plan.

Suggestions from PCPs included the following:

- Ways to increase patient responsibility
- Need for increased patient education about health insurance, health behaviors, primary care, appropriate ER use, and medication adherence
- Improve accessibility to and availability of other practitioners (especially specialists including mental health and addiction providers)
- Increase reimbursement to encourage practitioners to participate
- Need for increased provider education and up-to-date information about what is/is not covered, program features, administrative processes, billing for HRA completion, and costs faced by patients
- Need for better coverage for some specific services (e.g., behavioral health, physical therapy)
- Formularies are too limited, lack transparency, and require too much paperwork to obtain authorization for necessary prescription drugs
- Suggested streamlining formularies between Medicaid plans, keeping an updated list of preferred medications and more transparency around medication rejections
- Reduce the complexity of paperwork
- HRA had mixed responses; some saw it as more paperwork or redundant with existing primary care practice, others saw it as worthwhile
- Patient churn on and off and between types of coverage is challenging, especially because patients are often unaware of the change

Impact of the Healthy Michigan Plan:

- Many respondents reported that Healthy Michigan Plan had a positive impact by allowing patients to get much needed care, improving financial stability, providing a sense of dignity, improving mental health, increasing accessibility to care and compliance (especially with medications), helping people to engage in healthy behaviors like quitting smoking, and saving lives
- Some reported a negative impact, saying that it has "opened a flood gate" and there are not enough practitioners, that too many new patients are seeking [pain] medications, and that it even influenced their decision to change careers or retire

IN-DEPTH INTERVIEWS WITH PRIMARY CARE PRACTITIONERS
RESULTS

The results section begins with a brief description and summary table of the characteristics of 19 primary care providers who care for Medicaid/HMP patients, and who participated in in-depth semi-structured telephone interviews between December 2014 and April 2015. The next section provides key findings from those interviews. The main topics appear in boxes, followed by key findings in bold font, a brief summary explanation in regular font, if indicated, and illustrative quotations, in italics.

Characteristics of Primary Care Practitioners Interviewed

Between December 2014 and April 2015, we conducted 19 semi-structured telephone interviews with sixteen physicians (84%) and three non-physician (16%) primary care practitioners. Of the sixteen physicians interviewed, fourteen specialized in family medicine (88%) and two in internal medicine (12%). Five of these providers practiced in the City of Detroit (26%); four practiced in Marquette, Baraga, or Iron County (21%); four practiced in Kent County (21%); three in Midland, Bay, or Saginaw County (16%); and three in Alcona, Alpena, or Oscoda County (16%). PCPs interviewed came from both urban and rural settings, had a range of years in practice, included private practices, hospital-based practices, Federally Qualified Health Centers, rural clinics and free/low-cost clinics.

Table 22. Personal, Professional and Practice Characteristics of PCP Interviewees (N=19)

Personal characteristics		
Gender	N	%
Male	12	63
Female	7	37
Professional characteristics		
Provider type		
Physician	16	84
Non-Physician (NP/PA)	3	16
Specialty		
Family medicine	14	74
Internal medicine	2	11
Nurse practitioner (NP)	1	5
Physician's Assistant (PA)	2	11
Years in practice		
<10 years	5	26
10-20 years	6	32
>20 years	8	42
Practice characteristics		
Presence of non-physician providers in practice		
Yes	16	84
No	3	16
Practice type		
Federally qualified health center (FQHC)	5	26
Large/hospital-based practice	3	16
Free/low-cost clinic	2	11
Practice type		
Small, private practice	7	37
Rural health clinic	2	11

Table 22 (continued). Personal, Professional and Practice Characteristics of PCP Interviewees

Practice characteristics	N	%
Urbanicity		
Urban	12	63
Rural	7	37

Interview results are presented in the following format:
Key Findings
Representative quote(s)

PCP Understanding of Healthy Michigan Plan and its Features

There was significant variation among the PCPs in their understanding of the Healthy Michigan Plan and its features, and therefore their ability to navigate or help patients obtain services.

> *I had a ton of exposure during the development and the implementation of Healthy Michigan because we were trying to get all of our thousands of enrollees [on the county health plan] onto Healthy Michigan. So that would be back when I first heard about it.*
>
> – Urban physician, FQHC

> *Really the only thing I know about the expansion is in early 2014 we started getting a way lot more requests for a new patient visit than we've ever had before. I was just like, "what is going on? We don't get 25 requests for new patients/month." So when it started really climbing, that's when I figured out, "Okay. It's probably due to the Obamacare Medicaid expansion."*
>
> – Urban physician; Small, private practice

> *I'm not aware of a change in how patients can get access to care with regards to transportation since Healthy Michigan has begun. Is there…I don't know…Is there some additional payment available for patients to get to doctors and dentists with Healthy Michigan?*
>
> – Rural physician; Large, hospital-based practice

Many PCPs perceived that the Healthy Michigan Plan cost-sharing requirements may create some misunderstandings among patients but were supportive of patients making financial contributions to their care.

> *The only significant difficulty that I foresee is with the copay issue. I have a concern that patients see this as free for the first six months, and now all of a sudden are confronted with a bill that they don't understand how they got.*
>
> – Urban physician, Free/low-cost clinic

> *We've got it posted in the front where people exit, and I looked at the amounts and thought, "Well, it's pretty fair actually." You know, it's not break the bank copays, but it gets people to think, "Well, yeah, you know, that's less than the cost of a pack of cigarettes."*
>
> – Rural physician, Rural health clinic

> *For the most part, the patients have it all filled out ahead of time … And then the nurse puts in their vitals, their last cholesterol and things like that on that sheet. We look that over and answer a couple of questions on the back.*
>
> – Rural physician, FQHC

The health risk assessments. So, part of my selling point is, "Okay, you're going to get half off on your copays. We've done it. You're set," you know, kind of thing. While that doesn't totally engage them in the process (LAUGHTER), you know, we continue to work on that.

– Urban physician, FQHC

Some of the plans, and I think these might be the Medicare/Medicaid plans, have offered patients like a gift card or something, and that has prompted a lot of patients to really make sure that we fill those forms out, but I don't recall patients really telling me, "Well, I have to pay a low copay because you fill out this form for me."

– Urban physician; Large, hospital-based practice

PCPs found the Healthy Michigan Plan's Health Risk Assessment useful for identifying health risks, disease detection, discussing risks with patients, and setting health goals.

…In the last month, I've signed up two people [for Weight Watchers]…two or three people to that, and one of them is really sticking to it. She's already lost 10 pounds. She really likes it. She's hoping that she can get an extension on it. The other two I haven't really heard back from yet. They just started it, but I personally think that's a great benefit because a lot of people need education on how to properly eat and what a good diet actually is instead of just Popeye's chicken.

– Urban physician; Small, private practice

There were some people that came in with the Healthy Michigan plan and their health risk assessment, although I don't remember anybody that said, "Hey, you have no issues." It was at least, "You need to stop smoking," or "work on your diet or exercise," and "get a flu shot," if not needing management for diabetes or asthma or other things like that.

– Rural physician, FQHC

PCP Decision Making on Acceptance of Medicaid/Healthy Michigan Plan Patients

PCPs described influences on the Medicaid acceptance decision at the provider level (illness burden and psychosocial needs of Medicaid patients), practice level (capacity to see both new and established patients), health system level (availability of specialists and administrative structures), and the policy environment level (reimbursement).

There are days when we'll look at each other and it's like, "I think we've got enough people like that." It's like the person who takes the energy of dealing with six ordinary people.

– Rural physician assistant, Rural health clinic

It has to do with what our capacity is. So looking at schedules, looking at next appointments, are we able to adequately care for the patients that we're currently responsible for.

– Urban physician, Free/low-cost clinic

In terms of referral and specialty care, it is still tricky. So while our ability to care for them has dramatically expanded, our ability to tap into our disjointed healthcare system in terms of specialty care, I think, maybe hasn't changed a whole lot. I think if I lived closer to [medical center] or closer to some other big training centers, that would probably be different. But like private specialists don't really care if they're uninsured or if they have Healthy Michigan.

– Urban physician, FQHC

I think the actual decision as to whether to accept Healthy Michigan patients … is made ... at a higher level... It's at the health system level... I wouldn't really be involved in making that decision, nor would most of my clinic leadership.

– Urban physician; Large, hospital-based practice

I've been hearing about [the Medicaid/Medicare primary care rate bump], but I don't feel like I've paid attention to details..

–Urban physician; Large, hospital-based practice

For our clinic, [reimbursement amount] plays no role in whether we accept more Medicaid patients … we're gonna serve that population and take care of them … We'll do whatever reasonably we can do to get paid for that, but that doesn't make or break the decision whether we're going to do that.

– Urban physician, Free/low-cost clinic

[A]s long as the rural health center plans still pay me adequately, I don't foresee making any changes. If they were to all of a sudden say, "Okay, we're only going to reimburse 40% or 50% of what we used to," that would be enough to put me out of business. So I would think twice about seeing those patients then, but as long as they continue the way they have been for the last six years that I've owned the clinic, I don't see making any changes. It works just fine.

– Rural nurse practitioner, Rural health clinic

Overall Impact of Healthy Michigan Plan on Beneficiaries

Many of the PCPs interviewed had favorable views of the Healthy Michigan Plan and its overall benefits for patients and health systems.

I think…I hate to tell you, but so far everything has been easier. I don't know that I've had anything that's worse. There might be something with drugs as far as ordering stuff, but across the board that's not just Healthy Michigan. I mean they want us to use generics. We're happy to do that. Once in a while, a generic is not going to do it, but I don't think I've had…I can't think of anything that is really negative about it. It's like…People just…I think they're just…They're thankful for it. People aren't overly demanding. They're not coming in acting like, "I deserve this. I want an MRI of my entire body. Nobody's like that, you know? They just…It's like, you know…It's really…It's kind of a nice working together partnership. It's like I usually tell people, "Let's get you caught up." It has become my motto for that. It's like, "We're gonna get you caught up."

– Rural physician assistant, Free/low-cost clinic

Yes. [E]very single day this law has changed my patients' lives…So I get to be in this special niche where I feel like I have a front row seat to the good things that happen as a result of Healthy Michigan….So for example, half the patients I would see pre-Healthy Michigan had essentially nothing in terms of health insurance, right?...I could almost do no labs. I could do very limited health maintenance. I certainly could do no referrals and had a really difficult time getting any type of imaging or substantive workup apart from a physical exam and some in-house kind of labs because people were petrified of the bills that would accumulate.

– Urban physician, FQHC

You know, the Healthy Michigan part has made a big difference…The idea of more people having insurance is good for everyone. Now we'll see long-term in terms of the cost and everything. I know that's a big challenge, but there's no doubt…Like the reimbursement of specifically the hospitals in the city, they're doing much better knowing that a lot of the patients that never had insurance before, do have insurance and that they can get some reimbursement instead of having to, you know, worry about some of the challenges of, you know, unnecessary care.

– Urban physician, FQHC

This program is helping people. It's helping working people, not the totally indigent people who are on disability who are already getting things. These are people…like a parent, a relative of yours that's been working and can't afford the insurance which is ridiculous.

– Urban physician; Small, private practice

Many of these people are working and so they're going to be able to continue working and paying taxes and contributing to society, where if you ignore your diabetes and you ignore your blood pressure, eventually you might end up losing limbs, losing your kidneys. Now you're on disability and, oh look, now you qualify for Medicaid.

– Urban physician; Small, private practice

PCPs noted that their patients were relieved of the stigma and worry associated with not being able to pay for needed care, and able to get needed services they could not previously afford.

They don't have that stigma any longer of not being insured and there's not that barrier between us about them worrying about the money, even though we really never made a big deal of it, but they could feel that. I don't know. I think they feel more worth.

– Rural physician; Small, private practice

Well, I learned a long time ago if the patient doesn't take the medicine, they don't get better. There are a lot of different reasons they don't take it, but the easy one is that if they don't have insurance to cover it and they don't ever pick it up, then they're not going to take it. So I mean I think it plays into every decision where we're ordering a test or recommending a treatment or medication or a referral because if they have financial barriers to getting that done, they're not going to get it done. So I'd say it has a humungous effect.

– Rural physician, FQHC

People are definitely more receptive to the idea of talking about healthcare maintenance items now as opposed to just wanting to deal with the acute issue. It may be because they feel less stressed about the ability to actually be able to get the test done because they understand that it's a…It's a benefit covered under the insurance.

– Urban physician, FQHC

The positive impact of the Healthy Michigan Plan has had a ripple effect in encouraging people to get covered and seek needed care.

Not only are they maybe talking to other people who are then applying and have applied and have gotten the insurance coverage…It just seems like more people are coming, both uninsured and insured because they maybe heard good things about the ease with which they've been able to get care or they've seen how maybe other peoples' circumstances have seemingly changed. I just feel like there's been kind of…a positive ripple effect of people just pursuing care, whether insured or not.

– Urban physician, FQHC

I know a lot of people that didn't have access to healthcare before are getting it now. The ones who were able to get Medicaid that weren't otherwise qualified for it before are starting to get help now, and we're able to find the conditions that they have never been able to get tested for before and treat them for it.

– Urban physician; Small, private practice

Healthy Michigan Plan is Meeting Many Unmet Health Needs

PCPs reported many examples of patients with unmet health care needs, whose health and well-being greatly improved after enrolling in Healthy Michigan Plan. This was particularly true for patients who were previously uninsured and for those with chronic illness (e.g., diabetes, asthma, hypertension) that were often diagnosed after enrolling in Healthy Michigan Plan.

Upon receiving health insurance and upon his daughter's recommendation, he [patient in his early 60s] pursued care and that was his first …according to him, his first physical evaluation of any sort in 40 years, and he has just…It wasn't a full health maintenance exam. It was a new patient evaluation, and in the time in that initial evaluation he was found to be hypertensive. Upon subsequent labs, you know, ordered on that visit, he was found to be diabetic and upon routine referral at that initial visit for an eye exam, given his hypertension, he was found to have had…hemianopia, which later was determined to be caused by a prior stroke.

– Urban physician, FQHC

A lot of neglected… A lot of chronic diseases that have been neglected. Because before, what would suddenly make that person decide to come in and see the doctor and pay out of pocket if they hadn't been doing that for three years? There's nothing to make them come in and take care of it. They wanted to, but they couldn't afford it. They weren't even seeing anybody. Now suddenly, there's this opportunity to get health insurance or to get Medicaid, and so now they are coming to the doctor because they know that they need to get their diabetes under control.

– Urban physician; Small, private practice

*She's only 33 and I had five diagnoses at the end….. it's even double that if you're 70. They waited all this time. They haven't had a doctor; you have to, at least, touch on everything the first time you see them… you have to know what's wrong with them***.**

-Urban physician; Small, private practice

So yesterday I had a patient… The guy's got totally uncontrolled diabetes….He's like 53. He hadn't been to a doctor, he thinks, since his twenties. The only reason he came in . . .because he got this new insurance. He had his little health risk assessment. He's like, "Alright. I'm going in."

-Urban physician, FQHC

PCPs reported an increased ability to provide preventive services and tests that had previously been an unmet need.

I know a lot of people that didn't have access to healthcare before are getting it now. The ones who were able to get Medicaid that weren't otherwise qualified for it before are starting to get help now, and we're able to find the conditions that they have never been able to get tested for before and treat them for it.

- Urban physician; Small, private practice

I think on one level, it's a sense of relief that they don't have to go to the ER for urgent things, that they can come to us first if it's something that we can handle, and then just having a chance to confirm that either they're healthy or that there are issues that they need to work on. I guess from my perspective is that we finally get the chance to do prevention because if someone doesn't have insurance and doesn't see a doctor, then there's no way we can do any kind of prevention. We're just kind of dealing with the end-stage results of whatever's been going on and hasn't been treated. So I mean what I've heard people say is "I just want to stay healthy or find out if I'm healthy," and to me that says a lot.

– Urban physician; Large, hospital-based practice

We're taking care of the comorbidities before they happen. In the long run, the program is going to pay for itself. We're identifying diabetics. Hypertension is rampant.

-Urban physician; Small, private practice

Coverage for dental services, prescription drugs, and mental health services were specifically noted as unmet needs being addressed by the Healthy Michigan Plan. Access to these services were described "as a lifesaver." PCPs reported increased ability to connect people to needed services, though challenges remain, especially in the area of mental health.

I refer a lot for mental health services and counseling, and a lot of these people just don't know about the services out there. So being able to connect people with the appropriate care that they need or could use in the future, I think, has been really valuable.

– Urban physician; Large, hospital-based practice

For thirteen years, getting dental has been like pulling teeth… It's been very difficult for our patient population. Dental is a huge issue. I would say well over half of our folks have significant dental problems that haven't been cared for in years.

– Urban physician; Free/low-cost clinic

[W]*hile it doesn't allow them to access say whatever specialist they want, by all means, they have access to things that I think are appropriate for them, i.e. this particular study, that particular lab, this particular workup…In addition to that, they also now have access to a pharmaceutical formulary which is, you know, light years better than what they had when they were looking at, "Okay, what's the $4 Wal-Mart offer me?"*

– Urban physician; FQHC

PCPs reported challenges finding local specialists for referrals. In some cases, this was because of a general shortage of specialists in the area, but often it was noted that there are too few practitioners willing to accept patients with Healthy Michigan Plan/Medicaid coverage. Some PCPs also reported that their patients had difficulty accessing counseling services for healthy behavior change.

For the most part. It can still take up to six months to see a psychiatrist unless you get admitted to the hospital. But then if you get admitted to the hospital, the private psychiatrist will see you….the ones that work for the hospital that don't take Medicaid or Medicare. And then at discharge, you really aren't going to see the other psychiatrist any quicker. It's kind of a mess. But I don't blame Medicaid expansion for that. It was a mess before then.

– Urban physician; Small, private practice

Dermatology is a huge issue…Yeah, in this county…In this county we have a huge problem because we have no place to send our Medicaid patients. And obviously they can't afford to do it out of pocket.

– Rural nurse practitioner; Rural health center

The specialty offices that don't accept Medicaid, don't accept Healthy Michigan plan Medicaid either…So, I mean, I don't think that's changed with the Healthy Michigan plan.

– Urban physician; Free/low-cost clinic

[I]n terms of referral and specialty care, it is still tricky. So while our ability to care for them has dramatically expanded, our ability to tap into our disjointed healthcare system in terms of specialty care, I think, maybe hasn't changed a whole lot. I think if I lived closer to [medical center] or closer to some other big training centers, that would probably be different. But like private specialists don't really care if they're uninsured or if they have Healthy Michigan.

– Urban physician; FQHC

We have no dermatologists in this county. So when I try to refer one of my HMP patients to a dermatologist [in another county], there are no offices that will take [healthplan] patients.

-Rural nurse practitioner; Rural health center

We have a Medicaid dental clinic here, but it's a long wait to get in. …up here no one accepts Medicaid … They kind of just pull people's teeth out and not do the usual restorative work.

-Rural physician; Small, private-practice

We do have. . . a smoking cessation program in our health system, but they don't take Medicaid patients. ... we do have a weight management program, but they don't take Medicaid.

-Urban physician; Large, hospital-based practice

PCPs noted that connecting patients to mental health services remains particularly challenging.

[W]e've got community mental health services available but they don't have enough money and they're too busy, and the patients suffer because of that. And Medicaid helps that to a modest degree, but there's still not enough providers and still not enough, I guess, reimbursement from Medicaid.

– Urban physician; Free/low-cost clinic

In our area, due to the limited resources, I think it is difficult that there's not enough psychiatrists and counselors around....and there doesn't seem to be any stability with respect to who is a practicing psychiatrist within the community, meaning individuals might have a psychiatrist for a couple of months, and then somebody else new comes on board. So I do think it's an area that is not being handled well.

– Rural physician; Small, private practice

PCPs noted that barriers to care, such as transportation, are reduced but remain.

You've solved the insurance problem, but then there are certain other parts of their life that makes it hard for them to deal with the healthcare system, and that is they may not follow up with appointments, they may not go to appointments, they may not be so good at communicating their history, they may not follow through with getting medications even if they have insurance. It's kind of like a whole host of behavioral parts to it. So, solving the insurance issue is a really important part, but then really many of these people almost like need a case manager to help make sure all the other little pieces come together because just leaving them on their own, they won't necessarily get the care.

– Urban physician; Small, private practice

Transportation has always been an issue with our patients. We've provided transportation for our uninsured patients, and we know that about one-third of our patients wouldn't have been able to get here or to their specialty appointments without that. Now fortunately [Healthy Michigan Plan health plan] does provide transportation. There's two barriers to their transportation. One is the amount of time patients have to call ahead to get it, which is understandable. But for our patients, sometimes difficult. And the fact that it tends to run late. In some circumstances, it's not a real predictable timeframe. So that's been a challenge. I know I've had one patient who's been so frustrated. We referred her to counseling. She made two counselling appointments, and transportation didn't pick her up for either.

– Urban physician; Free/low-cost clinic

That's a great question. That's a great question. Transportation is huge. That's a huge, huge issue that sort of is under the radar for most people. That's a huge issue for my patients. People just don't have cars, and they don't have family or friends with cars. If you don't have insurance, you are stuck. I just had a guy…I had two guys yesterday who I hadn't seen in, I don't know, maybe six months. Both of them. "I just can't get in to see you, doc." "I can't get in to see you." I said to them yesterday, "Well how did you get in to see me today?" "Oh, I just called my insurance." Fantastic!

– Rural physician; FQHC

ER Use

PCPs discussed a number of factors influencing high rates of ER use including culture or habit, sense of urgency for care and need for afterhours care. Some PCPs noted that some Healthy Michigan Plan beneficiaries use the ER because it's convenient. Even for those practices with extended hours, their office may not be open at convenient time for patients, and their schedules may not coincide with when health issues arise.

I mean those people who use the ER…sometimes it's just the culture. That's just how they've been …they…I don't want to say "conditioned," but maybe long-term circumstances or habit or what have you…They just tend to utilize the ER as a means of…almost like a secondary or a primary care clinic.

– Urban physician assistant, FQHC

You know, to some degree, it is convenience. You know, we have a few days where we're open to 6:00 or 7:00, but not every day, and we're not open on Saturdays or Sundays…People who work day shift… It's easier for them to go to the ER or something for a minor thing because they don't have to take time off work. That's a big deal.

– Rural physician; Small, private practice

Yeah, I know what you mean. The question is it somehow more convenient or timely or something to go to the ER or come to the office? And I think sometimes people have that perception, but they always wait for 3 hours in the ER. They're never in and out in 20 minutes, you know.

– Urban physician, FQHC

The families up here that I know have always done that do it because…Like the one lady, for example, might be sitting and watching television at 6:00, and she gets a little twinge in her abdomen. Because she has an anxiety condition, she talks herself into the fact that she's got colon cancer, and she goes to the ER in about a 20-minute time frame.

– Rural nurse practitioner, Rural health clinic

PCPs also discussed ways to reduce ER use such as educating patients on appropriate use, providing other sources of afterhours care (e.g., urgent care), and imposing a financial penalization or higher cost sharing for inappropriate ER use.

You know, I mean I think it still comes to education and availability…continuing to try to educate patients on, you know, why it is important to kind of…appropriately pursue care. So, you know, kind of having a conversation with patients about…why it's in their best interest to come to their primary care office, though it may take a little longer to do so than to go to the ER, and also making sure that we have available appointments so a patient doesn't feel, you know, as if they have no other alternative. So, you know, having office hours that…evening office hours…having a fair amount of those and getting appropriate…appropriately trained triage staff to be able to adequately address patients' acute care needs and questions when they call in.

– Urban Physician Assistant, FQHC

If you go to the ER and you're not admitted to the hospital, you're charged a significant amount…That tends to deter people, and I think that's the only way things are going to change and whether the ER's have a triage person that can determine this is an ER-appropriate problem and send people elsewhere, but I think it…There has to be some financial consequences …Even if it's a small amount. I know you're dealing with economically disadvantaged people, but even a small amount of money tends to sometimes affect behaviors.

– Rural physician; Small, private practice

I think certainly accessibility because I'm sure part of it has to do with accessibility. So possibly providing extended hours, weekend hours…Clearly the health system does have access, extended hours, weekend hours…They're not really well-located for MY patients in the sense that my patients live in downtown [city], are in the [city] area specifically, and they don't necessarily have access to some of these facilities which tend to be near [city], but not necessarily in [city]. So I think that maybe setting up that kind of an urgent care close to the hospital, right here. If it means co-locating it next to the ER so we can send the urgent care-type patients there; that would be certainly something that we can do.

– Urban physician; Large, hospital-based practice

PCPs noted that the hospitals play a role in rates of ER use.

The hospital is not incentivized to send those people away because they're paying customers. They want to support having a busy ER. There are some places that actively deter people from going to the emergency room where they'll do a medical screen and exam and say, "No. Your problem is not acute. You don't need to be seen in the emergency room today. Go back and make an appointment with your primary care doctor."

– Rural physician, FQHC

Actually I think it's 29 [minutes] right now, and then in mid and Northern Michigan, there are… billboards that tell you exactly what your wait time is right now in their ER. So it will say 8 minutes or 10 minutes or whatever their wait time is.

– Urban physician, Free/low-cost clinic

Impact of Healthy Michigan Plan on PCP Practice

PCPs reported utilizing a variety of practice innovations including co-locating mental health care, case management, community health workers, same-day appointments, extended hours and use of midlevel practitioners.

At our office, we have two behavioral health specialists. I think they're both MSWs. So they do counseling and group therapy and so our clinic is kind of special. We're able to route a lot of people to them.

– Rural physician, FQHC

I think our office has become much more accommodating with phone calls for same-day appointments. So we've done a better job at looking at schedules, at planning for this… for these kinds of patients that fall into the acute care category. So we're able to do that a lot more readily. We're a large clinic than we used to be. We've got more providers, and that certainly makes a difference also. So there's multiple reasons for it.

– Rural physician; Large, hospital-based practice

Yeah. We have a number of people working as caseworkers now. That's been a big change in the last year. I should probably mention that…We're part of MIPIC, and I guess with the start of My Pick, we got financial support for a number of caseworkers, and then we sort of steal their time for basically

any insurance that needs some management. We're having a lot of…We're getting a lot of help with case managers for people coming out of hospitals to coordinate care there.

– Rural physician, FQHC

So, one of the pieces that we are developing now is using our navigator to reach out to those patients. As we see new people assigned to us and we don't see an appointment on the schedule, reaching out to them, helping them get into care.

– Urban physician, Free/low-cost clinic

That [co-location] has been very helpful especially to our Medicaid patients …we can get those people in quickly and get treatment, which was otherwise very difficult. …now it's less of a barrier for them to get behavioral health services.

-Rural physician; Small, private practice

PCPs noted an increase in administrative burden as a result of the Healthy Michigan Plan because of increased paperwork and need for more communication. PCPs reported that pre-authorizations, multiple formularies, patient churn in and out of insurance and (sometimes) HRAs presented challenges for their practice.

Yes. Much more work for the staff. Not much more, but, of course, it's [HRA] more work for the staff because of the long requirements and things have to be dated the same day as this thing or that thing. Yeah, it's much more of a pain in the neck for them. And I understand that we get some $25…some malarkey for doing it, and the patient gets some discount on something.

– Urban physician, Free/low-cost clinic

But this insurance wouldn't let us order a stress test. They felt that we needed to do a separate stress ECG and then order a separate 2D echo. So that was one scenario where, you know, I actually had to do a physician-to-physician contact because I didn't think it made sense, but that was the only way they would cover it. So I had to order two separate tests where one could have probably given me the answer I was seeking.

– Urban physician; Large, hospital-based practice

For me, the bigger issue, I think, for us is that, you know, there are certain insurances that we do accept even in the Healthy Michigan plan, and some we do and some we don't. So what will end up happening is maybe they had an appointment to see me, and they come in and then, of course, we don't accept that one. So then they…I would say for the most part they're not too happy about that. Then they'll get sent to talk with one of the insurance people, and they'll find a way to fix it if it is fixable.

– Urban physician, FQHC

So we've also had an influx of or an increase in the number of medical prior authorizations that have created basically a headache for us because there's no standardization amongst the Medicaid plans…Yeah, and they're flip-flopping fairly regularly with respect to…This drug might be covered for a period of time, and then a short while later, they don't cover that drug. So we've got to go through the process for another medication. That requires more staff time. It doesn't necessarily benefit patient care.

– Rural physician; Small, private practice

PCPs noted their practices were considerably busier since implementation of the Healthy Michigan Plan.

So our plan is to continue accepting more…We're open to those three Medicaids right now… straight Medicaid, Meridian and Priority. So we see new patients every day with those, and that's…That's

what our game plan is at least for the time being. We're not…We're not overwhelmed enough with the patients that we can't do that.

– Urban physician, Free/low-cost clinic

Some PCPs hired new staff to increase their capacity to handle the increase in demand.

So we had to hire…create a position for somebody to basically find out who takes Medicaid and arrange for those referrals, as well as process those prior authorizations for various tests. So it did require us to hire somebody or create a position for somebody to handle that…So, nonetheless that's an increase cost to us.

– Rural physician; Small, private practice

We're going to be able to hire a full-time social worker…. if we didn't have Medicaid expansion, there's no way we'd have the dollars to do that.

- Urban physician, FQHC

For some PCPs, wait times also increased.

We accept all comers. Period. Doors are open. Come on in. But I have to add a comment to that or a clarification…a qualification to that…There are so many patients now that are in the system that even for routine follow-up stuff, we can't get them in." So what's happened is…The results of this great expansion and people now trying to come get primary care…She [site manager] *said to me this week, "We'll probably have to close your panel, although I don't think we're allowed to close your panel per FQHC guidelines."*

– Urban physician, FQHC

Some PCPs noted that the Healthy Michigan Plan has an impact on their relationships with patients.

So I do think by requiring one to come in…it [an initial appointment] helps to facilitate the beginning, hopefully in most cases, of a relationship between the provider and the patient. It helps assign…It helps align them together hopefully with some mutual goals in the interest of the patient. So, yes, I do think bringing them in and kind of making that a requirement is helpful. I think it's just helpful because it works to establish that relationship.

– Urban physician, FQHC

Part of my concern is it's going to decrease trust. From the standpoint that before our patients were getting free care, [so] they knew that our only incentive for caring for them was their best interest. That incentive hasn't changed. The revenue that we get from Healthy Michigan is great, but…it's not even enough to pay our staff. It's not going to change what the providers have in any way, but that may not be the perception our patients have. Especially as people talk about, you know, "Well, if your doctor says no to this, it's because they get more money if they don't refer." And before when we

didn't refer, patients understood it was either we couldn't get it or it wasn't in their best interest or whatever.

– Urban physician, Free/low-cost clinic

Some PCPs noted that reimbursement rates are an important consideration depending on the type/structure of their practice.

Well, we're a rural health clinic. So that means we're reimbursed for Medicaid patients. We get a flat amount for them irrespective of the complexity of the visit, and it's more favorable than if we were just taking straight Medicaid. So right now we can afford to see Medicaid patients as being part of

the rural health clinic initiative, but if we weren't and the reimbursement for primary care reverted back to the old way of doing things with Medicaid, we would probably have to change how we handle things with respect to taking new Medicaid patients and how many Medicaid patients we take. So I know the current Medicaid reimbursement scheme is par with Medicare in Michigan.

– Rural physician; Rural health clinic

You're talking about government reimbursing at the Medicare rates. That was 2013 and 2014 that did that…So far they haven't approved to do that in 2015 or 2016, and the rates that they pay for…the plans pay for Medicaid patients are substandard…you know, are markedly below any other insurances in this country. So they definitely are underpaying primary care providers. There's no two ways about that.

– Urban physician; Small, private practice

So, it hasn't affected our practice because as an FQHC we're reimbursed differently than . . . Medicaid reimburses a hospital practice or a private practice. Because we have to see all comers including all uninsured, and we can't cherry pick…I shouldn't say "cherry pick." We can't self-select what patients we see and won't see…We get "x" dollars for every Medicaid visits. We get "x" dollars for every whatever, with the assumption that we'll see everybody.

– Urban physician, FQHC

It's not affected our practice directly, but it seems that especially in a couple of the counties around us, that the number of private providers who are accepting Medicaid has actually, if anything, gone down, and so what we're finding are patients coming out of other practices, especially private practices with no cost base reimbursement, coming to us or asking to get in line to be with us.

– Rural physician, FQHC

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Report on the 2016 Healthy Michigan Voices Enrollee Survey

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University of Michigan
Institute for Healthcare Policy & Innovation

Report Authors: Susan Dorr Goold, Jeffrey Kullgren

Healthy Michigan Voices Evaluation Team: John Ayanian, Erin Beathard, Tammy Chang, Sarah Clark, Susan Dorr Goold, Adrianne Haggins, Edith Kieffer, Matthias Kirch, Jeffrey Kullgren, Sunghee Lee, Ann-Marie Rosland, Zachary Rowe, Erin Sears, Erica Solway, Lisa Szymecko, Renuka Tipirneni

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EXECUTIVE SUMMARY

The University of Michigan Institute for Healthcare Policy & Innovation (IHPI) is conducting the evaluation of the Healthy Michigan Plan (HMP) as required by the Centers for Medicare & Medicaid Services (CMS) through a contract with the Michigan Department of Health and Human Services (MDHHS). This report presents selected findings from the responses to the Healthy Michigan Voices (HMV) enrollee survey conducted January-October 2016.

Methods

Sampling for the Healthy Michigan Voices enrollee survey was performed monthly, beginning in January 2016. At time of sample selection, beneficiaries must have had:

- At least 12 months total HMP enrollment in fee for service (FFS) or managed care (MC)
- HMP enrollment (FFS or MC) in 10 of past 12 months
- Have HMP-MC enrollment in 9 of past 12 months
- HMP-MC in the month sampled
- Age between 19 years and 64 years 8 months
- Complete address, phone number, and federal poverty level (FPL) fields in the Data Warehouse
- Michigan address
- Preferred language of English, Arabic, or Spanish

Exclusion in one month of sampling did NOT prohibit inclusion in a subsequent month.

The sampling plan was based on four grouped prosperity regions in the state (Upper Peninsula/North West/North East; West/East Central/East; South Central/South West/South East; Detroit) and three FPL categories (0-35%; 36-99%; ≥100%). In total, 4,090 HMP enrollees participated in the HMV survey, and the weighted response rate for the 2016 Healthy Michigan Voices enrollee survey was 53.7%.

Many items on the survey were drawn from large national surveys. When established measures were not available, items specific to HMP (e.g., items about Health Risk Assessments, understanding of HMP) were developed based on findings from 67 semi-structured interviews with HMP beneficiaries conducted by the evaluation team. New items underwent cognitive testing and pre-testing for timing and flow before being included in the survey instrument. Responses were recorded in a computer-assisted telephone interviewing (CATI) system.

The evaluation team calculated descriptive statistics for responses to all questions with weights calculated and applied to adjust for the probability of selection, nonresponse bias, and other factors. Statistical analyses of bivariate and multivariate relationships were also performed.

Results

Insurance Coverage Prior to HMP

- 57.9% did not have insurance at any time in the year before enrolling in HMP.

Current Health Status/Change in Health with HMP

- 47.8% said their physical health had gotten better since enrolling in HMP.
- 38.2% said their mental and emotional health had gotten better since enrolling in HMP.
- 39.5% said their dental health had gotten better since enrolling in HMP.

Chronic Health Conditions

- 69.2% reported they had a chronic health condition, with 60.8% reporting at least one physical health condition and 32.1% reporting at least one mental health condition.
- 30.6% reported that they had a chronic health condition that was newly diagnosed since enrolling in HMP.
- 18.4% reported they had a functional limitation.

Health Risk Assessment (HRA)

- 49.3% self-reported completing an HRA. While higher than the completion rate in the MDHHS Data Warehouse, this may be due to enrollees completing the patient portion only, recall bias, or misidentifying completion of other forms as completing the HRA.
- 45.9% of those who said they completed an HRA did so because a primary care provider (PCP) suggested it; 33% did so because they received the form in the mail; 12.6% completed it over the phone at time of enrollment.
- Only 0.1% said they completed the HRA to save money on copays and contributions.
- Most of those who reported completing the HRA felt it was valuable for improving their health (83.7%) and was helpful for their PCP to understand their health needs (89.7%). 80.7% of those who said they completed an HRA chose to work on a health behavior.

Health Behaviors and Health Education

- 37.7% of beneficiaries reported smoking or using tobacco in the last 30 days, and 75.2% of these people said they wanted to quit. Of these, 90.7% were working on cutting back or quitting right now.

Regular Source of Care and Primary Care Utilization Prior to HMP

- 73.8% said that in the year before enrolling in HMP they had a place they usually went for health care. Of those, 16.8% said that place was an urgent care center and 16.2% reported the emergency room (ER), while 65.1% reported a doctor's office or clinic.
- 20.6% had not had a primary care visit in five or more years before enrolling in HMP.

Regular Source of Care and Primary Care Utilization with HMP

- 92.2% reported that in the year since enrolling in HMP they had a place they usually went for health care. Of those, 5.8% said that place was an urgent care center and 1.7% reported the emergency room, while 75.2% reported a doctor's office or clinic.
- 85.2% of those who reported having a PCP had a visit with their PCP in the last year. 83.9% of these said it was very easy or easy to get an appointment with their PCP.
- Beneficiaries who were older, white, female, reported worse health, and had any chronic condition were more likely than other beneficiaries to have seen a PCP in the past 12 months.
- Those who reported seeing a PCP in the preceding 12 months were more likely to report improved access to preventive care, completing an HRA, being counseled about health behaviors and being diagnosed with a chronic condition since enrollment.

Foregone Care Prior to and with HMP

- 33% of beneficiaries reported not getting care they needed in the year before enrollment in HMP; 77.5% attributed this to cost concerns. In the year preceding the survey (i.e., since enrolling in HMP), 15.6% reported foregone care; 25.4% attributed that to cost concerns.
- 83.3% agreed or strongly agreed that without HMP they would not be able to go to a doctor.

Changes in Access to Care

- Few beneficiaries (less than 5%) reported their ability to access primary care, specialty care, mental health care, substance use treatment, prescription medication, cancer screening, prevention of health problems and birth control/family planning had worsened since enrolling in HMP; 6.2% reported access to dental care worsened.

Emergency Room Use with HMP

- 28.0% of those who visited the ER in the past year said they called their usual provider's office first. 64% said they were more likely to contact their usual doctor's office before going to the ER than before they had HMP.
- Respondents who used the ER were more likely than those who did not use the ER to report their health as fair/poor (40.1% vs. 23.2%) and to report chronic physical or mental health conditions (79.4% vs. 62.8%).

Impact of HMP on Employment, Education and Ability to Work

- 48.9% reported they were employed/self-employed, 27.6% were out of work, 11.3% were unable to work, and 2.5% were retired.
- HMP enrollees were more likely to be employed if their health status was excellent, very good, or good vs. fair or poor (56.1% vs. 32.3%) or if they had no chronic conditions (59.8% vs. 44.1%).

- Compared to employed enrollees, enrollees who were out of work or unable to work were more likely to be older, male, lower income, veterans, in fair/poor health, and with chronic physical or mental health conditions or limitations.
- Employed respondents missed a mean of 7.2 work days in the past year due to illness. 68.4% said this was the same as before HMP, 17.2% said less and 12.3% said more.
- Among employed respondents, over two-thirds (69.4%) reported that getting HMP insurance helped them to do a better job at work.
- For the 27.6% of respondents who were out of work, 54.5% strongly agreed/agreed that HMP made them better able to look for a job.
- For the 12.8% of respondents who had changed jobs in the past 12 months, 36.9% strongly agreed/agreed that having HMP insurance helped them get a better job.

Knowledge and Understanding of HMP Coverage

- The majority of respondents knew that HMP covers routine dental visits (77.2%), eyeglasses (60.4%), and counseling for mental or emotional problems (56%). Only one-fifth (21.2%) knew that HMP covers name brand as well as generic medications.

Challenges Using HMP Coverage

- Few (15.5%) survey respondents reported that they had questions or problems using their HMP coverage. Among those who did, about half (47.7%) reported getting help or advice, and most (74.2%) of those said that they got an answer or solution.

Out-of-Pocket Healthcare Spending Prior to and with HMP

- 44.7% said they had problems paying medical bills in the year before HMP. Of those, 67.1% said they or their family was contacted by a collections agency.
- 85.9% said that since enrolling in HMP their problems paying medical bills got better.

Perspectives on Cost-Sharing

- 87.6% strongly agreed or agreed that the amount they pay overall for HMP seems fair.
- 88.8% strongly agreed or agreed that the amount they pay for HMP is affordable.

Knowledge and Understanding of HMP Cost-Sharing Requirements

- Only 26.4% were aware that contributions are charged monthly regardless of health care use. Just 14.4% of respondents were aware that they could not be disenrolled from HMP for not paying their bill. Only 28.1% were aware that they could get a reduction in the amount they have to pay if they complete an HRA. 75.6% of respondents were aware that some kinds of visits, tests, and medicines have no copays.

MI Health Account Statement

- 68.2% said they received a MI Health Account statement. 88.3% strongly agreed/agreed they carefully review each statement to see how much they owe. 88.4% strongly agreed/agreed the statements help them be more aware of the cost of health care.

Information Seeking Behaviors

- 71.6% reported being somewhat or very likely to find out how much they might have to pay for a health service before going to get the service.

Perceived Discrimination

- Most respondents did not report feeling judged or treated unfairly by medical staff in the past 12 months because of their race or ethnic background (96.4%) or because of how well they spoke English (97.4%); but 11.6% of respondents felt judged or treated unfairly by medical staff in the past 12 months because of their ability to pay for care or the type of health coverage they had.

Social Interactions

- 67.6% of respondents said that they get together socially with friends or relatives who live outside their home at least once a week; 79.8% said that they amount they engage in social interactions is about the same as before they enrolled in HMP.

Reproductive Health

- Among reproductive age female respondents, 38.4% did not know whether there was a change in their access to family planning services, while 35.5% reported better access and 24.8% reported about the same access. Those with inconsistent health insurance or uninsurance prior to HMP were significantly more likely to report improved access.

Impact on Those with Chronic Health Conditions

- Prior to HMP, 77.2% of those with a chronic physical or mental health condition had a regular source of care, 64.7% of whom said that source of care was a doctor's office or clinic. After HMP, 95.2% had a regular source of care, and 93.1% said it was a doctor's office or clinic.
- In the year prior to HMP enrollment, 58.3% of those with a chronic physical or mental health condition did not have insurance, only 42.1% had seen a PCP, and 51.7% had problems paying medical bills.
- Since HMP enrollment, 89.6% of those with a chronic physical or mental health condition reported seeing a PCP, 64.6% reported their ability to fill prescriptions improved, and 86.3% reported their ability to pay medical bills had improved.
- Respondents with a chronic physical or mental health condition reported overall improvements in their physical (51.9%) and mental health (42.4%) after enrolling in HMP; 7.5% and 6.1% reported their physical and mental health status had worsened.

Impact on Those with Chronic Mood Disorder and Substance Use Disorder

- Since enrollment in HMP, 48.9% of respondents with a self-reported mood disorder (MD) and 50.5% with a self-reported substance use disorder (SUD) reported that their mental health had gotten better.
- Most respondents with a MD reported that having HMP has led to a better life (91.9% strongly agreed/agreed) as did respondents with a SUD (95.8% strongly agreed/agreed).

- Prior to HMP, 37% of respondents who self-reported a SUD used the emergency room as a regular source of care; after at least one year of HMP the emergency room as a regular source of care dropped to 3.6%.

Conclusions

- More than half of respondents, including more than half of those with chronic conditions, did not have insurance at any time in the year before enrolling in HMP. Foregone care, usually due to cost, lessened considerably after enrollment. Most respondents said that without HMP they would not be able to go to the doctor. **HMP does not appear to have replaced employment-based insurance and has greatly improved access to care for underserved persons.**
- The percentage of enrollees who had a place they usually went for health care increased with HMP to over 90%, and naming the ER as a regular source of care declined significantly after enrolling in HMP (from 16.2% to 1.7%). **An emphasis on primary care and disease prevention shifts care-seeking away from acute care settings.**
- A significant majority said since enrolling in HMP their problems paying medical bills had gotten better. Most respondents agreed that **the amount they pay overall for HMP seems fair and is affordable, although monthly contributions affected perceptions of affordability**.
- There were some areas in which **beneficiary understanding of coverage** (e.g., dental, vision and family planning) **and cost-sharing requirements needs to improve**.
- About half of respondents reported completing an HRA, bearing in mind the limits to self-reported data. **Most respondents addressed health risks for reasons other than financial incentives.**
- HMP enrollees with mood disorder or substance use disorder reported improved health, improved access to services and treatment, and were less likely to name the emergency room or urgent care as a regular source of care. Those with substance use disorder still report using the emergency room more often than those with other chronic illnesses.
- Many HMP enrollees reported improved functioning, ability to work, and job seeking after obtaining health insurance through Medicaid expansion. **HMP may help its beneficiaries maintain or obtain employment.**
- Chronic health conditions were common among enrollees in Michigan's Medicaid expansion program, even though most enrollees were under 50 years old. Almost half of these conditions were newly diagnosed after enrolling in HMP. **Enrollees with chronic conditions reported improved access to care and medication, all crucial to successfully managing these conditions and avoiding future disabling complications.** Despite the relatively short term of their enrollment in HMP, almost half of respondents said their physical health had gotten better and nearly 40% said their emotional and mental health and dental health had gotten better since enrolling in HMP, **attesting to the health impact of Medicaid expansion**.

INTRODUCTION

The University of Michigan Institute for Healthcare Policy & Innovation (IHPI) is conducting the evaluation of the Healthy Michigan Plan (HMP) as required by the Centers for Medicare & Medicaid Services (CMS) through a contract with the Michigan Department of Health and Human Services (MDHHS). This report presents findings from responses of the Healthy Michigan Voices (HMV) enrollee survey. From January through October 2016, 4,090 beneficiaries completed the Heathy Michigan Voices survey of current HMP beneficiaries. This is an update to the interim report submitted to CMS in September 2016. Findings from the 2016 Healthy Michigan Voices survey of those who have disenrolled from the Healthy Michigan Plan will be available in late 2017.

METHODS

Sampling for the Healthy Michigan Voices survey was performed monthly, beginning in January 2016. At the time of sample selection, beneficiaries must have had:

- At least 12 months total HMP enrollment in fee for service (FFS) or managed care (MC)
- HMP enrollment (FFS or MC) in 10 of past 12 months
- Have HMP-MC enrollment in 9 of past 12 months
- HMP-MC in the month sampled
- Age between 19 years and 64 years 8 months
- Complete address, phone number, and federal poverty level (FPL) fields in the Data Warehouse
- Michigan address
- Preferred language of English, Arabic, or Spanish

Exclusion in one month of sampling did not prohibit inclusion in a subsequent month. Each month's sample was drawn to reflect the target sampling plan, proportional to the characteristics of Healthy Michigan Plan beneficiaries as a whole.

The sampling plan was based on four grouped prosperity regions in the state (Upper Peninsula/North West/North East; West/East Central/East; South Central/South West/South East; Detroit) and three FPL categories (0-35%; 36-99%; ≥100%)

Sampling Plan

	Prosperity Region				
	UP/NW/NE	W/EC/E	SC/SW/SE	DET	Total
Federal Poverty Level					
0-35%	7.0%	12.0%	8.0%	12.8%	39.9%
36-99%	6.0%	10.5%	7.0%	11.2%	34.8%
≥100%	4.9%	7.5%	5.0%	8.0%	25.5%

The 4,090 respondents included in this first report of selected findings closely mirror the sampling plan:

Characteristics of the 4,090 HMV Survey Respondents

	Prosperity Region				
	UP/NW/NE	W/EC/E	SC/SW/SE	DET	Total
Federal Poverty Level					
0-35%	288	503	323	486	1,600
	7.0%	12.3%	7.9%	11.9%	39.1%
36-99%	246	467	309	428	1,450
	6.0%	11.4%	7.6%	10.5%	35.5%
≥100%	212	295	205	328	1,040
	5.2%	7.2%	5.0%	8.0%	25.4%
Total N complete	746	1,265	837	1,242	4,090
Total % complete	18.2%	30.9%	20.5%	30.4%	100.00%

HMP beneficiaries selected for the HMV beneficiary survey sample were mailed an introductory packet that contained a letter explaining the project, a brochure about the project, and a postage-paid postcard that could be used to indicate preferred time/day for interview. A toll-free number was provided for beneficiaries who wished to call in at their convenience; otherwise, Healthy Michigan Voices interviewers placed phone calls to sampled beneficiaries between the hours of 9 am and 9 pm. Surveys were conducted in English, Arabic and Spanish; beneficiaries who could not speak one of those languages were excluded from participation.

Survey Design

The survey included measures of demographics, health, access, insurance status and acute care decision making. Many measures were established measures drawn from national surveys, including the National Health and Nutrition Exam Survey (NHANES)[1], the Health Tracking Household Survey (HTHS)[2], the National Health Interview Survey (NHIS)[3], the Behavioral Risk Factor Surveillance System (BRFSS, and MiBRFSS), the Short Form Health Survey (SF-12)[4], the Food Attitudes and Behaviors Survey, the Consumer Assessment of Healthcare Providers and Systems (CAHPS)[5], the Employee Benefit Research Institute Consumer Engagement in Healthcare Survey (CEHCS)[6], the Health Tracking Household Survey, the Commonwealth Fund Health Quality Survey, and the U.S. Census. New items and scales for which established measures were not available, or which were specific to HMP (e.g., items about Health Risk

[1] NHANES (National Health and Nutrition Exam Survey, CDC)
[2] HTHS (Health Tracking Household Survey)
[3] NHIS (National Health Interview Survey, CDC)
[4] SF-12 (Short Form Health Survey, RAND)
[5] CAHPS (Consumer Assessment of Healthcare Providers and Systems)
[6] Consumer Engagement in Health Care Survey (EBRI: CEHCS)

Assessments, understanding of HMP), were developed based on findings from 67 semi-structured interviews with HMP beneficiaries conducted by the evaluation team. New items underwent cognitive testing, and pre-testing for timing and flow before being included in the survey instrument.

Responses were recorded in a computer-assisted telephone interviewing (CATI) system programmed with the HMV survey.

Survey Response Characteristics

Overall, 9,350 Healthy Michigan Program enrollees were sampled throughout the data collection period. Seven cases with non-mailable addresses were excluded from the population; 100 cases were never mailed or called because data collection goals were achieved; 16 cases were never called because we did not have language-specific interviewers available. Thus, 123 of the original 9,350 were never contacted by phone.

Pre-notification letters were sent to the remaining 9,227 cases, which included a postcard to identify best time/number to call or refusal to participate. Phone calls were made to enrollees who did not refuse by postcard. Some numbers did not work, hence, no contact was established; some numbers worked but no contact was ever established, not allowing us to ascertain eligibility; and other numbers worked and contact was established.
We summarize the results briefly as follows:

Table 1. Call Results to Sampled Individuals

Description	n	Call Result
Total sample	9,350	
Nonmailable (e.g., bad address)	7	n/a
Not included – response goals achieved	100	n/a
Not called	16	n/a
Total sample contact attempted	9,227	
Contact never established		
1) Phone number not working	885	Nonworking number
2) Working but no contact made (e.g., left voicemail but never spoke with a person)	1,360	Unknown eligibility (UN)
Contact established		
3) Enrollee verified not at that number	583	Ineligible
4) Out of state	30	Ineligible
5) Deceased	3	Ineligible
6) Non-HMV language	36	Ineligible
7) Jail/Treatment facility	2	Ineligible
8) Refusal (by mail/phone)	945	Refusal (R)

9) Noncontact with enrollee (Spoke with a person other than enrollee) Other nonresponse (Spoke with an enrollee but did not participate for reasons other than clear refusal)	1,247	Noncontact (NC), Other (O)
10) Full completion	4,090	Interview (I)[7]
11) Partial completion	46*	Partial Interview (P)

*Eighteen cases were originally considered full completion but later recoded to partial completion after the weights were calculated because they had more than 20% of items missing.

There are many ways to calculate response rates as outlined by the American Association for Public Opinion Research (AAPOR, 2016[8]). Response rate formula 3 defined below is one of the common formulas used, particularly for telephone surveys.

$$RR3 = \frac{I}{(I+P)+(R+NC+O)+e\times UN}$$

where e is an estimate eligibility rate for the cases for which we cannot ascertain eligibility and the rest are noted in the table above. One way to estimate e is to use our call results among those we established contacts. As shown above, categories 3) through 7) are deemed ineligible, making 8) through 11) eligible among all contacted. Hence,

$$e = \frac{945+1237+4090+46}{9350-7-100-16-885-1360} = 90.6(\%)$$

By applying e as estimated above, we obtain the following response rate:

$$RR3 = \frac{4090}{(4090+46)+(945+1247)+.906\times 1360} = 54.1(\%)$$

The weighted response rate was calculated to ascertain the response rate that is not subject to the sample design. We used the selection weight (w_1 in the weighting steps document) to the RR3 formula and used weights applicable for known eligibility cases (w_3 in the weighting steps document) to e, the estimated eligibility rate. The results are as follows:

$$weighted\ e = 89.9(\%)$$

$$Weighted\ RR3 = 53.7(\%)$$

Thus, the weighted response rate for the 2016 Healthy Michigan Voices enrollee survey was 53.7%.

[7] NOTE: There was one case that responded to HMV but whose data were over-written due to system issues. This case was considered as a respondent in the response rate calculation but there were no survey data for this case.
[8] The American Association for Public Opinion Research. 2016. Standard Definitions: Final Dispositions of Case Codes and Outcome Rates for Surveys. 9th edition. AAPOR. Access from http://www.aapor.org/AAPOR_Main/media/publications/Standard-Definitions20169theditionfinal.pdf

Analyses

We calculated descriptive statistics for responses to all questions in the survey and these are highlighted in the tables within the body of this report. Weights were calculated and applied to data to adjust for the probability of selection (see Selection Weight, below), nonresponse bias (see Nonresponse Adjustment) and other adjustments (Nonworking Number adjustment, Unknown Eligibility adjustment, Known Eligibility adjustment). **As a result, please note that the proportions included in this report reflect how the results we observed would apply to the eligible population of HMP enrollees** (based on inclusion and exclusion criteria described on page 9). The number of individuals who responded to each survey question is noted in the tables in the report. When N is less than 4,090, this indicates that either some respondents missed that question or the question was part of a skip pattern and was therefore only asked of a subset of respondents according to their previous responses.

For analyses of bivariate and multivariate relationships, the types of analysis, models, variables included and how defined are described in text within this report and are included in the tables in the Appendix of this report. The specific tests are described in the table legends.

In a small number of cases (46), beneficiaries asked to end the survey early or did not follow the intended skip patterns, and their responses were excluded from this analysis. In cases where respondents skipped or refused to answer specific questions, those observations are not included in the analysis for those questions.

Selection Weight

The Healthy Michigan Voices survey sample was drawn each month from January through October 2016 from the HMP enrolled population using stratification which combines FPL and prosperity region. The same stratification sample design determined at the outset of the project was used every month. In each month, the eligible population was defined as HMP enrollees in the Data Warehouse who met the eligibility criteria listed on page 9.
Starting in the second month of sampling, beneficiaries sampled in the previous month(s) were excluded from the population.

Reflecting the sample design, the first step used an inverse of sampling probability and calculated selection weights for sample unit *i* in sampling month *m* in sampling stratum *h* as follows:

$$w_{1,hmi} = \frac{N_{hm}}{n_{hm}}$$

where N_{mh} is the population size and n_{mh} is the sample size.

We made adjustment for nonworking numbers, ineligible cases, unknown eligibility cases and nonresponse (noncontacts and refusal combined) separately as follows.

Nonworking Number Adjustment

Nonworking numbers were considered out of our target population. These numbers were considered out of scope and removed from the sample. We used the following adjustment, $f_{2,hmi}$, factor for this.

$$f_{2,hmi} = \begin{cases} 0, & if\ i\ was\ not\ a\ working\ number \\ \dfrac{\sum_i w_{1,hmi}}{\sum_i I\_WR_i \times w_{1,hmi}}, & if\ i\ was\ a\ working\ number \end{cases}$$

where I_WR_i was a 1/0 indicator for working number status (1: working number, 0: nonworking number). Essentially, $f_{2,hmi}$ removed the nonworking numbers from the scope and weighted up working numbers proportionally within each sampling stratum and month. The resulting weight was:

$$w_{2,hmi} = f_{2,hmi} \times w_{1,hmi}$$

Unknown Eligibility Adjustment

Besides the nonworking numbers, there were working numbers that were never contacted. With these cases, HMV eligibility could not be ascertained. Moreover, the eligibility rate may have differed systematically across strata and some other observed characteristics in the HMP enrollee data. Thus, a new adjustment factor was applied to the weight from the previous stage:

$$f_{3,hmi} = \begin{cases} 0, & if\ eligibility\ is\ unknown\ for\ i \\ \dfrac{\sum_i w_{2,hmi}}{\sum_i I\_UE_i \times w_{2,hmi}}, & if\ eligibility\ is\ known\ for\ i \end{cases}$$

where I_UE_i was a 1/0 indicator for unknown eligibility status (1: known eligibility; 0: unknown eligibility. The resulting weight was:

$$w_{3,hmi} = f_{3,hmi} \times w_{2,hmi}$$

Known Eligibility Adjustment

Among those who were contacted, some may not have been eligible for HMV for various reasons related to the eligibility criteria in Section 1. These cases fell outside of the target population and, hence, were removed through the following:

$$f_{4,hmi} = \begin{cases} 0, & if\ i\ is\ ineligible \\ \dfrac{\sum_i w_{3,hmi}}{\sum_i I\_EL_i \times w_{3,hmi}}, & if\ i\ is\ eligible \end{cases}$$

where I_EL_i was a 1/0 indicator for eligibility status (1: eligible; 0: ineligible). The resulting weight was:

$$w_{4,hmi} = f_{4,hmi} \times w_{3,hmi}$$

Nonresponse Adjustment

Those who are contacted and eligible were retained after the previous step. This did not necessarily mean a direct contact had been made with the enrollee. With some numbers, contact with the sample enrollee was never established. With the remainder, when an interview was solicited, some may have refused or declined participation for various reasons. These were all considered as nonresponse. Overall, there were 6,327 eligible cases; among them, 4,090 were respondents (64.6%).[9]

From the HMV sample frame data, we considered the following characteristics for nonresponse analysis as they were available for both respondents and nonrespondents:

- Sex
- Age (19-34; 35-49; 50-64 years old)
- Race/ethnicity (Hispanic; Non-Hispanic White; Non-Hispanic Black; Non-Hispanic other)
- First HMP month (2 years or more ago; less than 2 years ago)

Additionally, we had the following sampling information available for both respondents and nonrespondents:

- Stratum (FPL x Region)
- FPL
- Region
- Sampling month

Table 2 includes the number of eligible cases by characteristics listed above and the proportion of respondents among eligible cases. Younger and male enrollees were less likely to respond than their counterparts. Based on race/ethnicity, non-Hispanic Black enrollees were most likely to respond, and those in the non-Hispanic other group were least likely to do so. While the proportion of respondents was similar across income levels, among the four regions, Detroit had the lowest proportion. Among 12 strata, UP/NW/NE with 100%+ FPL at 69.5% and W/EC/E with 36-99% FPL at 69.2% had the highest proportion of respondents. Detroit with 36-99% FPL had the lowest proportion at 58.9%. No clear pattern was observed by sampling month. Nonresponse did not occur identically across characteristics as seen in Table 2, which required an adjustment. Following Lee and Valliant (2008)[10], a logistic regression model was used to predict response while controlling for differences in characteristics between respondents and nonrespondents. The predictors included age, sex, race/ethnicity, first month on HMP, sampling strata, sampling month and the interaction between sampling strata and sampling month. The adjustment factor, $f_{5,i}$, was the inverse of response propensity predicted from the logistic regression. The resulting weight was:

$$w_{5,imh} = w_{4,mhi} \times f_{5,i}$$

[9] There was one case that responded to HMV but whose data were over-written due to system issues. This case was considered as a respondent in the response rate calculation but dropped in the weighting as there were no survey data for this case.

[10] Lee S, Valliant R. 2008. Weighting telephone samples using propensity scores. Advances in Telephone Survey Methodology. 170-183.

Table 2. Proportion of Respondents Among Eligible Cases by Sample Characteristics (for Non-Response Adjustments for Weighting Purpose)

Characteristics	Eligible (n)	Respondents (%)	Characteristics	Eligible (n)	Respondents (%)
Total	6,327	64.9	**Sampling Stratum**		
Age			1. UP/NW/NE, 0-35%	443	65.2
19-35 years old	2,304	60.2	2. UP/NW/NE, 36-99%	385	63.9
36-49 years old	1,755	64.4	3. UP/NW/NE, 100%+	305	69.5
50-64 years old	2,268	70.1	4. W/EC/E, 0-35%	742	68.1
Sex			5. W/EC/E, 36-99%	676	69.2
Female	3,562	67.8	6. W/EC/E, 100%+	464	63.8
Male	2,765	61.2	7. SC/SW/SE, 0-35%	481	67.6
Race/Ethnicity			8. SC/SW/SE, 36-99%	468	66.2
Hispanic	174	64.4	9. SC/SW/SE, 100%+	315	65.1
Non-Hispanic White	4,396	64.4	10. DET, 0-35%	799	61.3
Non-Hispanic Black	1,121	68.8	11. DET, 36-99%	733	58.9
Non-Hispanic Other	636	61.6	12. DET, 100%+	516	63.8
First month on HMP			**Sampling Month**		
Less than 2 yrs ago	3,518	62.6	1	422	61.8
2 yrs or more ago	2,809	67.8	2	576	64.9
FPL			3	698	66.5
0-35%	2,465	65.3	4	735	65.4
36-99%	2,262	64.4	5	701	66.9
100%+	1,600	65.1	6	680	67.8
Region			7	866	68.8
UP/NW/NE	1,133	65.9	8	658	63.2
W/EC/E	1,882	67.4	9	654	57.6
SC/SW/SE	1,264	66.5	10	337	61.7
DET	2,048	61.1			

Post-stratification

The target population of the HMV survey is HMP enrollees ever eligible for HMV (as defined in Section 1) between January and October 2016. There were 384,262 such persons. From the sample frame data we had information about the characteristics of this population. Table 3 compares the population and the sample weighted by nonresponse adjustment weight ($w_{5,imh}$) with respect to age, sex, race/ethnicity, first month enrolled in HMP, sampling stratum, FPL and region. Our weighted sample matched the population reasonably well across most characteristics, except for age, sex and first month on HMP. Compared to the population, our sample overrepresented beneficiaries who were older, females or who enrolled in HMP during the first 3 months of HMP. Hence, this known discrepancy was handled through post-stratification. All the characteristics in Table 3 were controlled for in the post-stratification

using an iterative proportional fitting method (Deville et al., 1993)[11]. This process forced the sample to match the population with respect to the controlled characteristics.
Post-stratification may force the weights to be extreme. These extreme weights increase the variability of estimates and, in turn, lower statistical power. In order to minimize the effect of extreme weights, these weights are trimmed. To address this issue we used the Individual and Global Cap Value (IGCV) method introduced by Izrael et al. (2009)[12]. This method sets thresholds for minimum and maximum adjustment factors in relation to the individual weights and to all weights globally. Specifically, our procedure set the global high cap at 7, the global low cap at 0.12, the individual high cap at 5 and the individual low cap at 0.2. The trimmed weights were normalized to the population total of 384,262. The resulting weight is $w_{6,imh}$. Table 3 includes the sample characteristics weighted by $w_{6,imh}$. When using the post-stratified weight, the sample matched perfectly. However, compared to when using the nonresponse adjustment weight, there was a slight increase in standard error due to variability in weights introduced by post-stratification.

[11] Deville JC, Särndal CE, Sautory O. 1993. Generalized raking procedures in survey sampling. *Journal of the American Statistical Association*. 88(423):1013-20.

[12] Izrael D, Battaglia MP, Frankel MR. 2009. Extreme survey weight adjustment as a component of sample balancing (aka raking). In Proceedings from the Thirty-Fourth Annual SAS Users Group International Conference.

Table 3. Comparison of Eligible HMP Population and HMV Sample

Characteristics	Population		Sample				
				Weighted by w_5		Weighted by w_6	
	N	%	n	%	SE	%	SE
Total	384,262		4,090				
Age							
19-35 years old	163,071	42.4	1,380	36.9	0.9	42.3	1.0
36-49 years old	113,660	29.6	1,125	28.1	0.8	29.6	0.9
50-64 years old	107,531	28.0	1,585	34.9	0.9	28.1	0.8
Sex							
Female	197,883	51.5	2,409	54.1	0.9	51.6	1.0
Male	186,379	48.5	1,681	45.9	0.9	48.4	1.0
Race/Ethnicity							
Non-Hispanic White	232,688	60.6	2,784	63.1	0.9	60.4	1.0
Non-Hispanic Black	91,208	23.7	807	23.2	0.8	25.8	0.9
Other	60,366	15.7	499	13.7	0.7	13.8	0.7
First month on HMP							
4-6, 2014	158,983	41.4	2,146	49.7	0.9	41.5	0.9
7-12, 2014	89,945	23.4	1,111	27.6	0.8	23.4	0.8
2015	135,334	35.2	833	22.7	0.8	35.2	1.1
Strata							
1. UP/NW/NE, 0-35%	13,282	3.5	288	3.6	0.2	3.5	0.1
2. UP/NW/NE, 36-99%	11,835	3.1	246	3.3	0.2	3.1	0.1
3. UP/NW/NE, 100%+	9,291	2.4	212	2.6	0.2	2.4	0.0
4. W/EC/E, 0-35%	52,224	13.6	503	13.4	0.6	13.6	0.3
5. W/EC/E, 36-99%	33,157	8.6	467	8.8	0.4	8.6	0.2
6. W/EC/E, 100%+	24,248	6.3	295	6.5	0.4	6.3	0.2
7. SC/SW/SE, 0-35%	34,675	9.0	323	8.7	0.5	9.0	0.3
8. SC/SW/SE, 36-99%	20,909	5.4	309	5.5	0.3	5.5	0.2

9. SC/SW/SE, 100%+	15,569	4.1	205	4.0	0.3	4.1	0.2
10. DET, 0-35%	99,024	25.8	486	25.0	1.0	25.7	0.5
11. DET, 36-99%	43,569	11.3	428	11.7	0.6	11.2	0.4
12. DET, 100%+	26,479	6.9	328	6.9	0.4	6.9	0.2
FPL							
0-35%	199,205	51.8	1,600	50.7	0.9	51.8	0.5
36-99%	109,470	28.5	1,450	29.3	0.8	28.4	0.4
100%+	75,587	19.7	1,040	20.0	0.6	19.8	0.3
Region							
UP/NW/NE	34,408	9.0	746	9.4	0.4	9.0	0.2
W/EC/E	109,629	28.5	1,265	28.8	0.8	28.6	0.4
SC/SW/SE	71,153	18.5	837	18.2	0.6	18.6	0.4
DET	169,072	44.0	1,242	43.6	1.0	43.8	0.5

RESULTS

Demographic Characteristics of Respondents

After weighting, demographic characteristics of respondents closely match characteristics of the eligible HMP population as a whole (see Table 3, above).

Table 4. Demographic Characteristics

	%	95% CI
Gender (n=4,090)		
F (n=2,409)	51.6	[49.6,53.5]
M (n=1,681)	48.4	[46.5,50.4]
Age (n=4,090)		
19-34 (n=1,303)	40.0	[38.0,42.0]
35-50 (n=1,301)	34.0	[32.1,35.9]
51-64 (n=1,486)	26.0	[24.5,27.6]
Race (n=4,039)		
White (n=2,784)	61.2	[59.3,63.0]
Black or African American (n=807)	26.1	[24.3,27.9]
Other (n=306)	8.8	[7.7,10.0]
More than one (n=142)	4.0	[3.3,4.9]

Hispanic/Latino (n=4,056)		
Yes (n=188)	5.2	[4.4,6.2]
No (n=3,856)	94.3	[93.3,95.2]
Don't know (n=12)	0.5	[0.2,0.9]
Arab, Chaldean, Middle Eastern (n=4,055)		
Yes (n=204)	6.2	[5.3,7.2]
No (n=3,842)	93.6	[92.5,94.5]
Don't know (n=9)	0.3	[0.1,0.6]
Region (n=4,090)		
Upper Peninsula/Northwest/Northeast (n=746)	9.0	[8.6,9.4]
West/East Central/East (n=1,265)	28.6	[27.8,29.4]
South Central/Southwest/Southeast (n=837)	18.6	[17.8,19.3]
Detroit Metro (n=1,242)	43.8	[42.8,44.9]
FPL (n=4,090)		
0-35% (n=1,600)	51.8	[50.8,52.8]
36-99% (n=1,450)	28.4	[27.6,29.3]
≥100% (n=1,040)	19.8	[19.1,20.4]
Medicaid Health Plan (n=4,088)		
Aetna (n=58)	1.7	[1.2,2.3]
Blue Cross (n=356)	11.6	[10.2,13.1]
Harbor (n=18)	0.7	[0.4,1.3]
McLaren (n=633)	13.0	[11.9,14.2]
Meridian (n=1,265)	29.8	[28.1,31.6]
Midwest (n=3)	0.1	[0.0,0.2]
Molina (n=701)	18.0	[16.5,19.5]
Priority (n=268)	5.9	[5.2,6.7]
Total Health Care (n=85)	2.8	[2.2,3.7]
United (n=443)	13.2	[11.8,14.7]
Upper Peninsula Health Plan (n=258)	3.2	[2.8,3.6]
Employment Status (n=4,075)		
Employed or self-employed (n=2,079)	48.8	[47.0,50.7]
Out of work ≥1 year (n=707)	19.7	[18.1,21.3]
Out of work <1 year (n=258)	7.9	[6.8,9.1]
Homemaker (n=217)	4.5	[3.8,5.3]
Student (n=161)	5.2	[4.3,6.2]
Retired (n=167)	2.5	[2.1,3.0]
Unable to work (n=479)	11.3	[10.1,12.5]
Don't know (n=7)	0.2	[0.1,0.4]
Veteran (n=4,086)		
Yes (n=125)	3.4	[2.7,4.2]
No (n=3,958)	96.5	[95.7,97.2]
Don't know (n=3)	0.1	[0.0,0.5]

Marital Status (n=4,073)		
Married (n=1,008)	20.4	[19.0,21.8]
Partnered (n=185)	4.3	[3.6,5.1]
Divorced (n=865)	18.2	[16.8,19.6]
Widowed (n=147)	2.8	[2.3,3.4]
Separated (n=119)	2.8	[2.3,3.4]
Never Married (n=1,745)	51.6	[49.6,53.5]
Don't know (n=4)	0.1	[0.0,0.2]
Any chronic health condition present (n=4,090)		
Yes (n=2,986)	69.2	[67.3,71.0]
No (n=1,104)	30.8	[29.0,32.7]
At least one physical health condition present (n=4,090)		
Yes (n=2,689)	60.8	[58.8,62.8]
No (n=1,401)	39.2	[37.2,41.2]
At least one mental health condition present (n=4,090)		
Yes (n=1,351)	32.1	[30.3,33.9]
No (n=2,739)	67.9	[66.1,69.7]
Other household enrollee (n=4,082)		
Yes (n=1,592)	35.7	[34.0,37.5]
No (n=2,289)	58.0	[56.1,59.8]
Don't know (n=201)	6.3	[5.3,7.6]

Insurance Coverage Prior to HMP

More than half (57.9%) of survey respondents did not have health insurance at any time in the 12 months prior to HMP enrollment. Of those who reported having health insurance at some point during the 12 months prior to HMP enrollment, the majority (73.8%) had health insurance for all 12 months. Thus, less than one-third (30.2%) of all respondents reported that they had insurance for all 12 months prior to enrolling in HMP. Approximately half (50.8%) of survey respondents who reported having health insurance at any time in the 12 months prior to HMP enrollment had Medicaid, MiChild, or health coverage through another state health program, while a quarter (26.2%) had private insurance through a job or union. Among those who reported private insurance they purchased themselves or someone else purchased (10.2%), approximately one-third (31.5%) purchased the insurance on the healthcare.gov website, and 61.8% of those respondents who purchased health insurance on the healthcare.gov website reported receiving a subsidy.

	%	95% CI
At any time during the 12 months BEFORE you enrolled in the Healthy Michigan Plan, did you have any type of health insurance? (n=4,087)		
Yes (n=1,667)	40.7	[38.8,42.6]
No (n=2,374)	57.9	[55.9,59.8]
Don't know (n=46)	1.4	[1.0,2.1]

[If Yes] Did you have health insurance for all 12 months, 6-11 months, less than 6 months, or not at all? (n=1,667)		
All 12 months (n=1,235)	73.8	[71.1,76.5]
6-11 months (n=245)	15.2	[13.0,17.6]
Less than 6 months (n=129)	7.6	[6.2,9.3]
Don't know (n=58)	3.4	[2.5,4.7]
What type of health insurance did you have?* (n=1,622)		
Medicaid, MiChild, or other state program (n=834)	50.8	[47.7,53.9]
Private insurance provided through a job or union (n=409)	26.2	[23.6,29.0]
Private insurance purchased by you or someone else (n=157)	10.2	[8.3,12.6]
County health plan (n=127)	6.3	[5.2,7.7]
Veterans Health or VA care (n=21)	1.4	[0.8,2.3]
CHAMPUS, TRICARE, other military coverage (n=3)	0.3	[0.1,1.2]
Medicare (n=5)	0.3	[0.1,0.7]
Indian Health Service (n=3)	0.1	[0.0,0.3]
Other (n=83)	5.6	[4.3,7.3]
Don't know (n=23)	1.2	[0.8,1.9]
[If private insurance purchased by you or someone else] Was this insurance purchased on the HealthCare.gov exchange? (n=152)		
Yes (n=59)	31.5	[22.6,41.9]
No (n=75)	55.4	[44.1,66.2]
Don't know (n=18)	13.1	[7.6,21.7]
[If Yes] Did you receive a subsidy? (n=59)		
Yes (n=37)	61.8	[43.9,76.9]
No (n=18)	29.0	[18.1,43.1]
Don't know (n=4)	9.3	[2.2,31.3]

**Respondents were able to provide more than one response for this question; As a result, percentages may exceed 100%.*

Impact of Prior Year Insurance Status on Improvements in Foregone Care, Access and Health

Respondents who were uninsured all 12 months in the year prior to enrolling in HMP were more likely than those who were insured all 12 months, and those who were insured part of the year, to report foregoing care during that year, and more likely to report foregoing care due to cost concerns (See Appendix Table 1).

Those who were insured all 12 months prior to enrolling in HMP were less likely to report improvements in access to care or improvements in physical, mental or oral health (See Appendix Table 1).

Those who were insured all 12 months prior to HMP agreed less that HMP had reduced stress and they worried less about something bad happening to their health (See Appendix Table 1).

Current Health Status/Change in Health with HMP

More than one-third of respondents rated their health as either excellent or very good (36.3%). Since enrolling in the Healthy Michigan Plan, most respondents reported their physical health had improved (47.8%) or stayed the same (46.1%), their mental health had improved (38.2%) or stayed the same (56.8%) and their dental health had improved (39.5%) or stayed the same (45.5%). About one-third (31.7%) of survey respondents reported losing weight in the past year.

	Mean or %	95% CI
In general, would you say your health is... (n=4,088)		
Excellent (n=337)	9.5	[8.4,10.8]
Very good (n=1,041)	26.8	[25.0,28.7]
Good (n=1,448)	33.8	[32.0,35.7]
Fair (n=931)	22.2	[20.7,23.8]
Poor (n=324)	7.5	[6.6,8.6]
Don't know (n=7)	0.1	[0.0,0.4]
For how many days in the past 30 days was your physical health not good? (n=4,033)		
<14 of past 30 days (n=3,055)	77.2	[75.5,78.7]
≥14 of past 30 days (n=978)	22.8	[21.3,24.5]
For how many days in the past 30 days was your physical health not good? (n=4,033)	Mean 6.8	[6.4,7.2]
Overall, since you enrolled in the Healthy Michigan Plan, would you say your physical health has gotten better, stayed the same, OR gotten worse? (n=4,086)		
Gotten better (n=1,961)	47.8	[45.8,49.8]
Stayed the same (n=1,851)	46.1	[44.2,48.1]
Gotten worse (n=256)	5.5	[4.8,6.4]
Don't know (n=18)	0.5	[0.3,1.0]
For how many days in the past 30 days was your mental health not good? (n=4,002)		
<14 of past 30 days (n=3,226)	80.1	[78.5,81.7]
≥14 of past 30 days (n=776)	19.9	[18.3,21.5]
For how many days in the past 30 days was your mental health not good? (n=4,002)	Mean 6.0	[5.6,6.4]
Overall, since you enrolled in Healthy Michigan Plan, would you say your mental and emotional health has gotten better, stayed the same, OR gotten worse? (n=4,080)		
Gotten better (n=1,550)	38.2	[36.3,40.1]
Stayed the same (n=2,318)	56.8	[54.8,58.7]
Gotten worse (n=186)	4.6	[3.9,5.5]
Don't know (n=26)	0.5	[0.3,0.7]

During the past 30 days, for how many days did poor physical or mental health keep you from doing your usual activities, such as self-care, work, or recreation? (n=4,079)		
0-13 days (n=3,277)	80.6	[79.1,82.1]
14-30 days (n=749)	18.2	[16.8,19.8]
Don't know (n=53)	1.1	[0.8,1.6]
During the past 30 days, for how many days did poor physical or mental health keep you from doing your usual activities, such as self-care, work, or recreation? (n=4,026) [Note: Same as above but excludes "Don't know"]		
<14 of past 30 days (n=3,277)	81.6	[80.0,83.0]
≥14 of past 30 days (n=749)	18.4	[17.0,20.0]
During the past 30 days, for how many days did poor physical or mental health keep you from doing your usual activities, such as self-care, work, or recreation? (n=4,026)	Mean 5.3	[4.9,5.7]
Since you enrolled in the Healthy Michigan Plan, has the health of your teeth and gums gotten better, stayed the same, OR gotten worse? (n=4,084)		
Gotten better (n=1,641)	39.5	[37.6,41.5]
Stayed the same (n=1,809)	45.5	[43.5,47.5]
Gotten worse (n=443)	10.4	[9.3,11.6]
Don't know (n=191)	4.6	[3.9,5.5]
Compared to 12 months ago, how would you describe your weight? (n=4,084)		
Lost weight (n=1,300)	31.7	[29.9,33.6]
Gained weight (n=1,036)	26.4	[24.7,28.2]
Stayed about the same (n=1,732)	41.5	[39.6,43.4]
Don't know (n=16)	0.4	[0.2,0.7]

Chronic Health Conditions

More than two-thirds (69.2%) reported any chronic health condition with 60.8% reporting at least one physical health condition and 32.1% reporting at least one mental health condition. About one-fourth (23.7%) reported having both a physical health condition and a mental health condition. Nearly one-third (30.3%) reported that they had a chronic health condition that was newly diagnosed since enrolling in HMP. Almost one-fifth (18.4%) of respondents reported a functional limitation.

	Col %	95% CI
At least one physical health condition present (n=4,090)		
Yes (n=2,689)	60.8	[58.8,62.8]
No (n=1,401)	39.2	[37.2,41.2]
At least one mental health condition present (n=4,090)		
Yes (n=1,351)	32.1	[30.3,33.9]
No (n=2,739)	67.9	[66.1,69.7]

Any chronic health condition present (n=4,090)		
Yes (n=2,986)	69.2	[67.3,71.0]
No (n=1,104)	30.8	[29.0,32.7]
Any physical health condition AND any mental health condition		
Yes (n=1,054)	23.7	[22.2,25.3]
No (n=3,036)	76.3	[74.7,77.8]
Any new diagnoses since HMP enrollment (n=4,090)		
Yes (n=1,318)	30.6	[28.8,32.4]
No (n=2,772)	69.4	[67.6,71.2]
Functional limitations (n=4,026)		
Yes (n=749)	18.4	[17.0,20.0]
No (n=3,277)	81.6	[80.0,83.0]

The most common chronic conditions reported were hypertension (31.3%), mood disorder (30.4%), and other health conditions (29.2%). Respondents frequently found out about these chronic conditions after enrollment in HMP.

	%	95% CI
Has a doctor or other health professional every told you that you had any of the following?		
Hypertension (n=4,089)		
Yes (n=1,411)	31.3	[29.6,33.1]
No (n=2,661)	68.2	[66.4,69.9]
Don't know (n=17)	0.5	[0.3,0.9]
[If Yes] Did you find out you had [Hypertension] before or after you enrolled in the Healthy Michigan Plan? (n=1,411)		
Before (n=960)	66.6	[63.4,69.7]
After (n=441)	32.4	[29.4,35.6]
Don't know (n=10)	0.9	[0.4,2.0]
Heart disease (n=4,089)		
Yes (n=426)	9.7	[8.6,10.9]
No (n=3,645)	90.0	[88.8,91.1]
Don't know (n=18)	0.3	[0.2,0.5]
[If Yes] Did you find out you had [Heart disease] before or after you enrolled in the Healthy Michigan Plan? (n=426)		
Before (n=290)	65.6	[59.3,71.4]
After (n=135)	34.3	[28.5,40.6]
Don't know (n=1)	0.1	[0.0,0.8]
Diabetes (n=4,089)		
Yes (n=499)	10.8	[9.7,12.0]
No (n=3,574)	88.8	[87.6,89.9]
Don't know (n=16)	0.4	[0.2,0.7]

[If Yes] Did you find out you had [Diabetes] before or after you enrolled in the Healthy Michigan Plan? (n=499)		
Before (n=331)	63.8	[58.1,69.1]
After (n=163)	35.4	[30.1,41.1]
Don't know (n=5)	0.8	[0.3,2.4]
Cancer (non-skin) (n=4,089)		
Yes (n=203)	3.7	[3.2,4.4]
No (n=3,876)	96.0	[95.3,96.6]
Don't know (n=10)	0.3	[0.1,0.6]
[If Yes] Did you find out you had [Cancer (non-skin)] before or after you enrolled in the Healthy Michigan Plan? (n=203)		
Before (n=130)	60.3	[51.8,68.3]
After (n=72)	39.2	[31.3,47.8]
Don't know (n=1)	0.5	[0.1,3.2]
Mood disorder (n=4,084)		
Yes (n=1,288)	30.4	[28.7,32.2]
No (n=2,786)	69.2	[67.4,71.0]
Don't know (n=10)	0.4	[0.2,0.8]
[If Yes] Did you find out you had [Mood disorder] before or after you enrolled in the Healthy Michigan Plan? (n=1,288)		
Before (n=941)	70.9	[67.5,74.0]
After (n=342)	28.8	[25.7,32.2]
Don't know (n=5)	0.3	[0.1,0.9]
Stroke (n=4,089)		
Yes (n=88)	1.9	[1.5,2.5]
No (n=3,997)	97.9	[97.3,98.4]
Don't know (n=4)	0.2	[0.0,0.5]
[If Yes] Did you find out you had [Stroke] before or after you enrolled in the Healthy Michigan Plan? (n=88)		
Before (n=53)	59.8	[46.7,71.7]
After (n=35)	40.2	[28.3,53.3]
Don't know (n=0)	0.0	
Asthma (n=4,088)		
Yes (n=725)	17.1	[15.7,18.6]
No (n=3,353)	82.7	[81.2,84.1]
Don't know (n=10)	0.2	[0.1,0.4]
[If Yes] Did you find out you had [Asthma] before or after you enrolled in the Healthy Michigan Plan? (n=725)		
Before (n=637)	86.6	[83.0,89.5]
After (n=84)	12.9	[10.0,16.4]
Don't know (n=4)	0.6	[0.2,2.0]

Chronic bronchitis, COPD, emphysema (n=4,089)		
Yes (n=479)	10.5	[9.4,11.7]
No (n=3,594)	89.1	[87.9,90.2]
Don't know (n=16)	0.4	[0.2,0.8]
[If Yes] Did you find out you had [Chronic bronchitis, COPD, emphysema] before or after you enrolled in the Healthy Michigan Plan? (n=479)		
Before (n=304)	65.0	[59.5,70.2]
After (n=173)	34.8	[29.6,40.3]
Don't know (n=2)	0.2	[0.0,0.8]
Substance use disorder (n=4,088)		
Yes (n=165)	4.1	[3.4,5.0]
No (n=3,916)	95.7	[94.8,96.4]
Don't know (n=7)	0.2	[0.1,0.5]
[If Yes] Did you find out you had [Substance use disorder] before or after you enrolled in the Healthy Michigan Plan? (n=165)		
Before (n=148)	88.9	[81.6,93.5]
After (n=15)	9.5	[5.3,16.3]
Don't know (n=2)	1.6	[0.4,7.1]
Other chronic condition (n=4,087)		
Yes (n=1,317)	29.2	[27.5,30.9]
No (n=2,759)	70.5	[68.8,72.2]
Don't know (n=11)	0.3	[0.1,0.5]
[If Yes] Did you find out you had [Other chronic condition] before or after you enrolled in the Healthy Michigan Plan? (n=1,317)		
Before (n=829)	63.8	[60.6,67.0]
After (n=451)	33.6	[30.5,36.8]
Don't know (n=37)	2.6	[1.7,3.9]

Health Risk Assessment (HRA)

Approximately half (49.3%) of survey respondents reported that they remembered completing the HRA. This is higher than the completion rate obtained using data from the MDHHS Data Warehouse. One potential explanation for this discrepancy between the self-reported rate and the State reported rate is that some respondents may have completed only the patient portion of the HRA but reported HRA completion in the survey; without also turning in the provider portion of the HRA such partial completions would be marked incomplete in the Data Warehouse. Other potential reasons include recall bias or misunderstanding about the HRA as a special form developed for Healthy Michigan Plan enrollees (e.g., some respondents may be unable to differentiate between the HRA and other health questionnaires they had completed). Among those who reported completing the HRA, the most common reasons for completion were that their primary care provider (PCP) suggested it (45.9%), they got it in the mail (33%),

and/or that they completed it during enrollment on the phone (12.6%). Among respondents who reported getting the HRA in the mail, 71.9% said they took the form to their PCP.

	%	95% CI
Do you remember completing the Health Risk Assessment? (n=4,089)		
Yes (n=2,102)	49.3	[47.3,51.2]
No (n=1,681)	42.7	[40.8,44.7]
Don't know (n=306)	8.0	[6.9,9.2]
[If Yes] What led you to complete it?* (n=2,102)		
PCP suggested (n=996)	45.9	[43.2,48.7]
Got it in the mail (n=693)	33.0	[30.4,35.6]
At enrollment on the phone (n=253)	12.6	[10.9,14.6]
Health plan suggested (n=149)	7.3	[6.0,8.9]
To stay on top of my health (n=64)	2.9	[2.1,3.9]
Gift card/money/reward (n=57)	2.5	[1.8,3.4]
To save money on copays/cost-sharing (n=2)	0.1	[0.0,0.3]
Other (n=50)	2.7	[1.8,4.0]
Don't know (n=79)	3.9	[3.0,5.2]
[If 'Got it in the mail'] Did you take the form to your primary care provider? (n=622)		
Yes (n=481)	71.9	[66.5,76.7]
No (n=106)	22.4	[17.8,27.7]
Don't know (n=35)	5.7	[3.7,8.8]

**Respondents were able to provide more than one response for this question. As a result, percentages may exceed 100%.*

A majority of those who reported completing the HRA felt that the HRA was valuable for improving their health (83.7%) and was helpful for their PCP to understand their health needs (89.7%). About one-third (31.5%) of those who said they completed the HRA felt that the HRA was not that helpful because they already knew what they needed to do to be healthy.

	%	95% CI
I think doing the Health Risk Assessment was valuable for me to improve my health. (n=2,100)		
Strongly agree (n=399)	19.0	[16.8,21.3]
Agree (n=1,354)	64.7	[62.0,67.4]
Neutral (n=222)	10.2	[8.7,12.1]
Disagree (n=104)	4.8	[3.8,6.1]
Strongly disagree (n=10)	0.6	[0.3,1.2]
Don't know (n=11)	0.6	[0.3,1.5]

I think doing the Health Risk Assessment was helpful for my primary care provider to understand my health needs. (n=2,099)		
Strongly agree (n=515)	24.9	[22.6,27.4]
Agree (n=1,369)	64.8	[62.1,67.4]
Neutral (n=121)	6.1	[4.9,7.6]
Disagree (n=62)	2.4	[1.8,3.4]
Strongly disagree (n=8)	0.4	[0.2,0.8]
Don't know (n=24)	1.3	[0.8,2.2]
I know what I need to do to be healthy, so the Health Risk Assessment wasn't that helpful. (n=2,100)		
Strongly agree (n=92)	4.5	[3.5,5.7]
Agree (n=567)	27.0	[24.7,29.5]
Neutral (n=308)	16.8	[14.7,19.2]
Disagree (n=1,024)	46.2	[43.5,48.9]
Strongly disagree (n=87)	4.2	[3.2,5.6]
Don't know (n=22)	1.2	[0.7,2.1]

Among those who reported completing the HRA, 80.7% reported choosing to work on at least one health behavior. The most common behaviors that respondents reported selecting were related to nutrition/diet (57.2%) and exercise/activity (52.6%). Among respondents who chose to work on a health behavior, 61.3% said their health care provider or health plan helped them work on this behavior. Some (8%) said there was help they wanted that they did not get.

	%	95% CI
After going through the Health Risk Assessment, or at a primary care visit, did you choose to work on a healthy behavior or do something good for your health? (n=2,100)		
Yes (n=1,690)	80.7	[78.5,82.8]
No (n=393)	18.6	[16.6,20.9]
Don't know (n=17)	0.6	[0.3,1.1]
[If Yes] What did you choose to do?* (n=1,690)		
Nutrition/diet (n=947)	57.2	[54.2,60.2]
Exercise/activity (n=915)	52.6	[49.5,55.7]
Reduce/quit tobacco use (n=317)	18.4	[16.2,20.9]
Lose weight (n=191)	10.1	[8.5,11.9]
Reduce/quit alcohol consumption (n=55)	3.4	[2.5,4.8]
Take medicine regularly (n=32)	2.3	[1.5,3.5]
Monitor my blood pressure/blood sugar (n=33)	1.5	[1.0,2.2]
Flu shot (n=20)	0.9	[0.5,1.4]
Follow-up appointment for chronic disease (n=11)	0.6	[0.3,1.1]
Go to the dentist (n=7)	0.4	[0.2,1.1]
Treatment for substance use disorder (n=3)	0.2	[0.0,0.5]
Other (n=98)	5.4	[4.3,6.8]
Don't know (n=11)	0.8	[0.4,1.7]

Did your health care provider or health plan help you work on this healthy behavior? (n=1,677)		
Yes (n=1,088)	61.3	[58.2,64.4]
No (n=382)	26.3	[23.5,29.3]
NA (n=200)	11.9	[10.1,14.0]
Don't know (n=7)	0.4	[0.2,1.0]
[If Yes or No] Was there help that you wanted that you didn't get? (n=1,470)		
Yes (n=131)	8.0	[6.6,9.7]
No (n=1,313)	90.0	[88.0,91.7]
NA (n=18)	1.2	[0.6,2.3]
Don't know (n=8)	0.8	[0.3,2.0]

**Respondents were able to provide more than one response for this question; As a result, percentages may exceed 100%.*

Forty percent of survey respondents agreed that information about healthy behavior rewards led them do something they might not have done otherwise. A quarter (26.1%) disagreed, and one-fifth (21.3%) said they did not know.

	%	95% CI
Information about the healthy behavior rewards that I can earn has led me to do something I might not have done otherwise. (n=4,084)		
Strongly agree (n=204)	5.2	[4.4,6.3]
Agree (n=1,431)	35.4	[33.5,37.3]
Neutral (n=487)	12.0	[10.8,13.3]
Disagree (n=969)	24.1	[22.4,25.8]
Strongly disagree (n=75)	2.0	[1.5,2.6]
Don't know (n=918)	21.3	[19.8,22.9]

Health Behaviors and Health Education

More than one-third (36.7%) of survey respondents reported getting a flu shot last fall or winter. Almost one-third (31.9%) of survey respondents reported exercising every day for at least 20 minutes, 48.8% of respondents reported drinking sugary drinks two or fewer days per week, and 37.5% of respondents reported eating three or more servings of fruits or vegetables every day.

	%	95% CI
Did you get a flu shot last fall or winter? (n=4,090)		
Yes (n=1,592)	36.7	[34.8,38.6]
No (n=2,463)	62.4	[60.4,64.3]
Don't know (n=35)	0.9	[0.6,1.5]

In the last 7 days, how many days did you exercise for at least 20 minutes? (n=4,089)		
Every day (n=1,392)	31.9	[30.1,33.7]
3-6 days (n=1,334)	33.5	[31.6,35.4]
1-2 days (n=606)	15.9	[14.4,17.4]
0 days (n=746)	18.4	[17.0,20.0]
Don't know (n=11)	0.3	[0.1,0.6]
In the last 7 days, how many days did you drink sugary drinks, like soda or pop, sweetened fruit drinks, sports drinks, or energy drinks? (n=4,088)		
Every day (n=1,281)	32.4	[30.6,34.3]
3-6 days (n=688)	18.7	[17.2,20.4]
1-2 days (n=886)	21.4	[19.8,23.0]
0 days (n=1,231)	27.4	[25.8,29.2]
Don't know (n=2)	0.1	[0.0,0.3]
In the last 7 days, how many days did you eat 3 or more servings of fruits or vegetables in a day? (n=4,087)		
Every day (n=1,609)	37.5	[35.6,39.4]
3-6 days (n=1,374)	33.6	[31.8,35.5]
1-2 days (n=603)	16.4	[15.0,18.0]
0 days (n=476)	11.8	[10.5,13.1]
Don't know (n=25)	0.7	[0.4,1.1]

About half of respondents reported talking with a health professional about exercise (48.6%) and diet and nutrition (49.8%) in the past 12 months. Among those who reported binge drinking behavior in the past seven days, 30.3% reported talking to a health professional about safe alcohol use.

	%	95% CI
In the last 12 months, has a doctor, nurse, or other health professional talked with you about exercise? (n=4,090)		
Yes (n=2,091)	48.6	[46.7,50.6]
No (n=1,983)	50.9	[48.9,52.9]
Don't know (n=16)	0.4	[0.2,1.0]
In the last 12 months, has a doctor, nurse, or other health professional talked with you about diet and nutrition? (n=4,089)		
Yes (n=2,107)	49.8	[47.8,51.8]
No (n=1,966)	49.7	[47.7,51.7]
Don't know (n=16)	0.5	[0.2,1.1]
In the last 7 days, on how many days did you have 5 or more alcoholic drinks (males) or 4 or more alcoholic drinks (females)? (n=4,087)		
Every day (n=43)	1.1	[0.8,1.6]
3-6 days (n=145)	4.0	[3.3,4.9]
1-2 days (n=556)	14.5	[13.1,16.0]
0 days (n=3,341)	80.3	[78.7,81.9]
Don't know (n=2)	0.1	[0.0,0.4]

[If response other than 0 days] In the last 12 months, has a doctor, nurse, or other health professional talked with you about safe alcohol use? (n=747)		
Yes (n=234)	30.3	[26.3,34.6]
No (n=511)	69.6	[65.2,73.6]
Don't know (n=2)	0.1	[0.0,0.6]

More than one-third (37.7%) of survey respondents reported smoking or using tobacco in the past thirty days. Among those who smoked or used tobacco in the past thirty days, 75.2% reported wanting to quit. Of those who said they would like to quit smoking or using tobacco, 90.7% reported working on cutting back or quitting right now. Among those currently working on quitting or reducing tobacco use, over half (54%) of respondents reported receiving advice or assistance from a health professional or health plan on how to quit in the past 12 months.

	%	95% CI
In the last 30 days, have you smoked or used tobacco? (n=4,089)		
Yes (n=1,533)	37.7	[35.9,39.7]
No (n=2,556)	62.3	[60.3,64.1]
[If Yes] Do you want to quit smoking or using tobacco? (n=1,530)		
Yes (n=1,186)	75.2	[72.0,78.1]
No (n=319)	23.3	[20.4,26.4]
Don't know (n=25)	1.5	[0.9,2.5]
[If Yes] Are you working on cutting back or quitting right now? (n=1,186)		
Yes (n=1,059)	90.7	[88.7,92.4]
No (n=124)	9.1	[7.4,11.1]
Don't know (n=3)	0.2	[0.1,0.8]
In the past 12 months, did you receive any advice or assistance from a health professional or your health plan on how to quit smoking? (n=1,531)		
Yes (n=877)	54.0	[50.8,57.3]
No (n=644)	45.4	[42.2,48.7]
Don't know (n=10)	0.5	[0.3,1.1]

Few (5.9%) survey respondents reported using drugs or medications in the past 30 days to affect mood or aid in relaxation. Among those who reported using drugs or medications for mood or to aid in relaxation, 52.9% used these drugs or medications almost every day. More than one-third (37.1%) of respondents who used these drugs sometimes or every day reported speaking with a health professional about the use of these drugs or medications.

	%	95% CI
In the last 30 days, have you used drugs or medications to affect your mood or help you relax? This includes prescription drugs taken differently than how you were told to take them, as well as street drugs. (n=4,086)		
Yes (n=222)	5.9	[5.1,7.0]
No (n=3,862)	94.0	[92.9,94.9]
Don't know (n=2)	0.1	[0.0,0.3]

[If Yes] How often? Would you say Almost every day, Sometimes, Rarely, or Never? (n=222)		
Almost every day (n=115)	52.9	[44.4,61.2]
Sometimes (n=64)	28.6	[21.6,36.9]
Rarely (n=41)	17.6	[12.0,25.0]
Never (n=2)	0.9	[0.2,3.8]
[If 'Sometimes' or 'Almost every day'] In the last 12 months, has a doctor, nurse, or other health professional talked with you about your use of these drugs or medications? (n=179)		
Yes (n=77)	37.1	[29.2,45.7]
No (n=102)	62.9	[54.3,70.8]

Regular Source of Care and Primary Care Utilization Prior to HMP

In the 12 months prior to HMP enrollment, about three-quarters (73.8%) of survey respondents reported having a place they would usually go for a checkup, when they felt sick, or when they wanted advice about their health and 24% of survey respondents reported not having a regular source of care. Among respondents who reported having a place that they would go for health care in the 12 months prior to HMP enrollment, a doctor's office (47.9%) was the most common place reported, while 16.2% reported the emergency room as their usual place for care. Many (40.1%) survey respondents had not had a primary care visit in the year before HMP enrollment and more than one-fifth (20.6%) had not had a primary care visit in five years or more.

	%	95% CI
In the 12 months before enrolling in the Healthy Michigan Plan, was there a place that you usually would go to for a checkup, when you felt sick, or when you wanted advice about your health? (n=4,084)		
Yes (n=3,051)	73.8	[72.0,75.5]
No (n=955)	24.0	[22.4,25.8]
NA (n=73)	2.1	[1.5,2.8]
Don't know (n=5)	0.1	[0.1,0.4]
[If Yes] What kind of place was it? (n=3,051)		
Doctor's office (n=1,498)	47.9	[45.7,50.2]
Clinic (n=557)	17.2	[15.5,18.9]
Urgent care/walk-in (n=529)	16.8	[15.2,18.6]
Emergency room (n=409)	16.2	[14.6,18.1]
Other place (n=56)	1.8	[1.3,2.4]
Don't know (n=2)	0.1	[0.0,0.2]
Before you enrolled in the Healthy Michigan Plan, about how long had it been since you had a primary care visit? (n=4,086)		
Less than 1 year before HMP (n=1,647)	40.1	[38.2,42.1]
1 to 5 years (n=1,577)	37.8	[35.9,39.7]
More that 5 years (n=813)	20.6	[19.0,22.2]
Don't know (n=49)	1.5	[1.0,2.1]

Regular Source of Care and Primary Care Utilization with HMP

Most (92.2%) survey respondents indicated that in the past 12 months of HMP enrollment there is a place they usually go when they need a checkup, feel sick, or want advice about their health. A doctor's office (75.2%) was the most common place respondents went to for health care in the 12 months enrolled in HMP and just 1.7% reported the emergency room. Among those who usually go to a doctor's office or clinic for health care, 60.6% reported that this is not the same place they went prior to HMP enrollment. Among respondents who reported going to a doctor's office or clinic for their health care, most (96.7%) respondents said this was their primary care provider (PCP) through their HMP coverage. Among the respondents who chose urgent care or the emergency room as their usual place for care while enrolled in HMP, 32.4% said they did not have a PCP through HMP. Among those respondents who used urgent care or the emergency room as their usual place of care and who had a PCP through HMP, about half (49.1%) chose their provider and about half (49.4%) said their plan assigned one.

	%	95% CI
In the last 12 months, is there a place you usually go when you need a checkup, feel sick, or want advice about your health? (n=4,088)		
Yes (n=3,850)	92.2	[90.8,93.4]
No (n=194)	6.2	[5.2,7.4]
NA (n=44)	1.6	[1.0,2.4]
[If Yes] What kind of a place was it? (n=3,850)		
Doctor's office (n=2,934)	75.2	[73.4,77.0]
Clinic (n=640)	16.5	[15.0,18.1]
Urgent care/walk-in (n=181)	5.8	[4.8,6.9]
Emergency room (n=65)	1.7	[1.3,2.2]
Other place (n=29)	0.8	[0.5,1.2]
Don't know (n=1)	0.0	[0.0,0.2]
[If Doctor's Office or Clinic] Is this the same place where you went before you enrolled in Healthy Michigan? (n=3,551)		
Yes (n=1,438)	39.3	[37.3,41.4]
No (n=2,111)	60.6	[58.5,62.6]
Don't know (n=2)	0.1	[0.0,0.3]
[If Doctor's Office or Clinic] And is this your primary care provider for your Healthy Michigan Plan Coverage? (n=3,552)		
Yes (n=3,438)	96.7	[95.8,97.4]
No (n=103)	3.1	[2.4,3.9]
Don't know (n=11)	0.2	[0.1,0.5]
[If the place they usually go for care is NOT their PCP --OR-- usual source of care is urgent care/walk-in clinic or the ER] Do you have a primary care provider through your Healthy Michigan Plan coverage? (n=652)		
Yes (n=418)	63.6	[58.7,68.3]
No (n=208)	32.4	[27.9,37.3]
Don't know (n=26)	3.9	[2.5,6.2]

[If Yes] Did you choose your primary care provider or did your plan assign you to one? (n=216)		
Chose my PCP (n=103)	49.1	[40.3,58.0]
Plan assigned my PCP (n=109)	49.4	[40.5,58.3]
Don't know (n=4)	1.5	[0.5,4.5]

The majority (85.2%) of respondents who reported having a PCP indicated that they saw their PCP in the past 12 months. For survey respondents who reported not seeing their PCP in the previous 12 months while enrolled in HMP, the most common reason given was that they were healthy and did not need to see a provider. Most (91.1%) respondents who had seen their PCP reported talking about things they can do to be healthy and prevent medical problems. Among those who had seen their PCP, 83.9% said it was easy or very easy to get an appointment to see their PCP. For those who said it was difficult or very difficult to schedule an appointment, the most common reason for this difficulty was not getting an appointment soon enough.

	%	95% CI
Have you seen your primary care provider in the past 12 months? (n=3,851)		
Yes (n=3,386)	85.2	[83.5,86.7]
No (n=453)	14.5	[13.0,16.2]
Don't know (n=12)	0.3	[0.2,0.6]
[If Yes] Did you and the primary care provider talk about things you can do to be healthy and prevent medical problems? (n=3,386)		
Yes (n=3,131)	91.1	[89.6,92.3]
No (n=243)	8.5	[7.3,9.9]
Don't know (n=12)	0.4	[0.2,0.9]
In the last 12 months, how easy or difficult was it to get an appointment to see your primary care provider? (n=3,386)		
Very easy (n=1,432)	41.9	[39.8,44.0]
Easy (n=1,443)	42.0	[39.9,44.1]
Neutral (n=274)	8.9	[7.7,10.3]
Difficult (n=166)	4.8	[4.0,5.8]
Very Difficult (n=69)	2.3	[1.7,3.1]
Don't know (n=2)	0.1	[0.0,0.4]
[If Difficult or Very Difficult] What made it difficult? (n=235)		
Couldn't get an appointment soon enough (n=195)	84.0	[77.8,88.8]
Inconvenient hours (n=46)	18.5	[13.3,25.2]
Couldn't get through on the telephone (n=21)	7.7	[4.6,12.7]
Transportation (n=12)	3.7	[1.9,6.9]
Other (n=15)	9.0	[4.8,16.4]

[If No - Have not seen PCP in past 12 months] Why not?* (n=452)		
Healthy/didn't need to see doctor (n=274)	63.4	[57.6,68.8]
Couldn't get appointment (n=37)	7.0	[4.8,10.0]
Transportation difficulties/too far (n=23)	5.5	[3.3,9.1]
See a specialist instead (n=19)	4.2	[2.2,7.6]
Don't like my PCP/staff (n=18)	3.9	[2.3,6.5]
Inconvenient hours (n=10)	3.0	[1.3,6.8]
Don't like doctors in general (n=8)	1.5	[0.6,3.4]
Other (n=149)	30.6	[25.6,36.3]
Don't know (n=3)	0.5	[0.1,1.5]

**Respondents were able to provide more than one response for this question; As a result, percentages may exceed 100%.*

Primary Care Utilization and Experience

Beneficiaries who were older, white, female, reported worse health, and had any chronic condition were more likely than other beneficiaries to have seen a PCP in the past 12 months. Ethnicity, employment, income and marital status were not associated with likelihood of PCP visit in past 12 months (See Appendix Table 2).

Respondents who reported a PCP visit within the previous 12 months, compared to those who did not, were more likely to report improvement in access to specialty care, help with staying healthy, and cancer screening. Respondents who reported a PCP visit within the previous 12 months, compared to those who did not, were more likely to report completing an HRA, being counseled about exercise, nutrition, tobacco cessation (for those who used tobacco) and being counseled about safe alcohol use (for those who reported unsafe alcohol intake). Respondents who reported a PCP visit within the previous 12 months, compared to those who did not, were more likely to report being diagnosed with a chronic condition since enrollment in HMP (See Appendix Table 3).

Foregone Care Prior to HMP

One-third (33%) of respondents reported not getting the health care they needed in the 12 months prior to HMP enrollment. The most common reasons for not getting the care they needed prior to HMP were being worried about the cost (77.5%) and not having health insurance (67.4%).

	%	95% CI
In the 12 months before enrolling in the Healthy Michigan Plan, was there any time when you didn't get the health care services you needed? (n=4,084)		
Yes (n=1,409)	33.0	[31.2,34.8]
No (n=2,638)	65.9	[64.0,67.7]
Don't know (n=37)	1.1	[0.8,1.7]

[If Yes] Why didn't you get the care you needed?* (n=1,409)		
You were worried about the cost (n=1,121)	77.5	[74.5,80.2]
You did not have health insurance (n=927)	67.4	[64.2,70.4]
Your health plan wouldn't pay for the treatment (n=105)	7.9	[6.3,9.8]
The doctor or hospital wouldn't accept your health insurance (n=60)	4.0	[3.0,5.4]
You couldn't get an appointment soon enough (n=54)	3.5	[2.6,4.8]
You didn't have transportation (n=36)	2.7	[1.9,4.0]
Other (n=99)	7.3	[5.7,9.4]
Don't know (n=6)	0.5	[0.2,2.0]
Other (write-in): Respondent did not have a doctor (n=24)	1.2	[0.8,1.9]
Other (write-in): Respondent was not satisfied with the care they received (n=19)	1.1	[0.6,1.9]

**Respondents were able to provide more than one response for this question; As a result, percentages may exceed 100%.*

Foregone Care with HMP

Over one-fifth (22%) of survey respondents reported that there was a time when they needed help or advice when their usual clinic or doctor's office was closed. Among these respondents, 46.8% said they tried to contact their provider's office after they were closed to get help or advice. Among those who tried to contact their provider's office after it was closed, 56.5% said they were able to talk to someone. Among respondents who did not contact their provider's office when they needed help or advice, the main reason for not contacting them was because the office was closed.

	%	95% CI
In the last 12 months was there a time when you needed help or advice when your usual clinic or doctor's office was closed? (n=4,063)		
Yes (n=916)	22.0	[20.4,23.6]
No (n=3,132)	77.6	[76.0,79.1]
Don't know (n=15)	0.4	[0.2,0.9]
[If Yes] In the most recent case, did you try to contact your provider's office after they were closed to get help or advice? (n=916)		
Yes (n=429)	46.8	[42.8,50.7]
No (n=484)	52.7	[48.7,56.7]
[If Yes] Were you able to talk to someone? (n=428)		
Yes (n=243)	56.5	[50.6,62.2]
No (n=184)	43.0	[37.3,48.9]
Don't know (n=1)	0.5	[0.1,3.2]

[If No-Did not try to contact provider's office] Why didn't you try to contact your provider's office?* (n=488)		
It was closed (n=347)	69.5	[64.2,74.3]
I felt it was an emergency and went to ER/ called 911 (n=78)	15.6	[12.1,19.9]
Decided to wait to see if condition resolved (n=31)	6.5	[4.3,9.8]
Unsure how to contact provider (n=3)	1.2	[0.3,4.5]
Other (n=99)	21.8	[17.5,26.9]
Don't know (n=9)	1.8	[0.8,3.6]

**Respondents were able to provide more than one response for this question; As a result, percentages may exceed 100%.*

Among all survey respondents, 15.6% said that in the past 12 months there was a time when they did not get the medical or dental care they needed. The most common reasons for not getting the care they needed with HMP were because their health plan would not pay for the treatment (39.6%) and being worried about the cost (25.4%). Those who cited a reason other than the options supplied for not getting the medical or dental care they needed often reported that dental procedures such as crowns and root canals are not covered and indicated that it was difficult to find a dentist who accepted their insurance. Among respondents who did not get needed care because they could not afford it, 63.2% reported dental care as the type of care they wanted.

	%	95% CI
In the last 12 months, was there any time when you didn't get the medical or dental care you needed? (n=4,084)		
Yes (n=629)	15.6	[14.3,17.1]
No (n=3,433)	84.0	[82.5,85.3]
Don't know (n=22)	0.4	[0.2,0.6]
[If Yes] Why didn't you get the care you needed?* (n=629)		
Your health plan wouldn’t pay for the treatment (n=251)	39.6	[34.9,44.5]
You were worried about the cost (n=155)	25.4	[21.3,29.9]
The doctor or hospital wouldn’t accept your health insurance (n=141)	23.9	[19.8,28.5]
You couldn’t get an appointment soon enough (n=73)	11.5	[8.7,14.9]
You did not have health insurance (n=41)	8.5	[5.8,12.4]
You didn’t have transportation (n=30)	6.1	[3.9,9.4]
Other (n=199)	29.8	[25.6,34.4]

[If Yes - 'Your health plan wouldn't pay for the treatment', 'You were worried about the cost', 'The doctor or hospital wouldn't accept your health insurance', OR 'You did not have health insurance'] Was there any time in the last 12 months when you needed or wanted any of the following but could not afford it?* (n=393)		
Dental care (including check-ups) (n=252)	63.2	[57.0,69.0]
To see a specialist (n=79)	21.7	[16.8,27.5]
Prescription medication [not over the counter] (n=72)	19.9	[15.3,25.5]
A checkup, physical or wellness visit (n=47)	13.3	[9.6,18.2]
Mental health care or counseling (n=30)	8.9	[5.8,13.3]
Substance use treatment services (n=2)	0.7	[0.2,2.6]
Other (n=49)	13.0	[9.2,17.9]
NONE (n=28)	5.6	[3.8,8.3]
Don't know (n=1)	0.2	[0.0,1.7]

**Respondents were able to provide more than one response for this question; As a result, percentages may exceed 100%.*

Changes in Access to Care

Many respondents reported greater ability to get prescription medications (59.3%), primary care (57.8%), help staying healthy or preventing health problems (52%), dental care (46.1%), specialist care (44.4%), mental health care (27.5%), and cancer screening (25.7%) after enrolling in HMP compared to before they had HMP coverage. About half (46.7%) of respondents did not know if their ability to get mental health care through HMP was better, worse, or about the same as compared to before enrolling in HMP, though only 2.5% reported that it was worse. The majority (80.7%) of respondents did not know if their ability to get substance use treatment services through HMP was better, worse, or about the same compared to before enrolling in HMP though only 0.2% reported that it was worse. While most (58.6%) respondents did not know if their ability to get cancer screening though HMP was better, worse, or about the same compared to before HMP, 25.7% said it was better. The majority (71%) of respondents also said they did not know if their ability to get birth control/family planning services through HMP is better, worse, or the about the same compared to before HMP.

	%	95% CI
Would you say that your ability to get primary care through the Healthy Michigan Plan is better, worse, or about the same, compared to before? (n=4,085)		
Better (n=2,381)	57.8	[55.8,59.7]
Worse (n=93)	2.4	[1.9,3.1]
About the same (n=1,483)	35.9	[34.0,37.8]
Don't know (n=128)	3.9	[3.1,4.9]

Would you say that your ability to get specialist care through the Healthy Michigan Plan is better, worse, or about the same, compared to before? (n=4,085)		
Better (n=1,901)	44.4	[42.5,46.4]
Worse (n=177)	4.2	[3.5,5.1]
About the same (n=911)	22.6	[21.0,24.3]
Don't know (n=1,096)	28.7	[26.9,30.6]
Would you say that your ability to get dental care through the Healthy Michigan Plan is better, worse, or about the same, compared to before? (n=4,084)		
Better (n=1,930)	46.1	[44.1,48.0]
Worse (n=255)	6.2	[5.4,7.3]
About the same (n=1,138)	29.3	[27.5,31.2]
Don't know (n=761)	18.4	[16.9,19.9]
Would you say that your ability to get mental health care through the Healthy Michigan Plan is better, worse, or about the same, compared to before? (n=4,084)		
Better (n=1,077)	27.5	[25.8,29.3]
Worse (n=97)	2.5	[1.9,3.2]
About the same (n=923)	23.3	[21.6,25.0]
Don't know (n=1,987)	46.7	[44.8,48.7]
Would you say that your ability to get substance use treatment services through the Healthy Michigan Plan is better, worse, or about the same, compared to before? (n=4,083)		
Better (n=341)	9.8	[8.6,11.1]
Worse (n=9)	0.2	[0.1,0.4]
About the same (n=319)	9.3	[8.1,10.6]
Don't know (n=3,414)	80.7	[79.0,82.3]
Would you say that your ability to get prescription medications through the Healthy Michigan Plan is better, worse, or about the same, compared to before? (n=4,085)		
Better (n=2,497)	59.3	[57.4,61.3]
Worse (n=121)	3.1	[2.5,3.9]
About the same (n=1,017)	25.9	[24.2,27.7]
Don't know (n=450)	11.6	[10.4,13.0]
Would you say that your ability to get cancer screening through the Healthy Michigan Plan is better, worse, or about the same, compared to before? (n=4,084)		
Better (n=1,156)	25.7	[24.1,27.5]
Worse (n=26)	0.6	[0.4,1.0]
About the same (n=627)	15.0	[13.7,16.5]
Don't know (n=2,275)	58.6	[56.7,60.5]

Would you say that your ability to get help with staying healthy or preventing health problems through the Healthy Michigan Plan is better, worse, or about the same, compared to before? (n=4,084)		
Better (n=2,142)	52.0	[50.0,53.9]
Worse (n=48)	1.1	[0.8,1.5]
About the same (n=1,338)	32.5	[30.7,34.3]
Don't know (n=556)	14.5	[13.2,16.0]
Would you say that your ability to get birth control/family planning services through the Healthy Michigan Plan is better, worse, or about the same, compared to before? (n=4,082)		
Better (n=568)	16.1	[14.6,17.7]
Worse (n=16)	0.5	[0.3,0.8]
About the same (n=472)	12.4	[11.1,13.8]
Don't know (n=3,026)	71.0	[69.1,72.8]

Emergency Room Use with HMP

Over one-third (37.6%) of survey respondents reported going to a hospital emergency room (ER) for care in the past 12 months. Of those who went to the ER in the past 12 months, 83.8% felt that the problem needed to be handled in the ER. Over one-quarter (28.0%) of respondents with an ER visit in the past 12 months said they tried to contact their usual provider's office to get help or advice before going to the ER. Among those who tried to contact their provider, 76.6% reported talking to someone. Among those who talked to someone from their provider's office before going to the ER, the most common reason for going to the ER was because the provider said to go (75.7%).

	%	95% CI
During the past 12 months, did you go to a hospital emergency room about your own health (whether or not you were admitted overnight)? (n=4,090)		
Yes (n=1,456)	37.6	[35.7,39.6]
No (n=2,611)	61.8	[59.8,63.7]
Don't know (n=23)	0.6	[0.3,1.0]
[If Yes] Thinking about the last time you were at the emergency room, did you think your problem needed to be handled in the emergency room? (n=1,455)		
Yes (n=1,249)	83.8	[81.1,86.2]
No (n=186)	14.9	[12.6,17.6]
Don't know (n=20)	1.2	[0.8,2.0]
Thinking about the last time you were at the emergency room, did you try to contact your usual provider's office to get help or advice before going to the emergency room? (n=1,456)		
Yes (n=424)	28.0	[25.2,30.9]
No (n=1,025)	71.7	[68.7,74.5]
Don't know (n=7)	0.3	[0.1,0.8]

[If Yes] Did you talk to someone? (n=424)		
Yes (n=319)	76.6	[71.3,81.2]
No (n=105)	23.4	[18.8,28.7]
[If Yes] Why did you end up going to the ER?* (n=319)		
Provider said to go to the ER (n=250)	75.7	[68.9,81.5]
Symptoms didn't improve or got worse (n=36)	14.3	[9.6,20.9]
You could get an appointment soon enough (n=33)	8.0	[5.4,11.8]
Provider advice wasn't helpful (n=12)	3.0	[1.6,5.5]
No response from the provider (n=5)	2.1	[0.7,6.2]
Other (n=51)	16.5	[11.9,22.5]
Don't know (n=2)	0.3	[0.1,1.2]

**Respondents were able to provide more than one response for this question; As a result, percentages may exceed 100%.*

Among respondents who did not try to contact their provider before going to the ER: 20% arrived to the ER by ambulance, 74.8% went to the ER because it was the closest place to receive care, 18.5% went because they get most of their care at the ER, 64.3% felt the problem was too serious for a doctor's office or clinic, 63.6% reported their usual clinic was closed, and 25.4% said they needed to get care at a time that would not make them to miss school or work.

	%	95% CI
[If No - Did not try to contact usual provider's office before going to the ER] Which of these were true of this particular ER visit? (n=978)		
You arrived by ambulance or other emergency vehicle		
Yes (n=191)	20.0	[17.0,23.3]
No (n=787)	80.0	[76.7,83.0]
You went to the ER because it´s your closest place to receive care		
Yes (n=724)	74.8	[71.4,78.0]
No (n=245)	24.3	[21.2,27.7]
You went to the ER because you get most of your care at the emergency room		
Yes (n=156)	18.5	[15.5,22.0]
No (n=818)	80.8	[77.4,83.9]
Don't know (n=4)	0.6	[0.2,1.8]
The problem was too serious for a doctor's office or clinic		
Yes (n=657)	64.3	[60.3,68.1]
No (n=294)	32.9	[29.2,36.8]
Don't know (n=27)	2.8	[1.6,4.9]
Your doctor´s office or clinic was not open		
Yes (n=628)	63.6	[59.8,67.3]
No (n=297)	30.8	[27.3,34.5]
Don't know (n=52)	5.6	[3.9,7.8]

You needed to get care at a time that would not make you miss work or school		
Yes (n=240)	25.4	[22.1,29.1]
No (n=721)	72.7	[68.9,76.1]
Don't know (n=17)	1.9	[1.1,3.4]

About two-thirds (64.0%) of all respondents said they are more likely to contact their usual provider before going to the ER compared to before HMP.

	%	95% CI
In general, compared to before you had the Healthy Michigan Plan, are you more likely, less likely, or about as likely to contact your usual doctor's office before going to the emergency room? (n=4,081)		
More likely (n=2,722)	64.0	[62.1,65.9]
Less likely (n=289)	8.3	[7.2,9.6]
About as likely (n=910)	23.5	[21.8,25.2]
Don't know (n=160)	4.2	[3.4,5.0]

**Respondents were able to provide more than one response for this question; As a result, percentages may exceed 100%.*

Impact of HMP on Acute Care Seeking

Respondents who used the ER were more likely than those who did not use the ER to report their health as fair/poor (40.1% vs. 23.2%) and less likely to report excellent/very good health (59.9% vs. 76.8%) (See Appendix Table 4). Respondents who used the ER reported chronic physical or mental health conditions more often than those who did not use the ER (79.4% vs. 62.8%) (See Appendix Table 5).

Impact of HMP on Employment, Education and Ability to Work

While most (78.3%) respondents who were students indicated that the number of days they missed school in the past year was about the same compared to the 12 months before HMP enrollment, 16.5% reported that they missed fewer days in the past year compared to the 12 months before. Among employed or self-employed respondents, 69.4% felt that getting health coverage through HMP helped them do a better job at work. Among respondents who were employed or self-employed, 27.6% reported changing jobs in the past 12 months. Among those who changed jobs in the past 12 months, 36.9% felt that having health coverage through HMP helped them get a better job. For those out of work for less than or more than a year, 54.5% of respondents felt that having HMP made them better able to look for a job.

	Mean or %	95% CI
[If a student] In the past 12 months, about how many days did you miss school because of illness or injury (do not include maternity leave)? (n=159)	Mean 2.9	[1.5,4.3]
Compared to the 12 months before this time, was this more, less, or about the same? (n=160)		
More (n=8)	4.4	[2.0,9.7]
Less (n=27)	16.5	[10.2,25.5]
About the same (n=124)	78.3	[69.1,85.4]
Don't know (n=1)	0.8	[0.1,5.3]
[If employed/self-employed or out of work for less than a year] In the past 12 months, about how many days did you miss work at a job or business because of illness or injury (do not include maternity leave)? (n=2,309)	Mean 7.5	[6.1,9.0]
Compared to the 12 months before this time, was this more, less, or about the same? (n=2,331)		
More (n=299)	12.7	[11.1,14.4]
Less (n=384)	16.6	[14.7,18.6]
About the same (n=1,611)	68.7	[66.2,71.0]
Don't know (n=37)	2.1	[1.3,3.2]
[If employed or self-employed] Has getting health insurance through the Healthy Michigan Plan helped you do a better job at work? (n=2,077)		
Yes (n=1,431)	69.4	[66.8,71.8]
No (n=549)	25.9	[23.6,28.4]
Don't know (n=97)	4.7	[3.7,6.0]
Have you changed jobs in the last 12 months? (n=1,979)		
Yes (n=447)	27.6	[24.9,30.4]
No (n=1,531)	72.3	[69.5,75.0]
Don't know (n=1)	0.1	[0.0,0.6]
[If Yes] Having health insurance through the Healthy Michigan Plan helped me get a better job. (n=447)		
Strongly agree (n=33)	7.7	[5.0,11.6]
Agree (n=123)	29.2	[23.6,35.4]
Neutral (n=103)	21.5	[17.1,26.7]
Disagree (n=150)	33.5	[27.8,39.6]
Strongly disagree (n=30)	6.4	[4.2,9.6]
Don't know (n=8)	1.8	[0.8,4.0]

[If out of work for less than or more than a year] Having healthy insurance through the Healthy Michigan Plan has made me better able to look for a job. (n=957)		
Strongly agree (n=158)	16.2	[13.5,19.3]
Agree (n=389)	38.3	[34.6,42.2]
Neutral (n=185)	19.3	[16.1,22.9]
Disagree (n=143)	17.2	[14.0,20.8]
Strongly disagree (n=35)	3.5	[2.4,5.2]
Don't know (n=47)	5.5	[3.9,7.7]
[If homemaker, retired, or unable to work] In the past 12 months, about how many days were you unable to do your activities because of illness or injury? (n=809)	Mean 135.4	[122.2,148.6]
Compared to the 12 months before this time, was this more, less, or about the same? (n=859)		
More (n=151)	18.6	[15.4,22.2]
Less (n=131)	16.8	[13.7,20.6]
About the same (n=551)	61.2	[56.8,65.3]
Don't know (n=26)	3.4	[2.1,5.5]

Compared to employed enrollees, enrollees who were out of work or unable to work were more likely to be older (27.5% of out of work enrollees and 42.1% unable to work enrollees vs. 20.0% of employed enrollees were aged 51-64), male (57.2% of out of work enrollees and 53.9% of unable to work enrollees vs. 45.5% of employed enrolles were male), lower income (79.1% of out of work enrollees and 73.8% of unable to work enrollees vs. 33.7% of employed enrollees had incomes that were 0-35% FPL), veterans (3.9% of out of work enrollees and 5.9% of unable to work enrollees vs. 2.3% of employed enrollees), in fair/poor health (33.7% of out of work enrollees and 73.4% of unable to work enrollees vs. 19.6% of employed enrollees), and with chronic physical or mental health conditions (65.1% of out of work enrollees and 87.5% of unable to work enrollees vs. 53.8% of employed enrollees had physical health conditions; 35.3% of out of work enrollees and 61.7% of unable to work enrollees vs. 25.2% of employed enrollees had mental health conditions) or limitations (24.4% of out of work enrollees and 68.8% of unable to work enrollees vs. 13.3% of employed enrollees had physical impariments; 25.0% of out of work enrollees and 48.4% of unable to work enrollees vs. 11.6% of employed enrollees had mental impairments) (See Appendix Table 9).

HMP enrollees were more likely to be employed if their health status was excellent, very good, or good vs. fair or poor (56.1% vs. 32.3%) or if they had no chronic conditions (59.8% vs. 44.1%) (See Appendix Tables 11 and 12). Employed respondents missed a mean of 7.2 work days in the past year due to illness. 68.4% said this was about the same as before HMP, 17.2% said less and 12.3% said more (See Appendix Table 13).

Enrollees were 1.7 times more likely to report being out of work if aged 51-64, 1.8 times as likely if male, 1.9 times as likely if African-American, 1.5 times as likely if in fair/poor health, 1.5 times as likely if with mental health conditions, or functional limitations (1.4 times as likely if

with physical limitation; 2.0 times as likely if with mental limitation). Enrollees were more likely to report being unable to work if older (2.3 times more likely for 35-50-year-olds, 4.2 times more likely for 51-64-year-olds), 1.9 times as likely if male, 3.5 times as likely if in fair/poor health, 1.7 times as likely if with with chronic physical health conditions, 2.6 times as likely if with chronic mental health condition, or functional limitations (5.1 times as likely if they reported a physical limitation; 2.3 times as likely if they reported a mental limitation) (See Appendix Table 14).

Employed enrollees with improved physical or mental health since HMP enrollment were 4.1 times more likely to report that HMP helped them to do a better job at work (See Appendix Table 15). Enrollees who were out of work with improved physical or mental health since HMP enrollment were 2.8 times more likely to report that HMP made them better able to look for a job. Enrollees who had a recent job change and improved physical or mental health since HMP enrollment were 3.2 times more likely to report that HMP helped them get a better job (See Appendix Table 16).

Impact of HMP on Access to Dental Care and Oral Health

Better access to dental care since HMP was reported by 46.1% of respondents, with students and younger respondents less likely to report better access (See Appendix Table 18). Improved oral health of their teeth and gums was reported by 39.5% of respondents, with students and younger respondents most likely to report no change in their oral health (See Appendix Table 20).

Survey respondents who were aware of their HMP dental coverage were significantly more likely to report improved access to dental care and improved oral health since HMP compared to those who were unaware (See Appendix Table 21). Among survey respondents who reported foregoing needed medical or dental care due to cost since HMP, 63.2% reported foregoing dental care. Foregone care varied by both employment status and region (See Appendix Table 19).

Among those who reported better access to dental care, 51.2% strongly agreed or agreed that HMP helped them to get a better job, 61.5% strongly agreed or agreed that HMP helped them to look for a job; and 77.8% reported doing a better job at work; all of these were significantly greater than responses for those who reported no change or worse access to dental care. Among those who reported better access to dental care, 67.9% reported improved oral health, significantly greater than those who reported no change or worse access to dental care. There was no significant impact of better access to dental care with HMP on ER use in the past year (See Appendix Table 22).

Perspectives on HMP Coverage

The majority of survey respondents agreed that it is very important for them personally to have health insurance (97.4%), that they do not worry as much about something bad happening to

their health since HMP enrollment (69%), that having HMP has taken a lot of stress off of them (87.9%), that without HMP they would not be able to go to the doctor (83.3%), and that having HMP has helped them live a better life (89.2%).

	%	95% CI
It is very important for me personally to have health insurance. (n=4,084)		
Strongly agree (n=1,892)	44.6	[42.6,46.5]
Agree (n=2,101)	52.8	[50.8,54.8]
Neutral (n=43)	1.3	[0.9,2.0]
Disagree (n=43)	1.2	[0.8,1.8]
Strongly disagree (n=4)	0.1	[0.0,0.3]
Don't know (n=1)	0.0	[0.0,0.1]
I don't worry as much about something bad happening to my health since enrolling in the Healthy Michigan Plan. (n=4,081)		
Strongly agree (n=700)	17.0	[15.6,18.5]
Agree (n=2,142)	52.0	[50.0,54.0]
Neutral (n=352)	8.8	[7.8,9.9]
Disagree (n=764)	18.8	[17.3,20.3]
Strongly disagree (n=78)	2.2	[1.6,2.8]
Don't know (n=45)	1.3	[0.9,1.9]
Having the Healthy Michigan Plan has taken a lot of stress off me. (n=4,087)		
Strongly agree (n=1,147)	26.0	[24.4,27.7]
Agree (n=2,495)	61.9	[60.0,63.7]
Neutral (n=220)	6.5	[5.5,7.6]
Disagree (n=195)	4.7	[4.0,5.6]
Strongly disagree (n=15)	0.4	[0.2,0.7]
Don't know (n=15)	0.5	[0.3,0.9]
Without the Healthy Michigan Plan, I wouldn't be able to go to the doctor. (n=4,085)		
Strongly agree (n=1,212)	28.2	[26.5,29.9]
Agree (n=2,211)	55.1	[53.2,57.1]
Neutral (n=166)	4.1	[3.4,5.0]
Disagree (n=450)	11.2	[10.0,12.5]
Strongly disagree (n=31)	1.0	[0.7,1.5]
Don't know (n=15)	0.4	[0.2,0.7]
Having the Healthy Michigan Plan has helped me live a better life. (n=4,083)		
Strongly agree (n=1,067)	25.0	[23.4,26.8]
Agree (n=2,609)	64.2	[62.3,66.1]
Neutral (n=255)	6.9	[6.0,8.0]
Disagree (n=119)	3.0	[2.4,3.7]
Strongly disagree (n=13)	0.3	[0.2,0.5]
Don't know (n=20)	0.6	[0.3,1.1]

Knowledge and Understanding of HMP Coverage

There were some gaps in knowledge among survey respondents about the health care services covered by HMP. The majority of respondents knew that HMP covers routine dental visits (77.2%), eyeglasses (60.4%), and counseling for mental or emotional problems (56%). Only one-fifth (21.2%) were aware that HMP covers name brand as well as generic medications.

	%	95% CI
My Healthy Michigan Plan covers routine dental visits. (n=4,086)		
Yes (n=3,170)	77.2	[75.4,78.8]
No (n=175)	3.9	[3.3,4.7]
Don't know (n=741)	18.9	[17.3,20.6]
My Healthy Michigan Plan covers eyeglasses. (n=4,086)		
Yes (n=2,590)	60.4	[58.5,62.4]
No (n=314)	7.8	[6.8,9.0]
Don't know (n=1,182)	31.8	[29.9,33.7]
My Healthy Michigan Plan covers counseling for mental or emotional problems. (n=4,086)		
Yes (n=2,318)	56.0	[54.0,57.9]
No (n=104)	3.1	[2.4,3.9]
Don't know (n=1,664)	40.9	[39.0,42.9]
Only generic medicines are covered by my Healthy Michigan Plan. (n=4,085)		
Yes (n=1,451)	35.8	[33.9,37.7]
No (n=892)	21.2	[19.7,22.9]
Don't know (n=1,742)	43.0	[41.0,44.9]

The majority (83.2%) of respondents reported rarely or never needing help reading instructions, pamphlets, or other written material from a doctor, pharmacy or health plan.

	%	95% CI
How often do you need to have someone help you read instructions, pamphlets, or other written materials from a doctor, pharmacy, or health plan? (n=4,088)		
Never (n=3,031)	72.6	[70.8,74.3]
Rarely (n=413)	10.6	[9.5,12.0]
Sometimes (n=390)	10.6	[9.4,11.9]
Often (n=94)	2.4	[1.8,3.1]
Always (n=157)	3.7	[3.1,4.5]
Don't know (n=3)	0.0	[0.0,0.1]

Challenges Using HMP Coverage

Few (15.5%) survey respondents reported that they had questions or problems using their HMP coverage. Among those who had questions or problems, about half (47.7%) reported getting

help or advice. The most commonly reported sources of help were from a health plan hotline, someone at the doctor's office, and an option outside of the provided responses. Among those who reported an option other than the ones provided, common responses were getting help from a case worker or someone at the pharmacy. Most (74.2%) of those who reported receiving help said that they got an answer or solution to their question.

	%	95% CI
Have you had any questions or problems using your Healthy Michigan Plan insurance? (n=4,089)		
Yes (n=632)	15.5	[14.2,17.0]
No (n=3,449)	84.3	[82.8,85.7]
Don't know (n=8)	0.2	[0.1,0.3]
[If Yes] Did anyone give you help or advice? (n=632)		
Yes (n=324)	47.7	[42.8,52.5]
No (n=302)	51.2	[46.4,56.1]
Don't know (n=6)	1.1	[0.4,3.2]
[If Yes] Who helped you?* (n=324)		
Health Plan Hotline (n=100)	32.2	[26.3,38.8]
Someone at my doctor's office (n=83)	22.4	[17.6,28.2]
HMP Beneficiary Hotline (n=46)	14.7	[10.6,20.0]
Helpline (n=39)	13.9	[9.4,20.1]
Friend/Relative (n=9)	2.8	[1.4,5.5]
Community health worker (n=6)	1.4	[0.5,3.6]
Other (n=96)	29.8	[24.2,36.1]
Don't know (n=5)	2.1	[0.8,5.9]
Did you get an answer or solution to your question(s)? (n=324)		
Yes (n=238)	74.2	[68.0,79.5]
No (n=83)	24.7	[19.4,30.8]
Don't know (n=3)	1.1	[0.4,3.5]

**Respondents were able to provide more than one response for this question; As a result, percentages may exceed 100%.*

Out-of-Pocket Healthcare Spending Prior to HMP

In the 12 months prior to HMP enrollment, almost one-quarter (23.3%) of respondents spent more than $500 out of pocket for their own medical and dental care. In the 12 months prior to HMP enrollment, 44.7% of respondents reported having problems paying medical bills. Of those who reported having problems paying their medical bills, 67.1% reported being contacted by a collections agency and 30.7% thought about filing for bankruptcy. Among those who thought about it, 21.4% filed for bankruptcy.

	%	95% CI
During the 12 months BEFORE you were enrolled in HMP, about how much did you spend out-of-pocket for your own medical and dental care? (n=4,082)		
Less than $50 (n=1,696)	42.4	[40.4,44.3]
$51-100 (n=376)	8.9	[7.9,10.1]
$101-500 (n=954)	22.8	[21.2,24.6]
$501-2,000 (n=605)	14.3	[13.0,15.7]
$2,001-3,000 (n=153)	4.0	[3.3,5.0]
$3,001-5,000 (n=119)	2.7	[2.2,3.4]
More than $5,000 (n=91)	2.3	[1.8,3.0]
Don't know (n=88)	2.5	[1.9,3.3]
In the 12 months before enrolling in the Healthy Michigan Plan, did you have problems paying medical bills? (n=4,085)		
Yes (n=1,869)	44.7	[42.7,46.6]
No (n=2,196)	54.9	[52.9,56.8]
Don't know (n=20)	0.4	[0.3,0.7]
[If Yes] Because of these problems paying medical bills, have you or your family been contacted by a collections agency? (n=1,869)		
Yes (n=1,235)	67.1	[64.4,69.8]
No (n=618)	31.8	[29.2,34.6]
Don't know (n=16)	1.0	[0.5,2.0]
Because of these problems paying medical bills, have you or your family thought about filing for bankruptcy? (n=1,869)		
Yes (n=559)	30.7	[28.1,33.5]
No (n=1,304)	68.9	[66.2,71.6]
Don't know (n=6)	0.3	[0.1,0.8]
[If Yes] Did you file for bankruptcy? (n=559)		
Yes (n=128)	21.4	[17.6,25.9]
No (n=429)	77.7	[73.1,81.8]
Don't know (n=2)	0.8	[0.2,4.4]

Out-of-Pocket Healthcare Spending with HMP

In the past 12 months, the majority (63.2%) of respondents reported spending less than $50 out-of-pocket for their own medical or dental care. Among survey respondents who previously had problems paying their medical bills (in the 12 months prior to HMP), most (85.9%) felt that their problems paying medical bills have gotten better since enrolling in HMP.

	%	95% CI
During the last 12 months, about how much did you spend out-of-pocket for your own medical and dental care? (n=4,076)		
Less than $50 (n=2,540)	63.2	[61.3,65.1]
$51-100 (n=503)	11.8	[10.6,13.1]
$101-500 (n=705)	17.2	[15.7,18.8]
$501-2,000 (n=210)	4.7	[4.0,5.6]
$2,001-3,000 (n=33)	0.8	[0.5,1.3]
$3,001-5,000 (n=15)	0.3	[0.1,0.6]
More than $5,000 (n=10)	0.3	[0.1,0.6]
Don't know (n=60)	1.6	[1.2,2.3]
[If Yes - Had problems paying medical bills in the 12 months before HMP] Since enrolling in Healthy Michigan, have your problems paying medical bills gotten worse, stayed the same, or gotten better? (n=1,869)		
Gotten better (n=1,629)	85.9	[83.7,87.9]
Stayed the same (n=176)	10.6	[8.9,12.6]
Gotten worse (n=51)	2.6	[1.9,3.7]
Don't know (n=13)	0.9	[0.4,1.8]

Perspectives on Cost-Sharing

The majority (87.6%) of survey respondents agreed that the amount they have to pay for HMP coverage seems fair. Most (88.8%) respondents agreed that the amount they pay for HMP coverage is affordable. Almost three-quarters (72.1%) of respondents agreed that they would rather take some responsibility to pay something for their health care than not pay anything.

	%	95% CI
The amount I have to pay overall for the Healthy Michigan Plan seems fair. (n=4,082)		
Strongly agree (n=1,065)	24.8	[23.2,26.5]
Agree (n=2,568)	62.8	[60.9,64.7]
Neutral (n=145)	4.2	[3.4,5.2]
Disagree (n=153)	4.0	[3.3,4.8]
Strongly disagree (n=28)	0.8	[0.5,1.3]
Don't know (n=123)	3.4	[2.7,4.2]
The amount I pay for the Healthy Michigan Plan is affordable. (n=4,084)		
Strongly agree (n=1,073)	25.1	[23.4,26.8]
Agree (n=2,606)	63.7	[61.8,65.6]
Neutral (n=132)	3.9	[3.2,4.9]
Disagree (n=139)	3.5	[2.9,4.3]
Strongly disagree (n=28)	0.7	[0.4,1.2]
Don't know (n=106)	3.0	[2.4,3.8]

I'd rather take some responsibility to pay something for my health care than not pay anything. (n=4,073)		
Strongly agree (n=653)	14.8	[13.5,16.2]
Agree (n=2,396)	57.3	[55.3,59.2]
Neutral (n=326)	8.7	[7.6,10.0]
Disagree (n=541)	14.6	[13.2,16.0]
Strongly disagree (n=77)	2.1	[1.6,2.8]
Don't know (n=80)	2.5	[1.9,3.3]

Knowledge and Understanding of HMP Cost-Sharing Requirements

Only one-quarter (26.4%) of respondents were aware that contributions are charged monthly regardless of health care use. Approximately one-fifth (20.7%) of respondents were aware that there is a limit or maximum on the amount they might have to pay. Few (14.4%) respondents were aware that they could not be disenrolled from HMP for not paying their bill. Just over one-quarter (28.1%) of respondents were aware that they could get a reduction in the amount they have to pay if they complete a health risk assessment. The majority (75.6%) of respondents were aware that some kinds of visits, tests, and medicines have no copays.

	%	95% CI
Contributions are what I am charged every month for Healthy Michigan Plan coverage even if I do not use any health care. (n=4,081)		
Yes (n=1,149)	26.4	[24.7,28.1]
No (n=986)	23.4	[21.8,25.1]
Don't know (n=1,946)	50.2	[48.3,52.2]
There is no limit or maximum on the amount I might have to pay in copays or contributions. (n=4,083)		
Yes (n=856)	20.7	[19.2,22.3]
No (n=952)	23.0	[21.4,24.7]
Don't know (n=2,275)	56.3	[54.3,58.2]
I could be dropped from the Healthy Michigan Plan for not paying my bill. (n=4,084)		
Yes (n=1,371)	34.2	[32.3,36.1]
No (n=571)	14.4	[13.0,15.8]
Don't know (n=2,142)	51.5	[49.5,53.5]
I may get a reduction in the amount I might have to pay if I complete a health risk assessment. (n=4,081)		
Yes (n=1,161)	28.1	[26.3,30.0]
No (n=438)	10.7	[9.6,12.0]
Don't know (n=2,482)	61.1	[59.2,63.1]
Some kinds of visits, tests, and medicines have no copays. (n=4,084)		
Yes (n=3,176)	75.6	[73.8,77.3]
No (n=161)	4.6	[3.8,5.5]
Don't know (n=747)	19.8	[18.2,21.5]

MI Health Account

The majority (68.2%) of respondents reported that they received a MI Health Account statement.

	%	95% CI
Have you received a bill or statement from the state that showed the services you received and how much you owe for the Healthy Michigan Plan? It's called your MI Health Account Statement. (n=4,090)		
Yes (n=3,011)	68.2	[66.3,70.1]
No (n=951)	28.5	[26.6,30.4]
Don't know (n=128)	3.3	[2.7,4.1]

Among respondents who reported receiving a MI Health Account statement, 88.3% agreed that they carefully review each statement to see how much they owe, 88.4% agreed that the statements help them be more aware of the cost of health care, 30.8% agreed that the information in the statement led them to change some of their health care decisions.

	%	95% CI
I carefully review each MI Health Account statement to see how much I owe. (n=3,005)		
Strongly agree (n=765)	25.3	[23.4,27.4]
Agree (n=1,910)	63.0	[60.8,65.1]
Neutral (n=97)	3.5	[2.8,4.5]
Disagree (n=193)	6.9	[5.8,8.1]
Strongly disagree (n=30)	0.9	[0.6,1.5]
Don't know (n=10)	0.3	[0.2,0.6]
The MI Health Account statements help me be more aware of the cost of health care. (n=3,005)		
Strongly agree (n=654)	22.0	[20.2,24.0]
Agree (n=1,981)	66.4	[64.2,68.5]
Neutral (n=134)	4.4	[3.6,5.4]
Disagree (n=185)	5.6	[4.7,6.7]
Strongly disagree (n=21)	0.5	[0.3,0.8]
Don't know (n=30)	1.0	[0.6,1.5]
Information I saw in a MI Health Account statement led me to change some of my decisions about health care. (n=3,006)		
Strongly agree (n=134)	5.2	[4.2,6.3]
Agree (n=749)	25.6	[23.7,27.6]
Neutral (n=420)	14.9	[13.2,16.7]
Disagree (n=1,513)	48.0	[45.8,50.3]
Strongly disagree (n=104)	3.3	[2.6,4.2]
Don't know (n=86)	3.0	[2.3,4.0]

Information Seeking Behaviors

More than half (58.9%) of all survey respondents agreed that the amount they might have to pay for prescriptions influences their decisions about filling prescriptions.

	%	95% CI
The amount I might have to pay for my prescriptions influences my decisions about filling prescriptions. (n=4,084)		
Strongly agree (n=625)	15.7	[14.3,17.2]
Agree (n=1,736)	43.2	[41.2,45.2]
Neutral (n=282)	7.0	[6.0,8.0]
Disagree (n=1,162)	28.0	[26.3,29.8]
Strongly disagree (n=154)	3.5	[2.9,4.2]
Don't know (n=125)	2.8	[2.2,3.5]

Among all respondents, 71.6% reported being somewhat or very likely to find out how much they might have to pay for a health service before going to get it, 67.9% reported being somewhat or very likely to talk with their doctor about how much different health care options would cost them, 75.3% reported that they were somewhat or very likely to ask their doctor to recommend a less costly prescription drug, and 78.1% reported that they were somewhat or very likely to check reviews or ratings of quality before choosing a doctor or hospital.

	%	95% CI
Find out how much you might have to pay for a health service before you go to get it. (n=4,076)		
Very likely (n=1,816)	45.0	[43.0,46.9]
Somewhat likely (n=1,096)	26.6	[24.9,28.4]
Somewhat unlikely (n=490)	12.1	[10.9,13.4]
Very unlikely (n=589)	14.4	[13.1,15.8]
Don't know (n=85)	2.0	[1.5,2.6]
Talk with your doctor about how much different health care options would cost you. (n=4,076)		
Very likely (n=1,611)	40.8	[38.9,42.8]
Somewhat likely (n=1,135)	27.1	[25.4,28.8]
Somewhat unlikely (n=551)	13.8	[12.4,15.2]
Very unlikely (n=682)	15.9	[14.5,17.3]
Don't know (n=97)	2.4	[1.9,3.1]
Ask your doctor to recommend a less costly prescription drug. (n=4,074)		
Very likely (n=2,153)	50.9	[48.9,52.8]
Somewhat likely (n=990)	24.4	[22.7,26.1]
Somewhat unlikely (n=331)	9.7	[8.4,11.0]
Very unlikely (n=496)	12.8	[11.5,14.1]
Don't know (n=104)	2.4	[1.9,3.0]

Check reviews or ratings of quality before choosing a doctor or hospital. (n=4,074)		
Very likely (n=2,169)	53.8	[51.8,55.7]
Somewhat likely (n=973)	24.3	[22.7,26.1]
Somewhat unlikely (n=344)	8.3	[7.3,9.5]
Very unlikely (n=473)	11.0	[9.9,12.3]
Don't know (n=115)	2.5	[2.0,3.1]

Impact of HMP Premium Contributions on Cost-Conscious Behaviors

Beneficiaries with incomes 100 to 133% of the FPL, and therefore subject to monthly contributions, were no more likely then beneficiaries with incomes 36 to 99% of the FPL who are not subject to monthly premium contributions to agree they carefully review their MI Health Account statements (86.0% vs. 88.7%), inquire about costs of services before getting them (70.4% vs. 72.9%), talk to providers about costs of health services (67.8 vs. 68.6%), or ask for less costly medications (77.0% vs.78.2%) (See Appendix Table 24).

Beneficiaries with incomes 100 to 133% of the FPL were less likely than beneficiaries with incomes 36 to 99% of the FPL without monthly premium contributions to agree their health care payments were affordable (84.9% vs. 90.8%; P = 0.001), but were no more likely to report foregoing needed care due to cost in the previous 12 months of HMP enrollment (10.4% vs. 12.0%) (See Appendix Table 25).

Perceived Discrimination

Most respondents did not report feeling judged or treated unfairly by medical staff in the past 12 months because of their race or ethnic background (96.4%) or because of how well they spoke English (97.4%); however, 11.6% of respondents felt judged or treated unfairly by medical staff in the past 12 months because of their ability to pay for care or the type of health coverage they had.

	%	95% CI
In the last 12 months, have you ever felt that the doctor or medical staff judged you unfairly or treated you with disrespect because of your race or ethnic background. (n=4,076)		
Yes (n=114)	2.9	[2.3,3.6]
No (n=3,928)	96.4	[95.6,97.0]
Don't know (n=34)	0.8	[0.5,1.1]
In the last 12 months, have you ever felt that the doctor or medical staff judged you unfairly or treated you with disrespect because of how well you speak English. (n=4,075)		
Yes (n=64)	1.7	[1.3,2.3]
No (n=3,975)	97.4	[96.6,97.9]
Don't know (n=36)	0.9	[0.6,1.5]

In the last 12 months, have you ever felt that the doctor or medical staff judged you unfairly or treated you with disrespect because of your ability to pay for care or the type of health insurance you have. (n=4,077)		
Yes (n=465)	11.6	[10.4,12.9]
No (n=3,551)	87.0	[85.7,88.3]
Don't know (n=61)	1.4	[1.1,1.9]

Respondents who reported using the emergency room in the past year were more likely than those who did not use the emergency room to report being judged/treated unfairly by race (4.7% vs 1.7%), and ability to pay (15.5% vs. 9.2%) (See Appendix Tables 6 and 7).

Social Interactions

Two-thirds (67.6%) of respondents said that they get together socially with friends or relatives who live outside their home at least once a week. Most (79.8%) respondents reported that the amount they are involved with their family, friends, and/or community is about the same as before they enrolled in HMP.

	%	95% CI
How often do you get together socially with friends or relatives who live outside your home? (n=4,076)		
Every day (n=543)	14.0	[12.7,15.5]
Every few days (n=999)	23.7	[22.0,25.3]
Every week (n=1,217)	29.9	[28.1,31.7]
Every month (n=850)	21.0	[19.4,22.6]
Once a year or less (n=437)	10.9	[9.7,12.2]
Don't know (n=30)	0.6	[0.4,1.0]
Since enrolling in the Healthy Michigan Plan are you involved with your family, friends or community more, less, or about the same? (n=4,077)		
More (n=590)	15.1	[13.7,16.6]
Less (n=184)	4.4	[3.7,5.3]
About the same (n=3,284)	79.8	[78.2,81.4]
Don't know (n=19)	0.6	[0.4,1.1]

Selected Sub-Population Analyses

Reproductive Health

Among reproductive age women respondents age 19-45, 38.4% “did not know” whether there was a change in their access to family planning services, while 35.5% reported better access, 24.8% reported about the same access, and 1.4% reported worse access. Reproductive age women with inconsistent health insurance or that were uninsured in the year prior to HMP coverage were significantly more likely to report improved access to family planning services compared to those who were fully insured in the prior year (See Appendix Table 27).

Impact on Those with Chronic Health Conditions

A total of 68.1% of respondents reported that they had any chronic disease or mood disorder. More than half (59.9%) of respondents reported at least one chronic physical condition (ranging from 9.7% for heart disease to 31.3% for hypertension), 30.9% reported a chronic mental health condition (depression, anxiety, or bipolar disorder), and 22.6% reported both a physical and mental health chronic condition. Forty-four percent (44%) of those reporting a chronic condition reported they were newly diagnosed since enrolling in HMP. About one-third (30.6%) of all respondents were diagnosed with a new chronic physical condition or mood disorder since enrolling in HMP. This ranged from 32.4-35.4% of those with common physical health conditions (hypertension, heart disease, diabetes, COPD), 40.2% of those with stroke, and 28.8% of those with mood disorder.

	%	95% CI
Physical Chronic Disease[13] (n=4,090)		
Yes (n=2,640)	59.9	[57.9,61.8]
No (n=1,450)	40.1	[38.2,42.1]
Mood Disorder or Mental Health Condition (n=4,090)		
Yes (n=1,301)	30.9	[29.1,32.7]
No (n=2,789)	69.1	[67.3,70.9]
Any Chronic Disease or Mood Disorder (n=4,090)		
Yes (n=2,939)	68.1	[66.2,70.0]
No (n=1,151)	31.9	[30.0,33.8]
[If Any Chronic Disease or Mood Disorder] Any New Diagnoses since HMP Enrollment (n=2,939)		
Yes (n=1,297)	44.0	[41.7,46.3]
No (n=1,642)	56.0	[53.7,58.3]
Physical Chronic Disease and Mood or Mental Disorder (n=4,090)		
Yes (n=1,002)	22.6	[21.1,24.2]
No (n=3,088)	77.4	[75.8,78.9]
Any New Diagnoses since HMP Enrollment (n=4,090)		
Yes (n=1,318)	30.6	[28.8,32.4]
No (n=2,772)	69.4	[67.6,71.2]
Functional Limitations (n=4,026)		
Yes (n=749)	18.4	[17.0,20.0]
No (n=3,277)	81.6	[80.0,83.0]

Among those with a chronic physical or mental health condition in the year prior to HMP enrollment, 58.3% did not have insurance, only 42.1% had seen a primary care provider, and 51.7% had problems paying medical bills (See Appendix Table 30). Since HMP enrollment, 89.6% of those with a chronic physical or mental health condition reported seeing a primary

[13] For these analyses, chronic illness does not include cancer.

care doctor, 64.6% reported their ability to fill prescription medications improved, and 86.3% reported their ability to pay medical bills had improved (See Appendix Tables 31 and 32). Prior to HMP 77.2% of those with a chronic physical or mental health condition had a regular source of care, 64.7% of whom said that source of care was a doctor's office or clinic. After HMP, 95.2% had a regular source of care, and 93.1% said it was a doctor's office or clinic (See Appendix Table 32).

Respondents with a chronic physical or mental health condition reported overall improvements in their physical (51.9%) and mental health (42.4%) status after enrolling in HMP, while 7.5% and 6.1% reported their physical and mental health status had worsened (See Appendix Table 31).

During HMP coverage, 18.4% of those with a chronic physical or mental health condition reported not getting medical or dental care they needed, with perceived health plan non-coverage (38.5%), cost (25.7%) and insurance not accepted (23.7%) the most common reasons (See Appendix Table 32).

Impact on Those with Mood Disorder and Substance Use Disorder

Nearly half (46.2%) of respondents who said they had a mood disorder stated that they had better access to mental health care, however, 20.3% did not know (See Appendix Table 39). Nearly half (48.3%) of respondents with SUD stated that they had better access to treatment, however 33.6% did not know. Most respondents without a self-reported SUD (82.8%) did not know how having HMP impacted their ability to get substance use treatment services (See Appendix Table 40). Since enrollment in HMP, 48.9% of respondents with a self-reported mood disorder (MD) and 50.7% with a self-reported substance use disorder (SUD) reported that their mental health had gotten better (See Appendix Table 41).

Respondents with a mood disorder reported that having HMP has led to a better life (92% strongly agreed or agreed) with more social connection and involvement with family and friends (21% stated more) and at higher rates than all HMP beneficiaries (12.6%). For respondents with a SUD, 95.8% strongly agreed or agreed that having HMP led to a better life and reported HMP led to more social connection and involvement with family and friends (23.2%) at higher rates than among respondents without a substance use disorder at 14.8% (See Appendix Tables 42 and 43).

Prior to HMP, 37% respondents who self-reported a SUD used the emergency room as a regular source of care, while after having HMP coverage, the percentage of those with a self-reported SUD who said they used the emergency room as a regular source of care dropped to 3.6% (See Appendix Tables 34 and 36). However, in the last 12 months (on HMP) those with a mood disorder and those with SUD were more likely to go to the ER than those without a mood disorder or SUD (50.5% MD v. 31.9% without a MD; 60.4% SUD v. 36.6% without a SUD) (See Appendix Table 37).

Respondents with SUD chose the ER due to proximity over other reasons (87.6% with a SUD v. 73.9% without a SUD) (See Appendix Table 44). For ER visits in general, respondents with a SUD have a higher odds of going to the emergency room (odds ratio 2.4) compared to all HMP beneficiaries (See Appendix Table 38).

CONCLUSIONS

- More than half of respondents, including more than half of those with chronic conditions, did not have insurance at any time in the year before enrolling in HMP. More than one-third of respondents reported not getting the care they needed in the year before enrolling in HMP and most respondents reported that their ability to get care had improved since enrolling in HMP. Foregone care, usually due to cost, lessened considerably after enrollment. Over half of respondents reported better access to primary care, help with staying healthy, and cancer screening. **HMP does not appear to have replaced employment-based insurance and has greatly improved access to care for most enrollees.**
- The percentage of enrollees who had a place they usually went for health care increased with HMP to over 90%, and naming the emergency room as a regular source of care declined significantly after enrolling in HMP (from 16.2% to 1.7%). For unscheduled health needs, some HMP beneficiaries sought advice from their regular source of care prior to seeking care, and the majority were referred to the emergency room. Those who used the emergency room had a higher chronic disease burden, and poorer health status. **The HMP emphasis on primary care and disease prevention appears to have shifted much care-seeking from acute care settings to primary care settings.**
- A significant majority of respondents agreed or strongly agreed that without HMP they would not be able to go to the doctor, that HMP helped them live a better life, and since enrolling in HMP their problems paying medical bills had gotten better. Premium contributions did not seem to have initially increased engagement in cost-conscious behaviors or to have increased foregone care due to cost, but did affect the perceived affordability of HMP. **Most respondents agreed that the amount they pay overall for HMP seems fair and is affordable, although enrollees subject to monthly contributions were somewhat less likely to perceive HMP as being affordable**.
- There were some areas in which beneficiaries showed a limited knowledge of HMP and its covered benefits (e.g., dental, vision and family planning) and misunderstanding about the cost-sharing requirements under HMP. A small number of respondents reported questions or problems using their HMP coverage. **These areas provide opportunities to improve beneficiaries' understanding of their coverage.**
- About half of respondents reported completing an HRA, bearing in mind the limits to self-reported data. Most HMP enrollees who completed the HRA believed it was beneficial. They rarely reported completing it because of incentives to reduce their cost-sharing. Most respondents who completed the HRA reported receiving help from their PCP or health plan on a healthy behavior. **Most respondents who recalled completing an HRA found this beneficial and received support to engage in a healthy behavior.**

- Dental coverage for HMP beneficiaries improved access to dental care and improved oral health for many, although many beneficiaries were unaware of dental coverage and were were less likely to report improved access and oral health. **Increasing beneficiary awareness of coverage for dental services has the potential to improve oral and overall health.**
- Many HMP enrollees reported improved functioning, ability to work, and job seeking after obtaining health insurance through Medicaid expansion. HMP enrollees who reported improved physical or mental health since HMP were more likely to report that HMP helped them to do a better job at work, made them better able to look for a job, and helped them get a better job. While many HMP enrollees attributed improvements in employment and ability to work to improved physical, mental and dental health due to covered services, some had ongoing barriers to employment. **HMP may influence beneficiaries' ability to obtain or maintain employment.**
- About half of reproductive-aged women HMP beneficiaries did not know whether there was a change in their access to family planning services compared to before HMP coverage. Those who previously had no or inconsistent health insurance, compared to those with consistent health insurance, reported improved access to family planning services. **Improved dissemination of the family planning services covered by HMP could help beneficiaries better meet their reproductive health needs.**
- Chronic health conditions were common among enrollees in Michigan's Medicaid expansion program, even though most respondents were under 50 years old. Almost half of these conditions were newly diagnosed after enrolling in HMP. Prior to HMP enrollment, a majority of enrollees with chronic illness lacked health insurance and could not access needed care. In particular, HMP enrollees with mood disorder or substance use disorder reported improved health, improved access to services and treatment, and were less likely to name the emergency room or urgent care as a regular source of care. **Enrollees with chronic conditions reported improved access to care and medications, all crucial to successfully managing these conditions and avoiding future disabling complications.**
- Overall, since enrolling in HMP almost half of respondents said their physical health had gotten better, and nearly 40% said their emotional and mental health and their dental health had improved. **These improvements underscore the impact of HMP on enrollees' health and well-being in addition to its effects on their ability to access needed care.**

APPENDIX

Impact of Prior Year Insurance Status on Improvements in Foregone Care, Access, and Health

Table 1. Insurance Status Prior to HMP: Impact on Outcomes

Outcomes[1]	All	Uninsured all 12 months [REF] (n=2,374)	Insured part of 12 months (n=374)	Insured all 12 months (n=1,235)
	Mean or %	% [95% CI]	% [95% CI]	% [95% CI]
Foregone care in 12 months prior to HMP enrollment	33.0	42.2 [39.7,44.7]	31.2 ** [25.7,36.8]	17.3 *** [14.8,19.8]
Foregone care due to cost in 12 months prior to HMP enrollment[2]	25.9	34.4 [31.9,36.8]	24.3 ** [19.2,29.4]	10.6 *** [8.6,12.6]
Improved access to prescription medicines	59.3	67.9 [65.4,70.3]	62.1 [55.9,68.4]	43.0 *** [39.6,46.5]
Improved access to primary care	57.8	68.7 [66.2,71.2]	57.4 ** [51.0,63.8]	37.9 *** [34.3,41.4]
Improved access to help with staying healthy	52.0	60.3 [57.8,62.8]	55.4 [49.0,61.7]	36.2 *** [32.8,39.6]
Improved access to dental care	46.1	54.1 [51.5,56.7]	48.0 [41.6,54.3]	32.3 *** [28.9,35.7]
Improved access to specialist care	44.4	51.8 [49.3,54.4]	44.1 * [37.8,50.4]	31.6 *** [28.2,34.9]
Improved access to mental health care	27.5	32.0 [29.6,34.4]	26.4 [20.4,32.3]	18.5 *** [15.7,21.3]
Improved access to cancer screening	25.7	31.3 [28.9,33.6]	23.4 * [18.2,28.7]	17.2 *** [14.8,19.6]
Improved physical health	47.8	54.3 [51.8,56.9]	50.6 [44.0,57.2]	34.6 *** [31.1,38.0]
Improved mental health	38.2	42.2 [39.6,44.7]	36.3 [30.0,42.7]	30.9 *** [27.3,34.4]
Improved oral health	39.5	44.4 [41.8,47.0]	40.1 [34.0,46.1]	31.5 *** [28.2,34.9]
I don't worry so much…[mean score, 0-4]	Mean 2.64	2.73 [2.67,2.78]	2.71 [2.56,2.86]	2.49 *** [2.41,2.57]
Having HMP has taken a lot of stress off me [mean score, 0-4]	Mean 3.09	3.16 [3.12,3.19]	3.17 [3.09,3.24]	2.99 *** [2.94,3.05]

NOTE: * denotes $P < 0.05$, ** denotes $P < 0.01$, and *** denotes $P < 0.001$.

[1]Results are adjusted for sex, age, income (0-33%FPL, 33-100%, 100-133%) race/ethnicity (NHW, AA, Hispanic, Arab/Chaldean, Others), urbanicity, health status and presence of any chronic condition.

[2]Going without health care because 'you were worried about the cost,' 'you did not have health insurance,' 'the doctor or hospital wouldn't accept your health insurance,' or 'your health plan wouldn't pay for the treatment.'

Primary Care Utilization and Experience

Table 2. Healthy Michigan Plan Beneficiary Characteristics, by PCP Visit in the Past 12 Months

	PCP visit in the past 12 months				
	Yes		No		*P*-value[1]
	Row %	95% CI	Row %	95% CI	
All[2] (n=4,090)	79.3	[77.5,80.9]	20.7	[19.1,22.5]	
Age					<0.001
19-34 (n=1,303)	72.1	[68.8,75.1]	27.9	[24.9,31.2]	
35-50 (n=1,301)	81.0	[78.0,83.7]	19.0	[16.3,22.0]	
51-64 (n=1,486)	88.1	[85.8,90.0]	11.9	[10.0,14.2]	
Gender					<0.001
Male (n=1,681)	73.6	[70.6,76.4]	26.4	[23.6,29.4]	
Female (n=2,409)	84.6	[82.7,86.4]	15.4	[13.6,17.3]	
FPL					0.364
0-35% (n=1,600)	78.7	[75.9,81.3]	21.3	[18.7,24.1]	
36-99% (n=1,450)	81.0	[78.3,83.5]	19.0	[16.5,21.7]	
≥100% (n=1,040)	78.2	[74.9,81.2]	21.8	[18.8,25.1]	
Race					<0.001
White (n=2,784)	82.5	[80.5,84.4]	17.5	[15.6,19.5]	
Black or African American (n=807)	74.4	[70.2,78.3]	25.6	[21.7,29.8]	
Other (n=306)	73.9	[67.4,79.5]	26.1	[20.5,32.6]	
More than one (n=142)	73.4	[62.5,82.0]	26.6	[18.0,37.5]	
Hispanic/Latino					0.331
Yes (n=188)	74.4	[66.4,81.0]	25.6	[19.0,33.6]	
No (n=3,856)	79.5	[77.7,81.3]	20.5	[18.7,22.3]	
DK (n=12)	68.2	[30.8,91.2]	31.8	[8.8,69.2]	
Arab, Chaldean, Middle Eastern					0.387
Yes (n=204)	82.4	[74.6,88.2]	17.6	[11.8,25.4]	
No (n=3,842)	79.0	[77.2,80.8]	21.0	[19.2,22.8]	
DK (n=9)	61.9	[24.4,89.1]	38.1	[10.9,75.6]	
Health status					<0.001
Excellent (n=337)	67.9	[61.3,73.8]	32.1	[26.2,38.7]	
Very good (n=1,041)	71.9	[67.9,75.7]	28.1	[24.3,32.1]	
Good (n=1,448)	81.3	[78.3,84.0]	18.7	[16.0,21.7]	
Fair (n=931)	86.3	[83.3,88.9]	13.7	[11.1,16.7]	
Poor (n=324)	90.7	[86.4,93.8]	9.3	[6.2,13.6]	
Any chronic health condition present					<0.001
Yes (n=2,986)	85.1	[83.2,86.8]	14.9	[13.2,16.8]	
No (n=1,104)	66.2	[62.5,69.8]	33.8	[30.2,37.5]	
Employment status					0.103
Yes (n=2,079)	77.8	[75.2,80.2]	22.2	[19.8,24.8]	
No (n=2,011)	80.7	[78.2,82.9]	19.3	[17.1,21.8]	

Married or partnered					0.102
Yes (n=1,193)	81.6	[78.4,84.5]	18.4	[15.5,21.6]	
No (n=2,880)	78.5	[76.4,80.5]	21.5	[19.5,23.6]	

[1] Pearson chi-square analyses

[2] Overall percentage of enrollees who had a PCP visit in the past year, regardless of whether or not they reported having a PCP

Table 3. Impact of PCP Visit in the Past 12 Months on Access, HRA, Counseling for Healthy Behavior and Diagnosis of New Chronic Condition

NOTE: Reported n is the number of observations in the logistic regression model

	Saw PCP in past 12 months		*P*-value[5]
	Yes (%)	No (%)	
Improved access to help with staying healthy[1] (n=4,004)	55.1 [52.8, 57.3]	40.1 [35.3, 44.9]	<0.001
Improved access to dental care[1] (n=4,011)	47.5 [45.3, 49.8]	41.1 [36.4, 45.9]	0.021
Improved access to specialty care[1] (n=4,012)	46.8 [44.6, 49.0]	35.6 [30.8, 40.4]	<0.001
Improved access to mental health care[1] (n=4,011)	28.0 [26.0, 30.1]	25.1 [20.7, 29.4]	0.242
Improved access to cancer screening[1] (n=3,997)	27.6 [25.7, 29.6]	18.0 [14.3, 21.6]	<0.001
Remembered completing an HRA (n=4,014)	52.8 [50.6, 55.1]	36.4 [31.7, 41.1]	<0.001
Reported being counseled about exercise (n=4,015)	55.4 [53.1, 57.6]	22.3 [18.4, 26.2]	<0.001
Reported being counseled about nutrition (n=4,014)	56.4 [54.1, 58.6]	24.7 [20.6, 28.7]	<0.001
Reported being counseled about tobacco cessation[2] (n=1,506)	61.6 [57.9, 65.2]	27.1 [20.2, 34.0]	<0.001
Reported being counseled about alcohol[3] (n=734)	36.2 [30.9, 41.5]	15.7 [8.4, 23.0]	<0.001
Reported being counseled about drug use[4] (n=173)	40.0 [30.4, 49.6]	30.1 [13.7, 46.5]	0.300
New diagnosis of chronic condition (n=4,015)	32.0 [30.1, 34.0]	22.7 [18.3, 27.0]	<0.001

[1]Participants reported that access to these health care resources had gotten better since enrollment in HMP

[2]Those who reported tobacco use

[3]Those who reported unsafe alcohol intake

[4]Those who reported unsafe drug use

[5] Logistic regression models included covariates age, gender, race, health status, FPL, employment, married/partnered and chronic condition

Impact of HMP on Acute Care Seeking

Table 4. Emergency Room Use in the Past 12 Months, by Health Status

	Health Status				
	Excellent, very good, or good		Fair or poor		*P*-value[1]
	Row %	95% CI	Row %	95% CI	
Any ER visits past 12 months (n=4,081)					<0.001
Yes (n=1,454)	59.9	[56.8,63.0]	40.1	[37.0,43.2]	
No (n=2,604)	76.8	[74.7,78.8]	23.2	[21.2,25.3]	

[1] Pearson chi-square analyses

Table 5. Emergency Room Use in the Past 12 Months, by Presence of Chronic Condition

	Any Chronic Health Condition Present				
	Yes		No		*P*-value[1]
	Row %	95% CI	Row %	95% CI	
Any ER visits past 12 months (n=4,090)					<0.001
Yes (n=1,456)	79.4	[76.4,82.1]	20.6	[17.9,23.6]	
No (n=2,611)	62.8	[60.3,65.2]	37.2	[34.8,39.7]	

[1] Pearson chi-square analyses

Table 6. Emergency Room Use in the Past 12 Months, by Perceived Discrimination Because of Race

	Discrimination: Race/Ethnicity				
	Yes		No		*P*-value[1]
	Row %	95% CI	Row %	95% CI	
Any ER visits past 12 months (n=4,076)					<0.001
Yes (n=1,451)	4.7	[3.5,6.3]	95.0	[93.4,96.3]	
No (n=2,603)	1.8	[1.3,2.5]	97.2	[96.4,97.8]	

[1] Pearson chi-square analyses

Table 7. Emergency Room Use in the Past 12 Months, by Perceived Discrimination Because of Ability to Pay

	Discrimination: Health Insurance/Ability to Pay				
	Yes		No		*P*-value[1]
	Row %	95% CI	Row %	95% CI	
Any ER visits past 12 months (n=4,077)					<0.001
Yes (n=1,452)	15.5	[13.4,17.9]	83.1	[80.6,85.3]	
No (n=2,603)	9.2	[7.8,10.8]	89.4	[87.8,90.9]	

[1] Pearson chi-square analyses

Table 8. Emergency Room Use in the Past 12 Months, by Perceived Discrimination Because of Ability to Speak English

	Discrimination: Ability to Speak English				
	Yes		No		*P*-value[1]
	Row %	95% CI	Row %	95% CI	
Any ER visits past 12 months (n=4,075)					0.003
Yes (n=1,451)	2.3	[1.5,3.4]	97.5	[96.3,98.3]	
No (n=2,602)	1.4	[0.9,2.0]	97.3	[96.3,98.1]	

[1] Pearson chi-square analyses

Impact of HMP on Beneficiary Employment, Education and Ability to Work

Table 9. Demographic and Health Characteristics for HMP Enrollees by Employment Status

	All	Employed or self-employed	Out of work, Total	Homemaker	Student	Retired	Unable to work	*P*-value
	% [95% CI]	% [95% CI]	% [95% CI]	% [95% CI]	% [95% CI]	% [95% CI]	% [95% CI]	
Age								
19-34	39.9 [37.9,41.9]	45.8 [43.0,48.6]	34.8 [30.9-38.9]	37.9 [30.1,46.3]	87.5 [81.4,91.8]	0	14.8 [10.6,20.2]	<0.001
35-50	34.0 [32.2,36.0]	34.2 [31.6,36.8]	37.7 [33.8-41.8]	35.1 [27.5,43.6]	8.5 [5.0,14.2]	1.1 [0.3,4.5]	43.1 [37.6,48.8]	
51-64	26.1 [24.6,27.6]	20.0 [18.3,21.9]	27.5 [24.4-30.8]	27.0 [20.7,34.3]	4.0 [2.1,7.7]	98.9 [95.5,99.7]	42.1 [36.8,47.5]	
Male Gender	48.5 [46.5,50.4]	45.5 [42.7,48.3]	57.2 [53.3,61.1]	6.8 [3.7,12.1]	53.3 [43.8,62.4]	51.3 [41.7,60.8]	53.9 [48.3,59.4]	<0.001
Race								
White or Caucasian	61.3 [59.4,63.2]	62.2 [59.5,64.9]	55.2 [51.1-59.2]	66.2 [58.0,73.5]	53.9 [44.3,63.2]	74.3 [63.0,83.1]	70.3 [64.7,75.4]	<0.001
Black or African-American	25.9 [24.2,27.7]	24.2 [21.8,26.8]	34.4 [30.6-38.5]	10.4 [6.3,16.7]	24.8 [17.9,33.4]	16.4 [9.3,27.2]	21.9 [17.3,27.3]	
Other	8.8 [7.7,10.0]	9.4 [7.9,11.2]	5.9 [4.4-7.9]	21.2 [15.3,28.7]	18.3 [11.2,28.6]	5.0 [2.0,11.9]	4.3 [2.5,7.3]	
More than one race	4.0 [3.3,4.9]	4.1 [3.1,5.5]	4.4 [3.0-6.5]	2.2 [1.0,5.1]	3.0 [1.0,8.2]	4.3 [1.1,15.4]	3.6 [2.1,6.1]	
Ethnicity								
Hispanic/Latino	5.2 [4.4,6.2]	6.1 [4.9,7.6]	4.6 [3.1-6.6]	4.9 [2.5,9.3]	6.5 [2.5,15.5]	2.8 [1.2,6.5]	3.3 [1.8,6.0]	0.429
Arab/Chaldean/Middle Eastern	6.2 [5.3,7.2]	7.3 [5.9,9.0]	2.7 [1.7-4.1]	21.1 [14.8,29.1]	14.6 [8.8,23.3]	0	1.2 [0.3,4.9]	<0.001
FPL								
0-35%	51.7 [50.7,52.7]	33.7 [31.3,36.3]	79.1 [76.5-81.5]	27.4 [19.8,36.8]	57.6 [48.4,66.3]	32.2 [23.0,42.9]	73.8 [69.4,77.8]	<0.001
36-99%	28.5 [27.6,29.3]	38.1 [36.1,40.1]	15.0 [12.9-17.3]	46.6 [38.7,54.6]	21.5 [15.5,29.0]	35.4 [26.9,44.9]	13.9 [10.9,17.6]	
≥100%	19.8 [19.2,20.5]	28.1 [26.5,29.8]	5.9 [4.7-7.4]	26.0 [20.0,33.0]	20.9 [14.4,29.3]	32.4 [25.0,40.9]	12.2 [9.6,15.4]	
Veteran	3.4 [2.7,4.2]	2.3 [1.6,3.3]	3.9 [2.6-5.8]	0.5 [0.1,2.0]	3.0 [1.0,8.7]	13.4 [7.6,22.5]	5.9 [3.7,9.2]	0.001
Health Status								
Excellent, very good, or good	70.1 [68.4,71.9]	80.3 [78.1,82.4]	66.1 [62.3-69.6]	77.5 [70.2,83.5]	81.1 [72.5,87.6]	75.9 [67.8,82.5]	26.2 [21.5,31.5]	<0.001
Fair or poor	29.7 [28.0,31.5]	19.6 [17.5,21.9]	33.7 [30.1-37.4]	22.5 [16.5,29.8]	18.9 [12.4,27.5]	24.1 [17.5,32.2]	73.4 [68.1,78.1]	
Chronic Health Condition	69.2 [67.3,71.0]	62.3 [59.5,65.0]	74.0 [69.9-77.6]	66.0 [57.5,73.7]	52.6 [43.1,62.0]	77.8 [67.5,85.6]	94.0 [90.6,96.2]	<0.001
Physical Health Condition	60.8 [58.8,62.8]	53.8 [51.0,56.6]	65.1 [60.9-69.0]	58.4 [49.9,66.3]	40 [31.4,49.3]	76.3 [66.0,84.1]	87.5 [82.6,91.2]	<0.001
Diabetes	10.8 [9.7,12.0]	8.8 [7.5,10.4]	11.4 [9.3-13.9]	9.9 [5.8,16.3]	4.1 [1.8,9.3]	9.3 [5.4,15.6]	22.3 [17.9,27.4]	<0.001
Hypertension	31.3 [29.6,33.1]	24.9 [22.7,27.3]	37.6 [33.8-41.5]	20.6 [15.2,27.2]	10.7 [6.7,16.5]	46.2 [36.7,55.9]	54.2 [48.5,59.8]	<0.001
Cardiovascular Disease	9.8 [8.7,11.0]	7.1 [5.9,8.6]	10.4 [8.2-13.2]	6.6 [4.0,10.6]	3.7 [1.7,7.9]	12.5 [8.2,18.7]	22.9 [18.3,28.2]	<0.001
Asthma	17.1 [15.7,18.6]	14.7 [12.9,16.6]	16.1 [13.5-19.1]	22.8 [16.5,30.8]	21.2 [14.4,30.1]	14.2 [8.0,24.0]	26.6 [21.9,31.9]	<0.001
COPD	10.5 [9.5,11.7]	7.6 [6.2,9.1]	11.2 [9.2-13.6]	10.6 [5.9,18.2]	2.9 [1.2,7.2]	17.4 [11.8,25.0]	23.7 [19.3,28.8]	<0.001
Cancer	3.7 [3.2,4.4]	2.8 [2.1,3.6]	2.7 [1.8-4.1]	5.2 [3.1,8.6]	1.8 [0.5,6.5]	7.6 [4.5,12.5]	10.2 [7.4,14.0]	<0.001
Mental Health Condition	32.2 [30.4,34.0]	25.2 [22.9,27.7]	35.3 [31.7-39.1]	24.2 [18.0,31.5]	30.2 [22.1,39.8]	20.3 [13.3,29.8]	61.7 [56.1,66.9]	<0.001
Mood disorder	30.5 [28.7,32.3]	23.5 [21.2,25.9]	33.7 [30.1-37.4]	23.9 [17.8,31.3]	26.6 [19.1,35.8]	19.9 [12.9,29.5]	59.6 [54.1,65.0]	<0.001
Other	0.8 [0.4,1.3]	0.8 [0.4,1.8]	0.2 [0.0-1.1]	0.3 [0.0,1.8]	3.7 [1.0,12.6]	0.4 [0.1,2.8]	1.2 [0.5,2.8]	0.008

Functional Impairment (≥14 of past 30 days)								
Physical	22.9 [21.3,24.5]	13.3 [11.6,15.3]	24.4 [21.2-27.9]	21.3 [15.0,29.1]	7.6 [4.3,13.1]	24.0 [17.3,32.2]	68.8 [63.2,73.8]	<0.001
Mental	19.9 [18.3,21.5]	11.6 [10.1,13.4]	25.0 [21.7-28.7]	15.1 [9.8,22.4]	16.2 [9.8,25.4]	13.6 [8.8,20.4]	48.4 [42.7,54.1]	<0.001

Table 10. Demographic and Health Characteristics for HMP Enrollees who are Out of Work, ≥ 1 year vs. <1 year

	Out of work ≥ 1 year		Out of work <1 year		Out of work, Total	
	%	[95% CI]	%	[95% CI]	%	[95% CI]
Age						
19-34	28.8	[24.6,33.4]	49.8	[42.2,57.4]	34.8	[30.9-38.9]
35-50	40.0	[35.3,44.9]	32.1	[25.9,39.0]	37.7	[33.8-41.8]
51-64	31.2	[27.4,35.3]	18.1	[13.2,24.3]	27.5	[24.4-30.8]
Male Gender	58.4	[53.7,62.9]	54.5	[46.9,61.9]	57.2	[53.3,61.1]
Race						
White or Caucasian	58.0	[53.2,62.6]	48.2	[40.7,55.8]	55.2	[51.1-59.2]
Black or African-American	31.9	[27.5,36.7]	40.8	[33.1,48.9]	34.4	[30.6-38.5]
Other	6.1	[4.3,8.5]	5.7	[3.2,9.8]	5.9	[4.4-7.9]
More than one race	4.1	[2.5,6.6]	5.4	[2.8,9.9]	4.4	[3.0-6.5]
Ethnicity						
Hispanic/Latino	5.0	[3.2,7.7]	3.5	[1.7,7.2]	4.6	[3.1-6.6]
Arab/Chaldean/Middle Eastern	2.6	[1.6,4.1]	3.0	[1.3,7.2]	2.7	[1.7-4.1]
FPL						
0-35%	81.8	[78.7,84.6]	72.4	[66.6,77.6]	79.1	[76.5-81.5]
36-99%	13.9	[11.4,16.9]	17.6	[13.7,22.3]	15.0	[12.9-17.3]
≥100%	4.3	[3.1,5.8]	10.0	[7.0,14.0]	5.9	[4.7-7.4]
Veteran	4.7	[3.0,7.2]	2.0	[0.8,4.8]	3.9	[2.6-5.8]
Health Status						
Excellent, very good, or good	63.6	[59.1,67.9]	72.2	[65.3,78.2]	66.1	[62.3-69.6]
Fair or poor	36.1	[31.8,40.6]	27.8	[21.8,34.7]	33.7	[30.1-37.4]
Chronic Health Condition	75.9	[71.3,80.0]	69.1	[60.6,76.4]	74.0	[69.9-77.6]
Physical Health Condition	68.2	[63.4,72.6]	57.4	[49.4,65.0]	65.1	[60.9-69.0]
Diabetes	13.8	[11.1,17.1]	5.2	[3.0,8.7]	11.4	[9.3-13.9]
Hypertension	39.8	[35.3,44.5]	32.0	[25.6,39.2]	37.6	[33.8-41.5]
Cardiovascular Disease	11.3	[8.6,14.8]	8.2	[5.1,12.9]	10.4	[8.2-13.2]
Asthma	16.3	[13.2,19.9]	15.6	[11.2,21.3]	16.1	[13.5-19.1]
COPD	12.6	[10.1,15.6]	7.8	[5.0,12.0]	11.2	[9.2-13.6]
Cancer	2.4	[1.5,3.9]	3.5	[1.6,7.2]	2.7	[1.8-4.1]
Mental Health Condition	35.1	[30.8,39.6]	35.9	[29.3,43.0]	35.3	[31.7-39.1]
Mood disorder	33.5	[29.3,38.0]	33.9	[27.5,41.0]	33.7	[30.1-37.4]
Other	0.2	[0.0,1.6]	0		0.2	[0.0-1.1]

Functional Impairment (≥14 of past 30 days)						
Physical	26.2	[22.3,30.5]	19.8	[14.7,26.3]	24.4	[21.2-27.9]
Mental	26.3	[22.3,30.8]	21.8	[16.2,28.7]	25.0	[21.7-28.7]

Table 11. Employment Status Among Healthy Michigan Plan Enrollees, by Health Status

	Health Status						
	Excellent, very good, or good		Fair or poor		Total		*P*-value[1]
	Col %	95% CI	Col %	95% CI	Col %	95% CI	
Employment Status (n=4,059)							<0.001
Employed or self-employed (n=2,076)	56.1	[53.7,58.4]	32.3	[29.1,35.5]	48.9	[47.0,50.8]	
Out of work ≥1 year (n=705)	17.9	[16.0,19.9]	23.9	[21.0,27.0]	19.7	[18.1,21.3]	
Out of work <1 year (n=258)	8.1	[6.8,9.7]	7.4	[5.7,9.4]	7.9	[6.8,9.1]	
Homemaker (n=217)	5.0	[4.2,6.0]	3.4	[2.5,4.7]	4.5	[3.8,5.3]	
Student (n=161)	6.0	[4.9,7.4]	3.3	[2.1,5.1]	5.2	[4.3,6.2]	
Retired (n=167)	2.7	[2.2,3.4]	2.0	[1.5,2.8]	2.5	[2.1,3.0]	
Unable to work (n=475)	4.2	[3.4,5.2]	27.8	[24.8,31.0]	11.3	[10.1,12.5]	

[1] Pearson chi-square analyses

Table 12. Employment Status Among Healthy Michigan Plan Enrollees, by Presence of Chronic Condition

	Any Chronic Health Condition Present						
	Yes		No		Total		*P*-value[1]
	Col %	95% CI	Col %	95% CI	Col %	95% CI	
Employment Status (n=4,068)							<0.001
Employed or self-employed (n=2,079)	44.1	[41.9,46.3]	59.8	[55.9,63.5]	48.9	[47.0,50.8]	
Out of work ≥1 year (n=707)	21.6	[19.7,23.6]	15.4	[12.7,18.5]	19.7	[18.1,21.3]	
Out of work <1 year (n=258)	7.9	[6.7,9.2]	7.9	[5.7,10.8]	7.9	[6.8,9.1]	
Homemaker (n=217)	4.3	[3.6,5.2]	5.0	[3.7,6.7]	4.5	[3.8,5.3]	
Student (n=161)	3.9	[3.1,5.0]	8.0	[6.0,10.4]	5.2	[4.3,6.2]	
Retired (n=167)	2.8	[2.3,3.5]	1.8	[1.1,2.9]	2.5	[2.1,3.0]	
Unable to work (n=479)	15.3	[13.8,17.0]	2.2	[1.4,3.5]	11.3	[10.1,12.5]	

[1] Pearson chi-square analyses

Table 13. Ability to Work Among Healthy Michigan Plan Enrollees Who Are Employed/Self-Employed

	Mean or %	95% CI
[If employed or self-employed] In the past 12 months, about how many days did you miss work at a job or business because of illness or injury (do not include maternity leave)?	Mean 7.2	[5.6,8.7]
Compared to the 12 months before this time, was this more, less, or about the same? (n=2,074)		
More (n=261)	12.3	[10.7,14.1]
Less (n=345)	17.2	[15.2,19.5]
About the same (n=1,437)	68.4	[65.8,70.9]
Don't know (n=31)	2.1	[1.2,3.4]

Table 14. Multivariable Logistic Regression Analysis of Association between HMP Enrollee Demographic and Health Characteristics and being Out of Work or Unable to Work

	Outcomes[1]			
	Out of Work		Unable to Work	
Characteristic	aOR (95% CI)	*P*-value	aOR (95% CI)	*P*-value
Age				
19-34	[ref]	[ref]	[ref]	[ref]
35-50	1.29 (0.99-1.67)	0.056	2.34 (1.45-3.75)	<0.001
51-64	1.67 (1.29-2.17)	<0.001	4.20 (2.64-6.65)	<0.001
Male gender	1.80 (1.45-2.23)	<0.001	1.88 (1.35-2.63)	<0.001
Race				
White or Caucasian	[ref]	[ref]	[ref]	[ref]
Black or African-American	1.93 (1.50-2.49)	<0.001	1.16 (0.76-1.78)	0.483
Other	0.75 (0.50-1.11)	0.148	0.51 (0.25-1.06)	0.072
More than one race	1.25 (0.72-2.18)	0.423	1.02 (0.49-2.15)	0.954
Fair or poor health	1.47 (1.15-1.89)	0.003	3.52 (2.42-5.11)	<0.001
Chronic Health Condition [reference = none]				
Physical	1.11 (0.88-1.42)	0.378	1.73 (1.08-2.79)	0.023
Mental	1.47 (1.16-1.87)	0.001	2.61 (1.82-3.73)	<0.001
Functional Limitation [reference = none]				
Physical	1.43 (1.07-1.92)	0.016	5.10 (3.54-7.33)	<0.001
Mental	1.95 (1.46-2.60)	<0.001	2.29 (1.56-3.37)	<0.001

aOR = adjusted odds ratio; CI = confidence interval

[1]Each column represents a different multivariable logistic regression model.

Table 15. Factors Associated with Employment and Ability to Work, Among Healthy Michigan Plan Enrollees who were Employed/Self-employed

Characteristic	Outcomes[1]			
	Employed or Self-Employed (Weighted N=106,619)		Better Job at Work (Weighted N=75,282)	
	aOR (95% CI)	*P*- value	aOR (95% CI)	*P*-value
Physical or mental health better since HMP enrollment	1.08 (0.89, 1.30)	0.44	4.08 (3.11, 5.35)	<0.001
Age				
19-34	Reference		Reference	
35-50	0.98 (0.78, 1.24)	0.89	0.96 (0.70, 1.31)	0.78
51-64	0.56 (0.45, 0.70)	<0.001	1.10 (0.80, 1.51)	0.57
Female gender	1.00 (0.83, 1.21)	0.98	1.42 (1.08, 1.85)	0.01
Race				
White or Caucasian	Reference		Reference	
Black or African American	0.96 (0.77, 1.21)	0.74	1.55 (1.10, 2.19)	0.01
Other	0.87 (0.61, 1.23)	0.44	1.24 (0.69, 2.21)	0.47
More than one race	1.10 (0.67, 1.82)	0.71	1.70 (0.79, 3.67)	0.18
FPL				
0-35%	Reference		Reference	
36-99%	3.72 (3.02, 4.58)	<0.001	0.79 (0.54, 1.15)	0.22
100-133%	4.40 (3.51, 5.52)	<0.001	0.62 (0.42, 0.90)	0.01
Fair or poor health	0.67 (0.53, 0.83)	<0.001	1.09 (0.76, 1.57)	0.64
Chronic health condition	0.84 (0.67, 1.06)	0.14	1.57 (1.18, 2.09)	0.002
Functional limitation, physical or mental	0.26 (0.19, 0.34)	<0.001	1.20 (0.69, 2.09)	0.53

aOR = adjusted odds ratio; CI = confidence interval; HMP = Healthy Michigan Plan

[1]Each column represents a different multivariable logistic regression model. In the first model, employment status was dichotomized as employed/self-employed vs. all other responses. We checked for collinearity of variables, including health status/chronic condition/function and there was no collinearity in the model.

Table 16. Factors Associated with Job Seeking Ability, Among Healthy Michigan Plan Enrollees who Had a Recent Job Change or were Out of Work

Characteristic	Outcomes[1]			
	Better able to look for job[2] (Weighted N=35,711)		Helped get a better job[3] (Weighted N=9,275)	
	aOR (95% CI)	*P*- value	aOR (95% CI)	*P*-value
Physical or mental health better since HMP enrollment	2.82 (1.93, 4.10)	<0.001	3.20 (1.69, 6.09)	<0.001
Age				
19-34	Reference		Reference	
35-50	1.36 (0.87, 2.11)	0.17	1.01 (0.55, 1.87)	0.97
51-64	1.76 (1.14, 2.72)	0.01	1.30 (0.65, 2.59)	0.46
Female gender	0.73 (0.50, 1.07)	0.10	0.72 (0.41, 1.25)	0.24
Race				
White or Caucasian	Reference		Reference	
Black or African American	0.80 (0.53, 1.22)	0.30	1.31 (0.68, 2.55)	0.42
Other	1.52 (0.73, 3.19)	0.27	1.69 (0.65, 4.41)	0.28
More than one race	0.51 (0.22, 1.23)	0.13	0.46 (0.13, 1.67)	0.24
FPL				
0-35%	Reference		Reference	
36-99%	0.83 (0.53, 1.29)	0.40	0.90 (0.47, 1.73)	0.76
100-133%	0.74 (0.41, 1.36)	0.33	0.60 (0.31, 1.17)	0.13
Fair or poor health	1.17 (0.79, 1.74)	0.42	1.17 (0.56, 2.45)	0.67
Chronic health condition	0.87 (0.54, 1.40)	0.57	1.31 (0.72, 2.36)	0.37
Functional limitation, physical or mental	0.85 (0.56, 1.30)	0.46	1.51 (0.47, 4.89)	0.49

aOR = adjusted odds ratio; CI = confidence interval; HMP = Healthy Michigan Plan

[1]Each column represents a different multivariable logistic regression model.

[2]Strongly agree or agree that "Having health insurance through the Healthy Michigan Plan has made me better able to look for a job."

[3]Strongly agree or agree that "Having health insurance through the Healthy Michigan Plan helped me get a better job."

Impact of HMP on Access to Dental Care and Oral Health

Table 17. Healthy Michigan Plan Beneficiary Characteristics, by Awareness of Dental Care Coverage

	My Healthy Michigan Plan covers routine dental visits.						
	Yes		No		Don't know		*P*-value[1]
	Row %	95% CI	Row %	95% CI	Row %	95% CI	
Age							0.524
19-34 (n=1,303)	76.9	[73.8,79.8]	4.6	[3.4,6.2]	18.5	[15.8,21.4]	
35-50 (n=1,300)	76.7	[73.6,79.5]	3.4	[2.5,4.6]	20.0	[17.3,23.0]	
51-64 (n=1,483)	78.2	[75.6,80.6]	3.7	[2.7,5.0]	18.1	[15.9,20.6]	
Total (n=4,086)	77.2	[75.4,78.8]	3.9	[3.3,4.7]	18.9	[17.3,20.6]	
FPL							0.016
0-35% (n=1,599)	77.1	[74.3,79.7]	2.9	[2.1,4.1]	20.0	[17.5,22.7]	
36-99% (n=1,448)	78.5	[75.9,80.9]	4.9	[3.7,6.4]	16.6	[14.5,18.9]	
≥100% (n=1,039)	75.3	[72.0,78.3]	5.2	[3.9,7.1]	19.4	[16.7,22.5]	
Total (n=4,086)	77.2	[75.4,78.8]	3.9	[3.3,4.7]	18.9	[17.3,20.6]	
Region							0.087
UP/NW/NE (n=745)	78.6	[75.0,81.7]	2.9	[1.9,4.4]	18.5	[15.5,22.0]	
W/EC/E (n=1,264)	79.0	[76.2,81.5]	3.3	[2.4,4.6]	17.7	[15.3,20.3]	
SC/SW/SE (n=836)	72.5	[68.5,76.2]	4.6	[3.3,6.4]	22.9	[19.3,26.9]	
DET (n=1,241)	77.7	[74.6,80.5]	4.2	[3.1,5.7]	18.1	[15.5,21.0]	
Total (n=4,086)	77.2	[75.4,78.8]	3.9	[3.3,4.7]	18.9	[17.3,20.6]	
Employment status							0.364
Employed or self-employed (n=2,078)	77.9	[75.5,80.2]	4.0	[3.1,5.2]	18.0	[15.9,20.4]	
Out of work ≥1 year (n=705)	74.4	[69.7,78.6]	3.4	[2.0,5.7]	22.2	[18.2,26.8]	
Out of work <1 year (n=258)	78.9	[72.1,84.4]	3.8	[2.1,7.0]	17.3	[12.2,24.0]	
Homemaker (n=217)	79.3	[72.3,84.9]	6.1	[3.1,11.7]	14.6	[10.1,20.6]	
Student (n=161)	75.3	[66.1,82.6]	5.4	[2.9,10.0]	19.3	[12.6,28.5]	
Retired (n=167)	80.1	[72.8,85.8]	3.8	[1.8,7.7]	16.1	[11.0,23.1]	
Unable to work (n=479)	77.1	[72.4,81.2]	2.2	[1.3,3.7]	20.7	[16.7,25.3]	
Don't know (n=7)	53.2	[15.8,87.3]	0		46.8	[12.7,84.2]	
Total (n=4,072)	77.2	[75.4,78.8]	3.8	[3.2,4.6]	19.0	[17.4,20.7]	

[1] Pearson chi-square analyses

Table 18. Healthy Michigan Plan Beneficiary Characteristics, by Perceived Dental Care Access

	Would you say that your ability to get dental care through the Healthy Michigan Plan is better, worse, or about the same, compared to before?								
	Better		Worse		About the same		Don't know		*P*-value[1]
	Row %	95% CI	Row %	95% CI	Row %	95% CI	Row %	95% CI	
Age									<0.001
19-34 (n=1,302)	44.4	[41.1,47.8]	6.4	[4.8,8.4]	35.2	[31.9,38.6]	14.1	[11.9,16.6]	
35-50 (n=1,298)	47.7	[44.3,51.1]	5.9	[4.6,7.6]	26.1	[23.2,29.1]	20.3	[17.5,23.4]	
51-64 (n=1,484)	46.4	[43.3,49.6]	6.5	[5.1,8.3]	24.7	[22.1,27.5]	22.4	[19.9,25.0]	
Total (n=4,084)	46.1	[44.1,48.0]	6.2	[5.4,7.3]	29.3	[27.5,31.2]	18.4	[16.9,19.9]	
FPL									0.104
0-35% (n=1,596)	46.8	[43.7,49.9]	5.3	[4.1,7.0]	28.2	[25.4,31.2]	19.7	[17.3,22.2]	
36-99% (n=1,448)	46.3	[43.2,49.4]	6.8	[5.4,8.7]	29.6	[26.7,32.6]	17.3	[15.0,19.8]	
≥100% (n=1,040)	43.6	[40.2,47.2]	7.8	[6.0,10.1]	32.1	[28.8,35.5]	16.5	[14.0,19.3]	
Total (n=4,084)	46.1	[44.1,48.0]	6.2	[5.4,7.3]	29.3	[27.5,31.2]	18.4	[16.9,19.9]	
Region									0.566
UP/NW/NE (n=746)	48.8	[44.7,52.9]	6.5	[4.9,8.5]	28.0	[24.3,32.0]	16.8	[14.1,19.8]	
W/EC/E (n=1,263)	47.3	[44.2,50.5]	5.9	[4.4,7.8]	28.1	[25.3,31.1]	18.6	[16.2,21.3]	
SC/SW/SE (n=835)	45.4	[41.4,49.5]	5.8	[4.2,8.0]	27.9	[24.1,31.9]	20.9	[17.9,24.3]	
DET (n=1,240)	44.9	[41.5,48.4]	6.6	[5.1,8.5]	31.0	[27.9,34.4]	17.4	[14.9,20.3]	
Total (n=4,084)	46.1	[44.1,48.0]	6.2	[5.4,7.3]	29.3	[27.5,31.2]	18.4	[16.9,19.9]	
Employment status									<0.001
Employed or self-employed (n=2,077)	48.2	[45.5,51.0]	5.5	[4.5,6.7]	30.1	[27.6,32.7]	16.2	[14.3,18.2]	
Out of work ≥1 year (n=704)	45.7	[41.0,50.4]	4.9	[3.1,7.7]	25.3	[21.4,29.6]	24.2	[20.2,28.7]	
Out of work <1 year (n=258)	43.0	[35.8,50.5]	9.0	[4.9,15.8]	28.8	[22.1,36.4]	19.3	[13.8,26.2]	
Homemaker (n=217)	48.0	[39.8,56.3]	5.7	[3.2,9.8]	33.8	[26.5,41.9]	12.6	[8.6,18.1]	
Student (n=160)	32.3	[24.6,41.0]	12.8	[7.6,20.9]	43.8	[34.5,53.6]	11.1	[6.6,18.0]	
Retired (n=167)	48.6	[39.0,58.3]	7.4	[3.8,13.9]	24.8	[17.3,34.3]	19.2	[13.1,27.1]	
Unable to work (n=479)	44.1	[38.6,49.7]	6.8	[4.4,10.4]	27.1	[22.2,32.5]	22.0	[17.8,27.0]	
Don't know (n=7)	58.7	[17.6,90.4]	0		0		41.3	[9.6,82.4]	
Total (n=4,069)	46.1	[44.1,48.0]	6.2	[5.3,7.2]	29.4	[27.6,31.3]	18.3	[16.9,19.9]	

[1] Pearson chi-square analyses

Table 19. Healthy Michigan Plan Beneficiary Characteristics, by Forgone Dental Care

	Forgone dental care due to cost[1]				
	Yes		No		*P*-value[2]
	Row %	95% CI	Row %	95% CI	0.537
Age					
19-34 (n=136)	65.3	[55.1,74.3]	34.7	[25.7,44.9]	
35-50 (n=132)	58.5	[47.9,68.3]	41.5	[31.7,52.1]	
51-64 (n=125)	66.1	[54.1,76.3]	33.9	[23.7,45.9]	
Total (n=393)	63.2	[57.0,69.0]	36.8	[31.0,43.0]	
FPL					0.282
0-35% (n=156)	59.9	[50.6,68.5]	40.1	[31.5,49.4]	
36-99% (n=142)	64.1	[53.2,73.7]	35.9	[26.3,46.8]	
≥100% (n=95)	72.0	[60.8,81.0]	28.0	[19.0,39.2]	
Total (n=393)	63.2	[57.0,69.0]	36.8	[31.0,43.0]	
Region					0.047
UP/NW/NE (n=55)	57.2	[42.3,70.9]	42.8	[29.1,57.7]	
W/EC/E (n=115)	61.1	[50.8,70.6]	38.9	[29.4,49.2]	
SC/SW/SE (n=92)	50.6	[38.9,62.2]	49.4	[37.8,61.1]	
DET (n=131)	70.5	[59.6,79.5]	29.5	[20.5,40.4]	
Total (n=393)	63.2	[57.0,69.0]	36.8	[31.0,43.0]	
Employment status					0.008
Employed or self-employed (n=196)	61.5	[52.6,69.8]	38.5	[30.2,47.4]	
Out of work ≥1 year (n=67)	68.6	[53.9,80.3]	31.4	[19.7,46.1]	
Out of work <1 year (n=26)	82.5	[64.3,92.5]	17.5	[7.5,35.7]	
Homemaker (n=18)	79.2	[52.8,92.8]	20.8	[7.2,47.2]	
Student (n=19)	78.9	[55.9,91.7]	21.1	[8.3,44.1]	
Retired (n=9)	70.3	[31.8,92.3]	29.7	[7.7,68.2]	
Unable to work (n=58)	41.3	[25.6,59.1]	58.7	[40.9,74.4]	
Total (n=393)	63.2	[57.0,69.0]	36.8	[31.0,43.0]	

[1] Going without dental care because 'you were worried about the cost,' 'you did not have health insurance,' 'the doctor or hospital wouldn't accept your health insurance,' or 'your health plan wouldn't pay for the treatment.'

[2] Pearson chi-square analyses

Table 20. Healthy Michigan Plan Beneficiary Characteristics, by Oral Health

	Since you enrolled in the Healthy Michigan Plan, has the health of your teeth and gums gotten better, stayed the same, or gotten worse?								
	Gotten better		Stayed the same		Gotten worse		Don't know		*P*-value[1]
	Row %	95% CI	Row %	95% CI	Row %	95% CI	Row %	95% CI	
Age									<0.001
19-34 (n=1,302)	38.8	[35.6,42.1]	50.1	[46.7,53.6]	8.1	[6.5,10.1]	2.9	[2.0,4.2]	
35-50 (n=1,299)	39.9	[36.6,43.3]	42.1	[38.7,45.5]	12.5	[10.5,14.9]	5.5	[4.1,7.4]	
51-64 (n=1,483)	40.1	[37.1,43.3]	42.9	[39.8,46.0]	11.0	[9.2,13.0]	6.0	[4.7,7.8]	
Total (n=4,084)	39.5	[37.6,41.5]	45.5	[43.5,47.5]	10.4	[9.3,11.6]	4.6	[3.9,5.5]	
FPL									0.198
0-35% (n=1,597)	40.0	[37.0,43.1]	44.0	[40.9,47.2]	11.1	[9.4,13.0]	4.9	[3.8,6.4]	
36-99% (n=1,448)	40.7	[37.7,43.8]	44.9	[41.8,48.0]	9.9	[8.1,12.0]	4.6	[3.4,6.0]	
≥100% (n=1,039)	36.6	[33.3,40.0]	50.3	[46.8,53.9]	9.2	[7.4,11.3]	3.9	[2.7,5.6]	
Total (n=4,084)	39.5	[37.6,41.5]	45.5	[43.5,47.5]	10.4	[9.3,11.6]	4.6	[3.9,5.5]	
Region									0.053
UP/NW/NE (n=745)	40.9	[36.9,45.0]	44.4	[40.3,48.5]	9.3	[7.3,11.8]	5.5	[3.9,7.5]	
W/EC/E (n=1,263)	38.2	[35.2,41.3]	46.9	[43.7,50.1]	9.0	[7.4,10.8]	6.0	[4.5,7.9]	
SC/SW/SE (n=836)	36.4	[32.7,40.4]	46.6	[42.5,50.8]	13.0	[10.5,15.9]	4.0	[2.8,5.6]	
DET (n=1,240)	41.4	[38.0,44.9]	44.4	[40.9,47.9]	10.4	[8.6,12.6]	3.8	[2.7,5.4]	
Total (n=4,084)	39.5	[37.6,41.5]	45.5	[43.5,47.5]	10.4	[9.3,11.6]	4.6	[3.9,5.5]	
Employment status									<0.001
Employed or self-employed (n=2,077)	40.1	[37.4,42.8]	46.9	[44.2,49.7]	9.2	[7.8,10.8]	3.8	[2.9,5.0]	
Out of work ≥1 year (n=704)	35.9	[31.6,40.4]	48.9	[44.2,53.7]	11.3	[8.6,14.7]	3.9	[2.6,5.8]	
Out of work <1 year (n=258)	43.2	[35.8,50.9]	42.0	[34.6,49.8]	9.0	[6.1,13.1]	5.8	[3.2,10.1]	
Homemaker (n=217)	43.3	[35.2,51.7]	45.3	[37.3,53.5]	9.3	[5.9,14.4]	2.2	[0.8,5.6]	
Student (n=161)	34.6	[26.4,43.7]	51.0	[41.5,60.3]	9.4	[5.7,15.0]	5.1	[2.0,12.8]	
Retired (n=167)	44.9	[35.3,54.9]	41.7	[32.7,51.3]	10.1	[5.9,16.7]	3.3	[1.4,7.5]	
Unable to work (n=478)	39.7	[34.3,45.4]	35.6	[30.5,41.1]	15.8	[12.0,20.6]	8.9	[6.0,12.9]	
Don't know (n=7)	27.0	[6.5,66.1]	39.3	[10.5,78.2]	0		33.7	[5.6,81.3]	
Total (n=4,069)	39.4	[37.5,41.4]	45.6	[43.7,47.6]	10.4	[9.3,11.6]	4.6	[3.8,5.5]	

[1] Pearson chi-square analyses

Table 21. Perceived Access to Dental Care, Forgone Dental Care, Dental Health, ER Use, and Missed Work or School, by Awareness of Dental Care Coverage

	Awareness of dental care coverage				
	Yes		No[1]		*P*-value[2]
	Row %	95% CI	Row %	95% CI	
Ability to get dental care					<0.001
Better (n=1,929)	92.6	[90.9,94.0]	7.4	[6.0,9.1]	
Worse (n=255)	63.6	[55.6,70.8]	36.4	[29.2,44.4]	
About the same (n=1,137)	72.3	[68.7,75.6]	27.7	[24.4,31.3]	
Don't know (n=760)	51.0	[46.4,55.6]	49.0	[44.4,53.6]	
Total (n=4,081)	77.2	[75.4,78.8]	22.8	[21.2,24.6]	
Forgone dental care due to cost[3]					0.277
Yes (n=252)	64.9	[57.2,71.9]	35.1	[28.1,42.8]	
No (n=141)	71.6	[61.3,80.1]	28.4	[19.9,38.7]	
Total (n=393)	67.4	[61.3,72.9]	32.6	[27.1,38.7]	
Dental health status					<0.001
Gotten better (n=1,641)	92.3	[90.6,93.8]	7.7	[6.2,9.4]	
Stayed the same (n=1,809)	69.9	[67.0,72.7]	30.1	[27.3,33.0]	
Gotten worse (n=443)	58.9	[53.1,64.5]	41.1	[35.5,46.9]	
Don't know (n=189)	59.5	[50.3,68.0]	40.5	[32.0,49.7]	
Total (n=4,082)	77.2	[75.4,78.8]	22.8	[21.2,24.6]	
Any ER visits past 12 months					0.785
Yes (n=1,455)	77.4	[74.4,80.0]	22.6	[20.0,25.6]	
No (n=2,609)	77.1	[74.9,79.2]	22.9	[20.8,25.1]	
Don't know (n=22)	69.6	[43.6,87.2]	30.4	[12.8,56.4]	
Total (n=4,086)	77.2	[75.4,78.8]	22.8	[21.2,24.6]	
Days of school missed					0.896
None (n=94)	74.3	[62.0,83.7]	25.7	[16.3,38.0]	
1-7 days (n=50)	78.4	[58.7,90.2]	21.6	[9.8,41.3]	
More than 7 days (n=15)	76.0	[48.0,91.6]	24.0	[8.4,52.0]	
Total (n=159)	75.8	[66.4,83.2]	24.2	[16.8,33.6]	

Days of work missed					0.930
None (n=1,180)	78.4	[75.1,81.3]	21.6	[18.7,24.9]	
1-7 days (n=744)	77.9	[73.6,81.6]	22.1	[18.4,26.4]	
More than 7 days (n=384)	77.2	[71.7,82.0]	22.8	[18.0,28.3]	
Total (n=2,308)	78.0	[75.7,80.2]	22.0	[19.8,24.3]	

[1] Includes "Don't know" responses

[2] Pearson chi-square analyses

[3] Going without dental care because 'you were worried about the cost,' 'you did not have health insurance,' 'the doctor or hospital wouldn't accept your health insurance,' or 'your health plan wouldn't pay for the treatment.'

Table 22. Perceived Impact of HMP on Employment, ER Use, and Dental Health, by Perceived Access to Dental Care

	Would you say that your ability to get dental care through the Healthy Michigan Plan is better, worse, or about the same, compared to before?										
	Better		Worse		About the same		Don't know		Total		*P*-value[1]
	Col %	95% CI	Col %	95% CI	Col %	95% CI	Col %	95% CI	Col %	95% CI	
HMP helped me get a better job (n=447)											<0.001
Strongly agree (n=33)	12.0	[7.1,19.5]	4.6	[1.1,17.3]	3.8	[1.5,9.6]	4.0	[1.0,15.3]	7.7	[5.0,11.6]	
Agree (n=123)	39.2	[30.2,49.0]	17.6	[5.5,44.0]	25.6	[17.2,36.2]	10.5	[5.2,20.2]	29.2	[23.6,35.4]	
Neutral (n=103)	17.8	[12.7,24.4]	36.7	[20.0,57.3]	20.0	[12.5,30.5]	31.4	[19.0,47.1]	21.5	[17.1,26.7]	
Disagree (n=150)	24.4	[17.4,33.1]	35.8	[18.5,57.8]	44.6	[34.1,55.6]	35.7	[22.6,51.4]	33.5	[27.8,39.6]	
Strongly disagree (n=30)	5.7	[2.8,11.4]	5.3	[1.2,21.2]	4.9	[2.0,11.3]	12.0	[6.1,22.3]	6.4	[4.2,9.6]	
Don't know (n=8)	0.9	[0.3,2.9]	0		1.1	[0.2,4.9]	6.4	[1.8,20.3]	1.8	[0.8,4.0]	
Better job at work (n=2,075)											<0.001
Yes (n=1,430)	76.8	[73.2,80.0]	56.9	[46.7,66.5]	63.3	[58.2,68.1]	63.1	[56.6,69.0]	69.4	[66.8,71.8]	
No (n=548)	19.2	[16.2,22.6]	34.4	[25.5,44.4]	32.6	[28.0,37.6]	30.3	[24.8,36.5]	25.9	[23.6,28.3]	
Don't know (n=97)	4.0	[2.8,5.8]	8.7	[4.4,16.4]	4.1	[2.4,6.9]	6.6	[4.1,10.5]	4.7	[3.7,6.0]	
HMP helped me look for job (n=955)											<0.001
Strongly agree (n=158)	18.9	[14.8,23.7]	11.0	[4.7,23.3]	11.8	[7.9,17.3]	17.7	[12.0,25.5]	16.3	[13.6,19.4]	
Agree (n=388)	42.6	[37.2,48.3]	17.1	[8.6,31.3]	41.6	[34.0,49.7]	31.2	[24.2,39.1]	38.2	[34.5,42.1]	
Neutral (n=185)	17.0	[12.9,22.0]	7.6	[3.6,15.5]	21.1	[14.8,29.3]	25.2	[18.0,34.0]	19.4	[16.2,23.0]	
Disagree (n=143)	14.1	[10.5,18.7]	51.3	[33.3,69.0]	16.9	[11.7,23.8]	14.7	[8.6,24.1]	17.2	[14.1,20.9]	
Strongly disagree (n=35)	3.8	[2.1,6.9]	4.3	[1.2,14.6]	3.6	[1.7,7.6]	2.8	[1.2,6.2]	3.5	[2.4,5.2]	
Don't know (n=46)	3.6	[2.1,6.2]	8.7	[2.4,27.3]	5.0	[2.5,9.6]	8.4	[4.4,15.6]	5.4	[3.8,7.6]	

Any ER visits past 12 months (n=4,084)											0.474
Yes (n=1,452)	38.5	[35.8,41.3]	43.1	[35.4,51.1]	35.0	[31.5,38.8]	37.0	[32.7,41.5]	37.5	[35.6,39.4]	
No (n=2,609)	60.8	[58.0,63.6]	56.9	[48.9,64.6]	64.4	[60.7,68.0]	62.4	[57.9,66.7]	61.9	[60.0,63.8]	
Don't know (n=23)	0.7	[0.3,1.6]	0		0.5	[0.2,1.3]	0.6	[0.2,1.4]	0.6	[0.3,1.0]	
Dental health status (n=4,081)											<0.001
Gotten better (n=1,641)	67.9	[65.2,70.6]	14.4	[9.2,21.9]	20.9	[18.0,24.1]	7.0	[5.0,9.8]	39.6	[37.7,41.5]	
Stayed the same (n=1,807)	26.6	[24.1,29.3]	33.9	[26.8,41.8]	68.9	[65.4,72.3]	59.5	[55.0,63.9]	45.5	[43.6,47.5]	
Gotten worse (n=443)	4.5	[3.6,5.7]	46.9	[39.2,54.8]	8.8	[7.0,11.0]	15.2	[12.3,18.6]	10.4	[9.3,11.6]	
Don't know (n=190)	1.0	[0.5,1.7]	4.8	[2.6,8.7]	1.4	[0.9,2.3]	18.2	[15.0,22.0]	4.5	[3.8,5.4]	

[1] Pearson chi-square analyses

Impact of HMP Premium Contributions on Cost-Conscious Behaviors

Table 23. Healthy Michigan Plan Beneficiary Characteristics, by Federal Poverty Level

Characteristic[1]	FPL 0-35%		FPL 36-99%		FPL ≥100%		Total		*P*-value[2]
	%	95% CI	%	95% CI	%	95% CI	%	95% CI	
Age									0.035
19-34 (n=1,303)	38.1	[35.0,41.3]	40.5	[37.4,43.7]	44.0	[40.4,47.6]	40.0	[38.0,42.0]	
35-50 (n=1,301)	36.1	[33.1,39.1]	33.6	[30.7,36.6]	29.2	[26.1,32.5]	34.0	[32.1,35.9]	
51-64 (n=1,486)	25.9	[23.5,28.3]	25.9	[23.5,28.5]	26.8	[24.1,29.7]	26.0	[24.5,27.6]	
Gender									<0.001
Male (n=1,681)	57.2	[54.1,60.2]	39.1	[36.0,42.3]	39.0	[35.5,42.6]	48.4	[46.5,50.4]	
Female (n=2,409)	42.8	[39.8,45.9]	60.9	[57.7,64.0]	61.0	[57.4,64.5]	51.6	[49.6,53.5]	
Race/ethnicity									<0.001
White, non-Hispanic (n=2,714)	54.4	[51.4,57.4]	62.9	[59.9,65.9]	66.7	[63.4,69.9]	59.3	[57.3,61.1]	
Black, non-Hispanic (n=800)	32.6	[29.7,35.6]	18.2	[15.8,21.0]	19.3	[16.7,22.1]	25.9	[24.1,27.7]	
Hispanic (n=78)	1.9	[1.2,2.9]	2.4	[1.6,3.5]	2.4	[1.4,4.0]	2.1	[1.6,2.8]	
Other (n=448)	11.2	[9.3,13.3]	16.4	[14.1,19.1]	11.7	[9.5,14.3]	12.8	[11.5,14.2]	
Region									<0.001
UP/NW/NE (n=746)	6.7	[6.2,7.2]	10.9	[10.1,11.7]	12.3	[11.5,13.2]	9.0	[8.6,9.4]	
W/EC/E (n=1,265)	26.2	[25.1,27.5]	30.5	[29.1,31.9]	32.1	[30.4,33.8]	28.6	[27.8,29.4]	
SC/SW/SE (n=837)	17.4	[16.2,18.7]	19.2	[18.2,20.3]	20.6	[19.2,22.1]	18.6	[17.8,19.3]	
DET (n=1,242)	49.6	[48.1,51.2]	39.4	[37.6,41.2]	35.0	[33.3,36.7]	43.8	[42.8,44.9]	

Married or partnered									<0.001
Yes (n=1,193)	13.8	[11.9,16.0]	34.6	[31.7,37.5]	38.7	[35.4,42.2]	24.6	[23.2,26.2]	
No (n=2,880)	86.2	[84.0,88.1]	65.4	[62.5,68.3]	61.3	[57.8,64.6]	75.4	[73.8,76.8]	
Health status									<0.001
Excellent, very good, or good (n=2,826)	64.1	[61.1,66.9]	75.7	[73.1,78.2]	78.6	[75.6,81.3]	70.2	[68.5,72.0]	
Fair or poor (n=1,255)	35.9	[33.1,38.9]	24.3	[21.8,26.9]	21.4	[18.7,24.4]	29.8	[28.0,31.5]	
Any chronic health condition									<0.001
Yes (n=2,986)	72.9	[69.8,75.7]	66.2	[63.1,69.1]	63.9	[60.4,67.2]	69.2	[67.3,71.0]	
No (n=1,104)	27.1	[24.3,30.2]	33.8	[30.9,36.9]	36.1	[32.8,39.6]	30.8	[29.0,32.7]	
Any health insurance in 12 months before HMP enrollment									<0.001
Yes (n=1,667)	35.4	[32.5,38.4]	44.8	[41.7,48.0]	48.6	[45.0,52.1]	40.7	[38.8,42.6]	
No (n=2,374)	62.6	[59.6,65.6]	54.1	[50.9,57.2]	50.9	[47.3,54.4]	57.9	[55.9,59.8]	
Cost-related access barriers in 12 months before HMP enrollment[3]									0.666
Yes (n=1,341)	32.4	[29.6,35.4]	31.2	[28.4,34.2]	30.6	[27.5,33.9]	31.7	[29.9,33.6]	
No (n=2,706)	67.6	[64.6,70.4]	68.8	[65.8,71.6]	69.4	[66.1,72.5]	68.3	[66.4,70.1]	
Carefully review MIHA statements[4]									0.387
Yes (n=2,675)	88.7	[86.2,90.8]	89.1	[86.4,91.3]	86.5	[83.4,89.1]	88.3	[86.8,89.7]	
No (n=330)	11.3	[9.2,13.8]	10.9	[8.7,13.6]	13.5	[10.9,16.6]	11.7	[10.3,13.2]	
Find out about service costs[5]									0.232
Yes (n=2,912)	70.3	[67.4,73.0]	73.5	[70.7,76.1]	72.1	[68.8,75.1]	71.5	[69.7,73.3]	
No (n=1,164)	29.7	[27.0,32.6]	26.5	[23.9,29.3]	27.9	[24.9,31.2]	28.5	[26.7,30.3]	
Talk with doctor about costs[6]									0.736
Yes (n=2,746)	67.3	[64.3,70.1]	68.7	[65.7,71.6]	68.4	[65.0,71.6]	67.9	[66.0,69.7]	
No (n=1,330)	32.7	[29.9,35.7]	31.3	[28.4,34.3]	31.6	[28.4,35.0]	32.1	[30.3,34.0]	
Ask doctor about less costly drug[7]									<0.001
Yes (n=3,143)	71.6	[68.7,74.4]	79.0	[76.4,81.4]	79.3	[76.2,82.0]	75.2	[73.4,76.9]	
No (n=931)	28.4	[25.6,31.3]	21.0	[18.6,23.6]	20.7	[18.0,23.8]	24.8	[23.1,26.6]	
Check reviews or ratings of quality[8]									0.058
Yes (n=3,142)	76.4	[73.7,79.0]	79.6	[77.0,82.0]	80.4	[77.6,82.9]	78.1	[76.4,79.7]	
No (n=932)	23.6	[21.0,26.3]	20.4	[18.0,23.0]	19.6	[17.1,22.4]	21.9	[20.3,23.6]	

Fewer medical bill problems in previous 12 months of HMP enrollment[9]									0.191
Yes (n=1,629)	84.4	[80.9,87.4]	88.3	[84.6,91.2]	86.9	[82.9,90.1]	85.9	[83.7,87.9]	
No (n=240)	15.6	[12.6,19.1]	11.7	[8.8,15.4]	13.1	[9.9,17.1]	14.1	[12.1,16.3]	
Payments affordable for HMP[10]									0.015
Yes (n=3,679)	88.6	[86.4,90.5]	91.1	[88.9,92.9]	85.9	[83.2,88.2]	88.8	[87.4,90.0]	
No (n=405)	11.4	[9.5,13.6]	8.9	[7.1,11.1]	14.1	[11.8,16.8]	11.2	[10.0,12.6]	
Foregone care due to cost in previous 12 months of HMP enrollment[3]									0.589
Yes (n=439)	11.2	[9.3,13.3]	11.8	[9.9,14.1]	10.1	[8.2,12.4]	11.1	[10.0,12.5]	
No (n=3,623)	88.8	[86.7,90.7]	88.2	[85.9,90.1]	89.9	[87.6,91.8]	88.9	[87.5,90.0]	

[1]n does not sum to 4,090 for every characteristic due to skip patterns, "don't know" responses, or non-responses for individual items.
[2]pearson chi-square analyses
[3]Going without health care because 'you were worried about the cost,' 'you did not have health insurance,' 'the doctor or hospital wouldn't accept your health insurance,' or 'your health plan wouldn't pay for the treatment.'
[4]Strongly agree or agree that carefully review MIHA statements.
[5]Very or somewhat likely to find out about the costs of services before receiving them.
[6]Very or somewhat likely to talk with doctors about how much services will cost.
[7]Very or somewhat likely to ask doctors about a less costly prescription drug.
[8]Very or somewhat likely to check quality reviews or ratings before getting care.
[9]Among individuals with problems paying medical bills in the 12 months before enrolling in HMP.
[10]Strongly agree or agree that payments for HMP are affordable.

Table 24. Engagement in Cost-Conscious Behaviors among Subgroups of HMP Beneficiaries

Subgroup[2]	Outcomes[1]														
	Carefully review MIHA statements[3] (n=2,924)			Find out about service costs[4] (n=3,979)			Talk with doctor about costs[5] (n=3,978)			Ask doctor about less costly drug[6] (n=3,978)			Check reviews or ratings of quality[7] (n=3,977)		
	%	95% CI		%	95% CI		%	95% CI		%	95% CI		%	95% CI	
FPL															
0-35%	89.3	87.0	91.5	71.6	68.8	74.4	68.1	65.2	71.0	73.8*	71.0	76.6	77.8	75.2	80.4
36-99% (ref)	88.7	86.0	91.3	72.9	70.0	75.8	68.6	65.5	71.6	78.2	75.4	80.9	79.0	76.3	81.6
100+%	86.0	83.0	89.0	70.4	67.0	73.8	67.8	64.3	71.3	77.0	73.7	80.2	78.4	75.4	81.4
Gender															
Male (ref)	87.4	85.1	89.8	69.7	67.0	72.4	67.2	64.3	70.1	71.5	68.7	74.2	75.0	72.4	77.6
Female	89.2	87.3	91.1	73.6*	71.3	76.0	69.1	66.7	71.5	79.6***	77.3	81.8	81.3***	79.1	83.4

Age															
19-34 (ref)	86.2	83.5	88.9	76.9	74.0	79.8	72.0	68.9	75.1	77.6	74.6	80.6	82.3	79.5	85.0
35-50	88.2	85.5	90.9	67.0***	63.5	70.2	64.8**	61.5	68.2	72.7*	69.5	75.8	75.7**	72.7	78.8
51-64	91.4**	89.3	93.5	70.0**	67.0	73.0	66.6*	63.5	69.7	76.2	73.4	79.0	75.3**	72.6	78.1
Race/ethnicity															
White, non-Hispanic (ref)	89.1	87.3	90.9	72.7	70.2	75.2	68.8	66.2	71.3	78.9	76.5	81.2	78.4	76.1	80.7
Black, non-Hispanic	88.4	85.0	91.8	71.8	67.9	75.7	69.3	65.2	73.4	73.3*	69.4	77.2	81.3	77.9	84.7
Hispanic	83.9	73.3	94.5	51.3**	37.0	65.6	51.9*	37.8	66.0	59.9**	46.0	73.8	64.1*	50.1	78.1
Other	85.5	80.3	90.6	70.2	65.0	75.4	65.6	59.9	71.2	68.0***	62.7	73.3	72.8*	67.3	78.2
Marital status															
Not married or partnered (ref)	88.1	86.3	89.9	71.6	69.5	73.6	67.9	65.8	70.1	74.7	72.7	76.7	77.1	75.1	79.0
Married or partnered	89.4	86.8	92.1	72.2	68.7	75.7	68.9	65.3	72.6	78.3	75.0	81.7	81.6	78.8	84.4
Region															
UP/NW/NE (ref)	86.7	82.9	90.6	68.0	63.8	72.2	66.8	62.6	71.0	76.2	72.2	80.2	70.3	66.2	74.5
W/EC/E	90.2	87.8	92.5	72.2	69.2	75.2	69.6	66.5	72.6	76.7	73.8	79.6	79.8***	77.2	82.4
SC/SW/SE	87.5	84.4	90.7	71.5	67.7	75.3	67.8	64.1	71.5	78.0	74.7	81.4	79.0**	75.9	82.1
DET	88.0	85.3	90.7	72.3	69.1	75.5	67.7	64.3	71.2	73.8	70.6	77.0	78.5**	75.4	81.6
Health status															
Excellent, very good, or good (ref)	89.3	87.5	91.0	72.5	70.3	74.7	68.4	66.1	70.7	76.6	74.4	78.8	79.1	77.0	81.2
Fair or poor	86.1	82.9	89.4	69.9	66.6	73.2	67.7	64.3	71.0	73.1	69.9	76.3	76.3	73.3	79.4
Any chronic health condition															
No (ref)	86.9	83.4	90.4	74.2	70.8	77.6	70.7	67.2	74.3	75.1	71.6	78.6	81.6	78.5	84.7
Yes	89.0	87.3	90.7	70.7	68.4	72.9	67.1	64.8	69.4	75.8	73.6	77.9	76.8*	74.7	78.9
Any health insurance in 12 months before HMP enrollment															
No (ref)	88.9	87.0	90.8	70.8	68.5	73.2	69.1	66.8	71.5	75.5	73.2	77.8	76.7	74.5	78.9
Yes	87.7	85.3	90.1	73.0	70.2	75.8	66.7	63.7	69.8	75.7	72.9	78.5	80.5*	78.0	83.1
Forgone care due to cost in 12 months before HMP enrollment[8]															
No (ref)	89.2	87.5	90.9	70.1	67.9	72.4	67.9	65.6	70.2	74.5	72.4	76.7	77.5	75.4	79.5
Yes	87.0	83.8	89.8	75.0*	72.0	78.0	68.8	65.4	72.1	77.8	74.7	80.9	79.7	76.9	82.6

NOTES: * denotes $P < 0.05$, ** denotes $P < 0.01$, and *** denotes $P < 0.001$.

[1]The columns for each outcome depict marginal estimates from a logistic regression model in which the dependent variable is the respective outcome and the independent variables are all of the characteristics in the table rows.
[2]Subgroups denoted by (ref) are the reference for statistical tests.
[3]Strongly agree or agree that carefully review MIHA statements.
[4]Very or somewhat likely to find out about the costs of services before receiving them.
[5]Very or somewhat likely to talk with doctors about how much services will cost.
[6]Very or somewhat likely to ask doctors about a less costly prescription drug.
[7]Very or somewhat likely to check quality reviews or ratings before getting care.
[8]Going without health care because 'you were worried about the cost,' 'you did not have health insurance,' 'the doctor or hospital wouldn't accept your health insurance,' or 'your health plan wouldn't pay for the treatment.'

Table 25. Health Care Affordability Among Subgroups of HMP Beneficiaries

Subgroup[2]	Outcomes[1]								
	Fewer medical bill problems[3] (n=1,816)			Payments affordable[4] (n=3,982)			Forgone care due to cost[5] (n=3,967)		
	%	95% CI		%	95% CI		%	95% CI	
FPL									
0-35%	84.8	81.7	88.0	89.2	87.1	91.2	10.9	9.0	12.9
36-99% (ref)	88.3	84.7	91.9	90.8	88.7	92.3	12.0	9.7	14.2
100+%	85.3	81.1	89.5	84.9**	82.1	87.7	10.4	8.2	12.7
Gender									
Male (ref)	84.4	81.0	87.8	89.1	87.0	91.1	10.2	8.3	12.2
Female	87.0	84.5	89.6	88.5	86.8	90.3	11.9	10.2	13.6
Age									
19-34 (ref)	83.4	79.2	87.6	88.3	86.0	90.6	13.7	11.2	16.2
35-50	85.3	82.0	88.6	87.9	85.5	90.3	9.9*	8.1	11.8
51-64	89.4*	86.6	92.3	90.8	88.8	92.8	9.2**	7.3	11.1
Race/ethnicity									
White, non-Hispanic (ref)	87.4	84.7	90.1	91.7	90.3	93.2	10.3	8.8	11.8
Black, non-Hispanic	84.8	80.6	89.1	84.0***	80.7	87.3	10.5	7.7	13.3
Hispanic	91.5	79.1	100.0	86.8	87.3	95.3	18.4	7.1	29.7
Other	79.7	71.0	88.4	85.3**	80.8	89.7	14.9*	10.5	19.3

Marital status									
Not married or partnered (ref)	85.7	83.3	88.1	88.9	87.4	90.4	11.1	9.7	12.6
Married or partnered	86.2	81.7	90.6	88.6	86.0	91.3	11.1	8.6	13.6
Sampling Region									
UP/NW/NE (ref)	82.1	76.8	87.3	90.9	87.9	94.0	8.3	6.0	10.6
W/EC/E	87.8*	84.3	91.2	88.6	86.3	90.9	10.8	8.7	12.9
SC/SW/SE	86.4	82.2	90.7	88.9	86.3	91.4	11.3	8.9	13.8
DET	85.1	81.4	88.8	88.6	86.4	90.8	11.9*	9.5	14.2
Health status									
Excellent, very good, or good (ref)	87.4	84.8	90.0	90.0	88.4	91.6	10.2	8.7	11.7
Fair or poor	83.2	79.5	86.8	85.8**	83.0	88.6	13.1*	10.6	15.6
Any chronic health condition									
No (ref)	85.7	80.7	90.7	88.4	85.7	91.0	7.7	5.6	9.8
Yes	85.8	83.4	88.3	89.0	87.4	90.6	12.5**	10.9	14.2
Any health insurance in 12 months before HMP enrollment									
No (ref)	86.9	84.5	89.4	89.8	88.3	91.4	9.7	8.2	11.2
Yes	83.3	79.4	87.3	87.3	84.9	89.6	13.4**	11.2	15.6
Forgone care due to cost in 12 months before HMP enrollment[6]									
No (ref)	83.2	80.2	86.2	89.6	88.1	91.0	8.1	6.8	9.5
Yes	88.8**	85.9	91.7	87.0	84.2	89.8	17.6***	14.8	20.5

NOTES: * denotes $P < 0.05$, ** denotes $P < 0.01$, and *** denotes $P < 0.001$.

[1]The columns for each outcome depict marginal estimates from a logistic regression model in which the dependent variable is the respective outcome and the independent variables are all of the characteristics in the table rows.

[2]Subgroups denoted by (ref) are the reference for statistical tests.

[3]Among individuals with problems paying medical bills in the 12 months before enrolling in HMP.

[4]Strongly agree or agree that payments for HMP are affordable.

[5]Going without health care in the previous 12 months of HMP enrollment because 'you were worried about the cost,' 'you did not have health insurance,' 'the doctor or hospital wouldn't accept your health insurance,' or 'your health plan wouldn't pay for the treatment.'

[6]Going without health care in the 12 months before HMP enrollment because 'you were worried about the cost,' 'you did not have health insurance,' 'the doctor or hospital wouldn't accept your health insurance,' or 'your health plan wouldn't pay for the treatment.'

Reproductive Health

Table 26. Characteristics of Reproductive Age Females

	Col %	95% CI
Age (n=1,168)		
19-34 (n=754)	68.1	[64.8,71.3]
35-45 (n=414)	31.9	[28.7,35.2]
Race (n=1,162)		
White (n=769)	61.7	[58.2,65.2]
Black or African American (n=254)	24.9	[21.9,28.2]
Other (n=90)	8.5	[6.7,10.6]
More than one (n=49)	4.9	[3.4,6.8]
FPL (n=1,168)		
0-35% (n=312)	40.1	[36.8,43.6]
36-99% (n=490)	34.5	[31.8,37.4]
≥100% (n=366)	25.3	[23.0,27.7]
Married or partnered (n=1,166)		
Yes (n=337)	23.7	[21.2,26.4]
No (n=829)	76.3	[73.6,78.8]
Health status (n=1,168)		
Excellent, very good, or good (n=905)	76.5	[73.4,79.4]
Fair or poor (n=263)	23.5	[20.6,26.6]
Health insurance in 12 months before HMP enrollment (n=1,167)		
Insured all 12 months (n=434)	36.4	[33.1,39.9]
Insured less than 12 months (n=129)	12.0	[9.7,14.6]
Not insured (n=570)	48.4	[44.9,52.0]
Don't know (n=34)	3.2	[2.1,4.8]
PCP visit in the past 12 months (n=1,168)		
Yes (n=947)	80.4	[77.5,83.0]
No (n=221)	19.6	[17.0,22.5]

Table 27. Healthy Michigan Plan Beneficiary Characteristics and Ability to Get Birth Control/Family Planning Services

	Would you say that your ability to get birth control/family planning services through the Healthy Michigan Plan is better, worse, or about the same, compared to before?								
	Better		Worse		About the same		Don't know		*P*-value[1]
	Row %	95% CI	Row %	95% CI	Row %	95% CI	Row %	95% CI	
Age									<0.001
19-34 (n=753)	40.9	[36.6,45.3]	1.9	[1.0,3.5]	26.9	[23.3,30.9]	30.3	[26.3,34.6]	
35-45 (n=413)	24.1	[19.4,29.5]	0.3	[0.0,2.4]	20.2	[15.4,26.0]	55.4	[49.3,61.4]	
Total (n=1,166)	35.5	[32.2,39.0]	1.4	[0.7,2.5]	24.8	[21.8,28.0]	38.4	[34.9,41.9]	
Race									0.224
White (n=767)	34.4	[30.4,38.7]	1.9	[1.0,3.6]	23.0	[19.6,26.8]	40.7	[36.4,45.2]	
Black or African American (n=254)	35.3	[28.3,43.0]	0.4	[0.1,3.1]	29.4	[23.1,36.7]	34.8	[27.9,42.3]	
Other (n=90)	48.0	[36.4,59.8]	0		25.7	[16.5,37.5]	26.3	[17.4,37.7]	
More than one (n=49)	32.9	[19.5,49.7]	2.5	[0.4,16.1]	24.7	[11.8,44.7]	39.9	[24.3,57.8]	
Total (n=1,160)	35.7	[32.4,39.2]	1.4	[0.8,2.5]	24.9	[22.0,28.1]	38.0	[34.5,41.5]	
FPL									0.280
0-35% (n=311)	34.8	[28.7,41.4]	1.9	[0.8,4.7]	21.4	[16.1,27.7]	41.9	[35.3,48.8]	
36-99% (n=490)	36.9	[32.0,42.2]	0.5	[0.2,1.8]	26.2	[22.0,30.8]	36.3	[31.6,41.3]	
≥100% (n=365)	34.7	[29.4,40.4]	1.7	[0.7,4.1]	28.2	[23.3,33.6]	35.5	[30.2,41.1]	
Total (n=1,166)	35.5	[32.2,39.0]	1.4	[0.7,2.5]	24.8	[21.8,28.0]	38.4	[34.9,41.9]	
Married or partnered									0.890
Yes (n=337)	34.1	[28.6,40.1]	1.1	[0.4,2.9]	25.3	[20.3,30.9]	39.6	[34.0,45.5]	
No (n=827)	36.1	[32.1,40.2]	1.5	[0.7,3.0]	24.7	[21.2,28.5]	37.8	[33.7,42.1]	
Total (n=1,164)	35.6	[32.3,39.1]	1.4	[0.8,2.5]	24.8	[21.9,28.0]	38.2	[34.8,41.8]	
Health status									0.114
Excellent, very good, or good (n=903)	35.3	[31.6,39.2]	1.0	[0.5,1.9]	26.4	[23.0,30.1]	37.3	[33.4,41.4]	
Fair or poor (n=263)	36.2	[29.1,43.8]	2.6	[0.9,7.3]	19.5	[14.4,25.9]	41.7	[34.7,49.0]	
Total (n=1,166)	35.5	[32.2,39.0]	1.4	[0.7,2.5]	24.8	[21.8,28.0]	38.4	[34.9,41.9]	
Health insurance in 12 months before HMP enrollment									<0.001
Insured all 12 months (n=434)	27.5	[22.3,33.2]	2.5	[1.1,5.5]	35.3	[30.2,40.9]	34.7	[29.4,40.3]	
Insured less than 12 months (n=127)	33.8	[24.4,44.7]	1.0	[0.1,6.5]	21.9	[14.5,31.8]	43.3	[33.0,54.2]	
Not insured (n=570)	42.5	[37.6,47.5]	0.5	[0.2,1.3]	17.9	[14.1,22.6]	39.1	[34.1,44.2]	
Don't know (n=34)	28.2	[11.9,53.2]	3.1	[0.4,19.4]	18.7	[8.5,36.1]	50.0	[29.4,70.6]	
Total (n=1,165)	35.5	[32.2,39.0]	1.4	[0.8,2.5]	24.8	[21.9,28.0]	38.3	[34.9,41.8]	

PCP visit in the past 12 months									0.376
Yes (n=945)	36.8	[33.0,40.7]	1.2	[0.6,2.2]	24.8	[21.5,28.4]	37.2	[33.4,41.2]	
No (n=221)	30.2	[23.6,37.8]	2.1	[0.6,7.7]	24.7	[18.7,31.7]	43.0	[35.4,50.9]	
Total (n=1,166)	35.5	[32.2,39.0]	1.4	[0.7,2.5]	24.8	[21.8,28.0]	38.4	[34.9,41.9]	

[1] Pearson chi-square analyses

Impact on Those with Chronic Health Conditions

Table 28. Functional Limitations Among Those with Chronic Conditions

	Functional Limitations				
	Yes		No		*P*-value[1]
	Row %	95% CI	Row %	95% CI	
Physical Chronic Disease					<0.001
Yes (n=2,590)	24.8	[22.8,26.9]	75.2	[73.1,77.2]	
No (n=1,436)	9.1	[7.2,11.5]	90.9	[88.5,92.8]	
Total (n=4,026)	18.4	[17.0,20.0]	81.6	[80.0,83.0]	
Mood Disorder or Mental Health Condition					<0.001
Yes (n=1,279)	35.3	[32.1,38.7]	64.7	[61.3,67.9]	
No (n=2,747)	10.9	[9.5,12.5]	89.1	[87.5,90.5]	
Total (n=4,026)	18.4	[17.0,20.0]	81.6	[80.0,83.0]	
Any Chronic Disease or Mood Disorder					<0.001
Yes (n=2,885)	24.4	[22.5,26.4]	75.6	[73.6,77.5]	
No (n=1,141)	5.8	[4.1,8.3]	94.2	[91.7,95.9]	
Total (n=4,026)	18.4	[17.0,20.0]	81.6	[80.0,83.0]	

[1] Pearson chi-square analyses

Table 29. Healthy Michigan Plan Beneficiary Characteristics Among Those with Chronic Disease and Among Those with Functional Limitations

	Any Chronic Disease or Mood Disorder		Functional Limitations	
	Col %	95% CI	Col %	95% CI
Age (n=4,090)				
19-34 (n=1,303)	32.5	[30.3,34.8]	23.5	[19.5,28.1]
35-50 (n=1,301)	36.7	[34.5,39.0]	40.2	[35.9,44.7]
51-64 (n=1,486)	30.8	[28.9,32.8]	36.3	[32.2,40.5]

Gender (n=4,090)				
Male (n=1,681)	46.7	[44.4,49.0]	50.6	[46.1,55.1]
Female (n=2,409)	53.3	[51.0,55.6]	49.4	[44.9,53.9]
Race (n=4,039)				
White (n=2,784)	64.4	[62.2,66.6]	63.7	[59.0,68.1]
Black/African American (n=807)	24.8	[22.8,26.9]	23.6	[19.7,28.0]
Other (n=306)	6.8	[5.7,8.0]	8.0	[5.6,11.1]
More than one (n=142)	4.0	[3.1,5.1]	4.8	[3.2,7.0]
Hispanic/Latino (n=4,056)				
Yes (n=188)	4.7	[3.8,5.9]	6.1	[4.0,9.3]
No (n=3,856)	94.7	[93.5,95.7]	93.5	[90.3,95.8]
Don't Know (n=12)	0.6	[0.3,1.2]	0.4	[0.1,2.6]
Arab, Chaldean, Middle Eastern (n=4,055)				
Yes (n=204)	3.8	[3.0,4.8]	3.8	[2.3,6.3]
No (n=3,842)	95.8	[94.8,96.7]	95.9	[93.4,97.5]
Don't Know (n=9)	0.3	[0.2,0.7]	0.3	[0.0,1.9]
Marital status (n=4,073)				
Not married or partnered (n=2,880)	75.6	[73.7,77.3]	78.0	[74.2,81.4]
Married or partnered (n=1,193)	24.4	[22.7,26.3]	22.0	[18.6,25.8]
Health status (n=4,081)				
Excellent (n=337)	4.5	[3.7,5.6]	1.5	[0.7,3.1]
Very good (n=1,041)	19.5	[17.6,21.5]	8.3	[5.7,11.9]
Good (n=1,448)	37.1	[34.9,39.4]	20.9	[17.6,24.7]
Fair (n=931)	28.3	[26.3,30.4]	37.7	[33.4,42.2]
Poor (n=324)	10.5	[9.2,12.0]	31.6	[27.5,35.9]
Physical health not good any days in past 30 days (n=4,090)				
Yes (n=2,082)	58.0	[55.7,60.3]	88.0	[84.5,90.8]
No (n=2,008)	42.0	[39.7,44.3]	12.0	[9.2,15.5]
Mental health not good any days in past 30 days (n=4,090)				
Yes (n=1,635)	49.1	[46.8,51.4]	75.1	[71.2,78.7]
No (n=2,455)	50.9	[48.6,53.2]	24.9	[21.3,28.8]

Table 30. Access to Care Prior to HMP Enrollment Among Those With Chronic Disease

	Any Chronic Disease or Mood Disorder		Physical Chronic Disease		Mood Disorder or Mental Health Condition		Functional Limitations	
	Col %	95% CI	Col %	95% CI	Col %	95% CI	Col %	95% CI
Any health insurance in 12 months before HMP enrollment (n=4,087)								
Yes (n=1,667)	40.8	[38.5,43.0]	40.3	[38.0,42.7]	44.0	[40.6,47.6]	41.1	[36.8,45.7]
No (n=2,374)	58.3	[56.0,60.5]	58.7	[56.4,61.1]	55.0	[51.5,58.5]	57.1	[52.6,61.6]
Don't Know (n=46)	1.0	[0.6,1.5]	1.0	[0.6,1.6]	0.9	[0.5,1.7]	1.7	[0.7,4.3]
Insurance duration before HMP enrollment (n=1,667)								
All 12 months (n=1,235)	74.9	[71.7,77.9]	75.2	[71.9,78.3]	74.5	[69.5,78.9]	66.4	[59.2,72.9]
6-11 months (n=245)	14.4	[12.1,17.2]	14.3	[11.9,17.1]	14.1	[10.8,18.2]	17.6	[12.7,23.8]
Less than 6 months (n=129)	6.7	[5.2,8.5]	6.8	[5.2,8.8]	6.5	[4.4,9.6]	11.0	[6.9,17.0]
Don't know (n=58)	4.0	[2.8,5.8]	3.6	[2.5,5.3]	4.9	[2.9,8.2]	5.0	[2.7,9.3]
Problems paying medical bills before HMP enrollment (n=4,085)								
Yes (n=1,869)	51.7	[49.4,54.0]	52.9	[50.5,55.3]	52.7	[49.2,56.2]	59.4	[54.9,63.8]
No (n=2,196)	47.9	[45.6,50.2]	46.8	[44.4,49.2]	47.0	[43.5,50.5]	40.0	[35.6,44.5]
Don't Know (n=20)	0.4	[0.2,0.7]	0.3	[0.1,0.7]	0.3	[0.1,0.8]	0.6	[0.2,1.7]
Didn't get care needed before HMP enrollment (n=4,084)								
Yes (n=1,409)	38.4	[36.2,40.7]	39.2	[36.8,41.5]	41.8	[38.4,45.2]	47.3	[42.8,51.9]
No (n=2,638)	60.6	[58.4,62.9]	59.8	[57.5,62.2]	57.5	[54.1,60.9]	51.8	[47.3,56.3]
Don't Know (n=37)	1.0	[0.6,1.5]	1.0	[0.6,1.6]	0.7	[0.4,1.3]	0.9	[0.3,2.4]
PCP visit timing before HMP enrollment (n=4,086)								
Less than 1 year before HMP (n=1,647)	42.1	[39.8,44.4]	41.9	[39.6,44.3]	45.6	[42.1,49.1]	40.4	[36.1,44.9]
1 to 5 years (n=1,577)	36.2	[34.0,38.4]	36.0	[33.8,38.4]	35.1	[31.9,38.4]	36.8	[32.6,41.3]
More that 5 years (n=813)	20.4	[18.6,22.5]	20.7	[18.7,22.8]	18.7	[16.0,21.6]	21.5	[17.9,25.6]
Don’t Know (n=49)	1.3	[0.8,2.0]	1.3	[0.8,2.1]	0.7	[0.4,1.3]	1.3	[0.6,2.5]

Table 31. Impact of HMP on Chronic Disease Care Access and Function Among Enrollees With Chronic Illness

	Any Chronic Disease or Mood Disorder		Physical Chronic Disease		Mood Disorder or Mental Health Condition		Functional Limitations	
	Col %	95% CI	Col %	95% CI	Col %	95% CI	Col %	95% CI
Ability to get mental health care (n=4,084)								
Better (n=1,077)	32.2	[30.0,34.4]	29.7	[27.5,32.0]	46.4	[42.9,49.9]	36.2	[31.9,40.7]
Worse (n=97)	3.4	[2.7,4.4]	2.9	[2.2,3.9]	6.2	[4.7,8.2]	8.1	[5.9,11.1]
About the same (n=923)	22.1	[20.2,24.1]	21.4	[19.5,23.4]	27.1	[24.1,30.4]	21.4	[17.9,25.3]
Don't know (n=1,987)	42.3	[40.1,44.6]	46	[43.6,48.4]	20.2	[17.6,23.1]	34.3	[30.2,38.6]
Ability to get prescription meds (n=4,085)								
Better (n=2,497)	64.6	[62.3,66.8]	64.6	[62.3,66.9]	67.6	[64.3,70.7]	66.7	[62.3,70.9]
Worse (n=121)	3.9	[3.0,4.9]	4.0	[3.1,5.2]	4.5	[3.2,6.1]	7.0	[4.9,9.8]
About the same (n=1,017)	24.6	[22.6,26.6]	24.6	[22.6,26.8]	23.5	[20.7,26.6]	22.0	[18.4,26.1]
Don't know (n=450)	7.0	[5.9,8.3]	6.8	[5.6,8.1]	4.4	[3.2,6.1]	4.3	[2.8,6.6]
Ability to pay medical bills (n=1,869)								
Gotten worse (n=51)	3.1	[2.2,4.4]	3.3	[2.3,4.6]	4.2	[2.6,6.6]	5.5	[3.3,9.1]
Stayed the same (n=176)	9.8	[8.0,11.9]	9.7	[7.8,12.0]	9.5	[7.0,12.7]	13.5	[9.6,18.7]
Gotten better (n=1,629)	86.3	[83.8,88.4]	86.6	[84.1,88.7]	85.0	[81.1,88.2]	80.0	[74.4,84.6]
Don't know (n=13)	0.9	[0.4,2.1]	0.5	[0.2,1.1]	1.4	[0.4,4.2]	1.0	[0.3,3.3]
Physical health status (n=4,086)								
Gotten better (n=1,961)	51.9	[49.6,54.2]	52.9	[50.5,55.3]	50.2	[46.7,53.6]	41.5	[37.1,46.0]
Stayed the same (n=1,851)	40.3	[38.0,42.6]	38.5	[36.2,40.8]	39.0	[35.6,42.5]	38.6	[34.2,43.2]
Gotten worse (n=256)	7.5	[6.4,8.6]	8.2	[7.1,9.5]	10.3	[8.6,12.4]	19.1	[16.0,22.6]
Don't know (n=18)	0.4	[0.2,0.7]	0.4	[0.2,0.7]	0.5	[0.2,1.3]	0.8	[0.3,1.9]
Mental health status (n=4,080)								
Gotten better (n=1,550)	42.4	[40.1,44.7]	40.8	[38.4,43.2]	48.7	[45.2,52.2]	34.9	[30.7,39.3]
Stayed the same (n=2,318)	50.9	[48.6,53.2]	52.8	[50.4,55.2]	40.1	[36.7,43.6]	47.0	[42.5,51.6]
Gotten worse (n=186)	6.1	[5.1,7.4]	5.7	[4.7,6.9]	10.8	[8.8,13.2]	17.1	[13.8,20.9]
Don't know (n=26)	0.6	[0.4,0.9]	0.7	[0.4,1.1]	0.4	[0.2,0.8]	1.1	[0.5,2.1]

Table 32. Opportunities for Improvement of Chronic Disease Care in HMP

	Any Chronic Disease or Mood Disorder		Physical Chronic Disease		Mood Disorder or Mental Health Condition		Functional Limitations	
	Col %	95% CI	Col %	95% CI	Col %	95% CI	Col %	95% CI
Foregone care in past 12 months (n=4,084)								
Yes (n=629)	18.4	[16.6,20.3]	17.7	[15.9,19.6]	22.5	[19.8,25.6]	27.8	[23.8,32.1]
No (n=3,433)	81.4	[79.5,83.1]	82.1	[80.1,83.8]	77.2	[74.2,80.0]	72.0	[67.6,76.0]
Don't Know (n=22)	0.2	[0.1,0.4]	0.2	[0.1,0.5]	0.2	[0.1,0.6]	0.2	[0.1,0.7]
Foregone care because worried about cost (n=629)								
Yes (n=155)	25.7	[21.2,30.8]	25.3	[20.6,30.8]	28.8	[22.7,35.7]	26.8	[19.7,35.3]
No (n=474)	74.3	[69.2,78.8]	74.7	[69.2,79.4]	71.2	[64.3,77.3]	73.2	[64.7,80.3]
Foregone care because no insurance (n=629)								
Yes (n=41)	8.9	[5.8,13.3]	6.8	[4.3,10.6]	9.0	[4.8,16.2]	8.8	[4.0,18.2]
No (n=588)	91.1	[86.7,94.2]	93.2	[89.4,95.7]	91.0	[83.8,95.2]	91.2	[81.8,96.0]
Foregone care because insurance not accepted (n=629)								
Yes (n=141)	23.7	[19.1,28.9]	25.1	[20.2,30.9]	24.6	[18.7,31.5]	23.2	[16.4,31.8]
No (n=488)	76.3	[71.1,80.9]	74.9	[69.1,79.8]	75.4	[68.5,81.3]	76.8	[68.2,83.6]
Foregone care because health plan wouldn't pay (n=629)								
Yes (n=251)	38.5	[33.4,43.9]	39.6	[34.2,45.4]	34.9	[28.5,42.0]	37.9	[29.7,47.0]
No (n=378)	61.5	[56.1,66.6]	60.4	[54.6,65.8]	65.1	[58.0,71.5]	62.1	[53.0,70.3]
Foregone care because couldn’t get an appointment soon enough (n=630)								
Yes (n=73)	10.0	[7.4,13.5]	10.4	[7.6,14.1]	11.5	[7.7,16.8]	15.6	[10.2,23.1]
No (n=557)	90.0	[86.5,92.6]	89.6	[85.9,92.4]	88.5	[83.2,92.3]	84.4	[76.9,89.8]
Forgone care because no transportation (n=629)								
Yes (n=30)	6.7	[4.1,10.6]	5.2	[3.2,8.6]	9.9	[5.8,16.5]	9.2	[5.2,15.7]
No (n=599)	93.3	[89.4,95.9]	94.8	[91.4,96.8]	90.1	[83.5,94.2]	90.8	[84.3,94.8]
Foregone checkup due to cost[1] (n=393)								
Yes (n=47)	13.9	[9.7,19.6]	12.9	[9.0,18.3]	16.5	[10.2,25.4]	13.1	[7.7,21.5]
No (n=346)	86.1	[80.4,90.3]	87.1	[81.7,91.0]	83.5	[74.6,89.8]	86.9	[78.5,92.3]
Forgone specialty care due to cost[2] (n=393)								
Yes (n=79)	24.5	[18.7,31.4]	25.7	[19.6,32.9]	26.0	[18.1,35.7]	33.8	[23.0,46.5]
No (n=314)	75.5	[68.6,81.3]	74.3	[67.1,80.4]	74.0	[64.3,81.9]	66.2	[53.5,77.0]

PCP visit in the past 12 months								
Yes (n=3,386)	89.6	[87.8,91.1]	90.5	[88.7,92.0]	90.1	[87.3,92.4]	92.4	[88.8,94.9]
No (n=453)	10.2	[8.7,12.0]	9.3	[7.8,11.0]	9.7	[7.5,12.6]	7.2	[4.7,10.8]
Don't Know (n=12)	0.2	[0.1,0.5]	0.3	[0.1,0.6]	0.1	[0.0,0.5]	0.4	[0.1,1.5]
Regular place of care before HMP enrollment (n=4,084)								
Yes (n=3,051)	77.2	[75.1,79.1]	77.2	[75.0,79.2]	78.3	[75.3,80.9]	75.1	[70.8,78.9]
No (n=955)	21.6	[19.7,23.6]	21.5	[19.5,23.6]	21.2	[18.5,24.1]	22.0	[18.4,26.1]
NA (n=73)	1.1	[0.7,1.7]	1.2	[0.8,1.8]	0.5	[0.2,1.2]	2.6	[1.4,4.9]
Don't know (n=5)	0.1	[0.0,0.4]	0.2	[0.1,0.5]	0.1	[0.0,0.6]	0.3	[0.1,1.4]
Regular place of care before HMP enrollment--location (n=3,051)								
Clinic (n=557)	17.4	[15.5,19.4]	17.5	[15.5,19.6]	16.2	[13.5,19.4]	17.3	[13.3,22.1]
Doctor's office (n=1,498)	47.3	[44.7,49.9]	47.0	[44.3,49.7]	49.9	[45.9,53.9]	46.8	[41.7,51.9]
Urgent care/walk-in (n=529)	16.1	[14.3,18.1]	16.3	[14.4,18.4]	14.5	[12.1,17.3]	13.0	[10.3,16.4]
Emergency room (n=409)	17.3	[15.3,19.5]	17.5	[15.4,19.8]	16.8	[14.0,20.0]	19.9	[16.0,24.5]
Other place (n=56)	1.8	[1.3,2.6]	1.7	[1.1,2.5]	2.5	[1.5,4.0]	3.0	[1.7,5.4]
Don't know (n=2)	0.1	[0.0,0.3]	0.1	[0.0,0.4]	0.1	[0.0,0.7]	0	
Regular place of care past 12 months (n=4,088)								
Yes (n=3,850)	95.2	[93.8,96.3]	96.0	[94.7,97.0]	94.7	[92.4,96.4]	93.2	[89.4,95.7]
No (n=194)	4.1	[3.1,5.4]	3.5	[2.6,4.8]	4.4	[2.9,6.4]	5.0	[2.9,8.3]
NA (n=44)	0.7	[0.4,1.4]	0.5	[0.3,0.9]	0.9	[0.3,2.6]	1.8	[0.7,4.9]
Regular place of care past 12 months--location (n=3,850)								
Clinic (n=640)	16.0	[14.3,17.8]	16.5	[14.7,18.4]	14.4	[12.2,16.9]	17.3	[14.0,21.1]
Doctor's office (n=2,934)	77.1	[75.0,79.0]	76.7	[74.6,78.8]	79.7	[76.8,82.4]	75.9	[71.6,79.8]
Urgent care/walk-in (n=181)	4.8	[3.8,6.0]	4.6	[3.5,5.9]	3.8	[2.6,5.6]	4.1	[2.3,7.0]
Emergency room (n=65)	1.5	[1.1,2.2]	1.6	[1.1,2.3]	1.2	[0.8,2.1]	1.7	[0.8,3.4]
Other place (n=29)	0.6	[0.4,1.0]	0.6	[0.3,1.0]	0.8	[0.4,1.7]	1.1	[0.4,2.8]
Don't know (n=1)			0		0		0	

[1] Going without a checkup because 'you were worried about the cost,' 'you did not have health insurance,' 'the doctor or hospital wouldn't accept your health insurance,' or 'your health plan wouldn't pay for the treatment.'

[2] Going without specialty care because 'you were worried about the cost,' 'you did not have health insurance,' 'the doctor or hospital wouldn't accept your health insurance,' or 'your health plan wouldn't pay for the treatment.'

Impact on Those with Mood Disorder and Substance Use Disorder

Table 33. Regular Source of Care Prior to HMP Among Those with a Mood Disorder and Among Those with a Substance Use Disorder

	In the 12 months before enrolling in the Healthy Michigan Plan, was there a place that you usually would go to for a checkup, when you felt sick, or when you wanted advice about your health?								
	Yes		No		NA		Don't know		*P*-value[1]
	Row %	95% CI	Row %	95% CI	Row %	95% CI	Row %	95% CI	
Mood disorder									0.002
Yes (n=1,287)	78.0	[75.0,80.7]	21.4	[18.7,24.4]	0.5	[0.2,1.2]	0.1	[0.0,0.6]	
No (n=2,781)	71.9	[69.6,74.0]	25.2	[23.2,27.4]	2.7	[2.0,3.7]	0.2	[0.1,0.5]	
Don't know (n=10)	100.0		0		0		0		
Total (n=4,078)	73.8	[72.1,75.5]	24.0	[22.3,25.7]	2.1	[1.5,2.8]	0.1	[0.1,0.4]	
Substance use disorder									0.650
Yes (n=165)	79.6	[70.9,86.3]	20.0	[13.5,28.8]	0.3	[0.0,2.3]	0		
No (n=3,910)	73.5	[71.7,75.2]	24.2	[22.5,26.0]	2.1	[1.6,2.9]	0.2	[0.1,0.4]	
Don't know (n=7)	87.9	[43.9,98.5]	12.1	[1.5,56.1]	0		0		
Total (n=4,082)	73.8	[72.0,75.5]	24.0	[22.4,25.8]	2.1	[1.5,2.8]	0.1	[0.1,0.4]	

[1] Pearson chi-square analyses

Table 34. Type of Regular Source of Care Prior to HMP Among Those with a Mood Disorder and Among Those with a Substance Use Disorder

	[If Yes-Regular source of care prior to HMP] What kind of place was it?												
	Clinic		Doctor's office		Urgent care/walk-in		Emergency room		Other place		Don't know		*P*-value[1]
	Row %	95% CI	Row %	95% CI	Row %	95% CI	Row %	95% CI	Row %	95% CI	Row %	95% CI	
Mood disorder													0.117
Yes (n=1,013)	16.0	[13.3,19.0]	49.9	[45.9,53.9]	14.5	[12.1,17.4]	17.0	[14.2,20.3]	2.5	[1.5,4.1]	0.1	[0.0,0.7]	
No (n=2,026)	17.8	[15.8,20.1]	47.0	[44.2,49.8]	18.0	[15.9,20.3]	15.7	[13.7,18.0]	1.4	[1.0,2.2]	0	[0.0,0.3]	
Don't know (n=10)	3.1	[0.4,20.8]	54.6	[20.1,85.2]	0		42.3	[13.2,78.0]	0		0		
Total (n=3,049)	17.2	[15.5,18.9]	48.0	[45.7,50.3]	16.8	[15.2,18.5]	16.3	[14.6,18.1]	1.8	[1.3,2.4]	0.1	[0.0,0.2]	

Substance use disorder													<0.001
Yes (n=131)	12.2	[7.4,19.5]	32.9	[23.1,44.4]	16.1	[9.6,25.9]	37.0	[27.1,48.1]	1.1	[0.2,4.6]	0.7	[0.1,5.0]	
No (n=2,913)	17.4	[15.7,19.3]	48.6	[46.2,50.9]	16.8	[15.2,18.7]	15.3	[13.6,17.2]	1.8	[1.3,2.5]	0	[0.0,0.2]	
Don't know (n=6)	0		100.0		0		0		0		0		
Total (n=3,050)	17.2	[15.5,18.9]	48.0	[45.7,50.3]	16.8	[15.1,18.5]	16.2	[14.6,18.1]	1.8	[1.3,2.4]	0.1	[0.0,0.2]	

[1] Pearson chi-square analyses

Table 35. Regular Source of Care with HMP Among Those with a Mood Disorder and Among Those with a Substance Use Disorder

	In the last 12 months, is there a place you usually go when you need a checkup, feel sick, or want advice about your health?						
	Yes		No		NA		*P*-value[1]
	Row %	95% CI	Row %	95% CI	Row %	95% CI	
Mood disorder							0.028
Yes (n=1,288)	95.2	[93.0,96.7]	3.9	[2.6,5.7]	0.9	[0.3,2.6]	
No (n=2,784)	90.9	[89.1,92.4]	7.3	[6.0,8.9]	1.8	[1.2,2.9]	
Don't know (n=10)	93.9	[64.8,99.2]	0		6.1	[0.8,35.2]	
Total (n=4,082)	92.2	[90.8,93.4]	6.2	[5.2,7.4]	1.6	[1.1,2.4]	
Substance use disorder							0.803
Yes (n=165)	94.0	[85.2,97.7]	6.0	[2.3,14.8]	0		
No (n=3,914)	92.1	[90.7,93.3]	6.2	[5.2,7.5]	1.6	[1.1,2.5]	
Don't know (n=7)	100.0		0		0		
Total (n=4,086)	92.2	[90.8,93.4]	6.2	[5.2,7.4]	1.6	[1.0,2.4]	

[1] Pearson chi-square analyses

Table 36. Type of Regular Source of Care with HMP Among Those with a Mood Disorder and Among Those with a Substance Use Disorder

	[If Yes-Regular source of care with HMP] What kind of place was it?												
	Clinic		Doctor's office		Urgent care/walk-in		Emergency room		Other place		Don't know		*P*-value[1]
	Row %	95% CI	Row %	95% CI	Row %	95% CI	Row %	95% CI	Row %	95% CI	Row %	95% CI	
Mood disorder													0.058
Yes (n=1,245)	14.6	[12.3,17.1]	79.5	[76.6,82.1]	3.9	[2.6,5.6]	1.3	[0.8,2.1]	0.8	[0.4,1.7]	0		
No (n=2,590)	17.4	[15.6,19.4]	73.2	[70.9,75.4]	6.7	[5.4,8.2]	1.9	[1.4,2.6]	0.8	[0.5,1.3]	0	[0.0,0.3]	
Don't know (n=9)	0		96.7	[77.8,99.6]	3.3	[0.4,22.2]	0		0		0		
Total (n=3,844)	16.5	[15.0,18.0]	75.2	[73.4,77.0]	5.8	[4.8,6.9]	1.7	[1.3,2.2]	0.8	[0.5,1.2]	0	[0.0,0.2]	
Substance use disorder													0.815
Yes (n=159)	17.4	[11.0,26.4]	71.2	[61.0,79.6]	5.8	[2.0,15.5]	3.6	[1.4,9.0]	2.0	[0.6,7.3]	0		
No (n=3,682)	16.5	[15.0,18.1]	75.4	[73.5,77.1]	5.8	[4.8,6.9]	1.6	[1.2,2.1]	0.7	[0.5,1.1]	0	[0.0,0.2]	
Don't know (n=7)	6.8	[0.8,39.7]	93.2	[60.3,99.2]	0		0		0		0		
Total (n=3,848)	16.5	[15.1,18.1]	75.2	[73.4,77.0]	5.8	[4.8,6.9]	1.7	[1.3,2.2]	0.8	[0.5,1.2]	0	[0.0,0.2]	

[1] Pearson chi-square analyses

Table 37. Emergency Room Use in Past 12 Months Among Those with a Mood Disorder and Among Those with a Substance Use Disorder

	Any ER visits past 12 months						
	Yes		No		Don't know		*P*-value[1]
	Row %	95% CI	Row %	95% CI	Row %	95% CI	
Mood disorder							<0.001
Yes (n=1,288)	50.5	[47.0,54.0]	48.1	[44.6,51.6]	1.4	[0.7,2.8]	
No (n=2,786)	31.9	[29.7,34.2]	67.9	[65.6,70.1]	0.2	[0.1,0.5]	
Don't know (n=10)	61.5	[23.3,89.4]	38.5	[10.6,76.7]	0		
Total (n=4,084)	37.7	[35.8,39.6]	61.8	[59.8,63.7]	0.6	[0.3,1.0]	
Substance use disorder							<0.001
Yes (n=165)	60.4	[50.7,69.3]	38.7	[29.9,48.4]	0.9	[0.1,5.9]	
No (n=3,916)	36.6	[34.7,38.5]	62.9	[60.9,64.8]	0.6	[0.3,1.0]	
Don't know (n=7)	88.3	[56.5,97.8]	11.7	[2.2,43.5]	0		
Total (n=4,088)	37.7	[35.8,39.6]	61.8	[59.8,63.7]	0.6	[0.3,1.0]	

[1] Pearson chi-square analyses

Table 38. Factors Associated with ER Use Among HMP Enrollees

	Outcome: Emergency Room Visit in Past 12 Months		
	aOR	95% CI	*P*-value
Predictors:			
Age	0.979	[0.9716, 0.98549]	0.001
FPL	0.998	[0.9958, 0.99922]	0.004
Hypertension diagnosis[1]	1.795	[1.485, 2.16907]	0.001
Stroke diagnosis[1]	1.999	[1.1728, 3.40759]	0.011
Asthma diagnosis[1]	1.507	[1.2104, 1.87552]	0.001
COPD diagnosis[1]	2.118	[1.6104, 2.78609]	0.001
Substance use disorder diagnosis[1]	2.395	[1.5293, 3.74951]	0.001

aOR = adjusted odds ratio; CI = confidence interval; HMP = Healthy Michigan Plan

NOTE: The odds ratios presented here represent the results of a single logistic regression model adjusting for age, FPL, and presence or absence of the listed diagnoses.

[1]Diagnoses were dichotomized as not present (0) vs. present (1).

Table 39. Perceived Access to Mental Health Care Among Those with a Mood Disorder and Among Those with a Substance Use Disorder

	Would you say that your ability to get mental health care through the Healthy Michigan Plan is better, worse, or about the same, compared to before?								
	Better		Worse		About the same		Don't know		*P*-value[1]
	Row %	95% CI	Row %	95% CI	Row %	95% CI	Row %	95% CI	
Mood disorder									<0.001
Yes (n=1,287)	46.2	[42.7,49.7]	6.3	[4.8,8.3]	27.2	[24.1,30.5]	20.3	[17.6,23.2]	
No (n=2,781)	19.4	[17.5,21.5]	0.8	[0.5,1.2]	21.6	[19.6,23.7]	58.2	[55.8,60.6]	
Don't know (n=10)	7.2	[1.5,28.4]	0		24.0	[5.0,65.6]	68.8	[31.1,91.5]	
Total (n=4,078)	27.5	[25.8,29.4]	2.5	[1.9,3.1]	23.3	[21.6,25.1]	46.7	[44.8,48.7]	
Substance use disorder									<0.001
Yes (n=165)	46.6	[37.2,56.3]	3.0	[1.2,7.4]	22.8	[16.1,31.2]	27.6	[19.1,38.1]	
No (n=3,910)	26.7	[24.9,28.6]	2.5	[1.9,3.2]	23.2	[21.5,25.1]	47.6	[45.6,49.6]	
Don't know (n=7)	11.7	[2.2,43.5]	0		64.5	[24.6,91.0]	23.8	[4.8,65.8]	
Total (n=4,082)	27.5	[25.8,29.3]	2.5	[1.9,3.2]	23.3	[21.6,25.1]	46.7	[44.8,48.7]	

[1] Pearson chi-square analyses

Table 40. Perceived Access to Substance Use Treatment Among Those with a Substance Use Disorder

	Would you say that your ability to get substance use treatment services through the Healthy Michigan Plan is better, worse, or about the same, compared to before?								
	Better		Worse		About the same		Don't know		*P*-value[1]
	Row %	95% CI	Row %	95% CI	Row %	95% CI	Row %	95% CI	
Substance use disorder									<0.001
Yes (n=165)	48.3	[38.7,58.1]	1.7	[0.4,6.6]	16.4	[11.0,23.7]	33.6	[25.2,43.1]	
No (n=3,909)	8.1	[7.0,9.4]	0.1	[0.1,0.3]	8.9	[7.7,10.3]	82.8	[81.1,84.4]	
Don't know (n=7)	6.8	[0.8,39.7]	0		54.7	[16.4,88.1]	38.6	[9.9,78.2]	
Total (n=4,081)	9.8	[8.6,11.1]	0.2	[0.1,0.4]	9.3	[8.1,10.6]	80.7	[79.0,82.3]	

[1] Pearson chi-square analyses

Table 41. Change in Mental Health Status Among Those with a Mood Disorder and Among Those with a Substance Use Disorder

	Overall, since you enrolled in Healthy Michigan Plan, would you say your mental and emotional health has gotten better, stayed the same, or gotten worse?								
	Gotten better		Stayed the same		Gotten worse		Don't know		*P*-value[1]
	Row %	95% CI	Row %	95% CI	Row %	95% CI	Row %	95% CI	
Mood disorder									<0.001
Yes (n=1,286)	48.9	[45.4,52.4]	39.8	[36.5,43.3]	10.9	[8.9,13.3]	0.4	[0.2,0.9]	
No (n=2,778)	33.3	[31.1,35.6]	64.4	[62.1,66.7]	1.8	[1.3,2.4]	0.5	[0.3,0.9]	
Don't know (n=10)	82.2	[53.9,94.8]	14.7	[3.9,42.7]	3.1	[0.4,20.8]	0		
Total (n=4,074)	38.2	[36.3,40.2]	56.7	[54.7,58.7]	4.6	[3.8,5.4]	0.5	[0.3,0.7]	
Substance use disorder									<0.001
Yes (n=165)	50.7	[41.0,60.3]	40.5	[31.2,50.5]	8.8	[4.6,16.1]	0		
No (n=3,906)	37.6	[35.7,39.6]	57.5	[55.5,59.5]	4.3	[3.6,5.2]	0.5	[0.3,0.8]	
Don't know (n=7)	46.5	[12.1,84.5]	11.7	[1.4,55.1]	41.8	[7.9,85.8]	0		
Total (n=4,078)	38.2	[36.3,40.1]	56.7	[54.8,58.7]	4.6	[3.9,5.5]	0.5	[0.3,0.7]	

[1] Pearson chi-square analyses

Table 42. Perceived Impact of HMP Among Those with a Mood Disorder and Among Those with a Substance Use Disorder

	Having the Healthy Michigan Plan has helped me live a better life.												
	Strongly agree		Agree		Neutral		Disagree		Strongly disagree		Don't know		*P*-value[1]
	Row %	95% CI	Row %	95% CI	Row %	95% CI	Row %	95% CI	Row %	95% CI	Row %	95% CI	
Mood disorder													<0.001
Yes (n=1,286)	32.1	[28.9,35.5]	59.9	[56.4,63.4]	4.3	[3.0,6.0]	2.4	[1.6,3.7]	0.6	[0.3,1.4]	0.6		
No (n=2,781)	21.9	[20.0,23.9]	66.1	[63.8,68.3]	8.1	[6.8,9.5]	3.2	[2.5,4.1]	0.2	[0.1,0.3]	0.6	[0.3,1.2]	
Don't know (n=10)	36.2	[10.5,73.3]	63.8	[26.7,89.5]	0		0		0		0		
Total (n=4,077)	25.1	[23.4,26.8]	64.2	[62.3,66.1]	6.9	[5.9,8.0]	2.9	[2.4,3.7]	0.3	[0.2,0.5]	0.6	[0.3,1.1]	
Substance use disorder													<0.001
Yes (n=165)	35.5	[27.2,44.8]	60.3	[50.7,69.1]	1.6	[0.6,4.4]	2.6	[0.4,13.8]	0		0		
No (n=3,909)	24.6	[22.9,26.3]	64.5	[62.5,66.4]	7.1	[6.1,8.3]	2.9	[2.3,3.6]	0.3	[0.2,0.6]	0.6	[0.4,1.1]	
Don't know (n=7)	34.8	[8.5,75.4]	23.4	[5.3,62.4]	0		41.8	[7.9,85.8]	0		0		
Total (n=4,081)	25.0	[23.4,26.8]	64.2	[62.3,66.1]	6.9	[5.9,8.0]	2.9	[2.4,3.7]	0.3	[0.2,0.5]	0.6	[0.3,1.1]	

[1] Pearson chi-square analyses

Table 43. Change in Frequency of Involvement with Family and Friends Among Those with a Mood Disorder and Among Those with a Substance Use Disorder

	Since enrolling in the Healthy Michigan Plan are you involved with your family, friends or community more, less, or about the same?								
	More		Less		About the same		Don't know		*P*-value[1]
	Row %	95% CI	Row %	95% CI	Row %	95% CI	Row %	95% CI	
Mood disorder									<0.001
Yes (n=1,287)	21.0	[18.1,24.2]	8.3	[6.5,10.5]	70.0	[66.6,73.2]	0.7	[0.3,1.5]	
No (n=2,774)	12.6	[11.1,14.3]	2.6	[2.0,3.5]	84.2	[82.4,85.9]	0.6	[0.3,1.2]	
Don't know (n=10)	4.6	[0.6,28.5]	25.2	[3.9,73.9]	70.2	[26.1,94.0]	0		
Total (n=4,071)	15.1	[13.7,16.6]	4.4	[3.7,5.3]	79.8	[78.2,81.4]	0.6	[0.3,1.1]	
Substance use disorder									0.001
Yes (n=165)	23.2	[16.0,32.2]	8.3	[4.0,16.4]	67.4	[57.6,75.9]	1.1	[0.2,7.6]	
No (n=3,903)	14.8	[13.3,16.3]	4.2	[3.5,5.1]	80.4	[78.8,82.0]	0.6	[0.3,1.1]	
Don't know (n=7)	23.8	[5.4,63.1]	41.8	[7.9,85.8]	34.4	[8.4,75.0]	0		
Total (n=4,075)	15.1	[13.7,16.6]	4.4	[3.7,5.3]	79.8	[78.2,81.4]	0.6	[0.4,1.1]	

[1] Pearson chi-square analyses

Table 44. Went to ER Because of Proximity Among Those with a Mood Disorder and Among Those with a Substance Use Disorder

	Went to the ER because it's your closest place to receive care[1]						
	Yes		No		Don't know		*P*-value[2]
	Row %	95% CI	Row %	95% CI	Row %	95% CI	
Mood disorder							0.940
Yes (n=398)	75.1	[69.5,80.1]	24.1	[19.3,29.8]	0.7	[0.1,3.6]	
No (n=575)	74.4	[69.9,78.4]	24.6	[20.7,29.1]	1.0	[0.4,2.3]	
Don't know (n=4)	89.8	[45.8,98.9]	10.2	[1.1,54.2]	0		
Total (n=977)	74.8	[71.3,77.9]	24.3	[21.2,27.8]	0.9	[0.4,1.9]	
Substance use disorder							0.035
Yes (n=70)	87.6	[77.6,93.5]	10.1	[5.3,18.5]	2.3	[0.3,14.7]	
No (n=907)	73.9	[70.2,77.2]	25.4	[22.1,29.0]	0.8	[0.3,1.8]	
Don't know (n=1)	0		100.0		0		
Total (n=978)	74.8	[71.4,78.0]	24.3	[21.2,27.7]	0.9	[0.4,1.9]	
Mood or substance use disorder							0.791
No (n=559)	74.3	[69.7,78.3]	25.0	[21.0,29.5]	0.7	[0.3,1.7]	
Yes (n=418)	75.5	[70.0,80.3]	23.4	[18.7,28.8]	1.1	[0.3,3.8]	
Total (n=977)	74.8	[71.3,77.9]	24.3	[21.2,27.8]	0.9	[0.4,1.9]	

[1] Asked of respondents with an ER visit in the past 12 months who said they did not try to contact their usual provider's office to get help or advice before going to the ER

[2] Pearson chi-square analyses

The Healthy Michigan Plan
Public Act 107 of 2013 §105d (8), (9)
2015 Report on Uncompensated Care and Insurance Rates

December 31, 2016

Submitted to the Michigan Department of Health and Human Services
and the Michigan Department of Insurance and Financial Services

Prepared by the University of Michigan Institute for Healthcare Policy & Innovation
in collaboration with the University of Michigan School of Public Health

§*105d (8)* The program described in this section is created in part to extend health coverage to the state's low-income citizens and to provide health insurance cost relief to individuals and to the business community by reducing the cost shift attendant to uncompensated care. Uncompensated care does not include courtesy allowances or discounts given to patients. The Medicaid hospital cost report shall be part of the uncompensated care definition and calculation. In addition to the Medicaid hospital cost report, the department of community health shall collect and examine other relevant financial data for all hospitals and evaluate the impact that providing medical coverage to the expanded population of enrollees described in subsection (1)(a) has had on the actual cost of uncompensated care. This shall be reported for all hospitals in the state. By December 31, 2014, the department of community health shall make an initial baseline uncompensated care report containing at least the data described in this subsection to the legislature and each December 31 after that shall make a report regarding the preceding fiscal year's evidence of the reduction in the amount of the actual cost of uncompensated care compared to the initial baseline report. The baseline report shall use fiscal year 2012-2013 data. Based on the evidence of the reduction in the amount of the actual cost of uncompensated care borne by the hospitals in this state, beginning April 1, 2015, the department of community health shall proportionally reduce the disproportionate share payments to all hospitals and hospital systems for the purpose of producing general fund savings. The department of community health shall recognize any savings from this reduction by September 30, 2016. All the reports required under this subsection shall be made available to the legislature and shall be easily accessible on the department of community health's website.

§*105d (9)* The department of insurance and financial services shall examine the financial reports of health insurers and evaluate the impact that providing medical coverage to the expanded population of enrollees described in subsection (1)(a) has had on the cost of uncompensated care as it relates to insurance rates and insurance rate change filings, as well as its resulting net effect on rates overall. The department of insurance and financial services shall consider the evaluation described in this subsection in the annual approval of rates. By December 31, 2014, the department of insurance and financial services shall make an initial baseline report to the legislature regarding rates and each December 31 after that shall make a report regarding the evidence of the change in rates compared to the initial baseline report. All the reports required under this subsection shall be made available to the legislature and shall be made available and easily accessible on the department of community health's website.

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Executive Summary

This report, pursuant to §105d (8) and (9) of Public Act 107 of 2013, provides the annual update to the baseline estimate of uncompensated care borne by Michigan hospitals as it relates to insurance rates and rate setting.

The main source of data for the uncompensated care portion is cost reports that hospitals submit annually to the Michigan Department of Health and Human Services (MDHHS). The initial report, submitted in December 2014, provided baseline data on hospital uncompensated care from 2013, i.e., prior to the implementation of the Healthy Michigan Plan (HMP). The December 2015 report presented data from 2014. Because of reporting lags and the timing of hospital fiscal years, these data represented post-HMP experience for only a subset of hospitals, and even in those cases the most recent data represented a mix of pre- and post-HMP data. The most recent data used in this report were submitted in 2015. For most hospitals, these data pertain to fiscal year 2015 and represent a full 12 months of post-HMP experience. For a subset of hospitals, the most recent data available are for fiscal year 2014 and therefore represent a mix of pre- and post-HMP data. We present results for 2013, 2014 and 2015, though for the purposes of evaluating the effect of the HMP on hospital uncompensated care, the cleanest comparisons are between 2013 and 2015.

Two main sources of data, key informant interviews and Michigan DIFS rate filings, provide information on the contribution of uncompensated care to premium rates, rate change filings, and the net effect on rates overall, in the year before and each of the two years following implementation of the Healthy Michigan Plan.

Key findings: §105d (8) Uncompensated Care

The cost report data indicate that the cost of uncompensated care provided by Michigan hospitals fell dramatically after the implementation of the Healthy Michigan Plan. Comparing data from 2013 and 2015 for a consistent set of hospitals, uncompensated care costs decreased by almost 50 percent. For the average hospital, annual uncompensated care expenses fell from $7.21 million to $3.77 million. Expressed as a percentage of total hospital expenses, uncompensated care decreased from 5.2 percent to 2.9 percent. Over 90 percent of hospitals submitting data for both FY 2013 and FY 2015 saw a decline in uncompensated care between those two years.

Key findings: §105d (9) Insurance Premium Rates

There was no evidence from the interviews and rate filings that the Healthy Michigan Plan affected health plan premium rates. Review and analysis of DIFS rate filings showed changes in the increases requested in premium rates by year and by product and market. The average weighted premium rate increase requested in filings declined from 2013-2015: 7.55% in 2013, 5.77% in 2014, and 5.20% in 2015. While the requested rate increase varied by products and markets, reasons given in the filings for the rate requests were related most often to increasing medical and pharmaceutical costs.

Interviews with key stakeholders revealed concerns with increasing medical and pharmacy costs. Some respondents expressed concerns about future premium changes as a result of changes in the methodology for determining risk adjustment or expiration in 2016 of the Federal reinsurance program. With the reinsurance program, all individual, small group, and large group market issuers of fully-insured major medical products, as well as self-funded plans, contributed funds to the reinsurance program since 2014, with proceeds distributed to insurers who had enrollees with high medical expenses. For 2016, these reinsurance payments reduced individual market premiums by an estimated 4 to 6 percent. Without the reinsurance program, some insurers will need to raise their premiums in 2017 by a comparable percentage to make up for the loss of the reinsurance funds.[1]

The report details the decrease in uncompensated care costs since the Medicaid expansion; however, there was no evidence from the interviews and rate filings that the Healthy Michigan Plan affected health plan premium negotiations or premium rates.

Challenges in Quantifying the Impact of Uncompensated Care Costs and the Healthy Michigan Plan on Premium Rates

Developing health insurance premium rates involves numerous stakeholders, such as insurers, hospitals, employers, physicians, pharmacy benefit managers, pharmaceutical and medical device manufacturers, to name a few. There are also complex rate setting methodologies, and propriety information, overlaid on continually changing medical and insurance markets. In addition, not all plans and policies offered in a state are subject to regulation, review, and approval by the state. There is no single source of data that provides all necessary elements for analysis. These and other factors make it difficult to attribute observed premium rate changes to the Healthy Michigan Plan.

The academic literature in health economics and health policy does not provide direct theoretical or empirical support for a transfer of the costs of uncompensated care or of shortfalls in Medicare and Medicaid payments to private payers, despite perceptions of the existence of cost shift.[2] Cost shifting has been defined as "the phenomenon in which changes in administered prices of one payer lead to compensating changes in prices charged to other payers."[3] Prior research demonstrates that uncompensated care as a share of overall health care costs has remained relatively flat while the private payment to cost ratio has increased, suggesting that factors other than changes in uncompensated care explain changes in private insurance premiums.[4]

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[1] http://kff.org/private-insurance/perspective/what-to-look-for-in-2017-aca-marketplace-premium-changes/

[2] Couglin TA, Holahan, J, Caswell, K, McGrath, M. Uncompensated care for the uninsured: A detailed examination. Kaiser Family Foundation report. May 30, 2013. Available from: http://kff.org/report-section/uncompensated-care-for-the-uninsured-in-2013-a-detailed-examination-cost-shifting-and-remaining-uncompensated-care-costs-8596/

[3] Ginsburg P. Can hospitals and physicians shift the effects of cuts in Medicare reimbursement to private payers? Health Aff [Internet]. 2003;(Web Exclusive):W3–472 to W3–479. Available from: http://content.healthaffairs.org/content/early/2003/10/08/hlthaff.w3.472.full.pdf

[4] Forslund TO. Cost shifting and the impact of new hospitals on existing markets. Wyoming Department of Health. 2014.

A number of factors contribute to changes in private insurance premiums, with changes in public payer rates and in uncompensated care being just two of these factors. Even in situations where a hospital has a large share of market power, hospitals may employ other strategies rather than increase prices when faced with revenue shortfalls, including cost cutting and "volume shifting," and lowering private prices to attract more private volume.[5] Even if cost shifting does occur at its maximum, the amount that would potentially be shifted to employers is less than 3% of private insurance premiums.[6] The complex interplay of factors that explain changes in private insurance rates, as also noted in the literature, makes it very difficult to attribute changes in insurance premiums to the reductions in uncompensated care resulting from the Healthy Michigan Plan.

Conclusion

Based on hospital cost reports submitted to MDHHS, Michigan hospitals experienced a substantial decline in the costs of uncompensated care in FY 2015 compared to FY 2013. Yet rate filings and interviews with key stakeholders do not demonstrate a connection between reductions in uncompensated care and premium rates.

[5] Frakt A. How much do hospitals cost shift? A review of the evidence. Milbank Q. 2011;89(1):90–130.
[6] Couglin TA, Holahan, J, Caswell, K, McGrath, M. Uncompensated care for the uninsured: A detailed examination. Kaiser Family Foundation report. May 30, 2013. Available from: http://kff.org/report-section/uncompensated-care-for-the-uninsured-in-2013-a-detailed-examination-cost-shifting-and-remaining-uncompensated-care-costs-8596/

§105d (8): Uncompensated Care

Thomas Buchmueller, University of Michigan Stephen M. Ross School of Business
Helen Levy, University of Michigan Institute for Social Research
Sayeh Nikpay, Vanderbilt University School of Medicine
Jordan Rhodes, University of Michigan Stephen M. Ross School of Business

Introduction

In order to measure the effect of the Healthy Michigan Plan, §105(d)(8) of Public Act 107 requires the Department of Community Health (DCH), now the Department of Health and Human Services (DHHS), to publish annual reports on uncompensated care in Michigan. This section of the report, *The Healthy Michigan Plan: Uncompensated Care*, fulfills the requirement of §105(d)(8). The analysis is based on data from Medicaid cost reports submitted to the state annually from 2013 to 2015.

Background

The 2015 PA 107 report presented quarterly state-level data on inpatient hospital discharges from 2003 to the third quarter of 2014. These data revealed immediate changes in payer mix in Michigan after the implementation of the Healthy Michigan Plan. The Medicaid share of hospital discharges rose from 17 percent in the 1st quarter of 2014 – before HMP – to 20 percent in the 3rd quarter of 2014. At the same time the uninsured share of discharges also fell by three percentage points, from 4 percent to 1 percent. These sharp changes, which followed a decade in which payer mix shifted very gradually, suggested a significant effect of the Healthy Michigan Plan. Other published research using data from Michigan[7] and comparing a greater number of states that implemented the ACA Medicaid expansion also indicate a significant reduction in uninsured discharges and an increase in Medicaid discharges after Medicaid expansion.[8]

Data: Medicaid cost reports

Each year, Michigan hospitals submit cost reports to the State Medicaid program. Based on several data elements contained in these reports, it is possible to calculate the cost of uncompensated care provided by each hospital.

Uncompensated care is the sum of two different types of costs: charity care and bad debt. ***Charity care*** is the cost of medical care for which there was no expectation of payment because the patient has been deemed unable to pay. ***Bad debt*** is the cost of medical care for which there was an expectation of payment because the patient was deemed to be able to pay for care, but ultimately payment was not received. Both types of uncompensated care may arise from patients

[7] Davis MA, Gebremariam A, Ayanian JZ. Changes in insurance coverage among hospitalized non-elderly adults after Medicaid expansion in Michigan. JAMA 2016; 315:2617-8.
[8] Hempstead K, Cantor JC. State Medicaid expansion and changes in hospital volume according to payer. New England Journal of Medicine 2016; 374(2): 196-198. Nikpay S, Buchmueller T, Levy HG. 2016. Affordable Care Act Medicaid expansion reduced uninsured hospital stays in 2014. Health Affairs 2016; 35 (1):106-110.

who are uninsured or from those who are under-insured and unable to afford deductibles or other cost-sharing required by their insurance plans when they receive hospital care. Changes in Disproportionate Share Hospital (DSH) payments do not have a direct impact on uncompensated care. For more information on the definition of uncompensated care, please see Appendix A.

The cost reports for state fiscal year (FY) 2015 include data on 142 hospitals. Hospitals vary in the timing of their fiscal years and this variation affects the timing of when data is reported to the state. Table 1 summarizes the timing of hospital fiscal years and indicates how this timing affects our ability to measure changes in uncompensated care before and after the implementation of the Healthy Michigan Plan (HMP).

For hospitals with fiscal years ending in the first three quarters of the calendar year (i.e., before September 30) the most recent submission pertains to their 2015 fiscal year. Regardless of the exact timing, FY 2015 started after April 1, 2014. Thus, all data from FY 2015 represents 12 months of post-HMP experience. There is variation, however, in how data for FY 2014 lines up with the start of the HMP. For hospitals with fiscal years ending in the first quarter, FY 2014 ended before the start of HMP enrollment, which means that FY 2014 represents 12 months of pre-HMP data. In contrast, for hospitals with fiscal years ending in the second or third quarter, FY 2014 started before and ended after the establishment of the program. Thus, for these hospitals FY 2014 represents a mix of pre- and post-HMP experience. Hospitals with fiscal years ending in the fourth quarter always submit their cost report data with a lag. For this group, the most recent (2015) submission contains data from FY 2014. For a large majority of these hospitals, the fiscal year ends on December 31, which means that 9 months of FY 2014 fell in the post-HMP period.

Uncompensated care, FY 2013 to FY 2015

Table 2 presents data on hospital uncompensated care for FY 2013, FY 2014 and FY 2015. Two sets of results are presented for FY 2013 and FY 2014. One pertains to all hospitals reporting data for those years—142 hospitals in 2013 and 141 hospitals in 2014. To facilitate comparisons with FY 2015, results for 2013 and 2014 are also reported for the subset of hospitals for which FY 2015 data are available. Results for each individual hospital are reported in Appendix C Table 1.

The data show that all Michigan hospitals provided approximately $1.1 billion in uncompensated care in FY 2013, which represented 4.8 percent of total hospital expenses. This amount declined to $913.5 million in FY 2014, representing 4.1 percent of total hospital expenses. As noted, only a fraction of FY 2014 fell after the start of the HMP.

FY 2015 is the first fiscal year that began after the HMP was in place. Thus, the impact of the HMP is more readily seen by focusing on the 88 hospitals that reported data for 2013 and 2015.[9] In the baseline year, the average amount of uncompensated care for this subset of hospitals was lower than the average for all hospitals ($7.2 million vs. 7.8 million) though uncompensated care as a percentage of total expenses was slightly higher (5.2 percent vs. 4.8 percent). For these

[9] For one hospital that changed the timing of its fiscal year, no data from 2014 are available. This hospital is in the data set in both 2013 and 2015. Therefore, comparisons between those two years are for the same set of hospitals.

hospitals, the mean number of months of HMP exposure for this group in FY 2014 was 3.3 months. The results show that uncompensated care expenses fell 0.4 percentage points between FY 2013 and FY 2014, to an average of 4.8 percent. There was a further decline in FY 2015 to 2.9 percent of total expenses. For the 88 hospitals reporting 2015 data, the total amount of uncompensated care provided in 2015 was $332.1 million, or 53 percent of the amount of uncompensated care provided by those same hospitals in 2013.

Figure 1 presents the results in graphical form, breaking out the results for FY 2014 in a slightly different way. For that year, hospitals are grouped according to HMP exposure, i.e., the number of months in FY 2014 that fell after April 1, 2014, when the HMP plan started. It is important to note that the separate categories for FY 2014 consist of different hospitals, and therefore comparisons among the different results for 2014 should be interpreted cautiously. With that caveat noted, the data suggest that uncompensated care fell shortly after the HMP went into effect. Among hospitals for which half of FY 2014 occurred after the HMP was in place, uncompensated care was 4.3 percent of total expenses, reduced from 4.8 percent for all hospitals in 2013. Among hospitals with 9 months of post-HMP experience in FY 2014, uncompensated care was 2.9 percent of total expenses, essentially the same as the rate in 2015.

Figure 2 presents the full distribution of the change between 2013 and 2015 in uncompensated care as a percentage of total expenses for the 89 hospitals submitting data for both years. Uncompensated care fell as a percentage of expenses for 94 percent of these hospitals (83 out of 88). The median change was 2.0 percentage points, just slightly below the mean difference of 2.3 percentage points shown in Table 2. Thirty percent of hospitals experienced a decline of 3 percentage points or more.

Conclusion

This is the third in a series of annual reports analyzing changes in uncompensated care following the implementation of the Healthy Michigan Plan. This year's report is the first to present data representing a full year of experience after the program was in place (for most, but not all, hospitals). The results indicate a substantial decline in uncompensated care. Over 90 percent of hospitals submitting data for FY 2015 saw a decline in uncompensated care measured as a percentage of total expenses between 2013 and 2015. For this group as a whole, uncompensated care expenses fell nearly by half between 2013 and 2015.

Table 1. The Distribution of Michigan Hospitals by the Timing of their Fiscal Year and Availability of Medicaid Cost Report Data

FY ends in:		Data Available for Hospital Fiscal Year 2013	2014	2015
1st Quarter	number of hospitals	9	9	9
	months post-HMP	0	0	12
2nd Quarter	number of hospitals	61	60	60
	months post-HMP	0	3	12
3rd Quarter	number of hospitals	19	19	19
	months post-HMP	0	6	12
4th Quarter	number of hospitals	53	53	0
	months post-HMP	0	9	---

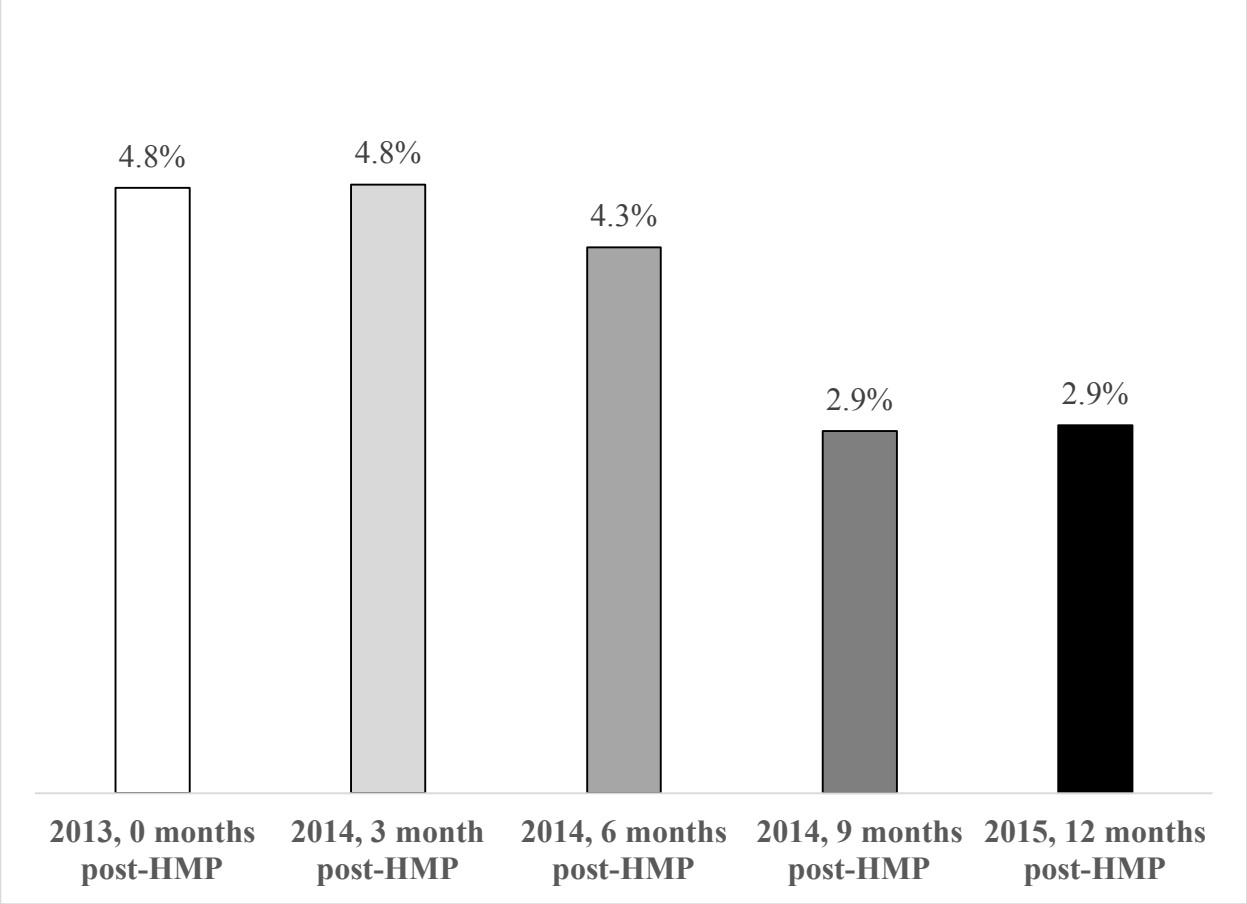
Notes: Hospitals are categorized according to the timing of the fiscal years. The first row in panel gives the number of hospitals in the category reporting data for each fiscal year. Because hospitals submit data with a lag, for hospitals with fiscal years ending in the fourth quarter, the 2015 submission pertains to their FY 2014. The second row in each panel gives the mean number of months in that fiscal year that fell after April 1, 2014.

Table 2. Uncompensated Care Costs, Hospital FY 2013, FY 2014 and FY 2015

	All Hospitals		Hospital FY Ends Q1 – Q3		
	2013	**2014**	**2013**	**2014**	**2015**
Number of Hospitals	142	141	88	87	88
Mean months post-HMP	0	5.4	0	3.3	12
Uncompensated Care Costs					
Total (millions)	$1110.4	$913.5	$627.0	$590.0	$332.1
Mean (millions)	$7.82	$6.47	$7.21	$6.78	$3.77
As a % of Total Costs	4.8%	4.1%	5.2%	4.8%	2.9%

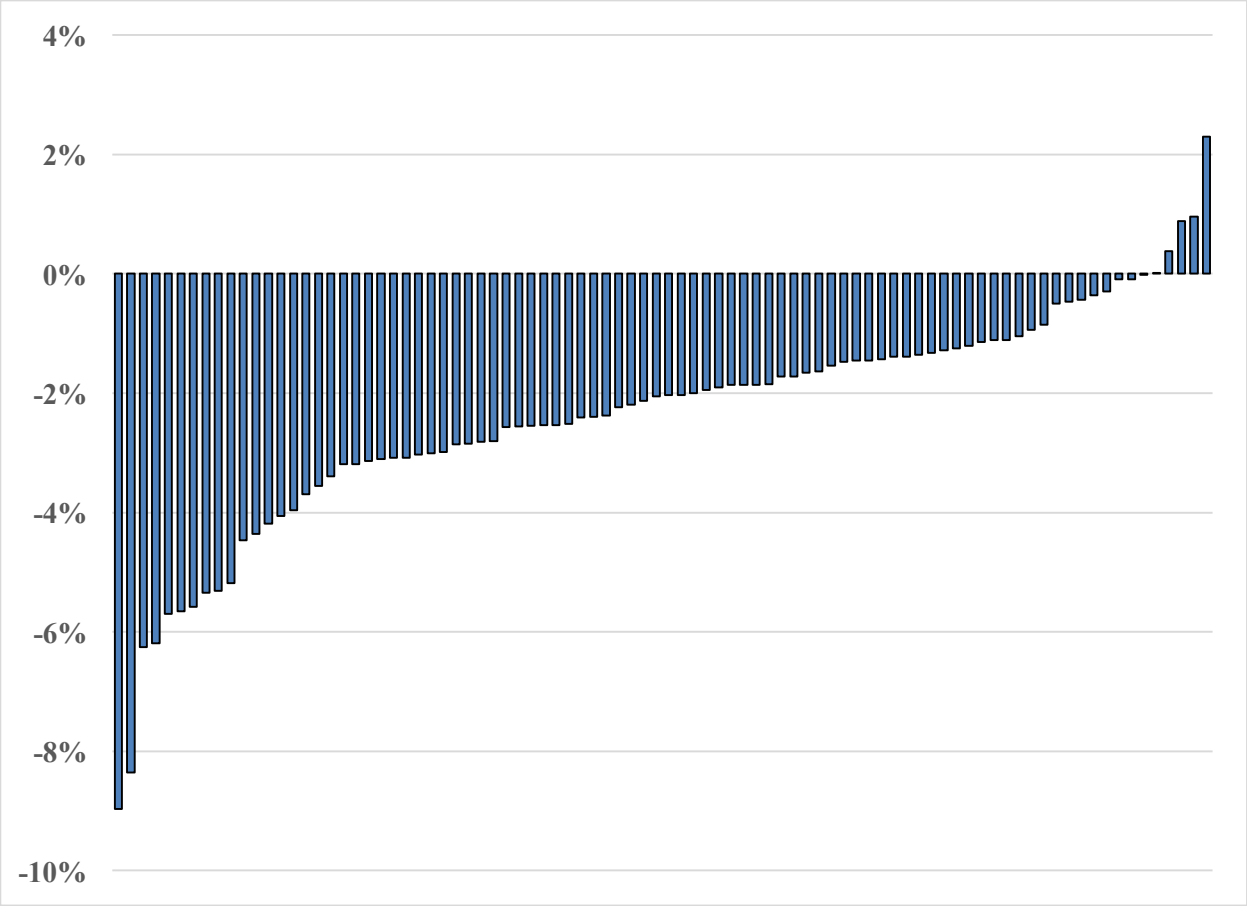
Notes: The figures for uncompensated care as a percentage of total hospital costs represent unweighted means.

Figure 1. Uncompensated Care as a Percentage of Total Expenses, by Exposure to the Healthy Michigan Plan, 2013 to 2015



Notes: The figures represent unweighted means for hospitals in each category. The first column presents data for all 142 hospitals that submitted data for FY 2013. This corresponds to column 1 of Table 2. The next 3 columns report FY 2014 results for hospitals with 3, 6 and 9 months of exposure to the HMP. The number of hospitals in these categories are 61, 19 and 53, respectively. Data are not reported for 9 hospitals for which FY 2014 ended before the HMP start date of April 1, 2014. FY 2015 data are for 88 hospitals that submitted data for that year. This figure corresponds to column 5 of Table 2.

Figure 2. Change in Uncompensated Care as a Percentage of Total Expenses Between 2013 and 2015 for Hospitals Reporting Data in Both Years



Notes: The sample consists of 88 hospitals for which FY 2015 data are available. Each bar represents the change for an individual hospital.

§105d (9): Insurance Premium Rates

Kyle Grazier, University of Michigan School of Public Health
Charley Willison, University of Michigan School of Public Health

Introduction

To measure the effect the Healthy Michigan Plan "has had on the cost of uncompensated care as it relates to insurance rates and insurance rate change filings, as well as its resulting net effect on rates overall," §105d (9) of Public Act 107 of 2013 requires the Department of Insurance and Financial Services (DIFS) to make an annual report each December 31 regarding the evidence of the change in rates compared to the initial baseline report in December 2014. This section of the report, *The Healthy Michigan Plan: Insurance Premium Rates,* fulfills the requirement of §105d (9) of 2013.

Two main sources of data, key informant interviews and Michigan DIFS rate filings, provide information on the contribution of uncompensated care to premium rates, rate change filings, and the net effect on rates overall, in the year before and each of the two years following implementation of the Healthy Michigan Plan.

To summarize the complex processes of premium rate setting and factors that affect changes in those rates, and to provide context for the analysis, the appendices to this report provide a synopsis of the methodology for premium setting, a table of factors that contribute to rate increases, and additional figures referenced in the report.

Background

Gathering all the necessary data to determine the cost of uncompensated care as it relates to insurance premiums is challenging and complex. Determining the reasons and mechanisms behind changes in premium rates by different types of plans and in different markets requires actuarial science, as well as knowledge of the local, state, and federal business, health, and political environments. Additionally, some ACA regulations and guidance affect individual markets differently from small and large group markets, including some ACA provisions that sunset. For instance, the Federal transitional reinsurance program ends in 2016.

Developing health insurance premium rates involves numerous stakeholders, such as insurers, hospitals, employers, physicians, pharmacy benefit managers, pharmaceutical and medical device manufacturers, to name a few. There are also complex rate setting methodologies, and propriety information, overlaid on continually changing medical and insurance markets.

Additionally, not all plans offered in the state are subject to regulation, review, and approval by the state. More than half of Michigan employees of organizations offering health insurance are in self-insured plans; these employers are not subject to state plan rate review and approval, premium taxes, or mandated benefits. Rate filings do not include the detailed information required to determine the contribution of uncompensated care to rates, even for fully insured health plans that are subject to DIFS regulatory authority. In addition, contracts that might detail

the relationship between health care costs and insurance prices are often proprietary. Although DIFS and MDHHS collect data supporting their functions and mandates, they do not have access or authority to collect detailed data from those proprietary contracts.

There is no single source of data that provides all necessary elements for analysis. These and other factors make it difficult to attribute observed premium rate changes to the Healthy Michigan Plan.

To help inform understanding of insurance rates and rate changes in the year before and each of the two years following implementation of the Healthy Michigan Plan, the next sections of the report provides analysis of interviews with key informants and analysis of filings data available from DIFS.

Analysis of Key Informant Interviews

A stratified sampling approach used type and size of organization and region of the state to identify the interviewees.[10] Semi-structured telephone interviews were conducted in each of the last three years with Michigan employers, healthcare insurers, and healthcare providers.[11] The interviews focused on the respondent's experiences with and impressions of the effects of the Healthy Michigan Plan on premium rates and the processes used to determine those rates. Respondents were specifically asked to comment on premium rate negotiations and rate setting, and the role of uncompensated care costs in those processes.

Thirty-one employers, health insurers and healthcare providers provided responses in the summer 2016. Characteristics of respondents appear in Appendix D. Interviewees were designated decision-makers or persons with appropriate expertise and experience in their organizations; these included benefits managers, senior-level financial officers, executives, and contract negotiators.[12]

Although a small sample of employers cannot be representative of the state's business types, locations, size, industry, or insurance behaviors, we sought to include comments from employers from across the state who could contribute unique and varying perspectives that might be associated with public and employer opinion on the impact of HMP on health coverage in Michigan.

Interview Responses

Respondents' reports of factors affecting premium rates, and excerpts from their interviews appear in Appendix F. This section provides a summary of these responses by category of respondent.

[10] The Michigan Care Improvement Registry (MCIR) groups Michigan counties into six regions (https://www.mcir.org/). Key informant interviews for the three years used a convenience sample, loosely stratified by all six MCIR geographic regions with additional targeting in the southeast and southwest markets with the highest number of HMP enrollees, and a range of industry codes across the state.

[11] Given the Institutional Review Board (IRB) conditions of approval, no firms are identified by name in this report.

[12] The initial interviews for the 2013 baseline report were conducted with 29 Michigan-based employers. The 2014 report included completed interviews with 56 employers located in all MCIR sections of the state.

All Respondents

- Employers, health insurers, and healthcare providers did not identify the Healthy Michigan Plan or changes in uncompensated care as affecting insurance premium rates.

Employers

- Large employers were concerned about the current and future regulations on cost of benefits, risk pools, penalty payments, and special taxes.
- Large and small employers are seeking ways to reduce the costs of benefits through plan management and benefit design; large employers were using workplace wellness approaches to improve employee health and use of services.
- Large employers expressed concern about needing to offer less-competitive benefit packages in the future to avoid the Cadillac tax.
- Small employers expected instability in the individual and small group markets.
- Small employers noted their concern with their ability to offer health benefits to employees at an affordable price.

Hospitals and Healthcare Providers

- Healthcare providers noted fluctuations in patient volume related to changes in healthcare coverage. The changes in volume and patient insurance coverage affect operating margins that impact payment rates and negotiations.
- Hospitals noted concern with decreasing federal and nonfederal reimbursement rates relative to costs of providing services.
- Hospitals reported decreases in their bad debt post-ACA, market plans, and Medicaid expansion, but did not associate these policies with premium rate changes.
- Hospitals and hospital systems reported separately negotiated contracts with payers, but reported no detectible impact of uncompensated care or the Healthy Michigan Plan on those negotiations.
- Hospital uncompensated care costs have decreased since Medicaid expansion but it was unlikely that these decreases have a material impact on premium rates or are technically detectable in changes in premium rates.

Insurers and Health Plans

- Insurers were unable to negotiate for reductions in price increases as a result of the decrease in hospital uncompensated care costs.
- Insurers expressed concern over the increasing costs of pharmaceuticals and their impact on premiums.
- Insurers expressed concern about ending the federal transitional reinsurance program in 2017 and the effects on premiums.
- Insurers noted the impact on current and future revenues of the ACA regulations on risk adjustment and reinsurance.

Analysis of Department of Financial and Insurance Services (DIFS) Rate Filings

Each year, health plans are required to submit rates for review by DIFS. This requirement applies to health insurers selling individual plans, group conversion policies, Medicare supplemental

policies, small employer group plans, and plans sold by health maintenance organizations. DIFS does not set health insurance rates.[13] DIFS does not review the rates for government entities, commercial large group plans (coverage through an employer with more than 50 employees), or self-insured employers (health benefits provided by an employer with its own funds). Approximately 54% of private sector enrollees in Michigan firms offering health insurance are in self-insured plans. [14, 15]

In 2016, DIFS provided all health plan filings submitted and with dispositions in 2013, 2014, and 2015, with tracking codes to link individual filings for download from the public access System for Electronic Rate/Form Filing (SERFF) portal. Rate filings consist of multiple Federal and state-mandated forms, formats, and templates for each product.[16] The list of abstracted elements from filings from 2013, 2014, and 2015, as well as inclusions and exclusions in selection of filings for analysis appear in Appendix E. There is no specific line item or cell in the filings forms or templates for the cost of "uncompensated care" or its contribution to rates. Filings analysis includes only those filings that noted a requested increase or decrease in premium rates. New products were excluded due to the absent experience period**.**

To provide context for the analysis, and to summarize the processes of premium rate setting and review, Appendices G and H provide definitions, a synopsis of the methodology for premium setting, and a table of factors that contribute to rate increases.

Findings from Rate Filings Analysis

Table 4 presents selected characteristics of the filings by year. Appendix E supplements this table with additional analysis of market, product, reasons for increase/decrease, and trend rates presented in tables and charts.

[13] DIFS Health Coverage Rates and Rate Reviews: http://www.michigan.gov/difs/0,5269,7-303-12902_35510-113481--,00.html
[14] Source: Agency for Healthcare Research and Quality, Center for Financing, Access and Cost Trends. 2013, 2014, 2015 Medical Expenditure Panel Survey-Insurance Component.
[15] Self-Insured Health Plans: Recent Trends by Firm Size, 1996–2015 By Paul Fronstin, Ph.D., Employee Benefit Research Institute "examines recent trends in self-insured health plans among private-sector establishments and workers based on data from the Medical Expenditure Panel Survey Insurance Component (MEPS-IC). Data are presented in the aggregate and by establishment size." 2016, Employee Benefit Research Institute–Education and Research Fund.
[16] These may include but are not limited to written (free form text) description of methodology for determination of premium rates, medical rates forms, network data, rates tables with free text annotations, actuarial memorandum, unified rate review template (URRT), justifications and attestations, summary of benefits and coverage and associated rates, evidence of accreditation, SERFF tracking numbers of any document that is amended from its original version, filing notes, correspondence, disposition.

Table 4: Selected Characteristics of DIFS Rate Filings Analyzed by Year [17]

	2015	2014	2013
Percent premium rate change requested (Average Weighted)	5.22	5.77	7.55
Health plan filings for premium rate changes	59	44	54
Number of filings requesting a decrease in premium rates	7	8	4
Number (Percent) of filings, by market	N (%)	N (%)	N (%)
Individual	19 (32)	7 (16)	10 (19)
Small Group	19 (32)	18 (41)	2 (4)
Large Group	21 (36)	19 (43)	42 (78)
Number (Percent) of filings, by product	N (%)	N (%)	N (%)
HMO	31 (53)	22 (50)	36 (67)
PPO	14 (24)	12 (27)	7 (13)
MM	11 (19)	8 (18)	10 (19)
POS	3 (5)	2 (5)	1 (2)
Percent rate change requested, by product	Ave %	Ave %	Ave %
HMO	3.4	2.4	6.2
PPO	6.5	7.8	8.7
MM	8.6	12.0	11.7
POS	5.7	5.8	6.7
Reasons for premium rate change, by percent of filings	%	%	%
Medical costs	93	68	85
Use of services	88	64	52
Benefit changes	58	48	44
ACA non-benefit changes (Taxes, risk pools, provider networks)	58	55	37
Morbidity of enrollees	49	64	52
Medical Costs Trend Rate (Ave %) reported in Actuarial Memoranda, etc.	6.73%	8.70%	7.33 %

[17] Additional data tables and charts appear in Appendix E.

Summary Findings

- The filings do not indicate that the Healthy Michigan Plan affected the number, plan type, or market of premium rate change requests.

- Filings do not reveal an effect of changes in uncompensated care on premium rate changes.

- The number of rate filings submitted for premium rate change requests increased slightly in 2015. This likely reflects the transitions in plan design, addition of essential benefits, and ACA policies and formula for reinsurance and risk adjustment.

- The percent premium rate change requested (average weighted) per filing decreased each year of the study, to its lowest rate in 2015, 5.22%.
    - Percent premium rate change requested ("Average Weighted"): 2013: 7.55%; 2014: 5.77%; 2015: 5.22%

- There were fewer and a smaller proportions of filings with very high (above 10%) rate change requests in 2015 and 2014 than in 2013; there were more single outlier negative and positive rate requests in 2015.

- The individual market showed the most variation in premium rates requested. The outlier rates appear more often in the individual market, and in the HMO product, in every year.

- The smallest rate changes requested in each year were in HMO product filings; largest rate change requested were in filings for the Major Medical products in each year.

- In all product categories, the average rate change requested was lowest in 2015, compared with 2013 and 2014.

- Filings noted the following reasons for requesting a premium rate increase:
    - Medical costs: Changes in prices and costs of medical services were noted in 85% of filings in 2013; 68% of filings in 2014; and in 93% of filings in 2015.
    - Utilization of Services: Increases in use of medical and health services, and in intensity of services: 2013: 52%; 2014: 64%; 2015: 88%.
    - Benefits: Changes in benefit design, plan features, out of pocket costs, and provider networks: 2013: 44%; 2014: 48%; 2015: 58%.
    - ACA: Changes in required coverage, medical loss ratios, single risk pools, taxes, fees: 2013: 37%; 2014: 55%; 2015: 58%.
    - Morbidity: Changes in the extent and types of disease or illness within the intended pool of covered individuals: 2013: 52%; 2014: 64%; 2015: 49%.

- Increases in medical prices and costs was the most common reason for requesting a rate change by large group, small group, and individual plans; and for HMO, PPO, and Major Medical (MM) plans in each of the three years. There were too few Point of Service (POS) plans to note trends.

- Changes in plan benefits was noted as the reason for changes in rates by large group plans in 2013 and 2014; and in individual markets in 2015.

- An increasing proportion of all filings each year noted utilization of services as a reason for the rate change.

- Medical Cost Trend rate was at its lowest of the three years in 2015, at 6.73% (2013: 7.33%; 2014: 8.70%)

- The Medical Cost Trend rates tended to be higher in large and small groups filings, rather than in the individual market filings. The distribution of Medical Cost Trend rates reported by large groups was wider and more variable.

- HMO plan filings noted increases in premium rates due to increasing pharmacy costs and increasing outpatient visits and professional services. Inpatient hospital use remained stable over the three years.

Conclusion

Interview respondents and rate filings did not identify the Healthy Michigan Plan as a factor affecting changes in premiums in 2013, 2014, or 2015.

Overall Conclusion

Based on hospital cost reports submitted to MDHHS, Michigan hospitals experienced a substantial decline in the costs of uncompensated care in FY 2015 compared to FY 2013. Yet rate filings and interviews with key stakeholders do not offer a connection between reductions in uncompensated care and premium rates.

Appendix A: Literature Review on Cost Shifting

Governmental reports

1. Key issues in analyzing major health insurance proposals. [Internet]. Congress of the United States Congressional Budget Office. 2008 [cited 2014 Nov 21]. p. 112. Available from: http://www.cbo.gov/sites/default/files/12-18-keyissues.pdf

This CBO report notes that cost shifting can only occur under certain conditions. One example is limited competition in which an isolated community is served by a single hospital or in a competitive provider market to offset the costs of uncompensated care or to make up for low public payment rates. Uncompensated care and low payment rates from public programs may result in hospitals reducing their costs by providing care that is less intensive or of lower quality.

2. Forslund TO. Cost shifting and the impact of new hospitals on existing markets. Wyoming Department of Health. 2014.

In its analysis of cost shifting in Wyoming, the Wyoming Department of Health reached two conclusions: First, cost shifting is one of three potential strategies that hospitals can pursue in the face of revenue shortfalls. Two other strategies, including cost cutting and "volume shifting" or lowering private prices to attract more private volume, may also be used. Second, hospitals' ability to cost shift depends on their market power. This analysis of Wyoming data supports the conclusion that hospital market concentration is one of the more significant factors driving prices paid by the private sector. Market power is more strongly associated with changes in private prices than uncompensated or unreimbursed care. However, the report notes that just because a hospital has more market power does not necessarily mean that they engage in cost shifting.

Reviews of the literature and observable trends

1. Frakt AB. How much do hospitals cost shift? A review of the evidence. Millbank Q; 2011; 89(1): 90-130.

In reviewing the evidence on cost shifting, Frakt notes that policymakers should view with skepticism hospital and insurance industry commentary on the existence of inevitable, visible, or large-scale cost shifting. Some cost shifting may be caused by changes in public payment policy, but this is one of many possible effects on private insurance prices. Rather the author cautions that changes in the balance of market power between hospitals and health insurers which result in consolidation can have a significant impact on private insurance rates.

2. Couglin TA, Holahan, J, Caswell, K, McGrath, M. Uncompensated care for the uninsured: A detailed examination. Kaiser Family Foundation. May 30, 2013. Available from: http://kff.org/report-section/uncompensated-care-for-the-uninsured-in-2013-a-detailed-examination-cost-shifting-and-remaining-uncompensated-care-costs-8596/

This Kaiser Family Foundation report notes that there is limited evidence to indicate that increases in uncompensated care have caused hospitals to increase their charges for those with private insurance. The report notes that even as the uninsured rate grew over the past two decades, hospitals' uncompensated care as a share of overall cost has remained steady. Further,

the private payment to cost ratio has steadily increased since 2001, which suggests that the rise in private surpluses is related to other forces, not a result of the cost of care provided to the uninsured. The authors estimate that in 2013, $21.1 billion in providers' uncompensated care costs could be financed by private insurance in the form of higher payments and ultimately higher insurance premiums. Total private health insurance expenditures in 2013 are estimated to be $925.2 billion, so the amount potentially associated with uncompensated care cost shift would be 2.3% of private health insurance costs in 2013. The authors note that even if the $21.1 billion estimate is an underestimate by a wide margin, the potential cost shift from uncompensated care would account for only 4.6% of private health insurance in 2013.

3. Lee J, Berenson R, Mayes R, Gauthier A. Medicare payment policy: Does cost shifting matter? Heal Aff. 2003;W3–480.

The authors examine cost shifting through the lens of Medicare payment policy and state that the extent to which cost shifting impacts private payers and hospitals is a result of their market power and the amount of revenue in the system. Medicare payment policy is based on responsibility to patients as well as supporting the public good. Payment rates are influenced by interest groups and budgetary considerations. The majority of the time Medicare payments cover their responsibilities to Medicare patients and the community. However, if providers' prices rise, and neither public nor private payers' compensation follows suit, consumers pay more. The result is that people lose coverage, which the authors note is the ultimate cost shift.

Theoretical understandings of cost shift

1. Dobson A, DaVanzo J, Sen N. The cost-shift payment "hydraulic": Foundation, history, and implications. Health Aff. 2006;25(1):22-33.

This paper reviews empirical examples of cost shift that show a correlation between lower Medicaid reimbursements and higher private insurance premiums leading to the explanation of cost shift as a potential explanation for increase in private premiums. In reality, the authors note that the potential for cost shift varies greatly over time and across health care markets. Hospitals can absorb some degree of cost shifting pressure through increases in efficiency and decreases in service intensity.

2. Frakt A. The end of cost shifting and the quest for hospital productivity. Health Serv Res. 2014;49(1):1–10.

This article explores the ways hospitals may respond to reductions in Medicare payments. Frakt describes cost shifting as one hypothesis for the ways in which hospitals may attempt to gain revenue in the face of declining Medicare payments. However, hospitals can also raise private prices commensurate with their market power in the absence of a public payment shortfall. Frakt notes that although there are circumstances under which hospitals could and did cost shift at high rates, recent research suggests that it is a far less pervasive phenomenon today.

3. Ginsburg P. Can hospitals and physicians shift the effects of cuts in Medicare reimbursement to private payers? Health Aff [Internet]. 2003;(Web Exclusive):W3–472 to W3–479. Available from: http://content.healthaffairs.org/content/early/2003/10/08/hlthaff.w3.472.full.pdf

This paper attempts to reconcile the different thinking between health care executives and economists regarding cost shifting. The potential for cost shifting varies according to structural factors that in turn vary by time and geography, and while Ginsburg says there is a theoretical basis exists for cost shifting, he shows other models where hospitals have room to adjust before cost shifting occurs.

4. Santerre R. The welfare loss from hospital cost-shifting behavior: A partial equilibrium analysis. Health Econ. 2005;14(6):621–6.

Microeconomic theory suggests that cost shifting can take place under specific conditions, and empirical studies indicate that cost shifting may have occurred in certain instances. This study models potential welfare loss caused by hospital cost shifting under ideal yet possible conditions.

Empirical studies

1. Friesner D, Rosenman R. Cost shifting revisited: The case of service intensity. Health Care Manag Sci. 2002;5(1):15–24.

This research found support for cost shift in some nonprofit hospitals in California while no cost shift was observed in profit-maximizing hospitals. However, both types of hospitals respond to lower service intensity, thus supporting the theoretical conclusion that lower service intensity may be utilized as an alternative to cost shifting.

2. Garthwaite C, Gross T, Notowidigdo MJ. Hospitals as insurers of last resort [Internet]. NBER Working Paper. 2015. Available from: http://www.nber.org/papers/w21290

The authors used previously confidential hospital financial data obtained through a research partnership with the American Hospital Association from 1984 to 2011 to study uncompensated care provided by hospitals and found that the uncompensated care costs for hospitals increase in response to the size of the uninsured population. They found that each additional uninsured person costs local hospitals $900 each year in uncompensated care. Nonprofit hospitals were found to be more exposed to changes in demand for uncompensated care. The closure of a nearby hospital increases the uncompensated care costs of remaining hospitals. Increases in the uninsured population were found to lower hospital profit margins, which suggests that hospitals cannot or do not pass along all increased costs onto patients with private insurance.

3. Showalter M. Physicians' cost shifting behavior: Medicaid versus other patients. Contemp Econ Policy. 1997;15(2):74–84.

This article examines whether physicians practice cost shifting. This study found, in contradiction to cost shift, that lower Medicaid reimbursement rates resulted in physicians charging lower fees to privately insured patients though evidence also suggests that lower Medicaid reimbursements tend to cause physicians to treat fewer Medicaid patients.

4. Wagner KL. Shock, but no shift: Hospitals' responses to changes in patient insurance mix. J Health Econ. 2016;49:46-58.

Wagner analyzes hospital cost-shifting in response to a change in patient insurance mix resulting from recent Medicaid expansions for individuals with disabilities. Wagner found that hospitals actually reduced charges for disabled patients with private insurance. While the ACA Medicaid expansions affect a broader population and the results of this study may not be generalizable, the findings do suggest that cost-shifting is not the only way in which hospitals respond to a revenue reduction.

5. White C. Contrary to cost-shift theory, lower Medicare hospital payment rates for inpatient care lead to lower private premium rates. Health Aff. 2013;32(5):935–43.

Policymakers believe when Medicare constrains its payment rates for hospital inpatient care, private insurers pay higher rates. This demonstrates that slow growth in Medicare inpatient hospital payment rates also results in slow growth in private hospital payment rates. Greater reductions in Medicare payment rates led to a reduction in private payment rates, reflecting hospitals' efforts to rein in operating costs at a time of lower Medicare payments. Hospitals facing cuts in Medicare payment rates may also reduce the payment rates they seek from private payers to attract more privately insured patients.

6. White C, Wu V. How Do Hospitals Cope with Sustained Slow Growth in Medicare Prices? Health Serv Res. 2013;49(1):11-31.

White and Wu analyze the effects of changes in Medicare inpatient hospital prices on hospitals' overall revenues, operating expenses, profits, assets, and staffing. The authors findings suggest that hospitals recoup Medicare cuts not through cost shifting, but instead they adjust their operating expenses over time.

7. Wu V. Hospital cost shifting revisited: new evidence from the Balanced Budget Act of 1997. Int J Healthc Financ Econ. 2010;10(1):61–83.

Wu analyzes hospital cost shifting using a natural experiment generated by the Balanced Budget Act of 1997. This study found that urban hospitals were able to shift part of the burden of Medicare payment reductions onto private payers, but the overall degree of cost shifting was very small, and changes were based on the hospital's share of privately insured patients.

8. Zwanziger J, Bamezai A. Evidence of cost shifting in California hospitals. Health Aff. 2006;25(1):197–203.

This study of California hospitals examines whether decreases in Medicare/Medicaid payments were associated with increases in private insurance payments. A 1% decrease in Medicare price was associated with a 0.17% increase in the price for privately insured patients. This suggests that cost shifting from public to private payers accounted for a small percentage of the total increase in private payer prices from 1997-2001 in California.

Appendix B: Data Elements for Calculating Uncompensated Care and Discharges

Data Elements and Methods for Calculating Uncompensated Care

1. Defining uncompensated care

Uncompensated care is defined as the cost of charity care plus the cost of bad debt.

Charity care is the cost of medical care for which there was no expectation of payment because the patient has been deemed unable to pay for care. Each hospital has its own criteria for identifying patients who are eligible for charity care. For example, hospitals in the Mercy Health system pay 100% of the charges for patients who are uninsured and have family income below 100% of the federal poverty level. The University of Michigan's charity care program pays 55% of total charges for uninsured patients that do not qualify for public insurance programs, have family income below 400% of the federal poverty level, and meet several other criteria. However, not all discounted medical care is charity care. Discounts provided for prompt payment or discounts negotiated between the patient and the provider to standard managed care rates do not represent charity care.

Bad debt is the cost of medical care for which there was an expectation of payment because the patient was deemed to be able to pay for care. For example, bad debt includes the unpaid medical bills of an uninsured patient who applied for charity care but did not meet the hospital's specific criteria. Insured patients who face deductibles and coinsurance payments for hospital care can also generate bad debt.

Hospitals report charity care and bad debt separately on the Michigan Medicaid Forms, though as just noted hospitals vary in the criteria they use to distinguish charity care from bad debt. Even within a particular hospital, rules governing eligibility for charity care are often not strictly applied and may take into account the judgment of individuals determining eligibility.

For purposes of this report, Medicaid and Medicare shortfalls — the difference between reimbursements by these programs and the cost of care— are not included in the estimate of uncompensated care. Similarly, expenditures for community health education, health screening or immunization, transportation services, or loss on health professions education or research are not considered uncompensated care. Although the hospital does not expect to receive reimbursement for these services, they do not represent medical care for an individual. These costs incurred by hospitals fall into the broader category of "community benefit," a concept used by the Internal Revenue Service in assessing hospitals' non-profit status.

2. Measuring uncompensated care using Michigan Medicaid cost report data

The cost of charity care is measured as full charges for uninsured charity care patients minus patient payments toward partial charity discounts, multiplied by the cost-to-charge ratio. The cost of bad debt is measured as unpaid patient charges for which an effort was made to collect payment minus any recovered payments, multiplied by the cost-to-charge ratio. Bad debts

include charges for uninsured patients who did not qualify for a reduction in charges through a charity care program, and unpaid coinsurance, co-pays and deductibles for insured patients.

The cost-to-charge ratio is the ratio of the cost of providing medical care to what is charged for medical care, aggregated to the hospital-level. For example, a cost-to-charge ratio of 0.6 means that on average, 60 cents of every charged dollar covers the cost of care. Variation in cost-to-charge ratios among different payment source categories reflects differences in the mix of services received by patients in those categories. Charity care and bad debt charges for uninsured patients are translated to costs using the cost-to-charge ratio for uninsured patients. Bad debt charges for insured patients are translated to costs using the whole hospital cost-to-charge ratio.

The specific data elements from the Michigan Medicaid Forms (MMF) that are used for these calculations are as follows.

Measures of care for which payment was not received enter positively:

- Uninsured charity care charges (MMF line 6.00)
  Full charge of care provided to patients who have no insurance and qualify for full or partial charity care. Payment is not expected.

- Uninsured patient-pay charges (MMF line 6.10)
  Full charge of care provided to patients who have no insurance and do not qualify for full or partial charity care (self-pay). Payment is expected but hospital has not yet made a reasonable attempt to collect payment.

- Uninsured bad debts (MMF line 6.36)
  Full charge of care provided to patients who have no insurance and do not qualify for charity care. Payment is expected and hospital has made a reasonable attempt to collect payment.

- Third party bad debts (MMF line 6.38)
  Insured patients' unpaid coinsurance, co-pays or deductibles when there is an expectation of payment. This includes gross Medicare bad debts. Payment is expected and the hospital has made a reasonable attempt to collect the amount from the patient

These amounts are offset by payments that were received by patients who qualify for charity care as well as bad debt recoveries. These payments enter the calculation of uncompensated care negatively:

- Uninsured payments from charges (MMF line 6.60)
  Total payments made by uninsured charity care patients and uninsured self-pay patients towards charges.

- Recoveries for uninsured bad debt (MMF line 10.96)

Recovered amounts for uninsured bad debts, which can include amounts that were collected from patients or amounts from community sources (such as an uncompensated care pool).

- Recoveries for third party bad debts and offsets (MMF line 10.98)
  Recovered amounts for insured patients' co-pays, co-insurance and deductibles, including Medicare beneficiaries.

The cost-to-charge ratios used in the calculation are:

- Uninsured inpatient cost-to-charge ratio
  Cost-to-charge ratio calculated by MDHHS for the purposes of determining Disproportionate Share Hospital (DSH) payments. It is used to convert charges for care provided to uninsured patients to costs.

- Whole hospital cost-to-charge ratio
  Cost-to-charge ratio calculated by MDHHS and used to convert charges for care provided to insured patients to costs.

In addition to measuring the dollar amount of uncompensated care costs, we also measure these costs relative to total hospital costs (MMF line 11.30) as a percentage.

Appendix C: Uncompensated Care Data by Hospital

Table 1. Uncompensated Care Expenses by Individual Hospital, FY 2013, FY 2014 and FY 2015

Hospital Name	CMS ID	Qtr of FY end	FY 2013 Total UC	FY 2013 as a % of Cost	FY 2014 Total UC	FY 2014 as a % of Cost	FY 2015 Total UC	FY 2015 as a % of Cost
Allegan General Hospital	1328	4	1.73	4.5%	1.69	4.4%	----	----
Allegiance Health	92	2	35.39	9.8%	29.41	8.0%	15.50	4.2%
Alpena Regional Medical Center	36	2	2.53	2.9%	1.84	2.0%	0.94	1.0%
Aspirus Grand View Hospital	1333	2	1.98	5.1%	2.30	5.9%	0.59	1.6%
Aspirus Keweenaw Hospital	1319	2	1.34	4.5%	1.40	4.2%	0.90	2.5%
Aspirus Ontonagon Hospital	1309	2	0.16	1.7%	0.11	1.1%	0.42	4.0%
Baraga County Memorial Hospital	1307	3	0.99	6.7%	0.78	5.1%	0.47	3.0%
Barbara Ann Karmanos Cancer Hospital	297	3	2.11	1.0%	1.98	1.0%	1.41	0.6%
BCA StoneCrest Center	4038	4	0.13	0.8%	0.11	0.7%	----	----
Beaumont Hospital - Dearborn	20	4	17.82	3.5%	13.14	2.4%	----	----
Beaumont Hospital - Farmington Hills	151	4	16.42	6.9%	7.57	3.1%	----	----
Beaumont Hospital - Taylor	270	4	6.05	5.1%	3.50	2.8%	----	----
Beaumont Hospital - Trenton	176	4	3.44	2.8%	2.33	1.8%	----	----
Beaumont Hospital - Wayne	142	4	7.84	6.6%	5.10	4.1%	----	----
Beaumont Hospital, Grosse Pointe	89	4	9.01	5.4%	5.48	3.3%	----	----
Beaumont Hospital, Royal Oak	130	4	45.87	4.0%	22.50	2.0%	----	----
Beaumont Hospital, Troy	269	4	19.35	3.9%	12.35	2.3%	----	----
Bell Memorial Hospital	1321	2	3.18	8.7%	1.38	4.4%	0.33	1.1%
Borgess Hospital	117	2	27.17	7.6%	20.59	5.8%	12.92	3.6%
Borgess-Lee Memorial Hospital	1315	2	4.00	13.7%	3.70	12.7%	2.18	7.6%
Brighton Hospital	279	2	----	----	----	----	----	----
Bronson Battle Creek Hospital	75	4	15.34	8.5%	11.31	6.6%	----	----
Bronson Lake View Hospital	1332	4	2.76	6.2%	2.43	5.9%	----	----

Bronson Methodist Hospital	17	4	49.41	10.2%	30.27	6.4%	----	----
Caro Community Hospital	1329	4	0.47	4.8%	0.48	4.5%	----	----
Charlevoix Area Hospital	1322	1	0.87	3.1%	0.96	3.2%	0.45	1.4%
Children's Hospital of Michigan	3300	4	3.48	1.1%	3.56	1.1%	----	----
Chippewa War Memorial Hospital	239	4	2.35	3.3%	1.03	1.3%	----	----
Clinton Memorial Hospital	1326	4	0.62	2.6%	0.71	3.1%	----	----
Community Health Center, Branch County	22	4	5.55	9.2%	3.60	5.9%	----	----
Covenant Medical Center, Inc.	70	2	9.72	2.7%	8.08	2.3%	3.35	0.9%
Crittenton Hospital	254	4	5.26	2.6%	3.32	1.8%	----	----
Deckerville Community Hospital	1311	2	0.21	3.5%	0.41	6.0%	0.25	3.9%
Detroit Receiving Hospital	273	4	31.25	14.3%	14.65	6.7%	----	----
Dickinson County Memorial Hospital	55	4	1.57	2.2%	0.91	1.2%	----	----
Doctors' Hospital of Michigan	13	4	3.48	12.9%	1.62	7.0%	----	----
Eaton Rapids Medical Center	1324	2	1.55	9.9%	1.76	9.5%	1.25	7.1%
Edward W. Sparrow Hospital	230	4	21.31	3.1%	17.34	2.5%	----	----
Forest Health Medical Center, Inc.	144	4	0.40	1.2%	0.28	0.8%	----	----
Forest View Psychiatric Hospital	4030	4	0.19	1.4%	0.17	1.2%	----	----
Garden City Hospital	244	4	6.08	5.2%	5.24	4.4%	----	----
Garden City Hospital	244	4	6.08	5.2%	5.24	4.4%	----	----
Genesys Regional Medical Center	197	2	14.78	4.0%	14.46	3.8%	5.59	1.5%
Harbor Beach Community Hospital	1313	4	0.06	0.8%	0.14	1.6%	----	----
Harbor Oaks Hospital	4021	2	0.06	0.5%	0.15	1.3%	0.18	1.4%
Harper University Hospital	104	4	8.63	2.2%	6.90	1.6%	----	----
Havenwyck Hospital	4023	2	0.22	0.9%	0.32	1.1%	0.22	0.7%
Hayes Green Beach Memorial Hospital	1327	1	3.56	7.8%	4.23	9.8%	2.21	4.9%
Healthsource Saginaw	275	4	0.19	0.8%	0.29	1.1%	----	----
Helen Newberry Joy Hospital	1304	4	1.85	7.4%	1.21	4.8%	----	----
Henry Ford Hospital	53	4	96.32	8.5%	83.36	7.6%	----	----
Henry Ford Macomb Hospital	47	4	14.63	4.7%	12.39	4.1%	----	----

Henry Ford West Bloomfield Hospital	302	4	6.24	2.5%	6.91	2.8%	----	----
Henry Ford Wyandotte Hospital	146	4	21.43	9.1%	16.46	7.2%	----	----
Hills & Dales General Hospital	1316	3	0.61	3.2%	0.50	2.5%	0.45	2.2%
Hillsdale Community Health Center	37	2	2.65	5.6%	2.10	4.6%	1.86	4.1%
Holland Community Hospital	72	1	4.82	3.0%	5.50	3.3%	3.38	1.9%
Hurley Medical Center	132	2	27.29	9.4%	16.01	5.4%	10.04	3.2%
Huron Medical Center	118	3	0.80	2.9%	0.75	2.5%	0.40	1.3%
Huron Valley - Sinai Hospital	277	4	8.62	5.7%	3.35	2.0%	----	----
Ionia County Memorial Hospital	1331	4	1.39	5.4%	1.08	4.2%	----	----
Kalkaska Memorial Health Center	1301	2	1.90	8.9%	1.83	8.4%	0.70	3.6%
Kingswood Psychiatric Hospital	4011	4	0.20	1.0%	0.11	0.6%	----	----
Lakeland Community Hospital - Watervliet	78	3	2.04	9.2%	1.56	6.3%	0.38	1.5%
Lakeland Hospital - St. Joseph	21	3	13.91	5.3%	12.10	4.3%	7.20	2.5%
Mackinac Straits Hospital	1306	1	2.20	11.3%	2.03	9.2%	1.73	7.2%
Marlette Regional Hospital	1330	2	0.76	3.4%	0.85	4.0%	0.64	3.1%
Marquette General Hospital	54	2	3.95	2.0%	3.37	1.9%	0.76	0.4%
Mary Free Bed Hospital & Rehab. Center	3026	1	0.86	1.9%	1.48	3.0%	0.67	1.4%
McKenzie Memorial Hospital	1314	3	0.59	4.6%	0.42	3.3%	0.30	2.4%
McLaren - Central Michigan	80	3	2.23	2.9%	2.08	2.7%	1.19	1.6%
McLaren - Greater Lansing	167	3	7.52	2.7%	11.18	4.2%	6.52	2.2%
McLaren Bay Regional	41	3	6.79	2.9%	5.82	2.3%	4.01	1.5%
McLaren Flint	141	3	14.07	3.7%	12.86	3.3%	4.75	1.2%
McLaren Lapeer Region	193	3	5.64	5.6%	5.77	5.8%	3.25	3.2%
McLaren Oakland	207	3	5.87	5.0%	6.49	5.2%	3.65	2.9%
McLaren-Northern Michigan	105	3	5.05	2.9%	3.42	1.9%	1.75	0.9%
Memorial Healthcare	121	4	2.04	2.6%	1.21	1.6%	----	----
Memorial Medical Center of W. Michigan	110	2	2.25	4.1%	1.84	3.3%	1.63	2.8%
Mercy Health Partners - Hackley Campus	66	2	10.88	6.8%	6.80	4.2%	4.02	2.4%
Mercy Health Partners - Lakeshore Campus	1320	2	1.03	6.4%	0.81	4.0%	0.54	3.3%

Mercy Health Partners - Mercy Campus	4	2	8.79	6.2%	7.47	3.4%	4.17	1.8%
Metro Health Hospital	236	2	13.20	6.1%	11.79	4.9%	10.60	3.7%
Mid Michigan Medical Center - Gladwin	1325	2	0.87	4.4%	0.91	4.4%	0.72	3.2%
Mid Michigan Medical Center - Clare	180	2	1.62	5.3%	2.77	8.4%	0.94	2.7%
Mid Michigan Medical Center - Gratiot	30	2	3.06	3.8%	2.74	3.5%	1.59	2.0%
Mid Michigan Medical Center - Midland	222	2	7.50	3.1%	7.27	2.9%	5.32	1.9%
Mount Clemens Regional Medical Center	227	3	19.85	8.1%	18.17	6.9%	8.90	3.3%
Munising Memorial Hospital	1308	1	0.44	5.8%	0.55	7.6%	0.32	4.1%
Munson Healthcare Cadillac Hospital	81	2	2.73	4.5%	2.64	3.7%	1.76	2.6%
Munson Healthcare Grayling Hospital	58	2	2.48	4.2%	1.87	2.6%	1.57	2.6%
Munson Medical Center	97	2	22.54	5.0%	17.25	3.8%	8.12	1.8%
North Ottawa Community Hospital	174	2	2.03	4.7%	1.73	3.8%	1.15	2.2%
Oakland Regional Hospital	301	4	0.10	0.4%	0.11	0.5%	----	----
Oaklawn Hospital	217	1	4.35	5.1%	2.99	3.5%	1.62	1.9%
Otsego County Memorial Hospital	133	4	1.34	2.6%	0.97	1.8%	----	----
Paul Oliver Memorial Hospital	1300	2	1.09	8.2%	0.97	7.2%	0.72	5.2%
Pennock Hospital	40	3	2.23	4.7%	2.57	5.9%	2.07	4.6%
Pine Rest Christian Hospital	4006	2	0.53	1.0%	0.63	1.0%	0.61	0.9%
Port Huron Hospital	216	3	7.58	4.7%	7.10	4.3%	4.45	2.8%
Promedica Bixby Hospital	5	4	1.18	1.7%	1.33	1.9%	----	----
ProMedica Herrick Hospital	1334	4	0.58	1.9%	0.65	2.4%	----	----
ProMedica Monroe Regional Hospital	99	2	9.39	6.5%	9.08	6.9%	6.34	4.6%
Providence Hospital	19	2	0.00	0.0%	20.71	3.6%	14.43	2.4%
Rehabilitation Institute	3027	4	1.51	1.9%	0.93	1.2%	----	----
Saint Mary's Standish Community Hospital	1305	2	0.87	4.5%	0.84	4.6%	0.49	2.6%
Samaritan Behavioral Center	4040	4	0.08	1.0%	0.05	0.6%	----	----
Scheurer Hospital	1310	2	1.54	5.4%	1.38	4.5%	1.35	4.0%
Schoolcraft Memorial Hospital	1303	4	0.33	1.7%	0.28	1.4%	----	----
Sheridan Community Hospital	1312	1	1.02	8.1%	1.01	7.4%	1.28	9.1%

Sinai-Grace Hospital	24	4	27.02	8.7%	11.42	3.8%	----	----
South Haven Community Hospital	85	2	1.42	4.6%	0.95	2.9%	0.39	1.2%
Southeast Michigan Surgical Hospital	264	4	0.04	0.3%	0.11	0.9%	----	----
Southwest Regional Rehabilitation Hospital	3025	2	0.45	3.9%	0.32	3.3%	----	----
Sparrow Carson Hospital	208	4	1.37	3.2%	1.77	4.3%	----	----
Spectrum Health	38	2	32.61	2.9%	40.51	3.4%	20.39	1.6%
Spectrum Health - Reed City Campus	1323	2	2.87	6.8%	3.14	6.8%	1.72	3.6%
Spectrum Health Big Rapids	93	2	2.61	5.8%	2.06	4.3%	1.99	3.8%
Spectrum Health Gerber Memorial	106	2	2.92	5.0%	3.37	5.6%	2.51	4.1%
Spectrum Health United Memorial - Kelsey	1317	2	0.87	7.0%	1.22	9.4%	0.91	7.0%
Spectrum Health United Memorial - United	35	2	2.55	4.4%	0.00	0.0%	2.26	3.3%
Spectrum Health Zeeland Community	3	2	1.56	3.9%	2.35	5.3%	1.72	3.4%
St Joseph Mercy Chelsea	259	2	2.55	2.8%	2.72	2.9%	0.99	1.0%
St. Francis Hospital & Medical Group	1337	3	4.16	7.3%	3.24	6.0%	1.87	3.2%
St. John Hospital and Medical Center	165	2	35.80	5.5%	34.65	5.3%	19.52	2.9%
St. John Macomb-Oakland, Macomb	195	2	21.95	6.2%	20.03	5.9%	11.44	3.3%
St. John River District Hospital	241	2	1.17	2.7%	1.11	2.4%	0.63	1.5%
St. Joseph Mercy Hospital - Ann Arbor	156	2	29.89	4.5%	26.09	4.3%	11.34	1.9%
St. Joseph Mercy Livingston Hospital	69	2	8.23	8.9%	7.23	8.0%	2.51	3.4%
St. Joseph Mercy Oakland	29	2	13.68	4.8%	18.41	6.7%	5.27	1.8%
St. Joseph Mercy Port Huron	31	2	4.87	7.3%	3.66	5.8%	1.26	2.0%
St. Mary Mercy Hospital	2	2	10.55	5.3%	14.36	7.1%	6.04	2.9%
St. Mary's Health Care (Grand Rapids)	59	2	15.48	4.7%	12.72	3.6%	7.78	1.8%
St. Mary's of Michigan Medical Center	77	2	17.86	8.0%	13.69	6.5%	5.33	2.6%
Straith Memorial Hospital	71	4	0.03	0.3%	0.03	0.3%	----	----
Sturgis Memorial Hospital	96	3	2.29	7.0%	1.86	5.5%	1.33	3.9%
Tawas St. Joseph Hospital	100	2	2.17	5.3%	1.41	3.6%	1.21	3.0%
The Behavioral Center of Michigan	4042	4	0.08	0.9%	0.09	1.0%	----	----
Three Rivers Health	15	4	2.54	6.6%	1.68	4.4%	----	----

University of Michigan Health System	46	2	51.02	2.4%	54.64	2.4%	37.08	1.5%
UP Health System - Portage	108	4	1.09	1.9%	0.54	1.1%	----	----
West Branch Regional Medical Center	95	1	2.17	5.8%	2.02	5.3%	1.75	4.5%

Notes: Because hospitals submit their data with a lag, for hospitals with fiscal years ending in the fourth quarter the most recent data available are from hospital FY 2014.

Appendix D: Key Stakeholder Interviews: Respondent Characteristics

Healthcare Providers		*N=9*
Size	Small/Private Practice	2
	Medium/Hospital	1
	Large/Regional Hospital System	6
Payer Mix	Primarily Private	6
	Primarily Public	1
	Mixed	1
	Other	1
Employers		*N=17*
Size	Small Employer 50 or fewer Employees	9
	Medium Employer 51-499	4
	Large Employer 500+	4
Payer Mix	Self-Funded	4
	Mixed	2
	Fully Insured	9
	N/A	2
Economic Sector	Professional, Scientific and Technical Services	3
	Retail Trade	3
	Healthcare	1
	Accommodation and Food Service	3
	Construction	2
	Finance and Insurance	1
	Manufacturing	2
	Other Services	2
Health Insurers		*N=6*
Market	Public	2
	Private	4
Covered members	< 250,000	1
	500,000 -1 million	2
	>1 million	3

Appendix E: DIFS Filings Sampling Exclusions, Inclusions and Rationale

Filings Sampling Exclusions

- Filings without a requested premium rate change. We are interested in the causes of rate change; thus we are excluding from our sample filings that did not submit a rate increase or decrease.
- New products. New products are filings that are submitted to go on the market in the coming year. These filings do not have any prior experience or claims data to compare or predict change in premium rates.
- 2016 filing data. 2016 filing data are incomplete; not all of the filings have been submitted which will apply to 2017 premium rates.

Filings Sampling Inclusions

Insurance filings provide a multitude of data. The following elements were abstracted from each 2015 filing for which a change (negative or positive) in rates was requested.

- Descriptive Data:
  - Filing Number
  - Date
  - Company Name

- Market
  - Health Insurance Market (Individual, Small Group, Large Group, Other)
  - Product Type

- Reason(s) for Rate Change
  - Reason for Rate Change (direct quotes from filings if available)
  - Medical Costs (trend in cost of medical care, physician contracts, etc.)
  - Morbidity (change in morbidity level of risk pool)
  - Benefits (change in benefits offered)
  - ACA (i.e., taxes and fees, legislative compliance, essential health benefits)
  - Utilization of Services (increasing or decreasing)
  - Demographics (age, community rating)
  - Other (i.e., tobacco Status)

Experience [Experience period is a time period used to calculate the premium in order to evaluate risk and return] and Claims

- Affected Policy Holders
- Covered Lives Benefit Change
- Benefit Change
- % Change Approved – weighted average
- Percent Rate Change Requested – weighted average
- Requested Rate: Annual – weighted average

Total Annual Premium Rate

- Premium Rate Change
- Prior Rate: Annual – weighted average
- Projected Earned Premium
- Projected Incurred Claims (Annual Dollars)

Medical Costs
- Trend Factors %
- Medical Trend %
- MLR %
- Pharmacy Trend %

Administrative
- Administrative Fees (Dollars PMPM)
- Administrative Fees % of Premium
- Profit and Risk % of Premium
- Taxes and Fees
    - Taxes and Fees % of Premium
- Uniform Rate Review Template
    - Administrative Expenses % (projected experience)
    - Profit and Risk % (projected experience)
    - Taxes and Fees % (PMPM component of premium increase)
    - Taxes and Fees as a percentage % (projected experience)
    - Single Risk Pool Gross Premium Avg Rate (PMPM)
    - Inpatient (Component of Premium Increase Dollars PMPM)
    - Outpatient (Component of Premium Increase Dollars PMPM)
    - Professional (Component of Premium Increase Dollars PMPM)
    - Prescription (Component of Premium Increase Dollars PMPM)
    - Other (Component of Premium Increase Dollars PMPM)

Rationale for DIFS Filings Inclusions (Drivers of Premium Rates)

Health insurers include several factors in the creation of the premium rate. The state requires that filings include the actuarial methods and data used. Often, this section of the filings is noted as "Confidential/Proprietary/Trade Secret." Many insurers contract with actuarial firms; these firms often use proprietary methods for estimating risk, based on data specific to a number of plan and population features, including the plan type, size, benefits, region, and estimated numbers and types of claims.

Proposed Rate Increases: When included, the filing sections enumerate the contributions of the following (as titled on the forms) to the rate:

- **Medical Loss Ratio (MLR)**: The claims experience on Michigan policies in a specific block of business must be adequate to achieve an 80% Federal Medical Loss Ratio.

- **Allowed and Incurred Claims Incurred during the Experience Period**: Allowed Claims data are available to the company directly from company claims records, with some estimation due to timing issues.

- **Claim Liabilities for Medical Business** are often calculated using proprietary methods.

- **Benefit Categories:** Claims are assigned to each of the varying benefit category by place services were administered, and types of medical services rendered.

- **Projection Factors**
    - **Single Risk Pools**, for policy years beginning after 1/1/14.
    - **Changes in Morbidity of the Population Insured**: The assumptions used are from the experience period to the projection period.
    - **Trend Factors (cost/utilization):** The assumption for cost and utilization is often developed from nationwide claim trend studies, using experience from similar products that were marketed earlier.
    - **Changes in Benefits, Demographics, and other factors: Non-Benefit Expenses and Risk Margin Profit & Risk Margin:** Projected premiums include a percent of premium for risk, contingency, and profit margin. Assumptions are often derived from analysis of pre-tax underwriting gain, less income taxes payable on the underwriting gain, and on the insurer fee, which is not deductible for income tax purposes.

- **Taxes and Fees** include premium tax, insurer fees, risk adjustment fees, exchange fees, and federal income tax.
    - **Premium Tax**: The premium tax rate is 1.25% on Michigan gross direct premiums written in the state of Michigan.
    - **Insurer Fees**: This is a permanent fee that applies to fully insured coverage. This fee will fund tax credits for insurance coverage purchased on the exchanges. The total fee increases from $8B in 2014 to $14.3B in 2018 (indexed to premium for subsequent years). Each insurer's assessment will be based on earned health insurance premiums in the prior year, with certain exclusions.
    - **Risk Adjustment Fees**: The HHS Notice of Benefit and Payment Parameters includes a section on risk adjustment user fees and specifies a $0.08 per member per month user fee for the benefit year 2014. For benefit year 2015, HHS imposes a per-enrollee-per-month risk adjustment fee of $0.10, and for 2016 benefit year, $0.15. (See Federal Register / Vol. 80, No. 39 / Friday, February 27, 2015 / Rules and Regulations 10759).
    - **Federal Income Tax**: Income tax is calculated as 35% * (Pre-Tax Income + Insurer Fees), since insurer fees are not tax deductible.
    - **Reinsurance Fees**: This is a temporary fee that applies to all commercial groups (both fully insured and self-funded) and individual business from 2014 to 2016 for the purpose of funding the reinsurance pool for high cost claimants in the individual market during this three-year transitional period. The total baseline amounts to be collected to fund this pool are $12B in 2014, $8B in 2015, and $5B in 2016, and

individual states can add to this baseline. Each insurer is assessed on a per capita basis. This fee expires in 2017.

- **Changes in Medical Service Costs:** There are many different health care cost trends that contribute to increases in the overall U.S. health care spending each year. These trend factors affect health insurance premiums, which can mean a premium rate increase to cover costs. Some of the key health care cost trends that have affected this year's rate actions include:
    - **Coverage Mandates** – Estimated impacts of changes in benefit design and administration due to the Patient Protection and Affordable Care Act mandates. Direct impacts include the effects of specific changes made to comply with new Federal and State laws.
    - **Increasing Cost of Medical Services** – Annual increases in reimbursement rates to health care providers, such as hospitals, doctors and pharmaceutical companies. The price of care can be affected by the use of expensive procedures, such as surgery, as opposed to monitoring or certain medications.
    - **Increased Utilization** – Annual increases in the number of office visits and other services. In addition, total health care spending may vary by the intensity of care and/or use of different types of health services.
    - **Higher Costs from Deductible Leveraging** – Health care costs may rise every year, while deductibles and copayments may remain the same.
    - **Impact of New Technology** - Improvements to medical technology and clinical practice may require use of more expensive services, leading to increased health care spending and utilization.
    - **Underwriting Wear Off** – The variation by policy duration in individual medical insurance claims, where claims are higher at later policy durations as more time has elapsed since initial underwriting.

- **Administrative Costs:** Expected benefit and administrative costs.

Factors that determine premiums vary by type of plan *market* (individual plans, small group plans, and large group plans):

Individual Plans (for those who purchase their coverage directly from an insurer, not job-based coverage):

- Age (the premium rate cannot vary more than 3 to 1 for adults for all plans)
- Benefits and cost-sharing selected
- Number of family members on the plan
- Location of residence in Michigan
- Tobacco use (the premium rate cannot vary by more than 1.5 to 1)

Small Group Plans (for those who have coverage through an employer with 50 or fewer employees):

- Benefits the employer selects
- How much the employer contributes to the cost
- Family size

- Age (the premium rate cannot vary more than 3 to 1 for adults for all plans)
- Tobacco use (the premium rate cannot vary by more than 1.5 to 1)
- Location of employer in Michigan

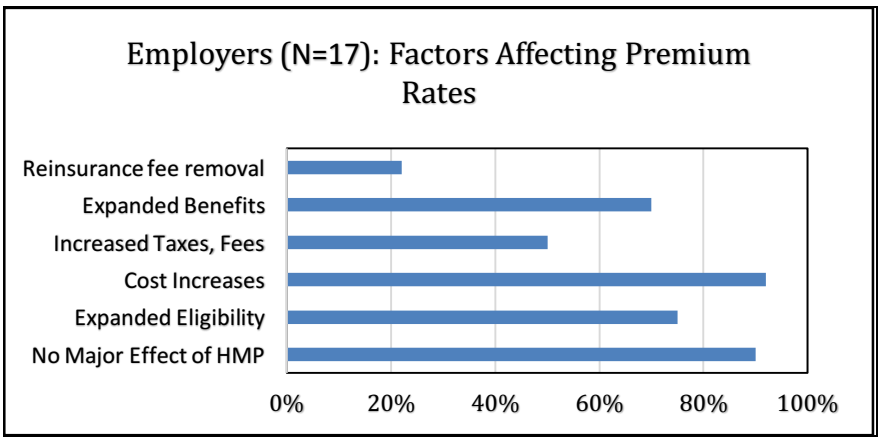
Large Group Plans (for those who have coverage through an employer with more than 50 employees):

- Benefits the employer selects
- Employee census information including age, gender, family status, health status and geographic location
- How much the employer contributes to the cost
- Industry
- Group size
- Wellness programs

Appendix F: Results from Stakeholder Interviews and DIFS Rate Filings Analysis

I. Interview Respondents' Reports on Factors Affecting Premium Rates

Employers:



"…yes, we are paying a lot more fees, we pay a lot of fees and don't get more administrative effort to file reports for all folks …"

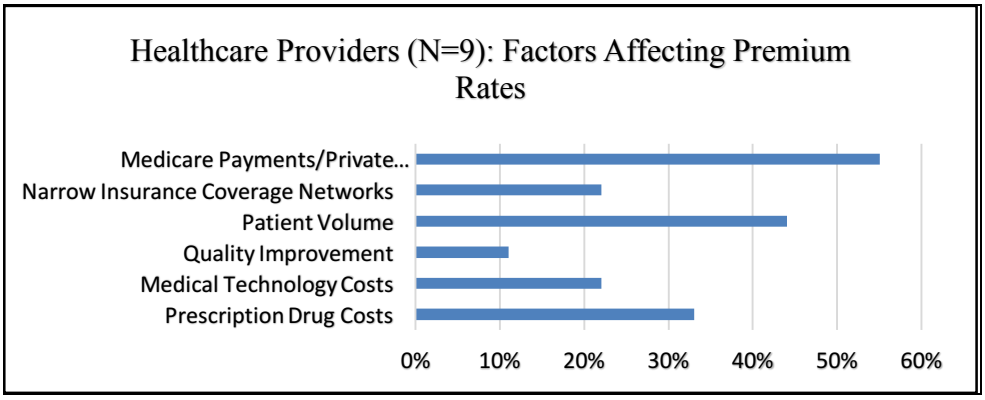
"Decision-making for benefits and ACA has seen the biggest changes…"

"It's [the decision to offer health insurance] almost entirely based on cost; I don't think changes to the Medicaid expansion have influenced it… it's been pretty consistently cost-prohibitive… would like to be able to offer it, but it has just been so expensive that we haven't been able to."

"…Same portfolio as the previous year…Overall, we didn't have to make the drastic adjustments that other employers or insurers did - our rates didn't change much because we already offered pretty extensive coverage."

"…Employees have a larger co-premium pay than before. That increased co-premium has been the biggest change this year. We pay more out of pocket."

Hospitals and Healthcare Providers



"Medicare reimbursement definitely affects the payment rates, depending on if it changes."

"If a major payer comes to us and says 'your case costs are too high- we are excluding you from our network' this has major implications for who we treat, our volumes, and all; if they include us in their narrow network, they have the bargaining power to keep their rates below our costs- this puts us in a financial bind…"

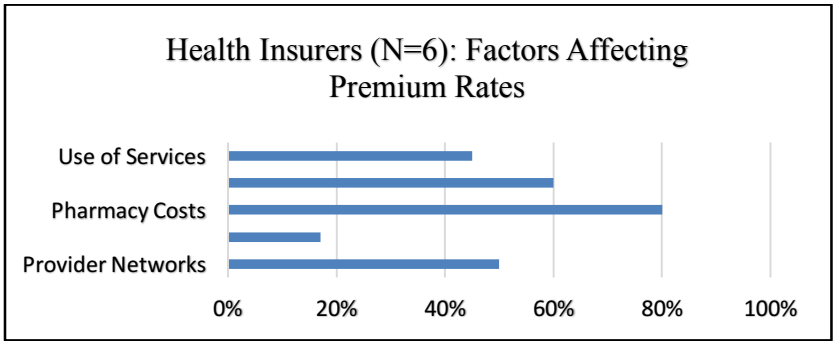
"Volume is critical, and so is the role of consumerism…the dynamics have changed where it is not just the payers making the payments, a key piece is coming from the patient …"

"Patient safety and quality often increase costs in the short run, with reporting and payment tied to quality, but in the long run, quality and quality improvement are why we exist."

"…we've actually thought of changes to charity care to include people who are underinsured because of the [now] significant contributions people have to make…"

"Technology and device costs and the prescription drug costs are the biggest concerns for our payment rates."

Health Insurers



"In the individual market it becomes enrollee membership, a lot of selection issues, lots of healthy enrollees are not enrolling, so we are seeing issues of high use and cost with too many unhealthy persons in the market."

"Then there is also the issue of more of a regulation in terms of the federal reinsurance is going away, so we are losing the protections there for the individual and small group markets."

"As we are reflecting on changes in healthcare costs, pharmacy is becoming a big driver of it…."

"The biggest factors [affecting premium rates] are medical costs and pharmacy cost trends, medical inflation in general. Medical cost has been relatively low over the past year, and pharmacy has really been the biggest contributor."

"Pharmaceutical absolutely, specialty especially… you need the tools and care coordination to handle it … but pharmacy is so out of control, these single patent companies charging whatever they want…."

"I think [Healthy Michigan] has helped hospitals, but they definitely don't say, 'because we've got more money, because our uncompensated care has decreased, we're going to give you a price discount'…and we can't say the same thing in fairness, 'we had a good operating margin, so we'll pay you more,' we don't do it either, in all fairness. It just doesn't work that way, in consideration of all of the other costs and factors affecting costs."

"For the health insurance exchange we had to build our own premium – we based that on our hospital contracts, this is the number one factor, and it's a new market, so that is difficult."

"We are trying to keep premiums down and narrow our provider networks [to keep the costs down]."

II. DIFS Rate Analysis Tables and Charts

The findings from the rate filings analysis are organized into four sections:

A. Number and type of filing
B. Magnitude of the premium rate change requested
C. Reasons for premium rate changes requested
D. Medical cost trend rates noted in filings
All data are presented by year of filing (2013, 2014, and 2015).

A. Number and Type of Filing

Number of filings with rate change increase or decrease by market, by year

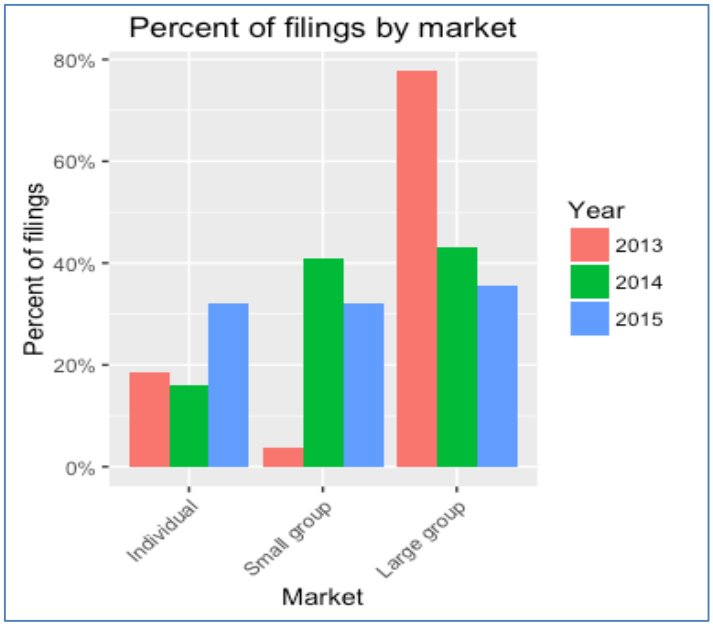
Year	Market	Decrease	Increase
2013	Individual	1	9
	Small group	0	2
	Large group	3	39
2014	Individual	1	6
	Small group	1	17
	Large group	6	13
2015	Individual	3	16
	Small group	4	15
	Large group	0	21

Number of filings with rate change increase or decrease by product, by year

Year	Product	Decrease	Increase
2013	HMO	4	32
	PPO	0	7
	MM	0	10
	POS	0	1
2014	HMO	8	14
	PPO	0	12
	MM	0	8
	POS	0	2
2015	HMO	6	25
	PPO	1	13
	MM	0	11
	POS	0	3

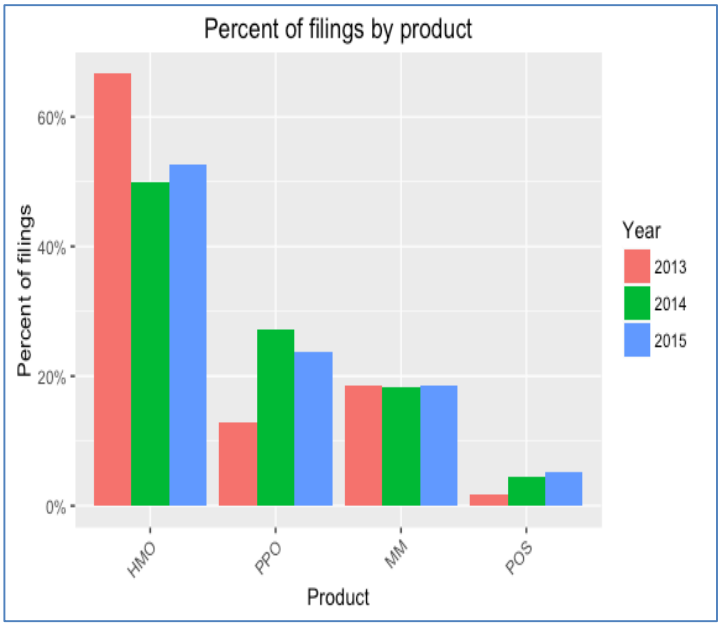
Percent of Filings Requesting Rate Change, by Market, by Year

Year	Individual	Small group	Large group
2013	18.5%	3.7%	77.8%
2014	15.9%	40.9%	43.2%
2015	32.2%	32.2%	35.6%



Percent of Filings Requesting Rate Change, by Product, by Year

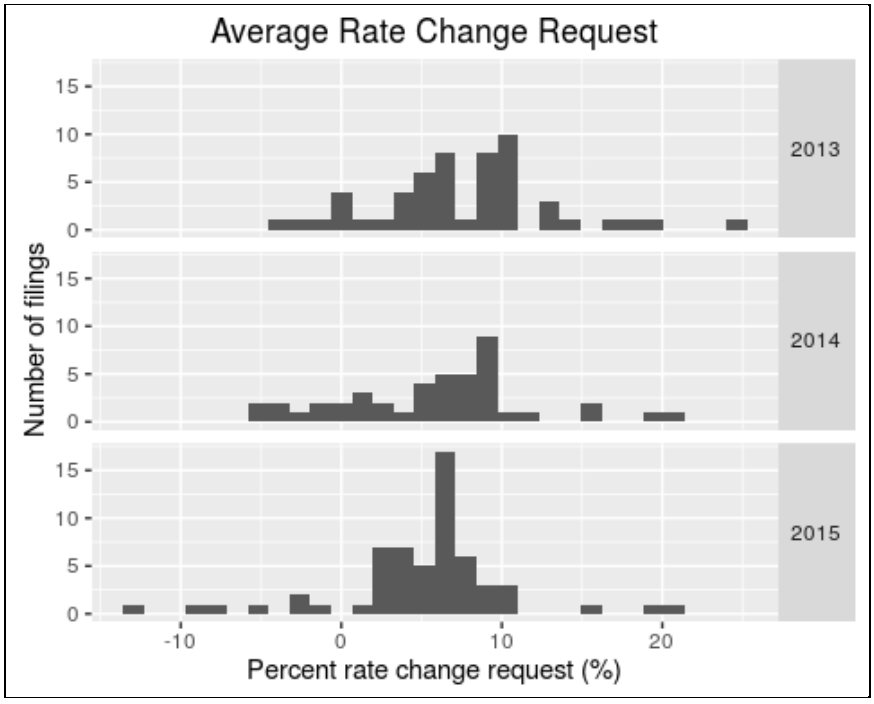
Year	HMO	PPO	MM	POS
2013	66.7%	13.0%	18.5%	1.9%
2014	50.0%	27.3%	18.2%	4.5%
2015	52.5%	23.7%	18.6%	5.1%



B. Magnitude of the Premium Rate Requested

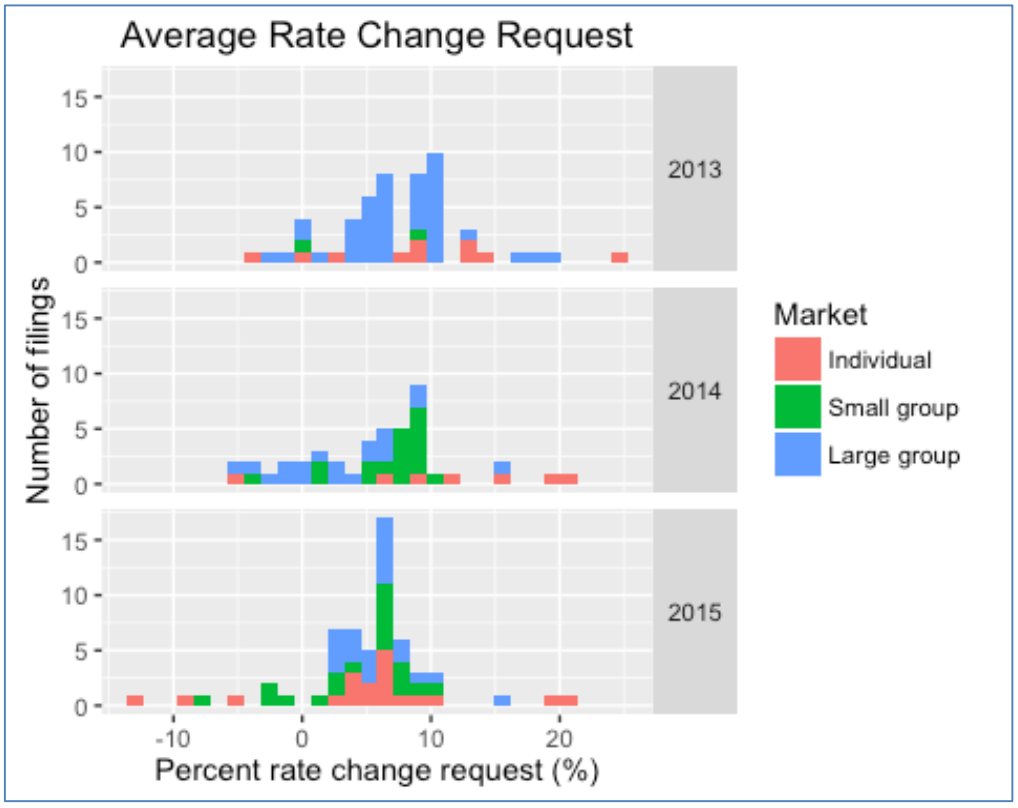
Percent Rate Change Request by Year (%)

Year	Filings	Average (%)	Min (%)	Max (%)
2013	54	7.55	-3.97	25.0
2014	44	5.77	-5.10	21.0
2015	59	5.22	-12.60	20.5



Percent Rate Change Request, by Market, by Year (%)

Year	Market	Filings	Average (%)	Min (%)	Max (%)
2013	Individual	10	8.87	-3.97	25.00
	Small group	2	4.68	0.50	8.86
	Large group	42	7.37	-3.19	19.80
2014	Individual	7	10.90	-4.90	21.00
	Small group	18	6.63	-3.70	9.90
	Large group	19	3.07	-5.10	15.00
2015	Individual	19	5.20	-12.60	20.50
	Small group	19	4.13	-8.30	9.90
	Large group	21	6.21	2.90	15.00



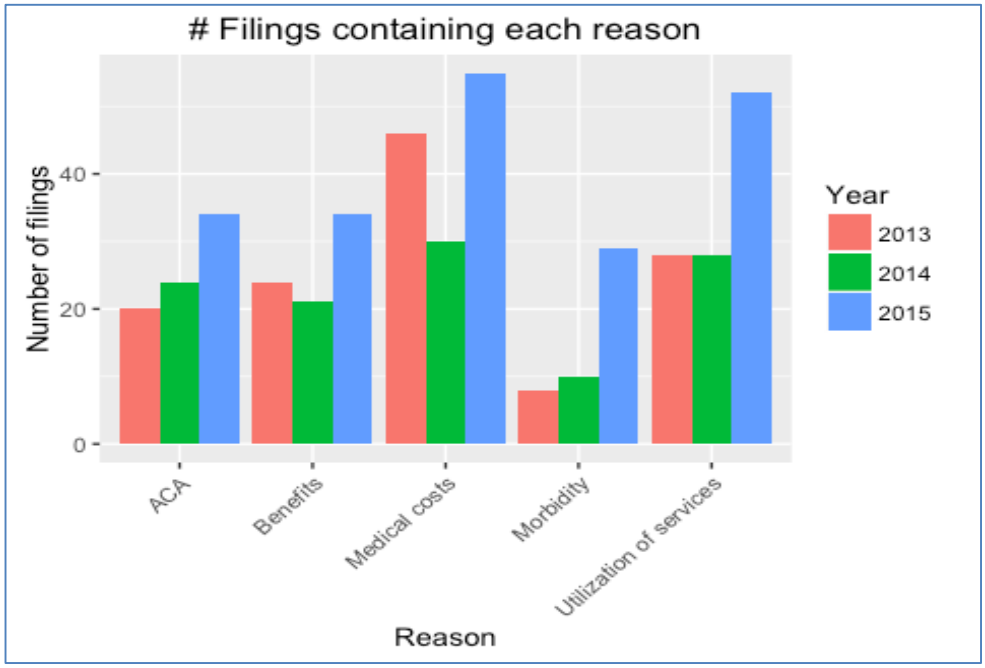
Percent Rate Change Request, by Product, by Year

Year	Product	Filings	Average (%)	Min (%)	Max (%)
2013	HMO	36	6.20	-3.97	18.50
	PPO	7	8.67	0.50	14.60
	MM	10	11.69	5.48	25.00
	POS	1	6.73	6.73	6.73
2014	HMO	22	2.41	-5.10	9.50
	PPO	12	7.76	1.27	19.00
	MM	8	12.00	9.00	21.00
	POS	2	5.84	2.90	8.77
2015	HMO	31	3.40	-12.60	9.90
	PPO	14	6.48	-8.30	20.50
	MM	11	8.58	0.80	20.00
	POS	3	5.70	4.10	6.50

C. Reasons for Premium Rate Changes Requested

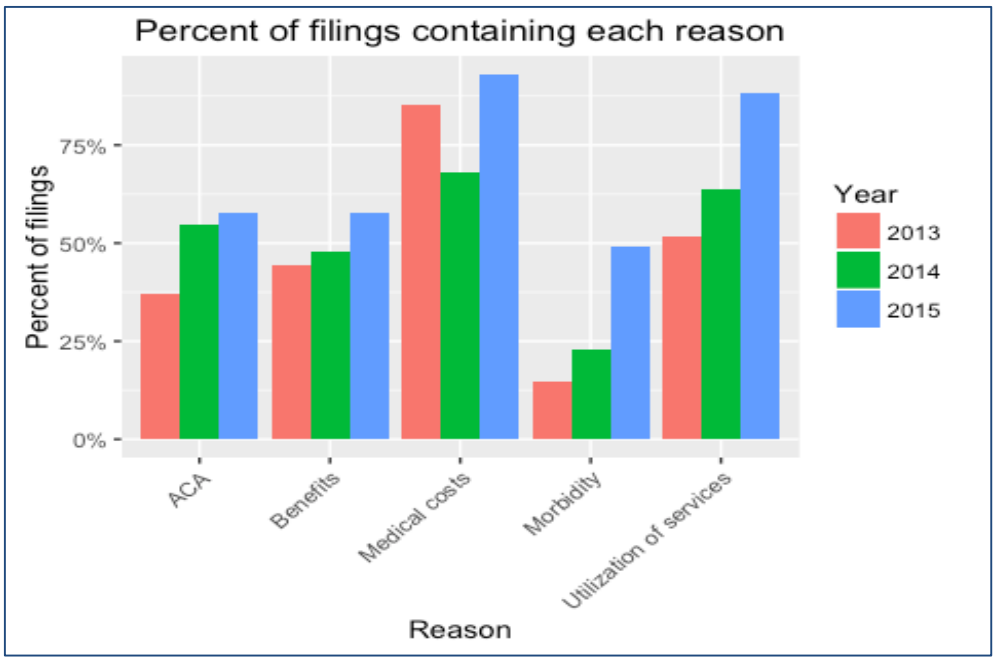
Number of Filings by Reasons for Rate Change Request, by Year

Year	ACA	Benefits	Medical costs	Morbidity	Utilization of services
2013	20	24	46	8	28
2014	24	21	30	10	28
2015	34	34	55	29	52



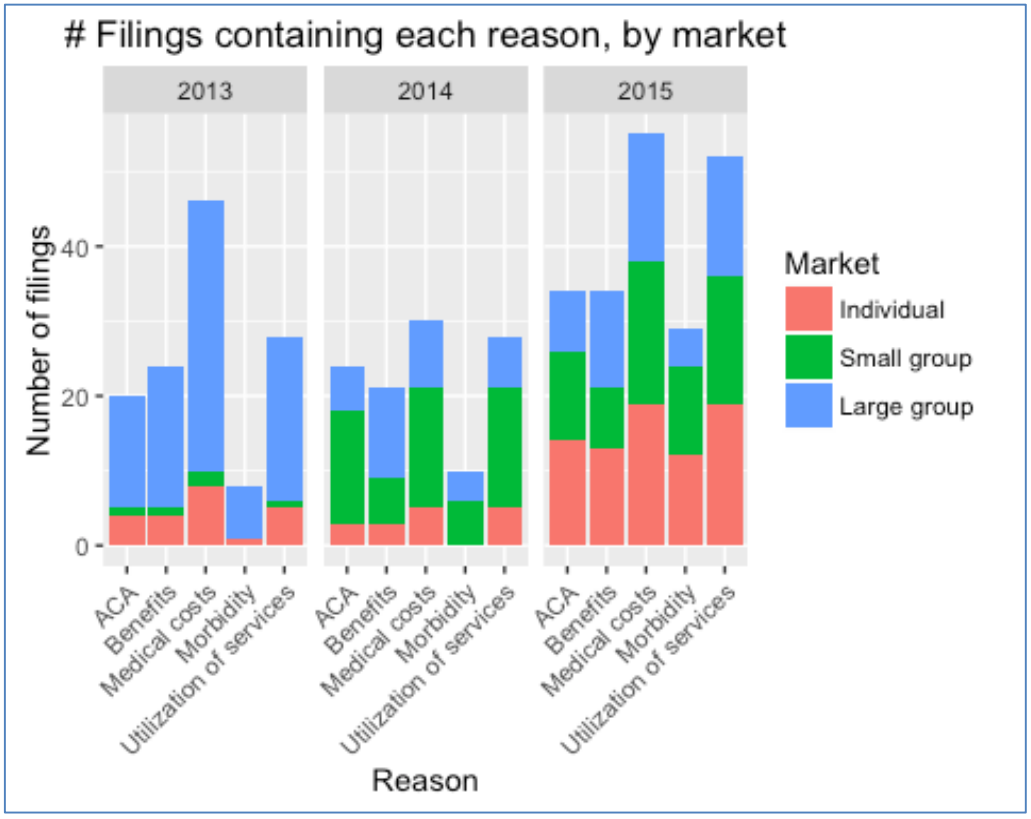
Percent of Filings by Reason for Rate Change Request, by Year

Year	ACA	Benefits	Medical costs	Morbidity	Utilization of services
2013	37.0%	44.4%	85.2%	14.8%	51.9%
2014	54.5%	47.7%	68.2%	22.7%	63.6%
2015	57.6%	57.6%	93.2%	49.2%	88.1%



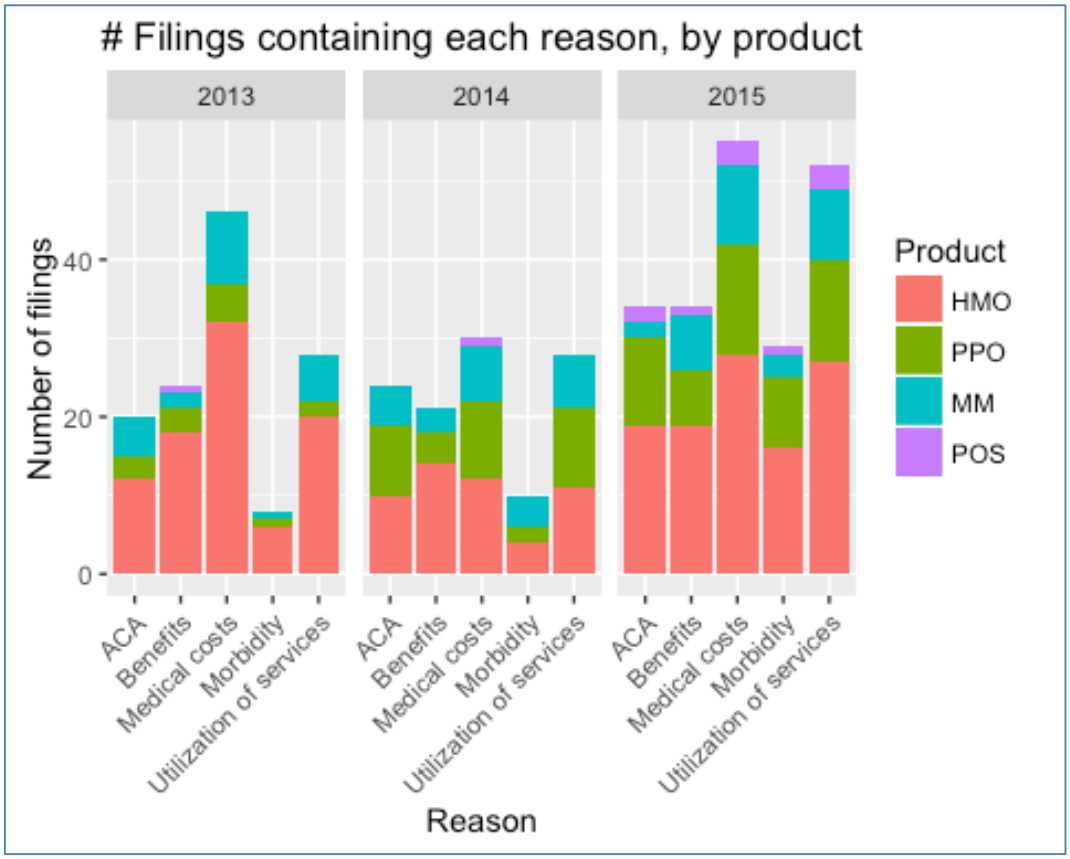
Number of Filings Noting Selected Reasons for Changes in Premium Rates, by Market, by Year

Year	Market	ACA	Benefits	Medical costs	Morbidity	Utilization of services
2013	Individual	4	4	8	1	5
	Small group	1	1	2	0	1
	Large group	15	19	36	7	22
2014	Individual	3	3	5	0	5
	Small group	15	6	16	6	16
	Large group	6	12	9	4	7
2015	Individual	14	13	19	12	19
	Small group	12	8	19	12	17
	Large group	8	13	17	5	16



Number of Filings Noting Selected Reasons for Changes in Premium Rates, by Product, by Year

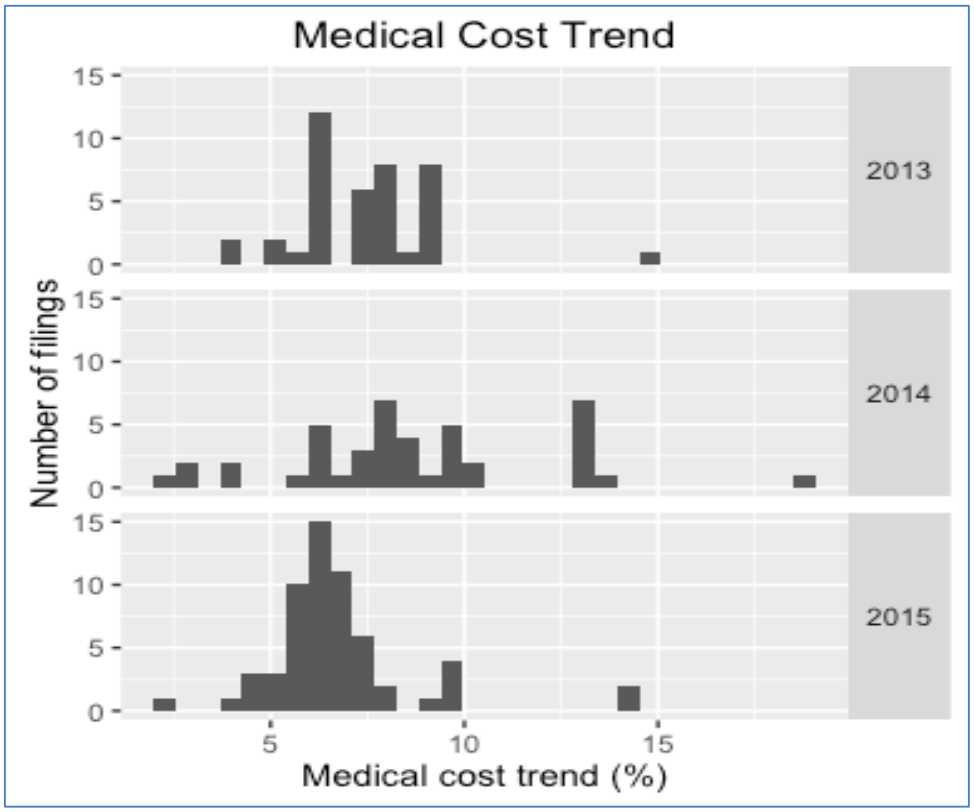
Year	Product	ACA	Benefits	Medical costs	Morbidity	Utilization of services
2013	HMO	12	18	32	6	20
	PPO	3	3	5	1	2
	MM	5	2	9	1	6
	POS	0	1	0	0	0
2014	HMO	10	14	12	4	11
	PPO	9	4	10	2	10
	MM	5	3	7	4	7
	POS	0	0	1	0	0
2015	HMO	19	19	28	16	27
	PPO	11	7	14	9	13
	MM	2	7	10	3	9
	POS	2	1	3	1	3



D. Medical/ RX Cost Trend Rates Noted in Filings (Actuarial memos)

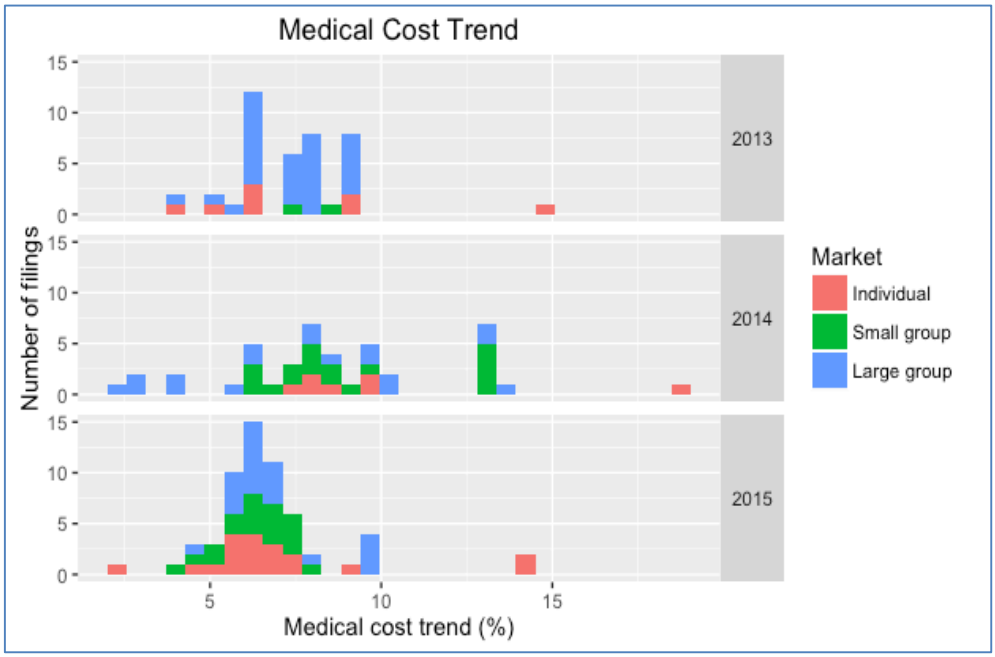
Medical/RX Cost Trend Rate, by Year

Year	Filings	Average (%)	Min (%)	Max (%)
2013	54	7.33	4.0	14.6
2014	44	8.70	2.5	19.0
2015	59	6.73	2.5	14.5



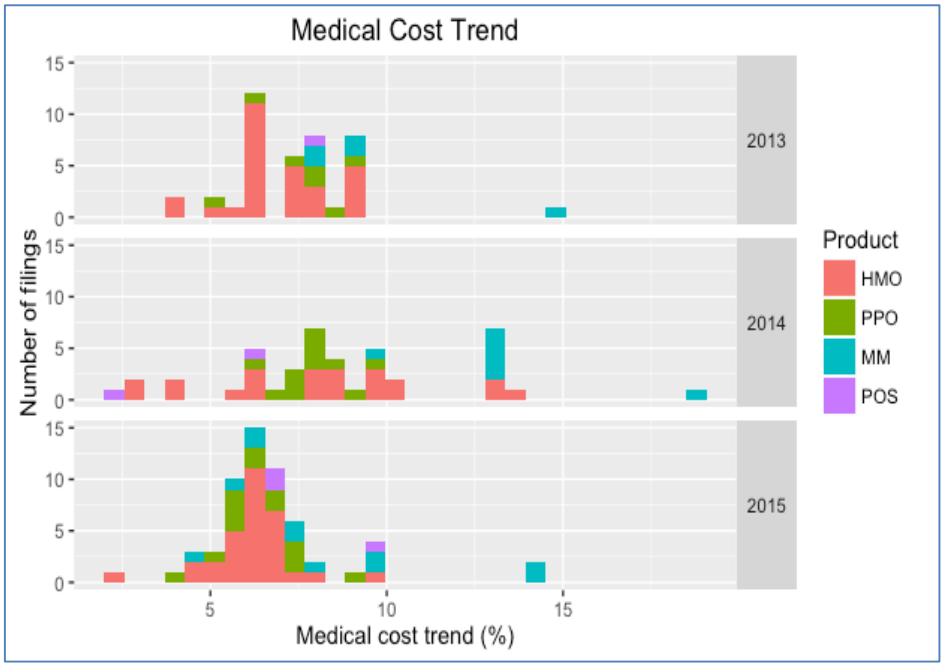
Medical/RX Cost Trend Rate, by Market, by Year

Year	Market	Filings	Average (%)	Min (%)	Max (%)
2013	Individual	10	7.60	4.0	14.60
	Small group	2	7.85	7.2	8.50
	Large group	42	7.22	4.2	8.84
2014	Individual	7	10.06	7.5	19.00
	Small group	18	9.16	6.0	13.00
	Large group	19	7.71	2.5	13.70
2015	Individual	19	6.98	2.5	14.50
	Small group	19	6.29	4.0	7.90
	Large group	21	6.89	4.6	9.60



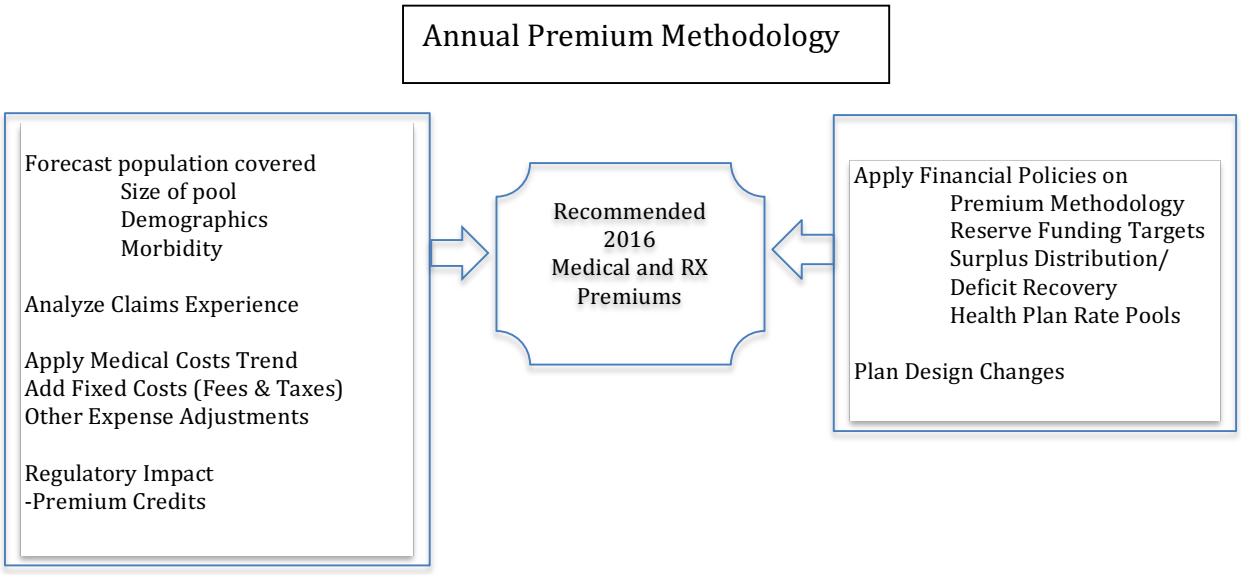
Medical/RX Cost Trend Rate, by Product, by Year

Year	Product	Filings	Average (%)	Min (%)	Max (%)
2013	HMO	36	6.88	4.0	8.9
	PPO	7	7.41	5.2	9.1
	MM	10	9.64	7.9	14.6
	POS	1	7.70	7.7	7.7
2014	HMO	22	8.05	2.9	13.7
	PPO	12	7.91	6.0	9.9
	MM	8	13.37	9.6	19.0
	POS	2	4.25	2.5	6.0
2015	HMO	31	6.16	2.5	9.5
	PPO	14	6.36	4.0	9.0
	MM	11	8.54	4.3	14.5
	POS	3	7.70	6.8	9.5



Appendix G: Overview of Process for Setting Health Insurance Premiums

Actuaries develop premiums based on projected medical claims and administrative costs for a pool of individuals or groups with insurance. Pooling risks allows the costs of the less healthy to be subsidized by the healthy. In general, the larger the risk pool, the more predictable and stable premiums can be. But, the composition of the risk pool is also important. Although the ACA prohibits insurers from charging different premiums to individuals based on their health status, premium levels reflect the health status of an insurer's risk pool as a whole. The majority of premium dollars goes to medical claims, which reflect unit costs (e.g., the price for a given health care service), utilization, the mix and intensity of services, and plan design. Premiums must cover administrative costs, including those related to product development, enrollment, claims processing, and regulatory compliance. They also must cover taxes, assessments and fees, as well as profit (or, for not-for-profit insurers, a contribution to surplus). Laws and regulations can affect the composition of risk pools, projected medical spending, and the amount of taxes, assessments and fees that need to be included in premiums.



Appendix H: Major Drivers of Premium Rate Changes Over Time

FACTORS IN PREMIUM INCREASES	
Risk Pool Composition	
Composition of the risk pool and How it compares to what was projected How it is expected to change	CMS Proposed Standard Age Curve published in the Federal Register on November 26, 2012. This age curve has a 3:1 ratio for age rating. There is also a published factor for children. Insurer expectations regarding the composition of the enrollee risk pool, including the distribution of enrollees by age, gender, and health status.
Single risk pool requirement	The ACA requires that insurers use a single risk pool when developing rates. That is, experience inside and outside the health insurance marketplaces (exchanges) must be combined when determining premiums. Premiums for 2016 will reflect demographics and health status factors of enrollees both inside and outside of the marketplace, as was true for 2014 and 2015.
Transitional policy for non-ACA-compliant plans	For states that adopted the transitional policy that allowed non-ACA compliant plans to be renewed, the risk profile of 2014 ACA-compliant plans might be worse than insurers projected. This would occur if lower-cost individuals retain their prior coverage and higher-cost people move to new coverage. The transitional policy was instituted after 2014 premiums were finalized; meaning insurers were not able to incorporate this policy into their premiums.
Regional, within-Michigan variations	Premiums are set at the state level (with regional variations allowed within a state) and will reflect state- and insurer-specific experience. These factors are reflected in the trend factors reported by insurers.
Reduction of reinsurance program funds	The ACA transitional reinsurance program provides for payments to plans when they have enrollees with especially high claims, thereby offsetting a portion of the costs of higher-cost enrollees in the individual market. This reduces the risk to insurers, allowing them to offer premiums lower than they otherwise would be. Funding for the reinsurance program comes from contributions from all health plans; these contributions are then used to make payments to ACA-compliant plans in the individual market (For more information see: http://kff.org/health-reform/issue-brief/explaining-health-care-reform-risk-adjustment-reinsurance-and-risk-corridors/).

Prices & use of services	
Medical trend: Underlying growth in health care costs	The increase in medical trend reflects the increase in per-unit costs of services and increases in health care utilization and intensity
	Short term National projection: National Health spending growth projected to rise 6.1% 2014-2015 (adjusted for inflation (CPI-U)). Long term projection: 2015-2022 national health spending projected to grow 6.2% annually. Health care reform impact on trend projected to be an average increase of 0.1% annually from 2012 to 2022 (CMS report on National Heath Expenditure Projections 2012-2022).
Employer Plan Taxes & Fees	
Temporary Reinsurance Fees (2014 thru 2016)	Fees from self-insured plans will be used to make reinsurance payments to individual market insurers that cover high-cost individuals in each state. National fee rate of $63 per (non-Medicare) member per year for 2014, $44 PMPY for 2015, and $31.50 PMPY for 2016.
Temporary tax for PCORI fees (2012 thru 2018)	Assessments will fund "patient centered outcomes research trust fund" Fees basis: $1 per covered health plan member per year for CY 2012, $2 per member per year for CY 2013, with PMPY amounts indexed to per capita increases in National Health Expenditures for years 2014-2018.
Employer Shared Responsibility for Health Care, "Pay or Play"	Requires large employers to "offer" medical coverage to employees averaging 30 or more hours of work per week Health care coverage will be offered to temporary employees Medical plans offered must satisfy mandated coverage levels; Employee premium must not exceed 9.5% of the employees pay rate Employers must successfully "offer" coverage to 70% of their qualified population beginning 2015, and 95% by 2016

Health claims assessment tax of 1% of claims and/or premium	State of Michigan Public Act 142 of 2011: Effective Jan 2012, applies to medical, Rx and dental services delivered in Michigan to Michigan residents
Plan Structure & Operations	
Changes in provider networks	Mix of practitioner specialties; "narrowness" of network
Changes in provider reimbursement structures	Per service payment formulae; example: Inpatient stays paid on DRG, Percent of Charges, bundled rates
Benefit package changes	Changes to benefit packages (e.g., through changes in cost-sharing requirements or benefits covered) can affect claim costs and therefore premiums. This can occur even if a plan's actuarial value level remains unchanged.
Risk margin changes	Insurers build risk margins into the premiums to reflect the level of uncertainty regarding the costs of providing coverage. These margins provide a cushion in case costs are greater than projected. Greater levels of uncertainty typically result in higher risk margins and higher premiums.
Changes in administrative costs	Wages, information technology, profit
Increase in the health insurer fee	In 2014, the ACA health insurer fee is scheduled to collect $8 billion from health insurers. The fee will increase to $11.3 billion in 2015 and gradually further to $14.3 billion in 2018, after which it will be indexed to the rate of premium growth. The fee is allocated to insurers based on their prior year's premium revenue as a share of total market premium revenue. In general, insurers pass along the fee to enrollees through an increase to the premium. The effect on premiums will depend on the number of enrollees over which the fee is spread—a greater number of enrollees will translate to the fee being a smaller addition to the premium. The increase in health insurer fee collections from 2014 to 2015 will, in most cases, lead to a small increase in 2015 premiums relative to 2014 (See Exchange and Insurance Market Standards for 2015 and Beyond (Final Rule), Federal Register: 79 (101), May 27, 2014. Available at: http://www.gpo.gov/fdsys/pkg/FR-2014-05-27/pdf/2014-11657.pdf.

Changes in geographic regions	Within a state, health insurance premiums are allowed to vary across geographic regions established by the state according to federal criteria. Changes in the number of geographic regions in the state or how those regions are defined could cause premium changes that would vary across areas. For instance, assuming no other changes, if a lower-cost region and a higher-cost region are combined into one region for premium rating purposes, individuals in the lower-cost area would see premium increases, and individuals in the higher-cost areas would see premium reductions.
Market Competition	
Market forces and product positioning	Insurers might withstand short-term losses in order to achieve long-term goals. Due to the ACA's uniform rating rules and transparency requirements imposed by regulators, premiums are much easier to compare than before the ACA, and some insurers lowered their premiums after they were able to see competitors' premiums.

PUBLIC NOTICE

Michigan Department of Health and Human Services

Medical Services Administration

Healthy Michigan Plan §1115 Demonstration Waiver Extension Application

The Michigan Department of Health and Human Services (MDHHS) is hereby providing notice that it will be holding a public hearing and comment period seeking public input on the submission of its demonstration waiver extension application to the Centers for Medicare & Medicaid Services (CMS). MDHHS is seeking a 3-year extension of the Medicaid Expansion §1115 Demonstration Waiver, known as the Healthy Michigan Plan (HMP) which expires December 31, 2018.

HMP Demonstration Description and Objectives

MDHHS implemented HMP, administered under the §1115 Demonstration Waiver authority (Project No. 11-W-00245/5), on April 1, 2014. Through HMP, MDHHS has extended health care coverage to over 650,000 low-income Michigan residents who were previously either uninsured or underinsured. It is anticipated that annual enrollment will remain consistent. HMP is built upon systemic innovations that improve quality and stabilize health care costs. Other key program elements include: the advancement of health information technology; structural incentives for healthy behaviors and personal responsibility; encouraging use of high value services; and promoting the overall health and well-being of Michigan residents.

HMP Demonstration Program Overview

Michigan residents between the ages of 19-64 with incomes at or below 133% of the federal poverty level, and who do not qualify or are enrolled in Medicare or another Medicaid program are eligible for comprehensive healthcare coverage through HMP. Beneficiaries have the opportunity to participate in the Healthy Behaviors Incentives Program which rewards beneficiaries for their conscientious use of health care services. Applicable beneficiary cost-sharing provisions, including co-payments and contributions are outlined in the HMP waiver protocols.

The HMP Marketplace Option will be effective as of April 1, 2018, with monthly rolling enrollment thereafter. HMP beneficiaries who have incomes above 100% of the FPL and have not completed the healthy behavior requirements of the Healthy Behaviors Incentive Program will transition to the Marketplace Option, absent an applicable exception such as being medically frail, or exempt from premiums or cost-sharing pursuant to

42 CFR 447.56, as outlined in the Marketplace protocol. Additionally, beneficiary cost-sharing obligations are outlined in the Marketplace protocol.

HMP Demonstration Evaluation

The HMP Demonstration's program objectives and hypotheses, as identified in the waiver Special Terms and Conditions, are being assessed consistent with the CMS-approved evaluation plan. The evaluation examines multiple hypotheses associated with the following seven specific domains:

1. The extent to which the increased availability of health insurance reduces the costs of uncompensated care borne by hospitals;
2. The extent to which availability of affordable health insurance results in a reduction in the number of uninsured/underinsured individuals who reside in Michigan;
3. 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;
4. The extent to which beneficiaries believe that HMP has a positive impact on personal health outcomes and financial well-being;
5. Whether requiring beneficiaries to make contributions toward the cost of their health care has an impact on the continuity of their coverage, and whether collecting an average co-pay from beneficiaries in lieu of copayments at the point of service, and increasing communication to beneficiaries about their required contributions (through quarterly statements) affects beneficiaries' propensity to use services; and
6. Whether providing an MIHA into which beneficiaries' contributions are deposited, that provides quarterly statements that include explanation of benefits (EOB) information and details utilization and contributions, and allows for reductions in future contribution requirements, deters beneficiaries from receiving needed health services or encourages beneficiaries to be more cost-conscious.
7. Whether the preponderance of the evidence about the costs and effectiveness of the Marketplace Option when considered in its totality demonstrates cost effectiveness taking into account both initial and longer-term costs and other impacts such as improvements in service delivery and health outcomes.

HMP Demonstration Waiver and Expenditure Authorities

MDHHS seeks the continuation of the following waivers of state plan requirements contained in §1902 of the Social Security Act, subject to the Special Terms & Conditions for the HMP §1115 Demonstration:

- *Premiums, § 1092(a)(14), insofar as it incorporates §§ 1916 and 1916A* - To the extent necessary to enable the state to require monthly premiums for individuals eligible in the adult population described in section 1902(a)(10)(A)(i)(VIII) of the Act, who have incomes between 100 and 133 percent of the federal poverty level (FPL).
- *State-wideness § 1902(a)(1)* - To the extent necessary to enable the state to require enrollment in managed care plans only in certain geographical areas for

those eligible in the adult population described in section 1902(a)(10)(A)(i)(VIII) of the Act.

- *Freedom of Choice § 1902(a)(23)(A)* - To the extent necessary to enable the state to restrict freedom of choice of provider for those eligible in the adult population described in section 1902(a)(10)(A)(i)(VIII) of the Act . No waiver of freedom of choice is authorized for family planning providers.
- *Proper and Efficient Administration § 1902(a)(4)* - To enable the State to limit beneficiaries to enrollment in a single prepaid inpatient health plan or prepaid ambulatory health plan in a region or region(s) and restrict disenrollment from them.
- *Comparability § 1902(a)(17)* - To the extent necessary to enable the state to vary the premiums, cost-sharing and healthy behavior reduction options as described in these terms and conditions.
- *Payment of Providers §§ 1902(a)(13) and 1902 (a)(30)* - To the extent necessary to permit the state to limit payment to providers for individuals enrolled in the Marketplace Option to amounts equal to the market-based rates determined by the Qualified Health Plan providing primary coverage for services under the Marketplace Option.
- *Prior Authorization § 1902(a)(54), as it incorporates §1927(d)(5)* - To permit the state to require that requests for prior authorization for drugs in the Marketplace Option be addressed within 72 hours, rather than 24 hours. A 72-hour supply of the requested medication will be provided in the event of an emergency.

Additionally, MDHHS seeks the continuation of the CMS-approved expenditure authorities:

- Expenditures for Healthy Behaviors Program incentives that offset beneficiary cost sharing liability.
- Expenditures for part or all of the cost of private insurance premiums, and for payments to reduce cost sharing, for individuals enrolled in a Marketplace issuer health plan through the Marketplace Option, to the extent that such expenditures do not meet cost effectiveness requirements or include amounts for benefits that are not otherwise covered under the approved state plan (but are incidental to coverage of state plan benefits).
- To the extent necessary to permit the state to offer premium assistance and cost sharing reduction payments that are determined to be cost effective using state developed tests of cost effectiveness that differ from otherwise permissible tests for cost effectiveness.

Public Hearing, Review of Documents, and Comment Submission

A public hearing for this demonstration extension application is scheduled for 2:00 p.m. on October 19, 2017, at the Michigan Public Health Institute, Interactive Learning & Conference Center, 2436 Woodlake Circle, Suite 380, Okemos, MI. This public hearing will provide an overview and discussion of the demonstration waiver extension. All

interested parties will be provided the opportunity to provide comments on the HMP demonstration waiver extension application.

Copies of information related to the proposed demonstration waiver extension application, as well as written comments regarding the proposed demonstration waiver extension may be reviewed by the public at Capital Commons Center, 400 South Pine Street, Lansing, Michigan. Additionally, copies of information related to the demonstration waiver extension are available on the Healthy Michigan Plan webpage: http://www.michigan.gov/healthymichiganplan. The webpage will be updated as appropriate.

Any comments on this notice and the application may be submitted in writing to: Michigan Department of Health and Human Services, Program Policy Division, Bureau of Medicaid Policy and Health System Innovation, Attention: Medicaid Policy, P.O. Box 30479, Lansing, MI 48909-7979, or via email at healthymichiganplan@michigan.gov. All comments should include a “Demonstration Waiver Extension” reference somewhere in the written submission, or in the subject line, if email is used. Comments will be accepted until October 30, 2017.

Michigan Department of Health & Human Services
Health Michigan Plan
§1115 Demonstration Waiver Extension

Public Comments and Responses
October 31, 2017

Dental Coverage Comment

Comment: We strongly support the Michigan Department of Health and Human Services' request for an extension of the Healthy Michigan Plan §1115 Demonstration Waiver. We urge the Department to ensure that the MI Marketplace Option enrollees have access to the same suite of benefits as those beneficiaries who receive their health coverage through a Healthy Michigan Plan health plan, notably dental coverage.

Response: In accordance with the Healthy Michigan Plan Waiver Special Terms and Conditions, beneficiaries enrolling in the MI Marketplace Option will receive the 10 Essential Health Benefits, in accordance with the Affordable Care Act requirements. Additional wrap-around benefits will also be available, consistent with the State's approved Alternative Benefit Plan (ABP) for the Marketplace Option. These wrap-around benefits are limited to Non-Emergency Medical Transportation, family planning services provided by out-of-network providers and any ABP Marketplace Option Medicaid-covered services provided by a Federally Qualified Health Center, Tribal Health Center, or Rural Health Clinic when not otherwise covered by their Qualified Health Plan.

STATE OF MICHIGAN
DEPARTMENT OF HEALTH AND HUMAN SERVICES
LANSING

RICK SNYDER
GOVERNOR

NICK LYON
DIRECTOR

August 16, 2017

NAME
TITLE
ADDRESS
CITY STATE ZIP

Dear Tribal Chair and Health Director:

RE: Healthy Michigan Plan §1115 Demonstration Waiver Extension

This letter, in compliance with Section 1902(a)(73) and Section 2107(e)(1)(C) of the Social Security Act, serves as notice of intent to all Tribal Chairs and Health Directors that the Michigan Department of Health and Human Services (MDHHS) will be seeking an extension of the Healthy Michigan Plan §1115 Demonstration Waiver.

The primary goal of the Healthy Michigan Plan waiver is to improve access to health care services for low income Michigan residents who are uninsured or underinsured, while implementing a comprehensive benefit package with the intent to improve health outcomes. The anticipated effective date of this waiver extension is January 1, 2019.

MDHHS expects that the waiver extension will have a positive impact on Native American beneficiaries, as they will be able to continue to receive services through the Healthy Michigan Plan and will be able to voluntarily enroll in the managed care delivery system. Additionally, Native American enrollees will continue to have coverage without cost sharing or premium obligations.

MDHHS expects to make the waiver renewal request available for public comment in the early fall of 2017. Once the document is available for public review, MDHHS will provide an update to the Tribal Chairs and Health Directors, as well as other stakeholders, and share additional information on the public comment process. MDHHS also plans to seek consultation on this waiver renewal request during the Quarterly Tribal Health Directors conference call on August 28, 2017 at 3:00 p.m.

In addition, MDHHS will be arranging an additional meeting at a future date for the purpose of tribal consultation in order to discuss this waiver extension request. This consultation meeting will allow tribes the opportunity to address any concerns and voice any suggestions, revisions, or objections to be relayed to the author of the proposal.

If you would like additional information or wish to schedule a group or individual consultation meeting, please contact Lorna Elliott-Egan, MDHHS Liaison to the Michigan Tribes. Lorna can be reached at 517-284-4034, or via email at Elliott-EganL@michigan.gov. **Please provide all input by September 30, 2017.**

MDHHS appreciates the continued opportunity to work collaboratively with you to care for the residents of our state.

Sincerely,

Chris Priest, Director
Medical Services Administration

cc: Keri Toback, Region V, CMS
Leslie Campbell, Region V, CMS
Pamela Carson, Region V, CMS
Ashley Tuomi, MHPA, Executive Director, American Indian Health and Family Services of Southeastern Michigan
L. John Lufkins, Executive Director, Inter-Tribal Council of Michigan, Inc.
Keith Longie, Acting Area Director, Indian Health Service - Bemidji Area Office
Lorna Elliott-Egan, MDHHS

Distribution List for L 17-36
August 16, 2017

Mr. Levi Carrick, Sr., Tribal Chairman, Bay Mills Indian Community
Ms. Audrey Breakie, Health Director, Bay Mills (Ellen Marshall Memorial Center)
Mr. Thurlow Samuel McClellan, Chairman, Grand Traverse Band Ottawa & Chippewa Indians
Ms. Ruth Bussey, Health Director, Grand Traverse Band Ottawa/Chippewa
Mr. Kenneth Meshigaud, Tribal Chairman, Hannahville Indian Community
Ms. G. Susie Meshigaud, Health Director, Hannahville Health Center
Mr. Warren C. Swartz, Jr., President, Keweenaw Bay Indian Community
Ms. Carole LaPointe, Health Director, Keweenaw Bay Indian Community - Donald Lapointe Health/Educ Facility
Mr. James Williams, Jr., Tribal Chairman, Lac Vieux Desert Band of Lake Superior Chippewa Indians
Ms. Sadie Valliere, Health & Human Services Director, Lac Vieux Desert Band
Mr. Larry Romanelli, Ogema, Little River Band of Ottawa Indians
Mr. Donald MacDonald, Health Director, Little River Band of Ottawa Indians
Ms. Regina Gasco-Bentley, Tribal Chairman, Little Traverse Bay Band of Odawa Indians
Ms. Jodi Werner, Health Director, Little Traverse Bay Band of Odawa
Mr. Scott Sprague, Chairman, Match-E-Be-Nash-She-Wish Potawatomi Indians (Gun Lake Band)
Ms. Kelly Wesaw, Health Director, Match-E-Be-Nash-She-Wish Potawatomi
Mr. Jamie Struck, Tribal Chairman, Nottawaseppi Huron Band of Potawatomi Indians
Ms. Rosalind Johnston, Health Director, Huron Potawatomi Inc.- Tribal Health Department
Mr. John Warren, Tribal Chairman, Pokagon Band of Potawatomi Indians
Mr. Matt Clay, Health Director, Pokagon Potawatomi Health Services
Mr. Frank Cloutier, Tribal Chief, Saginaw Chippewa Indian Tribe
Mrs. Karmen Fox, Executive Health Director, Nimkee Memorial Wellness Center
Mr. Aaron Payment, Tribal Chairman, Sault Ste. Marie Tribe of Chippewa Indians
Mr. Joel Lumzden, Health Director, Sault Ste. Marie Tribe of Chippewa Indians - Health Center

CC: Keri Toback, Region V, CMS
Leslie Campbell, Region V, CMS
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Lorna Elliott-Egan, MDHHS

STATE OF MICHIGAN
DEPARTMENT OF HEALTH AND HUMAN SERVICES
LANSING

RICK SNYDER
GOVERNOR

NICK LYON
DIRECTOR

October 4, 2017

NAME
TITLE
ADDRESS
CITY STATE ZIP

Dear Tribal Chair and Health Director:

RE: Healthy Michigan Plan §1115 Demonstration Waiver Extension

On August 16, 2017, the Michigan Department of Health and Human Services (MDHHS) issued letter L 17-36 to all Tribal Chairs and Health Directors, in compliance with Section 1902(a)(73) and Section 2107(e)(1)(C) of the Social Security Act, providing notice of the department's intent to submit its renewal application to the Centers for Medicare & Medicaid Services (CMS) to request an extension of the Healthy Michigan Plan §1115 Demonstration Waiver. This letter provides additional follow-up information regarding the opportunities for tribal consultation, attendance at a public forum, and the submission of written comments during the public comment period.

The primary goal of the Healthy Michigan Plan is to improve access to health care services for low-income Michigan residents who are uninsured or underinsured, while implementing a comprehensive benefit package with the intent to improve health outcomes. The expected effective date of this waiver extension is January 1, 2019. MDHHS expects that the waiver extension will have a positive impact on Native American populations located in the state, as they will be able to continue to receive services through the Healthy Michigan Plan and will be able to voluntarily enroll in the managed care delivery system.

MDHHS will hold a conference call meeting on October 18, 2017 at 10:00 a.m. EST with Tribal Chairs and Health Directors as well as other stakeholders. This consultation meeting will allow for an opportunity to address any concerns and voice any suggestions, revisions, or objections to regarding the renewal application.

MDHHS will also be holding a public hearing which is scheduled on October 19, 2017 at 2:00 p.m. EST at the Michigan Public Health Institute, Interactive Learning & Conference Center, 2436 Woodlake Circle, Suite 380, Okemos, MI.

A copy of the complete §1115 waiver renewal application is available on the MDHHS website at www.michigan.gov/healthymichiganplan. You may also request a hard copy of the renewal application by contacting MDHHS by email at healthymichiganplan@michigan.gov. Input regarding the Healthy Michigan Plan Demonstration waiver renewal request is highly encouraged. All comments on the topic should include the title "Healthy Michigan Plan Waiver Renewal Request" in the subject line. **Please provide all input by November 20, 2017**.

If you would like additional information, hard copies of the waiver renewal application, or wish to schedule a group or individual consultation meeting, please contact Lorna Elliott-Egan MDHHS Liaison to the Michigan Tribes. Lorna can be reached at 517-284-4034, or via email at Elliott-EganL@michigan.gov.

MDHHS appreciates the continued opportunity to work collaboratively with you to care for the residents of our state.

Sincerely,

Chris Priest, Director
Medical Services Administration

cc: Keri Toback, Region V, CMS
Leslie Campbell, Region V, CMS
Ashley Tuomi, MHPA, Executive Director, American Indian Health and Family Services of Southeastern Michigan
L. John Lufkins, Executive Director, Inter-Tribal Council of Michigan, Inc.
Keith Longie, Director, Indian Health Service - Bemidji Area Office
Lorna Elliott-Egan, MDHHS

Distribution List for L 17-46
October 4, 2017

Mr. Levi Carrick, Sr., Tribal Chairman, Bay Mills Indian Community
Ms. Audrey Breakie, Health Director, Bay Mills (Ellen Marshall Memorial Center)
Mr. Thurlow Samuel McClellan, Chairman, Grand Traverse Band Ottawa & Chippewa Indians
Ms. Ruth Bussey, Health Director, Grand Traverse Band Ottawa/Chippewa
Mr. Kenneth Meshigaud, Tribal Chairman, Hannahville Indian Community
Ms. G. Susie Meshigaud, Health Director, Hannahville Health Center
Mr. Warren C. Swartz, Jr., President, Keweenaw Bay Indian Community
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Keith Longie, Director, Indian Health Service - Bemidji Area Office
Lorna Elliott-Egan, MDHHS

Michigan Department of Community Health
MDCH
Rick Snyder, Governor
James K. Haveman, Director

Medical Services Administration

Medical Care Advisory Council

Minutes

Date: Tuesday February 11, 2014

Time: 1:30 – 4:30 p.m.

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

Attendees: **Council Members:** Jan Hudson, Marilyn Litka-Klein, Cheryl Bupp, Warren White, Kim Sibilsky, Dave Herbel, Barry Cargill, Priscilla Cheever, Jackie Doig, Alison Hirschel, Robin Reynolds, Larry Wagenknecht, Kim Singh, Tewana Nettles-Robinson

Staff: Steve Fitton, Jackie Prokop, Dick Miles, Farah Hanley, Charles Overbey, Cindy Linn, Cathy Stiffler, Amy Allen, Debera Eggleston, Marie LaPres, Pam Diebolt

Welcome and Introductions

Jan Hudson opened the meeting and introductions were made.

Affordable Care Act Implementation - Healthy Michigan Plan

The Section 1115 demonstration waiver amendment for the Healthy Michigan Plan was approved by the Centers for Medicare and Medicaid Services (CMS) in December 2013 and the Healthy Michigan Plan will begin April 1, 2014.

Waiver Status - Terms and Conditions

The Michigan Department of Community Health (MDCH) has been working with CMS on the special terms and conditions that must be completed for the Healthy Michigan Plan to begin. Some of the items include sending in a waiver acceptance letter, transition planning for the current Adult Benefits Waiver (ABW) population, and finding a way to identify individuals that were denied eligibility on the Federally Facilitated Marketplace and MIBridges that may now be eligible for the Healthy Michigan Plan.

The transition plan for the ABW population has been approved. There are more than 60,000 people in the ABW program that will be automatically transitioned into the Healthy Michigan Plan without having to complete a new eligibility determination. A new Modified Adjusted Gross Income (MAGI) application will be completed at their next annual redetermination date.

Changes to Medicaid Health Plan contracts have been sent to CMS for review. The draft health plan rates for the Healthy Michigan Plan were released last week to the health plans for review, and department staff met with the health plans to receive feedback.

As a part of the special terms and conditions for the Healthy Michigan Plan, the Department must provide additional information to CMS regarding how the MI Health Accounts will work, including how contributions will be collected and a description of how the beneficiary will receive quarterly statements letting them know how much they owe in copayments. MDCH will send in a draft of the plan to CMS by the end of March 2014.

There was a question about consequences for not adhering to Healthy Behaviors. There are two possibilities that MDCH is researching. One is placing the individual into the Benefits Monitoring Program (BMP) though the details have not been worked out. The other possibility is taking money from state tax returns. MDCH is working with the Department of Treasury to see how that could happen and details are being looked at. Jan Hudson suggested community service workers reach out to individuals and see if they need help.

A draft of the Health Risk Assessment form (HRA) was shared with all attendees. The HRA was developed to promote the overall health and well-being of beneficiaries, which when completed, provides beneficiaries the opportunity to earn incentives for actively engaging in the health care system.

Public Act 107 of 2013 calls for copayments to be waived for any visit that is related to a chronic condition, with the goal to promote greater access to services that prevent the progression of and complications related to chronic diseases. A list of chronic conditions will be compiled in the near future.

Under the Healthy Michigan Plan, "Health Saving like Accounts" (HSAs) called MI Health Accounts will be created to engage consumers in the cost of their health care. Copayments will not be collected during the first six months after health plan enrollment, but an initial average monthly copayment history will be established during this time. The average monthly copayment amounts will be collected and retained by the MHPs starting in the 7th month. The average monthly copayment history will then be recalculated each subsequent six months. No Point-Of-Service (POS) copayments will be collected from beneficiaries enrolled in health plans. If a beneficiary is exempt from enrollment in the health plans and is in Fee-For-Service (FFS) they will continue to pay copayments at POS to the providers.

Protocols for the MI Healthy Account and Healthy Behaviors will be available at a later date.

Outreach and Enrollment Plans

MDCH has created a beneficiary handbook that describes the Healthy Michigan Plan. The handbook is in the process of being mailed out to ABW beneficiaries. It will be posted to the website this week. There will also be webinars, provider brochures and posters made available for outreach. A Healthy Michigan Plan logo has been created.

The Department reported it is still exploring expedited enrollment options but they will not be ready to implement by April 1 because of Federal Waiver requirements.

Coordination with DHS

Two follow up questions from the last meeting were answered by DHS.

Are local offices referring to the navigators? Yes, they have resource information and they are referring to the navigators if appropriate. There is a resource guide that lists the link to the navigators and that link has been provided to DHS staff.

Will there be certified application counselors in the local DHS offices? A few urban offices do have certified application counselors. Otherwise, they have resource information and are referring to the navigators if questions arise.

MAGI Implementation Update

MDCH is using the MAGI Methodology for eligibility. The department is working out some system issues, but it is working well overall.

Symposium on High Emergency Room Utilizers - Follow-up

The initial symposium was held in November 2013. A link to the presentations will be sent to the group. Three workgroups are now being established. Anyone interested in joining the workgroups may contact Dr. Eggleston. Workgroup meetings will be held monthly and the first meeting is scheduled for February 27, 2014. Once the three workgroups have completed their reviews, their findings will be presented at a summit with national speakers. Subsequently, a report will be developed to send to the legislature.

Dual Eligibles Integration Project - Update

The Memorandum of Understanding (MOU), which lays out the structure of the program, will be signed soon. MDCH is pleased with the progress that is being made with the Dual Eligibles Integration Project in view of the complexity. A phased enrollment process is planned to begin in July 2014, which begins with opt-in enrollment followed by passive enrollment. Progress continues on the rate structure development.

State Innovation Model (SIM) Update

MDCH received a planning grant to look at ways to implement payment and delivery reforms and will be applying for a testing grant for implementation. After stakeholder meetings and developing several high level recommendations on payment and service delivery reforms, MDCH is ready to move into the Implementation Phase and select the testing regions. Grant award announcements are expected in the near future.

FY 2015 Executive Budget Recommendations

Charles Overbey shared the Executive Budget for fiscal year (FY) 2015. The governor recommended a $52.1 Billion total State budget, with $9.8 billion in the general fund (GF). The GF is up 7% this fiscal year. There are increases in the budget for education. The governor proposed tax relief with a Homestead Property Tax credit. $250 million was proposed for road repairs. One hundred additional state troopers were recommended for public safety. $120 million is proposed to be added to the rainy day fund. Half of the projected savings that will be achieved from the Healthy Michigan Plan, totaling $122 million, will be deposited into the Michigan Health Savings Fund. These monies will help pay for Medicaid expansion in the future as the Federal funding is reduced from 100% to 90%.

The MDCH budget is $17.4 billion total, $2.9 billion GF. Some of the increases that occurred in the budget were replacing losses in the federal medical assistance percentage (FMAP) and increases in Medicaid caseloads. The Medicaid caseload is estimated to increase slightly in FY 2015 to 1.84 million individuals, and 400,000 more individuals are estimated to be found eligible for the Healthy Michigan Plan. The governor proposed $5 million to enhance senior services. The budget recommended $9.6 million in state funds, $16.4 million in federal funds for the MiChoice program, eliminating the waiting list. Healthy Kids Dental will be expanded to Kalamazoo and Macomb counties if the Executive recommendation is approved by the Legislature.

Funding to continue 50% of the primary care rate increase is recommended. While the HICA tax shortfall was acknowledged, no funding solution was recommended within the Executive Budget recommendations.

$2.5 million was recommended for the Michigan Home Visitation Initiative, which will promote better birth and health outcomes for pregnant women and their children residing in rural areas. $2 million was proposed for a pilot project for child and adolescent health to increase access to nursing and behavioral health services.

Mental Health Commission Recommendations

In January 2013, the Governor issued two executive orders (EO) creating the Mental Health and Wellness Commission and the Mental Health Diversion Council. The Mental Health Diversion Council met to talk about improving options and outcomes for people with mental health concerns who are involved in the criminal justice system. The Mental Health and Wellness Commission met to strengthen and improve the system of mental health support and the delivery of services.

Recommendations released in January were focused on person centeredness, personal choice, and integration and innovation. Most discussions surrounded how mental health and physical health connect to create overall wellbeing. The 29 page report is located on www.michigan.gov website for those who would like to read it. The Governor is expected to issue another EO to continue the Commission so that more issues can be addressed as much work remains to be done.

Policy Updates

Healthy Michigan Plan Provider Policy - This policy went out for public comment in December 2013. A fair number of public comments were received and plans are to incorporate many comments into the final bulletin. Internal staff has also added comments that will be incorporated. The policy will be released as a final bulletin on February 28, 2014 with an effective date of April 1, 2014.

1357-NEMT - This policy will affect the Beneficiary Administrative Manual (BAM) and the Bridge's Eligibility Manual (BEM). It makes it clear that those beneficiaries who have provided their own non-emergency medical transportation (NEMT) in the past and now need assistance because a change of circumstance, can receive transportation assistance.

1403-BEM - Comments are due on February 23, 2014. This is a BEM manual update. It modifies eligibility to no longer include Institutional status. This policy will be back dated to October 2013.

The meeting was adjourned at 4:00pm.

Next Meeting - May 27, 2014 1pm-4pm

Michigan Department of Community Health
MDCH
Rick Snyder, Governor
James K. Haveman, Director

Medical Services Administration

Medical Care Advisory Council

Minutes

Date: Tuesday, May 27, 2014

Time: 1:00 – 4:30 p.m.

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

Attendees: **Council Members:** Jan Hudson, Marilyn Litka-Klein, Amy Zaagman, William Mayer, Elmer Cerano, Jeff Wieferich, Amy Hundley, Roger Anderson, Andrew Farmer, Cheryl Bupp, Eric Roads for Larry Wagenknecht, David Lalumia, Alison Hirschel, Barry Cargill, Pam Lupo, Cindy Schnetzler, Jackie Doig, Priscilla Cheever, Doug Patterson for Kim Sibilsky, Robin Reynolds, Kim Singh, Linda Vale

Staff: Steve Fitton, Brian Keisling, Monica Kwasnik, Cindy Linn, Marie LaPres, Jackie Prokop, Pam Diebolt, Kathy Stiffler, Debera Eggleston, Dick Miles

Welcome and Introductions

Jan Hudson opened the meeting and introductions were made.

Affordable Care Act Implementation

Healthy Michigan Plan

Enrollment Update, including catch-up processing

Enrollment in the Healthy Michigan Plan is above projection at 269,473 individuals. The population is fairly young; 43.5% of those found to be eligible are under the age of 35. The Michigan Department of Community Health (MDCH) continues to address any concerns there may be in regards to enrollment and the eligibility system. Oakland and Livingston Counties have lower enrollment than surrounding areas. Early implementation issues identified include:

- Plan First! terminations, reprocessing and needed system changes,
- Legal immigrants being incorrectly approved for ESO Medicaid,
- 5% disregard not being correctly applied,
- Issues with coverage for pregnant teens

If the Modified Adjusted Gross Income (MAGI) application is filled out electronically with no missing fields, it is consistently returning a result in less than 10 seconds. Individuals can begin to receive services the day they receive an approval. The mihealth cards and enrollment packets have been delivered to beneficiaries within a week of the application approval. MDCH reports that call volumes to the help line are very high, 900 calls/hour but hold times have been manageable with the addition of 50 staff members.

Protocols – Healthy Behaviors and MI Health Account

The Department is in the process of submitting the Healthy Behaviors and MI Health Account protocols to the Centers for Medicare and Medicaid Services (CMS). Approximately 4 weeks ago, MDCH released a public notice and sent out e-mails to staff and Medical Care Advisory Council members requesting input on the draft protocols.

The MI Health Account will be operationalized on October 1, 2014. The MI Health Account removes the majority of cost sharing at the point of service and replaces it with an accounting, payment, and education fund that the Department is working to implement. For health plan covered services, copayments will be paid through the MI Health Account, removing providers from that function. Individuals with income above 100% of the Federal Poverty Level, a small percentage of enrollees to date, will also contribute an additional 2% of income to the MI Health Account.

Payments to the account will be made monthly. The goal of the MI Health Account is to engage and inform individuals about health care costs by sending out health account statements.

Michigan Public Act 107 of 2013 calls for provisions encouraging beneficiaries to engage in or maintain Healthy Behaviors thus allowing contributions to be reduced. With input from stakeholders and health plans, the Health Risk Assessment (HRA) was developed. Once an applicant is approved for the Healthy Michigan Plan and a health plan is chosen, the beneficiary will be asked the first 10 questions from the HRA by Michigan Enrolls. The information provided to Michigan Enrolls is given to the health plan that was chosen by the beneficiary, who can then determine any further action needed. When the beneficiary goes to their Primary Care Physician (PCP) for a visit, the provider will then complete the full HRA. For the Healthy Behaviors incentives to be processed, the PCP must complete the attestation form in the HRA.

The Council discussed the MI Health Account and Healthy Behaviors at length.

Expedited Enrollment Waiver for Supplemental Nutrition Assistance Program (SNAP) and Parents

The waiver was recently signed by the Medical Services Administration and has been sent to CMS. The waiver will allow an expedited enrollment process for the Healthy Michigan Plan for recipients of SNAP benefits and parents of Medicaid-eligible children.

Operational Waivers Update

The Department reports that all three (enrollment and eligibility, alternate benefit plan, and 100% federal funding) State Plan Amendments (SPAs) required for the Healthy Michigan Plan have been approved by CMS.

Plan First! Termination

Concern was expressed about the termination of the Plan First! Program, access to services for those who relied on that program, and issues with Healthy Michigan Plan enrollment.

Community Mental Health (CMH) Funding and Transition Issues

There were many concerns raised and a long discussion concerning the transition of CMH clients to the Healthy Michigan Plan. The variation in services from CMH to CMH adds confusion. The Department explained the payment process and their intent to forward fund as much as possible to keep at least as many dollars flowing into the system as previously. Lynda Zeller requested stories of those who were losing services to understand what services are being discontinued, and offered to work with CMH's to resolve issues.

Dual Eligibles Integration Project – Update and Review of MI Health Link Quality Strategy

The Memorandum of Understanding (MOU) was approved by CMS at the beginning of April 2014 which gives the Department opportunity to move forward with the project. The Department is on target for a phased implementation beginning January 1, 2015 in the first two regions: the eight counties in the southwest part of the state, and the Upper Peninsula; to be followed by Macomb and Wayne Counties three months later. Implementation dates are contingent upon CMS approving the capitation rates so

that the waivers can be completed. The Department is working with the actuary on rate development. MDCH is pleased with the progress that is being made with the Dual Eligibles Integration Project in view of the complexity of the project.

The Department is in the process of developing the three-way contract among the Integrated Care Organizations (ICOs), MDCH, and CMS. The contract must be signed by October 7, 2014 in order to meet the timelines for implementation on January 1, 2015.

Dick Miles requested council member input on the MI Health Link Quality Strategy document. This document was sent with the meeting agenda via e-mail. For questions or comments on this document, send an e-mail to the MDCH Integrated Care mailbox at integratedcare@michigan.gov. Dick explained that MDCH is also looking for public input on the Quality Strategies. A public forum will be held on June 4, 2014 at the Macomb County Intermediate School District (ISD).

FY 2015 Budget

Steve reported that, roads, Detroit bankruptcy, and the Health Insurance Claims Assessment (HICA) and Use Tax issues are top budget priorities and must be resolved before funding targets can be set. Unresolved major issues in the MDCH budget include:

- actuarially sound rates for Health Maintenance Organizations (HMOs),
- small and rural hospital pool, and
- funding to keep primary care rates near Medicare and from falling back to previous rates. Jan Hudson will draft a letter in support of continuing the increased primary care rate increase at whatever level the Legislature can fund.

ER High Utilizers Project – Update

A High Utilizers Project handout was shared with the Council members. The initial symposium was held in November 2013 to discuss the overuse and misutilization of Emergency Room (ER) visits. Two patient populations were identified at the symposium and data was collected to help identify reasons for high ER utilization. It was discovered that 66% of Medicaid recipients are not high utilizers, but 6% have 5 or more visits in a year.

After the symposium, three work groups were established.

- Coordination and Integration of Care
- Innovations and Reimbursement
- Preventable ER Use

A forum will be held on June 5, 2014 at the Michigan State University Union Building to continue the ongoing work group activities. The forum will include a presentation of the findings from each of the work groups and the Council will receive feedback on those findings.

A follow-up report to the Legislature describing the main issues and broad recommendations must be completed by December 31, 2015.

Steve raised the issue of whether there can be significant cost savings from reduced ER use in view of hospital cost structures and their methods for allocating costs.

Policy Updates

A policy update handout was given to each attendee.

MSA 14-06 – This policy was issued on February 27, 2014. The policy is the quarterly update bulletin and also included information regarding the new Document Management Portal in CHAMPS. This portal will be another option to upload documents in addition to the EZ Link portal. There is a tutorial on the new Document Management Portal at www.michigan.gov/medicaidproviders.

1328-EPSDT - This policy is out for its third public comment until June 12, 2014. The policy will result in a new Early and Periodic Screening, Diagnosis and Treatment (EPSDT) chapter for the Medicaid Provider Manual and will include the most recent American Academy of Pediatrics (AAP) Periodicity recommendations.

1421-DME – This policy is out for public comment until June 6, 2014. This is a follow-up to a policy that was issued last year regarding coverage of wearable cardioverter defibrillators.

Next Meeting: August 13, 2014, 1:00 p.m. – 4:00 p.m. at the Michigan Public Health Institute (MPHI)

Michigan Department of Community Health

Rick Snyder, Governor
James K. Haveman, Director

Medical Services Administration

Medical Care Advisory Council

Minutes

Date: Tuesday August 19, 2014

Time: 1:00 pm – 4:00 pm

Where: Michigan Health and Hospital Association Headquarters
2112 University Park Drive
Okemos, MI

Attendees: **Council Members:** Jan Hudson, Jackie Doig, Kim Singh, Dave Herbel, Kim Sibilsky, Diane Haas, Amy Hundley, Vicki Kunz for Marilyn Litka-Klein, Marion Owen, Cindy Schnetzler, Mike Vizena, Cheryl Bupp, April Stopczynski, Elmer Cerano

Staff: Steve Fitton, Dick Miles, Jackie Prokop, Brian Barrie, Pam Diebolt, Marie LaPres, Kathy Stiffler, Monica Kwasnik, Michelle Best

Attendees: Jamie Galbraith

Welcome and Introductions

Jan Hudson opened the meeting and introductions were made.

Healthy Michigan Plan

As of August 18, 2014, there are 364,929 beneficiaries enrolled in the Healthy Michigan Plan.

Enrollment Update, Including Catch-Up Processing

There are still many pending applications that are being processed. No significant problems with processing were reported. Approximately 30 percent of all applicants who apply through MIBridges are able to complete the application process without needing to contact a caseworker, which is noted as a significant process benefit for submitting electronic applications. A request was made for information about the specific number of pending Healthy Michigan Plan applications to be sent to the Medical Care Advisory Council (MCAC). Jan Hudson will send those numbers to the council.

The Michigan Department of Community Health (MDCH) has begun processing Healthy Michigan Plan Applications that were received through the Federally Facilitated Marketplace (FFM). The applications that are being processed are going through the system at a much higher rate than was expected, though some pending applications are still anticipated for applicants who need to provide additional information. Though the FFM initially reported receiving 110,000 applications for the Healthy Michigan Plan, to date there have been 85,000 applications received by MDCH from the FFM. Many of those applicants were found to have already been enrolled in the Healthy Michigan Plan or other Medicaid programs.

What's Working Well

- The Healthy Michigan Plan applications that have been submitted through MIBridges are mostly going through the system without any problems.

- A meeting attendee asked if those applicants who apply for insurance in the FFM would be notified if they are eligible for the Healthy Michigan Plan. In response, it was noted that the FFM is able to assess potential eligibility for Michigan Medicaid programs, including the Healthy Michigan Plan, using the Modified Adjusted Gross Income (MAGI) methodology, but only Michigan Medicaid can make a final eligibility determination. Once an application is received by MDCH from the FFM, MDCH will send a notice to the applicant if they are found to be eligible for a Medicaid program. The two-way communication process between Michigan Medicaid and the FFM is still in development, but the Department is hoping to have it completed in time for the next Marketplace open enrollment period in November.
- The Federally Qualified Health Centers (FQHCs) have begun using Health Risk Assessments (HRAs), and they have been communicating well with the Department.
- The Medicaid Health Plans (MHPs) have reported that more people are getting dental coverage as a result of the Healthy Michigan Plan.
- Michigan Enrolls has added staff to the call center reduce wait times for beneficiaries applying for health care coverage by phone.

What's Not Working Well

- The MHPs have been experiencing problems with communication between the MIBridges system and Community Health Automated Medicaid Processing System (CHAMPS), resulting in retroactive enrollments into the Health Plans. Such enrollments should always be prospective. This problem has since been resolved.
- The Department of Human Services (DHS) has been experiencing computer problems that affect the department's ability to retroactively enroll beneficiaries into Medicaid programs prior to the first of the month in which they apply, regardless of determined eligibility prior to that date.
- Community Mental Health (CMH) Provider Organizations are facilitating enrollment into health plans for people from the community who come in with behavioral health illnesses, including substance use disorder. These beneficiaries require up to two months until their health plan selection is complete. The provider organizations are not being allowed to enroll with CHAMPS, since they are being told they are not a specialty provider. Medicaid does not currently enroll licensed psychologists and social workers into CHAMPS, but this is proposed as a future possibility. In many cases it was found that many Behavioral Health claims were being denied due to being improperly billed.
- A request was made for primary care physicians to be reimbursed using Mental Health assessment codes for initial behavioral health evaluations, in order to better serve the expanded Healthy Michigan Plan-eligible population. In response, MDCH indicated that this issue has been brought up before and will be revisited in future meetings.
- Some individuals are being denied Healthy Michigan Plan coverage if they have children who are already covered by Medicaid and therefore do not check the box on the MAGI application indicating that they want to apply for coverage for their children at the time they submit their own application. It was also reported that those applying for coverage through the FFM have not had any problems.
- Beginning August 2, 2014, applicants who apply for Medicaid and self-attest to legal residency or citizenship are being given full Medicaid benefits but will still go through a 90 day verification process. Previously, beneficiaries who self-attested to legal residency or citizenship were

given Emergency Services Only (ESO) Medicaid until their status could be verified. If the individual doesn't answer the residency question or attest citizenship, MDCH is having DHS caseworkers verify that ESO should be given instead of full Medicaid coverage. Council members indicated that issues continue.

- There was discussion regarding whether current communication about Medicaid benefits is sufficient in the case where clients apply for Medicaid Health Care Coverage and are only eligible for a deductible plan or ESO.
- There have been implementation problems identified with Presumptive Eligibility (PE) that have forced its delay. The federal regulations have also changed to restrict coverage, including restrictions on hospitalization for pregnant women. The Department has been encouraging patients to fill out the entire MAGI application to avoid potential problems with PE.
- Income and the 5 percent disregard may not be appropriately determined in some instances. MDCH responded that the 5 percent disregard is being applied correctly, and goes to applicants whose income exceeds 133 percent of the Federal Poverty Level (FPL).
- There have been reports of some DHS offices not knowing how to handle certain issues regarding applicants' income.

Protocols – Healthy Behaviors and MIHealth Account

A public notice has been issued for the Healthy Behaviors and MIHealth Account protocols, and the Department is anticipating approval from the Centers for Medicare and Medicaid Services (CMS) by the end of August. There were several changes made as a result of comments on the draft protocols. For more information, a consultation summary containing comments and MDCH responses on the protocols has been posted to the Healthy Michigan Plan website at: www.michigan.gov/healthymichiganplan >> Healthy Michigan Plan Waiver Protocols. In addition, MIHealth account statements will be shared with focus groups to obtain feedback.

Expedited Enrollment Waiver for the Supplemental Nutritional Assistance Program (SNAP) and Parents

Approval from CMS has been granted for the Expedited Enrollment Waiver for SNAP. No timeline for implementation is yet known.

Fiscal Year (FY) 2015 Budget

Dick Miles gave an overview of the MDCH budget for FY 2015, including the expansion of the Healthy Kids Dental program to Kalamazoo and Macomb counties, the addition of $26 million to the MI Choice program, and the expansion of the Program of All-Inclusive Care for the Elderly (PACE). An appropriation for the continued Primary Care Rate increase (at about 50% of the original increase) was included, as well as for the Disproportionate Share Hospital (DSH) Pool to support OB/GYNs, and the rural hospital pool, expanded Medicaid coverage for Breast Pumps and additional money for Home Help program providers. The state law regarding the primary care rate increase restricts the increase to Pediatrics, Family Practice and Internal Medicine. An attendee asked why OB/GYNs were not included in the rate increase, and staff noted that they are still being reimbursed up to 95 percent of the Medicare rate.

Staff voiced concern about the potential impact that the recent Michigan Supreme Court ruling in *International Business Machines (IBM) v. Department of Treasury* could have on the Medicaid program, noting that the decision in favor of IBM could cost the State of Michigan more than $1 billion in tax revenue.

Steve Fitton summarized the general fund appropriation for CMH, noting that it was not spread equally throughout the State of Michigan. He also expressed concern about dual eligibles, those on spend-down, and the differences among communities. Lynda Zeller added that the Behavioral Health and Developmental Disabilities Administration (BHDDA) is working with MSA to cover beneficiaries who need mild to moderate behavioral health services immediately before they are able to enroll in a health plan. Steve noted that FY 2015 funding is potentially an issue.

Long-Term Care

MI Choice

The MI Choice Program transitioned from a FFS payment model to a capitated payment model in October 2013. As a result of this transition, the payment structure to MI Choice waiver agencies was modified to pay agencies at the highest end of the trend rate in order to accommodate individuals with significant support needs who were not transitioning out of nursing homes. Additional funding has also been allocated to ease the transition for those with significant financial needs. MI Choice waiver agencies are now classified as Prepaid Ambulatory Health Plans (PAHPs) under the new capitated payment model, which requires the waiver agencies to submit to more federal regulations.

Currently, each long-term care program has its own Level of Care Determination (LOCD), and the state is working to implement a system (part of the waiver terms and conditions) in which the LOCD is completed in a conflict-free setting. This would allow the three long-term care programs (nursing facilities, MI Choice and PACE) to use the same LOCD. Financial eligibility is different for all three programs.

Integrated Care for Dually Eligible Beneficiaries

MDCH is working to have three-way contracts in place for integrated care among CMS, Integrated Care Organizations (ICOs) and the State of Michigan by early October, in order to implement the first two pilot regions of the state by January 1, 2015. Discussion continues between the ICOs and PIHPs concerning roles and responsibilities. Staff reiterated the complexity of this project.

Home Help Audit

An audit of the Home Help program at the end of June revealed 13 findings and two material issues. The potential liability for state repayment to the federal government is about $1.5 million. It was also discovered that some Home Help providers had criminal backgrounds, though it was noted that beneficiaries are free to choose their own providers.

Two policies are currently in process to provide for criminal background checks for home help personal care service providers. A policy outlining mandatory exclusions for home help personal care service providers (e.g., Medicare fraud, elder abuse, etc.) has been issued as a final policy for implementation on September 1, 2014. A separate policy discussing permissive exclusions is to be implemented in October. This policy would allow providers convicted of certain crimes to serve as a home help aide if a beneficiary signs a consent form acknowledging awareness of the provider's criminal past.

A policy that would limit Home Help agency providers to hiring employees rather than using contract workers, and restrict family members of beneficiaries to working as individual providers rather than agency employees, is currently out for public comment. The intent of the policy changes is to protect the beneficiary but not limit access.

Managed Care Rebid – Issues to Address to Improve Contracts

There is a planned re-procurement for the Health Maintenance Organizations (HMOs) that contract with Medicaid. The Department is seeking input on what should be included in the bid and in the contracts to improve the quality of the program. Some suggestions were to include dental coverage in Managed Care Plans and improve Non-Emergency Medical Transportation (NEMT) coverage, and to standardize data collection, formularies, quality measures and reporting across all Managed Care Plans. The current contracts expire on September 30, 2015. An announcement was made about a stakeholder meeting to discuss the rebid prior to the November MCAC meeting. This procurement will be the largest in state history ($40 billion for 5 years). Awards are not expected until the end of July 2015. The Department is exploring folding the MIChild program into this bid.

Policy Updates

A policy update handout was given to each attendee.

1427-HMP – This policy discusses updates to Healthy Michigan Plan Provider policy, and is posted for public comment until August 27.

Children's Health Insurance Program (CHIP) Reauthorization

Steve Fitton voiced support for a reauthorization of CHIP. He also solicited input on budget priorities for FY 2016.

Next Meeting: November 19, 2014

Michigan Department of Community Health
MDCH
Rick Snyder, Governor
Nick Lyon, Director

Medical Services Administration

Medical Care Advisory Council

Minutes

Date: Wednesday, November 19, 2014

Time: 1:00 pm – 4:30 pm

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

Attendees: **Council Members:** Robin Reynolds, David Herbel, Jan Hudson, Marilyn Litka-Klein, Michael Vizena, Larry Wagenknecht, David Lalumia, Doug Patterson, (for Kim Sibilsky), Alison Hirschel, Cheryl Bupp, Marion Owen, Chris Rodriquez, Rebecca Blake, Andrew Farmer, April Stopczynski, Barry Cargill, Warren White, Katie Linehan (for Elan Nichols), Bill Mayer, Kim Singh, Tawana Robinson (for Kate Kohn-Parrott)

Staff: Steve Fitton, Dick Miles, Jackie Prokop, Cindy Linn, Pam Diebolt, Marie LaPres, Kathy Stiffler, Monica Kwasnik, Kim Hamilton, Debera Eggleston, Cynthia Edwards, Lynda Zeller

Attendees: Abigail Larsen

Welcome and Introductions

Jan Hudson opened the meeting and introductions were made.

ER High Utilizers Project

The draft of the Emergency Room (ER) High Utilizers report was recently issued for comment and distributed to MCAC members. Comments were due by December 3, 2014. The draft report includes the recommendations that were proposed during the ER High Utilizers Project work group that met earlier in the year. These recommendations include: creating standard definitions; developing an advisory committee regarding ER high utilizers; promoting a health information exchange; payment reform; statewide narcotic guidelines; increasing access to primary care; incentivizing providers to see patients immediately after ER visits; educating the public on proper use of the ER; and to promote care coordination. A council member also suggested the creation of guidelines for the disposal of unused narcotics by providers.

Many of the programs for ER high utilizers have been funded through grants, and MDCH has been looking into requesting permanent funding from the legislature. This issue will be included in the report that is due to the legislature December 31, 2014.

Healthy Michigan Plan

Jackie Prokop and Monica Kwasnik gave an update on the implementation of the Healthy Michigan Plan. As of November 17, 2014, the official enrollment in the Healthy Michigan Plan was reported at 459,207 beneficiaries, and enrollment has been increasing at a rate of 1,000 to 1,500 new beneficiaries per day. To bring new meeting attendees up-to-date, Jackie reviewed the eligibility requirements for the Healthy Michigan Plan.

The on-line application process for the Healthy Michigan Plan continues to run quite smoothly; those who complete an application with all information included are able to receive an eligibility determination within 10 seconds. Council members were provided with a handout of a PowerPoint presentation for additional information.

A study is underway at the University of Michigan to review access to primary care.

Eligibility Issues and Fixes

MDCH has experienced a problem with some beneficiaries were being placed into Emergency Services Only (ESO) Medicaid when the Modified Adjusted Gross Income (MAGI) application was unable to immediately verify their citizenship status, even if they did meet federal citizenship requirements. As a solution, MDCH will now grant full Medicaid benefits to applicants who indicated that they are citizens at the time of application, if a check against federal records is not able to immediately verify this information, for a period of 90 days until a final determination of their citizenship status can be made. The Department of Human Services (DHS) is currently in the process of reaching out to applicants who were incorrectly placed into ESO Medicaid in order to grant them the full Medicaid benefits for which they are eligible. Jackie encouraged meeting attendees to share any problems they see with Medicaid eligibility with MDCH so that solutions can continue to be addressed. Issues were also identified with refugees and Plan First!

Changes to Eligibility Determination System

Steve Fitton gave an update on coming changes to the Eligibility Determination System, noting that the Healthy Michigan Plan legislation requires MDCH to submit a report to the legislature by December 31, 2014 about future plans for implementing the Healthy Michigan Plan. Because the Medicaid caseload has more than doubled in the last decade, MDCH is continually looking for ways to improve service to an expanded population of beneficiaries with new technology.

MIHealth Account Statements and Payments

The first round of MIHealth account statements were sent out in mid-October to beneficiaries who were moved to the Healthy Michigan Plan from the Adult Benefits Waiver (ABW). Of these, approximately 3,400 beneficiaries are required to pay copayments. Approximately 20,000 beneficiaries are not required to contribute any payment. Copayment amounts will be recalculated every three months.

Over $5,000 in copayments has already been collected from 821 individuals. Most paid for the full quarter instead of the monthly amount due. The November statements will include those that need to pay both copayments and contributions.

Protocols – Healthy Behaviors

Monica Kwasnik shared an update on the use of Health Risk Assessments (HRAs) by Healthy Michigan Plan beneficiaries enrolled in health plans. As of November 19, 2014, MDCH had received 25,000 completed HRAs. Data collected from these HRAs will be available in future HRA reports, which are released monthly and posted to the Healthy Michigan Plan website at: www.michigan.gov/healthymichiganplan >> Health Risk Assessment. Meeting attendees were provided with a copy of the September 2014 HRA report.

Healthy Michigan Plan beneficiaries who are enrolled in a health plan may complete an HRA and have their contribution amounts reduced. Once the HRA is completed, signed by the beneficiary's Primary Care Physician (PCP) and submitted to the appropriate health plan, the beneficiary will be

eligible to have their contribution amount reduced by half if their income is between 100% and 133% of the Federal Poverty Level (FPL). Beneficiaries with an income at or below 100% of the FPL will receive a $50 gift card for completing an HRA.

The council discussed the impact of the Healthy Michigan Plan on access to primary care and dental care for beneficiaries. Despite the expanded patient population, no significant problems have been reported with new beneficiaries gaining access to a primary care physician, even though some other states reporting problems in this area. One study by the University of Michigan found that because of extensive outreach efforts, access to primary care has actually increased with the implementation of the Healthy Michigan Plan.

Due to problems reported by some dental providers, a council member suggested that many Healthy Michigan Plan beneficiaries who are able to receive dental care for the first time could benefit from education on proper etiquette for dental office visits. MDCH and the health plans currently distribute information to new beneficiaries about their rights and responsibilities in a health plan.

Second Waiver Development

The second waiver for the Healthy Michigan Plan must be submitted by September 30, 2015 and approved by December 31, 2015. Steve Fitton stressed the importance of highlighting the successes of the Healthy Michigan Plan to the incoming members of the legislature in order to ensure continued support for the direction of the program. Steve indicated that the number of people impacted will be relatively small, as the vast majority of Healthy Michigan Plan enrollees have incomes below the Federal Poverty Level.

Managed Care Rebid

Following the August 2014 MCAC meeting, a stakeholder survey for the Managed Care Rebid was administered by the Michigan State University Institute for Health Policy and distributed to 317 different groups, including the MCAC and MSA. As a result of the survey, there were four major pillars for the rebid that were identified, including population health management, pay-for-value, integration of care, and structural transformation. It was acknowledged that each of these pillars may not have a universally-accepted definition, with population health management having the greatest variation in its definition among interested parties. MDCH has been working with independent consultants to gain a better understanding of how to implement the four pillars.

A council member asked if the managed care rebid would provide an opportunity for MDCH to remove the carve-out for the integration of behavioral health and physical health services. In response, Steve assured the member that MDCH is committed to improving the integration of care between behavioral health and physical health. Discussions are ongoing for how to accomplish this goal. Kathy Stiffler added that major changes to the integration of care are needed to make the system work well.

The current Managed Care contract will expire on September 30, 2015, and the Department of Technology, Management and Budget (DTMB) is seeking a new contract effective October 1, 2015 for five years, with three optional one-year extensions. There are no plans to expand or reduce the number of health plans contracted with Managed Care, as the focus will be on having the right number of plans for each region. Health plans may be able to submit a bid for operating in part of a region rather than the whole. The number of regions for the rebid has not yet been finalized. The Request for Proposal is expected by the end of January 2015.

The results of the survey were discussed, including information on the topics that received the most comments. Several stakeholders who participated in the survey commented on the lack of access to transportation for health plan beneficiaries. MDCH staff acknowledged that transportation access is a state-wide problem in Michigan, as many health plans are unable to find vendors to transport beneficiaries. Other topics that received multiple comments on the survey include the complexity of the enrollment system process, concerns about whether there are adequate networks in place for behavioral health and the number of visits, and for greater emphasis to be placed on quality and quality reporting. Council members each received a summary of the survey results.

Medicaid Caseload Decline

Jan Hudson raised concern over the recent decline in Medicaid caseloads, mainly among children and pregnant women. In this category, enrollment has declined from almost 615,000 beneficiaries in October 2013 to 530,000 in September 2014. The possible reasons for this decline in enrollment were discussed at length.

Integrated Care for Dual Eligibles

MDCH now has contracts in place with seven Integrated Care Organizations (ICOs) for the new Integrated Care Demonstration project, called MI Health Link. These ICOs include one located in the Upper Peninsula, two in Southwestern Michigan, and six in the Southeastern region. Implementation will occur in two phases, with implementation planned for the Upper Peninsula and Southwestern Michigan in the beginning of 2015, and for Wayne and Macomb Counties later in the year.

Before implementation can occur, MDCH needs approval of 1915(b) and 1915(c) waivers for the community-based long-term care component of the program, as well as approval of 34 different letters from the Centers for Medicare and Medicaid Services (CMS) to cover multiple aspects of implementation. Additionally, MDCH needs to set up outreach and educational opportunities, ensure provider network adequacy, and take steps to comply with Medicare requirements for the program. All of the health plans have passed their readiness reviews, and MDCH has received a $12 million implementation grant to help launch the program. A council member expressed concern that funds are not being made available to educate and prepare individuals in a reasonable amount of time. Some policies are not yet in place. There are still several contracts that need to be finalized, but Dick Miles expressed encouragement that the program is moving forward.

Policy Updates

A policy handout was given to each attendee.

MSA 14-30 – This policy was issued October 9, 2014. The policy added a new Early and Periodic Screening, Diagnosis and Treatment (EPSDT) chapter in the Medicaid Provider Manual and includes the most recent American Academy of Pediatrics (AAP) Periodicity recommendations.

MSA 14-47 – This policy was issued October 31, 2014. The policy will adopt the American Academy of Pediatric Dentistry (AAPD) recommendations for Pediatric Oral Health Assessment, Preventive Services, and Anticipatory Guidance/Counseling schedule.

Member Terms/Chairperson for 2015

Jan Hudson noted several members of the MCAC whose terms were expiring at the end of 2014, and encouraged the members to indicate their interest in renewing their term via email. Jan accepted the council's nomination for another term as Chairperson.

Medicaid Enactment 50th Anniversary July 30, 2015

The council discussed ideas for commemorating the 50th anniversary of Medicaid enactment. Jan asked council members to share suggestions with her.

4:30 – Adjourn

Next Meeting: To be scheduled

Michigan Department of Community Health

Rick Snyder, Governor
Nick Lyon, Director

Medical Services Administration

Medical Care Advisory Council

Minutes

Date: Thursday, February 19, 2015

Time: 1:00 pm – 4:30 pm

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

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

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

Welcome and Introductions

Jan Hudson opened the meeting and introductions were made.

Managed Care Rebid

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

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

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

Budget

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

FY 2015 Adjustments

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

FY 2016 Executive Budget

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

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

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

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

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

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

Healthy Michigan Plan

Eligibility Issues and Fixes

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

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

Healthy Behaviors Update

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

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

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

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

Data on Utilization

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

MIHealth Account Statements and Payments

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

Second Waiver Development

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

High Emergency Room (ER) Utilizer Report

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

Integrated Care for Dual Eligibles

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

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

Behavioral Health Initiatives

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

Policy Updates

A policy handout was distributed to each attendee.

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

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

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

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

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

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

Medicaid Enactment 50th Anniversary July 30, 2015

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

4:30 – Adjourn

Next Meeting: May 4, 2015

Medical Services Administration

Medical Care Advisory Council

Minutes

Date: Tuesday, May 5, 2015

Time: 1:00 pm – 4:30 pm

Where: Michigan Health and Hospital Association Headquarters
2112 University Park Dr.
Okemos, MI

Attendees: **Council Members:** Jan Hudson, Michael Vizena, Marilyn Litka-Klein, Cheryl Bupp, Kimberly Singh, Alison Hirschel, David Herbel, Priscilla Cheever, Amy Zaagman, Linda Vail, Robin Reynolds, Marion Owen, Barry Cargill, Warren White, Rebecca Blake, Kim Sibilsky

Staff: Steve Fitton, Tim Becker, Dick Miles, Kathy Stiffler, Jackie Prokop, Susan Yontz, Marie LaPres, Cindy Linn, Pam Diebolt, Eric Kurtz, Elizabeth Hertel, Christina Severin, Leslie Asman, Sarah Slocum, Farah Hanley

Other Attendees: Tori Johnson

Welcome and Introductions

Jan opened the meeting and introductions were made. Steve Fitton also announced that he will be retiring from his position as director of the Medical Services Administration in June 2015.

Healthy Michigan Plan

Eligibility Issues and Fixes – Schedule for Fixes

The Department has implemented two of the first three planned releases in Bridges to correct systems problems related to Healthy Michigan Plan eligibility. The third release is scheduled to begin June 20, 2015, and will address the issue of parents being denied Healthy Michigan Plan coverage when they do not include dependent children on their application who already have coverage, problems with shifting beneficiaries into the Transitional Medical Assistance (TMA) program when their eligibility ends for Family Independence Program payments, and the incorrect denials of retroactive coverage for new Healthy Michigan Plan beneficiaries at the time of enrollment. The release will be issued in multiple parts, with the goal of being completed within 6-8 weeks. The first two releases in R6 primarily included Bridges, Modified Adjusted Gross Income (MAGI) and HUB system updates related to technical changes, system fixes addressing previous work around issues, account transfers, and security enhancements.

The next release is planned for September 2015, and will focus on a long-term fix for Presumptive Eligibility (PE). Since it was last discussed at the February Medical Care Advisory Council (MCAC) meeting, MDHHS has received approval from the Centers for Medicare and Medicaid Services (CMS) to offer PE to beneficiaries through the end of the month if they are subsequently found to be ineligible for coverage based on the submission of a full MAGI application. MDHHS has also received CMS approval to make changes to the eligibility criteria for the Freedom to Work program, and the needed systems changes should be included in a release in Bridges no later than September 2015.

Second Waiver Development

Public Act 107 of 2013 requires MDHHS to submit a second waiver to CMS by September 1, 2015, with approval by December 30, 2015, in order to continue to provide benefits under the Healthy Michigan Plan. As discussed at the February MCAC meeting, the second waiver would require that beneficiaries who have had Healthy Michigan Plan coverage for 48 cumulative months and have incomes over 100% of the FPL to:

- Purchase insurance from the Federally Facilitated Marketplace (FFM) and receive a subsidy, or
- Remain on the Healthy Michigan Plan and contribute a higher rate for cost-sharing.

Contribution responsibilities for beneficiaries who choose to remain in the Healthy Michigan Plan would increase from 2% of income to 3.5%, and the total cap on cost-sharing would be increased from 5% of income to 7%. In order to implement these changes, the Department has been researching several different types of waivers to use, including a Section 1115 Demonstration waiver amendment, a 1916(f) cost-sharing waiver, and a Section 1332 waiver. The Section 1332 waiver is typically tied to the health care exchanges established by the Affordable Care Act (ACA), and MDHHS is exploring its potential applications for the Healthy Michigan Plan. MDHHS staff discussed details related to the 1115 waiver amendment and the requirements of the 1332 waiver, and how they apply to the Healthy Michigan Plan. The Department has been discussing the state-mandated waiver requirements with CMS and other stakeholders, and is working toward developing waivers that can be approved. MDHHS staff once again stressed the importance of educating lawmakers on the successes of the Healthy Michigan Plan, and noted that only a very small percentage of Healthy Michigan Plan beneficiaries would be affected by the cost-sharing requirements in the second waiver, and under current law, the program would be discontinued for all enrollees if the waiver is not approved, not just those with incomes above 100% FPL. Steve also noted that no one can meet the 48 months criteria until April 1, 2018 – two years after the program would be terminated if the waiver is not approved or the Healthy Michigan Plan law is not changed.

MIHealth Account Payments

To date, 250,000 MIHealth account statements have been mailed to Healthy Michigan Plan beneficiaries who have enrolled in a health plan. MDHHS is working with Maximus to compile an executive report to simplify data from these statements, and the report is expected to be available for distribution to the MCAC soon. The Department is also working with the University of Michigan to interview beneficiaries who have received a MIHealth account statement in order to assess the need for future changes.

High Utilizer Report

The Emergency Room (ER) High Utilizer report that was discussed at the February MCAC meeting is now available on the MDHHS website at www.michigan.gov/medicaidproviders >> High Utilizers. The report details 11 recommendations to the legislature for addressing the needs of high utilizer patients in Michigan, and implementation discussions have begun.

Integrated Care for Dual Eligibles (MI Health Link)

MI Health Link has now been implemented in each of the first four demonstration regions (Upper Peninsula, Southwest Michigan, Macomb County and Wayne County). Voluntary enrollment across all four regions totaled 1,144 beneficiaries as of May 4, 2015, while approximately 8,500 beneficiaries have been passively enrolled in the Upper Peninsula and Southwest Michigan as of May 1, 2015. Approximately 18,000 individuals have opted out of MI Health Link enrollment since February. MDHHS currently has contracts in place with seven health plans to provide benefits under the MI Health Link Program, including the Upper Peninsula Health Plan (UPHP), Meridian Health Plan, Aetna Better Health of Michigan, AmeriHealth Michigan, Fidelis SecureCare of Michigan, Molina Healthcare, and HAP Midwest Health Plan.

MDHHS has engaged in numerous outreach activities to promote the MI Health Link program, including provider webinars, conferences, informational forums, and beneficiary letters to provide information about MI Health Link to individuals who may not have other opportunities to learn about the program. Many third-party organizations and the health plans are also engaging in outreach on behalf of the Department. Attendees were invited to email integratedcare@michigan.gov with any comments or questions related to the MI Health Link program, and also visit www.michigan.gov/mihealthlink for additional information.

In addition to implementing MI Health Link, MDHHS has also opened new Program of All-Inclusive Care for the Elderly (PACE) organizations in Saginaw and Lansing, with several more planned in the near future.

Managed Care Rebid

Kathy Stiffler gave an update on the Managed Care rebid, announcing that the Request for Proposal (RFP) is on track to be released by May 8, 2015, with bids to be due in early August. Two bid meetings are planned following the release of the RFP, and questions and answers from these meetings will become an official part of the bid. Additionally, the council was provided with a progress report on the following items that were discussed at the February MCAC meeting:

- The conversion of MIChild, Michigan's Children's Health Insurance Program (CHIP), from a stand-alone program to a Medicaid expansion program is planned for January 1, 2016, but could possibly be delayed pending CMS approval of a Section 1115 waiver and systems changes in CHAMPS and Bridges.
- Pharmacy benefits will remain part of the Medicaid Health Plan (MHP) benefit package, but all MHPs will be required to use a common formulary and the same administrative rules for pharmacy services.
- In order to improve access and to provide more comprehensive care for all Medicaid Fee-for-Service and MHP beneficiaries, MDHHS plans to issue a separate RFP specific to dental benefits to provide improved access to all Medicaid beneficiaries, not just those enrolled in a health plan.

FY 2016 Budget

Discussions for both the Michigan Department of Community Health (MDCH) and Department of Human Services (DHS) budgets are now in the conference workgroup negotiation stage, and meetings among MDHHS staff, the State Budget Office, and legislators are scheduled for the week of May 11, 2015 to discuss Medicaid funding and caseload projections. The Revenue Estimating Conference is scheduled to take place on Friday, May 15, 2015. Projected revenue to fund the FY 2016 department budgets will be agreed upon as will the caseloads to be funded.

MDHHS staff noted several spending reductions in the legislature's version of the budget, including a $14 million reduction in General Fund (GF) appropriation for the Mental Health and Wellness Commission, to be replaced with money from the Michigan Health Endowment Fund, $3 million in GF reduction for MDHHS administration associated with the merger of MDCH and DHS, and several county office closures. Staff also reported that the proposed increase in the Health Insurance Claims Assessment (HICA) tax from 0.75% to 1.3% that was included in the Executive Budget Recommendation did not receive approval from the legislature, which created a budget shortfall of approximately $180 million in State GF or $540 million in program expenditures when federal funds are included.

The legislature also approved increases in funding for certain program areas, including an increase in actuarial soundness for the Prepaid Inpatient Health Plans (PIHPs) of 1.5% and a 2% increase for the MHPs, and an increase of $20 million for Community Mental Health (CMH) non-Medicaid services. The primary care rate adjustment that was implemented on January 1, 2015 was annualized, and was also approved by both chambers. The House of Representatives approved funding for an expansion of ***Healthy Kids Dental*** into Kent County, Oakland County, and Wayne County for children up to the age of 9, while the Senate proposal offered coverage to all children with an effective date of July 1, 2016. The House and Senate also offered different proposals for improving access to Medicaid adult dental coverage in the fourth quarter of FY 2016. The legislature rejected the proposed changes and reductions in hospital financing related to graduate medical education, small and rural hospital adjustor and the OB/GYN special payment to rural hospitals.

Approximately $100 million gross in managed care savings was identified among three program areas, including $54.5 million in savings by implementing a common formulary for pharmacy benefits, $15 million in savings from the new Medicaid RFP for three quarters, and $31.8 million in savings assumed by moving all MHP laboratory rates to Medicaid Fee-for-Service rates. Significant savings were also realized through a projected decline in Medicaid caseloads in FY 2015 and continued in FY 2016.

CHIP Extension

Steve Fitton reported that CHIP funding was extended with a federal match rate of approximately 98% in FY 2016, but the primary care rate increase for CHIP was not approved.

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

On April 10, 2015, Executive Order 2015-4 became effective to create MDHHS by merging MDCH and DHS. A revised budget proposal was submitted to the legislature to combine the MDCH and DHS budgets following the merger, totaling approximately $24 billion, nearly 46% of the state budget. No additional staffing reductions or other savings were proposed as a direct result of the creation of MDHHS; staff indicated that a main goal of the merger is to facilitate a more efficient delivery of services to Michigan citizens.

Eight guiding principles for the new department were also outlined, including treating a person as a whole person, delivering services in a smarter way with less fragmentation, supporting dignity in all stages of life, improving outcomes through integration and coordination, interrupting generational poverty and supporting self-sufficiency of those who are able, ensuring the safety, well-being and permanence of children in the State's care, ensuring the safety and wellness of vulnerable adults and the elderly, and improving the health of Michigan citizens in a cost-effective manner. A handout of the new organization chart for MDHHS was provided to meeting attendees, and several areas were discussed.

Council members expressed concern about issues related to non-emergency medical transportation. Tim Becker requested specific examples of transportation issues.

Jan Hudson invited meeting attendees to share any problems they encounter related to services being combined in MDHHS, as well as any proposed solutions, with herself or Tim Becker. If emailing Tim Becker, attendees were reminded to also copy his assistant, Patricia Ray.

State Implementation Model (SIM) Grant Implementation

MDHHS has started the assessments for both the Accountable Systems of Care capacity, which closed on May 4, 2015, and the Community Health Innovation Region Assessment, which will close on May 11, 2015. Once all assessments have closed, the Department will begin identifying which responses are possible to follow up on and begin scheduling site visits with respondents. The results from the assessments will be used to make decisions about where to start piloting the SIM Grant in Michigan. The State has received $70 million from the federal government for SIM Grant implementation over the next 4 years. The FY 2016 recommendation includes $20 million for the project. The current focus includes: payers, doctors and hospitals; who can/will become Accountable Care Organizations; and high users of services.

Consolidation of 1915B&C Waivers to 1115 Waiver

The Medicaid Managed Specialty Service System covers persons with substance use disorders, severe mental illnesses, intellectual and developmental disabilities, and children with serious emotional disturbances. The program operates under five different waivers, including three 1915(c) waivers for the habilitation support for persons with developmental disabilities, the Serious Emotional Disturbances Waiver (SEDW) and Children's Waiver Program, a 1915(i) autism waiver, and a 1915(b) waiver. MDHHS is exploring several options for consolidating these waivers, including using a section 1115 waiver or a combination of a section 1115 and 1915(i) waiver. Moving the system onto a single Section 1115 waiver would allow the system to maintain the Managed Care delivery system that is currently offered. CMS encouraged the use of a 1915(i) waiver, but it would impose an income limitation of 150% of the FPL for beneficiaries in the waiver program. All of the current waivers for the Behavioral Health and Developmental Disabilities Medicaid Managed Specialty Service System are tied together under the 1915(b) waiver, which will expire on December 31, 2015.

Policy Updates

A policy bulletin update handout was distributed to meeting attendees, and several bulletins were highlighted.

Medicaid Enactment 50th Anniversary July 30, 2015

Jan Hudson reviewed the list of individuals who volunteered in February to serve on a committee to plan events commemorating the 50th anniversary of Medicaid enactment, and also invited others present to participate.

4:30 – Adjourn

Next Meeting: August 12, 2015

Michigan Department of Health and Human Services
Medical Services Administration

Medical Care Advisory Council

Minutes

Date: Wednesday, August 12, 2015

Time: 1:00 pm – 4:30 pm

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

Attendees: **Council Members:** Jan Hudson, Kim Sibilsky, Bill Mayer, Marion Owen, David Lalumia, Cheryl Bupp, April Stopczynski, Elmer Cerano, Pam Lupo, Warren White, Rebecca Blake, Kimberly Singh, Katie Linehan, Robin Reynolds, Marilyn Litka-Klein, Barry Cargill, Alison Hirschel, Andrew Farmer, Mark Swan (for Cindy Schnetzler), Larry Wagenknecht

Staff: Kathy Stiffler, Dick Miles, Jackie Prokop, Lynda Zeller, Farah Hanley, Erin Emerson, Marie LaPres, Pam Diebolt, Cindy Linn, Sarah Slocum, Priscilla Cheever, Carrie Waggoner, Leslie Asman, Robert Hovenkamp, Abbey Babb, Christina Severin

Other Attendees: Denise Cushaney

Welcome and Introductions

Jan Hudson opened the meeting and introductions were made. Members of the planning committee for the Medicaid 50th Anniversary Celebration that took place on July 30, 2015 were recognized, and handouts from the event were made available for those who were unable to attend.

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

The Michigan Department of Health and Human Services (MDHHS) budget for FY 2016 is now in place. Several provisions affecting the Medicaid program were discussed, including an adjustment for actuarial soundness to keep Health Maintenance Organizations (HMOs) operational as they cover 75% of the Medicaid population, an adjustment for Prepaid Inpatient Health Plans (PIHPs), funding for an expansion of the ***Healthy Kids Dental*** program to cover children in Wayne, Oakland and Macomb counties up to the age of 13, and funding for a new psychiatric residential treatment wing of the Hawthorn Center for one quarter. In addition, an appropriation was included for an expansion of Program of All-Inclusive Care for the Elderly (PACE) programs, as well as for full funding for the Healthy Michigan Plan for FY 2015 and FY 2016. MDHHS staff also reported the closure of the W.J. Maxey Boys Training Center and several county MDHHS offices, but noted that no staff layoffs will result from the county office closures. Staff will be reassigned to other locations.

A council member expressed concern about cuts to Community Mental Health (CMH) services. In response, MDHHS staff reported that the Department received a $20 million supplemental appropriation to recognize unmet needs in FY 2015 and FY 2016.

In FY 2017, MDHHS anticipates additional GF needs of approximately $420 million, which includes over $100 million required in General Fund (GF) matching funds for the Healthy Michigan Plan, an anticipated $120 million shortfall if the legislature declines approval of an increase in the Health Insurance Claims Assessment (HICA) tax, as well as the expiration of the use tax, which brings in about $200 million per year, but ends on December 31, 2016.

Adult Dental Remains Fee-for-Service (FFS)

Kathy Stiffler reported that the Legislature did not approve funding to include adult dental benefits in the Managed Care Rebid. The MHPs are currently only required to cover adult dental benefits for the Healthy Michigan Plan population. Adult dental benefits for non-Healthy Michigan Plan Medicaid beneficiaries remain a FFS benefit.

Medicaid Director Search

The MCAC was informed that MDHHS has not yet named a new director for the Medical Services Administration (MSA), and that Kathy Stiffler will continue to serve as acting director until the position is filled.

Healthy Michigan Plan

Second Waiver Development/Progress

MDHHS staff discussed the details of Public Act 107 of 2013 requirements as they relate to the waiver amendment. MDHHS released a concept paper regarding the second waiver for the Healthy Michigan Plan on May 27, 2015, which is available on the MDHHS website at www.michigan.gov/healthymichiganplan >> Healthy Michigan Plan Second Waiver Document(s) and Public Hearing Information. A public hearing was also held on June 24, 2015 to discuss the waiver, which must be submitted to the Centers for Medicare and Medicaid Services (CMS) by September 1, 2015 and approved by December 31, 2015 for the Healthy Michigan Plan to continue. The Department has received many positive comments in response to the concept paper and public hearing, and council members were encouraged to continue to share their comments with MDHHS once the waiver is submitted to CMS for approval. Discussions between MDHHS and CMS regarding the second waiver have been productive throughout the waiver development process, and MDHHS believes that the requirements of the law can be met through a Section 1115 waiver. If an additional waiver is needed to meet the requirements of the law, the Department will also consider submitting a Section 1332 waiver for approval.

The waiver would require beneficiaries who have been enrolled in the Healthy Michigan Plan for 48 cumulative months and have incomes between 100% and 133% of the Federal Poverty Level (FPL) for each of the 48 months to:

- Leave the Healthy Michigan Plan and receive a subsidy to purchase health insurance from the Federally Facilitated Marketplace (FFM); or
- Remain on the Healthy Michigan Plan and pay a larger portion of their income toward cost-sharing and contributions.

MDHHS anticipates that the increased cost-sharing requirements of the second waiver will affect only a subset of the 100,000 beneficiaries with incomes greater than 100% FPL out of approximately 600,000 currently enrolled. If the second waiver is not approved, State law requires that the Healthy Michigan Plan must end on April 30, 2016, even though April 1, 2018 is the earliest date that any beneficiary can reach 48 cumulative months of enrollment. Jan Hudson noted that other states, such as Iowa and Arkansas, have received approval from CMS to implement hardship waivers for Medicaid beneficiaries who have difficulty meeting cost-sharing obligations, and encouraged MDHHS to consider seeking such a waiver as well.

Eligibility Issues and Fixes

Jackie Prokop provided attendees with an update regarding the Medicaid eligibility issues that were discussed at the May 2015 MCAC meeting, including parents who were denied Healthy Michigan Plan coverage when they did not include dependent children on their application, problems with shifting beneficiaries into the Transitional Medical Assistance (TMA) program when their eligibility ends for Family Independence program payments, and the incorrect denials of retroactive coverage for Healthy Michigan Plan beneficiaries at the time of enrollment. MDHHS implemented a release in Bridges to fix these issues, and began to re-process Medicaid applications for affected beneficiaries the weekend of August 8-9. Reprocessing is expected to be completed in September.

Each beneficiary affected by reprocessing will receive a letter from MDHHS as Bridges corrects his/her file. In response to an inquiry from the council, MDHHS staff noted that regardless of a beneficiary's current enrollment status in a Medicaid Health Plan (MHP), claims for services provided during the beneficiary's retroactive eligibility period will be processed through the Medicaid FFS system. All providers will also receive a letter containing information regarding the reprocessing efforts, and what to expect if a beneficiary for whom they provided services is granted retroactive eligibility upon reprocessing. Jan Hudson requested that the MCAC receive a copy of the provider letter when it is distributed.

MI Health Account Payments

Kathy Stiffler reported that MDHHS is currently working with MHPs and Maximus to develop an executive report containing information about MI Health Account payments. A draft report has been completed, and MDHHS plans to have a final report ready to publish on the MDHHS website within a month following the MCAC meeting. A council member sought clarification about who a beneficiary should contact if they have questions regarding their MI Health Account statement. In response, MDHHS staff explained that if a beneficiary's income changed since their previous statement, they should contact their MDHHS caseworker to make the adjustment to their case. Other questions regarding MI Health Account statements should be directed to Maximus or the Beneficiary Help Line.

The MCAC was provided with statistics from the draft version of the Executive Report regarding the payment rate of contributions owed from beneficiaries by cohort, and council members were reminded that beneficiaries can reduce the contribution amount that they owe by completing a Health Risk Assessment (HRA) and choosing one or more healthy behaviors to address. MDHHS will not reduce contribution amounts for beneficiaries who complete an HRA unless they choose to engage in one or more healthy behaviors. An HRA report is published monthly on the MDHHS website at www.michigan.gov/healthymichiganplan >> Health Risk Assessment.

As of July 2015, about $1.5 million had been collected. It is important to note that the Healthy Michigan Plan is a new program and MIHealth account billings are a totally new process for everyone. In addition, the University of Michigan, as part of their evaluation, is conducting focus groups of beneficiaries to determine the level of beneficiary understanding and obtain comments on the statements.

Managed Care Rebid

MDHHS issued a Request for Proposal (RFP) for a new managed care contract on May 8, 2015, and bids from MHPs were due on August 3, 2015. The new contracts will begin on January 1, 2016, while the current contracts have been extended through December 31, 2015. The first contract year will run for nine months to get back on the state fiscal year schedule.

Common Formulary Development

At the May 2015 MCAC meeting, it was announced that pharmacy benefits would remain part of the MHP benefit package and that pharmacies would be required to use a common formulary and the same administrative rules for pharmacy services. A draft version of the MHP common formulary was released for public comment on August 4, 2015 with proposed Medicaid policy 1540-Pharmacy, and comments are due on September 8, 2015. MDHHS plans to publish the final version of the MHP common formulary on January 1, 2016. MHPs will then integrate the common formulary in their claims system and will begin transitioning members' drug therapies to the common formulary starting April 1, 2016, with an expected completion date of September 30, 2016. A stakeholder meeting was held on August 11, 2015 to discuss the common formulary, and MDHHS received several comments, including concerns about coverage for the drugs that remain carved out of the MHP benefit package. In response, MDHHS staff clarified that the individual drugs that remain carved out of the MHP benefit package will be covered through Medicaid FFS. An additional stakeholder meeting is scheduled for November 19, 2015 to present the final version of the common formulary and take questions.

Integrated Care for Dual Eligibles (MI Health Link)

Dick Miles gave an update on the MI Health Link demonstration, reporting that it became operational in March 2015, and currently serves approximately 35,000 beneficiaries among the four demonstration regions (Upper Peninsula, Southwest Michigan, Macomb County and Wayne County). A majority of beneficiaries are passively enrolled, and 40 to 50 percent of passive enrollees typically opt out of the program. After the final phase of the program's implementation in the four demonstration regions is complete at the end of September 2015, it is anticipated that 50,000 or more beneficiaries will be enrolled in MI Health Link.

MDHHS has experienced some problems with MI Health Link implementation that it is working to resolve, which include:

- Many MHPs reported that they were not receiving payment from MDHHS for services provided to MI Health Link beneficiaries.
- The Department has found eligibility inconsistencies in the Medicaid and Medicare files for some beneficiaries.
- Problems with billing Medicare and Medicaid claims from Mental Health providers who previously did not participate with both programs have also been experienced.
- Guardianship issues continue and are being worked on to resolve.

CMS has also granted MDHHS the option to send in a letter of support for extending the MI Health Link Demonstration by an additional two years. The letter would be non-binding, but extending the MI Health Link Demonstration would provide for its operation through 2020 and allow a more valid evaluation.

Dick also announced that Susan Yontz will be retiring from her position as director of the Integrated Care Division at the end of August 2015.

Merger of the Michigan Department of Community Health (MDCH) and the Department of Human Services (DHS) – Issues

At the May 2015 MCAC meeting, Tim Becker and Jan Hudson invited the MCAC members to share comments with them regarding any issues related to the merger of MDCH and DHS; problems with access to Non-Emergency Medical Transportation (NEMT) were raised. Jan again asked meeting attendees to share their concerns, and in response, several council members reported instances of beneficiaries who have experienced long wait times or who have difficulty receiving transportation services, particularly in the Metropolitan Detroit area. Also reported were caseworker denials for services indicating there are no funds for transportation. Kathy Stiffler observed there are not sufficient, reliable providers statewide. Several suggestions for addressing these problems were discussed, including providing for an exemption to the Limousine Act for personal care services providers to allow them to transport patients to medical appointments.

Implementation of Home Help Program Changes

The Medicaid Home Help program provides services to qualified beneficiaries who need assistance with activities of daily living. The program currently serves approximately 55,000 beneficiaries with an equal number of providers. An audit of the Home Help program in June 2014 revealed several areas of concern, including discrepancies between provider logs submitted and the services that were provided, and enrolled providers with criminal backgrounds. MDHHS has implemented several changes to the program to address these issues, including moving to an Electronic Services Verification (ESV) system within the Community Health Automated Medicaid Processing System (CHAMPS) for the submission of provider logs, which requires individual home help providers to enroll in CHAMPS, and the Department now conducts criminal background checks on all current and prospective individual home help providers. A parallel paper services verification system was also put into place for providers who meet certain criteria.

Per bulletin MSA 15-06, the ESV system was implemented on June 1, 2015, but due to problems with some providers having difficulty accessing the system, MDHHS has decided to delay negative action toward providers who are unable to submit provider logs via ESV while the issues are addressed. Critical decisions must be made on electronic verification. MDHHS has also issued bulletin MSA 14-40, which allows beneficiaries to sign a consent form in order to continue working with providers who have been convicted of certain types of crimes. Providers convicted of crimes such as Medicare or Medicaid fraud, patient abuse, etc., are ineligible to participate in the program, per bulletin MSA 14-31.

Behavioral Health Initiatives

Lynda Zeller acknowledged that there are pockets of the state where service and service delivery are issues. Some regions are doing really impressive work, particularly around the coordination of physical and behavioral health services.

MDHHS is working to implement several new projects related to behavioral health, including:

- The Department has applied for a planning grant to set up Certified Community Behavioral Health Clinics (CCBHCs). If selected for planning grant money, Michigan would be able to set up a prospective payment system for behavioral health clinics that take on additional responsibility, such as for physical health. Eight states will be selected to receive the planning grant from the federal government. The grant would allow for up to 10 CCBHCs to be established in Michigan.
- MDHHS currently provides Specialty Managed Care Services under section 1915(b) and 1915(c) waiver authorities. Under the section 1915(b) waiver, MDHHS is able to provide wraparound services to individuals in their homes or work places, rather than in an institutional setting. Due to cost-effectiveness issues with the current 1915(b) waiver services, MDHHS is in the process of exploring other waiver options to continue providing these services, including a section 1115 waiver or a 1915(i) waiver. No cuts to services or eligibility are planned as a result of this change.
- While the Healthy Michigan Plan has greatly increased access to behavioral health services for its 600,000 beneficiaries, nine out of ten Prepaid Inpatient Health Plans (PIHPs) were found to have been serving a much lower percentage of this population than MDHHS anticipated. The Department is working to identify barriers that might prevent beneficiaries from accessing these services. In addition, funding to serve those eligible for Medicare and Medicaid and spend-down individuals continues to be a challenge.
- A State Medicaid Directors letter was issued to discuss ways to strengthen Substance Use Disorder (SUD) services, including the use of the Innovation Accelerator Program (IAP) to identify coverage gaps that currently exist within states. MDHHS is scheduled for a conference call with CMS on Friday, August 14 to discuss the IAP. Governor Snyder has also created The Prescription Drug and Opioid Abuse task force to discuss SUD services, which meets weekly. A list of recommendations for SUD treatment services developed by the task force is expected to be released in the fall.
- Lynda clarified that the uniform consent form for SUD services needs to be signed by a clinician from each provider with an active relationship with a beneficiary to be valid. It does not provide for an automated gateway for providers to share information among each other.
- The Behavioral Health and Developmental Disabilities Administration (BHDDA) is also working with MSA on the Defending Childhood Initiative, which is focused on early intervention and prevention of trauma in early childhood.
- Michigan has been selected to be part of the National Governor's Association task force on high users of emergency room services. As a component of the project, the Department is looking for options/opportunities to implement recommendations from Michigan's report *Recommendations for Addressing the Needs of High Utilizer/Super Utilizer Patients in Michigan.*

Policy Updates

A policy bulletin update handout was distributed to each attendee, and several policy changes were discussed.

Chairperson and Consumer Representation for 2016

MDHHS requested a consumer representative(s) be added to the MCAC in 2016, and the council discussed outreach ideas to find the right individual(s) to fill the role. Jan also announced that she will be retiring in early 2016, and asked the council to begin considering candidates to fill the MCAC Chair position.

4:30 – Adjourn

Next Meeting: November 18, 2015

Michigan Department of Health and Human Services
Medical Services Administration

Medical Care Advisory Council

Minutes

Date: Wednesday, November 18, 2015

Time: 1:00 pm – 4:30 pm

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

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

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

Other Attendees: Mark Swan, Betsy Wile

Welcome and Introductions

Jan Hudson opened the meeting and introductions were made.

Welcome back to Chris Priest, Medicaid Director

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

State Innovation Model (SIM) Update

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

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

Healthy Michigan Plan

Waiver Amendment Progress

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

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

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

MIHealth Account Report

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

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

U of M Evaluation of MIHealth Account Statements

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

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

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

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

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

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

Specialty Drugs

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

Managed Care Rebid

Recommendations for Contract Awards

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

Common Formulary Update

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

Quality Strategy

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

MIChild Conversion

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

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

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

Integrated Care for Dual Eligibles (MI Health Link)

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

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

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

Implementation of Home Help Program Changes

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

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

Behavioral Health Issues

Certified Community Behavioral Health Clinics (CCBHCs)

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

Common Consent Form

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

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

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

Policy Updates

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

Chairperson and Consumer Representation for 2016

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

4:30 – Adjourn

Next Meeting: February 29, 2016

Michigan Department of Health and Human Services
Medical Services Administration

Medical Care Advisory Council

Minutes

Date: Monday, February 29, 2016

Time: 1:00 pm – 4:30 pm

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

Attendees: **Council Members:** Robin Reynolds, Karlene Ketola, Cheryl Bupp, Marie DeFer, Warren White, Cindy Schnetzler, Jan Hudson, Barry Cargill, Marion Owen, Alison Hirschel, Marilyn Litka-Klein, Robert Sheehan, Amy Zaagman, Elmer Cerano, Linda Vail, Rebecca Blake, Mark Klammer, Kimberly Singh, Dave Lalumia, Andrew Farmer, Eric Roath, Susan Yontz, (for Dave Herbel), William Mayer, April Stopczynski, Lydia Starrs (for Rebecca Cienki)

Staff: Chris Priest, Dick Miles, Kathy Stiffler, Lynda Zeller, Farah Hanley, Jackie Prokop, Brian Keisling, Erin Emerson, Pamela Diebolt, Cindy Linn, Michelle Best, Logan Dreasky

Other Attendees: Marc Arnold, Dominic Pallone

Welcome and Introductions

Robin Reynolds opened the meeting and introductions were made.

Update on Flint

The Michigan Department of Health and Human Services (MDHHS) has submitted a waiver request to the Centers for Medicare and Medicaid Services (CMS) to address issues related to the Flint water crisis. Pending CMS approval, MDHHS will:

- Expand Medicaid eligibility to children up to age 21 and pregnant woman who;
  - Are served by the Flint water system or were served by the Flint water system between April 2014 and the date on which the Flint water system is deemed safe by the appropriate authorities, AND
  - Have household incomes up to 400 percent of the federal poverty level (FPL). Individuals up to age 21 and pregnant women with household income above 400 percent FPL can buy in to unsubsidized coverage under the program.
- Establish a targeted case management group and services for children up to age 21 and pregnant women as described above.
- Utilize Medicaid resources for lead abatement in Flint.

The waiver documents are available on the MDHHS website at www.michigan.gov/mdhhs >> Section 1115 Waiver – Expanded Medicaid Eligibility for Flint Residents. Individuals may submit comments related to the waiver to MSAPolicy@michigan.gov until March 17, 2016. MDHHS expects that up to 15,000 individuals will be newly eligible for Medicaid coverage under the waiver, and is working with its health plan partners in the area on testing and outreach to vulnerable populations.

A council member requested that MDHHS consider submitting a State Plan Amendment to expand Children's Health Insurance Program (CHIP) coverage to lawfully present immigrant children and pregnant women in the Flint area who have resided in the United States for less than five years.

Healthy Michigan Plan

Waiver Approval

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

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

Copayment and cost-sharing obligations for beneficiaries who elect to leave the Healthy Michigan Plan and receive insurance through the FFM will remain the same; however, they will only be eligible for reductions in their copayment and cost-sharing requirements if they remain on the Healthy Michigan Plan and choose to engage in one or more healthy behaviors. Wraparound services will be available to Healthy Michigan Plan beneficiaries who purchase coverage on the FFM through Medicaid Fee-for-Service. MDHHS must also seek approval for revised Healthy Behavior Protocols from CMS.

As discussed at the Medical Care Advisory Council (MCAC) meeting in November, Kathy Stiffler announced that MDHHS intends to distribute a Provider Satisfaction Survey for providers who actively participate with the Medicaid Health Plans in the spring of 2016.

A meeting attendee also requested that MDHHS allow beneficiaries to submit their own documentation related to the HRA and Healthy Behavior attestations instead of relying on the Medicaid Health Plans (MHPs).

FY2017 Executive Budget Recommendation

Budget Recommendation

The Governor recommended an appropriation of $24.7 billion gross and $4.4 billion General Fund (GF) for MDHHS in FY 2017, which accounts for an expected decline in traditional Medicaid caseload in FY 2017. Other highlights of the Executive Budget Recommendation include:

- $26.3 million in spending to reflect cost increases driven by a new policy that expands autism coverage for children up to age 21
- $118 million in spending for a 2% actuarial soundness rate increase for Medicaid Health Maintenance Organizations (HMOs) and a 1.5% increase for Prepaid Inpatient Health Plans (PIHPs)
- Approximately $105 million in GF savings anticipated in FY 2017, FY 2018 and FY 2019 from the Healthy Michigan Plan hospital provider tax payments
- $58 million revenue adjustment from the anticipated discontinuation of the use tax on December 31, 2016 and corresponding increase in the Health Insurance Claims Assessment (HICA) tax from 0.75% to 1%
- $7.6 million to support opening a wing at the Center for Forensic Psychiatry in Ypsilanti to treat an additional 30 patients
- Approximately $50 million Gross and $4.9 million GF Information Technology (IT) funding for the Integrated Services Delivery (ISD) Model
- $7.7 million GF for the Michigan State Automated Child Welfare System (MiSACWS)
- $26 million Gross and $9 million GF to expand the ***Healthy Kids Dental*** program in Wayne, Oakland and Macomb Counties to cover children up to age 21
- $5.2 million reduction for the counties related to services for foster care due to the implementation of a county cost-sharing requirement
- $4.7 million Gross and $1 million GF to expand the current supplemental for food-related resources in Flint, including $150,000 for food inspection costs

- $1.1 million to support Child and Adolescent Health Centers in Flint, including 6 additional Pathways to Potential Community Health Workers (CHWs)
- $7 million Gross and $5 million GF for behavioral health services in Flint
- $1.5 million Gross and $1 million GF for additional lead investigations
- $2.2 million GF supplemental appropriation for Flint

In response to an inquiry regarding the proposed IT funding for the ISD model, MDHHS staff noted that the Department intends to streamline service delivery into a single system, and that existing systems are not being replaced.

A meeting attendee also asked whether additional funds will be made available to assist adults who have been exposed to lead in Flint. In response, MDHHS staff noted that most funds appropriated in response to the Flint water crisis are not age-specific, such as supplemental Community Mental Health (CMH) funding, and Local Health Department (LHD) funds for blood lead testing.

Specialty Drugs

The legislature has approved a supplemental appropriation of $164 million Gross and $46 million GF in FY 2016 for coverage of a new hepatitis C drug, and the Governor has requested an additional $164 million Gross and $45 million GF for continued coverage in FY 2017. MDHHS is expecting that approximately 7,200 beneficiaries will qualify for the medication. In addition, the Governor has requested $66.3 million Gross and $44 million GF for coverage of a new cystic fibrosis medication. Both medications are expected to become available on March 1, 2016.

Impact of Minimum Wage Increase

Farah Hanley reported that the Governor has requested funding for an adult home help provider wage increase in FY 2017. No funding has been requested at this time for a wage increase for direct care workers, though the Department has discussed the issue with the legislature.

Integration of Behavioral Health and Physical Health Boilerplate

The Michigan House of Representatives has held hearings to discuss section 298 of the FY 2017 Executive Budget Bill, which would require MDHHS to transfer funds currently provided to Prepaid Inpatient Health Plans (PIHPs) through the Medicaid mental health services, Medicaid substance use disorder services, and Healthy Michigan Plan – behavioral health and autism services lines to the Health Plan services line by September 30, 2017. The consensus is that while people believe there is a great opportunity to discuss whether the current system of integrating behavioral health and physical health is best organized to provide the best outcomes for beneficiaries, there are concerns about language that moves PIHPs and MHPs together. A workgroup has been called by the Lieutenant Governor, which is currently in the process of conducting a call for facts related to the proposed transfer of funds. Lynda Zeller encouraged the MCAC to share facts with her at zellerl2@michigan.gov. A meeting attendee requested that the workgroup consider incarcerated individuals who develop behavioral health issues that were not present prior to imprisonment.

Behavioral Health Updates

Certified Community Behavioral Health Clinics (CCBHCs)

Michigan has been selected for a planning grant to establish CCHBCs, which provide more comprehensive care than Community Mental Health Services Programs (CMHSPs). In order to be chosen as one of the eight states to receive final demonstration grants, MDHHS must submit a final application by October 31, 2016. A request for certification will be sent to clinics eligible to become CCBHCs in Mid-March, and the Department will choose the 10 applicants that present the best opportunity for success in the demonstration. MDHHS must complete all prospective CCHBC site visits by July 2016.

Managed Care

Implementation of Rebid

Kathy Stiffler provided an update on the implementation of new MHP contracts, which became effective on January 1, 2016. MDHHS is continuing to work to develop resources to define MHP expectations in several areas, including coverage of Targeted Case Management (TCM) services for children with elevated blood lead levels. The new contract also includes plans to move coverage of Maternal Infant Health Program (MIHP) services into the MHPs effective October 1, 2016. Kathy noted that that some MHPs have changed service areas as a result of the rebid, and offered to share a map of areas covered by each MHP with the MCAC (see attached map).

Common RX Formulary

MDHHS is working to implement a common drug formulary for all MHPs, and is on track to begin communications with beneficiaries regarding the transition on April 1, 2016 and complete the transition by October 1, 2016. The Department will provide an opportunity for interested stakeholders to submit comments related to the Common Formulary once each quarter.

Eligibility Redetermination Letter

MDHHS staff and meeting attendees discussed ongoing issues with the Medicaid eligibility redetermination process, including inconsistencies in the process among different areas, and beneficiaries with no change in income or assets being denied coverage upon redetermination. As a possible solution to this problem, a meeting attendee requested that MDHHS implement a simplified redetermination process for beneficiaries with no change in circumstances. Attendees also discussed the need for improved coordination among MDHHS and the MHPs for communication with beneficiaries regarding the redetermination process.

Since MI Health Link enrollees who lose eligibility upon redetermination may only be passively enrolled into an Integrated Care Organization (ICO) once per calendar year, MDHHS staff discussed the possibility of requiring ICOs to continue to provide coverage for these individuals for up to 90 days following redetermination. The Department also plans to issue a policy to allow a beneficiary to keep their case open while working through the redetermination process in both Modified Adjusted Gross Income (MAGI) and Supplemental Security Income (SSI) groups, as part of a systems release in June 2016. MDHHS staff and meeting attendees also discussed several ideas for improving the redetermination process, including the possibility of temporarily suspending redetermination while systems problems are addressed, the feasibility of using IRS tax returns for eligibility redeterminations and simplifying beneficiary notices and forms.

Long-Term Care Services and Supports Updates

MI Health Link

Dick Miles provided an update on the MI Health Link Program, and noted that enrollment is a concern. At the end of the passive enrollment period in September, total enrollment in MI Health Link included 42,500 beneficiaries, and has since declined to 32,800. In addition to the issues related to eligibility redeterminations experienced by many Medicaid programs, MI Health Link is also experiencing problems with enrollment discrepancies and systems glitches that MDHHS is working to resolve. Dick also shared that marketing will be a priority for the MI Health Link program in the future, in order to encourage more individuals to voluntarily enroll.

Nursing Home Transition

The State of Michigan was awarded a grant in 2009 to help with nursing home transitions, called "*Money Follows the Person*", and has since used those funds to transition 3,000 individuals. However, due to a recent reduction in funding by the federal government, MDHHS is currently in the process of developing a plan to reduce the size of the program.

Level of Care Determination (LOCD)

MDHHS is currently considering the conflict-free LOCD, and has received funds for the project as part of the implementation grant for MI Health Link. However, some waiver agencies have expressed concern about how the new system will impact their processes. No successful bidders were received after the Department issued a Request for Proposal (RFP) for conflict-free LOCDs in the fall of 2015. MDHHS is in the process of working with CMS to determine CMS's legal authority for the conflict free LOCD mandate.

Policy Updates

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

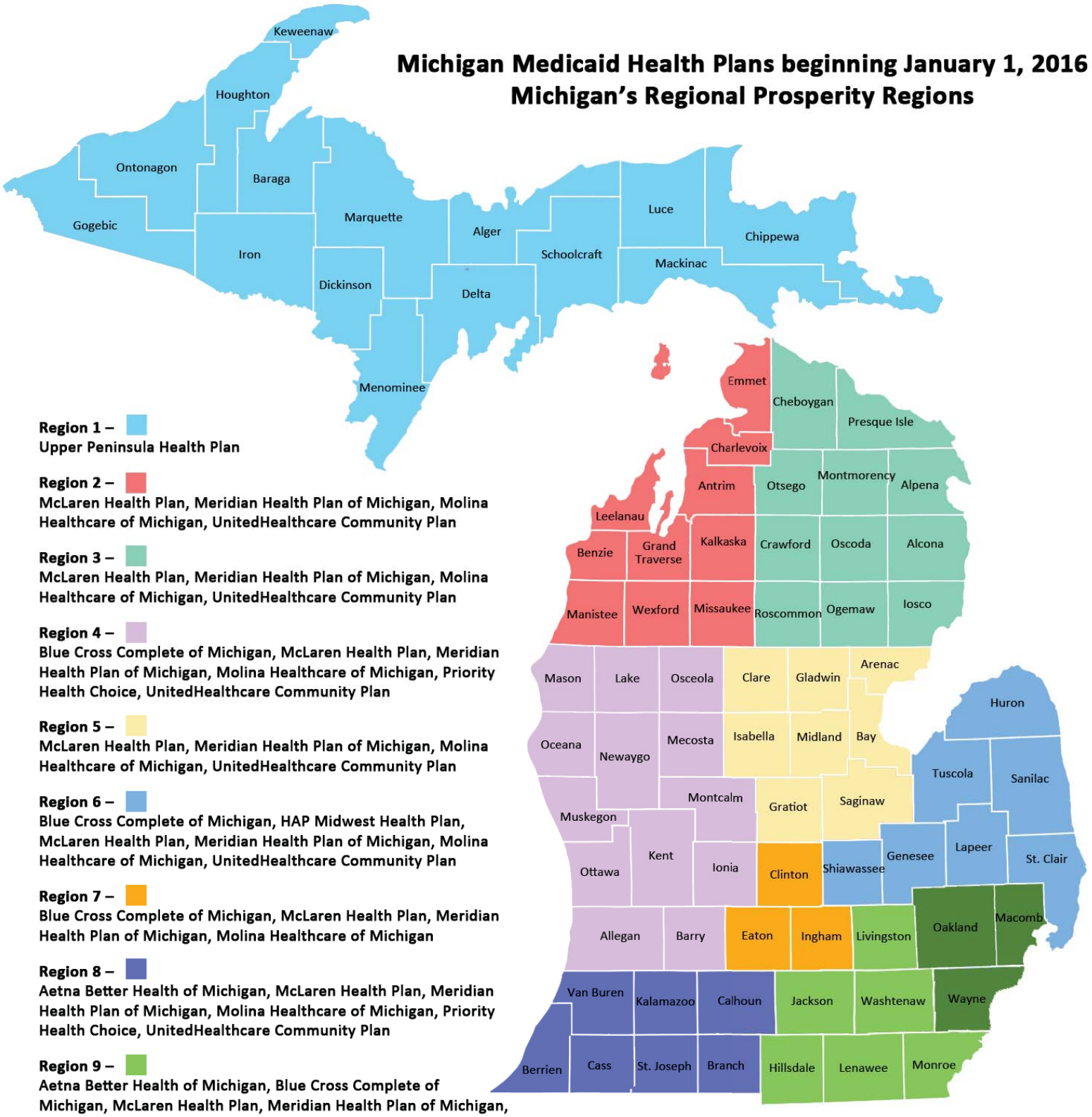
Consumer Representation for 2016 Update

Robin Reynolds welcomed a new MCAC member as a consumer representative, and discussed with MDHHS staff and meeting attendees ideas for reaching out to other beneficiaries who may be interested in providing their input to the MCAC.

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

Next Meeting: May 10, 2016

Michigan Medicaid Health Plans beginning January 1, 2016
Michigan's Regional Prosperity Regions



Region 1 –
Upper Peninsula Health Plan

Region 2 –
McLaren Health Plan, Meridian Health Plan of Michigan, Molina Healthcare of Michigan, UnitedHealthcare Community Plan

Region 3 –
McLaren Health Plan, Meridian Health Plan of Michigan, Molina Healthcare of Michigan, UnitedHealthcare Community Plan

Region 4 –
Blue Cross Complete of Michigan, McLaren Health Plan, Meridian Health Plan of Michigan, Molina Healthcare of Michigan, Priority Health Choice, UnitedHealthcare Community Plan

Region 5 –
McLaren Health Plan, Meridian Health Plan of Michigan, Molina Healthcare of Michigan, UnitedHealthcare Community Plan

Region 6 –
Blue Cross Complete of Michigan, HAP Midwest Health Plan, McLaren Health Plan, Meridian Health Plan of Michigan, Molina Healthcare of Michigan, UnitedHealthcare Community Plan

Region 7 –
Blue Cross Complete of Michigan, McLaren Health Plan, Meridian Health Plan of Michigan, Molina Healthcare of Michigan

Region 8 –
Aetna Better Health of Michigan, McLaren Health Plan, Meridian Health Plan of Michigan, Molina Healthcare of Michigan, Priority Health Choice, UnitedHealthcare Community Plan

Region 9 –
Aetna Better Health of Michigan, Blue Cross Complete of Michigan, McLaren Health Plan, Meridian Health Plan of Michigan, Molina Healthcare of Michigan, UnitedHealthcare Community Plan

Region 10 –
Aetna Better Health of Michigan, Blue Cross Complete of Michigan, Harbor Health Plan, McLaren Health Plan, Meridian Health Plan of Michigan, Molina Healthcare of Michigan, Total Health Care, UnitedHealthcare Community Plan

MDHHS
Michigan Department of Health & Human Services
RICK SNYDER, GOVERNOR | NICK LYON, DIRECTOR

Michigan Department of Health and Human Services
Medical Services Administration

Medical Care Advisory Council

Minutes

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

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

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

Other Attendees: Dominic Pallone

Welcome and Introductions

Robin Reynolds opened the meeting and introductions were made.

Update on Flint

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

Budget Update/Boilerplate

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

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

Healthy Michigan Plan

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

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

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

Behavioral Health Updates

Integration of Behavioral Health and Physical Health

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

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

Certified Community Behavioral Health Clinics (CCBHCs)

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

Eligibility Redetermination Update

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

Federal Regulatory Guidance

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

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

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

Managed Care

Common RX Formulary Update

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

Provider Surveys

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

Maternal Infant Health Program (MIHP) Transition

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

Long Term Care Services and Supports Updates

MI Health Link

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

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

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

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

Policy Updates

Revised Organizational Chart for MDHHS

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

Health Homes/MI Care Team

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

Other

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

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

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

Next Meeting: August 9, 2016

Michigan Department of Health and Human Services
Medical Services Administration

Medical Care Advisory Council

Meeting Minutes

Date: Tuesday, August 9, 2016
Time: 1:00 pm – 4:30 pm
Where: Michigan Public Health Institute (MPHI)
2436 Woodlake Circle
Okemos, MI 48864

Attendees: **Council Members:** Robin Reynolds, Rebecca Blake, Susan Steinke (for Alison Hirschel), Marie DeFer, Michelle Best (for Amy Hundley), Barry Cargill, Amy Zaagman, Priscilla Cheever, Dianne Haas, William Mayer, Pam Lupo, Jeffrey Towns, Vicki Kunz (for Marilyn Litka-Klein), David Herbel, Robert Sheehan, Lisa Dedden Cooper, Kim Singh, Cheryl Bupp, Eric Roath, April Stopczynski, Warren White, Karlene Ketola, Travar Pettway

Staff: Chris Priest, Dick Miles, Kathy Stiffler, Tom Renwick, Deb Eggleston, Jackie Prokop, Erin Emerson, Marie LaPres, Cindy Linn, Susan Kangas, Phillip Bergquist

Other Attendees: Tiffany Stone, Aimee Dedic, Brad Christiansen

Welcome and Introductions

Robin Reynolds opened the meeting and introductions were made.

Update on Flint

The Michigan Department of Health and Human Services (MDHHS) received approval from the Centers for Medicare and Medicaid Services (CMS) on May 9, 2016 to implement a waiver to provide coverage for children and pregnant women with incomes up to 400 percent of the federal poverty level (FPL) who were impacted by Flint water. To date, approximately 23,000 beneficiaries have enrolled in coverage under the waiver, and MDHHS is continuing to work with its partners operating in Genesee County to conduct outreach to eligible individuals.

Budget/Boilerplate Implementation

The State of Michigan budget for Fiscal Year (FY) 2017 (Public Act 268 of 2016) was signed into law on June 29, 2016, and includes an appropriation of $24.8 billion gross and $4.4 billion General Fund (GF) for MDHHS. The FY 2017 GF allocation for MDHHS represents an increase of approximately 5.5% ($230 million) from FY 2016. MDHHS staff discussed several

items contained within in the FY 2017 MDHHS budget, including:

- $110 million GF for coverage of specialty drugs to treat Cystic Fibrosis and Hepatitis C
- $83 million GF to account for a decrease in federal revenues
- $177 million GF to account for an adjustment to the Federal Medical Assistance Percentage (FMAP) for FY 2017
- $7.6 million GF to open a new wing at the Center for Forensic Psychiatry
- $8.9 million GF to complete the expansion of the ***Healthy Kids Dental*** program to cover all beneficiaries up to age 21 in Kent, Oakland and Wayne counties
- $3 million GF to increase non-Medicaid mental health services
- $1.7 million GF for a 15% Medicaid Private Duty Nursing rate increase
- $5.6 million GF for an increase of $5 per day to private foster care agencies that perform case management services
- $2.5 million GF for Senior Community Services
- A large investment in information technology for Integrated Service Delivery at MDHHS county offices and for modernization of the Michigan Statewide Automated Child Welfare Information System (MiSACWIS)
- $2.7 million GF for housing and outreach specialists to offset a reduction in federal resources for the Money Follows the Person Grant
- $172 million total reduction in funding for various MDHHS programs, which includes the discontinuation of the Health Insurance Claims Assessment (HICA)

Chris Priest provided an update on the implementation of the budget, and noted that while the Department's outlook on the budget is positive overall, several items contained in Governor Snyder's executive recommendation did not receive approval from the legislature, including a proposed reserve fund for coverage of specialty drugs.

Federal Regulatory Guidance

L Letter re: RX Reimbursement

On February 11, 2016, the Centers for Medicare and Medicaid Services (CMS) issued a new regulation to change the reimbursement methodology for pharmacists as it relates to dispensing fees and ingredient costs. MDHHS has issued a survey to Michigan pharmacists related to the new rule, and meeting attendees were reminded that completion is mandatory, as the results will be used to determine Medicaid reimbursement rates for outpatient drugs. In response to an inquiry regarding the confidentiality of information submitted with the survey, Chris Priest indicated that MDHHS has been working with legal counsel to ensure the privacy of respondents.

Other

MDHHS is also continuing to work through CMS guidance related to Medicaid managed care and is in the process of establishing a framework to assist all impacted areas.

Healthy Michigan Plan

Beginning April 1, 2018, under the terms of a second waiver for the Healthy Michigan Plan, beneficiaries who have been enrolled in the Healthy Michigan Plan for 48 months and have incomes above 100 percent of the Federal Poverty Level (FPL) may either:

- Remain on the Healthy Michigan Plan, complete a Health Risk Assessment and engage in one or more healthy behaviors, or
- Leave the Healthy Michigan Plan and receive coverage from the Federally Facilitated Marketplace (FFM).

MDHHS is currently working with the Department of Insurance and Financial Services (DIFS) to implement the provisions of the second waiver, including:

- Establishing guidelines for Qualified Health Plans (QHPs) to offer products on the FFM for marketplace-eligible beneficiaries,
- Defining “medically frail” individuals, and
- Revising the Healthy Behaviors protocols.

In response to an inquiry, MDHHS staff noted that QHPs are not required to be Medicaid Health Plans in order to provide coverage to marketplace-eligible beneficiaries.

Managed Care

Provider Surveys

MDHHS is in the process of developing a survey for providers to give input on their experience working with the Medicaid Health Plans, and plans to distribute a draft copy to members of the Medical Care Advisory Council (MCAC) for review by the end of August 2016. When the survey is released, providers will be randomly assigned a health plan to evaluate. Once the survey is completed, the Department will share the results with the Medicaid Health Plans prior to public release.

Other

Kathy Stiffler reported that many areas within the State of Michigan continue to experience a shortage of providers of Non-Emergency Medical Transportation (NEMT) for Medicaid beneficiaries. The Department met with LogistiCare, the State's Medicaid NEMT contractor, and the participating Health Plans on June 6, 2016 to discuss ways to improve access to NEMT services, and Kathy offered to share notes from the meeting with the MCAC. MDHHS staff and meeting attendees also discussed several ideas to improve access to NEMT, including providing mileage reimbursement to Medicaid beneficiaries who own their own vehicles, and providing special arrangements for Maternal Infant Health Program (MIHP) beneficiaries.

Behavioral Health Updates

Integration of Behavioral Health & Physical Health (298)

Following the release of the Governor's Executive Budget Recommendation in February 2016, which called for the integration of behavioral health and physical health services, the Lieutenant Governor convened a work group to discuss the issue. The stakeholder group has met several times to date, and has been working to complete a set of draft recommendations for the integration of behavioral health and physical health services by October 2016 for stakeholder comment before the final report is due to the legislature in mid-January. MDHHS also plans to establish at least three "affinity groups," each consisting of a select group of stakeholders (i.e., consumers and their families, providers, and state association representatives) to provide feedback on the work group's recommendations. Additional information regarding the Stakeholder 298 Work Group is also available on the MDHHS website at www.michigan.gov/stakeholder298.

Certified Community Behavioral Health Clinics (CCBHCs)

In October 2015, the State of Michigan received a planning grant to certify at least two clinics as CCBHCs, which provide intensive person-centered multi-disciplinary evidence-based screening, assessment, and diagnostic treatment and prevention services for individuals with mental health concerns. MDHHS has received 26 applications from potential sites seeking certification as CCBHCs, and plans to choose up to 10 clinics to participate in the demonstration. A minimum of two clinics (one rural and on urban) are needed for MDHHS to submit an implementation grant application for CCBHCs, which is due by October 31, 2016.

Other

MDHHS submitted a Section 1115 waiver application to CMS in July 2016, which will allow the Department to administer behavioral health services under a single waiver authority once approved. The 30 day public comment period for the waiver application is now closed, and the Department is continuing to work through the approval process with CMS.

Eligibility Redetermination Update

Implementation Progress

In June 2016, MDHHS issued a release in Bridges to implement a system for passive redetermination of Medicaid eligibility for the Modified Adjusted Gross Income (MAGI) group, which included approximately 50 percent of the beneficiaries enrolled in MAGI programs. A second release is scheduled for October 2016 to passively enroll the remaining MAGI beneficiaries. Implementation of a system for passive redetermination for non-MAGI groups (e.g., Supplemental Security Income [SSI] recipients) is planned for in future releases beginning in January 2017. Beneficiaries who wish to be a part of the passive redetermination process must provide their consent at the time of application. Once consent is given, MDHHS will be able to access the beneficiary's federal and state tax returns for the purpose of determining subsequent eligibility for Medicaid programs. MDHHS staff and meeting attendees also discussed ideas to simplify the redetermination process.

State Innovation Model (SIM) Update

MDHHS staff provided an update on the implementation of the SIM project and gave an overview of its many components, including: a patient-centered medical home related strategy through accountable systems of care; testing of new community health innovation regions; an investment in health information technology and health information exchange; and a collaborative learning network and overall stakeholder engagement approach to policy development. MDHHS has been actively involved in stakeholder engagement regarding the SIM in recent months, and has scheduled a summit for potential SIM participants on August 10 and 11 to discuss the project.

Michigan was announced as a statewide region for the Comprehensive Primary Care Plus (CPC+) program during the week of August 1, 2016, with Medicare, Blue Cross Blue Shield of Michigan and Priority Health participating as partners. Since this announcement, MDHHS has been exploring opportunities to align its work with Patient Centered Medical Homes (PCMHs) through the SIM initiative to the CPC+ program. MDHHS staff indicated that the CPC+ program has a care model focus similar to that which was included in the Blueprint for Health Innovation and the SIM. The Department is also in the process of developing a concept paper for a custom demonstration option to engage providers that were excluded from the CPC+ program. Medicaid is not included as a participating partner in CPC+, though a practice may

participate with Medicare, Medicaid, and commercial payers by taking part in CPC+ and the PCMH SIM initiative simultaneously. For more information related to the PCMH SIM initiative, providers may visit the MDHHS website at www.michigan.gov/mdhhs >> Doing Business with MDHHS >> Health Care Providers >> State Innovation Model or email SIM@mail.mihealth.org.

Long Term Care Services and Supports Updates

MI Health Link

Dick Miles reported on several updates in the implementation of the MI Health Link program for individuals who are dually eligible for Medicare and Medicaid, including:

- In July 2016, MDHHS implemented a process within the MI Health Link program known as deeming, in which MI Health Link beneficiaries who lose their Medicaid eligibility may remain enrolled in MI Health Link for up to 90 days while their eligibility status is resolved.
- The Department began to passively enroll eligible individuals into MI Health Link on a monthly basis in June 2016, and enrollment in the demonstration has now stabilized at approximately 37,800 beneficiaries. MDHHS is also working to encourage individuals who are dually eligible for Medicare and Medicaid to enroll in MI Health Link voluntarily.
- MDHHS is working collaboratively with the Michigan Association of Health Plans and Integrated Care Organizations to develop a process to address ongoing issues with enrollment discrepancies in Medicare and Medicaid for MI Health Link beneficiaries.
- MDHHS is in the process of working with various stakeholders to organize a summit to educate providers on the MI Health Link program, with a focus on care coordination and person-centered planning. The summit is planned for November 9, 2016.

Home Help

MDHHS is working to develop a new section within the Medical Services Administration that will serve as a single point of accountability for the Home Help program, and will post a position for a Section Manager in the near future. The Department also plans to begin requiring Home Help workers to submit a new Electronic Services Verification (ESV) or Paper Services Verification (PSV) log to receive payment for services beginning in October 2016. The Department is also in the process of implementing the provisions of the Fair Labor Standards Act Home Care Rule, which establishes guidelines for minimum wage, travel and overtime pay.

Conflict-Free Level of Care Determination (LOCD)

As discussed in previous meetings, MDHHS issued a Request for Proposal (RFP) for conflict-free LOCDs in the fall of 2015, but did not receive any successful bidders. The Department has since met with CMS to determine CMS' legal authority to implement the conflict-free LOCD

mandate, whether it is through the use of independent entities or using existing agencies with a firewall.

Brain Injury Waiver

MDHHS is currently accepting public comments on a Section 1115 waiver application that will provide necessary services and supports to individuals suffering a qualifying brain injury. A webinar will be held to discuss the waiver on August 10, 2016, as well as an in-person public hearing on August 17, 2016. Additional information regarding the waiver application is available on the MDHHS website at www.michigan.gov/mdhhs >> Assistance Programs >> Health Care Coverage >> Michigan Brain Injury (BI) Waiver.

Home Health

Dick Miles and participants discussed the fact that the State of Michigan has not allowed enrollment of new Home Health providers in Southeast Michigan since 2013, and that CMS is expanding the moratorium statewide. The Department may be allowed to seek a waiver in certain areas to prevent coverage gaps. A meeting participant also expressed concern about coverage gaps in home health services for beneficiaries who transition from Medicaid to private insurance coverage, and requested information about existing programs within MDHHS that offer assistance with transitioning beneficiaries from Medicaid to private insurance.

Policy Updates

MI Care Team

Bulletin MSA 16-13 was issued on June 1, 2016, and established the MI Care Team Primary Care Health Home benefit effective July 1, 2016. Ten Federally Qualified Health Centers (FQHCs) are participating in MI Care Team, and are currently providing services to 276 beneficiaries with an additional 61 enrollees pending.

Temporary Relocation

MDHHS staff located on the seventh floor of the Capitol Commons Center (400 S. Pine Street in Lansing), have moved temporarily to the fourth floor of the Lewis Cass Building (located at 320 S. Walnut Street in Lansing).

Zika Update

Letter L 16-39, regarding covered services related to the Zika virus was issued to all Medicaid providers on July 11, 2016. To date, 17 Michigan residents have contracted the Zika virus while traveling.

A policy bulletin handout was distributed to meeting attendees, and proposed policy 1611-MIHP, regarding changes in benefit administration of Maternal Infant Health Program services for beneficiaries enrolled in a Medicaid Health Plan was also discussed, in addition to Letter L 16-40, regarding increasing access to Naloxone for opioid overdose.

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

Next Meeting: Wednesday, November 16, 2016

Michigan Department of Health and Human Services
Medical Services Administration

Medical Care Advisory Council

Meeting Minutes

Date: Wednesday, November 16, 2016

Time: 1:00 pm – 4:30 pm

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

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

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

Other Attendees: Tiffany Stone

Welcome, Introductions

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

Update on Flint

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

Budget/Boilerplate Update

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

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

Health Insurance Claim Adjustment (HICA) Tax Update

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

Federal Regulatory Guidance Update

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

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

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

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

Medicaid Managed Care

Provider Surveys

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

Healthy Kids Dental Bid

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

Medicaid/Other

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

2016 Access Monitoring Review Plan

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

Healthy Michigan Plan

Second Waiver Update

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

Eligibility Redetermination Update

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

Behavioral Health Updates

Integration of Behavioral Health and Physical Health

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

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

Certified Community Behavioral Health Clinics (CCBHCs)

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

State Innovation Model (SIM)

Leadership Changes

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

Medicare Patient-Centered Medical Home (PCMH) Model

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

Long Term Care Services and Supports Updates

MI Health Link

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

Other

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

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

Policy Updates

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

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

Next Meeting: Thursday, February 16, 2017

Michigan Department of Health and Human Services
Medical Services Administration

Medical Care Advisory Council

Meeting Minutes

Date: Thursday, February 16, 2017

Time: 1:00 pm – 4:30 pm

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

Attendees: **Council Members:** Robin Reynolds, Jeff Towns, Kim Singh, Amy Zaagman, Joanne Sheldon (for Loretta Bush), April Stopcyzinski, Pam Lupo, Julie Cassidy (for Emily Schwartzkopf), Alison Hirschel, Marilyn Litka-Klein, Dominick Pallone, Dave Lalumia, Mark Klammer, Marion Owen, Linda Vail, Travar Pettway, Eric Roath, Rebecca Blake, Warren White, Lisa Dedden Cooper, Dave Herbel

Staff: Chris Priest, Farah Hanley, Lynda Zeller, Kathy Stiffler, Brian Keisling, Brian Barrie, Marie LaPres, Pam Diebolt, Erin Emerson, Jon Villasurda, Michelle Best

Welcome, Introductions and Announcements

Robin Reynolds opened the meeting and introductions were made.

Federal Update

Chris Priest reported that the U.S. House of Representatives is scheduled to begin discussing legislation to repeal parts of the Affordable Care Act (ACA) beginning the week of February 27, 2017. Because the details of any potential new legislation and its impact on MDHHS are currently unknown, the Department is continuing to implement its programs as planned while also advocating for the Healthy Michigan Plan at the federal level. MDHHS staff and meeting attendees discussed ways to promote the Healthy Michigan Plan at length, while Robin Reynolds offered to draft a letter of support for the program on behalf of the Medical Care Advisory Council (MCAC).

Budget/Boilerplate Update

2017 Update/2018 Proposed Budget

The Governor submitted a budget proposal for Fiscal Year (FY) 2018 to the legislature on February 8, 2017, which contained a recommendation of $25.6 billion gross and $4.5 billion

general fund (GF) for the Michigan Department of Health and Human Services (MDHHS). Highlights of the Executive Budget Recommendation for MDHHS include:

- $55.5 million GF to fund the Federal Matching Assistance Percentage (FMAP) reduction for the Healthy Michigan Plan across Medicaid and Behavioral Health
- A one percent increase in actuarial soundness for Prepaid Inpatient Health Plans (PIHPs) and Medicaid Health Plans (MHPs)
- A wage increase of $0.50 for direct care workers
- Funding for 72 new full-time staff members across five State hospitals
- Funding for a 200 bed replacement facility for the Caro Center
- $12 million gross ($3 million GF) to expand contracted Non-Emergency Medical Transportation (NEMT) broker services beyond Southeast Michigan
- Funding for 51 additional Pathways to Potential workers
- A recommended increase in the child clothing allowance from $140 per month to $200 per month
- Funding for 95 additional full-time adult services workers
- Increased funding for foster care parent support, as well as an increase in private foster care agency rates
- Funding for an Integrated Service Delivery Information Technology (IT) initiative
- Increase in the emergency shelter per diem rate from $12 to $16
- Additional funding for delivery of in-home meals and services for seniors
- Additional funding for Flint
- $1 million for university autism programs
- $2 million to implement the recommendations of the child lead poisoning elimination board

MDHHS staff noted that there were several earmark eliminations included in the Executive Budget Recommendation, but expressed the Department's support for the Governor's proposed budget for the MDHHS Medical Services Administration.

Flint Update

MDHHS received approval from the Centers for Medicare & Medicaid Services (CMS) on May 9, 2016 for a waiver to provide coverage for children and pregnant women with incomes up to 400% of the Federal Poverty Level (FPL) impacted by Flint water, and the Department is continuing outreach and enrollment efforts among individuals eligible for coverage. On November 14, 2016, MDHHS received CMS approval for a State Plan Amendment to allow Michigan to implement a new health services initiative (HSI) for the enhancement and expansion of the current lead abatement program, effective January 1, 2017. As part of this expansion, the state will provide coordinated and targeted lead abatement services to eligible properties in the impacted areas of Flint, Michigan and other areas within the State of Michigan. As of February 16, 2017, 20 homes in Flint have received or are currently receiving lead abatement services, while 45 additional homes have been targeted for outreach. The

Department is also working to identify additional communities for lead abatement services. A residence located in Flint or other targeted community identified by MDHHS may be eligible for lead abatement services if a Medicaid or Children's Health Insurance Program (CHIP)-eligible child or pregnant woman lives in the home.

Medicaid Managed Care

Provider Surveys

The MHP provider survey that was discussed at the previous MCAC meeting has now been finalized. To conduct the survey, MDHHS will randomly select providers to complete surveys related to their experience working with a specific MHP. If a provider completes the survey for the MHP to which they are assigned, they may complete additional surveys for any MHP they choose. The survey will be distributed to providers electronically by February 28, 2017.

The Department also plans to conduct a phone survey in March 2017 related to beneficiaries' experiences using Medicaid NEMT services. In addition, the Michigan Health Endowment fund has provided a grant to the Michigan League for Public Policy to study various issues related to Medicaid NEMT services.

Healthy Kids Dental Bid

MDHHS is preparing to release a Request for Proposal (RFP) for a new ***Healthy Kids Dental*** contract, and is aiming to issue contracts to more than one statewide vendor. Kathy Stiffler reported that the RFP has been delayed from its initial planned release, and that the new contract is not likely to be in effect by October 1, 2017 as discussed at the previous MCAC meeting. In response to a concern raised by a meeting attendee, MDHHS staff indicated that while the goal in seeking more than one vendor is to provide greater access to services, contracts will only be awarded to vendors that have an adequate provider network.

Health Insurance Claims Assessment (HICA) Tax

In 2016, Governor Snyder vetoed legislation to reconfigure the way Michigan's 6% use tax on Health Maintenance Organizations (HMOs) is utilized. CMS has disallowed the use tax, and it was scheduled to sunset on December 31, 2016. Chris Priest reported that following the previous MCAC meeting, the Michigan House and Senate passed legislation placing a moratorium on the use tax in order to implement the CMS requirement. Legislation to reconfigure the way the use tax is utilized has been re-introduced in the state Senate, with the understanding that the State plans to discuss the details of a potential replacement with CMS after the new administration's leadership is in place.

Other

A meeting attendee requested information on the Department's treatment of Substance Use Disorder (SUD) services. In response, MDHHS staff and meeting attendees discussed several programs within the Medical Services Administration and Behavioral Health and Developmental Disabilities Administration that have been developed for the treatment of SUD.

Healthy Michigan Plan

Second Waiver Update (MI Health Account, Marketplace Protocol, Healthy Behaviors)

Under the terms of the second waiver, beginning April 1, 2018, Healthy Michigan Plan beneficiaries with incomes above 100% of the FPL who do not meet the criteria for "Medically Frail" and who have not completed a Health Risk Assessment (HRA) must leave the Healthy Michigan Plan and receive coverage from the Federally Facilitated Marketplace (FFM). Kathy Stiffler reported that MDHHS has released guidance to the health plans related to eligibility criteria for members of the Healthy Michigan Plan to receive services on the FFM, and that MDHHS is continuing to work with the Department of Insurance and Financial Services (DIFS) to develop coverage parameters for the health plans that serve this population. MDHHS will not require health plans on the FFM to develop a new product specific to Healthy Michigan Plan beneficiaries, but will instead allow the plans to use existing products to provide services to this population, and sign a Memorandum of Understanding (MOU) to implement special coverage provisions required by the second waiver. Approximately 125,000 Healthy Michigan Plan beneficiaries currently have incomes above 100% of the FPL.

The Department is also working to update the Healthy Behavior Protocols and MI Health Account Statement. The revised MI Health Account Statements will be sent to Healthy Michigan Plan beneficiaries beginning April 1, 2017.

A meeting attendee raised a concern regarding the online MI Health Account Portal by reporting that a beneficiary is charged an additional fee if their bank account information is entered incorrectly when attempting to pay their bill. MDHHS staff indicated they would check into this concern.

Behavioral Health Updates

PA 298 – Models

Lynda Zeller introduced Jon Villasurda as the new State Assistant Administrator for the Behavioral Health and Developmental Disabilities Administration, and gave an update on the Stakeholder 298 work group process that was convened to discuss the integration of behavioral health and physical health services. As of February 16, 2017, the work group process is nearly complete, and as a result of the work group's efforts, the Department

submitted an interim report to the legislature containing 70 recommendations in 13 categories to improve behavioral health and physical health outcomes. MDHHS is currently working to complete financial models for the implementation of the group's recommendations, which are due to the legislature on March 15, 2017. A Stakeholder forum is also planned for February 24, 2017 to discuss the work group process. The interim legislative report will be posted for public comment beginning at 3:00 p.m. on February 16, 2017 until February 28, 2017. Following the public comment period, MDHHS will submit a final report to the legislature that will contain the group's 70 recommendations, financial models and service delivery models. After the submission of the final report, the Department will continue to discuss benchmarks and outcomes for the implementation of the report's recommendations with the legislature.

1115 Waiver Status

MDHHS submitted a Section 1115 waiver to CMS in July 2016 to allow the administration of behavioral health services under a single waiver authority. The Department is continuing to work through the approval process with CMS, and MDHHS staff noted that conversations with their federal partners have been constructive.

Other

On February 17, 2017, MDHHS will submit the state's response to the Substance Abuse and Mental Health Services Administration's (SAMHSA) Opioid State Targeted Response (STR) grant. The grant is made available only to states based on demographics, and will award a multi-year grant of $16 million to promote the recommendations of the Opioid Commission Report and the goals of the new opioid commission. The five areas outlined in the report include prevention, treatment, policy and outcomes, regulation, and enforcement.

State Innovation Model (SIM)

On January 1, 2017, the health plans began making payments to providers under the SIM program. Providers were previously reimbursed for these services as part of the Michigan Primary Care Transformation (MiPCT) initiative. Chris Priest also reported that Tom Curtis, who previously worked on the SIM project in the Policy, Planning & Legislative Services Administration, has been hired as the Quality Improvement and Program Development section manager within the Managed Care Plan Division of the Medical Services Administration.

On February 15, 2017, the Medicaid MiPCT evaluation team presented the Medicaid evaluation results of the MiPCT pilot to the MHPs. MiPCT formed the basis for the Patient-Centered Medical Home (PCMH) model within SIM, and the results of the evaluation demonstrated improved outcomes and costs among the high-risk population. Kathy Stiffler offered to share the evaluation results with meeting attendees.

Long-Term Care Services and Supports Updates

Brian Barrie provided an update on several topics related to long-term care services and supports, which include:

- The federal comment period for Michigan's Section 1115 Brain Injury Waiver ended on February 12, 2017, and MDHHS has received CMS approval for its implementation effective April 1, 2017.
- MDHHS established a pilot program to coordinate NEMT services through the MI Choice Waiver agencies, which decreased NEMT prior authorization decisions for beneficiaries from two and a half weeks to approximately 20 minutes in the pilot regions. The Department has received CMS approval for a waiver amendment to expand the program statewide effective April 1, 2017, and is now working toward implementation.
- MDHHS is revising the redetermination process for the home help program by eliminating the requirement that certain beneficiaries whose circumstances are not expected to change submit a Medical Needs Assessment Form (DHS-54A) upon eligibility redetermination.
- MDHHS is working to improve the assessment process for home help program beneficiaries who have complex care needs.
- MDHHS is developing a quality initiative for the Adult Protective Services program in order to better assess outcomes for its beneficiaries.
- MDHHS is in the process of moving the Level of Care Determination (LOCD) operation from the Bridges system into CHAMPS, which will provide the Department with the opportunity to design and implement changes to the LOCD process based on recommendations from the LOCD stakeholder group that met in 2015.
- MDHHS is working with a design team to develop a sustainable program model for nursing facility transitions. The design team has identified 18 core values for the new system to follow, and four action teams have been created to address the pre-nursing facility transition phase, transition phase, post-transition phase, and policy implications of the new sustainable program model.
- Design teams will also begin work in the near future to address changes to Michigan Rehabilitation Services, the Preadmission Screening and Annual Resident Review (PASARR) assessment, the nursing facility admission and discharge processes, person-centered planning, and quality within the Michigan Veterans Administration (VA) homes.

MDHHS staff and meeting attendees discussed at length the importance of incorporating beneficiary input into the process of designing changes to the long-term care services and supports initiatives highlighted above, in order to ensure that the needs of consumers are being met.

Policy Updates

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

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

Next Meeting: Tuesday, May 23, 2017

Michigan Department of Health and Human Services
Medical Services Administration

Medical Care Advisory Council

Meeting Minutes

Date: Monday, June 26, 2017
Time: 8:30 a.m. – 12:00 p.m.
Where: Peckham Industries
3510 Capital City Blvd.
Lansing, MI 48906-2102

Attendees: **Council Members:** Robin Reynolds, Marilyn Litka-Klein, Barry Cargill, Dominick Pallone, Deb Brinson, Alison Hirschel, Warren White, Amy Zaagman, Stacy Hettiger (for Rebecca Blake), Michelle Best (for Amy Hundley), Linda Vail, Emily Schwarzkopf, Pam Lupo, Robert Sheehan, Dave LaLumia, Kimberly Singh, April Stopczynski, Jeffrey Towns

Staff: Chris Priest, Farah Hanley, Lynda Zeller, Erin Emerson, Dick Miles, Kathy Stiffler, Dave Schneider, Jackie Prokop, Pam Diebolt, Marie LaPres, Cindy Linn

Other Attendees: Mary Vizcarra, Salli Pung

Welcome, Introductions, Announcements

Robin Reynolds opened the meeting and introductions were made.

Federal Updates

Chris Priest reported that the U.S. Senate has released its own version of a bill to repeal and replace the Affordable Care Act (ACA) and discussed the ways in which it would impact the Medicaid program if adopted. If enacted, the bill would:

- Allow states that have not yet expanded Medicaid eligibility to do so at the regular Federal Matching Assistance Percentage (FMAP) rate;
- Gradually decrease the FMAP rate in current expansion states to the regular FMAP beginning in 2021, which, over time, would result in an estimated cost of $800 million General Fund for the State of Michigan;
- Immediately implement cuts to the Disproportionate Share Hospital (DSH) pool that were included as part of the Affordable Care Act (ACA) in states that expanded Medicaid eligibility, while non-expansion states would be exempt from DSH pool cuts;
- Transform the Medicaid program to a per-capita cap model and exclude children who receive a disability eligibility determination;
- Change the base year calculation to allow states to choose eight consecutive fiscal quarters from 2014 through the third quarter of FY 2017 to set their base rate;

- Require the federal Department of Health and Human Services (HHS) to consult with the states before issuing new guidance related to Medicaid;
- Allow states to expand access to mental health and substance use disorders at the regular match rate;
- No longer require states to offer up to 90 days of retroactive Medicaid eligibility for new enrollees beginning October 1, 2017; and
- Gradually reduce states' provider tax limit to 5%.

MDHHS staff and meeting attendees discussed the proposed legislation at length.

Budget/Boilerplate Update

2017 Updates

The legislature has approved a supplemental Fiscal Year (FY) 2017 budget, which includes funding to implement the pilots approved in the FY 2018 budget around the integration of physical health and behavioral health services.

2018 Proposed Budget

The FY 2018 budget has been approved by the legislative conference committee and forwarded to the governor for review. Farah Hanley indicated that nearly all of the priorities established by MDHHS leadership and the governor for the department were approved in the final legislative draft of the budget, which include:

- Funding for the MDHHS Integrated Service Delivery (ISD) initiative to develop a universal caseload concept, which will affect caseworkers in the field, enable the establishment of a universal call center, and support necessary systems changes;
- Full funding for Medicaid Health Plan actuarial soundness (which assumes that the ACA insurer fee will not be reinstated);
- Full funding for the Medicaid program at the Department's caseload projections for FY 2018;
- $500,000 to support a public transit pilot in areas of the state where Non-Emergency Medical Transportation (NEMT) services are currently unavailable;
- $5.7 million for a direct primary care pilot program in Wayne, Oakland, Macomb, Washtenaw and Livingston counties that will work directly with providers to provide services at a lower per-member-per-month payment;
- $240,000 for the I Vaccinate program to minimize the occurrence of vaccine-preventable diseases;
- $45 million to fund a direct care worker wage increase of $0.50;
- Funding for 72 additional staff at state psychiatric hospitals;
- Funding for a new Caro Psychiatric hospital, which was approved through the capital outlay process;

- Funding for the Psychiatric Residential Transition Unit to assist children in the Hawthorn Center for Children in preparing for the community;
- Funding for 95 additional adult services workers;
- An increase in the foster care provider administrative rate;
- Funding for a vapor intrusion office, drinking water unit, and childhood lead poisoning prevention unit within the Population Health Administration;
- Funding for out-state dental clinics; and
- Funding for pregnancy prevention programs.

In addition, a few reductions included in the FY 2018 budget were noted as well, including:

- A $750,000 reduction in funding for the Mental Health and Wellness Commission; and
- A reduction in funding for university autism programs.

Healthy Michigan Plan

Second Waiver Update

MDHHS is continuing to move forward with implementing the terms of the second waiver for the Healthy Michigan Plan. Under the terms of the waiver beginning April 1, 2018, individuals who have been enrolled in the Healthy Michigan Plan for at least 12 months, have incomes above 100% of the federal poverty level (FPL) and do not meet the criteria for "medically frail" may:

- Remain on the Healthy Michigan plan if they choose to engage in one or more healthy behaviors; or
- If they do not agree to engage in one or more healthy behaviors, they will receive insurance coverage from the Federally Facilitated Marketplace (FFM).

Insurance carriers interested in offering plans on the FFM for this population filed rates on June 14, 2017, and MDHHS is working with the Department of Insurance and Financial Services (DIFS) to establish a Marketplace option in all counties for Healthy Michigan Plan beneficiaries. As part of this process, many plans filed two sets of rates to account for the possibility that cost-sharing reductions are not approved in federal law. MDHHS also plans to issue a revised Healthy Behaviors Incentives Protocol and Operational Protocol for the MI Health Accounts, as well as a Healthy Michigan Plan Marketplace Operation Operational Protocol related to the implementation of the Second Waiver. MDHHS staff and meeting attendees discussed at length coverage options and the urgency of assuring at least two health plan product offerings in every county for the Healthy Michigan Plan population (except the Upper Peninsula, which only needs one). An exception will be requested of CMS if less than two offerings are available in all Lower Peninsula counties. Plans continue to work to finalize their networks. Staff noted that dental benefits will not be provided through the health plans for members of the Healthy Michigan Plan Marketplace population.

Healthy Behaviors Update

Kathy Stiffler shared that MDHHS is working to revise the Health Risk Assessment (HRA) form by removing the option to include beneficiary biometric data (e.g., cholesterol levels, blood pressure, etc.) and convert the HRA to an electronic format from the current paper form. This will allow providers to submit the form directly to MDHHS for staff to forward to the correct health plan. The Department's goal with moving to the new submission system is for timelier processing of HRAs and greater beneficiary participation in healthy behaviors. Currently, 18% of Healthy Michigan Plan beneficiaries have completed an HRA and are engaging in one or more healthy behaviors.

Other

The current Healthy Michigan Plan §1115 Demonstration Waiver expires on December 31, 2018, and MDHHS is working to submit a request for extension to the Centers for Medicare & Medicaid Services (CMS) by December 31, 2017.

Medicaid Managed Care

Provider Surveys

MDHHS worked with the Michigan State University Institute for Health Policy to develop and distribute a survey to providers related to their experience in working with the health plans. To conduct the survey, MDHHS randomly selected providers to rate their experience working with a specific health plan. Providers who completed a survey of the health plan to which they were assigned were allowed to survey additional health plans of their choosing. The survey was distributed to 5,607 providers (in anticipation of a low response rate) with a statewide target sample of 2,317. However, only 5% of all providers completed a survey, (11% of the target sample). A draft report showing the results of the survey was distributed to meeting attendees. MDHHS staff indicated that while the Department does not plan to publish the report due to the low response rate, some findings will be shared with individual Medicaid Health Plans.

Healthy Kids Dental Bid Update

MDHHS is currently accepting bids for a new ***Healthy Kids Dental*** contract, and has extended the deadline for submissions to July 31, 2017. Award notices will be posted on www.buy4michigan.com in October or November 2017, with a contract start date of April 1, 2018. While Delta Dental is currently the only provider with a contract to provide services to ***Healthy Kids Dental*** program beneficiaries, the Department aims to award new contracts to more than one statewide vendor. If more than one contract is awarded, a systems change will be required to allow beneficiaries the choice of enrolling in any available plan. Additional information regarding the ***Healthy Kids Dental*** contract award process is available on the web at www.buy4michigan.com.

Prescriber Enrollment – Community Health Automated Medicaid Processing System (CHAMPS)

Despite ongoing outreach efforts by MDHHS, several prescribers providing services to Medicaid beneficiaries are not currently enrolled in CHAMPS as required by CMS. Compliance was expected July 1, 2013, but implementation has again been postponed to allow more time for prescribers to enroll to avoid medication access issues. Further outreach efforts will be implemented.

Behavioral Health Updates

Parity Rule

MDHHS staff provided meeting attendees with copies of a printed presentation detailing the Department's efforts to comply with the Mental Health Parity and Addiction Equity Act of 2008 and gave an overview of the document.

Section 298 – Models

The Stakeholder 298 work group that was convened to discuss the integration of behavioral health and physical health services has submitted a final report containing 72 policy recommendations to the legislature, and it has been forwarded to the Governor for review. MDHHS is now working internally to make preparations for carrying out the recommendations of the report and to develop benchmarks for implementation of the pilots approved in the FY 2018 budget. The Department must also submit a report to the legislature by November 1, 2017 to propose remedies to any potential barriers to implementation.

1115 Waiver Status

MDHHS submitted a Section 1115 Waiver to CMS in July 2016, which would allow the administration of all behavioral health services under a single waiver authority, and is continuing to work through the approval process with its federal partners.

Other

Lynda Zeller addressed several other topics related to behavioral health services, including:

- The Behavioral Health and Developmental Disabilities Administration (BHDDA) is working with other areas of MDHHS and stakeholders to identify specific barriers to access to care for inpatient psychiatric services, in order to develop policy to address the issue.
- A letter was issued by the MDHHS Bureau of Community Based Services to offer guidance to providers regarding the department's process for establishing psychiatric Institute for Mental Disease (IMD) rates.

- BHDDA is working with the National Governor's Association (NGA) to:
  - Explore ways to increase access to health care in rural areas, with an emphasis on behavioral health services; and
  - Improve information sharing among providers related to better care coordination, with a specific focus on behavioral health services.

Long Term Care Services and Supports Updates

Dick Miles provided an update on several initiatives related to Long Term Care that were included in the FY 2018 budget, including:

- The establishment of a nursing facility quality measure initiative to provide a supplemental payment to nursing facilities based on their 5-star ratings from the CMS Nursing Home Compare (NHC) website;
- $150,000 in funding for an electronic visit verification (EVV) system for personal care service providers beginning in 2019;
- A provision that will allow MDHHS additional flexibility for Program of All Inclusive Care for the Elderly (PACE) expansion outside of the regular budget cycle;
- General fund support to continue the Hospice Residence program;
- $3.7 million in funding to support housing and outreach specialists related to nursing facility transitions; and
- A provision to allow MDHHS to explore the implementation of managed long term care supports and services.

In addition to long term care services and supports items included in the FY 2018 budget, Mr. Miles also shared the following updates:

- MDHHS is working to submit a renewal request to CMS for the MI Choice Waiver, which currently expires in October 2018.
- The MI Choice program was converted to a capitated payment model in October 2013, and the Department is continuing to provide assistance to MI Choice waiver agencies as needed to help with the transition.
- The Medicaid Home Help program is in the process of converting to a new time and task care management model for providers.
- As of June 26, 2017, approximately 38,000 beneficiaries are enrolled in the MI Health Link demonstration program for individuals who are dually eligible for Medicare and Medicaid. The demonstration is currently authorized through 2020, MDHHS is continuing to evaluate the program and make improvements where necessary.
- The PACE program is continuing to expand with 2,000 beneficiaries currently enrolled, and MDHHS is preparing to open a new PACE center in Newaygo County.

Policy Updates

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

The meeting was adjourned at 12:00 p.m.

Michigan Department of Health and Human Services
Medical Services Administration

Medical Care Advisory Council

Meeting Minutes

Date: Wednesday, August 30, 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, Amy Zaagman, Jeff Towns, Emily Schwarzkopf, David Herbel, Stacey Hettiger (for Rebecca Blake), Rod Auton, April Stopczyinski, Kim Singh, Michelle Best (for Amy Hundley), Eric Liu, Barry Cargill, Robert Sheehan, Elmer Cerano, Dan Thompson (for Loretta Bush), Dan Wojciak (for Alison Hirschel), Diane Haas, Marilyn Litka-Klein, Debra Brinson, Dominick Pallone

Staff: Chris Priest, Farah Hanley, Dick Miles, Kathy Stiffler, Jackie Prokop, Cindy Linn, Marie LaPres, Jon Villasurda

Other Attendees: Salli Pung

Welcome, Introductions, Announcements

Robin Reynolds opened the meeting and introductions were made.

Medicaid Managed Care

Healthy Kids Dental Bid Update

Kathy Stiffler reported that bids for a new ***Healthy Kids Dental*** contract were due on July 31, 2017. The Joint Evaluation Committee has met to review the submissions, and is currently in the process of developing its final recommendations. The award winner(s) will be announced on www.buy4michigan.com for the new contract(s) to begin on April 1, 2018. **UPDATE:** following the meeting, the start date for the new ***Healthy Kids Dental*** contract was changed to October 1, 2018.

Member Transportation Survey

MDHHS distributed a survey to Medicaid beneficiaries to identify their utilization experience or knowledge of Medicaid transportation services. Surveys were distributed to both users and non-users of Medicaid transportation services. To date, more users have responded to the survey than non-users. MDHHS plans to conclude the survey process at the end of August 2017 or the first week of September, and will share results at the next Medical Care Advisory Council (MCAC) meeting.

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. ISD will also include an assessment tool that individuals can use to indicate if they would like information on programs offered through any agency within the State of Michigan, and a central call center that beneficiaries may contact with questions. A pilot ISD system has been tested in select areas of the State, and MDHHS hopes to launch the system statewide by the end of 2017. As part of ISD implementation, the DHS-1171 – Assistance Application will be revised to allow individuals to apply for health care coverage in addition to other MDHHS programs when completing the form. ISD implementation will not impact the current Medicaid redetermination process, as its focus will be to improve efficiency in the delivery of services.

Behavioral Health Updates

Section 298

As discussed at the previous MCAC meeting, the Stakeholder 298 workgroup that was convened to discuss the integration of behavioral health and physical health services has submitted a final report to the legislature containing 72 policy recommendations. Following the submission of the report, the legislature directed MDHHS through PA 107 of 2017 to pilot three fully integrated financial models based on the policy recommendations and submit a report back to the legislature by November 1, 2017 identifying any barriers to the integration of behavioral health and physical health services. Any savings found as a result of integration must be re-invested into providing behavioral health services.

In response to a concern raised by a meeting attendee, MDHHS staff indicated that the Department intends to involve relevant stakeholders, including beneficiaries in the implementation process as early as possible to assist in the development of a Request for Information (RFI) that MDHHS plans to release in the next month. If three or more entities respond to the RFI, the Department must initiate a competitive bid process for those interested in participating with the pilot. The pilot models must be implemented by March 1, 2018.

Section 1115 Waiver Update

MDHHS conducted a site visit with the Centers for Medicare & Medicaid Services (CMS) related to the submission of its Section 1115 Waiver request to implement all behavioral health services under a single waiver authority. During the site visit, CMS indicated that the B3 services and supports provisions of the waiver, which would expand housing services and supports, are currently under review with general counsel for the federal department of Health and Human Services (HHS). MDHHS staff noted that CMS will proceed with the waiver approval process once general council issues an opinion, and that the Department's 1915(b) and 1915(c) waivers are still in place pending a decision by CMS.

Other

MDHHS has convened the Michigan Inpatient Psychiatric Access Discussion (MIPAD) to address barriers to access for inpatient psychiatric care.

Long Term Care Services and Supports Updates

Modernizing Continuum of Care (MCC): System and Process Changes

Effective January 2, 2018, MDHHS will implement the MCC project to improve the communication between Bridges and CHAMPS that will reduce processing time for a variety of functions and reduce errors related to admission and enrollment, as well as discharge and disenrollment. Key features of the MCC project include:

- Level of Care (LOC) codes will be replaced by Program Enrollment Type (PET) codes. The PET codes more precisely reflect program options and provide additional information on living arrangements and exemption reasons.
- Specific providers will directly enter admission/discharge or enrollment/disenrollment information in CHAMPS. This will result in real-time changes to the National Provider Identifier (NPI) and the beneficiary's PET code. As part of this change, the MSA-2565-C form will no longer be used for facility admissions.
- Providers will be able to view a roster of all beneficiaries for whom they have submitted admission or enrollment information in CHAMPS. This roster will allow the provider to see an individual's admission or enrollment information, Medicaid status, and information on discharged beneficiaries.
- When a nursing facility enters admission information for an individual who does not have active or pending Medicaid eligibility, a Medicaid Application Patient of Nursing Facility (DHS-4574) will be automatically mailed to the individual.

Three proposed policies that each discuss a different component of the MCC project (1717-MCC, 1718-MCC and 1719-MCC) are currently posted for public comment until October 17, 2017.

Other

In addition to the MCC project, Dick Miles also shared the following updates related to long term care services and supports:

- MDHHS is in the process of seeking a renewal of the MI Choice Home and Community Based Services (HCBS) waiver, which currently expires on December 31, 2018. The Department will hold meetings with interested parties to discuss the waiver extension request beginning in September 2017.
- MDHHS will also host stakeholder meetings to discuss the possibility of moving to a managed long-term care system.

- In 2016, a new Home Help policy section was established within the Bureau of Medicaid Policy and Health System Innovation, and is now nearly fully staffed.
- To comply with federal requirements, MDHHS is working to implement an Electronic Visit Verification (EVV) system to document Home Help provider visits to a client's home. The EVV system must be in place by January 1, 2019.
- MDHHS is working through the Lean process to establish a sustainable business model for nursing facility transitions.

Budget/Boilerplate Update

2018 Budget Update

Farah Hanley reported that the Fiscal Year (FY) 2018 budget has been approved by the Governor, and includes many of the priorities established by Department leadership and the Governor that were discussed at the previous MCAC meeting.

2019 Budget

In FY 2019, MDHHS anticipates approximately $200 million in additional general fund costs due to inflation, increased Medicaid caseload, and a reduction in the Federal Matching Assistance Percentage (FMAP) rate that is due to a rise in per capita income in the State of Michigan. The State of Michigan will also need to contribute an additional $30 million in matching funds for the Healthy Michigan Plan in FY 2019. In addition to increased costs in FY 2019, general fund revenue is expected to decrease by approximately $400 million due to various tax credits taking effect, including a new homestead property tax credit, a transportation earmark from general income tax receipts, and a use tax earmark. Because of this cost and revenue forecast, Farah Hanley advised meeting attendees that MDHHS expects that while the FY 2019 budget will maintain current Department programs, new investments will likely not be included at the same level as in FY 2018.

Statewide Integrated Governmental Management Application (SIGMA)

On October 3, 2017, MDHHS will implement a new system known as SIGMA to improve the way Michigan performs all financial activities, including budgeting, accounting, payments and grant opportunities. Meeting attendees were advised that with the launch of SIGMA at the beginning of a new fiscal year, payment to providers for Pay Cycle 40 will be delayed by one week, from October 5, 2017 to October 12. On October 12, providers will receive payments for two pay cycles.

Healthy Michigan Plan

Waiver Renewal and Protocols Out for Public Comment

MDHHS is in the process of preparing to implement the second waiver for the Healthy Michigan Plan. The Healthy Michigan Plan waiver renewal will include and be based on what is approved in the protocols by the federal government. Under the terms of the waiver 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 one or more healthy behaviors must leave the Healthy Michigan Plan and receive insurance coverage from the Marketplace. As part of the waiver, MDHHS revised the Healthy Behavior Protocol and MI Health Account Protocol, which define the healthy behaviors process and cost-sharing requirements for Healthy Michigan Plan beneficiaries, and created the Marketplace Option Operational Protocol. MDHHS is accepting public comments on the Healthy Michigan Plan second waiver operational protocols until September 13, 2017, which can be accessed on the web at www.michigan.gov/healthymichiganplan.

Healthy Behavior Protocol

Under the current Health Risk Assessment (HRA) process, MDHHS receives notification that a beneficiary has chosen to participate in the healthy behavior only after the beneficiary completes the HRA with their primary care provider (PCP) and attests to one or more healthy behaviors, and the PCP then submits the HRA to the beneficiary's health plan. As outlined in the revised Healthy Behavior Protocol, MDHHS has modified the HRA form by removing biometric data (e.g., cholesterol levels, blood pressure, etc.) and has added an electronic format and centralized fax number for ease of submission. This will allow for timelier processing of HRAs and help to encourage greater beneficiary participation in the Healthy Behaviors Incentive program. Additionally, a specific group of preventive services that will be identified through encounter data and participation in approved wellness programs will also count as engaging in healthy behaviors.

Marketplace Plan Protocol

Handouts outlining the process for Healthy Michigan Plan beneficiaries to transition to the Marketplace, as well as the process for determining if an individual meets the criteria for "medically frail" as described in the Marketplace Option Operational Protocol, were provided to meeting attendees and discussed at length. In response to an inquiry, MDHHS staff clarified that women who become pregnant after transitioning to Marketplace coverage from the Healthy Michigan Plan may then transition out of the Marketplace and will be exempt from cost-sharing and premium obligations.

MI Health Account Protocol

The MI Health Account Protocol has been updated per state law to indicate that Healthy Michigan Plan beneficiaries with incomes above 100% FPL and participate in one or more healthy behaviors will now have their premium and cost-sharing obligations suspended once their cost-sharing reaches three percent of their income.

Healthy MI Waiver Renewal Update

MDHHS is working to submit a renewal application for the Healthy Michigan Plan §1115 Demonstration Waiver to CMS, which currently expires on December 31, 2018. The waiver renewal application must be submitted by December 31, 2017, and will be posted for public comment prior submission. MDHHS will also host a public hearing to provide an overview and discussion of the Healthy Michigan Plan waiver renewal application where all interested parties will have an opportunity to provide comments. Details regarding the public hearing will be announced at a later date.

MDHHS has finalized which insurance carriers have agreed to provide coverage to current Healthy Michigan Plan beneficiaries who transition to the Marketplace. At least two products will be offered in all counties in the Lower Peninsula, while Blue Cross Blue Shield of Michigan (BCBSM) will offer coverage to the Healthy Michigan Plan population in all 15 counties in the Upper Peninsula. Other health plans that will offer coverage to the Healthy Michigan Plan population include McLaren Health Plan, Meridian Health Plan, Priority Health Choice Inc., and Total Healthcare Inc.

Federal Update

Health Care Reform Update/Marketplace/Rate Filing

Chris Priest reported that the U.S. Senate was unable to pass the proposal to repeal and replace the Affordable Care Act (ACA) that was discussed at the previous MCAC meeting. Congress is scheduled to conduct hearings on a proposal to reduce cost-sharing amounts for health plans operating on the Marketplace during the week of September 5, 2017, and Mr. Priest noted that the outcome of this legislation will have direct implications for the Healthy Michigan Plan. The federal government is continuing to engage with states regarding waiver requests for their Medicaid expansion programs, which include a request from Arkansas to reduce Medicaid eligibility in their expansion program to 100% FPL. If approved, Mr. Priest advised that other states may submit similar requests. Approximately 120,000 Healthy Michigan Plan beneficiaries have incomes above 100% FPL.

Children's Health Insurance Program (CHIP) Reauthorization

CHIP currently expires on September 30, 2017, and must be re-authorized as part of a federal spending bill to continue. While Chris Priest expressed optimism that the program will be renewed, congress is also considering an extension of the FMAP increase for CHIP that was authorized by the ACA. If CHIP is not reauthorized, the State of Michigan currently has the resources to fund the program through the second quarter of 2018 at the current FMAP rate.

Policy Updates

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

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