RICK SNYDER
GOVERNOR

STATE OF MICHIGAN
EXECUTIVE OFFICE
LANSING

BRIAN CALLEY
LT. GOVERNOR

September 10, 2018

The Honorable Alex Azar II
Secretary
U.S. Department of Health & Human Services
200 Independence Ave, SW
Washington, D.C. 20201

Dear Secretary Azar:

On behalf of the State of Michigan, I am pleased to submit the State's Healthy Michigan Plan (HMP) §1115 Demonstration Extension Application Amendment (Project No. 11-W-00245/5), in accordance with Michigan Public Act 208 of 2018. 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. The State of Michigan is requesting approval for a 5-year extension of the demonstration waiver.

Through HMP, the Michigan Department of Health and Human Services has extended healthcare coverage to over 1,000,000 eligible low-income Michigan residents, with a current enrollment of approximately 655,000. The HMP program has made a significant impact on the health and well-being of Michigan residents and the proposed waiver extension amendment will enable the State to continue those efforts. Michigan seeks approval to empower individuals in our HMP program to improve their health by actively engaging in their communities and working to gain the skills necessary for independence and long-term success. The attached demonstration extension application amendment is designed to promote accountability, self-sufficiency, and independence from public assistance.

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 a quality healthcare benefit program that improves 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
AMENDED: September 10, 2018

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 (MDHHS) 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, 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 1,000,000 low-income Michigan residents who were previously either uninsured or underinsured. The current HMP enrollment is approximately 655,000. 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 beneficiary 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 was referred to as the "Marketplace Option." Beneficiaries who were impacted by that amendment were those:

- With income above 100% of the FPL,
- Enrolled in an 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

On June 22, 2018, Gov. Rick Snyder signed Public Act (PA) 208 of 2018, included as Attachment A. As a result, MDHHS seeks to amend certain elements of the HMP through this demonstration extension amendment to comply with State law. Specifically, MDHHS seeks approval to amend the HMP waiver eligibility for health care coverage and cost-sharing

requirements applicable to individuals between 100% and 133% of the FPL who have had 48 months of cumulative eligibility for health care coverage through HMP. MDHHS also seeks provisions to address exemptions related to cost-sharing, medically frail individuals, and beneficiary hardship. Additionally, MDHHS seeks to add workforce engagement requirements as a condition of HMP eligibility for able-bodied adults ages 19 to 62. Finally, MDHHS seeks to end the Marketplace Option benefit.

In furtherance of Medicaid program objectives, Michigan seeks to promote work and community engagement and provide incentives to beneficiaries to increase their sense of purpose, build a healthy lifestyle, and further the positive physical and mental health benefits associated with work. MDHHS workforce engagement requirements are designed to assist, encourage, and prepare an able-bodied adult for a life of self-sufficiency and independence from governmental interference. Studies provide evidence of the correlation between income and health; as income increases overall health status improves. Risk factors such as smoking, obesity and poor nutrition are disproportionately evident in lower income groups. Chronic disease, depression, addiction and premature death rise as incomes drop. Income is also a driving force behind health disparities.[1,2,3] These new HMP requirements are expected to help beneficiaries realize the mental and physical health benefits associated with gainful employment by incentivizing engagement in the workforce and providing future opportunities to obtain health care coverage through their employer or the federal marketplace. In addition, studies indicate that employment and community engagement are beneficial for health, particularly depression, general mental health, life satisfaction, and wellbeing.[4,5]

Approval of this demonstration extension application request would allow the State of Michigan to continue to provide comprehensive health care coverage while incorporating new innovative approaches and structural incentives to increase beneficiary engagement in healthy behaviors and to promote personal responsibility in maintaining health care coverage. Furthermore, approval of an extension of the HMP waiver, which is currently set to expire on December 31, 2018, will continue to build on already achieved success. Michigan is requesting approval for a 5-year extension of the demonstration waiver.

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[1] National Center for Health Statistics. (2012). *Health, United States, 2011: With Special Feature on Socioeconomic Status and Health.* Hyattsville, MD: US Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Health Statistics. Retrieved from: http://www.cdc.gov/nchs/data/hus/hus11.pdf.

[2] Braveman, Paula A., Catherine Cubbin, Susan Egerter, David R. Williams, and Elsie Pamuk. (2010). "Socioeconomic Disparities in Health in the United States: What the Patterns Tell Us." *American Journal of Public Health* 100 (S1): S186–S196. Retrieved from: http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2837459/.

[3] Pollack, C. E., C. Cubbin, A. Sania, M. Hayward, D. Vallone, B. Flaherty, and P. A. Braveman. (2013). "Do Wealth Disparities Contribute to Health Disparities within Racial/Ethnic Groups?" *Journal of Epidemiology and Community Health* 67 (5): 439–45. Retrieved from: http://www.ncbi.nlm.nih.gov/pubmed/23427209.

[4] Van der Noordt, M., Jzelenberg, H., Droomers, M., and Proper,K. (2014) Health effects of employment: a systemic review of prospective studies. *Occupational and Environmental Medicine, 71*(10), 730-736.

[5] Jenkinson, C., Dickens, A., Jones, K., Thompson-Coon, J., Taylor, R., Rogers, M., … Richards, S. (2013). Is volunteering a public health intervention? A systematic review and meta-analysis of the health and survival of volunteers. *BMC Public Health, 13*(773), 1-10.

Approval for this extension amendment request is being sought effective January 1, 2019 with up to 6 months to implement the 48 months of cumulative coverage change in cost-sharing and healthy behaviors, and up to 12 months to implement the workforce engagement provisions.

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 (MAGI) 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 effectuated the Marketplace Option program updates.

The Marketplace Option amendment provided that beneficiaries with incomes greater than 100% of the FPL who had been enrolled in an HMP health plan for 12 consecutive months could be required to receive their health benefits through the Marketplace Option if they had not completed a healthy behavior.

PA 208 of 2018 amended HMP provisions that effectively eliminated the implementation of the Marketplace Option. It also directed MDHHS to seek new innovative approaches in administering the HMP with the goal of removing health related obstacles inhibiting or prohibiting enrollees from achieving their highest level of personal productivity. Through these new activities, MDHHS believes that these changes will more effectively encourage beneficiaries to engage in healthy behaviors and increase awareness of personal responsibility.

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;
- Strengthening beneficiary engagement and personal responsibility;
- Encouraging individuals to seek preventive care, adopt healthy behaviors, and make responsible decisions about their healthcare;
- Supporting coordinated strategies to address social determinants of health in order to promote positive health outcomes, greater independence, and improved quality of life;
- Helping uninsured or underinsured individuals manage their health care issues;
- Encouraging quality, continuity, and appropriate medical care; and

This demonstration will incorporate an evaluation aimed at studying the effects infusing 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;
  - The extent to which beneficiaries feel that HMP has a positive impact on personal health outcomes and financial well-being;
  - Whether a possible loss of HMP eligibility-encourages beneficiaries to engage in a healthy behavior and comply with the cost-sharing requirements; and
  - The extent to which workforce engagement requirements impact individuals who transition from Medicaid obtain employer sponsored or other health insurance coverage, and how such transitions affect health and 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)

As part of this extension application for HMP, MDHHS seeks approval to continue certain demonstration provisions for individuals with income at or below 100% of the FPL. In addition, the State seeks to amend the HMP waiver eligibility and cost-sharing requirements for individuals with income between 100% and 133% of the FPL as described below:

a) Beneficiaries with income at or below 100% of the FPL

HMP beneficiaries who are at or below 100% of the FPL will continue to have eligibility for health care coverage and cost-sharing responsibilities consistent with the process outlined in the Healthy Michigan Healthy Behaviors Incentives Protocol and the Operational Protocol for the MI Health Accounts, included as Attachments B and C respectively.

b) Beneficiaries with income between 100% and 133% of the FPL

(1) After 48 months of HMP Eligibility
In order to maintain eligibility for HMP, individuals enrolled in Medicaid health plans with income between 100% and 133% of the FPL, who have had 48 months of cumulative HMP eligibility must**:**

- Complete or actively engage in an annual healthy behavior with effort given to making the healthy behaviors in subsequent years incrementally more challenging; and
- Pay a premium of 5% of their income (no co-pays required), not to exceed limits defined in 42 CFR 447.56(f).

After 48 months of cumulative HMP eligibility, beneficiaries will not be eligible for any cost sharing reductions and their MI Health Account will no longer be utilized for cost sharing liabilities.

(2) Loss of Eligibility for Health Care Coverage

Beneficiaries who have not met the program's healthy behavior or cost-sharing requirements will be notified 60 days before the end of their 48th month that their coverage under the HMP program will be ending. They will become eligible for HMP coverage again once they have come into compliance with the healthy behavior and cost-sharing requirements, at which point they will be re-enrolled the first day of the next available month.

MDHHS is working to identify supports and services that will assist individuals with meeting the cost sharing and healthy behavior requirements. MDHHS is exploring alternative payment methods and ways to provide additional assistance and expand the options for completing a health risk assessment and healthy behavior.

(3) Medically Frail Exemption

Individuals described in 42 CFR 440.315 will be exempt from the 48 months cumulative enrollment loss of coverage and from the 5% premium provision. Individuals will be given the option to self-report his/her medically frail status. The Medically Frail Identification Process is included as Attachment D.

(4) Cost-Sharing Exempt Status

Individuals who are exempt from premiums and cost-sharing pursuant to 42 CFR 447.56 will be exempt from the 5% premium requirement of the 48 months cumulative enrollment provision. This includes, but is not limited to, pregnant women, Native Americans, and children under 21 years of age. However, all beneficiaries exempt from paying premiums will still be required to complete or actively engage in an annual healthy behavior in order to remain on HMP. In the event an individual's cost-sharing exemption status changes (e.g. they turn 21 years old), he or she will be required to maintain compliance with HMP healthy behaviors and cost-sharing requirements, assuming other eligibility criteria are met.

(5) Hardship Exemption

MDHHS will consider hardship exemptions for the following:

- Cost-sharing responsibilities
- Loss of coverage

Examples of hardship exemptions may include, but are not limited to, the birth or death of a family member living with the beneficiary, a family emergency or other life changing event (divorce, domestic violence, etc.), or a temporary illness or injury.

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.

3. Cost-Sharing

All HMP beneficiaries are required to adhere to the cost-sharing requirements outlined in the MIHA protocol. 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 an MHP may earn incentives on the basis of their active, appropriate participation in the health care delivery system. After 48 months of cumulative HMP eligibility, beneficiaries with incomes between 100% and 133% of the FPL will not be eligible for any cost-sharing reductions related to healthy behavior completion incentives, nor will they be eligible for any refunds.

Beneficiaries who are exempt from cost-sharing requirements by law, regulation or program policy will be exempt from cost-sharing obligations via the MI Health Account (e.g. individuals receiving hospice care, pregnant women receiving pregnancy-related services, individuals eligible for Children's Special Health Care Services, Native Americans in compliance with 42 CFR 447.56, etc.). Similarly, services that are exempt from cost sharing by law, regulation or program policy (e.g. preventive and family planning services), or as defined by the State's Healthy Behaviors Incentives Operational Protocol, will also be exempt for HMP beneficiaries.

Beneficiaries who are at or below 100% of the FPL will continue to pay cost-sharing consistent with the process outlined in the Operational Protocol for the MI Health Accounts. 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's HRA tool and submission process, seek to increase the promotion of beneficiary engagement in the Healthy Behaviors Incentives Program. The program has also expanded the scope of services and medications associated with chronic medical conditions 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 beneficiaries are provided through a managed care delivery system.

All HMP eligible beneficiaries are initially mandatorily enrolled into an 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.

5. Workforce Engagement Requirements

Beginning January 1, 2020, MDHHS seeks to implement work requirements for able-bodied adults as a condition of eligibility for HMP consistent with PA 208 of 2018. Once implemented, beneficiaries 19 to 62 years of age must work or engage in specified educational, job training, or community service activities for at least 80 hours per month to remain covered through the HMP unless they qualify for an exemption. HMP beneficiaries who are subject to workforce engagement requirements will be required to demonstrate that they are meeting the requirements through monthly verification. Beneficiaries who fail to meet the requirements will lose HMP coverage until they comply.

Workforce engagement requirements include the following:

- Participation of an average of 80 hours per month of qualifying activities or a combination of any qualifying activities; and
- Self-attest to compliance with, or exemption from, workforce engagement requirements to MDHHS on a monthly basis.

MDHHS will offer internet reporting for self-attestation using technology already in place with increasing rates of utilization. MDHHS intends to offer telephone reporting options for beneficiaries with limited or no internet access.

The following is the list of qualifying activities:

- Employment, self-employment, or having income consistent with being employed or self-employed (makes at least minimum wage for an average of 80 hours per month);
- Education directly related to employment (i.e., high school equivalency test preparation, postsecondary education);
- Job training directly related to employment;
- Vocational training directly related to employment;
- Unpaid workforce engagement directly related to employment (i.e., internship);

- Tribal employment programs;
- Participation in a substance use disorder treatment (court ordered, prescribed by a licensed medical professional, or Medicaid-funded Substance Use Disorder (SUD) treatment;
- Community service completed with a non-profit 501(c)(3) or 501(c)(4) organization (can only be used as a qualifying activity for up to 3 months in a 12-month period); and
- Job search directly related to job training.

A beneficiary is allowed 3 months of noncompliance within a 12-month reporting period. After 3 months of noncompliance, a beneficiary who remains noncompliant will not receive health care coverage for at least one month and will be required to come into compliance before coverage is reinstated.

The following individuals are exempt from workforce engagement requirements:

- A caretaker of a family member under 6 years of age (only one parent at a time can claim this exemption);
- Beneficiaries currently receiving temporary or permanent long-term disability benefits from a private insurer or from the government;
- Full-time student who is not a dependent or whose parent/guardian qualifies for Medicaid
- Pregnant women;
- A caretaker of a dependent with a disability who needs full-time care based on a licensed medical professional's order (this exemption is allowed one time per household);
- A caretaker of an incapacitated individual even if the incapacitated individual is not a dependent of the caretaker;
- Beneficiaries who have proven they meet a good cause temporary exemption (as defined in PA 208 of 2018);
- Beneficiaries designated as medically frail;
- Beneficiaries with a medical condition resulting in a work limitation according to a licensed medical professional order;
- Beneficiaries who have been incarcerated within the last 6 months;
- Beneficiaries currently receiving unemployment benefits from the State of Michigan; and
- Beneficiaries under 21 years of age who had previously been in foster care placement in this state.

Additionally, beneficiaries in compliance with or exempt from the work requirements of the Supplemental Nutrition Assistance Program or Temporary Assistance for Needy Families Program are deemed compliant with or exempt from the workforce engagement requirements outlined above. Additional reporting will not be required.

MDHHS shall enforce the provisions of this section by conducting the compliance review process on medical assistance recipients under HMP who are required to meet the workforce engagement requirements of this section. If an individual is found, through the compliance review process, to have misrepresented his or her compliance with the workforce engagement

requirements in this section, he or she shall not be allowed to participate in the HMP for a one-year period. However, if an individual is locked out of the HMP program and subsequently becomes eligible for another Medicaid program, they may begin receiving services under the other Medicaid program once their eligibility for the other program is determined.

MDHHS is working to identify supports and services that will assist individuals with meeting the workforce engagement requirements and plans to leverage existing partnerships with community stakeholders whenever possible. For example, MDHHS is exploring Michigan Works Agency programs available to Medicaid beneficiaries and ways to assist with transportation and child care needs. In addition, MDHHS is in discussions to develop a new work partnership program that will connect beneficiaries in need of work to health-related jobs that have labor shortages (e.g. home health aides, home help providers, certified nurse assistants and non-emergency medical transportation providers). Additionally, MDHHS is committed to providing early and robust communication, beneficiary education and advocacy involvement to help assure that HMP members do not lose coverage because of lack of understanding the systems or process. MDHHS plans to utilize lessons learned during the implementation of the original HMP waiver, including the use of focus group testing, to assure that communications are clear, understandable and actionable.

Section III – Waivers and Expenditure Authorities

A. Waiver Authorities

MDHHS requests 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 income between 100 and 133 percent of the 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 the Special Terms and Conditions.

- *Provision of Medical Assistance §1902(a)(8) and § 1902(a)(10)* - To the extent necessary to enable the state to not make medical assistance available to beneficiaries who fail to comply with healthy behavior incentive program or workforce engagement requirements unless the beneficiary is exempted.

- *Eligibility §1902(a)(10) or § 1902(a)(52)* - To the extent necessary to enable the State to bar re-enrollment, until qualifications are met, for beneficiaries with income above 100 percent of the FPL who have lost coverage due to failure to complete or actively engage in a healthy behavior, fail to pay cost-sharing requirements, and fail to meet workforce engagement requirements subject to the exemptions and qualifying events described herein.

- *Reasonable Promptness §1902(a)(3) and § 1902(a)(8)* - To the extent necessary to enable the State to prohibit participation in HMP for a one-year period for beneficiaries who have misrepresented their compliance with workforce engagement requirements.

B. Expenditure Authorities

- Expenditures for Healthy Behaviors Program incentives that offset beneficiary cost sharing liability.

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 MHPs 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 E 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, 2018.

Table 2: Healthy Michigan Plan Budget Neutrality Monitoring

	DY 5 - PMPM	DY 6 - PMPM	DY 7 - PMPM	DY 8 - PMPM	DY 9 - PMPM
Approved HMP PMPM	$ 667.36	$ 602.21	$ 569.80	$ 598.86	$ 629.40
Actual HMP PMPM (YTD)	$ 478.00	$ 478.47	$ 499.28	$ 468.75	$ 407.64
Total Expenditures (YTD)	$1,785,379,000.00	$3,477,577,652.00	$3,874,699,771.00	$3,905,254,785.00	$1,727,739,555.00
Total Member Months (YTD)	3,735,115	7,268,118	7,760,576	8,331,177	4,238,422

Healthy Michigan demonstration expenditure and enrollment projections developed by Milliman, Inc., an MDHHS actuarial contractor, are detailed in the following table, which has been updated to reflect the per member per month increases related to the passage of P.A. 175 of 2018, the Insurance Provider Assessment, as well as additional revenues for directed payments to physicians and hospitals.

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

* The Healthy Michigan Plan currently provides monthly coverage to approximately 655,000 individuals. MDHHS has determined that approximately 400,000 of the enrolled beneficiaries could be impacted by the waiver amendment changes, such as now having to pay increased cost-sharing to remain enrolled, complete healthy behaviors to remain enrolled, and/or obtain work or engage in other qualifying activities, report these activities monthly and timely, and maintain records to document these activities should supporting documentation be requested by MDHHS as part of the workforce engagement compliance review process. As the State implements the newly approved requirements, it will undertake active outreach to beneficiaries and partner with community stakeholders to ensure that beneficiaries understand program requirements and do not lose coverage as a result of noncompliance. MDHHS will actively monitor enrollment over the course of the demonstration.

Table 4
State of Michigan - Department of Health and Human Services
Healthy Michigan Expansion
Section 1115 Demonstration PMPM Development

	Managed Care Population						
	Projected Enrollment	**Medical Services Base**	**GME, SNAF, HRA**	**Applicable Taxes**	**Administrative**	**Health Insurer Fee**	**FFS-Rx**
CY 2018	551,854	$309.91	$107.33	$16.53	$41.19	$11.87	$59.16
CY 2019	554,614	312.62	118.04	22.54	41.55	12.37	63.89
CY 2020	557,387	323.57	119.22	22.54	43.00	12.71	69.00
CY 2021	560,173	334.90	120.41	22.54	44.51	13.06	74.52
CY 2022	562,974	346.62	121.61	22.54	46.06	13.42	80.48

	Fee-For-Service Population			**Behavioral Health**	**Total Rate**
	Projected Enrollment	**Base Cost**	**MACI Payments**		
CY 2018	125,249	$266.53	$205.37	$41.19	$573.47
CY 2019	124,623	277.90	207.43	43.54	598.83
CY 2020	124,000	289.76	209.50	45.06	618.58
CY 2021	123,380	302.12	211.60	46.64	639.21
CY 2022	122,763	315.00	213.71	48.27	660.74

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 F 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 anticipated timeline for upcoming reports.

MDHHS will ensure that its evaluation design for the current Section 1115 demonstration is updated to reflect the changes described herein. Specifically, the Department will evaluate how increased cost-sharing impacts utilization as well as the choice of coverage for the subset of beneficiaries affected by the above changes. MDHHS will examine the waiver's impact on the beneficiaries through the §1115 Demonstration Monitoring and Evaluation Process. The Healthy Michigan Evaluation Domain IV currently assesses the beneficiaries' views on the impact of HMP through a beneficiary survey data. The Healthy Michigan Voices No Longer Enrolled Report will assess the impact on those beneficiaries whose health coverage ended and then compare those results to those who remain enrolled in the program. Currently, the No Longer Enrolled Report has focuses on the two following aims: (1) consumer behavior and health insurance literacy and (2) decisions about when, where, and how to seek coverage. Updates and additions will also be incorporated into the State's quality strategy as appropriate, and timely and accurate reporting on the implementation process will occur through the State's existing Section 1115 waiver reporting process, consistent with directives from the CMS.

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 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 co-payments 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;
7. Whether a possible loss of HMP eligibility for health care coverage encourages beneficiaries to engage in a healthy behavior and comply with the cost-sharing requirements; and
8. The extent to which workforce engagement requirements impact beneficiaries who transition from Medicaid obtain employer sponsored or other health insurance coverage, and how such transitions affect health and well-being.

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 MDHHS 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 G.1) are highlighted below.

Providers expressed varying degrees of familiarity with features of HMP.

- 71% were very/somewhat familiar with completing an 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.

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 that 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 emergency room (ER) use and identified facilitators and barriers to doing so.

- 30% felt that they could influence non-urgent 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 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 in 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 the 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 FPL). 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 G.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.
- 30.1% 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; 33.0% 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 now working on cutting back or quitting.

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 more than five 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 ER, 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.

- 33.0% 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 agree or 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. 64.0% said they were more likely to contact their usual doctor's office before going to the ER than before they had HMP.
- Enrollees who were younger, female, and resided in regions with a higher proportion of uninsured were more likely to self-report any ER visits in the past 12 months. Other factors that were significantly associated with any self-reported ER use were a greater number of outpatient visits, 2 or more chronic conditions, a mental health or substance use disorder condition, fair or poor health, or perceived discrimination related to their insurance or ability to pay.

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

- 48.8% 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 (56.0%). 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 co-pays. 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. 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. Domain V/VI Report

The focus of Domains V and VI is to evaluate the role of cost-sharing in the program with a focus on:

1) whether the cost-sharing structure, specifically the assessment of co-payments for certain medical services and monthly contributions, affects how much enrollees spend (Hypothesis 1);
2) whether the cost-sharing structure affects the services enrollees use (Hypothesis 2);
3) whether the cost-sharing structure affects enrollees' likelihood of disenrolling from the program (Hypothesis 3); and
4) whether healthy behavior rewards are associated with more use of preventive care (Hypothesis 4).

Methods

Data

To find out how cost-sharing affected behavior, the evaluation team focused on those enrollees who had experience with the cost-sharing features of the Healthy Michigan Plan (HMP). Cost-sharing begins after six months of continuous enrollment in an HMP managed care plan. Enrollment data from the MDHHS Data Warehouse was used to determine the study population and included enrollees who met the following criteria:

- First month of HMP managed care (MC) between April 2014 and March 2015 (1st year of HMP):
- HMP MC enrollment for at least 18 consecutive months:
- Between 22 and 62 years old in 2014; and
- Not enrolled in a special program (e.g. nursing home care, hospice care).

The evaluation team analyzed data from a 30-month period (April 2014-September 2016). Enrollees in other Medicaid programs for a portion of this 30 months were included if they met the criteria above. For some analyses, survey data was used as described in the body of the report. A copy of the report is included as Attachment G.3.

Analysis

For all hypotheses, the evaluation team completed statistical analyses of multivariate relationships between outcomes (e.g. total spending, service use, disenrollment) and key explanatory variables of interest, cost-sharing and income as a percent of the federal poverty level (FPL). The team utilized linear and non-linear regression techniques that have been validated to provide accurate associations between variables and tested the results with alternative models. For hypotheses 1 and 2, the team compared spending and use of preventive care and other services for three different income groups: 0-35% FPL, 36-99% FPL, 100+% FPL. Since many in the 0-35% group had no reported income, they were effectively exempt from cost-sharing. Those in the 36-99% category faced co-payments for services used but not monthly contributions, and those in the 100+% category faced both co-payments and monthly contributions. For hypothesis 3, the team compared disenrollment for those who had cost-sharing against those who did not, and especially focused on those close to 100% FPL. For hypothesis 4, the team examined whether enrollees with a completed health risk assessment were more likely to use a preventive service.

Results

Demographic Characteristics

The population of 158,369 enrollees who met the selection criteria were:

- 55% female;
- 64% white;
- Likely to live in the Detroit Metro area (42%); and
- Likely to have an income at 0-35% FPL (58%).

Cost-Sharing Characteristics

- Slightly more than half of the population (51%) had a cost-sharing obligation (either a co-pay or contribution that generated a non-zero statement).
- The average quarterly statement for those with an obligation was $16.85 ($11.11 for those below 100% FPL and $30.93 for those at or above 100% FPL).
- Overall, about one quarter (23%) of all enrollees who owed anything paid in full, about half (48%) of those who owed money made no payments.
- People above 100% of FPL were more likely to pay some or all of their statement than people below despite their higher average obligations.

- After the first potential 6-month period of cost-sharing (months 7-12 of enrollment), rates of payment dropped. For those who paid at least once, an estimated 65% paid in full for months 7-12 and 56% paid in full for months 13-18.

1. Medical and Pharmaceutical Spending (Hypothesis 1)

Spending here is defined not just as the cost-sharing amount the enrollee is obligated to pay for the service, but as the total amount spent by both the health plan and the enrollee.

- Average monthly amount spent (April 2014-Sept 2016): $360.
- Median monthly spending: $136.
- Those with incomes 0-35% FPL spent more per month ($391) than those with incomes 36-99% FPL ($313) or 100+% FPL ($327).
- Pharmaceutical spending increased for the entire HMP population with 18 months of continuous enrollment. That result is consistent with, and probably driven by, the initiation and maintenance of medications for chronic disease.
- Medical spending remained flat or declined for those with higher levels of cost-sharing, either from co-payments or monthly contributions. Though IHPI cannot definitively attribute this change to cost-sharing attributes of HMP, these general patterns may indicate that those with monthly contributions may have become more efficient users of the healthcare system over time.

2. Service Use (Hypothesis 2)

- The evaluation team used services exempt from co-payments (vs. services where co-payments are likely) as an indicator of which services the state deems high (vs. low) value. During the study period, 81% of enrollees received a co-pay exempt preventive service (exemption often based on care for a chronic condition per program rules). 56% received a service likely to have a co-payment and incurred a co-payment for it (vision exam, chiropractic treatment, new patient visit, office consultation). All income groups had similar rates of co-pay exempt and co-pay likely service use.
- Co-pay exempt preventive service use and co-pay likely service use declined over time.
- Use of the emergency department declined over time.

3. Disenrollment (Hypothesis 3)

- People with co-pay exempt chronic conditions are less likely to disenroll than those without. Among those with co-payments, those with the highest co-payments are less likely to disenroll.
- Enrollees just above 100% FPL have a higher rate of disenrollment than those just below it, which may be caused by monthly contributions. However, those with evidence of higher medical needs do not have higher disenrollment above 100% FPL, suggesting the plan retains clinically vulnerable populations regardless of cost sharing obligations.
- Among previously enrolled individuals, those with cost-sharing obligations and those who pay their obligations are more likely than those without obligations to gain insurance after disenrolling from HMP, underscoring that disenrollment does not always lead to uninsurance.

- In a survey of those no longer enrolled in Healthy Michigan, most enrollees said the amount they had to pay was fair and affordable. Among those with any cost obligations, 89% said they felt the amount they had to pay was fair and 95% said the amount they had to pay was affordable.

4. Healthy Behaviors (Hypothesis 4)

- People who have a recorded attestation for a completed Heath Risk Assessment are much more likely than those who do not have an attestation to have a preventive visit (84% vs. 50%), have a preventive screening (93% vs. 71%), and use a co-pay exempt medication to control a chronic disease (66% vs. 48%).

5. Conclusion

Overall, IHPI found that cost-sharing requirements may reduce the amount spent by plans and enrollees on medical services, though IHPI could not rule out other causes of the decline. Cost-sharing does not appear to affect the mix of high- and low-value services used in this population. Monthly contribution amounts may cause increased disenrollment from the plan among those with low medical spending and no chronic conditions but not among those with higher medical needs. While people who complete Health Risk Assessments are more likely to also complete healthy preventive behaviors, IHPI could not determine if the health risk assessments themselves increased these behaviors or if they were both the result of a physician visit.

F. 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 G.4).

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.

G. 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, providing additional details about the enrollee experience.

H. 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 for 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 were available in the fall of 2017.

Domain IV: Provider and Enrollee Perspectives
Final interim reports for the 2016 HMV survey and Primary Care Provider survey were available at 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 were 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.

I. Evaluation Plan for Extension Period

During the extension period, IHPI will continue to field and analyze the data from the Annual HMV Survey. 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

For Demonstration Extension Submitted December 6, 2017

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 H.

A public hearing regarding the proposed demonstration waiver extension was 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 I.

For Demonstration Extension Amendment Submitted September 10, 2018

MDHHS began its discussions on the proposed demonstration extension application amendments at the MCAC meeting which took place on June 18, 2018. MDHHS expanded its public engagement on July 9, 2018 by posting the proposed demonstration expansion application amendment request on the MDHHS dedicated HMP webpage available at www.michigan.gov/healthymichiganplan. On this webpage, the public was informed about the demonstration waiver amendment 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 July 9, 2018, which included, among other information, details regarding the proposed demonstration waiver amendment, as well as the website, hearing and public comment information. A copy of the notice is included as Attachment J.

A public hearing regarding the proposed demonstration extension application amendment was held on July 31, 2018, from 2:00 p.m. – 3:00 p.m. at the Michigan Library and Historical Center located at 702 W Kalamazoo St, Lansing, MI 48915. A second public hearing was held August 1, 2018 from 2:00 p.m. – 3:00 p.m. at the Cadillac Place located at 3044 West Grand Boulevard Detroit, Michigan. In addition to the notice procedures described above, MDHHS sent email notifications of this event to providers, stakeholders and the media. The public hearing in Lansing had webinar capability and both public hearings had telephone and in-person capability (with sign interpretation available for those present). Comments were accepted until August 12, 2018. As required by the existing Special Terms and Conditions, a summary of the comments received with notes of any changes to the proposal are included as Attachment K. The attachment also includes copies of all the written comments received.

The webinar and all materials were promptly posted to the HMP website for interested parties to review to assist them in their comments if they had been unable to attend in person or by telephone.

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 L.

As part of the demonstration extension application amendment process, MDHHS also issued a letter on July 9, 2018 notifying Tribal Chairs and Health Directors of the proposed waiver changes and amended application. A copy of the notice is included as Attachment M.

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*

Additional Tribal Consultation for Extension Application Amendment

- *July 11, 2018 – In person meeting – Quarterly Tribal Health Director's Association Meeting*
- *August 6, 2018 – Tribal Consultation Conference Call*
- *August 27, 2018 – In person meeting – Tribal Consultation Meeting*

Tribal Consultation Summary

A consultation conference call and two in-person meetings were held with the tribes to discuss the waiver extension amendment. A summary of the tribal comments is included as Attachment N. The attachment also includes copies of all the written comments received.

C. Post-Award Forums

In accordance with the HMP Waiver Special Terms and 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, 2017, and 2018 meetings are included as Attachment O.

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.

E. Additional Stakeholder Engagement for Extension Application Amendment

- Durable Medical Equipment Liaison Meeting on June 25, 2018, in Lansing, MI
- Pharmacy Liaison Meeting on June 8, 2018, in Lansing, MI
- Medicaid Health Plan and MDHHS Operation Meeting on July 10, 2018, in Okemos, MI
- Michigan Association for Local Public Health -Administrator's Forum on July 12, 2018, in Okemos, MI
- Michigan Association of Health Plans on July 13, 2018, in Lansing, MI
- Michigan State Medical Society/Medicaid Quarterly Meeting on July 16, 2018, in Lansing, MI

- Michigan Primary Care Association Meeting on July 16, 2018, in Lansing, MI
- Conference Call with MDHHS and Governor's Office on July 17, 2018 that included the following Associations:
    - American Cancer Society Cancer Action Network
    - American Diabetes Association
    - American Heart Association
    - American Lung Association
    - Chronic Disease Coalition
    - Epilepsy Foundation in Michigan
    - Hemophilia Federation of America
    - Hemophilia Foundation of Michigan
    - Leukemia and Lymphoma Society
    - Lutheran Services in America
    - National Multiple Sclerosis Society
    - National Organization for Rare Disorders
    - March of Dimes
- Cystic Fibrosis Association – Conference Call with MDHHS, July 27, 2018.
- Medical Care Advisory Council Meeting on August 8, 2018, in Okemos, MI
- The Olmstead Group Meeting on August 9, 2018, in Lansing, MI

Section VII – List of Attachments

Attachment A: Public Act 208 of 2018

Attachment B: Revised Healthy Behaviors Incentive Protocol

Attachment C: Revised MI Health Account Operational Protocol

Attachment D: Medically Frail Identification Process

Attachment E: Monitoring Reports

Attachment F: Healthy Michigan Plan Evaluation Plan

Attachment G: 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. Domain V/VI Report
4. Public Act 107 of 2013 §105d(8) 2015 Report on Uncompensated Care

Attachment H: Public Notice

Attachment I: Public Comment Summary

Attachment J: Public Notice – Demonstration Extension Application Amendment

Attachment K: Public Comment Summary and Written Comments Submitted

Attachment L: Tribal Notice

Attachment M: Tribal Notice – Demonstration Extension Application Amendment

Attachment N: Tribal Comment Summary and Written Comments Submitted

Attachment O: Medical Care Advisory Council Meeting Minutes

Act No. 208
Public Acts of 2018
Approved by the Governor
June 22, 2018
Filed with the Secretary of State
June 22, 2018
EFFECTIVE DATE: September 20, 2018

STATE OF MICHIGAN
99TH LEGISLATURE
REGULAR SESSION OF 2018

Introduced by Senators Shirkey, Pavlov, Hildenbrand, MacGregor, Hune, Emmons, Brandenburg, Colbeck, Proos, Schmidt and Robertson

ENROLLED SENATE BILL No. 897

AN ACT to amend 1939 PA 280, entitled "An act to protect the welfare of the people of this state; to provide general assistance, hospitalization, infirmary and medical care to poor or unfortunate persons; to provide for compliance by this state with the social security act; to provide protection, welfare and services to aged persons, dependent children, the blind, and the permanently and totally disabled; to administer programs and services for the prevention and treatment of delinquency, dependency and neglect of children; to create a state department of social services; to prescribe the powers and duties of the department; to provide for the interstate and intercounty transfer of dependents; to create county and district departments of social services; to create within certain county departments, bureaus of social aid and certain divisions and offices thereunder; to prescribe the powers and duties of the departments, bureaus and officers; to provide for appeals in certain cases; to prescribe the powers and duties of the state department with respect to county and district departments; to prescribe certain duties of certain other state departments, officers, and agencies; to make an appropriation; to prescribe penalties for the violation of the provisions of this act; and to repeal certain parts of this act on specific dates," by amending section 105d (MCL 400.105d), as added by 2013 PA 107, and by adding sections 107a and 107b.

The People of the State of Michigan enact:

Sec. 105d. (1) The department shall seek a waiver from the United States Department of Health and Human Services to do, without jeopardizing federal match dollars or otherwise incurring federal financial penalties, and upon approval of the waiver shall do, all of the following:

(a) Enroll individuals eligible under section 1396a(a)(10)(A)(i)(VIII) of title XIX who meet the citizenship provisions of 42 CFR 435.406 and who are otherwise eligible for the medical assistance program under this act into a contracted health plan that provides for an account into which money from any source, including, but not limited to, the enrollee, the enrollee's employer, and private or public entities on the enrollee's behalf, can be deposited to pay for incurred health expenses, including, but not limited to, co-pays. The account shall be administered by the department and can be delegated to a contracted health plan or a third party administrator, as considered necessary.

(b) Ensure that contracted health plans track all enrollee co-pays incurred for the first 6 months that an individual is enrolled in the program described in subdivision (a) and calculate the average monthly co-pay experience for the enrollee. The average co-pay amount shall be adjusted at least annually to reflect changes in the enrollee's co-pay experience. The department shall ensure that each enrollee receives quarterly statements for his or her account that include expenditures from the account, account balance, and the cost-sharing amount due for the following 3 months. The enrollee shall be required to remit each month the average co-pay amount calculated by the contracted health plan into the enrollee's account. The department shall pursue a range of consequences for enrollees who consistently fail to meet their cost-sharing requirements, including, but not limited to, using the MIChild program as a template and closer oversight by health plans in access to providers.

(c) Give enrollees described in subdivision (a) a choice in choosing among contracted health plans.

(d) Ensure that all enrollees described in subdivision (a) have access to a primary care practitioner who is licensed, registered, or otherwise authorized to engage in his or her health care profession in this state and to preventive services. The department shall require that all new enrollees be assigned and have scheduled an initial appointment with their primary care practitioner within 60 days of initial enrollment. The department shall monitor and track contracted health plans for compliance in this area and consider that compliance in any health plan incentive programs. The department shall ensure that the contracted health plans have procedures to ensure that the privacy of the enrollees' personal information is protected in accordance with the health insurance portability and accountability act of 1996, Public Law 104-191.

(e) Require enrollees described in subdivision (a) with annual incomes between 100% and 133% of the federal poverty guidelines to contribute not more than 5% of income annually for cost-sharing requirements. Cost-sharing includes co-pays and required contributions made into the accounts authorized under subdivision (a). Contributions required in this subdivision do not apply for the first 6 months an individual described in subdivision (a) is enrolled. Required contributions to an account used to pay for incurred health expenses shall be 2% of income annually. Except as otherwise provided in subsection (20), notwithstanding this minimum, required contributions may be reduced by the contracting health plan. The reductions may occur only if healthy behaviors are being addressed as attested to by the contracted health plan based on uniform standards developed by the department in consultation with the contracted health plans. The uniform standards shall include healthy behaviors such as completing a department approved annual health risk assessment to identify unhealthy characteristics, including alcohol use, substance use disorders, tobacco use, obesity, and immunization status. Except as otherwise provided in subsection (20), co-pays can be reduced if healthy behaviors are met, but not until annual accumulated co-pays reach 2% of income except co-pays for specific services may be waived by the contracted health plan if the desired outcome is to promote greater access to services that prevent the progression of and complications related to chronic diseases. If the enrollee described in subdivision (a) becomes ineligible for medical assistance under the program described in this section, the remaining balance in the account described in subdivision (a) shall be returned to that enrollee in the form of a voucher for the sole purpose of purchasing and paying for private insurance.

(f) Implement a co-pay structure that encourages use of high-value services, while discouraging low-value services such as nonurgent emergency department use.

(g) During the enrollment process, inform enrollees described in subdivision (a) about advance directives and require the enrollees to complete a department-approved advance directive on a form that includes an option to decline. The advance directives received from enrollees as provided in this subdivision shall be transmitted to the peace of mind registry organization to be placed on the peace of mind registry.

(h) Develop incentives for enrollees and providers who assist the department in detecting fraud and abuse in the medical assistance program. The department shall provide an annual report that includes the type of fraud detected, the amount saved, and the outcome of the investigation to the legislature.

(i) Allow for services provided by telemedicine from a practitioner who is licensed, registered, or otherwise authorized under section 16171 of the public health code, 1978 PA 368, MCL 333.16171, to engage in his or her health care profession in the state where the patient is located.

(2) For services rendered to an uninsured individual, a hospital that participates in the medical assistance program under this act shall accept 115% of Medicare rates as payments in full from an uninsured individual with an annual income level up to 250% of the federal poverty guidelines. This subsection applies whether or not either or both of the waivers requested under this section are approved, the patient protection and affordable care act is repealed, or the state terminates or opts out of the program established under this section.

(3) Not more than 7 calendar days after receiving each of the official waiver-related written correspondence from the United States Department of Health and Human Services to implement the provisions of this section, the department shall submit a written copy of the approved waiver provisions to the legislature for review.

(4) The department shall develop and implement a plan to enroll all existing fee-for-service enrollees into contracted health plans if allowable by law, if the medical assistance program is the primary payer and if that enrollment is cost-effective. This includes all newly eligible enrollees as described in subsection (1)(a). The department shall include contracted health plans as the mandatory delivery system in its waiver request. The department also shall pursue any and all necessary waivers to enroll persons eligible for both Medicaid and Medicare into the 4 integrated care demonstration regions. The department shall identify all remaining populations eligible for managed care, develop plans for their integration into managed care, and provide recommendations for a performance bonus incentive plan mechanism for long-term care managed care providers that are consistent with other managed care performance bonus incentive plans. The department shall make recommendations for a performance bonus incentive plan for long-term care managed care providers of up to 3% of their Medicaid capitation payments, consistent with other managed care performance bonus incentive plans. These payments shall comply with federal requirements and shall be based on measures that identify the appropriate use of long-term care services and that focus on consumer satisfaction, consumer choice, and other appropriate quality measures applicable to community-based and nursing home services. Where appropriate,

these quality measures shall be consistent with quality measures used for similar services implemented by the integrated care for duals demonstration project. This subsection applies whether or not either or both of the waivers requested under this section are approved, the patient protection and affordable care act is repealed, or the state terminates or opts out of the program established under this section.

(5) The department shall implement a pharmaceutical benefit that utilizes co-pays at appropriate levels allowable by the Centers for Medicare and Medicaid Services to encourage the use of high-value, low-cost prescriptions, such as generic prescriptions when such an alternative exists for a branded product and 90-day prescription supplies, as recommended by the enrollee's prescribing provider and as is consistent with section 109h and sections 9701 to 9709 of the public health code, 1978 PA 368, MCL 333.9701 to 333.9709. This subsection applies whether or not either or both of the waivers requested under this section are approved, the patient protection and affordable care act is repealed, or the state terminates or opts out of the program established under this section.

(6) The department shall work with providers, contracted health plans, and other departments as necessary to create processes that reduce the amount of uncollected cost-sharing and reduce the administrative cost of collecting cost-sharing. To this end, a minimum 0.25% of payments to contracted health plans shall be withheld for the purpose of establishing a cost-sharing compliance bonus pool beginning October 1, 2015. The distribution of funds from the cost-sharing compliance pool shall be based on the contracted health plans' success in collecting cost-sharing payments. The department shall develop the methodology for distribution of these funds. This subsection applies whether or not either or both of the waivers requested under this section are approved, the patient protection and affordable care act is repealed, or the state terminates or opts out of the program established under this section.

(7) The department shall develop a methodology that decreases the amount an enrollee's required contribution may be reduced as described in subsection (1)(e) based on, but not limited to, factors such as an enrollee's failure to pay cost-sharing requirements and the enrollee's inappropriate utilization of emergency departments.

(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 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 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, the department shall proportionally reduce the disproportionate share payments to all hospitals and hospital systems for the purpose of producing general fund savings. The department 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's website.

(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's website.

(10) The department shall explore and develop a range of innovations and initiatives to improve the effectiveness and performance of the medical assistance program and to lower overall health care costs in this state. The department shall report the results of the efforts described in this subsection to the legislature and to the house and senate fiscal agencies by September 30, 2015. The report required under this subsection shall also be made available and easily accessible on the department's website. The department shall pursue a broad range of innovations and initiatives as time and resources allow that shall include, at a minimum, all of the following:

(a) The value and cost-effectiveness of optional Medicaid benefits as described in federal statute.

(b) The identification of private sector, primarily small business, health coverage benefit differences compared to the medical assistance program services and justification for the differences.

(c) The minimum measures and data sets required to effectively measure the medical assistance program's return on investment for taxpayers.

(d) Review and evaluation of the effectiveness of current incentives for contracted health plans, providers, and beneficiaries with recommendations for expanding and refining incentives to accelerate improvement in health outcomes, healthy behaviors, and cost-effectiveness and review of the compliance of required contributions and co-pays.

(e) Review and evaluation of the current design principles that serve as the foundation for the state's medical assistance program to ensure the program is cost-effective and that appropriate incentive measures are utilized. The review shall include, at a minimum, the auto-assignment algorithm and performance bonus incentive pool. This subsection applies whether or not either or both of the waivers requested under this section are approved, the patient protection and affordable care act is repealed, or the state terminates or opts out of the program established under this section.

(f) The identification of private sector initiatives used to incent individuals to comply with medical advice.

(11) By December 31, 2015, the department shall review and report to the legislature the feasibility of programs recommended by multiple national organizations that include, but are not limited to, the council of state governments, the national conference of state legislatures, and the American legislative exchange council, on improving the cost-effectiveness of the medical assistance program.

(12) The department in collaboration with the contracted health plans and providers shall create financial incentives for all of the following:

(a) Contracted health plans that meet specified population improvement goals.

(b) Providers who meet specified quality, cost, and utilization targets.

(c) Enrollees who demonstrate improved health outcomes or maintain healthy behaviors as identified in a health risk assessment as identified by their primary care practitioner who is licensed, registered, or otherwise authorized to engage in his or her health care profession in this state. This subsection applies whether or not either or both of the waivers requested under this section are approved, the patient protection and affordable care act is repealed, or the state terminates or opts out of the program established under this section.

(13) The performance bonus incentive pool for contracted health plans that are not specialty prepaid health plans shall include inappropriate utilization of emergency departments, ambulatory care, contracted health plan all-cause acute 30-day readmission rates, and generic drug utilization when such an alternative exists for a branded product and consistent with section 109h and sections 9701 to 9709 of the public health code, 1978 PA 368, MCL 333.9701 to 333.9709, as a percentage of total. These measurement tools shall be considered and weighed within the 6 highest factors used in the formula. This subsection applies whether or not either or both of the waivers requested under this section are approved, the patient protection and affordable care act is repealed, or the state terminates or opts out of the program established under this section.

(14) The department shall ensure that all capitated payments made to contracted health plans are actuarially sound. This subsection applies whether or not either or both of the waivers requested under this section are approved, the patient protection and affordable care act is repealed, or the state terminates or opts out of the program established under this section.

(15) The department shall maintain administrative costs at a level of not more than 1% of the department's appropriation of the state medical assistance program. These administrative costs shall be capped at the total administrative costs for the fiscal year ending September 30, 2016, except for inflation and project-related costs required to achieve medical assistance net general fund savings. This subsection applies whether or not either or both of the waivers requested under this section are approved, the patient protection and affordable care act is repealed, or the state terminates or opts out of the program established under this section.

(16) The department shall establish uniform procedures and compliance metrics for utilization by the contracted health plans to ensure that cost-sharing requirements are being met. This shall include ramifications for the contracted health plans' failure to comply with performance or compliance metrics. This subsection applies whether or not either or both of the waivers requested under this section are approved, the patient protection and affordable care act is repealed, or the state terminates or opts out of the program established under this section.

(17) The department shall withhold, at a minimum, 0.75% of payments to contracted health plans, except for specialty prepaid health plans, for the purpose of expanding the existing performance bonus incentive pool. Distribution of funds from the performance bonus incentive pool is contingent on the contracted health plan's completion of the required performance or compliance metrics. This subsection applies whether or not either or both of the waivers requested under this section are approved, the patient protection and affordable care act is repealed, or the state terminates or opts out of the program established under this section.

(18) The department shall withhold, at a minimum, 0.75% of payments to specialty prepaid health plans for the purpose of establishing a performance bonus incentive pool. Distribution of funds from the performance bonus incentive pool is contingent on the specialty prepaid health plan's completion of the required performance of compliance metrics that shall include, at a minimum, partnering with other contracted health plans to reduce nonemergent emergency department utilization, increased participation in patient-centered medical homes, increased use of electronic health records and data sharing with other providers, and identification of enrollees who may be eligible for services through the United States Department of Veterans Affairs. This subsection applies whether or not either or both of the waivers

requested under this section are approved, the patient protection and affordable care act is repealed, or the state terminates or opts out of the program established under this section.

(19) The department shall measure contracted health plan or specialty prepaid health plan performance metrics, as applicable, on application of standards of care as that relates to appropriate treatment of substance use disorders and efforts to reduce substance use disorders. This subsection applies whether or not either or both of the waivers requested under this section are approved, the patient protection and affordable care act is repealed, or the state terminates or opts out of the program established under this section.

(20) By October 1, 2018, in addition to the waiver requested in subsection (1), the department shall seek an additional waiver from the United States Department of Health and Human Services that requires individuals who are between 100% and 133% of the federal poverty guidelines and who have had medical assistance coverage for 48 cumulative months beginning on the date of their enrollment into the program described in subsection (1) by the date of the waiver implementation to choose 1 of the following options:

(a) Complete a healthy behavior as provided in subsection (1)(e) with intentional effort given to making subsequent year healthy behaviors incrementally more challenging in order to continue to focus on eliminating health-related obstacles inhibiting enrollees from achieving their highest levels of personal productivity and pay a premium of 5% of income. A required contribution for a premium is not eligible for reduction or refund.

(b) Suspend eligibility for the program described in subsection (1)(a) until the individual complies with subdivision (a).

(21) The department shall notify enrollees 60 days before the enrollee would lose coverage under the current program that this coverage is no longer available to them and that, in order to continue coverage, the enrollee must comply with the option described in subsection (20)(a).

(22) The medical coverage for individuals described in subsection (1)(a) shall remain in effect for not longer than a 16-month period after submission of a new or amended waiver request under subsection (20) if a new or amended waiver request is not approved within 12 months after submission. The department must notify individuals described in subsection (1)(a) that their coverage will be terminated by February 1, 2020 if a new or amended waiver request is not approved within 12 months after submission.

(23) If a new or amended waiver requested under subsection (20) is denied by the United States Department of Health and Human Services, medical coverage for individuals described in subsection (1)(a) shall remain in effect for a 16-month period after the date of submission of the new or amended waiver request unless the United States Department of Health and Human Services approves a new or amended waiver described in this subsection within the 12 months after the date of submission of the new or amended waiver request. A request for a new or amended waiver under this subsection must comply with the other requirements of this section and must be provided to the chairs of the senate and house of representatives appropriations committees and the chairs of the senate and house of representatives appropriations subcommittees on the department budget, at least 30 days before submission to the United States Department of Health and Human Services. If a new or amended waiver request under this subsection is not approved within the 12-month period described in this subsection, the department must give 4 months' notice that medical coverage for individuals described in subsection (1)(a) shall be terminated.

(24) If a new or amended waiver requested under subsection (20) is canceled by the United States Department of Health and Human Services or is invalidated, medical coverage for individuals described in subsection (1)(a) shall remain in effect for 16 months after the date of submission of a new or amended waiver unless the United States Department of Health and Human Services approves a new or amended waiver described in this subsection within the 12 months after the date of submission of the new or amended waiver. A request for a new or amended waiver under this subsection must comply with the other requirements of this section and must be provided to the chairs of the senate and house of representatives appropriations committees and the senate and house of representatives appropriations subcommittees on the department budget at least 30 days before submission to the United States Department of Health and Human Services. If a new or amended waiver under this subsection is not approved within the 12-month period described in this subsection, the department must give 4 months' notice that medical coverage for individuals described in subsection (1)(a) shall be terminated.

(25) If a new or amended waiver request under subsection (23) or (24) is approved by the United States Department of Health and Human Services but does not comply with the other requirements of this section, medical coverage for individuals described in subsection (1)(a) shall be terminated 4 months after the new or amended waiver has been determined to be in noncompliance. The department must notify individuals described in subsection (1)(a) at least 4 months before the termination date that enrollment shall be terminated and the reason for termination.

(26) Individuals described in 42 CFR 440.315 are not subject to the provisions of the waiver described in subsection (20).

(27) The department shall make available at least 3 years of state medical assistance program data, without charge, to any vendor considered qualified by the department who indicates interest in submitting proposals to contracted health plans in order to implement cost savings and population health improvement opportunities through the use of innovative information and data management technologies. Any program or proposal to the contracted health plans

must be consistent with the state's goals of improving health, increasing the quality, reliability, availability, and continuity of care, and reducing the cost of care of the eligible population of enrollees described in subsection (1)(a). The use of the data described in this subsection for the purpose of assessing the potential opportunity and subsequent development and submission of formal proposals to contracted health plans is not a cost or contractual obligation to the department or the state.

(28) This section does not apply if either of the following occurs:

(a) If the department is unable to obtain either of the federal waivers requested in subsection (1) or (20).

(b) If federal government matching funds for the program described in this section are reduced below 100% and annual state savings and other nonfederal net savings associated with the implementation of that program are not sufficient to cover the reduced federal match. The department shall determine and the state budget office shall approve how annual state savings and other nonfederal net savings shall be calculated by June 1, 2014. By September 1, 2014, the calculations and methodology used to determine the state and other nonfederal net savings shall be submitted to the legislature. The calculation of annual state and other nonfederal net savings shall be published annually on January 15 by the state budget office. If the annual state savings and other nonfederal net savings are not sufficient to cover the reduced federal match, medical coverage for individuals described in subsection (1)(a) shall remain in effect until the end of the fiscal year in which the calculation described in this subdivision is published by the state budget office.

(29) The department shall develop, administer, and coordinate with the department of treasury a procedure for offsetting the state tax refunds of an enrollee who owes a liability to the state of past due uncollected cost-sharing, as allowable by the federal government. The procedure shall include a guideline that the department submit to the department of treasury, not later than November 1 of each year, all requests for the offset of state tax refunds claimed on returns filed or to be filed for that tax year. For the purpose of this subsection, any nonpayment of the cost-sharing required under this section owed by the enrollee is considered a liability to the state under section 30a(2)(b) of 1941 PA 122, MCL 205.30a.

(30) For the purpose of this subsection, any nonpayment of the cost-sharing required under this section owed by the enrollee is considered a current liability to the state under section 32 of the McCauley-Traxler-Law-Bowman-McNeely lottery act, 1972 PA 239, MCL 432.32, and shall be handled in accordance with the procedures for handling a liability to the state under that section, as allowed by the federal government.

(31) By November 30, 2013, the department shall convene a symposium to examine the issues of emergency department overutilization and improper usage. The department shall submit a report to the legislature that identifies the causes of overutilization and improper emergency service usage that includes specific best practice recommendations for decreasing overutilization of emergency departments and improper emergency service usage, as well as how those best practices are being implemented. Both broad recommendations and specific recommendations related to the Medicaid program, enrollee behavior, and health plan access issues shall be included.

(32) The department shall contract with an independent third party vendor to review the reports required in subsections (8) and (9) and other data as necessary, in order to develop a methodology for measuring, tracking, and reporting medical cost and uncompensated care cost reduction or rate of increase reduction and their effect on health insurance rates along with recommendations for ongoing annual review. The final report and recommendations shall be submitted to the legislature by September 30, 2015.

(33) For the purposes of submitting reports and other information or data required under this section only, "legislature" means the senate majority leader, the speaker of the house of representatives, the chairs of the senate and house of representatives appropriations committees, the chairs of the senate and house of representatives appropriations subcommittees on the department budget, and the chairs of the senate and house of representatives standing committees on health policy.

(34) As used in this section:

(a) "Patient protection and affordable care act" means the patient protection and affordable care act, Public Law 111-148, as amended by the federal health care and education reconciliation act of 2010, Public Law 111-152.

(b) "Peace of mind registry" and "peace of mind registry organization" mean those terms as defined in section 10301 of the public health code, 1978 PA 368, MCL 333.10301.

(c) "State savings" means any state fund net savings, calculated as of the closing of the financial books for the department at the end of each fiscal year, that result from the program described in this section. The savings shall result in a reduction in spending from the following state fund accounts: adult benefit waiver, non-Medicaid community mental health, and prisoner health care. Any identified savings from other state fund accounts shall be proposed to the house of representatives and senate appropriations committees for approval to include in that year's state savings calculation. It is the intent of the legislature that for fiscal year ending September 30, 2014 only, $193,000,000.00 of the state savings shall be deposited in the roads and risks reserve fund created in section 211b of article VIII of 2013 PA 59.

(d) "Telemedicine" means that term as defined in section 3476 of the insurance code of 1956, 1956 PA 218, MCL 500.3476.

Sec. 107a. (1) The purpose of adding workforce engagement requirements to the medical assistance program as provided in section 107b is to assist, encourage, and prepare an able-bodied adult for a life of self-sufficiency and independence from government interference.

(2) As used in this section and section 107b:

(a) "Able-bodied adult" means an individual at least 19 to 62 years of age who is not pregnant and who does not have a disability that makes him or her eligible for medical assistance under section 105d.

(b) "Caretaker" means a parent or an individual who is taking care of a child in the absence of a parent or an individual caring for a disabled individual as described in section 107b(1)(f)(*v*). A caretaker is not subject to the workforce engagement requirements established under section 107b if he or she is not a medical assistance recipient under section 105d.

(c) "Child" means an individual who is not emancipated under 1968 PA 293, MCL 722.1 to 722.6, who lives with a parent or caretaker, and who is either of the following:

(*i*) Under the age of 18.

(*ii*) Age 18 and a full-time high school student.

(d) "Good cause temporary exemption" means:

(*i*) The recipient is an individual with a disability as described in subtitle A of title II of the Americans with disabilities act of 1990, 42 USC 12131 to 12134, section 504 of title V of the rehabilitation act of 1973, 29 USC 794, or section 1557 of the patient protection and affordable care act, Public Law 111-148, who is unable to meet the workforce engagement requirements for reasons related to that disability.

(*ii*) The recipient has an immediate family member in the home with a disability under federal disability rights laws and is unable to meet the workforce engagement requirements for reasons related to the disability of that family member.

(*iii*) The recipient or an immediate family member, who is living in the home with the recipient, experiences hospitalization or serious illness.

(e) "Incapacitated individual" means that term as defined in section 1105 of the estates and protected individuals code, 1998 PA 386, MCL 700.1105.

(f) "Medically frail" means that term as described in 42 CFR 440.315(f).

(g) "Qualifying activity" means any of the following:

(*i*) Employment or self-employment, or having income consistent with being employed or self-employed. As used in this subparagraph, "having income consistent with being employed or self-employed" means an individual makes at least minimum wage for an average of 80 hours per month.

(*ii*) Education directly related to employment, including, but not limited to, high school equivalency test preparation program and postsecondary education.

(*iii*) Job training directly related to employment.

(*iv*) Vocational training directly related to employment.

(*v*) Unpaid workforce engagement directly related to employment, including, but not limited to, an internship.

(*vi*) Tribal employment programs.

(*vii*) Participation in substance use disorder treatment.

(*viii*) Community service.

(*ix*) Job search directly related to job training.

(h) "Recipient" means an individual receiving medical assistance under this act.

(i) "Substance use disorder" means that term as defined in section 100d of the mental health code, 1974 PA 258, MCL 330.1100d.

(j) "Unemployment benefits" means benefits received under the Michigan employment security act, 1936 (Ex Sess) PA 1, MCL 421.1 to 421.75.

Sec. 107b. (1) No later than October 1, 2018, the department must apply for or apply to amend a waiver under section 1115 of the social security act, 42 USC 1315, and submit subsequent waivers to prohibit and prevent a lapse in the workforce engagement requirements as a condition of receiving medical assistance under section 105d. The waiver must be a request to allow for all of the following:

(a) A requirement of 80 hours average per month of qualifying activities or a combination of any qualifying activities, to count toward the workforce engagement requirement under this section.

(b) A requirement that able-bodied recipients verify that they are meeting the workforce engagement requirements by the tenth of each month for the previous month's qualifying activities through MiBridges or any other subsequent

system. A recipient is allowed 3 months of noncompliance within a 12-month period. The recipient may use a noncompliance month either by self-reporting that he or she is not in compliance that month or by the default method of not reporting compliance for that month. The department shall notify the recipient after each time a noncompliance month is used. After a recipient uses 3 noncompliance months in a 12-month period, the recipient loses coverage for at least 1 month until he or she becomes compliant under this section.

(c) Allow substance use disorder treatment that is court-ordered, prescribed by a licensed medical professional, or is a Medicaid-funded substance use disorder treatment, to count toward the workforce engagement requirements if the treatment impedes the ability to meet the workforce engagement requirements.

(d) A requirement that community service must be completed with a nonprofit organization that is exempt from taxation under section 501(c)(3) or 501(c)(4) of the internal revenue code of 1986, 26 USC 501. Community service can only be used as a qualifying activity for up to 3 months in a 12-month period.

(e) A requirement that a recipient who is also a recipient of the supplemental nutrition assistance program or the temporary assistance for needy families program who is in compliance with or exempt from the work requirements of the supplemental nutrition assistance program or the temporary assistance for needy families program is considered to be in compliance with or exempt from the workforce engagement requirements in this section.

(f) An exemption for a recipient who meets 1 or more of the following conditions:

(*i*) A recipient who is the caretaker of a family member who is under the age of 6 years. This exemption allows only 1 parent at a time to be a caretaker, no matter how many children are being cared for.

(*ii*) A recipient who is currently receiving temporary or permanent long-term disability benefits from a private insurer or from the government.

(*iii*) A recipient who is a full-time student who is not a dependent of a parent or guardian or whose parent or guardian qualifies for Medicaid. This subparagraph includes a student in a postsecondary institution or certificate program.

(*iv*) A recipient who is pregnant.

(*v*) A recipient who is the caretaker of a dependent with a disability which dependent needs full-time care based on a licensed medical professional's order. This exemption is allowed 1 time per household.

(*vi*) A recipient who is the caretaker of an incapacitated individual even if the incapacitated individual is not a dependent of the caretaker.

(*vii*) A recipient who has proven that he or she has met the good cause temporary exemption.

(*viii*) A recipient who has been designated as medically frail.

(*ix*) A recipient who has a medical condition that results in a work limitation according to a licensed medical professional's order.

(*x*) A recipient who has been incarcerated within the last 6 months.

(*xi*) A recipient who is receiving unemployment benefits from this state. This exemption applies during the period the recipient received unemployment benefits and ends when the recipient is no longer receiving unemployment benefits.

(*xii*) A recipient who is under 21 years of age who had previously been in a foster care placement in this state.

(2) After the waiver requested under this section is approved, the department must include, but is not limited to, all of the following, as approved in the waiver, in its implementation of the workforce engagement requirements under this section:

(a) A requirement of 80 hours average per month of qualifying activities or a combination of any qualifying activities counts toward the workforce engagement requirement under this section.

(b) A requirement that able-bodied recipients must verify that they are meeting the workforce engagement requirements by the tenth of each month for the previous month's qualifying activities through MiBridges or any other subsequent system. A recipient is allowed 3 months of noncompliance within a 12-month period. The recipient may use a noncompliance month either by self-reporting that he or she is not in compliance that month or by the default method of not reporting compliance for that month. The department shall notify the recipient after each time a noncompliance month is used. After a recipient uses 3 noncompliance months in a 12-month period, the recipient loses coverage for at least 1 month until he or she becomes compliant under this section.

(c) Allowing substance use disorder treatment that is court-ordered, is prescribed by a licensed medical professional, or is a Medicaid-funded substance use disorder treatment, to count toward the workforce engagement requirements if the treatment impedes the ability to meet the workforce engagement requirements.

(d) A requirement that community service must be completed with a nonprofit organization that is exempt from taxation under section 501(c)(3) or 501(c)(4) of the internal revenue code of 1986, 26 USC 501. Community service can only be used as a qualifying activity for up to 3 months in a 12-month period.

(e) A requirement that a recipient who is also a recipient of the supplemental nutrition assistance program or the temporary assistance for needy families program who is in compliance with or exempt from the work requirements of the supplemental nutrition assistance program or the temporary assistance for needy families program is considered to be in compliance with or exempt from the workforce engagement requirements in this section.

(f) An exemption for a recipient who meets 1 or more of the following conditions:

(*i*) A recipient who is the caretaker of a family member who is under the age of 6 years. This exemption allows only 1 parent at a time to be a caretaker, no matter how many children are being cared for.

(*ii*) A recipient who is currently receiving temporary or permanent long-term disability benefits from a private insurer or from the government.

(*iii*) A recipient who is a full-time student who is not a dependent of a parent or guardian or whose parent or guardian qualifies for Medicaid. This subparagraph includes a student in a postsecondary institution or a certificate program.

(*iv*) A recipient who is pregnant.

(*v*) A recipient who is the caretaker of a dependent with a disability which dependent needs full-time care based on a licensed medical professional's order. This exemption is allowed 1 time per household.

(*vi*) A recipient who is the caretaker of an incapacitated individual even if the incapacitated individual is not a dependent of the caretaker.

(*vii*) A recipient who has proven that he or she has met the good cause temporary exemption.

(*viii*) A recipient who has been designated as medically frail.

(*ix*) A recipient who has a medical condition that results in a work limitation according to a licensed medical professional's order.

(*x*) A recipient who has been incarcerated within the last 6 months.

(*xi*) A recipient who is receiving unemployment benefits from this state. This exemption applies during the period the recipient received unemployment benefits and ends when the recipient is no longer receiving unemployment benefits.

(*xii*) A recipient who is under 21 years of age who had previously been in a foster care placement in this state.

(3) The department may first direct recipients to existing resources for job training or other employment services, child care assistance, transportation, or other supports. The department may develop strategies for assisting recipients to meet workforce engagement requirements under this section.

(4) Beginning October 1, 2018 and each year the department submits a waiver to prohibit and prevent a lapse in the workforce engagement requirements after that, the Medicaid director must submit to the governor, the senate majority leader, and the speaker of the house of representatives a letter confirming the submission of the waiver request required under subsection (1).

(5) Beginning January 1, 2020, the department must execute a survey to obtain the information needed to complete an evaluation of the medical assistance program under section 105d to determine how many recipients have left the Healthy Michigan program as a result of obtaining employment and medical benefits.

(6) The department must execute a survey to obtain the information needed to submit a report to the legislature beginning January 1, 2021, and every January 1 after that, that shows, for medical assistance under section 105d known as Healthy Michigan, the number of exemptions from workforce engagement requirements granted to individuals in that year and the reason the exemptions were granted.

(7) The department shall enforce the provisions of this section by conducting the compliance review process on medical assistance recipients under section 105d who are required to meet the workforce engagement requirements of this section. If a recipient is found, through the compliance review process, to have misrepresented his or her compliance with the workforce engagement requirements in this section, he or she shall not be allowed to participate in the Healthy Michigan program under section 105d for a 1-year period.

(8) The department shall implement the requirements of this section no later than January 1, 2020, and shall notify recipients to whom the workforce engagement requirements described in this section are likely to apply of the workforce engagement requirements 90 days in advance.

(9) The cost of initial implementation of the workforce engagement requirements required under this section shall not be considered when determining the cost-benefit analysis required under section 105d(28)(b). The cost of initial implementation does not include the cost of ongoing administration of the workforce engagement requirements. The ongoing costs of administering the workforce engagement requirements required under this section may have up to a $5,000,000.00 general fund/general purpose revenue limit that shall not be counted when determining the cost-benefit analysis required under section 105d(28)(b). Any ongoing costs above $5,000,000.00 of general fund/general purpose revenue to administer the workforce engagement requirements under this section shall be considered in the cost-benefit analysis required under section 105d(28)(b).

(10) Beginning January 1, 2020, medical assistance recipients who are not exempt from the workforce engagement requirements under this section must be in compliance with this section. Beginning January 1, 2020, a medical assistance applicant who is not exempt from the work engagement requirements under this section must be in compliance with this section not more than 30 days after an eligibility determination is made.

(11) The department shall not withdraw, terminate, or amend any waiver submitted under this section without the express approval of the legislature in the form of a bill enacted by law.

Enacting section 1. This amendatory act takes effect 90 days after the date it is enacted into law.

This act is ordered to take immediate effect.

[redacted]
Secretary of the Senate

[redacted]
Clerk of the House of Representatives

Approved 6/22/18 9:12 AM

[redacted]
Governor

ATTACHMENT B
Healthy Michigan Plan Healthy Behaviors Incentives Operational Protocol

I. Background

The Michigan Department of Health and Human Services ("Department"), in consultation with stakeholders, developed a Healthy Behaviors Incentives Program specific to the Healthy Michigan Plan managed care population. The purpose of the Healthy Behaviors Incentives Program is to encourage beneficiaries to maintain and implement healthy behaviors as identified in collaboration with their health care provider primarily via a standardized health risk assessment. Uniform standards were developed to ensure that all Healthy Michigan Plan managed care members have the opportunity to earn incentives and that those incentives are applied consistently by the managed care plans or their vendor.

Following evaluation and additional feedback from stakeholders, the Department is updating the Healthy Behaviors Incentives Program to promote greater beneficiary engagement and reward progress towards healthy behaviors over time. These proposed changes are meant to strengthen the program's capacity to encourage behavior change for both new and existing enrollees. The Department modified the Healthy Michigan Plan Health Risk Assessment and the overall incentive framework in support of these goals, expanding the scope of services and medications deemed exempt from cost-sharing as a way to reduce barriers to needed care, and detailing the impact of certain healthy activities on delivery system options as described below.

II. Health Risk Assessment

Healthy Michigan Plan (HMP) beneficiaries are expected to remain actively engaged with the Healthy Behaviors Incentives Program each year that they are in the Healthy Michigan Plan. The Department has developed a Health Risk Assessment (HRA) that assesses a broad range of health issues and behaviors including, but not limited to, the following:

- Physical activity
- Nutrition
- Alcohol, tobacco, and substance use
- Mental health
- Influenza vaccination

The Health Risk Assessment is available for completion by all Healthy Michigan Plan managed care members. New beneficiaries continue to be informed about the program when they first enroll by the enrollment broker and in the welcome packets they receive from their managed care plan. In order to remain relevant and appropriate for members who have completed multiple annual Health Risk Assessments, the form accounts for consideration of progress on the previous year's goals for existing members, as attested by the primary care provider. Additional healthy behaviors have been added to the Health Risk Assessment, such as recommended cancer screenings and preventive dental care, to ensure the selection of targeted healthy behaviors is sufficiently diverse for members who have already achieved multiple healthy behavior goals. As some healthy behavior goals may require significant annual effort to maintain (i.e. not regressing into prior tobacco use), an additional goal of maintaining previously achieved healthy behaviors goal(s) has also been added. Existing

beneficiaries will also be encouraged to make subsequent year healthy behaviors incrementally more challenging, working with their primary care provider to build on the goals of prior years**.** The revised Health Risk Assessment can be found in Appendix 3.

Assistance with completion of the Health Risk Assessment is available to new and existing beneficiaries. To start the Health Risk Assessment, members can answer the first self-report portion on their own, with the assistance of the enrollment broker or with assistance from their selected managed care plan. Another option which is available is that members can answer the first portion of the Health Risk Assessment online through a secure statewide beneficiary portal called the MyHealthButton. The Health Risk Assessment has also been translated into Spanish and Arabic. The self-report sections include assessment of engagement in healthy behaviors and questions that indicate how much assistance beneficiaries may need to achieve health in regard to particular issues. The final portion of the Health Risk Assessment will be done in the primary care provider's office and includes attestations by the provider that the beneficiary has acknowledged changes in behavior that may need to be made, and the members willingness/ability to address those behaviors.

Successful entry into any health care system includes an initial visit to a primary care provider, especially for beneficiaries who may have unmet health needs. For Healthy Michigan Plan managed care members, this initial appointment can include a conversation about the healthy behaviors identified in the Health Risk Assessment, member concerns about their own health needs, member readiness to change, and provider attestations of members willingness/ability to address health needs. Healthy Michigan Plan beneficiaries are expected to contact their primary care provider within 60 days of enrollment to schedule a well care appointment and complete the Health Risk Assessment, though there is no penalty for beneficiaries who choose not to do so.

An annual preventive visit is a benefit of the Healthy Michigan Plan and existing members are encouraged to complete an annual Health Risk Assessment with their primary care provider. As the program matures, Healthy Michigan Plan members will increasingly be at different stages of behavior change. The revisions to the Health Risk Assessment are designed to keep the program meaningful for both newly enrolled members and those who have begun to make significant lifestyle changes.

III. Additional Mechanisms to Document Healthy Behavior Activities

To improve the ability of individuals to participate in the Healthy Behaviors Incentives Program, additional mechanisms to document healthy behaviors have been added for individuals who may have completed healthy behavior activities but do not have a submitted Health Risk Assessment for documentation. The documentation includes claims/encounters data and documented participation in wellness and population health management programs, including those submitted by a managed care plan. While HMP beneficiaries are required to complete a healthy behavior annually, new HMP enrollees are initially required to commit to a healthy behavior and must complete the healthy behavior within their first 12 months of coverage.

The Department will use claims and encounter data to document healthy behaviors for managed care plan members who utilize preventive and wellness services that meet the following criteria.

Make and keep an appointment for any of the following:

- Annual preventive visit
- Preventive dental services
- Appropriate cancer screening
- Advisory Committee on Immunization Practices (ACIP) recommended vaccination(s)
- Other preventive screening

The associated codes for the health services listed above can be found in Appendix 4. This mechanism to document healthy behaviors will primarily involve the review of historical claims information (from the preceding 12 months) for the presence of the selected codes. The Department may also consider pre-natal services for pregnant women as meeting the healthy behavior requirements.

In addition, with the introduction of the new managed care contract in January 2016, all managed care plans must ensure its members have access to evidence based/best practices wellness programs to reduce the impact of common risk factors such as obesity or hypertension. These programs can take many forms such as evidence-based tobacco cessation support, health coaching services and free or reduced cost gym memberships. The managed care plans are also required to provide population health management programs which address social determinants of health such as food security or health literacy. These kinds of programs play an important role in helping members achieve their healthy behavior goal(s) and provide important skills and resources so that individuals can self-manage their health. To encourage participation in these valuable programs, members with documented participation in approved managed care plan wellness and population health management programs will also be eligible for Healthy Behaviors Incentives.

Individuals who participate in the healthy behaviors incentives program through the utilization of preventive and wellness services or the managed care plan wellness programs will also be encouraged to make subsequent year healthy behavior activities incrementally more challenging. Managed care plans will be required to monitor the annual progress of enrollees on these healthy behavior goals and facilitate the adoption of increasingly substantial goals each year. The department will work with the managed care plans to ensure uniform standards are applied for determining annual improvement through these activities.

IV. Healthy Behaviors Incentives

Healthy Michigan Plan managed care members will be rewarded for addressing behaviors necessary for improving health. The Department believes that this approach serves as an innovative model that rewards members for appropriate use of their health care benefits. Appendix 5 graphically describes the eligibility criteria for Healthy Behaviors Incentives. Managed care members who complete a Health Risk Assessment with a primary care provider attestation and agree to address or maintain healthy behaviors will receive an incentive. Existing members must also review their progress on their previous year's goal with their primary care provider, who must attest on the Health Risk Assessment that the individual achieved or made significant progress towards their selected healthy behavior goal(s) over the last year to be eligible for an incentive. All individuals receiving an incentive are eligible for a 50 percent reduction in co-pays for the rest of the year once the enrollee has paid 2 percent of their income in co-pays. Individuals who pay a contribution (those above 100 percent of the Federal Poverty Level) will also be eligible for a reduction in their monthly contribution to 1 percent of income. To encourage consistent multi-year participation in the Healthy Behaviors Incentives Program, individuals who pay a contribution (those above 100 percent of the Federal Poverty Level) will have their monthly contribution waived in its entirety if they complete an annual Health Risk Assessment on time each year over two or more years. Members who complete an assessment and acknowledge that changes are necessary but who have significant physical, mental or social barriers to addressing them at this time (as attested by the primary care provider) are also eligible for the incentives.

Managed care plan members who complete the Health Risk Assessment but decline to engage in healthy behaviors are not eligible for incentives.

Members may complete more than one Health Risk Assessment during a year, but may only receive an incentive once per year. Members who initially decline to address behavior change may become eligible if they return to the provider, complete the assessment, and agree to address one or more behavior changes, as attested to by their primary care provider. Members do NOT have to complete the initial appointment or assessment during a specific window of time to be eligible for the incentive. The clock on the annual incentive begins when the member completes the initial appointment and assessment.

Individuals who do not complete a Health Risk Assessment but are identified as completing a healthy behaviors activity as documented through specific claims/encounter data or

documented participation in wellness and population health management programs will earn the same contribution and co-pay reductions as individuals who complete the Health Risk Assessment and agree to address or maintain a healthy behavior. Similar to the Health Risk Assessment, existing beneficiaries will review their progress on their previous year's goal with their managed care plan to ensure that only enrollees who exhibit improvement in each subsequent year are eligible for incentives.

Any earned reductions in cost-sharing will be applied through the MI Health Account, as detailed in the MI Health Account Operational Protocol. Consistent with State law, a member who has earned a reduction in cost-sharing but is subsequently found to be in 'consistently fail to pay' status, will lose all or a portion of that reduction for the remainder of the year in which it was earned. All individuals will lose the 50 percent reduction in co-pays. Those individuals who pay a contribution (those above 100 percent of the Federal Poverty Level) will lose eligibility for the reduction in their monthly contribution to 1 percent of income, but their monthly contribution will not exceed 2 percent of income. A member has consistently failed to pay when either of the following has occurred: no payments have been received for 90 consecutive calendar days, or less than 50 percent of total cost-sharing requirements have been met by the end of the year.

V. Cost Sharing Reductions and Eligibility Changes – Post 48 Months Cumulative Enrollment

HMP beneficiaries who are at or below 100 percent of the Federal Poverty Level (FPL)will continue to have eligibility coverage and cost-sharing responsibilities consistent with the process outlined above. No changes post 48 months cumulative enrollment will impact this population.

To maintain eligibility for HMP, individuals enrolled in Medicaid health plans with income between 100 percent and 133 percent of the FPL, who have had 48 months of cumulative HMP eligibility coverage must**:**

- Complete or actively engage in an annual healthy behavior with effort given to making the healthy behaviors in subsequent years incrementally more challenging; and
- Pay a premium of 5 percent of their income (no co-pays required), not to exceed limits defined in 42 CFR 447.56(f).

After 48 months of cumulative HMP eligibility coverage, beneficiaries will not be eligible for any cost sharing reductions and their MI Health Account will no longer be utilized for cost sharing liabilities.

Loss of Eligibility for Health Care Coverage

Beneficiaries above 100 percent of the FPL who have not met the program's healthy behavior or cost-sharing requirements will lose their coverage under HMP consistent with the

HMP demonstration extension application amendment as approved by the Centers for Medicare and Medicaid Services (CMS). Beneficiaries will be notified of this action 60 days before the end of their 48th month. Individuals who are exempt from premiums and cost-sharing pursuant to 42 CFR 447.56 will be exempt from the 5 percent premium requirement of the 48 months cumulative enrollment provision. This includes, but is not limited to, pregnant women, Native Americans, and children under 21 years of age. However, beneficiaries exempt from the premiums requirement will still be required to satisfy the healthy behavior requirement to remain on HMP. In the event an individual's exemption status changes (e.g. they turn 21 years old), he or she will be required to maintain compliance with HMP healthy behavior and cost-sharing requirements, assuming other eligibility criteria are met.

To facilitate completion of the healthy behavior requirements by beneficiaries once they are notified of this action, the Department has worked with a vendor to create a telephonic option for Health Risk Assessment completion. This HRA Unit will enable HMP beneficiaries who have been notified to complete the entire Health Risk Assessment telephonically with a health educator or registered nurse. This Health Risk Assessment information will be entered into the state's Medicaid claims processing system (the state's Medicaid Management Information System or MMIS) and securely routed to the beneficiary's managed care plan. It will also be available through the Medicaid claims processing system for review and follow-up by the beneficiary's primary care provider.

Enrollees will be able to have their loss of coverage lifted if they meet the program's healthy behavior and cost-sharing requirements. To meet the healthy behavior requirement, the individual will need to complete the Health Risk Assessment telephonically through the HRA Unit. Once the loss of coverage is lifted, the member's new managed care plan will receive their completed Health Risk Assessment information securely transmitted from the Department and will be responsible for providing the beneficiary with structured ongoing support in their efforts to improve healthy behaviors. The Health Risk Assessment information will also be available through the Medicaid claims processing system to the beneficiary's primary care provider so that the information can be reviewed between the primary care provider and the member at their next appointment.

VI. Structured Interventions to Assist with Identified Healthy Behaviors

Beneficiaries will have access to structured ongoing support in their efforts to improve healthy behaviors as identified through the Healthy Behaviors Incentives Program. All managed care plans are required to have policies in place indicating how they use the Health Risk Assessment data to identify members who have identified healthy behaviors goal(s) and their process for outreach and education to these members. They are also required to report annually on the members reached and provide documentation of the support services, education or other interventions provided by the managed care plan. Examples of these interventions include patient education, health coaching and linkages to community programs. In addition, all managed care plans have robust care management programs to assist their members in obtaining health goals. For example, all managed care plans have a diabetes case management program which includes information on nutrition and physical

activity. The information gleaned from the Health Risk Assessment can be used by the managed care plans to determine suitability for member enrollment into this type of care management program, or for referral for other covered services that will assist the member in changing unhealthy behaviors or maintaining current healthy activities.

Once a member has been identified as in need of any covered services, managed care plans coordinate care with necessary providers to ensure that timely, appropriate services are rendered. The managed care plans are contractually obligated to cover smoking cessation counseling and treatment in accordance with Treating Tobacco Use and Dependence: 2008 Update, issued by the US Department of Health and Human Services. It includes counseling, telephonic quit line support, over-the-counter and prescription medications, and combination therapy. Annual preventive visits, Advisory Committee on Immunization Practices (ACIP) recommended vaccinations and treatments for alcohol use, substance use disorder and mental health issues are covered services under the Healthy Michigan Plan. Managed care plans also cover maternity care and dental services for Healthy Michigan Plan enrollees. The Department expects managed care plans to adhere to recognized clinical practice guidelines for the treatment of Healthy Michigan Plan members.

VII. Reducing Financial Barriers

Financial barriers to appropriate care can influence the health-seeking behaviors of low-income populations. For this reason, preventive services are exempt from co-pay requirements as outlined in the MI Health Account Operational Protocol. In addition, per the Healthy Michigan Plan legislation (Public Act 107 of 2013), and in an effort to remove barriers to necessary care for Healthy Michigan Plan members, the Department has eliminated co-pays 'to promote greater access to services that prevent the progression of and complications related to chronic diseases'. The Department believes that by eliminating co-pays for services related to chronic disease and the associated pharmaceuticals, members will be better able to achieve their health goals. An expanded list of these chronic disease and associated codes is attached (Appendix 2).

VIII. Reducing Access Barriers

Access to care for Medicaid members is critical. The Department has and will continue to measure access to necessary providers, especially primary care providers upon whom Healthy Michigan Plan managed care members rely to earn their incentives. With passage of the Healthy Michigan Plan legislation, network adequacy reports were developed for each county in the state based on the potential enrollment of new members into the Healthy Michigan Plan. Departmental estimates of potential enrollment indicated no counties that required an increased network to fall within the Department's required primary care provider to member ratio of 1:750. Further, on January 1, 2016, Michigan Medicaid implemented a new managed care contract which requires a primary care provider to member ratio of 1:500 to further strengthen network adequacy.

In addition, Healthy Michigan Plan members may receive services, including the initial appointment and completion of the Health Risk Assessment, through Fee-For-Service (FFS)

before they are enrolled in a managed care plan. Given the short time period (usually one month) that new enrollees are in FFS before enrollment in a managed care plan, the Department expects there to be relatively few instances of a FFS provider completing the initial appointment and the Health Risk Assessment. When it does occur, the managed care plans are responsible for either working directly with the FFS provider to obtain the Health Risk Assessment or assisting the member in getting the necessary Health Risk Assessment information from the provider. Providers have also been instructed to give each beneficiary a copy of their completed assessment at the initial appointment, so the beneficiary can forward a copy of their completed Health Risk Assessment to their health plan after enrollment. Beneficiaries who complete the Health Risk Assessment during the FFS period are eligible for the incentives upon enrollment into a managed care plan.

IX. Education and Outreach Strategy

The Department has developed a four-pronged education strategy that will ensure members hear the same message across different entities and will maximize the potential for member engagement in healthy behaviors and achievement of incentives. At all potential points of contact in the enrollment process (the enrollment broker, the Department, managed care plans, and providers), members will receive information about the Healthy Behaviors Incentives Program including eligibility requirements. To ensure consistency, member engagement scripts with Healthy Behaviors Incentives Program information will be developed and shared with the enrollment broker and the managed care plans.

Language has been included in the Healthy Michigan Plan handbook, brochures and other member communications to inform beneficiaries about potential reductions in their cost-sharing based on their engagement in healthy behaviors. This language will be expanded to inform members about the new opportunities to be eligible for incentives through the Healthy Behaviors Incentives Program. It will also include information about beneficiaries with incomes between 100 percent and 133 percent of the FPL who have had 48 months of cumulative eligibility coverage not being eligible for incentives and losing eligibility from HMP if they fail to complete a healthy behavior or pay cost-sharing obligations. The Department will ensure that updated language is provided at all potential points of contact.

The Department's enrollment broker can facilitate member questions on the Health Risk Assessment, inform beneficiaries about the Healthy Behaviors Incentives, assist them with choosing a primary care provider, and encourage them to schedule and complete their initial appointment. When managed care plans make welcome calls to new Healthy Michigan Plan members, their scripts include information about the Healthy Behaviors Incentives Program. During these calls, managed care plans will assist members in scheduling an initial appointment and can arrange for transportation if necessary. All managed care plans send welcome packets to new members within 10 days of enrollment into the plan. These packets will include written information on the Healthy Behaviors Incentives Program at no higher than a 6.9 grade level. Managed care plans will also include Healthy Behaviors Incentives Program information on their website and in their member newsletters.

The MI Health Account quarterly statement received by each Healthy Michigan Plan member is intended to be an educational tool that will present information regarding any reductions earned via the Healthy Behaviors Incentives Program. It also includes reminders for members about potential cost-sharing reductions and incentives that may be available for them. The detailed contents of the MI Health Account statement are discussed in the MI Health Account Operational Protocol.

Information about the Healthy Behaviors Incentives Program and how to participate is also included in the mobile application for beneficiaries, the MyHealthButton, which was developed by the Department for beneficiaries in 2015. It includes an online option for starting the Health Risk Assessment, a repository where beneficiaries can see their completed Health Risk Assessment results submitted by their primary care provider, and tools and resources to assist them with achieving their selected healthy behavior goal(s). There has been statewide outreach to inform beneficiaries of this new online option. The Department will continue to develop new education and outreach initiatives on the Healthy Behaviors Incentives Program for the duration of the demonstration.

X. Provider Strategy

Primary care provider participation plays a key role in healthy behavior change, and collaborative effort between beneficiaries and their health care providers is essential for the success of the Healthy Behaviors Incentives Program. For this reason, the Department developed an outreach strategy for providers which was carried out in 2014 and involved collaboration with the Michigan State Medical Society, the Michigan Osteopathic Association, Michigan Academy of Family Physicians and the Michigan Primary Care Association. The Department also sent a letter to all practitioners, Federally Qualified Health Centers, Tribal Health Centers, Rural Health Centers, and managed care plans on June 13, 2014 and a policy bulletin (14-39) was distributed to all providers on August 28, 2014. Not only did this ensure that providers were adequately informed about the Healthy Behaviors Incentives Program, but they were able to share a consistent message with patients. These same mechanisms will be used to inform providers about updates to the program. The Department has been in discussion with provider organizations regarding these changes and distributed bulletins on these changes to providers in the summer of 2017.

The Department developed a voluntary, web-based training for providers which covered the Healthy Michigan Plan Health Risk Assessment, Healthy Behaviors Incentives, and associated processes. The training is available for completion online and has continuing medical education (CME) units associated with it. The Department regularly updates the course content as necessary and annually evaluates whether the course remains relevant for providers.

Managed care plans provide current information about the Healthy Behaviors Incentives Program to the providers in their networks through provider newsletters and provider portals. Managed care plans are also required to pay an incentive to providers who complete the Health Risk Assessment with their Healthy Michigan Plan members. Details of the provider incentive and payment mechanism are plan-specific and are made available to providers by

the managed care plans with which they participate. Providers who work with patients to complete the Health Risk Assessment during the FFS period may be are eligible for the managed care plan provider incentive once the member has enrolled in the managed care plan.

Currently, the Health Risk Assessment submission process for providers is different for each managed care plan. Based on feedback from providers about the complexity of keeping track of multiple plan-specific methods for secure submission of completed Health Risk Assessments, the Department implemented two secure state-wide submission processes to streamline the process for providers. The Department began working to develop these processes in February 2017 and they were completed in March 2018. These new processes allow providers to submit completed HRAs via a central MDHHS fax line or through a direct data entry option within the state's Medicaid claims processing system via a new HRA Provider Profile. The Department is working in partnership with multiple provider groups and the managed care plans to educate providers about the new submission options. When a provider completes a Health Risk Assessment for a managed care member utilizing either the central MDHHS fax or through direct data entry into the claims processing system, the completed Health Risk Assessment being securely routed to the appropriate managed care plan for application of incentives.

XI. Data Systems and Monitoring Processes

Health Risk Assessment data is put into electronic file formats and securely transferred from the enrollment broker and managed care plans to the State's data warehouse, where it is then stored. The files include member name and ID number, the member's managed care plan, and the name and National Provider Identifier of the primary care provider who completed the Health Risk Assessment so that Health Risk Assessment data can be tracked and monitored at the beneficiary, provider and plan level. Health Risk Assessment data can be cross referenced with care provided to beneficiaries through encounter data. Health Risk Assessment data is monitored monthly and the Department developed a measure of Health Risk Assessment completion which is reported quarterly. This measure was also included in the performance bonus for managed care plans starting in SFY2016.

The healthy behaviors file will now be expanded to include the new Healthy Behaviors Incentives Program data. Managed care plans will generate a list of members who are eligible for incentives because the member participated in approved wellness programs. This information will be submitted to the Department through modification of the healthy behaviors file. The Department will identify the members who are eligible for incentives because the member utilized identified wellness health services documented through claims/encounters. Development of these modifications began in spring 2017 and extensive testing occurred prior to implementation in the fall of 2017. This data will then be stored in the State's data warehouse. Just like the Health Risk Assessment data, it will be possible to query all aspects of the program data and new queries and performance measures will be developed for tracking and monitoring at the beneficiary, provider and plan level.

Cross-referencing with encounter data also assists with monitoring provider accountability. Managed care plans are required to set standards for accountability for their provider networks. In addition, the Department developed an Access to Care measure specific to the Healthy Michigan Plan managed care population to determine how many new members completed an initial appointment within 150 days of enrollment into the managed care plan. This measure is based on encounter data extracted from the State's data warehouse and is tracked by region, managed care plan, and as a state overall. In SFY2016, this measure was included in the Performance Bonus for the managed care plans as well.

The Department receives the amount of cost-sharing expected and received by each Healthy Michigan Plan member from the MI Health Account vendor. On a quarterly basis, the Department cross references a sample of beneficiaries with records in the State's data warehouse indicating they had earned a reduction with beneficiaries who had reductions processed. A sample of each managed care plan's population is pulled. Results are processed and reported to confirm accurate application of cost-sharing reductions. Plans found to be in non-compliance with processes and procedures related to application of cost-sharing reductions are subject to established remedies and sanctions, per the Medicaid Health Plan contract.

All Healthy Michigan Plan beneficiaries will have the opportunity to contest various facets of the Healthy Behaviors Incentives Program through the Medicaid health plans and the Department, as appropriate.

XII. Ongoing Engagement of Stakeholders and the Public

The Department began planning the Healthy Behaviors Incentives Program in December 2013. During that planning period, the Department held regular meetings with the managed care plans, provider organizations and the Medical Care Advisory Council, which is made up of staff from the Department, managed care plans, local health departments, medical, oral, and mental health providers, various advocacy groups, and Medicaid beneficiaries. Informational presentations were made to stakeholder and advocacy groups, as well as Tribal partners. The Department has continued to elicit feedback from managed care plans, providers and other stakeholders throughout the duration of the Healthy Behaviors Incentives Program. Results from data analysis are discussed annually during both the Clinical Advisory Committee and Medical Care Advisory Council meetings and stakeholder input was considered for these program changes. The Department monitors feedback on the program from the beneficiary helpline, provider helpline, and all advocacy and stakeholder groups. Results from interim reports of surveys and other investigations carried out by the University of Michigan as part of the program evaluation have also been taken into consideration.

The Department will continue to elicit feedback from providers, beneficiaries, managed care plans and other stakeholders about the Healthy Behaviors Incentives Program. Stakeholder input will be considered for any program changes, and feedback will be accepted on an ongoing basis. The Department will continue to monitor the managed care plans' implementation of the incentives program to ensure that adequate outreach and education

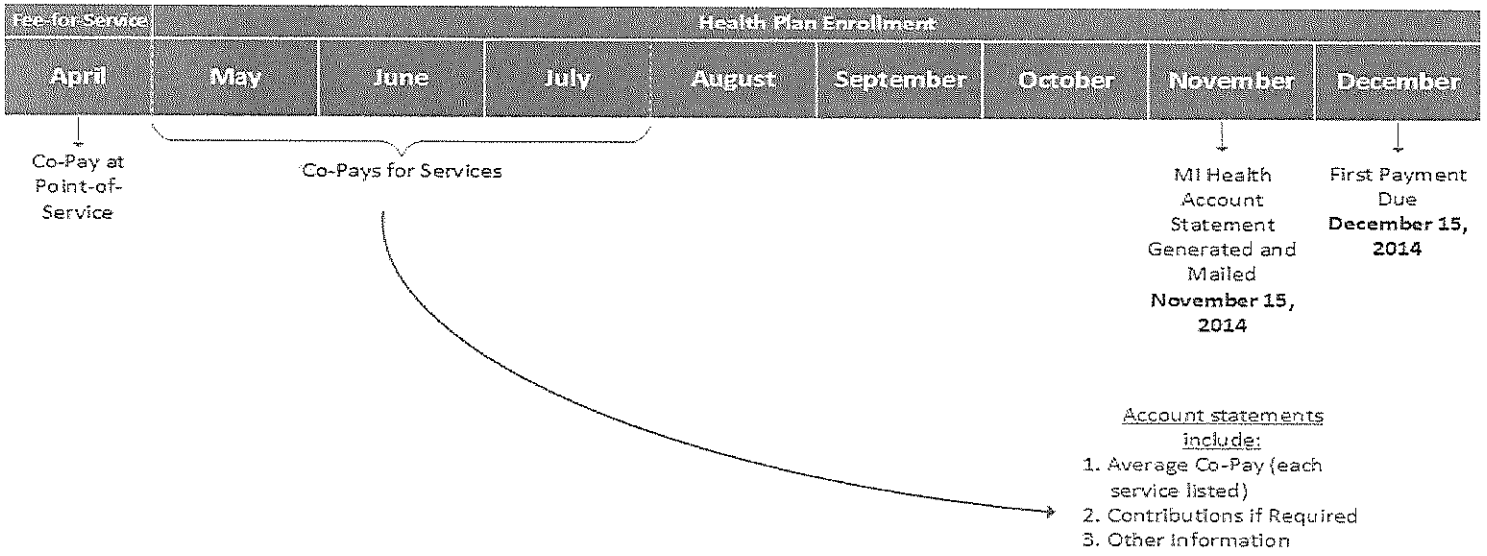
efforts are maintained throughout the demonstration. The Department will report on the Healthy Behaviors Incentives Program each year to stakeholder and advocacy groups. Through the formal evaluation, the department will publish reports on access to care, self-reported health status, and other relevant measures of success and engagement.

ATTACHMENT D
Healthy Behaviors Incentives Program Protocol
Appendix 1: MI Health Account Operation Timeline

Appendix 1

MI Health Account Operation Timeline

Beneficiary Cost Sharing Obligations



HEALTHY MICHIGAN PLAN

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Treatment Category	Drug Class	Description	Chronic Condition(s) Treated
Alzheimer's Disease	H1A	ALZHEIMER'S THERAPY, NMDA RECEPTOR ANTAGONISTS	Alzheimer's Disease and Related Disorders or Senile Dementia
	H1C	ALZHEIMER'S THX,NMDA RECEPTOR ANTAG-CHOLINES INHIB	Alzheimer's Disease and Related Disorders or Senile Dementia
	J1B	CHOLINESTERASE INHIBITORS	Alzheimer's Disease and Related Disorders or Senile Dementia
Anemia	C3B	IRON REPLACEMENT	Anemia (Includes Sickle Cell Disease)
	C6E	VITAMIN E PREPARATIONS	Anemia (Includes Sickle Cell Disease)
	C6F	PRENATAL VITAMIN PREPARATIONS	Anemia (Includes Sickle Cell Disease)
	C6L	VITAMIN B12 PREPARATIONS	Anemia (Includes Sickle Cell Disease)
	C6M	FOLIC ACID PREPARATIONS	Anemia (Includes Sickle Cell Disease)
	C6Q	VITAMIN B6 PREPARATIONS	Anemia (Includes Sickle Cell Disease)
	N1B	ERYTHROPOIESIS-STIMULATING AGENTS	Anemia (Includes Sickle Cell Disease)
	N1F	THROMBOPOIETIN RECEPTOR AGONISTS	Anemia (Includes Sickle Cell Disease)
	N1H	SICKLE CELL ANEMIA AGENTS	Anemia (Includes Sickle Cell Disease)
	P1M	LHRH (GNRH) AGONIST ANALOG PITUITARY SUPPRESSANTS	Anemia (Includes Sickle Cell Disease)
	P1P	LHRH(GNRH)AGNST PIT.SUP-CENTRAL PRECOCIOUS PUBERTY	Anemia (Includes Sickle Cell Disease)
	P5A	GLUCOCORTICOIDS	Anemia (Includes Sickle Cell Disease)
	V1I	CHEMOTHERAPY RESCUE/ANTIDOTE AGENTS	Anemia (Includes Sickle Cell Disease)
	V1O	ANTINEOPLASTIC LHRH(GNRH) AGONIST,PITUITARY SUPPR.	Anemia (Includes Sickle Cell Disease)
	W7K	ANTISERA	Anemia (Includes Sickle Cell Disease)
Arthritis	C7A	HYPERURICEMIA TX - XANTHINE OXIDASE INHIBITORS	RA/OA (Rheumatoid Arthritis/Osteoarthritis)
	D6A	DRUGS TO TX CHRONIC INFLAMMATORY DISEASE OF COLON	RA/OA (Rheumatoid Arthritis/Osteoarthritis)
	D6A	DRUGS TO TX CHRONIC INFLAMMATORY DISEASE OF COLON	RA/OA (Rheumatoid Arthritis/Osteoarthritis)
	D6F	DRUG TX-CHRONIC INFLAM. COLON DX,5-AMINOSALICYLAT	RA/OA (Rheumatoid Arthritis/Osteoarthritis)
	H3D	ANALGESIC/ANTIPYRETICS, SALICYLATES	RA/OA (Rheumatoid Arthritis/Osteoarthritis)
	P1E	ADRENOCORTICOTROPHIC HORMONES	RA/OA (Rheumatoid Arthritis/Osteoarthritis)
	P5A	GLUCOCORTICOIDS	RA/OA (Rheumatoid Arthritis/Osteoarthritis)
	Q5E	TOPICAL ANTI-INFLAMMATORY, NSAIDS	RA/OA (Rheumatoid Arthritis/Osteoarthritis)
	R1R	URICOSURIC AGENTS	RA/OA (Rheumatoid Arthritis/Osteoarthritis)
	S2B	NSAIDS, CYCLOOXYGENASE INHIBITOR - TYPE ANALGESICS	RA/OA (Rheumatoid Arthritis/Osteoarthritis)
	S2C	GOLD SALTS	RA/OA (Rheumatoid Arthritis/Osteoarthritis)
	S2I	ANTI-INFLAMMATORY, PYRIMIDINE SYNTHESIS INHIBITOR	RA/OA (Rheumatoid Arthritis/Osteoarthritis)
	S2J	ANTI-INFLAMMATORY TUMOR NECROSIS FACTOR INHIBITOR	RA/OA (Rheumatoid Arthritis/Osteoarthritis)
	S2J	ANTI-INFLAMMATORY TUMOR NECROSIS FACTOR INHIBITOR	RA/OA (Rheumatoid Arthritis/Osteoarthritis)
	S2K	ANTI-ARTHRITIC AND CHELATING AGENTS	RA/OA (Rheumatoid Arthritis/Osteoarthritis)
	S2L	NSAIDS,CYCLOOXYGENASE-2(COX-2) SELECTIVE INHIBITOR	RA/OA (Rheumatoid Arthritis/Osteoarthritis)
	S2M	ANTI-INFLAM. INTERLEUKIN-1 RECEPTOR ANTAGONIST	RA/OA (Rheumatoid Arthritis/Osteoarthritis)
	S2N	ANTI-ARTHRITIC, FOLATE ANTAGONIST AGENTS	RA/OA (Rheumatoid Arthritis/Osteoarthritis)
	S2N	ANTI-ARTHRITIC, FOLATE ANTAGONIST AGENTS	RA/OA (Rheumatoid Arthritis/Osteoarthritis)
	S2P	NSAID,COX INHIBITOR-TYPE AND PROTON PUMP INHIBITOR	RA/OA (Rheumatoid Arthritis/Osteoarthritis)
	S2Q	ANTINFLAMMATORY, SEL.COSTIM.MOD.,T-CELL INHIBITOR	RA/OA (Rheumatoid Arthritis/Osteoarthritis)
	S2T	NSAIDS(COX NON-SPEC.INHIB)AND PROSTAGLANDIN ANALOG	RA/OA (Rheumatoid Arthritis/Osteoarthritis)
	S2V	ANTI-INFLAMMATORY, INTERLEUKIN-1 BETA BLOCKERS	RA/OA (Rheumatoid Arthritis/Osteoarthritis)
	S2X	NSAID AND HISTAMINE H2 RECEPTOR ANTAGONIST COMB.	RA/OA (Rheumatoid Arthritis/Osteoarthritis)

The information on this page serves as a reference only. It does not guarantee that services are covered. Providers are instructed to refer to the Michigan Medicaid Provider Manual, MSA Bulletins and other relevant policy for specific coverage and reimbursement policies. This information can be found on the Medicaid Policy & Forms web page. If there are discrepancies between the information on this page and the Provider Manual, such as rate or coverage determinations, they will be resolved in favor of the Provider Manual language.

Treatment Category	Drug Class	Description	Chronic Condition(s) Treated
Arthritis Con't.	S2Z	ANTI-INFLAMMATORY,PHOSPHODIESTERASE-4(PDE4) INHIB.	RA/OA (Rheumatoid Arthritis/Osteoarthritis)
	V1B	ANTINEOPLASTIC - ANTIMETABOLITES	RA/OA (Rheumatoid Arthritis/Osteoarthritis)
	Z2E	IMMUNOSUPPRESSIVES	RA/OA (Rheumatoid Arthritis/Osteoarthritis)
	Z2U	MONOCLONAL ANTIBODY-HUMAN INTERLEUKIN 12/23 INHIB	RA/OA (Rheumatoid Arthritis/Osteoarthritis)
	Z2V	INTERLEUKIN-6 (IL-6) RECEPTOR INHIBITORS	RA/OA (Rheumatoid Arthritis/Osteoarthritis)
	Z2W	ANTI-CD20 (B LYMPHOCYTE) MONOCLONAL ANTIBODY	RA/OA (Rheumatoid Arthritis/Osteoarthritis)
	Z2Z	JANUS KINASE (JAK) INHIBITORS	RA/OA (Rheumatoid Arthritis/Osteoarthritis)
Behavioral Health/Substance Abuse	C0D	Anti Alcoholic Preparations	Alcohol Dependence
	H3T	NARCOTIC ANTAGONISTS	Alcohol Dependence
	H2E	SEDATIVE-HYPNOTICS,NON-BARBITURATE	Alcohol Dependence and Depression
	H2F	ANTI-ANXIETY DRUGS	Alcohol Dependence and Depression
	H2D	BARBITURATES	Anxiety
	H2E	SEDATIVE-HYPNOTICS,NON-BARBITURATE	Bipolar Disorder
	H2F	ANTI-ANXIETY DRUGS	Bipolar Disorder
	H2G	ANTIPSYCHOTICS,PHENOTHIAZINES	Bipolar Disorder
	H2M	BIPOLAR DISORDER DRUGS	Bipolar Disorder
	H2S	SELECTIVE SEROTONIN REUPTAKE INHIBITOR (SSRIS)	Bipolar Disorder
	H2U	TRICYCLIC ANTIDEPRESSANTS,REL.NON-SEL.REUPT-INHIB	Bipolar Disorder
	H4B	ANTICONVULSANTS	Bipolar Disorder
	H7D	NOREPINEPHRINE AND DOPAMINE REUPTAKE INHIB (NDRIS)	Bipolar Disorder
	H7E	SEROTONIN-2 ANTAGONIST/REUPTAKE INHIBITORS (SARIS)	Bipolar Disorder
	H7T	ANTIPSYCHOTIC,ATYPICAL,DOPAMINE,SEROTONIN ANTAGNST	Bipolar Disorder
	H7X	ANTIPSYCHOTICS, ATYP, D2 PARTIAL AGONIST/5HT MIXED	Bipolar Disorder
	H7Z	SSRI-ANTIPSYCH, ATYPICAL,DOPAMINE,SEROTONIN ANTAG	Bipolar Disorder
	H8W	ANTIPSYCHOTIC-ATYPICAL,D3/D2 PARTIAL AG-5HT MIXED	Bipolar Disorder
	H2H	MONOAMINE OXIDASE(MAO) INHIBITORS	Depression
	H2M	BIPOLAR DISORDER DRUGS	Depression
	H2S	SELECTIVE SEROTONIN REUPTAKE INHIBITOR (SSRIS)	Depression
	H2U	TRICYCLIC ANTIDEPRESSANTS & REL. NON-SEL. RU-INHIB	Depression
	H2W	TRICYCLIC ANTIDEPRESSANT/PHENOTHIAZINE COMBINATNS	Depression
	H2X	TRICYCLIC ANTIDEPRESSANT/BENZODIAZEPINE COMBINATNS	Depression
	H4B	ANTICONVULSANTS	Depression
	H7B	ALPHA-2 RECEPTOR ANTAGONIST ANTIDEPRESSANTS	Depression
	H7C	SEROTONIN-NOREPINEPHRINE REUPTAKE-INHIB (SNRIS)	Depression
	H7D	NOREPINEPHRINE AND DOPAMINE REUPTAKE INHIB (NDRIS)	Depression
	H7E	SEROTONIN-2 ANTAGONIST/REUPTAKE INHIBITORS (SARIS)	Depression
	H7J	MAOIS - NON-SELECTIVE & IRREVERSIBLE	Depression
	H7Z	SSRI & ANTIPSYCH,ATYP,DOPAMINE&SEROTONIN ANTAG CMB	Depression
	H8P	SSRI & 5HT1A PARTIAL AGONIST ANTIDEPRESSANT	Depression
	H8T	SSRI & SEROTONIN RECEPTOR MODULATOR ANTIDEPRESSANT	Depression
	H2G	ANTI-PSYCHOTICS,PHENOTHIAZINES	Schizophrenia
	H7O	ANTIPSYCHOTICS,DOPAMINE ANTAGONISTS,BUTYROPHENONES	Schizophrenia
	H7P	ANTIPSYCHOTICS,DOPAMINE ANTAGONISTS, THIOXANTHENES	Schizophrenia
	H7S	ANTIPSYCHOTICS,DOPAMINE ANTAGONST,DIHYDROINDOLONES	Schizophrenia

Treatment Category	Drug Class	Description	Chronic Condition(s) Treated
Behavioral Health/Substance Abuse Con't.	H7U	ANTIPSYCHOTICS, DOPAMINE & SEROTONIN ANTAGONISTS	Schizophrenia
	H7T	ANTIPSYCHOTICS,ATYPICAL,DOPAMINE,& SEROTONIN ANTAG	Schizophrenia and Depression
	H7X	ANTIPSYCHOTICS, ATYP, D2 PARTIAL AGONIST/5HT MIXED S	Schizophrenia and Depression
	H2G	ANTIPSYCHOTICS,PHENOTHIAZINES	Schizophrenia, Schizotypal, Delusional, and Other Non-Mood Psychotic Disorders
	H6J	ANTIEMETIC/ANTIVERTIGO AGENTS	Schizophrenia, Schizotypal, Delusional, and Other Non-Mood Psychotic Disorders
	H7O	ANTIPSYCHOTICS,DOPAMINE ANTAGONISTS,BUTYROPHENONES	Schizophrenia, Schizotypal, Delusional, and Other Non-Mood Psychotic Disorders
	H7P	ANTIPSYCHOTICS,DOPAMINE ANTAGONISTS, THIOXANTHENES	Schizophrenia, Schizotypal, Delusional, and Other Non-Mood Psychotic Disorders
	H7S	ANTIPSYCHOTICS,DOPAMINE ANTAGONST,DIHYDROINDOLONES	Schizophrenia, Schizotypal, Delusional, and Other Non-Mood Psychotic Disorders
	H7T	ANTIPSYCHOTIC,ATYPICAL,DOPAMINE,SEROTONIN ANTAGNST	Schizophrenia, Schizotypal, Delusional, and Other Non-Mood Psychotic Disorders
	H7U	ANTIPSYCHOTICS, DOPAMINE AND SEROTONIN ANTAGONISTS	Schizophrenia, Schizotypal, Delusional, and Other Non-Mood Psychotic Disorders
	H7X	ANTIPSYCHOTICS, ATYP, D2 PARTIAL AGONIST/5HT MIXED	Schizophrenia, Schizotypal, Delusional, and Other Non-Mood Psychotic Disorders
	H8W	ANTIPSYCHOTIC-ATYPICAL,D3/D2 PARTIAL AG-5HT MIXED	Schizophrenia, Schizotypal, Delusional, and Other Non-Mood Psychotic Disorders
	C0D	ANTI-ALCOHOLIC PREPARATIONS	Substance Use Disorder
	H3W	NARCOTIC WITHDRAWAL THERAPY AGENTS	Substance Use Disorder
Cancer	C6M	FOLIC ACID PREPARATIONS	Cancer - All Inclusive
	C7F	APPETITE STIM. FOR ANOREXIA,CACHEXIA,WASTING SYND.	Cancer - All Inclusive
	F1A	ANDROGENIC AGENTS	Cancer - All Inclusive
	H2E	SEDATIVE-HYPNOTICS,NON-BARBITURATE	Cancer - All Inclusive
	H2F	ANTI-ANXIETY DRUGS	Cancer - All Inclusive
	H3A	ANALGESICS, NARCOTICS	Cancer - All Inclusive
	H6J	ANTIEMETIC/ANTIVERTIGO AGENTS	Cancer - All Inclusive
	H7O	ANTIPSYCHOTICS,DOPAMINE ANTAGONISTS,BUTYROPHENONES	Cancer - All Inclusive
	H7T	ANTIPSYCHOTIC,ATYPICAL,DOPAMINE,SEROTONIN ANTAGNST	Cancer - All Inclusive
	J9A	INTESTINAL MOTILITY STIMULANTS	Cancer - All Inclusive
	N1C	LEUKOCYTE (WBC) STIMULANTS	Cancer - All Inclusive
	N1E	PLATELET PROLIFERATION STIMULANTS	Cancer - All Inclusive
	P1M	LHRH (GNRH) AGONIST ANALOG PITUITARY SUPPRESSANTS	Cancer - All Inclusive
	P4L	BONE RESORPTION INHIBITORS	Cancer - All Inclusive
	P5A	GLUCOCORTICOIDS	Cancer - All Inclusive
	R2A	FLUORESCENCE CYSTOSCOPY/OPTICAL IMAGING AGENTS	Cancer - All Inclusive
	S2N	ANTI-ARTHRITIC, FOLATE ANTAGONIST AGENTS	Cancer - All Inclusive
	V1A	ANTINEOPLASTIC - ALKYLATING AGENTS	Cancer - All Inclusive
	V1B	ANTINEOPLASTIC - ANTIMETABOLITES	Cancer - All Inclusive
	V1C	ANTINEOPLASTIC - VINCA ALKALOIDS	Cancer - All Inclusive
	V1D	ANTIBIOTIC ANTINEOPLASTICS	Cancer - All Inclusive
	V1E	STEROID ANTINEOPLASTICS	Cancer - All Inclusive

Treatment Category	Drug Class	Description	Chronic Condition(s) Treated
Cancer Con't.	V1F	ANTINEOPLASTICS,MISCELLANEOUS	Cancer - All Inclusive
	V1G	RADIOACTIVE THERAPEUTIC AGENTS	Cancer - All Inclusive
	V1I	CHEMOTHERAPY RESCUE/ANTIDOTE AGENTS	Cancer - All Inclusive
	V1J	ANTINEOPLASTIC - ANTIANDROGENIC AGENTS	Cancer - All Inclusive
	V1O	ANTINEOPLASTIC LHRH(GNRH) AGONIST,PITUITARY SUPPR.	Cancer - All Inclusive
	V1Q	ANTINEOPLASTIC SYSTEMIC ENZYME INHIBITORS	Cancer - All Inclusive
	V1R	PHOTOACTIVATED, ANTINEOPLASTIC AGENTS (SYSTEMIC)	Cancer - All Inclusive
	V1T	SELECTIVE ESTROGEN RECEPTOR MODULATORS (SERMS)	Cancer - All Inclusive
	V1W	ANTINEOPLASTIC EGF RECEPTOR BLOCKER MCLON ANTIBODY	Cancer - All Inclusive
	V1X	ANTINEOPLAST HUM VEGF INHIBITOR RECOMB MC ANTIBODY	Cancer - All Inclusive
	V2A	NEOPLASM MONOCLONAL DIAGNOSTIC AGENTS	Cancer - All Inclusive
	V3C	ANTINEOPLASTIC - MTOR KINASE INHIBITORS	Cancer - All Inclusive
	V3E	ANTINEOPLASTIC - TOPOISOMERASE I INHIBITORS	Cancer - All Inclusive
	V3F	ANTINEOPLASTIC - AROMATASE INHIBITORS	Cancer - All Inclusive
	V3N	ANTINEOPLASTIC - VEGF-A,B AND PLGF INHIBITORS	Cancer - All Inclusive
	V3P	ANTINEOPLASTIC - VEGFR ANTAGONIST	Cancer - All Inclusive
	V3R	ANTINEOPLASTIC,ANTI-PROGRAMMED DEATH-1 (PD-1) MAB	Cancer - All Inclusive
	V3Y	ANTI-PROGRAMMED CELL DEATH-LIGAND 1 (PD-L1) MAB	Cancer - All Inclusive
	W7B	VIRAL/TUMORIGENIC VACCINES	Cancer - All Inclusive
	Z2G	IMMUNOMODULATORS	Cancer - All Inclusive
	Z8B	PORPHYRINS AND PORPHYRIN DERIVATIVE AGENTS	Cancer - All Inclusive
Chronic Cardiovascular Disease	A1A	DIGITALIS GLYCOSIDES	Atrial Fibrillation
	A2A	ANTIARRHYTHMICS	Atrial Fibrillation
	A9A	CALCIUM CHANNEL BLOCKING AGENTS	Atrial Fibrillation
	J7A	ALPHA/BETA-ADRENERGIC BLOCKING AGENTS	Atrial Fibrillation
	J7C	BETA-ADRENERGIC BLOCKING AGENTS	Atrial Fibrillation
	M9L	ANTICOAGULANTS,COUMARIN TYPE	Atrial Fibrillation
	M9T	THROMBIN INHIBITORS, SELECTIVE, DIRECT, REVERSIBLE	Atrial Fibrillation
	M9V	DIRECT FACTOR XA INHIBITORS	Atrial Fibrillation
	M9V	DIRECT FACTOR XA INHIBITORS	DVT
	M9E	THROMBIN INHIBITORS,SEL.,DIRECT,&REV.-HIRUDIN TYPE	DVT and Ischemic Heart Disease
	M9K	HEPARIN AND RELATED PREPARATIONS	DVT and Ischemic Heart Disease
	M9L	ANTICOAGULANTS,COUMARIN TYPE	DVT and Ischemic Heart Disease
	M9T	THROMBIN INHIBITORS,SELECTIVE,DIRECT, & REVERSIBLE	DVT and Ischemic Heart Disease
	M9F	THROMBOLYTIC ENZYMES	DVT and Stroke/Transient Ischemic Attack
	A7B	VASODILATORS,CORONARY Ischemic	Heart Disease and Heart Failure
	A1A	DIGITALIS GLYCOSIDES	Heart Failure
	A1C	INOTROPIC DRUGS	Heart Failure
	A7J	VASODILATORS, COMBINATION	Heart Failure
	J7C	BETA-ADRENERGIC BLOCKING AGENTS	Heart Failure and Ischemic Heart Disease
	C6N	NIACIN PREPARATIONS	Hyperlipidemia
	D7L	BILE SALT SEQUESTRANTS	Hyperlipidemia
	M4D	ANTIHYPERLIPIDEMIC - HMG COA REDUCTASE INHIBITORS	Hyperlipidemia and Ischemic Heart Disease
	M4E	LIPOTROPICS	Hyperlipidemia and Ischemic Heart Disease

Treatment Category	Drug Class	Description	Chronic Condition(s) Treated
Chronic Cardiovascular Disease Con't.	M4L	ANTIHYPERLIPIDEMIC-HMG COA REDUCTASE INHIB.&NIACIN	Hyperlipidemia and Ischemic Heart Disease
	M4M	ANTIHYPERLIP.HMG COA REDUCT INHIB&CHOLEST.AB.INHIB	Hyperlipidemia and Ischemic Heart Disease
	M4I	ANTIHYPERLIP - HMG-COA&CALCIUM CHANNEL BLOCKER CB	Hyperlipidemia, Hypertension, Ischemic Heart Disease
	A4A	ANTIHYPERTENSIVES, VASODILATORS	Hypertension
	A4B	ANTIHYPERTENSIVES, SYMPATHOLYTIC	Hypertension
	A4C	ANTIHYPERTENSIVES, GANGLIONIC BLOCKERS	Hypertension
	A4K	ACE INHIBITOR/CALCIUM CHANNEL BLOCKER COMBINATION	Hypertension
	A4T	RENIN INHIBITOR, DIRECT	Hypertension
	A4U	RENIN INHIBITOR,DIRECT AND THIAZIDE DIURETIC COMB	Hypertension
	A4V	ANGIOTEN.RECEPTR ANTAG./CAL.CHANL BLKR/THIAZIDE CB	Hypertension
	A4W	RENIN INHIBITOR,DIRECT & ANGIOTENSIN RECEPT ANTAG.	Hypertension
	A4X	RENIN INHIBITOR, DIRECT & CALCIUM CHANNEL BLOCKER	Hypertension
	A4Y	ANTIHYPERTENSIVES, MISCELLANEOUS	Hypertension
	A4Z	RENIN INHIB, DIRECT& CALC.CHANNEL BLKR & THIAZIDE	Hypertension
	J7B	ALPHA-ADRENERGIC BLOCKING AGENTS	Hypertension
	J7B	ALPHA-ADRENERGIC BLOCKING AGENTS	Hypertension
	J7E	ALPHA-ADRENERGIC BLOCKING AGENT/THIAZIDE COMB	Hypertension
	J7H	BETA-ADRENERGIC BLOCKING AGENTS/THIAZIDE & RELATED	Hypertension
	A7H	VASOACTIVE NATRIURETIC PEPTIDES	Hypertension and Heart Failure
	J7A	ALPHA/BETA-ADRENERGIC BLOCKING AGENTS	Hypertension and Heart Failure
	R1E	CARBONIC ANHYDRASE INHIBITORS	Hypertension and Heart Failure
	R1F	THIAZIDE AND RELATED DIURETICS	Hypertension and Heart Failure
	R1H	POTASSIUM SPARING DIURETICS	Hypertension and Heart Failure
	R1L	POTASSIUM SPARING DIURETICS IN COMBINATION	Hypertension and Heart Failure
	R1M	LOOP DIURETICS	Hypertension and Heart Failure
	A4F	ANTIHYPERTENSIVES, ANGIOTENSIN RECEPTOR ANTAGONIST	Hypertension, Ischemic Heart Disease and Heart Failure
	A4H	ANGIOTENSIN RECEPTOR ANTGNST & CALC.CHANNEL BLOCKR	Hypertension, Ischemic Heart Disease and Heart Failure
	A4I	ANGIOTENSIN RECEPTOR ANTAG./THIAZIDE DIURETIC COMB	Hypertension, Ischemic Heart Disease and Heart Failure
	A4J	ACE INHIBITOR/THIAZIDE & THIAZIDE-LIKE DIURETIC	Hypertension, Ischemic Heart Disease and Heart Failure
	A9A	CALCIUM CHANNEL BLOCKING AGENTS	Hypertension, Ischemic Heart Disease and Heart Failure
	A2C	ANTIANGINAL & ANTI-ISCHEMIC AGENTS,NON-HEMODYNAMIC	Ischemic Heart Disease
	C4A	ANTIHYPERGLY.DPP-4 INHIBITORS &HMG COA RI(STATINS)	Ischemic Heart Disease
	M4E	LIPOTROPICS	Ischemic Heart Disease
	M9D	ANTIFIBRINOLYTIC AGENTS	Ischemic Heart Disease
	A4D	ANTIHYPERTENSIVES, ACE INHIBITORS Hypertension,	Ischemic Heart Disease and Heart Failure
	A7C	VASODILATORS,PERIPHERAL	Ischemic Heart Disease and Stroke/Transient Ischemic Attack
	M9P	PLATELET AGGREGATION INHIBITORS	Ischemic Heart Disease and Stroke/Transient Ischemic Attack
Chronic Kidney Disease	A4A	HYPOTENSIVES, VASODILATORS	Chronic Kidney Disease
	A4B	HYPOTENSIVES, SYMPATHOLYTIC	Chronic Kidney Disease
	A4C	HYPOTENSIVES, GANGLIONIC BLOCKERS	Chronic Kidney Disease
	A4D	HYPOTENSIVES, ACE BLOCKING TYPE	Chronic Kidney Disease
	A4F	HYPOTENSIVES-ANGIO RECEPTOR ANTAG	Chronic Kidney Disease
	A4H	ANGITNS RCPT ANTGST & CA.CHNL BLCKR	Chronic Kidney Disease
	A4I	ANG REC ANT/THZ & THZ-REL DIU COMBS	Chronic Kidney Disease

Treatment Category	Drug Class	Description	Chronic Condition(s) Treated
Chronic Kidney Disease Con't.	A4J	ACE INH/THZ & THZ-LIKE DIURET COMBS	Chronic Kidney Disease
	A4K	ACE INHIBITOR/CCB COMBINATION	Chronic Kidney Disease
	A4N	ARB-BB COMBINATION	Chronic Kidney Disease
	A4T	RENIN INHIBITOR, DIRECT	Chronic Kidney Disease
	A4U	RENIN INHB, DIRCT/THIAZD DIURET CMB	Chronic Kidney Disease
	A4V	ANGTN.RCPT ANT/CA.CHANL BLK/THZD CB	Chronic Kidney Disease
	A4W	RENIN INHBT,DRCT & ANGTN RCPT ANTAG	Chronic Kidney Disease
	A4X	RENIN INHBTR, DRCT & CA CHNNL BLCKR	Chronic Kidney Disease
	A4Y	HYPOTENSIVES, MISCELLANEOUS	Chronic Kidney Disease
	A4Z	RENIN INHB,DRCT/CA CHNL BLK/THZD CB	Chronic Kidney Disease
	A7J	VASODILATORS,COMBINATION	Chronic Kidney Disease
	C1A	ELECTROLYTE DEPLETERS	Chronic Kidney Disease
	C1F	CALCIUM REPLACEMENT	Chronic Kidney Disease
	C3B	IRON REPLACEMENT	Chronic Kidney Disease
	C4A	ANTIHYPERGLY DPP4 INHB & HMG COA RI	Chronic Kidney Disease
	C4B	ANTIHYPERGLY-Glucocort Recpt Bl	Chronic Kidney Disease
	C4C	ANTIHYPERGLY,DPP-4 INH&THIAZOL	Chronic Kidney Disease
	C4D	Antihyperglycemic SGLT2	Chronic Kidney Disease
	C4E	SGLT2 INHIB-BIGUANIDE CMB	Chronic Kidney Disease
	C4F	ANTIHYPERGLY,(DPP-4) INHI & BIG CMB	Chronic Kidney Disease
	C4G	INSULINS	Chronic Kidney Disease
	C4H	ANTIHYPERGLY,AMYLIN ANALOG TYPE	Chronic Kidney Disease
	C4I	ANTIHYPERGLY,INCRETIN MIMETIC	Chronic Kidney Disease
	C4J	ANTIHYPERGLYCEMIC, DPP-4 INHIBITORS	Chronic Kidney Disease
	C4K	ORAL HYPOGLYCEMICS, SULFONYLUREAS	Chronic Kidney Disease
	C4L	ORAL HYPOGLYC., NON-SULFONYLUREAS	Chronic Kidney Disease
	C4M	HYPOGLYCEMICS, ALPHA-GLUCOSIDASE	Chronic Kidney Disease
	C4N	HYPOGLYCEMICS, INSULIN-RESPONSE	Chronic Kidney Disease
	C4R	HYPOG,INSUL-RESPON & INSUL RELEA CB	Chronic Kidney Disease
	C4S	HYPOGLY,INSUL-REL STIM & BIGUAN CMB	Chronic Kidney Disease
	C4T	HYPOGLY,INSUL-RESP ENHAN & BIGU CMB	Chronic Kidney Disease
	C4V	ANTHYPERGLYCEMIC-DOPAM RCPTR AGONST	Chronic Kidney Disease
	C4W	SGLT-2/DPP-4 CMB	Chronic Kidney Disease
	C4X	INSULIN, LONG ACT-GLP1 REC.AG	Chronic Kidney Disease
	C6D	VITAMIN D PREPARATIONS	Chronic Kidney Disease
	D7L	BILE SALT SEQUESTRANTS	Chronic Kidney Disease
	J7B	ALPHA-ADRENERGIC BLOCKING AGENTS	Chronic Kidney Disease
	M4D	ANTIHYPERLIPD-HMG COA REDUCT INHB	Chronic Kidney Disease
	M4E	LIPOTROPICS	Chronic Kidney Disease
	M4J	ANTHYPRLIPD-HMG COA & PL AG INH CMB	Chronic Kidney Disease
	M4L	ANTIHYPERLIPD-HMG COA & NIACIN COMB	Chronic Kidney Disease
	M4M	ANTHYPRLPD-HMG COA & CHL AB INH CMB	Chronic Kidney Disease
	M9K	HEPARIN AND RELATED PREPARATIONS	Chronic Kidney Disease
	N1B	ERYTHROPOIESIS-STIMULATING AGENTS	Chronic Kidney Disease
	P4D	HYPERPARATHYROID TX AGENTS - VITAMIN D ANALOG-TYPE	Chronic Kidney Disease

Treatment Category	Drug Class	Description	Chronic Condition(s) Treated
Chronic Kidney Disease Con't.	P4M	CALCIMIMETIC,PARATHYROID CALCIUM ENHANCER	Chronic Kidney Disease
	R1M	LOOP DIURETICS	Chronic Kidney Disease
Chronic Pulmonary Disease	Z2F	MAST CELL STABILIZERS	Asthma
	Z4B	LEUKOTRIENE RECEPTOR ANTAGONISTS	Asthma
	A1B	XANTHINES	Asthma and COPD
	A1D	GENERAL BRONCHODILATOR AGENTS	Asthma and COPD
	B6M	GLUCOCORTICOIDS, ORALLY INHALED	Asthma and COPD
	J5A	ADRENERGIC AGENTS,CATECHOLAMINES	Asthma and COPD
	J5D	BETA-ADRENERGIC AGENTS	Asthma and COPD
	J5G	BETA-ADRENERGIC AND GLUCOCORTICOID COMBINATIONS	Asthma and COPD
	J5J	BETA-ADRENERGIC AND ANTICHOLINERGIC COMBINATIONS	COPD
	Z2X	PHOSPHODIESTERASE-4 (PDE4) INHIBITORS	COPD
	B0B	CYSTIC FIB-TRANSMEMB CONDUCT.REG.(CFTR)POTENTIATOR	Cystic Fibrosis
	B0F	CYSTIC FIBROSIS-CFTR POTENTIATOR-CORRECTOR COMBIN.	Cystic Fibrosis
	B3A	MUCOLYTICS	Cystic Fibrosis
	C6E	VITAMIN E PREPARATIONS	Cystic Fibrosis
	W1A	PENICILLINS	Cystic Fibrosis
	W1F	AMINOGLYCOSIDES	Cystic Fibrosis
	W1N	POLYMYXIN AND DERIVATIVES	Cystic Fibrosis
	W1P	BETALACTAMS	Cystic Fibrosis
	W1Q	QUINOLONES	Cystic Fibrosis
	W1S	CARBAPENEMS (THIENAMYCINS)	Cystic Fibrosis
	W1Y	CEPHALOSPORINS - 3RD GENERATION	Cystic Fibrosis
	W1Z	CEPHALOSPORINS - 4TH GENERATION	Cystic Fibrosis
Diabetes	C4B	ANTIHYPERGLYCEMIC-GLUCOCORTICOID RECEPTOR BLOCKER	Diabetes Mellitus
	C4C	ANTIHYPERGLY,DPP-4 ENZYME INHIB &THIAZOLIDINEDIONE	Diabetes Mellitus
	C4D	ANTIHYPERGLYCEMC-SOD/GLUC COTRANSPORT2(SGLT2)INHIB	Diabetes Mellitus
	C4F	ANTIHYPERGLYCEMIC,DPP-4 INHIBITOR & BIGUANIDE COMB	Diabetes Mellitus
	C4G	INSULINS	Diabetes Mellitus
	C4H	ANTIHYPERGLYCEMIC, AMYLIN ANALOG-TYPE	Diabetes Mellitus
	C4I	ANTIHYPERGLY,INCRETIN MIMETIC(GLP-1 RECEP.AGONIST)	Diabetes Mellitus
	C4J	ANTIHYPERGLYCEMIC, DPP-4 INHIBITORS	Diabetes Mellitus
	C4K	ANTIHYPERGLYCEMIC, INSULIN-RELEASE STIMULANT TYPE	Diabetes Mellitus
	C4L	ANTIHYPERGLYCEMIC, BIGUANIDE TYPE	Diabetes Mellitus
	C4M	ANTIHYPERGLYCEMIC, ALPHA-GLUCOSIDASE INHIBITORS	Diabetes Mellitus
	C4N	ANTIHYPERGLYCEMIC,THIAZOLIDINEDIONE(PPARG AGONIST)	Diabetes Mellitus
	C4R	ANTIHYPERGLYCEMIC,THIAZOLIDINEDIONE & SULFONYLUREA	Diabetes Mellitus
	C4S	ANTIHYPERGLYCEMIC,INSULIN-REL STIM.& BIGUANIDE CMB	Diabetes Mellitus
	C4T	ANTIHYPERGLYCEMIC,THIAZOLIDINEDIONE & BIGUANIDE	Diabetes Mellitus
	C4V	ANTIHYPERGLYCEMIC - DOPAMINE RECEPTOR AGONISTS	Diabetes Mellitus

Treatment Category	Drug Class	Description	Chronic Condition(s) Treated
Glaucoma	Q2G	OPHTHALMIC ANTIFIBROTIC AGENTS	Glaucoma
	Q6G	MIOTICS/OTHER INTRAOC. PRESSURE REDUCERS	Glaucoma
	Q6J	MYDRIATICS	Glaucoma
	R1B	OSMOTIC DIURETICS	Glaucoma
	R1E	CARBONIC ANHYDRASE INHIBITORS	Glaucoma
Hemophilia	M0E	ANTIHEMOPHILIC FACTORS	Hemophilia
	M0F	FACTOR IX PREPARATIONS	Hemophilia
	M0I	FACTOR IX COMPLEX (PCC) PREPARATIONS	Hemophilia
	M0K	FACTOR X PREPARATIONS	Hemophilia
	M9D	ANTIFIBRINOLYTIC AGENTS	Hemophilia
HIV	W5C	ANTIVIRALS, HIV-SPECIFIC, PROTEASE INHIBITORS	HIV
	W5I	ANTIVIRALS, HIV-SPECIFIC, NUCLEOTIDE ANALOG, RTI	HIV
	W5J	ANTIVIRALS, HIV-SPECIFIC, NUCLEOSIDE ANALOG, RTI	HIV
	W5K	ANTIVIRALS, HIV-SPECIFIC, NON-NUCLEOSIDE, RTI	HIV
	W5L	ANTIVIRALS, HIV-SPEC., NUCLEOSIDE ANALOG, RTI COMB	HIV
	W5M	ANTIVIRALS, HIV-SPECIFIC, PROTEASE INHIBITOR COMB	HIV
	W5N	ANTIVIRALS, HIV-SPECIFIC, FUSION INHIBITORS	HIV
	W5O	ANTIVIRALS, HIV-SPEC, NUCLEOSIDE-NUCLEOTIDE ANALOG	HIV
	W5P	ANTIVIRALS, HIV-SPEC, NON-PEPTIDIC PROTEASE INHIB	HIV
	W5Q	ARTV CMB NUCLEOSIDE,NUCLEOTIDE,&NON-NUCLEOSIDE RTI	HIV
	W5T	ANTIVIRALS, HIV-SPECIFIC, CCR5 CO-RECEPTOR ANTAG.	HIV
	W5U	ANTIVIRALS,HIV-1 INTEGRASE STRAND TRANSFER INHIBTR	HIV
	W5X	ARV CMB-NRTI,N(T)RTI, INTEGRASE INHIBITOR	HIV
Lead Exposure	C8A	METALLIC POISON,AGENTS TO TREAT	Lead Exposure
	C8C	LEAD POISONING, AGENTS TO TREAT (CHELATING-TYPE)	Lead Exposure
Liver Disease	D7A	BILE SALTS	Liver Disease, Cirrhosis and Other Liver Conditions (except Viral Hepatitis)
	D7E	FARNESOID X RECEPTOR (FXR) AGONIST, BILE AC ANALOG	Liver Disease, Cirrhosis and Other Liver Conditions (except Viral Hepatitis)
	D7U	BILIARY DIAGNOSTICS,RADIOPAQUE	Liver Disease, Cirrhosis and Other Liver Conditions (except Viral Hepatitis)
	D9A	AMMONIA INHIBITORS	Liver Disease, Cirrhosis and Other Liver Conditions (except Viral Hepatitis)
	M0B	PLASMA PROTEINS	Liver Disease, Cirrhosis and Other Liver Conditions (except Viral Hepatitis)
	M0G	ANTIPORPHYRIA FACTORS	Liver Disease, Cirrhosis and Other Liver Conditions (except Viral Hepatitis)
	M9U	THROMBOLYTIC - NUCLEOTIDE TYPE	Liver Disease, Cirrhosis and Other Liver Conditions (except Viral Hepatitis)
	P5A	GLUCOCORTICOIDS	Liver Disease, Cirrhosis and Other Liver Conditions (except Viral Hepatitis)
	R1H	POTASSIUM SPARING DIURETICS	Liver Disease, Cirrhosis and Other Liver Conditions (except Viral Hepatitis)
	R1L	POTASSIUM SPARING DIURETICS IN COMBINATION	Liver Disease, Cirrhosis and Other Liver Conditions (except Viral Hepatitis)

Treatment Category	Drug Class	Description	Chronic Condition(s) Treated
Liver Disease Con't.	R1M	LOOP DIURETICS	Liver Disease, Cirrhosis and Other Liver Conditions (except Viral Hepatitis)
	V1B	ANTINEOPLASTIC - ANTIMETABOLITES	Liver Disease, Cirrhosis and Other Liver Conditions (except Viral Hepatitis)
	V1D	ANTIBIOTIC ANTINEOPLASTICS	Liver Disease, Cirrhosis and Other Liver Conditions (except Viral Hepatitis)
	V1Q	ANTINEOPLASTIC SYSTEMIC ENZYME INHIBITORS	Liver Disease, Cirrhosis and Other Liver Conditions (except Viral Hepatitis)
	W1F	AMINOGLYCOSIDES	Liver Disease, Cirrhosis and Other Liver Conditions (except Viral Hepatitis)
	W4C	AMEBICIDES	Liver Disease, Cirrhosis and Other Liver Conditions (except Viral Hepatitis)
	W9C	RIFAMYCINS AND RELATED DERIVATIVE ANTIBIOTICS	Liver Disease, Cirrhosis and Other Liver Conditions (except Viral Hepatitis)
	N1F	THROMBOPOIETIN RECEPTOR AGONISTS	Viral Hepatitis
	P5A	GLUCOCORTICOIDS	Viral Hepatitis
	W0A	HEPATITIS C VIRUS - NS5A REPLICATION COMPLEX INHIB	Viral Hepatitis
	W0B	HEP C VIRUS-NS5B POLYMERASE AND NS5A INHIB. COMBO.	Viral Hepatitis
	W0D	HEPATITIS C VIRUS - NS5A, NS3/4A, NS5B INHIB CMB.	Viral Hepatitis
	W0E	HEPATITIS C VIRUS- NS5A AND NS3/4A INHIBITOR COMB	Viral Hepatitis
	W5A	ANTIVIRALS, GENERAL	Viral Hepatitis
	W5F	HEPATITIS B TREATMENT AGENTS	Viral Hepatitis
	W5G	HEPATITIS C TREATMENT AGENTS	Viral Hepatitis
	W5I	ANTIVIRALS, HIV-SPECIFIC, NUCLEOTIDE ANALOG, RTI	Viral Hepatitis
	W5V	HEPATITIS C VIRUS NS3/4A SERINE PROTEASE INHIB.	Viral Hepatitis
	W5Y	HEP C VIRUS,NUCLEOTIDE ANALOG NS5B POLYMERASE INH	Viral Hepatitis
	W7B	VIRAL/TUMORIGENIC VACCINES	Viral Hepatitis
	W7K	ANTISERA	Viral Hepatitis
	Z2E	IMMUNOSUPPRESSIVES	Viral Hepatitis
	Z2G	IMMUNOMODULATORS	Viral Hepatitis
Medical Supplies	X2A	NEEDLES/NEEDLELESS DEVICES	Medical Supplies
	X2B	SYRINGES AND ACCESSORIES	Medical Supplies
	X5B	BANDAGES AND RELATED SUPPLIES	Medical Supplies
	Y7A	RESPIRATORY AIDS,DEVICES,EQUIPMENT	Medical Supplies
	Y9A	DIABETIC SUPPLIES	Medical Supplies
Obesity	D5A	FAT ABSORPTION DECREASING AGENTS	Obesity
	J5B	ADRENERGICS, AROMATIC, NON-CATECHOLAMINE	Obesity
	J8A	ANTI-OBESITY - ANOREXIC AGENTS	Obesity
	J8C	ANTI-OBESITY SEROTONIN 2C RECEPTOR AGONISTS	Obesity
Osteoporosis	C1F	CALCIUM REPLACEMENT	Osteoporosis
	C6D	VITAMIN D PREPARATIONS	Osteoporosis
	F1A	ANDROGENIC AGENTS	Osteoporosis
	G1A	ESTROGENIC AGENTS	Osteoporosis
	G1D	ESTROGEN-PROGESTIN WITH ANTIMINERALOCORTICOID COMB	Osteoporosis
	G1G	ESTROGEN-SELECTIVE ESTROGEN RECEPTOR MOD(SERM)COMB	Osteoporosis

Treatment Category	Drug Class	Description	Chronic Condition(s) Treated
	P4B	BONE FORMATION STIM. AGENTS - PARATHYROID HORMONE	Osteoporosis
	P4L	BONE RESORPTION INHIBITORS	Osteoporosis
	P4N	BONE RESORPTION INHIBITOR AND VITAMIN D COMBS.	Osteoporosis
	P4O	BONE RESORPTION INHIBITOR AND CALCIUM COMBINATIONS	Osteoporosis
Smoking Cessation	J3A	SMOKING DETERRENT AGENTS (GANGLIONIC STIM,OTHERS)	Tobacco Use Disorder
	J3C	SMOKING DETERRENT-NICOTINIC RECEPT.PARTIAL AGONIST	Tobacco Use Disorder
Stroke	C4A	ANTIHYPERGLY. DPP-4 INHIBITORS-HMG COA RI(STATINS)	Stroke/Transient Ischemic Attack
	H3D	ANALGESIC/ANTIPYRETICS, SALICYLATES	Stroke/Transient Ischemic Attack
	M4D	ANTIHYPERLIPIDEMIC - HMG COA REDUCTASE INHIBITORS	Stroke/Transient Ischemic Attack
	M4L	ANTIHYPERLIPIDEMIC-HMG COA REDUCTASE INHIB.-NIACIN	Stroke/Transient Ischemic Attack
	M9K	HEPARIN AND RELATED PREPARATIONS	Stroke/Transient Ischemic Attack
	M9P	PLATELET AGGREGATION INHIBITORS	Stroke/Transient Ischemic Attack

Health Risk Assessment

INSTRUCTIONS

The Healthy Michigan Plan is very interested in helping you get healthy and stay healthy. We want to ask you a few questions about your current health. Your doctor and your health plan will use this information to better meet your health needs. The information you provide in this form is personal health information protected by federal and state law and will be kept confidential. It CANNOT be used to deny health care coverage.

We also encourage you to see your doctor for a check-up as soon as possible after you enroll with a health plan, and at least once a year after that. An annual check-up appointment is a covered benefit of the Healthy Michigan Plan. Contact your health plan if you need transportation assistance to get to and from this appointment.

If you need assistance with completing this form, contact your health plan. You can also call the Beneficiary Help Line at 1-800-642-3195 or TTY 1-866-501-5656 if you have questions.

You can also learn more at this website: www.healthymichiganplan.org.

Instructions for completing this Health Risk Assessment for Healthy Michigan Plan:

- Answer the questions in sections 1-3 as best you can. You are not required to answer all of the questions.
- Call your doctor's office to schedule an annual check-up appointment. Take this form with you to your appointment.
- Your doctor or other primary care provider will complete section 4. He or she will send your results to your health plan.
- There is a Healthy Behavior Reward for agreeing to address or maintain healthy behaviors on your health risk assessment. This reward can be a gift card or a reduction in monthly MI Health Account payments, depending on your income.
- Don't forget to complete a new health risk assessment each year.

After your appointment, keep a copy or printout of this form that has your doctor's signature on it. This is your record that you completed your annual Health Risk Assessment.

For questions and/or problems, or help to translate, call the Beneficiary Help Line at 1-800-642-3195 or TTY 1-866-501-5656.

Spanish: Si necesita ayuda para traducir o entender este texto, por favor llame al telefono, 1-800-642-3195 or TTY 1-866-501-5656

Arabic: TTY 1-866-501-5656

إذا كان لديكم أيّ سؤال، يرجى الإتصال بخط المساعدة على الرقم المجاني ١-٨٠٠-٦٤٢-٣١٩٥

HEALTHY MICHIGAN PLAN

Health Risk Assessment

First Name, Middle Name, Last Name, and Suffix				Date of Birth (mm/dd/yyyy)
Mailing Address		Apartment or Lot Number		**mihealth** Card Number
City	State	Zip Code	Phone Number	Other Phone Number

SECTION 1 - Initial assessment questions (check one for each question)

1. In general, how would you rate your health? ☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

2. Has a doctor told you that you have hearing loss or are deaf? ☐ Yes ☐ No

3. (For women only) Are you currently pregnant? ☐ Yes ☐ No ☐ Not applicable (men only)

4. In the last 7 days, how often did you exercise for at least 20 minutes in a day?

☐ Every day ☐ 3-6 days ☐ 1-2 days ☐ 0 days

Exercise includes walking, housekeeping, jogging, weights, a sport or playing with your kids. It can be done on the job, around the house, just for fun or as a work-out.

5. In the last 7 days, how often did you eat 3 or more servings of fruits or vegetables in a day?

☐ Every day ☐ 3-6 days ☐ 1-2 days ☐ 0 days

Each time you ate a fruit or vegetable counts as one serving. It can be fresh, frozen, canned, cooked or mixed with other foods.

6. In the last 7 days, how often did you have (5 or more for men, 4 or more for women) alcoholic drinks at one time? ☐ Never ☐ Once a week ☐ 2-3 times a week ☐ More than 3 times during the week

1 drink is 1 beer, 1 glass of wine, or 1 shot.

7. In the last 30 days have you smoked or used tobacco? ☐ Yes ☐ No

If YES, Do you want to quit smoking or using tobacco?

☐ Yes ☐ I am working on quitting or cutting back right now ☐ No

8. How often is stress a problem for you in handling everyday things such as your health, money, work, or relationships with family and friends?

☐ Almost every day ☐ Sometimes ☐ Rarely ☐ Never

HEALTHY MICHIGAN PLAN

Health Risk Assessment

First Name, Middle Name, Last Name, and Suffix	mihealth Card Number

9. Do you use drugs or medications (other than exactly as prescribed for you) which affect your mood or help you to relax? ☐ Almost every day ☐ Sometimes ☐ Rarely ☐ Never

This includes illegal or street drugs and medications from a doctor or drug store if you are taking them differently than exactly how your doctor told you to take them.

10. Have you had a flu shot in the last year? ☐ Yes ☐ No

11. How long has it been since you last visited a dentist or dental clinic for any reason?

☐ Never ☐ Within the last year ☐ Between 1-2 years ☐ Between 3-5 years ☐ More than 5 years

12. Do you have access to transportation for medical appointments?

☐ Yes ☐ No ☐ Sometimes, but it is not reliable

Transportation could be your own car, a friend who drives you, a bus pass, or taxi. Your health plan can help you with a ride to and from medical appointments.

13. Do you need help with food, clothing, utilities, or housing? ☐ Yes ☐ No

This could be trouble paying your heating bill, no working refrigerator, or no permanent place to live.

14. A checkup is a visit to a doctor's office that is NOT for a specific problem. How long has it been since your last checkup? ☐ Within the last year ☐ Between 1-3 years ☐ More than 3 years

SECTION 2 - Annual appointment

A routine checkup is an important part of taking care of your health. An annual check-up appointment is a covered benefit of the Healthy Michigan Plan and your health plan can help you with a ride to and from this appointment.

Date of appointment: _____
(mm/dd/yyyy)

At my appointment, I would most like to talk with my doctor about:

_____

An annual appointment gives you a chance to talk to your doctor and ask any questions you may have about your health including questions about medications or tests you might need.

Take this form to your check-up and complete the rest of the form with your doctor at this appointment.

Health Risk Assessment

First Name, Middle Name, Last Name, and Suffix	mihealth Card Number

Section 3 - Readiness to change

Your Healthy Behavior

Small everyday changes can have a big impact on your health. Think about the changes you would be most interested in making over the next year**.** It is also important to get any health screenings recommended by your doctor.

Now that you have thought about your healthy behavior, answer questions 1 - 3. For each question, use the scale provided and pick a number from 0 through 5.

		0	1	2	3	4	5
1.	**Thinking about your healthy behavior, do you want to make some small lifestyle changes in this area to improve your health?**	I don't want to make changes now		I want to learn more about changes I can make		Yes, I know the changes I want to start making	
2.	**How much support do you think you would get from family or friends if they knew you were trying to make some changes?**	I don't think family or friends would help me		I think I have some support		Yes, I think family or friends would help me	
3.	**How much support would you like from your doctor or your health plan to make these changes?**	I do not want to be contacted		I want to learn more about programs that can help me		Yes, I am interested in signing up for programs that can help me	

Section 4 – To be completed by your primary care provider

Primary care providers should fill out this form for Healthy Michigan Plan beneficiaries enrolled in Managed Care Plans only. Fill in the "Healthy Behaviors Goals Progress" question and select a "Healthy Behavior Goals" statement in discussion with your patient. Sign the Primary Care Provider Attestation, including the date of the appointment. Both parts of Section 4 must be filled in for the attestation to be considered complete.

Healthy Behaviors Goals Progress

Did the patient maintain or achieve/make significant progress towards their selected health behavior goal(s) over the last year?

- ☐ Not applicable – this is the first known Healthy Michigan Plan Health Risk Assessment for this patient.
- ☐ Yes
- ☐ No
- ☐ Patient had a serious medical, behavioral, or social condition or conditions which precluded addressing unhealthy behaviors.

Health Risk Assessment

First Name, Middle Name, Last Name, and Suffix	mihealth Card Number

Healthy Behavior Goals

Choose one of the following for the next year:

☐ 1. Patient does not have health risk behaviors that need to be addressed at this time.

☐ 2. Patient has identified at least one behavior to address over the next year to improve their health (choose one or more below):

- ☐ *Increase physical activity, learn more about nutrition and improve diet, and/or weight loss*
- ☐ *Reduce/quit tobacco use*
- ☐ *Annual influenza vaccine*
- ☐ *Follow-up appointment for screening or management (if necessary) of hypertension, cholesterol and/or diabetes*
- ☐ *Follow-up appointment for recommended cancer or other preventative screening(s)*
- ☐ *Other: explain* _____
- ☐ *Reduce/quit alcohol consumption*
- ☐ *Treatment for substance use disorder*
- ☐ *Dental visit*
- ☐ *Follow-up appointment for maternity care/reproductive health*
- ☐ *Follow-up appointment for mental health/behavioral health*

☐ 3. Patient has a serious medical, behavioral or social condition(s) which precludes addressing unhealthy behaviors at this time.

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

☐ 5. Patient has committed to maintain their previously achieved Healthy Behavior Goal(s).

Primary Care Provider Attestation

I certify that I have examined the patient named above and the information is complete and accurate to the best of my knowledge. I have provided a copy of this Health Risk Assessment to the member listed above.

Provider Last Name	Provider First Name	National Provider Identifier (NPI)
Provider Telephone Number		Date of Appointment
Signature		Date

Submit form by fax or via CHAMPS:

Fax to: 517-763-0200

CHAMPS: The Health Risk Assessment form can be submitted and viewed in the CHAMPS system via the Health Risk Assessment Questionnaire Web Page.

AUTHORITY: MCL 400.105(d)(1)(e)

COMPLETION: Is voluntary, but required for participation in certain Healthy Michigan Plan programs.

PREVENTIVE DENTAL SERVICES	
PROCEDURE CODE	**DIAGNOSIS CODE**
D0120	Z0120, Z0121, Z1384
D0191	Z0120, Z0121, Z1384
D1110	Z0120, Z0121, Z1384
D1354	Z0120, Z0121

ACIP VACCINES	
PROCEDURE CODE	**DIAGNOSIS CODE**
90620	NA
90621	NA
90630	NA
90632	NA
90636	NA
90649	NA
90650	NA
90651	NA
90654	NA
90656	NA
90658	NA
90661	NA
90670	NA
90673	NA
90674	NA
90686	NA
90688	NA
90707	NA
90714	NA
90715	NA
90716	NA
90732	NA
90733	NA
90734	NA
90736	NA
90740	NA
90744	NA
90746	NA
90747	NA
G0008	NA
G0009	NA
G0010	NA
Q2034	NA
Q2035	NA
Q2036	NA
Q2037	NA
Q2038	NA
Q2039	NA

ANNUAL PREVENTIVE VISIT	
PROCEDURE CODE	**DIAGNOSIS CODE**
99385	NA
99386	NA
99395	NA
99396	NA
99401	NA
99402	NA

CANCER SCREENING: BREAST	
PROCEDURE CODE	**DIAGNOSIS CODE**
77063	NA
77067	NA
G0202	NA

CANCER SCREENING: CERVICAL/VAGINAL	
PROCEDURE CODE	**DIAGNOSIS CODE**
87623	NA
87624	NA
87625	NA
88141	NA
88142	NA
88143	NA
88147	NA
88148	NA
88155	NA
88164	NA
88165	NA
88166	NA
88167	NA
88174	NA
88175	NA
G0101	NA
G0476	NA
Q0091	NA

CANCER SCREENING: COLORECTAL	
PROCEDURE CODE	**DIAGNOSIS CODE**
45330	Z1211, Z1212, Z1213, Z800, Z8371, Z86010
45331	Z1211, Z1212, Z1213, Z800, Z8371, Z86010
45333	Z1211, Z1212, Z1213, Z800, Z8371, Z86010
45338	Z1211, Z1212, Z1213, Z800, Z8371, Z86010
45346	Z1211, Z1212, Z1213, Z800, Z8371, Z86010
45378	Z1211, Z1212, Z1213, Z800, Z8371, Z86010
45380	Z1211, Z1212, Z1213, Z800, Z8371, Z86010
45384	Z1211, Z1212, Z1213, Z800, Z8371, Z86010
45385	Z1211, Z1212, Z1213, Z800, Z8371, Z86010
45388	Z1211, Z1212, Z1213, Z800, Z8371, Z86010
81528	NA
82270	NA
82274	Z1211, Z1212, Z1213, Z800, Z8371, Z86010
G0104	NA
G0105	NA
G0121	NA
G0328	NA

CANCER SCREENING: LUNG	
PROCEDURE CODE	**DIAGNOSIS CODE**
71250	F172, Z122, Z720, Z87891
G0297	NA

CANCER SCREENING: PROSTATE	
PROCEDURE CODE	**DIAGNOSIS CODE**
84152	Z125, Z8042
84153	Z125, Z8042
84154	Z125, Z8042
G0102	NA
G0103	NA

HEP C VIRUS INFECTION SCREENING	
PROCEDURE CODE	**DIAGNOSIS CODE**
86803	NA
G0472	NA

HIV SCREENING	
PROCEDURE CODE	**DIAGNOSIS CODE**
86689	Z114
86701	Z114
86702	Z114
86703	Z114
87389	Z114
87390	Z114
87391	Z114
87534	Z114
87535	Z114
87536	Z114
87537	Z114
87538	Z114
87539	Z114
87806	Z114
G0432	NA
G0433	NA
G0435	NA

OSTEOPOROSIS SCREENING	
PROCEDURE CODE	**DIAGNOSIS CODE**
76977	Z13820, Z8262
77078	Z13820, Z8262
77080	Z13820, Z8262
77081	Z13820, Z8262

STI SCREENING: CHLAMYDIA	
PROCEDURE CODE	**DIAGNOSIS CODE**
87110	NA
87270	NA
87320	NA
87490	NA
87491	NA
87492	NA
87810	NA

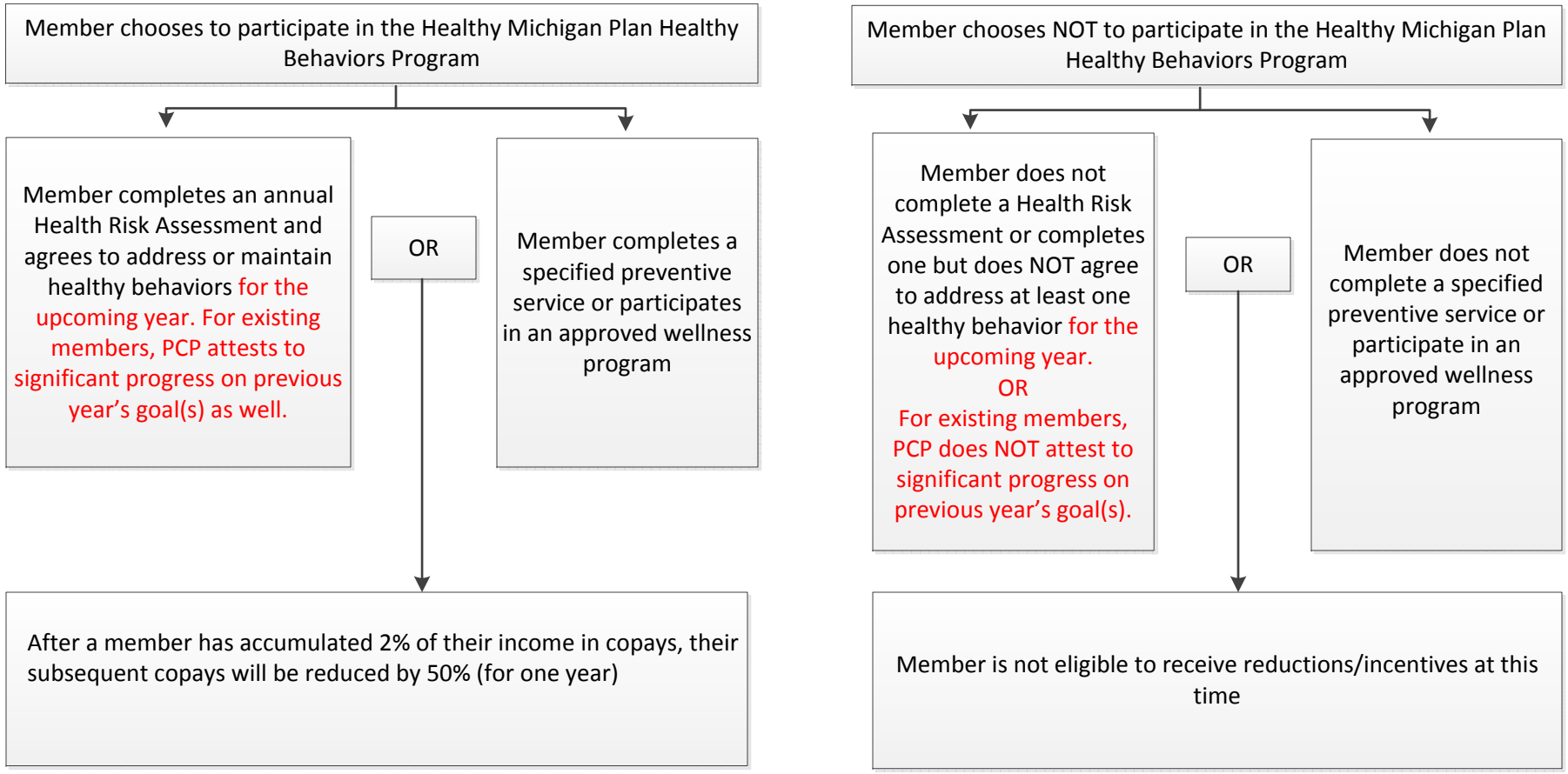
STI SCREENING: GONORRHEA	
PROCEDURE CODE	**DIAGNOSIS CODE**
87590	NA
87591	NA
87592	NA
87850	NA

STI SCREENING: HEP B (NONPREGNANT)	
PROCEDURE CODE	**DIAGNOSIS CODE**
86704	NA
86705	NA
86706	NA
87340	NA
G0499	NA

STI SCREENING: SYPHILIS (NONPREGNANT)	
PROCEDURE CODE	**DIAGNOSIS CODE**
86592	NA
86593	NA

TUBERCULOSIS SCREENING	
PROCEDURE CODE	**DIAGNOSIS CODE**
86480	Z111, Z201
86481	Z111, Z201
86580	Z111, Z201
87116	Z111, Z201

Healthy Michigan Plan Healthy Behaviors Incentives Eligibility and Distribution
Income ≤ 100% FPL



Note: Members may complete a Healthy Behavior at any time during the year to become eligible for the incentives program.

Note: Reductions in monthly contributions or copays are not effective until payments begin to be made, after 6 months of enrollment.

Note: Members who complete an HRA and acknowledge that changes are necessary but who have significant physical, mental or social barriers to addressing them at this time (as attested by the primary care provider) are also eligible for the incentives.

Healthy Michigan Plan Healthy Behaviors Incentives Eligibility and Distribution
Income > 100% FPL

Member chooses to participate in the Healthy Michigan Plan Healthy Behaviors Program

Member completes an annual Health Risk Assessment and agrees to address or maintain healthy behaviors for the upcoming year. For existing members, PCP attests to significant progress on previous year's goals as well.

OR

Member completes a specified preventive service or participates in an approved wellness program

Reduction in monthly contributions to 1% of income (for one year). The monthly contribution is waived if the member maintains timely annual participation over 2 or more years

AND

After a member has accumulated 2% of their income in copays, their subsequent copays will be reduced by 50% (for one year)

Post 48 Months Cumulative Enrollment: After 48 months of cumulative eligibility, members above 100% of the FPL will no longer be eligible for incentives and will pay a premium of 5% of their income in compliance with 42 CFR 447.56(f).

Note: Members may complete a Healthy Behavior at any time during the year to become eligible for the incentives program. Reductions in monthly contributions or copays are not effective until payments begin to be made, after 6 months of enrollment. Members who complete an HRA and acknowledge that changes are necessary but who have significant physical, mental or social barriers to addressing them at this time (as attested by the primary care provider) are also eligible for the incentives.

Member chooses not to participate in the Healthy Michigan Plan Healthy Behaviors Program

Member does not complete a Health Risk Assessment or completes one but does NOT agree to address at least one healthy behavior for the upcoming year.
OR
For existing members, PCP does NOT attest to significant progress on previous year's goal(s).

OR

Member does not complete a specified preventive service or participate in an approved wellness program

Member is not eligible to receive reductions in monthly contributions or copays at this time.

Post 48 Months Cumulative Enrollment: After 48 months of cumulative eligibility coverage, member whose income is greater than 100% of the FPL and has not met the program's healthy behavior or cost-sharing requirements will lose coverage under HMP consistent with the HMP waiver renewal amendment as approved by CMS.

Enrollee completes a Health Risk Assessment and agrees to address or maintain healthy behaviors through HRA Unit

Enrollee meets healthy behavior requirements to lift HMP loss of coverage.

Enrollee does not complete a Health Risk Assessment or completes one but does NOT agree to address at least one healthy behavior

HMP loss of coverage remains in place.

ATTACHMENT C
Operational Protocol for the MI Health Accounts

I. Purpose

This document describes the background, along with the requirements for development, implementation and operation of the MI Health Account. These requirements apply to the Michigan Department of Health and Human Services ("Department"), the Department's contracted health plans, and the Department's selected MI Health Account vendor[1] as further described below.

II. Background

All individuals enrolled in the Healthy Michigan Plan through the Department's contracted Medicaid health plans will have access to a MI Health Account. The MI Health Account is a unique health care savings vehicle through which various cost-sharing requirements, which include co-pays and additional contributions for beneficiaries with higher incomes, will be satisfied, monitored and communicated to the beneficiary. The Department has established uniform standards and expectations for the MI Health Account's operation through this Operational Protocol and by contract as appropriate.

III. Cost-Sharing

Cost-sharing, as described further below, includes both co-pays and, when applicable to the beneficiary, contributions based on income. Once enrolled in a Medicaid health plan, most cost-sharing obligations will be satisfied through the MI Health Account. However, point of service co-pays may be required for a limited number of services that are carved out of the health plans, such as certain drugs.

Beneficiaries who are exempt from cost-sharing requirements by law, regulation or program policy will be exempt from cost-sharing obligations via the MI Health Account (e.g. individuals receiving hospice care, pregnant women receiving pregnancy-related services, individuals eligible for Children's Special Health Care Services, Native Americans in compliance with 42 CFR 447.56, etc.). Similarly, services that are exempt from cost-sharing by law, regulation or program policy (e.g. preventive and family planning services), or as defined by the State's Healthy Behaviors Incentives Operational Protocol, will also be exempt for Healthy Michigan Plan beneficiaries.

In addition, those services that are considered private and confidential under the Department's Explanation of Benefits framework will be excluded from the MI Health Account statement and, therefore, will be exempt from cost sharing for these Healthy Michigan Plan enrollees. The Department, in cooperation with its Data Warehouse vendor, will ensure that the claims information submitted to the MI Health Account vendor for use in preparing the MI Health Account statement excludes those confidential services and/or

[1] There is a single vendor that all of the Department's contracted Medicaid health plans use for the MI Health Account function. This vendor is designated as a mandatory subcontractor for the health plans, and each of the plans contract with the MI Health Account vendor to provide services related to the MI Health Account, consistent with this protocol. The Department also holds a contract with the MI Health Account vendor which lays out the vendor's obligation to both the Department and the health plans with respect to the MI Health Account function.

medications outlined in this framework. The Department's Explanation of Benefits framework is updated by the Department at least annually, is shared with the contracted health plans for use in preparing Explanation of Benefits documents for federal health care program beneficiaries, and is available to other providers upon request. Finally, unless otherwise specified by this Operational Protocol or the Healthy Behaviors Incentives Operational Protocol, co-pay amounts will be consistent with Michigan's State Plan.

A. Co-pays

The Healthy Michigan Plan utilizes an innovative approach to co-pays that is intended to reduce barriers to valuable health care services and promote consumer engagement. During a Healthy Michigan Plan beneficiary's first six months of enrollment in a health plan, there will be no co-pays collected at the point of service for health plan covered services. At the end of the six-month period, an average monthly co-pay experience for the beneficiary will be calculated. The initial look-back period will include encounters during the first three months of enrollment in a health plan in order to account for claim lag and allow for stabilization of the encounter data. Analysis of the beneficiary's co-pay experience will be recalculated on a quarterly basis going forward. The following examples, along with the attached **Appendix 1** (which is a more general, visual representation of a beneficiary enrolling with a health plan in May) provide further clarification.

During her first three months in a Healthy Michigan Plan health plan, a beneficiary has the following services: In April 2014, she visits her physician for a sinus infection ($2 co-pay). In May (2014), she visits the dentist for a filling ($3 co-pay), and fills one preferred prescription for antibiotics at the pharmacy ($1 co-pay). The beneficiary will receive notice of these potential co-pay amounts at the time the services are rendered. All of the above claims are paid by the health plan in June 2014. The MI Health Account vendor receives claim information on this beneficiary from the Department's Data Warehouse vendor in early October 2014, which includes claims paid during April, May and June of 2014 for services that occurred on or after April 1, 2014. This claim information includes the above services with the related co-pay amounts.

The MI Health Account vendor calculates the average monthly co-pay experience for that beneficiary to be $2 ($6 in expenditures divided over a three-month period equals an average of $2 per month). Therefore, this beneficiary will be required to remit $2 per month into the MI Health Account for the next three months. The beneficiary will receive her first quarterly MI Health Account statement on or about October 15, 2014 with her first payment of $2 due November 15, 2014; her second payment due December 15, 2014 and her third payment due January 15, 2015. The beneficiary (and all other Healthy Michigan Plan beneficiaries) will also have the option to pay the entire amount due all at once. The MI Health Account vendor will recalculate the average monthly co-pay experience for the beneficiary in January 2015, which will be based on the beneficiary's co-payments from July, August, and September of 2014. The beneficiary will then be notified of her new monthly co-payment obligation in January 2015, which was in effect during February, March, and April of 2015.

During another beneficiary's first three months in a Healthy Michigan Plan health plan, a beneficiary has the following services: A visit to her doctor for a preventive visit ($0 co-pay) in April of 2014; a visit to an endocrinologist to assess and control her diabetes in May of 2014 ($0 co-pay); and finally, she fills a diabetes related prescription ($0 co-pay) in June of 2014. All of the above claims are paid by the health plan in June 2014. The MI Health Account vendor receives claim information on this beneficiary from the Department's Data Warehouse vendor in early October 2014, which includes claims paid during April, May and June of 2014 for services that occurred on or after April 1, 2014. This claim information includes the above services with the related co-pay amounts.

The MI Health Account vendor calculates the average monthly co-pay experience for this beneficiary to be $0 because none of these services have co-pays associated with them. This beneficiary will not be required to remit any funds to the MI Health Account for co-pays over the next three months, but will receive a quarterly MI Health Account statement detailing her services for educational purposes.

The average co-pay amount is re-calculated every three months to reflect the beneficiary's current utilization of healthcare services, consistent with available data. The Department will consider the dates of service and adjudication date for claims received to determine the beneficiary's experience and calculate the co-pay amount going forward. These co-pay amounts will be based on encounter data submitted by the health plans to the Department, and will be shared via interface with the MI Health Account vendor. The MI Health Account vendor is then responsible for communicating the co-pay amounts due to the beneficiary via a quarterly account statement as described in Section VII.A.1. This account statement will include a summary of account activity and any future amounts due, as well as a detailed (encounter level) explanation of services received. As noted earlier, one important exception to the amount of encounter level detail provided is that confidential services will not be shown on the MI Health Account statement; therefore, the beneficiary will have no cost-sharing associated with those services. The provision of this encounter level data to the beneficiary is key to engaging the beneficiary as a more active consumer of health care services and will also provide sufficient information for the beneficiary to recognize and pursue resolution of any discrepancies through the process described in Section X. The Department reserves the right to modify the account statement at any time, in consultation with the Centers for Medicare and Medicaid Services (CMS).

The co-pay amounts collected from the beneficiary by the MI Health Account vendor will be disbursed to the health plans and will not accumulate in the MI Health Account. In addition, there will be no distribution of funds from the MI Health Account to the beneficiary to pay co-pays. However, information regarding co-pays owed and paid will be included as an informational item on the MI Health Account quarterly statement, as further defined and described in Section VII.A.1. Ensuring that beneficiaries are aware of the amounts owed, or why payment was not required (i.e., a preventive service was provided), is a key component of the Healthy Michigan Plan.

The health plans, in cooperation with the State and MI Health Account vendor, will be responsible for beneficiary education and engagement consistent with Section VII.

Reductions in co-pays will be implemented consistent with the State's Healthy Behaviors Incentives Operational Protocol. The MI Health Account vendor is responsible for determining when each beneficiary has reached the threshold that enables co-pay reductions to occur. The MI Health Account vendor will also communicate co-pay reductions to the beneficiary as part of the MI Health Account statement (see Section V for further discussion).

B. Required Contributions

In addition to any relevant co-pays, a monthly contribution is also required for beneficiaries whose income places them above 100 percent of the Federal Poverty Level (FPL). Consistent with state law, contributions are not required during the first six months the individual is enrolled in a health plan. However, the MI Health Account vendor will notify the beneficiary, via the MI Health Account statement, a welcome letter and, when applicable, through scripts used by the vendor's customer service representatives, that contributions will be required on a monthly basis starting in month seven.

Consistent with the Special Terms and Conditions and the Healthy Behaviors Incentives Operational Protocol, the contribution amount will not exceed two percent of the amount that represents the beneficiary's percentage of the FPL, with reductions occurring for Healthy Behaviors as described therein. However, in practice, The Department plans to consider family composition when calculating contribution amounts. For example, when a beneficiary with several dependents qualifies for the Healthy Michigan Plan, the Department will consider that fact when assessing their contribution amount. For example:

> A beneficiary with three dependents has an annual income of around $28,000. A beneficiary with no children has an annual income of around $14,000. Both apply for the Healthy Michigan Plan. Due to difference in their family size, both beneficiaries would be eligible for the Healthy Michigan Plan at 120 percent of the FPL. The contribution for both will not exceed $23 per month because some income from the beneficiary with three dependents will be recognized as support for these dependents.

In addition, the Department intends to consider the fact that multiple Healthy Michigan Plan covered individuals reside in the same household when calculating contribution amounts. For example, if both individuals in a married couple qualify for the Healthy Michigan Plan at 101 percent of the FPL, each would be required to pay no more than $13 per month for their individual coverage (or $26 per month for the household). This modification is intended to align the amounts contributed by the household more closely with that of the federal exchange as well as existing regulatory limits on household cost-sharing.

The MI Health Account vendor will calculate the required contribution amount and communicate this to the beneficiary, along with instructions for payment, as part of the MI Health Account quarterly statement.

IV. Impact of Healthcare Services Received on the MI Health Account

Beneficiary contributions to the MI Health Account are not the first source of payment for health care services rendered. The health plans are responsible for 'first dollar' coverage of any health plan covered services the beneficiary receives up to a specified amount, though that amount will vary from person to person. For example:

- For individuals at or below 100 percent of the FPL, because co-pays will not accumulate in the account, the health plans will be responsible for payment of all health plan covered services.

- For individuals above 100 percent of the FPL (who make additional monthly contributions to the account), the health plan may utilize beneficiary funds from the MI Health Account once the beneficiary has received a certain amount and type of health care services.

    - This means that the amount the health plans must pay before tapping beneficiary contributions will vary from beneficiary to beneficiary based on his or her annual contribution amount.
    - The amount of health plan responsibility for these beneficiaries will be based on the following formula:

$1000 – (amount of beneficiary's annual contribution) =

Health Plan "First Dollar" Coverage Amount

To further explain this calculation, if an individual has a required annual contribution of $300 per year, the health plan will be responsible for the first $700 of services before using any beneficiary contributions. In addition, given the limitations on cost-sharing and the importance of maintaining beneficiary confidentiality, the impact of various services on funds in the MI Health Account will vary. The following are examples of how the MI Health Account vendor will determine the amount of MI Health Account funds, if any, that may be used to offset the cost of certain services covered by the health plan.

A beneficiary has a monthly contribution requirement of $25, which he remits as required. The beneficiary receives no services for the first nine months he is in the health plan. Therefore, the beneficiary has contributed $75 (no contributions for the first six months, followed by three months of contributions) into the MI Health Account and none of those funds have been utilized by the health plan. The beneficiary's total annual contribution is expected to be $300.

In month 10, the beneficiary contracts strep throat and visits his primary care provider for evaluation and treatment. Per the above formula, the health plan will be responsible for payment of the first $700 in services. The cost of the office visit, strep test and antibiotic are less than $700, therefore, the health plan is responsible for the cost of all of those services and may not receive funds from the MI Health Account.

A beneficiary has a monthly contribution requirement of $20, which she remits as required. The beneficiary does not receive any services in the first nine months she is in the health plan. Therefore, the beneficiary has contributed $60 (no contributions for the first six months plus three months of contributions) and none of those funds have been utilized by the health plan. The beneficiary's total annual contribution is expected to be $240.

In month 10, the beneficiary develops appendicitis and requires surgery. Per the above formula, the health plan will be responsible for the first $760 in services. The fees for the surgery are more than $760. After the health plan pays for the first $760 of services, it may receive funds from the MI Health Account (in this case, $60). The beneficiary will continue to owe $20 per month until her remaining obligation ($180) is satisfied. In the interim, the health plan will pay the providers involved the remaining fees for the services provided, and may receive the next $180 remitted by the beneficiary.

In addition, as noted above, only services covered by the health plans will impact the MI Health Account. As a result, any items or services that are carved out of the health plans (e.g. psychotropic drugs, PIHP services) will not impact the MI Health Account or be reflected on any account statement. The Department and the contracted health plans identify the services that will be carved-out of the health plan's scope of coverage via the managed care contracts. These contracts are available via the State's website. The MI Health Account statement will also clarify for the beneficiary that the statement may not reflect all health care services that they received (i.e., because the service was confidential, the claim was not submitted or the health plan does not cover the service).

The following scenario illustrates a beneficiary requiring a carved-out service and the cost-sharing impact:

A beneficiary has a monthly contribution of $20, and he pays timely for three months (for a total of $60). The beneficiary fills a prescription for a psychotropic drug at his local pharmacy. The beneficiary will be responsible for paying any applicable co-payment for that drug at the pharmacy (point of service). The health plan will not be responsible for payment for the psychotropic drug as this is a service that is carved out from the health plans, and there will be no impact on the MI Health Account as a result. In addition, no funds from the MI Health Account will be distributed to the beneficiary to pay any required co-pay at the point of service.

Finally, any services considered confidential under the Department's Explanation of Benefits framework or otherwise excluded from cost sharing based on law, regulation or program policy will not be subject to any cost-sharing through the MI Health Account. This limitation includes the use of beneficiary contributions by the health plans once the plan's first dollar responsibility is exceeded. While no confidential services may be reflected on the MI Health Account statement, services that do not require suppression but are exempt from cost sharing of any type must be reflected on the statement as a service for which no payment is required, such as preventive services which are described in the following example.

A beneficiary has a monthly contribution of $20, and she pays timely for three months (for a total of $60). The following month, the beneficiary has colonoscopy and mammogram screenings that result in fees in excess of $1000. The health plan must pay for these preventive services and may not seek funds from the MI Health Account for those services. The MI Health Account statement will reflect that preventive services are exempt from any cost sharing on the part of the beneficiary.

V. Cost-Sharing Reductions

Both types of cost sharing (co-pays and contributions) may be reduced if certain requirements are met.

A. Reductions Related to Chronic Conditions

The health plans must waive co-pays if doing so promotes greater access to services that prevent the progression of and complications related to chronic disease, consistent with the following. The Department has provided the health plans with lists of conditions and services, which include both diagnosis codes and drug classes, for which co-pays must be waived for all Healthy Michigan Plan beneficiaries. These lists are included as **Appendix 2**. The health plans may suggest additions or revisions to these lists, and the Department will review these suggestions annually. However, any additions must be approved in advance by the Department and shared with the MI Health Account vendor and all other contracted health plans to ensure consistency and appropriate calculation and collection of amounts owed. The Department will continue to engage stakeholders on this issue and ensure transparency and access to information surrounding these lists, which will include both provider and beneficiary education and outreach, policy bulletins when appropriate, and online availability of the lists. Any reductions to the lists must be approved in advance by CMS.

B. Healthy Behavior Cost-Sharing Reductions

1. Co-Pays

Co-pays may also be reduced if a beneficiary engages in certain healthy behaviors, as detailed in the Healthy Behaviors Incentives Operational Protocol. Before co-pays may be reduced, a beneficiary's co-payments must reach a 2 percent threshold of their income.

The evaluation period for determining whether a beneficiary has satisfied the threshold for co-pay reduction will be the beneficiary's enrollment year. This means that the beneficiary will have one year to make progress toward the threshold of co-payments before that threshold resets. Once the threshold is reached, the reductions will be processed and reflected on the next available MI Health Account statement. Additional information on the criteria for earning these reductions is included in the Healthy Behaviors Incentives Operational Protocol.

2. Contribution Reductions

The MI Health Account vendor, with participation by and oversight from the health plans and the Department, is responsible for ensuring that the calculation and collection of all cost-sharing amounts is performed in accordance with the Healthy Behaviors Incentives Operational Protocol with respect to the waiver or reduction of any required cost sharing. This includes, but is not limited to, the existence of appropriate interfaces between the Department, the health plans and the MI Health Account vendor to transmit account information, encounter data and any other beneficiary information necessary to provide an accurate accounting of amounts due, received and expended from the MI Health Account. See the Healthy Michigan Plan Healthy Behaviors Incentives Operational Protocol for further information.

C. Cost Sharing Reduction Changes - Post 48 Months Cumulative Enrollment

1. Beneficiaries with income at or below 100 percent of the FPL

HMP beneficiaries who are at or below 100 percent of the FPL will continue to have eligibility coverage and cost-sharing responsibilities consistent with the process outlined in the Healthy Michigan Plan Healthy Behaviors Incentives Protocol. No changes post 48 months cumulative enrollment will impact this population.

2. Beneficiaries with an income between 100 percent and 133 percent of the FPL

After 48 months of HMP eligibility coverage

To maintain eligibility for HMP, individuals with income between 100 percent and 133 percent of the FPL who have had 48 months of cumulative eligibility coverage must:

- Complete or actively engage in an annual healthy behavior with effort given to making the healthy behaviors in subsequent years incrementally more challenging; and
- Pay a premium of 5 percent of their income (no co-pays required), not to exceed limits defined in 42 CFR 447.56(f).

After 48 months of cumulative HMP eligibility coverage, beneficiaries will not be eligible for any cost-sharing reductions, and their MI Health Account will no longer be utilized for cost-sharing liabilities.

3. Loss of Coverage and Additional Provisions

Beneficiaries above 100 percent of the FPL who have not met the healthy behavior or cost-sharing requirements will lose their coverage under HMP consistent with the HMP waiver renewal amendment as approved by CMS. Beneficiaries will be notified of this action 60 days before the end of their 48th month. Individuals who are exempt from premiums and cost-sharing pursuant to 42 CFR 447.56 will be exempt from the 5 percent premium requirement of the 48 months cumulative enrollment provision. This includes, but is not limited to, pregnant women, Native Americans, and children under 21 years of age. However, beneficiaries exempt from the premiums requirement will still be required to satisfy the healthy behavior requirement in order to remain on HMP. In the event an individual's exemption status changes (e.g. they turn 21 years old), he or she will be required to maintain compliance with HMP healthy behavior and cost-sharing requirements, assuming other eligibility criteria are met.

a. Account Balance owed at 48 months

Any balance owed on the MI Health Account at the time a beneficiary meets the post 48-month cumulative enrollment period will have the balance owed sent to the Michigan Department of Treasury for offset in accordance with Section VIII of this Operational Protocol for the MI Health Accounts.

VI. Account Administration

The health plans, the MI Health Account vendor and the Department are jointly responsible for ensuring that procedures and system requirements are in place to ensure appropriate account functions, consistent with the following:

- Interest on account balances is not required.

- Upon a beneficiary's death, the balance of any funds in the MI Health Account will be returned to the State after a 120-day claims run-off period.

- State law limits the return of funds contributed by the beneficiary to the beneficiary only for the purchase of private insurance.

- When the beneficiary is no longer eligible for the Healthy Michigan Plan, the balance of any funds contributed by the beneficiary will be issued to the beneficiary, after a 120-day claims run-off period, for the purchase of private health insurance coverage. The vendor will utilize information provided via the Department's claims and eligibility systems, along with its own account expenditure information, to determine whether or not a beneficiary qualifies for a voucher.

- The MI Health Account vendor must modify the amount of required cost sharing if the beneficiary reports a change in income, and communicate any changes in amounts owed to the beneficiary, the health plan and the Department, as appropriate. Beneficiaries are required to notify their Department of Health and Human Services specialist of any changes, and are made aware of this requirement in both the rights and responsibilities section of the beneficiary handbook, communications from the Department and the MI Health Account statement. The Department is the system of record for these changes, and the MI Health Account vendor will make adjustments as needed via information received from the Department's eligibility system.

- All amounts received from the beneficiary will be credited to any balance owed, and will be reflected on the next available quarterly statement. Similarly, disbursement of funds by the MI Health Account vendor to the health plans from the MI Health Account (when applicable) is required in a timely manner, following appropriate verification of claims for covered services.

- The MI Health Account vendor will be responsible for the transfer of funds and appropriate credit and debit information in the event a beneficiary changes plans.

- Beneficiaries lack a property interest in MI Health Account funds contributed by them. To that end, any amounts in the MI Health Account are not considered income to the beneficiary upon distribution and will not be counted as assets.

- No interest may be charged to the beneficiary on accrued co-pay or contribution liabilities. Beneficiary consequences for failure to pay are described in this Operational Protocol and may not include loss of eligibility, enrollment or access to services.

- Any amounts remaining in the account after the first year will not offset the beneficiary's contribution requirement for the next year. In addition, the amount that must be covered by the health plan as 'first dollar' will decrease in each subsequent enrollment year when beneficiary contributions remain in the account. For example, if

a beneficiary contributes $250 in the first year and this amount rolls over to the next year, in year 2, the beneficiary will contribute $250 and the health plan will be responsible for the first $500 in services (consistent with the framework described herein).

- The maximum amount of beneficiary funds that may accumulate in a MI Health Account is capped at $1000. If a beneficiary's MI Health Account balance reaches $1000, his or her contributions will be suspended until the account balance falls below $1000. The health plans may utilize these funds for services rendered consistent with this Operational Protocol.

- The MI Health Account vendor must provide multiple options for the beneficiary to remit co-pays and contributions due. These options must include, at a minimum check, money order, electronic transfer (e.g. Automated Clearing House or ACH), and may include other payments through a designated partner such as Western Union, Walmart or Meijer. Any such partner must be free or low cost and prior approved by the Department.

- Months 7-18 of enrollment in a health plan will constitute the first year for MI Health Account accounting purposes.

- The MI Health Account vendor has a process in place to accept third party contributions to the MI Health Account on behalf of the beneficiary. This includes ensuring that any amounts received are credited to the appropriate beneficiary and the remitter (or individual who made the payment) is tracked, and providing multiple options for individuals or entities to make contributions on behalf of a beneficiary (e.g. money order, check, online ACH, etc.). Because the amount of beneficiary funds that can accumulate in the MI Health Account is capped at $1000, third parties may not contribute amounts in excess of that limit. State law does not limit which individuals or entities may contribute to the MI Health Account on the beneficiary's behalf, and any third party's contribution will be applied directly to the beneficiary's contribution requirement. Because the beneficiary lacks a property interest in any amounts in the MI Health Account, including his or her own contributions, the contributions of any third party are not considered income, assets or resources of the beneficiary for any purpose.

- In the event contributions are received from a third party as a part of a Federal health initiative, such as the Ryan White Program, all excess funds must be returned to the appropriate remitter (i.e., the person or program who made the payment), if required by relevant law and regulation.

- After 48 months of cumulative HMP eligibility coverage, beneficiaries will not be eligible for any cost sharing reductions and their MI Health Account will no longer be utilized for cost sharing liabilities.

The Department will monitor both the health plans and the MI Health Account vendor for compliance with the above requirements.

VII. Beneficiary and Provider Engagement

A. Beneficiaries

1. MI Health Account Statements

A primary method of increasing awareness of health care costs and promoting consumer engagement in this population will be through the use of a quarterly MI Health Account Statement. These MI Health Account statements will be easy to understand and drafted at the appropriate grade reading level and will reflect the principles outlined in this Operational Protocol, as well as the Healthy Behaviors Incentives Operational Protocol when applicable.

The MI Health Account vendor must provide the beneficiary with at least the following information on a quarterly basis (along with year-to-date information when appropriate):

- MI Health Account balance
- Expenditures by the health plan for covered services over the past three months
- Co-pay amount due for next three months
- Co-pays collected in previous three months
- Past due amounts
- Contribution amount due for the next three months
- Contributions collected in previous three months
- Reduction to co-pays applied when calculating the amount due for the next three months due to beneficiary compliance with healthy behaviors (as applicable)
- Reduction to contributions applied when calculating the amount owed due to beneficiary compliance with healthy behaviors (as applicable)
- An appropriate subset of encounter-level information regarding services received, including (but not limited to) the following:
    - A description of the procedure, drug or service received
    - Date of service
    - Co-payment amount assigned to that service
    - Provider information
    - Amount paid for the service

The MI Health Account statement must contain the above information, and be in a form and format approved by the Department, in consultation with CMS. Hard copies of these statements must be sent to beneficiaries through U.S. mail on a quarterly basis, though beneficiaries may elect to receive electronic statements as

approved by the Department. In terms of expenditure information, the MI Health Account statement will reflect only those services provided by the health plans and will only share utilization details consistent with privacy and confidentiality laws and regulations. The MI Health Account statement will also include information for beneficiaries on what to do if they have questions or concerns about the services or costs shown on the statement. Beneficiaries will also have the option to utilize the health plan's grievance process, as appropriate. Additional detail regarding beneficiary rights in this regard is contained in Section X.

2. Beneficiary Education

Both the health plans and the MI Health Account vendor will be responsible for beneficiary education regarding the role of the MI Health Account and the beneficiary's cost-sharing responsibilities. While the MI Health Account statements are designed to provide beneficiaries with information on health care costs and related financial responsibilities, it is important that the beneficiary also receive information that helps them become a more informed health care consumer.

The Department's contract with the health plans requires the plans' member services staff to have general knowledge of the MI Health Account, appropriate contact information for the MI Health Account vendor for more specific questions, and the ability to address any complaints members have regarding the MI Health Account vendor. In addition, because the MI Health Account vendor is a subcontractor of the health plans, the plans are required by contract to monitor the MI Health Account vendor's operations.

The MI Health Account vendor will be responsible for providing sufficient staffing and other administrative support to handle beneficiary questions regarding the MI Health Account, and will be obligated to educate beneficiaries (via in person, telephone, written or electronic communication) regarding these topics. This education must include information on how to use the statements and make required contributions and co-pays, and address any questions or complaints regarding the beneficiary's use of the MI Health Account. The health plans are responsible for providing members with handbooks that include information about the Healthy Michigan Plan generally, including the MI Health Account and its cost-sharing mechanism. Finally, the Department will work with the health plans and the provider community to ensure that information on potential cost-sharing amounts is provided to the beneficiary at the point of service.

B. Providers

The health plans, on behalf of the state, will be responsible for education within their provider networks regarding the unique cost-sharing framework of the MI Health Account as it applies to the Healthy Michigan Plan. This may include in-person

contact (on an individual or group basis), as well as information provided in newsletters, email messages and provider portals. This education must include, but is not limited to, the following topics:

- The co-payment mechanism and the impact on provider collection;
- The importance of providing services without collection of payment at the point of service for all health plan covered services;
- Options for reducing required contributions to the MI Health Account (as more fully described in the Healthy Behaviors Incentives Operational Protocol), including provider responsibilities associated with those reductions; and
- The elimination of co-pays (through the MI Health Account mechanism) for certain chronic conditions (as more fully described in the Healthy Behaviors Incentives Operational Protocol), as well as the scope of coverage and cost-sharing exemptions for preventive services.

The Department has partnered with various professional associations within the state, as well as its provider outreach division, to ensure that education regarding the Healthy Michigan Plan and the MI Health Account occurs consistent with procedures already in place to address education needs in light of program changes.

C. Ongoing Strategy

The Department will receive regular reports from the MI Health Account vendor and the health plans regarding the operation of the MI Health Account. For example, the MI Health Account vendor will provide regular reports to the Department and the health plans regarding MI Health Account collections and disbursements, and may provide additional information regarding beneficiary engagement and understanding as reflected through the vendor's call center operations upon the Department's request. This information will allow the Department, the health plans and the MI Health Account vendor to identify opportunities for improvement, make any needed adjustments and evaluate the success of any changes.

The Department will also continue to elicit feedback from the health plans, providers, beneficiaries and other stakeholders about the MI Health Account. Account operations information will be shared and/or discussed, as appropriate, with various stakeholders, including the Medical Care Advisory Council, the Michigan Association of Health Plans, the Michigan State Medical Society and the health plans themselves. The Department meets with the Medical Care Advisory Council and the Michigan State Medical Society quarterly, and with the health plans and their trade association generally on a monthly basis. Stakeholder input will be considered for any program changes, and feedback will be accepted on an ongoing basis via the Department's dedicated Healthy Michigan Plan email address.

Finally, the health plans will be evaluated on the success of cost-sharing collections as required by State law through the cost-sharing bonus. This measure will be monitored

by the Department annually, with the opportunity for program changes to address any identified deficiencies.

VIII. Consequences

State law requires that the Department develop a range of consequences for those beneficiaries who consistently fail to meet payment obligations under the Healthy Michigan Plan. These consequences will impact those beneficiaries whose payment history meets the Department's definition of non-compliance with respect to cost-sharing. For the purposes of initiating the consequences described below, non-compliant means either: 1) That the beneficiary has not made any cost-sharing payments (co-pays or contributions) in more than 90 consecutive calendar days; or 2) that the beneficiary has met less than 50 percent of his or her cost-sharing obligations as calculated over a one-year period.

In addition to the consequences described herein, the Department may limit potential reductions for those who fail to pay required cost-sharing (as this consequence is required by State law). Information on the impact of these consequences on any cost-sharing reductions is included in the Healthy Behaviors Incentives Operational Protocol.

All beneficiaries who are non-compliant with cost-sharing obligations will be subject to the following consequences. First, the MI Health Account vendor will prepare targeted messaging for the beneficiary regarding his or her delinquent payment history and the amounts owed. This may occur via the MI Health Account statement or other written or electronic forms of correspondence, and may include telephone contact as appropriate.

In addition, State law requires the Department to work with the Michigan Department of Treasury to offset state tax returns, and access lottery winnings when applicable, for beneficiaries who consistently fail to meet payment obligations. The Department has a formal arrangement with the Department of Treasury to pursue a state tax return offset for individuals who fail to pay required cost-sharing and have not responded to the messaging strategy outlined above**.** The Department is also considering additional methods for pursuing these funds, including through its internal collection and program support process. All beneficiaries will have access to due process prior to the initiation of any tax offset process, and these debts will not be reported to credit reporting agencies. The health plans may receive recovered funds, but only to the extent that the plan would have been entitled had the beneficiary paid as required. All other funds recovered will revert to the State. The Department also plans to allow the health plans to pursue additional beneficiary consequences for non-payment, consistent with the State law authorizing the creation of the Healthy Michigan Plan, subject to formal approval prior to any implementation. However, loss of eligibility, denial of enrollment in a health plan, or denial of services is not permitted.

Finally, regardless of the consequences pursued by the Department or the health plans, providers may not deny services for failure to pay required cost-sharing amounts. The health plans are responsible for communicating this to their contracted providers through

the plan's provider education process, and for monitoring provider practices to ensure that access to services is not denied for non-payment of cost sharing.

IX. Reporting Requirements

Both the health plans and the MI Health Account vendor are required to develop, generate and distribute reports to the Department, and make information available to each other as necessary to support the functioning of the MI Health Account, both as specified in this Operational Protocol and upon the Department's request. The following information is available and shared as described herein:

- The health plans, in cooperation with the MI Health Account vendor, must provide to the Department an accounting for review to verify that the MI Health Account function is operating in accordance with this Operational Protocol; and

- On a monthly basis, the MI Health Account vendor will provide the Department with information on co-pays and contributions due, reductions applied, and collections by enrollee.

X. Grievances and Appeals

Healthy Michigan Plan beneficiaries will have the opportunity to contest various facets of the MI Health Account function through the relevant processes operated by the health plans, and the Department when appropriate, consistent with federal law and regulation and this Operational Protocol. Any dispute regarding the receipt of services (as shown on the MI Health Account statement) must be pursued through the relevant health plan and will be treated as a grievance, while any action taken by the health plans that serves to limit access to covered services would be considered an adverse action and entitle the beneficiary to the full complement of appeal rights permitted by law and/or contract.

Disputes regarding increases in cost-sharing amounts (outside of the variances in the average monthly co-pay experience described herein) will be investigated by the Department, in cooperation with the MI Health Account vendor, with right to a Medicaid Fair Hearing. Other concerns or complaints associated with the operation of the MI Health Account will be addressed by the Department, with the assistance of the MI Health Account vendor. The Department will provide beneficiaries with information on the appeals process for cost-sharing changes associated with the MI Health Account, as well as general information on how to address complaints or other concerns.

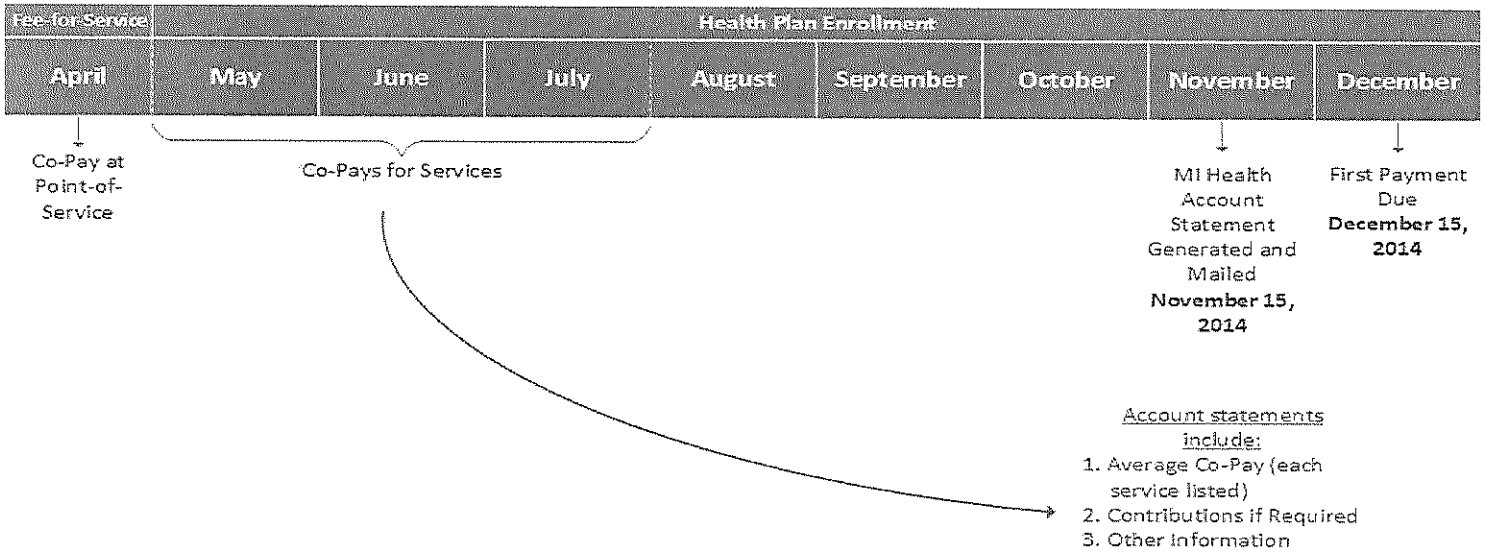
The health plans are required by contract to inform beneficiaries of the grievance and appeals process at the time of enrollment, any time an enrollee files a grievance, and any time the plan takes an action that would entitle the beneficiary to appeal rights. Health plan member handbooks also contain instructions on how to file a grievance.

ATTACHMENT D
Healthy Behaviors Incentives Program Protocol
Appendix 1: MI Health Account Operation Timeline

Appendix 1

MI Health Account Operation Timeline

Beneficiary Cost Sharing Obligations



HEALTHY MICHIGAN PLAN

DRAFT

Treatment Category	Drug Class	Description	Chronic Condition(s) Treated
Alzheimer's Disease	H1A	ALZHEIMER'S THERAPY, NMDA RECEPTOR ANTAGONISTS	Alzheimer's Disease and Related Disorders or Senile Dementia
	H1C	ALZHEIMER'S THX,NMDA RECEPTOR ANTAG-CHOLINES INHIB	Alzheimer's Disease and Related Disorders or Senile Dementia
	J1B	CHOLINESTERASE INHIBITORS	Alzheimer's Disease and Related Disorders or Senile Dementia
Anemia	C3B	IRON REPLACEMENT	Anemia (Includes Sickle Cell Disease)
	C6E	VITAMIN E PREPARATIONS	Anemia (Includes Sickle Cell Disease)
	C6F	PRENATAL VITAMIN PREPARATIONS	Anemia (Includes Sickle Cell Disease)
	C6L	VITAMIN B12 PREPARATIONS	Anemia (Includes Sickle Cell Disease)
	C6M	FOLIC ACID PREPARATIONS	Anemia (Includes Sickle Cell Disease)
	C6Q	VITAMIN B6 PREPARATIONS	Anemia (Includes Sickle Cell Disease)
	N1B	ERYTHROPOIESIS-STIMULATING AGENTS	Anemia (Includes Sickle Cell Disease)
	N1F	THROMBOPOIETIN RECEPTOR AGONISTS	Anemia (Includes Sickle Cell Disease)
	N1H	SICKLE CELL ANEMIA AGENTS	Anemia (Includes Sickle Cell Disease)
	P1M	LHRH (GNRH) AGONIST ANALOG PITUITARY SUPPRESSANTS	Anemia (Includes Sickle Cell Disease)
	P1P	LHRH(GNRH)AGNST PIT.SUP-CENTRAL PRECOCIOUS PUBERTY	Anemia (Includes Sickle Cell Disease)
	P5A	GLUCOCORTICOIDS	Anemia (Includes Sickle Cell Disease)
	V1I	CHEMOTHERAPY RESCUE/ANTIDOTE AGENTS	Anemia (Includes Sickle Cell Disease)
	V1O	ANTINEOPLASTIC LHRH(GNRH) AGONIST,PITUITARY SUPPR.	Anemia (Includes Sickle Cell Disease)
	W7K	ANTISERA	Anemia (Includes Sickle Cell Disease)
Arthritis	C7A	HYPERURICEMIA TX - XANTHINE OXIDASE INHIBITORS	RA/OA (Rheumatoid Arthritis/Osteoarthritis)
	D6A	DRUGS TO TX CHRONIC INFLAMMATORY DISEASE OF COLON	RA/OA (Rheumatoid Arthritis/Osteoarthritis)
	D6A	DRUGS TO TX CHRONIC INFLAMMATORY DISEASE OF COLON	RA/OA (Rheumatoid Arthritis/Osteoarthritis)
	D6F	DRUG TX-CHRONIC INFLAM. COLON DX,5-AMINOSALICYLAT	RA/OA (Rheumatoid Arthritis/Osteoarthritis)
	H3D	ANALGESIC/ANTIPYRETICS, SALICYLATES	RA/OA (Rheumatoid Arthritis/Osteoarthritis)
	P1E	ADRENOCORTICOTROPHIC HORMONES	RA/OA (Rheumatoid Arthritis/Osteoarthritis)
	P5A	GLUCOCORTICOIDS	RA/OA (Rheumatoid Arthritis/Osteoarthritis)
	Q5E	TOPICAL ANTI-INFLAMMATORY, NSAIDS	RA/OA (Rheumatoid Arthritis/Osteoarthritis)
	R1R	URICOSURIC AGENTS	RA/OA (Rheumatoid Arthritis/Osteoarthritis)
	S2B	NSAIDS, CYCLOOXYGENASE INHIBITOR - TYPE ANALGESICS	RA/OA (Rheumatoid Arthritis/Osteoarthritis)
	S2C	GOLD SALTS	RA/OA (Rheumatoid Arthritis/Osteoarthritis)
	S2I	ANTI-INFLAMMATORY, PYRIMIDINE SYNTHESIS INHIBITOR	RA/OA (Rheumatoid Arthritis/Osteoarthritis)
	S2J	ANTI-INFLAMMATORY TUMOR NECROSIS FACTOR INHIBITOR	RA/OA (Rheumatoid Arthritis/Osteoarthritis)
	S2J	ANTI-INFLAMMATORY TUMOR NECROSIS FACTOR INHIBITOR	RA/OA (Rheumatoid Arthritis/Osteoarthritis)
	S2K	ANTI-ARTHRITIC AND CHELATING AGENTS	RA/OA (Rheumatoid Arthritis/Osteoarthritis)
	S2L	NSAIDS,CYCLOOXYGENASE-2(COX-2) SELECTIVE INHIBITOR	RA/OA (Rheumatoid Arthritis/Osteoarthritis)
	S2M	ANTI-INFLAM. INTERLEUKIN-1 RECEPTOR ANTAGONIST	RA/OA (Rheumatoid Arthritis/Osteoarthritis)
	S2N	ANTI-ARTHRITIC, FOLATE ANTAGONIST AGENTS	RA/OA (Rheumatoid Arthritis/Osteoarthritis)
	S2N	ANTI-ARTHRITIC, FOLATE ANTAGONIST AGENTS	RA/OA (Rheumatoid Arthritis/Osteoarthritis)
	S2P	NSAID,COX INHIBITOR-TYPE AND PROTON PUMP INHIBITOR	RA/OA (Rheumatoid Arthritis/Osteoarthritis)
	S2Q	ANTINFLAMMATORY, SEL.COSTIM.MOD.,T-CELL INHIBITOR	RA/OA (Rheumatoid Arthritis/Osteoarthritis)
	S2T	NSAIDS(COX NON-SPEC.INHIB)AND PROSTAGLANDIN ANALOG	RA/OA (Rheumatoid Arthritis/Osteoarthritis)
	S2V	ANTI-INFLAMMATORY, INTERLEUKIN-1 BETA BLOCKERS	RA/OA (Rheumatoid Arthritis/Osteoarthritis)
	S2X	NSAID AND HISTAMINE H2 RECEPTOR ANTAGONIST COMB.	RA/OA (Rheumatoid Arthritis/Osteoarthritis)

The information on this page serves as a reference only. It does not guarantee that services are covered. Providers are instructed to refer to the Michigan Medicaid Provider Manual, MSA Bulletins and other relevant policy for specific coverage and reimbursement policies. This information can be found on the Medicaid Policy & Forms web page. If there are discrepancies between the information on this page and the Provider Manual, such as rate or coverage determinations, they will be resolved in favor of the Provider Manual language.

Treatment Category	Drug Class	Description	Chronic Condition(s) Treated
Arthritis Con't.	S2Z	ANTI-INFLAMMATORY,PHOSPHODIESTERASE-4(PDE4) INHIB.	RA/OA (Rheumatoid Arthritis/Osteoarthritis)
	V1B	ANTINEOPLASTIC - ANTIMETABOLITES	RA/OA (Rheumatoid Arthritis/Osteoarthritis)
	Z2E	IMMUNOSUPPRESSIVES	RA/OA (Rheumatoid Arthritis/Osteoarthritis)
	Z2U	MONOCLONAL ANTIBODY-HUMAN INTERLEUKIN 12/23 INHIB	RA/OA (Rheumatoid Arthritis/Osteoarthritis)
	Z2V	INTERLEUKIN-6 (IL-6) RECEPTOR INHIBITORS	RA/OA (Rheumatoid Arthritis/Osteoarthritis)
	Z2W	ANTI-CD20 (B LYMPHOCYTE) MONOCLONAL ANTIBODY	RA/OA (Rheumatoid Arthritis/Osteoarthritis)
	Z2Z	JANUS KINASE (JAK) INHIBITORS	RA/OA (Rheumatoid Arthritis/Osteoarthritis)
Behavioral Health/Substance Abuse	C0D	Anti Alcoholic Preparations	Alcohol Dependence
	H3T	NARCOTIC ANTAGONISTS	Alcohol Dependence
	H2E	SEDATIVE-HYPNOTICS,NON-BARBITURATE	Alcohol Dependence and Depression
	H2F	ANTI-ANXIETY DRUGS	Alcohol Dependence and Depression
	H2D	BARBITURATES	Anxiety
	H2E	SEDATIVE-HYPNOTICS,NON-BARBITURATE	Bipolar Disorder
	H2F	ANTI-ANXIETY DRUGS	Bipolar Disorder
	H2G	ANTIPSYCHOTICS,PHENOTHIAZINES	Bipolar Disorder
	H2M	BIPOLAR DISORDER DRUGS	Bipolar Disorder
	H2S	SELECTIVE SEROTONIN REUPTAKE INHIBITOR (SSRIS)	Bipolar Disorder
	H2U	TRICYCLIC ANTIDEPRESSANTS,REL.NON-SEL.REUPT-INHIB	Bipolar Disorder
	H4B	ANTICONVULSANTS	Bipolar Disorder
	H7D	NOREPINEPHRINE AND DOPAMINE REUPTAKE INHIB (NDRIS)	Bipolar Disorder
	H7E	SEROTONIN-2 ANTAGONIST/REUPTAKE INHIBITORS (SARIS)	Bipolar Disorder
	H7T	ANTIPSYCHOTIC,ATYPICAL,DOPAMINE,SEROTONIN ANTAGNST	Bipolar Disorder
	H7X	ANTIPSYCHOTICS, ATYP, D2 PARTIAL AGONIST/5HT MIXED	Bipolar Disorder
	H7Z	SSRI-ANTIPSYCH, ATYPICAL,DOPAMINE,SEROTONIN ANTAG	Bipolar Disorder
	H8W	ANTIPSYCHOTIC-ATYPICAL,D3/D2 PARTIAL AG-5HT MIXED	Bipolar Disorder
	H2H	MONOAMINE OXIDASE(MAO) INHIBITORS	Depression
	H2M	BIPOLAR DISORDER DRUGS	Depression
	H2S	SELECTIVE SEROTONIN REUPTAKE INHIBITOR (SSRIS)	Depression
	H2U	TRICYCLIC ANTIDEPRESSANTS & REL. NON-SEL. RU-INHIB	Depression
	H2W	TRICYCLIC ANTIDEPRESSANT/PHENOTHIAZINE COMBINATNS	Depression
	H2X	TRICYCLIC ANTIDEPRESSANT/BENZODIAZEPINE COMBINATNS	Depression
	H4B	ANTICONVULSANTS	Depression
	H7B	ALPHA-2 RECEPTOR ANTAGONIST ANTIDEPRESSANTS	Depression
	H7C	SEROTONIN-NOREPINEPHRINE REUPTAKE-INHIB (SNRIS)	Depression
	H7D	NOREPINEPHRINE AND DOPAMINE REUPTAKE INHIB (NDRIS)	Depression
	H7E	SEROTONIN-2 ANTAGONIST/REUPTAKE INHIBITORS (SARIS)	Depression
	H7J	MAOIS - NON-SELECTIVE & IRREVERSIBLE	Depression
	H7Z	SSRI & ANTIPSYCH,ATYP,DOPAMINE&SEROTONIN ANTAG CMB	Depression
	H8P	SSRI & 5HT1A PARTIAL AGONIST ANTIDEPRESSANT	Depression
	H8T	SSRI & SEROTONIN RECEPTOR MODULATOR ANTIDEPRESSANT	Depression
	H2G	ANTI-PSYCHOTICS,PHENOTHIAZINES	Schizophrenia
	H7O	ANTIPSYCHOTICS,DOPAMINE ANTAGONISTS,BUTYROPHENONES	Schizophrenia
	H7P	ANTIPSYCHOTICS,DOPAMINE ANTAGONISTS, THIOXANTHENES	Schizophrenia
	H7S	ANTIPSYCHOTICS,DOPAMINE ANTAGONST,DIHYDROINDOLONES	Schizophrenia

Treatment Category	Drug Class	Description	Chronic Condition(s) Treated
Behavioral Health/Substance Abuse Con't.	H7U	ANTIPSYCHOTICS, DOPAMINE & SEROTONIN ANTAGONISTS	Schizophrenia
	H7T	ANTIPSYCHOTICS,ATYPICAL,DOPAMINE,& SEROTONIN ANTAG	Schizophrenia and Depression
	H7X	ANTIPSYCHOTICS, ATYP, D2 PARTIAL AGONIST/5HT MIXED S	Schizophrenia and Depression
	H2G	ANTIPSYCHOTICS,PHENOTHIAZINES	Schizophrenia, Schizotypal, Delusional, and Other Non-Mood Psychotic Disorders
	H6J	ANTIEMETIC/ANTIVERTIGO AGENTS	Schizophrenia, Schizotypal, Delusional, and Other Non-Mood Psychotic Disorders
	H7O	ANTIPSYCHOTICS,DOPAMINE ANTAGONISTS,BUTYROPHENONES	Schizophrenia, Schizotypal, Delusional, and Other Non-Mood Psychotic Disorders
	H7P	ANTIPSYCHOTICS,DOPAMINE ANTAGONISTS, THIOXANTHENES	Schizophrenia, Schizotypal, Delusional, and Other Non-Mood Psychotic Disorders
	H7S	ANTIPSYCHOTICS,DOPAMINE ANTAGONST,DIHYDROINDOLONES	Schizophrenia, Schizotypal, Delusional, and Other Non-Mood Psychotic Disorders
	H7T	ANTIPSYCHOTIC,ATYPICAL,DOPAMINE,SEROTONIN ANTAGNST	Schizophrenia, Schizotypal, Delusional, and Other Non-Mood Psychotic Disorders
	H7U	ANTIPSYCHOTICS, DOPAMINE AND SEROTONIN ANTAGONISTS	Schizophrenia, Schizotypal, Delusional, and Other Non-Mood Psychotic Disorders
	H7X	ANTIPSYCHOTICS, ATYP, D2 PARTIAL AGONIST/5HT MIXED	Schizophrenia, Schizotypal, Delusional, and Other Non-Mood Psychotic Disorders
	H8W	ANTIPSYCHOTIC-ATYPICAL,D3/D2 PARTIAL AG-5HT MIXED	Schizophrenia, Schizotypal, Delusional, and Other Non-Mood Psychotic Disorders
	C0D	ANTI-ALCOHOLIC PREPARATIONS	Substance Use Disorder
	H3W	NARCOTIC WITHDRAWAL THERAPY AGENTS	Substance Use Disorder
Cancer	C6M	FOLIC ACID PREPARATIONS	Cancer - All Inclusive
	C7F	APPETITE STIM. FOR ANOREXIA,CACHEXIA,WASTING SYND.	Cancer - All Inclusive
	F1A	ANDROGENIC AGENTS	Cancer - All Inclusive
	H2E	SEDATIVE-HYPNOTICS,NON-BARBITURATE	Cancer - All Inclusive
	H2F	ANTI-ANXIETY DRUGS	Cancer - All Inclusive
	H3A	ANALGESICS, NARCOTICS	Cancer - All Inclusive
	H6J	ANTIEMETIC/ANTIVERTIGO AGENTS	Cancer - All Inclusive
	H7O	ANTIPSYCHOTICS,DOPAMINE ANTAGONISTS,BUTYROPHENONES	Cancer - All Inclusive
	H7T	ANTIPSYCHOTIC,ATYPICAL,DOPAMINE,SEROTONIN ANTAGNST	Cancer - All Inclusive
	J9A	INTESTINAL MOTILITY STIMULANTS	Cancer - All Inclusive
	N1C	LEUKOCYTE (WBC) STIMULANTS	Cancer - All Inclusive
	N1E	PLATELET PROLIFERATION STIMULANTS	Cancer - All Inclusive
	P1M	LHRH (GNRH) AGONIST ANALOG PITUITARY SUPPRESSANTS	Cancer - All Inclusive
	P4L	BONE RESORPTION INHIBITORS	Cancer - All Inclusive
	P5A	GLUCOCORTICOIDS	Cancer - All Inclusive
	R2A	FLUORESCENCE CYSTOSCOPY/OPTICAL IMAGING AGENTS	Cancer - All Inclusive
	S2N	ANTI-ARTHRITIC, FOLATE ANTAGONIST AGENTS	Cancer - All Inclusive
	V1A	ANTINEOPLASTIC - ALKYLATING AGENTS	Cancer - All Inclusive
	V1B	ANTINEOPLASTIC - ANTIMETABOLITES	Cancer - All Inclusive
	V1C	ANTINEOPLASTIC - VINCA ALKALOIDS	Cancer - All Inclusive
	V1D	ANTIBIOTIC ANTINEOPLASTICS	Cancer - All Inclusive
	V1E	STEROID ANTINEOPLASTICS	Cancer - All Inclusive

Treatment Category	Drug Class	Description	Chronic Condition(s) Treated
Cancer Con't.	V1F	ANTINEOPLASTICS,MISCELLANEOUS	Cancer - All Inclusive
	V1G	RADIOACTIVE THERAPEUTIC AGENTS	Cancer - All Inclusive
	V1I	CHEMOTHERAPY RESCUE/ANTIDOTE AGENTS	Cancer - All Inclusive
	V1J	ANTINEOPLASTIC - ANTIANDROGENIC AGENTS	Cancer - All Inclusive
	V1O	ANTINEOPLASTIC LHRH(GNRH) AGONIST,PITUITARY SUPPR.	Cancer - All Inclusive
	V1Q	ANTINEOPLASTIC SYSTEMIC ENZYME INHIBITORS	Cancer - All Inclusive
	V1R	PHOTOACTIVATED, ANTINEOPLASTIC AGENTS (SYSTEMIC)	Cancer - All Inclusive
	V1T	SELECTIVE ESTROGEN RECEPTOR MODULATORS (SERMS)	Cancer - All Inclusive
	V1W	ANTINEOPLASTIC EGF RECEPTOR BLOCKER MCLON ANTIBODY	Cancer - All Inclusive
	V1X	ANTINEOPLAST HUM VEGF INHIBITOR RECOMB MC ANTIBODY	Cancer - All Inclusive
	V2A	NEOPLASM MONOCLONAL DIAGNOSTIC AGENTS	Cancer - All Inclusive
	V3C	ANTINEOPLASTIC - MTOR KINASE INHIBITORS	Cancer - All Inclusive
	V3E	ANTINEOPLASTIC - TOPOISOMERASE I INHIBITORS	Cancer - All Inclusive
	V3F	ANTINEOPLASTIC - AROMATASE INHIBITORS	Cancer - All Inclusive
	V3N	ANTINEOPLASTIC - VEGF-A,B AND PLGF INHIBITORS	Cancer - All Inclusive
	V3P	ANTINEOPLASTIC - VEGFR ANTAGONIST	Cancer - All Inclusive
	V3R	ANTINEOPLASTIC,ANTI-PROGRAMMED DEATH-1 (PD-1) MAB	Cancer - All Inclusive
	V3Y	ANTI-PROGRAMMED CELL DEATH-LIGAND 1 (PD-L1) MAB	Cancer - All Inclusive
	W7B	VIRAL/TUMORIGENIC VACCINES	Cancer - All Inclusive
	Z2G	IMMUNOMODULATORS	Cancer - All Inclusive
	Z8B	PORPHYRINS AND PORPHYRIN DERIVATIVE AGENTS	Cancer - All Inclusive
Chronic Cardiovascular Disease	A1A	DIGITALIS GLYCOSIDES	Atrial Fibrillation
	A2A	ANTIARRHYTHMICS	Atrial Fibrillation
	A9A	CALCIUM CHANNEL BLOCKING AGENTS	Atrial Fibrillation
	J7A	ALPHA/BETA-ADRENERGIC BLOCKING AGENTS	Atrial Fibrillation
	J7C	BETA-ADRENERGIC BLOCKING AGENTS	Atrial Fibrillation
	M9L	ANTICOAGULANTS,COUMARIN TYPE	Atrial Fibrillation
	M9T	THROMBIN INHIBITORS, SELECTIVE, DIRECT, REVERSIBLE	Atrial Fibrillation
	M9V	DIRECT FACTOR XA INHIBITORS	Atrial Fibrillation
	M9V	DIRECT FACTOR XA INHIBITORS	DVT
	M9E	THROMBIN INHIBITORS,SEL.,DIRECT,&REV.-HIRUDIN TYPE	DVT and Ischemic Heart Disease
	M9K	HEPARIN AND RELATED PREPARATIONS	DVT and Ischemic Heart Disease
	M9L	ANTICOAGULANTS,COUMARIN TYPE	DVT and Ischemic Heart Disease
	M9T	THROMBIN INHIBITORS,SELECTIVE,DIRECT, & REVERSIBLE	DVT and Ischemic Heart Disease
	M9F	THROMBOLYTIC ENZYMES	DVT and Stroke/Transient Ischemic Attack
	A7B	VASODILATORS,CORONARY Ischemic	Heart Disease and Heart Failure
	A1A	DIGITALIS GLYCOSIDES	Heart Failure
	A1C	INOTROPIC DRUGS	Heart Failure
	A7J	VASODILATORS, COMBINATION	Heart Failure
	J7C	BETA-ADRENERGIC BLOCKING AGENTS	Heart Failure and Ischemic Heart Disease
	C6N	NIACIN PREPARATIONS	Hyperlipidemia
	D7L	BILE SALT SEQUESTRANTS	Hyperlipidemia
	M4D	ANTIHYPERLIPIDEMIC - HMG COA REDUCTASE INHIBITORS	Hyperlipidemia and Ischemic Heart Disease
	M4E	LIPOTROPICS	Hyperlipidemia and Ischemic Heart Disease

Treatment Category	Drug Class	Description	Chronic Condition(s) Treated
Chronic Cardiovascular Disease Con't.	M4L	ANTIHYPERLIPIDEMIC-HMG COA REDUCTASE INHIB.&NIACIN	Hyperlipidemia and Ischemic Heart Disease
	M4M	ANTIHYPERLIP.HMG COA REDUCT INHIB&CHOLEST.AB.INHIB	Hyperlipidemia and Ischemic Heart Disease
	M4I	ANTIHYPERLIP - HMG-COA&CALCIUM CHANNEL BLOCKER CB	Hyperlipidemia, Hypertension, Ischemic Heart Disease
	A4A	ANTIHYPERTENSIVES, VASODILATORS	Hypertension
	A4B	ANTIHYPERTENSIVES, SYMPATHOLYTIC	Hypertension
	A4C	ANTIHYPERTENSIVES, GANGLIONIC BLOCKERS	Hypertension
	A4K	ACE INHIBITOR/CALCIUM CHANNEL BLOCKER COMBINATION	Hypertension
	A4T	RENIN INHIBITOR, DIRECT	Hypertension
	A4U	RENIN INHIBITOR,DIRECT AND THIAZIDE DIURETIC COMB	Hypertension
	A4V	ANGIOTEN.RECEPTR ANTAG./CAL.CHANL BLKR/THIAZIDE CB	Hypertension
	A4W	RENIN INHIBITOR,DIRECT & ANGIOTENSIN RECEPT ANTAG.	Hypertension
	A4X	RENIN INHIBITOR, DIRECT & CALCIUM CHANNEL BLOCKER	Hypertension
	A4Y	ANTIHYPERTENSIVES, MISCELLANEOUS	Hypertension
	A4Z	RENIN INHIB, DIRECT& CALC.CHANNEL BLKR & THIAZIDE	Hypertension
	J7B	ALPHA-ADRENERGIC BLOCKING AGENTS	Hypertension
	J7B	ALPHA-ADRENERGIC BLOCKING AGENTS	Hypertension
	J7E	ALPHA-ADRENERGIC BLOCKING AGENT/THIAZIDE COMB	Hypertension
	J7H	BETA-ADRENERGIC BLOCKING AGENTS/THIAZIDE & RELATED	Hypertension
	A7H	VASOACTIVE NATRIURETIC PEPTIDES	Hypertension and Heart Failure
	J7A	ALPHA/BETA-ADRENERGIC BLOCKING AGENTS	Hypertension and Heart Failure
	R1E	CARBONIC ANHYDRASE INHIBITORS	Hypertension and Heart Failure
	R1F	THIAZIDE AND RELATED DIURETICS	Hypertension and Heart Failure
	R1H	POTASSIUM SPARING DIURETICS	Hypertension and Heart Failure
	R1L	POTASSIUM SPARING DIURETICS IN COMBINATION	Hypertension and Heart Failure
	R1M	LOOP DIURETICS	Hypertension and Heart Failure
	A4F	ANTIHYPERTENSIVES, ANGIOTENSIN RECEPTOR ANTAGONIST	Hypertension, Ischemic Heart Disease and Heart Failure
	A4H	ANGIOTENSIN RECEPTOR ANTGNST & CALC.CHANNEL BLOCKR	Hypertension, Ischemic Heart Disease and Heart Failure
	A4I	ANGIOTENSIN RECEPTOR ANTAG./THIAZIDE DIURETIC COMB	Hypertension, Ischemic Heart Disease and Heart Failure
	A4J	ACE INHIBITOR/THIAZIDE & THIAZIDE-LIKE DIURETIC	Hypertension, Ischemic Heart Disease and Heart Failure
	A9A	CALCIUM CHANNEL BLOCKING AGENTS	Hypertension, Ischemic Heart Disease and Heart Failure
	A2C	ANTIANGINAL & ANTI-ISCHEMIC AGENTS,NON-HEMODYNAMIC	Ischemic Heart Disease
	C4A	ANTIHYPERGLY.DPP-4 INHIBITORS &HMG COA RI(STATINS)	Ischemic Heart Disease
	M4E	LIPOTROPICS	Ischemic Heart Disease
	M9D	ANTIFIBRINOLYTIC AGENTS	Ischemic Heart Disease
	A4D	ANTIHYPERTENSIVES, ACE INHIBITORS Hypertension,	Ischemic Heart Disease and Heart Failure
	A7C	VASODILATORS,PERIPHERAL	Ischemic Heart Disease and Stroke/Transient Ischemic Attack
	M9P	PLATELET AGGREGATION INHIBITORS	Ischemic Heart Disease and Stroke/Transient Ischemic Attack
Chronic Kidney Disease	A4A	HYPOTENSIVES, VASODILATORS	Chronic Kidney Disease
	A4B	HYPOTENSIVES, SYMPATHOLYTIC	Chronic Kidney Disease
	A4C	HYPOTENSIVES, GANGLIONIC BLOCKERS	Chronic Kidney Disease
	A4D	HYPOTENSIVES, ACE BLOCKING TYPE	Chronic Kidney Disease
	A4F	HYPOTENSIVES-ANGIO RECEPTOR ANTAG	Chronic Kidney Disease
	A4H	ANGITNS RCPT ANTGST & CA.CHNL BLCKR	Chronic Kidney Disease
	A4I	ANG REC ANT/THZ & THZ-REL DIU COMBS	Chronic Kidney Disease

Treatment Category	Drug Class	Description	Chronic Condition(s) Treated
Chronic Kidney Disease Con't.	A4J	ACE INH/THZ & THZ-LIKE DIURET COMBS	Chronic Kidney Disease
	A4K	ACE INHIBITOR/CCB COMBINATION	Chronic Kidney Disease
	A4N	ARB-BB COMBINATION	Chronic Kidney Disease
	A4T	RENIN INHIBITOR, DIRECT	Chronic Kidney Disease
	A4U	RENIN INHB, DIRCT/THIAZD DIURET CMB	Chronic Kidney Disease
	A4V	ANGTN.RCPT ANT/CA.CHANL BLK/THZD CB	Chronic Kidney Disease
	A4W	RENIN INHBT,DRCT & ANGTN RCPT ANTAG	Chronic Kidney Disease
	A4X	RENIN INHBTR, DRCT & CA CHNNL BLCKR	Chronic Kidney Disease
	A4Y	HYPOTENSIVES, MISCELLANEOUS	Chronic Kidney Disease
	A4Z	RENIN INHB,DRCT/CA CHNL BLK/THZD CB	Chronic Kidney Disease
	A7J	VASODILATORS,COMBINATION	Chronic Kidney Disease
	C1A	ELECTROLYTE DEPLETERS	Chronic Kidney Disease
	C1F	CALCIUM REPLACEMENT	Chronic Kidney Disease
	C3B	IRON REPLACEMENT	Chronic Kidney Disease
	C4A	ANTIHYPERGLY DPP4 INHB & HMG COA RI	Chronic Kidney Disease
	C4B	ANTIHYPERGLY-Glucocort Recpt Bl	Chronic Kidney Disease
	C4C	ANTIHYPERGLY,DPP-4 INH&THIAZOL	Chronic Kidney Disease
	C4D	Antihyperglycemic SGLT2	Chronic Kidney Disease
	C4E	SGLT2 INHIB-BIGUANIDE CMB	Chronic Kidney Disease
	C4F	ANTIHYPERGLY,(DPP-4) INHI & BIG CMB	Chronic Kidney Disease
	C4G	INSULINS	Chronic Kidney Disease
	C4H	ANTIHYPERGLY,AMYLIN ANALOG TYPE	Chronic Kidney Disease
	C4I	ANTIHYPERGLY,INCRETIN MIMETIC	Chronic Kidney Disease
	C4J	ANTIHYPERGLYCEMIC, DPP-4 INHIBITORS	Chronic Kidney Disease
	C4K	ORAL HYPOGLYCEMICS, SULFONYLUREAS	Chronic Kidney Disease
	C4L	ORAL HYPOGLYC., NON-SULFONYLUREAS	Chronic Kidney Disease
	C4M	HYPOGLYCEMICS, ALPHA-GLUCOSIDASE	Chronic Kidney Disease
	C4N	HYPOGLYCEMICS, INSULIN-RESPONSE	Chronic Kidney Disease
	C4R	HYPOG,INSUL-RESPON & INSUL RELEA CB	Chronic Kidney Disease
	C4S	HYPOGLY,INSUL-REL STIM & BIGUAN CMB	Chronic Kidney Disease
	C4T	HYPOGLY,INSUL-RESP ENHAN & BIGU CMB	Chronic Kidney Disease
	C4V	ANTHYPERGLYCEMIC-DOPAM RCPTR AGONST	Chronic Kidney Disease
	C4W	SGLT-2/DPP-4 CMB	Chronic Kidney Disease
	C4X	INSULIN, LONG ACT-GLP1 REC.AG	Chronic Kidney Disease
	C6D	VITAMIN D PREPARATIONS	Chronic Kidney Disease
	D7L	BILE SALT SEQUESTRANTS	Chronic Kidney Disease
	J7B	ALPHA-ADRENERGIC BLOCKING AGENTS	Chronic Kidney Disease
	M4D	ANTIHYPERLIPD-HMG COA REDUCT INHB	Chronic Kidney Disease
	M4E	LIPOTROPICS	Chronic Kidney Disease
	M4J	ANTHYPRLIPD-HMG COA & PL AG INH CMB	Chronic Kidney Disease
	M4L	ANTIHYPERLIPD-HMG COA & NIACIN COMB	Chronic Kidney Disease
	M4M	ANTHYPRLPD-HMG COA & CHL AB INH CMB	Chronic Kidney Disease
	M9K	HEPARIN AND RELATED PREPARATIONS	Chronic Kidney Disease
	N1B	ERYTHROPOIESIS-STIMULATING AGENTS	Chronic Kidney Disease
	P4D	HYPERPARATHYROID TX AGENTS - VITAMIN D ANALOG-TYPE	Chronic Kidney Disease

Treatment Category	Drug Class	Description	Chronic Condition(s) Treated
Chronic Kidney Disease Con't.	P4M	CALCIMIMETIC,PARATHYROID CALCIUM ENHANCER	Chronic Kidney Disease
	R1M	LOOP DIURETICS	Chronic Kidney Disease
Chronic Pulmonary Disease	Z2F	MAST CELL STABILIZERS	Asthma
	Z4B	LEUKOTRIENE RECEPTOR ANTAGONISTS	Asthma
	A1B	XANTHINES	Asthma and COPD
	A1D	GENERAL BRONCHODILATOR AGENTS	Asthma and COPD
	B6M	GLUCOCORTICOIDS, ORALLY INHALED	Asthma and COPD
	J5A	ADRENERGIC AGENTS,CATECHOLAMINES	Asthma and COPD
	J5D	BETA-ADRENERGIC AGENTS	Asthma and COPD
	J5G	BETA-ADRENERGIC AND GLUCOCORTICOID COMBINATIONS	Asthma and COPD
	J5J	BETA-ADRENERGIC AND ANTICHOLINERGIC COMBINATIONS	COPD
	Z2X	PHOSPHODIESTERASE-4 (PDE4) INHIBITORS	COPD
	B0B	CYSTIC FIB-TRANSMEMB CONDUCT.REG.(CFTR)POTENTIATOR	Cystic Fibrosis
	B0F	CYSTIC FIBROSIS-CFTR POTENTIATOR-CORRECTOR COMBIN.	Cystic Fibrosis
	B3A	MUCOLYTICS	Cystic Fibrosis
	C6E	VITAMIN E PREPARATIONS	Cystic Fibrosis
	W1A	PENICILLINS	Cystic Fibrosis
	W1F	AMINOGLYCOSIDES	Cystic Fibrosis
	W1N	POLYMYXIN AND DERIVATIVES	Cystic Fibrosis
	W1P	BETALACTAMS	Cystic Fibrosis
	W1Q	QUINOLONES	Cystic Fibrosis
	W1S	CARBAPENEMS (THIENAMYCINS)	Cystic Fibrosis
	W1Y	CEPHALOSPORINS - 3RD GENERATION	Cystic Fibrosis
	W1Z	CEPHALOSPORINS - 4TH GENERATION	Cystic Fibrosis
Diabetes	C4B	ANTIHYPERGLYCEMIC-GLUCOCORTICOID RECEPTOR BLOCKER	Diabetes Mellitus
	C4C	ANTIHYPERGLY,DPP-4 ENZYME INHIB &THIAZOLIDINEDIONE	Diabetes Mellitus
	C4D	ANTIHYPERGLYCEMC-SOD/GLUC COTRANSPORT2(SGLT2)INHIB	Diabetes Mellitus
	C4F	ANTIHYPERGLYCEMIC,DPP-4 INHIBITOR & BIGUANIDE COMB	Diabetes Mellitus
	C4G	INSULINS	Diabetes Mellitus
	C4H	ANTIHYPERGLYCEMIC, AMYLIN ANALOG-TYPE	Diabetes Mellitus
	C4I	ANTIHYPERGLY,INCRETIN MIMETIC(GLP-1 RECEP.AGONIST)	Diabetes Mellitus
	C4J	ANTIHYPERGLYCEMIC, DPP-4 INHIBITORS	Diabetes Mellitus
	C4K	ANTIHYPERGLYCEMIC, INSULIN-RELEASE STIMULANT TYPE	Diabetes Mellitus
	C4L	ANTIHYPERGLYCEMIC, BIGUANIDE TYPE	Diabetes Mellitus
	C4M	ANTIHYPERGLYCEMIC, ALPHA-GLUCOSIDASE INHIBITORS	Diabetes Mellitus
	C4N	ANTIHYPERGLYCEMIC,THIAZOLIDINEDIONE(PPARG AGONIST)	Diabetes Mellitus
	C4R	ANTIHYPERGLYCEMIC,THIAZOLIDINEDIONE & SULFONYLUREA	Diabetes Mellitus
	C4S	ANTIHYPERGLYCEMIC,INSULIN-REL STIM.& BIGUANIDE CMB	Diabetes Mellitus
	C4T	ANTIHYPERGLYCEMIC,THIAZOLIDINEDIONE & BIGUANIDE	Diabetes Mellitus
	C4V	ANTIHYPERGLYCEMIC - DOPAMINE RECEPTOR AGONISTS	Diabetes Mellitus

Treatment Category	Drug Class	Description	Chronic Condition(s) Treated
Glaucoma	Q2G	OPHTHALMIC ANTIFIBROTIC AGENTS	Glaucoma
	Q6G	MIOTICS/OTHER INTRAOC. PRESSURE REDUCERS	Glaucoma
	Q6J	MYDRIATICS	Glaucoma
	R1B	OSMOTIC DIURETICS	Glaucoma
	R1E	CARBONIC ANHYDRASE INHIBITORS	Glaucoma
Hemophilia	M0E	ANTIHEMOPHILIC FACTORS	Hemophilia
	M0F	FACTOR IX PREPARATIONS	Hemophilia
	M0I	FACTOR IX COMPLEX (PCC) PREPARATIONS	Hemophilia
	M0K	FACTOR X PREPARATIONS	Hemophilia
	M9D	ANTIFIBRINOLYTIC AGENTS	Hemophilia
HIV	W5C	ANTIVIRALS, HIV-SPECIFIC, PROTEASE INHIBITORS	HIV
	W5I	ANTIVIRALS, HIV-SPECIFIC, NUCLEOTIDE ANALOG, RTI	HIV
	W5J	ANTIVIRALS, HIV-SPECIFIC, NUCLEOSIDE ANALOG, RTI	HIV
	W5K	ANTIVIRALS, HIV-SPECIFIC, NON-NUCLEOSIDE, RTI	HIV
	W5L	ANTIVIRALS, HIV-SPEC., NUCLEOSIDE ANALOG, RTI COMB	HIV
	W5M	ANTIVIRALS, HIV-SPECIFIC, PROTEASE INHIBITOR COMB	HIV
	W5N	ANTIVIRALS, HIV-SPECIFIC, FUSION INHIBITORS	HIV
	W5O	ANTIVIRALS, HIV-SPEC, NUCLEOSIDE-NUCLEOTIDE ANALOG	HIV
	W5P	ANTIVIRALS, HIV-SPEC, NON-PEPTIDIC PROTEASE INHIB	HIV
	W5Q	ARTV CMB NUCLEOSIDE,NUCLEOTIDE,&NON-NUCLEOSIDE RTI	HIV
	W5T	ANTIVIRALS, HIV-SPECIFIC, CCR5 CO-RECEPTOR ANTAG.	HIV
	W5U	ANTIVIRALS,HIV-1 INTEGRASE STRAND TRANSFER INHIBTR	HIV
	W5X	ARV CMB-NRTI,N(T)RTI, INTEGRASE INHIBITOR	HIV
Lead Exposure	C8A	METALLIC POISON,AGENTS TO TREAT	Lead Exposure
	C8C	LEAD POISONING, AGENTS TO TREAT (CHELATING-TYPE)	Lead Exposure
Liver Disease	D7A	BILE SALTS	Liver Disease, Cirrhosis and Other Liver Conditions (except Viral Hepatitis)
	D7E	FARNESOID X RECEPTOR (FXR) AGONIST, BILE AC ANALOG	Liver Disease, Cirrhosis and Other Liver Conditions (except Viral Hepatitis)
	D7U	BILIARY DIAGNOSTICS,RADIOPAQUE	Liver Disease, Cirrhosis and Other Liver Conditions (except Viral Hepatitis)
	D9A	AMMONIA INHIBITORS	Liver Disease, Cirrhosis and Other Liver Conditions (except Viral Hepatitis)
	M0B	PLASMA PROTEINS	Liver Disease, Cirrhosis and Other Liver Conditions (except Viral Hepatitis)
	M0G	ANTIPORPHYRIA FACTORS	Liver Disease, Cirrhosis and Other Liver Conditions (except Viral Hepatitis)
	M9U	THROMBOLYTIC - NUCLEOTIDE TYPE	Liver Disease, Cirrhosis and Other Liver Conditions (except Viral Hepatitis)
	P5A	GLUCOCORTICOIDS	Liver Disease, Cirrhosis and Other Liver Conditions (except Viral Hepatitis)
	R1H	POTASSIUM SPARING DIURETICS	Liver Disease, Cirrhosis and Other Liver Conditions (except Viral Hepatitis)
	R1L	POTASSIUM SPARING DIURETICS IN COMBINATION	Liver Disease, Cirrhosis and Other Liver Conditions (except Viral Hepatitis)

Treatment Category	Drug Class	Description	Chronic Condition(s) Treated
Liver Disease Con't.	R1M	LOOP DIURETICS	Liver Disease, Cirrhosis and Other Liver Conditions (except Viral Hepatitis)
	V1B	ANTINEOPLASTIC - ANTIMETABOLITES	Liver Disease, Cirrhosis and Other Liver Conditions (except Viral Hepatitis)
	V1D	ANTIBIOTIC ANTINEOPLASTICS	Liver Disease, Cirrhosis and Other Liver Conditions (except Viral Hepatitis)
	V1Q	ANTINEOPLASTIC SYSTEMIC ENZYME INHIBITORS	Liver Disease, Cirrhosis and Other Liver Conditions (except Viral Hepatitis)
	W1F	AMINOGLYCOSIDES	Liver Disease, Cirrhosis and Other Liver Conditions (except Viral Hepatitis)
	W4C	AMEBICIDES	Liver Disease, Cirrhosis and Other Liver Conditions (except Viral Hepatitis)
	W9C	RIFAMYCINS AND RELATED DERIVATIVE ANTIBIOTICS	Liver Disease, Cirrhosis and Other Liver Conditions (except Viral Hepatitis)
	N1F	THROMBOPOIETIN RECEPTOR AGONISTS	Viral Hepatitis
	P5A	GLUCOCORTICOIDS	Viral Hepatitis
	W0A	HEPATITIS C VIRUS - NS5A REPLICATION COMPLEX INHIB	Viral Hepatitis
	W0B	HEP C VIRUS-NS5B POLYMERASE AND NS5A INHIB. COMBO.	Viral Hepatitis
	W0D	HEPATITIS C VIRUS - NS5A, NS3/4A, NS5B INHIB CMB.	Viral Hepatitis
	W0E	HEPATITIS C VIRUS- NS5A AND NS3/4A INHIBITOR COMB	Viral Hepatitis
	W5A	ANTIVIRALS, GENERAL	Viral Hepatitis
	W5F	HEPATITIS B TREATMENT AGENTS	Viral Hepatitis
	W5G	HEPATITIS C TREATMENT AGENTS	Viral Hepatitis
	W5I	ANTIVIRALS, HIV-SPECIFIC, NUCLEOTIDE ANALOG, RTI	Viral Hepatitis
	W5V	HEPATITIS C VIRUS NS3/4A SERINE PROTEASE INHIB.	Viral Hepatitis
	W5Y	HEP C VIRUS,NUCLEOTIDE ANALOG NS5B POLYMERASE INH	Viral Hepatitis
	W7B	VIRAL/TUMORIGENIC VACCINES	Viral Hepatitis
	W7K	ANTISERA	Viral Hepatitis
	Z2E	IMMUNOSUPPRESSIVES	Viral Hepatitis
	Z2G	IMMUNOMODULATORS	Viral Hepatitis
Medical Supplies	X2A	NEEDLES/NEEDLELESS DEVICES	Medical Supplies
	X2B	SYRINGES AND ACCESSORIES	Medical Supplies
	X5B	BANDAGES AND RELATED SUPPLIES	Medical Supplies
	Y7A	RESPIRATORY AIDS,DEVICES,EQUIPMENT	Medical Supplies
	Y9A	DIABETIC SUPPLIES	Medical Supplies
Obesity	D5A	FAT ABSORPTION DECREASING AGENTS	Obesity
	J5B	ADRENERGICS, AROMATIC, NON-CATECHOLAMINE	Obesity
	J8A	ANTI-OBESITY - ANOREXIC AGENTS	Obesity
	J8C	ANTI-OBESITY SEROTONIN 2C RECEPTOR AGONISTS	Obesity
Osteoporosis	C1F	CALCIUM REPLACEMENT	Osteoporosis
	C6D	VITAMIN D PREPARATIONS	Osteoporosis
	F1A	ANDROGENIC AGENTS	Osteoporosis
	G1A	ESTROGENIC AGENTS	Osteoporosis
	G1D	ESTROGEN-PROGESTIN WITH ANTIMINERALOCORTICOID COMB	Osteoporosis
	G1G	ESTROGEN-SELECTIVE ESTROGEN RECEPTOR MOD(SERM)COMB	Osteoporosis

Treatment Category	Drug Class	Description	Chronic Condition(s) Treated
	P4B	BONE FORMATION STIM. AGENTS - PARATHYROID HORMONE	Osteoporosis
	P4L	BONE RESORPTION INHIBITORS	Osteoporosis
	P4N	BONE RESORPTION INHIBITOR AND VITAMIN D COMBS.	Osteoporosis
	P4O	BONE RESORPTION INHIBITOR AND CALCIUM COMBINATIONS	Osteoporosis
Smoking Cessation	J3A	SMOKING DETERRENT AGENTS (GANGLIONIC STIM,OTHERS)	Tobacco Use Disorder
	J3C	SMOKING DETERRENT-NICOTINIC RECEPT.PARTIAL AGONIST	Tobacco Use Disorder
Stroke	C4A	ANTIHYPERGLY. DPP-4 INHIBITORS-HMG COA RI(STATINS)	Stroke/Transient Ischemic Attack
	H3D	ANALGESIC/ANTIPYRETICS, SALICYLATES	Stroke/Transient Ischemic Attack
	M4D	ANTIHYPERLIPIDEMIC - HMG COA REDUCTASE INHIBITORS	Stroke/Transient Ischemic Attack
	M4L	ANTIHYPERLIPIDEMIC-HMG COA REDUCTASE INHIB.-NIACIN	Stroke/Transient Ischemic Attack
	M9K	HEPARIN AND RELATED PREPARATIONS	Stroke/Transient Ischemic Attack
	M9P	PLATELET AGGREGATION INHIBITORS	Stroke/Transient Ischemic Attack

Medically Frail Identification Process

Healthy Michigan Plan (HMP) beneficiaries who are considered medically frail in accordance with 42 CFR 440.315(f) are exempt from the 48-month cumulative enrollment suspension of coverage requirement. Additionally, HMP beneficiaries who are considered medically frail are exempt from the workforce engagement requirements as a condition of receiving medical coverage.

MDHHS will identify individuals who are medically frail by the following methods: 1) Self-identification, 2) claims analysis, and 3) health care provider referral.

Individuals who are identified as medically frail will retain the status for 12 months, after which time an annual review will be required.

Self-Identification

MDHHS will allow individuals to self-attest to their medically frail status through the application for medical assistance program application: Application for Health Coverage & Help Paying Costs (DCH-1426) or through completion of a Medical Exemption Request form.

With respect to the application, individuals who answer "yes" to either of these questions will be designated as medically frail:

1) Does the applicant "have a physical, mental, or emotional health condition that causes limitations in activities (like bathing, dressing, daily chores, etc.) or live in a medical facility or nursing home?" (Paper Application)
2) Does the applicant: a) "have a physical disability or mental health condition that limits their ability to work, attend school, or take care of their daily needs?" or b) "need help with activities of daily living (like bathing, dressing, and using the bathroom), or live in a medical facility or nursing home?" (Online Application)

If an individual becomes medically frail during a period of eligibility, he or she may update his or her application information. Alternatively, an individual may complete an MDHHS Medical Exemption Request form that requires a signature from a health care provider.

Retrospective Claims Analysis

When available, MDHHS will review health care claims data available within Community Health Automated Medicaid Processing System (CHAMPS) from the preceding 12 months for the presence of select diagnosis codes to identify individuals considered medically frail. The list of codes is included as Appendix A. MDHHS may pursue updates to this list on an annual basis, in consultation with CMS as appropriate. The claims data to be reviewed include the following:

a. ICD-10 diagnosis codes (over 500 codes selected) that identify:
   - Individuals with disabling mental disorders;
   - Individuals with chronic substance use disorders;
   - Individuals with serious and complex medical conditions;

- Individuals with a physical, intellectual or developmental disability that significantly impairs their ability to perform one or more activities of daily living;

b. Whether a beneficiary is in a nursing home, hospice, or is receiving home help services.

Health Care Provider Referral

Medicaid enrolled providers will be able to recommend that an individual be considered medically frail through clinical judgement in cases where individuals may have not self-identified or had a claim indicating medical frailty. Health care providers whose scope of practice qualifies them to assess an individual as medically frail will be able to complete a Medical Exemption Request form on behalf of an individual. Exemption forms will be accepted at any time.

Appendix A: Medically Frail Diagnosis Codes

CODE	DESCRIPTION
A170	TUBERCULOUS MENINGITIS
A171	MENINGEAL TUBERCULOMA
A1781	TUBERCULOMA OF BRAIN AND SPINAL CORD
A1782	TUBERCULOUS MENINGOENCEPHALITIS
A1783	TUBERCULOUS NEURITIS
A1789	OTHER TUBERCULOSIS OF NERVOUS SYSTEM
A179	TUBERCULOSIS OF NERVOUS SYSTEM UNSPECIFIED
A1801	TUBERCULOSIS OF SPINE
A1802	TUBERCULOUS ARTHRITIS OF OTHER JOINTS
A1803	TUBERCULOSIS OF OTHER BONES
A1809	OTHER MUSCULOSKELETAL TUBERCULOSIS
A1810	TUBERCULOSIS OF GENITOURINARY SYSTEM UNSPECIFIED
A1811	TUBERCULOSIS OF KIDNEY AND URETER
A1812	TUBERCULOSIS OF BLADDER
A1813	TUBERCULOSIS OF OTHER URINARY ORGANS
A1814	TUBERCULOSIS OF PROSTATE
A1815	TUBERCULOSIS OF OTHER MALE GENITAL ORGANS
A1816	TUBERCULOSIS OF CERVIX
A1817	TUBERCULOUS FEMALE PELVIC INFLAMMATORY DISEASE
A1818	TUBERCULOSIS OF OTHER FEMALE GENITAL ORGANS
A182	TUBERCULOUS PERIPHERAL LYMPHADENOPATHY
A1831	TUBERCULOUS PERITONITIS
A1832	TUBERCULOUS ENTERITIS
A1839	RETROPERITONEAL TUBERCULOSIS
A184	TUBERCULOSIS OF SKIN AND SUBCUTANEOUS TISSUE
A1850	TUBERCULOSIS OF EYE UNSPECIFIED
A1851	TUBERCULOUS EPISCLERITIS
A1852	TUBERCULOUS KERATITIS
A1853	TUBERCULOUS CHORIORETINITIS
A1854	TUBERCULOUS IRIDOCYCLITIS
A1859	OTHER TUBERCULOSIS OF EYE
A186	TUBERCULOSIS OF INNER MIDDLE EAR
A187	TUBERCULOSIS OF ADRENAL GLANDS
A1881	TUBERCULOSIS OF THYROID GLAND
A1882	TUBERCULOSIS OF OTHER ENDOCRINE GLANDS
A1883	TUBERCULOSIS OF DIGESTIVE TRACT ORGANS NEC
A1884	TUBERCULOSIS OF HEART
A1885	TUBERCULOSIS OF SPLEEN
A1889	TUBERCULOSIS OF OTHER SITES
B20	HUMAN IMMUNODEFICIENCY VIRUS HIV DISEASE
B900	SEQUELAE OF CENTRAL NERVOUS SYSTEM TUBERCULOSIS

CODE	DESCRIPTION
B901	SEQUELAE OF GENITOURINARY TUBERCULOSIS
B902	SEQUELAE OF TUBERCULOSIS OF BONES AND JOINTS
B908	SEQUELAE OF TUBERCULOSIS OF OTHER ORGANS
D5700	HB-SS DISEASE WITH CRISIS, UNSPECIFIED
D5701	HB-SS DISEASE WITH ACUTE CHEST SYNDROME
D5702	HB-SS DISEASE WITH SPLENIC SEQUESTRATION
D571	SICKLE-CELL DISEASE WITHOUT CRISIS
D5720	SICKLE-CELL/HB-C DISEASE WITHOUT CRISIS
D57211	SICKLE-CELL/HB-C DISEASE WITH ACUTE CHEST SYNDROME
D57212	SICKLE-CELL/HB-C DISEASE WITH SPLENIC SEQUESTRATION
D57219	SICKLE-CELL/HB-C DISEASE WITH CRISIS, UNSPECIFIED
D5740	SICKLE-CELL THALASSEMIA WITHOUT CRISIS
D57411	SICKLE-CELL THALASSEMIA WITH ACUTE CHEST SYNDROME
D57412	SICKLE-CELL THALASSEMIA WITH SPLENIC SEQUESTRATION
D57419	SICKLE-CELL THALASSEMIA WITH CRISIS, UNSPECIFIED
D5780	OTHER SICKLE-CELL DISORDERS WITHOUT CRISIS
D57811	OTHER SICKLE-CELL DISORDERS WITH ACUTE CHEST SYNDROME
D57812	OTHER SICKLE-CELL DISORDERS WITH SPLENIC SEQUESTRATION
D57819	OTHER SICKLE-CELL DISORDERS WITH CRISIS, UNSPECIFIED
D808	OTHER IMMUNODEF W/PREDOMINANTLY ANTIBODY DEFECTS
D809	IMMUNODEF W/PREDOMINANTLY ANTIBODY DEFECTS UNS
D810	SEVERE COMBINED IMMUNODEF W/RETICULAR DYSGENESIS
D811	SEVERE COMBINED IMMUNODEF LOW T & B-CELL NUMBERS
D812	SEVERE COMBINED IMMULODEF W/NORMAL B-CELL NUMBRS
D813	ADENOSINE DEAMINASE DEFICIENCY
D814	NEZELOFS SYNDROME
D815	PURINE NUCLEOSIDE PHOSPHORYLASE DEFICIENCY
D816	MAJ HISTOCOMPATIBILITY COMPLX CLASS I DEFICIENCY
D817	MAJ HISTOCOMPATIBILTY COMPLX CLASS II DEFICIENCY
D81810	BIOTINIDASE DEFICIENCY
D81818	OTHER BIOTIN-DEPENDENT CARBOXYLASE DEFICIENCY
D81819	BIOTIN-DEPENDENT CARBOXYLASE DEFICIENCY UNS
D8189	OTHER COMBINED IMMUNODEFICIENCIES
D819	COMBINED IMMUNODEFICIENCY UNSPECIFIED
D820	WISKOTT-ALDRICH SYNDROME
D821	DI GEORGES SYNDROME
D823	IMMUNODEFIC FLW HEREDITARY DEFECT RESPONS TO EBV
D828	IMMUNODEFIC ASSOCIATED W/OTH SPEC MAJOR DEFECT
D829	IMMUNODEFICIENCY ASSOCIATED W/MAJOR DEFECTS UNS
D830	CVI W/PREDOMINANT ABN OF B-CELL NUMBERS & FUNCT
D831	CVI W/PREDOMINANT IMMUNOREGULATORY T-CELL D/O
D832	CVI WITH AUTOANTIBODIES TO B- OR T-CELLS
E701	OTHER HYPERPHENYLALANINEMIAS

CODE	DESCRIPTION
E7502	TAY-SACHS DISEASE
E7521	FABRY-ANDERSON DISEASE
E7522	GAUCHER DISEASE
E7523	Krabbe disease
E75240	NIEMANN-PICK DISEASE TYPE A
E75241	NIEMANN-PICK DISEASE TYPE B
E75242	NIEMANN-PICK DISEASE TYPE C
E75243	NIEMANN-PICK DISEASE TYPE D
E75248	OTHER NIEMANN-PICK DISEASE
E75249	NIEMANN-PICK DISEASE UNSPECIFIED
E7525	Metachromatic leukodystrophy
E7529	Other sphingolipidosis
E840	CYSTIC FIBROSIS WITH PULMONARY MANIFESTATIONS
E8419	CYSTIC FIBROSIS W/OTH INTESTINAL MANIFESTATIONS
E848	CYSTIC FIBROSIS WITH OTHER MANIFESTATIONS
E849	CYSTIC FIBROSIS UNSPECIFIED
E8840	MITOCHONDRIAL METABOLISM DISORDER UNSPECIFIED
F0150	VASCULAR DEMENTIA WITHOUT BEHAVIORAL DISTURBANCE
F0151	VASCULAR DEMENTIA WITH BEHAVIORAL DISTURBANCE
F0280	DEMENTIA OTH DZ CLASS ELSW W/O BEHAVRL DISTURB
F0281	DEMENTIA OTH DISEAS CLASS W/BEHAVIORAL DISTURB
F0390	UNSPEC DEMENTIA WITHOUT BEHAVIORAL DISTURBANCE
F0391	UNSPECIFIED DEMENTIA WITH BEHAVIORAL DISTURBANCE
F04	AMNESTIC DISORDER DUE KNOWN PHYSIOLOGICAL COND
F060	PSYCHOTIC DISORDER W HALLUCIN DUE TO KNOWN PHYSIOL CONDITION
F061	CATATONIC DISORDER DUE TO KNOWN PHYSIOLOGICAL CONDITION
F062	PSYCHOTIC DISORDER W DELUSIONS DUE TO KNOWN PHYSIOL COND
F0631	MOOD DISORDER DUE TO KNOWN PHYSIOL COND W DEPRESSV FEATURES
F0632	MOOD DISORD D/T PHYSIOL COND W MAJOR DEPRESSIVE-LIKE EPSD
F0633	MOOD DISORDER DUE TO KNOWN PHYSIOL COND W MANIC FEATURES
F0634	MOOD DISORDER DUE TO KNOWN PHYSIOL COND W MIXED FEATURES
F064	ANXIETY DISORDER DUE TO KNOWN PHYSIOLOGICAL CONDITION
F10121	ALCOHOL ABUSE WITH INTOXICATION DELIRIUM
F1014	ALCOHOL ABUSE WITH ALCOHOL-INDUCED MOOD DISORDER
F10150	ALCOHOL ABUSE W/INDUCED PSYCHOTIC D/O W/DELUSION
F10151	ALCOHOL ABUSE W/INDUCED PSYCHOTIC D/O W/HALLUC
F10159	ALCOHOL ABUSE W/ALCOHOL-INDUCED PSYCHOT D/O UNS
F10180	ALCOHOL ABUSE W/ALCOHOL-INDUCED ANXIETY DISORDER
F10221	ALCOHOL DEPENDENCE WITH INTOXICATION DELIRIUM
F10231	ALCOHOL DEPENDENCE WITH WITHDRAWAL DELIRIUM
F10232	ALCOHOL DEPENDENCE WITHDRAWAL PERCEPTUAL DISTURB
F1024	ALCOHOL DEPENDENCE W/ALCOHOL-INDUCED MOOD D/O
F10250	ALCOHOL DEPENDENCE INDUCD PSYCHOT D/O DELUSION

CODE	DESCRIPTION
F10251	ALCOHOL DEPENDENCE INDUCED PSYCHOTIC D/O HALLUC
F10259	ALCOHOL DEPENDENCE W/INDUCED PSYCHOTIC D/O UNS
F1026	ALCOHOL DEPENDENCE W/INDUCD-PERSIST AMNESTIC D/O
F1027	ALCOHOL DEPENDENCE W/INDUCED-PERSISTING DEMENTIA
F10280	ALCOHOL DEPENDENCE W/ALCOHOL-INDUCED ANXIETY D/O
F1097	ALCOHOL USE UNS W/INDUCED-PERSISTING DEMENTIA
F11121	OPIOID ABUSE WITH INTOXICATION DELIRIUM
F11122	OPIOID ABUSE W/INTOXICATION W/PERCEPTUAL DISTURB
F1114	OPIOID ABUSE WITH OPIOID-INDUCED MOOD DISORDER
F11150	OPIOID ABUSE W/INDUCD PSYCHOT D/O W/DELUSIONS
F11151	OPIOID ABUSE W/INDUCD PSYCHOT D/O W/HALLUCIN
F11159	OPIOID ABUSE W/OPIOID-INDUCD PSYCHOT D/O UNS
F11221	OPIOID DEPEND W/ INTOXICATION DELIRIUM
F11222	OPIOID DEPEND W/ INTOXICATION W/PERCEPTUAL DIST
F1123	OPIOID DEPENDENCE WITH WITHDRAWAL
F1124	OPIOID DEPEND W/INDUCD MOOD DISORDER
F11250	OPIOID DEPEND W/INDUCD PSYCHOTIC D/O W/DELUSIONS
F11251	OPIOID DEPEND W/INDUCD PSYCHOTIC D/O W/HALLUC
F11259	OPIOID DEPEND W/INDUCD PSYCHOTIC D/O UNS
F12121	CANNABIS ABUSE WITH INTOXICATION DELIRIUM
F12122	CANNABIS ABUSE W/INTOX W/PERCEPTUAL DISTURB
F12150	CANNABIS ABUSE W/PSYCHOTIC DISORDER W/ DELUSIONS
F12151	CANNABIS ABUSE W/PSYCHOT D/O W/HALLUCINATIONS
F12159	CANNABIS ABUSE W/ PSYCHOTIC DISORDER UNSPECIFIED
F12180	CANNABIS ABUSE W/CANNABIS-INDUCED ANXIETY D/O
F12221	CANNABIS DEPENDENCE WITH INTOXICATION DELIRIUM
F12222	CANNABIS DEPENDENCE W/INTOX W/PERCEPTUAL DIST
F12250	CANNABIS DEPENDENCE W/PSYCHOTIC D/O W/DELUSIONS
F12251	CANNABIS DEPENDENCE W/PSYCHOT D/O W/HALLUCIN
F12259	CANNABIS DEPENDENCE W/PSYCHOTIC DISORDER UNS
F12280	CANNABIS DEPENDENCE W/CANNABIS-INDUC ANXIETY D/O
F13121	SEDATIVE HYPNOTIC/ANXIOLYT ABUS W/INTOX DELIRIUM
F1314	SEDATIVE HYP/ANXIOLYTIC ABUSE W/INDUCED MOOD D/O
F13150	SEDATV HYP/ANXIOLYTIC ABUSE IND PSYCH D/O DELUS
F13151	SEDATV HYP/ANXIOLYTIC ABUSE IND PSYCH D/O HALLUC
F13159	SEDATV HYP/ANXIOLYTIC ABUSE IND PSYCHOT D/O UNS
F13180	SEDATV HYP/ANXIOLYTIC ABUSE W/INDUCD ANXIETY D/O
F13221	SEDATIVE HYP/ANXIOLYTIC DEPEND W/INTOX DELIRIUM
F13231	SEDATV HYP/ANXIOLYTIC DEPEND W/WITHDRWL DELIRIUM
F13232	SEDATV HYP/ANXIOLYTIC DEPEND W/D W/PERCEPTL DIST
F1324	SEDATV HYP/ANXIOLYTIC DEPEND W/INDUCD MOOD D/O
F13250	SEDATV HYP/ANXIOLYTIC DEPEND W/IND PSYCH D/O DEL
F13251	SEDATV HYP/ANXIOLYT DEPEND IND PSYCH D/O HALLUC

CODE	DESCRIPTION
F1326	SEDATV HYP/ANXIOLYT DEPEND IND PERSIST AMNES D/O
F1327	SEDATV HYP/ANXIOLYT DEPEND IND PERSIST DEMENTIA
F13280	SEDATV HYP/ANXIOLYT DEPEND W/INDUC ANXIETY D/O
F14121	COCAINE ABUSE WITH INTOXICATION WITH DELIRIUM
F14122	COCAINE ABUSE W/INTOXICATION W/PERCEPTUAL DIST
F1414	COCAINE ABUSE WITH COCAINE-INDUCED MOOD DISORDER
F14150	COCAINE ABUSE W/INDUCD PSYCHOT D/O W/DELUSIONS
F14151	COCAINE ABUSE W/INDUCD PSYCHOT D/O W/HALLUCIN
F14159	COCAINE ABUSE W/COCAINE-INDUCD PSYCHOT D/O UNS
F14180	COCAINE ABUSE W/COCAINE-INDUCED ANXIETY DISORDER
F14221	COCAINE DEPENDENCE WITH INTOXICATION DELIRIUM
F14222	COCAINE DEPENDENCE W/INTOX W/PERCEPTUAL DIST
F1423	COCAINE DEPENDENCE WITH WITHDRAWAL
F1424	COCAINE DEPENDENCE W/COCAINE-INDUCED MOOD D/O
F14250	COCAINE DEPENDENCE W/INDUC PSYCHOT D/O W/DELUSN
F14251	COCAINE DEPENDENCE W/INDUC PSYCHOT D/O W/HALLUC
F14259	COCAINE DEPENDENCE W/INDUCED PSYCHOT D/O UNS
F14280	COCAINE DEPENDENCE W/COCAINE-INDUCED ANXIETY D/O
F15121	OTHER STIMULANT ABUSE WITH INTOXICATION DELIRIUM
F15122	OTHER STIMULANT ABUSE W/INTOX W/PERCEPTUAL DIST
F1514	OTHER STIMULANT ABUSE W/INDUCED MOOD DISORDER
F15150	OTHER STIMULANT ABUSE W/INDUCD PSYCHOT D/O W/DEL
F15151	OTHER STIMULANT ABUSE INDUC PSYCHOT D/O W/HALLUC
F15159	OTHER STIMULANT ABUSE W/INDUC PSYCHOT D/O UNS
F15180	OTHER STIMULANT ABUSE W/INDUCED ANXIETY DISORDER
F15221	OTHER STIMULANT DEPENDENCE W/INTOX DELIRIUM
F15222	OTHER STIMULANT DEPENDENCE INTOX W/PERCEPTL DIST
F1523	OTHER STIMULANT DEPENDENCE WITH WITHDRAWAL
F1524	OTH STIMULANT DEPEND W/INDUCED MOOD DISORDER
F15250	OTH STIMULANT DEPEND W/INDUCED PSYCHOT D/O W/DEL
F15251	OTH STIMULANT DEPEND INDUC PSYCHOT D/O W/HALLUC
F15259	OTH STIMULANT DEPEND W/INDUCED PSYCHOT D/O UNS
F15280	OTH STIMULANT DEPEND W/INDUCED ANXIETY DISORDER
F16121	HALLUCINOGEN ABUSE W/INTOXICATION WITH DELIRIUM
F16122	HALLUCINOGEN ABUSE W/INTOX W/PERCEPTUAL DISTURB
F1614	HALLUCINOGEN ABUSE W/INDUCED MOOD DISORDER
F16150	HALLUCINOGEN ABUSE W/INDUCED PSYCHOT D/O W/DELUS
F16151	HALLUCINOGEN ABUSE W/INDUCD PSYCHOT D/O W/HALLUC
F16159	HALLUCINOGEN ABUSE W/INDUCD PSYCHOT DISORDER UNS
F16180	HALLUCINOGEN ABUSE W/INDUCED ANXIETY DISORDER
F16183	HALLUCINOGEN ABUSE W/PERSISTING PERCEPTION D/O
F16221	HALLUCINOGEN DEPENDENCE W/INTOX W/DELIRIUM
F1624	HALLUCINOGEN DEPENDENCE W/INDUCED MOOD DISORDER

CODE	DESCRIPTION
F16250	HALLUCINOGEN DEPEND INDUC PSYCHOT D/O W/DELUSION
F16251	HALLUCINOGEN DEPEND INDUC PSYCHOT D/O W/HALLUCIN
F16259	HALLUCINOGEN DEPENDENCE W/INDUCD PSYCHOT D/O UNS
F16280	HALLUCINOGEN DEPENDENCE W/INDUC ANXIETY DISORDER
F16283	HALLUCINOGEN DEPENDENCE W/PERSIST PERCEPTION D/O
F18121	INHALANT ABUSE WITH INTOXICATION DELIRIUM
F1814	INHALANT ABUSE W/INHALANT-INDUCED MOOD DISORDER
F18150	INHALANT ABUSE W/INDUCED PSYCHOT D/O W/DELUSIONS
F18151	INHALANT ABUSE W/INDUCED PSYCHOT D/O W/HALLUCIN
F18159	INHALANT ABUSE W/INHALANT-INDUCD PSYCHOT D/O UNS
F1817	INHALANT ABUSE WITH INHALANT-INDUCED DEMENTIA
F18180	INHALANT ABUSE W/INHALANT-INDUCED ANXIETY D/O
F18221	INHALANT DEPENDENCE WITH INTOXICATION DELIRIUM
F1824	INHALANT DEPENDENCE W/INHALANT-INDUCED MOOD D/O
F18250	INHALANT DEPEND W/INDUC PSYCHOT D/O W/DELUSIONS
F18251	INHALANT DEPEND W/INDUC PSYCHOT D/O W/HALLUCIN
F18259	INHALANT DEPEND W/INHAL-INDUCD PSYCHOT D/O UNS
F1827	INHALANT DEPENDENCE W/INHALANT-INDUCED DEMENTIA
F18280	INHALANT DEPENDENCE W/INHAL-INDUCD ANXIETY D/O
F19121	OTH PSYCHOACTIVE SBSTNC ABUSE INTOXICAT DELIRIUM
F19122	OTH PSYCHOACTIVE SBSTNC ABUSE INTOX PERCEPT DIST
F1914	OTH PSYCHOACTIVE SBSTNC ABUSE W/INDUCD MOOD D/O
F19150	OTH PSYCHOACTIV SBSTNC ABUSE IND PSYCHOT D/O DEL
F19151	OTH PSYCHOACTV SBSTNC ABUSE IND PSYCH D/O HALLUC
F19159	OTH PSYCHOACTIV SBSTNC ABUSE INDUC PSYCH D/O UNS
F1916	OTH PSYCHOACTV SBSTNC ABUS IND PERSIST AMNES D/O
F1917	OTH PSYCHOACTV SBSTNC ABUSE INDUC PERSIST DEMENT
F19180	OTH PSYCHOACTIVE SBSTNC ABUSE INDUCD ANXIETY D/O
F19221	OTH PSYCHOACTIVE SBSTNC DEPEND INTOX DELIRIUM
F19222	OTH PSYCHOACTV SBSTNC DEPEND INTOX PERCEPTL DIST
F19231	OTH PSYCHOACTIVE SBSTNC DEPEND WITH W/D DELIRIUM
F19232	OTH PSYCHOACTV SBSTNC DEPEND W/D W/PERCEPTL DIST
F1924	OTH PSYCHOACTIVE SBSTNC DEPEND W/INDUCD MOOD D/O
F19250	OTH PSYCHOACTV SBSTNC DEPEND IND PSYCH D/O W/DEL
F19251	OTH PSYCHOACTV SBSTNC DEPND IND PSYCH D/O HALLUC
F19259	OTH PSYCHOACTV SBSTNC DEPEND INDUC PSYCH D/O UNS
F1926	OTH PSYCHOACTV SBSTNC DEPEND IND PERSIST AMNES
F1927	OTH PSYCHOACTV SBSTNC DEPEND IND PERSIST DEMENT
F19280	OTH PSYCHOACTIVE SBSTNC DEP W/INDUC ANXIETY D/O
F200	PARANOID SCHIZOPHRENIA
F201	DISORGANIZED SCHIZOPHRENIA
F202	CATATONIC SCHIZOPHRENIA
F203	UNDIFFERENTIATED SCHIZOPHRENIA

CODE	DESCRIPTION
F205	RESIDUAL SCHIZOPHRENIA
F2081	SCHIZOPHRENIFORM DISORDER
F2089	OTHER SCHIZOPHRENIA
F209	SCHIZOPHRENIA UNSPECIFIED
F21	SCHIZOTYPAL DISORDER
F22	DELUSIONAL DISORDERS
F23	BRIEF PSYCHOTIC DISORDER
F24	SHARED PSYCHOTIC DISORDER
F250	SCHIZOAFFECTIVE DISORDER BIPOLAR TYPE
F251	SCHIZOAFFECTIVE DISORDER DEPRESSIVE TYPE
F258	OTHER SCHIZOAFFECTIVE DISORDERS
F259	SCHIZOAFFECTIVE DISORDER UNSPECIFIED
F28	OTH PSYCHOT D/O NOT DUE SUBSTANCE/PHYSIOLOG COND
F29	UNS PSYCHOSIS NOT DUE SUBSTANCE/PHYSIOLOG COND
F3012	MANIC EPISODE WITHOUT PSYCHOTIC SYMPTOMS, MODERATE
F3013	MANIC EPISODE, SEVERE, WITHOUT PSYCHOTIC SYMPTOMS
F302	MANIC EPISODE, SEVERE WITH PSYCHOTIC SYMPTOMS
F3112	BIPOLAR DISORD, CRNT EPISODE MANIC W/O PSYCH FEATURES, MOD
F3113	BIPOLAR DISORD, CRNT EPSD MANIC W/O PSYCH FEATURES, SEVERE
F312	BIPOLAR DISORD, CRNT EPISODE MANIC SEVERE W PSYCH FEATURES
F3132	BIPOLAR DISORDER, CURRENT EPISODE DEPRESSED, MODERATE
F314	BIPOLAR DISORD, CRNT EPSD DEPRESS, SEV, W/O PSYCH FEATURES
F315	BIPOLAR DISORD, CRNT EPSD DEPRESS, SEVERE, W PSYCH FEATURES
F3162	BIPOLAR DISORDER, CURRENT EPISODE MIXED, MODERATE
F3163	BIPOLAR DISORD, CRNT EPSD MIXED, SEVERE, W/O PSYCH FEATURES
F3164	BIPOLAR DISORD, CRNT EPISODE MIXED, SEVERE, W PSYCH FEATURES
F321	MAJOR DEPRESSIVE DISORDER, SINGLE EPISODE, MODERATE
F322	MAJOR DEPRESSV DISORD, SINGLE EPSD, SEV W/O PSYCH FEATURES
F323	MAJOR DEPRESSV DISORD, SINGLE EPSD, SEVERE W PSYCH FEATURES
F331	MAJOR DEPRESSIVE DISORDER, RECURRENT, MODERATE
F332	MAJOR DEPRESSV DISORDER, RECURRENT SEVERE W/O PSYCH FEATURES
F333	MAJOR DEPRESSV DISORDER, RECURRENT, SEVERE W PSYCH SYMPTOMS
F4001	AGORAPHOBIA WITH PANIC DISORDER
F410	Panic disorder [episodic paroxysmal anxiety]
F4311	POST-TRAUMATIC STRESS DISORDER, ACUTE
F4312	POST-TRAUMATIC STRESS DISORDER, CHRONIC
F440	DISSOCIATIVE AMNESIA
F441	DISSOCIATIVE FUGUE
F444	CONVERSION DISORDER WITH MOTOR SYMPTOM OR DEFICIT
F445	CONVERSION DISORDER WITH SEIZURES OR CONVULSIONS
F446	CONVERSION DISORDER WITH SENSORY SYMPTOM OR DEFICIT
F447	CONVERSION DISORDER WITH MIXED SYMPTOM PRESENTATION
F4481	DISSOCIATIVE IDENTITY DISORDER

CODE	DESCRIPTION
F4522	BODY DYSMORPHIC DISORDER
F481	DEPERSONALIZATION-DEREALIZATION SYNDROME
F600	PARANOID PERSONALITY DISORDER
F601	SCHIZOID PERSONALITY DISORDER
F71	Moderate intellectual disabilities
F72	Severe intellectual disabilities
F73	Profound intellectual disabilities
F801	Expressive language disorder
F840	AUTISTIC DISORDER
F845	ASPERGERS SYNDROME
F848	OTHER PERVASIVE DEVELOPMENTAL DISORDERS
F849	PERVASIVE DEVELOPMENTAL DISORDER UNSPECIFIED
F952	TOURETTES DISORDER
G041	TROPICAL SPASTIC PARAPLEGIA
G114	HEREDITARY SPASTIC PARAPLEGIA
G1221	AMYOTROPHIC LATERAL SCLEROSIS
G130	PARANEOPLASTIC NEUROMYOPATHY AND NEUROPATHY
G131	OTH SYSTEM ATROPHY PRIM AFFECT CNS NEOPLASTIC DZ
G231	PROGRESSIVE SUPRANUCLEAR OPHTHALMOPLEGIA
G300	ALZHEIMERS DISEASE WITH EARLY ONSET
G301	ALZHEIMERS DISEASE WITH LATE ONSET
G308	OTHER ALZHEIMERS DISEASE
G309	ALZHEIMERS DISEASE UNSPECIFIED
G3109	OTHER FRONTOTEMPORAL DEMENTIA
G3183	DEMENTIA WITH LEWY BODIES
G35	MULTIPLE SCLEROSIS
G450	VERTEBRO-BASILAR ARTERY SYNDROME
G451	CAROTID ARTERY SYNDROME HEMISPHERIC
G452	MULTIPLE & BILATERAL PRECEREBRAL ARTERY SYND
G453	AMAUROSIS FUGAX
G454	TRANSIENT GLOBAL AMNESIA
G458	OTH TRANSIENT CERBRL ISCHEMIC ATTACKS & REL SYND
G459	TRANSIENT CEREBRAL ISCHEMIC ATTACK UNSPECIFIED
G460	MIDDLE CEREBRAL ARTERY SYNDROME
G461	ANTERIOR CEREBRAL ARTERY SYNDROME
G462	POSTERIOR CEREBRAL ARTERY SYNDROME
G710	MUSCULAR DYSTROPHY
G731	LAMBERT-EATON SYNDROME IN NEOPLASTIC DISEASE
G800	SPASTIC QUADRIPLEGIC CEREBRAL PALSY
G801	SPASTIC DIPLEGIC CEREBRAL PALSY
G802	SPASTIC HEMIPLEGIC CEREBRAL PALSY
G803	ATHETOID CEREBRAL PALSY
G804	ATAXIC CEREBRAL PALSY

CODE	DESCRIPTION
G808	OTHER CEREBRAL PALSY
G809	CEREBRAL PALSY UNSPECIFIED
G8100	FLACCID HEMIPLEGIA AFFECTING UNSPECIFIED SIDE
G8101	FLACCID HEMIPLEGIA AFFECTING RIGHT DOMINANT SIDE
G8102	FLACCID HEMIPLEGIA AFFECTING LEFT DOMINANT SIDE
G8103	FLACCID HEMIPLEGIA AFFECTING RT NONDOMINANT SIDE
G8104	FLACCID HEMIPLEGIA AFFECTING LT NONDOMINANT SIDE
G8110	SPASTIC HEMIPLEGIA AFFECTING UNSPECIFIED SIDE
G8111	SPASTIC HEMIPLEGIA AFFECTING RIGHT DOMINANT SIDE
G8112	SPASTIC HEMIPLEGIA AFFECTING LEFT DOMINANT SIDE
G8113	SPASTIC HEMIPLEGIA AFFECTING RT NONDOMINANT SIDE
G8114	SPASTIC HEMIPLEGIA AFFECTING LT NONDOMINANT SIDE
G8190	HEMIPLEGIA UNS AFFECTING UNSPECIFIED SIDE
G8191	HEMIPLEGIA UNS AFFECTING RIGHT DOMINANT SIDE
G8192	HEMIPLEGIA UNS AFFECTING LEFT DOMINANT SIDE
G8193	HEMIPLEGIA UNS AFFECTING RIGHT NONDOMINANT SIDE
G8194	HEMIPLEGIA UNS AFFECTING LEFT NONDOMINANT SIDE
G8220	PARAPLEGIA UNSPECIFIED
G8221	PARAPLEGIA COMPLETE
G8222	PARAPLEGIA INCOMPLETE
G8250	QUADRIPLEGIA UNSPECIFIED
G8251	QUADRIPLEGIA C1-C4 COMPLETE
G8252	QUADRIPLEGIA C1-C4 INCOMPLETE
G8253	QUADRIPLEGIA C5-C7 COMPLETE
G8254	QUADRIPLEGIA C5-C7 INCOMPLETE
G830	DIPLEGIA OF UPPER LIMBS
G8310	MONOPLEGIA LOWER LIMB AFFECTING UNSPECIFIED SIDE
G8311	MONOPLEGIA LOWER LIMB RIGHT DOMINANT SIDE
G8312	MONOPLEGIA LOWER LIMB LEFT DOMINANT SIDE
G8313	MONOPLEGIA LOWER LIMB RIGHT NONDOMINANT SIDE
G8314	MONOPLEGIA LOWER LIMB LEFT NONDOMINANT SIDE
G8320	MONOPLEGIA UPPER LIMB AFFECTING UNSPECIFIED SIDE
G8321	MONOPLEGIA UPPER LIMB RIGHT DOMINANT SIDE
G8322	MONOPLEGIA UPPER LIMB LEFT DOMINANT SIDE
G8323	MONOPLEGIA UPPER LIMB RIGHT NONDOMINANT SIDE
G8324	MONOPLEGIA UPPER LIMB LEFT NONDOMINANT SIDE
G8330	MONOPLEGIA UNS AFFECTING UNSPECIFIED SIDE
G8331	MONOPLEGIA UNS AFFECTING RIGHT DOMINANT SIDE
G8332	MONOPLEGIA UNS AFFECTING LEFT DOMINANT SIDE
G8333	MONOPLEGIA UNS AFFECTING RIGHT NONDOMINANT SIDE
G8334	MONOPLEGIA UNS AFFECTING LEFT NONDOMINANT SIDE
H4930	TOTAL EXTERNAL OPHTHALMOPLEGIA UNSPECIFIED EYE
H4931	TOTAL EXTERNAL OPHTHALMOPLEGIA RIGHT EYE

CODE	DESCRIPTION
H4932	TOTAL EXTERNAL OPHTHALMOPLEGIA LEFT EYE
H4933	TOTAL EXTERNAL OPHTHALMOPLEGIA BILATERAL
H4940	PROGRESSIVE EXTERNAL OPHTHALMOPLEGIA UNS EYE
H4941	PROGRESSIVE EXTERNAL OPHTHALMOPLEGIA RIGHT EYE
H4942	PROGRESSIVE EXTERNAL OPHTHALMOPLEGIA LEFT EYE
H4943	PROGRESSIVE EXTERNAL OPHTHALMOPLEGIA BILATERAL
H5120	INTERNUCLEAR OPHTHALMOPLEGIA UNSPECIFIED EYE
H5121	INTERNUCLEAR OPHTHALMOPLEGIA RIGHT EYE
H5122	INTERNUCLEAR OPHTHALMOPLEGIA LEFT EYE
H5123	INTERNUCLEAR OPHTHALMOPLEGIA BILATERAL
H52511	INTERNAL OPHTHALMOPLEGIA COMPLETE TOTAL RT EYE
H52512	INTERNAL OPHTHALMOPLEGIA COMPLETE TOTAL LT EYE
H52513	INTERNAL OPHTHALMOPLEGIA COMPLETE TOTAL BILAT
H52519	INTERNAL OPHTHALMOPLEGIA COMPLETE TOTAL UNS EYE
I120	HYPERTENSIVE CKD W/STAGE 5 CKD OR ESRD
I1311	HTN HEART & CKD W/O HF W/STAGE 5 CKD OR ESRD
I132	HTN HEART & CKD W/HF W/STAGE 5 CKD OR ESRD
I132	HTN HEART & CKD W/HF W/STAGE 5 CKD OR ESRD
I69351	HEMIPLEGIA FLW CEREBRAL INFARCT AFF RT DOM SIDE
I69352	HEMIPLEGIA FLW CEREBRAL INFARCT AFF LT DOM SIDE
I69353	HEMIPLEGIA FLW CEREBRAL INFARCT AFF RT NON-DOM
I69354	HEMIPLEGIA FLW CEREBRAL INFARCT AFF LT NON-DOM
I69359	HEMIPLEGIA FLW CEREBRAL INFARCT AFFCT UNS SIDE
M623	IMMOBILITY SYNDROME PARAPLEGIC
N184	CHRONIC KIDNEY DISEASE STAGE 4 SEVERE
N185	CHRONIC KIDNEY DISEASE STAGE 5
N186	END STAGE RENAL DISEASE
Q050	CERVICAL SPINA BIFIDA WITH HYDROCEPHALUS
Q051	THORACIC SPINA BIFIDA WITH HYDROCEPHALUS
Q052	LUMBAR SPINA BIFIDA WITH HYDROCEPHALUS
Q053	SACRAL SPINA BIFIDA WITH HYDROCEPHALUS
Q054	UNSPECIFIED SPINA BIFIDA WITH HYDROCEPHALUS
Q055	CERVICAL SPINA BIFIDA WITHOUT HYDROCEPHALUS
Q056	THORACIC SPINA BIFIDA WITHOUT HYDROCEPHALUS
Q057	LUMBAR SPINA BIFIDA WITHOUT HYDROCEPHALUS
Q058	SACRAL SPINA BIFIDA WITHOUT HYDROCEPHALUS
Q059	SPINA BIFIDA UNSPECIFIED
Q900	Trisomy 21, nonmosaicism (meiotic nondisjunction)
Q901	Trisomy 21, mosaicism (mitotic nondisjunction)
Q902	Trisomy 21, translocation
Q909	Down syndrome, unspecified
Q910	Trisomy 18, nonmosaicism (meiotic nondisjunction)
Q911	Trisomy 18, mosaicism (mitotic nondisjunction)

CODE	DESCRIPTION
Q912	Trisomy 18, translocation
Q913	Trisomy 18, unspecified
Q914	Trisomy 13, nonmosaicism (meiotic nondisjunction)
Q915	Trisomy 13, mosaicism (mitotic nondisjunction)
Q916	Trisomy 13, translocation
Q917	Trisomy 13, unspecified
Q920	Whole chromosome trisomy, nonmosaicism (meiotic nondisjunction)
Q921	Whole chromosome trisomy, mosaicism (mitotic nondisjunction)
Q922	Partial trisomy
Q925	Duplications with other complex rearrangements
Q9261	Marker chromosomes in normal individual
Q9262	Marker chromosomes in abnormal individual
Q927	Triploidy and polyploidy
Q928	Other specified trisomies and partial trisomies of autosomes
Q929	Trisomy and partial trisomy of autosomes, unspecified
Q930	Whole chromosome monosomy, nonmosaicism (meiotic nondisjunction)
Q931	Whole chromosome monosomy, mosaicism (mitotic nondisjunction)
Q932	Chromosome replaced with ring, dicentric or isochromosome
Q937	Deletions with other complex rearrangements
Q9381	Velo-cardio-facial syndrome
Q9388	Other microdeletions
Q9389	Other deletions from the autosomes
Q939	Deletion from autosomes, unspecified
Q952	Balanced autosomal rearrangement in abnormal individual
Q953	Balanced sex/autosomal rearrangement in abnormal individual
Q992	Fragile X chromosome
R532	FUNCTIONAL QUADRIPLEGIA
Z510	ENCOUNTER FOR ANTINEOPLASTIC RADIATION THERAPY
Z5111	ENCOUNTER FOR ANTINEOPLASTIC CHEMOTHERAPY
Z5112	ENCOUNTER FOR ANTINEOPLASTIC IMMUNOTHERAPY
Z7682	AWAITING ORGAN TRANSPLANT STATUS
Z9911	DEPENDENCE ON RESPIRATOR VENTILATOR STATUS
Z9981	DEPENDENCE ON SUPPLEMENTAL OXYGEN

Medical Services Administration
Bureau of Medicaid Care Management and Quality Assurance

PERFORMANCE MONITORING REPORT

ANNUAL HEDIS MEASURES

Composite – All Plans

MDHHS
Michigan Department of Health & Human Services
RICK SNYDER, GOVERNOR | NICK LYON, DIRECTOR

January 2018

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

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Executive Summary

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

The Michigan Department of Health and Human Services (MDHHS) monitors the performance of the State's Medicaid Health Plans (MHPs) through twenty-eight (28) key performance measures aimed at improving the quality and efficiency of health care services provided to the Michigan residents enrolled in a Medicaid program. These measures include Medicaid Managed Care specific measures, Healthy Michigan Plan (HMP) measures, and HEDIS measures. **This report focuses only on the 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 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 2018 unless otherwise noted.

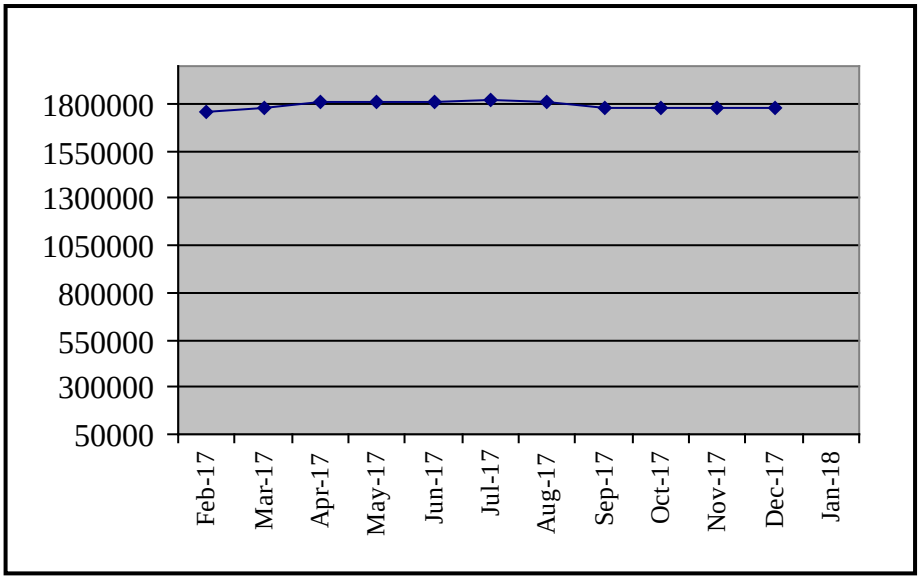
Table 1: Fiscal Year 2018[1]

Annually Reported Measures	Results
Timeliness of Prenatal Care	3/11
Postpartum Care	4/11
Childhood Immunizations	3/10
Well-Child Visits 0 – 15 Months	5/9
Well-Child Visits 3 to 6 Years	3/11
Adolescent Well Care Visits	2/11
Appropriate Testing for Children with Pharyngitis	4/10
Child Access to Care 12 to 24 Months	2/10
Child Access to Care 7 to 11 Years	2/11
Comprehensive Diabetes Care: HbA1c Testing	4/11
Comprehensive Diabetes Care: Eye Exam	4/11
Breast Cancer Screening	7/11
Chlamydia Screening in Women (Total)	7/11

Managed Care Enrollment

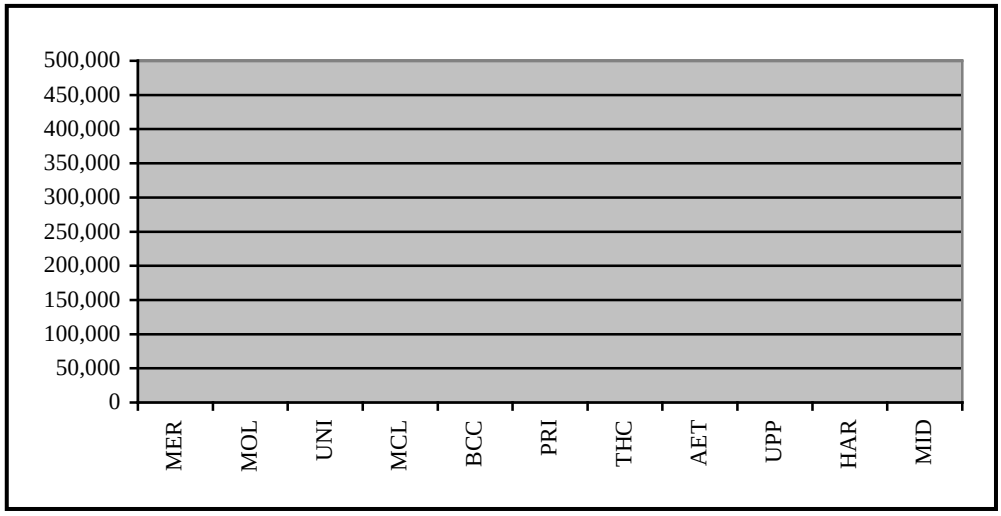
Michigan Medicaid Managed Care (MA-MC) enrollment has remained steady over the past year. Due to changes with the way the reports are pulled, current enrollment data is unavailable at this time.

Figure 1: Medicaid Managed Care Enrollment, February 2017 – January 2018



[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 2018



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 83%

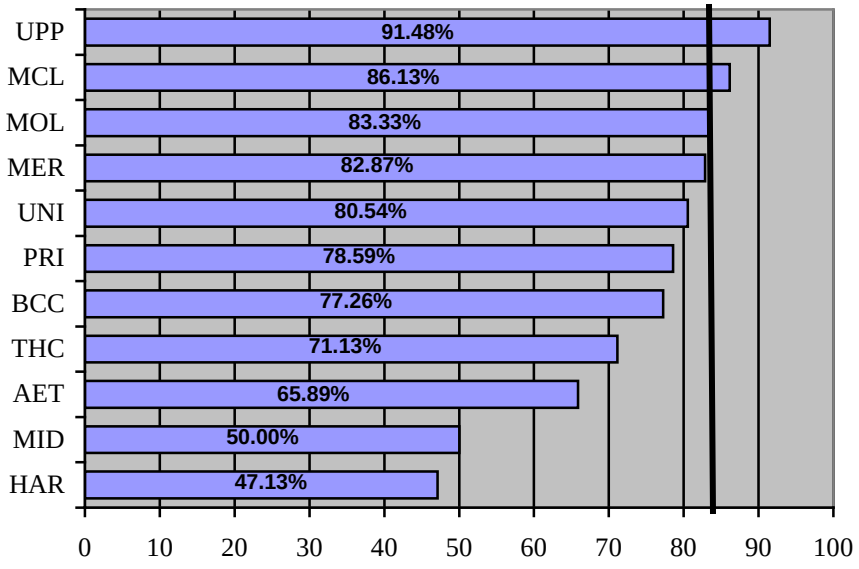
Measurement Period
Calendar Year 2016

Data Source
HEDIS 2017

Measurement Frequency
Annually

Summary: Three plans met or exceeded the standard, while eight plans (AET, BCC, HAR, MER, MID, PRI, THC, and UNI) did not. Results ranged from 47.13% to 91.48%

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 69%

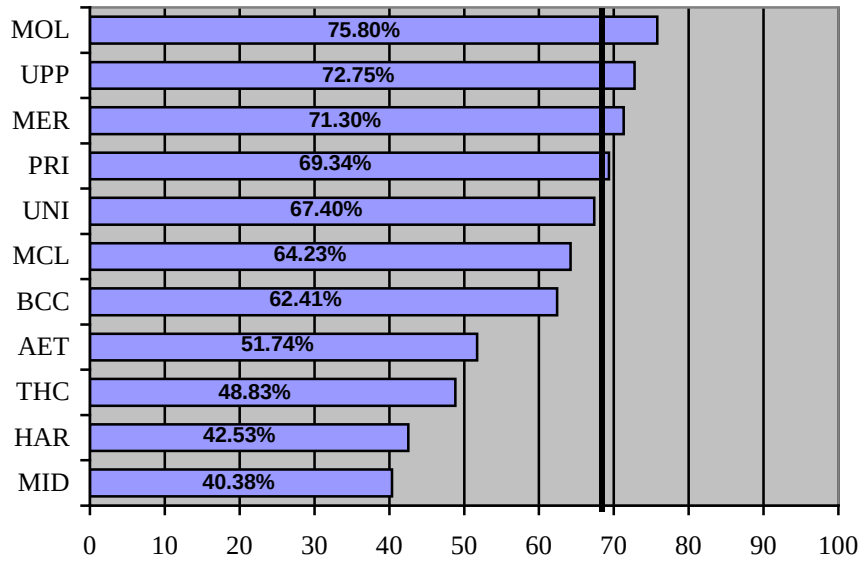
Measurement Period
Calendar Year 2016

Data Source
HEDIS 2017

Measurement Frequency
Annually

Summary: Summary: Four plans met or exceeded the performance standard, while seven plans (AET, BCC, HAR, MCL, MID, THC, and UNI) did not. Results ranged from 40.38% to 75.80%.

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%

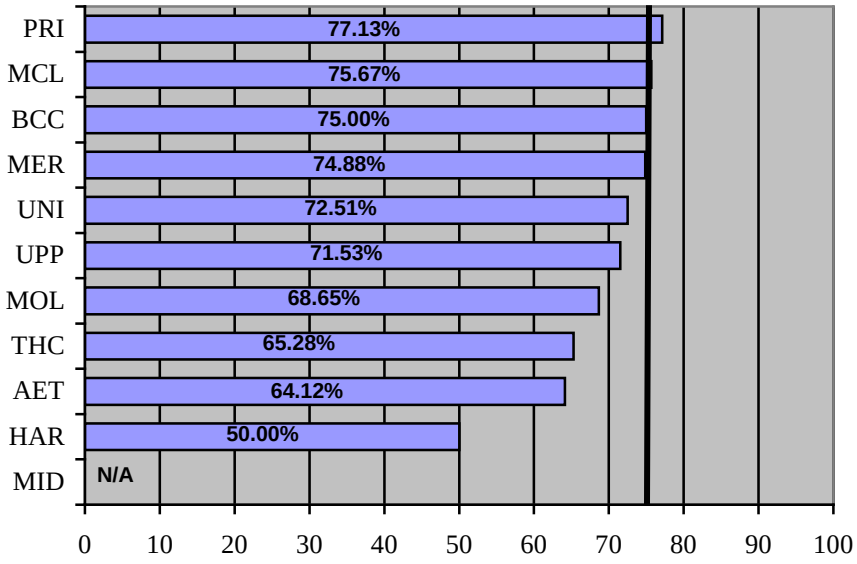
Measurement Period
Calendar Year 2016

Data Source
HEDIS 2017

Measurement Frequency
Annually

Summary: Three plans met or exceeded the standard, while seven plans (AET, HAR, MER, MOL, THC, UNI, and UPP) did not. Results ranged from 50.00% to 77.13%

Figure 5: Childhood Immunizations[2]



[2] N/A indicates that the plan had a numerator under 5 or a denominator under 30. Therefore a rate was not calculated.

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 68%

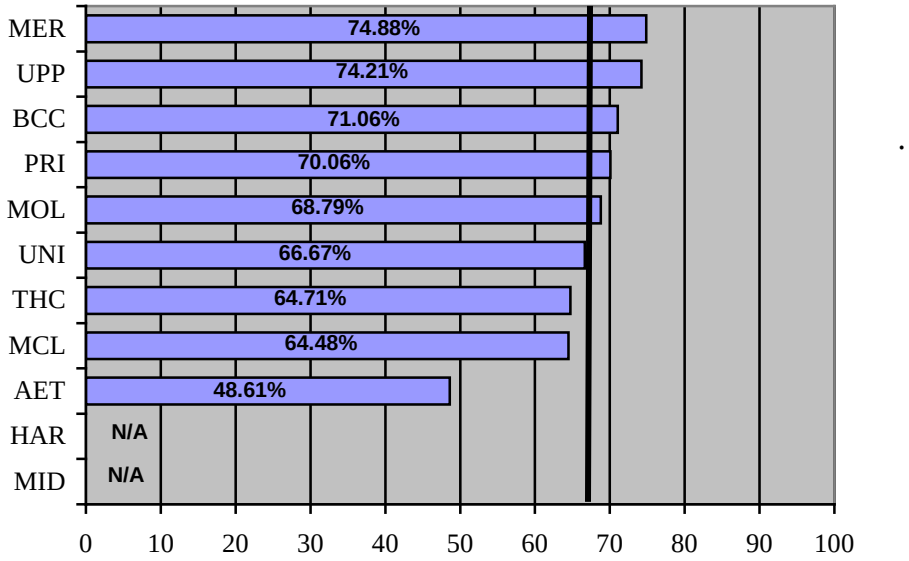
Measurement Period
Calendar Year 2016

Data Source
HEDIS 2017

Measurement Frequency
Annually

Summary: Five plans met or exceeded the standard, while four plans (AET, MCL, THC, and UNI) did not. Results ranged from 48.61% to 74.88%

Figure 6: Well-Child Visits 0-15 Months[3]



Well-Child Visits 0-15 Months Percentage

[3] N/A indicates that the plan had a numerator under 5 or a denominator under 30. Therefore a rate was not calculated.

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 76% (as shown on bar graph below)

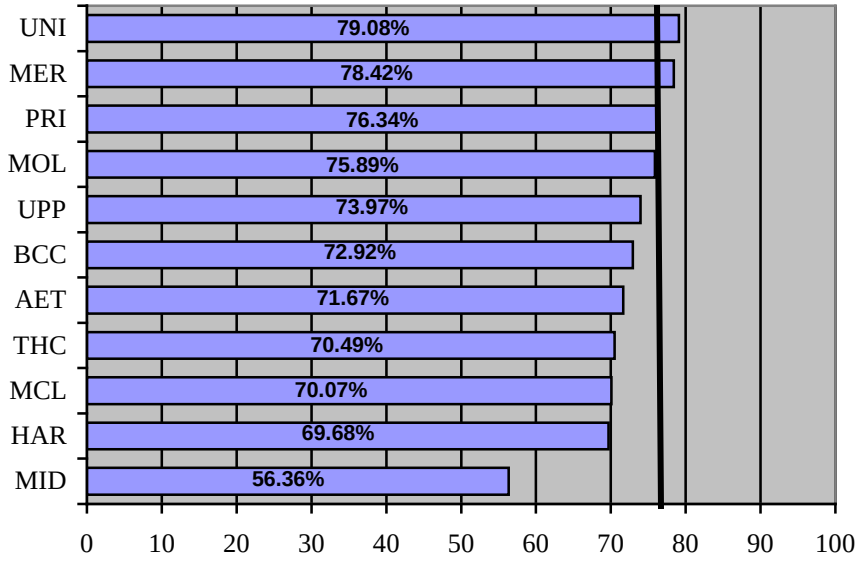
Measurement Period
Calendar Year 2016

Data Source
HEDIS 2017

Measurement Frequency
Annually

Summary: Three plans met or exceeded the standard, while eight plans (AET, BCC, HAR, MCL, MID, MOL, THC, and UPP) did not. Results ranged from 56.36% to 79.08%

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 56% (as shown on bar graph below)

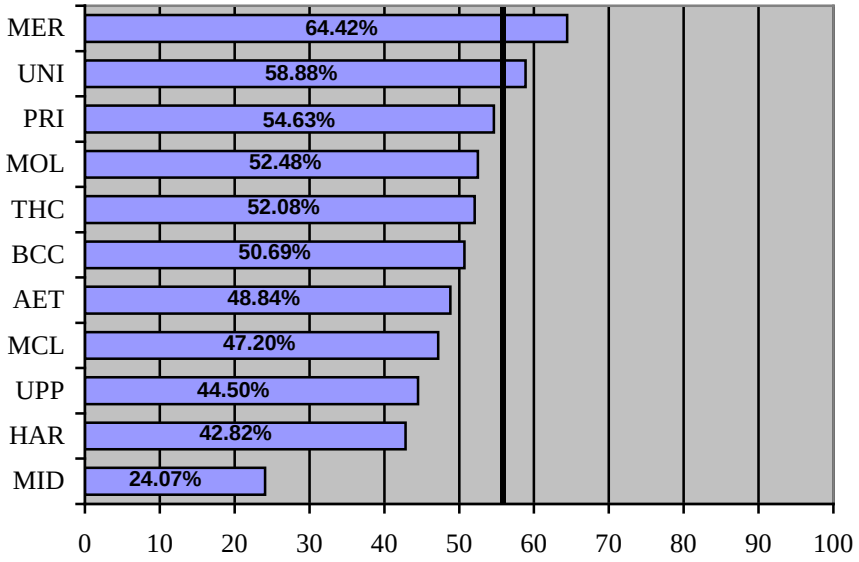
Measurement Period
Calendar Year 2016

Data Source
HEDIS 2017

Measurement Frequency
Annually

Summary: Two plans met or exceeded the standard, while nine plans (AET, BCC, HAR, MCL, MID, MOL, PRI, THC, and UPP) did not. Results ranged from 24.07% to 64.42%.

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

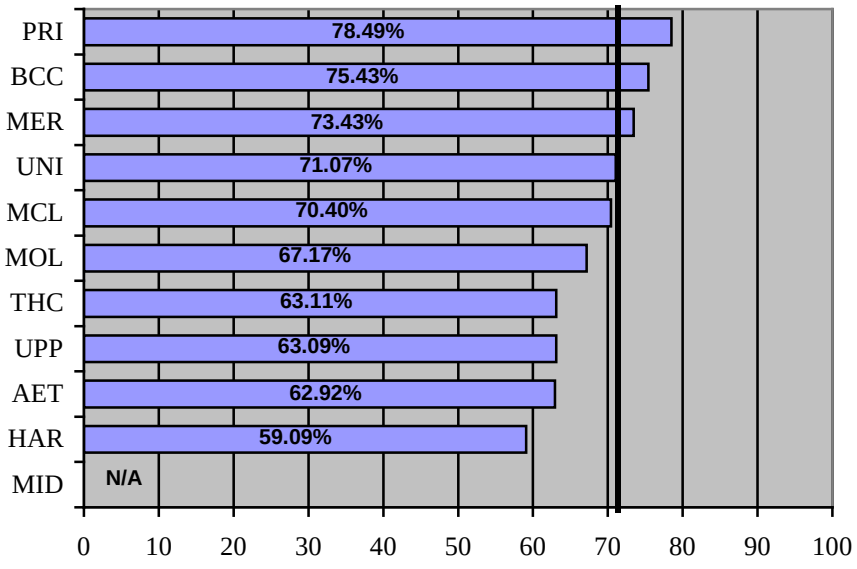
Measurement Period
Calendar Year 2016

Data Source
HEDIS 2017

Measurement Frequency
Annually

Summary: Four plans met or exceeded the standard, while six plans (AET, HAR, MCL, MOL, THC, and UPP) did not. Results ranged from 59.09% to 78.49%.

Figure 9: Appropriate Testing for Children with Pharyngitis[4]



Appropriate Testing for Children with Pharyngitis Percentage

[4] N/A indicates that the plan had a numerator under 5 or a denominator under 30. Therefore a rate was not calculated.

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)

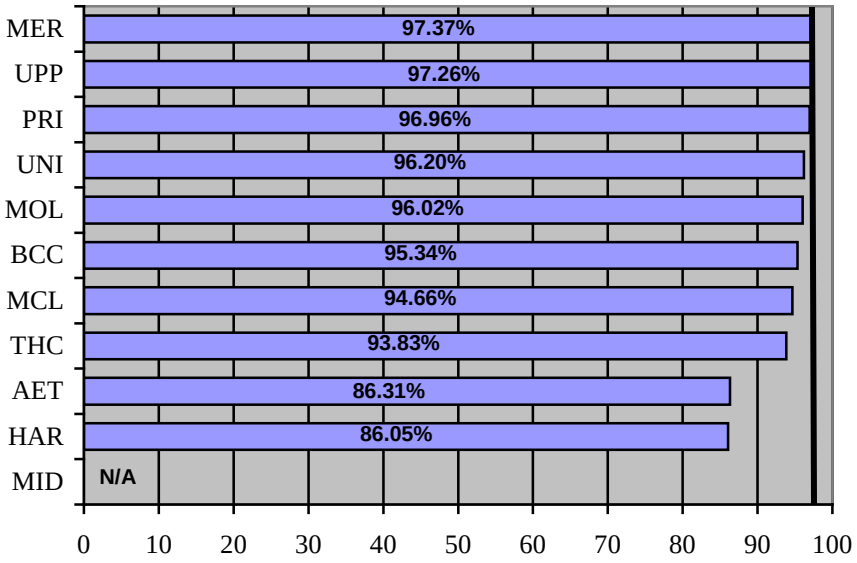
Measurement Period
Calendar Year 2016

Data Source
HEDIS 2017

Measurement Frequency
Annually

Summary: Two plans met or exceeded the standard, while eight plans (AET, BCC, HAR, MCL, MOL, PRI, THC, and UNI) did not. Results ranged from 86.05 to 97.37%.

Figure 10: Child Access to Care 12 to 24 Months[5]



Child Access to Care 12 to 24 Months Percentage

[5] N/A indicates that the plan had a numerator under 5 or a denominator under 30. Therefore a rate was not calculated.

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)

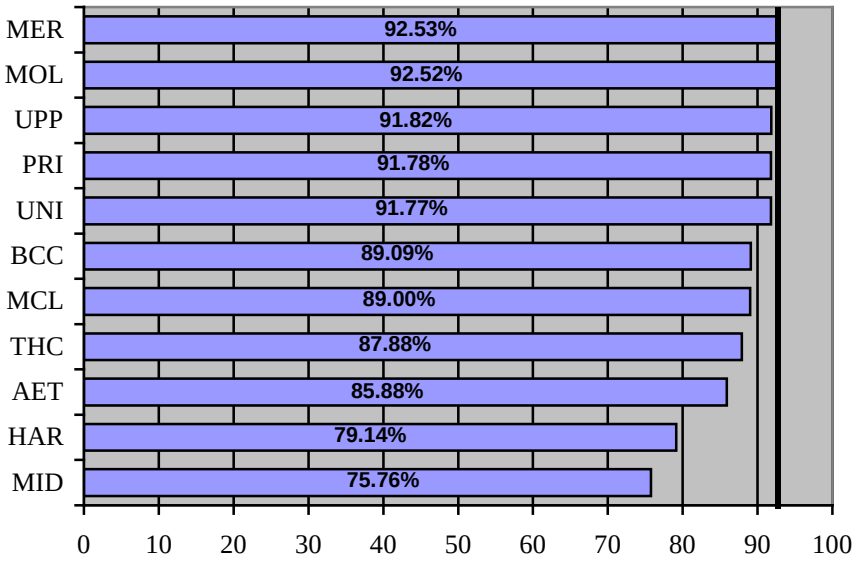
Measurement Period
Calendar Year 2016

Data Source
HEDIS 2017

Measurement Frequency
Annually

Summary: Two plans met or exceeded the standard, while nine plans (AET, BCC, HAR, MCL, MID, PRI, THC, UNI, and UPP) did not. Results ranged from 75.76% to 92.53%.

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 88% (as shown on bar graph below)

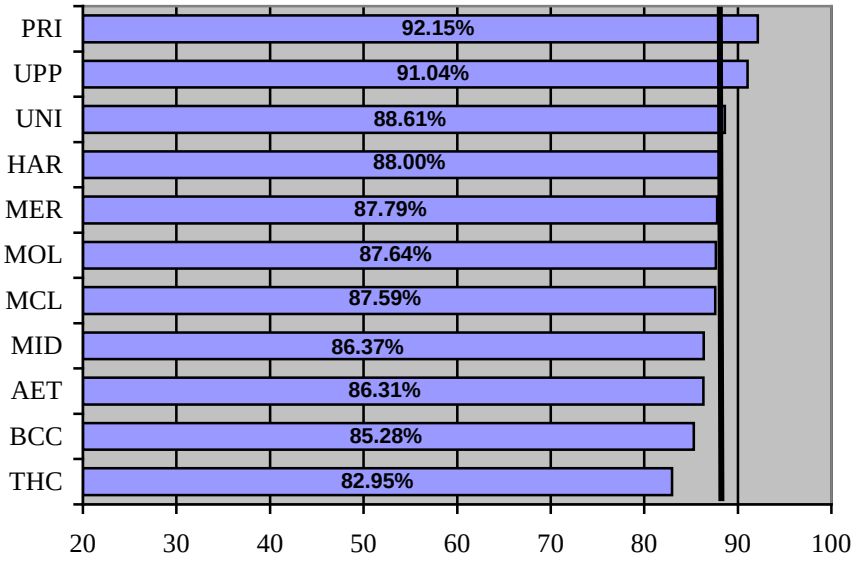
Measurement Period
Calendar Year 2016

Data Source
HEDIS 2017

Measurement Frequency
Annually

Summary: Four plans met or exceeded the standard, while seven plans (AET, BCC, MCL, MER, MID, MOL, and THC) did not. Results ranged from 82.95% to 92.15%.

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
At or above 63% (as shown on bar graph below)

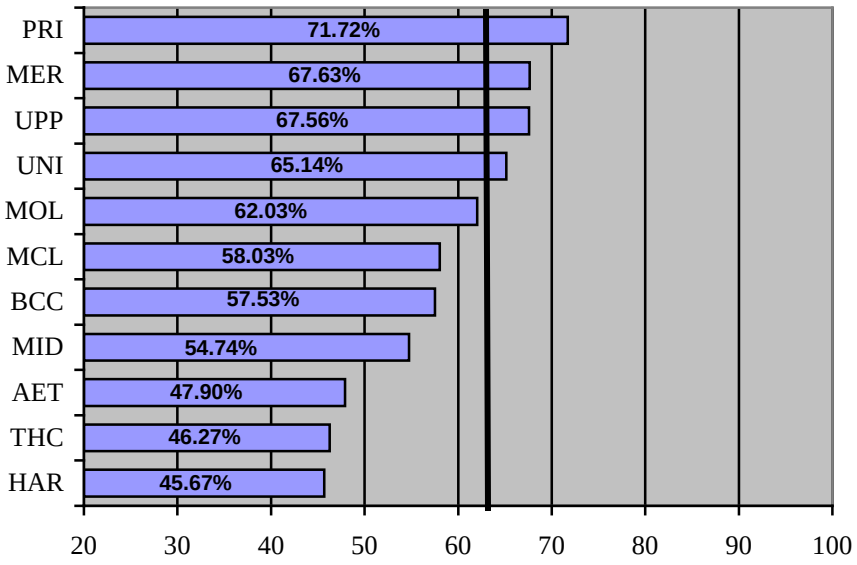
Measurement Period
Calendar Year 2016

Data Source
HEDIS 2017

Measurement Frequency
Annually

Summary: Four plans met or exceeded the standard, while seven plans (AET, BCC, HAR, MCL, MID, MOL, and THC) did not. Results ranged from 45.67% to 71.72%.

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 62% (as shown on bar graph below)

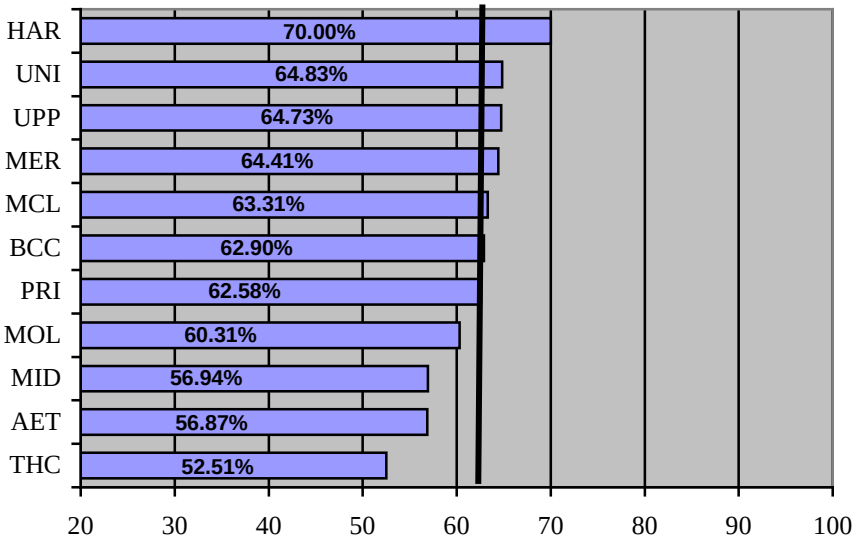
Measurement Period
Calendar Year 2016

Data Source
HEDIS 2017

Measurement Frequency
Annually

Summary: Seven plans met or exceeded the standard, while four plans (AET, MID, MOL, and THC) did not. Results ranged from 52.51% to 70.00%.

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 65% (as shown on bar graph below)

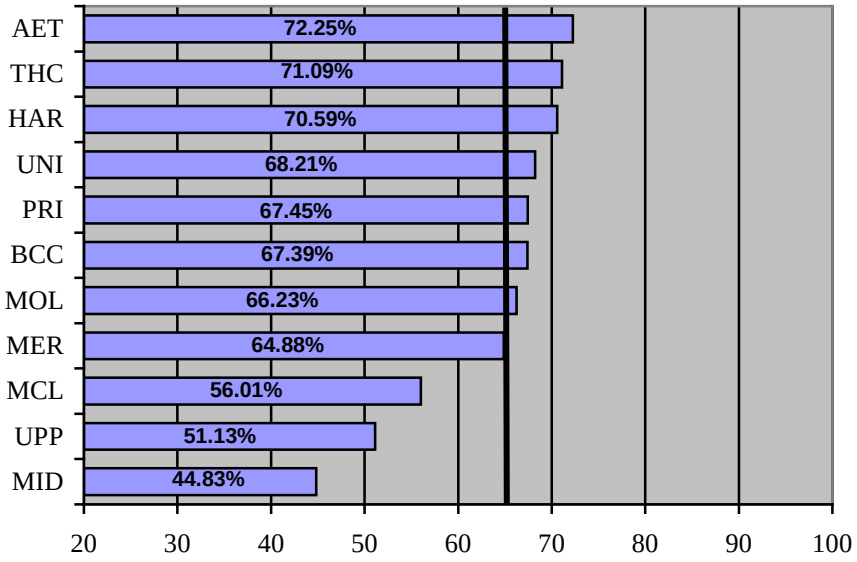
Measurement Period
Calendar Year 2016

Data Source
HEDIS 2017

Measurement Frequency
Annually

Summary: Seven plans met or exceeded the standard, while four plans (MCL, MER, MID, and UPP) did not. Results ranged from 44.83% to 72.25%

Figure 15: Chlamydia Screening in Women - Total



Chlamydia Screening in Women-Total Percentages

Appendix A: Composite Performance Monitoring Summary[6]

January 2018

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

[6] N/A indicates that the plan had a numerator under 5 or a denominator under 30. Therefore a rate was not calculated.

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**
	Calendar Year 2016	**83%**	**65.89%**	**No**
Postpartum Care	Calendar Year 2015	72%	45.56%	**No**
	Calendar Year 2016	**69%**	**51.74%**	**No**
Childhood Immunization	Calendar Year 2015	75%	60.88%	**No**
	Calendar Year 2016	**75%**	**64.12%**	**No**
Well-Child 0 to 15 Months	Calendar Year 2015	71%	44.68%	**No**
	Calendar Year 2016	**68%**	**48.61%**	**No**
Well-Child 3 to 6 Years	Calendar Year 2015	79%	71.30%	**No**
	Calendar Year 2016	**76%**	**71.67%**	**No**
Adolescent Well-Care Visits	Calendar Year 2015	60%	51.39%	**No**
	Calendar Year 2016	**56%**	**48.84%**	**No**
Appropriate Testing for Children with Pharyngitis	Calendar Year 2015	N/A	55.44%	N/A
	Calendar Year 2016	**71%**	**62.92%**	**No**
Child Access to Care 12 to 24 Months	Calendar Year 2015	97%	90.84%	**No**
	Calendar Year 2016	**97%**	**86.31%**	**No**
Child Access to Care 7 to 11 Years	Calendar Year 2015	92%	86.76%	**No**
	Calendar Year 2016	**92%**	**85.88%**	**No**
Diabetes Care: Hemoglobin A1c Testing	Calendar Year 2015	87%	84.36%	**No**
	Calendar Year 2016	**88%**	**86.31%**	**No**
Diabetes Care: Eye Exam	Calendar Year 2015	N/A	49.36%	NA
	Calendar Year 2016	**63%**	**47.90%**	**No**
Breast Cancer Screening	Calendar Year 2015	58%	63.10%	Yes
	Calendar Year 2016	**62%**	**56.87%**	**No**
Chlamydia Screening	Calendar Year 2015	62%	68.44%	Yes
	Calendar Year 2016	**65%**	**72.25%**	**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**
	Calendar Year 2016	**83%**	**77.26%**	**No**
Postpartum Care	Calendar Year 2015	72%	57.66%	**No**
	Calendar Year 2016	**69%**	**62.41%**	**No**
Childhood Immunization	Calendar Year 2015	75%	70.07%	**No**
	Calendar Year 2016	**75%**	**75.00%**	**Yes**
Well-Child 0 to 15 Months	Calendar Year 2015	71%	67.40%	**No**
	Calendar Year 2016	**68%**	**71.06%**	**Yes**
Well-Child 3 to 6 Years	Calendar Year 2015	79%	79.32%	**Yes**
	Calendar Year 2016	**76%**	**72.92%**	**No**
Adolescent Well-Care Visits	Calendar Year 2015	60%	60.10%	Yes
	Calendar Year 2016	**56%**	**50.69%**	**No**
Appropriate Testing for Children with Pharyngitis	Calendar Year 2015	N/A	72.61%	N/A
	Calendar Year 2016	**71%**	**75.43%**	**Yes**
Child Access to Care 12 to 24 Months	Calendar Year 2015	97%	94.89%	**No**
	Calendar Year 2016	**97%**	**95.34%**	**No**
Child Access to Care 7 to 11 Years	Calendar Year 2015	92%	90.84%	**No**
	Calendar Year 2016	**92%**	**89.09%**	**No**
Diabetes Care: Hemoglobin A1c Testing	Calendar Year 2015	87%	86.86%	**No**
	Calendar Year 2016	**88%**	**85.28%**	**No**
Diabetes Care: Eye Exam	Calendar Year 2015	N/A	62.04%	NA
	Calendar Year 2016	**63%**	**57.53%**	**No**
Breast Cancer Screening	Calendar Year 2015	58%	61.84%	Yes
	Calendar Year 2016	**62%**	**62.90%**	**Yes**
Chlamydia Screening	Calendar Year 2015	62%	69.65%	Yes
	Calendar Year 2016	**65%**	**67.39%**	**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**
	Calendar Year 2016	**83%**	**47.13%**	**No**
Postpartum Care	Calendar Year 2015	72%	33.33%	**No**
	Calendar Year 2016	**69%**	**42.53%**	**No**
Childhood Immunization	Calendar Year 2015	75%	44.29%	**No**
	Calendar Year 2016	**75%**	**50.00%**	**No**
Well-Child 0 to 15 Months	Calendar Year 2015	71%	N/A	N/A
	Calendar Year 2016	**68%**	**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**
	Calendar Year 2016	**76%**	**69.68%**	**No**
Adolescent Well-Care Visits	Calendar Year 2015	60%	35.51%	**No**
	Calendar Year 2016	**56%**	**42.82%**	**No**
Appropriate Testing for Children with Pharyngitis	Calendar Year 2015	N/A	N/A	N/A
	Calendar Year 2016	**71%**	**59.09%**	**No**

*****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**
	Calendar Year 2016	**97%**	**86.05%**	**No**
Child Access to Care 7 to 11 Years	Calendar Year 2015	92%	71.65%	**No**
	Calendar Year 2016	**92%**	**79.14%**	**No**
Diabetes Care: Hemoglobin A1c Testing	Calendar Year 2015	87%	75.64%	**No**
	Calendar Year 2016	**88%**	**88.00%**	**Yes**
Diabetes Care: Eye Exam	Calendar Year 2015	N/A	46.15%	NA
	Calendar Year 2016	**63%**	**45.67%**	**No**
Breast Cancer Screening	Calendar Year 2015	58%	64.71%	Yes
	Calendar Year 2016	**62%**	**70.00%**	**Yes**
Chlamydia Screening	Calendar Year 2015	62%	72.84%	Yes
	Calendar Year 2016	**65%**	**70.59%**	**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**
	Calendar Year 2016	**83%**	**86.13%**	**Yes**
Postpartum Care	Calendar Year 2015	72%	63.99%	**No**
	Calendar Year 2016	**69%**	**64.23%**	**No**
Childhood Immunization	Calendar Year 2015	75%	68.61%	**No**
	Calendar Year 2016	**75%**	**75.67%**	**Yes**
Well-Child 0 to 15 Months	Calendar Year 2015	71%	66.42%	**No**
	Calendar Year 2016	**68%**	**64.48%**	**No**
Well-Child 3 to 6 Years	Calendar Year 2015	79%	71.29%	**No**
	Calendar Year 2016	**76%**	**70.07%**	**No**
Adolescent Well-Care Visits	Calendar Year 2015	60%	46.23%	**No**
	Calendar Year 2016	**56%**	**47.20%**	**No**
Appropriate Testing for Children with Pharyngitis	Calendar Year 2015	N/A	70.37%	N/A
	Calendar Year 2016	**71%**	**70.40%**	**No**
Child Access to Care 12 to 24 Months	Calendar Year 2015	97%	95.44%	**No**
	Calendar Year 2016	**97%**	**94.66%**	**No**
Child Access to Care 7 to 11 Years	Calendar Year 2015	92%	87.98%	**No**
	Calendar Year 2016	**92%**	**89.00%**	**No**
Diabetes Care: Hemoglobin A1c Testing	Calendar Year 2015	87%	89.42%	Yes
	Calendar Year 2016	**88%**	**87.59%**	**No**
Diabetes Care: Eye Exam	Calendar Year 2015	N/A	56.20%	N/A
	Calendar Year 2016	**63%**	**58.03%**	**No**
Breast Cancer Screening	Calendar Year 2015	58%	58.78%	Yes
	Calendar Year 2016	**62%**	**63.31%**	**Yes**
Chlamydia Screening	Calendar Year 2015	62%	54.81%	Yes
	Calendar Year 2016	**65%**	**56.01%**	**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

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
	Calendar Year 2016	**83%**	**82.87%**	**No**
Postpartum Care	Calendar Year 2015	72%	68.53%	**No**
	Calendar Year 2016	**69%**	**71.30%**	**Yes**
Childhood Immunization	Calendar Year 2015	75%	72.79%	**No**
	Calendar Year 2016	**75%**	**74.88%**	**No**
Well-Child 0 to 15 Months	Calendar Year 2015	71%	75.21%	Yes
	Calendar Year 2016	**68%**	**74.88%**	**Yes**
Well-Child 3 to 6 Years	Calendar Year 2015	79%	77.27%	**No**
	Calendar Year 2016	**76%**	**78.42%**	**Yes**
Adolescent Well-Care Visits	Calendar Year 2015	60%	59.72%	**No**
	Calendar Year 2016	**56%**	**64.42%**	**Yes**
Appropriate Testing for Children with Pharyngitis	Calendar Year 2015	N/A	72.84%	N/A
	Calendar Year 2016	**71%**	**73.43%**	**Yes**
Child Access to Care 12 to 24 Months	Calendar Year 2015	97%	97.69%	Yes
	Calendar Year 2016	**97%**	**97.37%**	**Yes**
Child Access to Care 7 to 11 Years	Calendar Year 2015	92%	92.57%	Yes
	Calendar Year 2016	**92%**	**92.53%**	**Yes**
Diabetes Care: Hemoglobin A1c Testing	Calendar Year 2015	87%	85.60%	**No**
	Calendar Year 2016	**88%**	**87.79%**	**No**
Diabetes Care: Eye Exam	Calendar Year 2015	N/A	61.87%	NA
	Calendar Year 2016	**63%**	**67.63%**	**Yes**
Breast Cancer Screening	Calendar Year 2015	58%	59.57%	Yes
	Calendar Year 2016	**62%**	**64.41%**	**Yes**
Chlamydia Screening	Calendar Year 2015	62%	64.41%	Yes
	Calendar Year 2016	**65%**	**64.88%**	**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

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**
	Calendar Year 2016	**83%**	**50.00%**	**No**
Postpartum Care	Calendar Year 2015	72%	51.04%	**No**
	Calendar Year 2016	**69%**	**40.38%**	**No**
Childhood Immunization	Calendar Year 2015	75%	73.84%	**No**
	Calendar Year 2016	**75%**	**N/A**	**N/A**
Well-Child 0 to 15 Months	Calendar Year 2015	71%	56.02%	**No**
	Calendar Year 2016	**68%**	**N/A**	**N/A**
Well-Child 3 to 6 Years	Calendar Year 2015	79%	76.85%	**No**
	Calendar Year 2016	**76%**	**56.36%**	**No**
Adolescent Well-Care Visits	Calendar Year 2015	60%	54.99%	**No**
	Calendar Year 2016	**56%**	**24.07%**	**No**
Appropriate Testing for Children with Pharyngitis	Calendar Year 2015	N/A	67.98%	N/A
	Calendar Year 2016	**71%**	**N/A**	**N/A**
Child Access to Care 12 to 24 Months	Calendar Year 2015	97%	95.21%	**No**
	Calendar Year 2016	**97%**	**N/A**	**N/A**
Child Access to Care 7 to 11 Years	Calendar Year 2015	92%	89.22%	**No**
	Calendar Year 2016	**92%**	**75.76%**	**No**
Diabetes Care: Hemoglobin A1c Testing	Calendar Year 2015	87%	85.93%	**No**
	Calendar Year 2016	**88%**	**86.37%**	**No**
Diabetes Care: Eye Exam	Calendar Year 2015	N/A	57.19%	NA
	Calendar Year 2016	**63%**	**54.74%**	**No**
Breast Cancer Screening	Calendar Year 2015	58%	57.54%	**No**
	Calendar Year 2016	**62%**	**56.94%**	**No**
Chlamydia Screening	Calendar Year 2015	62%	61.37%	**No**
	Calendar Year 2016	**65%**	**44.83%**	**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**
	Calendar Year 2016	**83%**	**83.33%**	**Yes**
Postpartum Care	Calendar Year 2015	72%	67.87%	**No**
	Calendar Year 2016	**69%**	**75.80%**	**Yes**
Childhood Immunization	Calendar Year 2015	75%	68.43%	**No**
	Calendar Year 2016	**75%**	**68.65%**	**No**
Well-Child 0 to 15 Months	Calendar Year 2015	71%	63.84%	**No**
	Calendar Year 2016	**68%**	**68.79%**	**Yes**
Well-Child 3 to 6 Years	Calendar Year 2015	79%	76.15%	**No**
	Calendar Year 2016	**76%**	**75.89%**	**No**
Adolescent Well-Care Visits	Calendar Year 2015	60%	57.21%	**No**
	Calendar Year 2016	**56%**	**52.48%**	**No**
Appropriate Testing for Children with Pharyngitis	Calendar Year 2015	N/A	62.82%	N/A
	Calendar Year 2016	**71%**	**67.17%**	**No**
Child Access to Care 12 to 24 Months	Calendar Year 2015	97%	96.39%	**No**
	Calendar Year 2016	**97%**	**96.02%**	**No**
Child Access to Care 7 to 11 Years	Calendar Year 2015	92%	91.64%	**No**
	Calendar Year 2016	**92%**	**92.52%**	**Yes**
Diabetes Care: Hemoglobin A1c Testing	Calendar Year 2015	87%	86.04%	**No**
	Calendar Year 2016	**88%**	**87.64%**	**No**
Diabetes Care: Eye Exam	Calendar Year 2015	N/A	57.43%	NA
	Calendar Year 2016	**63%**	**62.03%**	**No**
Breast Cancer Screening	Calendar Year 2015	58%	59.67%	Yes
	Calendar Year 2016	**62%**	**60.31%**	**No**
Chlamydia Screening	Calendar Year 2015	62%	66.33%	Yes
	Calendar Year 2016	**65%**	**66.23%**	**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**
	Calendar Year 2016	**83%**	**78.59%**	**No**
Postpartum Care	Calendar Year 2015	72%	61.44%	**No**
	Calendar Year 2016	**69%**	**69.34%**	**Yes**
Childhood Immunization	Calendar Year 2015	75%	80.89%	Yes
	Calendar Year 2016	**75%**	**77.13%**	**Yes**
Well-Child 0 to 15 Months	Calendar Year 2015	71%	69.16%	**No**
	Calendar Year 2016	**68%**	**70.06%**	**Yes**
Well-Child 3 to 6 Years	Calendar Year 2015	79%	79.17%	Yes
	Calendar Year 2016	**76%**	**76.34%**	**Yes**
Adolescent Well-Care Visits	Calendar Year 2015	60%	52.58%	**No**
	Calendar Year 2016	**56%**	**54.63%**	**No**
Appropriate Testing for Children with Pharyngitis	Calendar Year 2015	N/A	79.07%	N/A
	Calendar Year 2016	**71%**	**78.49%**	**Yes**
Child Access to Care 12 to 24 Months	Calendar Year 2015	97%	97.75%	Yes
	Calendar Year 2016	**97%**	**96.96%**	**No**
Child Access to Care 7 to 11 Years	Calendar Year 2015	92%	92.05%	Yes
	Calendar Year 2016	**92%**	**91.78%**	**No**
Diabetes Care: Hemoglobin A1c Testing	Calendar Year 2015	87%	94.89%	Yes
	Calendar Year 2016	**88%**	**92.15%**	**Yes**
Diabetes Care: Eye Exam	Calendar Year 2015	N/A	68.80%	NA
	Calendar Year 2016	**63%**	**71.72%**	**Yes**
Breast Cancer Screening	Calendar Year 2015	58%	64.95%	Yes
	Calendar Year 2016	**62%**	**62.58%**	**Yes**
Chlamydia Screening	Calendar Year 2015	62%	67.36%	Yes
	Calendar Year 2016	**65%**	**67.45%**	**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**
	Calendar Year 2016	**83%**	**71.13%**	**No**
Postpartum Care	Calendar Year 2015	72%	47.33%	**No**
	Calendar Year 2016	**69%**	**48.83%**	**No**
Childhood Immunization	Calendar Year 2015	75%	58.56%	**No**
	Calendar Year 2016	**75%**	**65.28%**	**No**
Well-Child 0 to 15 Months	Calendar Year 2015	71%	54.86%	**No**
	Calendar Year 2016	**68%**	**64.71%**	**No**
Well-Child 3 to 6 Years	Calendar Year 2015	79%	69.44%	**No**
	Calendar Year 2016	**76%**	**70.49%**	**No**
Adolescent Well-Care Visits	Calendar Year 2015	60%	48.61%	**No**
	Calendar Year 2016	**56%**	**52.08%**	**No**
Appropriate Testing for Children with Pharyngitis	Calendar Year 2015	N/A	57.57%	N/A
	Calendar Year 2016	**71%**	**63.11%**	**No**
Child Access to Care 12 to 24 Months	Calendar Year 2015	97%	87.60%	**No**
	Calendar Year 2016	**97%**	**93.83%**	**No**
Child Access to Care 7 to 11 Years	Calendar Year 2015	92%	86.73%	**No**
	Calendar Year 2016	**92%**	**87.88%**	**No**
Diabetes Care: Hemoglobin A1c Testing	Calendar Year 2015	87%	82.98%	**No**
	Calendar Year 2016	**88%**	**82.95%**	**No**
Diabetes Care: Eye Exam	Calendar Year 2015	N/A	40.27%	NA
	Calendar Year 2016	**63%**	**46.27%**	**No**
Breast Cancer Screening	Calendar Year 2015	58%	49.67%	**No**
	Calendar Year 2016	**62%**	**52.51%**	**No**
Chlamydia Screening	Calendar Year 2015	62%	65.09%	Yes
	Calendar Year 2016	**65%**	**71.09%**	**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**
	Calendar Year 2016	**83%**	**80.54%**	**No**
Postpartum Care	Calendar Year 2015	72%	52.06%	**No**
	Calendar Year 2016	**69%**	**67.40%**	**No**
Childhood Immunization	Calendar Year 2015	75%	71.78%	**No**
	Calendar Year 2016	**75%**	**72.51%**	**No**
Well-Child 0 to 15 Months	Calendar Year 2015	71%	61.56%	**No**
	Calendar Year 2016	**68%**	**66.67%**	**No**
Well-Child 3 to 6 Years	Calendar Year 2015	79%	73.21%	**No**
	Calendar Year 2016	**76%**	**79.08%**	**Yes**
Adolescent Well-Care Visits	Calendar Year 2015	60%	54.74%	**No**
	Calendar Year 2016	**56%**	**58.88%**	**Yes**
Appropriate Testing for Children with Pharyngitis	Calendar Year 2015	N/A	63.13%	N/A
	Calendar Year 2016	**71%**	**71.07%**	**Yes**
Child Access to Care 12 to 24 Months	Calendar Year 2015	97%	96.54%	**No**
	Calendar Year 2016	**97%**	**96.20%**	**No**
Child Access to Care 7 to 11 Years	Calendar Year 2015	92%	91.17%	**No**
	Calendar Year 2016	**92%**	**91.77%**	**No**
Diabetes Care: Hemoglobin A1c Testing	Calendar Year 2015	87%	86.81%	**No**
	Calendar Year 2016	**88%**	**88.61%**	**Yes**
Diabetes Care: Eye Exam	Calendar Year 2015	N/A	64.31%	NA
	Calendar Year 2016	**63%**	**65.14%**	**Yes**
Breast Cancer Screening	Calendar Year 2015	58%	61.35%	Yes
	Calendar Year 2016	**62%**	**64.83%**	**Yes**
Chlamydia Screening	Calendar Year 2015	62%	65.12%	Yes
	Calendar Year 2016	**65%**	**68.21%**	**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 Pla0rtn – UPP

HEDIS:

Performance Measure	Measurement Period	Standard	Plan Result	Standard Achieved
Timeliness of Prenatal Care	Calendar Year 2015	86%	86.13%	Yes
	Calendar Year 2016	**83%**	**91.48%**	**Yes**
Postpartum Care	Calendar Year 2015	72%	71.78%	**No**
	Calendar Year 2016	**69%**	**72.75%**	**Yes**
Childhood Immunization	Calendar Year 2015	75%	73.24%	**No**
	Calendar Year 2016	**75%**	**71.53%**	**No**
Well-Child 0 to 15 Months	Calendar Year 2015	71%	74.21%	Yes
	Calendar Year 2016	**68%**	**74.21%**	**Yes**
Well-Child 3 to 6 Years	Calendar Year 2015	79%	69.59%	**No**
	Calendar Year 2016	**76%**	**73.97%**	**No**
Adolescent Well-Care Visits	Calendar Year 2015	60%	42.09%	**No**
	Calendar Year 2016	**56%**	**44.50%**	**No**
Appropriate Testing for Children with Pharyngitis	Calendar Year 2015	N/A	68.97%	N/A
	Calendar Year 2016	**71%**	**63.09%**	**No**
Child Access to Care 12 to 24 Months	Calendar Year 2015	97%	97.65%	Yes
	Calendar Year 2016	**97%**	**97.26%**	**Yes**
Child Access to Care 7 to 11 Years	Calendar Year 2015	92%	90.60%	**No**
	Calendar Year 2016	**92%**	**91.82%**	**No**
Diabetes Care: Hemoglobin A1c Testing	Calendar Year 2015	87%	91.61%	Yes
	Calendar Year 2016	**88%**	**91.04%**	**Yes**
Diabetes Care: Eye Exam	Calendar Year 2015	N/A	66.06%	NA
	Calendar Year 2016	**63%**	**67.56%**	**Yes**
Breast Cancer Screening	Calendar Year 2015	58%	59.64%	Yes
	Calendar Year 2016	**62%**	**64.73%**	**Yes**
Chlamydia Screening	Calendar Year 2015	62%	50.96%	**No**
	Calendar Year 2016	**65%**	**61.13%**	**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

Composite – All Plans

HEALTHY MICHIGAN PLAN

MDHHS
Michigan Department of Health & Human Services
RICK SNYDER, GOVERNOR | NICK LYON, DIRECTOR

April 2018

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

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Executive Summary

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

The Michigan Department of Health and Human Services (MDHHS) monitors the performance of the State's Medicaid Health Plans (MHPs) through twenty-eight (28) key performance measures aimed at improving the quality and efficiency of health care services provided to the Michigan residents enrolled in a Medicaid program. These measures include Medicaid Managed Care specific measures, Healthy Michigan Plan (HMP) measures, and HEDIS measures. **This report focuses only on the Healthy Michigan Plan (HMP) measures.** The following HMP measures will be included in this report:

Healthy Michigan Plan		
Adults' Generic Drug Utilization	*Timely Completion of Initial HRA*	*Completion of Annual HRA*
Outreach & Engagement to Facilitate Entry to PCP	*Adults' Access to Ambulatory Health Services*	*Transition into Consistently Fail to Pay (CFP) Status*
Transition out of Consistently Fail to Pay (CFP) Status		

Data for these measures are represented on a quarterly basis. The body of the report contains a cross-plan analysis of the most current data available for each of these measures. Measurement Periods may vary and are based on the specifications for that individual measure. Appendix A contains specific three letter codes identifying each of the MHPs. Appendix B contains the one-year plan specific analysis for each measure.

MHPs are contractually obligated to achieve specified standards for most measures. The following table displays the number of MHPs meeting or exceeding the standards for the performance measure versus total MHPs, as reported in the Performance Monitoring Report, during the listed quarter for fiscal year 2018 unless otherwise noted.

Table 1: Fiscal Year 2018[1]

Quarterly Reported Measures	Reported in 1st Quarter	Reported in 2nd Quarter	Reported in 3rd Quarter	Reported in 4th Quarter
Adults' Generic Drug Utilization	10/11	10/11		
Timely Completion of Initial HRA	5/9	4/9		
Completion of Annual HRA	N/A	N/A		
Outreach & Engagement to Facilitate Entry to PCP	7/11	6/11		
Adults' Access to Ambulatory Health Services	0/11	0/11		
Transition into CFP Status	N/A	N/A		
Transition out of CFP Status	N/A	N/A		

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

Healthy Michigan Plan Enrollment

The Healthy Michigan Plan (HMP-MC) enrollment has decreased slightly over the past year. In March 2018, enrollment was 521,660, down 22,894 enrollees (4.2%) from April 2017. A decrease of 9,044 enrollees (1.7%) was realized between February 2018 and March 2018.

Figure 1: HMP-MC Enrollment, April 2017 – March 2018

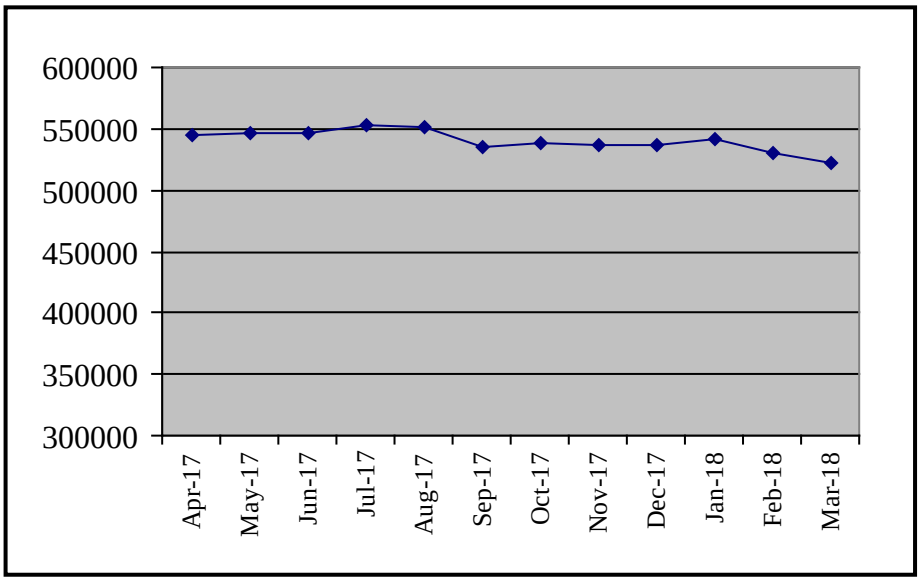
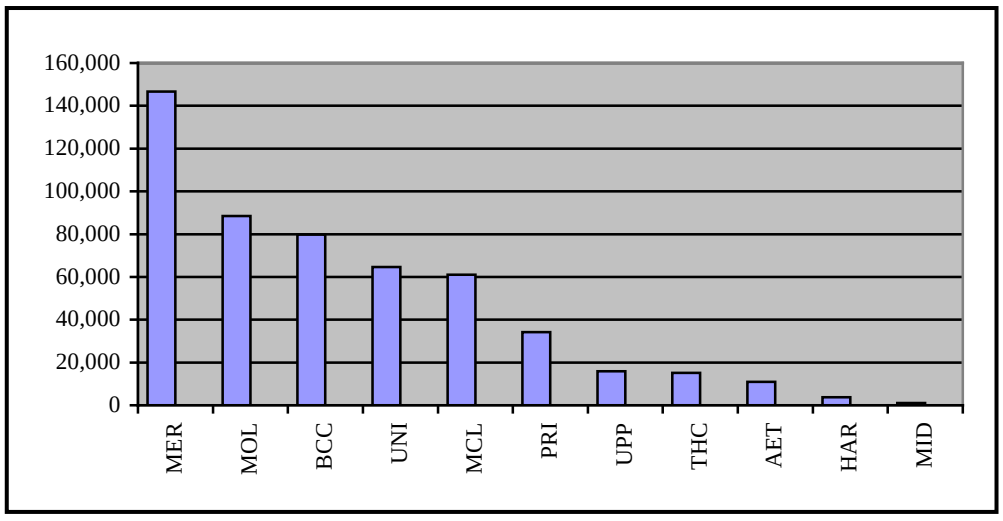


Figure 2: HMP-MC Enrollment by Medicaid Health Plan, March 2018



Medicaid Health Plan News

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

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

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

Cross-Plan Performance Monitoring Analyses

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

Adults' Generic Drug Utilization

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

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

Measurement Period
July 2017 –September 2017

Data Source
MDHHS Data Warehouse

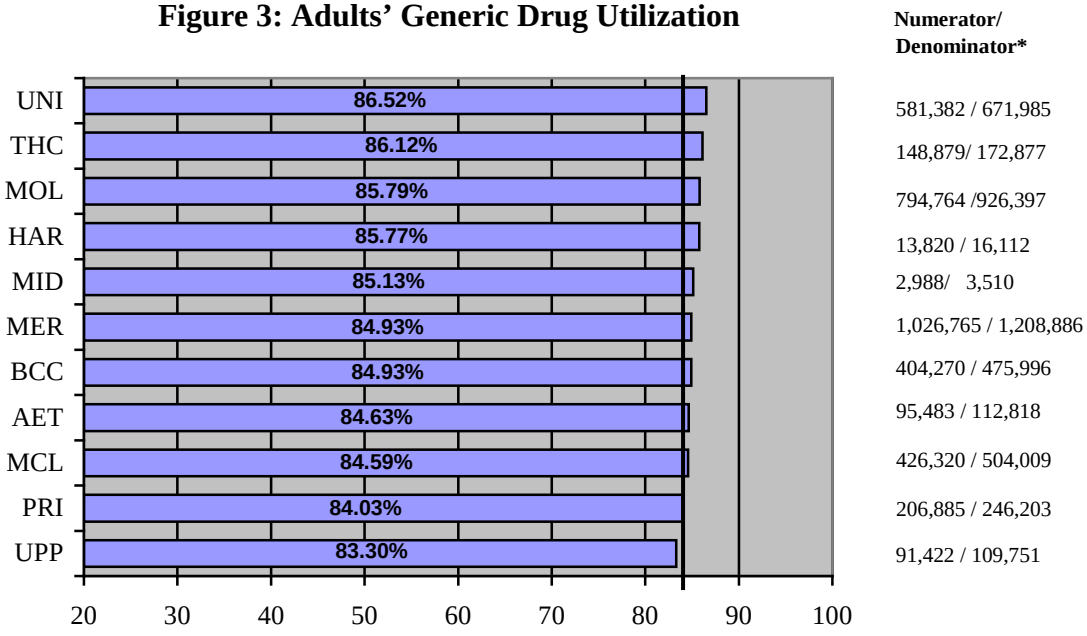
Measurement Frequency
Quarterly

Summary: Ten plans met or exceeded the standard, while one plan (UPP) did not. Results ranged from 83.30% to 86.52%.

Table 2: Comparison across Medicaid Programs

Medicaid Program	Numerator	Denominator	Percentage
Michigan Medicaid All	3,884,176	4,583,870	84.74%
Fee For Service (FFS) only	14,290	38,976	36.66%
Managed Care only	3,809,427	4,467,854	85.26%
MA-MC	1,930,288	2,273,003	84.92%
HMP-MC	1,839,311	2,148,619	85.60%

Figure 3: Adults' Generic Drug Utilization



Adult's Generic Drug Utilization Percentages

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

Timely Completion of Initial Health Risk Assessment (HRA)

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

Standard
At or above 9% (as shown on bar graph below)

Enrollment Dates
April 2017 – June 2017

Data Source
MDHHS Data Warehouse

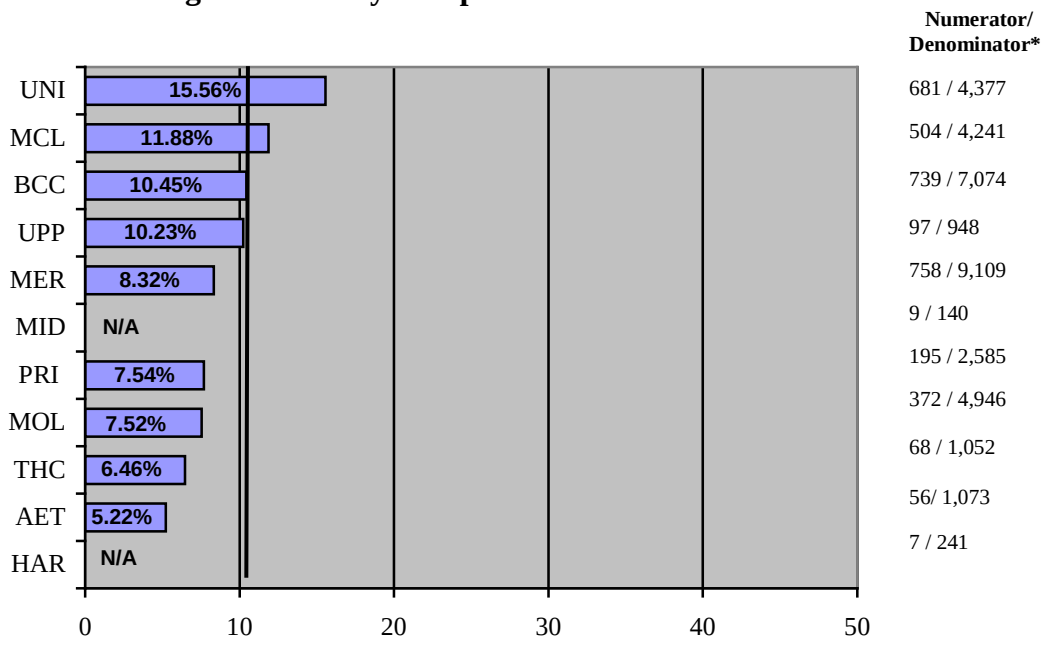
Measurement Frequency
Quarterly

Summary: Four plans met or exceeded the standard, while four plans (AET, HAR, MER, MID, MOL, PRI, and THC) did not. Results ranged from 5.22% to 15.56%.

Table 3: Program Total[2]

Medicaid Program	Numerator	Denominator	Percentage
HMP-MC	3,486	35,786	9.74%

Figure 4: Timely Completion of Initial HRA[3]



Timely Completion of Initial HRA Percentages

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

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

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

Completion of Annual Health Risk Assessment (HRA)

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

Standard
N/A – Informational Only

First Attestation Dates
October 2015 – September 2016

Second Attestation Dates
September 2016 – December 2017

Data Source
MDHHS Data Warehouse

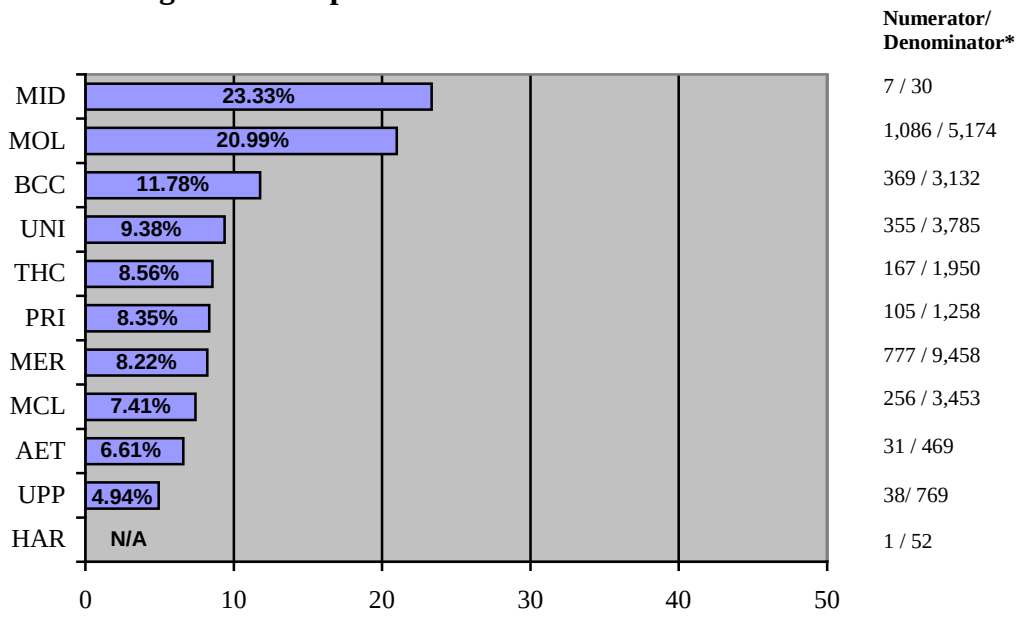
Measurement Frequency
Quarterly

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

Table 4: Program Total

Medicaid Program	Numerator	Denominator	Percentage
HMP-MC	3,239	30,857	10.50%

Figure 5: Completion of Annual HRA[4]



Completion of Annual HRA Percentages

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

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

Outreach and Engagement to Facilitate Entry to Primary Care

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

Standard
At or above 50% (as shown on bar graph below)

Enrollment Dates
April 2017 – June 2017

Data Source
MDHHS Data Warehouse

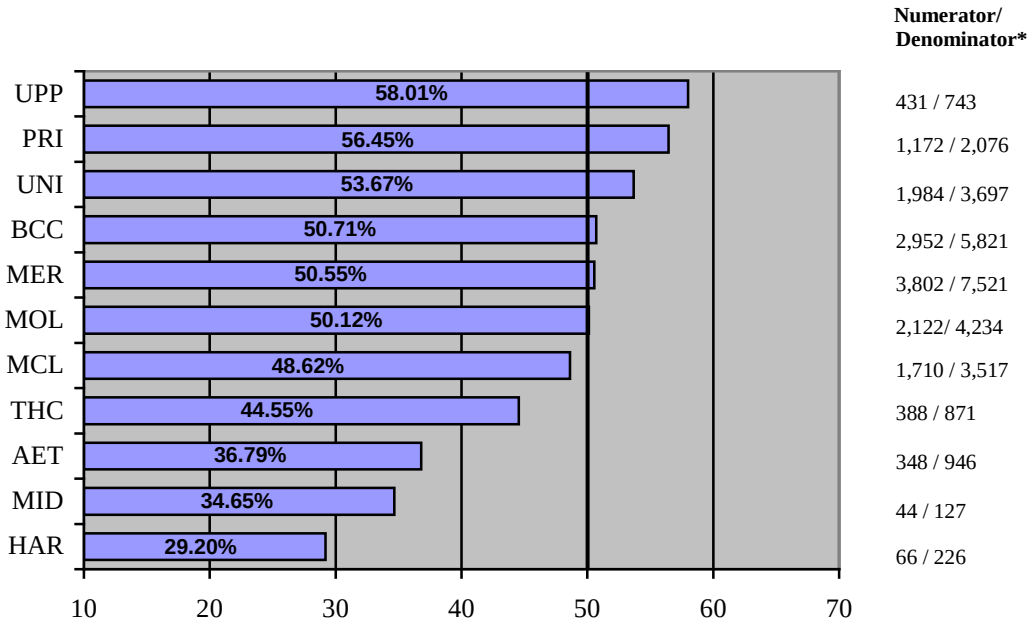
Measurement Frequency
Quarterly

Summary: Six plans met or exceeded the standard, while five plans (AET, HAR, MCL, MID, and THC) did not. Results ranged from 29.20% to 58.01%.

Table 5: Program Total[5]

Medicaid Program	Numerator	Denominator	Percentage
HMP-MC	21,026	35,786	58.75%

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



Outreach & Engagement to Facilitate Entry to Primary Care Percentages

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

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

Adults' Access to Ambulatory Health Services

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

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

Measurement Period
October 2016 – September 2017

Data Source
MDHHS Data Warehouse

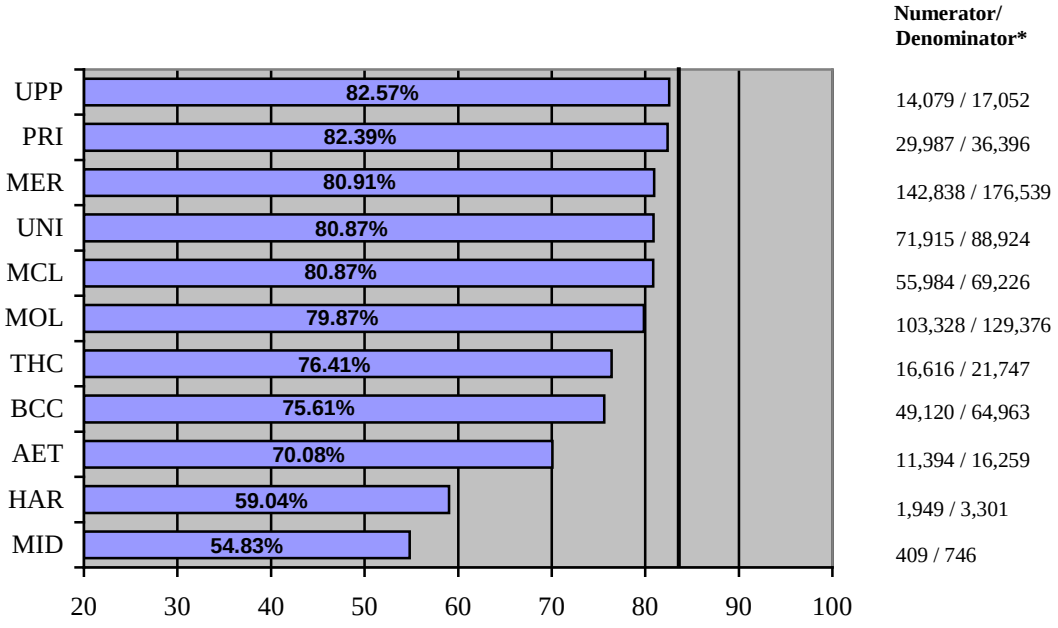
Measurement Frequency
Quarterly

Summary: None of the plans met or exceeded the standard. Results ranged from 54.83% to 82.57%.

Table 6: Comparison across Medicaid Programs

Medicaid Program	Numerator	Denominator	Percentage
Michigan Medicaid All	615,972	779,398	79.03%
Fee For Service (FFS) only	10,004	16,820	59.48%
Managed Care only	511,439	640,118	79.90%
MA-MC	226,496	274,619	82.48%
HMP-MC	231,170	301,246	76.74%

Figure 7: Adults' Access to Ambulatory Health Services



Adult's Access to Ambulatory Health Services Percentages

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

Transition into Consistently Fail to Pay (CFP) Status

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

Standard
N/A – Informational Only

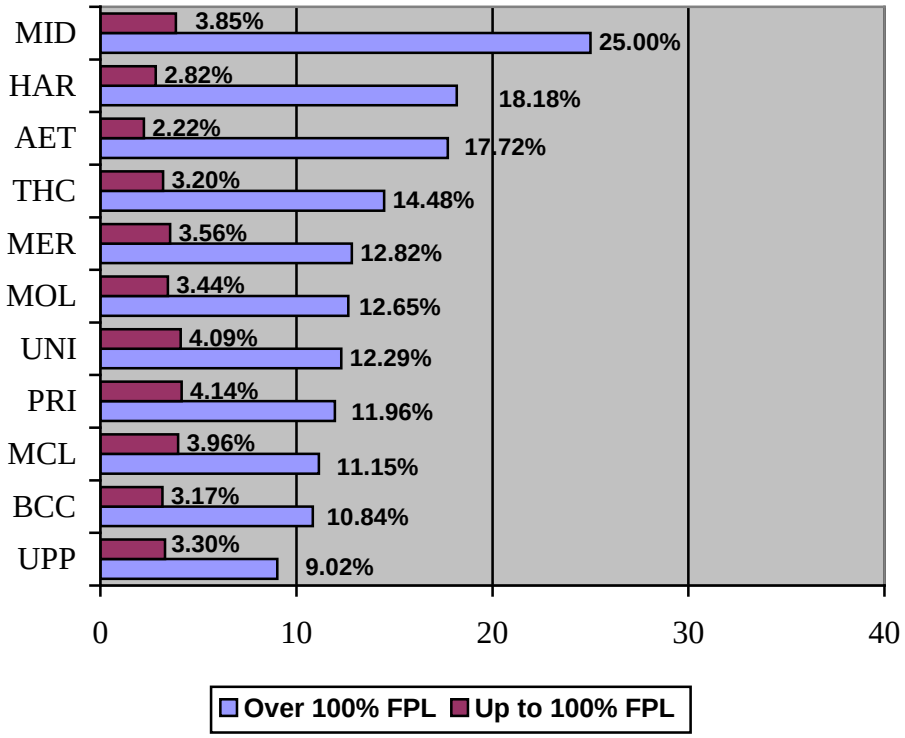
Measurement Period
February 2017 –March 2018

Data Source
MDHHS Data Warehouse

Measurement Frequency
Quarterly

Summary: The results shown are informational only. In Cohort 1, the results ranged from 9.02% to 25.00% for beneficiaries with income over 100% FPL. The results ranged from 2.22% to 4.14% for beneficiaries with income that never exceeded 100% FPL.
In Cohort 2, the results ranged from 5.00% to 50.00% for beneficiaries with income over 100% FPL. The results ranged from 1.23% to 3.47% for beneficiaries with income that never exceeded 100% FPL.
In Cohort 3, the results ranged from 9.21% to 28.57% for beneficiaries with income over 100% FPL. The results ranged from 0.00% to 3.58% for beneficiaries with income that never exceeded 100% FPL.

Figure 8: Transition into CFP Status - Cohort 1



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

Figure 9: Transition into CFP Status - Cohort 2

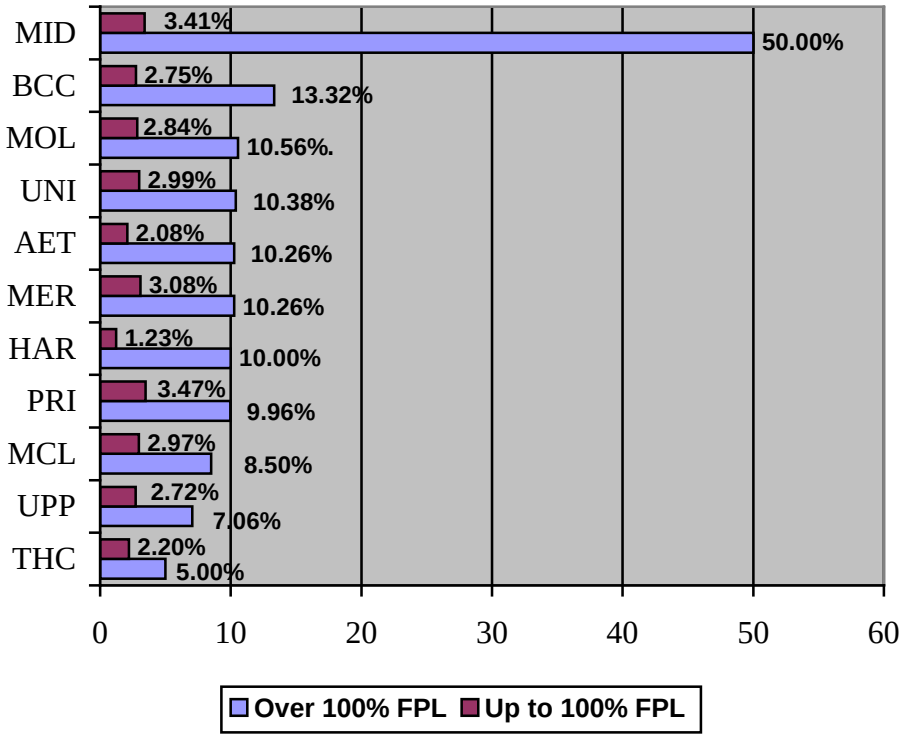
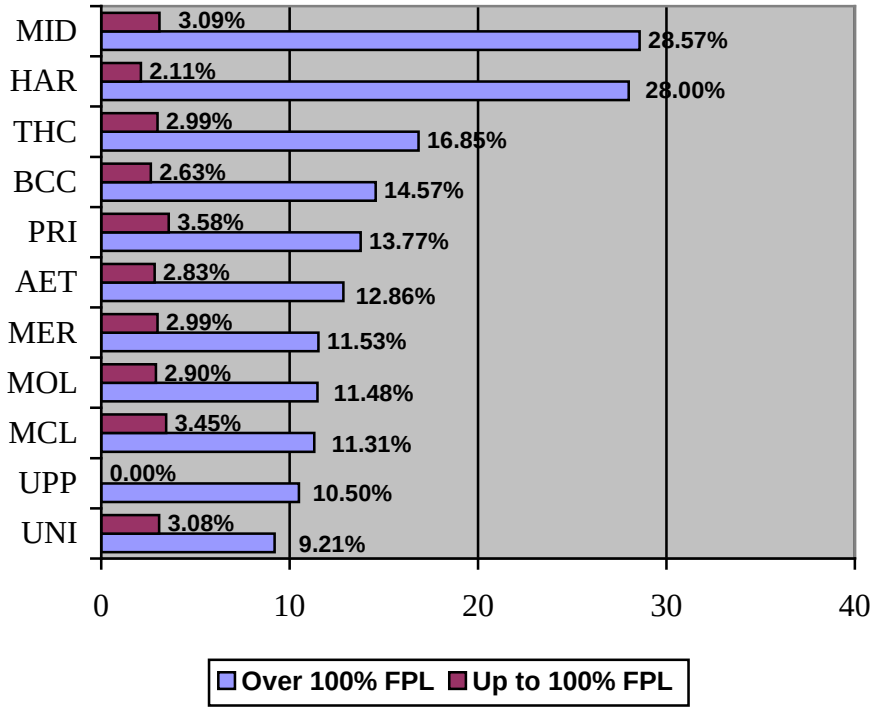


Figure 10: Transition into CFP Status - Cohort 3



Transition out of Consistently Fail to Pay (CFP) Status

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

Standard
N/A – Informational Only

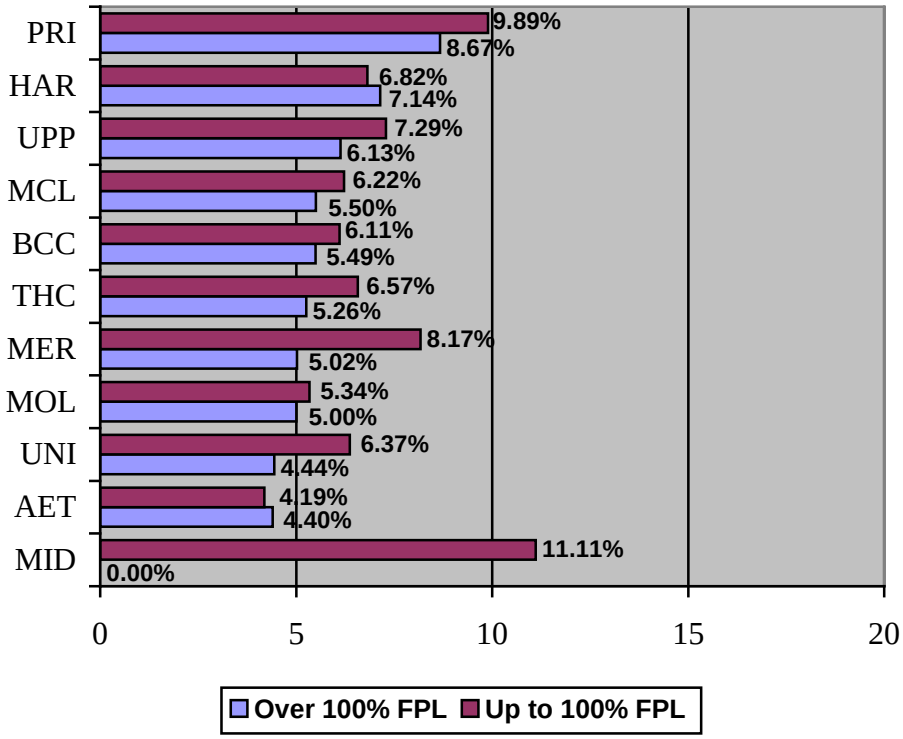
Measurement Period
February 2017 – March 2018

Data Source
MDHHS Data Warehouse

Measurement Frequency
Quarterly

Summary: The results shown are informational only. In Cohort 1, the results ranged from 0.00% to 8.67% for beneficiaries with income over 100% FPL. The results ranged from 4.19% to 11.11% for beneficiaries with income that never exceeded 100% FPL.
In Cohort 2, the results ranged from 0.00% to 16.67% for beneficiaries with income over 100% FPL. The results ranged from 0.00% to 100.00% for beneficiaries with income that never exceeded 100% FPL.
In Cohort 3, the results ranged from 1.26% to 28.57% for beneficiaries with income over 100% FPL. The results ranged from 0.00% to 7.46% for beneficiaries with income that never exceeded 100% FPL.

Figure 11: Transition out of CFP Status - Cohort 1



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

Figure 12: Transition out of CFP Status - Cohort 2

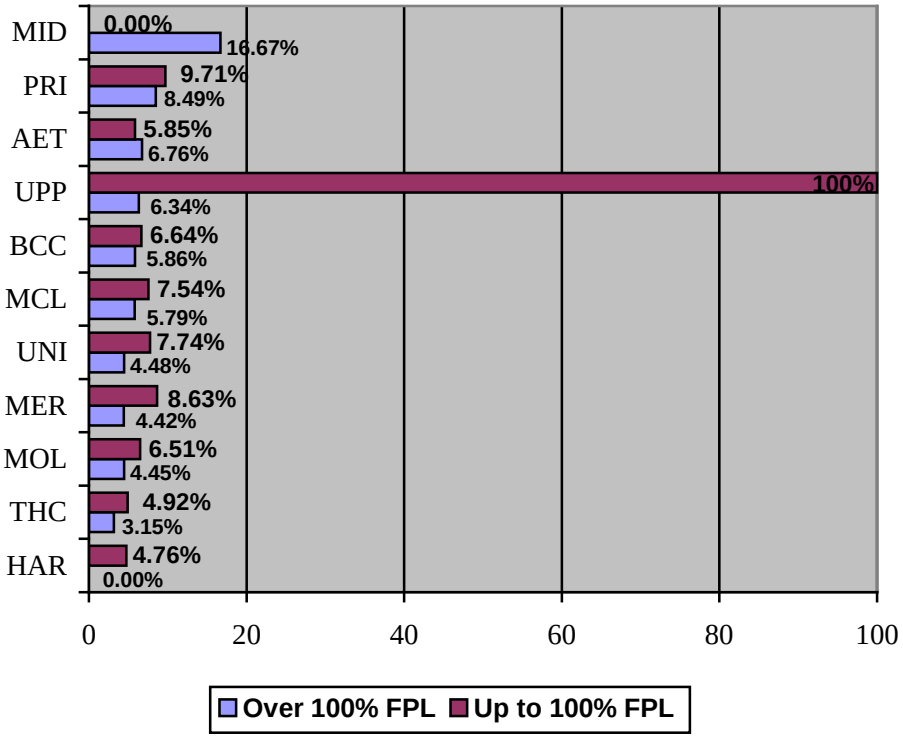
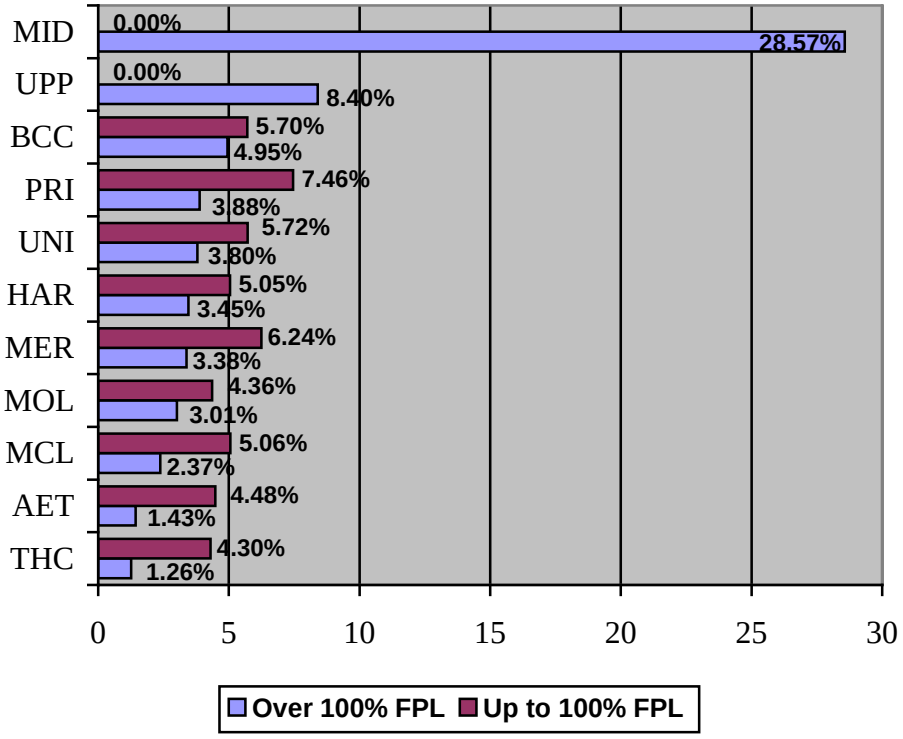


Figure 13: Transition out of CFP Status - Cohort 3



Appendix A: Three Letter Medicaid Health Plan Codes

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

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

Appendix B: One Year Plan-Specific Analysis

Aetna Better Health of Michigan – AET

HEALTHY MICHIGAN PLAN:

Performance Measure	Measurement Period	Standard	Plan Result	Standard Achieved
Adults' Generic Drug Utilization	Apr 17 – Jun 17	84%	84.64%	Yes
	Jul 17 – Sep 17	**84%**	**84.63%**	**Yes**
Timely Completion of HRA	Jan 17 – Mar 17	9%	7.45%	**No**
	Apr 17 – Jun 17	**9%**	**5.22%**	**No**
Completion of Annual HRA	Jun 16 – Sep 17	Informational Only	7.16%	N/A
	Sep 16 – Dec 17	**Informational Only**	**6.61%**	**N/A**
Outreach/Engagement to Facilitate Entry to Primary Care	Jan 17 – Mar 17	50%	38.78%	**No**
	Apr 17 – Jun 17	**50%**	**36.79%**	**No**
Adults' Access to Ambulatory Health Services	Jul 16 – Jun 17	83%	71.03%	**No**
	Oct 16 – Sep 17	**83%**	**70.08%**	**No**

Transition into CFP Status: [May 16 – Jun 17] [Aug 16 – Sep 17] [Nov 16 – Dec 17] [**Feb 17 – Dec 18]**											
Cohort 1 Standard	**>100% FPL Result**	**≤100% FPL Result**	**Standard Achieved**	**Cohort 2 Standard**	**>100% FPL Result**	**≤100% FPL Result**	**Standard Achieved**	**Cohort 3 Standard**	**>100% FPL Result**	**≤100% FPL Result**	**Standard Achieved**
Info Only	22.22%	3.80%	N/A	Info Only	16.92%	2.82%	N/A	Info Only	27.63%	4.11%	N/A
Info Only	13.85%	3.91%	N/A	Info Only	4.69%	3.01%	N/A	Info Only	16.92%	2.20%	N/A
Info Only	15.71%	2.32%	N/A	Info Only	8.70%	2.69%	N/A	Info Only	24.24%	1.18%	N/A
Info Only	**17.72%**	**2.22%**	**N/A**	**Info Only**	**10.26%**	**2.08%**	**N/A**	**Info Only**	**12.86%**	**2.83%**	**N/A**

Transition out of CFP Status: [May 16 – Jun 17] [Aug 16 – Sep 17] [Nov 16 – Dec 17] [**Feb 17 – Dec 18]**											
Cohort 1 Standard	**>100% FPL Result**	**≤100% FPL Result**	**Standard Achieved**	**Cohort 2 Standard**	**>100% FPL Result**	**≤100% FPL Result**	**Standard Achieved**	**Cohort 3 Standard**	**>100% FPL Result**	**≤100% FPL Result**	**Standard Achieved**
Info Only	0.00%	0.00%	N/A	Info Only	0.00%	1.89%	N/A	Info Only	0.00%	3.64%	N/A
Info Only	2.33%	5.30%	N/A	Info Only	2.56%	2.72%	N/A	Info Only	0.00%	3.57%	N/A
Info Only	6.82%	7.91%	N/A	Info Only	5.26%	8.57%	N/A	Info Only	2.52%	2.65%	N/A
Info Only	**4.40%**	**4.19%**	**N/A**	**Info Only**	**6.76%**	**5.85%**	**N/A**	**Info Only**	**1.43%**	**4.48%**	**N/A**

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

Appendix B: One Year Plan-Specific Analysis

Blue Cross Complete of Michigan – BCC

HEALTHY MICHIGAN PLAN:

Performance Measure	Measurement Period	Standard	Plan Result	Standard Achieved
Adults' Generic Drug Utilization	Apr 17 – Jun 17	84%	84.78%	Yes
	Jul 17 – Sep 17	**84%**	**84.93%**	**Yes**
Timely Completion of HRA	Jan 17 – Mar 17	9%	10.80%	Yes
	Apr 17 – Jun 17	**9%**	**10.45%**	**Yes**
Completion of Annual HRA	Jun 16 – Sep 17	Informational Only	12.34%	N/A
	Sep 16 – Dec 17	**Informational Only**	**11.78%**	**N/A**
Outreach/Engagement to Facilitate Entry to Primary Care	Jan 17 – Mar 17	50%	54.26%	Yes
	Apr 17 – Jun 17	**50%**	**50.71%**	**Yes**
Adults' Access to Ambulatory Health Services	Jul 16 – Jun 17	83%	75.93%	**No**
	Oct 16 – Sep 17	**83%**	**75.61%**	**No**

Transition into CFP Status: [May 16 – Jun 17] [Aug 16 – Sep 17] [Nov 16 – Dec 17] [**Feb 17 – Dec 18]**											
Cohort 1 Standard	**>100% FPL Result**	**≤100% FPL Result**	**Standard Achieved**	**Cohort 2 Standard**	**>100% FPL Result**	**≤100% FPL Result**	**Standard Achieved**	**Cohort 3 Standard**	**>100% FPL Result**	**≤100% FPL Result**	**Standard Achieved**
Info Only	16.32%	3.70%	N/A	Info Only	19.88%	4.14%	N/A	Info Only	18.76%	4.16%	N/A
Info Only	15.69%	4.39%	N/A	Info Only	14.63%	3.09%	N/A	Info Only	19.13%	2.95%	N/A
Info Only	13.90	3.92%	N/A	Info Only	14.86%	2.92%	N/A	Info Only	11.44%	2.56%	N/A
Info Only	**10.84%**	**3.17%**	**N/A**	**Info Only**	**13.32%**	**2.75%**	**N/A**	**Info Only**	**14.57%**	**2.63%**	**N/A**

Transition out of CFP Status: [May 16 – Jun 17] [Aug 16 – Sep 17] [Nov 16 – Dec 17] [**Feb 17 – Dec 18]**											
Cohort 1 Standard	**>100% FPL Result**	**≤100% FPL Result**	**Standard Achieved**	**Cohort 2 Standard**	**>100% FPL Result**	**≤100% FPL Result**	**Standard Achieved**	**Cohort 3 Standard**	**>100% FPL Result**	**≤100% FPL Result**	**Standard Achieved**
Info Only	1.09%	2.63%	N/A	Info Only	1.15%	2.52%	N/A	Info Only	0.64%	2.80%	N/A
Info Only	1.08%	3.91%	N/A	Info Only	2.04%	3.16%	N/A	Info Only	5.71%	8.15%	N/A
Info Only	7.93%	12.13%	N/A	Info Only	6.70%	8.39%	N/A	Info Only	4.78%	7.38%	N/A
Info Only	**5.49%**	**6.11%**	**N/A**	**Info Only**	**5.86%**	**6.64%**	**N/A**	**Info Only**	**4.95%**	**5.70%**	**N/A**

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

Performance Monitoring Report

Appendix B: One Year Plan-Specific Analysis

Harbor Health Plan – HAR

HEALTHY MICHIGAN PLAN:

Performance Measure	Measurement Period	Standard	Plan Result	Standard Achieved
Adults' Generic Drug Utilization	Apr 17 – Jun 17	84%	85.45%	Yes
	Jul 17 – Sep 17	**84%**	**85.77%**	**Yes**

Timely Completion of HRA	Jan 17 – Mar 17	9%	N/A	N/A
	Apr 17 – Jun 17	**9%**	**N/A**	**N/A**

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

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

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

Outreach/Engagement to Facilitate Entry to Primary Care	Jan 17 – Mar 17	50%	27.02%	**No**
	Apr 17 – Jun 17	**50%**	**29.20%**	**No**

Adults' Access to Ambulatory Health Services	Jul 16 – Jun 17	83%	59.35%	**No**
	Oct 16 – Sep 17	**83%**	**59.04%**	**No**

Transition into CFP Status: [May 16 – Jun 17] [Aug 16 – Sep 17] [Nov 16 – Dec 17] [**Feb 17 – Dec 18]**											
Cohort 1 Standard	**>100% FPL Result**	**≤100% FPL Result**	**Standard Achieved**	**Cohort 2 Standard**	**>100% FPL Result**	**≤100% FPL Result**	**Standard Achieved**	**Cohort 3 Standard**	**>100% FPL Result**	**≤100% FPL Result**	**Standard Achieved**
Info Only	12.50%	2.15%	N/A	Info Only	0.00%	2.17%	N/A	Info Only	28.00%	1.54%	N/A
Info Only	14.29%	2.24%	N/A	Info Only	12.50%	1.60%	N/A	Info Only	19.23%	1.46%	N/A
Info Only	25.00%	3.72%	N/A	Info Only	25.00%	1.36%	N/A	Info Only	11.11%	1.91%	N/A
Info Only	**18.18%**	**2.82%**	**N/A**	**Info Only**	**10.00%**	**1.23%**	**N/A**	**Info Only**	**28.00%**	**2.11%**	**N/A**

Transition out of CFP Status: [May 16 – Jun 17] [Aug 16 – Sep 17] [Nov 16 – Dec 17] [**Feb 17 – Dec 18]**											
Cohort 1 Standard	**>100% FPL Result**	**≤100% FPL Result**	**Standard Achieved**	**Cohort 2 Standard**	**>100% FPL Result**	**≤100% FPL Result**	**Standard Achieved**	**Cohort 3 Standard**	**>100% FPL Result**	**≤100% FPL Result**	**Standard Achieved**
Info Only	0.00%	0.00%	N/A	Info Only	0.00%	3.45%	N/A	Info Only	0.00%	0.00%	N/A
Info Only	0.00%	0.00%	N/A	Info Only	0.00%	0.00%	N/A	Info Only	6.73%	9.57%	N/A
Info Only	0.00%	6.67%	N/A	Info Only	0.00%	2.22%	N/A	Info Only	0.00%	1.15%	N/A
Info Only	**7.14%**	**6.82%**	**N/A**	**Info Only**	**0.00%**	**4.76%**	**N/A**	**Info Only**	**3.45%**	**5.05%**	**N/A**

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

Performance Monitoring Report

Appendix B: One Year Plan-Specific Analysis

McLaren Health Plan – MCL

HEALTHY MICHIGAN PLAN:

Performance Measure	Measurement Period	Standard	Plan Result	Standard Achieved
Adults' Generic Drug Utilization	Apr 17 – Jun 17	84%	84.43%	Yes
	Jul 17 – Sep 17	**84%**	**84.59%**	**Yes**
Timely Completion of HRA	Jan 17 – Mar 17	9%	10.83%	Yes
	Apr 17 – Jun 17	**9%**	**11.88%**	**Yes**
Completion of Annual HRA	Jun 16 – Sep 17	Informational Only	5.65%	N/A
	Sep 16 – Dec 17	**Informational Only**	**7.41%**	**N/A**
Outreach/Engagement to Facilitate Entry to Primary Care	Jan 17 – Mar 17	50%	54.59%	Yes
	Apr 17 – Jun 17	**50%**	**48.62%**	**No**
Adults' Access to Ambulatory Health Services	Jul 16 – Jun 17	83%	81.11%	**No**
	Oct 16 – Sep 17	**83%**	**80.87%**	**No**

Transition into CFP Status: [May 16 – Jun 17] [Aug 16 – Sep 17] [Nov 16 – Dec 17] [**Feb 17 – Dec 18]**

Cohort 1 Standard	>100% FPL Result	≤100% FPL Result	Standard Achieved	Cohort 2 Standard	>100% FPL Result	≤100% FPL Result	Standard Achieved	Cohort 3 Standard	>100% FPL Result	≤100% FPL Result	Standard Achieved
Info Only	13.91%	6.42%	N/A	Info Only	15.63%	5.88%	N/A	Info Only	18.73%	5.08%	N/A
Info Only	13.89%	5.14%	N/A	Info Only	10.57%	3.63%	N/A	Info Only	11.53%	2.78%	N/A
Info Only	10.29%	3.55%	N/A	Info Only	11.33%	3.17%	N/A	Info Only	9.86%	2.82%	N/A
Info Only	**11.15%**	**3.96%**	**N/A**	**Info Only**	**8.50%**	**2.97%**	**N/A**	**Info Only**	**11.31%**	**3.45%**	**N/A**

Transition out of CFP Status: [May 16 – Jun 17] [Aug 16 – Sep 17] [Nov 16 – Dec 17] [**Feb 17 – Dec 18]**

Cohort 1 Standard	>100% FPL Result	≤100% FPL Result	Standard Achieved	Cohort 2 Standard	>100% FPL Result	≤100% FPL Result	Standard Achieved	Cohort 3 Standard	>100% FPL Result	≤100% FPL Result	Standard Achieved
Info Only	2.34%	3.25%	N/A	Info Only	2.18%	3.56%	N/A	Info Only	2.36%	3.05%	N/A
Info Only	3.32%	4.97%	N/A	Info Only	1.94%	5.77%	N/A	Info Only	5.13%	8.18%	N/A
Info Only	9.59%	12.58%	N/A	Info Only	6.52%	12.95%	N/A	Info Only	5.95%	7.16%	N/A
Info Only	**5.50%**	**6.22%**	**N/A**	**Info Only**	**5.79%**	**7.54%**	**N/A**	**Info Only**	**2.37%**	**5.06%**	**N/A**

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

Appendix B: One Year Plan-Specific Analysis

Meridian Health Plan of Michigan – MER

HEALTHY MICHIGAN PLAN:

Performance Measure	Measurement Period	Standard	Plan Result	Standard Achieved
Adults' Generic Drug Utilization	Apr 17 – Jun 17	84%	84.55%	Yes
	Jul 17 – Sep 17	**84%**	**84.93%**	**Yes**
Timely Completion of HRA	Jan 17 – Mar 17	9%	12.42%	Yes
	Apr 17 – Jun 17	**9%**	**8.32%**	**No**
Completion of Annual HRA	Jun 16 – Sep 17	Informational Only	8.10%	N/A
	Sep 16 – Dec 17	**Informational Only**	**8.22%**	**N/A**
Outreach/Engagement to Facilitate Entry to Primary Care	Jan 17 – Mar 17	50%	55.12%	Yes
	Apr 17 – Jun 17	**50%**	**50.55%**	**Yes**
Adults' Access to Ambulatory Health Services	Jul 16 – Jun 17	83%	81.15%	**No**
	Oct 16 – Sep 17	**83%**	**80.91%**	**No**

Transition into CFP Status: [May 16 – Jun 17] [Aug 16 – Sep 17] [Nov 16 – Dec 17] [**Feb 17 – Dec 18]**

Cohort 1 Standard	>100% FPL Result	≤100% FPL Result	Standard Achieved	Cohort 2 Standard	>100% FPL Result	≤100% FPL Result	Standard Achieved	Cohort 3 Standard	>100% FPL Result	≤100% FPL Result	Standard Achieved
Info Only	15.87%	4.94%	N/A	Info Only	13.34%	5.18%	N/A	Info Only	19.84%	4.28%	N/A
Info Only	14.52%	4.61%	N/A	Info Only	14.19%	4.26%	N/A	Info Only	14.73%	3.35%	N/A
Info Only	11.23%	3.63%	N/A	Info Only	12.25%	3.51%	N/A	Info Only	10.69%	3.20%	N/A
Info Only	**12.82%**	**3.56%**	**N/A**	**Info Only**	**10.26%**	**3.08%**	**N/A**	**Info Only**	**11.53%**	**2.99%**	**N/A**

Transition out of CFP Status: [May 16 – Jun 17] [Aug 16 – Sep 17] [Nov 16 – Dec 17] [**Feb 17 – Dec 18]**

Cohort 1 Standard	>100% FPL Result	≤100% FPL Result	Standard Achieved	Cohort 2 Standard	>100% FPL Result	≤100% FPL Result	Standard Achieved	Cohort 3 Standard	>100% FPL Result	≤100% FPL Result	Standard Achieved
Info Only	0.94%	3.37%	N/A	Info Only	2.28%	3.03%	N/A	Info Only	1.80%	3.13%	N/A
Info Only	2.19%	4.75%	N/A	Info Only	2.11%	4.59%	N/A	Info Only	0.00%	0.00%	N/A
Info Only	7.72%	11.14%	N/A	Info Only	5.68%	10.61%	N/A	Info Only	5.68%	8.54%	N/A
Info Only	**5.02%**	**8.17%**	**N/A**	**Info Only**	**4.42%**	**8.63%**	**N/A**	**Info Only**	**3.38%**	**6.24%**	**N/A**

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

Appendix B: One Year Plan-Specific Analysis

HAP Midwest Health Plan – MID

HEALTHY MICHIGAN PLAN:

Performance Measure	Measurement Period	Standard	Plan Result	Standard Achieved
Adults' Generic Drug Utilization	Apr 17 – Jun 17	84%	84.73%	Yes
	Jul 17 – Sep 17	**84%**	**85.13%**	**Yes**

Timely Completion of HRA	Jan 17 – Mar 17	9%	N/A	N/A
	Apr 17 – Jun 17	**9%**	**N/A**	**N/A**

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

Completion of Annual HRA	Jun 16 – Sep 17	Informational Only	N/A	N/A
	Sep 16 – Dec 17	**Informational Only**	**23.33%**	**N/A**

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

Outreach/Engagement to Facilitate Entry to Primary Care	Jan 17 – Mar 17	50%	29.46%	**No**
	Apr 17 – Jun 17	**50%**	**34.65%**	**No**

Adults' Access to Ambulatory Health Services	Jul 16 – Jun 17	83%	53.19%	**No**
	Oct 16 – Sep 17	**83%**	**54.83%**	**No**

Transition into CFP Status: [May 16 – Jun 17] [Aug 16 – Sep 17] [Nov 16 – Dec 17] [**Feb 17 – Dec 18]**											
Cohort 1 Standard	**>100% FPL Result**	**≤100% FPL Result**	**Standard Achieved**	**Cohort 2 Standard**	**>100% FPL Result**	**≤100% FPL Result**	**Standard Achieved**	**Cohort 3 Standard**	**>100% FPL Result**	**≤100% FPL Result**	**Standard Achieved**
Info Only	25.00%	3.33%	N/A	Info Only	25.00%	0.00%	N/A	Info Only	0.00%	0.00%	N/A
Info Only	10.00%	4.17%	N/A	Info Only	N/A	2.90%	N/A	Info Only	16.67%	2.99%	N/A
Info Only	**18.18%**	**3.23%**	**N/A**	**Info Only**	**0.00**	**2.70%**	**N/A**	**Info Only**	**0.00%**	**1.35%**	**N/A**
Info Only	**25.00%**	**3.85%**	**N/A**	**Info Only**	**50.00%**	**3.41%**	**N/A**	**Info Only**	**28.57%**	**3.09%**	**N/A**

Transition out of CFP Status: [May 16 – Jun 17] [Aug 16 – Sep 17] [Nov 16 – Dec 17] [**Feb 17 – Dec 18]**											
Cohort 1 Standard	**>100% FPL Result**	**≤100% FPL Result**	**Standard Achieved**	**Cohort 2 Standard**	**>100% FPL Result**	**≤100% FPL Result**	**Standard Achieved**	**Cohort 3 Standard**	**>100% FPL Result**	**≤100% FPL Result**	**Standard Achieved**
Info Only	0.00%	0.00%	N/A	Info Only	0.00%	11.11%	N/A	Info Only	0.00%	0.00%	N/A
Info Only	0.00%	0.00%	N/A	Info Only	0.00%	11.11%	N/A	Info Only	5.36%	8.62%	N/A
Info Only	14.29%	12.50%	N/A	Info Only	0.00%	7.14%	N/A	Info Only	0.00%	0.00%	N/A
Info Only	**0.00%**	**11.11%**	**N/A**	**Info Only**	**16.67%**	**0.00%**	**N/A**	**Info Only**	**28.57%**	**0.00%**	**N/A**

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

Performance Monitoring Report

Appendix B: One Year Plan-Specific Analysis

Molina Healthcare of Michigan – MOL

HEALTHY MICHIGAN PLAN:

Performance Measure	Measurement Period	Standard	Plan Result	Standard Achieved
Adults' Generic Drug Utilization	Apr 17 – Jun 17	84%	85.83%	Yes
	Jul 17 – Sep 17	**84%**	**85.79%**	**Yes**
Timely Completion of HRA	Jan 17 – Mar 17	9%	8.04%	**No**
	Apr 17 – Jun 17	**9%**	**7.52%**	**No**
Completion of Annual HRA	Jun 16 – Sep 17	Informational Only	21.85%	N/A
	Sep 16 – Dec 17	**Informational Only**	**20.99%**	**N/A**
Outreach/Engagement to Facilitate Entry to Primary Care	Jan 17 – Mar 17	50%	50.59%	Yes
	Apr 17 – Jun 17	**50%**	**50.12%**	**Yes**
Adults' Access to Ambulatory Health Services	Jul 16 – Jun 17	83%	80.15%	**No**
	Oct 16 – Sep 17	**83%**	**79.87%**	**No**

Transition into CFP Status: [May 16 – Jun 17] [Aug 16 – Sep 17] [Nov 16 – Dec 17] [**Feb 17 – Dec 18]**

Cohort 1 Standard	>100% FPL Result	≤100% FPL Result	Standard Achieved	Cohort 2 Standard	>100% FPL Result	≤100% FPL Result	Standard Achieved	Cohort 3 Standard	>100% FPL Result	≤100% FPL Result	Standard Achieved
Info Only	16.04%	4.90%	N/A	Info Only	14.48%	4.99%	N/A	Info Only	20.16%	4.67%	N/A
Info Only	14.35%	4.91%	N/A	Info Only	13.00%	4.10%	N/A	Info Only	13.60%	3.00%	N/A
Info Only	12.21%	3.55%	N/A	Info Only	12.00%	2.89%	N/A	Info Only	10.66%	2.73%	N/A
Info Only	**12.65%**	**3.44%**	**N/A**	**Info Only**	**10.56%**	**2.84%**	**N/A**	**Info Only**	**11.48%**	**2.90%**	**N/A**

Transition out of CFP Status: [May 16 – Jun 17] [Aug 16 – Sep 17] [Nov 16 – Dec 17] [**Feb 17 – Dec 18]**

Cohort 1 Standard	>100% FPL Result	≤100% FPL Result	Standard Achieved	Cohort 2 Standard	>100% FPL Result	≤100% FPL Result	Standard Achieved	Cohort 3 Standard	>100% FPL Result	≤100% FPL Result	Standard Achieved
Info Only	1.20%	2.41%	N/A	Info Only	1.75%	2.66%	N/A	Info Only	1.30%	2.52%	N/A
Info Only	1.67%	2.82%	N/A	Info Only	2.35%	3.47%	N/A	Info Only	7.56%	11.04%	N/A
Info Only	7.06%	9.16%	N/A	Info Only	5.00%	9.34%	N/A	Info Only	4.72%	5.25%	N/A
Info Only	**5.00%**	**5.34%**	**N/A**	**Info Only**	**4.45%**	**6.51%**	**N/A**	**Info Only**	**3.01%**	**4.36%**	**N/A**

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

Performance Monitoring Report

Appendix B: One Year Plan-Specific Analysis

Priority Health Choice – PRI

HEALTHY MICHIGAN PLAN:

Performance Measure	Measurement Period	Standard	Plan Result	Standard Achieved
Adults' Generic Drug Utilization	Apr 17 – Jun 17	84%	84.09%	Yes
	Jul 17 – Sep 17	**84%**	**84.03%**	**Yes**
Timely Completion of HRA	Jan 17 – Mar 17	9%	11.97%	Yes
	Apr 17 – Jun 17	**9%**	**7.54%**	**No**
Completion of Annual HRA	Jun 16 – Sep 17	Informational Only	7.89%	N/A
	Sep 16 – Dec 17	**Informational Only**	**8.35%**	**N/A**
Outreach/Engagement to Facilitate Entry to Primary Care	Jan 17 – Mar 17	50%	59.94%	Yes
	Apr 17 – Jun 17	**50%**	**56.45%**	**Yes**
Adults' Access to Ambulatory Health Services	Jul 16 – Jun 17	83%	82.59%	**No**
	Oct 16 – Sep 17	**83%**	**82.39%**	**No**

Transition into CFP Status: [May 16 – Jun 17] [Aug 16 – Sep 17] [Nov 16 – Dec 17] [**Feb 17 – Dec 18]**

Cohort 1 Standard	>100% FPL Result	≤100% FPL Result	Standard Achieved	Cohort 2 Standard	>100% FPL Result	≤100% FPL Result	Standard Achieved	Cohort 3 Standard	>100% FPL Result	≤100% FPL Result	Standard Achieved
Info Only	11.93%	5.24%	N/A	Info Only	15.37%	4.87%	N/A	Info Only	14.40%	4.99%	N/A
Info Only	13.57%	6.90%	N/A	Info Only	13.01%	5.75%	N/A	Info Only	12.42%	4.90%	N/A
Info Only	11.36%	4.29%	N/A	Info Only	10.13%	3.37%	N/A	Info Only	8.18%	3.23%	N/A
Info Only	**11.96%**	**4.14%**	**N/A**	**Info Only**	**9.96%**	**3.47%**	**N/A**	**Info Only**	**13.77%**	**3.58%**	**N/A**

Transition out of CFP Status: [May 16 – Jun 17] [Aug 16 – Sep 17] [Nov 16 – Dec 17] [**Feb 17 – Dec 18]**

Cohort 1 Standard	>100% FPL Result	≤100% FPL Result	Standard Achieved	Cohort 2 Standard	>100% FPL Result	≤100% FPL Result	Standard Achieved	Cohort 3 Standard	>100% FPL Result	≤100% FPL Result	Standard Achieved
Info Only	2.16%	2.53%	N/A	Info Only	2.68%	4.14%	N/A	Info Only	1.37%	3.41%	N/A
Info Only	1.15%	5.61%	N/A	Info Only	1.59%	7.66%	N/A	Info Only	6.79%	5.61%	N/A
Info Only	9.45%	12.48%	N/A	Info Only	8.03%	10.93%	N/A	Info Only	8.98%	10.49%	N/A
Info Only	**8.67%**	**9.89%**	**N/A**	**Info Only**	**8.49%**	**9.71%**	**N/A**	**Info Only**	**3.88%**	**7.46%**	**N/A**

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

Performance Monitoring Report

Appendix B: One Year Plan-Specific Analysis

Total Health Care – THC

HEALTHY MICHIGAN PLAN:

Performance Measure	Measurement Period	Standard	Plan Result	Standard Achieved
Adults' Generic Drug Utilization	Apr 17 – Jun 17	84%	86.01%	Yes
	Jul 17 – Sep 17	**84%**	**86.12%**	**Yes**
Timely Completion of HRA	Jan 17 – Mar 17	9%	6.43%	**No**
	Apr 17 – Jun 17	**9%**	**6.46%**	**No**
Completion of Annual HRA	Jun 16 – Sep 17	Informational Only	8.86%	N/A
	Sep 16 – Dec 17	**Informational Only**	**8.56%**	**N/A**
Outreach/Engagement to Facilitate Entry to Primary Care	Jan 17 – Mar 17	50%	47.10%	**No**
	Apr 17 – Jun 17	**50%**	**44.55%**	**No**
Adults' Access to Ambulatory Health Services	Jul 16 – Jun 17	83%	76.45%	**No**
	Oct 16 – Sep 17	**83%**	**76.41%**	**No**

Transition into CFP Status: [May 16 – Jun 17] [Aug 16 – Sep 17] [Nov 16 – Dec 17] [**Feb 17 – Dec 18]**

Cohort 1 Standard	>100% FPL Result	≤100% FPL Result	Standard Achieved	Cohort 2 Standard	>100% FPL Result	≤100% FPL Result	Standard Achieved	Cohort 3 Standard	>100% FPL Result	≤100% FPL Result	Standard Achieved
Info Only	12.50%	3.80%	N/A	Info Only	19.70%	3.73%	N/A	Info Only	19.46%	3.02%	N/A
Info Only	16.92%	3.43%	N/A	Info Only	9.76%	3.55%	N/A	Info Only	15.11%	2.85%	N/A
Info Only	12.50%	2.87%	N/A	Info Only	11.76%	2.37%	N/A	Info Only	12.23%	2.37%	N/A
Info Only	**14.48%**	**3.20%**	**N/A**	**Info Only**	**5.00%**	**2.20%**	**N/A**	**Info Only**	**16.85%**	**2.99%**	**N/A**

Transition out of CFP Status: [May 16 – Jun 17] [Aug 16 – Sep 17] [Nov 16 – Dec 17] [**Feb 17 – Dec 18]**

Cohort 1 Standard	>100% FPL Result	≤100% FPL Result	Standard Achieved	Cohort 2 Standard	>100% FPL Result	≤100% FPL Result	Standard Achieved	Cohort 3 Standard	>100% FPL Result	≤100% FPL Result	Standard Achieved
Info Only	0.00%	2.60%	N/A	Info Only	1.71%	3.30%	N/A	Info Only	2.42%	2.71%	N/A
Info Only	2.10%	1.68%	N/A	Info Only	3.33%	3.13%	N/A	Info Only	7.79%	7.62%	N/A
Info Only	6.06%	12.24%	N/A	Info Only	3.03%	7.84%	N/A	Info Only	10.37%	5.66%	N/A
Info Only	**5.26%**	**6.57%**	**N/A**	**Info Only**	**3.15%**	**4.92%**	**N/A**	**Info Only**	**1.26%**	**4.30%**	**N/A**

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

Appendix B: One Year Plan-Specific Analysis

UnitedHealthcare Community Plan – UNI

HEALTHY MICHIGAN PLAN:

Performance Measure	Measurement Period	Standard	Plan Result	Standard Achieved
Adults' Generic Drug Utilization	Apr 17 – Jun 17	84%	86.38%	Yes
	Jul 17 – Sep 17	**84%**	**86.52%**	**Yes**
Timely Completion of HRA	Jan 17 – Mar 17	9%	17.94%	Yes
	Apr 17 – Jun 17	**9%**	**15.56%**	**Yes**
Completion of Annual HRA	Jun 16 – Sep 17	Informational Only	7.43%	N/A
	Sep 16 – Dec 17	**Informational Only**	**9.38%**	**N/A**
Outreach/Engagement to Facilitate Entry to Primary Care	Jan 17 – Mar 17	50%	53.75%	Yes
	Apr 17 – Jun 17	**50%**	**53.67%**	**Yes**
Adults' Access to Ambulatory Health Services	Jul 16 – Jun 17	83%	80.94%	**No**
	Oct 16 – Sep 17	**83%**	**80.87%**	**No**

Transition into CFP Status: [May 16 – Jun 17] [Aug 16 – Sep 17] [Nov 16 – Dec 17] [**Feb 17 – Dec 18]**

Cohort 1 Standard	>100% FPL Result	≤100% FPL Result	Standard Achieved	Cohort 2 Standard	>100% FPL Result	≤100% FPL Result	Standard Achieved	Cohort 3 Standard	>100% FPL Result	≤100% FPL Result	Standard Achieved
Info Only	13.25%	4.07%	N/A	Info Only	13.74%	3.83%	N/A	Info Only	17.84%	4.15%	N/A
Info Only	13.59%	4.44%	N/A	Info Only	12.04%	3.88%	N/A	Info Only	13.46%	4.93%	N/A
Info Only	14.35%	5.37%	N/A	Info Only	14.70%	4.98%	N/A	Info Only	10.85%	3.18%	N/A
Info Only	**12.29%**	**4.09%**	**N/A**	**Info Only**	**10.38%**	**2.99%**	**N/A**	**Info Only**	**9.21%**	**3.08%**	**N/A**

Transition out of CFP Status: [May 16 – Jun 17] [Aug 16 – Sep 17] [Nov 16 – Dec 17] [**Feb 17 – Dec 18]**

Cohort 1 Standard	>100% FPL Result	≤100% FPL Result	Standard Achieved	Cohort 2 Standard	>100% FPL Result	≤100% FPL Result	Standard Achieved	Cohort 3 Standard	>100% FPL Result	≤100% FPL Result	Standard Achieved
Info Only	1.33%	3.05%	N/A	Info Only	1.83%	3.95%	N/A	Info Only	2.75%	3.61%	N/A
Info Only	3.14%	5.19%	N/A	Info Only	2.70%	5.62%	N/A	Info Only	7.66%	12.39%	N/A
Info Only	7.18%	12.86%	N/A	Info Only	7.09%	9.13%	N/A	Info Only	5.08%	7.77%	N/A
Info Only	**4.44%**	**6.37%**	**N/A**	**Info Only**	**4.48%**	**7.74%**	**N/A**	**Info Only**	**3.80%**	**5.72%**	**N/A**

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

Performance Monitoring Report

Appendix B: One Year Plan-Specific Analysis

Upper Peninsula Health Plan – UPP

HEALTHY MICHIGAN PLAN:

Performance Measure	Measurement Period	Standard	Plan Result	Standard Achieved
Adults' Generic Drug Utilization	Apr 17 – Jun 17	84%	83.22%	**No**
	Jul 17 – Sep 17	**84%**	**83.30%**	**No**
Timely Completion of HRA	Jan 17 – Mar 17	9%	8.41%	**No**
	Apr 17 – Jun 17	**9%**	**10.23%**	**Yes**
Completion of Annual HRA	Jun 16 – Sep 17	Informational Only	4.02%	N/A
	Sep 16 – Dec 17	**Informational Only**	**4.94%**	**N/A**
Outreach/Engagement to Facilitate Entry to Primary Care	Jan 17 – Mar 17	50%	55.06%	Yes
	Apr 17 – Jun 17	**50%**	**58.01%**	**Yes**
Adults' Access to Ambulatory Health Services	Jul 16 – Jun 17	83%	82.94%	**No**
	Oct 16 – Sep 17	**83%**	**82.57%**	**No**

Transition into CFP Status: [May 16 – Jun 17] [Aug 16 – Sep 17] [Nov 16 – Dec 17] [**Feb 17 – Dec 18]**

Cohort 1 Standard	>100% FPL Result	≤100% FPL Result	Standard Achieved	Cohort 2 Standard	>100% FPL Result	≤100% FPL Result	Standard Achieved	Cohort 3 Standard	>100% FPL Result	≤100% FPL Result	Standard Achieved
Info Only	10.00%	6.90%	N/A	Info Only	13.95%	6.75%	N/A	Info Only	9.55%	5.92%	N/A
Info Only	11.70%	5.00%	N/A	Info Only	10.21%	4.41%	N/A	Info Only	9.15%	3.95%	N/A
Info Only	5.45%	3.41%	N/A	Info Only	7.48%	4.52%	N/A	Info Only	8.57%	2.62%	N/A
Info Only	**9.02%**	**3.30%**	**N/A**	**Info Only**	**7.06%**	**2.72%**	**N/A**	**Info Only**	**10.50%**	**0.00%**	**N/A**

Transition out of CFP Status: [May 16 – Jun 17] [Aug 16 – Sep 17] [Nov 16 – Dec 17] [**Feb 17 – Dec 18]**

Cohort 1 Standard	>100% FPL Result	≤100% FPL Result	Standard Achieved	Cohort 2 Standard	>100% FPL Result	≤100% FPL Result	Standard Achieved	Cohort 3 Standard	>100% FPL Result	≤100% FPL Result	Standard Achieved
Info Only	1.09%	2.25%	N/A	Info Only	4.32%	2.83%	N/A	Info Only	1.79%	3.74%	N/A
Info Only	2.28%	4.69%	N/A	Info Only	3.14%	5.21%	N/A	Info Only	2.70%	7.03%	N/A
Info Only	10.22%	12.30%	N/A	Info Only	7.38%	13.70%	N/A	Info Only	6.48%	9.79%	N/A
Info Only	**6.13%**	**7.29%**	**N/A**	**Info Only**	**6.34%**	**100.00%**	**N/A**	**Info Only**	**8.40%**	**0.00%**	**N/A**

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

Medical Services Administration
Bureau of Medicaid Care Management and Quality Assurance

PERFORMANCE MONITORING REPORT

Medicaid Managed Care

Composite – All Plans

April 2018

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

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Medicaid Managed Care

Appendixes

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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 28 key performance measures aimed at improving the quality and efficiency of health care services provided to the Michigan residents enrolled in a Medicaid program. These measures include Medicaid Managed Care specific measures, Healthy Michigan Plan (HMP) measures, and HEDIS measures. **This report focuses only on the 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 measures will be represented on a quarterly basis. The body of the report contains a cross-plan analysis of the most current data available for each of these measures. Measurement periods may vary and are based on the specifications for that individual measure. Appendix A contains specific three letter codes identifying each of the MHPs. Appendix B contains the one-year plan specific analysis for each measure.

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 timeframes for fiscal year 2018 unless otherwise noted.

Table 1: Fiscal Year 2018[1]

Monthly Reported Measures	**Reported in 1st Quarter**			**Reported in 2nd Quarter**			**Reported in 3rd Quarter**			**Reported in 4th Quarter**		
Blood Lead Testing	4/11	3/11	4/11	4/11	2/11	2/11						
Developmental Screening First Year of Life	7/11	6/11	7/11	5/11	7/11	8/11						
Developmental Screening Second Year of Life	8/11	8/11	9/11	8/11	8/11	6/11						
Developmental Screening Third Year of Life	7/11	7/11	7/11	6/11	6/11	6/11						
Claims Processing	9/11	7/11	8/11	8/11	9/11	8/11						
Encounter Data Reporting	10/11	11/11	10/11	10/11	10/11	10/11						
Pharmacy Encounter Data	10/11	9/11	9/11	11/11	11/11	11/11						
NEMT Encounter	N/A	N/A	N/A	N/A	N/A	N/A						
Provider File Reporting	10/11	10/11	10/11	11/11	11/11	9/11						

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 March 2018, enrollment was 1,713,717, down 93,809 enrollees (5.2%) from April 2017. A decrease of 38,294 enrollees (2.2%) was realized between February 2018 and March 2018.

Figure 1: Medicaid Managed Care Enrollment, April 2017 – March 2018

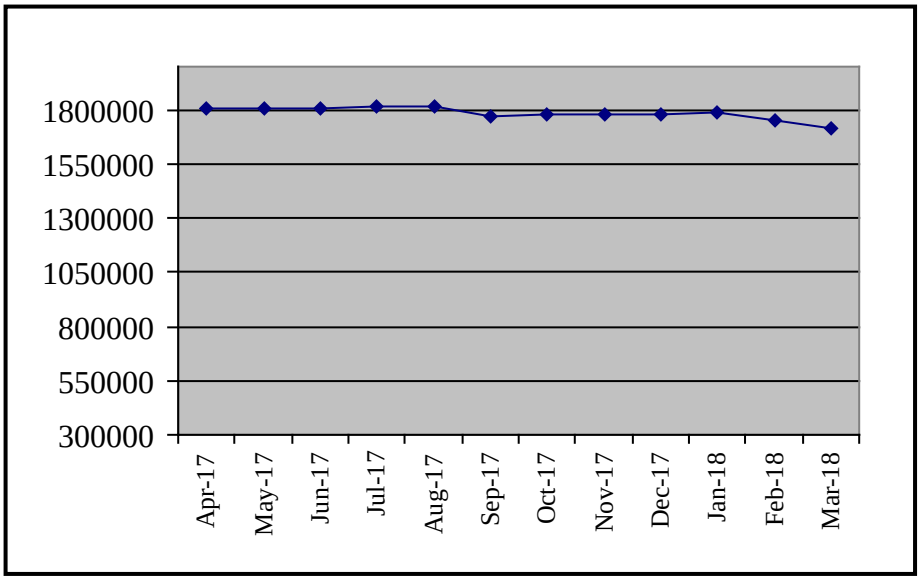
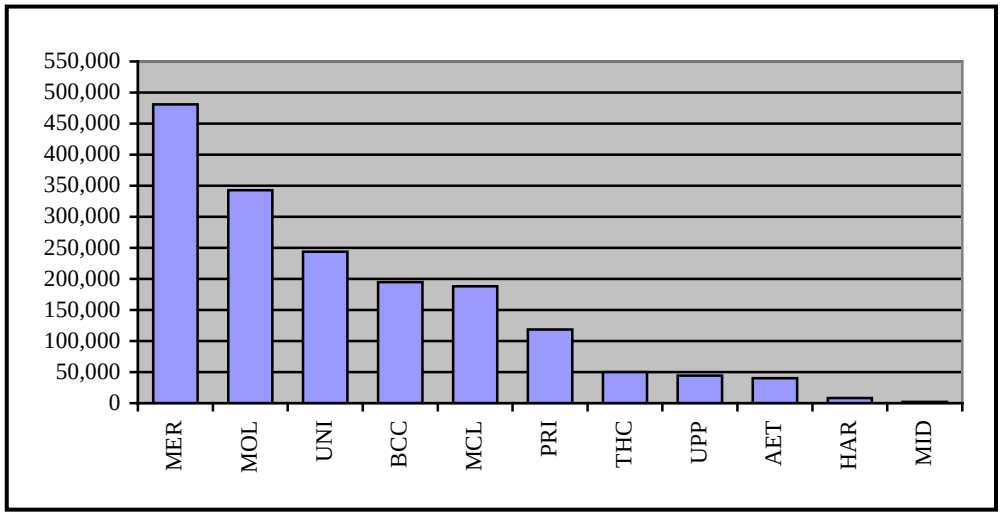


Figure 2: Medicaid Managed Care Enrollment by Health Plan, March 2018



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
The 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 2017 – December 2017

Data Source
MDHHS Data Warehouse

Measurement Frequency
Monthly

Summary: Four plans met or exceeded the standard in October, while seven plans (AET, BCC, MER, MOL, PRI, THC, and UNI)
Two plans met or exceeded the standard in November and December, while nine plans (AET, BCC, HAR, MER, MID, MOL, PRI, 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%	**72%**	**72%**	**71%**	**No**	**No**	**No**
BCC	81%	**74%**	**73%**	**73%**	**No**	**No**	**No**
HAR	81%	82%	**77%**	**72%**	Yes	**No**	**No**
MCL	81%	83%	82%	81%	Yes	Yes	Yes
MER	81%	**78%**	**77%**	**77%**	**No**	**No**	**No**
MID	81%	82%	**75%**	**77%**	Yes	**No**	**No**
MOL	81%	**75%**	**74%**	**74%**	**No**	**No**	**No**
PRI	81%	**80%**	**79%**	**79%**	**No**	**No**	**No**
THC	81%	**67%**	**67%**	**68%**	**No**	**No**	**No**
UNI	81%	**77%**	**77%**	**77%**	**No**	**No**	**No**
UPP	81%	85%	84%	83%	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 26% - First year of Life
At or above 33% - Second Year of Life
At or above 26% - Third Year of Life

Measurement Period
January 2018 – March 2018

Data Source
MDHHS Data Warehouse

Measurement Frequency
Monthly

Summary: For the ***first year of life***, five plans met or exceeded the standard for January, while six plans (AET, BCC, HAR, MID, THC, and UPP) did not. In February, seven plans met or exceeded the standard, while four plans (HAR, MID, THC, and UPP) did not. In March, eight plans met or exceeded the standard, while three plans (HAR, MID and UPP) did not.

For the ***second year of life***, eight plans met or exceeded the standard for January and February, while three plans (AET, HAR and UPP in January. AET, MID, and UPP in February) did not. In March, six plans met or exceeded the standard, while five plans (AET, HAR, MID, MOL, and UPP) did not.

For the ***third year of life***, six plans met or exceeded the standard for January, February and March, while five plans (AET, BCC, HAR, MID, and UPP in January and February. AET, HAR, MID, THC, and UPP in March) did not.

Table 3: Developmental Screening First Year of Life

MHP	Standard	Plan Result			Standard Achieved		
		Jan	Feb	Mar	Jan	Feb	Mar
AET	26%	**25.94%**	26.48%	26.58%	**No**	Yes	Yes
BCC	26%	**25.71%**	26.57%	27.99%	**No**	Yes	Yes
HAR	26%	**25.00%**	**24.39%**	**24.71%**	**No**	**No**	**No**
MCL	26%	30.13%	29.86%	31.04%	Yes	Yes	Yes
MER	26%	28.99%	29.15%	29.61%	Yes	Yes	Yes
MID	26%	**25.00%**	**22.22%**	**12.50%**	**No**	**No**	**No**
MOL	26%	26.94%	26.81%	26.98%	Yes	Yes	Yes
PRI	26%	30.71%	31.86%	31.76%	Yes	Yes	Yes
THC	26%	**24.62%**	**25.59%**	26.83%	**No**	**No**	Yes
UNI	26%	30.53%	30.85%	31.66%	Yes	Yes	Yes
UPP	26%	**20.90%**	**22.24%**	**23.33%**	**No**	**No**	**No**

Table 4: Developmental Screening Second Year of Life

MHP	Standard	Plan Result			Standard Achieved		
		Jan	Feb	Mar	Jan	Feb	Mar
AET	33%	**26.14%**	**24.90%**	**25.96%**	**No**	**No**	**No**
BCC	33%	37.22%	36.20%	35.10%	Yes	Yes	Yes
HAR	33%	**32.91%**	33.33%	**28.57%**	**No**	Yes	**No**
MCL	33%	40.11%	40.36%	40.68%	Yes	Yes	Yes
MER	33%	36.59%	36.77%	37.10%	Yes	Yes	Yes
MID	33%	40.00%	**26.67%**	**22.22%**	Yes	**No**	**No**
MOL	33%	33.90%	33.27%	**32.99%**	Yes	Yes	**No**
PRI	33%	41.86%	41.26%	42.63%	Yes	Yes	Yes
THC	33%	34.08%	34.39%	33.99%	Yes	Yes	Yes
UNI	33%	38.21%	38.37%	39.34%	Yes	Yes	Yes
UPP	33%	**22.70%**	**24.06%**	**26.69%**	**No**	**No**	**No**

Table 5: Developmental Screening Third Year of Life

MHP	Standard	Plan Result			Standard Achieved		
		Jan	Feb	Mar	Jan	Feb	Mar
AET	26%	**22.65%**	**21.95%**	**22.45%**	**No**	**No**	**No**
BCC	26%	**25.65%**	**25.87%**	26.17%	**No**	**No**	Yes
HAR	26%	**23.48%**	**24.62%**	**24.65%**	**No**	**No**	**No**
MCL	26%	33.58%	32.76%	32.89%	Yes	Yes	Yes
MER	26%	30.61%	30.39%	30.71%	Yes	Yes	Yes
MID	26%	**14.29%**	**17.39%**	**20.00%**	**No**	**No**	**No**
MOL	26%	26.86%	27.05%	26.97%	Yes	Yes	Yes
PRI	26%	38.51%	38.17%	38.03%	Yes	Yes	Yes
THC	26%	26.59%	26.75%	**25.70%**	Yes	Yes	**No**
UNI	26%	30.62%	30.57%	30.72%	Yes	Yes	Yes
UPP	26%	**17.83%**	**18.28%**	**19.23%**	**No**	**No**	**No**

Complaints

Measure
The 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 2017 – December 2017

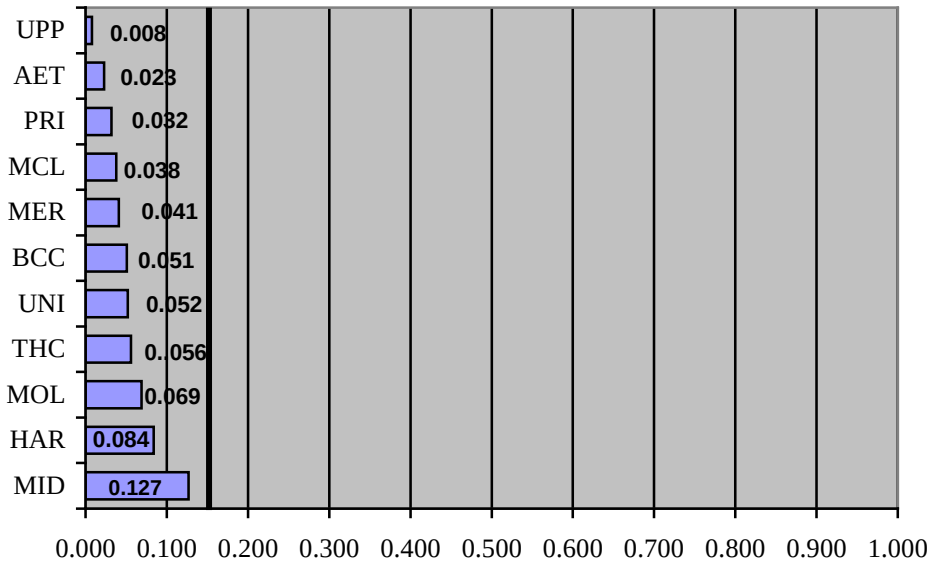
Data Source
Customer Relations System (CRM)

Measurement Frequency
Quarterly

Summary: All of the plans met or exceeded the standard. The results ranged from 0.008 to 0.127 complaints per 1,000 member months.

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

Figure 3: Complaints



Claims Processing

Measure
The 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 2017 – January 2018

Data Source
Claims report submitted by health plan

Measurement Frequency
Monthly

Summary: In November, eight plans met or exceeded the standard, while three plans (AET, HAR, and PRI) did not.
In December, nine plans met or exceeded the standard, while two plans (AET and HAR) did not.
In January, eight plans met or exceeded the standard, while three plans (AET, HAR, and UPP) did not.

Table 6: Claims Processing November 2017

MHP	Timely	Accurate	≥95%	≤12%	≤1%	Standard Achieved
AET	Yes	**No**	**93%**	4%	4.38%	**No**
BCC	Yes	Yes	100%	10%	0.00%	Yes
HAR	Yes	**No**	**78%**	0%	**69.60%**	**No**
MCL	Yes	Yes	100%	5%	0.05%	Yes
MER	Yes	Yes	97%	8%	0.00%	Yes
MID	Yes	Yes	100%	8%	0.00%	Yes
MOL	Yes	Yes	100%	2%	0.04%	Yes
PRI	Yes	**No**	**93%**	7%	0.19%	**No**
THC	Yes	Yes	100%	2%	0.00%	Yes
UNI	Yes	Yes	100%	9%	0.09%	Yes
UPP	Yes	Yes	100%	10%	0.00%	Yes

Table 7: Claims Processing December 2017

MHP	Timely	Accurate	≥95%	≤12%	≤1%	Standard Achieved
AET	Yes	**No**	**94%**	4%	**5.67%**	**No**
BCC	Yes	Yes	100%	1%	0.00%	Yes
HAR	Yes	**No**	**93%**	0%	**141.80%**	**No**
MCL	Yes	Yes	100%	5%	0.13%	Yes
MER	Yes	Yes	99%	8%	0.00%	Yes
MID	Yes	Yes	100%	7%	0.00%	Yes
MOL	Yes	Yes	100%	2%	0.01%	Yes
PRI	Yes	Yes	99%	8%	0.22%	Yes
THC	Yes	Yes	100%	2%	0.00%	Yes
UNI	Yes	Yes	100%	9%	0.11%	Yes
UPP	Yes	Yes	100%	10%	0.00%	Yes

Table 8: Claims Processing January 2018

MHP	Timely	Accurate	≥95%	≤12%	≤1%	Standard Achieved
AET	Yes	**No**	**87%**	8%	**6.96%**	**No**
BCC	Yes	Yes	100%	12%	0.01%	Yes
HAR	Yes	**No**	**72%**	0%	**48.10%**	**No**
MCL	Yes	Yes	99%	6%	0.11%	Yes
MER	Yes	Yes	98%	9%	0.55%	Yes
MID	Yes	Yes	100%	7%	0.00%	Yes
MOL	Yes	Yes	100%	2%	0.03%	Yes
PRI	Yes	Yes	99%	8%	0.33%	Yes
THC	Yes	Yes	100%	2%	0.00%	Yes
UNI	Yes	Yes	99%	8%	0.11%	Yes
UPP	Yes	**No**	99%	**14%**	0.00%	**No**

Encounter Data Reporting

Measure
Timely and complete encounter data submission

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

Measurement Period
January 2018 – March 2018

Data Source
MDHHS Data Exchange Gateway, MDHHS Data Warehouse

Measurement Frequency
Monthly

Summary: Ten plans met the standard of submitting a minimum volume of professional and institutional encounters paid in December 2017, by the 15th of January 2018, while one plan (UPP) did not.
Ten plans met the standard of submitting a minimum volume of professional and institutional encounters paid in January 2018, by the 15th of February 2018, while one plan (UPP) did not.
Ten plans met the standard of submitting a minimum volume of professional and institutional encounters paid in February 2017, by the 15th of March 2018, while one plan (MID) did not.

Table 9: Encounter Data Reporting January 2018

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	**No**	**No**	**No**

Table 10: Encounter Data Reporting February 2018

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	**No**	**No**	**No**

Table 11: Encounter Data Reporting March 2018

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

Pharmacy Encounter Data Reporting

Measure
Timely and complete pharmacy encounter data submission

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

Measurement Period
January 2018 – March 2018

Data Source
MDHHS Data Exchange Gateway, Encounter Data

Measurement Frequency
Monthly

Summary[2]: All plans met the standard of submitting a minimum volume of pharmacy encounters paid in December 2017, by the 15th of January 2018.
All plans met the standard of submitting a minimum volume of pharmacy encounters paid in January 2018, by the 15th of February 2018.
All plans met the standard of submitting a minimum volume of pharmacy encounters paid in February 2018, by the 15th of March 2018.

Table 12: Pharmacy Encounter Data Reporting January 2018

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	Yes	Yes	Yes

[2] All plans will receive a pass for the pharmacy encounter measure for this quarter while MDHHS reviews this measure internally.

Table 13: Pharmacy Encounter Data Reporting February 2018

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	Yes	Yes	Yes

Table 14: Pharmacy Encounter Data Reporting March 2018

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	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

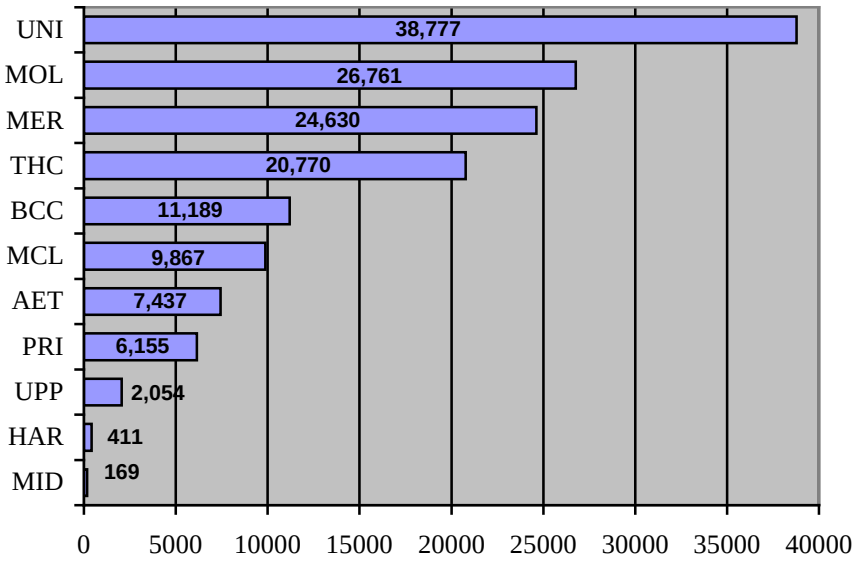
Measurement Period
October 2017 – December 2017

Data Source
MDHHS Data Exchange Gateway, Encounter Data

Measurement Frequency
Quarterly

Summary: The results shown are informational only. For MA-MC results ranged from 169 to 38,777. For HMP results ranged from 61 to 14,674. For CSHCS results ranged from 73 to 2,227.

Figure 4: NEMT MA-MC Encounter Submissions[3]



[3] Results on any of the graphs for this measure that show as "N/A" are for plans who did not submit transportation encounters for this measurement period.

Figure 5: NEMT HMP-MC Encounter Submissions

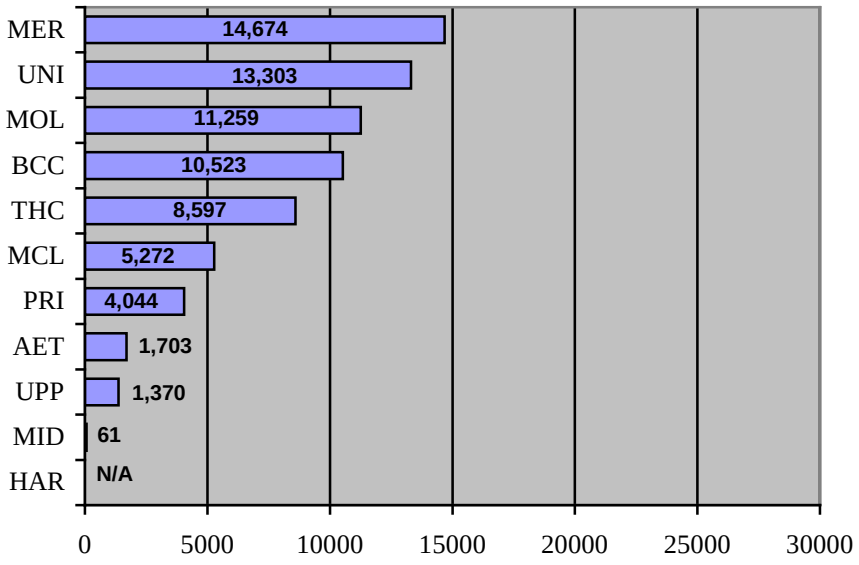
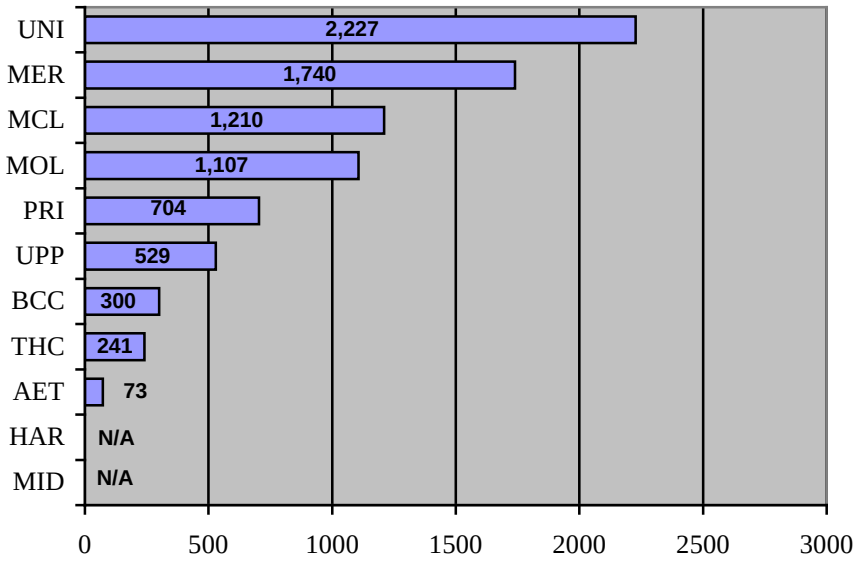


Figure 6: NEMT CSHCS-MC Encounter Submissions



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 2018 – February 2018

Data Source
MDHHS Data Exchange Gateway, Encounter Data

Measurement Frequency
Monthly

Summary: In October, November, and December, ten plans met the standard of submitting an error free provider file to Michigan ENROLLS by the last Thursday of the month, while one plan (HAR) did not.

Table 15: Provider File Reporting[4]

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

[4] Data was unavailable for January and February 2018 due to systems changes. Therefore, all plans will receive a pass for those two months.

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

Appendix B: One Year Plan-Specific Analysis

Aetna Better Health of Michigan – AET

Performance Measure	Measurement Period	Standard	Plan Result	Standard Achieved
Blood Lead Testing	Jul 17	81%	73%	**No**
	Aug 17	81%	73%	**No**
	Sep 17	81%	72%	**No**
	Oct 17	**81%**	**72%**	**No**
	Nov 17	**81%**	**72%**	**No**
	Dec 17	**81%**	**71%**	**No**

		Year 1	Result	Standard Achieved	Year 2	Result	Standard Achieved	Year 3	Result	Standard Achieved
Developmental Screening	Oct 17	26%	24.01%	**No**	33%	21.12%	**No**	26%	20.21%	**No**
	Nov 17	26%	25.16%	**No**	33%	23.61%	**No**	26%	20.90%	**No**
	Dec 17	26%	24.59%	**No**	33%	24.63%	**No**	26%	22.81%	**No**
	Jan 18	**26%**	**25.94%**	**No**	**33%**	**26.14%**	**No**	**26%**	**22.65%**	**No**
	Feb 18	**26%**	**26.48%**	**Yes**	**33%**	**24.90%**	**No**	**26%**	**21.95%**	**No**
	Mar 18	**26%**	**26.58%**	**Yes**	**33%**	**25.96%**	**No**	**26%**	**22.45%**	**No**

Complaints	Jul 17 – Sep 17	<.15/1000 MM	0.121	Yes
	Oct 17 – Dec 17	**<.15/1000 MM**	**0.023**	**Yes**

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

Claims Processing	Aug 17	T/A, ≥95%, ≤12%, ≤1.0%	T/NA, 94%, 3%, 0.54%	**No**
	Sep 17	T/A, ≥95%, ≤12%, ≤1.0%	T/NA, 90% 3%, 0.79%	**No**
	Oct 17	T/A, ≥95%, ≤12%, ≤1.0%	T/NA, 94%, 4%, 2.16%	**No**
	Nov 17	**T/A, ≥95%, ≤12%, ≤1.0%**	**T/NA, 93%, 4%, 4.38%**	**No**
	Dec 17	**T/A, ≥95%, ≤12%, ≤1.0%**	**T/NA, 94%, 4%, 5.67%**	**No**
	Jan 18	**T/A, ≥95%, ≤12%, ≤1.0%**	**T/NA, 87%, 8%, 6.96%**	**No**

Encounter Data	Oct 17	Timely, Complete	T,C	Yes
	Nov 17	Timely, Complete	T,C	Yes
	Dec 17	Timely, Complete	T,C	Yes
	Jan 18	**Timely, Complete**	**T,C**	**Yes**
	Feb 18	**Timely, Complete**	**T,C**	**Yes**
	Mar 18	**Timely, Complete**	**T,C**	**Yes**

Pharmacy Encounter Data	Oct 17	Timely, Complete	T,C	Yes
	Nov 17	Timely, Complete	T,C	Yes
	Dec 17	Timely, Complete	T,C	Yes
	Jan 18	**Timely, Complete**	**T,C**	**Yes***
	Feb 18	**Timely, Complete**	**T,C**	**Yes***
	Mar 18	**Timely, Complete**	**T,C**	**Yes***

*** All plans will receive a pass for the pharmacy encounter measure for this quarter while MDHHS reviews this measure internally.**

- 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

Aetna Better Health of Michigan – AET

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 17 – Sep 17	Info Only	7,490	N/A	Info Only	1,698	N/A	Info Only	142	N/A
	Oct 17 – Dec 17	**Info Only**	**7,437**	**N/A**	**Info Only**	**1,703**	**N/A**	**Info Only**	**73**	**N/A**

Provider File Reporting	Oct 17	Timely, Accurate	T,A	Yes
	Nov 17	Timely, Accurate	T,A	Yes
	Dec 17	Timely, Accurate	T,A	Yes
	Jan 18	**Timely, Accurate**	**T,A**	**Yes**
	Feb 18	**Timely, Accurate**	**T,A**	**Yes**
	Mar 18	**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 – BCC

Performance Measure	Measurement Period	Standard	Plan Result	Standard Achieved
Blood Lead Testing	Jul 17	81%	72%	**No**
	Aug 17	81%	73%	**No**
	Sep 17	81%	74%	**No**
	Oct 17	**81%**	**74%**	**No**
	Nov 17	**81%**	**73%**	**No**
	Dec 17	**81%**	**73%**	**No**

		Year 1	Result	Standard Achieved	Year 2	Result	Standard Achieved	Year 3	Result	Standard Achieved
Developmental Screening	Oct 17	26%	24.72%	**No**	33%	39.70%	Yes	26%	27.68%	Yes
	Nov 17	26%	25.39%	**No**	33%	36.74%	Yes	26%	26.55%	Yes
	Dec 17	26%	25.53%	**No**	33%	36.39%	Yes	26%	26.44%	Yes
	Jan 18	**26%**	**25.71%**	**No**	**33%**	**37.22%**	**Yes**	**26%**	**25.65%**	**No**
	Feb 18	**26%**	**26.57%**	**Yes**	**33%**	**36.20%**	**Yes**	**26%**	**25.87%**	**No**
	Mar 18	**26%**	**27.99%**	**Yes**	**33%**	**35.10%**	**Yes**	**26%**	**26.17%**	**Yes**

Complaints	Jul 17 – Sep 17	<.15/1000 MM	0.049	Yes
	Oct 17 – Dec 17	**<.15/1000 MM**	**0.051**	**Yes**

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

Claims Processing	Aug 17	T/A, ≥95%, ≤12%, ≤1.0%	T/A, 100%, 11%, 0.00%	Yes
	Sep 17	T/A, ≥95%, ≤12%, ≤1.0%	T/NA, 98%, 13%, 0.00%	**No**
	Oct 17	T/A, ≥95%, ≤12%, ≤1.0%	T/A, 100%, 10%, 0.00%	Yes
	Nov 17	**T/A, ≥95%, ≤12%, ≤1.0%**	**T/A, 100%, 10%, 0.00%**	**Yes**
	Dec 17	**T/A, ≥95%, ≤12%, ≤1.0%**	**T/A, 100%, 1%, 0.00%**	**Yes**
	Jan 18	**T/A, ≥95%, ≤12%, ≤1.0%**	**T/A, 100%, 12%, 0.01%**	**Yes**

Encounter Data	Oct 17	Timely, Complete	T,C	Yes
	Nov 17	Timely, Complete	T,C	Yes
	Dec 17	Timely, Complete	T,C	Yes
	Jan 18	**Timely, Complete**	**T,C**	**Yes**
	Feb 18	**Timely, Complete**	**T,C**	**Yes**
	Mar 18	**Timely, Complete**	**T,C**	**Yes**

Pharmacy Encounter Data	Oct 17	Timely, Complete	T,C	Yes
	Nov 17	Timely, Complete	T,C	Yes
	Dec 17	Timely, Complete	T,C	Yes
	Jan 18	**Timely, Complete**	**T,C**	**Yes**
	Feb 18	**Timely, Complete**	**T,C**	**Yes**
	Mar 18	**Timely, Complete**	**T,C**	**Yes**

*** All plans will receive a pass for the pharmacy encounter measure for this quarter while MDHHS reviews this measure internally.**

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

Appendix B: One Year Plan-Specific Analysis

Blue Cross Complete of Michigan – BCC

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 17 – Sep 17	Info Only	11,797	N/A	Info Only	10,967	N/A	Info Only	378	N/A
	Oct 17 – Dec 17	**Info Only**	**11,189**	**N/A**	**Info Only**	**10,523**	**N/A**	**Info Only**	**300**	**N/A**

Provider File Reporting	Oct 17	Timely, Accurate	T,A	Yes
	Nov 17	Timely, Accurate	T,A	Yes
	Dec 17	Timely, Accurate	T,A	Yes
	Jan 18	**Timely, Accurate**	**T,A**	**Yes**
	Feb 18	**Timely, Accurate**	**T,A**	**Yes**
	Mar 18	**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 – HAR

Performance Measure	Measurement Period	Standard	Plan Result	Standard Achieved
Blood Lead Testing	Jul 17	81%	75%	**No**
	Aug 17	81%	76%	**No**
	Sep 17	81%	76%	**No**
	Oct 17	**81%**	**82%**	**Yes**
	Nov 17	**81%**	**77%**	**No**
	Dec 17	**81%**	**72%**	**No**

		Year 1	Result	Standard Achieved	Year 2	Result	Standard Achieved	Year 3	Result	Standard Achieved
Developmental Screening	Oct 17	26%	26.23%	Yes	33%	41.38%	Yes	26%	23.38%	**No**
	Nov 17	26%	23.88%	**No**	33%	42.50%	Yes	26%	24.72%	**No**
	Dec 17	26%	27.54%	Yes	33%	40.35%	Yes	26%	23.96%	**No**
	Jan 18	**26%**	**25.00%**	**No**	**33%**	**32.91%**	**No**	**26%**	**23.48%**	**No**
	Feb 18	**26%**	**24.39%**	**No**	**33%**	**33.33%**	**Yes**	**26%**	**24.62%**	**No**
	Mar 18	**26%**	**24.71%**	**No**	**33%**	**28.57%**	**No**	**26%**	**24.65%**	**No**

Complaints	Jul 17 – Sep 17	<.15/1000 MM	0.080	Yes
	Oct 17 – Dec 17	**<.15/1000 MM**	**0.084**	**Yes**

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

Claims Processing	Aug 17	T/A, ≥95%, ≤12%, ≤1.0%	T/A, 100%, 0%, 0.00%	Yes
	Sep 17	T/A, ≥95%, ≤12%, ≤1.0%	T/NA, 84%, 0%, 27.48%	**No**
	Oct 17	T/A, ≥95%, ≤12%, ≤1.0%	T/NA, 41%, 50%, 22.47%	**No**
	Nov 17	**T/A, ≥95%, ≤12%, ≤1.0%**	**T/NA, 78%, 0%, 69.60%**	**No**
	Dec 17	**T/A, ≥95%, ≤12%, ≤1.0%**	**T/NA, 93%, 0%, 141.80%**	**No**
	Jan 18	**T/A, ≥95%, ≤12%, ≤1.0%**	**T/NA, 72%, 0%, 48.10%**	**No**

Encounter Data	Oct 17	Timely, Complete	NT,NC	**No**
	Nov 17	Timely, Complete	T,C	Yes
	Dec 17	Timely, Complete	T, NC	**No**
	Jan 18	**Timely, Complete**	**T,C**	**Yes**
	Feb 18	**Timely, Complete**	**T,C**	**Yes**
	Mar 18	**Timely, Complete**	**T,C**	**Yes**

Pharmacy Encounter Data	Oct 17	Timely, Complete	T,C	Yes
	Nov 17	Timely, Complete	T,NC	**No**
	Dec 17	Timely, Complete	NT,NC	**No**
	Jan 18	**Timely, Complete**	**T,C**	**Yes**
	Feb 18	**Timely, Complete**	**T,C**	**Yes**
	Mar 18	**Timely, Complete**	**T,C**	**Yes**

*** All plans will receive a pass for the pharmacy encounter measure for this quarter while MDHHS reviews this measure internally.**

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

Appendix B: One Year Plan-Specific Analysis

Harbor Health Plan – HAR

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 17 – Sep 17	Info Only	N/A	N/A	Info Only	N/A	N/A	Info Only	N/A	N/A
	Oct 17 – Dec 17	**Info Only**	**411**	**N/A**	**Info Only**	**N/A**	**N/A**	**Info Only**	**N/A**	**N/A**

"N/A" in the Results column indicate that no transportation encounters were submitted for the measurement period.

Provider File Reporting	Oct 17	Timely, Accurate	NT,NA	**No**
	Nov 17	Timely, Accurate	NT,NA	**No**
	Dec 17	Timely, Accurate	NT,NA	**No**
	Jan 18	**Timely, Accurate**	**T,A**	**Yes**
	Feb 18	**Timely, Accurate**	**T,A**	**Yes**
	Mar 18	**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

Performance Monitoring Report

Appendix B: One Year Plan-Specific Analysis

McLaren Health Plan – MCL

Performance Measure	Measurement Period	Standard	Plan Result	Standard Achieved
Blood Lead Testing	Jul 17	81%	84%	Yes
	Aug 17	81%	83%	Yes
	Sep 17	81%	83%	Yes
	Oct 17	**81%**	**83%**	**Yes**
	Nov 17	**81%**	**82%**	**Yes**
	Dec 17	**81%**	**81%**	**Yes**

		Year 1	Result	Standard Achieved	Year 2	Result	Standard Achieved	Year 3	Result	Standard Achieved
Developmental Screening	Oct 17	26%	29.53%	Yes	33%	40.22%	Yes	26%	31.34%	Yes
	Nov 17	26%	29.56%	Yes	33%	40.40%	Yes	26%	32.63%	Yes
	Dec 17	26%	29.83%	Yes	33%	33.90%	Yes	26%	33.92%	Yes
	Jan 18	**26%**	**30.13%**	**Yes**	**33%**	**40.11%**	**Yes**	**26%**	**33.58%**	**Yes**
	Feb 18	**26%**	**29.86%**	**Yes**	**33%**	**40.36%**	**Yes**	**26%**	**32.76%**	**Yes**
	Mar 18	**26%**	**31.04%**	**Yes**	**33%**	**40.68%**	**Yes**	**26%**	**32.89%**	**Yes**

Complaints	Jul 17 – Sep 17	<.15/1000 MM	0.051	Yes
	Oct 17 – Dec 17	**<.15/1000 MM**	**0.038**	**Yes**

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

Claims Processing	Aug 17	T/A, ≥95%, ≤12%, ≤1.0%	T/A, 100%, 5%, 0.12%	Yes
	Sep 17	T/A, ≥95%, ≤12%, ≤1.0%	T/A, 100%, 6%, 0.03%	Yes
	Oct 17	T/A, ≥95%, ≤12%, ≤1.0%	T/A, 100%, 6%, 0.03%	Yes
	Nov 17	**T/A, ≥95%, ≤12%, ≤1.0%**	**T/A, 100%, 5%, 0.05%**	**Yes**
	Dec 17	**T/A, ≥95%, ≤12%, ≤1.0%**	**T/A, 100%, 5%, 0.13%**	**Yes**
	Jan 18	**T/A, ≥95%, ≤12%, ≤1.0%**	**T/A, 99%, 6%, 0.11%**	**Yes**

Encounter Data	Oct 17	Timely, Complete	T,C	Yes
	Nov 17	Timely, Complete	T,C	Yes
	Dec 17	Timely, Complete	T,C	Yes
	Jan 18	**Timely, Complete**	**T,C**	**Yes**
	Feb 18	**Timely, Complete**	**T,C**	**Yes**
	Mar 18	**Timely, Complete**	**T,C**	**Yes**

Pharmacy Encounter Data	Oct 17	Timely, Complete	T,C	Yes
	Nov 17	Timely, Complete	T,C	Yes
	Dec 17	Timely, Complete	T,C	Yes
	Jan 18	**Timely, Complete**	**T,C**	**Yes**
	Feb 18	**Timely, Complete**	**T,C**	**Yes**
	Mar 18	**Timely, Complete**	**T,C**	**Yes**

*** All plans will receive a pass for the pharmacy encounter measure for this quarter while MDHHS reviews this measure internally.**

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

Appendix B: One Year Plan-Specific Analysis

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 17 – Sep 17	Info Only	9,150	N/A	Info Only	4,963	N/A	Info Only	950	N/A
	Oct 17 – Dec 17	**Info Only**	**9,867**	**N/A**	**Info Only**	**5,272**	**N/A**	**Info Only**	**1,210**	**N/A**

Provider File Reporting	Oct 17	Timely, Accurate	T,A	Yes
	Nov 17	Timely, Accurate	T,A	Yes
	Dec 17	Timely, Accurate	T,A	Yes
	Jan 18	**Timely, Accurate**	**T,A**	**Yes**
	Feb 18	**Timely, Accurate**	**T,A**	**Yes**
	Mar 18	**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 Specification

Performance Monitoring Report

Appendix B: One Year Plan-Specific Analysis

Meridian Health Plan – MER

Performance Measure	Measurement Period	Standard	Plan Result	Standard Achieved
Blood Lead Testing	Jul 17	81%	78%	**No**
	Aug 17	81%	78%	**No**
	Sep 17	81%	78%	**No**
	Oct 17	**81%**	**78%**	**No**
	Nov 17	**81%**	**77%**	**No**
	Dec 17	**81%**	**77%**	**No**

		Year 1	Result	Standard Achieved	Year 2	Result	Standard Achieved	Year 3	Result	Standard Achieved
Developmental Screening	Oct 17	26%	28.30%	Yes	33%	35.49%	Yes	26%	30.28%	Yes
	Nov 17	26%	28.61%	Yes	33%	36.49%	Yes	26%	30.34%	Yes
	Dec 17	26%	28.58%	Yes	33%	36.75%	Yes	26%	30.17%	Yes
	Jan 18	**26%**	**28.99%**	**Yes**	**33%**	**36.59%**	**Yes**	**26%**	**30.61%**	**Yes**
	Feb 18	**26%**	**29.15%**	**Yes**	**33%**	**36.77%**	**Yes**	**26%**	**30.39%**	**Yes**
	Mar 18	**26%**	**29.61%**	**Yes**	**33%**	**37.10%**	**Yes**	**26%**	**30.71%**	**Yes**

Complaints	Jul 17 – Sep 17	<.15/1000 MM	0.102	Yes
	Oct 17 – Dec 17	**<.15/1000 MM**	**0.041**	**Yes**

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

Claims Processing	Aug 17	T/A, ≥95%, ≤12%, ≤1.0%	T/NA, 93%, 6%, 0.00%	**No**
	Sep 17	T/A, ≥95%, ≤12%, ≤1.0%	T/A, 95%, 8%, 0.00%	Yes
	Oct 17	T/A, ≥95%, ≤12%, ≤1.0%	T/NA, 93%, 10%, 0.00%	**No**
	Nov 17	**T/A, ≥95%, ≤12%, ≤1.0%**	**T/A, 97%, 8%, 0.00%**	**Yes**
	Dec 17	**T/A, ≥95%, ≤12%, ≤1.0%**	**T/A, 99%, 8%, 0.00%**	**Yes**
	Jan 18	**T/A, ≥95%, ≤12%, ≤1.0%**	**T/A, 98%, 9%, 0.55%**	**Yes**

Encounter Data	Oct 17	Timely, Complete	T,C	Yes
	Nov 17	Timely, Complete	T,C	Yes
	Dec 17	Timely, Complete	T,C	Yes
	Jan 18	**Timely, Complete**	**T,C**	**Yes**
	Feb 18	**Timely, Complete**	**T,C**	**Yes**
	Mar 18	**Timely, Complete**	**T,C**	**Yes**

Pharmacy Encounter Data	Oct 17	Timely, Complete	T,C	Yes
	Nov 17	Timely, Complete	T,C	Yes
	Dec 17	Timely, Complete	T,C	Yes
	Jan 18	**Timely, Complete**	**T,C**	**Yes**
	Feb 18	**Timely, Complete**	**T,C**	**Yes**
	Mar 18	**Timely, Complete**	**T,C**	**Yes**

*** All plans will receive a pass for the pharmacy encounter measure for this quarter while MDHHS reviews this measure internally.**

- 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			
		MA-MC Standard	MA-MC Result	Standard Achieved	HMP Standard	HMP Result	Standard Achieved	CSHCS Standard	CSHCS Result	Standard Achieved
NEMT Encounter Submission	Jul 17 – Sep 17	Info Only	32,720	N/A	Info Only	23,023	N/A	Info Only	2,165	N/A
	Oct 17 – Dec 17	**Info Only**	**24,630**	**N/A**	**Info Only**	**14,674**	**N/A**	**Info Only**	**1,740**	**N/A**

Provider File Reporting	Oct 17	Timely, Accurate	T,A	Yes
	Nov 17	Timely, Accurate	T,A	Yes
	Dec 17	Timely, Accurate	T,A	Yes
	Jan 18	**Timely, Accurate**	**T,A**	**Yes**
	Feb 18	**Timely, Accurate**	**T,A**	**Yes**
	Mar 18	**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 – MID

Performance Measure	Measurement Period	Standard	Plan Result	Standard Achieved
Blood Lead Testing	Jul 17	81%	82%	Yes
	Aug 17	81%	73%	**No**
	Sep 17	81%	82%	Yes
	Oct 17	**81%**	**82%**	**Yes**
	Nov 17	**81%**	**75%**	**No**
	Dec 17	**81%**	**77%**	**No**

		Year 1	Result	Standard Achieved	Year 2	Result	Standard Achieved	Year 3	Result	Standard Achieved
Developmental Screening	Oct 17	26%	40.00%	Yes	33%	42.86%	Yes	26%	20.00%	**No**
	Nov 17	26%	33.33%	Yes	33%	42.86%	Yes	26%	16.67%	**No**
	Dec 17	26%	28.57%	Yes	33%	37.50%	Yes	26%	20.00%	**No**
	Jan 18	**26%**	**25.00%**	**No**	**33%**	**40.00%**	**Yes**	**26%**	**14.29%**	**No**
	Feb 18	**26%**	**22.22%**	**No**	**33%**	**26.67%**	**No**	**26%**	**17.39%**	**No**
	Mar 18	**26%**	**12.50%**	**No**	**33%**	**22.22%**	**No**	**26%**	**20.00%**	**No**

Complaints	Jul 17 – Sep 17	<.15/1000 MM	0.121	Yes
	Oct 17 – Dec 17	**<.15/1000 MM**	**0.127**	**Yes**

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

Claims Processing	Aug 17	T/A, ≥95%, ≤12%, ≤1.0%	T/A, 100%, 10%, 0.00%	Yes
	Sep 17	T/A, ≥95%, ≤12%, ≤1.0%	T/A, 100%, 10%, 0.00%	Yes
	Oct 17	T/A, ≥95%, ≤12%, ≤1.0%	T/NA, 100%, 12%, 0.00%	**No**
	Nov 17	**T/A, ≥95%, ≤12%, ≤1.0%**	**T/A, 100%, 8%, 0.00%**	**Yes**
	Dec 17	**T/A, ≥95%, ≤12%, ≤1.0%**	**T/A, 100%, 7%, 0.00%**	**Yes**
	Jan 18	**T/A, ≥95%, ≤12%, ≤1.0%**	**T/A, 100%, 7%, 0.00%**	**Yes**

Encounter Data	Oct 17	Timely, Complete	T,C	Yes
	Nov 17	Timely, Complete	T,C	Yes
	Dec 17	Timely, Complete	T,C	Yes
	Jan 18	**Timely, Complete**	**T,C**	**Yes**
	Feb 18	**Timely, Complete**	**T,C**	**Yes**
	Mar 18	**Timely, Complete**	**T,NC**	**No**

Pharmacy Encounter Data	Oct 17	Timely, Complete	T,NC	**No**
	Nov 17	Timely, Complete	T,NC	**No**
	Dec 17	Timely, Complete	T,NC	**No**
	Jan 18	**Timely, Complete**	**T,C**	**Yes**
	Feb 18	**Timely, Complete**	**T,C**	**Yes**
	Mar 18	**Timely, Complete**	**T,C**	**Yes**

*** All plans will receive a pass for the pharmacy encounter measure for this quarter while MDHHS reviews this measure internally.**

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

Appendix B: One Year Plan-Specific Analysis

HAP Midwest Health Plan – MID

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 17 – Sep 17	Info Only	180	N/A	Info Only	22	N/A	Info Only	4	N/A
	Oct 17 – Dec 17	**Info Only**	**169**	**N/A**	**Info Only**	**61**	**N/A**	**Info Only**	**N/A**	**N/A**

Provider File Reporting	Oct 17	Timely, Accurate	T,A	Yes
	Nov 17	Timely, Accurate	T,A	Yes
	Dec 17	Timely, Accurate	T,A	Yes
	Jan 18	**Timely, Accurate**	**T,A**	**Yes**
	Feb 18	**Timely, Accurate**	**T,A**	**Yes**
	Mar 18	**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 17	81%	75%	**No**
	Aug 17	81%	75%	**No**
	Sep 17	81%	75%	**No**
	Oct 17	**81%**	**75%**	**No**
	Nov 17	**81%**	**74%**	**No**
	Dec 17	**81%**	**74%**	**No**

		Year 1	Result	Standard Achieved	Year 2	Result	Standard Achieved	Year 3	Result	Standard Achieved
Developmental Screening	Oct 17	26%	27.76%	Yes	33%	36.48%	Yes	26%	28.12%	Yes
	Nov 17	26%	27.31%	Yes	33%	35.01%	Yes	26%	27.21%	Yes
	Dec 17	26%	27.10%	Yes	33%	33.79%	Yes	26%	26.98%	Yes
	Jan 18	**26%**	**26.94%**	**Yes**	**33%**	**33.90%**	**Yes**	**26%**	**26.86%**	**Yes**
	Feb 18	**26%**	**26.81%**	**Yes**	**33%**	**33.27%**	**Yes**	**26%**	**27.05%**	**Yes**
	Mar 18	**26%**	**26.98%**	**Yes**	**33%**	**32.99%**	**No**	**26%**	**26.97%**	**Yes**

Complaints	Jul 17 – Sep 17	<.15/1000 MM	0.105	Yes
	Oct 17 – Dec 17	**<.15/1000 MM**	**0.069**	**Yes**

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

Claims Processing	Aug 17	T/A, ≥95%, ≤12%, ≤1.0%	T/A, 100%, 2%, 0.03%	Yes
	Sep 17	T/A, ≥95%, ≤12%, ≤1.0%	T/A, 100%, 2%, 0.01%	Yes
	Oct 17	T/A, ≥95%, ≤12%, ≤1.0%	T/A, 100%, 2%, 0.03%	Yes
	Nov 17	**T/A, ≥95%, ≤12%, ≤1.0%**	**T/A, 100%, 2%, 0.04%**	**Yes**
	Dec 17	**T/A, ≥95%, ≤12%, ≤1.0%**	**T/A, 100%, 2%, 0.01%**	**Yes**
	Jan 18	**T/A, ≥95%, ≤12%, ≤1.0%**	**T/A, 100%, 2%, 0.03%**	**Yes**

Encounter Data	Oct 17	Timely, Complete	T,C	Yes
	Nov 17	Timely, Complete	T,C	Yes
	Dec 17	Timely, Complete	T,C	Yes
	Jan 18	**Timely, Complete**	**T,C**	**Yes**
	Feb 18	**Timely, Complete**	**T,C**	**Yes**
	Mar 18	**Timely, Complete**	**T,C**	**Yes**

Pharmacy Encounter Data	Oct 17	Timely, Complete	T,C	Yes
	Nov 17	Timely, Complete	T,C	Yes
	Dec 17	Timely, Complete	T,C	Yes
	Jan 18	**Timely, Complete**	**T,C**	**Yes**
	Feb 18	**Timely, Complete**	**T,C**	**Yes**
	Mar 18	**Timely, Complete**	**T,C**	**Yes**

*** All plans will receive a pass for the pharmacy encounter measure for this quarter while MDHHS reviews this measure internally.**

- 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			
		MA-MC Standard	MA-MC Result	Standard Achieved	HMP Standard	HMP Result	Standard Achieved	CSHCS Standard	CSHCS Result	Standard Achieved
NEMT Encounter Submission	Jul 17 – Sep 17	Info Only	23,399	N/A	Info Only	9,625	N/A	Info Only	1,066	N/A
	Oct 17 – Dec 17	**Info Only**	**26,761**	**N/A**	**Info Only**	**11,259**	**N/A**	**Info Only**	**1,107**	**N/A**

Provider File Reporting	Oct 17	Timely, Accurate	T,A	Yes
	Nov 17	Timely, Accurate	T,A	Yes
	Dec 17	Timely, Accurate	T,A	Yes
	Jan 18	**Timely, Accurate**	**T,A**	**Yes**
	Feb 18	**Timely, Accurate**	**T,A**	**Yes**
	Mar 18	**Timely, Accurate**	**NT,NA**	**No**

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

Appendix B: One Year Plan-Specific Analysis

Priority Health Choice – PRI

Performance Measure	Measurement Period	Standard	Plan Result	Standard Achieved
Blood Lead Testing	Jul 17	81%	82%	Yes
	Aug 17	81%	82%	Yes
	Sep 17	81%	82%	Yes
	Oct 17	**81%**	**80%**	**No**
	Nov 17	**81%**	**79%**	**No**
	Dec 17	**81%**	**79%**	**No**

		Year 1	Result	Standard Achieved	Year 2	Result	Standard Achieved	Year 3	Result	Standard Achieved
Developmental Screening	Oct 17	26%	30.52%	Yes	33%	42.82%	Yes	26%	35.92%	Yes
	Nov 17	26%	30.29%	Yes	33%	42.78%	Yes	26%	36.71%	Yes
	Dec 17	26%	30.21%	Yes	33%	41.53%	Yes	26%	37.40%	Yes
	Jan 18	**26%**	**30.71%**	**Yes**	**33%**	**41.86%**	**Yes**	**26%**	**38.51%**	**Yes**
	Feb 18	**26%**	**31.86%**	**Yes**	**33%**	**41.26%**	**Yes**	**26%**	**38.17%**	**Yes**
	Mar 18	**26%**	**31.76%**	**Yes**	**33%**	**42.63%**	**Yes**	**26%**	**38.03%**	**Yes**

Complaints	Jul 17 – Sep 17	<.15/1000 MM	0.045	Yes
	Oct 17 – Dec 17	**<.15/1000 MM**	**0.032**	**Yes**

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

Claims Processing	Aug 17	T/A, ≥95%, ≤12%, ≤1.0%	T/A, 99%, 5%, 0.19%	Yes
	Sep 17	T/A, ≥95%, ≤12%, ≤1.0%	T/A, 99%, 6%, 0.44%	Yes
	Oct 17	T/A, ≥95%, ≤12%, ≤1.0%	T/A, 99%, 7%, 0.96%	Yes
	Nov 17	**T/A, ≥95%, ≤12%, ≤1.0%**	**T/NA, 93%, 7%, 0.19%**	**No**
	Dec 17	**T/A, ≥95%, ≤12%, ≤1.0%**	**T/A, 99%, 8%, 0.22%**	**Yes**
	Jan 18	**T/A, ≥95%, ≤12%, ≤1.0%**	**T/A, 99%, 8%, 0.33%**	**Yes**

Encounter Data	Oct 17	Timely, Complete	T,C	Yes
	Nov 17	Timely, Complete	T,C	Yes
	Dec 17	Timely, Complete	T,C	Yes
	Jan 18	**Timely, Complete**	**T,C**	**Yes**
	Feb 18	**Timely, Complete**	**T,C**	**Yes**
	Mar 18	**Timely, Complete**	**T,C**	**Yes**

Pharmacy Encounter Data	Oct 17	Timely, Complete	T,C	Yes
	Nov 17	Timely, Complete	T,C	Yes
	Dec 17	Timely, Complete	T,C	Yes
	Jan 18	**Timely, Complete**	**T,C**	**Yes**
	Feb 18	**Timely, Complete**	**T,C**	**Yes**
	Mar 18	**Timely, Complete**	**T,C**	**Yes**

*** All plans will receive a pass for the pharmacy encounter measure for this quarter while MDHHS reviews this measure internally.**

- 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		
		MA-MC Standard	MA-MC Result	Standard Achieved	HMP Standard	HMP Result	Standard Achieved	CSHCS Standard	CSHCS Result	Standard Achieved
NEMT Encounter Submission	Jul 17 – Sep 17	Info Only	5,768	N/A	Info Only	3,748	N/A	Info Only	778	N/A
	Oct 17 – Dec 17	**Info Only**	**6,155**	**N/A**	**Info Only**	**4,044**	**N/A**	**Info Only**	**704**	**N/A**

Provider File Reporting	Oct 17	Timely, Accurate	T,A	Yes
	Nov 17	Timely, Accurate	T,A	Yes
	Dec 17	Timely, Accurate	T,A	Yes
	Jan 18	**Timely, Accurate**	**T,A**	**Yes**
	Feb 18	**Timely, Accurate**	**T,A**	**Yes**
	Mar 18	**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

Total Health Care – THC

Performance Measure	Measurement Period	Standard	Plan Result	Standard Achieved
Blood Lead Testing	Jul 17	81%	65%	**No**
	Aug 17	81%	65%	**No**
	Sep 17	81%	66%	**No**
	Oct 17	**81%**	**67%**	**No**
	Nov 17	**81%**	**67%**	**No**
	Dec 17	**81%**	**68%**	**No**

		Year 1	Result	Standard Achieved	Year 2	Result	Standard Achieved	Year 3	Result	Standard Achieved
Developmental Screening	Oct 17	26%	22.96%	**No**	33%	28.71%	**No**	26%	28.03%	Yes
	Nov 17	26%	23.12%	**No**	33%	31.21%	**No**	26%	28.26%	Yes
	Dec 17	26%	23.52%	**No**	33%	33.60%	Yes	26%	26.01%	Yes
	Jan 18	**26%**	**24.62%**	**No**	**33%**	**34.08%**	**Yes**	**26%**	**26.59%**	**Yes**
	Feb 18	**26%**	**25.59%**	**No**	**33%**	**34.39%**	**Yes**	**26%**	**26.75%**	**Yes**
	Mar 18	**26%**	**26.83%**	**Yes**	**33%**	**33.99%**	**Yes**	**26%**	**25.70%**	**No**

Complaints	Jul 17 – Sep 17	<.15/1000 MM	0.055	Yes
	Oct 17 – Dec 17	**<.15/1000 MM**	**0.056**	**Yes**

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

Claims Processing	Aug 17	T/A, ≥95%, ≤12%, ≤1.0%	T/A, 100%, 2%, 0.00%	Yes
	Sep 17	T/A, ≥95%, ≤12%, ≤1.0%	T/A, 100%, 2%, 0.00%	Yes
	Oct 17	T/A, >95%, <12%, <1.0%	T/A, 98%, 2%, 0.00%	Yes
	Nov 17	**T/A, ≥95%, ≤12%, ≤1.0%**	**T/A, 100%, 2%, 0.00%**	**Yes**
	Dec 17	**T/A, ≥95%, ≤12%, ≤1.0%**	**T/A, 100%, 2%, 0.00%**	**Yes**
	Jan 18	**T/A, ≥95%, ≤12%, ≤1.0%**	**T/A, 100%, 2%, 0.00%**	**Yes**

Encounter Data	Oct 17	Timely, Complete	T,C	Yes
	Nov 17	Timely, Complete	T,C	Yes
	Dec 17	Timely, Complete	T,C	Yes
	Jan 18	**Timely, Complete**	**T,C**	**Yes**
	Feb 18	**Timely, Complete**	**T,C**	**Yes**
	Mar 18	**Timely, Complete**	**T,C**	**Yes**

Pharmacy Encounter Data	Oct 17	Timely, Complete	T,C	Yes
	Nov 17	Timely, Complete	T,C	Yes
	Dec 17	Timely, Complete	T,C	Yes
	Jan 18	**Timely, Complete**	**T,C**	**Yes**
	Feb 18	**Timely, Complete**	**T,C**	**Yes**
	Mar 18	**Timely, Complete**	**T,C**	**Yes**

*** All plans will receive a pass for the pharmacy encounter measure for this quarter while MDHHS reviews this measure internally.**

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

Appendix B: One Year Plan-Specific Analysis

Total Health Care – THC

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 17 – Sep 17	Info Only	16,265	N/A	Info Only	6,955	N/A	Info Only	194	N/A
	Oct 17 – Dec 17	**Info Only**	**20,770**	**N/A**	**Info Only**	**8,597**	**N/A**	**Info Only**	**241**	**N/A**

Provider File Reporting	Oct 17	Timely, Accurate	T,A	Yes
	Nov 17	Timely, Accurate	T,A	Yes
	Dec 17	Timely, Accurate	T,A	Yes
	Jan 18	**Timely, Accurate**	**T,A**	**Yes**
	Feb 18	**Timely, Accurate**	**T,A**	**Yes**
	Mar 18	**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

UnitedHealthcare Community Plan – UNI

Performance Measure	Measurement Period	Standard	Plan Result	Standard Achieved
Blood Lead Testing	Jul 17	81%	76%	**No**
	Aug 17	81%	77%	**No**
	Sep 17	81%	77%	**No**
	Oct 17	**81%**	**77%**	**No**
	Nov 17	**81%**	**77%**	**No**
	Dec 17	**81%**	**77%**	**No**

		Year 1	Result	Standard Achieved	Year 2	Result	Standard Achieved	Year 3	Result	Standard Achieved
Developmental Screening	Oct 17	26%	28.32%	Yes	33%	37.30%	Yes	26%	28.86%	Yes
	Nov 17	26%	29.13%	Yes	33%	36.27%	Yes	26%	29.34%	Yes
	Dec 17	26%	29.26%	Yes	33%	36.97%	Yes	26%	30.41%	Yes
	Jan 18	**26%**	**30.53%**	**Yes**	**33%**	**38.21%**	**Yes**	**26%**	**30.62%**	**Yes**
	Feb 18	**26%**	**30.85%**	**Yes**	**33%**	**38.37%**	**Yes**	**26%**	**30.57%**	**Yes**
	Mar 18	**26%**	**31.66%**	**Yes**	**33%**	**39.34%**	**Yes**	**26%**	**30.72%**	**Yes**

Complaints	Jul 17 – Sep 17	<.15/1000 MM	0.058	Yes
	Oct 17 – Dec 17	**<.15/1000 MM**	**0.052**	**Yes**

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

Claims Processing	Aug 17	T/A, ≥95%, ≤12%, ≤1.0%	T/A, 100%, 8%, 0.58%	Yes
	Sep 17	T/A, ≥95%, ≤12%, ≤1.0%	T/A, 100%, 9%, 0.06%	Yes
	Oct 17	T/A, ≥95%, ≤12%, ≤1.0%	T/A, 100%, 9%, 0.07%	Yes
	Nov 17	**T/A, ≥95%, ≤12%, ≤1.0%**	**T/A, 100%, 9%, 0.09%**	**Yes**
	Dec 17	**T/A, ≥95%, ≤12%, ≤1.0%**	**T/A, 100%, 9%, 0.11%**	**Yes**
	Jan 18	**T/A, ≥95%, ≤12%, ≤1.0%**	**T/A, 99%, 8%, 0.11%**	**Yes**

Encounter Data	Oct 17	Timely, Complete	T,C	Yes
	Nov 17	Timely, Complete	T,C	Yes
	Dec 17	Timely, Complete	T,C	Yes
	Jan 18	**Timely, Complete**	**T,C**	**Yes**
	Feb 18	**Timely, Complete**	**T,C**	**Yes**
	Mar 18	**Timely, Complete**	**T,C**	**Yes**

Pharmacy Encounter Data	Oct 17	Timely, Complete	T,C	Yes
	Nov 17	Timely, Complete	T,C	Yes
	Dec 17	Timely, Complete	T,C	Yes
	Jan 18	**Timely, Complete**	**T,C**	**Yes**
	Feb 18	**Timely, Complete**	**T,C**	**Yes**
	Mar 18	**Timely, Complete**	**T,C**	**Yes**

*** All plans will receive a pass for the pharmacy encounter measure for this quarter while MDHHS reviews this measure internally.**

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

Appendix B: One Year Plan-Specific Analysis

UnitedHealthcare Community Plan – UNI

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 17 – Sep 17	Info Only	39,224	N/A	Info Only	13,391	N/A	Info Only	1,908	N/A
	Oct 17 – Dec 17	**Info Only**	**38,777**	**N/A**	**Info Only**	**13,303**	**N/A**	**Info Only**	**2,227**	**N/A**

Provider File Reporting	Oct 17	Timely, Accurate	T,A	Yes
	Nov 17	Timely, Accurate	T,A	Yes
	Dec 17	Timely, Accurate	T,A	Yes
	Jan 18	**Timely, Accurate**	**T,A**	**Yes**
	Feb 18	**Timely, Accurate**	**T,A**	**Yes**
	Mar 18	**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

Performance Monitoring Report

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 17	81%	84%	Yes
	Aug 17	81%	85%	Yes
	Sep 17	81%	85%	Yes
	Oct 17	**81%**	**85%**	**Yes**
	Nov 17	**81%**	**84%**	**Yes**
	Dec 17	**81%**	**83%**	**Yes**

		Year 1	Result	Standard Achieved	Year 2	Result	Standard Achieved	Year 3	Result	Standard Achieved
Developmental Screening	Oct 17	26%	16.62%	**No**	33%	18.24%	**No**	26%	14.84%	**No**
	Nov 17	26%	18.68%	**No**	33%	20.73%	**No**	26%	16.96%	**No**
	Dec 17	26%	19.40%	**No**	33%	22.08%	**No**	26%	17.40%	**No**
	Jan 18	**26%**	**20.90%**	**No**	**33%**	**22.70%**	**No**	**26%**	**17.83%**	**No**
	Feb 18	**26%**	**22.24%**	**No**	**33%**	**24.06%**	**No**	**26%**	**18.28%**	**No**
	Mar 18	**26%**	**23.33%**	**No**	**33%**	**26.69%**	**No**	**26%**	**19.23%**	**No**

Complaints	Jul 17 – Sep 17	<.15/1000 MM	0.045	Yes
	Oct 17 – Dec 17	**<.15/1000 MM**	**0.008**	**Yes**

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

Claims Processing	Aug 17	T/A, ≥95%, ≤12%, ≤1.0%	T/A, 100%, 10%, 0.00%	Yes
	Sep 17	T/A, ≥95%, ≤12%, ≤1.0%	T/A, 99%, 13%, 0.00%	**No**
	Oct 17	T/A, ≥95%, ≤12%, ≤1.0%	T/A, 99%, 11%, 0.00%	Yes
	Nov 17	**T/A, ≥95%, ≤12%, ≤1.0%**	**T/A, 100%, 10%, 0.00%**	**Yes**
	Dec 17	**T/A, ≥95%, ≤12%, ≤1.0%**	**T/A, 100%, 10%, 0.00%**	**Yes**
	Jan 18	**T/A, ≥95%, ≤12%, ≤1.0%**	**T/NA, 99%, 14%, 0.00%**	**No**

Encounter Data	Oct 17	Timely, Complete	T,C	Yes
	Nov 17	Timely, Complete	T,C	Yes
	Dec 17	Timely, Complete	T,C	Yes
	Jan 18	**Timely, Complete**	**T,NC**	**No**
	Feb 18	**Timely, Complete**	**T,NC**	**No**
	Mar 18	**Timely, Complete**	**T,C**	**Yes**

Pharmacy Encounter Data	Oct 17	Timely, Complete	T,C	Yes
	Nov 17	Timely, Complete	T,C	Yes
	Dec 17	Timely, Complete	T,C	Yes
	Jan 18	**Timely, Complete**	**T,C**	**Yes**
	Feb 18	**Timely, Complete**	**T,C**	**Yes**
	Mar 18	**Timely, Complete**	**T,C**	**Yes**

*** All plans will receive a pass for the pharmacy encounter measure for this quarter while MDHHS reviews this measure internally.**

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

Appendix B: One Year Plan-Specific Analysis

Upper Peninsula Health Plan – UPP

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 17 – Sep 17	Info Only	1,851	N/A	Info Only	1,303	N/A	Info Only	486	N/A
	Oct 17 – Dec 17	**Info Only**	**2,054**	**N/A**	**Info Only**	**1,370**	**N/A**	**Info Only**	**529**	**N/A**

Provider File Reporting	Oct 17	Timely, Accurate	T,A	Yes
	Nov 17	Timely, Accurate	T,A	Yes
	Dec 17	Timely, Accurate	T,A	Yes
	Jan 18	**Timely, Accurate**	**T,A**	**Yes**
	Feb 18	**Timely, Accurate**	**T,A**	**Yes**
	Mar 18	**Timely, Accurate**	**NT,NA**	**No**

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

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

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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.

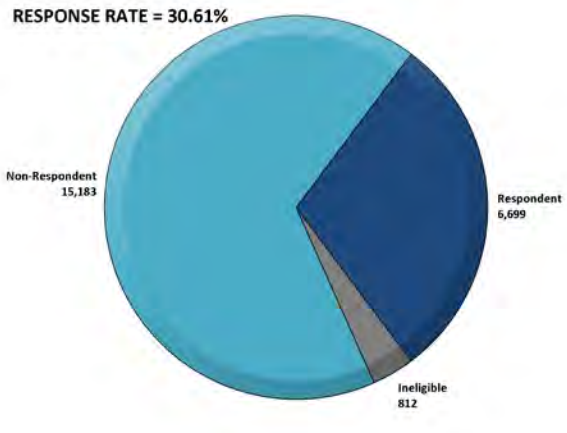
Key Findings

Survey Dispositions and Demographics

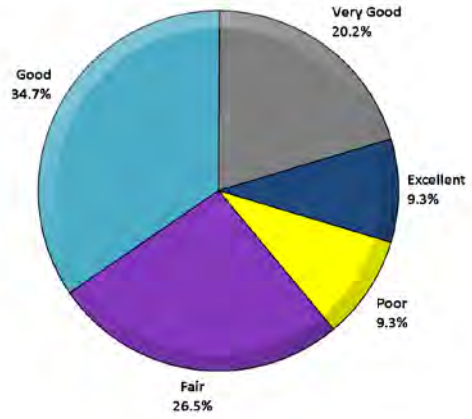
Figure 1-1 provides an overview of the MDHHS Medicaid Program survey dispositions and adult member demographics.

Figure 1-1: Survey Dispositions and Member Demographics

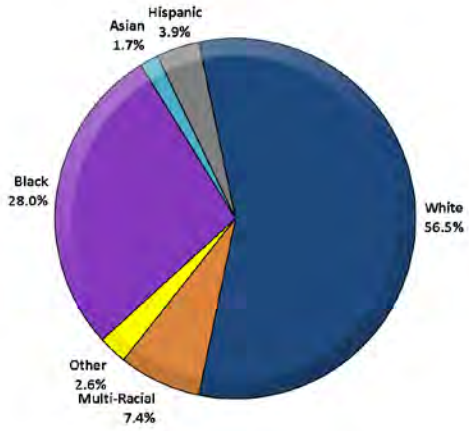
Survey Dispositions



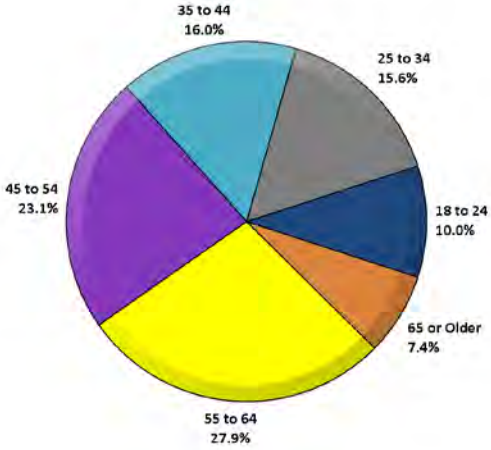
General Health Status



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.

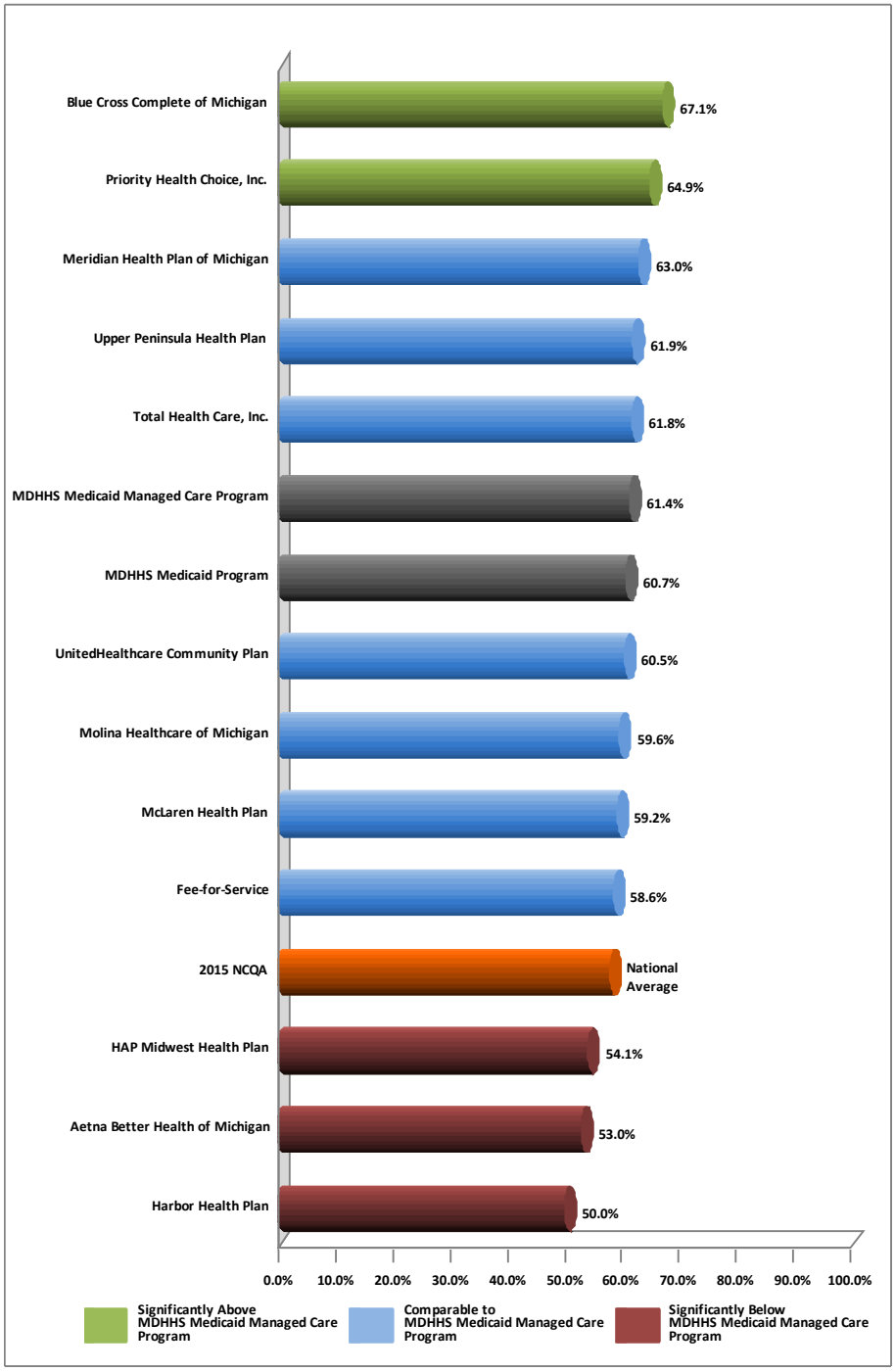
[3-3] The source for the national data contained in this publication is Quality Compass® 2015 and is used with the permission of the National Committee for Quality Assurance (NCQA). Quality Compass 2015 includes certain CAHPS data. Any data display, analysis, interpretation, or conclusion based on these 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.

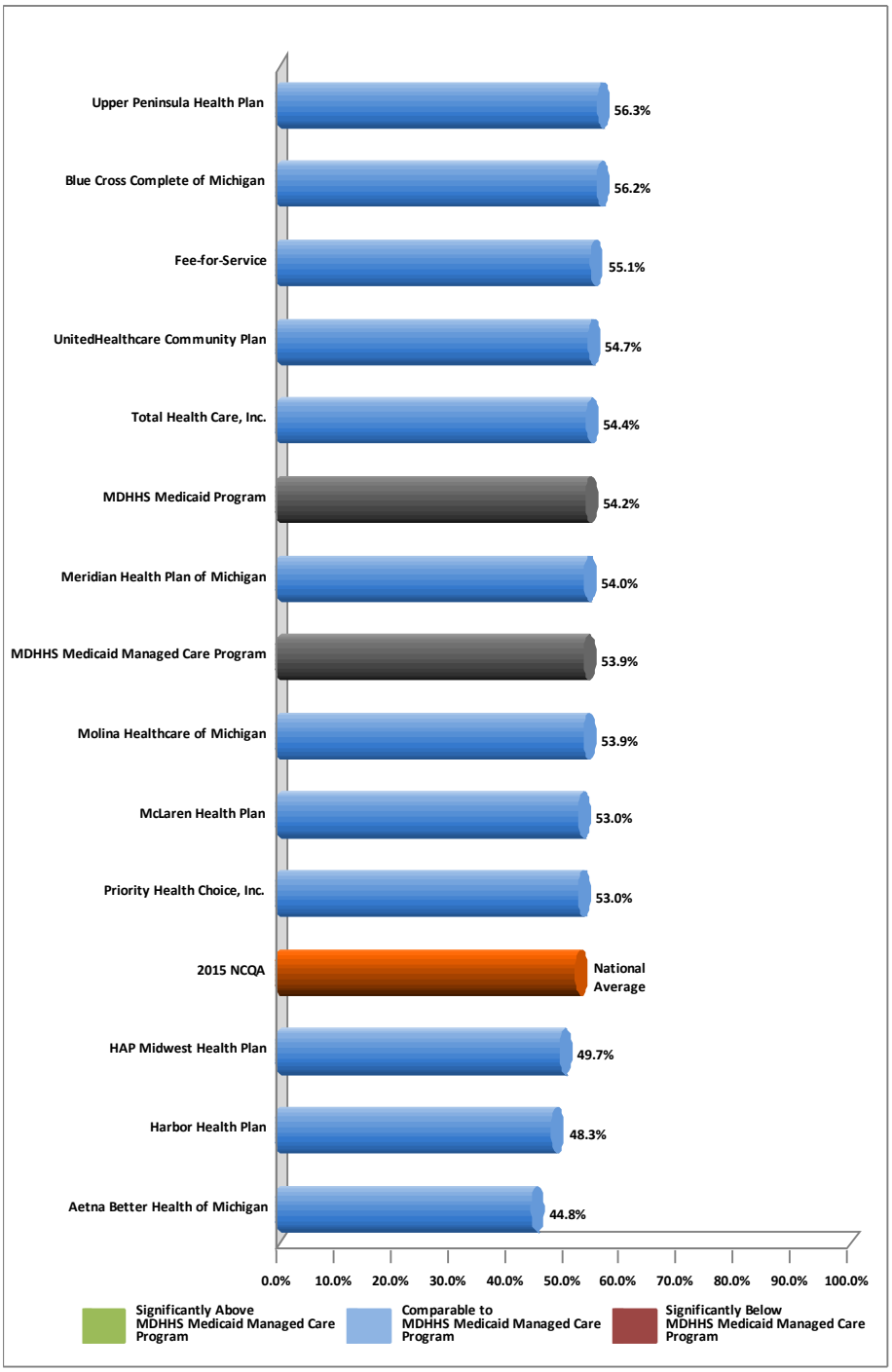
Figure 3-1: Rating of Health Plan Top-Box Rates



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.

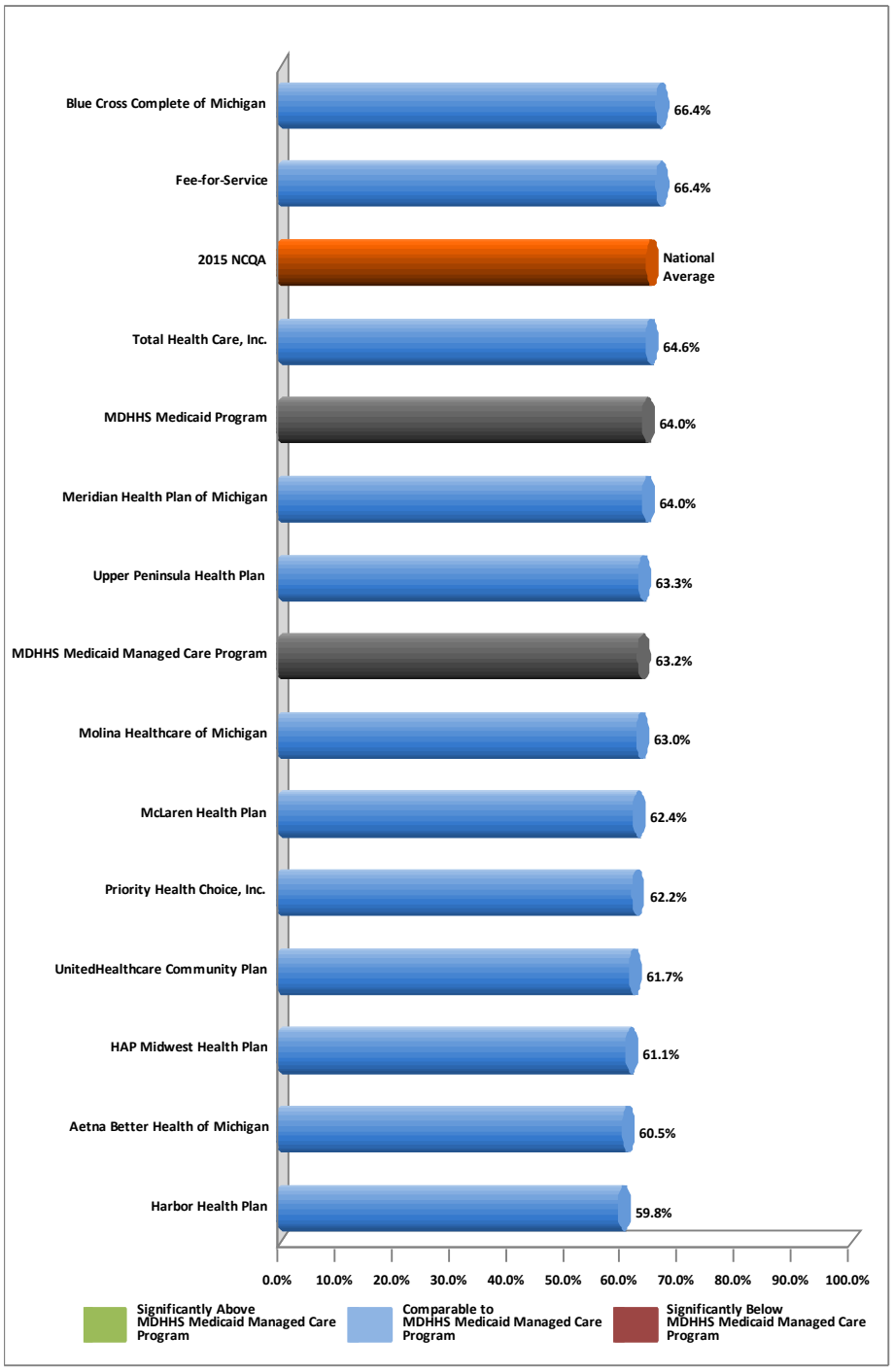
Figure 3-2: Rating of All Health Care Top-Box Rates



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.

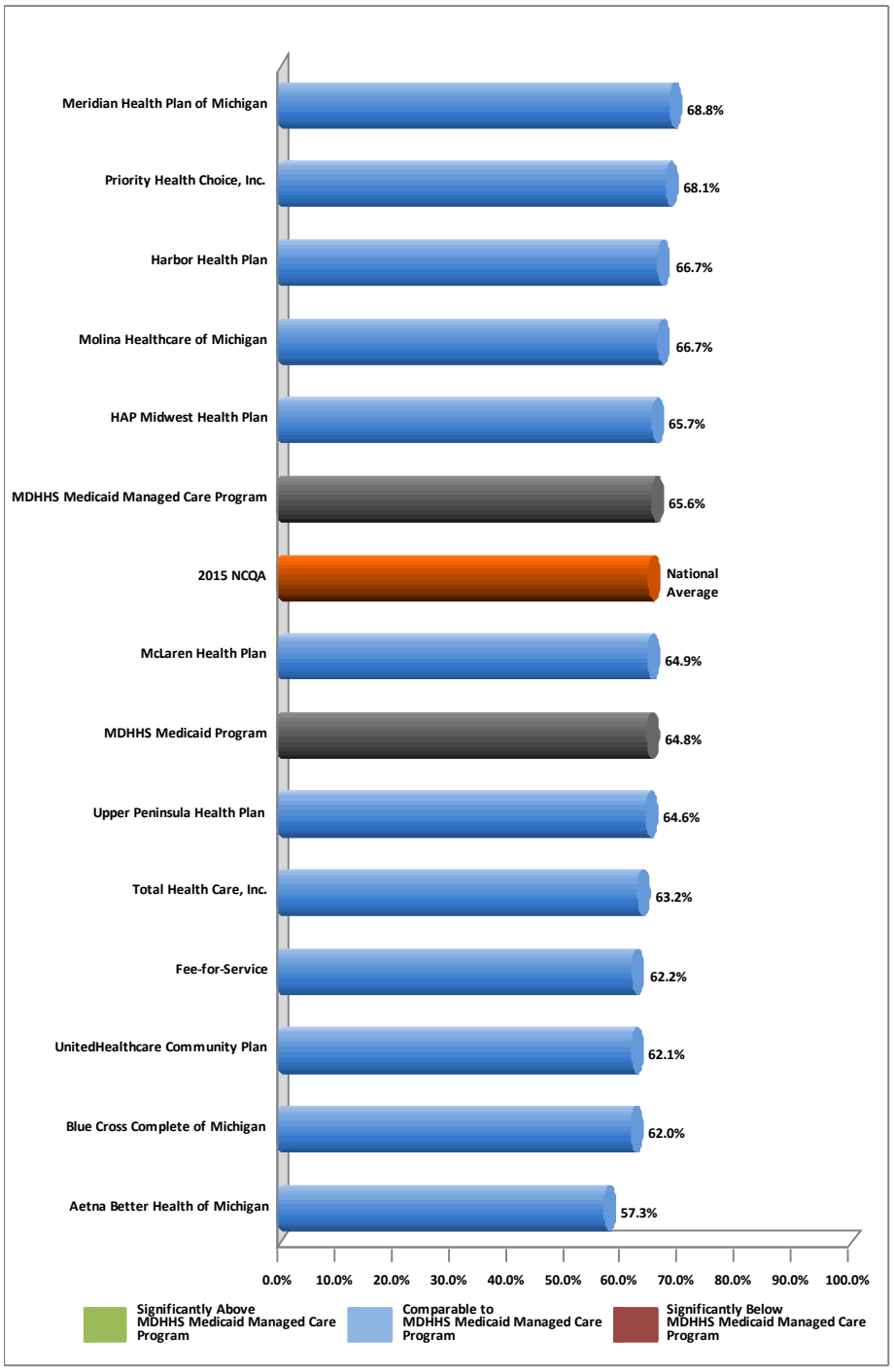
Figure 3-3: Rating of Personal Doctor Top-Box Rates



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

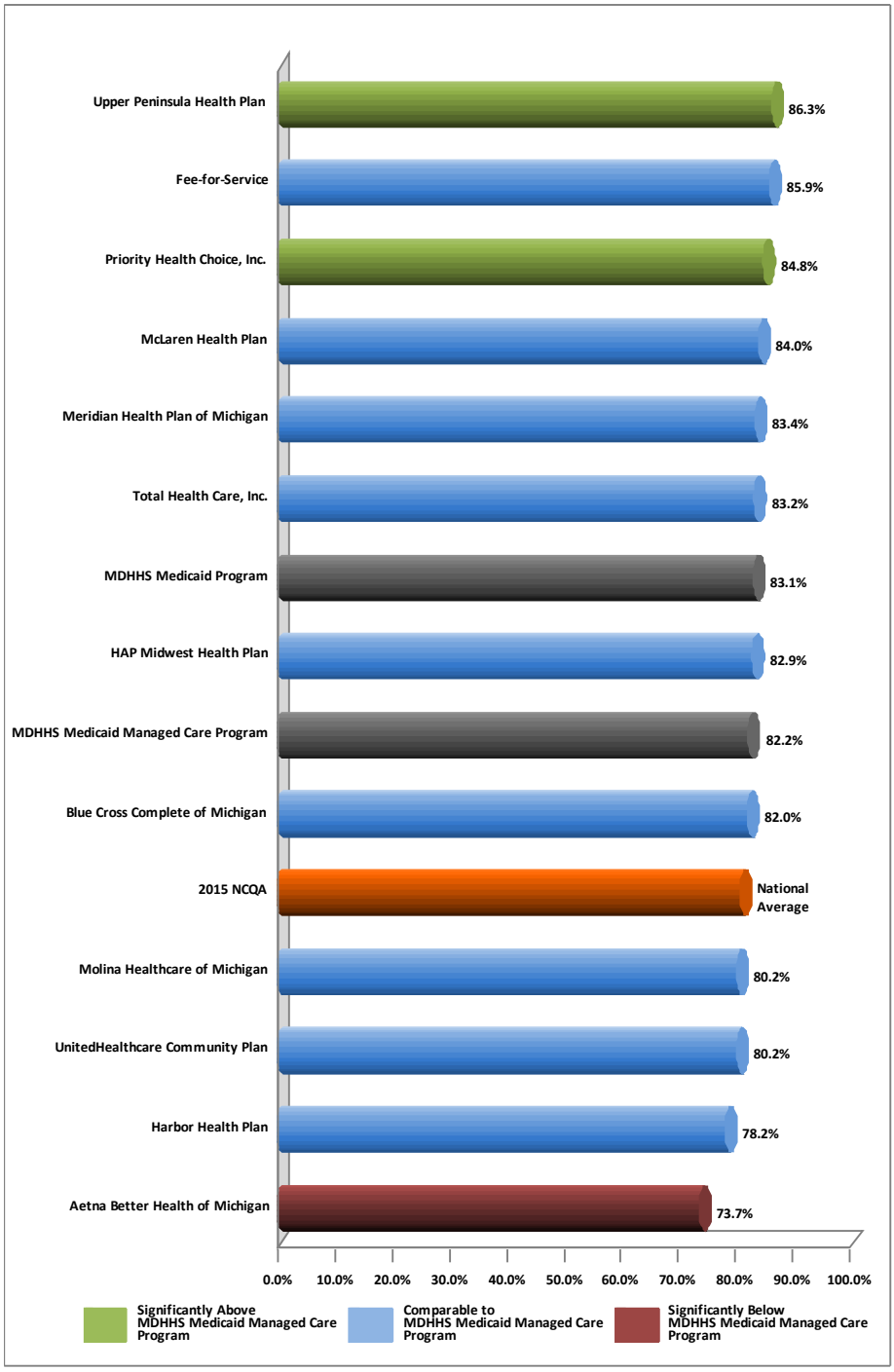
Two questions (Questions 14 and 25 in the CAHPS Adult Medicaid Health Plan Survey) were asked to assess how often it was easy to get needed care:

- **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

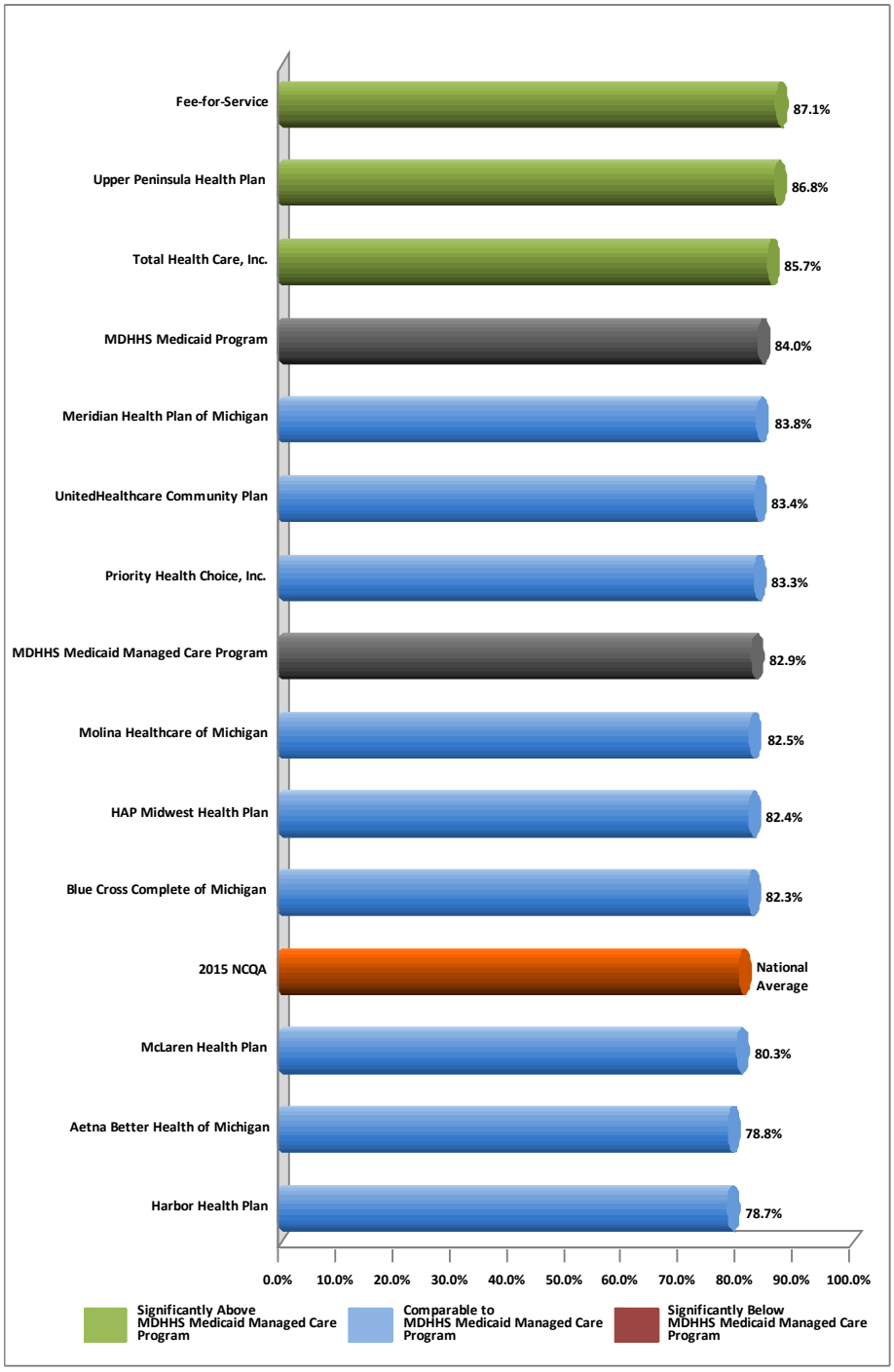
Two questions (Questions 4 and 6 in the CAHPS Adult Medicaid Health Plan Survey) were asked to assess how often adult members received care quickly:

- **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

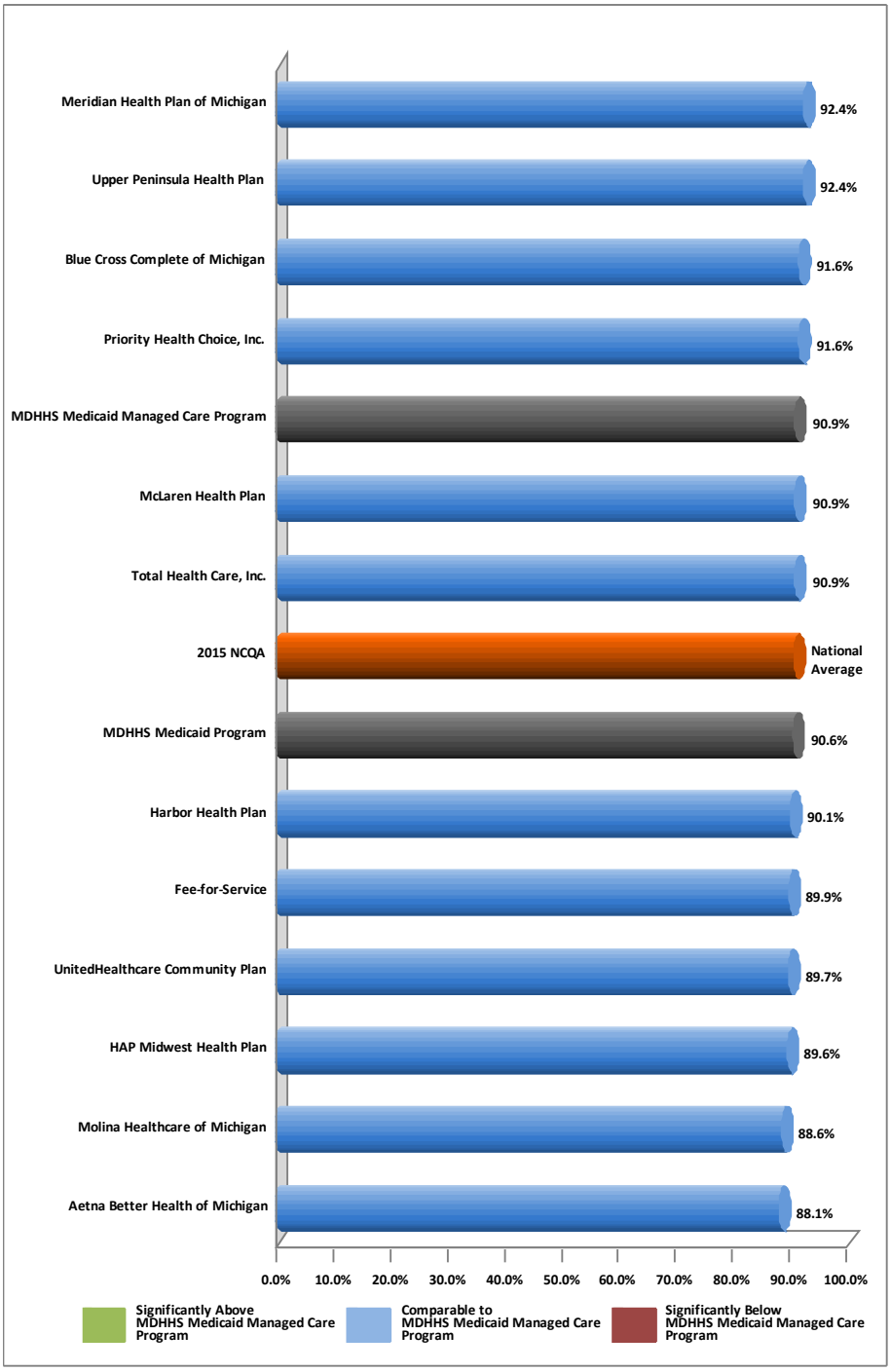
A series of four questions (Questions 17, 18, 19, and 20 in the CAHPS Adult Medicaid Health Plan Survey) was asked to assess how often doctors communicated well:

- **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

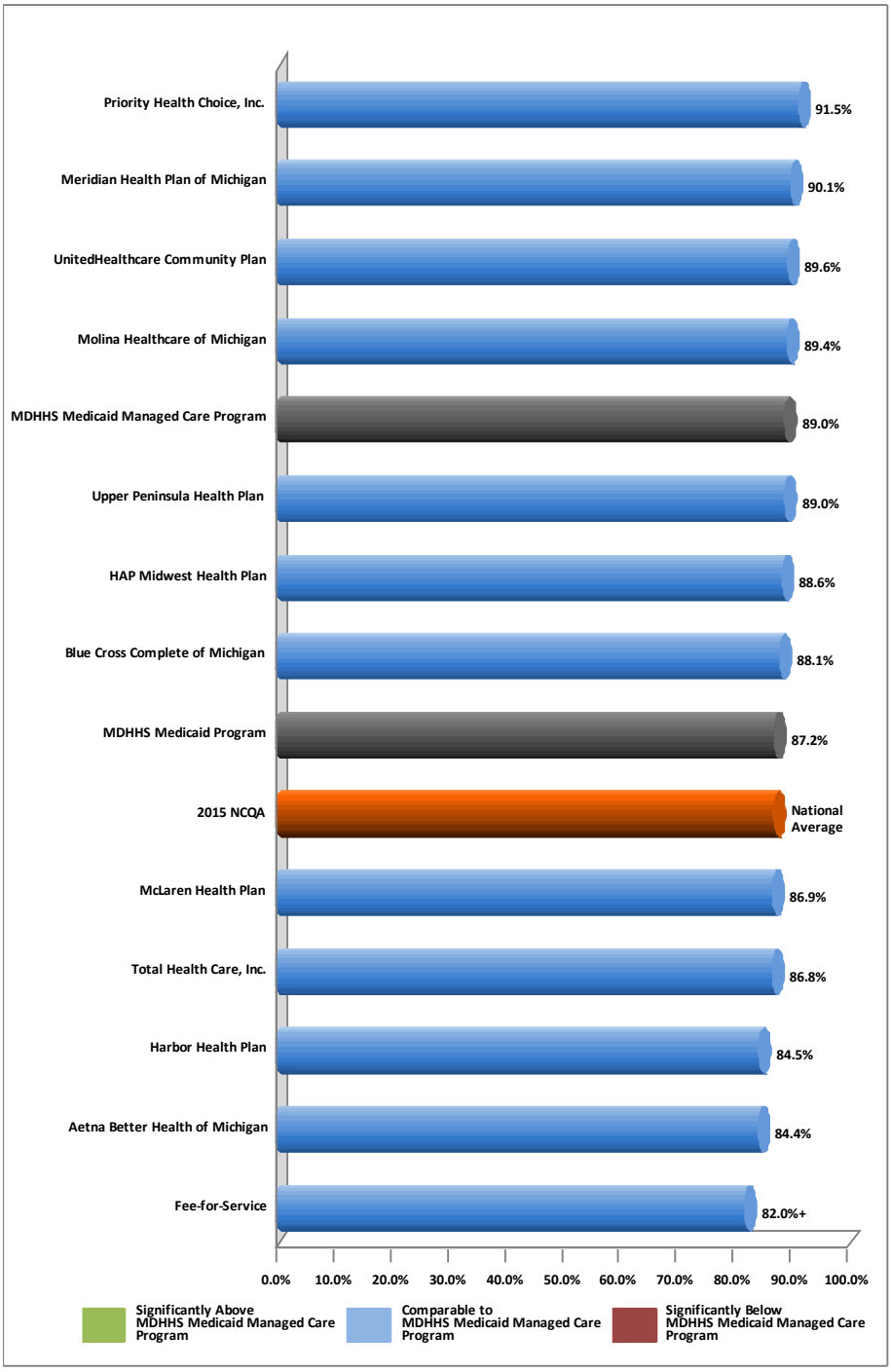
Two questions (Questions 31 and 32 in the CAHPS Adult Medicaid Health Plan Survey) were asked to assess how often adult members were satisfied with customer service:

- **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

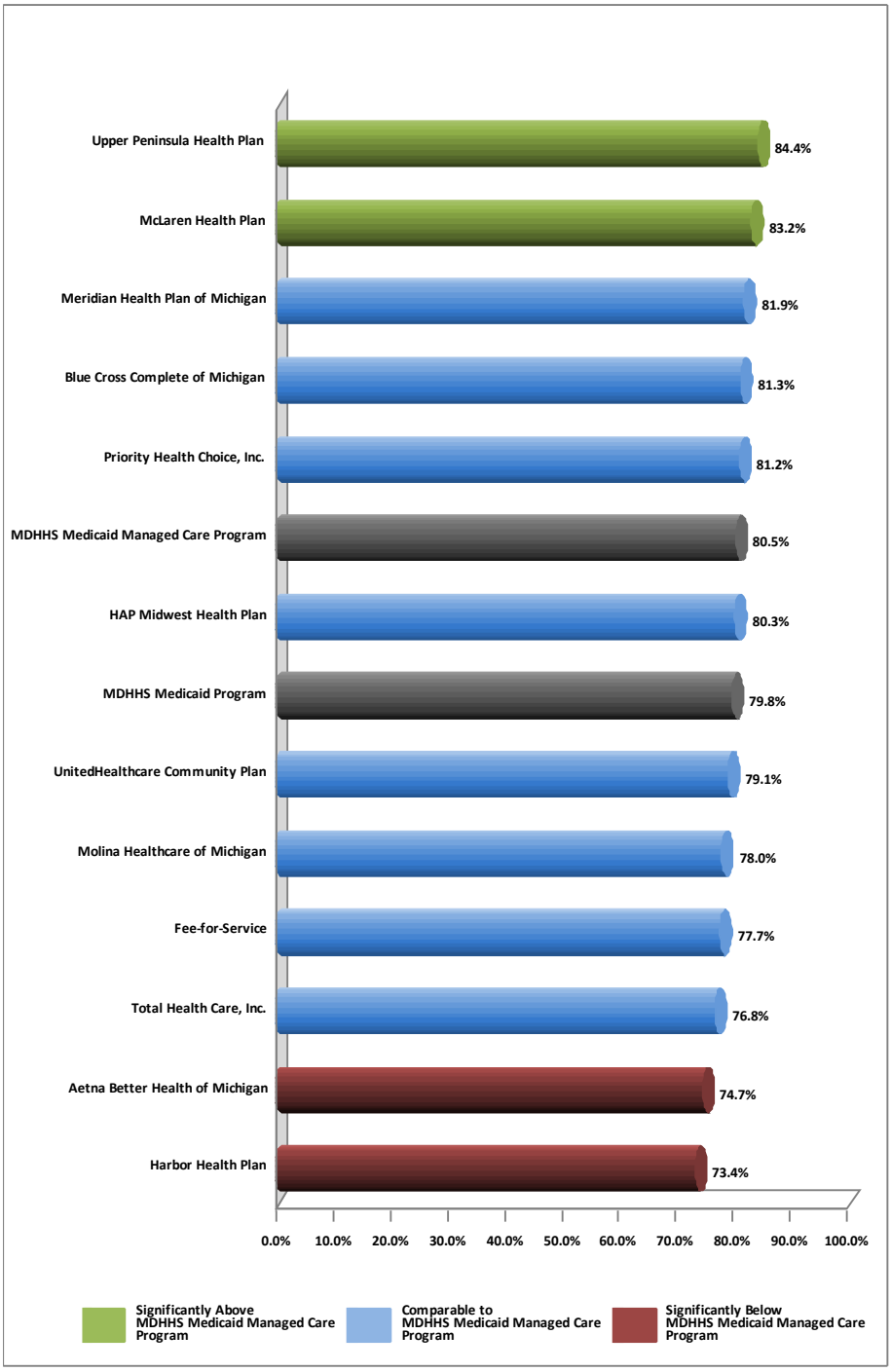
Three questions (Questions 10, 11, and 12 in the CAHPS Adult Medicaid Health Plan Survey) were asked regarding the involvement of adult members in decision making when starting or stopping a prescription medicine:

- **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

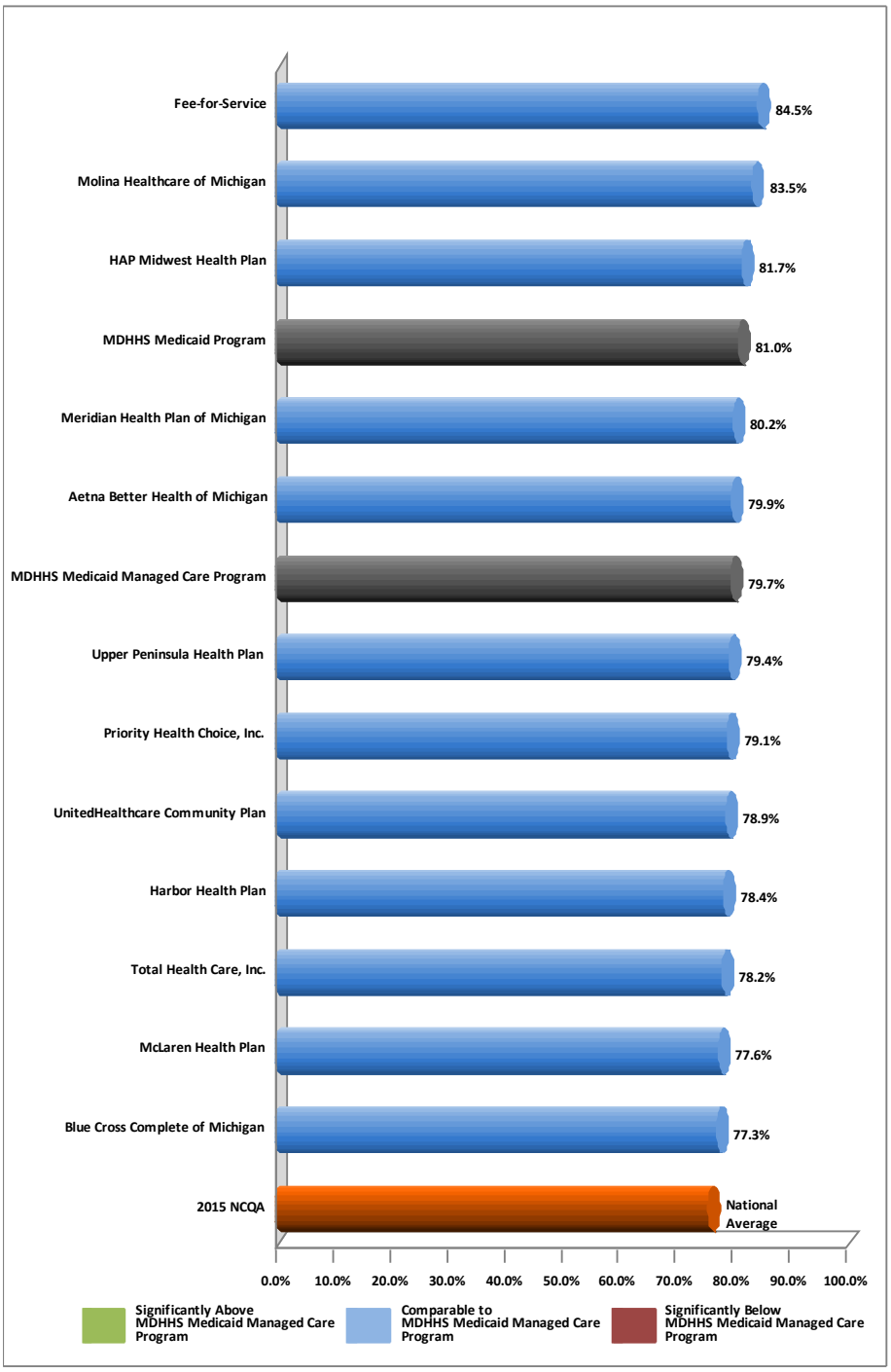
Adult members were asked how often they were advised to quit smoking or using tobacco by a doctor or other health provider (Question 40 in the CAHPS Adult Medicaid Health Plan Survey):

- **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

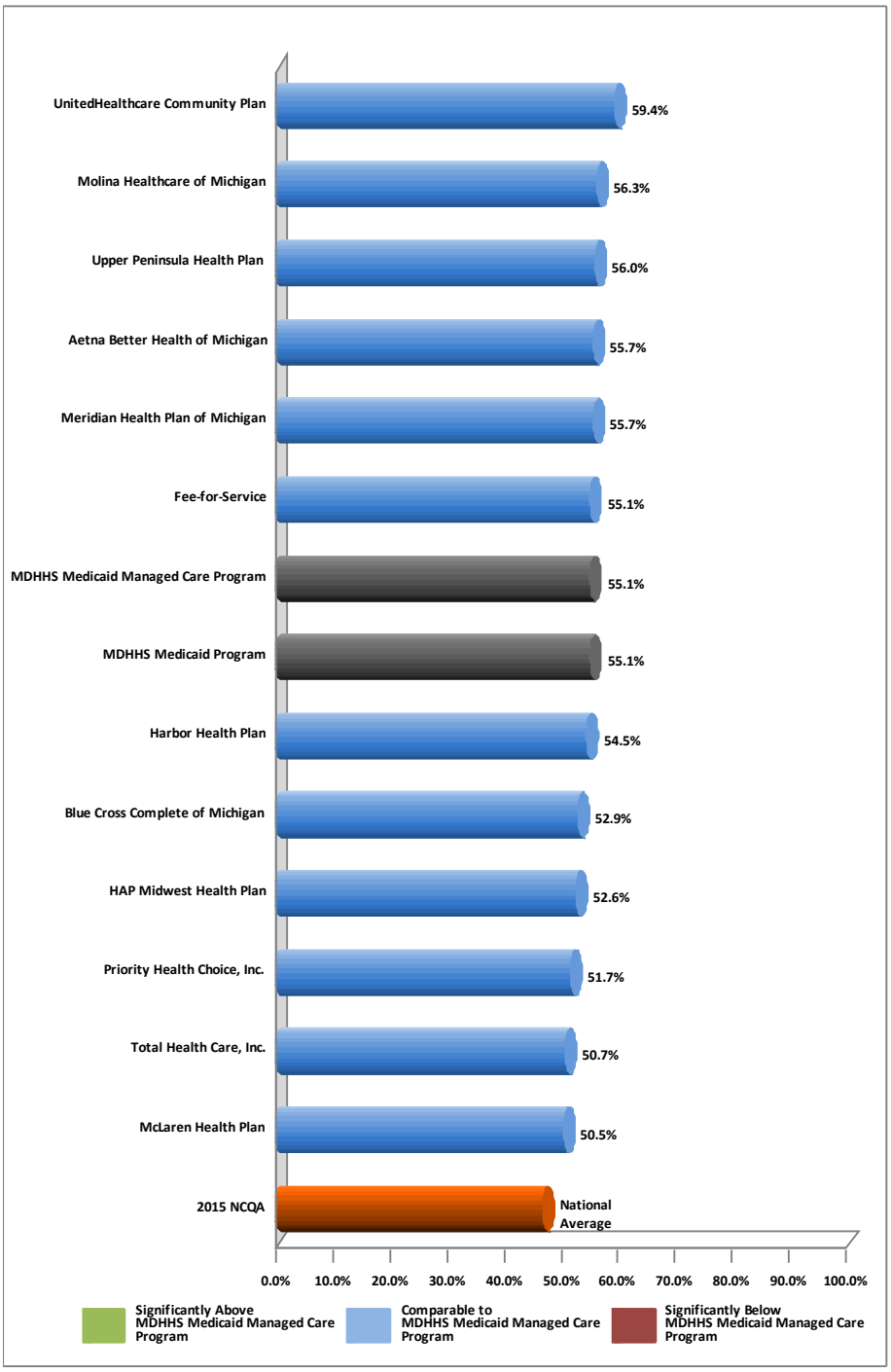
Adult members were asked how often medication was recommended or discussed by a doctor or other health provider to assist them with quitting smoking or using tobacco (Question 41 in the CAHPS Adult Medicaid Health Plan Survey):

- **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

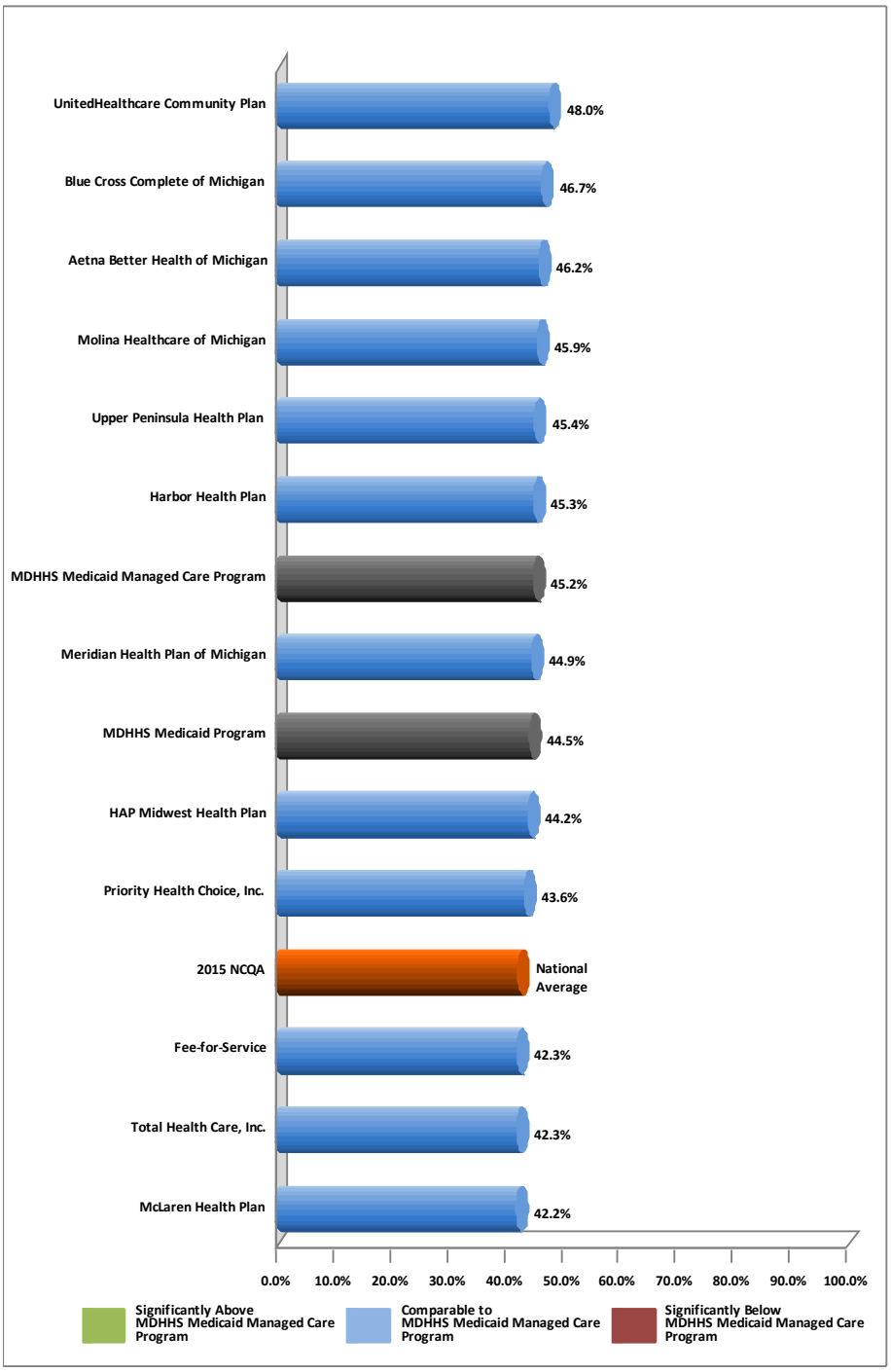
Adult members were asked how often their doctor or health provider discussed or provided methods and strategies other than medication to assist them with quitting smoking or using tobacco (Question 42 in the CAHPS Adult Medicaid Health Plan Survey):

- **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):

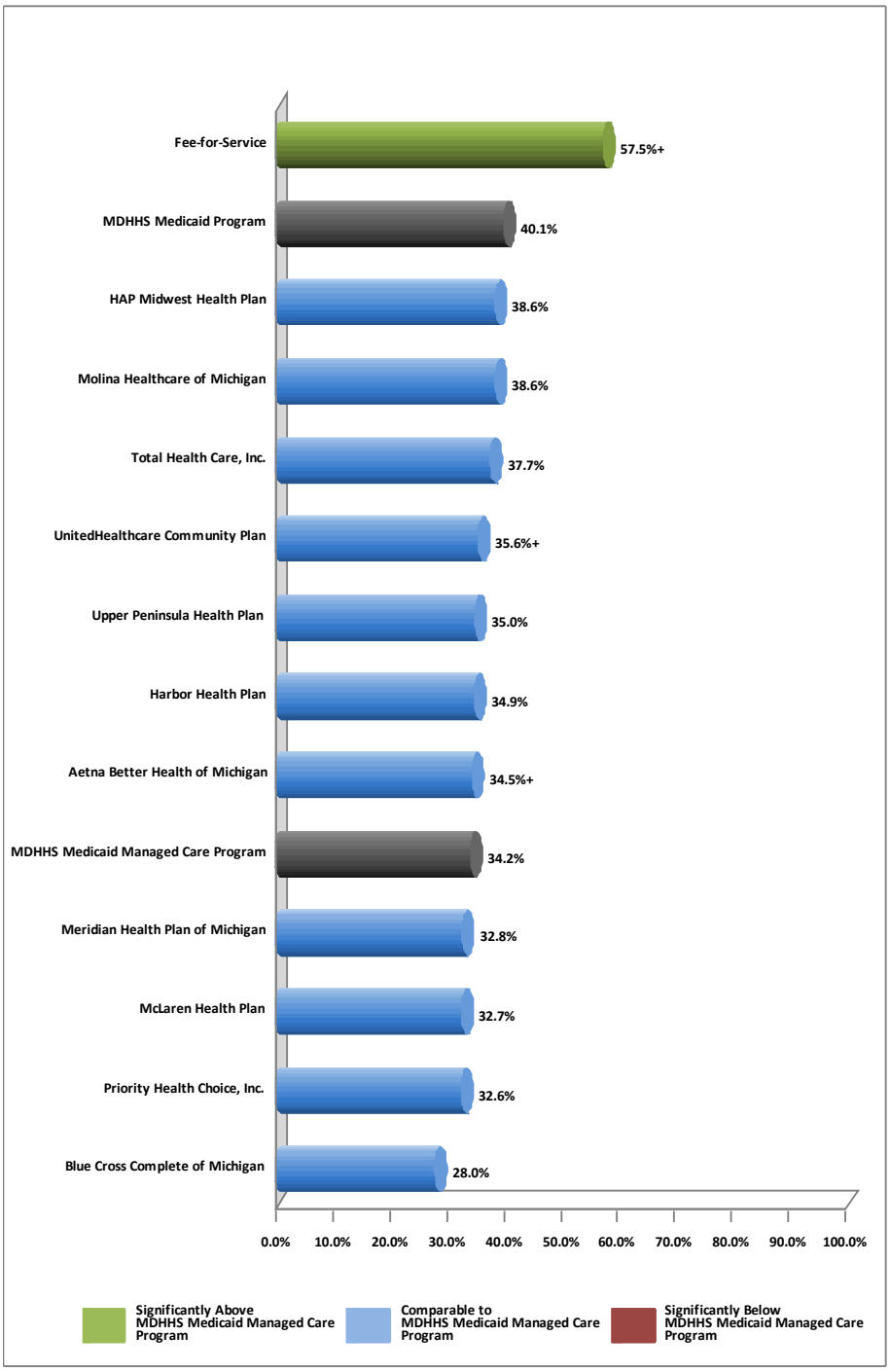
- **Question 43.** Do you take aspirin daily or every other day?
  - Yes
  - No
  - Don't know

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

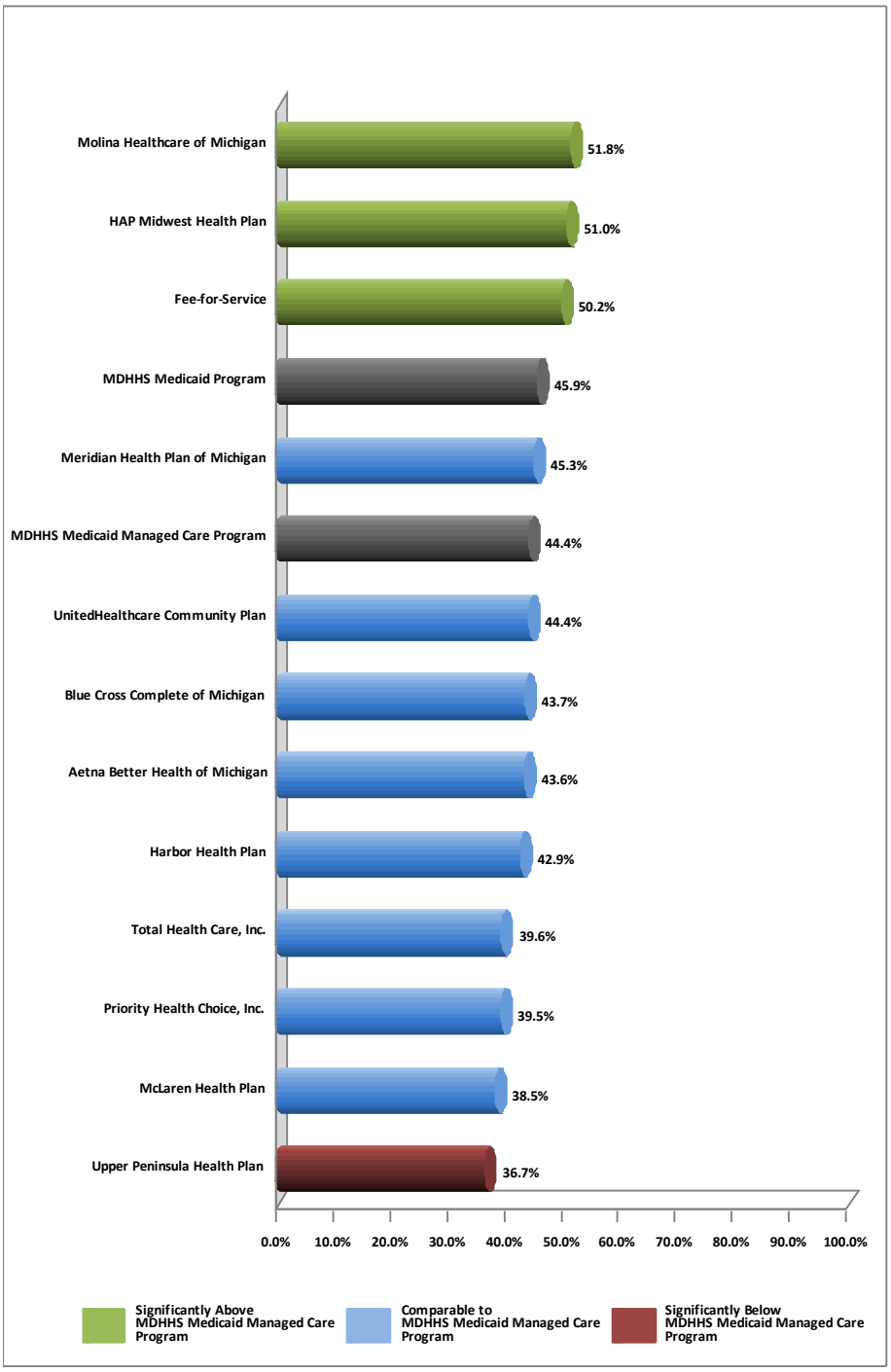
Adult members were asked if a doctor or health provider discussed with them the risks and benefits of aspirin to prevent a heart attack or stroke (Question 45 in the CAHPS Adult Medicaid Health Plan Survey):

- **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.

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 1-888-506-5134.

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

State of Michigan
Department of Health and Human Services

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

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HSAG HEALTH SERVICES ADVISORY GROUP

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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).

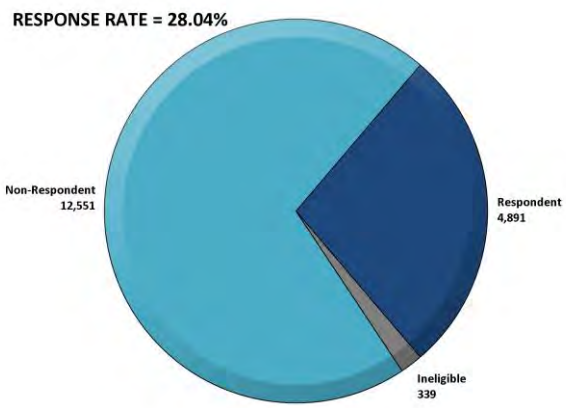
Key Findings

Survey Dispositions and Demographics

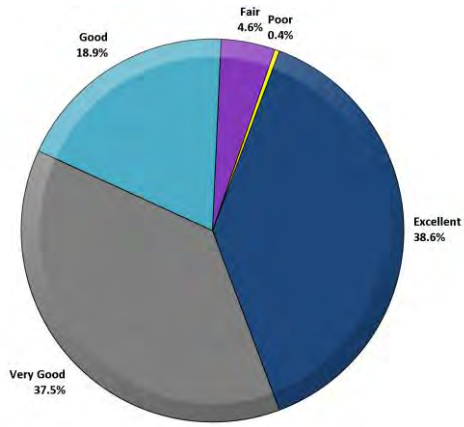
Figure 1-1 provides an overview of the MDHHS Medicaid Program survey dispositions and child member demographics.

Figure 1-1: Survey Dispositions and Member Demographics

Survey Dispositions



General Health Status



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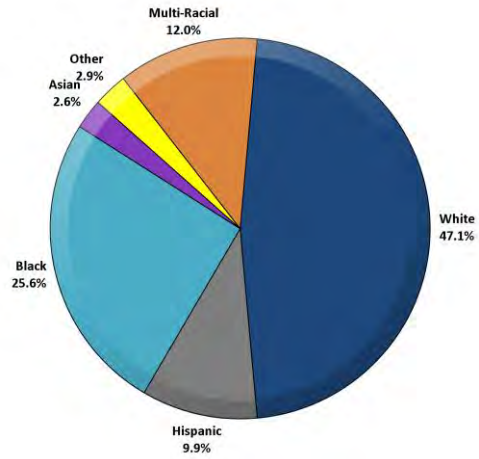
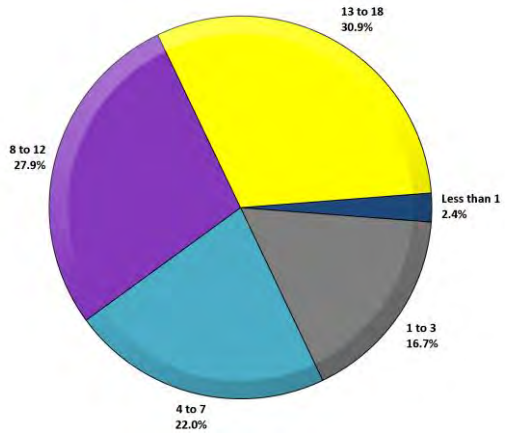


Age



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.

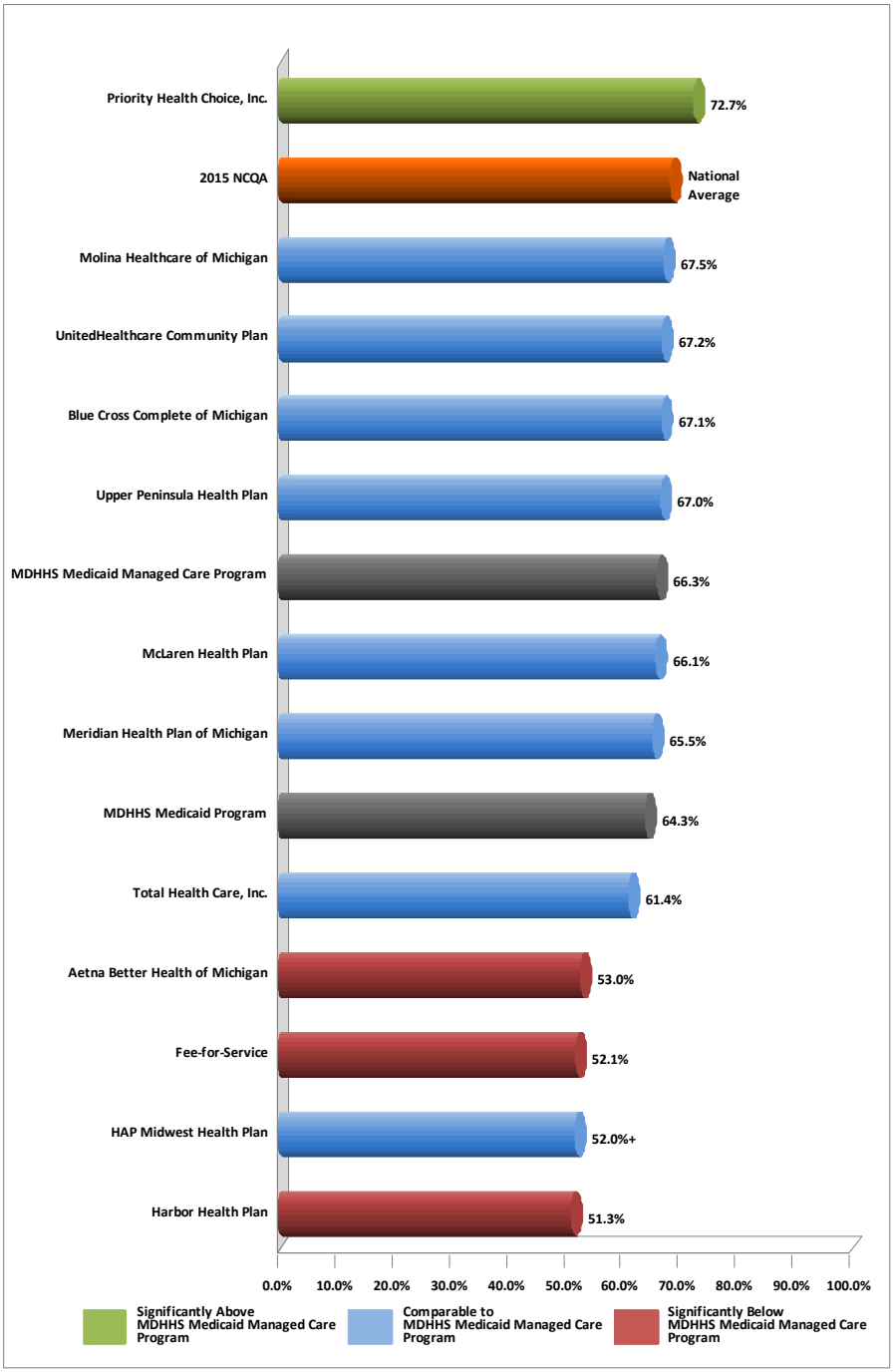
[3-3] The source for the national data contained in this publication is Quality Compass® 2015 and is used with the permission of the National Committee for Quality Assurance (NCQA). Quality Compass 2015 includes certain CAHPS data. Any data display, analysis, interpretation, or conclusion based on these 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

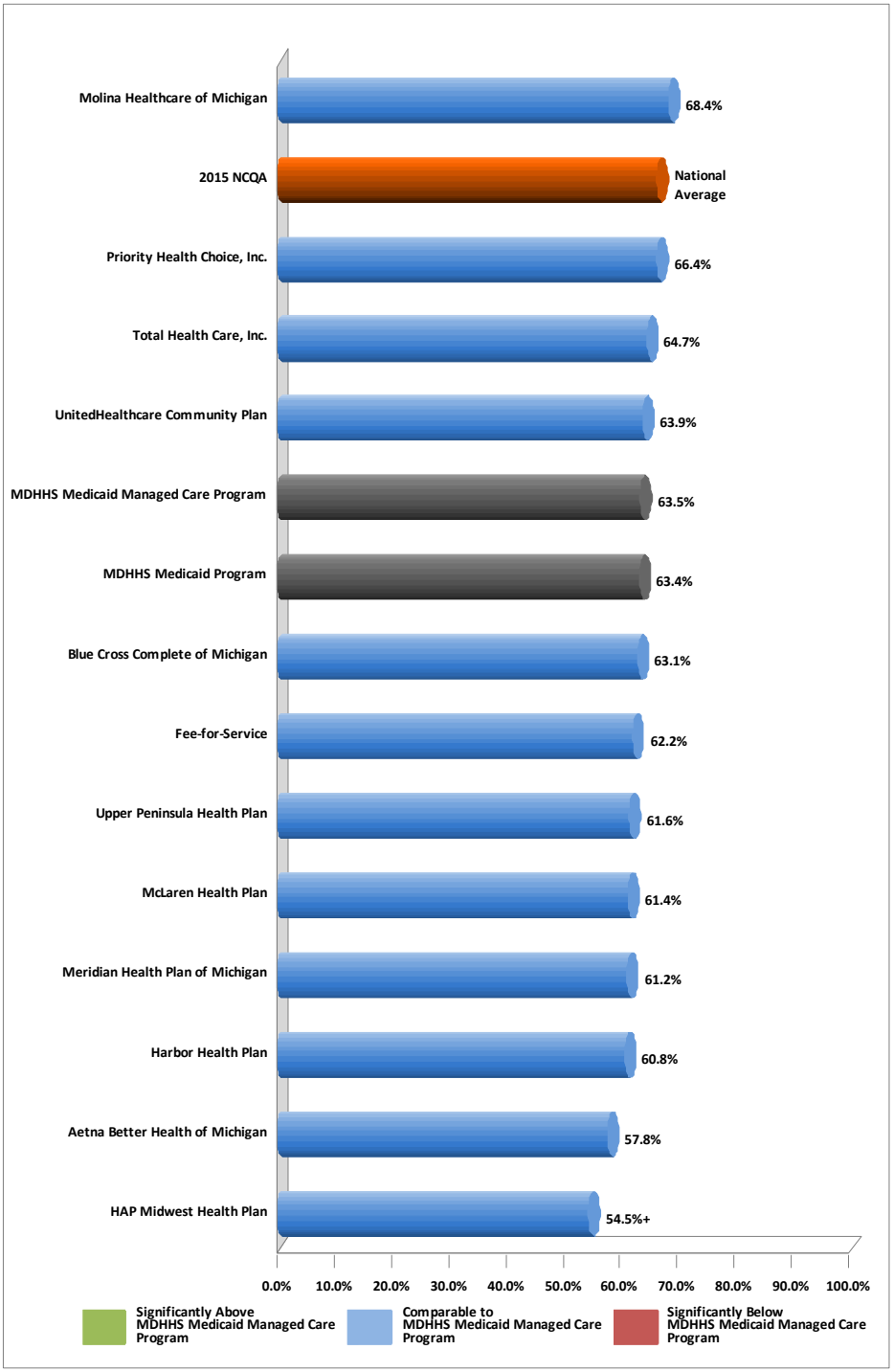


Note: + indicates fewer than 100 responses

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

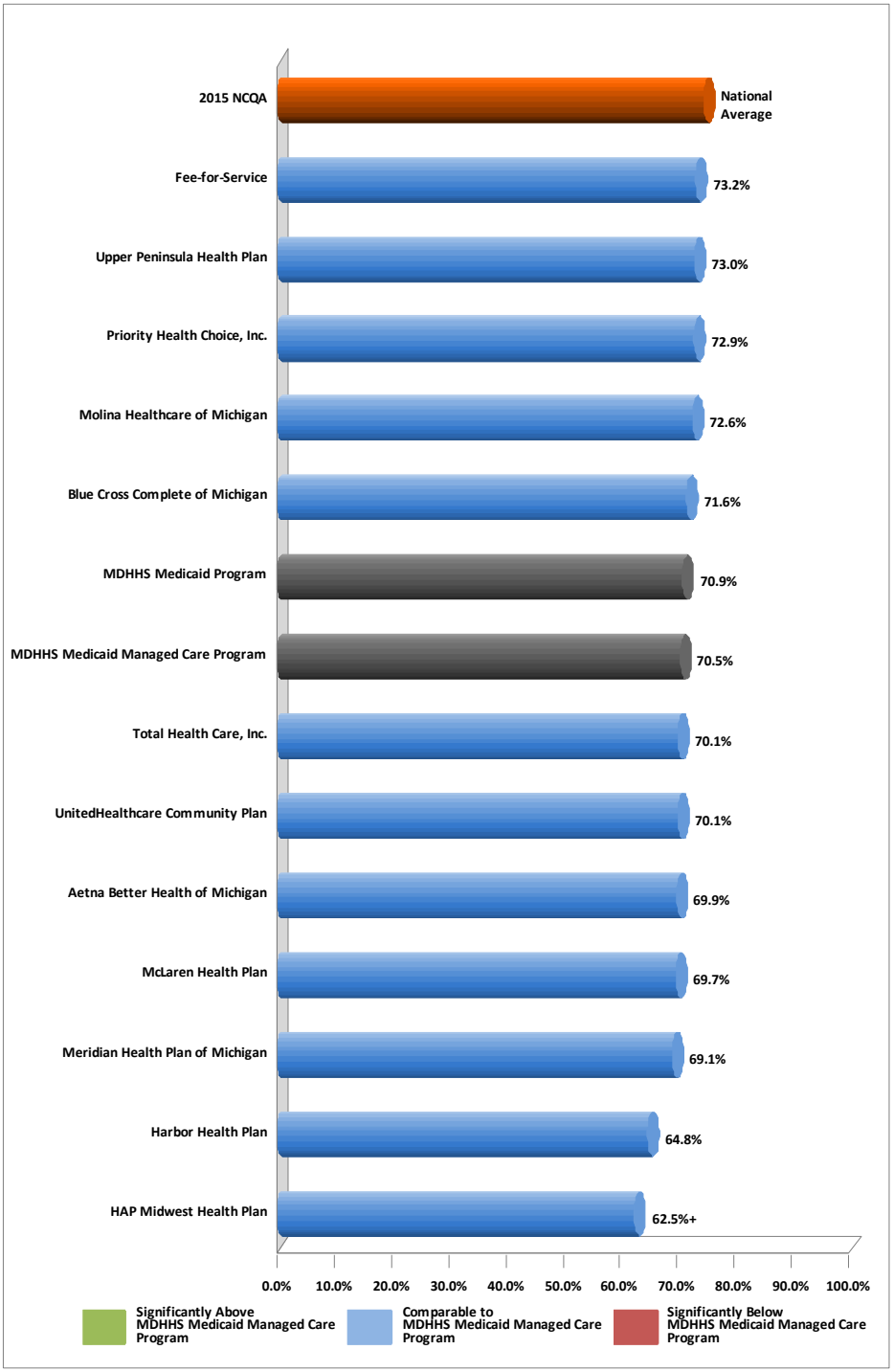


Note: + indicates fewer than 100 responses

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

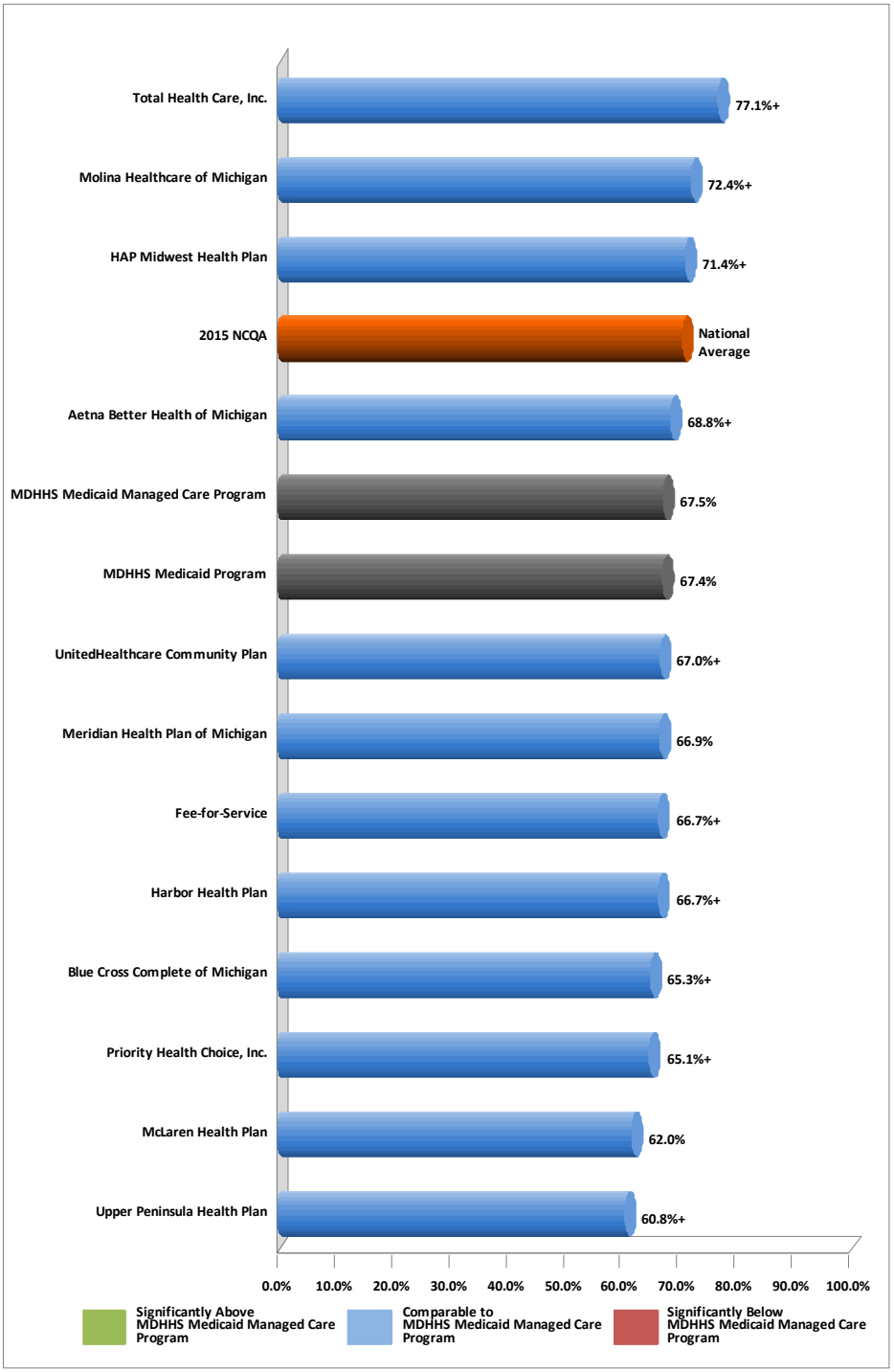


Note: + indicates fewer than 100 responses

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

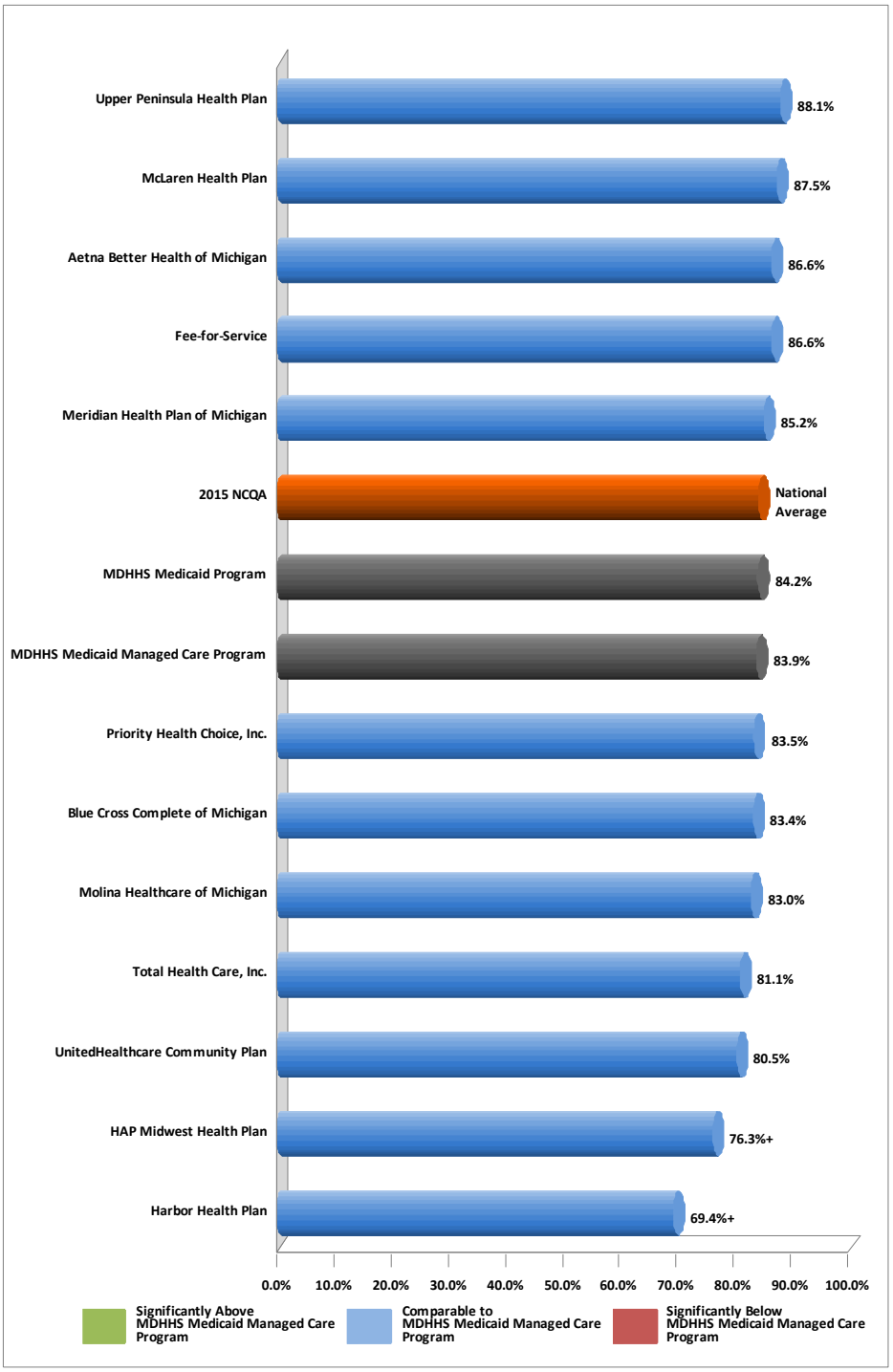
Two questions (Questions 14 and 28 in the CAHPS Child Medicaid Health Plan Survey) were asked to assess how often it was easy to get needed care:

- **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

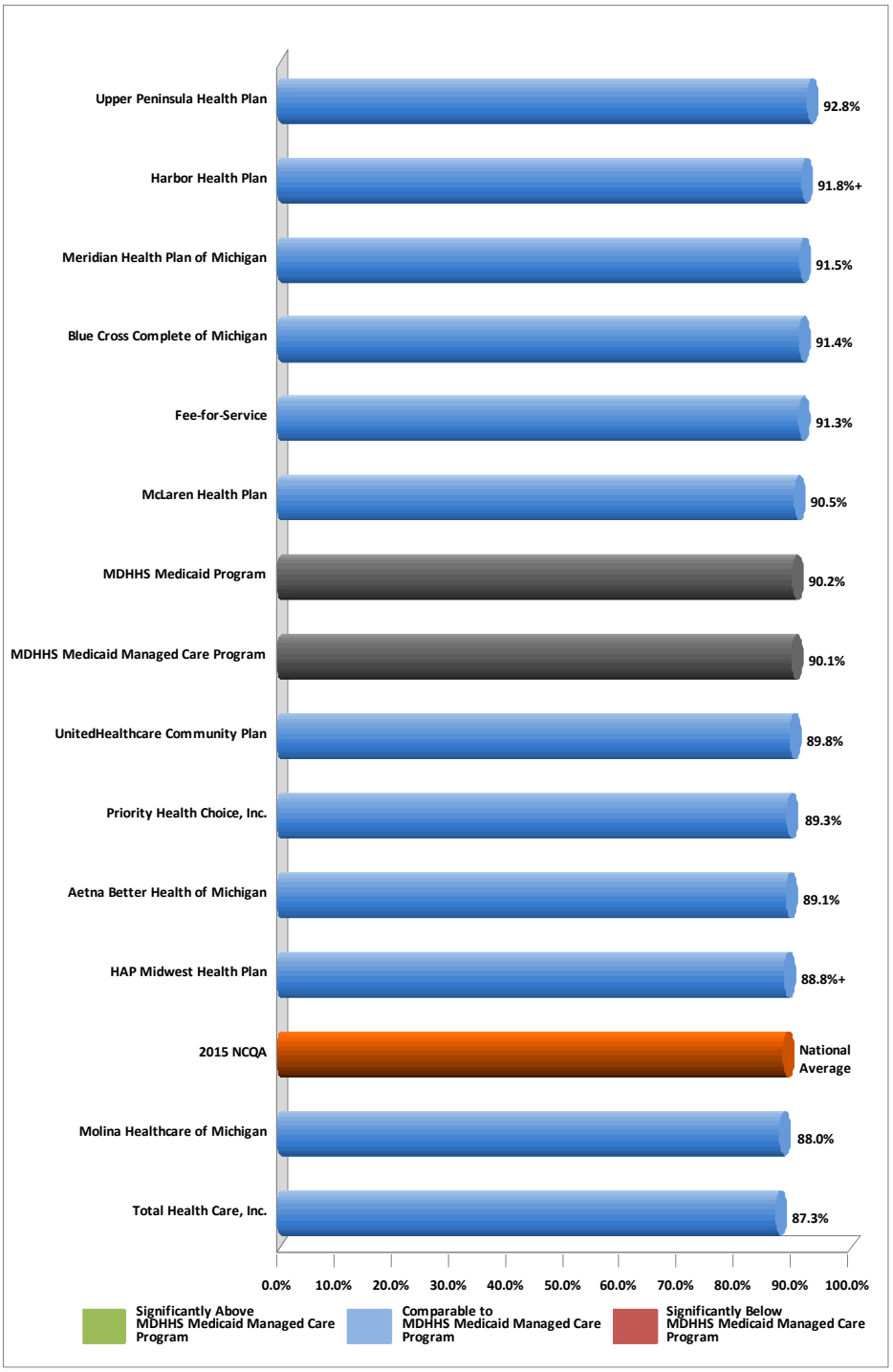
Two questions (Questions 4 and 6 in the CAHPS Child Medicaid Health Plan Survey) were asked to assess how often child members received care quickly:

- **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

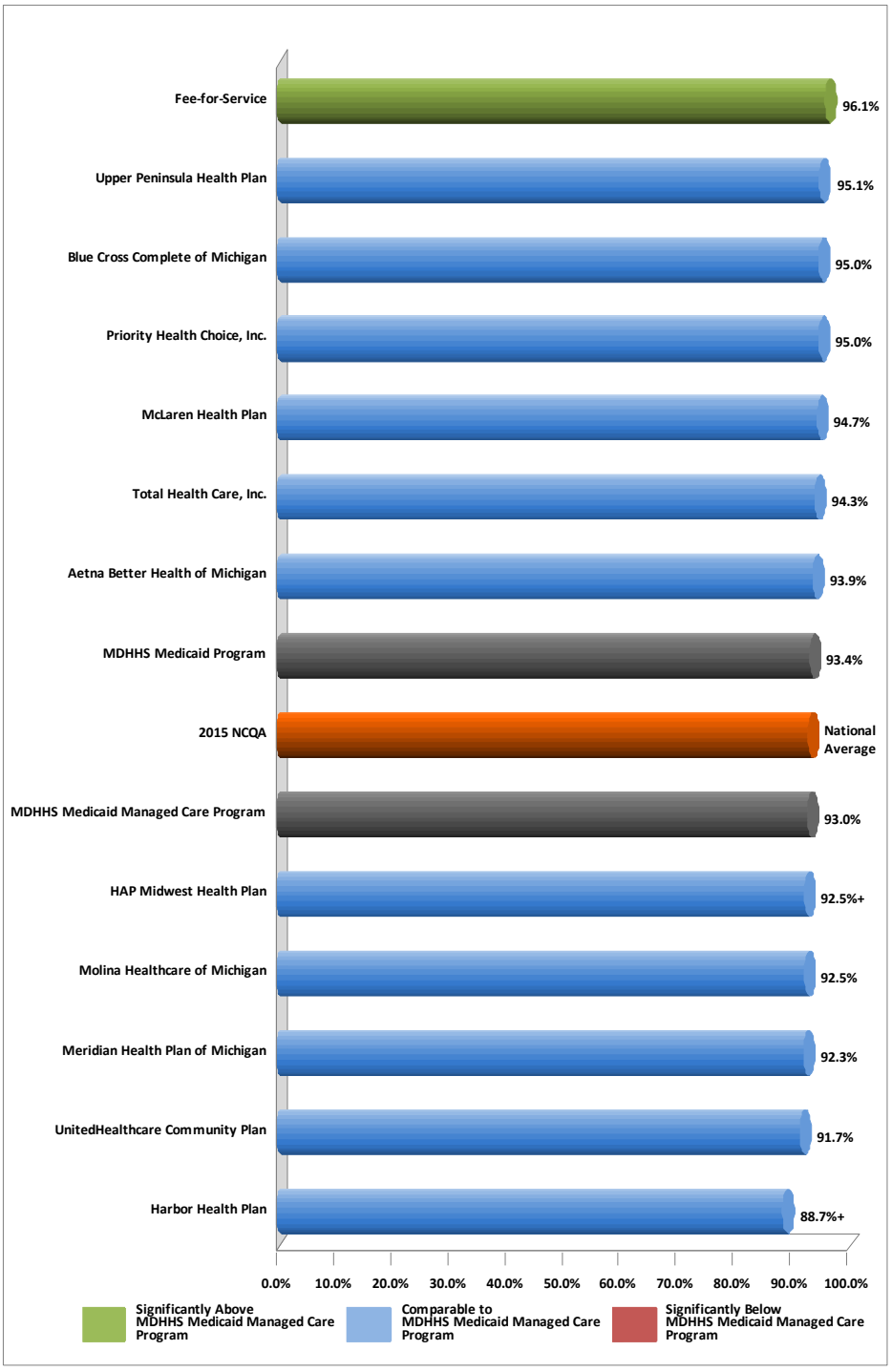
A series of four questions (Questions 17, 18, 19, and 22 in the CAHPS Child Medicaid Health Plan Survey) was asked to assess how often doctors communicated well:

- **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

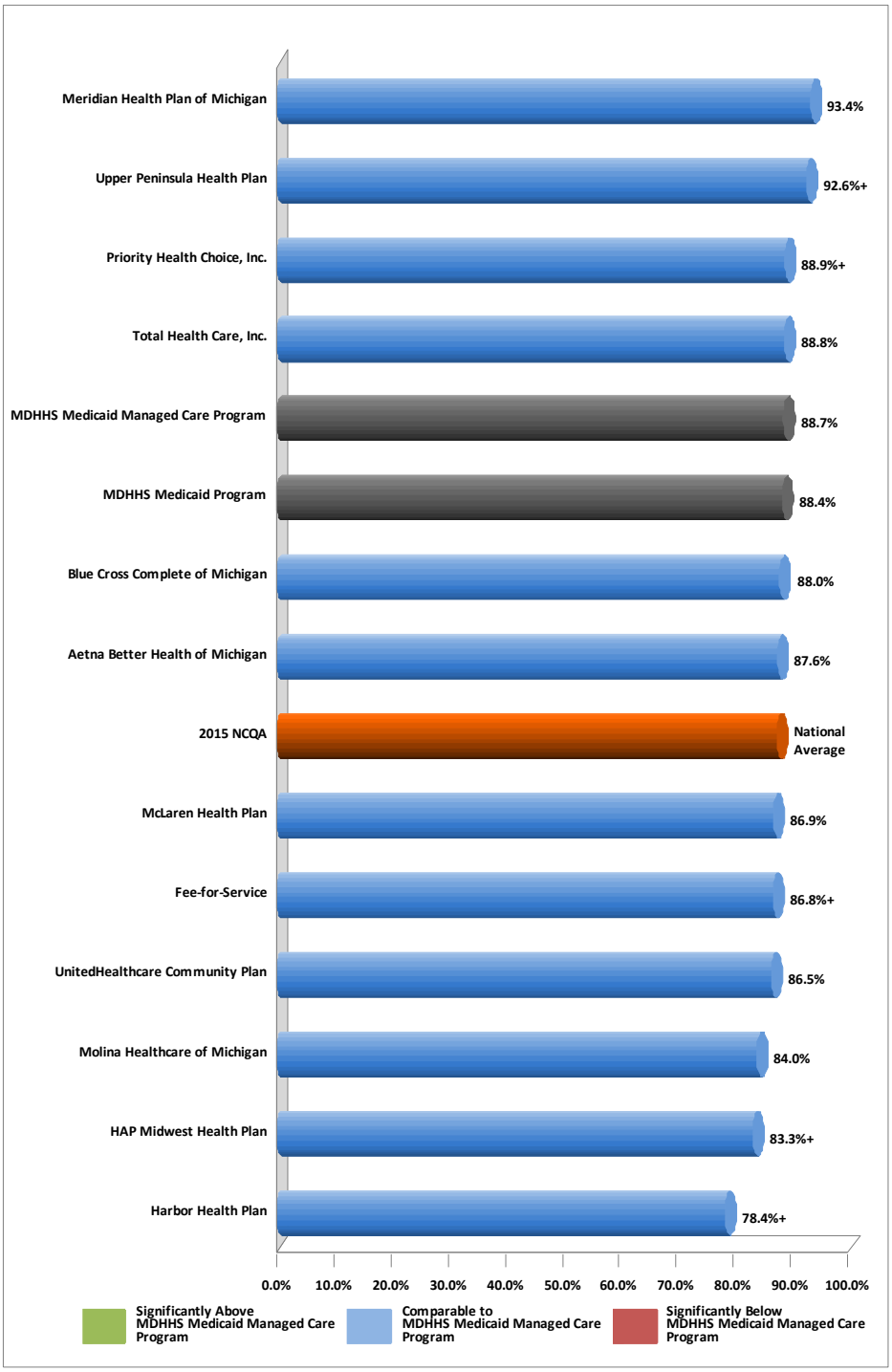
Two questions (Questions 32 and 33 in the CAHPS Child Medicaid Health Plan Survey) were asked to assess how often parents or caretakers were satisfied with customer service:

- **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

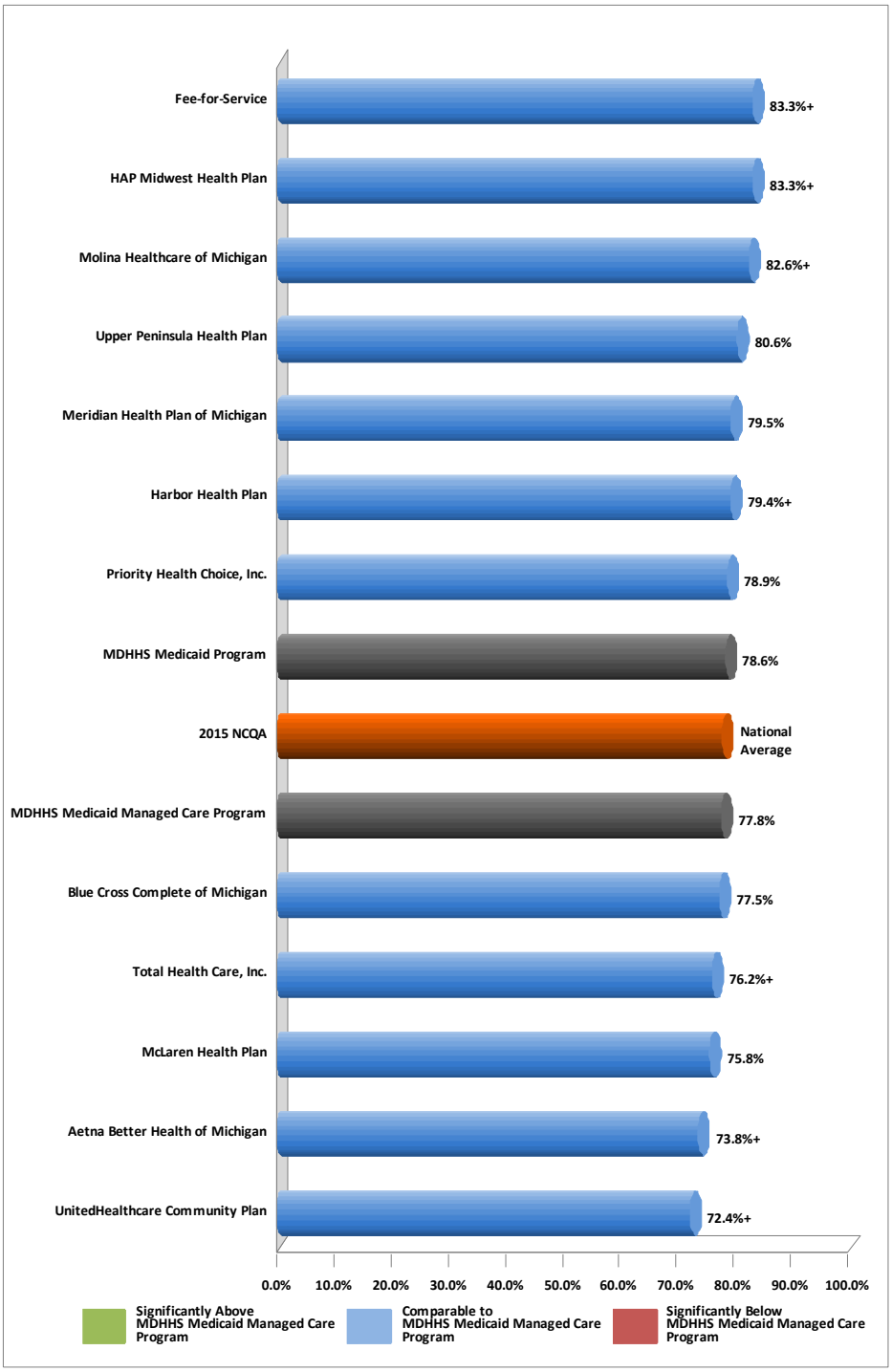
Three questions (Questions 10, 11, and 12 in the CAHPS Child Medicaid Health Plan Survey) were asked regarding the involvement of parents or caretakers in decision making when starting or stopping a prescription medicine for their child:

- **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 completely. Use only black or blue ink or dark pencil 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 <u>mental or emotional</u> health?

- ○ Excellent
- ○ Very good
- ○ Good
- ○ Fair
- ○ Poor

39. What is <u>your child's</u> 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 <u>your</u> 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

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

February 2017

HSAG HEALTH SERVICES ADVISORY GROUP

HSAG HEALTH SERVICES ADVISORY GROUP

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.

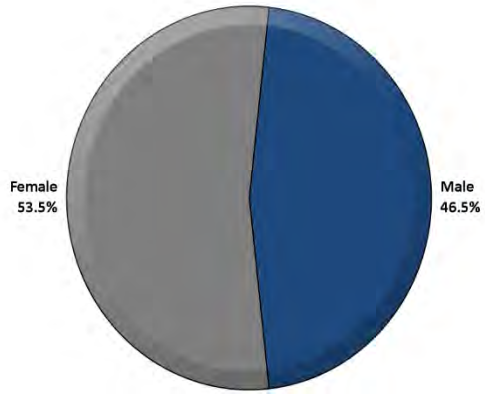
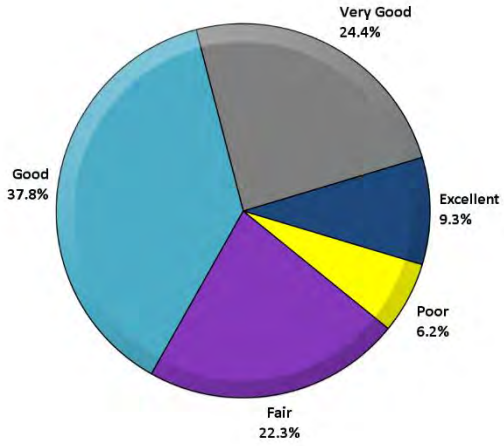
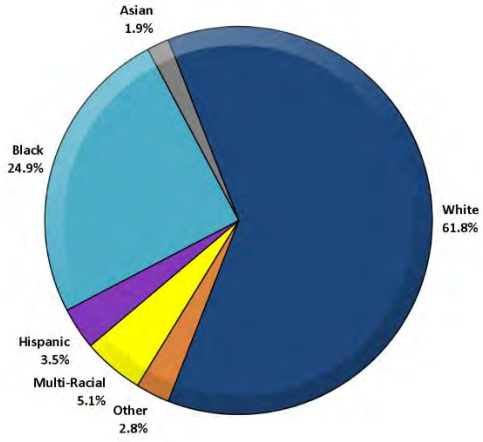
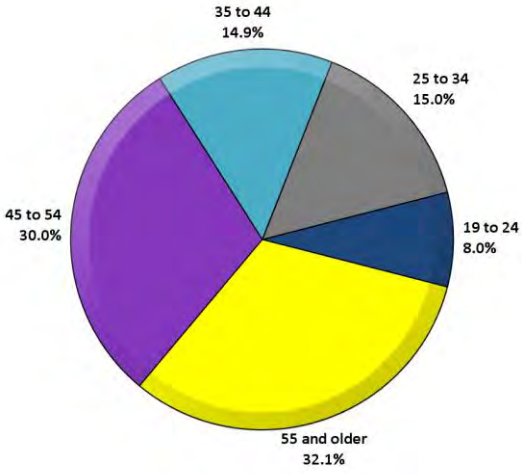
[1-1] CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).
[1-2] HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

Key Findings

Survey Demographics and Dispositions

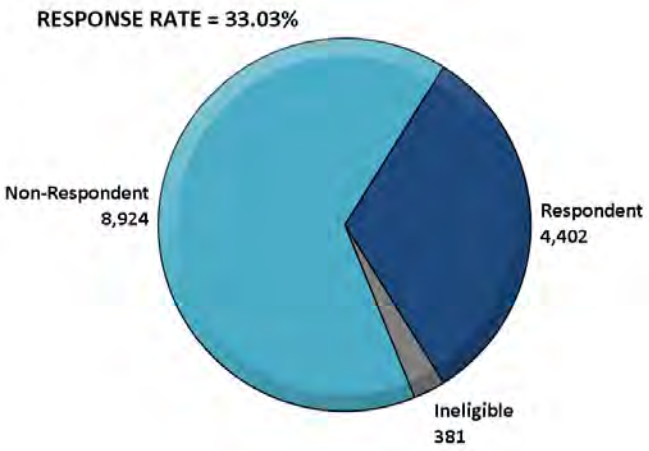
Table 1-1 provides an overview of the adult member demographics and survey dispositions for the MDHHS HMP Program.

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.

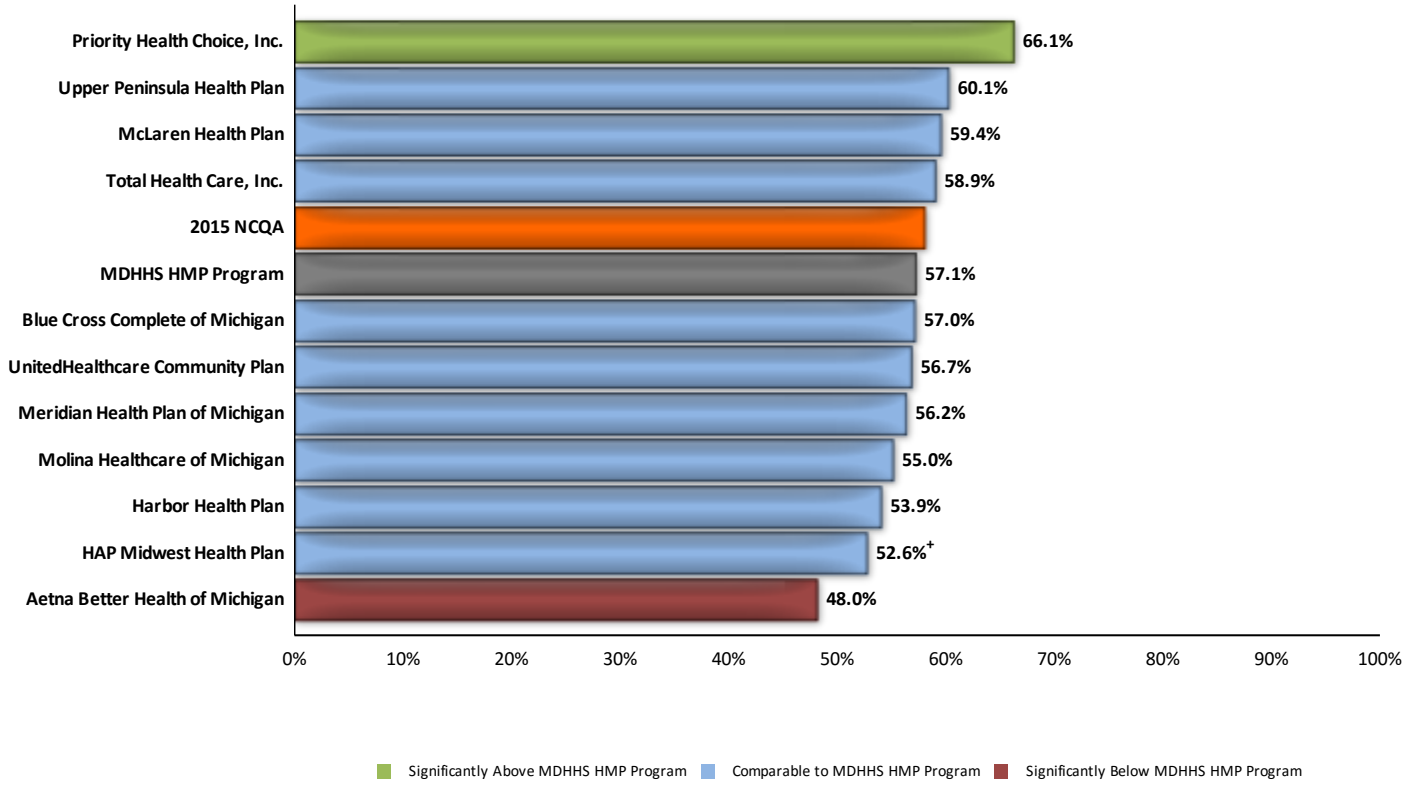
[3-5] The source for the national data contained in this publication is Quality Compass® 2015 and is used with the permission of the National Committee for Quality Assurance (NCQA). Quality Compass 2015 includes certain CAHPS data. Any data display, analysis, interpretation, or conclusion based on these 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

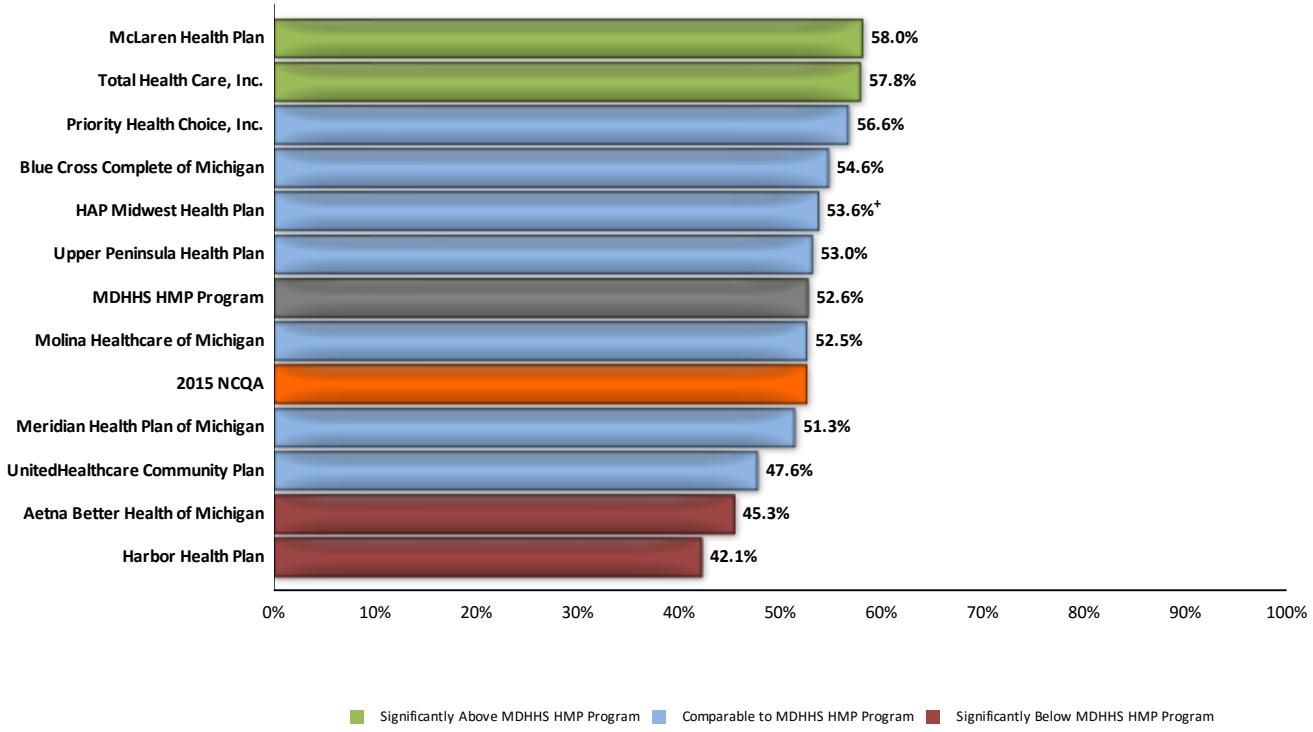


Note: + indicates fewer than 100 responses

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

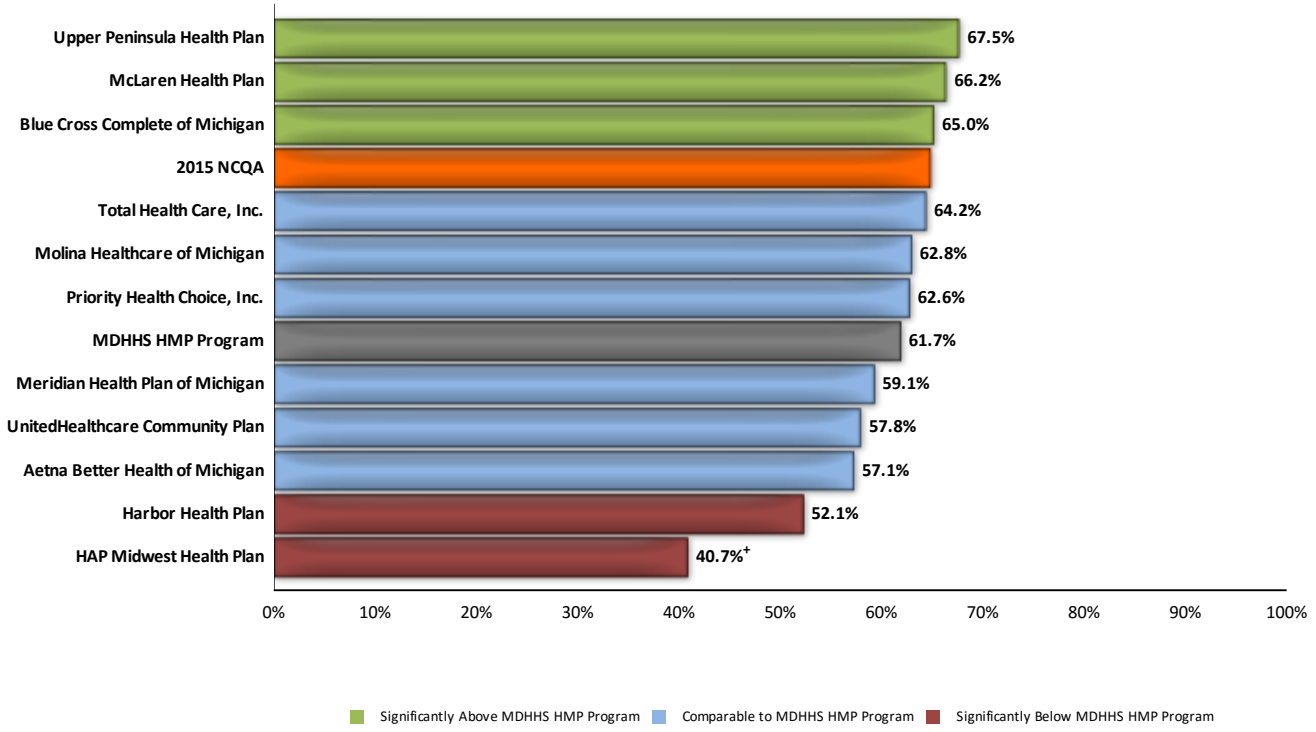


Note: + indicates fewer than 100 responses

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

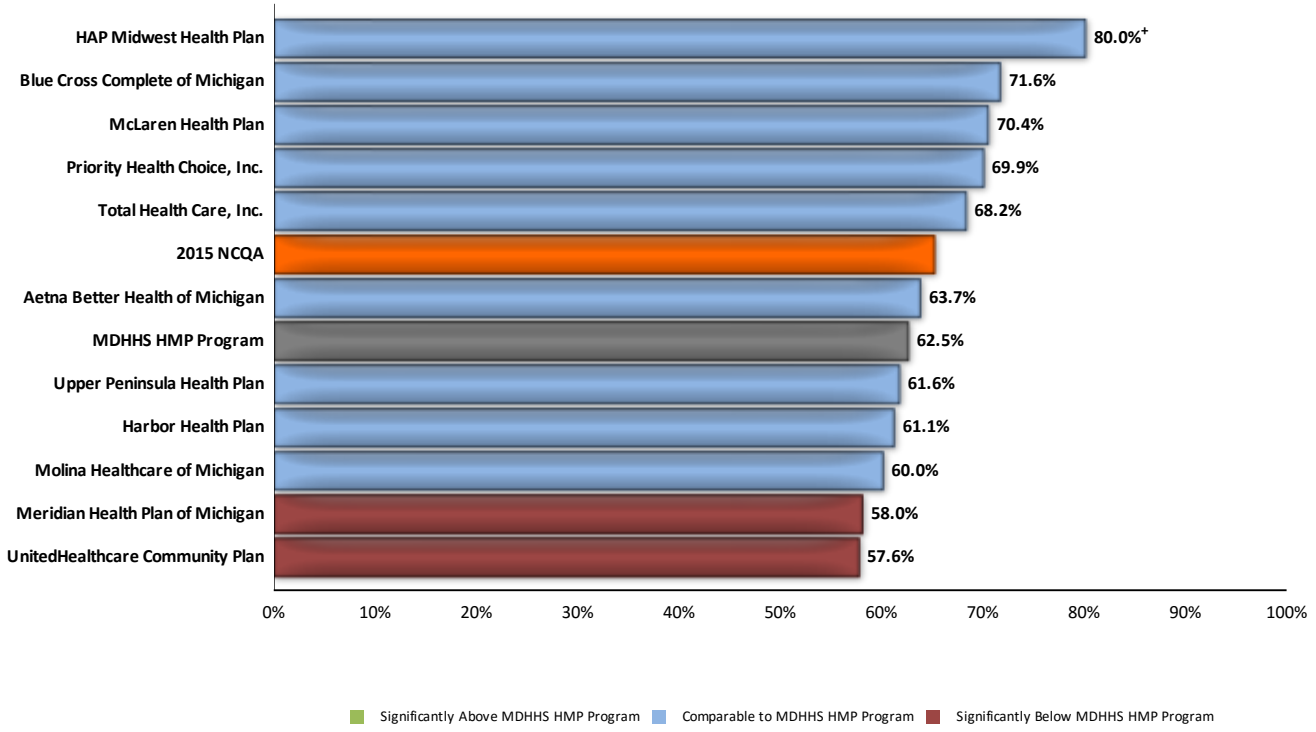


Note: + indicates fewer than 100 responses

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

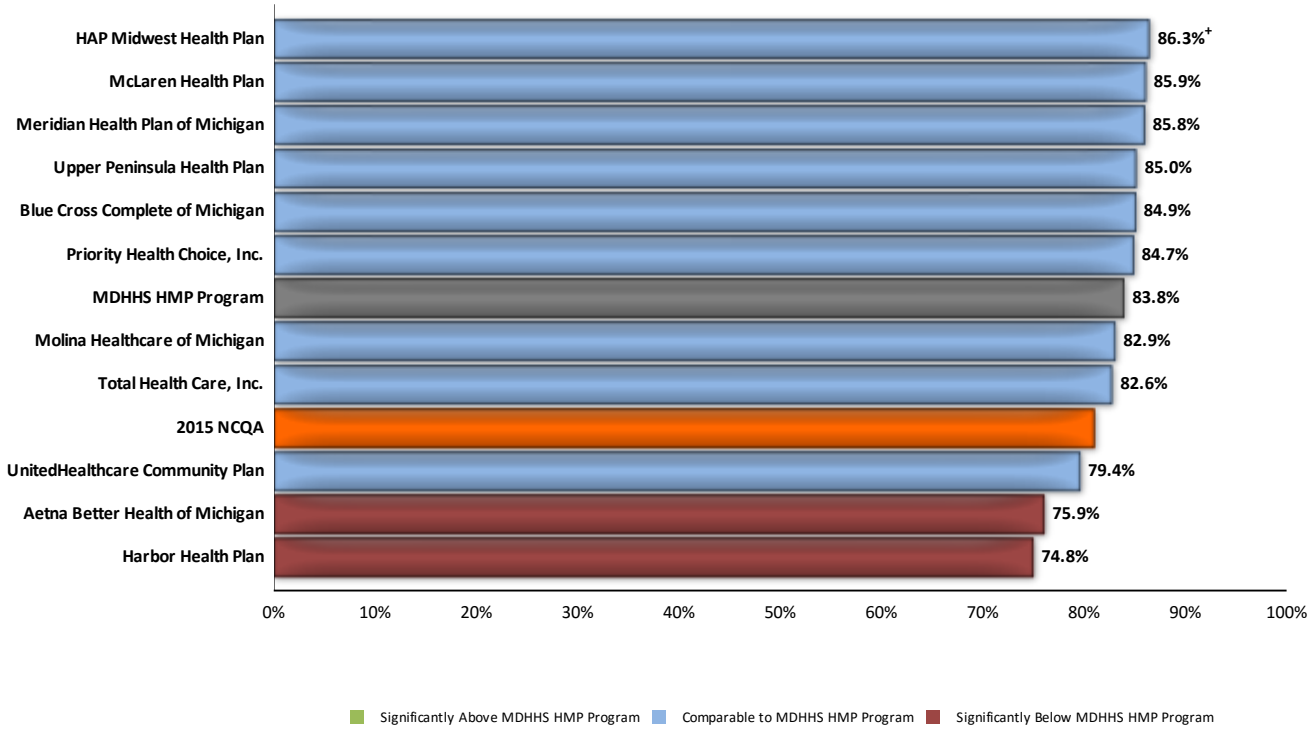
Two questions (Questions 14 and 25 in the CAHPS Adult Medicaid Health Plan Survey) were asked to assess how often it was easy to get needed care:

- **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

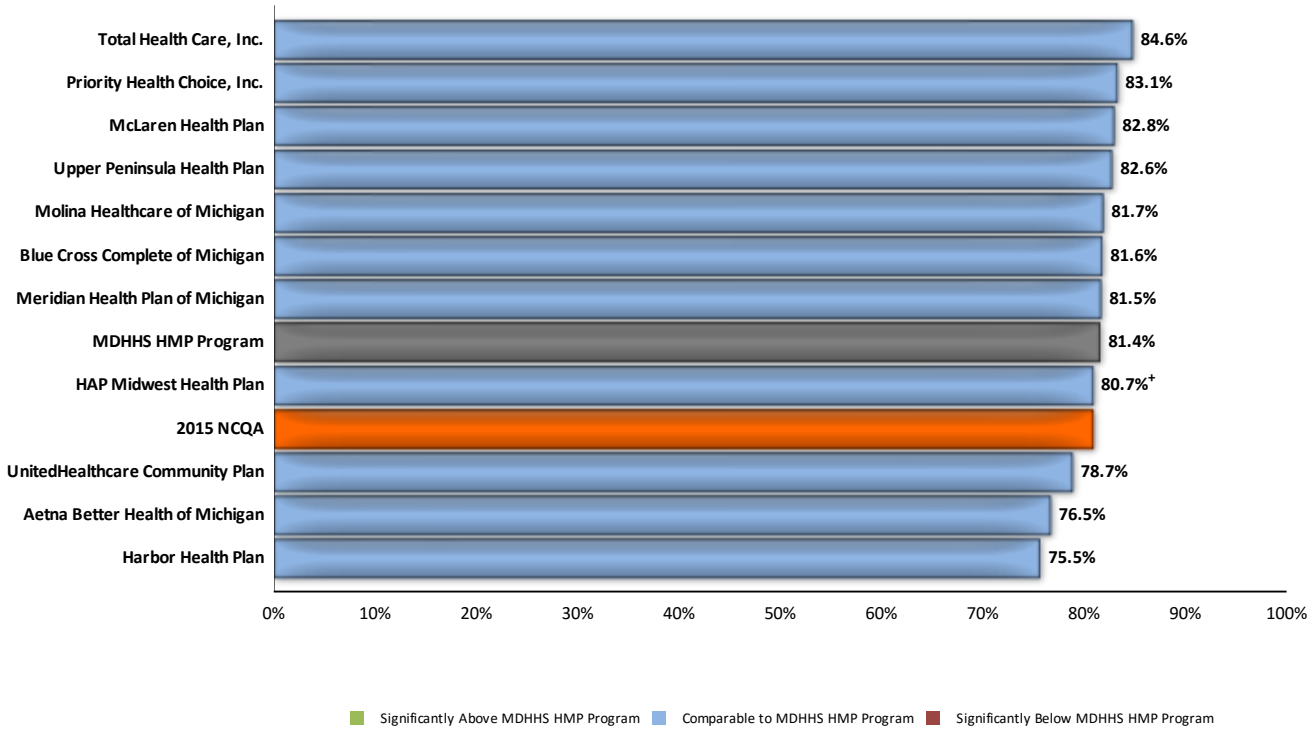
Two questions (Questions 4 and 6 in the CAHPS Adult Medicaid Health Plan Survey) were asked to assess how often adult members received care quickly:

- **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

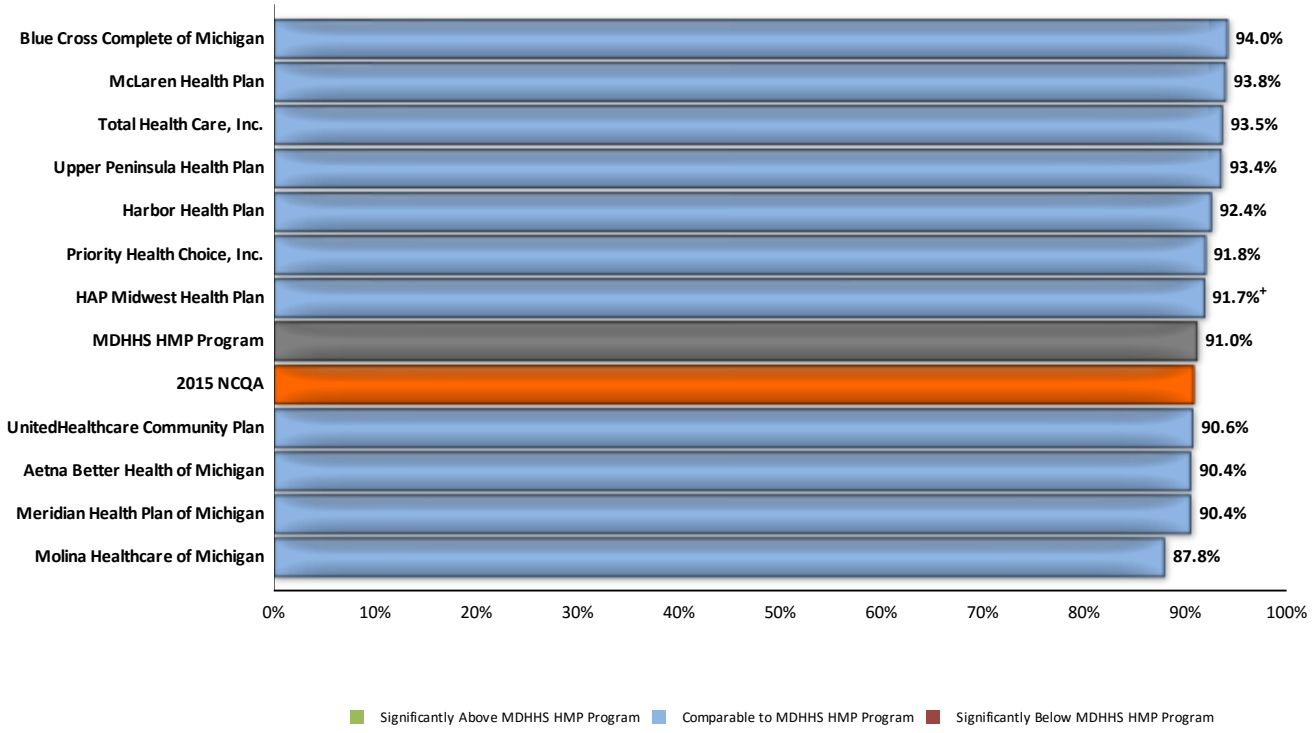
A series of four questions (Questions 17, 18, 19, and 20 in the CAHPS Adult Medicaid Health Plan Survey) was asked to assess how often doctors communicated well:

- **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

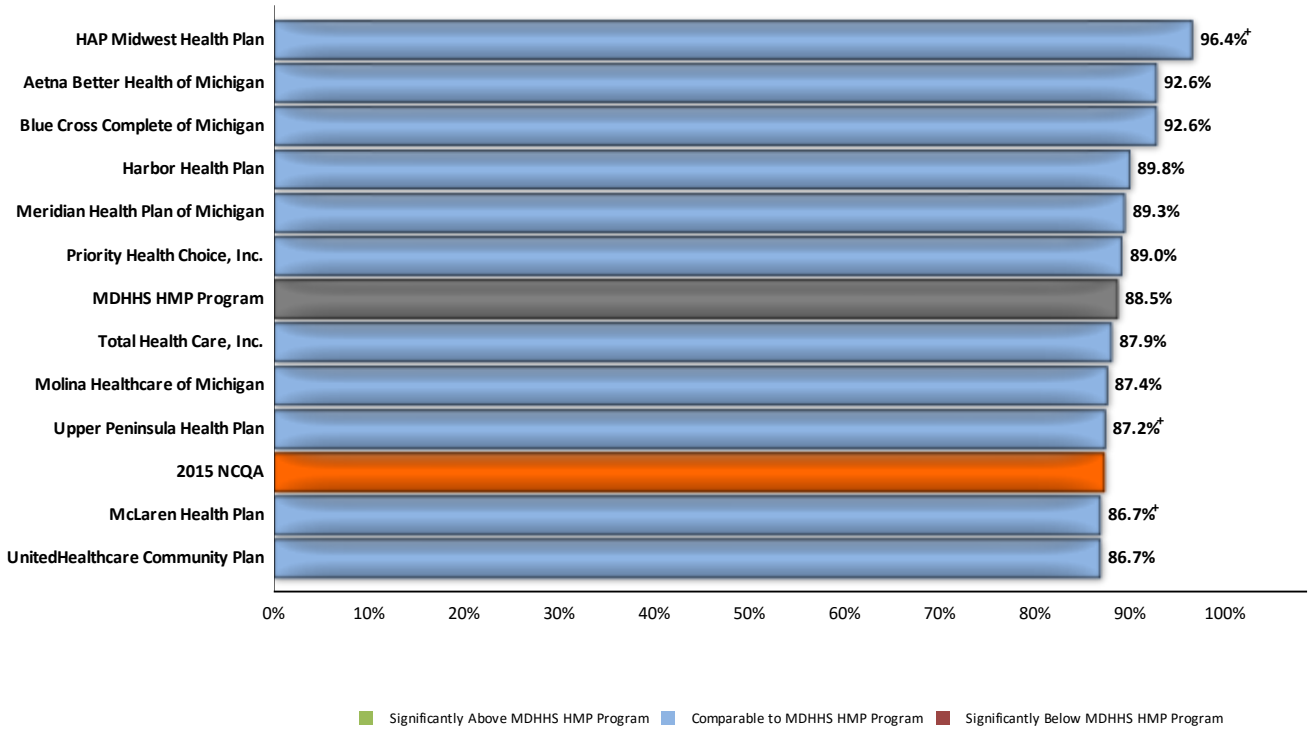
Two questions (Questions 31 and 32 in the CAHPS Adult Medicaid Health Plan Survey) were asked to assess how often adult members were satisfied with customer service:

- **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

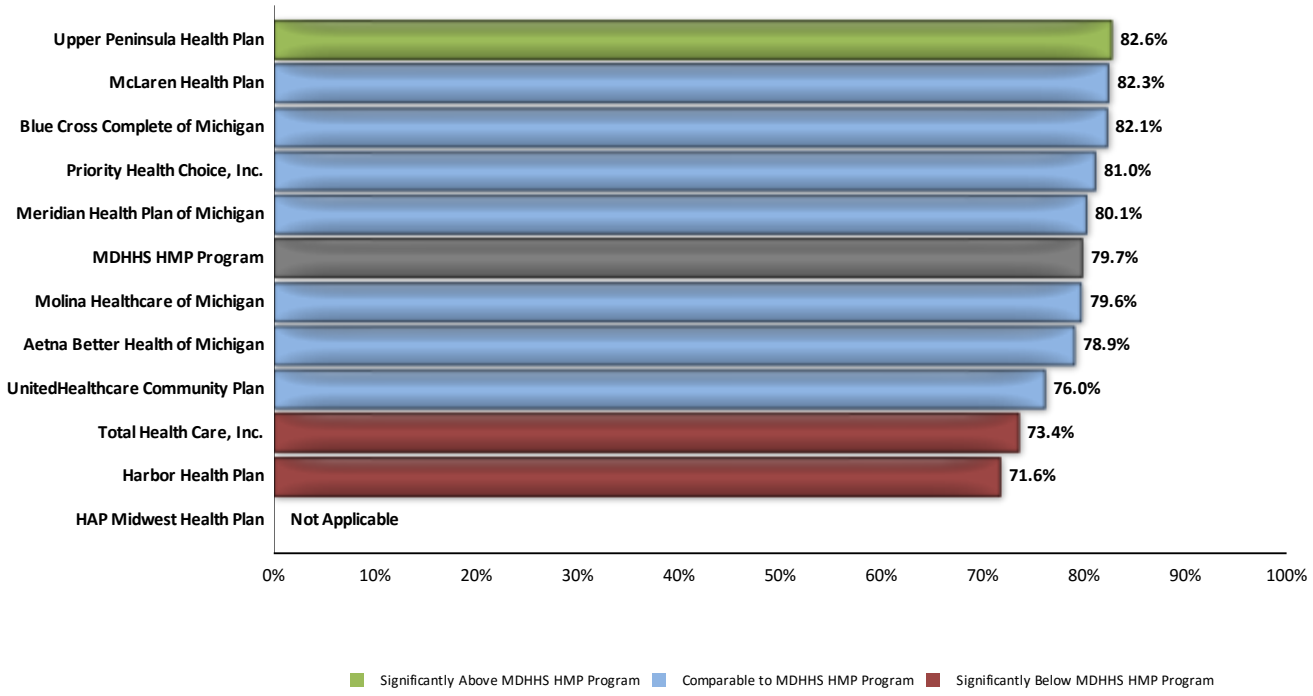
Three questions (Questions 10, 11, and 12 in the CAHPS Adult Medicaid Health Plan Survey) were asked regarding the involvement of adult members in decision making when starting or stopping a prescription medicine:

- **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

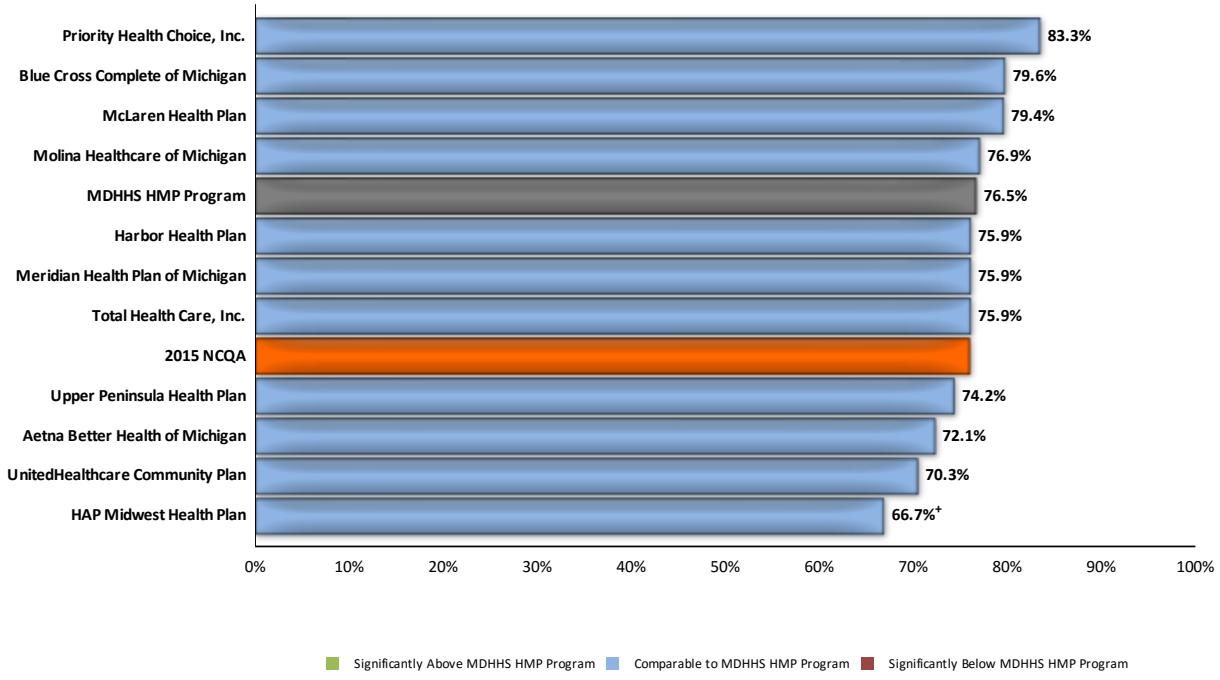
Adult members were asked how often they were advised to quit smoking or using tobacco by a doctor or other health provider (Question 40 in the CAHPS Adult Medicaid Health Plan Survey):

- **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

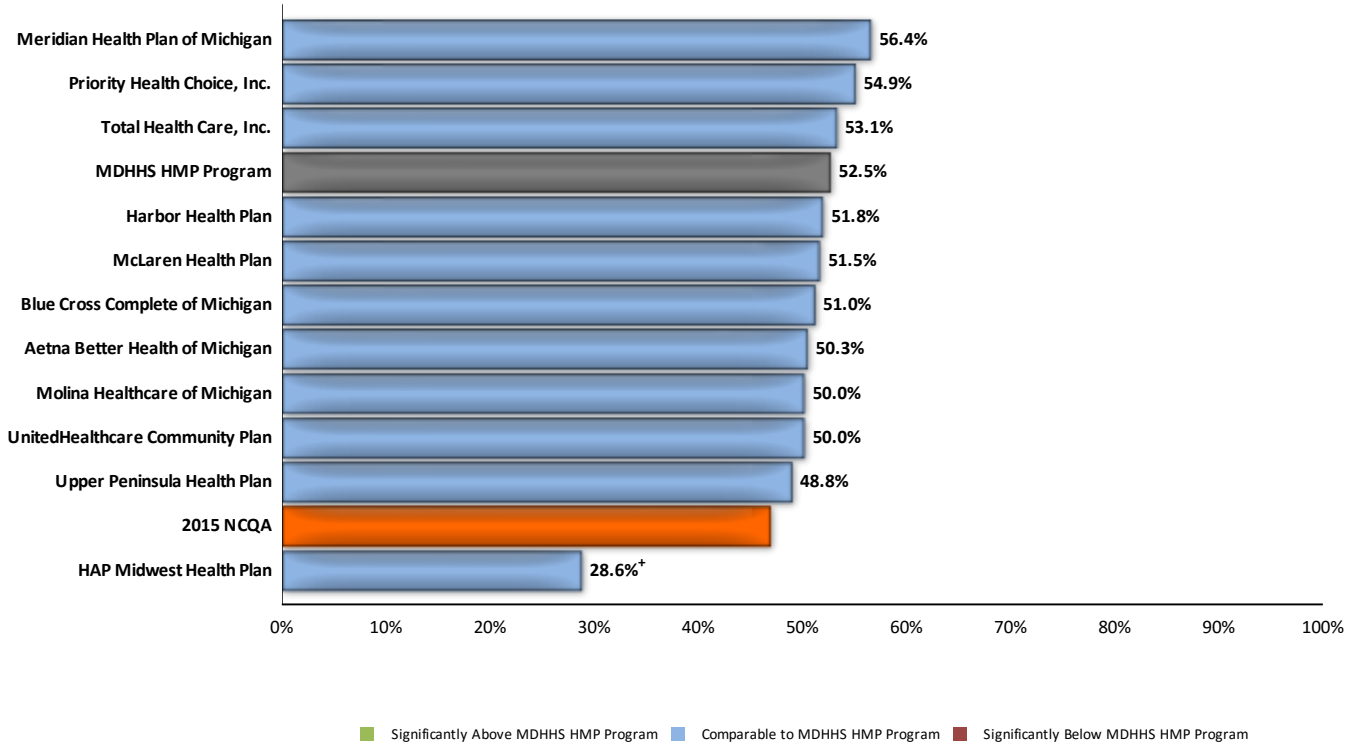
Adult members were asked how often medication was recommended or discussed by a doctor or other health provider to assist them with quitting smoking or using tobacco (Question 41 in the CAHPS Adult Medicaid Health Plan Survey):

- **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

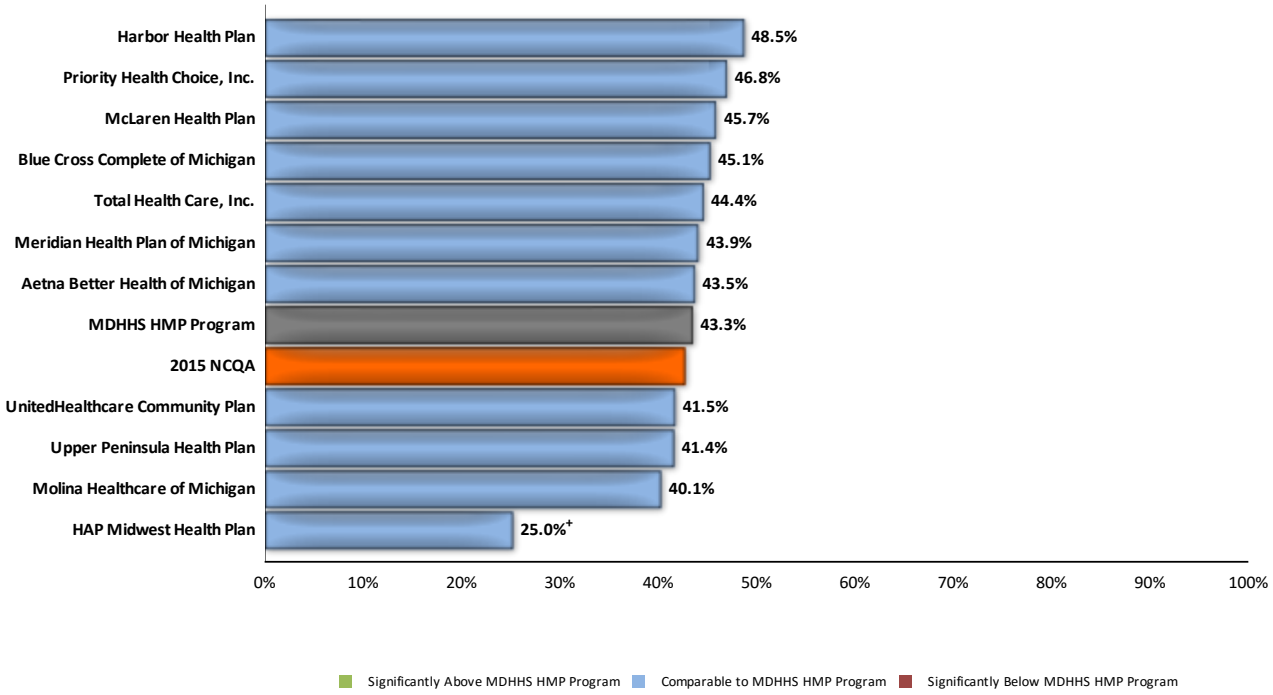
Adult members were asked how often their doctor or health provider discussed or provided methods and strategies other than medication to assist them with quitting smoking or using tobacco (Question 42 in the CAHPS Adult Medicaid Health Plan Survey):

- **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

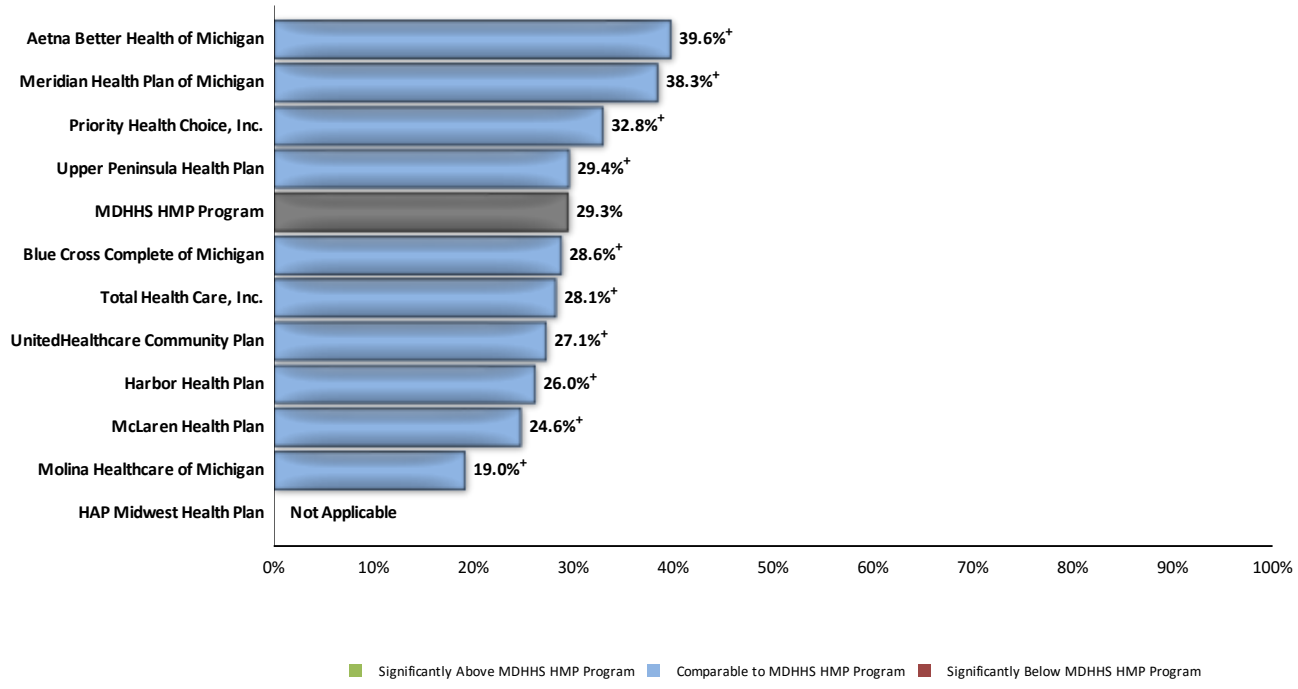
Adult members were asked if they currently take aspirin daily or every other day (Question 43 in the CAHPS Adult Medicaid Health Plan Survey):

- **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

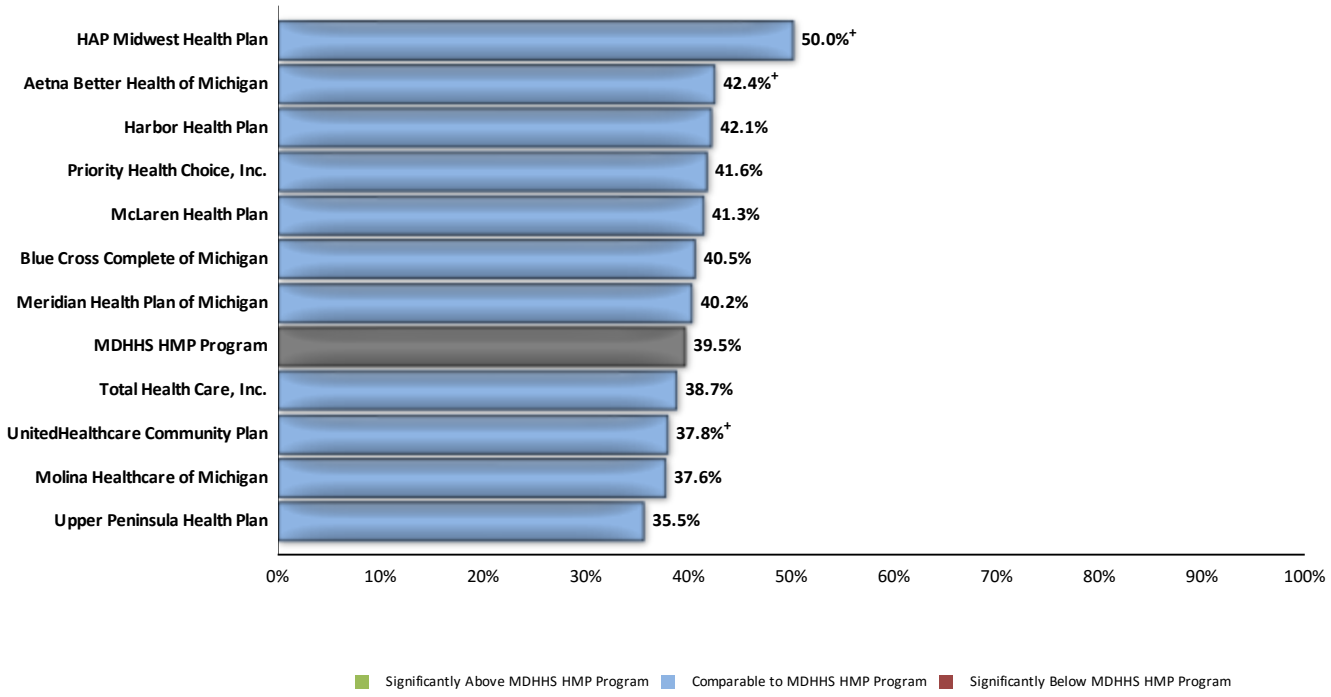
Adult members were asked if a doctor or health provider discussed with them the risks and benefits of aspirin to prevent a heart attack or stroke (Question 45 in the CAHPS Adult Medicaid Health Plan Survey):

- **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

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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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.

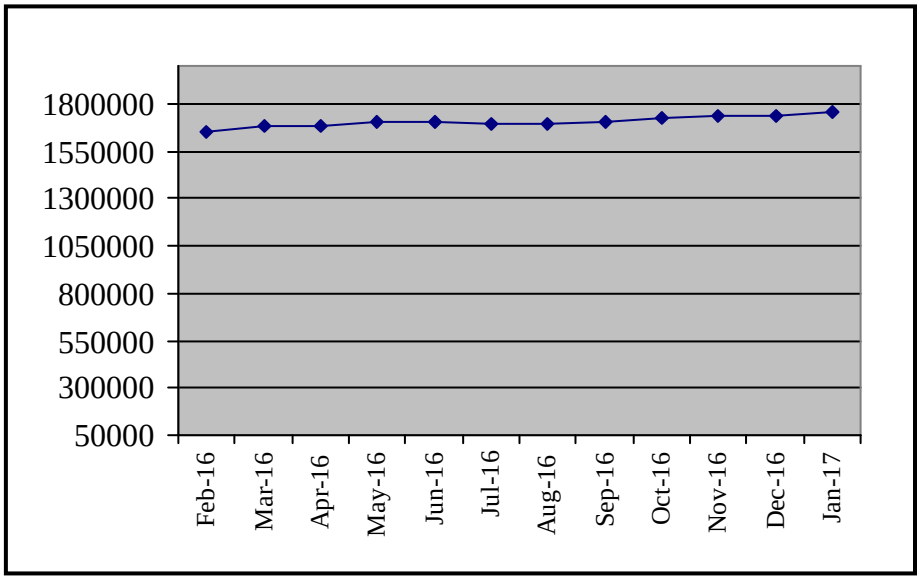
Table 1: Fiscal Year 2017[1]

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

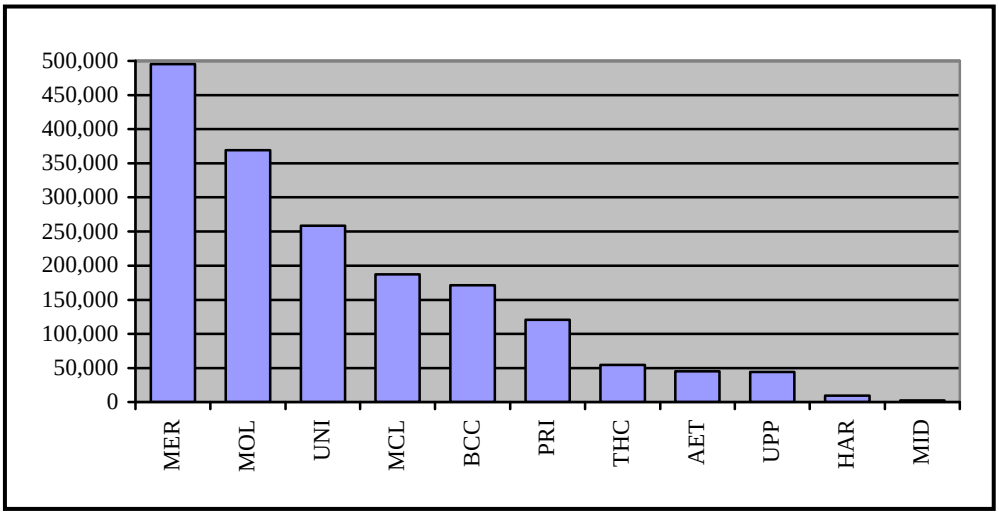
Michigan Medicaid Managed Care (MA-MC) enrollment has remained steady over the past year. In January 2017, enrollment was 1,757,652, up 103,154 enrollees (6.2%) from February 2016. An increase of 16,775 enrollees (1.0%) was realized between December 2016 and January 2017.

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%

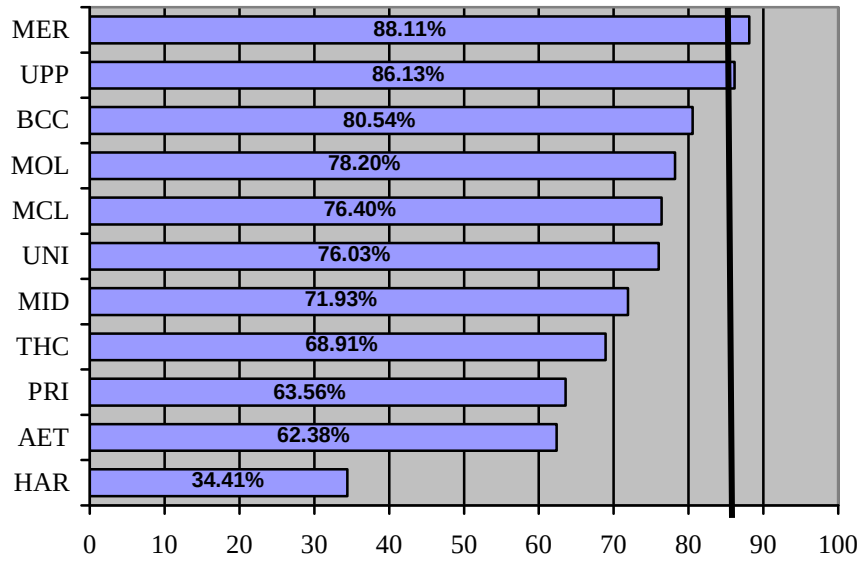
Measurement Period
Calendar Year 2015

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%

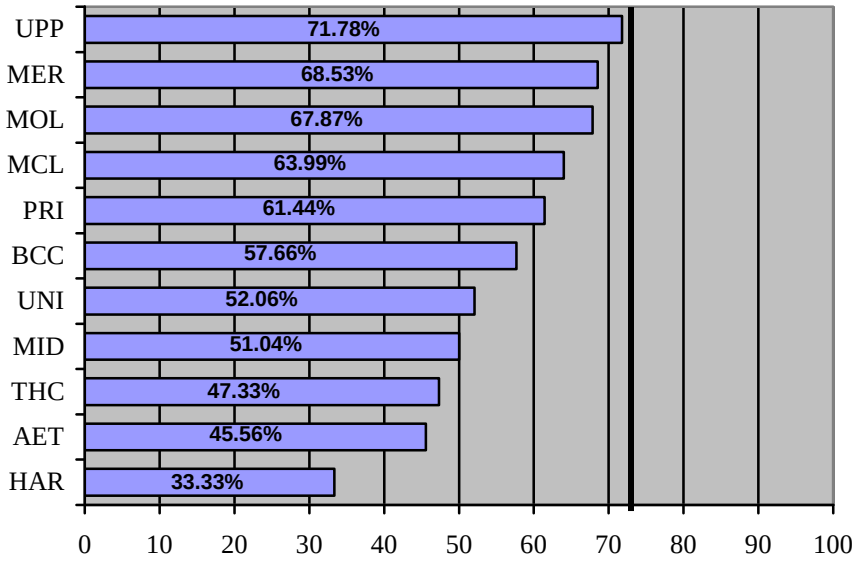
Measurement Period
Calendar Year 2015

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%

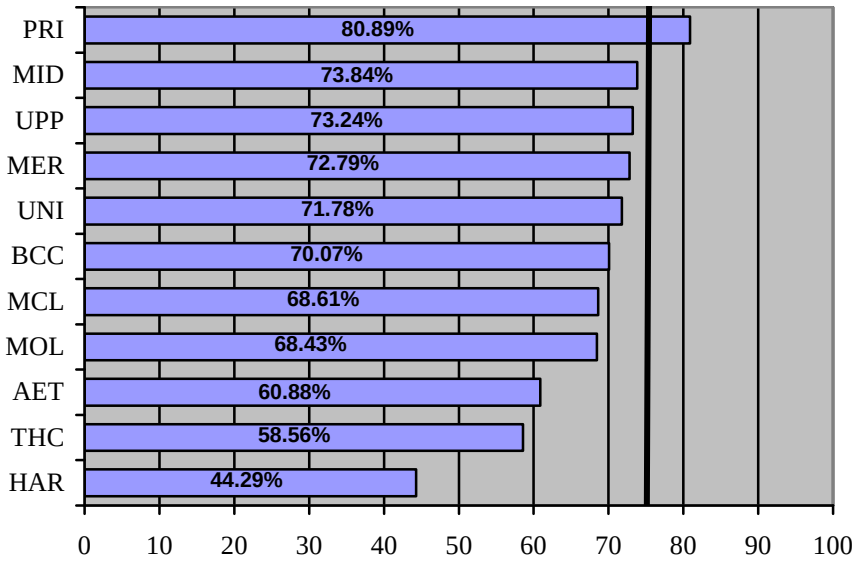
Measurement Period
Calendar Year 2015

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%

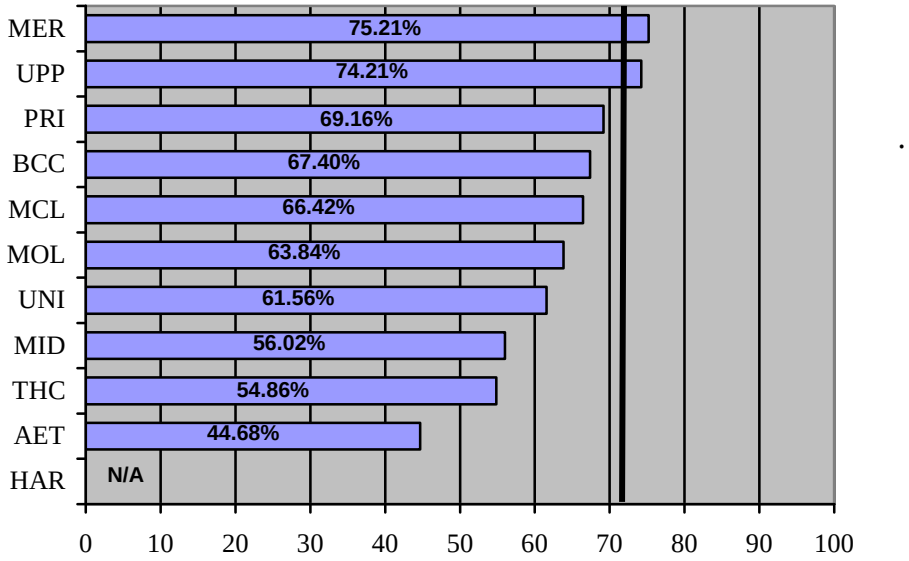
Measurement Period
Calendar Year 2015

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)

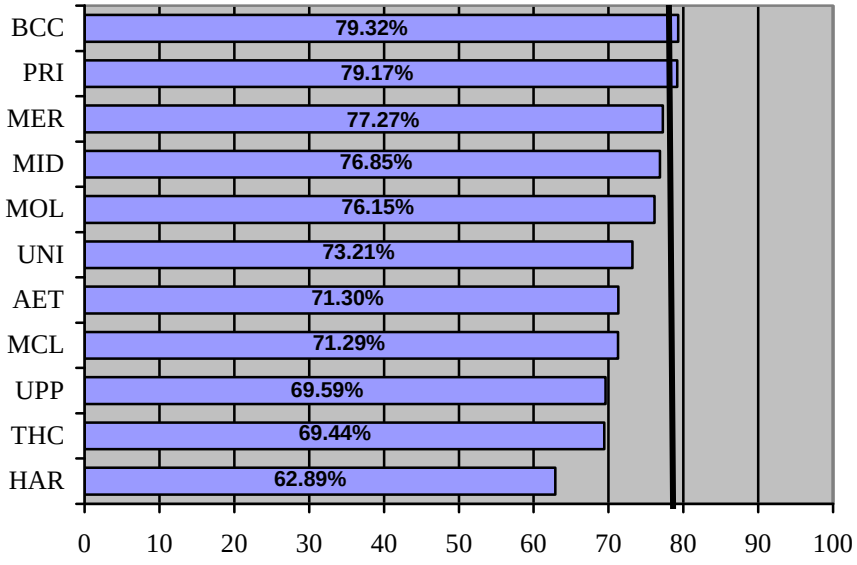
Measurement Period
Calendar Year 2015

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)

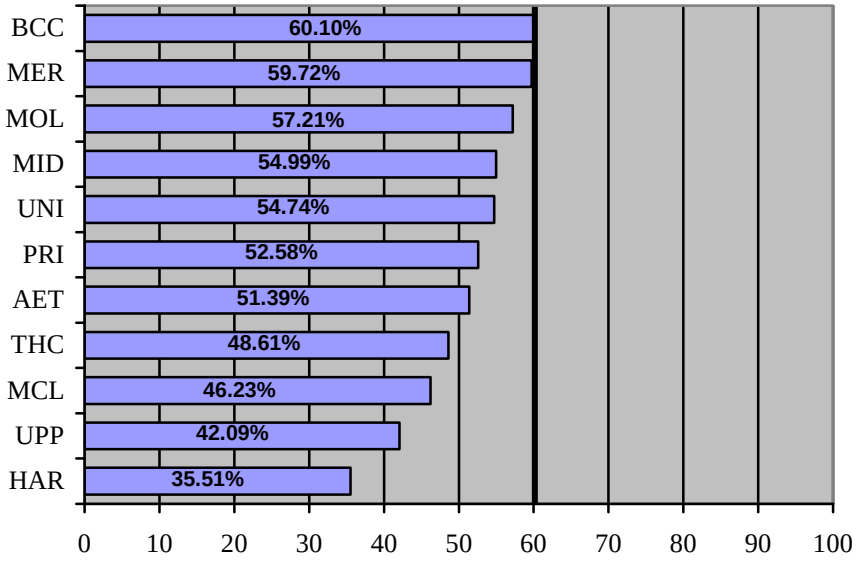
Measurement Period
Calendar Year 2015

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

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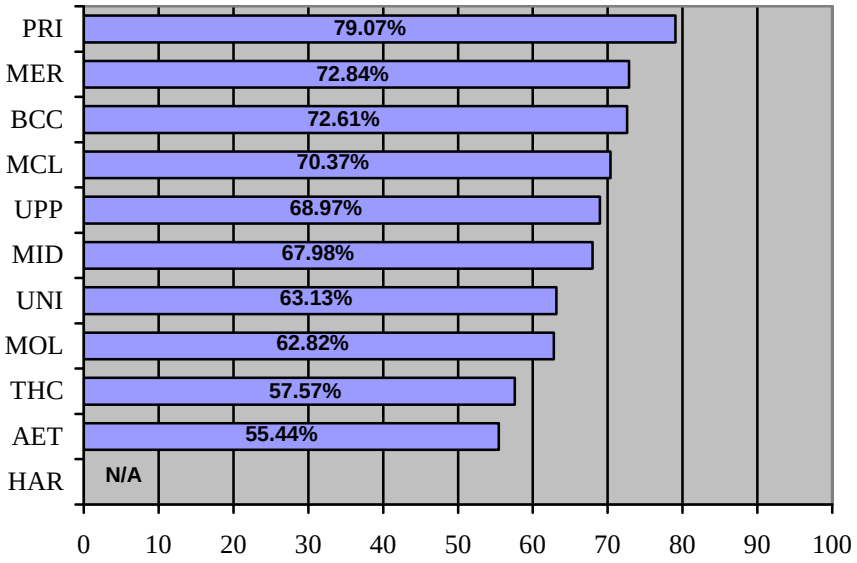
Measurement Period
Calendar Year 2015

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)

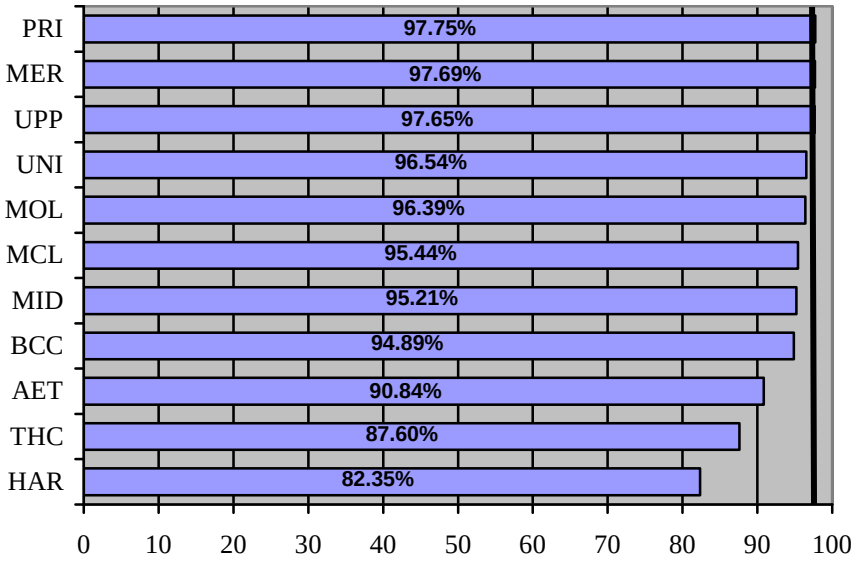
Measurement Period
Calendar Year 2015

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)

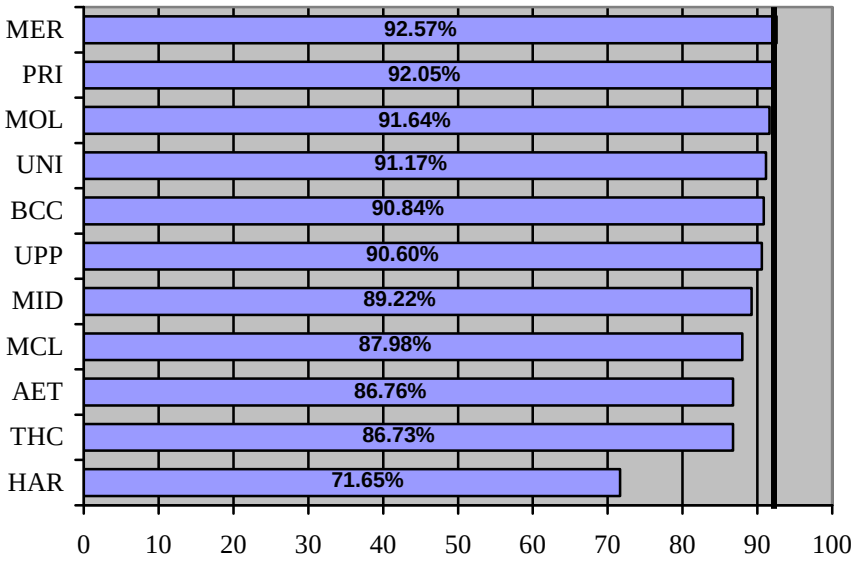
Measurement Period
Calendar Year 2015

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)

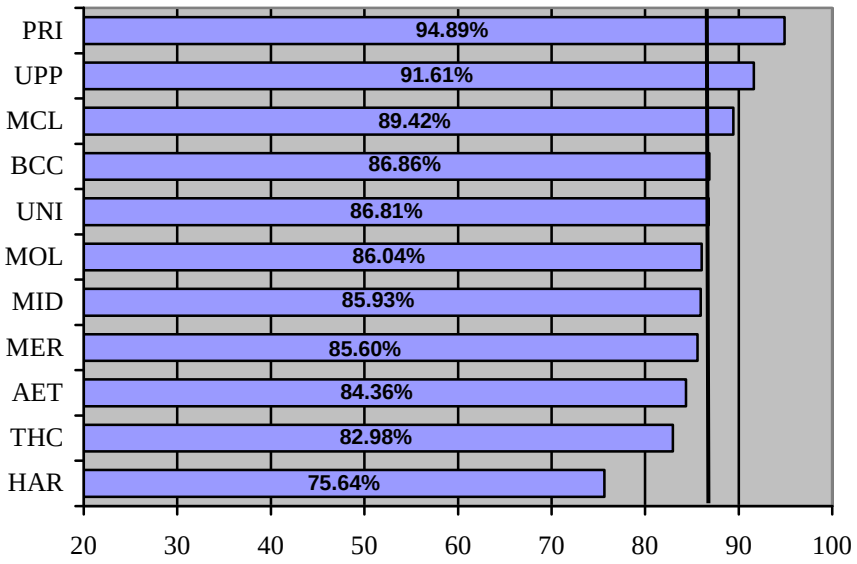
Measurement Period
Calendar Year 2015

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

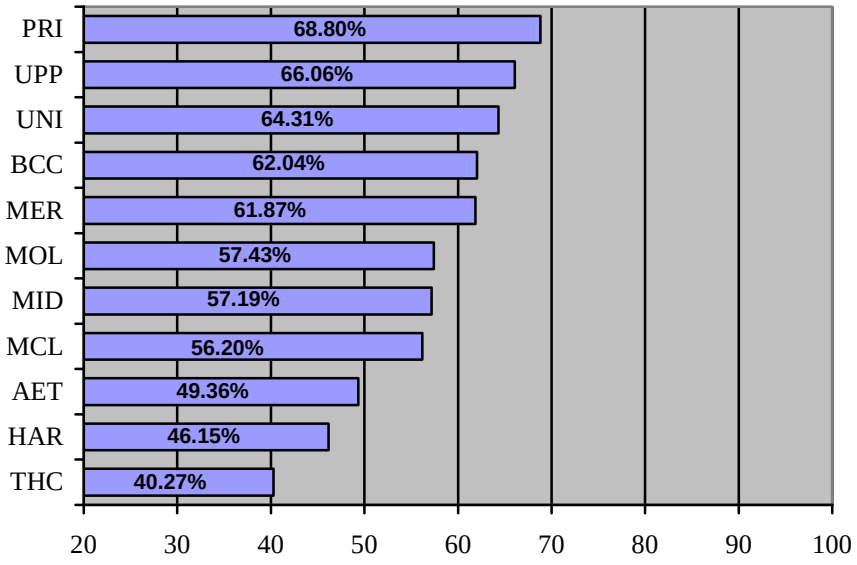
Measurement Period
Calendar Year 2015

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)

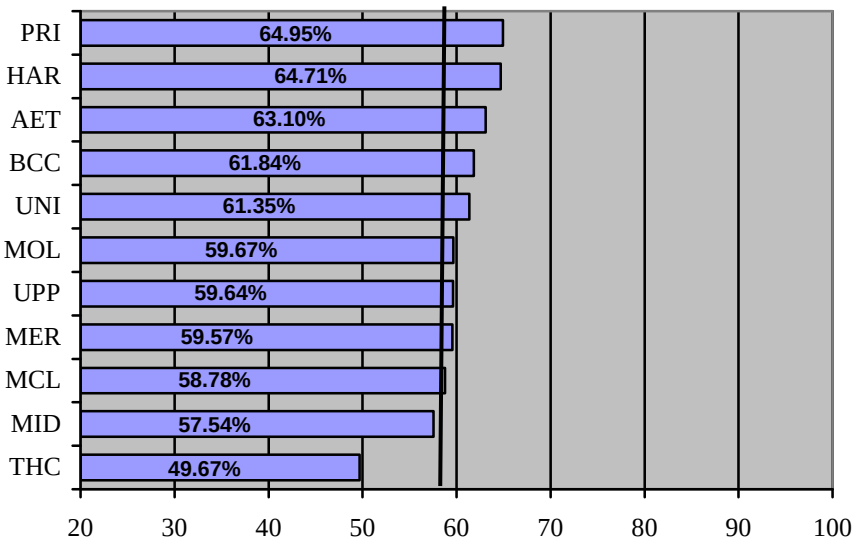
Measurement Period
Calendar Year 2015

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)

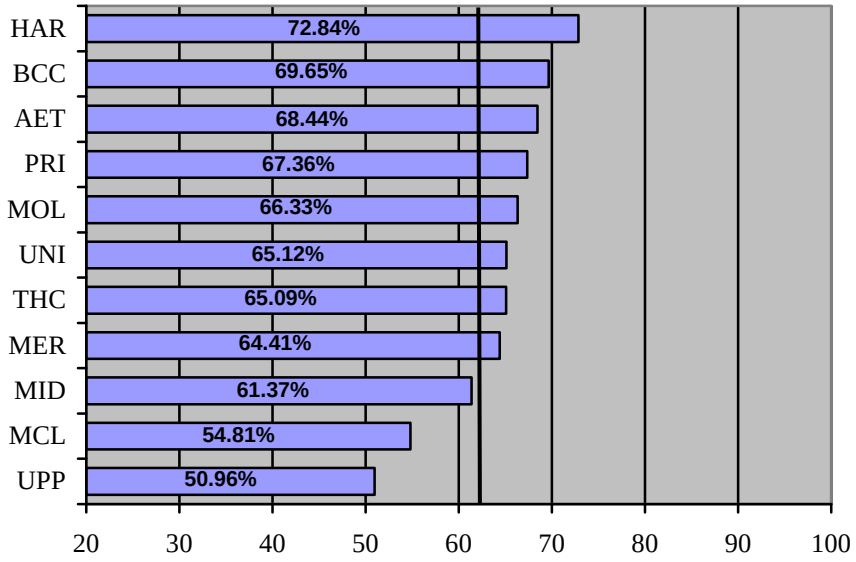
Measurement Period
Calendar Year 2015

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

HEALTHY MICHIGAN PLAN

MDHHS
Michigan Department of Health & Human Services
RICK SNYDER, GOVERNOR | NICK LYON, DIRECTOR

April 2017

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

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Healthy Michigan Plan

Appendixes

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Executive Summary

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

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

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

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

Measurement Frequency

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

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

Table 1: Fiscal Year 2017

Quarterly Reported Measures	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter
Adults' Generic Drug Utilization	11/11	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]

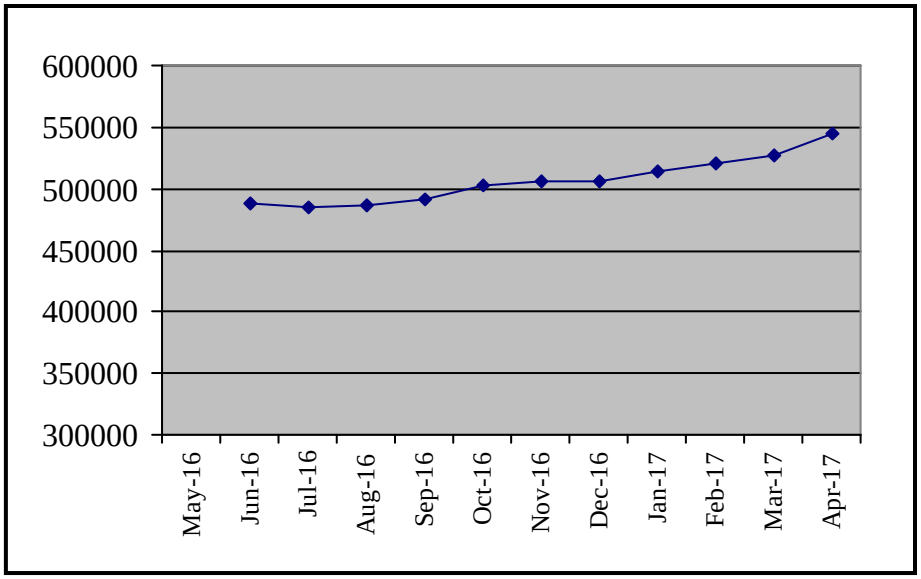
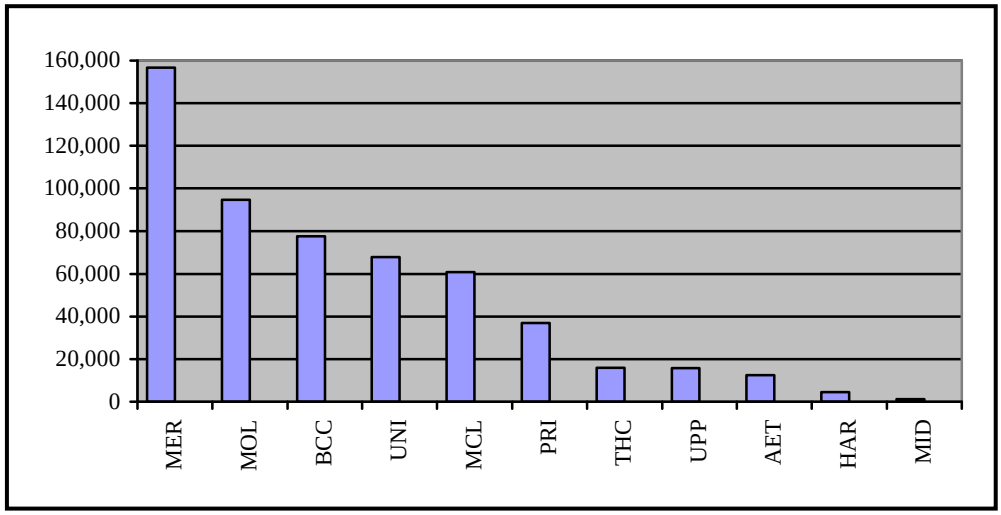


Figure 2: HMP-MC Enrollment by Medicaid Health Plan, April 2017



[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

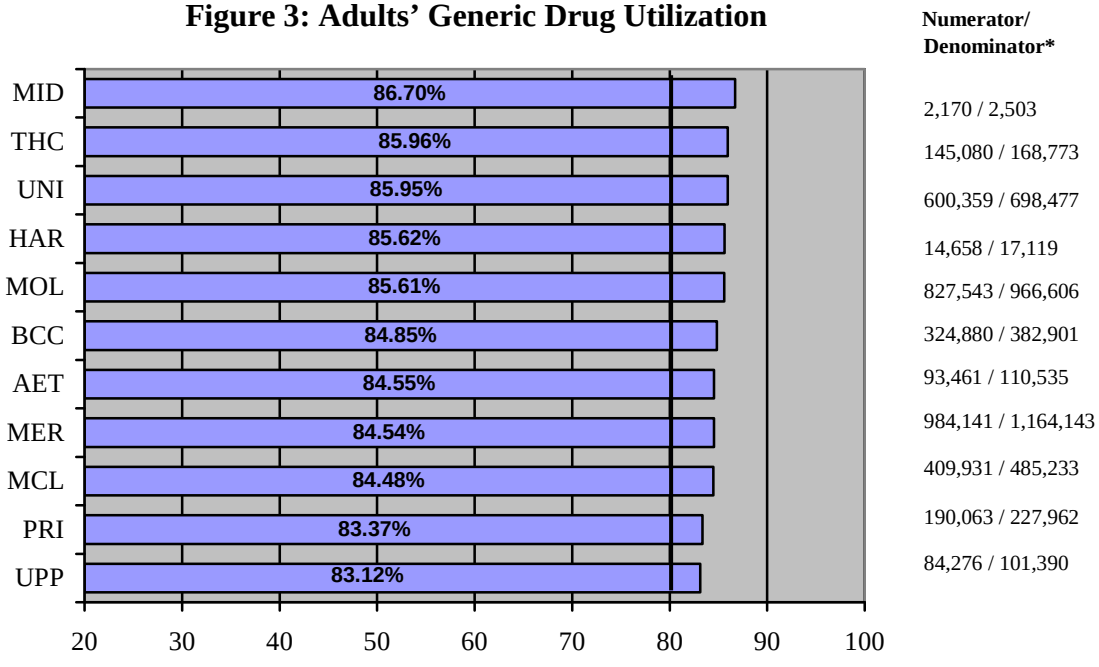
Measurement Frequency
Quarterly

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

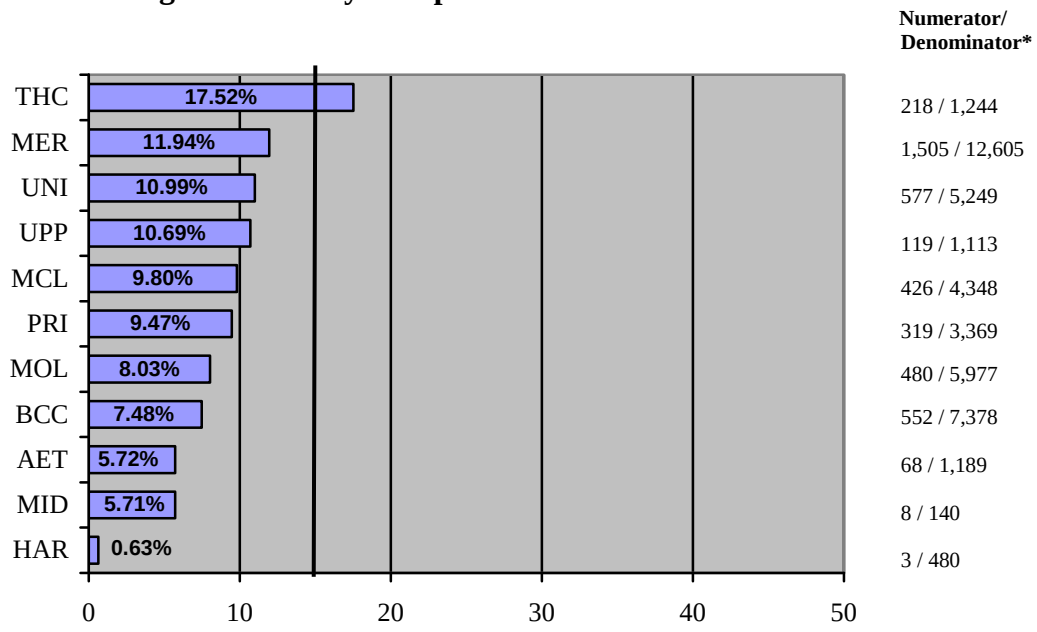
Measurement Frequency
Quarterly

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

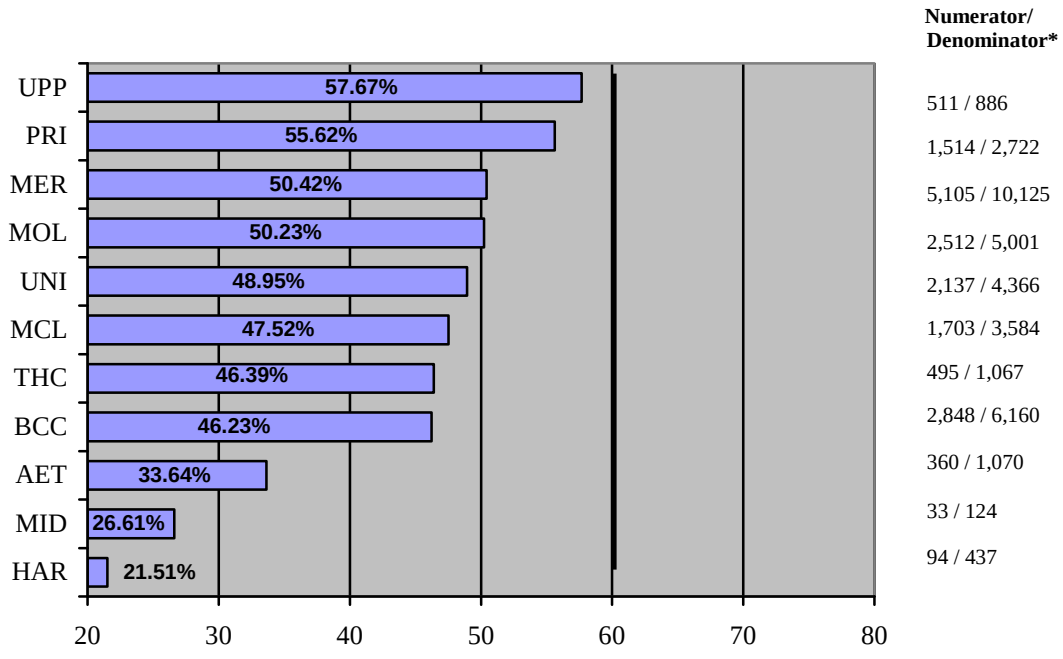
Measurement Frequency
Quarterly

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

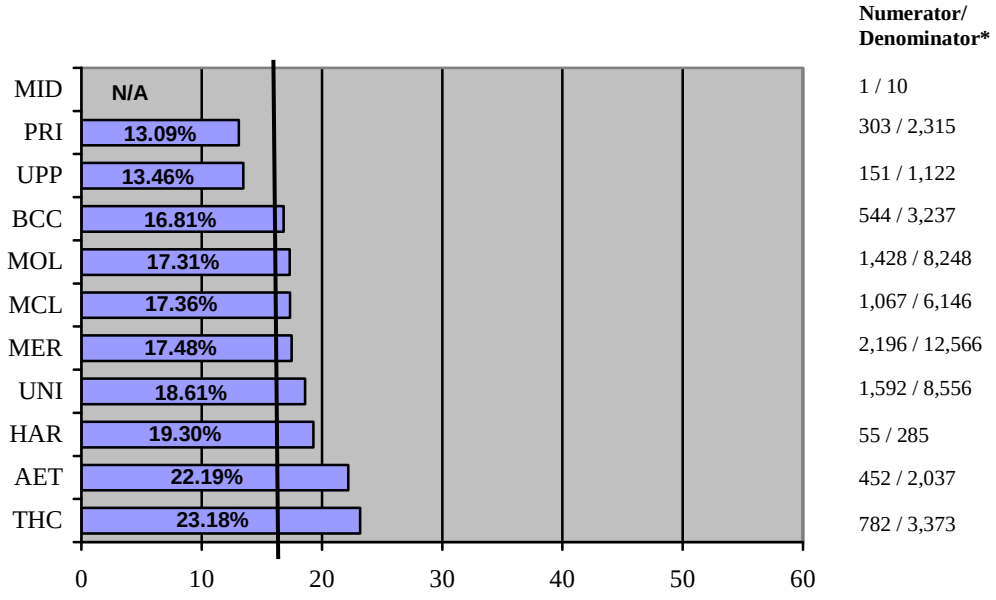
Summary: Two of the plans met or exceeded the standard, while eight plans (AET, BCC, HAR, MCL, MER, MOL, THC, and UNI) did not. Results ranged from 13.09% to 23.18%.

*****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

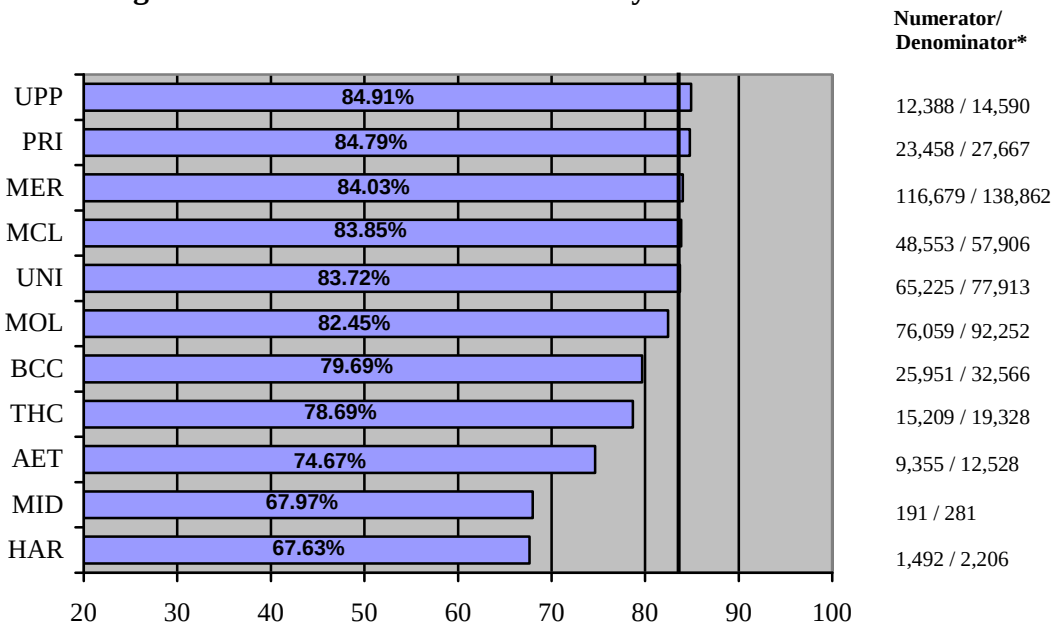
Measurement Frequency
Quarterly

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

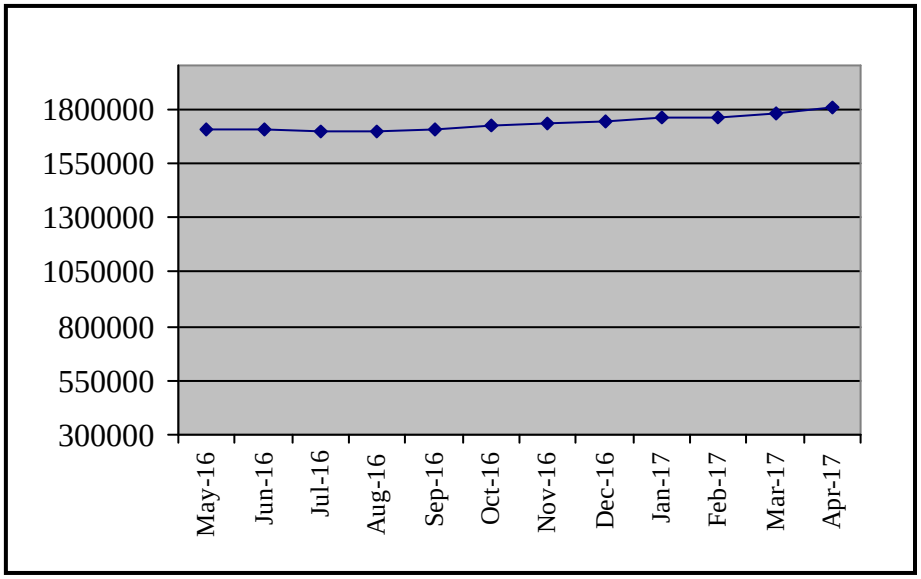
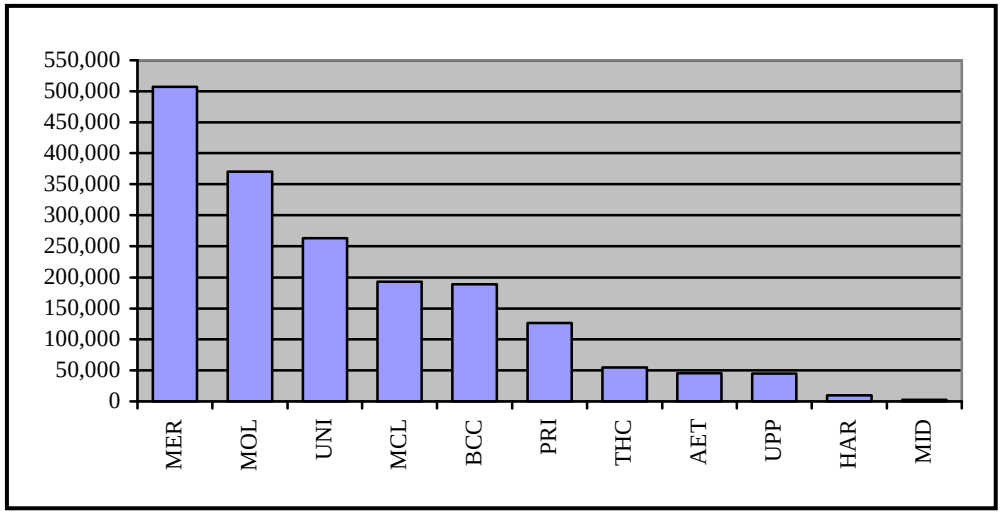


Figure 2: Medicaid Managed Care Enrollment by Health Plan, April 2017



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

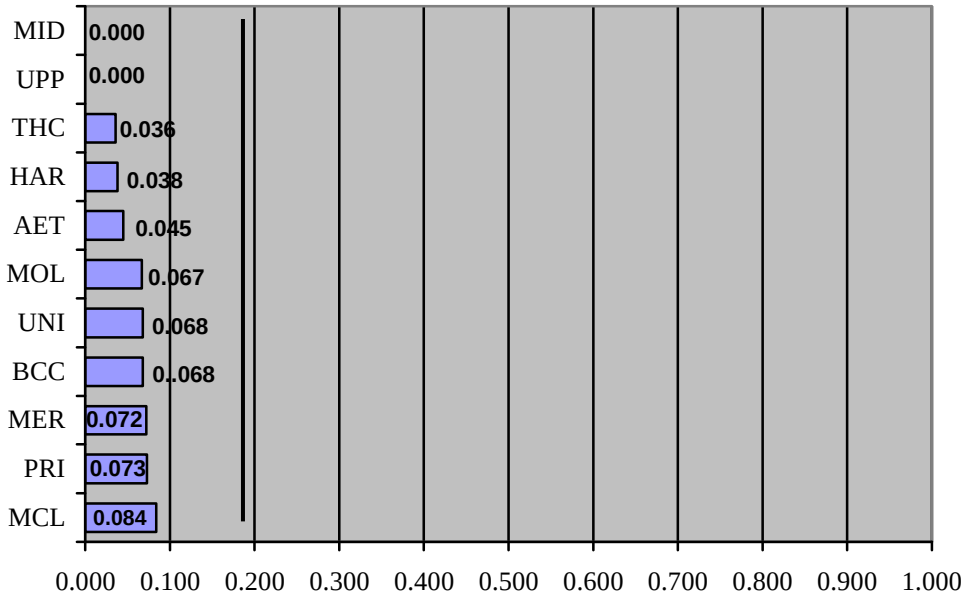
Data Source
Customer Relations System (CRM)

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 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	Yes	Yes	Yes

Table 14: Pharmacy Encounter Data Reporting March 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	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

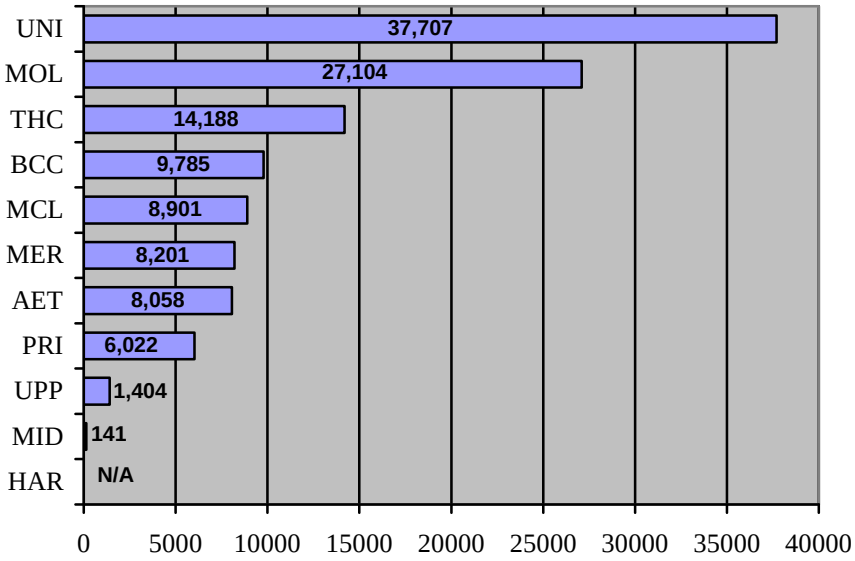
Measurement Period
January 2017 – March 2017

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

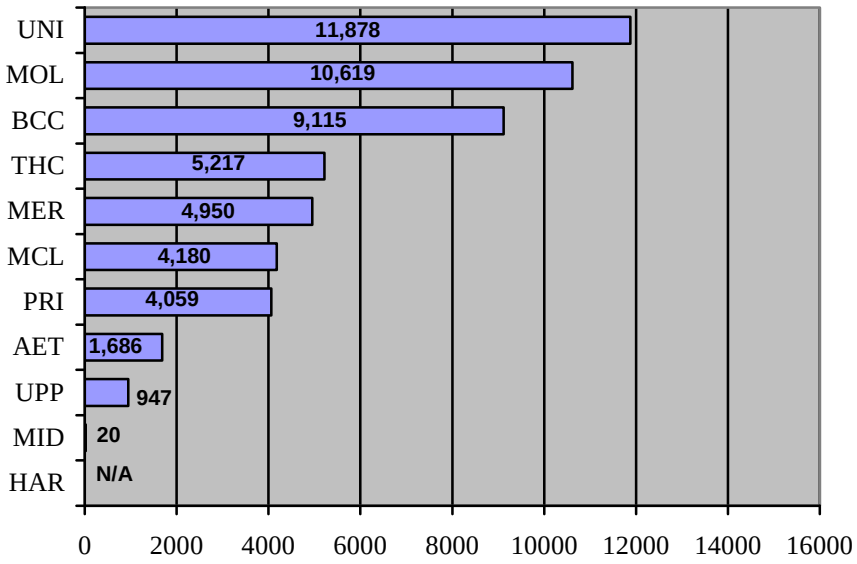
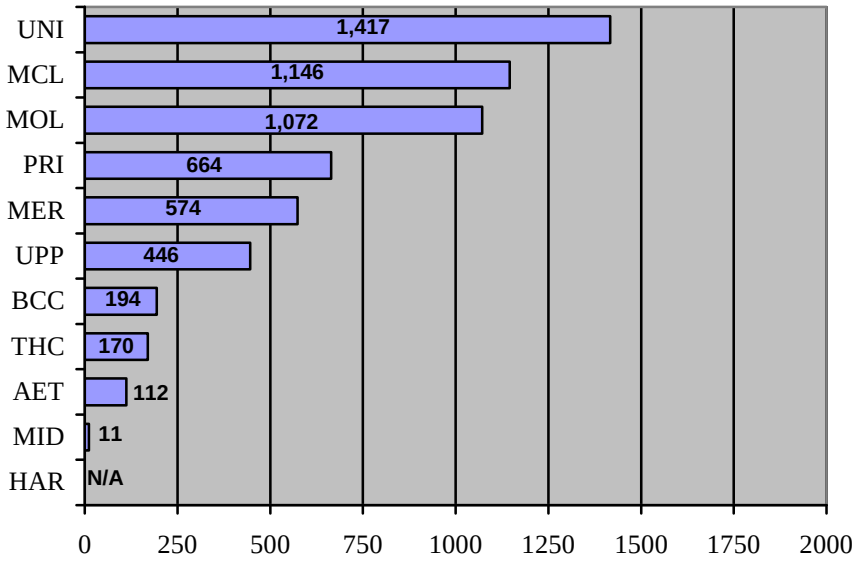


Figure 6: NEMT CSHCS-MC Encounter Submissions



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 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**

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

Appendix B: One Year Plan-Specific Analysis

Total Health Care – THC

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**

- Shaded areas represent data that are newly reported this month.
- 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**

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

Appendix B: One Year Plan-Specific Analysis

UnitedHealthcare Community Plan – UNI

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**

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

Appendix B: One Year Plan-Specific Analysis

Upper Peninsula Health Plan – UPP

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**

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

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**

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

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

April 2017

HSAG HEALTH SERVICES ADVISORY GROUP

Table of Contents

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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.

ATTACHMENT F
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 F
Demonstration Evaluation Plan

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ATTACHMENT F
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 F
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 F
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 F
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)									

	24.8	24.1	23.6	53.0	53.7	52.2			
<125% FPL	%	%	%	%	%	%	18,071	18,813	18,492
125-399%	15.2	14.6	14.0	13.8	14.6	14.3			
FPL	%	%	%	%	%	%	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)									
				37.7	38.7	39.3			
0-18	4.6%	4.2%	4.5%	%	%	%	23,412	22,347	22,033
	27.6	24.9	23.5	16.5	17.0	16.4			
19-34	%	%	%	%	%	%	16,847	17,135	16,895
	14.4	14.7	14.5	11.4	12.1	11.5			
35-64	%	%	%	%	%	%	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

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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2. Dombkowski K.J., Stanley R.M., Clark S.J. (2004). The influence of Medicaid managed care enrollment on emergency department utilization by children. *Archives of Pediatrics and Adolescent Medicine 158*, 17-21.

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.

4. Eklund S.A., Pittman J.L., Clark S.J. (2003) Michigan Medicaid's Healthy Kids Dental program: an assessment of the first 12 months. *Journal of the American Dental Association 134*, 1509-15.

ATTACHMENT F
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**

	(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 F
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

Arkansas Center for Health Improvement. Arkansas Health Care Independence Program ("Private Option") Section 1115 Demonstration Waiver Interim Report. Appendix 1 Arkansas Evaluation Hypotheses: Proposed & Final Test Indicators. Little Rock (AR): Arkansas Center for Health Improvement. June 16, 2016.

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U.S. Department of Health and Human Services Office of the Inspector General. Access to care: Provider availability in Medicaid managed care. Available at: http://oig.hhs.gov/oei/reports/oei-02-13-00670.pdf

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 F
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

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

January 16, 2018

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

INSTITUTE FOR HEALTHCARE POLICY & INNOVATION
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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

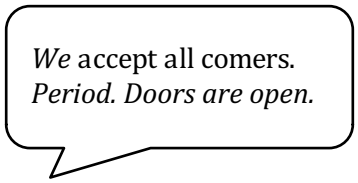
- 53% report knowing a patient's insurance at the beginning of an appointment
- 91% report that it is easy to find out a patient's insurance status
- 35% report intentionally ignoring a patient's insurance status

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
- 56% 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 predominantly uninsured, Medicaid and mixed payer mixes and suburban practices were more likely to report an increase in new patients. FQHCs, and those with predominantly 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.

Your working poor people who just were in between the cracks, didn't have anything, and now they've got something, which is great.

- 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.
- MiPCT practices were more likely to have newly co-located mental health in the past year.

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 some influence on HRA completion
- 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
- 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

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.

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

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.

- 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

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 improving 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

Conclusions

Our survey results, and the more detailed accounts from interviews, indicate that HMP has improved access to care and, especially for previously uninsured patients, led to new detection of serious conditions, adherence to medications, management of chronic conditions, and improved health behaviors.

PCPs in Michigan, as in other states, 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 regimens. Most PCPs also reported that the Healthy Michigan Plan had a positive impact on improved health behaviors, better ability to work or attend school, improved emotional wellbeing and improved ability to live independently. In interviews, PCPs described previously uninsured patients for whom they had identified serious illness early; survey results confirmed these are frequent experiences reported by PCPs.

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 care in primary care; and consulting with care coordinators, case managers, and community health workers. Perhaps due to those changes, few reported that established patients' access to same- or next-day appointments worsened.

We found that PCP demographics, salary structure, history of caring for the underserved and perceived practice capacity were all associated with continued acceptance of new Medicaid patients. These results confirm several of the same factors considered important to PCPs in prior studies – practice capacity, specialist availability, medical and psychosocial needs of Medicaid patients. In addition, PCPs in our survey placed less emphasis on reimbursement, perhaps because many served in salaried positions, or because they instead emphasized professional commitment to caring for the poor and underserved.

Access to some services (e.g., specialty care, mental health care) remains challenging. Disparities in access have been noted for Medicaid patients before and after the ACA in other states. As one of our interviewed physicians said, "It's kind of a mess. But I don't blame Medicaid expansion for that. It was a mess before then."

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

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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

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 (3,686 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 characteristics, and measures related to the Healthy Michigan Plan on a variety of topics, including:

- Plans to accept new Medicaid patients
- 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)
- New practice approaches adopted within the previous year
- Future plans regarding care of Medicaid patients

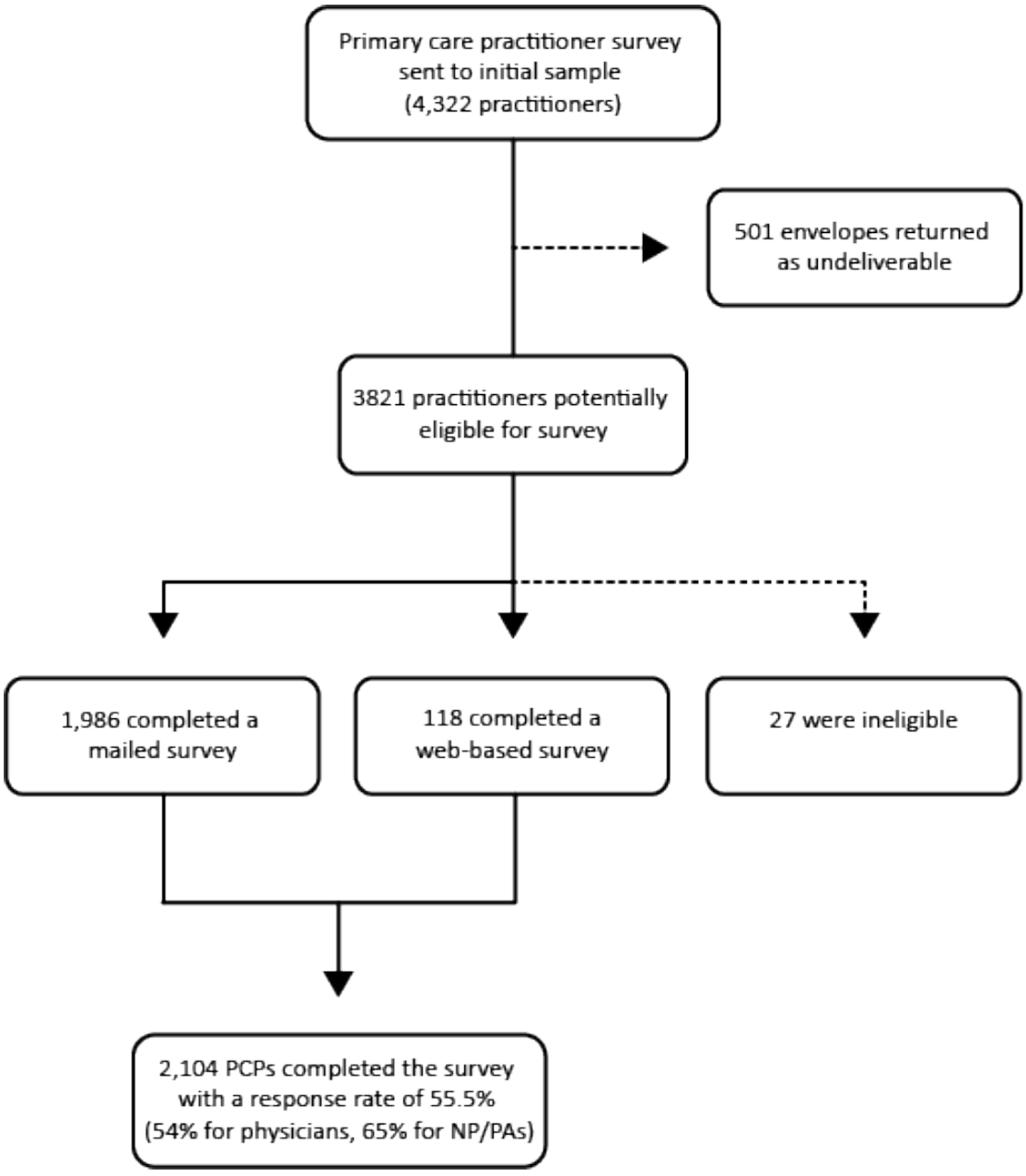
Drs. Goold, Campbell and Tipirneni developed the survey questions in collaboration with other members of the research team. The development process began by identifying the key survey domains through an iterative process with the members of the evaluation team. Then, literature searches identified survey 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) (Figure 1).

Figure 1. Flowchart of PCP Survey Response Rates



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 and practiced in urban areas (Table 1).

Table 1. Comparison of Respondents to Nonrespondents

	Respondents (N=2,104)	Nonrespondents (N=1,690)	p
Gender			
Female	44.6	43.7	NS
Male	55.4	56.3	
Birth Year			
1970 or earlier	71.0	69.5	NS
1971 or later	29.0	30.5	
Medicaid Managed Care Plans			
1 plan	20.5	20.1	NS
2 plans	27.2	25.7	
3 or more plans	52.3	54.2	
Practice setting			
FQHC	14.9	14.7	NS
Not FQHC	85.1	85.3	
Specialty			
Family/general practice	54.5	51.0	
Internal medicine	27.3	36.3	<.0001
Nurse practitioner/physician assistant	17.0	11.3	
Ob-gyn/other	1.2	1.4	
Urbanicity			
Urban	75.8	83.1	<0.001
Suburban	8.8	7.3	<0.001
Rural	15.4	9.6	
Region			
Upper Peninsula/Northwest/Northeast	14.5	8.3	
West/East Central/East	32.9	31.6	<0.001
South Central/Southwest/Southeast	21.3	23.9	
Detroit Metro	31.3	36.3	

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 multivariate 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. Multivariate 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. To address practice-level clustering where more than one PCP from a practice completed the survey, sensitivity analyses were performed for each regression model, adding practice ID as a random intercept in the model. Results from these analyses did not represent any changes in significance or direction of associations, and full output from these analyses can be found in the appendix.

RESULTS FROM SURVEY OF PRIMARY CARE PRACTITIONERS

Survey results are presented in the following format:

Topic

Key findings

Illustrative quote(s) from PCP interviews

Tables of Results

Numeric endnotes in tables refer to citations for survey measures

NS indicates p≥.05

Results of analysis of relationships (e.g., chi-square, multivariate logistic regression) with reference to tables in Appendix A.

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 non-physician 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).

Table 2. Personal, Professional and Practice Characteristics of PCP Respondents (N=2,104)

Personal characteristics		
Gender	**N**	**%**
Male	1,165	55.4
Female	939	44.6
Race		
White	1,583	79.3
Black/African-American	93	4.7
Asian/Pacific Islander	224	11.2
American Indian/Alaska Native	10	0.5
Other	86	4.3
Ethnicity		
Hispanic/Latino	46	2.3
Non-Hispanic/Latino	1,978	97.7
Professional characteristics		
Provider type	**N**	**%**
Physician	1,750	83.2
Non-Physician (NP/PA)	357	16.8
Specialty		
Family medicine	1,123	53.4
Internal medicine	507	24.1
Medicine-Pediatrics	67	3.2
General practice (GP)	24	1.1
Obstetrics/Gynecology (OB/Gyn)	12	0.6
Nurse practitioner (NP)	192	9.1
Physician's Assistant (PA)	165	7.8
Other	14	0.7

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Board/Specialty certification		
Yes	1,695	81.6
No	383	18.4
Years in practice		
<10 years	520	25.9
10-20 years	676	33.7
>20 years	810	40.4
Provider ownership of practice		
Full-owner	446	22.0
Partner/part-owner	232	11.4
Employee	1,352	66.6
Practice characteristics		
Practice size (mean, median, SD)	7.5, 5, 16.5	
Small (≤5 practitioners)[a]	1,157	57.5
Large (≥6 practitioners)	855	42.5
Presence of non-physician practitioners in practice[b]	1,275	71.7
Federally qualified health center (FQHC)	311	14.9
University/teaching hospital practice	276	13.1
Hospital-based practice (non-teaching)	643	30.7
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	522	27.4
Medicaid/Healthy Michigan Plan	686	36.0
Medicare	645	33.9
Uninsured	15	0.8
Mixed	37	1.9
Payment arrangement		
Fee-for-service	784	37.5
Salary	946	45.3
Capitation	44	2.1
Mixed	275	13.2
Other	40	1.9
Participation in MiPCT	511	24.3
Urbanicity[d]		
Urban	1,584	75.3
Suburban	193	9.2
Rural	327	15.5
Region		
Upper Peninsula/NW/NE	301	14.6
West/East Central/East	675	32.8
South Central/SW/SE	438	21.3
Detroit Metro	642	31.2

[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.

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).

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=2,081)	43.4%	47.2%	6.3%	2.7%	0.3%
I know what kind of insurance a patient has at the beginning of an encounter (n=2,081)	21.2%	32.2%	16.4%	20.5%	9.6%
I ignore a patient's insurance status on purpose so it doesn't affect my recommendations (n=2,078)	14.1%	20.8%	26.4%	27.8%	10.8%
I only find out about a patient's insurance coverage if they have trouble getting something I recommend (n=2,071)	13.6%	26.6%	19.0%	31.3%	9.5%

Familiarity with Healthy Michigan Plan

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 (Table 4).

We hypothesized that PCPs in different practice settings would differ in their familiarity with Healthy Michigan Plan.

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 (Appendix A, Table 1).

> *But I mean it's not reported to me. I don't know anything about their health accounts or MI Health account kind of thing.*
>
> - Rural physician; Small, private practice

Table 4. Familiarity with Healthy Michigan Plan

	Very familiar	Somewhat familiar	A little familiar	Not at all familiar
In general, how familiar are you with the Healthy Michigan Plan? (n=2,031)	15.1%	38.2%	27.4%	19.3%
How familiar are you with the following:				
How to complete a Health Risk Assessment (n=2,028)	47.6%	23.3%	13.6%	15.5%
How to submit a Health Risk Assessment (n=2,025)	34.6%	23.2%	17.5%	24.7%
Healthy behavior incentives that Healthy Michigan Plan Patients can receive (n=2,032)	12.6%	23.7%	27.0%	36.7%
Specialists available for Healthy Michigan Plan patients (n=2,027)	9.3%	27.3%	26.3%	37.1%
Mental health services available for Healthy Michigan Plan patients (n=2,032)	7.7%	18.2%	27.8%	46.4%
Out-of-pocket expenses Healthy Michigan Plan Patients have to pay (n=2,031)	6.7%	18.6%	28.4%	46.3%
Dental coverage in the Healthy Michigan Plan (2,032)	4.4%	13.5%	20.4%	61.7%

Acceptance of Medicaid and Healthy Michigan Plan

About 4 in 5 survey respondents reported accepting <u>new</u> Medicaid/Healthy Michigan Plan patients (Table 5). 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 (Table 6). Of PCPs' <u>established patients</u>, an average of 11% had Healthy Michigan Plan and 23% had Medicaid as their primary source of coverage (Table 2).

> *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

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 (Table 7).

We hypothesized that acceptance of new Medicaid/Healthy Michigan Plan patients would vary by PCPs' personal, professional and practice characteristics.

In multivariate analyses, PCPs were more likely to accept new Medicaid/Healthy Michigan Plan patients if the PCP was female, a racial minority, a non-physician provider, 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).

> *[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

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	%
Private (n=1,774)	87.0%
Medicaid* (n=1,517)	75.0%
Healthy Michigan Plan* (n=1,464)	72.8%
Medicare (n=1,717)	84.4%
No insurance (i.e., self-pay) (n=1,541)	76.4%

*Combined, 1,575 (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?[1]

The decision is entirely mine (n=459)	I have a lot of influence (n=275)	I have some influence (n=425)	I have no influence (n=866)
22.7%	13.6%	21.0%	42.8%

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 (n=2,049)	37.8%	31.1%	9.1%	8.6%	13.3%
Reimbursement amount (n=2,056)	25.9%	29.8%	13.3%	15.1%	15.9%
Availability of specialists who see Medicaid or Healthy Michigan Plan patients (n=2,052)	25.7%	30.1%	15.1%	13.8%	15.3%
Psychosocial needs of Medicaid or Healthy Michigan Plan patients (n=2,051)	19.7%	30.4%	18.3%	16.8%	14.8%
Illness burden of Medicaid or Healthy Michigan Plan patients (n=2,052)	18.0%	28.0%	21.5%	18.0%	14.4%

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 (n=2,073)	45.4%	26.8%	16.7%	7.2%	3.9%
It is my responsibility to provide care for patients regardless of their ability to pay (n=2,066)	42.3%	31.1%	13.6%	9.2%	3.8%
Caring for Medicaid/Healthy Michigan Plan patients enriches my clinical practice (n=2,067)	20.2%	28.5%	36.1%	11.9%	3.2%
Caring for Medicaid/Healthy Michigan Plan patients increases my professional satisfaction (n=2,064)	18.4%	26.3%	38.5%	12.6%	4.3%

In the past three years, have you provided care in a setting that serves poor and underserved patients with no anticipation of being paid?

Yes (n=1,153)	No (n=871)
57.0%	43.0%

Table 8. Multivariate 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	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]*
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]

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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	9.04 [6.33, 12.91]**	7.31 [5.05, 10.57]**
Medicare	1.66 [1.30, 2.13]**	2.04 [1.52, 2.73]**
Mixed	6.88 [2.09, 22.72]*	3.76 [2.24, 6.30]**

[a] Logistic regression model with odds ratios, adjusted for covariates of gender, years in training, physician vs. non-physician provider, and all listed covariates.

* $p < 0.05$, ** $p < 0.01$, *** $p < 0.001$

Changes in Practice

Most PCPs reported an increase in new patients and in the number of new patients who hadn't seen a PCP in many years (Table 9).

> *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 (Table 9).

> *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 in the past year. A substantial

minority had newly co-located mental health within primary care within the past year (Table 10).

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 (Table 11).

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 (Table 12).

Large, MiPCT, 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 12).

In multivariate analyses, FQHCs, those with predominantly uninsured, Medicaid and mixed payer mixes and suburban practices were more likely to report an increase in new patients. FQHCs, and those with predominantly 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 (Table 13 below, and Appendix A, Tables 15).

Large, FQHC, MiPCT, and rural practices, and those with predominantly Medicaid or uninsured patients, were more likely to have co-located mental health within the past year (Table 12).

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=2,020)	24.6%	31.6%	20.1%	6.4%	17.3%
Increase in number of new patients (n=2,021)	17.4%	34.9%	19.2%	9.6%	18.8%
Existing patients who had been uninsured or self-pay gained insurance (n=2,019)	15.9%	34.7%	24.9%	5.3%	19.2%
Existing patients changed from other insurance to Healthy Michigan Plan (n=2,019)	5.4%	26.2%	28.5%	8.7%	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 (n=2,104)	53.2%	46.8%
Hired additional office staff (n=2,104)	57.5%	42.5%
Consulted with care coordinators, case managers, community health workers (n=2,104)	55.8%	44.2%
Changed workflow processes for new patients (n=2,104)	41.7%	58.3%
Co-located mental health within primary care (n=2,104)	15.4%	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.

Table 11. Availability of Urgent Appointments

What proportion of your established patients who request a same- or next-day appointment at your primary practice can get one? (n=2,033)[7]

Almost all >80% (n=826)	Most 60-80% (n=527)	About half ~50% (n=237)	Some 20-40% (n=287)	Few <20% (n=122)	Don't know (n=34)
40.6%	25.9%	11.7%	14.1%	6.0%	1.7%

Over the past year, this proportion has:

Increased (n=682)	Decreased (n=316)	Stayed the same (n=883)	Don't know (n=123)
34.0%	15.8%	44.1%	6.1%

Table 12. Multivariate 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%	68.2%	49.0%	18.3%
Small	40.0%***	52.6%***	51.9%***	38.5%***	12.2%**
Practice type					
FQHC (ref)	62.4%	70.0%	72.6%	44.2%	29.9%***
Non-FQHC	52.1%**	57.1%**	56.1%***	42.8%	11.8%
Academic (ref)	49.2%	51.6%	52.1%	39.6%	13.9%
Non-academic	54.3%	60.1%	59.3%	43.5%	15.6%
Hospital-based (ref)	51.6%	59.3%	55.1%	42.8%	11.2%**
Not hospital-based	54.6%	58.8%	59.9%	43.1%	17.8%
Predominant payer mix					
Private (ref)	54.8%	60.0%	62.3%	40.7%	11.0%
Medicare	50.9%	58.8%	55.8%*	48.5%*	13.1%
Medicaid	53.2%	60.1%	55.5%*	44.0%	19.7%***
Uninsured	40.9%	34.5%	68.3%	40.5%	29.1%*
Mixed	57.6%	51.6%	59.9%	35.1%	15.3%
MiPCT					
Yes	52.8%	60.0%	78.0%***	44.4%	22.0%
No	53.8%	58.6%	52.3%	42.5%	13.1%
Urbanicity					
Urban (ref)	53.6%	60.0%	58.1%	41.5%	13.6%
Suburban	52.6%	50.5%*	53.3%	45.5%	14.8%
Rural	53.9%	58.9%	62.2%	48.3%	23.6%***

*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. All p-values are based on logistic regression analysis

* $p < 0.05$, ** $p < 0.01$, *** $p < 0.001$

Table 13. Multivariate 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?[1]	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.
[1]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
* $p < 0.05$, ** $p < 0.01$, *** $p < 0.001$

Experiences Caring for Healthy Michigan Plan Beneficiaries

Health Risk Assessment

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 (Table 14).

Most PCPs reported their practice has a process in place for submitting HRAs, but not for identifying patients who needed HRAs completed. Some PCPs 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 (Table 15, Figure 2).

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 (Table 16, Figure 3).

> *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 very or somewhat useful for identifying and discussing health risks, persuading patients to address their most important health risks, and documenting behavior change goals. About half found them very or somewhat useful for getting patients to change behavior (Table 17, Figure 4).

> *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

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 (Appendix A, Table 22).

Table 14. Health Risk Assessment Completion

Approximately how many Health Risk Assessments have you completed with Healthy Michigan Plan patients? (n=2,032)

None (n=420)	1-2 (n=235)	3-10 (n=503)	More than 10 (n=874)
20.7%	11. 6%	24.8%	43.0%

How often do your Healthy Michigan Plan patients bring in their Health Risk Assessment to complete at their initial office visit? (n=1,923)

Almost always (n=215)	Often (n=416)	Sometimes (n=720)	Rarely/never (n=572)
11.2%	21.6%	37.4%	29.7%

Table 15. 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=2,041)	61.2%	8.6%	30.1%
My practice has a process to identify Healthy Michigan Plan patients who need to complete an HRA. (n=2,042)	34.1%	25.2%	40.7%
I/my practice have been contacted by a Medicaid Health Plan about a patient who needs to complete an HRA. (n=2,040)	33.2%	21.5%	45.3%
I/my practice have received a financial bonus from a Medicaid Health Plan for helping patients complete HRAs. (n=2,033)	18.1%	16.7%	65.3%

Figure 2. Experience with Health Risk Assessments

Please report your experience with the following:

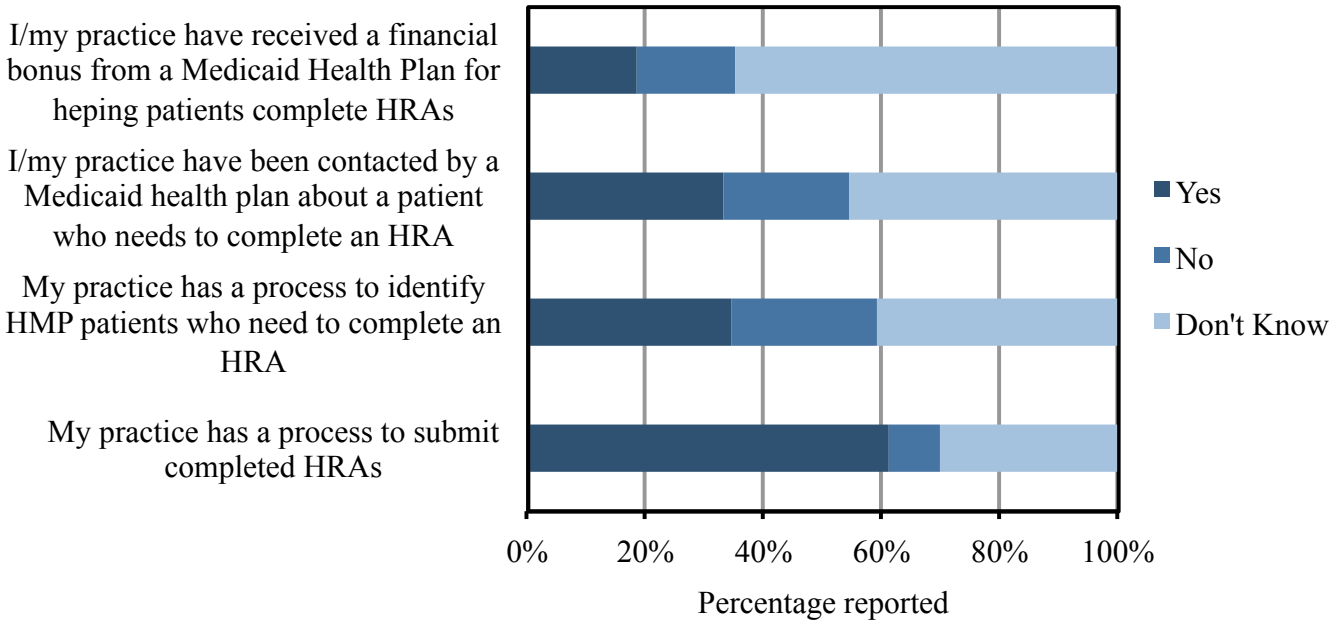


Table 16. Influence on Completing HRA

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=2,046)	26.8%	23.8%	7.6%	14.4%	27.5%
Patients' interest in addressing health risks (n=2,046)	21.4%	30.2%	18.3%	8.8%	21.3%
Financial incentives for practices (n=2,044)	18.3%	24.6%	12.6%	17.3%	27.3%

Figure 3. Influence on Completing HRA

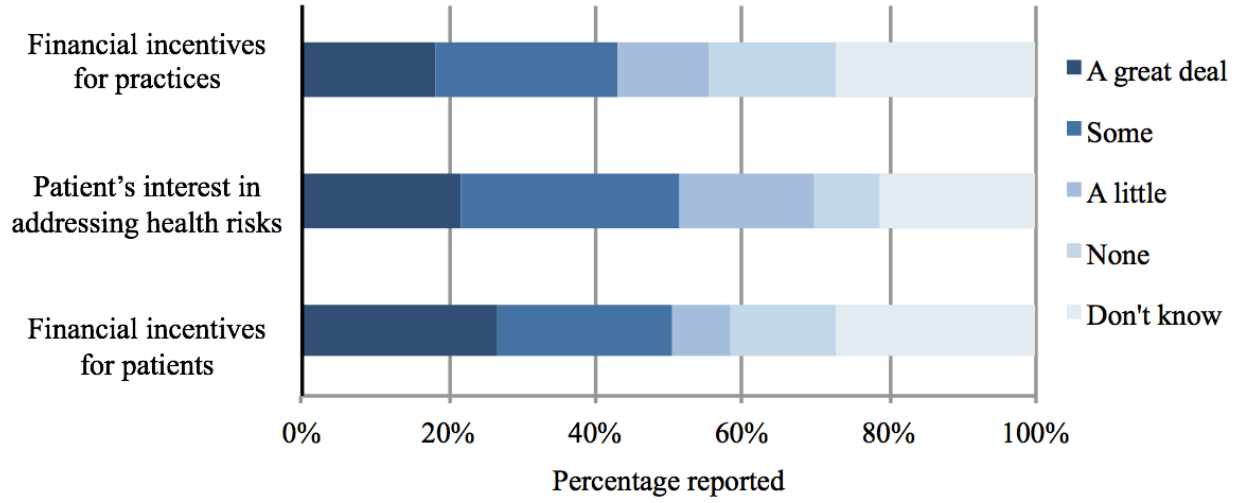
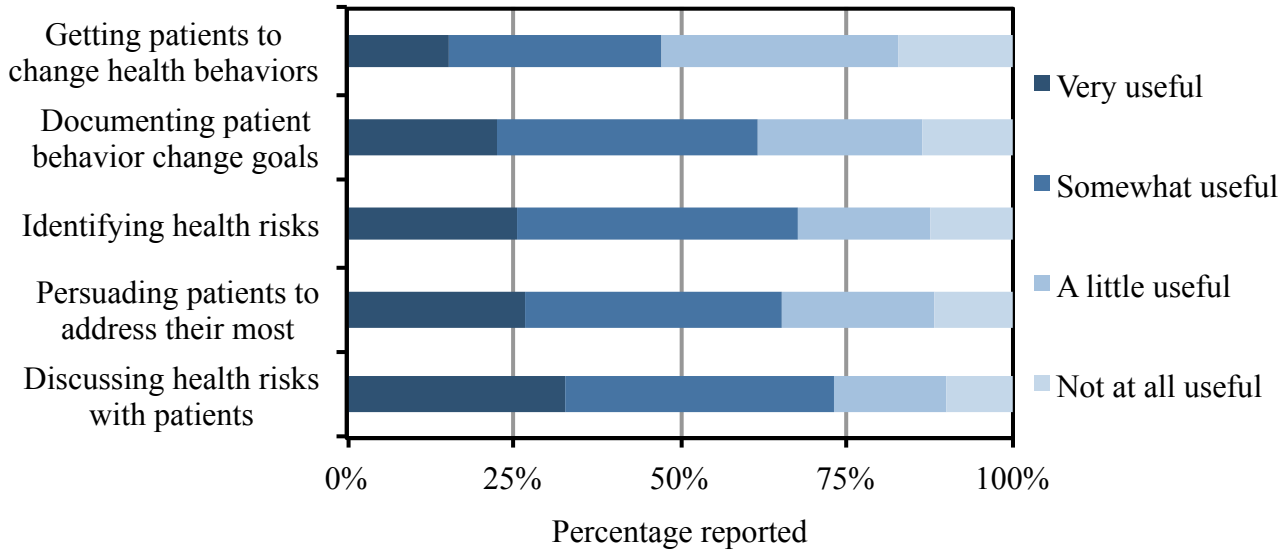


Table 17. Perceived Usefulness of HRA

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=1,828)	32.9%	40.1%	17.0%	10.0%
Persuading patients to address their most important health risks (n=1,828)	26.5%	38.9%	22.7%	11.9%
Identifying health risks (n=1,833)	25.7%	42.0%	20.1%	12.2%
Documenting patient behavior change goals (n=1,826)	22.4%	39.2%	24.6%	13.8%
Getting patients to change health behaviors (n=1,821)	15.2%	32.0%	35.8%	17.0%

Figure 4. Perceived Usefulness of HRA



PCPs were more likely to report a process to identify patients who needed to complete an HRA if they reported (Appendix A, Table 2):

- 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 (Appendix A, Table 22):

- Smaller practice size
- Co-location of mental health within primary care in the past year
- 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

We hypothesized that PCPs who identify a process in place at their practice for identifying patients who need to complete an HRA would report completing more HRAs and that was confirmed (Appendix A, Table 22). PCPs reporting greater familiarity with healthy behavior incentives and out of pocket expenses faced by patients also reported completing more HRAs.

Estimates of HRA completion rates by PCPs

It is not possible to link PCP surveys directly to HRA records, since the HRAs are linked to patients, and the PCP listed on the HRA does not have to be the assigned PCP (it could be any PCP within the plan). As a proxy, in July 2016 we retrieved the count of all HMP enrollees for whom the PCP respondent was the PCP of record, and the number of those enrollees who had a complete HRA on record (which may or may not have been completed by the PCP respondent) from the data warehouse,. Since these data reflected the number of enrollees per PCP and the number of HRAs completed about one year after the survey, we cannot draw firm conclusions based on the relationship between survey responses and this data.

HRA completion rates by PCP are not quite normally distributed (Appendix A, Figure 1).

	Mean (SE)	Median	Interquartile range (IQR)
HMP member count	94 (2.6)	53	27-111
HRA completions	18 (0.62)	9	4-20
Rate of HRA completions (HRA completions/HMP members)	19.6% (0.003)	15.8%	9.5-25.9%

We examined the relationship between HRA completion, as documented (attested) in the Data Warehouse, and provider characteristics, practice characteristics and PCP views of the HRA**.**

PCP familiarity with the HRA was the only consistent predictor of HRA completion, particularly after sensitivity analyses adjusting for practice ID (Appendix A, Tables 20, 21).

ER Use and Decision Making

The majority of PCPs surveyed reported 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 (Table 18).

PCPs who reported a greater sense of influence on ER use (Appendix Table 4):

- **Reported fewer years in practice**
- **Reported larger practice size**
- **Reported hiring new staff or clinicians in the past year**
- **Reported offering care coordination or social work assistance for patients with complex problems**

PCPs who reported a greater sense of responsibility for decreasing ER use (Appendix Table 4):

- **Reported fewer years in practice**
- **Were more likely to be non-physicians**
- **Reported larger practice size**
- **Reported practice changes in the past year including hiring new clinicians, consulting with care coordinators, case managers, or community health workers, changes in workflow, and newly co-locating mental health.**

- **Were more likely to report the availability of urgent appointments had increased**
- **Were more likely to report the availability of walk-in appointments and weekend and evening appointments at their practice**
- **Were more likely to report offering transportation assistance and care coordination or social work assistance**

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 (Table 19).

> *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

PCP views about other factors that affect ER use also influenced their sense of influence and responsibility (Appendix Table 4).

In multivariate analyses (Appendix Table 5), years in practice, Asian/Pacific Islander race and suburban location were associated with PCPs' sense of influence over ER use.

In multivariate analyses (Appendix Table 5), years in practice, non-physician status, practice size and changes in workflow in the past year and suburban location were associated with PCPs' sense of responsibility for 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.

How much can PCPs influence non-urgent ER use by their patients?

A great deal (n=608)	Some (n=886)	A little (n=460)	Not at all (n=80)
29.9%	43.6%	22.6%	3.9%

To what extent do you think it is your responsibility as a PCP to decrease non-urgent ER use?

Major Responsibility (n=740)	Some Responsibility (n=1,035)	Minimal responsibility (n=212)	No responsibility (n=43)
36.5%	51.0%	10.4%	2.1%

Table 18. 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 (n=2,010)	66.5%	30.2%	3.3%
Assistance with arranging transportation to appointments (n=2,008)	30.6%	57.0%	12.4%
24-hour telephone triage (n=2,015)	74.0%	21.7%	4.2%
Appointments during evenings and weekends (n=2,012)	55.8%	40.7%	3.5%
Care coordination/social work assistance for patients with complex problems (n=2,008)	56.5%	33.5%	10.1%

Table 19. 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 (n=2,030)	82.7%	13.4%	3.8%
Patients believe the ER provides better quality of care (2,026)	16.8%	39.4%	43.8%
The ER offers quicker access to specialists (n=2,028)	30.3%	35.7%	34.1%
Hospitals encourage use of the ER (n=2,012)	18.7%	28.7%	52.6%
The ER offers access to medications for patients with chronic pain (n=2,031)	50.7%	31.8%	17.5%
The ER is where patients are used to getting care (n=2,023)	59.5%	31.3%	9.2%

Access

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 (Table 20).

> *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 (Table 21).

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 20. Impact of Healthy Michigan Plan on Previously Uninsured Patients

Please think about what has changed for your patients <u>who were previously uninsured</u> 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 (n=2,005)	35.0%	39.4%	6.9%	1.5%	17.3%
Early detection of serious illness (n=2,002)	33.7%	37.4%	7.6%	2.0%	19.3%
Improved medication adherence (n=2,004)	28.3%	40.8%	10.7%	2.7%	17.5%
Improved health behaviors (n=2,005)	16.1%	40.4%	18.9%	5.3%	19.3%
Better ability to work or attend school (n=2,003)	13.1%	33.0%	19.9%	5.7%	28.3%
Improved emotional wellbeing (n=2,004)	16.4%	40.6%	17.4%	3.8%	21.9%
Improved ability to live independently (n=2,002)	11.9%	29.6%	21.9%	7.0%	29.5%

Table 21. 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?[7]					
Specialists **+ (n=2,059)	31.3%	35.4%	6.7%	0.9%	25.7%
Medications **+ (n=2,058)	15.6%	43.1%	16.0%	1.8%	23.5%
Mental Health Care **+ (n=2,059)	34.5%	25.4%	9.4%	1.7%	29.0%
Dental/Oral Health Care **+ (n=2,061)	30.2%	17.5%	6.4%	1.1%	44.8%
Treatment for substance use disorder **+ (n=2,058)	28.9%	21.7%	7.3%	1.5%	40.6%
Counseling and support for health behavior change **+ (n=2,060)	26.0%	26.4%	10.6%	2.7%	34.4%
How often do your privately insured patients have difficulty accessing the following?[7]					
Specialists **+ (n=2,074)	3.4%	31.3%	48.6%	13.2%	3.4%
Medications **+ (n=2,074)	6.6%	50.8%	34.7%	4.7%	3.3%
Mental Health Care **+ (n=2,072)	17.7%	43.1%	26.6%	6.0%	6.6%
Dental/Oral Health Care **+ (n=2,072)	7.5%	30.5%	30.1%	6.4%	25.5%
Treatment for substance use disorder **+ (n=2,071)	14.7%	38.6%	25.4%	4.7%	16.6%
Counseling and support for health behavior change **+ (n=2,072)	12.4%	38.7%	31.3%	6.9%	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.

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

We hypothesized that PCPs' likelihood of having cost conversations would vary by their PCPs' personal, professional and practice characteristics.

In multivariate 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. PCPs with fewer years in practice and in rural practices were

more likely to report a change in management due to cost conversations with patients (Tables 22, 23).

Have you ever discussed out-of-pocket medical costs with a Healthy Michigan Plan patient? (n=1,988)

Yes (n=445)	No (n=1,543)
22.4%	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 (n=247)	Me (n=171)	Somebody else in the practice (n=16)	Other (n=6)
56.1%	38.9%	3.6%	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 (n=248)	No (n=131)	Don't remember (n=61)
56.4%	29.8%	13.9%

Table 22. Unadjusted Association of PCP Personal, Professional and Practice Characteristics with Frequency of Cost Conversations and Change in Clinical Management due to Cost Conversations

	%	
	Cost Conversations†	Change in Management due to Cost Conversation‡
Personal characteristics		
Gender		
Male (n=345)	20.5%*	52.7%
Female (n=348)	24.7%	60.2%
Race		
White (n=571)	24.3%**	56.0%
Black/African American (n=22)	15.4%	57.1%
Asian/Pacific Islander (n=39)	12.3%	60.9%
Other/More than one (n=28)	17.5%	55.6%
Ethnicity		
Hispanic/Latino (n=23)	33.3%	53.3%
Not Hispanic/Latino (n=650)	22.0%	56.9%
Professional characteristics		
Provider type		
Physician (n=517)	20.4%**	54.1%
Non-physician (NP or PA) (n=176)	32.2%	63.6%
Specialty		
Family medicine (n=349)	21.6%**	52.2%*
Internal medicine (n=154)	17.8%	61.7%
Other physician specialty (n=14)	21.6%	27.3%
Non-physician (NP or PA) (n=176)	32.2%	63.6%
Years in practice		
<10 years (n=213)	25.1%	69.6%*
10-20 years (n=206)	20.8%	54.1%
>20 years (n=256)	22.8%	49.7%

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Prior care for underserved patients		
Yes (n=445)	25.8%**	57.1%
No (n=233)	18.1%	55.4%
Practice characteristics		
Practice size		
Small (≤5 providers) (n=393)	23.2%	56.4%
Large (>5 providers) (n=284)	22.1%	57.9%
FQHC practice		
Yes (n=152)	31.4%**	61.7%
No (n=535)	20.8%	54.8%
University/teaching hospital practice		
Yes (n=75)	18.3%	57.5%
No (n=605)	23.0%	56.5%
Hospital-based practice (non-teaching)		
Yes (n=216)	22.0%	62.1%
No (n=464)	22.5%	54.2%
Payer mix		
Medicaid/Uninsured predominant (n=281)	26.4%*	58.8%
Private/Medicare/Other predominant (n=360)	20.0%	55.7%
Practice characteristics		
Urbanicity		
Urban (n=480)	20.9%*	54.4%*
Suburban (n=62)	22.7%	47.6%
Rural (n=151)	29.3%	67.4%
Total	22.4%	56.4%

†Percent among total respondents

‡Percent among those respondents who had a cost conversation

* $p < 0.05$, ** $p < 0.01$, *** $p < 0.001$

Table 23. Multivariate 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	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]

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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]
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]

Logistic regression models with adjusted odds ratios. Models are adjusted for all listed variables.
†Each column represents a different multivariate model
* $p < 0.05$, ** $p < 0.01$, *** $p < 0.001$

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

RESULTS FROM IN-DEPTH INTERVIEWS WITH PRIMARY CARE PRACTITIONERS

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. Additional excerpts can be found in Appendix B.

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 24. 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

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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 <u>Health Risk Assessment</u> 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

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

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.

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]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

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 MiPCT, and I guess with the start of MiPCT, 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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Primary Care Practitioners' Views of the Impact of the Healthy Michigan Plan

Appendix A: Results from Multivariate Analyses

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Table 1. Bivariate associations between familiarity with HMP by practice types and predominant payer mix

Familiarity with Healthy Michigan Plan	A little/not at all familiar	Very/somewhat familiar	*p*-value
	N (Row %)	N (Row %)	
Practice size			0.047
Large practice	409 (49.4%)	419 (50.6%)	
Small practice	500 (44.8%)	615 (55.2%)	
Practice type			< 0.001
FHQC	101 (33.2%)	203 (66.8%)	
Non-FQHC	833 (48.8%)	874 (51.2%)	
University/teaching hospital			< 0.001
Academic	158 (58.5%)	112 (41.5%)	
Non-academic	771 (44.8%)	951 (55.2%)	
Hospital-based practice			0.043
Hospital-based	310 (50.0%)	310 (50.0%)	
Not hospital-based	619 (45.1%)	753 (54.8%)	
Predominant payer mix			< 0.001
Private	371 (56.5%)	286 (43.5%)	
Medicaid	206 (30.5%)	469 (69.5%)	
Medicare	236 (56.3%)	183 (43.7%)	
Uninsured	3 (25.0%)	9 (75.0%)	
Mixed	67 (47.5%)	74 (52.5%)	
Participating in MiPCT			0.023
Yes	254 (51.1%)	243 (48.9%)	
No	694 (45.2%)	840 (54.8%)	

p-values were calculated using Pearson's chi-square

Table 2. Bivariate associations between practice having a process to identify HMP patients who need HRA completed by practice characteristics

Practice has process to identify HMP patients who need HRA completed	Yes	No/don't know	
	Row %	Row %	*p*-value
Region			< 0.001
Upper Peninsula/Northwest/Northeast (n=296)	38.9	61.1	
West/East Central/East (n=656)	36.6	63.4	
South Central/Southwest/Southeast (n=422)	23.2	76.8	
Detroit Metro (n=623)	37.4	62.6	
Urbanicity			NS
Urban (n=1,530)	32.9	67.1	
Suburban (n=190)	35.8	64.2	
Rural (n=322)	38.8	61.2	
Practice size			NS
Large practice (6+) (n=837)	31.9	68.1	
Small practice (0-5) (n=1,118)	36.0	64.0	
New clinicians hired in past year?			NS
No/Not checked (n=953)	34.4	65.6	
Yes (n=1,089)	33.9	66.1	
New office staff hired in past year?			NS
No/Not checked (n=863)	31.9	68.1	
Yes (n=1,179)	35.8	64.2	
Consulted with care coordinators, case managers, community health workers in past year?			NS
No/Not checked (n=897)	32.7	67.3	
Yes (n=1,145)	35.3	64.7	
Changed workflow in past year?			NS
No/Not checked (n=1,185)	32.6	67.4	
Yes (n=857)	36.3	63.7	
Co-located Mental Health w/in Primary Care in past year?			< 0.001
No/Not checked (n=1,720)	31.6	68.4	
Yes (n=322)	47.5	52.5	
Payment arrangement			NS
FFS-predominant (n=758)	31.1	68.9	
Capitation-predominant (n=44)	40.9	59.1	
Salary-predominant (n=921)	36.2	63.8	
Mixed payment (n=266)	34.2	65.8	
Other payment arrangement (n=40)	42.5	57.5	
Predominant payer mix			< 0.001
Private (n=639)	22.5	77.5	
Medicaid (n=666)	47.4	52.6	
Medicare (n=407)	30.7	69.3	
Uninsured (n=11)	72.7	27.3	
Mixed (n=136)	33.1	66.9	
Received financial bonus for HRA completion			< 0.001
No/Don't know (n=1,664)	26.4	73.6	
Yes (n=365)	69.3	30.7	

p-values were calculated using Pearson's chi-square

Table 3. Bivariate associations between number of self-reported HRAs completed by practice characteristics

Number of HRAs completed (self-reported)	None	1-2	3-10	>10	
	Row %	Row %	Row %	Row %	*p*-value
Region					< 0.001
Upper Peninsula/Northwest/ Northeast (n=293)	13.7	5.5	24.2	56.7	
West/East Central/East (n=654)	18.5	10.6	23.9	47.1	
South Central/Southwest/Southeast (n=416)	31.0	16.1	22.8	30.0	
Detroit Metro (n=624)	19.1	12.2	27.6	41.2	
Urbanicity					< 0.001
Urban (n=1,527)	23.1	13.1	25.7	38.0	
Suburban (n=186)	11.8	9.1	18.8	60.2	
Rural (n=319)	14.1	5.6	23.5	56.7	
Practice size					< 0.001
Large practice (6+) (n=823)	23.9	13.4	25.3	37.4	
Small practice (0-5) (n=1,121)	17.8	10.4	24.8	47.0	
New clinicians hired in past year?					NS
No/Not checked (n=954)	19.7	10.4	26.1	43.8	
Yes (n=1,078)	21.5	12.6	23.6	42.3	
New office staff hired in past year?					NS
No/Not checked (n=863)	21.7	10.4	26.9	41.0	
Yes (n=1,169)	19.9	12.4	23.2	44.5	
Consulted with care coordinators, case managers, community health workers in past year?					NS
No/Not checked (n=899)	22.7	10.3	25.1	41.8	
Yes (n=1,133)	19.1	12.5	24.4	44.0	
Changed workflow in past year?					NS
No/Not checked (n=1,182)	21.3	10.9	26.3	41.5	
Yes (n=850)	19.8	12.5	22.6	45.2	
Co-located Mental Health w/in Primary Care in past year?					< 0.001
No/Not checked (n=1,714)	22.3	12.0	26.0	39.8	
Yes (n=318)	11.9	9.4	18.2	60.4	
Payment arrangement					0.008
FFS-predominant (n=754)	24.0	12.9	26.4	36.7	
Capitation-predominant (n=42)	19.0	9.5	21.4	50.0	
Salary-predominant (n=915)	18.0	10.9	23.1	48.0	
Mixed payment (n=268)	20.5	11.6	26.9	41.0	
Other payment arrangement (n=39)	20.5	5.1	20.5	53.8	
Predominant payer mix					< 0.001
Private (n=635)	27.6	14.3	26.8	31.3	
Medicaid (n=668)	9.7	8.1	17.1	65.1	
Medicare (n=409)	29.3	13.0	31.8	25.9	
Uninsured (n=12)	8.3	8.3	8.3	75.0	
Mixed (n=134)	15.7	15.7	30.6	38.1	

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Practice has process to identify HMP patients who need HRA completed					< 0.001
No/Don't know (n=1,312)	28.5	15.1	26.2	30.2	
Yes (n=694)	3.9	5.2	22.5	68.4	
Practice has process to submit completed HRAs					< 0.001
No/Don't know (n=764)	47.3	18.6	20.7	13.5	
Yes (n=1,243)	3.1	7.3	27.6	61.9	
Received financial incentive for HRA completion					< 0.001
No/Don't know (n=1,636)	23.8	12.8	25.7	37.7	
Yes (n=365)	2.7	6.6	21.1	69.6	
Familiarity with out-of-pocket HMP expenses					< 0.001
Very familiar (n=136)	2.2	1.5	16.9	79.4	
Somewhat familiar (n=371)	8.4	9.4	25.1	57.1	
A little familiar (n=560)	11.4	13.8	26.6	48.2	
Not at all familiar (n=904)	34.5	12.5	23.9	29.1	

p-values were calculated using Pearson's chi-square

Table 4. Bivariate analysis of demographic and practice characteristics and PCP influence and responsibility for decreasing ER use

		PCP influence on ER use			PCP responsibility for decreasing ER use		
	Total (%)	A little/ not at all (%)	Some/ a great deal (%)		Minimal/no (%)	Major/some (%)	
Years in practice (mean, [95%CI])		20.3 [19.3, 21.4]	18.2 [17.6, 18.8]	.001[a]	22.2 [20.7, 23.7]	18.3 [17.7, 18.9]	<.001[b]
				p[c]			p[c]
Race				.005			NS
White (n=1,553)	79.5	83.5	78.1		84.1	78.9	
Black/African American (n=92)	4.7	5.6	4.4		3.8	4.9	
Asian/Pacific Islander (n=215)	11.0	7.0	12.5		8.8	11.3	
American Indian/Alaska Native (n=10)	0.5	0.2	0.6		0.0	0.6	
Other (n=83)	4.2	3.7	4.5		3.3	4.3	
Hispanic/Latino				NS			NS
Yes (n=45)	2.3	1.9	2.4		1.2	2.4	
No (n=1,934)	97.7	98.1	97.6		98.8	97.6	
MD/Non-MD				NS			0.001
MD/DO (n= 1,692)	83.2	83.9	82.9		90.2	82.2	
Non-physicians (n= 342)	16.8	16.1	17.1		9.8	16.8	
Specialty				NS			.008
FM (n=1,088)	53.5	55.7	52.7		63.1	52.1	
GP (n=23)	1.1	1.3	1.1		2.0	1.0	
IM (n=487)	23.9	21.9	24.7		22	24.2	
Med-Peds (n=66)	3.2	3.1	3.3		2.4	3.4	
NP (n=186)	9.1	9.3	9.1		4.7	9.7	
OB/GYN (n=12)	0.6	1.1	0.4		0.8	0.6	
Other (n=13)	0.6	0.6	0.7		0.0	0.7	
PA (n=159)	7.8	7.0	8.1		5.1	8.2	
Urbanicity				.05			NS
Urban (n=1,530)	75.2	72.6	76.2		73.3	75.5	
Suburban (n=188)	9.2	11.9	8.3		9.4	9.2	
Rural (n=316)	15.5	15.6	15.5		17.3	15.2	

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Practice size				.01			<.001
Large practice (6+) (n=832)	42.6	38.0	44.3		30.9	44.2	
Small practice (0-5) (n=1,120)	57.4	62.0	55.7		69.1	55.8	
New clinicians hired in past year?				.04			.002
No/Not checked (n=946)	46.5	50.4	45.1		55.7	45.3	
Yes (n=1,088)	53.5	49.6	54.9		44.3	54.7	
New office staff hired in past year?				.03			NS
No/Not checked (n=859)	42.2	46.1	40.8		47.1	41.5	
Yes (n=1,175)	57.8	53.9	59.2		52.9	58.5	
Consulted with care coordinators, case managers, community health workers in past year?				NS			.01
No/Not checked (n=896)	44.1	44.3	44.0		51.4	43.0	
Yes (n=1,138)	55.9	55.7	56.0		48.6	57.0	
Changed workflow in past year?				NS			.001
No/Not checked (n=1,182)	58.1	60.6	57.2		67.5	56.7	
Yes (n=852)	41.9	39.4	42.8		32.5	43.3	
Co-located Mental Health w/in Primary Care in past year?				NS			.001
No/Not checked (n=1,720)	84.6	86.5	83.9		91.4	83.6	
Yes (n=314)	15.4	13.5	16.1		8.6	16.4	
Practice ownership				NS			.02
Full owner (n=431)	21.9	22.6	21.7		28.6	21.0	
Partner/part-owner (n=228)	11.6	9.9	12.2		12.5	11.4	
Employee (n=1,305)	66.4	67.5	66.1		58.9	67.5	
Underserved care within 3y				NS			NS
No (n=854)	43.2	45.3	42.4		45.2	42.8	
Yes (n=1,125)	56.8	54.7	57.6		54.8	57.2	

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Proportion of established patients who can get same-day/next-day appointment				NS			NS
Almost all (>80%) (n=807)	40.6	42.7	39.8		46.8	39.6	
Most (60-80%) (n=514)	25.9	24.2	26.4		20.0	26.8	
About half (~50%) (n=234)	11.8	12.6	11.5		13.2	11.6	
Some (20-40%) (n=280)	14.1	12.8	14.6		10.8	14.6	
Few (<20%) (n=121)	6.1	5.8	6.2		7.2	5.9	
Don't know (n=32)	1.6	1.9	1.5		2.0	1.6	
Proportion of established patients who can get same-day/next-day appointment has: _				NS			.02
Increased (n=671)	34.2	30.5	35.6		28.3	35.0	
Decreased (n=309)	15.8	17.0	15.3		17.4	15.6	
Stayed the same (n=862)	44	46.6	43.0		51.0	42.9	
Don’t know (n=119)	6.1	5.9	6.1				
Predominant payer mix				NS			.009
Private (n=653)	34.9	33.7	35.3		40.1	34.1	
Medicaid (n=663)	35.4	36.9	34.9		30.8	36.0	
Medicare (n=409)	21.8	21.7	21.9		17.7	22.4	
Uninsured (n=12)	0.6	0.2	0.8		0.0	0.7	
Mixed (n=136)	7.3	7.6	7.1		11.4	6.7	
Specialists available for HMP patients				NS			.009
Very familiar (n=185)	9.3	8.4	9.6		8.0	9.4	
Somewhat familiar (n=541)	27.2	25.3	27.9		19.1	28.4	
A little familiar (n=523)	26.3	26.5	26.3		31.1	25.7	
Not at all familiar (n=739)	37.2	39.8	36.2		41.8	36.5	
Mental health services available for HMP patients				NS			.02
Very familiar (n=153)	7.7	7.9	7.6		5.6	8.1	
Somewhat familiar (n=357)	17.9	16.9	18.3		13.1	18.5	
A little familiar (n=554)	27.8	25.7	28.6		25.9	28.1	
Not at all familiar (n=927)	46.6	49.6	45.4		55.4	45.3	

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Dental coverage in HMP				NS			.06
Very familiar (n=86)	4.3	4.7	4.2		2.4	4.6	
Somewhat familiar (n=269)	13.5	12.4	13.9		10.8	13.8	
A little familiar (n=402)	20.2	19.7	20.4		17.5	20.7	
Not at all familiar (n=1,234)	62.0	63.3	61.5		69.3	60.9	
Difficulty accessing specialists				NS			.03
Often (n=627)	31.3	32.5	30.9		37.4	30.5	
Sometimes (n=701)	35.0	33.8	35.5		27.6	36.1	
Rarely (n=133)	6.6	6.4	6.8		4.7	6.9	
Never (n=18)	0.9	1.1	0.8		0.8	0.9	
Don't know (n=522)	26.1	26.2	26.1		29.5	25.5	
Difficulty accessing medications				NS			.02
Often (n=310)	15.5	15.7	15.4		20.9	14.8	
Sometimes (n=857)	42.9	44.8	42.2		38.2	43.6	
Rarely (n=320)	16	14.2	16.7		11.8	16.7	
Never (n=36)	1.8	2.4	1.6		1.6	1.8	
Don't know (n=476)	23.8	22.8	24.2		27.6	23.2	
Difficulty accessing mental health care				NS			NS
Often (n=690)	34.5	33.8	34.7		35.0	34.4	
Sometimes (n=508)	25.4	25.4	25.4		21.3	26.0	
Rarely (n=183)	9.1	9.3	9.1		7.5	9.4	
Never (n=34)	1.7	3.0	1.2		2.0	1.7	
Don't know (n=586)	29.3	28.4	29.6		34.3	28.5	
Difficulty accessing dental care				NS			.05
Often (n=599)	29.9	33.0	28.8		34.6	29.2	
Sometimes (n=348)	17.4	14.8	18.3		11.4	18.2	
Rarely (n=128)	6.4	5.6	6.7		5.1	6.6	
Never (n=23)	1.1	1.7	1.0		0.8	1.2	
Don't know (n=904)	45.2	44.9	45.2		48.0	44.7	

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Difficulty accessing substance abuse treatment				.02			.03
Often (n=576)	28.8	29.8	28.5		31.9	28.4	
Sometimes (n=431)	21.6	18.4	22.7		13.8	22.6	
Rarely (n=145)	7.3	7.1	7.3		7.9	7.2	
Never (n=28)	1.4	2.6	1.0		2.0	1.3	
Don't know (n=819)	41.0	42.1	40.5		44.5	40.4	
Walk-in appointments available in practice				NS			.03
No/Don't know (n=673)	33.6	34.8	33.2		39.7	32.8	
Yes (n=1,331)	66.4	65.2	66.8		60.3	67.2	
Transportation assistance by practice				NS			.002
No/Don't know (n=1,389)	69.4	71.5	68.6		78.1	68.2	
Yes (n=613)	30.6	28.5	31.4		21.9	31.8	
24h telephone triage in practice				NS			NS
No/Don't know (n=521)	25.9	25.8	26.0		26.5	25.9	
Yes (n=1,488)	74.1	74.2	74.0		73.5	74.1	
Weekend/Evening appts in practice				NS			.005
No/Don't know (n=888)	44.3	47.4	43.1		52.6	43.1	
Yes (n=1,118)	55.7	52.6	56.9		47.4	56.9	
Care coordination/ social work for patients w/complex problems in practice				.03			<.001
No/Don't know (n=870)	43.4	47.4	42.0		57.2	41.5	
Yes (n=1,133)	56.6	52.6	58.0		42.8	58.5	
ER will provide care without appt				.01			NS
Major influence (n=1,677)	82.8	86.5	81.4		82.4	82.9	
Minor influence (n=272)	13.4	9.6	14.8		13.7	13.4	
Little or no influence (n=77)	3.8	3.9	3.8		3.9	3.8	
Patients believe ER provides better quality of care				.01			NS
Major influence (n=341)	16.9	17.2	16.7		19.4	16.5	
Minor influence (n=797)	39.4	34.2	41.3		33.2	40.2	
Little or no influence (n=884)	43.7	48.6	42.0		47.4	43.2	

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ER offers quicker access to specialists				NS			NS
Major influence (n=613)	30.3	28.9	30.8		32.7	29.9	
Minor influence (n=722)	35.7	34.5	36.1		31.5	36.3	
Little or no influence (n=689)	34.0	36.7	33.1		35.8	33.8	
Hospitals encourage use of ER				.01			<.001
Major influence (n=377)	18.8	22.9	17.3		32.5	16.8	
Minor influence (n=577)	28.7	25.5	29.9		22.2	29.7	
Little or no influence (n=1,054)	52.5	51.6	52.8		45.2	53.5	
ER offers access to meds for chronic pain				.001			.01
Major influence (n=1,029)	50.8	57.7	48.3		58.7	49.6	
Minor influence (n=644)	31.8	27.3	33.4		24.4	32.9	
Little or no influence (n=354)	17.5	15.0	18.3		16.9	17.5	
ER is where patients are used to getting care				<.001			<.001
Major influence (n=1,202)	59.6	70.1	55.7		72.0	57.7	
Minor influence (n=631)	31.3	24.4	33.7		22.0	32.7	
Little or no influence (n=185)	9.2	5.4	10.5		5.9	9.6	

Data in the table are shown as column percentages

"Predominant payer mix" is the 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.

[a] Years in practice did not violate Levene's test for equality of variances, df(1,1939)= .057, p= .811; therefore students t-test was used, t(1939)= 4.866, p < .001

[b] Years in practice did not violate Levene's test for equality of variances, df(1,1939)=2.664, p= .103; therefore students t-test was used, t(1939)= 3.429, p < .001

[c] *p*-value from Pearson's chi-squared test

Table 5. Multivariate analysis of PCP influence in ER use, and PCP responsibility in decreasing ER use

	PCP influence (N= 1,786)		PCP responsibility (N= 1,773)	
	aOR	95% CI	aOR	95% CI
Years in practice	0.99*	[0.98, 1.00]	0.98**	[0.97, 1.00]
Race				
White (ref)	1.00	[1.00, 1.00]	1.00	[1.00, 1.00]
Black/African American	0.81	[0.49, 1.35]	1.67	[0.70, 3.97]
Asian/Pacific Islander	1.89**	[1.27, 2.83]	1.61	[0.97, 2.69]
American Indian/Alaska Native	2.81	[0.35, 22.67]	1.00	[1.00, 1.00]
Other	1.35	[0.73, 2.51]	1.39	[0.58, 3.33]
Hispanic/Latino				
No (ref)	1.00	[1.00, 1.00]	1.00	[1.00, 1.00]
Yes	1.49	[0.64, 3.49]	4.82	[0.65, 35.91]
Physician				
Non-physician (NP/PA) (ref)	1.00	[1.00, 1.00]	1.00	[1.00, 1.00]
Physician	0.93	[0.68, 1.26]	0.54*	[0.33, 0.88]
Urbanicity				
Urban (ref)	1.00	[1.00, 1.00]	1.00	[1.00, 1.00]
Suburban	0.66*	[0.46, 0.93]	0.94	[0.57, 1.57]
Rural	1.00	[0.73, 1.36]	0.76	[0.51, 1.13]
Practice size				
Large practice (6+) (ref)	1.00	[1.00, 1.00]	1.00	[1.00, 1.00]
Small practice (0-5)	0.84	[0.66, 1.06]	0.66*	[0.48, 0.92]
New clinicians hired in past year?				
No (ref)	1.00	[1.00, 1.00]	1.00	[1.00, 1.00]
Yes	1.08	[0.84, 1.38]	1.20	[0.86, 1.67]
New office staff hired in past year?				
No/Not checked (ref)	1.00	[1.00, 1.00]	1.00	[1.00, 1.00]
Yes	1.15	[0.90, 1.46]	0.93	[0.68, 1.28]
Consulted with care coordinators, case managers, community health workers in past year?				
No/Not checked (ref)	1.00	[1.00, 1.00]	1.00	[1.00, 1.00]
Yes	0.81	[0.64, 1.03]	1.02	[0.75, 1.39]
Changed workflow in past year?				
No/Not checked (ref)	1.00	[1.00, 1.00]	1.00	[1.00, 1.00]
Yes	1.15	[0.91, 1.44]	1.41*	[1.03, 1.94]
Co-located Mental Health w/in Primary Care in past year?				
No/Not checked (ref)	1.00	[1.00, 1.00]	1.00	[1.00, 1.00]
Yes	1.16	[0.84, 1.60]	1.62	[0.97, 2.71]

Logistic regression with adjusted odds ratios; 95% confidence intervals in brackets. Each column is a separate model adjusted for the covariates shown.

* $p < 0.05$, ** $p < 0.01$, *** $p < 0.001$

Table 6. Multivariate analysis of PCP influence on ER use: sensitivity analysis with random intercept for practice ID

PCP influence on ER use[a]	Original model (N= 1,786)		Practice adjusted model (N= 1,786)	
	aOR	95% CI	aOR	95% CI
Years in practice	0.99*	[0.98, 1.00]	0.99*	[0.98, 1.00]
Race				
White (ref)	1.00	[1.00, 1.00]	1.00	[1.00, 1.00]
Black/African American	0.81	[0.49, 1.35]	0.80	[0.46, 1.39]
Asian/Pacific Islander	1.89**	[1.27, 2.83]	1.96**	[1.28, 3.01]
American Indian/Alaska Native	2.81	[0.35, 22.67]	3.04	[0.34, 26.82]
Other	1.35	[0.73, 2.51]	1.38	[0.71, 2.65]
Hispanic/Latino				
No (ref)	1.00	[1.00, 1.00]	1.00	[1.00, 1.00]
Yes	1.49	[0.64, 3.49]	1.59	[0.65, 3.91]
Physician				
Non-physician (NP/PA) (ref)	1.00	[1.00, 1.00]	1.00	[1.00, 1.00]
Physician	0.93	[0.68, 1.26]	0.91	[0.66, 1.27]
Urbanicity				
Urban (ref)	1.00	[1.00, 1.00]	1.00	[1.00, 1.00]
Suburban	0.66*	[0.46, 0.93]	0.63*	[0.42, 0.94]
Rural	1.00	[0.73, 1.36]	0.99	[0.70, 1.39]
Practice size				
Large practice (6+) (ref)	1.00	[1.00, 1.00]	1.00	[1.00, 1.00]
Small practice (0-5)	0.84	[0.66, 1.06]	0.83	[0.64, 1.08]
New clinicians hired in past year?				
No (ref)	1.00	[1.00, 1.00]	1.00	[1.00, 1.00]
Yes	1.08	[0.84, 1.38]	1.10	[0.84, 1.43]
New office staff hired in past year?				
No/Not checked (ref)	1.00	[1.00, 1.00]	1.00	[1.00, 1.00]
Yes	1.15	[0.90, 1.46]	1.17	[0.90, 1.52]
Consulted with care coordinators, case managers, community health workers in past year?				
No/Not checked (ref)	1.00	[1.00, 1.00]	1.00	[1.00, 1.00]
Yes	0.81	[0.64, 1.03]	0.79	[0.61, 1.03]
Changed workflow in past year?				
No/Not checked (ref)	1.00	[1.00, 1.00]	1.00	[1.00, 1.00]
Yes	1.15	[0.91, 1.44]	1.15	[0.90, 1.46]
Co-located Mental Health w/in Primary Care in past year?				
No/Not checked (ref)	1.00	[1.00, 1.00]	1.00	[1.00, 1.00]
Yes	1.16	[0.84, 1.60]	1.18	[0.84, 1.67]

Logistic regression analysis with adjusted odds ratios; 95% confidence intervals in brackets. First column shows model adjusted for all covariates shown. Second model adds a random intercept for the practice ID.

[a] "PCP influence on ER use" Responses dichotomized as Some influence or A great deal of influence vs. A little influence or No influence at all

* $p < 0.05$, ** $p < 0.01$, *** $p < 0.001$

Table 7. Multivariate analysis of PCP responsible for decreasing ER use: sensitivity analysis with random intercept for practice ID

PCP responsible for decreasing ER use[a]	Original model (N= 1,773)		Practice adjusted model (N= 1,773)	
	aOR	95% CI	aOR	95% CI
Years in practice	0.98**	[0.97, 1.00]	0.98*	[0.97, 1.00]
Race				
White (ref)	1.00	[1.00, 1.00]	1.00	[1.00, 1.00]
Black/African American	1.67	[0.70, 3.97]	1.73	[0.69, 4.34]
Asian/Pacific Islander	1.61	[0.97, 2.69]	1.59	[0.92, 2.76]
American Indian/Alaska Native	1.00	[1.00, 1.00]	1.00	[1.00, 1.00]
Other	1.39	[0.58, 3.33]	1.42	[0.56, 3.59]
Hispanic/Latino				
No (ref)	1.00	[1.00, 1.00]	1.00	[1.00, 1.00]
Yes	4.82	[0.65, 35.91]	5.54	[0.70, 44.04]
Physician				
Non-physician (NP/PA) (ref)	1.00	[1.00, 1.00]	1.00	[1.00, 1.00]
Physician	0.54*	[0.33, 0.88]	0.51*	[0.30, 0.87]
Urbanicity				
Urban (ref)	1.00	[1.00, 1.00]	1.00	[1.00, 1.00]
Suburban	0.94	[0.57, 1.57]	0.92	[0.53, 1.62]
Rural	0.76	[0.51, 1.13]	0.72	[0.46, 1.14]
Practice size				
Large practice (6+) (ref)	1.00	[1.00, 1.00]	1.00	[1.00, 1.00]
Small practice (0-5)	0.66*	[0.48, 0.92]	0.66*	[0.46, 0.95]
New clinicians hired in past year?				
No (ref)	1.00	[1.00, 1.00]	1.00	[1.00, 1.00]
Yes	1.20	[0.86, 1.67]	1.24	[0.86, 1.78]
New office staff hired in past year?				
No/Not checked (ref)	1.00	[1.00, 1.00]	1.00	[1.00, 1.00]
Yes	0.93	[0.68, 1.28]	0.92	[0.65, 1.31]
Consulted with care coordinators, case managers, community health workers in past year?				
No/Not checked (ref)	1.00	[1.00, 1.00]	1.00	[1.00, 1.00]
Yes	1.02	[0.75, 1.39]	1.01	[0.72, 1.41]
Changed workflow in past year?				
No/Not checked (ref)	1.00	[1.00, 1.00]	1.00	[1.00, 1.00]
Yes	1.41*	[1.03, 1.94]	1.46*	[1.03, 2.05]
Co-located Mental Health w/in Primary Care in past year?				
No/Not checked (ref)	1.00	[1.00, 1.00]	1.00	[1.00, 1.00]
Yes	1.62	[0.97, 2.71]	1.69	[0.97, 2.94]

Logistic regression analysis with adjusted odds ratios; 95% confidence intervals in brackets. First column shows model adjusted for all covariates shown. Second model adds a random intercept for the practice ID.

[a] "PCP responsible for decreasing ER use" Responses dichotomized as Major responsibility or Some responsibility vs. A little responsibility or No responsibility at all

* $p < 0.05$, ** $p < 0.01$, *** $p < 0.001$

Table 8. Multivariate analysis of HRA completion: sensitivity analysis with random intercept for practice ID

Complete any HRA[a]	Original model (N= 1,637)		Practice adjusted model (N= 1,637)	
	aOR	95% CI	aOR	95% CI
PCP familiarity with completing HRA				
Very familiar (ref)	1.00	[1.00, 1.00]	1.00	[1.00, 1.00]
Somewhat familiar	0.50	[0.20, 1.24]	0.50	[0.20, 1.24]
A little familiar	0.27**	[0.10, 0.71]	0.27**	[0.10, 0.71]
Not at all familiar	0.23*	[0.07, 0.76]	0.23*	[0.07, 0.76]
HRA useful for identifying health risks				
Very useful (ref)	1.00	[1.00, 1.00]	1.00	[1.00, 1.00]
Somewhat useful	0.95	[0.27, 3.36]	0.95	[0.27, 3.36]
A little useful	3.41	[0.42, 27.75]	3.41	[0.42, 27.75]
Not at all useful	11.13	[0.35, 350.17]	11.13	[0.35, 350.17]
HRA useful for discussing health risks				
Very useful (ref)	1.00	[1.00, 1.00]	1.00	[1.00, 1.00]
Somewhat useful	0.56	[0.13, 2.51]	0.56	[0.13, 2.51]
A little useful	0.04*	[0.00, 0.49]	0.04*	[0.00, 0.49]
Not at all useful	0.04	[0.00, 3.83]	0.04	[0.00, 3.83]
HRA useful for persuading patients to address risks				
Very useful (ref)	1.00	[1.00, 1.00]	1.00	[1.00, 1.00]
Somewhat useful	2.95	[0.62, 14.06]	2.95	[0.62, 14.06]
A little useful	26.95**	[2.87, 253.14]	26.95**	[2.87, 253.14]
Not at all useful	8.34	[0.33, 210.86]	8.34	[0.33, 210.86]
HRA useful for documenting patient behavior goals				
Very useful (ref)	1.00	[1.00, 1.00]	1.00	[1.00, 1.00]
Somewhat useful	0.71	[0.18, 2.84]	0.71	[0.18, 2.84]
A little useful	0.79	[0.14, 4.35]	0.79	[0.14, 4.35]
Not at all useful	1.32	[0.10, 17.34]	1.32	[0.10, 17.34]
HRA useful for getting patients to change behaviors				
Very useful (ref)	1.00	[1.00, 1.00]	1.00	[1.00, 1.00]
Somewhat useful	1.03	[0.25, 4.19]	1.03	[0.25, 4.19]
A little useful	0.87	[0.19, 3.94]	0.87	[0.19, 3.94]
Not at all useful	0.28	[0.03, 2.50]	0.28	[0.03, 2.50]
Provider type				
Non-physician (ref)	1.00	[1.00, 1.00]	1.00	[1.00, 1.00]
Physician	0.89	[0.40, 2.01]	0.89	[0.40, 2.01]
Practice location				
Non-urban (ref)	1.00	[1.00, 1.00]	1.00	[1.00, 1.00]
Urban	0.39*	[0.17, 0.93]	0.39*	[0.17, 0.93]

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Predominant payer mix				
Private (ref)	1.00	[1.00, 1.00]	1.00	[1.00, 1.00]
Medicaid	0.42*	[0.18, 0.99]	0.42*	[0.18, 0.99]
Medicare	1.34	[0.54, 3.33]	1.34	[0.54, 3.33]
Uninsured	0.05*	[0.00, 0.83]	0.05*	[0.00, 0.83]
Mixed	0.71	[0.18, 2.84]	0.71	[0.18, 2.84]
HMP-MC members assigned to PCP as of 7-25-2016	1.22***	[1.16, 1.27]	1.22***	[1.16, 1.27]

Logistic regression analysis with adjusted odds ratios; 95% confidence intervals in brackets. First column shows model adjusted for all covariates shown. Second model adds a random intercept for the practice ID.
[a] "Complete any HRA" Responses dichotomized as any completion rate greater than 0 vs completion rates equal to 0
* $p < 0.05$, ** $p < 0.01$, *** $p < 0.001$

Table 9. Multivariate analysis of HRA completion rate: sensitivity analysis with random intercept for practice ID

HRA completion rate	Original model (N= 1,637)		Practice adjusted model (N= 1,637)	
	Coefficients	95% CI	Coefficients	95% CI
PCP familiarity with completing HRA				
Very familiar (ref)	-	-	-	-
Somewhat familiar	1.19***	[0.74, 1.63]	-0.25***	[-0.38, -0.12]
A little familiar	1.56***	[0.96, 2.16]	-0.32***	[-0.49, -0.15]
Not at all familiar	2.98***	[2.11, 3.85]	-0.52***	[-0.72, -0.33]
HRA useful for identifying health risks				
Very useful (ref)	-	-	-	-
Somewhat useful	-0.45	[-1.07, 0.18]	0.08	[-0.12, 0.29]
A little useful	-0.39	[-1.24, 0.45]	0.09	[-0.18, 0.36]
Not at all useful	-0.50	[-1.68, 0.69]	0.12	[-0.28, 0.53]
HRA useful for discussing health risks				
Very useful (ref)	-	-	-	-
Somewhat useful	0.31	[-0.32, 0.93]	-0.08	[-0.28, 0.13]
A little useful	0.32	[-0.57, 1.20]	-0.08	[-0.37, 0.22]
Not at all useful	0.15	[-1.32, 1.62]	-0.08	[-0.55, 0.40]
HRA useful for persuading patients to address risks				
Very useful (ref)	-	-	-	-
Somewhat useful	0.01	[-0.65, 0.66]	0.02	[-0.19, 0.23]
A little useful	-0.47	[-1.31, 0.36]	0.14	[-0.13, 0.41]
Not at all useful	0.04	[-1.34, 1.43]	0.01	[-0.41, 0.43]
HRA useful for documenting patient behavior goals				
Very useful (ref)	-	-	-	-
Somewhat useful	-0.54	[-1.20, 0.11]	0.10	[-0.10, 0.30]
A little useful	-0.57	[-1.35, 0.20]	0.09	[-0.15, 0.33]
Not at all useful	-0.62	[-1.67, 0.43]	0.10	[-0.22, 0.43]
HRA useful for getting patients to change behaviors				
Very useful (ref)	-	-	-	-
Somewhat useful	-0.12	[-0.93, 0.68]	0.02	[-0.21, 0.26]
A little useful	0.00	[-0.86, 0.87]	-0.01	[-0.27, 0.25]
Not at all useful	0.07	[-1.04, 1.18]	-0.02	[-0.37, 0.32]
Provider type				
Non-physician (ref)	-	-	-	-
Physician	0.22	[-0.24, 0.68]	-0.03	[-0.19, 0.13]
Practice location				
Non-urban (ref)	-	-	-	-
Urban	0.48*	[0.09, 0.87]	-0.11	[-0.24, 0.02]

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Predominant payer mix				
Private (ref)	-	-	-	-
Medicaid	0.44*	[0.00, 0.88]	-0.08	[-0.23, 0.06]
Medicare	0.21	[-0.26, 0.68]	-0.04	[-0.19, 0.11]
Uninsured	0.21	[-1.58, 2.01]	-0.09	[-0.71, 0.53]
Mixed	0.50	[-0.22, 1.22]	-0.11	[-0.32, 0.11]
HMP-MC members assigned to PCP as of 7-25-2016	0.002*	[0.000, 0.004]	-0.0003	[-0.0008, 0.0001]

Generalized linear model with gamma distribution predicting the rate (%) of HRA completions; 95% confidence intervals in brackets. First column shows model adjusted for all covariates shown. Second model adds a random intercept for the practice ID.

* $p < 0.05$, ** $p < 0.01$, *** $p < 0.001$

Table 10. Multivariate analysis of consulted with care coordinator, case manager, or community health worker: sensitivity analysis with random intercept for practice ID

Consulted with care coordinators, case managers, community health workers in past year[a]	Original model (N= 1,652)		Practice adjusted model (N= 1,652)	
	aOR	95% CI	aOR	95% CI
Practice size				
Large practice (6+) (ref)	1.00	[1.00, 1.00]	1.00	[1.00, 1.00]
Small practice (0-5)	0.46***	[0.37, 0.59]	0.41***	[0.30, 0.56]
Practice type				
Non-FQHC (ref)	1.00	[1.00, 1.00]	1.00	[1.00, 1.00]
FQHC	2.30***	[1.59, 3.34]	2.53***	[1.61, 3.95]
Non-academic (ref)	1.00	[1.00, 1.00]	1.00	[1.00, 1.00]
Academic	0.70	[0.47, 1.07]	0.77	[0.47, 1.27]
Not hospital-based/non-teaching (ref)	1.00	[1.00, 1.00]	1.00	[1.00, 1.00]
Hospital-based (non-teaching)	0.79	[0.57, 1.09]	0.80	[0.54, 1.19]
Predominant payer mix				
Private (ref)	1.00	[1.00, 1.00]	1.00	[1.00, 1.00]
Medicaid	0.72*	[0.54, 0.95]	0.70*	[0.50, 0.98]
Medicare	0.73*	[0.53, 1.00]	0.68*	[0.47, 0.99]
Uninsured	1.36	[0.33, 5.66]	1.42	[0.26, 7.76]
Mixed	0.89	[0.58, 1.36]	0.87	[0.53, 1.44]
Participating in MiPCT				
No (ref)	1.00	[1.00, 1.00]	1.00	[1.00, 1.00]
Yes	3.58***	[2.65, 4.84]	4.23***	[2.89, 6.19]
Urbanicity				
Urban (ref)	1.00	[1.00, 1.00]	1.00	[1.00, 1.00]
Suburban	0.82	[0.56, 1.20]	0.79	[0.49, 1.26]
Rural	1.15	[0.84, 1.58]	1.26	[0.84, 1.87]
Sex				
Male (ref)	1.00	[1.00, 1.00]	1.00	[1.00, 1.00]
Female	1.02	[0.80, 1.30]	1.06	[0.80, 1.41]
Specialty care				
Family medicine (ref)	1.00	[1.00, 1.00]	1.00	[1.00, 1.00]
Internal medicine	0.85	[0.64, 1.14]	0.85	[0.60, 1.21]
Non-physician provider	1.39	[0.98, 1.96]	1.41	[0.94, 2.11]
Other	0.98	[0.59, 1.62]	1.00	[0.55, 1.81]
Practice ownership				
Full owner (ref)	1.00	[1.00, 1.00]	1.00	[1.00, 1.00]
Partner/part-owner	1.03	[0.70, 1.52]	1.00	[0.62, 1.60]
Employee	1.58*	[1.08, 2.31]	1.60*	[1.02, 2.50]
Years in practice	1.00	[0.99, 1.01]	1.00	[0.99, 1.01]

Logistic regression analysis with adjusted odds ratios; 95% confidence intervals in brackets. First column shows model adjusted for all covariates shown. Second model adds a random intercept for the practice ID.

[a] "Consulted with care coordinators, case managers, community health workers in past year" Responses dichotomized as Yes vs. No or Not checked

* $p < 0.05$, ** $p < 0.01$, *** $p < 0.001$

Table 11. Multivariate analysis of co-located mental health within primary care in past year: sensitivity analysis with random intercept for practice ID

Co-located Mental Health within Primary Care in past year[a]	Original model (N= 1,652)		Practice adjusted label (N= 1,652)	
	aOR	95% CI	aOR	95% CI
Practice size				
Large practice (6+) (ref)	1.00	[1.00, 1.00]	1.00	[1.00, 1.00]
Small practice (0-5)	0.57***	[0.41, 0.79]	0.43***	[0.26, 0.71]
Practice type				
Non-FQHC (ref)	1.00	[1.00, 1.00]	1.00	[1.00, 1.00]
FQHC	3.65***	[2.50, 5.33]	6.32***	[3.39, 11.79]
Non-academic (ref)	1.00	[1.00, 1.00]	1.00	[1.00, 1.00]
Academic	0.85	[0.52, 1.39]	0.85	[0.42, 1.74]
Not hospital-based/non-teaching (ref)	1.00	[1.00, 1.00]	1.00	[1.00, 1.00]
Hospital-based (non-teaching)	0.53**	[0.36, 0.79]	0.49*	[0.28, 0.88]
Predominant payer mix				
Private (ref)	1.00	[1.00, 1.00]	1.00	[1.00, 1.00]
Medicaid	2.18***	[1.45, 3.28]	2.65***	[1.51, 4.64]
Medicare	1.25	[0.76, 2.04]	1.44	[0.76, 2.74]
Uninsured	4.01*	[1.08, 14.96]	2.88	[0.47, 17.80]
Mixed	1.53	[0.81, 2.88]	1.13	[0.49, 2.61]
Participating in MiPCT				
No (ref)	1.00	[1.00, 1.00]	1.00	[1.00, 1.00]
Yes	2.15***	[1.50, 3.09]	2.41**	[1.39, 4.17]
Urbanicity				
Urban (ref)	1.00	[1.00, 1.00]	1.00	[1.00, 1.00]
Suburban	1.13	[0.66, 1.91]	1.55	[0.72, 3.35]
Rural	2.24***	[1.51, 3.33]	2.72**	[1.47, 5.02]
Sex				
Male (ref)	1.00	[1.00, 1.00]	1.00	[1.00, 1.00]
Female	0.99	[0.71, 1.37]	0.94	[0.62, 1.43]
Specialty care				
Family medicine (ref)	1.00	[1.00, 1.00]	1.00	[1.00, 1.00]
Internal medicine	1.19	[0.78, 1.82]	1.05	[0.58, 1.91]
Non-physician provider	1.12	[0.74, 1.69]	1.21	[0.70, 2.10]
Other	0.94	[0.46, 1.90]	0.66	[0.25, 1.77]
Practice ownership				
Full owner (ref)	1.00	[1.00, 1.00]	1.00	[1.00, 1.00]
Partner/part-owner	0.80	[0.36, 1.79]	0.59	[0.21, 1.65]
Employee	2.49**	[1.36, 4.58]	2.34*	[1.06, 5.15]
Years in practice	1.00	[0.99, 1.02]	1.00	[0.99, 1.02]

Logistic regression analysis with adjusted odds ratios; 95% confidence intervals in brackets. First column shows model adjusted for all covariates shown. Second model adds a random intercept for the practice ID.

[a] "Co-located Mental Health within Primary Care in past year" Responses dichotomized as Yes vs. No or Not checked

* $p < 0.05$, ** $p < 0.01$, *** $p < 0.001$

Table 12. Multivariate analysis of hiring additional clinicians within the past year: sensitivity analysis with random intercept for practice ID

Hired additional clinicians within the past year[a]	Original model (N= 1,652)		Practice adjusted model (N= 1,652)	
	aOR	95% CI	aOR	95% CI
Practice size				
Large practice (6+) (ref)	1.00	[1.00, 1.00]	1.00	[1.00, 1.00]
Small practice (0-5)	0.25***	[0.19, 0.31]	0.13***	[0.08, 0.20]
Practice type				
Non-FQHC (ref)	1.00	[1.00, 1.00]	1.00	[1.00, 1.00]
FQHC	1.64**	[1.15, 2.33]	1.89*	[1.10, 3.23]
Non-academic (ref)	1.00	[1.00, 1.00]	1.00	[1.00, 1.00]
Academic	0.78	[0.53, 1.17]	0.81	[0.44, 1.47]
Not hospital-based/non-teaching (ref)	1.00	[1.00, 1.00]	1.00	[1.00, 1.00]
Hospital-based (non-teaching)	0.87	[0.63, 1.19]	0.84	[0.52, 1.34]
Predominant payer mix				
Private (ref)	1.00	[1.00, 1.00]	1.00	[1.00, 1.00]
Medicaid	0.92	[0.70, 1.22]	0.99	[0.66, 1.50]
Medicare	0.83	[0.61, 1.14]	0.76	[0.49, 1.20]
Uninsured	0.51	[0.15, 1.77]	0.61	[0.10, 3.64]
Mixed	1.15	[0.75, 1.75]	1.18	[0.65, 2.14]
Participating in MiPCT				
No (ref)	1.00	[1.00, 1.00]	1.00	[1.00, 1.00]
Yes	0.95	[0.73, 1.25]	1.09	[0.70, 1.71]
Urbanicity				
Urban (ref)	1.00	[1.00, 1.00]	1.00	[1.00, 1.00]
Suburban	0.95	[0.65, 1.39]	1.22	[0.66, 2.25]
Rural	1.01	[0.74, 1.39]	1.18	[0.71, 1.98]
Sex				
Male (ref)	1.00	[1.00, 1.00]	1.00	[1.00, 1.00]
Female	0.97	[0.77, 1.23]	1.00	[0.72, 1.39]
Specialty care				
Family medicine (ref)	1.00	[1.00, 1.00]	1.00	[1.00, 1.00]
Internal medicine	1.13	[0.85, 1.50]	1.21	[0.79, 1.86]
Non-physician provider	1.15	[0.82, 1.61]	1.11	[0.68, 1.79]
Other	0.66	[0.40, 1.09]	0.49	[0.23, 1.04]
Practice ownership				
Full owner (ref)	1.00	[1.00, 1.00]	1.00	[1.00, 1.00]
Partner/part-owner	1.98***	[1.33, 2.93]	2.18*	[1.20, 3.96]
Employee	1.98***	[1.35, 2.90]	2.35**	[1.35, 4.10]
Years in practice	0.99**	[0.98, 1.00]	0.98*	[0.97, 1.00]

Logistic regression analysis with adjusted odds ratios; 95% confidence intervals in brackets. First column shows model adjusted for all covariates shown. Second model adds a random intercept for the practice ID.
[a] "Hired additional clinicians within the past year" Responses dichotomized as Yes vs. No or Not checked
* $p < 0.05$, ** $p < 0.01$, *** $p < 0.001$

Table 13. Multivariate analysis of hiring new office staff within the past year: sensitivity analysis with random intercept for practice ID

New office staff hired in past year[a]	Original model (N= 1,652)		Practice adjusted model (N= 1,652)	
	aOR	95% CI	aOR	95% CI
Practice size				
Large practice (6+) (ref)	1.00	[1.00, 1.00]	1.00	[1.00, 1.00]
Small practice (0-5)	0.51***	[0.41, 0.65]	0.39***	[0.27, 0.56]
Practice type				
Non-FQHC (ref)	1.00	[1.00, 1.00]	1.00	[1.00, 1.00]
FQHC	1.82***	[1.28, 2.58]	2.00**	[1.23, 3.24]
Non-academic (ref)	1.00	[1.00, 1.00]	1.00	[1.00, 1.00]
Academic	0.68	[0.47, 1.01]	0.76	[0.44, 1.29]
Not hospital-based/non-teaching (ref)	1.00	[1.00, 1.00]	1.00	[1.00, 1.00]
Hospital-based (non-teaching)	1.03	[0.75, 1.40]	1.13	[0.74, 1.74]
Predominant payer mix				
Private (ref)	1.00	[1.00, 1.00]	1.00	[1.00, 1.00]
Medicaid	1.00	[0.77, 1.31]	1.01	[0.70, 1.46]
Medicare	0.95	[0.70, 1.28]	0.94	[0.62, 1.40]
Uninsured	0.32	[0.09, 1.10]	0.19*	[0.04, 0.99]
Mixed	0.69	[0.46, 1.04]	0.66	[0.39, 1.14]
Participating in MiPCT				
No (ref)	1.00	[1.00, 1.00]	1.00	[1.00, 1.00]
Yes	1.06	[0.82, 1.39]	1.10	[0.74, 1.63]
Urbanicity				
Urban (ref)	1.00	[1.00, 1.00]	1.00	[1.00, 1.00]
Suburban	0.66*	[0.46, 0.94]	0.61	[0.36, 1.04]
Rural	0.95	[0.70, 1.29]	0.99	[0.63, 1.56]
Sex				
Male (ref)	1.00	[1.00, 1.00]	1.00	[1.00, 1.00]
Female	0.82	[0.65, 1.03]	0.77	[0.57, 1.03]
Specialty care				
Family medicine (ref)	1.00	[1.00, 1.00]	1.00	[1.00, 1.00]
Internal medicine	0.86	[0.65, 1.13]	0.88	[0.60, 1.29]
Non-physician provider	0.95	[0.68, 1.32]	0.99	[0.64, 1.53]
Other	0.75	[0.47, 1.21]	0.73	[0.38, 1.40]
Practice ownership				
Full owner (ref)	1.00	[1.00, 1.00]	1.00	[1.00, 1.00]
Partner/part-owner	2.25***	[1.53, 3.31]	2.80***	[1.63, 4.83]
Employee	1.38	[0.96, 1.99]	1.45	[0.88, 2.38]
Years in practice	0.98***	[0.97, 0.99]	0.98***	[0.96, 0.99]

Logistic regression analysis with adjusted odds ratios; 95% confidence intervals in brackets. First column shows model adjusted for all covariates shown. Second model adds a random intercept for the practice ID.

[a] "New office Staff hired in past year" Responses dichotomized as Yes vs. No or Not checked

* $p < 0.05$, ** $p < 0.01$, *** $p < 0.001$

Table 14. Multivariate analysis of changed workflow in the past year: sensitivity analysis with random intercept for practice ID

Changed workflow in past year[a]	Original model (N= 1,652)		Practice adjusted model (N= 1,652)	
	aOR	95% CI	aOR	95% CI
Practice size				
Large practice (6+) (ref)	1.00	[1.00, 1.00]	1.00	[1.00, 1.00]
Small practice (0-5)	0.65***	[0.52, 0.81]	0.61***	[0.46, 0.80]
Practice type				
Non-FQHC (ref)	1.00	[1.00, 1.00]	1.00	[1.00, 1.00]
FQHC	1.06	[0.77, 1.46]	0.99	[0.67, 1.47]
Non-academic (ref)	1.00	[1.00, 1.00]	1.00	[1.00, 1.00]
Academic	0.85	[0.58, 1.24]	0.87	[0.55, 1.36]
Not hospital-based/non-teaching (ref)	1.00	[1.00, 1.00]	1.00	[1.00, 1.00]
Hospital-based (non-teaching)	0.99	[0.73, 1.33]	1.00	[0.70, 1.42]
Predominant payer mix				
Private (ref)	1.00	[1.00, 1.00]	1.00	[1.00, 1.00]
Medicaid	1.15	[0.88, 1.50]	1.19	[0.87, 1.62]
Medicare	1.39*	[1.03, 1.87]	1.51*	[1.06, 2.14]
Uninsured	0.99	[0.30, 3.26]	0.88	[0.22, 3.56]
Mixed	0.78	[0.52, 1.18]	0.77	[0.48, 1.24]
Participating in MiPCT				
No (ref)	1.00	[1.00, 1.00]	1.00	[1.00, 1.00]
Yes	1.08	[0.84, 1.39]	1.12	[0.82, 1.54]
Urbanicity				
Urban (ref)	1.00	[1.00, 1.00]	1.00	[1.00, 1.00]
Suburban	1.18	[0.83, 1.68]	1.16	[0.75, 1.80]
Rural	1.33	[0.99, 1.78]	1.42	[0.99, 2.05]
Sex				
Male (ref)	1.00	[1.00, 1.00]	1.00	[1.00, 1.00]
Female	0.96	[0.77, 1.20]	0.95	[0.74, 1.23]
Specialty care				
Family medicine (ref)	1.00	[1.00, 1.00]	1.00	[1.00, 1.00]
Internal medicine	0.75*	[0.57, 0.98]	0.71*	[0.51, 0.99]
Non-physician provider	1.05	[0.77, 1.44]	1.07	[0.75, 1.55]
Other	0.80	[0.50, 1.27]	0.77	[0.44, 1.35]
Practice ownership				
Full owner (ref)	1.00	[1.00, 1.00]	1.00	[1.00, 1.00]
Partner/part-owner	1.00	[0.68, 1.45]	1.02	[0.65, 1.61]
Employee	0.86	[0.60, 1.23]	0.81	[0.53, 1.25]
Years in practice	0.98***	[0.97, 0.99]	0.98***	[0.97, 0.99]

Logistic regression analysis with adjusted odds ratios; 95% confidence intervals in brackets. First column shows model adjusted for all covariates shown. Second model adds a random intercept for the practice ID.

[a] "Changed workflow in past year" Responses dichotomized as Yes vs. No or Not checked

* $p < 0.05$, ** $p < 0.01$, *** $p < 0.001$

Table 15. Multivariate analysis of an increase in the number of new patients: sensitivity analysis with random intercept for practice ID

Increase in the number of new patients[a]	Original model (N= 1,638)		Practice adjusted model (N= 1,638)	
	aOR	95% CI	aOR	95% CI
Practice size				
Large practice (6+) (ref)	1.00	[1.00, 1.00]	1.00	[1.00, 1.00]
Small practice (0-5)	1.02	[0.81, 1.29]	1.05	[0.80, 1.37]
Practice type				
Non-FQHC (ref)	1.00	[1.00, 1.00]	1.00	[1.00, 1.00]
FQHC (ref)	1.34	[0.95, 1.90]	1.42	[0.95, 2.11]
Non-academic (ref)	1.00	[1.00, 1.00]	1.00	[1.00, 1.00]
Academic	0.89	[0.60, 1.31]	0.87	[0.56, 1.35]
Not hospital-based/non-teaching (ref)	1.00	[1.00, 1.00]	1.00	[1.00, 1.00]
Hospital-based (non-teaching)	0.81	[0.60, 1.12]	0.79	[0.55, 1.12]
Predominant payer mix				
Private (ref)	1.00	[1.00, 1.00]	1.00	[1.00, 1.00]
Medicaid	3.56***	[2.72, 4.65]	4.01***	[2.92, 5.50]
Medicare	1.16	[0.86, 1.56]	1.15	[0.83, 1.61]
Uninsured	6.43*	[1.36, 30.37]	7.31*	[1.36, 39.21]
Mixed	1.52*	[1.02, 2.27]	1.59*	[1.02, 2.48]
Urbanicity				
Urban (ref)	1.00	[1.00, 1.00]	1.00	[1.00, 1.00]
Suburban	1.48*	[1.01, 2.17]	1.55	[1.00, 2.42]
Rural	0.87	[0.63, 1.18]	0.85	[0.59, 1.22]
Sex				
Male (ref)	1.00	[1.00, 1.00]	1.00	[1.00, 1.00]
Female	1.45**	[1.15, 1.82]	1.48**	[1.15, 1.91]
Specialty care				
Family medicine (ref)	1.00	[1.00, 1.00]	1.00	[1.00, 1.00]
Internal medicine	1.09	[0.82, 1.43]	1.09	[0.80, 1.49]
Non-physician provider	1.32	[0.94, 1.86]	1.36	[0.93, 1.98]
Other	0.71	[0.43, 1.15]	0.72	[0.42, 1.25]
Practice ownership				
Full owner (ref)	1.00	[1.00, 1.00]	1.00	[1.00, 1.00]
Partner/part-owner	0.66*	[0.45, 0.97]	0.63*	[0.40, 0.98]
Employee	1.05	[0.73, 1.52]	1.08	[0.71, 1.63]
Years in practice	0.99	[0.98, 1.00]	0.99	[0.98, 1.00]

Logistic regression analysis with adjusted odds ratios; 95% confidence intervals in brackets. First column shows model adjusted for all covariates shown. Second model adds a random intercept for the practice ID.

[a] "Increase in the number of new patients" Responses dichotomized as To a great extent or To some extent vs. To a little extent or Not at all or Don't know

* $p < 0.05$, ** $p < 0.01$, *** $p < 0.001$

Table 16. Multivariate analysis of existing patients who had been uninsured or self-pay gained insurance: sensitivity analysis with random intercept for practice ID

Existing patients who had been uninsured or self-pay gained insurance[a]	Original model (N= 1,638)		Practice adjusted model (N= 1,638)	
	aOR	95% CI	aOR	95% CI
Practice size				
Large practice (6+) (ref)	1.00	[1.00, 1.00]	1.00	[1.00, 1.00]
Small practice (0-5)	1.05	[0.83, 1.31]	1.05	[0.82, 1.34]
Practice type				
Non-FQHC (ref)	1.00	[1.00, 1.00]	1.00	[1.00, 1.00]
FQHC (ref)	1.92***	[1.36, 2.72]	1.98***	[1.36, 2.87]
Non-academic (ref)	1.00	[1.00, 1.00]	1.00	[1.00, 1.00]
Academic	1.00	[0.69, 1.47]	1.01	[0.67, 1.51]
Not hospital-based/non-teaching (ref)	1.00	[1.00, 1.00]	1.00	[1.00, 1.00]
Hospital-based (non-teaching)	0.81	[0.60, 1.11]	0.80	[0.58, 1.11]
Predominant payer mix				
Private (ref)	1.00	[1.00, 1.00]	1.00	[1.00, 1.00]
Medicaid	2.61***	[2.01, 3.39]	2.74***	[2.06, 3.65]
Medicare	1.11	[0.83, 1.50]	1.12	[0.82, 1.53]
Uninsured	2.08	[0.59, 7.29]	2.07	[0.55, 7.71]
Mixed	1.44	[0.97, 2.15]	1.47	[0.96, 2.23]
Urbanicity				
Urban (ref)	1.00	[1.00, 1.00]	1.00	[1.00, 1.00]
Suburban	1.32	[0.91, 1.91]	1.34	[0.90, 1.99]
Rural	1.16	[0.86, 1.58]	1.17	[0.84, 1.63]
Sex				
Male (ref)	1.00	[1.00, 1.00]	1.00	[1.00, 1.00]
Female	1.35*	[1.07, 1.69]	1.36*	[1.07, 1.73]
Specialty care				
Family medicine (ref)	1.00	[1.00, 1.00]	1.00	[1.00, 1.00]
Internal medicine	0.96	[0.73, 1.26]	0.95	[0.71, 1.27]
Non-physician provider	1.54*	[1.10, 2.15]	1.55*	[1.09, 2.20]
Other	0.99	[0.61, 1.59]	1.00	[0.60, 1.65]
Practice ownership				
Full owner (ref)	1.00	[1.00, 1.00]	1.00	[1.00, 1.00]
Partner/part-owner	0.75	[0.51, 1.10]	0.74	[0.49, 1.10]
Employee	1.01	[0.70, 1.46]	1.02	[0.70, 1.50]
Years in practice	1.00	[0.99, 1.01]	1.00	[0.99, 1.01]

Logistic regression analysis with adjusted odds ratios; 95% confidence intervals in brackets. First column shows model adjusted for all covariates shown. Second model adds a random intercept for the practice ID.

[a] "Existing patients who had been uninsured or self-pay gained insurance" Responses dichotomized as To a great extent or To some extent vs. To a little extent or Not at all or Don't know

* $p < 0.05$, ** $p < 0.01$, *** $p < 0.001$

Table 17. Multivariate analysis of existing patients changed from other insurance to HMP: sensitivity analysis with random intercept for practice ID

Existing patients changed from other insurance to Healthy Michigan Plan[a]	Original model (N= 1,639)		Practice adjusted model (N= 1,639)	
	aOR	95% CI	aOR	95% CI
Practice size				
Large practice (6+) (ref)	1.00	[1.00, 1.00]	1.00	[1.00, 1.00]
Small practice (0-5)	1.17	[0.92, 1.49]	1.16	[0.88, 1.52]
Practice type				
Non-FQHC (ref)	1.00	[1.00, 1.00]	1.00	[1.00, 1.00]
FQHC (ref)	1.11	[0.79, 1.56]	1.12	[0.76, 1.64]
Non-academic (ref)	1.00	[1.00, 1.00]	1.00	[1.00, 1.00]
Academic	0.92	[0.61, 1.39]	0.91	[0.57, 1.43]
Not hospital-based/non-teaching (ref)	1.00	[1.00, 1.00]	1.00	[1.00, 1.00]
Hospital-based (non-teaching)	0.82	[0.59, 1.13]	0.79	[0.55, 1.13]
Predominant payer mix				
Private (ref)	1.00	[1.00, 1.00]	1.00	[1.00, 1.00]
Medicaid	2.62***	[1.98, 3.47]	2.84***	[2.07, 3.89]
Medicare	1.13	[0.80, 1.58]	1.12	[0.78, 1.62]
Uninsured	0.61	[0.13, 2.91]	0.54	[0.10, 2.84]
Mixed	1.46	[0.94, 2.26]	1.49	[0.93, 2.40]
Urbanicity				
Urban (ref)	1.00	[1.00, 1.00]	1.00	[1.00, 1.00]
Suburban	1.22	[0.83, 1.78]	1.30	[0.85, 2.00]
Rural	1.57**	[1.15, 2.14]	1.66**	[1.16, 2.37]
Sex				
Male (ref)	1.00	[1.00, 1.00]	1.00	[1.00, 1.00]
Female	1.17	[0.91, 1.49]	1.17	[0.90, 1.53]
Specialty care				
Family medicine (ref)	1.00	[1.00, 1.00]	1.00	[1.00, 1.00]
Internal medicine	1.22	[0.91, 1.65]	1.23	[0.88, 1.71]
Non-physician provider	1.45*	[1.05, 2.01]	1.55*	[1.08, 2.22]
Other	1.04	[0.62, 1.75]	1.05	[0.60, 1.84]
Practice ownership				
Full owner (ref)	1.00	[1.00, 1.00]	1.00	[1.00, 1.00]
Partner/part-owner	0.92	[0.60, 1.40]	0.92	[0.58, 1.45]
Employee	0.98	[0.66, 1.44]	0.97	[0.63, 1.47]
Years in practice	1.00	[0.99, 1.01]	1.00	[0.99, 1.01]

Logistic regression analysis with adjusted odds ratios; 95% confidence intervals in brackets. First column shows model adjusted for all covariates shown. Second model adds a random intercept for the practice ID.

[a] "Existing patients changed from other insurance to Healthy Michigan Plan" Responses dichotomized as To a great extent or To some extent vs. To a little extent or Not at all or Don't know

* $p < 0.05$, ** $p < 0.01$, *** $p < 0.001$

Table 18. Multivariate analysis of an increase in the number of new patients who have not seen a primary care practitioner in many years: sensitivity analysis with random intercept for practice ID

Increase in the number of new patients who have not seen a primary care practitioner in many years[a]	Original model (N= 1,638)		Practice adjusted model (N= 1,638)	
	aOR	95% CI	aOR	95% CI
Practice size				
Large practice (6+) (ref)	1.00	[1.00, 1.00]	1.00	[1.00, 1.00]
Small practice (0-5)	1.18	[0.94, 1.48]	1.19	[0.91, 1.54]
Practice type				
Non-FQHC (ref)	1.00	[1.00, 1.00]	1.00	[1.00, 1.00]
FQHC (ref)	1.45*	[1.02, 2.07]	1.54*	[1.04, 2.29]
Non-academic (ref)	1.00	[1.00, 1.00]	1.00	[1.00, 1.00]
Academic	1.07	[0.72, 1.57]	1.06	[0.68, 1.63]
Not hospital-based/non-teaching (ref)	1.00	[1.00, 1.00]	1.00	[1.00, 1.00]
Hospital-based (non-teaching)	0.97	[0.71, 1.32]	0.94	[0.66, 1.33]
Predominant payer mix				
Private (ref)	1.00	[1.00, 1.00]	1.00	[1.00, 1.00]
Medicaid	3.06***	[2.34, 4.01]	3.37***	[2.47, 4.59]
Medicare	1.18	[0.88, 1.57]	1.19	[0.86, 1.65]
Uninsured	1.87	[0.54, 6.51]	1.81	[0.46, 7.09]
Mixed	1.13	[0.76, 1.68]	1.17	[0.75, 1.81]
Urbanicity				
Urban (ref)	1.00	[1.00, 1.00]	1.00	[1.00, 1.00]
Suburban	1.19	[0.81, 1.74]	1.21	[0.78, 1.86]
Rural	0.79	[0.58, 1.07]	0.76	[0.53, 1.08]
Sex				
Male (ref)	1.00	[1.00, 1.00]	1.00	[1.00, 1.00]
Female	1.29*	[1.03, 1.62]	1.31*	[1.02, 1.68]
Specialty care				
Family medicine (ref)	1.00	[1.00, 1.00]	1.00	[1.00, 1.00]
Internal medicine	0.94	[0.72, 1.23]	0.91	[0.67, 1.24]
Non-physician provider	1.54*	[1.09, 2.18]	1.61*	[1.10, 2.34]
Other	0.81	[0.51, 1.31]	0.88	[0.52, 1.51]
Practice ownership				
Full owner (ref)	1.00	[1.00, 1.00]	1.00	[1.00, 1.00]
Partner/part-owner	0.83	[0.57, 1.22]	0.83	[0.54, 1.27]
Employee	1.00	[0.69, 1.44]	1.00	[0.67, 1.51]
Years in practice	1.00	[0.99, 1.01]	0.99	[0.98, 1.01]

Logistic regression analysis with adjusted odds ratios; 95% confidence intervals in brackets. First column shows model adjusted for all covariates shown. Second model adds a random intercept for the practice ID.

[a] "Increase in the number of new patients who have not seen a primary care practitioner in many years" Responses dichotomized as To a great extent or To some extent vs. To a little extent or Not at all or Don't know

* $p < 0.05$, ** $p < 0.01$, *** $p < 0.001$

Table 19. Predictive margins of primary care physician impact on emergency room use and primary care physician responsibility for emergency room use

	Primary care provider influence on emergency room use[a]		Primary care provider responsibility for emergency room use[b]	
	Predictive margins %	95% CI	Predictive margins %	95% CI
Race				
White	72.1	[69.8, 74.4]	86.6	[84.9, 88.4]
Black/African American	67.7	[57.2, 78.3	91.4	[84.9, 98.0]
Asian/Pacific Islander	82.9**	[77.6, 88.2]	91.2	[87.4, 95.0]
American Indian/Alaska Native	87.8	[65.6, 110.0]	-	-
Other	77.7	[67.3, 88.0]	89.9	[82.3, 97.5]
Hispanic/Latino				
Yes	73.2	[71.2, 75.3]	87.3	[85.8, 88.8]
No	80.2	[67.1, 93.3]	97.0	[91.2, 102.8]
MD/Non-MD				
MD/DO	74.5	[69.4, 79.6]	92.1*	[88.9, 95.3]
Non-physicians	73.1	[70.8, 75.4]	86.6	[84.8, 88.3]
Urbanicity				
Urban	74.2	[71.8, 76.6]	88.0	[86.3, 89.7]
Suburban	65.5*	[58.4, 72.7]	87.4	[82.4, 92.4]
Rural	74.2	[69.0, 79.4]	84.9	[80.5, 89.3]
Practice size				
Large practice (6+)	75.3	[72.1, 78.4]	90.0	[87.7, 92.3]
Small practice (0-5)	71.9	[69.0, 74.8]	85.8*	[83.6, 87.9]
New clinicians hired in past year?				
No/Not checked	72.6	[69.4, 75.8]	86.5	[84.2, 88.9]
Yes	74.0	[71.0, 77.1]	88.5	[86.2, 90.7]
New office staff hired in past year?				
No/Not checked	71.8	[68.4, 75.3]	87.9	[85.6, 90.2]
Yes	74.5	[71.7, 77.2]	87.1	[84.9, 89.4]
Consulted with care coordinators, case managers, community health workers in past year?				
No/Not checked	75.6	[72.5, 78.7]	87.4	[85.1, 89.7]
Yes	71.6	[68.7, 74.5]	87.6	[85.4, 89.8]
Changed workflow in past year?				
No/Not checked	72.2	[69.4, 75.0]	86.0	[83.9, 88.2]
Yes	74.9	[71.7, 78.0]	89.6*	[87.3, 91.9]
Co-located Mental Health w/in Primary Care in past year?				
No/Not checked	72.9	[70.7, 75.2]	86.9	[85.2, 88.6]
Yes	75.7	[70.5, 81.0]	91.4	[87.6, 95.2]

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Years in practice (intervals)	*		**	
0 years	77.4	[73.8, 81.0]	90.6	[88.2, 93.1]
10 years	75.3	[72.8, 77.8]	89.2	[87.3, 91.0]
20 years	73.1	[71.1, 75.2]	87.5	[86.0, 89.1]
30 years	70.9	[67.9, 73.8]	85.7	[83.6, 87.9]

[a] "How much can primary care practitioners influence non-urgent ER use by their patients?" Responses dichotomized as A great deal or Some vs. A little or Not at all

[b] "To what extent do you think it is your responsibility as a primary care practitioner to decrease non-urgent ER use?" Responses dichotomized as Major responsibility or Some responsibility vs. Minimal or No responsibility

Logistic regression with predicted margins; each column is a separate model/outcome, adjusted for all covariates shown.

The variable "Years in practice" was originally continuous, margins are estimated at specific cut shown. Significance testing was conducted on the continuous variable.

* $p < 0.05$, ** $p < 0.01$, *** $p < 0.001$

Table 20. Bivariate and multivariate associations of any HRA completion

PCP familiarity with completing HRA (n=1,898)	%[a]	OR	*p*-value	95% CI
Very familiar (n=928)	48.9	-		
Somewhat familiar (n=440)	23.2	0.50	NS	[0.20, 1.24]
A little familiar (n=248)	13.1	0.27	0.008	[0.10, 0.71]
Not at all familiar (n=282)	14.9	0.23	0.02	[0.07, 0.76]
HRA useful for identifying health risks (n=1,730)				
Very useful (n=453)	26.2	-		
Somewhat useful (n=727)	42.0	0.95	NS	[0.27, 3.36]
A little useful (n=347)	20.1	3.41	NS	[0.42, 27.75]
Not at all useful (n=203)	11.7	11.14	NS	[0.35, 350.18]
HRA useful for discussing health risks (n=1,727)				
Very useful (n=579)	33.5	-		
Somewhat useful (n=696)	40.3	0.56	NS	[0.13, 2.52]
A little useful (n=288)	16.9	0.04	0.01	[0.004, 0.485]
Not at all useful (n=164)	9.5	0.04	NS	[0.004, 3.828]
HRA useful for persuading patients to address risks (n=1,728)				
Very useful (n=464)	26.9	-		
Somewhat useful (n=674)	39.0	2.95	NS	[0.62, 14.06]
A little useful (n=394)	22.8	26.95	0.004	[2.87, 253.14]
Not at all useful (n=196)	11.3	8.34	NS	[0.33, 210.86]
HRA useful for documenting patient behavior goals (n=1,727)				
Very useful (n=391)	22.6	-		
Somewhat useful (n=683)	39.6	0.71	NS	[0.18, 2.84]
A little useful (n=424)	24.6	0.79	NS	[0.14, 4.35]
Not at all useful (n=229)	13.3	1.32	NS	[0.01, 17.34]
HRA useful for getting patients to change behaviors (n=1,722)				
Very useful (n=267)	15.5	-		
Somewhat useful (n=551)	32.0	1.03	NS	[0.25, 4.19]
A little useful (n=620)	36.0	0.87	NS	[0.19, 3.94]
Not at all useful (n=284)	16.5	0.28	NS	[0.03, 2.50]
Provider type (n=1,972)				
Non-physician (n=315)	16.0	-		
Physician (n=1,657)	84.0	0.89	NS	[0.40, 2.01]
Practice location (n=1,972)				
Non-urban (n=488)	24.8	-		
Urban (n=1,484)	75.3	0.39	0.03	[0.17, 0.93]
Predominant payer mix (n=1,787)				
Private (n=610)	34.1	-		
Medicaid (n=640)	35.8	0.42	0.05	[0.18, 0.99]
Medicare (n=393)	22.0	1.34	NS	[0.54, 3.33]
Uninsured (n=11)	0.6	0.05	0.04	[0.003, 0.830]
Mixed (n=133)	7.4	0.71	NS	[0.18, 2.84]

Bivariate association and adjusted logistic regression with odds ratios predicting any completion of HRA from data warehouse records. Multivariate model was adjusted for all variables shown, as well as the number of HMP members assigned to the PCP.

[a] Percent of respondents per level of familiarity with completing HRA.

Table 21. Rate of HRA completion by predictive factor

PCP familiarity with completing HRA	Completion rate (%)	*p*-value	95% CI
Very familiar	23.3	-	[22.1, 24.4]
Somewhat familiar	18.2	<0.001	[16.8, 19.5]
A little familiar	17.0	<0.001	[15.4, 18.6]
Not at all familiar	13.7	<0.001	[12.1, 15.2]
HRA useful for identifying health risks			
Very useful	18.9	-	[17.0, 20.9]
Somewhat useful	20.7	NS	[19.4, 22.1]
A little useful	20.5	NS	[18.4, 22.6]
Not at all useful	21.0	NS	[16.8, 25.1]
HRA useful for discussing health risks			
Very useful	21.2	-	[18.8, 23.5]
Somewhat useful	19.8	NS	[18.5, 21.1]
A little useful	19.8	NS	[17.5, 22.0]
Not at all useful	20.5	NS	[15.2, 25.8]
HRA useful for persuading patients to address risks			
Very useful	19.8	-	[17.6, 22.0]
Somewhat useful	19.8	NS	[18.4, 21.1]
A little useful	21.9	NS	[19.7, 24.2]
Not at all useful	19.6	NS	[15.3, 24.0]
HRA useful for documenting patient behavior goals			
Very useful	18.5	-	[16.6, 20.5]
Somewhat useful	20.7	NS	[19.3, 22.0]
A little useful	20.8	NS	[19.7, 22.6]
Not at all useful	21.0	NS	[17.5, 24.5]
HRA useful for getting patients to change behaviors			
Very useful	20.1	-	[17.0, 23.2]
Somewhat useful	20.7	NS	[19.1, 22.2]
A little useful	20.1	NS	[18.8, 21.4]
Not at all useful	19.8	NS	[17.2, 22.5]
Provider type			
Non-physician	21.0	-	[19.2, 22.8]
Physician	20.0	NS	[19.2, 20.9]
Practice location			
Non-urban	21.8	-	[20.2, 23.3]
Urban	19.7	0.02	[18.8, 20.5]
Predominant payer mix			
Private	21.3	-	[20.0, 22.7]
Medicaid	19.4	0.05	[18.3, 20.6]
Medicare	20.4	NS	[18.7, 22.1]
Uninsured	20.4	NS	[12.7, 28.0]
Mixed	19.2	NS	[16.7, 21.7]

Predicted HRA completion rates from GLM regression with gamma distribution predicting rate of completed HRAs using data warehouse records. Multivariate model was adjusted for all variables shown, as well as the number of HMP members assigned to the PCP.

Table 22. Multivariate analysis of associations with self-reported numbers of HRAs completed

	Number of HRAs completed (N= 1,697)	
	aOR	95% CI
Region		
Upper Peninsula/Northwest/Northeast	Reference	
West/East Central/East	0.71	[0.27, 1.89]
South Central/Southwest/Southeast	0.48	[0.17, 1.34]
Detroit Metro	0.61	[0.22, 1.70]
Urbanicity		
Urban	Reference	
Suburban	1.75**	[1.18, 2.59]
Rural	1.06	[0.41, 2.79]
Practice size		
Large practice (6+)	Reference	
Small practice (0-5)	1.49***	[1.20, 1.87]
New clinicians hired in past year?		
No/Not checked	Reference	
Yes	0.86	[0.68, 1.08]
New office staff hired in past year?		
No/Not checked	Reference	
Yes	1.17	[0.93, 1.46]
Consulted with care coordinators, case managers, community health workers in past year?		
No/Not checked	Reference	
Yes	1.01	[0.80, 1.26]
Changed workflow in past year?		
No/Not checked	Reference	
Yes	0.89	[0.72, 1.10]
Co-located Mental Health w/in Primary Care in past year?		
No/Not checked	Reference	
Yes	1.46*	[1.07, 1.99]
Payment arrangement		
FFS-predominant	Reference	
Capitation-predominant	1.72	[0.85, 3.49]
Salary-predominant	1.45**	[1.16, 1.82]
Mixed payment	1.06	[0.78, 1.45]
Other payment arrangement	1.50	[0.71, 3.17]
Predominant payer mix		
Private	Reference	
Medicaid	2.34***	[1.81, 3.03]
Medicare	0.75*	[0.58, 0.97]
Uninsured	3.41	[0.66, 17.53]
Mixed	1.24	[0.84, 1.83]
Practice has process to identify HMP patients who need HRA completed		
No/Don't know	Reference	
Yes	1.80***	[1.40, 2.32]

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Practice has process to submit completed HRAs		
No/Don't know	Reference	
Yes	7.88***	[6.16, 10.07]
Received financial bonus for HRA		
No/Don't know	Reference	
Yes	1.14	[0.84, 1.55]
Familiarity with HMP expenses		
Very familiar	Reference	
Somewhat familiar	0.49*	[0.27, 0.87]
A little familiar	0.47**	[0.27, 0.83]
Not at all familiar	0.48*	[0.27, 0.87]
Familiarity with healthy behavior incentives		
Very familiar	Reference	
Somewhat familiar	0.60*	[0.39, 0.92]
A little familiar	0.51**	[0.33, 0.80]
Not at all familiar	0.24***	[0.15, 0.38]
Model cuts		
Cut 1[a]	0.15**	[0.05, 0.50]
Cut 2[b]	0.43	[0.13, 1.43]
Cut 3[c]	2.48	[0.75, 8.18]

Ordered logistic regression with adjusted odds ratios adjusted for the covariates shown; 95% confidence intervals in brackets

Dependent variable ordinal categories are “None”, “1-2”, “3-10”, and “>10”

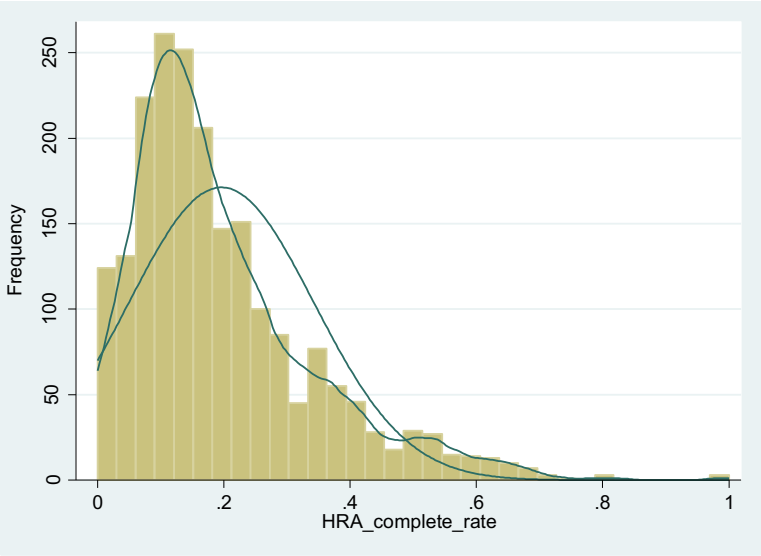
* $p < 0.05$, ** $p < 0.01$, *** $p < 0.001$

[a] Cut 1: Estimated cut point on the underlying latent variable used to differentiate category of None completed from 1-2, 3-10, and > 10 completed when the predictor variables are evaluated at zero

[b] Cut 2: Estimated cut point on the underlying latent variable used to differentiate categories of None and 1-2 completed from 3-10 and > 10 completed when the predictor variables are evaluated at zero

[c] Cut 3: Estimated cut point on the underlying latent variable used to differentiate categories of None, 1-2, and 3-10 completed from > 10 completed when the predictor variables are evaluated at zero

Figure 1. Distribution of HRA completion rates by PCP



Variable definitions

HRA rate: Calculated variable based on data warehouse information compiled 7/25/16. Rate represents the number of HMP members assigned to the PCP with a completed HRA attestation date divided by the total number of HMP members assigned to the PCP. PCPs with 0 HMP patients assigned at the date of data collection were marked as missing.

MiPCT: Indicator variable from the data warehouse marking practice participation in the Michigan Primary Care Transformation Project (MiPCT).

Predominant payer mix: Composite variable of all current payers: payer is considered predominant for the practice if it represents the highest share of payer types and >30% of physician's patients have this payer type. "Mixed" includes practices with more than one payer representing >30% of patients where there is a tie, or practices with <30% of patients for each payer type.

Urbanicity: 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.

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

Appendix B: Quotes from In-Depth Interviews with Primary Care Practitioners

1. Patient Descriptions

1.1 Unmet Needs

I think just the fact that so many things had not been addressed in the past and some of them just came in with lists. Like, "I've got bad teeth." "I have a hernia." "I haven't had a Pap smear in how long?" "I think my blood pressure is a problem." "I've got this skin thing." You know, "My hand is numb." . . . It's like the dam burst.

(Rural physician assistant, Rural health clinic)

I would say, you know, overall the patients are overall unhealthy in terms of having uncontrolled diseases which have been there for a while and which have resulted in some end-organ damage. They overall tend to be, you know, more overweight. Unhealthier habits such as smoking I would say are definitely more prevalent. Issues with both mental health as well as substance abuse.

(Urban physician; Large, hospital-based practice)

So we see a lot of people with asthma, and a number of patients who, you know, are just kind of eeking by on borrowed medications . . . Some part of medications that now we're able to get inhalers for them and do a pulmonary function test and start working on improving things instead of just damage control. Also, there's a number of people with diabetes . . . a number of people who hadn't had labs in two or three years and were just kind of type 1 diabetics who were managing their insulin, rarely checking their blood sugars and never getting the hemoglobin A1C.

(Rural physician; Large, hospital-based practice)

1.2 Long Time without Care

Most of the new people we got last year probably…. You know, I'd say, "When was your last physical?" And they'd say, "I don't know. I don't think I've ever had one," or "It's been 5 years plus." … Or the only thing they had was just going to the emergency room.

(Urban physician; Small, private practice)

So, for instance…two cases where gentlemen have walked in, not having been seen in, you know, in twenty years perhaps, if at all. One gentleman said he hadn't been to see the doctor in forty years. One had multifocal carcinoma upon presentation, and the other had hypertension, diabetes and was later found to have had a stroke, all prior to arrival at the office, but those were all new diagnoses made.

(Urban physician assistant, FQHC)

Literally I've had some patients who haven't seen a doctor for twenty years, and those who were kind of getting primary care in the emergency room, through like free clinics and things of that nature.

(Urban physician; Large, hospital-based practice)

Some are existing patients that now have insurance, and so now they can get the things done you had been wanting them to do, but I would say I've seen several that didn't have a doctor for years. They knew they had diabetes and other problems, but they didn't . . . They had no health insurance, and so they just ignored it for years. Now they're coming in and getting established.

(Urban physician; Small, private practice)

1.3 Patient Insurance Status

Back in the day prior to the Affordable Care Act and the Medicaid expansion, we had maybe 20% of our patients were insured, and the rest were low-income, uninsured. Most of our patients are employed...but, as I said, most of them had no insurance. So when Affordable Care passed and when Medicaid expansion in particular passed, then we started doing a lot more of insurance billing, and it kind of expanded the Medicaids which we participated with.

(Urban physician, Free/low-cost clinic)

We had a 45% increase in the people who basically signed up and named us at their providers. Some of those actually came out of our . . . offices, and so they were not necessarily new patients every one of them, but a large majority of them were. . . They were being seen other places or not being seen at all, and when they signed up and we increased, you know, basically our commitment to 45% new patients in the Medicaid plan, we didn't increase our providers by 45%, and I know we're having a real struggle here at times getting some of these people in when we've got already established patients who pretty much filled our time up even before we started this.

(Rural physician, FQHC)

1.4 Churn

You know, they'll say something like, "Can we do this before the end of the month because my insurance is going to lapse?" And then they come back and, you know, a few months later, "Well, I'm back on insurance." I mean it's just crazy.

(Rural physician assistant, Rural health clinic)

I have a sense that that seems to happen somewhat regularly, meaning like annually it seems like, but this is all new and so it's hard to say. ... I have no way of knowing if they've recently changed or if they're planning to change.

(Urban physician, FQHC)

It matters what they have now or if ... they know and bring it up, like "Hey, I'm gonna lose this," or "Let's not do that now. I'm enrolled for this new insurance plan.... Let's let these things off until next month or the first of the year or whatever.

(Rural physician, FQHC)

Especially with the county health plans, those were a month-to-month thing. They covered nothing.

(Urban physician; Small, private practice)

1.5 New Patient Population

We have so many working poor people up here. You know, they work two and three jobs, barely can scrape it together, and they're coming in after years of little or no care, especially the men because the women at least have the breast and pelvic exam program ... And it's like they are getting everything done. They are . . . It's like problems that have backed up over the years. Dental stuff is being taken care of. Vision is being taken care of, but they usually start with me, and it's been really wonderful.

(Rural physician assistant, Rural health clinic)

These are deserving people. They have genuine issues. They're not, you know, lying around. These are a lot of working poor people.

(Rural physician assistant, Rural health clinic)

We're in an area where there's a lot of working poor out there with no insurance at all. We're in a big, kind of logging and mom and pop machine shop area kind of thing. So those people basically didn't have any kind of insurance up until a year ago. ....A lot of them are these independent sorts that don't want anything to do with the federal government or anything having to do with government in general, and yet they kind of come in and on one hand they slam-bam the administration that got their insurance for them, and yet they'll turn around and say, "It's kind of nice having insurance."

(Rural physician, FQHC)

I think the majority have jobs ..., but they didn't have insurance ... Their employer didn't offer it ... They fell through the cracks because they weren't poor enough and they're working....

(Urban physician assistant, FQHC)

I think the newer patients I've had who've recently had insurance tend to be a little bit healthier because I think they have been engaged in the workforce somehow. . .

(Urban physician; Large, hospital-based practice)

2. Practice Characteristics

2.1 Patient-Centered Care

. . . we are really trying to follow an integrated health model, you know, with [organization] and because we have on-site behavioral health services in the primary care clinic, yes. There have been a number of patients who have walked in, been evaluated and had a subsequent behavioral evaluation and counselling services scheduled subsequently as a result of coming in.

(Urban physician assistant, FQHC)

Because we have onsite dental and, you know, often times with just the general evaluation, you know we will refer not only for just routine cleaning but obviously if we see some problematic issues. So, yes, they can receive care pretty seamlessly. We often times can even get patients seen for dental the same day that they are seen for medical.

(Urban physician assistant, FQHC)

So I would say that a primary care physician making an initial referral to a psychiatric or behavioral health has about a 10% chance of actually working due to all of the complexities in the systems and how they work ... This is if you're not co-located ... But if I have the psych social worker here and we can work out a plan right on site, then he/she can be active in making sure that the appointments are actually set up. . . making sure that the person knows where they're going and that they have transportation. It's much more effective. It's like going from a 10% to 80% chance that they will, you know, have . . . That they will actually connect with their therapist.

(Urban physician; Small, private practice)

So I mean we emphasize that we have. . . someone answering our phones 24/7. So if they have a concern and they're not sure if they should wait until tomorrow or go to the ER, call us first. We can help you talk through that. So we mention that as an option. For our patients that tend to go to the ER frequently, we have a nurse case manager as well. So for people who go frequently, we always touch base with them after the ER visit to say, "What happened? How could we prevent this? Do you need follow-up with our office?" So then we have a chance to talk in the office and say, "Look, what happened? Next time that that happens, please call us first. We're happy to talk." Sometimes that helps; sometimes it doesn't.

(Urban physician; Large, hospital-based practice)

2.2 Provider on Call/Phone Triage

The other thing we have is 24/7 phone call availability for a provider. So we pretty much insisted with our patients that they call us first unless, you know, they're sucking air on their back with chest pain . . . Then it's pretty clear they need to be in an ambulance, but short of that, we want them to call us and talk to us before they go running to the emergency room.

(Rural physician, FQHC)

There's been kind of a new promotion going on here which is called "Call Us First," which is just to try to repeat this message over and over to people that they should call their primary physician's office first before deciding what to do if they're sick after hours ... It's just a series of different messages throughout the system.

(Urban physician; Small, private practice)

They call the doctor on call. I think there's a difference between that and a hotline. A hotline implies to me somebody you don't know who just calls and they give you some good advice, but if they call me, I can tell them "I will see you tomorrow morning at 8:00."

(Rural physician; Small, private practice)

Our clinic specifically does not have after-hours service. So, you know, our clinic has traditional hours. . . . Our health system has set up some urgent care clinics. They are not very near our community, and that might be part of the reason why our patients go to the ED, but definitely kind of in the extended area there are urgent care centers which do have kind of extended hours, same-day clinics and that kind of thing. But I still don't really see our patients buying into that as much as we would hope.

(Urban physician; Large, hospital-based practice)

We do have a pretty good network with our home nurses to increase their visitations on our chronic disease patients to help adjust things as best they can. I get frequent phone calls from them when I'm on call at night after 8:00... trying to decide what to do with a patient who may be having some problems.

(Rural physician; Large, hospital-based practice)

2.3 Urgent Appointments

We keep slots open every day. If you call at 8:00 in the morning, you will be able to get in with your practitioner because even the busiest, fullest practice guy has got openings . . . Patients have learned I'm here, and if they come in and they're [another provider's] patient, but I'm seeing them and I realize this is bad, I'm going to immediately find [that provider] and bring him in. You know, and so that's another thing that I think has cut down on, "Well, let's just go to the ER" is that we can look right there.

(Rural physician assistant, Rural health clinic)

Just in parallel with Healthy Michigan, we re-formatted our schedule, . . . I guess that we just found that all of a sudden we had patients who are more willing to come in to see us. All the providers have re-formatted their schedule so that all of us now have whole half days where we're just dealing with acute emergent urgent care type stuff. Just trying to open up access to people who . . . just trying to decrease them going to the ER.

(Urban physician, FQHC)

3. Changes in Practice

3.1 Hired New Clinicians or Staff

So organization-wide. . . Thirty-nine persons have been slotted for new employment. So it's about an 8 or 10% staff addition as a result of Healthy Michigan.

(Urban physician, FQHC)

There are more PA's at our clinic than there used to be.

(Rural physician; Large, hospital-based practice)

Other things is we've been able to increase the number of persons who are answering phones so that our wait times for patients are improving. Another big problem we've had for years is how long patients have to wait for referrals. We've increased the staff for people processing referral requests, decreasing wait time for that…Patients don't have to wait as long to get their referrals processed.

(Urban physician, FQHC)

I know that we've hired new . . . new staff and support care . . . in support roles . . . a medical assistant.

(Urban physician assistant, FQHC)

This is kind of my personal beef with the Medicaid expansion plan is the huge requirement for prior authorization. So we have had to bring in a new secretary to the office just to handle prior authorization requests for our practice. Basically, even she alone cannot keep up with it. So, we have a couple of other secretaries who do prior authorizations, but that has been the biggest, I would say, my downside….

(Urban physician; Large, hospital-based practice)

3.2 Changes in Number of Patients

We've overwhelmed. (LAUGHTER) That's the short version. I mean, we are already, as you know with a federally qualified health center, we accept, always have accepted, Medicaid because we have a cost-base reimbursement agreement with the state for seeing those patients with the Medicaid expansion going up to whatever it was 133 or 137% or whatever that was . . . Then that gave us a whole lot more patients . . . current patients who now qualify for Medicaid under the Medicaid expansion. So, I guess that's the biggest change. All of a sudden, we've got a whole lot more patients serving the same population, but now they've got insurance.

(Urban physician, Free/low-cost clinic)

3.3 Wait Times

Whoa, we're sort of overrun and the house is full. So, we're still open. Any Healthy Michigan patient can call us and come see us, but it's not like you're going to probably get as timely care as would be ideal.

(Urban physician, FQHC)

Well, the goal has been to improve wait times. I just think that, to be honest, because we're encountering patients who may have been kind of off the grid, so to speak, without healthcare for so long, that when they come in, they have . . . It takes a lot . . . It's requiring more of us . . . more time to thoroughly evaluate the patient and kind of get them moving forward, you know, as far as healthcare.

(Urban physician assistant, FQHC)

It hasn't been a problem for us because . . . There's enough of us present and there's enough availability for appointments that I don't think it's been much of a problem.

(Rural physician; Large, hospital-based practice)

3.4 Administrative Burden

Say if they have [health plan A], a written referral on a prescription pad is pretty much useless. It's got to be all done online. For [health plan B], they don't have to have a formal referral, and for C and D [health plans] it's just gotta be written on a prescription pad. So, it [which HMP affiliated health plan] kind of basically steers me in the direction of how I give them referrals, and it also determines how I give them a prescription for an MRI or a CT scan. Some I know are going to require prior authorization right out of the gate, and some of them don't require prior authorization, and some of them I have to go online. Same thing. So, their insurance kind of determines, you know, what's going to be involved in getting them the necessary tests and medications.

(Urban physician; Small, private practice)

3.5 Practice Capacity/Flow

I know there's demands on how fast we've got to get them in, and that's probably the thing that got us the worst. I mean if they said, "Well, as long as you see them in the first year and start to pick up their care after that," we could have handled that, but the idea of a huge wave of people knocking on the door saying, "We need our first exam in three months," …It was overwhelming.

(Rural physician, FQHC)

3.6 Revenue

Since my center opened in like '95, they really hadn't done any facility updates in that twenty years. Now in the last six months, moneys have been freed up to . . . So for the first time ever, we had some rooms repainted. This is despite like bullet holes in the walls and other crazy stuff. They were patched and painted. Again, this all ties back to not so much like Healthy Michigan is directly paying for these things, but we went from having not an extra penny at the end of the fiscal year to, "Okay, we can breathe. So maybe we can start to do the things we want to do."

(Urban physician, FQHC)

So, we're actually getting revenue now. That's a new experience. It's certainly fairly low, but it's more than zero, and so that's awesome.

(Urban physician, Free/low-cost clinic)

[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)

4. Acceptance of Medicaid/Healthy Michigan Plan Patients

We just don't take anybody off the street. No. No matter what plan. We screen. They're screened.

(Urban physician; Small, private practice)

So unless we get new providers or, you know, somehow we can increase the providers we have up here available, we're gonna have to kind of turn the screws down a little bit and just slow down the intake

until we can get some. We're always working on that. I'll be honest, the pipeline for primary care in rural America is not getting more open. It seems to be getting tighter.

(Rural physician, FQHC)

Since we are part of this large health system, there are a lot of administrators that are involved in this decision-making process. So we do have monthly meetings with them, the physicians and the administrators, and these topics are discussed. Thus far, most providers have figured out... how to accommodate the higher number of patients without it having too much of an impact on how much time they're in the clinic. Clearly the more patients you see, the more paperwork and other after-hours work that a physician has to provide, and that does have its limits.

(Rural physician; Large, hospital-based practice)

Well, I mean that's kind of, sort of the fundamental basis of our clinic. So that's not really any decision at this point as to whether we're going to accept them. That's really kind of who we are. So that's kind of what our main mission is is to see people who are underinsured or uninsured.

(Urban physician; Small, private practice)

I chose to work at a clinic where I knew there was an 80% Medicaid population. So I think it's a population I knew I wanted to work with. I'm not sure what else to say, but I mean it's a population that I think needs care for many different perspectives in terms of, you know, social work, financial, mental health, and I think it's a valuable population for me to provide care to. It's meaningful for me.

(Urban physician; Large, hospital-based practice)

I guess the thing right now is that we're short staff providers, and so we don't have a lot of capacity for adding new patients. That's at my clinic. We recently had a provider that left, and we weren't able to fully replace that position. So the same amount of people, but less providers.

(Rural physician; Large, hospital-based practice)

For us it's a little bit different critter because we accept patients without insurance. And we don't charge. If you don't have insurance, we ask people for a $10 copay. If they can't afford it, we don't send them to collections or nothing like that. We still take care of people. So when they get Medicaid, now we're just getting paid for what we did when we didn't have that before.

(Urban physician, Free/low-cost clinic)

If they're coming from outside the county and there are chronic pain meds involved, you know we want the MAPs . . . that Michigan automated program where we can see where they've been getting the stuff from. Because you'll find somebody who is perfectly compliant, who has maybe gotten a few here and a few there, and then you see the person who's averaging over 300 pain pills/month, and they're getting them from multiple people. And you realize, "Oh, I don't want this person anywhere near my practice."

(Rural physician assistant, Rural health clinic)

5. Reimbursement Rates

You know, the previous Medicaid rate was not very good. . . We tended to limit new patients. We would occasionally take a new patient, but sometimes we'd feel like we just couldn't, but it's certainly better than the Medicaid rate. We're looking forward to when they can pay us like [the] Medicare rate at the time of service.

(Rural physician; Small, private practice)

Well, if they cut the reimbursement by half, then I can't afford to see them. Then I'd just see the new patients. Other people that I've been treating for free for years, I'll keep seeing. I have to pay my bills.
(Urban physician; Small, private practice)

I have heard that the reimbursement rates for primary care will be better or are better than they used to be, but that's about the extent of what I know.
(Urban physician; Large, hospital-based practice)

What I understand is they are currently at Medicare rates. And that that is supposed to change in 2015, and there's a debate about whether or not to extend them. If we are talking about access for patients long-term, they have to be extended or we're going to have a different crisis in this state in terms of again people with[Medicaid/HMP] cards with no access. I know the stories that we hear from our patients coming back from other Medicaid providers. . . haven't been positive. If we're serious about giving these folks true access to healthcare, then the providers need to be paid to provide that.
(Urban physician, Free/low-cost clinic)

Well, that would be great whenever we get it, but [HMP health plan] bundles it all up and sends it to us twice a year, and we have no idea when they're going to send it.... We don't get paid as we go along. Michigan Medicaid does, but [HMP health plan] does not ... When we get a check, it's just a check with no numbers attached to it, and we beg for the data. On which patient did we get this? Which bill did we get the uplift, because there's no accountability. It's just sort of a lump sum.
(Rural physician; Small, private practice)

6. Impact of Healthy Michigan Plan on Patients

6.1 Overall Impact on Patients and Their Health

We're getting a lot more . . . smoking cessation right now because the individuals coming in . . . now they can afford to get the patches or the gum or whatever . . . We're getting a lot more people trying to quit smoking, which is encouraging, but that's about the only change that I've seen.... I think there's a little bit of . . . maybe a little bit of freedom of choice there that they maybe didn't have before.
(Rural nurse practitioner, Rural health clinic)

It is a huge benefit. I think it's so interesting to hear some of the political rhetoric that you hear on TV... they don't really understand the waste that goes on in terms of . . . when people don't have insurance and what ends up happening that could have been fixed much sooner if they did have insurance.
(Urban physician, FQHC)

The people I've seen so far, lives are improving. You know, blood pressure is getting treated. Smoking is getting dealt with. Diet is . . . people are looking at eating, you know, somewhat differently.
(Rural physician assistant, Rural health clinic)

6.2 Reduced Financial Concern by Patients

They are no longer petrified about, "Oh, I can't afford that," or "I can't do that."
(Urban physician, FQHC)

So they have come to see me, and I've tended to bandage them when they got sick. We've done little in-office screens . . . limited, but this patient has almost no money but they're financially responsible. They have a little job, and they make their money and they do their job, but they're really scared of debt. So

they have never let me do much. They have never let me offer much. . . . They'll come to see me when they need me and that kind of thing. They got their Healthy Michigan. They show up and they're like, "Alright doctor, I want everything."

(Urban physician, FQHC)

The primary care and prescription parts . . . They just didn't do it because they knew they couldn't afford it. So now it's within reach. That makes it a little smoother for them.

(Rural nurse practitioner, Rural health clinic)

Her particular issue is mental health, and she's got a few mental health things. One of them is attention deficit disorder. Another is anxiety and panic disorder, and so the impact is a couple fold. First off, it's going to make it easier getting medications because she's no longer trying to pay cash to get medicines.

(Urban physician, Free/low-cost clinic)

6.3 Control of Chronic Conditions

Well, they're benefiting from being able to have any preventive services available to them…. Maybe they had high blood pressure and had other conditions when they were incarcerated, that they're now able to follow up on and get their medications for and so forth.

(Urban physician; Small, private practice)

I think the impact of that overall . . . this patient is now going to have some pretty longstanding health conditions managed, hopefully managed well. . . The risks for further sequelae due to those chronic medical conditions will be hopefully minimized. His risk for recurrent stroke . . . Now we can, you know, try and modify . . .minimize that risk. The same for end-organ damage with his kidneys, retinopathy . . . those types of things. I think we can positively impact that.

(Urban physician assistant, FQHC)

It's hard to measure that [impact of HMP on patients], but I really think that especially these people who knew they had chronic health problems, they were just ignoring them, and now they can actually get them taken care of. It's gonna add years onto their life because now it's not going to be uncontrolled diabetes. It's gonna be controlled diabetes and controlled hypertension and hyperlipidemia.

(Urban physician; Small, private practice)

6.4 Ripple Effect

Many patients in coming to our clinic with Healthy Michigan thought that they needed to have Healthy Michigan or have some sort of insurance to even be able to access care which is, in our case, being a federally qualified health center not the case. I mean they could come even if uninsured. So there have been a number of individuals who. . . I believe that they have been seen as a result of having the insurance . . . [they've] been able to get things like mammography, Pap smears, optometry services quite easily, and then also I believe have referred family members and friends who may not be insured to receive primary care because they understand that they can be seen without insurance here.

(Urban physician assistant, FQHC)

6.5 Disease Detection and Treatment

But I've had new people come in and say that they didn't have insurance until this came up. They're working two jobs, and luckily they fall just under the level where they can get it . . . We run cholesterol tests and sugar tests on them and anemia, and we find things with them.

(Urban physician; Small, private practice)

A guy said to us, "I'm so thankful to come in." We just checked him over, and criminy…. He's got all kinds of issues, you know, with cholesterol. We found out he's a diabetic now. We found out this prostate thing is elevated. Where he would have been out in the cold. A young guy, too.

(Urban physician; Small, private practice)

Getting new uninsured patients in, these folks have multiple problems going on. So like I did a new patient visit this last week where my problem list at the end of the visit had like twelve items on it. Most of them haven't had any preventive care.

(Urban physician, Free/low-cost clinic)

6.6 Patient Activation

I think they felt, and for whatever reason, that when they were coming in on sliding fee, that basically we were just covering their nickel for them. . . . They tended not to take advantage of primary care as much as they might have otherwise. And now that they've got coverage, I think they sort of feel empowered.

(Rural physician, FQHC)

They seem to feel freer to come to the office with the same things they might have taken to the ER a year ago, but that's also part of being established in an office practice for the first time in some cases, too.

(Rural physician, FQHC)

The only thing I have seen more directly for me . . . and this hasn't happened very often, but a few times it's like, "Oh, well I have insurance now. So, doc, can you get me that full body MRI? I need to make sure I get all the cancer blood tests because, you know, now I have insurance and I can get all that stuff." That discussion sometimes comes up a little bit more for me. "That's great that you have insurance, but that's not necessarily what we need to get for you."

(Urban physician, FQHC)

I think there's less barrier, and they're more willing to come in and talk about things because they know there's not going to be a problem every time we make a recommendation with trying to afford it and that kind of a thing .... I think they're more like a partner in the whole situation again rather than a one-sided recipient.

(Rural physician; Small, private practice)

7. Providers' Thoughts on ER Use

7.1 Appropriate/Inappropriate Use

I think a lot of times we have good relationships with people. They'd rather be seen by us, but we've also got people who just abuse the system in general. Every little twinge is, you know, Armageddon and they need to be seen immediately.

(Rural physician assistant, Rural health clinic)

The ones that abuse the ER don't call first. They just don't. The ER . . . The closest one . . The staff is very helpful there. They're very nice. It's probably a pleasant experience for them to go get pampered for simple things. So the ones that abuse it, I don't think that the Healthy Michigan Plan is going to change that. The only thing that will change is maybe some of the diabetics or the people who are being identified with high blood pressure and, you know, we work with those . . . We may save them a visit to the ER once a year, but the ones who are big abusers, it makes no difference if they have insurance or not. They just go there.

(Rural nurse practitioner, Rural health clinic)

You know, I've seen ER visit reports where it's been something relatively serious, and then I've seen it where it's been something ridiculous, to the point where I don't actually ask the patients this question, but what's running through my head is, "You went in over this?" So, I don't know if there's an absolute way to decrease ER visits. One of the things I encourage my patients to do is if it's not that serious or if it's just a sore throat, try urgent care first You won't wait as long, and it's not nearly as expensive .... We do have an after-hours phone number for people to call if it's something that needs attention right now this minute, but it's not an absolute emergency which requires an ER visit. Sometimes we get a call, and sometimes we don't.

(Urban physician; Small, private practice)

I mean they can ignore that recommendation and go there [the ER] directly, but then we'll catch them after they've made a few inappropriate visits and then we'll start . . . It's usually one of our nurse educators will get ahold of them during a visit and counsel them about how to take advantage of the system outside the ER ...

(Rural physician, FQHC)

They're always encouraged to call our office, and with the expanded hours we're going to be more apt to get them in. ... In fact, almost all of our patients that have an acute care issue when they call our office, we get them in, and that's a high priority. ... but we do know what the . . . The serious issues . . . They go to the ED.

(Rural physician; Large, hospital-based practice)

You know, I think that principally, lack of access as well as extended hours I'm sure does play a role, but I think some of it is . . . "If I'm really sick, I'm going to go to the ER" kind of an attitude which is also a problem there. Maybe it's our failure to pre-communicate to our patients that we are available to answer questions and kind of help manage the problem . . . help triage the problem. So it's certainly one of the things that's on our mind is to try to figure out how we can get a better handle on this to help our patients.

(Urban physician; Large, hospital-based practice)

Well, if they had a copay.. . . . I don't know if you can do that, but like if it's not an urgent thing and you end up in the ER, you end up with a copay with some sort of penalty. To bring it to their attention that they need to call their doctor first before they go to the ER, unless it's life threatening.

(Urban physician; Small, private practice)

Probably the majority of the ER visits tend to be something that could have been dealt with at our office. Probably in terms of hours and I think having patients understand that, you know, sometimes you can call us and it's okay to wait a little bit longer . . .But again, I think if we had more openings markedly available, then they might not feel they'd have to wait another week to get seen or if there is something urgent, that they can get seen that day, not have to wait until the next morning.

(Urban physician; Large, hospital-based practice)

There was a big partnership with [organization], and so somebody was able to prove to [organization] maybe 15 years ago now that, "Hey, if you take care of these patients up front and maybe you allow them to get specialized care, then …they won't come to the ER and get admitted for unnecessary care that could have been taken care of, you know, previously." ….I think a lot of docs do amazing work in primary care, but when there's an issue that needs to see a specialist, it's like, "Alright. Here's a list of docs. Go call them." And then the patient goes there, and it's like, "Well, you need to pay $250 to get seen," and they may not have that money.

(Urban physician, FQHC)

When we get ER reports, they follow through with the patient to see what is their plan for follow-up because a lot of times people get into this routine of you went to the ER once and now a week later you're not better, and so you go back to the ER. We're trying to prevent that because that's something we can have an effect on.

(Urban physician, Free/low-cost clinic)

I mean what can a health system do? I don't know. Change people's attitude. Change people's philosophy. I don't know. I don't know that health systems can do a whole lot about that, I mean without being punitive. I mean the way to fix it, of course, is be punitive and tell the patients after the fact this wasn't an emergency and we're not going to pay for it. What is that going to do? They've got no money to pay for it themselves.

(Urban physician, Free/low-cost clinic)

First of all, we've gone out in trying to change this for long before we ever started the new Medicaid folks because we're also in an ACO, and so there's financial incentive to try to keep them out of the ER. Plus, we know that the care there is going to be expensive. We also know that it's fractured.

(Rural physician, FQHC)

7.2 Patient Education about ER Use

Patient education [about ER use], but it doesn't work. We stress that to our people. "What the hell are you doing in urgent care again?" "What are you doing going to the emergency room again?" "Well, there was a 2 hour wait out there, doctor. … In my office sometimes… I'll see 60 -80 . . . rarely 80, but sometimes 80 . . . 60-70 people/day….We go through and evaluate each patient, but that goes when you sign up with me. If you don't like it, then sign up with another doctor. I can't do anything about it.

(Urban physician; Small, private practice)

I think a lot of it is education…. a lot of the young don't read newspapers any more. Thinking things that come across phones… The fact that if you have a cold, if you have these symptoms, going onto an antibiotic is not going to make you better faster. You know, that kind of mass education. Keep it simple, straightforward might help.

(Rural physician assistant, Rural health clinic)

I do a lot of teaching. Like if someone comes here for a sore throat or something, I teach them how they got what they got, what the natural progression is before it's going to be over. If they take a medication for it, teach them what the common side effects are and what allergic symptoms would be to try and make them educated enough so they don't feel the need to go to the ER over every little thing. . . . I guess that's what we do here. I spend a ton of time teaching, but that only works for the people who listen, I guess.

(Rural nurse practitioner, Rural health clinic)

Well, yeah, in my mind, a caseworker solves like a remedial problem, a very high intensity of inputs, and I think that can be good for people who are really quite somewhat impaired in their abilities, but there's kind of like a basic level in which maybe we should anticipate that most of these people don't know how to use a primary care physician. Things that you and I assume because of how we've grown up . . .They don't have in their baseline. And so, some sort of just like basic education to people about how to use a doctor's office… Like how does it work? How do you make an appointment? How do you come in? When should you call us? When should you call us if something's going wrong? If you don't get your medicine . . . What should you do if you're sick?

(Urban physician; Small, private practice)

I actually saw a patient yesterday . . . . I think he has Medicaid, not necessarily Healthy Michigan . . . But like he went [to the ER] last month for, you know, an upper respiratory infection and two months ago for like allergies. So I asked him what was the point? And his response, and I think this is kind of classic for a lot of people, was like, "Well, I didn't know if it was an emergency or not, and so that's why I went." Luckily it wasn't, and so we kind of talked about, you know, what other options could you go to get some other reassurance that it's not an emergency. And so we talked to him specifically about, "Just give a call, and we'll . . . We'll keep in touch."

(Urban physician, FQHC)

Is it an emergency? My throat is really sore. "Well, do you think you're going to die?" "No, of course, I'm not going to die." But they've got a really sore throat, so I'd better go to emergency. So I don't know if the education fixes that per se…. I don't know what fixes that.

(Urban physician, Free/low-cost clinic)

7.3 Recommending Other Sources of Care

I think convenience is an issue, and as more practices either have more extended hours and/or we make more use of urgent care versus emergency care, I think that can help a bit with that issue.

(Urban physician, Free/low-cost clinic)

8. Reasons for ER Use

8.1 Culture of ER Use

They don't listen. They don't pay attention. We've dismissed many patients because of that. It's more convenient to go to the emergency room. I can see on a weekend if they call me first and there's an issue, I'll tell the answering service or I'll talk to them and say, "Yeah, well, you'd better be checked. Do not wait until Monday." But a lot of them are just constantly going into the ER, and that's always been a problem….The pain, they feel, is worse, and they need to be seen right then.

(Urban physician; Small, private practice)

People go to the ER way more for many things. . . that aren't anyway near an emergency unfortunately, and it's just sort of a culture. "Oh, I don't feel good; I'll go to the ER," in the community where we're at. So it's hard. And I can envision how maybe Healthy Michigan or, excuse me, having Medicaid and getting some care may over time reduce that.

(Urban physician, FQHC)

In the whole state of Michigan, I think we're one of the highest ED utilization clinics in the state of Michigan. Our kind of copartner in this is, I believe, like another [city] clinic, and some of it is we think possibly some kind of a cultural issue. When you're really sick, you go to the ER type of attitude, but we

do have a lot of ED utilization, even amongst patients who just have had insurance and they're back in the ED with a problem, in spite of the fact that we do give literature and information about some urgent care centers and how to access us if it's after hours and things like that, but that is a challenge.

(Urban physician; Large, hospital-based practice)

I think some of these people honestly since they haven't had insurance, maybe ever, or haven't been to the doctor in a long time . . . They don't understand why they can't come in that day to be seen and why they can't go to the ER and tell everybody I'm their doctor, and then I start getting all these reports to review and I've never heard of this person. Some of these people are so ignorant of the healthcare system that they just don't really understand that I'm not your doctor until you see me, but I would say that's the case of people even who have private insurance.

(Urban physician; Small, private practice)

I think people use the ER whether they have insurance or not. They don't even think of, "I'm going to the ER and I'm going to get a bill." Their mindset is, "Well, I can't afford it anyway, and so I'm not paying for it." It's not even a big deal. So, whether they have insurance or not, I don't necessarily think I've seen an increase in people saying, "Well, I have insurance, and now it'll cover."

(Urban physician, FQHC)

8.2 Perceived Need

The vast majority of my patients that go to the ER took it upon themselves to go to the ER. They didn't call us first. If they called us first, it would be things like chest pain or can't breathe or might be having a stroke, or they're calling when we're closed. But then we usually say Urgent Care unless it's chest pain, I can't breathe or I'm having a stroke.

(Urban physician; Small, private practice)

Sometimes. . . it's a benign thing, but it's something they're very frightened about. So we had a young man who was having vertigo, and he had been seen here a couple of times for it. He didn't fully understand and was still frightened by it . . . And so he went to the ER.

(Urban physician, Free/low-cost clinic)

I think for some folks with mental health problems, until we get the mental health problem solved, there is nothing to be done because they're going to be scared in the middle of the night, have difficulty interpreting what they're feeling, and they're going to end up there.

(Urban physician, Free/low-cost clinic)

They're just worried. . . . I mean it's me judging them by the telephone…. I can't allay all of their fears that they have something bad going on. So that's the main thing . . . They're worried that they have a serious illness. They don't understand what's serious and what's not sometimes.

(Rural physician; Small, private practice)

8.3 Need for Off Hours Care/Convenience

Some other ones go there because the best ride they can get or the family members that give them transportation work during the day and are only available in the evening. So they just go to the ER because that's when they have a ride.

(Rural nurse practitioner, Rural health clinic)

I always ask them, "Why did you go? What happened? Are you feeling any better?" And usually it's, "Well, Saturday morning I woke up and . . ." or "Saturday I had a fall," or "Saturday I had trouble breathing and I went to the ER."

(Urban physician; Small, private practice)

We have a lot of population that lives downtown, and there is not an urgent care. The ER is much more accessible than an urgent care is downtown.

(Urban physician; Large, hospital-based practice)

8.4 Encouraged to Go by Their Provider

So sometimes we'll just order . . . I'll just order a troponin and order it stat. Then they call me. If it's elevated, I'll send them right over to the emergency room then . . . I tell them, "Hold them there. If it's elevated . . . It only takes a few minutes to run it . . . send them to the ER." People come in with leg pain. I send them over to the lab. I send them over to get a Doppler right away . . . venous . . . and if it comes back positive . . . Send them right to the emergency room. They evaluate them, and get them on medication right away . . . Or admit them if they need to be.

(Urban physician; Small, private practice)

We'll have people come in and realize they need to be in the ER. We got the wheelchair and I take them down there and confer with the ER doctor and tell them why. So it kind of goes both ways.

(Rural physician assistant, Rural health clinic)

Let's say someone had a patient this week with an abrupt turnaround from a recent hospitalization, had abnormal labs. He followed up the way he was supposed to have, but when we got his lab results, you know, the tests revealed that his acute condition was, you know, recurring. So in those instances, you know, we'll give them a call and say, "Hey, you've got to go to the ER for further evaluation, only because we can't directly admit you ourselves."

(Urban physician assistant, FQHC)

So most of the ones that have gone, so far that I'm aware of, have been people we've sent from the office… Two diabetics actually that we've sent, one twice and one once, who were completely out of control and things like that.

(Urban physician, Free/low-cost clinic)

Many of our patients have difficulty expressing what they're feeling adequately or giving a really good history, it's even hard to triage it on the phone. I know I have sent people into the ER where I'm 90% sure it's relatively benign, but I can't be certain enough with the history I'm getting to say "no, they don't belong there."

(Urban physician, Free/low-cost clinic)

9. Barriers to/Facilitators of Care

9.1 Wait Times

And yes, some people I want to get in where they have depression and things. They need somebody. It's very hard to get them in. It's a six-month wait, or they don't take them anymore. A six-month wait!

(Urban physician; Small, private practice)

Mental health services are always a problem. I don't recall offhand, but it depends on the plan and where they get referred to. . . . Most of the plans participate with one or two of the mental health facilities that are around. . . They have to call and make the appointment . . . the patient does, and a lot of times they are then seen by a psychologist. They are not seen by psychiatrists . . . seen by psychiatrists if they're needed . . . but that's usually a couple of months down the line.

(Urban physician; Small, private practice)

Some of those people were coming to see me already and they just didn't really have insurance .... But a lot of these people weren't accessing healthcare, and now they're trying to access healthcare. And while we've expanded. . . You know, we already had a shortage of family docs or internists or whatever primary care person you're thinking of. And so, you know, if you want a new appointment with me, you're looking at like a 10 or 12 week waiting list, okay? So that's just crazy... So all of these people have coverage. Now they all want to come to the clinic and be seen. They can't get to see me for a long time. "Well, I'll go to the ER." So while it's helped with coverage, there's a long way to go in terms of improvement for access.

(Urban physician, FQHC)

I just saw a guy today. . . He said, "They can't get me in for three months." ...He said, "They told me you'd fill my psych meds." I told him, "And they're right. I will." . . . He's a guy who's had issues over the decades. He needs to actually be sitting down with a shrink. They can't do anything for three months? He does not need to be without his meds.

(Rural physician assistant, Rural health clinic)

We have occasional newbies who move up here. "Oh, I have diabetes and where's the nearest endocrinologist?" "Sixty-five miles down the road, and he's booked three months down the road." We tell them, "We'll handle your diabetes unless you are totally out of whack or you have an insulin pump, or you're a really touchy brittle diabetic." I've got lots of diabetics in my practice.

(Rural physician assistant, Rural health clinic)

So now they're [CMH] starting to use Telehealth where they have psychiatrists from all over the country skyping with patients. Unfortunately, the psychiatrist is only available the one day a week they're skyping, and then if there's a medication question or question from me to that psychiatrist during the week, they're not available. But the staff takes a message, and they wait to ask them on the next Tuesday that they're skyping. It makes getting patients in to see a psychiatrist very difficult.

(Urban physician; Small, private practice)

I guess for the patients who have Medicaid, there are [dental] clinics that will accept Medicaid patients, but either there's a really long wait list or they have to go and just wait in line.

(Urban physician; Large, hospital-based practice)

You know dental is the same problem as it is in the whole state. You know, we have a Medicaid dental clinic here, but it's a long wait to get in. It's still a problem because regular dentists don't . . . I don't know about downstate, but up here no one accepts Medicaid.

(Rural physician; Small, private practice)

9.2 Administrative Burden

Philosophically I would say I would want my practice to accept Medicaid patients. If there were something that was in my power to make the process of taking care of the Medicaid patients less onerous. . . At the collective level as you are making that decision, I would hope that my system leadership

would advocate for kind of cutting the red tape that is sometimes required . . . which is what makes it difficult to care for Medicaid patients.

(Urban physician; Large, hospital-based practice)

Well, we accept three of them [Medicaid health plans] right now. We don't accept every one that's in [area of] Michigan. We no longer accept Healthplan A Medicaid or Healthplan B Healthy Michigan simply because they're such a pain ... to deal with.

(Urban physician, Free/low-cost clinic)

9.3 Acceptance of Medicaid/Healthy Michigan Plan Patients

My staff will do like a little quick run-through what medications do they take . . . Briefly, what are their health issues. If it's someone who has morphine addiction and they're trying to be brought down using suboxone ... that's not a good fit for her.... So we pretty much take everybody except we weed out the ones where I don't think it's a good fit.

(Rural nurse practitioner, Rural health clinic)

So I would say it's 10 times as hard to get dental care as it is medical care.

(Urban physician; Small, private practice)

So the mental health situation in this area . . .We have a couple of private psychiatrists . . . The only ones I'm really familiar with work for the hospital. They don't take Medicaid or Medicare.

(Urban physician; Small, private practice)

9.4 Workforce

I think the fundamental problem with regard to ER is related to access . . . primary care access. So I live in a real huge bottleneck. There's just not enough of me . . . There's not enough primary care . . .

(Urban physician, FQHC)

Well, we have a particular problem in this area because we're very underserved as far as mental health goes. In this county, all we have is the community mental health office, and...They don't have a full-time psychiatrist. ... if the counselor believes the person needs psychiatric intervention by the MD, then they get ahold of me and say, "Please write a referral so we can slide this person in with the psychiatrist." So it takes a long time.

(Rural nurse practitioner, Rural health clinic)

But it's [i.e. transportation] definitely a problem up here because where . . . Where we're located, the nearest hospital is 40 miles away. All of the specialists are a minimum of 40 miles away. So it's very . . . Travel is a very difficult obstacle here.

(Rural nurse practitioner, Rural health clinic)

We have no dermatologists in this county. So when I try to refer one of my patients to a dermatologist, there are no offices that will take the patients. So that's kind of a problem for us is the lack of specialists who take Medicaid patients in certain fields.

(Rural nurse practitioner, Rural health clinic)

Well, we were already getting a lot of new patient requests even before this because there's just not enough doctors in this area. I guess it picked up a little bit with that expansion, but I mean the hospital won't let us hire more staff. …So we just had to limit how many new patients we'll take.

(Urban physician; Small, private practice)

It doesn't help them very much if they have an insurance, but the nearest orthopedist is 1-1/2 hours away.

(Urban physician, Free/low-cost clinic)

9.5 Out-of-Pocket Costs

But, you know, those are two examples that I could repeat in my practice of people who didn't want any health intervention screening care because they were just nervous about the bills that would be generated. They don't want to know if they're supposed to be on a medicine because they're nervous about paying for it. Now they're okay to explore that.

(Urban physician, FQHC)

our population in general doesn't go to the ER very often and I think it's because when you're uninsured, you don't go to the ER because then you just get a big ass bill and now you've got to go to collections and then you bankrupt.

(Urban physician, Free/low-cost clinic)

You know, my practice style has and always will be do what's right for the patient and then worry about the cost afterwards, but it has made things a little easier now that they do have insurance. So my recommendations were always the same, but whether the individual went through with the plan when they didn't have insurance, did vary depending upon their own personal beliefs and, you know, personal financial situation.

(Rural physician; Large, hospital-based practice)

9.6 Patient-Primary Care Interactions

I just think that kind of . . . I believe it kind of helps to kind of develop the working relationship between the provider and the patient because we're talking, and they're allowed to talk relatively freely.

(Urban physician assistant, FQHC)

9.7 Transportation

That's a problem up here. It's a a widespread rural area. There are 320,000 people in the entire [area]. People live on the bush. People's cars freeze. People will have drunk driving on their record. They have to rely on other people to drive them in. I had three cancellations in one day where the driver fell through.

(Rural physician assistant, Rural health clinic)

I had two guys yesterday in my office who called their insurance, got transportation arranged, and came to see me. Most of the people I see are Medicaid. So, it's possible. But I can guarantee you that [lack of] transportation is a huge hindrance to good healthcare in the population that I see. So that as a benefit is a huge help.

(Urban physician, FQHC)

I think that's [transportation] actually a really good service because, again, my office is located in [city]. A lot of my patients, particularly Medicaid patients, have big transportation barriers….there is, I believe, like a three-day advance notice or something they have to give. So sometimes that can get in the way if the patient needs to come back … for . . . like an immediate short-term follow-up.

(Urban physician; Large, hospital-based practice)

A lot of the poor folks who would be on this program would live in Sawyer which is 18 miles away. They are offered like bus vouchers or something or advised they can take the bus, or they can actually get a voucher for a door-to-door bus, but it's very limited and very strict …. If you take a bus to the doctor's office and the office is behind, your bus has to leave.

(Rural physician; Small, private practice)

I didn't go to medical school to be screwing around with signing forms about getting people to and from their doctor's appointment. That doesn't help them be healthier per se. It doesn't require my involvement or my signature.

(Rural physician; Large, hospital-based practice)

10. Types of Care

10.1 Serious/Complex Mental Health

It's difficult but, you know, we do so much mental health stuff. I treat depression every day. I treat generalized anxiety every day. I don't need [organization] for that. I need them for my schizophrenic patients. I need them for out of control bipolars who've jumped off their meds. . . . You need them for the stuff that's really heavy duty. Severe depression or nonresponsive or, you know, you're thinking, "Does this person need shock therapy?" I can't order that.

(Rural physician assistant, Rural health clinic)

If they don't think you're bad enough, they won't see you. "Oh, ADHD? We don't do that." "Oh, it's just mild depression. No, you're okay. Go back to your doctor." . . . Even if they're severe enough to need a psychiatrist, I've seen people wait four to six months on a waiting list. If you miss any of your counseling appointments in between, they might kick you off the list. It's kind of brutal.

(Urban physician; Small, private practice)

You know, I think where you see this specifically is like I've had a couple of patients that I've been like long-term . . . you know, maybe has long-term psychiatric needs and not been able to get the correct care, and we've done our best to help them, but now you say, "Hey, let's get you set up," and now they're going to therapy, they're getting the correct medications that they need. That makes a humungous difference, I think, for them.

(Urban physician, FQHC)

The colocation is primarily they are health psychologists. So they're psychologists. They're not psychiatrists. So they do have limitation that they can do initial evaluations and counseling, but not really manage kind of complex . . . If the patient needs a prescription and it's for a simple condition like depression, we can certainly co-manage with them. But when we're dealing with more complex psychiatric illnesses, we do need these patients to be referred on to a psychiatrist, and at that point we have had problems with the patients not always having access to behavioral health, because many of the Medicaid plans, part of Healthy Michigan, are not accepted by the behavioral health department in our health system.

(Urban physician; Large, hospital-based practice)

10.2 Mental Health

Because there are so many mental health and social issues, it's probably overwhelming for most primary physicians to have a significant percentage of their practice be Medicaid without having a social worker or a care manager or an integrated psychiatric part to their practice.

(Urban physician; Small, private practice)

I think we would love to have colocation of mental health, but it hasn't been feasible from our discussions so far. You know, I mean we're trying to work more on group models of care to help with waiting times for patients and with patient satisfaction and just overall care, but that's been an ongoing theme we've been trying to improve.

(Urban physician; Large, hospital-based practice)

They can get into Psychiatry, but it's much more challenging. They have to go to three psychology visits. They can't miss those visits. Then they get referred to a psychiatrist who will see them for a short-term basis. Often I hear a lot of negative comments about the psychiatry experience that they have. The counseling piece generally has been okay and doable. If the patient is motivated to call and make the initial appointment, then I think it has been going well for them.

(Urban physician; Large, hospital-based practice)

10.3 Dental Care

The new one, they get some dental stuff too. They've had dental problems for years, and their teeth are falling out, affecting their hearts and everything else….

(Urban physician; Small, private practice)

I can't tell you how many times a day I get asked for antibiotics because of some form of dental infection, and either they can't get a dental appointment or it's two months into the future. I really don't know of very many patients that have an easy time getting dental.

(Urban physician; Small, private practice)

I mean even to get access to dental care. That was a huge problem in the past . . . Primary care doctors would see people with dental pain with abscesses, and they couldn't get in to see a dentist. So our job was often to put them on antibiotics and pain meds, and knowing that what they needed was to have an extraction or a root canal done.

(Rural physician; Large, hospital-based practice)

10.4 Primary Care

Access to preventative services, prescriptions, and more just access to physicians for medical problems . . . chronic disease management . . . All that is improved with Healthy Michigan. No question in my mind, and I'm sure that your data is going to support that.

(Rural physician; Large, hospital-based practice)

Because they just weren't going to come in for a complete physical that might cost them a lot of money, as much as we begged them to, or even if we gave them a deal. So now we can sit down, and they get sort of top notch review just like anybody else with good insurance. Complete exam, screening labs and talk about preventative care . . . Like finally they've recognized that they need this too…. It seems like

they're happy and relieved now to be covered, and they feel . . . that sense that there is a safety net there for them.

(Rural physician; Small, private practice)

I think one of the biggest benefits that I see from the insurance …now there's a lot of help in terms of the chronic disease management. I think we do see a high proportion of chronic disease, whether that's diabetes, blood pressure, smoking, obesity. And you know the nice thing about that is that it allows . . . more options.

(Urban physician, FQHC)

From the patient perspective though, I see tons of benefits because they get . . . preventative care . . . One of the big things is if you don't have insurance, you know the idea of getting a colonoscopy. That's not even feasible. You know, that's so expensive. And now that they have insurance . . . The same thing with some of the screening stuff, specifically mammograms and Pap smears, things like that.

(Urban physician, FQHC)

10.5 Specialty Care

With [healthplan], it's very easy. They don't have to have a formal referral, either prescription or online. They can just find one in the [healthplan] directory and go see them. . . . Sometimes the specialist will call me and say, "did you recommend this?" Sometimes I have, and sometimes I haven't. But, again… they don't need a formal referral.

(Urban physician; Small, private practice)

Specialists had a limited number of openings for the uninsured in the past… There were a certain number per month that different groups allowed . . . As far as I know, there's no change in saying "yes" to anybody who's got Healthy Michigan insurance. I would assume that all the specialists accept that in this area.

(Rural physician; Large, hospital-based practice)

So, for some specialties we had very good access. For other specialties, we had very limited or no access. So, there's a gynecologist . . . who's been incredibly generous, and so we've always had really good access for that. But things like neurology and neurosurgery have been a little more difficult. Dermatology is kind of forget it. Podiatry . . .If somebody had a significant problem, we could. Ear, Nose, Throat – again, you had to really have a very significant problem. Sleep studies for sleep apnea - which is very prevalent in our patients – we had no access for a long time. Over the last year or so, we've had some limited access, but with them having insurance, now I've got really good access for them.

(Urban physician, Free/low-cost clinic)

[C]ertain specialties we struggle with getting patients with Medicaid in. Like Rheumatology is probably the biggest one. Other than that, it's been actually pretty good. We've been able to get most of our patients with Medicaid into most specialties or other care that they need.

(Urban physician; Large, hospital-based practice)

Specialists – If they have no insurance versus they have Medicaid or Healthy Michigan Medicaid, again, there's just a world of difference because now I can get stuff done. You know, back in the day, we never used to order colonoscopies for patients if they were uninsured because nobody can afford $2,000 to have that done. But with Medicaid where that's a covered benefit, yeah, now we get to order them all the time on people.

(Urban physician, Free/low-cost clinic)

10.6 Testing and Pathology

Another great thing is screening colonoscopies for colon cancer. So under the program I was talking about, we could get them a colonoscopy . . . if I saw a polyp on sigmoid, I could send them. If they had a disease like ulcerative colitis, I could send them, but I could not get a screening colonoscopy, even for people with family history of colon cancer. Now, I can write the referral. They go! It's fantastic! I'm very excited.

(Urban physician, Free/low-cost clinic)

Let's say somebody has got a heart murmur. Somebody has got fluid in their legs, and you're listening to their heart and thinking, "Hmmm. I can get an EKG. I can send them for an echocardiogram . . . I can do this stuff. I can check a pro BNP. I can look at their kidney function." Before I'd have to call over to the lab and say, "Alright, how much is it going to cost this person to pay cash so we can check their kidney function?" ...You know, I'm not a money person. I'll take care of people, and Healthy Michigan has made that easier.

(Rural physician assistant, Rural health clinic)

So if you have diabetes, the good thing is that we can get labs. That's not an issue. [organization] has allowed us to get labs and actually doesn't even charge the patient for labs, which is pretty awesome.

(Urban physician, FQHC)

I am seeing patients come in and getting the care that they need. Yes, it sometimes is a headache because if I need something, I will have to run in through many channels and sometimes things don't get done. I have had patients, for instance, coming with a belly mass where they needed a CAT scan, and you know the prior authorization didn't go through and they waited like three months or four months before somebody figured out that they hadn't had a CAT scan. It delayed care which possibly could have had some adverse outcome.

(Urban physician; Large, hospital-based practice)

10.7 Hearing and Vision

. . . hearing aids. That's fantastic. Vision. . . . Most all the plans cover the vision. They get a checkup for that. They don't pay for their glasses….

(Urban physician; Small, private practice)

People like my age . . . fifties/sixties . . . [I] ask… "When's the last time you've had a good eye exam?" It's not like they need to go to an ophthalmologist, but, you know, I want them to go. We've got good optometry. If they see something that needs an ophthalmologist, I know they can refer them on.

(Rural physician assistant, Rural health clinic)

10.8 Medications and Supplies

[T]hey 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)

So if you are somebody who needs insulin, it can get really tricky if you don't have insurance because insulin can be hundreds of dollars. You would get people who would resist seeing you because they're afraid of how much things are going to cost, and so they just persist in their uncontrolled diabetes, and then all the complications that come with it. Once they're sort of like, "Okay, well, insulin is covered and

I can get my routine labs because that will get covered," well then they show up, and it just makes my life easier for sure, and theirs, I think. And then COPD . . . Some of the inhalers and other things that, you know, are recommended in terms of standard of care treatment . . . Those are also quite expensive and... If things are expensive, people are just not going to do it. It doesn't matter if it's the right thing or even if it helps them.

(Urban physician, FQHC)

I'm not a huge fan of [healthplan]. I mean it's better than no insurance, but they're pretty restrictive on a lot of things. If you call and you sit on hold and you fill out forms, then they finally give them the medicine. Half of the time, no, they still won't give them the medicine. So that's a frustration. You start to remember the drugs they're just never going to cover, and you just try to avoid those . . . Just like private insurance formularies. They change all the time... You just prescribe, and if the pharmacist shrugs his shoulders and says, "No, that's not covered," you say, "Then, what is? What do they cover?" It usually involves my staff having to call all the insurance companies, sit on hold and ask them that question.

(Urban physician; Small, private practice)

If I prescribe a medication that's not covered, the person doesn't call me often times. It's just not out of their mindset to think they can call me and say, "I'm having trouble." So, they either don't know that they should call or they can't call, or they're not skilled at using the phone and leaving a message and so forth. So what happens is if I prescribe somebody something on March 1st, they didn't get it at the pharmacy. They just let it drop until the next time they're here, and then I find out six weeks later that they didn't get the medication . . . So we could have solved the problem right away because I would have used some alternative, but to start with I don't have clear information about what's covered, and then secondly the patient isn't used to expecting to get something, and so they just take it for granted that they can't get it. End of story.

(Urban physician; Small, private practice)

Glucometer strips were our number one pharmacy cost. So, the fact that that cost is going away means we can do a lot more work in other areas. Awesome.

(Urban physician, Free/low-cost clinic)

The main challenges have been with contraception because they will only cover things like the NuvaRing or the patch if the patient can prove that they failed OCPs [oral contraceptives]. It's completely ridiculous because so many people can't remember to take those.

(Urban physician; Large, hospital-based practice)

The other issue that's been a problem is that there are some things that are covered by [healthplan] that are over-the-counter, but the pharmacies don't know about it. For example, vitamin D is covered in certain dosages. So I'll tell patients, "Look, I know it's covered. I've talked to [healthplan]. They've confirmed for me that it's covered. They go to the pharmacy, and the pharmacy says, "Sorry. You'll have to pay out of your pocket."

(Urban physician; Large, hospital-based practice)

And we had. . . a lot of people with asthma who were being managed with a borrowed nebulizer and the nebules from Walmart, packs of 100 because. . . That was the cheapest way for them to get asthma medication because they couldn't afford inhalers . . . So we're able to get medications for them and do a pulmonary function test ...start working on improving things instead of just damage control.

(Rural physician; Large, hospital-based practice)

But for the most part, I think, the access to medication makes a huge difference and especially when we're talking about chronic disease management. It's such a benefit.

(Urban physician, FQHC)

For generic drugs that are covered, not a problem, but even some of the generic drugs aren't covered. We have a formulary that is updated in our electronic medical record that works most of the time, that lets us know what's covered and what's not, but even then it's not accurate. The patient will go to the pharmacy to pick up their prescription, and it's not covered and then they can't dispense it, and then it's a big hassle for everybody and it doesn't . . . It's not resolved in a very timely fashion. So sometimes these individuals will go without their prescription for a couple of days until Medicaid processes their prior authorization.

(Rural physician; Large, hospital-based practice)

10.9 Substance Use Disorder

They don't come in actively seeking treatment. The only ones that I found here are the ones who have been sent in by court order or have lost their job and family is getting after them to either straighten up or get out. Those individuals don't come looking for help until something really dire happens, and some of them have, you know, even gone to jail and had their children taken away and have been given a choice, "Either straighten up or we'll take the children"….They have to be forced into it.

(Rural nurse practitioner, Rural health clinic)

They do provide evaluation and they can certainly provide the patient with some resources to get help, but we don't really do substance abuse counseling or treatment at our center.

(Urban physician; Large, hospital-based practice)

For a lot of our folks with substance abuse, … when they are ready to make the change, we've referred them through the state programs . . . Almost all of them have been uninsured to date. I haven't had anybody that's really under [healthplan] yet that's really ready to make that change.

(Urban physician, Free/low-cost clinic)

10.10 Pain Management

I'd say the one area where we have probably some limitations is the person who is outside our county who wants to come in with complex pain and mental health issues... You've got somebody who's on beaucoup pain meds. You get the feeling, you know, "why are you not in your own county?" It's either that people are refusing to prescribe any pain meds, which is ridiculous, or these are people who've burned their bridges.

(Rural physician assistant, Rural health clinic)

One of our biggest referrals for behavioral health for new people coming in are people who are on chronic pain meds. We pretty much insist that they participate . . . at least be offered, you know, assistance in behavioral health for chronic pain management, and it seems like pretty good numbers in the last year have taken advantage of that.

(Rural physician, FQHC)

If you turn in your paperwork and you're on a bunch of controlled substances and it appears that you expect me to start filling those, that sends off red flags. Not to say we don't, but we look and see why you're taking those things and let you know that we may disagree and may want to transition you to a

different medication or wean you off of them. If you're seeing a pain specialist and you plan on continuing the meds, fine. Then we don't . . . That's not a red flag.

(Urban physician; Small, private practice)

A lot of people go there [the ED] for pain medication. They ran out of the pain medication they have or they're not getting their pain treated in a way that they want. So they'll go to the ER and at least get a. . . short supply of opiate medications. That's it. That's a big component. A lot of people with musculoskeletal complaints, back pain that's chronic, will go to the ER.

(Rural physician; Large, hospital-based practice)

11. Health Risk Assessment

11.1 Process

[T]hey always complete their portion of it [HRA] prior to seeing me. So I don't discuss their . . .I don't go through the, "how do you feel your health is?" "Are you smoking?" "What are your goals?" I can see where that's probably trying to generate conversation. I don't do any of their portion with them. That's all done prior to me sitting down. So then I fill out everything . . . the physician portion; 80% of the time I fill that out in the room with them, and then that leads to a conversation about some appropriate health screenings . . . whether or not we want to check their cholesterol or, "Okay, I'm just looking at your BMI here. This is something that's going to be reported."

(Urban physician, FQHC)

I review it with them. If they haven't completed it, we go over it. I'll just ask them, you know, "what do you want to be serious about on here?" "Is there something you'd really like to go after?" For some guys, it's simple. I've . . . Guys say, "I want to drop 20 pounds." I'll ask them, "What do they drink?" "I drink a lot of pop." You know, "Hey. Just stop drinking pop. You'll probably drop 20 pounds right there."

(Rural physician assistant, Rural health clinic)

My girls would look on the computer first and see that they had straight Medicaid, which isn't the HMP . . . the Healthy Michigan plan. So the people would come in and they would have their HRA forms half filled out, or they would have been faxed to us half-filled out. So we were seeing on the computer that they didn't have HMP, but yet they were walking in with forms for it. So in the beginning, it was very confusing… Now people are starting to come through right from the get-go… It's a little smoother now than it was last year.

(Rural nurse practitioner, Rural health clinic)

The health risk assessment [sometimes] comes to us partially filled in based on the conversation that the caseworker had with the member, and so there was a real good lead-in that way because the person on the phone explained to the member "this is where you're going to go," and they helped them understand where my office is. So when they come in, they already feel like they actually belong here…They actually come in with a sense of continuity, like they're just on the next step of the ladder.

(Rural nurse practitioner, Rural health clinic)

But filling out that form facilitates those discussions . . . Usually the first visit is kind of more of a Q and A and introduction to each other, and the next we schedule for a full physical. So it gives us the opportunity to kind of prep folks for what they're going to get in a physical and why.

(Urban physician assistant, FQHC)

I would have to say we have not really done a good job of accommodating it...it's one of those, at the end of a visit, after the fact type of thing. ...I'm thinking maybe one of the better ways to facilitate it is to actually ask the patient at the check-in, "Do they have any forms that need to be completed?"

(Urban physician; Large, hospital-based practice)

Well, we've just had to change our policy so that the receptionist knew that when they called and said they had that form, it had to be scheduled as a physical. Yeah, that's really the big thing was just making sure they were scheduled appropriately and then billed appropriately. I mean it's supposed to be billed as a physical . . . To get that checkmark that "yes, you've done it," it's not going to register with [healthplan] that they've done it unless it comes in as a physical.

(Urban physician; Small, private practice)

It's a pretty long form. It would be nice to figure out a way to make it more simple and smaller.

(Urban physician; Small, private practice)

I think the nurses help do it before I get in the room. They'll like put some of the data in when they talk with the patient.

(Rural physician; Small, private practice)

Those sorts of things . . . a good primary care doctor would already have reviewed with the patient. So I feel it's kind of duplicate work and unnecessary clerical work for our staff . . . that it's already documented in the record, and I just don't think it changes behaviors.

(Rural physician; Large, hospital-based practice)

Well, all of the plans are doing the health risk assessment, which is great and we've been able to set up a process here so that. . . If they're patients that have been ours... we're able to do the health risk assessment here with their first visit. If it's a new patient, we do it at their second visit because we have some additional information that we can put into that to help set their goals. You know, having those tools to be able to help patients make . . . do goal-setting and move forward has been really helpful.

(Urban physician, Free/low-cost clinic)

A lot of times we get that as a fax where they've already pre-filled out their part [of the HRA] on either online or over the phone. You know, asking questions like, "So you actually do eat healthy?" "You do exercise." Sometimes they answer "no," and sometimes . . . Sometimes it's like, "Well, yeah, I do that. I walk a lot." Sometimes, it's "No, I just thought that's what they wanted to hear." You know, when they say . . . They checkmark on there, "I do want to quit smoking." And I'll say, "Well, would you like to try the patch?" They'll say, "No, not yet. I'm not ready just yet."

(Urban physician; Small, private practice)

11.2. Impact of HRA Completion and Discussion

Oh, we usually will talk about strategies to improve their health. Usually with obesity, addressing some of the factors that may be contributing to obesity, cholesterol issues and diabetes risk. Probably higher . . . equally as high on the totem pole, I guess, would be tobacco use. We talk a lot about cessation, and I refer a lot of people over to Michigan Quit line as a result of us kind of sitting down and specifically talking about those kinds of areas of interest on the HRA forms.

(Urban physician assistant, FQHC)

I think that it helps to focus what the patient wanted to work on with regard to their health issues, you know, and their risk factors.

(Urban physician; Small, private practice)

I'll tell you one patient for whom this was extremely helpful for me and hopefully for the patient, was a patient who I'd been taking care of for a long time, serious depression. We had been battling with the depression. I've known her for over twenty years. In the past, I knew she'd used marijuana, but she had stopped. The question that we had not talked about, and when my coordinator this on the front, it was about her marijuana use again. It was like, "Oh, you're using again," and it led us into that discussion, which we might not have had. She at least reportedly has stopped again so far, and her depression has improved, not controlled but better, and so that was a huge help. So sometimes it can clue us into things that we thought were addressed and done, but they're not.

(Urban physician, Free/low-cost clinic)

I think I do remember something at the end about something they were going to try to improve, but I've not seen anybody come back and have like some sort of . . . made some achievement or have I been asked to document that they made that change, do you know what I mean? I haven't seen that come back yet.

(Urban physician; Small, private practice)

Now what I have seen is that although I may bring that up on one visit and maybe I bring that up before I do the [HRA] questionnaire, over time they know because the next time they come back and they've had some goals that we've talked about and they got printed out and they were given to them, and then they come back and I can say, "How did these go?" Sometimes they say, "I didn't do any of them," and sometimes they say, "I did all of them."

(Urban physician, FQHC)

I haven't sensed that it's helped motivate them to be healthier. It's more a process that they have to go through.

(Rural physician; Large, hospital-based practice)

We've got weight management programs. We've got healthy eating classes every evening. We have a nutritionist that come in and hold "How to Grill Vegetables" classes. We do a lot of that stuff already, and so maybe because that's an option we already have available for patients that we've been running for a number of years. . . Maybe it's just kind of second nature to us and to our patients that these options are there. So…Does this help me in a discussion with the patient? I don't think so really whatsoever. Does it somehow tweak the patient that maybe they ought to get a flu shot this year? No. People either want it or they don't want it. Like I said, filling out a questionnaire is not going to help them decide that kind of stuff, I don't think.

(Urban physician, Free/low-cost clinic)

It seems to encourage not being passive about it. You know, that you are a partner in this.

(Rural physician assistant, Rural health clinic)

So when I get in and introduce myself and whatever the niceties are, then we usually start with that because that opens up the conversation and gets them talking about things . . . Because I have to reinforce what they're doing well already and the things where they need some improvement perhaps and then we get into the physical part of it.

(Rural nurse practitioner, Rural health clinic)

There are a few people who come in and say, "Well, I'm here because my insurance company told me I had to." They don't fully grasp it as being a part of health maintenance yet, but that will probably come with time.

(Rural nurse practitioner, Rural health clinic)

You know, there's still a long way to go in terms of people understanding their situation, but, you know, at least it's still . . . It's creating the conversation.

(Urban physician, FQHC)

11.3 HMP Impact on Health Behaviors

He got his first physical . . . He said it was the first one he had had in his life. He had never had a physical before. Also he started on the smoking cessation.

(Rural nurse practitioner, Rural health clinic)

The smoking cessation resources . . . Those are quite helpful. Also for the obese group, they haven't actually taken advantage of dietician services yet, but some of the diabetics have. So that's a resource that's helpful. Those are probably the two biggest ones. Smoking and diabetes are big in this area.

(Rural nurse practitioner, Rural health clinic)

Like I'll take advantage of community resources. For instance, the YMCA has a program to help patients who may be prediabetic or at significant risk for diabetes. So we'll initiate their participation in that program to help them additionally with behavioral and lifestyle changes for better health outcome and to minimize risk for, you know, diabetes and other chronic medical conditions . . . hypertension, and that type of thing.

(Urban physician assistant, FQHC)

12. Cost Sharing

I don't know anything about it because most of my patients . . . The ones that I'm seeing have no copays on the plans and they're mostly indigent.

(Urban physician; Small, private practice)

Well I actually don't pay attention to the copay part. I just like to know what insurance they have in case I need to do a referral or order medications or something. That's why I look at it, but I don't stand with them at their checking out at the end of their visit. So I wasn't sure if any of them had copays or not…. People have a hard time understanding copay versus deductible, and I guess I didn't realize that applied to anybody in our county on the Healthy Michigan plan.

(Rural nurse practitioner, Rural health clinic)

They could start making people pay something [for nonurgent ER visits] whether they have to pay $5 or $10 or $20. I think the biggest problem with healthcare is people have these little plastic cards that allow them to go somewhere and it doesn't cost them.

(Rural nurse practitioner, Rural health clinic)

Well, the first thing that comes to mind is the same way we give them benefits . . . you know, give them financial incentives for being healthy. We should take some of it back away if they overuse the ER inappropriately.

(Rural physician, FQHC)

The only other thing I really see that's important on the negative side is . . . that six-month lapse between service and payment. The other question I know that we've had in this office is . . . Let's say the patient gets that bill at the end of six months and they don't pay it. What happens to these folks? Because that's gonna be important for our planning down the road. Are those folks going to go back to being uninsured because then we have to be able to plan in six months to a year to be taking on a load of uninsured patients again.

(Urban physician, Free/low-cost clinic)

There's that stupid list of a dozen or so diseases that when people have regular Medicaid, but Healthy Michigan plan that if this is the primary diagnosis, then they're exempt from the copay, and if it's not, then they've got to pay the $2 copay. I mean that kind of stuff is a pain in the neck.

(Urban physician, Free/low-cost clinic)

13. Financial Incentives

I know that people have come in and they have told me they're here because they want a reward, or their insurance told them they would be rewarded for doing . . . whatever it is. . . As far as if they do particular behaviors, they get particular rewards? I've never had a conversation with a patient about that aspect. So I feel like the only rewards I'm aware of is they showed up, they filled out their health risk [assessment], and they get some reward.

(Urban physician, FQHC)

I have heard some people comment that if they come in, they get a $25 gift card to Wal-Mart or something like that. It didn't sound as though it was tied to anything other than coming in for their first visit.

(Rural nurse practitioner, Rural health clinic)

The only rewards program I know of is on [healthplan] and, you know, people bring their paperwork in and say, "Can you just basically sign this that I completed my mammogram this year so I can get a $15 gift card?" Or, "If my diabetes is controlled, I get a $20 gift card." Those are usually the ones that I see. I've got a couple of patients who every year, they're all over their [health plan] insurance. They know exactly what they have to do to get their gift cards, and they bring them in like clockwork, but not a whole lot of them do that. There's only a couple of people that I know of who routinely bring me in health rewards.

(Urban physician; Small, private practice)

They've never mentioned like, "Hey, I came in today because I know this is waived." They might know that it's a covered benefit and so they'll do it, but I would be unaware that it was because they had costs waived. But it's important for me to know because I can encourage them to come in then.

(Urban physician; Large, hospital-based practice)

I thought that it doesn't take effect for like a year, like to discount some premiums and that kind of stuff or discounts on co-insurance. That's just starting to take effect now. And most of ours qualify for the gift card because, again, their income is low enough that they don't have a lot of copays and stuff yet.

(Urban physician, Free/low-cost clinic)

14. PCP Communication

14.1 PCP Communication with Health Plans

All I know is that we got the communications and we got something telling us about . . . certain forms that we have to fill out for the . . . called the HRA forms. But I don't remember exactly, you know, the initial communications and how it was determined that we were going to get it.

(Urban physician; Small, private practice)

Like with [healthplan A and B], they have representatives who stop in periodically and actually do face-to-face questions and answers and verbally went over their programs.

(Rural nurse practitioner, Rural health clinic)

I got a couple of memos by mail. I didn't really pay that much attention to them…" until I started getting all these new patient requests.

(Urban physician; Small, private practice)

Well, it [i.e., communication with health plans] at least gave. . . a clear expectation of what those patients should receive upon initial evaluation and kind of help to explain what the goals were from the health care organizations in evaluating the patient's health status.

(Urban physician; Small, private practice)

The first we got was from a group called Free Clinics of Michigan, and then Michigan Primary Care Association …and, since then, of course, you've spoken to the provider reps of the individual insurance plans and that kind of stuff.

(Urban physician, Free/low-cost clinic)

14.2 PCP Communication with Patients

We've got some people who qualify for that [i.e., Medicaid cell phone]. Cell phones can be a problem though because a lot of times, you know, people let them lapse, like especially if they have something like a Trac fone. All of a sudden the number is out of order. It's harder to get a hold of people because there are less land lines. If it's something where we need to get a hold of the person, we'll dictate letters and send them. But a lot of times they get returned. People move around.

(Rural physician assistant, Rural health clinic)

A lot of my patients have those [Medicaid cell phones]. The minutes are quite limited, and so they are sort of always out of minutes, it feels like. I had a guy yesterday. I said, "Okay, so we're gonna have to call you when these labs come back. What's the best way to reach you?" And he pulls out his phone. "Oh, just call my Obama phone." We call people who utilize these . . . the Obama phones on a daily basis.

(Urban physician, FQHC)

I know some people that are on their third phone number. …That's one of our problems is people come in, they give us a phone number, and then a month or two later they'll call to make an appointment… And then when they go to do the courtesy call the day before to remind them, we don't have a good number. So when they do show up, we say "Okay, we need a better phone number for you," and they say, "Oh, yeah, I got a new Obama phone." Well, a lot of my patients go through phones faster than I go through shoes . . . No, I mean I'm sure it's [Medicaid cell phone] helped. I mean a lot of people wouldn't have access to a cell phone either way.

(Urban physician; Small, private practice)

The Obama phone is great. Yeah. People very . . . My understanding from those folks who have mentioned having it . . . That's enabled them to, for the most part, stay connected to the office and to, you know, maintain means by which to be contacted for information relating to medical care and whatnot.

(Urban physician assistant, FQHC)

As part of a medical home, we have a lot of services that we are trying to provide, by telephone services like titrating insulin and things like that, and the lack of available phone service has impacted. You know, many of the patients we cannot help are people that we cannot communicate with because. . . One week they have a phone; the next week they don't. I know I have had a few patients tell me that they have this [i.e., Medicaid cell phone] . . .

(Urban physician; Large, hospital-based practice)

Some [cell phones] are not really working, and some are….

(Urban physician; Small, private practice)

Here we have phone interpretation. Yeah, we have phone interpretation at the front desk. So if they call, you know, we schedule appointments and we can see them with phone interpretation, but if they're home and they need to call to make an appointment, that's when it gets challenging.

(Urban physician; Large, hospital-based practice)

15. Provider Knowledge about HMP and Medicaid Expansion

I may have received some emails [about HMP]. You know, I'm sure I did. As far as the . . . I have a variety of routine emails that come from state agencies that keep physicians apprised of things.

(Urban physician assistant, FQHC)

Well, I think that when the governor was trying to get this to be approved in Michigan, he had to go around to all the hospital systems and get CEO's of different hospital systems to get on board and say, "We guarantee that we are going to help you to see these people," because there wouldn't be any point in having a new program if everybody declined to see the patients.

(Urban physician; Small, private practice)

Oh, I think it was back when the governor finally got the motion in Congress to get that rolling after working with the feds. They had published a list of the requirements for being on Medicaid, and that was online. So that's probably . . . I learned about the same time everybody else did.

(Rural physician, FQHC)

…frankly I didn't even really understand that Healthy Michigan was the Medicaid expansion (LAUGHTER) until you called and started talking about it that way because there used to be a plan called… I'm thinking there was something with a very similar name that phased out when Medicaid expansion went through. We used to have a community charity voucher or discount program.

(Urban physician; Small, private practice)

I was impressed that our governor bucked his own party to do it because, of course, I was very much aware of how many people were falling through the cracks who were definitely poor and were told that they didn't qualify for Medicaid, but worked at a crappy job that didn't offer insurance. So, I knew we had expanded Medicaid. I just didn't understand…how they were doing it.

(Urban physician; Small, private practice)

My recollection is I first became aware of it [i.e., the Healthy Michigan Plan] in the newspaper, but more so from a bulletin from the Michigan State Medical Society.

(Rural physician; Large, hospital-based practice)

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

Appendix C: Primary Care Practitioner Survey Instrument

Healthy Michigan Plan Evaluation: Perspectives of Primary Care Practitioners

Thank you for completing this survey about your views and experiences caring for patients enrolled in the Healthy Michigan Plan (the expansion of Medicaid in Michigan). We recognize the difficulty distinguishing Healthy Michigan Plan patients from others, especially other Medicaid managed care patients. Please do the best you can. ***All individual responses will be kept confidential. Only aggregate responses will be reported.***

Section 1: Practice, Patient, and Personal Characteristics

Please answer questions about your practice with your primary practice location in mind.

1. In what year did you complete clinical training? _____

2. Are you board certified? ☐ No ☐ Yes → **2a. If yes, in which specialties?** _____

3. What is the zip code for your primary practice location? ___ ___ ___ ___ ___

4. Not including yourself, how many of the following practitioners are associated with you at this location?

a. Physicians: _____ c. Physician assistants: _____

b. Nurse practitioners: _____ d. Nurse midwives: _____

5. Has your practice made any of the following changes in the past year? *(check all that apply)*

☐ Hired additional clinicians (physicians, nurse practitioners, physician assistants, nurses, medical assistants)

☐ Hired additional office staff

☐ Consulted with care coordinators, case managers, community health workers, or similar professionals

☐ Changed workflow processes for new patients

☐ Co-located mental health within primary care

6. Regarding ownership of your practice, are you a:

☐ Full-owner

☐ Partner/part-owner

☐ Employee → **6a. If employee, what type of entity is your employer?**

- ☐ University or teaching hospital
- ☐ Hospital
- ☐ Other (*specify*):_____

7. What best describes the primary way you are paid for seeing patients?

☐ Fee-for-service ☐ Salary based

☐ Capitation or patient enrollment-based ☐ Other (*specify*): _____

8. In the past three years, have you provided care in a setting that serves poor and underserved patients with no anticipation of being paid?

☐ Yes ☐ No

9. What proportion of your <u>established</u> patients who request a same- or next-day appointment at your primary practice can get one?

☐ Almost all (>80%) ☐ Most (60-80%) ☐ About half (~50%) ☐ Some (20-40%) ☐ Few (<20%) ☐ Don't know

9a. Over the past year, this proportion has:

☐ Increased ☐ Decreased ☐ Stayed the same ☐ Don't know

10. Are you Hispanic or Latino? ☐ Yes ☐ No

11. What is your race? *(check all that apply)*

☐ Black or African American
☐ Asian
☐ American Indian or Alaska Native
☐ White (European, Middle Eastern, other)
☐ Native Hawaiian or Pacific Islander
☐ Other (*specify*): _____

12. Please estimate the proportion of patients you see who are: *(these do not have to add up to 100%)*

a. African American or Black: _____%
b. Hispanic or Latino: _____%
c. Do not speak English well enough to give an adequate history: _____%

13. Please estimate the percent of your patients who have each of the following as their primary source of health insurance coverage: *(total should add to 100%)*

a. Private insurance _____ %
b. Medicaid _____ %
c. Healthy Michigan Plan _____ %
d. Medicare _____ %
e. No insurance (i.e., self-pay) _____ %

Total = 100%

14. Are you currently accepting new patients with…?

a. Private insurance	☐ Yes	☐ No	☐ Don't know
b. Medicaid	☐ Yes	☐ No	☐ Don't know
c. Healthy Michigan Plan	☐ Yes	☐ No	☐ Don't know
d. Medicare	☐ Yes	☐ No	☐ Don't know
e. No insurance (i.e., self-pay)	☐ Yes	☐ No	☐ Don't know

Section 2: Experience with the Healthy Michigan Plan (HMP)

These questions ask about your experiences caring for patients enrolled in the Healthy Michigan Plan (Medicaid expansion). For more information about the Healthy Michigan Plan, see the enclosed Fact Sheet.

15. In general, how familiar are you with the Healthy Michigan Plan?

☐ Very familiar ☐ Somewhat familiar ☐ A little familiar ☐ Not at all familiar

16. How familiar are you with the following:

	Very familiar	Somewhat familiar	A little familiar	Not at all familiar
a. Specialists available for Healthy Michigan Plan patients	☐	☐	☐	☐
b. How to complete a Health Risk Assessment	☐	☐	☐	☐
c. Out-of-pocket expenses Healthy Michigan Plan patients have to pay	☐	☐	☐	☐
d. How to submit a Health Risk Assessment	☐	☐	☐	☐
e. Healthy behavior incentives that Healthy Michigan Plan patients can receive	☐	☐	☐	☐
f. Mental health services available for Healthy Michigan Plan patients	☐	☐	☐	☐
g. Dental coverage in the Healthy Michigan Plan	☐	☐	☐	☐

17. To what extent has your practice experienced the following since the Healthy Michigan Plan began in April 2014?

	To a great extent	To some extent	To a little extent	Not at all	Don't know
a. Increase in number of new patients	☐	☐	☐	☐	☐
b. Existing patients who had been uninsured or self-pay gained insurance	☐	☐	☐	☐	☐
c. Existing patients changed from other insurance to Healthy Michigan Plan	☐	☐	☐	☐	☐
d. Increase in the number of new patients who haven't seen a primary care practitioner in many years	☐	☐	☐	☐	☐

18. 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 some influence

☐ I have a lot of influence ☐ I have no influence

19. 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
a. Reimbursement amount	☐	☐	☐	☐	☐
b. Capacity to accept new patients with any type of insurance	☐	☐	☐	☐	☐
c. Availability of specialists who see Medicaid or Healthy Michigan Plan patients	☐	☐	☐	☐	☐
d. Illness burden of Medicaid or Healthy Michigan Plan patients	☐	☐	☐	☐	☐
e. Psychosocial needs of Medicaid or Healthy Michigan Plan patients	☐	☐	☐	☐	☐

20. How often do your <u>Healthy Michigan Plan</u> patients have difficulty accessing the following?

	Often	Sometimes	Rarely	Never	Don't know
a. Specialists	☐	☐	☐	☐	☐
b. Medications	☐	☐	☐	☐	☐
c. Mental health care	☐	☐	☐	☐	☐
d. Dental/oral health care	☐	☐	☐	☐	☐
e. Treatment for substance use disorder	☐	☐	☐	☐	☐
f. Counseling and support for health behavior change	☐	☐	☐	☐	☐

21. How often do your <u>privately insured patients</u> have difficulty accessing the following?

	Often	Sometimes	Rarely	Never	Don't know
a. Specialists	☐	☐	☐	☐	☐
b. Medications	☐	☐	☐	☐	☐
c. Mental health care	☐	☐	☐	☐	☐
d. Dental/oral health care	☐	☐	☐	☐	☐
e. Treatment for substance use disorder	☐	☐	☐	☐	☐
f. Counseling and support for health behavior change	☐	☐	☐	☐	☐

The questions on this page ask about your experiences with Health Risk Assessments (HRAs).

22. Approximately how many Health Risk Assessments have you completed with Healthy Michigan Plan patients?

☐ None ☐ 1-2 ☐ 3-10 ☐ More than 10

23. How often do your Healthy Michigan Plan patients bring in their Health Risk Assessment to complete at their initial office visit?

☐ Almost always ☐ Often ☐ Sometimes ☐ Rarely/never

24. Please report your experience with the following:

	Yes	No	Don't know
a. My practice has a process to identify Healthy Michigan Plan patients who need to complete an HRA.	☐	☐	☐
b. I/my practice have been contacted by a Medicaid Health Plan about a patient who needs to complete an HRA.	☐	☐	☐
c. My practice has a process to submit completed HRAs to the patient's Medicaid Health Plan.	☐	☐	☐
d. I/my practice have received a financial bonus from a Medicaid Health Plan for helping patients complete HRAs.	☐	☐	☐

25. How much influence do the following have on completion and submission of the Health Risk Assessment?

	A great deal of influence	Some influence	A little influence	No influence	Don't know
a. Financial incentives for patients	☐	☐	☐	☐	☐
b. Patients' interest in addressing health risks	☐	☐	☐	☐	☐
c. Financial incentives for practices	☐	☐	☐	☐	☐

26. For Healthy Michigan Plan patients who have completed their Health Risk Assessment, how useful has this been for each of the following:

	Very useful	Somewhat useful	A little useful	Not at all useful
a. Identifying health risks	☐	☐	☐	☐
b. Discussing health risks with patients	☐	☐	☐	☐
c. Persuading patients to address their most important health risks	☐	☐	☐	☐
d. Documenting patient behavior change goals	☐	☐	☐	☐
e. Getting patients to change health behaviors	☐	☐	☐	☐

The questions on this page ask about non-urgent emergency room (ER) use.

27. How much can primary care practitioners influence non-urgent ER use by their patients?

☐ A great deal ☐ Some ☐ A little ☐ Not at all

28. To what extent do you think it is your responsibility as a primary care practitioner to decrease non-urgent ER use?

☐ Major responsibility ☐ Some responsibility ☐ Minimal responsibility ☐ No responsibility

29. Does your practice offer any of the following to help Healthy Michigan Plan patients avoid non-urgent ER use?

	Yes	No	Don't know
a. Walk-in appointments.	☐	☐	☐
b. Assistance with arranging transportation to appointments	☐	☐	☐
c. 24-hour telephone triage	☐	☐	☐
d. Appointments during evenings and weekends	☐	☐	☐
e. Care coordination/social work assistance for patients with complex problems	☐	☐	☐

30. In your opinion, to what extent do the following factors influence non-urgent ER use?

	Major influence	Minor influence	Little or no influence
a. The ER will provide care without an appointment	☐	☐	☐
b. Patients believe the ER provides better quality of care	☐	☐	☐
c. The ER offers quicker access to specialists	☐	☐	☐
d. Hospitals encourage use of the ER	☐	☐	☐
e. The ER offers access to medicines for patients with chronic pain	☐	☐	☐
f. The ER is where patients are used to getting care	☐	☐	☐

31. What, in your experience, could decrease non-urgent ER use by Healthy Michigan Plan patients?

_____

_____

32. Please think about what has changed for your patients <u>who were previously uninsured</u> and are now covered by the Healthy Michigan Plan. Rate the extent to which you think the Healthy Michigan Plan has had an impact on each of the following for these patients: *(If you have no previously uninsured patients now covered by the Healthy Michigan Plan, choose "Don't know" for all.)*

	Great impact	Some impact	Little impact	No impact	Don't know
a. Better control of chronic conditions	☐	☐	☐	☐	☐
b. Improved medication adherence	☐	☐	☐	☐	☐
c. Better ability to work or attend school	☐	☐	☐	☐	☐
d. Improved ability to live independently	☐	☐	☐	☐	☐
e. Improved health behaviors	☐	☐	☐	☐	☐
f. Improved emotional wellbeing	☐	☐	☐	☐	☐
g. Early detection of serious illness	☐	☐	☐	☐	☐

33. When was the most recent time, if ever, you discussed out-of-pocket medical costs with a Healthy Michigan Plan patient?

☐ Yes ☐ No → ***If no, SKIP to Question 36***

34. Thinking of the most recent time you discussed out-of-pocket medical expenses with a Healthy Michigan Plan patient, who brought up the topic? *(check one)*

☐ The patient

☐ Me

☐ Somebody else in the practice (e.g., clerical or nursing staff)

☐ Other (*specify*): _____

35. 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?

☐ Yes ☐ No ☐ Don't remember

36. Given what you know about it, in general, do you support or oppose the continuation of the Healthy Michigan Plan?

☐ Support ☐ Oppose ☐ Don't know

37. What changes would you suggest for the Healthy Michigan Plan?

_____

_____

38. Please rate your agreement with each of the following statements.

	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree
a. All providers should care for some Medicaid/Healthy Michigan Plan patients.	☐	☐	☐	☐	☐
b. Caring for Medicaid/Healthy Michigan Plan patients enriches my clinical practice.	☐	☐	☐	☐	☐
c. Caring for Medicaid/Healthy Michigan Plan patients increases my professional satisfaction.	☐	☐	☐	☐	☐
d. It is my responsibility to provide care for patients regardless of their ability to pay.	☐	☐	☐	☐	☐

39. In general, to what extent do you agree or disagree with the following statements:

	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree
a. I know what kind of insurance a patient has at the beginning of an encounter.	☐	☐	☐	☐	☐
b. I ignore a patient's insurance status on purpose so it doesn't affect my recommendations.	☐	☐	☐	☐	☐
c. If I need to know a patient's insurance status it is easy to find out.	☐	☐	☐	☐	☐
d. I only find out about a patient's insurance coverage if they have trouble getting something I recommend.	☐	☐	☐	☐	☐

40. Is there anything else you would like to tell us about the impact of the Healthy Michigan Plan on your patients or your practice?

_____

_____

41. If you are you interested in receiving a special summary of survey findings, please provide your email address below. *(Your email will be used only for the purpose of sending survey findings.)*

Email address: _____@_____

Thank you for completing this survey. Please return the survey in the envelope provided.

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

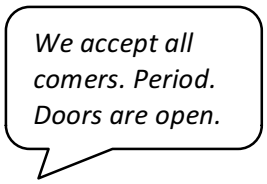
- 53% report knowing a patient's insurance at the beginning of an appointment
- 91% report that it is easy to find out a patient's insurance status
- 35% report intentionally ignoring a patient's insurance status

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

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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	
Internal medicine	27.3	36.3	<.0001
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 <u>Health Risk Assessment</u> 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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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.

$$f_{2,hmi} = \begin{cases} 0, & if\ i\ was\ not\ a\ working\ number \\ \frac{\sum_i w_{1,hmi}}{\sum_i I\_WR_i \times w_{1,hmi}}, & if\ i\ was\ a\ working\ number \end{cases}$$

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:

$$f_{3,hmi} = \begin{cases} 0, & if\ eligibility\ is\ unknown\ for\ i \\ \frac{\sum_i w_{2,hmi}}{\sum_i I\_UE_i \times w_{2,hmi}}, & if\ eligibility\ is\ known\ for\ i \end{cases}$$

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:

$$f_{4,hmi} = \begin{cases} 0, & if\ i\ is\ ineligible \\ \frac{\sum_i w_{3,hmi}}{\sum_i I\_EL_i \times w_{3,hmi}}, & if\ i\ is\ eligible \end{cases}$$

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

Report on the Impact of Cost Sharing in the Healthy Michigan Plan

Healthy Michigan Plan Evaluation Domains V/VI

July 30, 2018

University of Michigan
Institute for Healthcare Policy & Innovation

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INSTITUTE FOR HEALTHCARE POLICY & INNOVATION
UNIVERSITY OF MICHIGAN

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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). The focus of Domains V and VI is to evaluate the role of cost-sharing in the program with a focus on:

1) whether the cost-sharing structure, specifically the assessment of co-payments for certain medical services and monthly contributions, affects how much enrollees spend (Hypothesis 1)
2) whether the cost-sharing structure affects the services enrollees use (Hypothesis 2)
3) whether the cost-sharing structure affects enrollees' likelihood of disenrolling from the program (Hypothesis 3)
4) whether healthy behavior rewards are associated with more use of preventive care (Hypothesis 4).

Methods

Data

To find out how cost-sharing affected behavior, we focused on those enrollees who had experience with the cost-sharing features of the Healthy Michigan Plan (HMP). Cost-sharing begins after six months of continuous enrollment in an HMP managed care plan. We used enrollment data from the Michigan Department of Health and Human Services Data Warehouse to determine our study population and included enrollees who met the following criteria:

- First month of HMP managed care (MC) between April 2014 and March 2015 (1st year of HMP)
- HMP MC enrollment for at least 18 consecutive months
- Between 22 and 62 years old in 2014
- Not enrolled in a special program (e.g. nursing home care, hospice care)

We analyzed data from a 30-month period (April 2014-September 2016). Enrollees in other Medicaid programs for a portion of this 30 months were included if they met the criteria above. For some analyses, we used survey data as described in the body of the report.

Analysis

For all hypotheses, we completed statistical analyses of multivariate relationships between our outcomes (e.g. total spending, service use, disenrollment) and our key explanatory variables of interest, cost-sharing and income as a percent of the federal poverty level (FPL). We used linear and non-linear regression techniques that have been validated to provide accurate associations between variables and tested our results with alternative models. For hypotheses 1 and 2, we compared spending and use of preventive care and other services for three different income groups: 0-35% FPL, 36-99% FPL, 100+% FPL. Since many in the 0-35% group had no reported income, they were effectively exempt from cost-sharing. Those in the 36-99% category faced co-payments for services used but not monthly contributions, and those in the 100+% category faced both co-payments and monthly contributions. For hypothesis 3, we compared

disenrollment for those who had cost-sharing against those who did not, and especially focused on those close to 100% FPL. For hypothesis 4, we examined whether enrollees with a completed health risk assessment were more likely to use a preventive service.

Results

Demographic Characteristics

The population of 158,369 enrollees who met the selection criteria were:

- 55% female
- 64% white
- Likely to live in the Detroit Metro area (42%)
- Likely to have an income at 0-35% FPL (58%)

Cost-Sharing Characteristics

- Slightly more than half of the population (51%) had a cost-sharing obligation (either a co-pay or contribution that generated a non-zero statement)
- The average quarterly statement for those with an obligation was $16.85 ($11.11 for those below 100% FPL and $30.93 for those at or above 100% FPL)
- Overall, about one quarter (23%) of all enrollees who owed anything paid in full, about half (48%) of those who owed money made no payments
- People above 100% of FPL were more likely to pay some or all of their statement than people below despite their higher average obligations
- After the first potential 6-month period of cost-sharing (months 7-12 of enrollment), rates of payment dropped. For those who paid at least once, an estimated 65% paid in full for months 7-12 and 56% paid in full for months 13-18.

Medical and Pharmaceutical Spending (Hypothesis 1)

Spending here is defined not just as the cost-sharing amount the enrollee is obligated to pay for the service, but as the total amount spent by both the health plan and the enrollee.

- Average monthly amount spent (April 2014-Sept 2016): $360
- Median monthly spending: $136
- Those with incomes 0-35% FPL spent more per month ($391) than those with incomes 36-99% FPL ($313) or 100+% FPL ($327)
- Pharmaceutical spending increased for the entire HMP population with 18 months of continuous enrollment. That result is consistent with, and probably driven by, the initiation and maintenance of medications for chronic disease.
- Medical spending remained flat or declined for those with higher levels of cost-sharing, either from co-payments or monthly contributions. Though we cannot definitively attribute this change to cost-sharing attributes of HMP, these general patterns may indicate that those with monthly contributions may have become more efficient users of the healthcare system over time.

Service Use (Hypothesis 2)

- We use services exempt from co-payments (vs. services where co-payments are likely) as an indicator of which services the state deems high (vs. low) value. During the study period, 81% of enrollees received a co-pay exempt preventive service (exemption often based on care for a chronic condition per program rules). 56% received a service likely to have a co-payment and incurred a co-payment for it (vision exam, chiropractic treatment, new patient visit, office consultation). All income groups had similar rates of co-pay exempt and co-pay likely service use.
- Co-pay exempt preventive service use and co-pay likely service use declined over time.
- Use of the emergency department declined over time.

Disenrollment (Hypothesis 3)

- People with co-pay exempt chronic conditions are less likely to disenroll than those without. Among those with co-payments, those with the highest co-payments are less likely to disenroll.
- Enrollees just above 100% FPL have a higher rate of disenrollment than those just below it, which may be caused by monthly contributions. However, those with evidence of higher medical needs do not have higher disenrollment above 100% FPL, suggesting the plan retains clinically vulnerable populations regardless of cost sharing obligations.
- Among previously enrolled individuals, those with cost-sharing obligations and those who pay their obligations are more likely than those without obligations to gain insurance after disenrolling from HMP, underscoring that disenrollment does not always lead to uninsurance.
- In a survey of those no longer enrolled in Healthy Michigan, most enrollees said the amount they had to pay was fair and affordable. Among those with any cost obligations, 89% said they felt the amount they had to pay was fair and 95% said the amount they had to pay was affordable.

Healthy Behaviors (Hypothesis 4)

- People who have a recorded attestation for a completed Heath Risk Assessment are much more likely than those who do not have an attestation to have a preventive visit (84% vs 50%), have a preventive screening (93% vs 71%), and use a co-pay exempt medication to control a chronic disease (66% vs 48%).

Conclusion

Overall, we found that cost-sharing requirements may reduce the amount spent by plans and enrollees on medical services, though we could not rule out other causes of the decline. Cost-sharing does not appear to affect the mix of high- and low-value services used in this population. Monthly contribution amounts may cause increased disenrollment from the plan among those with low medical spending and no chronic conditions but not among those with higher medical needs. While people who complete Health Risk Assessments are more likely to also complete healthy preventive behaviors, we could not determine if the health risk assessments themselves increased these behaviors or if they were both the result of a physician visit.

Introduction

The University of Michigan Institute for Healthcare Policy & Innovation (IHPI) is conducting an 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 Domains V and VI of the evaluation, which assesses the impact of monthly contribution requirements and the impact of cost-sharing implemented through the MI Health Account framework. As outlined in the CMS Special Terms and Conditions, the focus of Domains V and VI is to 1) assess whether the contribution requirements for certain enrollees affect propensity to retain insurance or use health care services and 2) evaluate whether features of the MI Health Accounts deter enrollees from receiving certain health care services and/or encourage enrollees to be more cost conscious.

Background on Cost Sharing in the Healthy Michigan Plan

One of the key market-based features of the Healthy Michigan Plan is the MI Health Account, which facilitates cost-sharing for HMP enrollees. Cost-sharing obligations are tracked and paid through the MI Health Accounts and enrollees receive a new statement, with a payment schedule as applicable, each quarter. While Medicaid programs have historically placed little emphasis on patient-directed financial incentives, MI Health Accounts aim to encourage enrollees to take more responsibility when it comes to their healthcare costs, and perhaps modify their behaviors to reduce costs.

Some co-payments are waived for State-defined services to treat and manage chronic conditions (e.g., diabetes) and for preventive care. Additionally, certain populations are exempt from all co-payments including those who are pregnant, enrollees under age 21, enrollees receiving nursing home or hospice care, Native Americans and Alaskan Natives eligible to receive services furnished by an Indian health care provider or through referral under contract health care services, and individuals who are enrolled in Children's Special Health Care Services (CSHCS). Enrollees with incomes above 100% of the federal poverty level (FPL) also pay monthly contributions into their accounts, up to 2% of their annual income. All enrollees have an opportunity to reduce their co-payments and monthly contributions through completion of a health risk assessment and attesting to a healthy behavior.

During the first six months of enrollment, no co-payments or monthly contributions are due. All cost-sharing obligations begin in the 7th month or later of enrollment in a managed care plan and are based on service use and income. MI Health Account statements are sent quarterly to enrollees with cost-sharing obligations and include a monthly contribution based on income (for those above 100% FPL) and co-payments based on utilization of services. Enrollees generally are expected to pay monthly (1/3 of the quarterly statement) though can pay all at once. Not all health services or medications include co-payments, so enrollees are not always responsible for utilization-based cost sharing each quarter even if they do use services. Additionally, cost-sharing amounts can be reduced by completing a health risk assessment, and these reductions are shown on the MI Health Account statement.

If an enrollee fails to pay his or her required co-payments and/or monthly contributions, after a six-month grace period, state law directs MDHHS to pursue certain penalties or avenues for collection (e.g. offsets of state tax refunds or state lottery winnings), though enrollees cannot be disenrolled from the program due to failure to comply with payment requirements.

These novel benefit designs represent some of the first efforts to implement financial incentives among Medicaid enrollees. On one hand, these incentives have the potential to yield more engaged enrollees who make more informed choices about their use of health care services and their health behaviors. On the other hand, higher cost-sharing among these low-income individuals may delay receipt of necessary care which could lead to adverse health consequences.

Domain V/VI Hypotheses

The hypotheses as outlined in the CMS Special Terms and Conditions:

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 subject to co-payments) to higher-value categories (e.g., emergency-only emergency department visits, high priority office visits not subject to co-payments), 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.

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).

Methods

Below, we provide an overview of the methods and data sources that apply to testing the four specified hypotheses. Hypothesis-specific methods will be described later in the sub-sections devoted to each hypothesis.

Eligible Population

This report reflects a secondary analysis of administrative claims, cost sharing and enrollment data for Healthy Michigan Plan enrollees. The study population for hypotheses 1, 2, and 4 includes Medicaid enrollees ages 22-62 in 2014 who enrolled in a Healthy Michigan managed care plan between April 2014 and March 2015 and who were continuously enrolled for at least 18 months. We followed enrollees for up to 30 months if they remained continuously enrolled. We only measured periods during the 18 months or more of continuous enrollment, such that gaps in HMP enrollment were not allowed. Our study period included claims and cost-sharing information through September 2016. The 18-month eligibility requirement was selected to allow for an initial observation period of 6 months to serve as a baseline for health service utilization and spending prior to the receipt of the first MI Health Account statement, and a follow-up period of at least one year to allow measurement of utilization or spending changes. Enrollee eligibility months that include fee-for-service Medicaid, incarceration, and emergency services only are excluded (and thus do not count toward the 18-month eligibility criteria). To ensure that enrollees had not become Medicare eligible on the basis of age during our follow up period, we excluded enrollees younger than 22 in 2014, older than 64 in 2016 (62 in 2014), those in Children's Special Health Care Services, those in nursing homes, and those who ever received hospice services. Application of these criteria yielded an analytic population of 158,369 eligible enrollees; some analyses have slightly fewer enrollees due to missing variables. For portions of hypothesis 3, we relaxed the enrollment criteria, requiring at least 6 months of continuous enrollment rather than 18 as looking at changing behavior within the program was less relevant to the hypothesis. That population size is 469,465.

For additional analyses in hypotheses 3 and 4 we used samples who responded to two Healthy Michigan Voices surveys administered under Domain IV of the Healthy Michigan Plan evaluation. For hypothesis 3, which pertains to dropping coverage, we included respondents from the 2016-17 Healthy Michigan Voices survey of individuals no longer enrolled in the Healthy Michigan Plan who initially enrolled before March 2015 in order to match with our existing data. That sample includes 1,060 people. Analyses for hypothesis 4 include information from the 2016 Healthy Michigan Voices survey of current enrollees, which had a total of 4,090 respondents. We did not require continuous enrollment for these samples beyond that required to participate in the surveys.

Data Source

Administrative data were drawn from the MDHHS Data Warehouse. Data included Medicaid claims across service types (e.g., medical, pharmacy), program enrollment data, demographic

characteristics, health risk assessment completion and cost-share data. Claims related to substance abuse disorder were excluded from the dataset, consistent with MDHHS protocols, though enrollees with these claims were included, as was their non-substance abuse health care use. Data extraction was performed via a secure Virtual Private Network (VPN) connection by a data analyst with specific approval from MDHHS for this purpose, using existing protocols that require two layers of password protection. Data extraction is allowed under the authority of a Business Associates' Agreement between the University of Michigan and the MDHHS. Data processing, encryption and storage are done in accordance with a data security protocol approved by the MDHHS Compliance Office. Additionally, we used data from the 2016-17 Healthy Michigan Voices survey of individuals no longer enrolled in HMP and the 2016 Healthy Michigan Voices survey of current enrollees administered under Domain IV of the evaluation, as described above and in the methods section for each hypothesis.

Definitions

Demographic and Programmatic Characteristics: Demographic characteristics included age, gender, race, income level as a percent of FPL and MDHHS prosperity region. Age was evaluated in categories (under 30; 30 to 39; 40 to 49; over 50) based on birth year and held constant to reflect age in 2014. FPL was also evaluated in categories (0-35%; 36-99%; 100+ %) and allowed to change based on changes in FPL levels noted in enrollment data. Third-party liability (TPL) through concurrent public or private health insurance coverage was identified for each month of enrollment.

Spending: Spending measures are based on the total amount paid to health care providers for a service. Spending includes all medical care adjudicated through the claims process including outpatient visits, inpatient claims, emergency department visits, and pharmacy claims. It includes both the amount paid by the health plan, the state Medicaid program and, where applicable, the co-payment assessed to the enrollee. For most measures, medical spending for each enrollee was averaged at the monthly level.

Utilization-Based Measures: We used claims-based Current Procedural Terminology (CPT) codes to classify and define medical services and therapeutic class codes to define pharmaceuticals. We defined specific co-payment exempt services using state categories and specific lists of CPT codes defined by MDHHS. We defined co-pay likely services through claims-based analysis that allowed us to link CPT codes to co-payments. Specifically, we took a sample of claims from three non-contiguous months and measured which CPT codes were more often associated with co-payments. We then grouped these into service areas (e.g. vision exams, chiropractic services) and defined these groups as co-pay likely services. Co-pay likely medical services were those associated with a co-payment at least 50% of the time and the sample included at least 25 claims; co-pay likely medications were associated with a co-payment at least 40% of the time, with more than 3 claims.

Cost-sharing: Cost-sharing information comes from quarterly reports of enrollees' invoices and payments. The invoice amounts reflect the amount due and any reductions. We examined cost-sharing from the beginning of the program through the third quarter of 2016, combining monthly contribution and co-payment amounts to reflect the total amount that enrollees owe for each quarter, and applying the payment from that quarter to the amount due. For analysis over time, we calculated the fraction as the amount applied to each quarterly statement, divided by the total amount due.

For cross-sectional analyses, we calculated the total amounts owed and paid through the third quarter of 2016 and the fraction paid overall. We defined any fraction of 0.95 or above as full collection. Our calculated numbers represent the amount applied to an enrollees' account, which could differ from the amount paid in the case of overpayment. We coded any overpayments to reflect the full amount of the invoice owed and no more.

Co-payments: We identified co-payments through medical and pharmaceutical claims. The data do not reflect co-payments when they are waived for condition-based reasons, such as those waived for chronic diseases. However, the data may include co-payment amounts that are later waived or reduced for other reasons, including enrollees meeting their cost sharing limits or receiving reductions for Healthy Behavior rewards. Our analysis does not incorporate these later reductions.

Overall Analytic Plan for Testing Hypotheses

Domains V and VI use the implementation of cost sharing as a key independent variable to predict a number of outcomes. To provide context, we report descriptive statistics for the study population's demographic characteristics, as well as a characterization of the cost-sharing patterns (obligations and subsequent payments).

For hypotheses 1, 2 and 4, HMP enrollees' first 6 months in a health plan are compared against their later experiences, under the assumption that cost sharing implemented after the first 6 months of health plan enrollment may change behavior. We compare enrollees whose incomes are at 0-35 % of FPL and 36-99% of FPL, who are exempt from monthly contributions, to those above 100% of FPL, whose income and household size make them subject to monthly contributions. For hypothesis 3, we measured cost-sharing obligations and continued enrollment for those who are in an HMP managed care plan for at least 6 months continuously, excluding special populations mentioned above. We compared the obligations of those who disenroll from those who maintain enrollment for at least 6 to 12 more months.

Our statistical approach to all hypotheses uses multivariate regression models, either linear for continuous outcomes or discrete choice for binary outcomes. We use both fixed effects and repeated cross-sectional analysis to help evaluate the underlying dynamics of enrollee decisions. For outcomes in which data are skewed (i.e. spending outcomes), we use models that have been found less biased, including generalized linear models and transformations of the dependent variable. For a portion of the analysis for hypothesis 3, we use a regression discontinuity approach to measure disenrollment differences between those just above and just below the federal poverty line.

Results

Demographic Characteristics of Population

Sample characteristics are reported in Table 1, comparing the study population of enrollees continuously eligible for Healthy Michigan for at least 18 months (n=158,369) to shorter-term enrollees or those otherwise ineligible for inclusion in the analyses (n=411,169). Demographically, eligible enrollees were more likely to be older, female, and white compared to the ineligible population. The distribution of incomes and regions were quite similar across the two groups.

Table 1. Demographic Characteristics of Continuously Enrolled 18-30 Months in HMP Managed Care Plan vs. HMP Population Continuously Enrolled < 18 Months		
	Continuously Enrolled in HMP Managed Care 18+ months (n=158,369)	HMP Population Enrolled in Managed Care for < 18 months (n=411,169)
Age		
Under 35	30.0%	46.2%
35-44	21.8%	22.3%
45-54	29.9%	20.2%
55-62	18.3%	11.3%
Female	54.5%	50.5%
Race		
White	64.0%	58.2%
Black	24.2%	24.4%
American Indian/Alaskan Native	0.5%	0.8%
Hispanic	2.8%	3.7%
Asian/Pacific Islander	0.5%	0.6%
Other	7.9 %	12.3%
FPL		
0%	51.1%	47.6%
1-35%	7.2%	8.4%
36-99%	25.7%	27.7%
100+%	15.9%	16.3%
Region		
Upper Peninsula	3.6%	2.7%
Northwest	2.6%	2.8%
Northeast	3.2%	2.4%
West	12.0%	13.2%
East Central	6.7%	5.9%
East	11.5%	10.3%
Southeast	6.8%	7.7%
South Central	4.1%	4.3%
Southwest	7.1%	8.1%
Detroit Metro	42.3%	42.3%
Notes: Enrollees under 22 or over 62 in 2014 were excluded from both groups. Special exclusion populations (CSHCS), nursing home residence, hospice care) dropped from both groups compared here.		

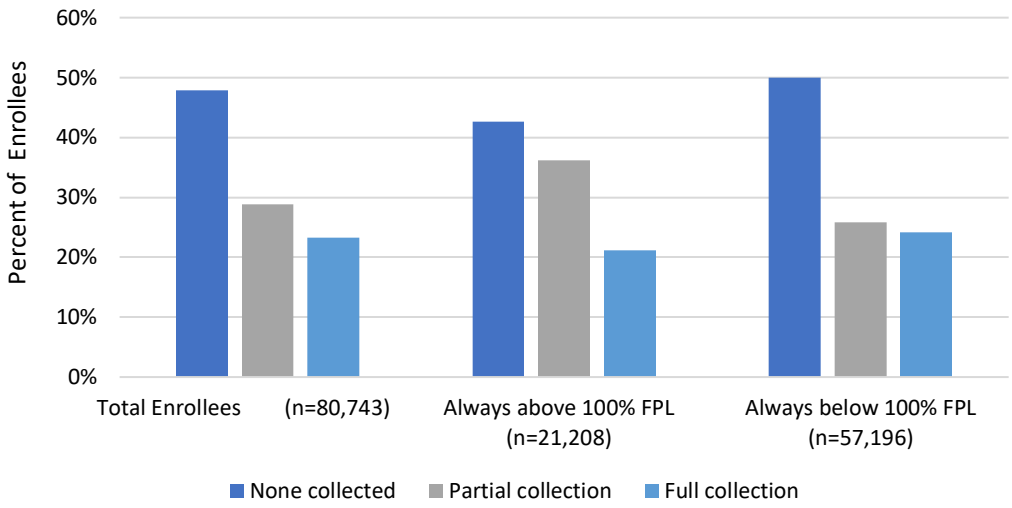
Cost-Sharing: Average Invoice Amounts and Payment Behavior

Average quarterly invoice amounts and payment status by FPL category are reported in Appendix Table 1.1. Slightly over half of those continuously enrolled for at least 18 months faced cost-sharing obligations. These obligations averaged $8.59 per quarter in the entire analysis sample, and $16.85 per quarter among those who actually faced obligations. Among those with obligations, payments

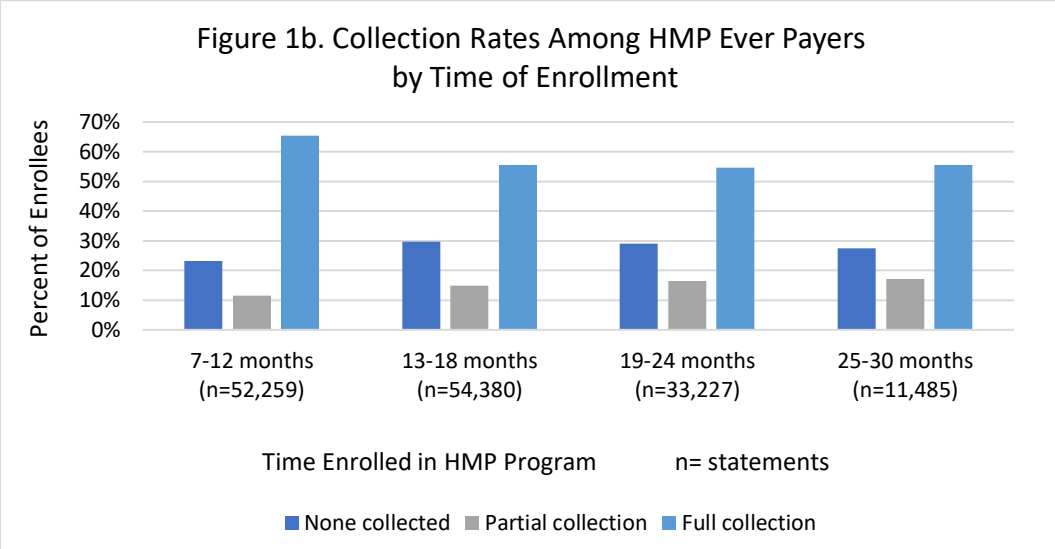
were collected from almost half of enrollees (Appendix Table 1.1a), with full payments being collected for about one fifth of enrollees. Enrollees with cost obligations who had an income above 100% FPL for the entire study period had a higher average quarterly invoice ($30.93) than those with an income below 100% FPL with cost obligations ($11.11).

Slightly less than half of enrollees with cost sharing obligations made no payments towards their obligation during the study period (Figure 1a). For those above 100% FPL, with substantially higher cost sharing obligations, rates of full payment were lower, though rates of partial payment were higher. Those with an income below 100% FPL were more likely to pay none of their obligation than those with higher incomes, despite having lower overall cost-sharing obligations. Results from an ordered logit model, adjusted for demographic characteristics (Table 1.2 in Appendix) confirmed these results, showing that those with higher incomes were more likely to pay some or all of their cost-sharing obligation.

Figure 1a. Collection Rates of HMP Enrollees with Cost-Sharing Obligations, by FPL



Among enrollees who made at least one payment (n=42,098), collection rates by 6-month time period are illustrated in Figure 1b. When split out by period, most enrollees who made at least one payment, paid in full within the period. Full payment was most likely in the period of 7-12 months of enrollment (that is, the first two quarters when obligations could be assessed). After that, full collections decreased after the first year of enrollment and remained at about 55%. Likewise, partial and non-payment remained roughly steady at about 16% and 30%, respectively, after the first period. Appendix Table 1.4 reports the predicted percentage of payment type per time frame from the two regression models; one is unadjusted and the other controls for age, gender, FPL and region. After adjusting for these characteristics, the overall patterns remain similar to the unadjusted observations in Figure 1b. In particular, Appendix Table 1.5 shows the probability of paying in full, controlling for an individual's initial payment behavior. Compared with the first period, an individual has lower likelihood of paying in full in later periods.



We examined the associations between cost-sharing amounts and perceived affordability or access barriers by linking cost-sharing data with 2016 HMV telephone survey data for 1,669 enrollees who had been enrolled in HMP for at least 18 months. We limited the cost-sharing data to the billed and collected premium contributions and co-payments in the 12 months prior to survey completion (sample characteristics in Appendix Table 1.8). We estimated the associations between cost-sharing amounts and perceived affordability and fairness of health care payments and delayed or foregone care in the previous 12 months. All models incorporated weights to adjust for probabilities of survey sampling and controlled for billed co-payments, age, gender, race/ethnicity, income, marital status, health status, and chronic conditions.

Compared to having no billed monthly contributions, we could not find associations between having moderate or high billed monthly contributions and enrollees being less likely to report health care payments as being affordable, less likely to report health care payments as being fair, or more likely to report delayed or foregone care due to cost (Appendix Table 1.9). Enrollees with higher cost-sharing obligations were more likely to pay at least some of what they were billed.

Hypothesis 1: Cost-Sharing and Total Cost of Care

> *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.*

One objective of the cost-sharing implemented through the MI Health Account framework is to enhance the efficiency of the use of health care services by making enrollees partially responsible for the cost of care (cost-sharing for services actually received) and, for those over 100% of FPL, for part of the cost of participating in the program through income-related monthly contributions. As a proxy for efficiency of health care use, we track how the total monthly cost of care changes over time for 22-62 year olds continuously enrolled for at least 18 months and compare that across enrollees at different income (and hence monthly contribution) levels. Because cost-sharing is capped at a certain percentage of income, the expected amount of cost-sharing increases with increasing income. The

lowest income enrollees (0-35% of FPL) will face little cost sharing in absolute terms, both because they are exempt from monthly contributions and because total cost-sharing is capped as a percentage of income. Higher income enrollees (36%-99% of FPL) are at risk for greater cost-sharing, but still face no monthly contributions. Finally, the highest income group of enrollees (100% or more of FPL) will face both co-payments and monthly contributions.

An ideal evaluation design would compare spending before and after HMP enrollment among HMP enrollees and an otherwise similar set of Medicaid enrollees not subject to cost-sharing. Because pre-HMP health care costs are unavailable and groups categorically exempt from cost-sharing are quite different than HMP Medicaid expansion enrollees who are subject to cost sharing, we cannot directly make such comparisons. Therefore, we track spending among enrollees over their enrollment period to determine how their costs change and whether that change varies across income groups. One might expect the first year of costs to differ from subsequent years for several reasons. First, there might be pent up demand among those newly gaining coverage. That is, it is possible that first year spending is higher simply because people who were previously uninsured had been delaying care due to cost. Second, the delivery of information on cost as well as cost obligations through the MI Health Account framework could encourage individuals to make more efficient use of the healthcare system, again lowering costs of care. Since such learning could take time and enrollees do not receive their first MI Health Account statement until after six months of enrollment in a health plan, such effects may not be visible until the second year of enrollment. Lastly, since it may take time for enrollees to make and complete appointments, initial costs might be low for some period of time as new enrollees establish provider relationships.

Methods

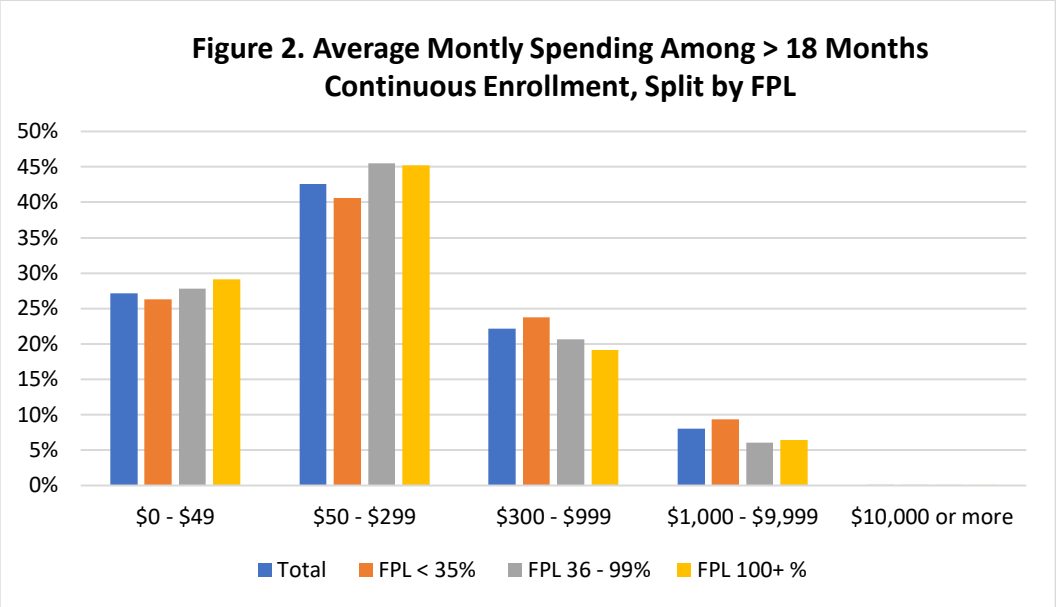
As described above, we captured all claims spending, including spending by managed care plans, and enrollee obligations. When comparing across income categories and time periods in regression analyses, we controlled for age, gender, region and the presence of other health insurance to reduce confounding by these demographic characteristics. As with most analyses of healthcare expenditures, the distribution of spending is highly right-skewed with a large number of enrollees spending a small amount, and a minority spending very large amounts during each period. Ordinary least squares regression, while the easiest to interpret, is known to produce biased results in these situations. Thus, we used a generalized linear model (GLM) to estimate and predict total spending for each time period and income category. These models produce more consistent and unbiased results with highly skewed outcome data.

All eligible enrollees are included in these analyses, regardless of whether they received a MI Health Account statement, as the objective was to test the effects of this design on the total spending of the eligible population.

Results

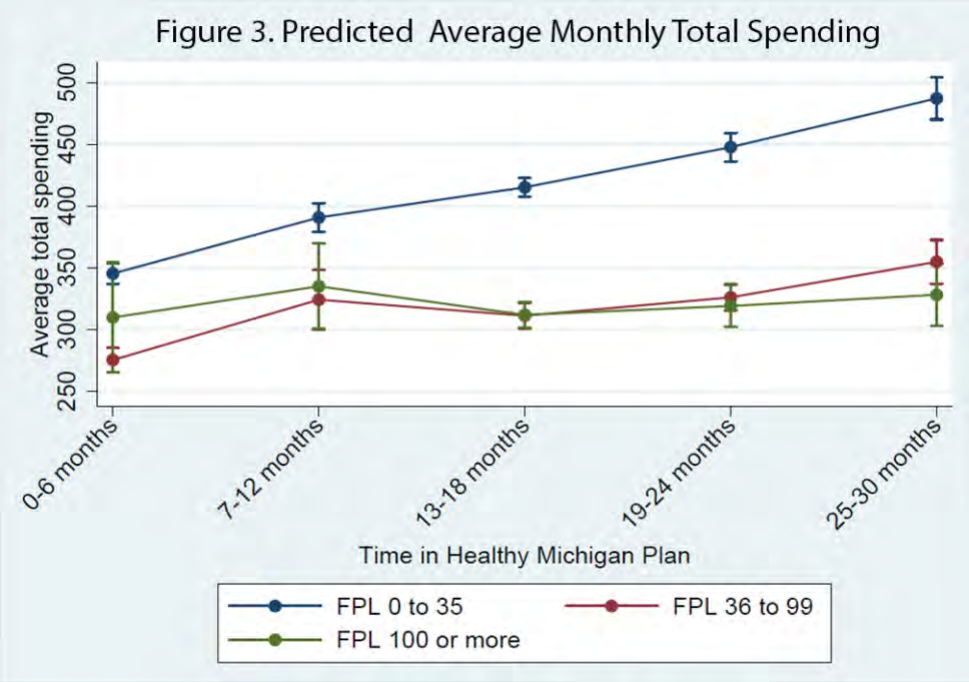
The distribution of average monthly spending by three income groupings (0-35% FPL, 36-99% FPL, and 100% or more of FPL) is shown in Figure 2. In each income category, the plurality of the population was in the $50-$299 monthly spending range. While the spending distribution did not

vary greatly across income groups, there was some trend towards lower income groups being slightly more likely to appear in the highest spending categories compared with the other income categories.

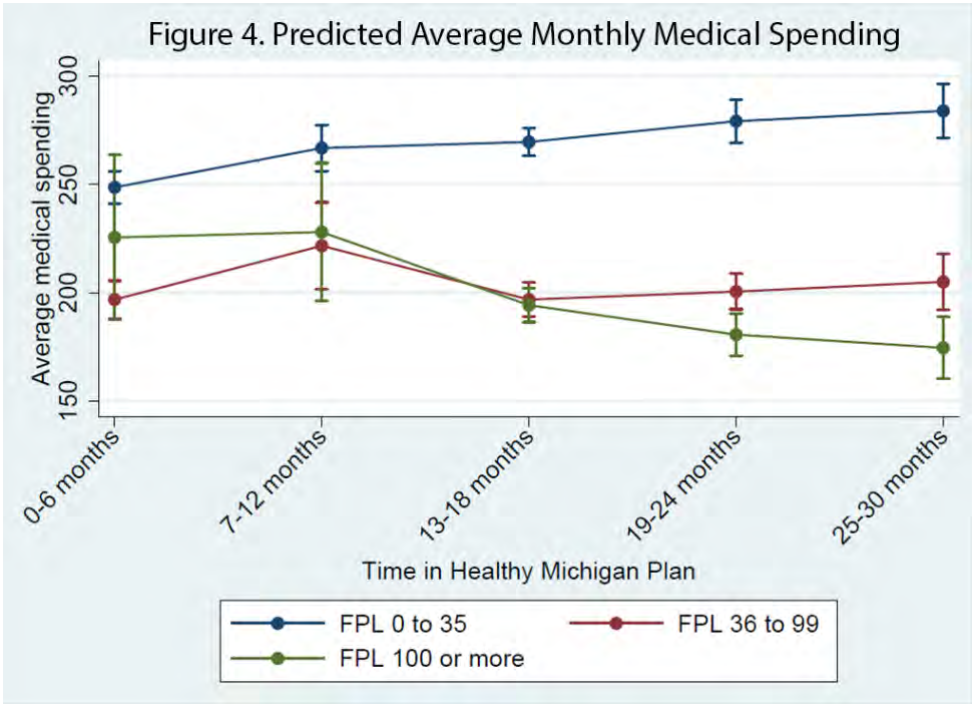


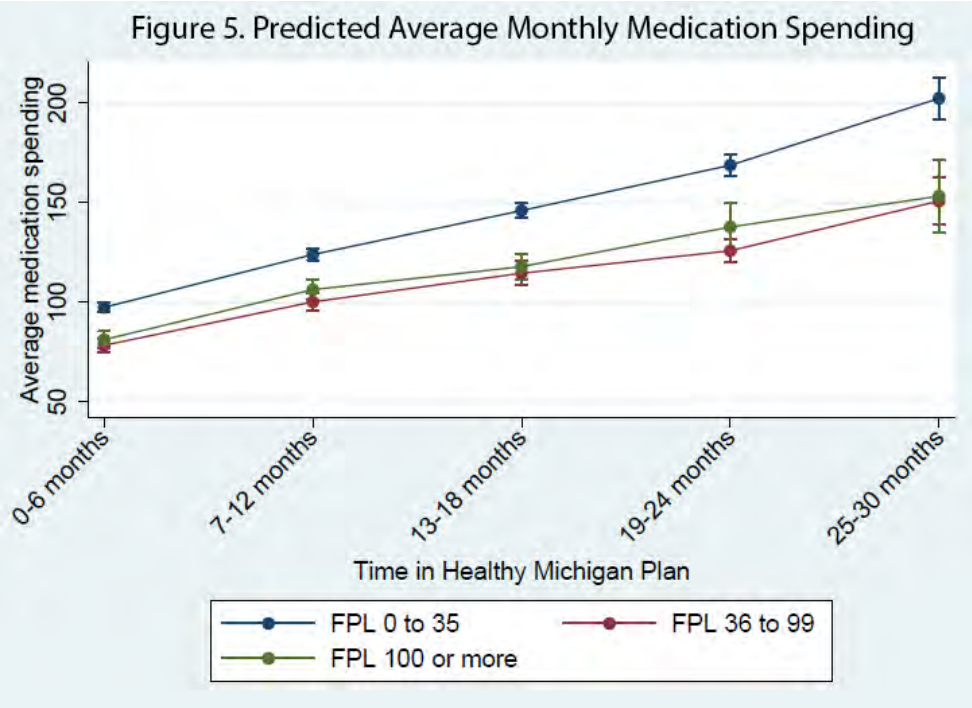
Overall, the average monthly amount spent was $360.04 (Appendix Table 2.1). Broken into categories, $238.44 was spent per month on medical services (including both inpatient and outpatient services) and $121.60 was spent on medications in the 18-month continuously eligible population. Spending amounts varied slightly by income; amounts are shown in Appendix Table 2.1. The amount of spending per month changed over time, as shown in the following figures.

Figure 3 shows the predicted total monthly spending by period of enrollment and by income group, adjusting for demographic differences through the GLM regression model. These values represent the average predicted spending for persons in each income category in each six-month time period, controlling for all other characteristics in the model (age, race, gender, region, other insurance). The bars illustrate the 95% confidence intervals for each estimated average value. Overall, spending was highest in each time period for the 0-35% FPL group. Spending in the two higher income groups was very similar. In all three income groups, spending rose in the 7-12 month period relative to the 0-6 month period. After the 7-12 month period, spending continued to rise for the 0-35% of FPL group, but stabilized in the higher income groups.



Figures 4 and 5 break spending trends into medical services and pharmaceuticals. For medical spending, the highest income group generally shows declining monthly spending after the first two periods. The lowest income group shows increasing spending and the group of enrollees with incomes of 36-99% FPL shows statistically flat spending through the study period. For pharmaceutical spending, all income groups show increasing trends with the length of enrollment.





Overall, the results show fairly stable spending in the middle and higher income groups, and spending growth in the lowest income group. All income groups show spending growth in pharmaceutical spending. Medical spending, on the other hand, remains stable or declines in groups with higher cost-sharing requirements. We did not examine the reason for the growth in pharmaceutical spending, though it is consistent with the idea of adherence to medications once a prescription is initiated. While the interpretation of medical spending results remains speculative, it is consistent with the possibility that cost-sharing deters medical spending.

Due to the limitations regarding lack of a comparison group of similar new Medicaid enrollees who did not face cost-sharing and/or monthly contributions, these findings should be interpreted with caution. However, the general patterns, particularly for medical spending, may indicate that those with monthly contributions may have become more efficient users of the healthcare system over time.

Hypothesis 2: Cost-Sharing and Effectiveness of Services

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.

Among medical professionals and health policy scholars, recognition is growing that health care services offer a spectrum of clinical benefits that are dependent on the patient, the provider, and the service itself. This recognition has led to research that defines differences between high- and low-value medical services, and measures the cost, benefit, and prevalence of these services. Low-value care includes a range of potential waste in the system, including medical errors, variations in price unrelated to quality, services that are more likely to cause harm than benefit, and services that are used more often or in a wider population of patients than they should be. High-value care includes many preventive screenings and tests, medications, and services that attenuate the progression of chronic disease, and care delivery settings appropriate to the urgency and severity of the medical condition (See Table 2 for specific services). Through insurance benefit design and other measures, policymakers and payers have begun to encourage delivery of services that provide high clinical value, while discouraging medical services that provide little to no value.

The Healthy Michigan Plan was crafted in this policy environment. When state policymakers designed the provisions of the Healthy Michigan Program, they sought a federal waiver in part to include more cost sharing than in other state Medicaid plans or, historically, in Michigan's own Medicaid program. The waiver allowed for cost sharing for the overall cost of the plan (similar to premiums in the commercial market) as well as common medical services, including physician office visits, dental visits, medications, and outpatient hospital clinic visits. Policymakers also sought to encourage enrollees to engage in healthy behaviors. Thus, many services considered beneficial to long-term health, such as high-value primary preventive screenings and services or medications related to specific chronic diseases, were exempted from co-payments. It was expected that these exemptions would signal to enrollees that these services were valuable and encourage their use.

In practice, the structure of the program means that cost-sharing is not consistently applied to all services across the population. There are some enrollees who are exempted from all co-payments as a class some enrollees who may be exempted for a certain portion of time, (e.g. those exempted for the rest of the year once they have paid 5% of their income). Additionally, certain services such as preventive care, radiologic imaging and laboratory tests are nearly always exempted from co-payments. That means that some services researchers typically use as a signal of low-value or wasteful care—unnecessary imaging for low-back pain or headache, for example —are not applicable in this context. It also means that there are rarely services for which a co-payment would always be assessed. Once those groups that are never subject to cost sharing are excluded, there may still be exemptions for reasons such as maximum out-of-pocket limits or because a visit was related to a chronic condition. However, there are certain services that are more likely to incur co-payments such as chiropractic care, vision services and hospital-associated urgent care (type B) visits.

There are also certain high-value services that are nearly always co-payment exempt, such as preventive services and medications for specific chronic diseases. These are services that designers of the Healthy Michigan Plan singled out as worthy of encouragement. Our hypothesis is that use of these services will rise relative to those that are more likely to incur a co-payment, and relative to the initial year of enrollment, as enrollees learn about the value of the service through financial incentives.

Methods

Co-payment exempt services selected for this analysis include a subset of those exempted from co-payments through HMP. We chose to examine preventive screenings and care, which applied to a large number of enrollees in our population. As described above, we defined co-pay likely services as those associated with co-payments at least 50% of the time for medical services and 40% or more for medications. Table 2 includes a full list of each service or medication. For the co-pay likely measure, we flagged any six-month period in which an enrollee had used at least one of these services and incurred at least one co-payment for that service. Similarly, for emergency department (ED) visits, we flagged ED claims and measured the proportion of the population with an ED visit in each time period.

It is important to note that most services used do not fall into either of these categories, and thus analysis of service use along these categories should not be taken as an indication of total service use.

Table 2. Co-Pay Exempt and Co-Pay Likely Services Analyzed

Service Type	Co-Pay Exempt	Co-Pay Likely
Visits	Well physical exam, preventive office visit, health risk assessment administration, preventive counseling, smoking/tobacco cessation counseling	Vision exams, contact lens visit, chiropractic treatment, new patient visit, office consultation
Screenings	Depression, BRCA testing, mammography, cervical cancer screen, sexually transmitted infections, cholesterol, colorectal cancer, diabetes, Hepatitis B/C, HIV, lung cancer, tuberculosis	
Medication Classes	Cardiovascular, COPD, diabetes, HIV, obesity, smoking	Metabolic deficiency, Hepatitis C, narcolepsy, hypnotics, cortisol, atypical antipsychotics, antineoplastic enzyme inhibitors, ADHD, ARV Comb-NRTIS and integrase inhibitor (infectious disease agent), Parkinson's disease, ammonia inhibitors, Mek 1 and Mek 2 inhibitors, Gaucher's disease,
Emergency Services	Emergency services	Non-urgent ED use

Notes: Co-pay exempt services were selected based on MDHHS definitions of co-pay exempt services which is available on the MDHHS website. Co-pay likely services were selected by looking at a sample of claims and measuring which services/medications were more likely to incur co-payments. Co-pay exempt and co-pay likely services were defined using claims prior to 2017; these classes may not be valid for later data periods, when the number of co-pay exempt services and medications list was expanded.

We compared use from year to year with the model specified below:

$$\Pr(Y_{it} = 1) = f(\beta_1 TimePeriod + \beta_2 FPL + \beta_3 Female + \beta_4 Age + \beta_5 GeographicRegion + \beta_6 Race + \beta_7 PaymentObligation + (\beta_8 \%OOPPaid) + \alpha_i + \varepsilon_{it})$$

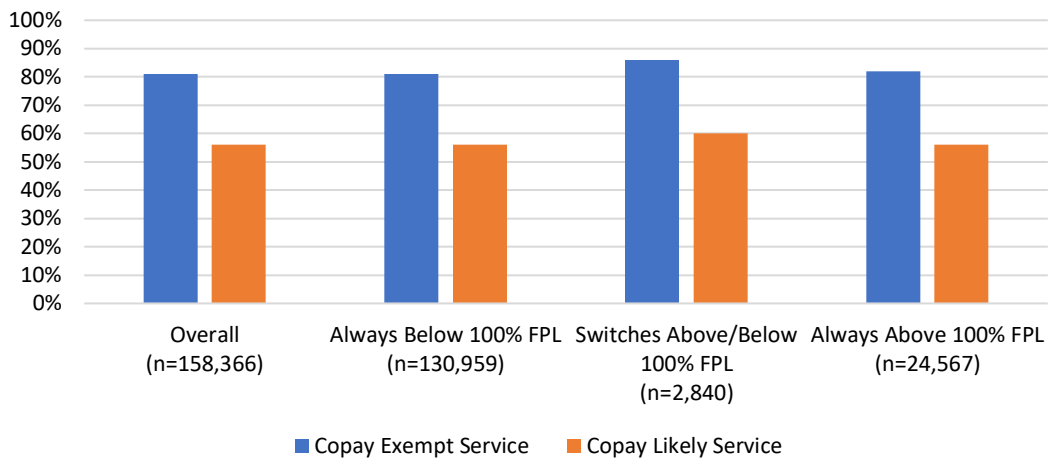
In this model, the dependent variable Y_{it} is an indicator for whether a person has received a co-pay exempt/co-pay likely service. Percent out-of-pocket (OOP) paid is only available for the subset with a cost sharing obligation, approximately 50% of the sample. We include other specifications as well,

such as FPL interacted with year. Our primary specification is a probit regression, though we also use a fixed-effects linear regression to measure individual change over time.

Results

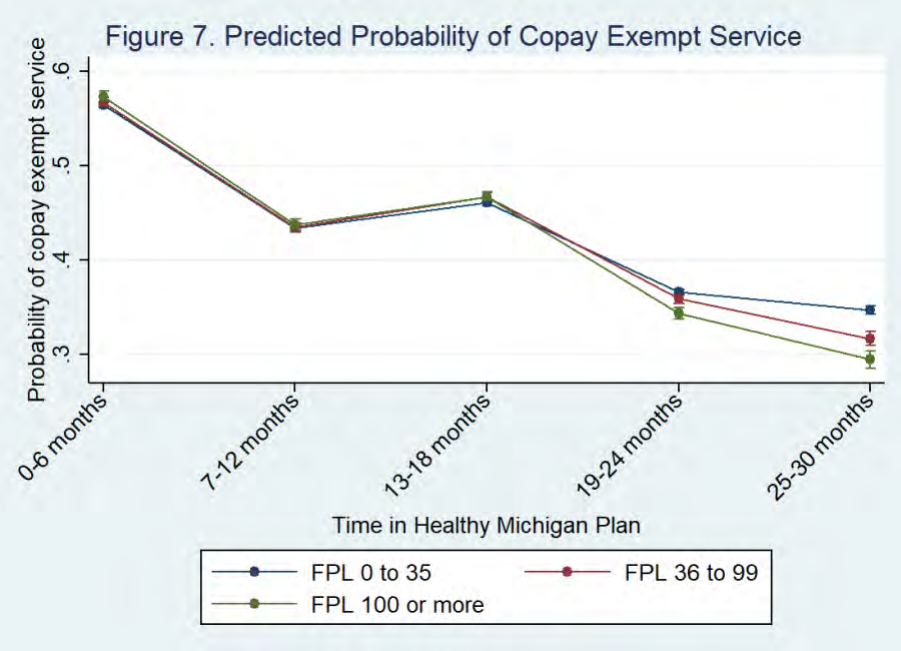
The analyses focus on three types of services: a variety of general medical services with and without co-payments, pharmaceuticals, and ED use. Figure 6 shows the percent of enrollees who ever received a co-pay exempt or co-pay likely medical service by FPL. Overall, 81% received one or more co-pay exempt medical services while 56% received at least one of the specified co-pay likely services. These percentages did not vary substantially across the three income groups.

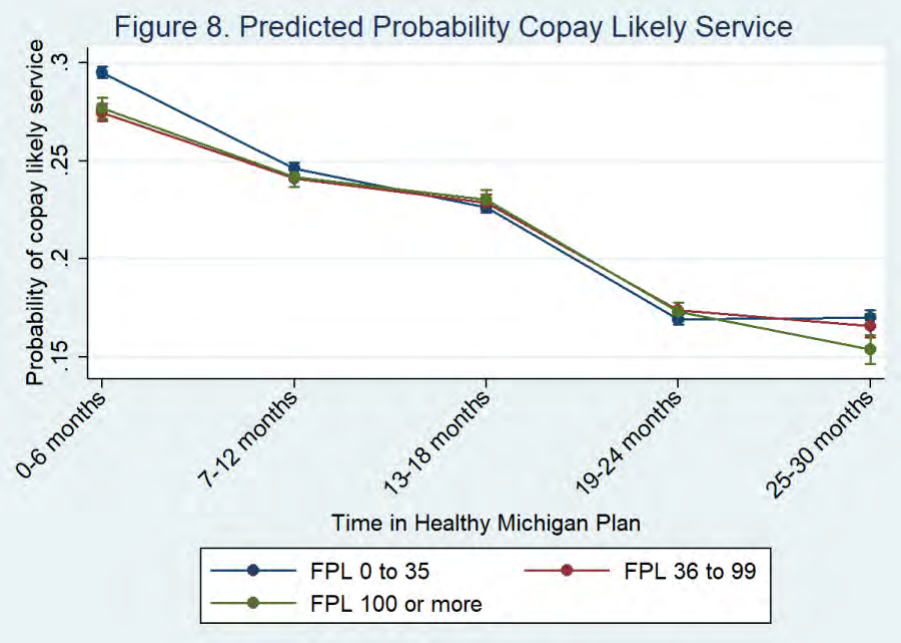
Figure 6. Percent of Population Ever Receiving Each Type of Service During Study Period



Predicted use of co-pay exempt and co-pay likely medical services by enrollee characteristics is reported in Appendix Table 3.1.1 Males and younger enrollees had fewer HMP claims for co-pay exempt and co-pay likely services. There were no consistent patterns in use of co-pay exempt services by income category, though those in the lower income group had a slightly higher usage of co-pay likely services than those in the 36-99% FPL and 100+% FPL groups.

Looking at use of services over time, Figures 7 and 8 illustrate predicted use of co-pay exempt and co-pay likely medical services, respectively, for the eligible population at each time enrolled in HMP by income category, adjusting for all other characteristics in the model. These figures show both types of use declined in a similar fashion as enrollees had been in the program for a longer period of time.

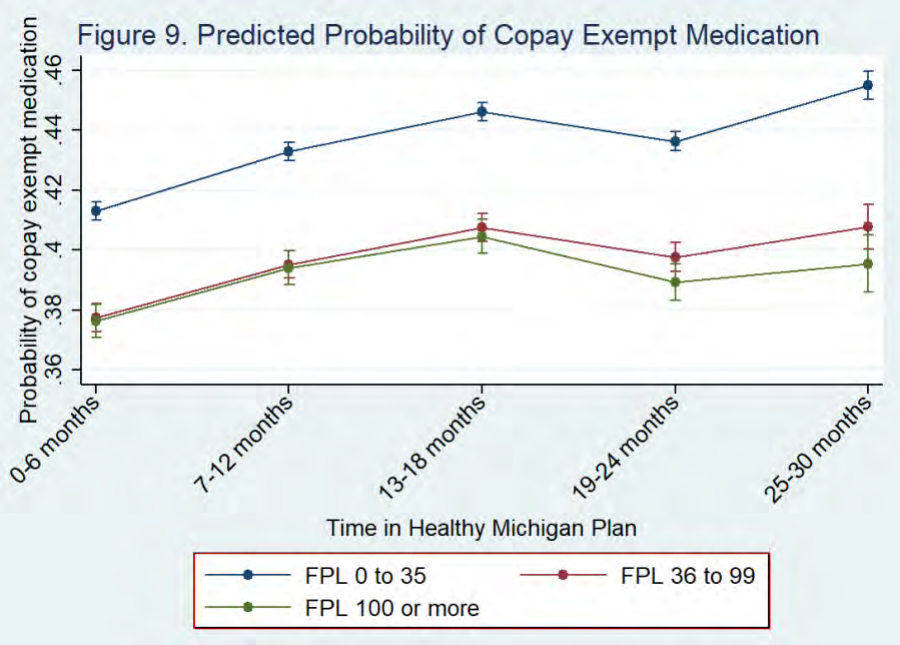




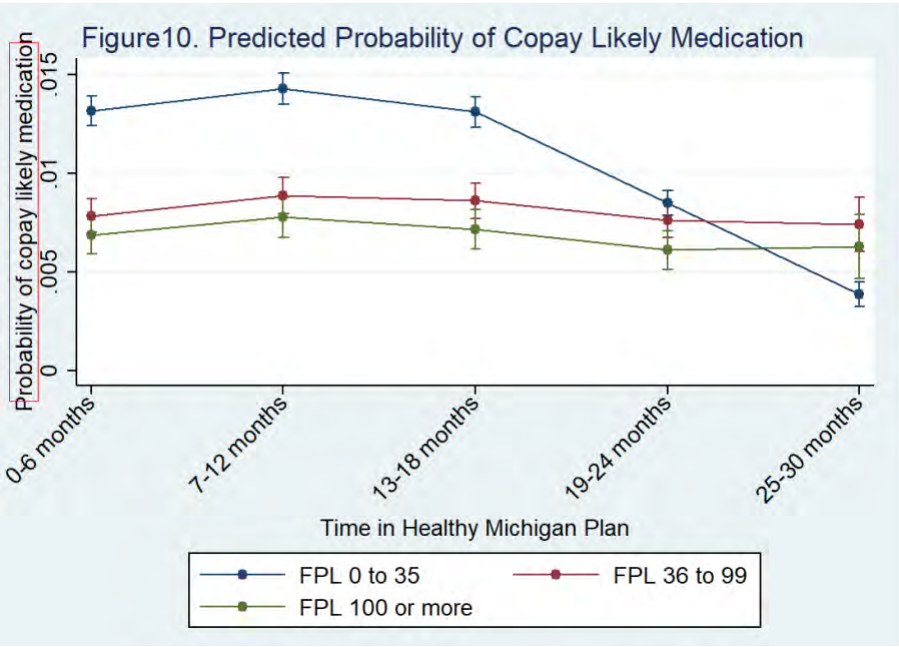
Similar analyses of co-pay exempt and co-pay likely prescription drugs show about half of enrollees received at least one co-pay exempt medication while only a small percent received a co-pay likely medication (reflecting the relatively small number of medications identified in that category). The likelihood of receiving a co-pay exempt medication varied only modestly with most enrollee characteristics (Appendix Table 3.2.1). Most notably, the percentage declined somewhat with income and rose substantially with age. Percent receiving a co-pay likely medication also varied only modestly with enrollee characteristics.

Looking over time, the use of co-pay exempt medications rose steadily with time enrolled in the program, starting at 40% in the first six months and ending at 43% in months 25-30 of eligibility as shown in Appendix Table 3.2.2. A slight decline was observed in the use of co-pay likely medications. Examining the trends separately by income level over enrollment time demonstrates that the use of

co-pay exempt medications was highest in the 0-35% FPL group and the increases in use with time enrolled were relatively consistent across all income groups (Figure 9).



Only a small percentage of the population used a pharmaceutical for which a co-payment was regularly assessed (<3.0% in all income groups combined across all time periods; Appendix Table 3.2.1). For drugs that were identified as co-pay likely use was also highest in the 0-35% FPL group initially, but that group's use declined beyond 18 months of enrollment (Figure 10).

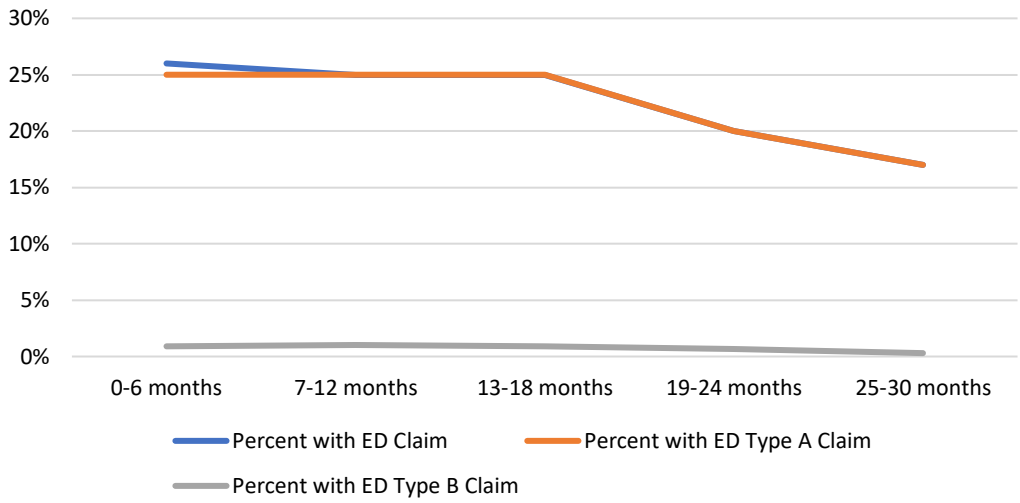


Finally, we consider co-payments for ED visits. The type of ED used can be examined using CPT codes, which are different depending on location of care. Visits associated with a hospital-based urgent care facility are often assessed a co-payment (23% of visits). By contrast, visits associated with a traditional emergency room are almost never assessed a co-payment (0.05% of visits) (Appendix Table 3.3.1). The fraction with a co-payment also decreased with increased visit severity (Appendix Table 3.3.1),

though hospital-based urgent care facility visits incurred co-payments more often for each level of severity.

Figure 11 shows a reduction in the percentage of the population using the ED from initial months of continuous enrollment over subsequent months. That reduction is confirmed in the regression model adjusting for other enrollee characteristics (Appendix Table 3.3.3). This overall trend was driven primarily by the Type A visits, which rarely assessed co-payments, but was also evident in the Type B visits that were more likely to result in a co-payment. Adjusting for all other characteristics in the model, average severity of ED visits rose substantially after 18 months of enrollment (Appendix Figure 3.3.2), which could imply that less severe illnesses were being seen in other settings.

Figure 11. Percentage of Enrollees with ED Claims by ED Type



Overall, the findings provide some evidence that the mix of pharmaceuticals used improved in terms of value the longer that individuals had been enrolled in HMP. For pharmaceuticals, use of co-pay exempt medications rose over time in all income groups, while the use of co-pay likely medications either remained stable or declined. The picture is less clear for co-pay exempt and co-pay likely medical services, where use declined by comparable amounts for both types of services, keeping the mix approximately constant. Finally, ED use of all types declined with time enrolled.

While the value mix of services, at least in terms of pharmaceuticals, improved as enrollees had longer tenure in the program, it is uncertain how much out-of-pocket cost contributed to these changes. Notably, the trends in the use of co-pay exempt medications were quite similar across income groups facing different exposure to monthly contributions. Similarly, most of the decline in ED use occurred in type A visits where co-payments were rarely assessed; however, we did not assess to what extent enrollees were aware of the lack of co-payments for type A visits.

There are other reasons that these findings should only be interpreted as suggestive. In addition to the concern about lack of a comparison group, the process of classifying services should be kept in mind. We measured a subset of co-pay exempt services defined by the program. Co-pay likely services were a group of services for which enrollees often incurred a co-payment; we measured the likelihood of using and incurring a co-payment for at least one of this group of services per period.

The findings could change if we had measured different bundles of services or operationalized our definitions of co-pay likely in a different way. Additionally, the results for co-pay likely pharmaceuticals should be interpreted with caution, as the number of these medications was very low.

Hypothesis 3: Disenrollment Associated with Cost-Sharing

> *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.*

Enrollees below 100% FPL only face cost-sharing for services actually received and therefore are expected to have little reason to let coverage lapse due to cost. However, enrollees above 100% FPL who have few health care needs may consider dropping coverage due to the required monthly contributions. Because those monthly contributions do not begin until 6 months after enrollment in a health plan and can be reduced by 50% by completing an HRA and choosing to engage in a healthy behavior, we expect most enrollees who remain eligible will have little incentive to let their enrollment lapse. To test these hypotheses, we assess the extent to which total cost-sharing obligations (co-payments for services and monthly contributions) are related to disenrollment from HMP in two ways. First, we examine enrollees' perceptions of the fairness and affordability of cost-sharing under HMP and by insurance status after disenrollment from HMP. If cost-sharing strongly influences disenrollment, we would expect to see a substantial of disenrollees becoming uninsured after leaving the HMP program. The assumption is that those who gain insurance left because of improved circumstances (e.g., accepting a job that offers insurance), while those who left HMP but did not obtain other coverage are more likely to have disenrolled for other reasons including dissatisfaction. Second, we examine disenrollment from the program in the population enrolled for at least 6 months. Here, we can assess likelihood of disenrollment by cost-sharing obligations but cannot observe whether enrollees left and gained other insurance or left for other reasons.

Methods

First, to determine the role of cost-sharing in disenrollment, we use the No Longer Enrolled (NLE) survey to assess reasons for failure to re-enroll. The NLE survey sample is drawn from enrollees who had at least 10 months of HMP enrollment followed by a period of at least 6 months (range 6-20 months) during which they were not enrolled in HMP or another Medicaid program. Survey questions explored enrollees' experiences during the period after their HMP coverage ended, including health insurance coverage, access to health services, and unmet health care needs. Surveys were conducted with 1,123 individuals who were no longer enrolled in HMP; our sample of 1,060 includes those enrolled before March 2015 who we could therefore link to our cost sharing data. We link the NLE data on reported insurance type since HMP ended to information on respondents' average cost-sharing levels and other characteristics while they were enrolled and to respondents' report of all health insurance during the 6-20 months from the time their HMP coverage ended to the time of the

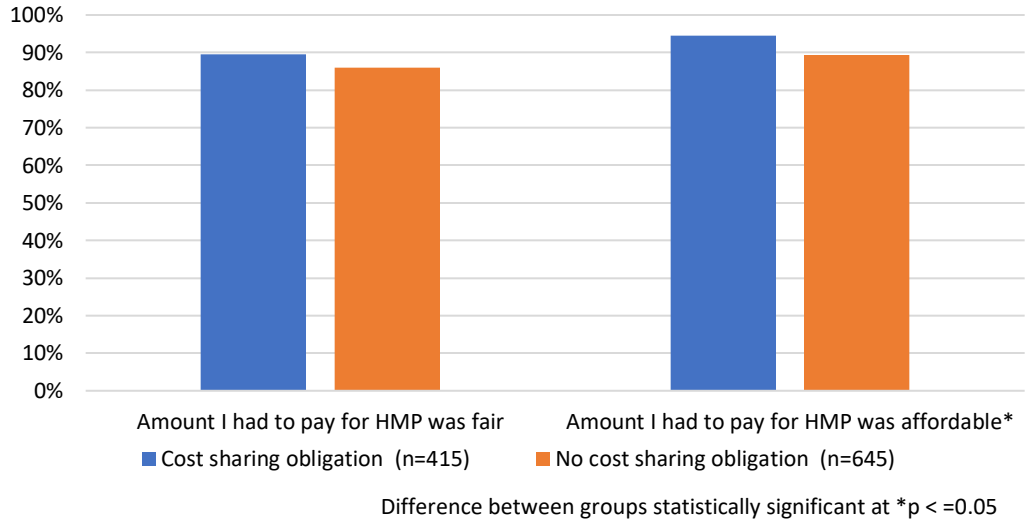
NLE survey. Specifically, we compare respondents who reported no insurance coverage post-HMP (on the assumption they found no insurance preferable to HMP) to those who reported other health insurance (employer-sponsored, individual and/or government-sponsored) at some point after their HMP coverage ended.

Additionally, we supplemented this analysis with two analyses of the full population of HMP enrollees to determine if cost sharing obligations were associated with a greater likelihood of disenrollment. Here, we used the population enrolled in an HMP managed care plan for at least 6 months continuously, who were not part of a special population (e.g. nursing home, hospice care, etc.; N=448,372 enrollees). We measured disenrollment as a drop from any Michigan Medicaid program, without reenrollment within 6 months. We merged enrollment data with quarterly cost sharing tables to measure contribution and co-payment amounts on the MI Health Account statement. We used statement date and amount owed on the MI Health Account statements, and examined whether the contribution, co-payment and total amounts predicted disenrollment within the next 11-month period. Second, to account for higher churn at the upper end of the eligible income spectrum, we measured disenrollment within 13 months of initial managed care enrollment for those just above and just below 100% FPL. We used enrollees in a managed care plan for more than 6 months continuously with an average income of 85% to 115% FPL (n=56,578 for this subpopulation; full population characteristics in Appendix Table 4.6 and Appendix Table 4.7). The assumption is that those individuals are relatively similar aside from the small difference in income, so if there is a jump in disenrollment near 100% FPL, it is more likely related to the contribution requirement triggered by exceeding that threshold. We analyzed these enrollees overall, and by subgroup based on medical spending and chronic disease claims.

Results

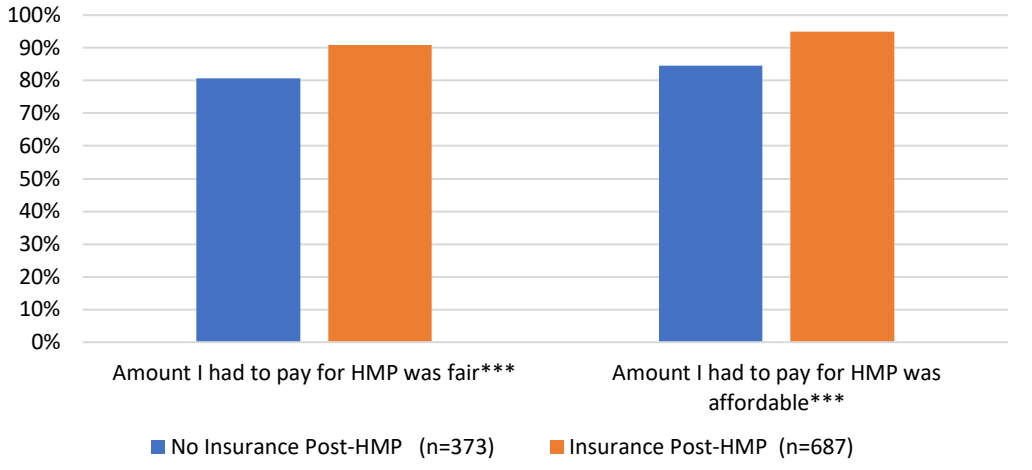
Figure 12 shows the percentages of NLE survey respondents who agreed that HMP's cost-sharing obligations were fair and affordable. Agreement was quite high, with 89% of those who faced obligations agreeing that they were fair and 95% agreeing that they were affordable.

Figure 12. Percent of NLE Respondents Who Agree with Statement Based on Cost-Sharing Obligation



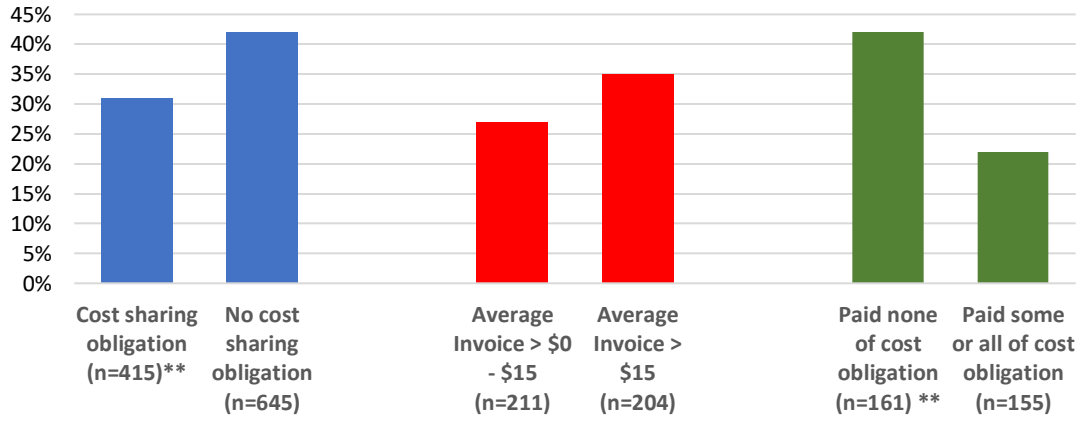
Agreement, while still high, was slightly lower among NLE survey respondents who didn't actually face an obligation. We did not test an explanation for this somewhat paradoxical result, though a possible reason could be payment for services not covered through HMP, such as for over-the-counter medications. Figure 13 splits the same two questions by whether or not the respondent had insurance post-HMP.

Figure 13. Percent of NLE Respondents Who Agree with Statement Based on Post-HMP Insurance Status



While agreement with both statements was high for both groups, those who did not have insurance post-HMP were less likely to agree that HMP's cost-sharing obligations were fair and affordable. Figure 14 shows that NLE survey respondents without cost-sharing obligations under HMP and those who did not pay their cost sharing obligation were more likely to report having no insurance post-HMP than those with such obligations. Those with invoices between $0 and $15 may be more likely

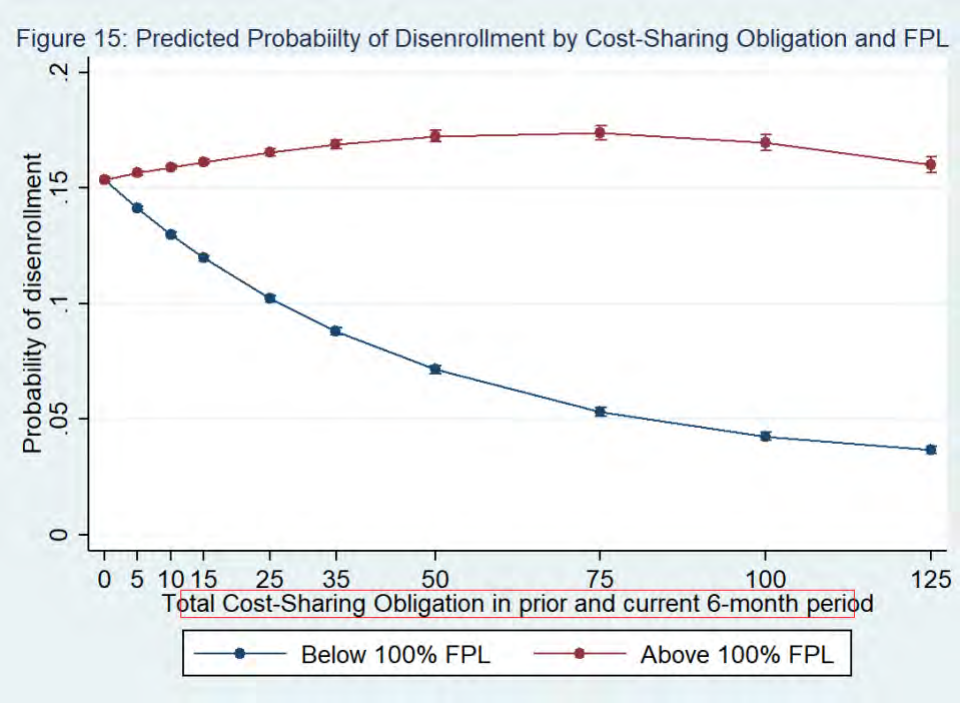
Figure 14. Percent of NLE Respondents in Each Category Who Reported No Insurance Post-HMP



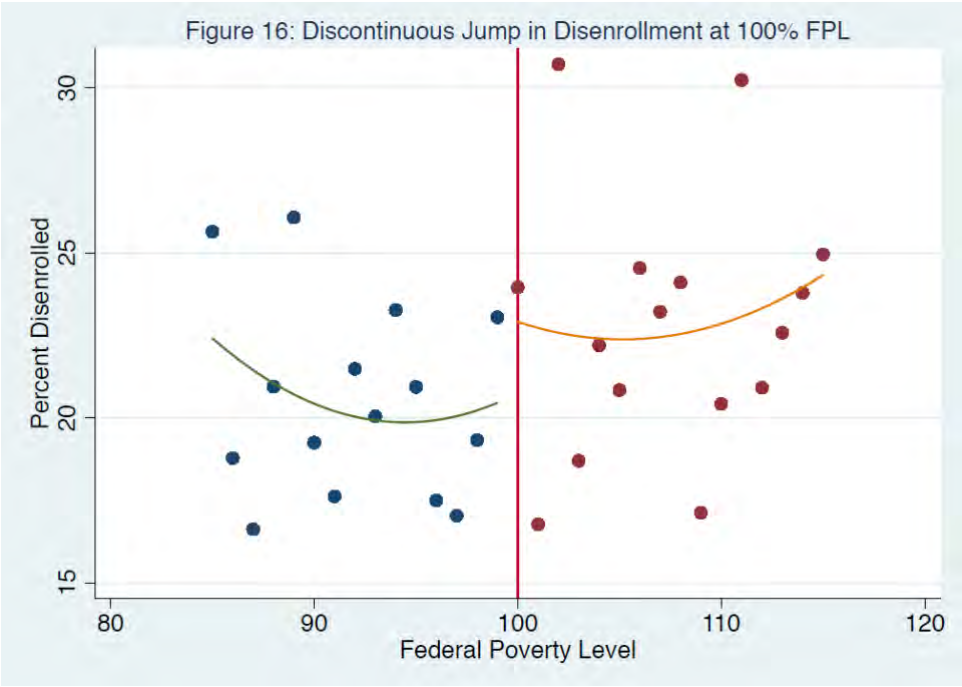
*1: Notes: Cost-sharing obligation applicable to whole population. Invoice applicable to population with cost-sharing obligation. Paid some/none applicable to population with cost-sharing obligation and at least one quarter of observation past invoice. **Difference between groups is statistically significant at p<0.01*

to transition to uninsurance, however that difference was not statistically significant, thus the differences could be attributed to statistical noise in the data given the relatively small sample. Finally, the relationship of cost obligation and payment compliance with not having insurance post-HMP is reported in Appendix Table 4.2 and was analyzed using regression models that control for observed enrollee characteristics. Because income (and hence contribution status) could vary over time, cost obligations and collections are averaged over the enrollee's time enrolled in HMP. In the first model, cost obligations are categorized as zero, positive up to $15.00, and over $15.00. As reported in the first section and shown in Appendix Table 1.1a, the overall average quarterly invoice in HMP for persons who face obligations but were below 100% FPL were $4.85 whereas obligations for those above 100% FPL (and hence were potentially subject to monthly contributions) were $26.71. Therefore, the higher category is likely dominated by persons who were typically over 100% FPL. That model finds that prior HMP enrollees in the $0.01-$15.00 category were more likely than those with no obligations to have insurance after they left HMP, though there was no significant difference between those without cost sharing obligations and those with > $15.00 average quarterly invoice. No other characteristics significantly differentiated prior HMP enrollees' subsequent insurance status. Collapsing the three obligation categories into two (zero vs. positive obligations) in the second model yielded similar results, with prior HMP enrollees facing cost-sharing being more likely to have subsequent insurance coverage. The third model is restricted to those who had obligations and shows that subsequent insurance was more likely among prior HMP enrollees for whom collections data indicated higher levels of compliance in paying their obligations.

Results from the analysis of the full population show that people with any cost-sharing obligation are less likely to disenroll than those without such obligations (Appendix Table 4.3). However, the effects are different by income. Figure 15 shows the probability of disenrollment in a period by the amount owed on MI health account statements. For those below 100% FPL, who are subject to co-payments only, higher cost-sharing amounts are associated with a lower likelihood of disenrollment.
For those above 100% FPL, who are subject to both monthly contributions and co-payments, higher cost-sharing obligations increase the probability of disenrollment up to about $75, after which probability of disenrollment decreases with increasing cost. Looking at co-payments only by income level, higher co-payments are associated with less likelihood of disenrollment regardless of FPL (Appendix Figure 4.2d). We also found that having at least one claim in a prior period decreases likelihood of disenrollment (18.1% for those with no prior claims; 5.3% for those with at least one prior claim; Appendix Table 4.5). These results are consistent with the idea that those with higher medical needs are less likely to drop HMP coverage.

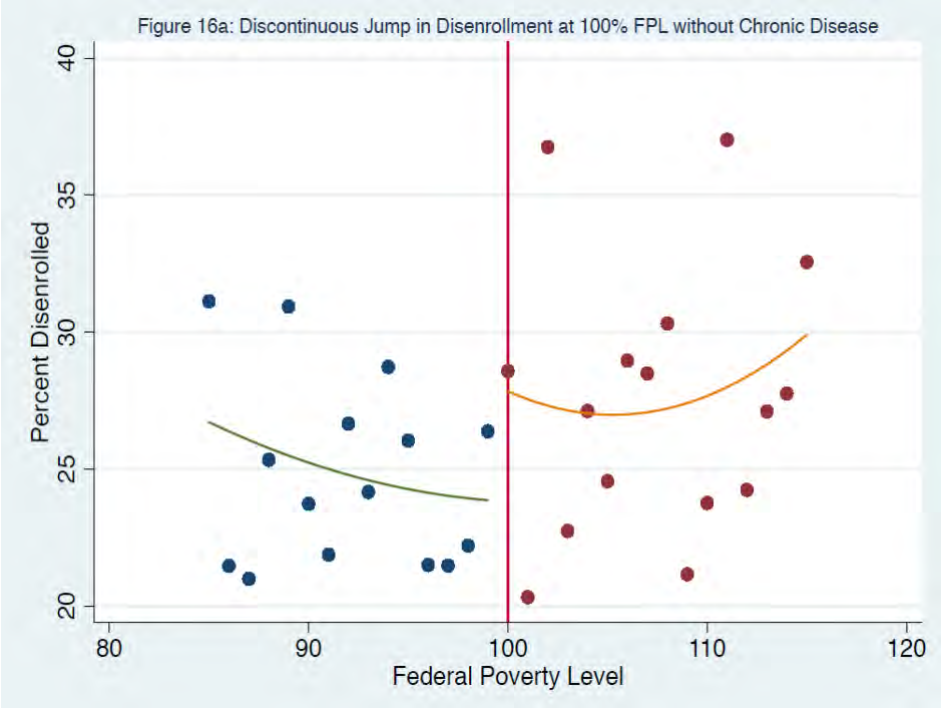


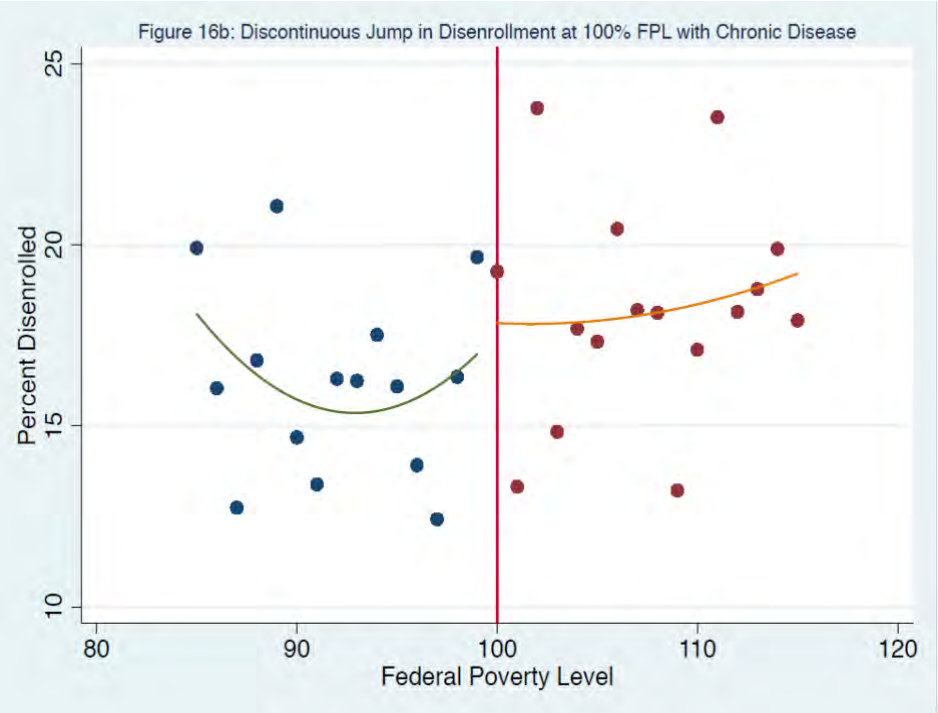
Looking specifically at the effect of monthly contributions on disenrollment, we found that at 100% FPL there is about a 2.6 percentage point jump in the probability of disenrollment. Restricting the analysis to those with monthly contributions, the jump at 100% FPL may be slightly higher, about 10 to 12 percentage points, though this result is sensitive to how we construct our model (Appendix Table 4.15).



Additionally, we split the population between those with no chronic disease claims and those with at least one chronic disease claim in their first 7 months of HMP-MC enrollment. As Figures 16a and 16b show, the jump in disenrollment at 100% FPL is higher for those without chronic disease claims. When we model this jump, controlling for demographic factors and measuring the magnitude of the

jump, we find a statistically significant relationship only in the group without chronic disease claims (Appendix Table 4.9). Combined with our analysis showing lower disenrollment for those with co-payments, this result suggests that those who have medical needs remain in the program despite cost-sharing obligations. Populations with lower medical needs may leave the program, a result that is consistent with previous studies showing low willingness to pay for insurance among lower income individuals, especially those without high health needs.





We limited our analysis to those who do not switch to other Medicaid programs (in Michigan) and who do not return to a Michigan Medicaid program for at least 6 months after disenrollment. However, we do not know whether those who disenrolled gained health insurance coverage in some other way, such as through the commercial insurance market.

Overall, the vast majority of people surveyed after they had disenrolled from HMP said their payments were fair and affordable. These results also show that prior HMP enrollees who went uninsured after leaving HMP were less likely to report they felt cost-sharing was affordable or fair. Using the full population of HMP enrollees, we found evidence that contributions, but not co-payments, may induce a slight increase in disenrollment from HMP managed care plans. The jump in disenrollment is higher for those without chronic conditions in HMP suggesting that vulnerable populations maintain coverage despite higher cost-sharing obligations. Higher co-payments, likely the result of increased service use and an indication of higher medical need, are associated with less likelihood of disenrollment. This could indicate that enrollees who need health care are receiving it and are motivated to stay enrolled in the program. Additionally, our survey results found that those with cost-sharing obligations are also more likely to report gaining insurance after disenrollment from HMP, suggesting disenrollment among those with cost-sharing obligations may not always lead to uninsurance.

Hypothesis 4: Healthy Behavior Rewards and Healthy Behaviors

A. Exemptions from cost-sharing 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.

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).

Methods

This hypothesis was analyzed using two different data sources. The first part of the hypothesis took advantage of several questions in the 2016 Healthy Michigan Voices (HMV) current enrollee survey:

- Compared to 12 months ago, how would you describe your weight? Have you lost weight; gained weight; or stayed about the same
- [*Asked of those who reported smoking or using tobacco in the past 30 days]* Are you working on cutting back or quitting right now?
- Since July 1, 2015, have you had a flu vaccine?

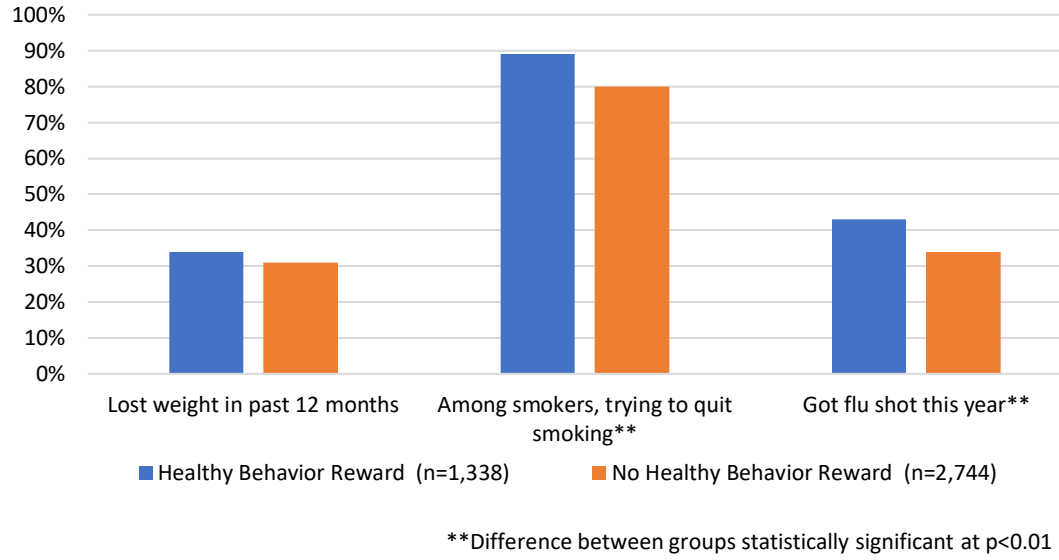
We linked answers on the HMV current enrollee survey to data from MDHHS relating to attestation of health risk assessment and agreement to a Healthy Behavior. We correlated affirmation of a healthy behavior with answers to questions about changes in healthy behaviors.

The second part of this hypothesis was tested using the same framework and population used in hypothesis 1 and 2, 22-64 year olds continuously enrolled for at least 18 months. We correlated affirmation of agreement to a healthy behavior with utilization of preventive services, preventive screenings and high-value medications. To measure service use, we used a subset of the services used for the analysis of hypothesis 2, with the same type of identification using flags to indicate receipt of service in a time period.

Results

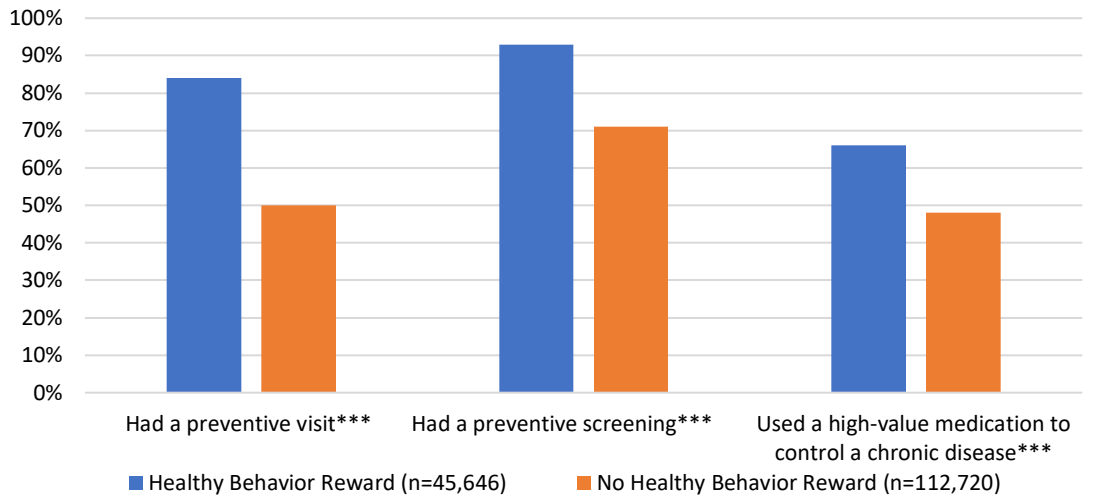
Figure 17 shows the percent of current enrollees who reported engaging in health behaviors based on whether or not they received a healthy behavior reward. Those who received a healthy behavior reward were significantly more likely to say they were trying to quit smoking, and to report they had a flu shot. However, there was no statistically significant difference in the percentage of respondents who reported that they had lost weight in the past year. In a probit regression model that controlled for demographic characteristics (including FPL), respondents who lost weight were statistically less likely to have received a healthy behavior reward, though the magnitude of the difference is relatively small (30.5% vs. 31.9%). Other results from the probit regression confirmed the unadjusted analyses in Figure 17 (Appendix Table 5.1).

Figure 17. Associations Between Healthy Behavior Rewards and Healthy Behaviors



Further evidence was developed using the set of enrollees aged 22-62 who were continuously enrolled for at least 18 months. Individuals who earned a health behavior reward were more likely to have a preventive visit, a preventive screening, or to have used a co-pay exempt drug for a chronic condition (Figure 18), but it should be noted that these are correlations and do not prove that receipt of a reward caused these differences.

Figure 18. Associations Between Healthy Behavior Rewards and Healthy Behaviors, Full Sample



***Difference between groups is statistically significant at p<0.01

Appendix Figures 5.1, 5.2 and 5.3 track these outcomes over time. For preventive visits and screenings, use declined with time in the program for both reward recipients and non-recipients, but the higher use among recipients persisted. For use of co-pay exempt medications, rates for both groups rose over time, and use was again consistently higher among reward recipients. Results for the full regression models for these three measures are reported in Appendix Table 5.2. All use measures were higher for older and female enrollees and varied modestly by income, race and region.

Finally, Appendix Table 5.3 reports a "difference-in-differences" model for each measure. This can be interpreted as reflecting changes over time for enrollees. Those who received a reward at any point had lower use of preventive visits and screening, but higher use of co-pay exempt drugs in their second year of the program compared with those who never received a healthy behavior reward. Preventive visits and preventive screening declined over time for both those who did and did not receive a reward but declined more quickly for those who did. This result may reflect that many of these services are not needed every year, such that those who received a healthy behavior reward were more likely to get the screenings in their initial enrollment periods. The use of high-value medications, typically for controlling chronic disease, rose for both groups and rose more quickly for those who received a reward.

Limitations

This study has several limitations. First, the results should be interpreted cautiously due to the lack of a control group of similar enrollees not subject to co-payments and monthly contributions. Second, the classification into co-pay exempt and co-pay likely as a proxy for high- and low-value services is not straightforward and relied on the likelihood of cost-sharing rather than a direct assessment of value and encompassed only a fraction of all services. Because cost-sharing was imposed infrequently for many services, the set of commonly used services with a high likelihood of co-payments was

limited. Third, the relationship between preventive service use and reward receipt may reflect correlations due to the same people pursuing both rewards and preventive services rather than reward receipt causing subsequent preventive care use. Fourth, the NLE survey does not allow direct comparison to those who continued enrollment.

Conclusions

Cost-sharing implemented through MI Health Accounts, consisting of co-payment for some services and monthly contributions for higher-income enrollees, was intended to raise enrollees' awareness of the cost of care and encourage efficient and effective use of care. In the primary analysis cohort of non-elderly adult enrollees with at least 18 months of continuous enrollment, there was some indication that enrollees facing higher cost-sharing made more efficient use of medical services over time relative to those facing lower cost sharing. However, trends in the use of co-pay exempt and co-pay likely services were similar across income groups that faced different exposures to cost-sharing. Receipt of a healthy behavior reward was associated with attempts to quit smoking, receipt of a flu shot, and higher use of other preventive services, but not with weight loss. Finally, there was evidence of a relationship between cost-sharing and disenrollment, though with different effects. Enrollees with co-payments were more likely to stay in the program. Enrollees with contributions were more likely to disenroll but only when they did not have evidence of higher medical needs, supporting the idea that the HMP retains clinically vulnerable populations despite cost-sharing. Results from our survey of those who had disenrolled from the program found that those with cost-sharing obligations and those who paid on their obligations were more likely than those without to gain insurance post-HMP enrollment, suggesting disenrollment does not always lead to uninsurance.

Report on the Impact of Cost Sharing in the Healthy Michigan Plan

Appendix A

Table and Figure of Contents

HMP Cost Share

Table 1.1 Average Invoice and Collection Amounts, Cross-Sectional

Average invoice, quarterly	$8.59
Median invoice, quarterly	$0.25
Average invoice (>$0), quarterly	$16.85
Median invoice (> $0), quarterly	$7.80
Average invoice, always < 100% FPL	$4.85
Median invoice, always < 100% FPL	$ 0.00
Average invoice, always > 100% FPL	$26.71
Median invoice, always > 100% FPL	$21.86
Fraction collected, overall*	0.39
Fraction collected, always < 100% FPL	0.38
Fraction collected, always > 100% FPL	0.41

*Fraction collected is conditional on having some cost-sharing obligation

Table 1.1a Invoice Amounts by Population and Collection Rates

	Average invoice ($)	Number of enrollees
Total population	8.59	158,322
Subset of total population with cost obligation	16.85	80,743
Collection category (Total population)		
None collected	15.21	38,645
Partial collection	23.31	23,302
Full collection	12.20	18,796
Always below 100% FPL	4.85	130,926
Subset of always below 100% FPL with cost obligation	11.11	57,196
Collection category (Always below 100% FPL)		
None collected	10.25	28,605
Partial collection	16.15	14,749
Full collection	7.52	13,842
Switches between 100 % FPL during study period	24.40	2,839
Subset of switches between 100% FPL during study period with cost obligation	29.62	2,339
Collection category (Switches between 100 % FPL during study period)		
None collected	29.23	995
Partial collection	35.17	875
Full collection	20.10	469
Always above 100% FPL	26.71	24,557
Subset of always below 100% FPL with cost obligation	30.93	21,208
Collection category (Always above 100% FPL)		
None collected	29.40	9,045
Partial collection	35.72	7,678
Full collection	25.80	4,485

Table 1.2 Regression Analysis of Predictors of Payment (Cross-sectional); Marginal Effects from Multivariable Ordered Logit Model

	No payment	Partial payment	Full payment	*p-value on regression coefficient*
Age				
Under 30	ref	ref	ref	
30 to 39	0.008	-0.003	-0.004	0.135
40 to 49	-0.059	0.022	0.038	< 0.001
Over 50	-0.206	0.047	0.158	< 0.001
Female	-0.004	0.001	0.003	0.233
Race				
White	ref	ref	ref	
Black	0.310	-0.129	-0.181	< 0.001
American Indian	0.200	-0.070	-0.130	< 0.001
Hispanic	0.142	-0.044	-0.098	< 0.001
Asian/Pacific Islander	-0.086	0.008	0.079	< 0.001
Unknown	0.031	-0.007	-0.024	< 0.001
FPL				
0-35 %	ref	ref	ref	
36-99 %	-0.024	0.007	0.017	< 0.001
100+ %	-0.044	0.011	0.033	< 0.001
Region				
Upper Peninsula	ref	ref	ref	
Northwest	0.003	-0.001	-0.002	0.780
Northeast	0.020	-0.004	-0.015	0.048
West	0.024	-0.006	-0.019	0.002
East Central	0.036	-0.009	-0.027	< 0.001
East	0.032	-0.008	-0.024	< 0.001
South Central	0.038	-0.009	-0.029	< 0.001
Southwest	0.060	-0.016	-0.045	< 0.001
Southeast	0.025	-0.006	-0.019	0.005
Detroit Metro	0.025	-0.006	-0.019	0.001
Total number of enrollees in model	80,743			

Enrollees in model if they have received a non-zero invoice and have no missing covariate values

Table 1.3 Subset of Enrollees who Ever Paid on Cost Sharing Obligation: Average Fraction Collected Over Time; Mean Collection Rates, with Frequency, by Period

6-month period of enrollment	Fraction collected	Number of non-missing observations in each period
7-12 months	0.71	52,259
13-18 months	0.63	54,380
19-24 months	0.64	33,227
25-30 months	0.66	11,485
Total n(obvs) = 42,098 **Total n(obvs/periods)=151,351**		

Table 1.3a Subset of Enrollees who Ever Paid on Cost Sharing Obligation: Average Fraction Collected Over Time; Mean Collection Rates, with Frequency, by Period

	Mean collection rates conditional on some collection, FPL <100		Mean collection rates conditional on some collection, FPL >=100	
	Fraction collected	**Number of non-missing observations**	**Fraction collected**	**Number of non-missing observations**
6-month period of enrollment				
7-12 months	0.72	34,972	0.70	17,287
13-18 months	0.64	35,333	0.63	19,047
19-24 months	0.64	21,590	0.64	11,637
25-30 months	0.66	7,813	0.65	3,672

Table 1.4 Predicted Percentage of Enrollees in Each Category of Collection Rate Category Among HMP Ever Payers, Ordered Logit Model, Bivariate and Multivariate Results

	Predicted percentage in each category per 6-month period of enrollment from ordered logit (Collection category on period; n= 151,351)				**Predicted percentage in each category per 6-month period of enrollment from ordered logit with demographic controls (Collection category on period; n= 148,784)***			
	No payment	**Partial payment**	**Full payment**	***p-value on regression coefficient***	**No payment**	**Partial payment**	**Full payment**	***p-value on regression coefficient***
Time period								
7-12 months	22.2%	13.0%	64.8%		22.2%	13.0%	64.8%	
13-18 months	29.7%	14.8%	55.5%	< 0.001	29.8%	14.8%	55.4%	< 0.001
19-24 months	29.8%	14.9%	55.3%	< 0.001	30.0%	14.9%	55.1%	< 0.001
25-30 months	29.0%	14.7%	56.4%	< 0.001	29.8%	14.8%	55.4%	< 0.001

*Controls for age (in categories), FPL (in categories), race, gender and region

Table 1.5 Fixed Effects Models of Fraction Paid and Propensity to Pay All or None of Obligations

	Log odds of ever-paying individual paying in full, by period		**Log odds of an ever-payer individual paying nothing, by period**		**Change in fraction collected by period among HMP ever payers, OLS with FE**	
	Paid in full	***p-value on regression coefficient***	**Paid nothing**	***p-value on regression coefficient***	**Marginal change in fraction paid, compared to reference**	***p-value on regression coefficient***
Time period						
7-12 months	ref		ref		ref	
13-18 months	-0.68	< 0.001	0.58	< 0.001	-0.09	< 0.001
19-24 months	-0.67	< 0.001	0.44	< 0.001	-0.07	< 0.001
25-30 months	-0.50	< 0.001	0.22	< 0.001	-0.04	< 0.001
Total observations (People/periods)	85,500		73,593		151,351	

Notes: The interpretation of the logit fixed effects models (for paid all or paid nothing) are in log odds of payment. For example, moving from the reference group of 7-12 months to 13-18 months in the paid in full panel changes the log odds of paying in full by -0.60.
OLS with FE = Ordinary least squares regression with fixed effects. The interpretation on these predictions is as the marginal change in the fraction of the total obligation paid, compared with the baseline period of 7-12 months after first enrolling. In a fixed effects mode, any unchanging characteristics of enrollees (gender or region, for example) are held constant.

Table 1.6 Demographic Characteristics of Select Subgroup: Ever-Payer HMP Enrollees with 25+ months of continuous eligibility and 3+ MI Health Account statements

	Continuously enrolled in HMP-MC 18+ months; non-exclusion population	HMP ever-payer population with 25 months or more of eligibility 3 MI Health Account statements (subset of population represented in left column)
Age		
22-34	30.0%	19.4%
35-44	21.8%	16.9%
45-54	29.9%	31.9%
55-64	18.3%	31.9%
Female	54.5%	65.3%
Race		
White	64.0%	80.1%
Black	24.2%	10.4%
American Indian/Alaskan Native	0.5%	0.3%
Hispanic	2.8%	2.1%
Asian/Pacific Islander	0.5%	0.6%
Other race	7.9%	6.5%
FPL		
0 %	51.1%	19.7%
1-35 %	7.2%	12.5%
36-99 %	25.7%	40.9%
100+ %	15.9%	26.9%
Region		
Upper Peninsula	3.6%	6.4%
Northwest	2.6%	4.1%
Northeast	3.2%	5.5%
West	12.0%	13.3%
East Central	6.7%	8.6%
East	11.5%	12.9%
Southeast	6.8%	7.9%
South Central	4.1%	4.5%
Southwest	7.1%	7.2%
Detroit Metro	42.3%	29.7%
Total enrollees	158,369	15,736

Exclusion from HMP if not enrolled for 18 months continuously or part of an exclusion population (hospice care, nursing home care, children's special health care services)
Unable currently to exclude pregnant women. There is a reduction reason for pregnancy so these enrollees should not show up in cost-sharing tables with positive invoices.

Table 1.7 Fixed Effects Models of Fraction Paid and Propensity to Pay All or None of Obligations, Subset of Long Enrolled and Frequent MI Health Account Statement

	Log odds of each category in Chamberlin fixed effects model		**Log odds of each category in Chamberlin fixed effects model**		**Fraction collected by period, ordinary least squares regression with fixed effects**	
	Full payment	***p-value on regression coefficient***	**No payment**	***p-value on regression coefficient***	**Marginal change in fraction paid, compared to reference**	***p-value on regression coefficient***
Time period						
7-12 months	0		0		0	
13-18 months	-0.583	< 0.001	0.823	< 0.001	-0.098	< 0.001
19-24 months	-0.816	< 0.001	0.742	< 0.001	-0.103	< 0.001
25-30 months	-0.525	< 0.001	0.418	< 0.001	-0.054	< 0.001
Total observations (People/periods)	39,954		33,489		67,478	

Notes: The interpretation of the logit fixed effects models (for paid all or paid nothing) are in log odds of payment. For example, in the 'paid in full' panel, moving from the reference group of 7-12 months to 13-18 months changes the log odds of paying in full by -0.44.
OLS with FE = Ordinary least squares regression with fixed effects. The interpretation on these predictions is as the marginal change in the fraction of the total obligation paid, compared with the baseline period of 7-12 months after first enrolling. In a fixed effects mode, any unchanging characteristics of enrollees (gender or region, for example) are held constant.

Table 1.8 Sample Characteristics of Eligible HMV Respondents (n=1,669)

Characteristic	n	%
Average billed quarterly premium contributions		
$0	1284	81.6
> $0 to $21	140	6.7
> $21	245	11.4
Average billed quarterly copayments		
$0	852	59.4
> $0 to $2	318	15.8
> $2	499	24.8
Payment of billed contributions and copayments in past 12 months (n=884)		
0%	345	43.1
1% to 95%	236	26.3
> 95%	303	30.6
FPL category		
0% to 35%	700	53.3
36% to 99%	584	28.5
≥ 100%	385	18.2
Female, %	998	53.2
Age, %		
18 to 34	441	34.1
35 to 50	515	33.6
51 to 64	713	32.3
Race, %		
White	1155	61.3
Black	328	27.0
Other	113	8.1
More than one	53	3.5
Married or partnered	396	19.7
Good, very good, or excellent health status	1101	67.0
Chronic condition	544	30.9

Table 1.9 Associations between billed premium contributions and survey measures of health care affordability

Characteristic	Outcomes[1]					
	Payments affordable[2] (n = 1,641)		Payments fair[3] (n = 1,641)		Foregone care due to cost[4] (n = 1,641)	
	Coefficient (95% CI)	*P*-value	Coefficient (95% CI)	*P*-value	Coefficient (95% CI)	*P*-value
Average billed quarterly premium contributions						
$0 (reference)						
> $0 to $21	.05	.11	.02	.55	.002	.94
> $21	-.02	.54	-.03	.55	-.02	.46
Average billed quarterly copayments						
$0 (reference)						
> $0 to $2	.02	.49	.02	.44	-.003	.88
> $2	.01	.74	.01	.57	.02	.28
FPL category						
0 to 35% (reference)						
36 to 99%	.005	.82	.01	.60	-.01	.50
≥ 100%	-0.56	.10	-.04	.29	-.01	.67
Female	-.02	.25	-.01	.57	.04	.02
Age						
18 to 34 (reference)						
35 to 50	.03	.26	.07	.02	-.02	.43
51 to 64	.05	.04	.06	.04	-.04	.06
Race						
White (reference)						
Black	-.05	.06	-.06	.04	-.02	.42
Other	-.08	.05	-.04	.39	.01	.69
More than one	-.04	.47	.01	.86s	.004	.93
Married or partnered	.04	.03	.02	.47	-.001	.95
G/VG/E health status	.05	.02	.04	.08	-.03	.15
Chronic condition	.01	.47	-.01	.74	.004	.84

CI = confidence interval; G = good; VG = very good; E = excellent

[1]Each column represents a different multivariable linear probability model. [2]Strongly agree or agree that payments affordable. [3]Strongly agree or agree that payments fair. [4]Went without health care in the past 12 months 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 1.10 Associations between billed premium contributions and payments of bills for contributions and co-pays (n=867)

Characteristic	Coefficient (95%CI)[1]	*P*-value
Average billed quarterly premium contributions		
$0 (ref)		
> $0 to $21	.42	.07
> $21	.44	.03
Average billed quarterly copayments		
$0 (ref)		
> $0 to $2	.30	.32
> $2	.76	.007
FPL category		
0 to 35% (ref)		
36 to 99%	.28	.26
≥ 100%	-.13	.63
Female	.04	.80
Age		
18 to 34 (ref)		
35 to 50	-.03	.90
51 to 64	.76	< .001
Race		
White (ref)		
Black	-1.52	< .001
Other	-.38	.22
More than one	-.33	.61
Married or partnered	-.25	.16
Good, very good, or excellent health status	1.05	< .001
Chronic condition	-.05	.75

CI = confidence interval

[1]Coefficients represent the log-odds of being in a higher payment category relative to lower payment categories.

Table 1.11 Marginal Effects from Logit Regression of Demographics on Garnishment

	Coefficient	*p-value on regression coefficient*
Age		
Under 30	ref	
30 to 39	0.002	0.050
40 to 49	-0.001	0.380
Over 50	-0.004	< 0.001
Female	0.007	< 0.001
Race		
White	0.011	< 0.001
Black	-0.008	0.080
American Indian	0.003	0.101
Hispanic	-0.014	0.006
Asian/Pacific Islander	-0.001	0.499
Unknown	0.011	< 0.001
FPL		
0-35 %	ref	
36-99 %	0.008	< 0.001
100+ %	0.040	< 0.001
Region		
Upper Peninsula	ref	
Northwest	0.000	0.888
Northeast	0.000	0.940
West	-0.002	0.449
East Central	0.001	0.732
East	0.002	0.370
South Central	0.003	0.290
Southwest	0.000	0.886
Southeast	-0.001	0.573
Detroit Metro	-0.006	0.002
Total people	158,322	

Table 1.12 Number of Enrollees with Garnishments in 2016, by Collection Category

	No payment	Partial payment	Full payment	Totals
No garnishment	36,684	22,433	18,745	77,862
Garnishment	1,961	869	51	2,881

Figure 1.1 Mean Federal Poverty Level, Cross-Sectional. Average FPL per enrollee from enrollment data, with 0 FPL included

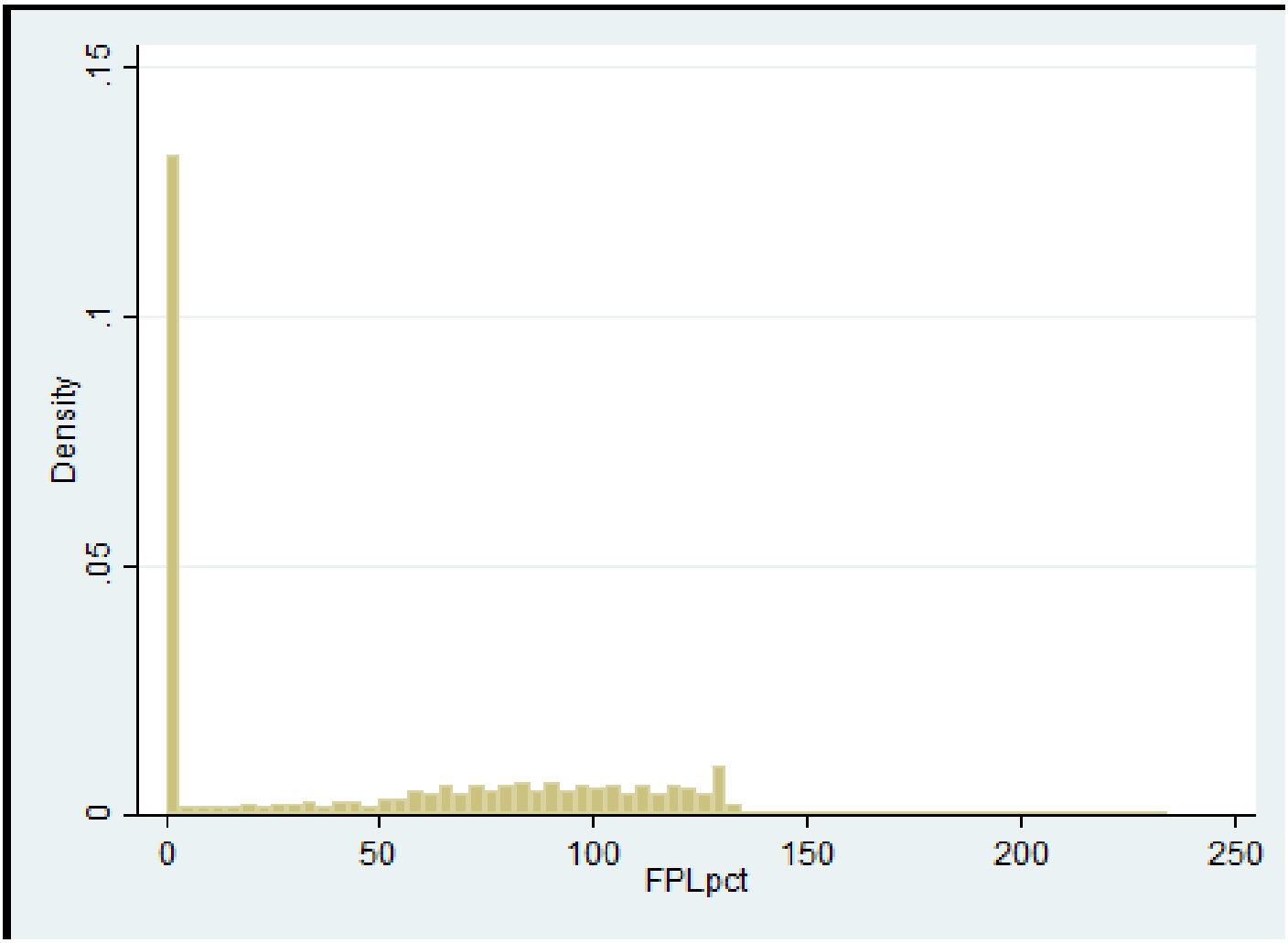


Figure 1.1a Mean Federal Poverty Level, Cross-Sectional. Average FPL per enrollee from enrollment data, without 0 FPL included

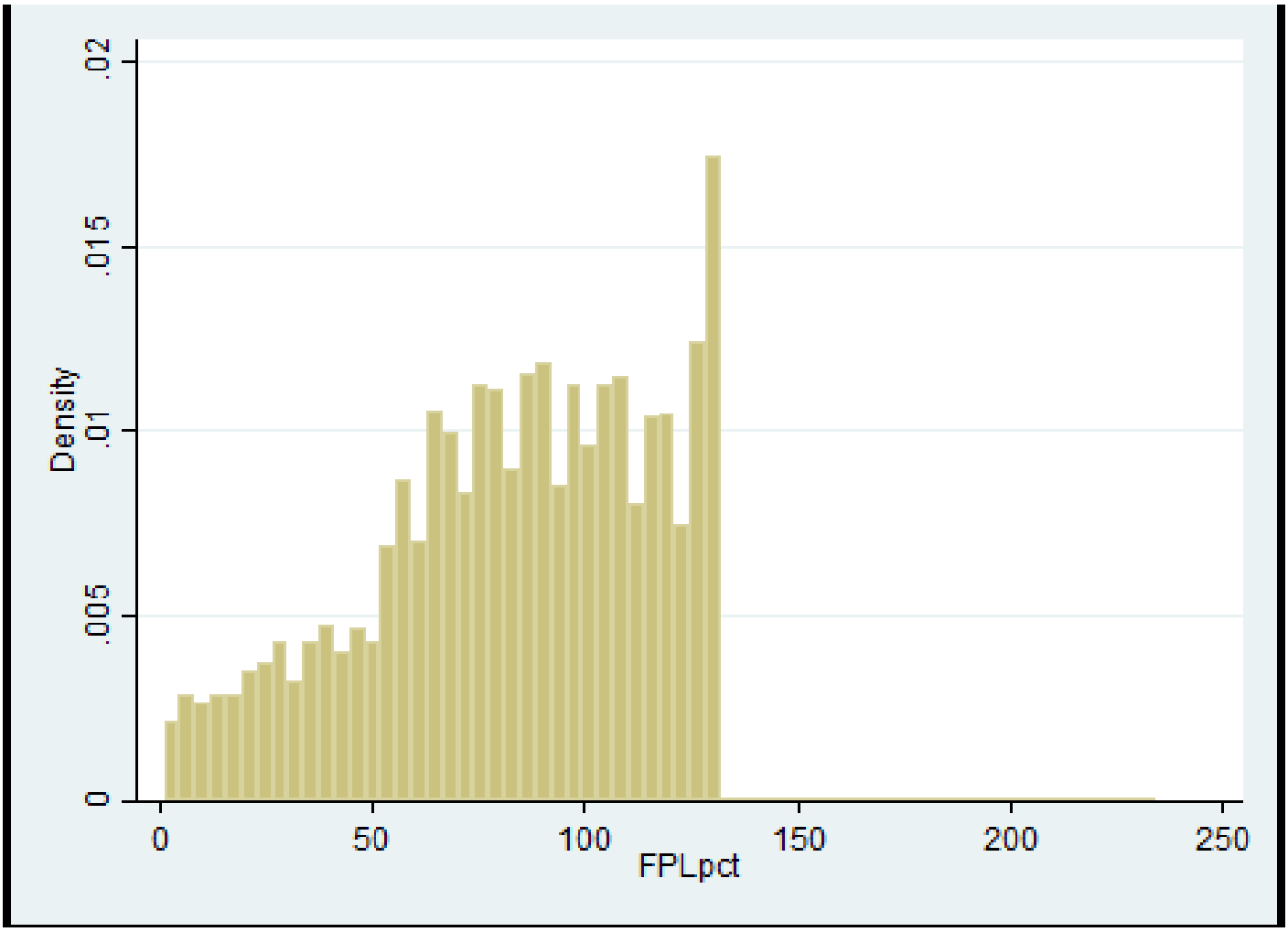


Figure 1.2 Percent Paid Over Time in 25+ Month Subset

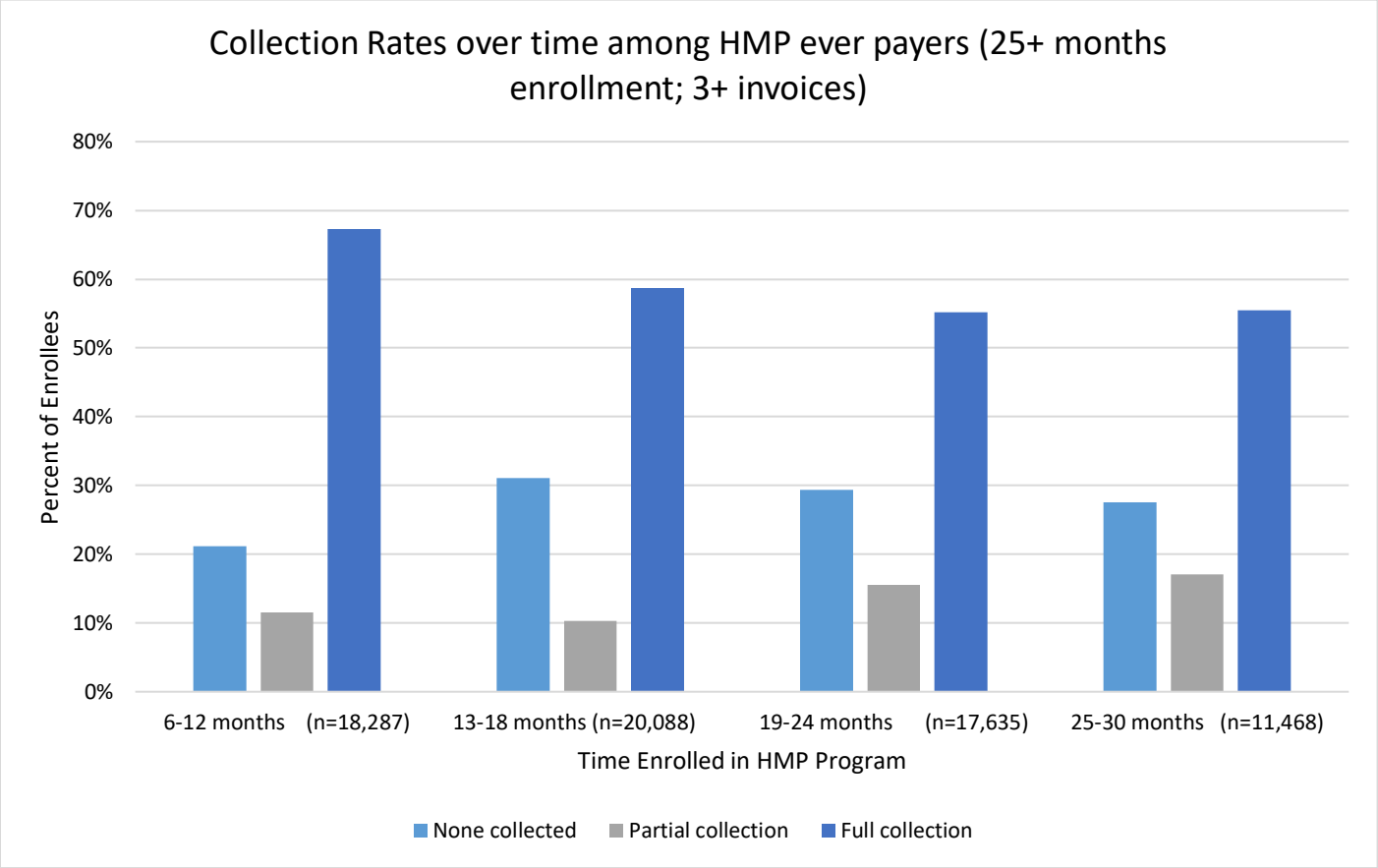
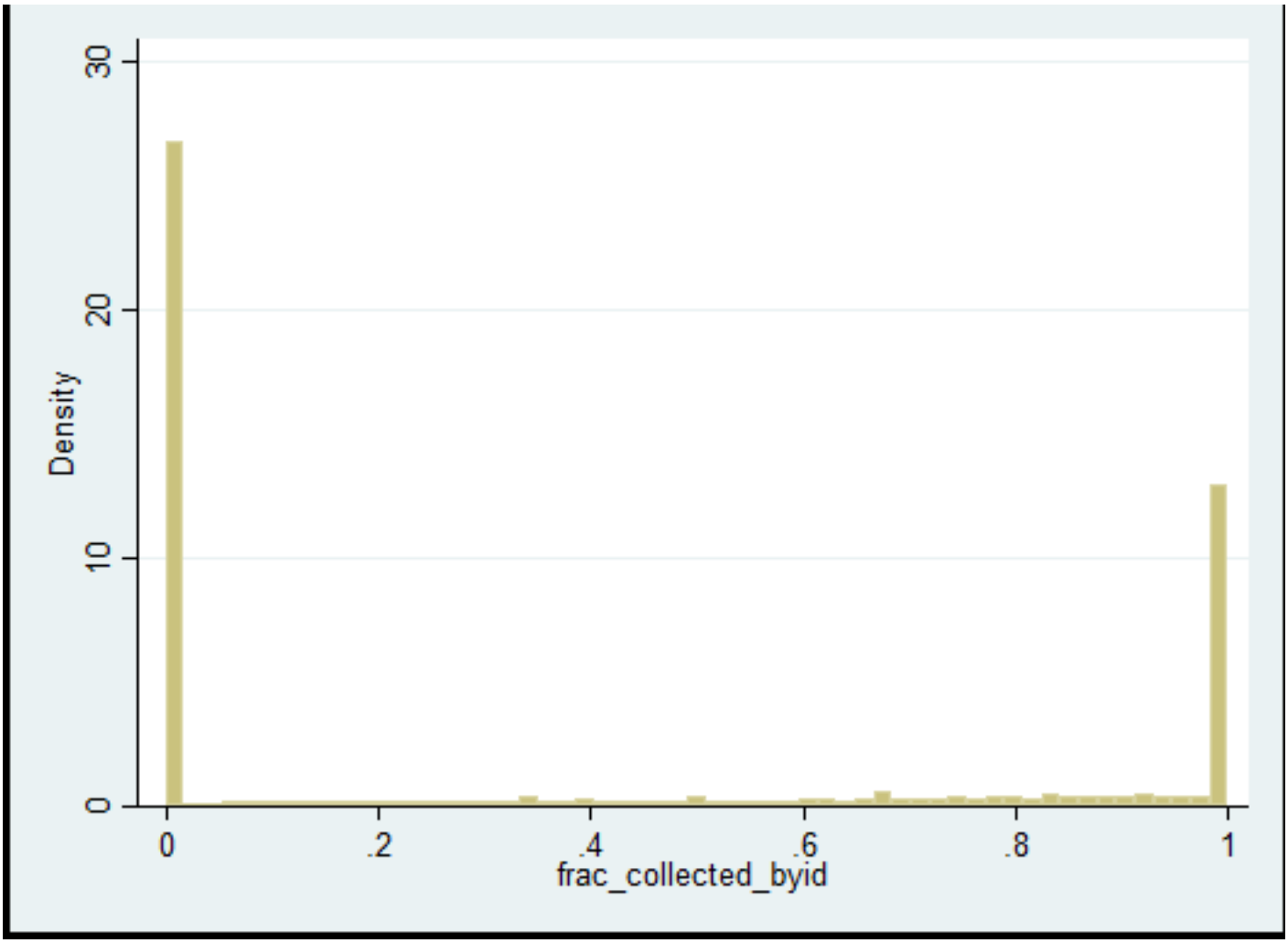


Figure 1.3 Payment Fraction Collected, Cross-Sectional Analysis



Note: In this graph the x-axis label, frac_collected_byid is the fraction of the invoice collected for each individual. This graph shows the density of collected fraction of invoices for HMP-MC individuals. The highest density (most individuals) have 0% of invoices collected, followed by 100% of invoice amounts collected. True fractions (between 0% and 100%) are more rare.

Hypothesis 1: Total Medical and Pharmaceutical Spending

Table 2.1 Cross-Sectional Descriptive Spending Results (April 2014 to Sept 2016)

	Overall	Mean FPL: 0-35 %	Mean FPL: 36-99 %	Mean FPL: 100+ %
Average monthly total spend	$ 360.04	$ 390.55	$ 313.32	$ 326.97
Average monthly medical spend	$ 238.44	$ 257.54	$ 209.66	$ 217.05
Average monthly Rx spend	$ 121.60	$ 133.01	$ 103.66	$ 109.92
Median monthly total spend	$ 135.63	$ 151.60	$ 122.07	$ 114.09
Median monthly medical spending	$ 90.61	$ 98.58	$ 83.53	$ 79.11
Median monthly Rx spending	$ 18.27	$ 21.72	$ 15.24	$ 14.42
Total enrollees	158,366	90,965	39,994	27,404

Table 2.2 Cross-Sectional Regression Analysis of Spending on Demographic Variables; Predicted Spending from GLM Regression

	Monthly total spending	*p-value on regression coefficient*	Monthly medical spending	*p-value on regression coefficient*	Monthly pharmaceutical spending	*p-value on regression coefficient*
Age						
Under 30	223.57		155.16		67.73	
30 to 39	295.32	< 0.01	191.45	< 0.01	103.06	< 0.01
40 to 49	408.62	< 0.01	262.88	< 0.01	145.99	< 0.01
Over 50	438.01	< 0.01	295.15	< 0.01	144.06	< 0.01
Gender						
Male	322.95		203.48		119.72	
Female	392.36	< 0.01	269.34	< 0.01	123.21	0.12
Race						
White	380.05		253.47		126.90	
Black	327.23	< 0.01	211.85	< 0.01	115.01	< 0.01
American Indian	560.96	0.11	417.77	0.11	141.91	0.20
Hispanic	342.06	0.01	219.04	< 0.01	122.37	0.67
Asian/Pacific Islander	247.71	< 0.01	159.12	< 0.01	89.17	0.02
Unknown	304.22	< 0.01	205.59	< 0.01	100.10	< 0.01
FPL						
0-35 %	396.05		263.67		133.18	
36-99 %	311.97	< 0.01	206.93	< 0.01	104.65	< 0.01
100+ %	314.44	< 0.01	206.24	< 0.01	107.48	< 0.01
Region						
Upper Peninsula	308.72	< 0.01	191.53	< 0.01	118.33	0.47
Northwest	322.63	< 0.01	206.43	< 0.01	116.93	0.38
Northeast	301.28	< 0.01	196.44	< 0.01	106.01	0.01
West	374.36	0.02	239.58	0.68	134.80	< 0.01
East Central	326.16	< 0.01	210.76	< 0.01	117.06	0.23
East	339.99	< 0.01	231.15	0.11	109.33	< 0.01
South Central	310.95	< 0.01	198.10	< 0.01	113.56	0.11
Southwest	356.18	0.53	236.96	0.87	120.44	0.60
Southeast	504.38	< 0.01	369.24	< 0.01	135.03	0.02
Detroit Metro	360.77		237.85		122.55	
Other health insurance						
No	353.50		234.52		119.38	
Yes	466.99	< 0.01	307.65	< 0.01	157.04	< 0.01
Total people	158,366					

Table 2.2a Coefficients from Other Regression Specifications of Spending

	Spending outcomes using ordinary least squares regression model (n=158,366)					Spending outcomes using generalized linear model -coefficients (n=158,366)					Marginal effects from generalized linear model- marginal effects (n=158,366)				
	Monthly spending	*p-value on regression coefficient*	Monthly medical spending	*p-value on regression coefficient*	Monthly pharmaceutical spending	*p-value on regression coefficient*	Monthly spending	*p-value on regression coefficient*	Monthly medical spending	*p-value on regression coefficient*	Monthly pharmaceutical spending	*p-value on regression coefficient*	Monthly spending	Monthly medical spending	Monthly pharmaceutical spending
Age															
Under 30	ref		ref		ref		ref		ref		ref		ref	ref	ref
30 to 39	74.69	< 0.01	38.55	< 0.01	36.15	< 0.01	0.28	< 0.01	0.21	< 0.01	0.42	< 0.01	71.75	36.29	35.34
40 to 49	186.84	< 0.01	106.98	< 0.01	79.86	< 0.01	0.60	< 0.01	0.53	< 0.01	0.77	< 0.01	185.06	107.72	78.27
Over 50	209.72	< 0.01	134.05	< 0.01	75.66	< 0.01	0.67	< 0.01	0.64	< 0.01	0.75	< 0.01	214.44	139.99	76.33
Gender															
Male	ref		ref		ref		ref		ref		ref		ref	ref	ref
Female	66.13	< 0.01	58.69	< 0.01	7.43	< 0.01	0.19	< 0.01	0.28	< 0.01	0.03	0.12	70.14	67.00	3.49
Race															
White	ref		ref		ref		ref		ref		ref		ref	ref	ref
Black	-56.53	< 0.01	-44.39	< 0.01	-12.14	< 0.01	-0.15	< 0.01	-0.18	< 0.01	-0.10	< 0.01	-52.82	-41.62	-11.88
American Indian	194.66	0.22	178.05	0.26	16.62	0.15	0.39	0.11	0.50	0.11	0.11	0.20	180.91	164.30	15.01
Hispanic	-45.70	< 0.01	-39.26	< 0.01	-6.43	0.44	-0.11	0.01	-0.15	< 0.01	-0.04	0.67	-37.99	-34.43	-4.52
Asian/Pacific Islander	-136.95	< 0.01	-101.52	< 0.01	-35.43	0.01	-0.43	< 0.01	-0.47	< 0.01	-0.35	0.02	-132.34	-94.35	-37.73
Unknown	-78.00	< 0.01	-51.96	< 0.01	-26.03	< 0.01	-0.22	< 0.01	-0.21	< 0.01	-0.24	< 0.01	-75.83	-47.88	-26.79
FPL															
0-35 %	ref		ref		ref		ref		ref		ref		ref	ref	ref
36-99 %	-84.46	< 0.01	-55.78	< 0.01	-28.68	< 0.01	-0.24	< 0.01	-0.24	< 0.01	-0.24	< 0.01	-84.08	-56.75	-28.54
100+ %	-75.01	< 0.01	-51.25	< 0.01	-23.76	< 0.01	-0.23	< 0.01	-0.25	< 0.01	-0.21	< 0.01	-81.61	-57.43	-25.70
Region															
Upper Peninsula	-59.65	< 0.01	-54.31	< 0.01	-5.34	0.34	-0.16	< 0.01	-0.22	< 0.01	-0.04	0.47	-52.05	-46.32	-4.22
Northwest	-42.57	< 0.01	-36.80	< 0.01	-5.77	0.37	-0.11	< 0.01	-0.14	< 0.01	-0.05	0.38	-38.14	-31.42	-5.63
Northeast	-60.02	< 0.01	-45.43	< 0.01	-14.59	0.01	-0.18	< 0.01	-0.19	< 0.01	-0.15	0.01	-59.49	-41.41	-16.54
West	16.22	0.01	0.98	0.82	15.24	< 0.01	0.04	0.02	0.01	0.68	0.10	< 0.01	13.59	1.73	12.25
East Central	-34.51	< 0.01	-28.41	< 0.01	-6.10	0.14	-0.10	< 0.01	-0.12	< 0.01	-0.05	0.23	-34.60	-27.09	-5.49
East	-21.56	< 0.01	-9.39	0.03	-12.17	< 0.01	-0.06	< 0.01	-0.03	0.11	-0.11	< 0.01	-20.78	-6.70	-13.23
South Central	-46.82	< 0.01	-40.92	< 0.01	-5.90	0.27	-0.15	< 0.01	-0.18	< 0.01	-0.08	0.11	-49.81	-39.76	-8.99
Southwest	-2.75	0.70	-1.93	0.73	-0.82	0.83	-0.01	0.53	< 0.01	0.87	-0.02	0.60	-4.59	-0.89	-2.12
Southeast	143.36	< 0.01	134.48	< 0.01	8.88	0.05	0.34	< 0.01	0.44	< 0.01	0.10	0.02	143.61	131.39	12.48
Detroit Metro	ref		ref		ref		ref		ref		ref		ref	ref	
Other health insurance															
No	ref		ref		ref		ref		ref		ref		ref	ref	ref
Yes	126.62	< 0.01	84.35	< 0.01	42.27	< 0.01	0.28	< 0.01	0.27	< 0.01	0.27	< 0.01	100.31	64.84	33.34

Table 2.3 Descriptive Spending by Year, with Poverty Level Splits

	Average per month total spending	Average per month medical spending	Average per month pharmaceutical spending	Enrollee/months
Overall				
Year 1	340.72	240.21	100.52	1,900,428
Year 2	377.87	235.12	142.75	1,597,191
Year 3	447.70	254.63	193.07	239,782
FPL 0-35 %				
Year 1	365.72	255.81	109.91	1,110,806
Year 2	423.89	264.39	159.50	949,918
Year 3	496.01	282.64	213.37	155,770
FPL 33-99 %				
Year 1	292.36	207.47	84.88	473,081
Year 2	311.12	195.38	115.73	392,257
Year 3	367.83	211.90	155.93	53,652
FPL 100+ %				
Year 1	325.31	234.40	90.91	316,505
Year 2	309.16	187.19	121.97	254,980
Year 3	341.12	186.49	154.63	30,342

Table 2.3a Descriptive Spending by 6-month Period

	Mean spending	Mean medical spending	Mean Pharmaceutical spending	Enrollee/months
Time period of enrollment				
All enrollees				
0-6 months	317.76	229.67	88.09	950,214
7-12 months	363.69	250.74	112.95	950,214
13-18 months	365.05	233.00	132.04	950,214
19-24 months	396.71	238.23	158.48	646,977
25-30 months	447.70	254.63	193.07	239,782
Enrollees with FPL 0-35 %				
0-6 months	340.99	244.61	96.38	554,530
7-12 months	390.37	266.96	123.40	556,276
13-18 months	409.03	262.19	146.83	560,021
19-24 months	445.23	267.55	177.68	389,897
25-30 months	496.01	282.64	213.37	155,770
Enrollees with FPL 36-99 %				
0-6 months	269.90	195.05	74.85	237,068
7-12 months	314.91	219.95	94.96	236,013
13-18 months	299.92	190.85	109.07	234,732
19-24 months	327.80	202.14	125.66	157,525
25-30 months	367.83	211.90	155.93	53,652
Enrollees with FPL 100+ %				
1-6 months	308.06	229.19	78.87	158,598
7-12 months	342.63	239.63	103.00	157,907
13-18 months	304.96	191.48	113.47	155,443
19-24 months	315.73	180.49	135.24	99,537
25-30 months	341.12	186.49	154.63	30,342

Table 2.4 Spending, including by Time Enrolled in Program, Predicted Effects from GLM Regression

	Predicted average monthly spending	*p-value on regression coefficient*	Predicted average monthly medical spending	*p-value on regression coefficient*	Predicted average monthly pharmaceutical spending	*p-value on regression coefficient*
Time period						
Months 0 -6	320.82		231.44		89.49	
Months 7-12	363.48	< 0.01	248.50	0.011	114.54	< 0.01
Months 13-18	368.30	< 0.01	236.60	0.248	132.23	< 0.01
Months 19-24	391.33	< 0.01	240.44	0.067	151.07	< 0.01
Months 25-30	422.98	< 0.01	243.24	0.028	179.46	< 0.01
FPL						
0-35 %	404.26		266.10		139.11	
36-99 %	309.40	0.922	202.32	0.220	106.69	< 0.01
100+ %	317.37	0.853	202.92	0.226	112.07	< 0.01
Age						
Under 30	229.18		156.85		71.67	
30 to 39	301.72	< 0.01	192.40	< 0.01	108.74	< 0.01
40 to 49	412.10	< 0.01	260.85	< 0.01	151.60	< 0.01
Over 50	440.08	< 0.01	293.48	< 0.01	147.05	< 0.01
Gender						
Male	329.41		204.24		125.09	
Female	398.24	< 0.01	270.09	< 0.01	128.37	0.020
Race						
White	385.81		253.10		132.48	
Black	331.91	< 0.01	213.45	< 0.01	119.12	< 0.01
American Indian	607.33	0.116	457.21	0.110	146.75	0.033
Hispanic	348.16	< 0.01	219.44	< 0.01	127.42	0.464
Asian/Pacific Islander	250.29	< 0.01	158.31	< 0.01	90.65	< 0.01
Unknown	312.98	< 0.01	208.55	< 0.01	105.74	< 0.01
Region						
Upper Peninsula	312.51	< 0.01	191.02	< 0.01	121.45	0.077
Northwest	331.41	< 0.01	208.94	< 0.01	122.57	0.159
Northeast	309.87	< 0.01	199.40	< 0.01	111.05	< 0.01
West	381.81	< 0.01	242.19	0.216	140.84	< 0.01
East Central	333.21	< 0.01	213.23	< 0.01	121.09	0.016
East	347.13	< 0.01	233.59	0.156	112.90	< 0.01
South Central	317.60	< 0.01	200.83	< 0.01	118.72	0.016
Southwest	362.11	0.510	239.00	0.864	124.78	0.119
Southeast	512.25	< 0.01	362.87	< 0.01	141.29	< 0.01
Detroit Metro	366.02		238.06		128.54	
Other health insurance						
No	365.08		238.88		126.28	
Yes	407.47	0.016	262.46	0.045	144.32	< 0.01
Total observations (Enrollee/periods)	681,712		681,712		681,712	

Table 2.4a Predicted Spending with FPL/Time Interactions and Demographics, Predicted Effects from GLM Regressions

	Total monthly spending	*p-value on regression coefficient*	Medical monthly spending	*p-value on regression coefficient*	Monthly pharmaceutical spending	*p-value on regression coefficient*
Time period and Federal poverty level						
0-6 Months: Below 35%	343.38		247.03		97.15	
0-6 Months: 36-99% FPL	271.79	< 0.01	194.88	< 0.01	76.79	< 0.01
0-6 Months: Above 100% FPL	305.12	0.114	222.59	0.233	79.68	< 0.01
7-12 Months: Below 35% FPL	388.46	< 0.01	264.99	0.013	123.75	< 0.01
7-12 Months: 36-99% FPL	320.22	0.358	219.75	0.360	98.22	0.909
7-12 Months: Above 100% FPL	329.18	0.613	224.76	0.603	103.71	0.586
13-18 Months: Below 35% FPL	413.06	< 0.01	268.29	< 0.01	145.55	< 0.01
13-18 Months: 36-99% FPL	307.08	0.022	195.35	0.014	111.69	0.447
13-18 Months: Above 100% FPL	306.32	0.020	191.42	0.010	114.88	0.346
19-24 Months: Below 35% FPL	445.17	< 0.01	277.76	< 0.01	168.04	< 0.01
19-24 Months: 36-99% FPL	321.46	0.011	199.08	0.018	122.41	0.033
19-24 Months: Above 100% FPL	314.41	< 0.015	179.01	< 0.01	134.41	0.648
25- 30 Months: Below 35% FPL	483.89	< 0.01	281.84	< 0.01	201.49	< 0.01
25- 30 Months: 36-99% FPL	348.52	0.010	201.87	0.031	147.28	0.141
25- 30 Months: Above 100% FPL	321.69	< 0.011	171.87	< 0.01	148.99	0.144
Age						
Under 30	228.85		156.48		71.70	
30 to 39	301.95	< 0.01	192.64	< 0.01	108.77	< 0.01
40 to 49	412.24	< 0.01	260.85	< 0.01	151.65	< 0.01
Over 50	440.07	< 0.01	293.29	< 0.01	147.13	< 0.01
Gender						
Male	329.50		204.11		125.14	
Female	398.30	< 0.01	270.08	< 0.01	128.43	0.019
Race						
White	253.07	< 0.01			132.53	0.011
Black	213.39	< 0.01		< 0.01	119.22	< 0.01
American Indian	451.02	0.113		0.107	146.87	0.033
Hispanic	219.39	< 0.01		< 0.01	127.42	0.457

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Asian/Pacific Islander	158.57	< 0.01		< 0.01	90.64	< 0.01
Unknown	208.65	< 0.01		< 0.01	105.77	< 0.01
Region						
Upper Peninsula	313.28	< 0.01	191.31	< 0.01	121.54	0.077
Northwest	331.42	< 0.01	209.31	< 0.01	122.52	0.148
Northeast	310.89	< 0.01	199.81	< 0.01	111.36	< 0.01
West	381.84	< 0.01	242.18	0.243	140.89	< 0.01
East Central	333.65	< 0.01	213.44	< 0.01	121.23	0.017
East	347.15	< 0.01	233.77	0.149	112.89	< 0.01
South Central	317.82	< 0.01	200.86	< 0.01	118.84	0.016
Southwest	362.21	0.483	238.81	0.924	124.87	0.122
Southeast	509.60	< 0.01	359.71	< 0.01	141.28	< 0.01
Detroit Metro	366.33	< 0.01	238.30		128.59	< 0.01
Other health insurance						
No	365.21		238.86		126.35	
Yes	405.21	0.018	260.90	0.057	143.96	< 0.01
Total observations (Enrollee/months)	681,697		681,697		681,697	

Table 2.4b Subset of HMP Enrollees with Cost Sharing Obligations: Predicted Spending with FPL and Time Interactions, Demographics and Collection Rates

	Total monthly spending	*p-value on regression coefficient*	Monthly medical spending	*p-value on regression coefficient*	Monthly pharmaceutical spending	*p-value on regression coefficient*
Collection category						
None collected	349.67		236.54		112.97	
Partial collection	364.43	0.027	231.56	0.328	134.88	< 0.01
Full collection	331.41	0.049	216.47	0.018	113.59	0.805
Time period						
Months 0-6	312.51		228.37		84.24	
Months 7-12	348.10	0.013	239.63	0.283	108.45	< 0.01
Months 13-18	351.82	< 0.01	227.85	0.941	124.46	< 0.01
Months 19-24	366.72	< 0.01	224.46	0.577	142.20	< 0.01
Months 25-30	396.78	< 0.01	226.71	0.823	169.65	< 0.01
FPL						
0-35 %	397.67		264.57		135.18	
36-99 %	325.68	< 0.01	214.60	< 0.01	111.36	< 0.01
100+ %	320.55	< 0.01	206.88	< 0.01	110.99	< 0.01
Age						
Under 30	228.21		158.74		66.59	
30 to 39	269.51	< 0.01	174.28	0.035	95.75	< 0.01
40 to 49	370.39	< 0.01	232.90	< 0.01	138.58	< 0.01
Over 50	444.03	< 0.01	298.45	< 0.01	146.12	< 0.01
Gender						
Male	322.01		196.65		125.64	
Female	364.36	< 0.01	248.11	< 0.01	116.31	< 0.01
Race						
White	360.75		239.80		120.74	
Black	329.72	< 0.01	208.47	< 0.01	122.29	0.576
American Indian	388.03	0.244	244.67	0.780	151.39	0.013
Hispanic	328.66	0.034	204.43	< 0.01	120.43	0.976
Asian/Pacific Islander	263.67	< 0.01	158.77	< 0.01	103.24	0.214
Unknown	303.29	< 0.01	205.07	< 0.01	101.53	< 0.01
Region						
Upper Peninsula	319.69	0.011	195.44	< 0.01	124.51	0.440
Northwest	321.87	0.019	208.36	0.014	113.23	0.184
Northeast	287.57	< 0.01	184.79	< 0.01	102.34	< 0.01
West	366.28	0.011	236.42	0.029	131.96	< 0.01
East Central	320.80	< 0.01	206.22	< 0.01	117.21	0.349
East	325.18	< 0.01	223.73	0.429	101.40	< 0.01
South Central	299.84	< 0.01	191.76	< 0.01	110.33	0.010
Southwest	350.17	0.649	228.70	0.748	123.09	0.440
Southeast	497.87	0.011	350.79	0.011	137.49	< 0.01
Detroit Metro	347.16		226.96		120.54	
Other health insurance						
No	348.84		229.74		119.12	
Yes	362.66	0.107	233.05	0.643	131.40	0.013
Total observations (Enrollee/periods)	340,254		340,254		340,254	

Table 2.5 Marginal Effects from a Fixed Effect Regression Model of Spending and Log of Spending

	Marginal difference in total monthly spending, compared to constant	***p-value on regression coefficient***	**Marginal effects of log of total monthly spending**	***p-value on regression coefficient***
Time period				
0-6 Months	ref		ref	
7-12 Months	45.91	< 0.01	-0.06	< 0.01
13-18 Months	48.47	< 0.01	-0.01	0.315
19-24 Months	74.11	< 0.01	-0.22	< 0.01
25-30 Months	110.09	< 0.01	-0.28	< 0.01
FPL				
0-35 %	ref		ref	
36-99 %	97.97	0.256	-0.02	0.566
100+ %	96.38	0.545	-0.04	0.194
Other health insurance				
No	ref		ref	
Yes	-71.26	0.479	-0.38	< 0.01
Constant	280.46		4.26	
Number enrollees	158,366		158,366	

Notes: The log of healthcare expenditures are often used in research rather than the actual dollar amounts because many people spend very little each month and a few people spend quite a bit. That spread of spending, particularly when a few numbers are much higher than most, has been shown difficult to model mathematically. Instead, using the log of the number, results in more accurate predictions. In this case, the log spending was taken by adding $1 to each spending outcome because the log of $0 is undefined.

Hypothesis 2: Medicaid Service Value – Medical Services

Table 3.1.1 Predicted Copay Exempt and Copay Likely Service Use from Probit Regression Model on Cross-Section of Enrollees; Predictions Signal Percent that ever used service during study period

	Copay exempt predicted use	*p-value on regression coefficient*	Copay likely predicted use	*p-value on regression coefficient*
FPL				
0-35 %	81.2%	ref	56.8%	ref
36-99 %	81.9%	0.01	55.8%	< 0.01
100+ %	81.7%	0.07	55.5%	< 0.01
Age				
Under 30	73.4%	ref	46.4%	ref
30 to 39	76.4%	< 0.01	52.4%	< 0.01
40 to 49	83.7%	< 0.01	59.8%	< 0.01
Over 50	87.3%	< 0.01	61.7%	< 0.01
Gender				
Male	73.3%	ref	50.7%	ref
Female	88.4%	< 0.01	61.1%	< 0.01
Race				
White	82.1%	ref	58.8%	ref
Black	79.8%	< 0.01	51.0%	< 0.01
American Indian	85.0%	0.02	37.1%	< 0.01
Hispanic	81.2%	0.10	55.9%	< 0.01
Asian/Pacific Islander	83.6%	0.25	55.4%	0.05
Unknown	81.1%	0.01	53.9%	< 0.01
Region				
Upper Peninsula	73.9%	< 0.01	54.5%	
Northwest	81.0%	< 0.01	52.7%	0.08
Northeast	79.7%	< 0.01	54.2%	0.79
West	80.8%	< 0.01	57.8%	< 0.01
East Central	81.0%	< 0.01	52.4%	0.01
East	83.1%	0.64	55.4%	0.20
South Central	78.2%	< 0.01	55.4%	0.32
Southwest	78.3%	< 0.01	49.3%	< 0.01
Southeast	79.2%	< 0.01	57.5%	< 0.01
Detroit Metro	83.2%	ref	58.4%	ref
Other health insurance				
No	81.5%	ref	56.5%	ref
Yes	81.4%	0.79	53.8%	< 0.01
Total enrollees	158,322		158,322	

Table 3.1.2 Predicted Copay Exempt and Copay Likely Service Use from Probit Regression Model on Repeated Cross-Sections of Enrollees; Predictions Signal Percent that ever used service in a time period since enrollment

	Copay exempt service use	*p-value on regression coefficient*	Copay likely service use	*p-value on regression coefficient*
Time period				
Months 0-6	56.6%		28.7%	
Months 7-12	43.5%	< 0.01	24.4%	< 0.01
Months 13-18	46.3%	< 0.01	22.8%	< 0.01
Months 19-24	36.0%	< 0.01	17.1%	< 0.01
Months 25-30	33.2%	< 0.01	16.7%	< 0.01
FPL				
0-35 %	44.8%		23.0%	
36-99 %	44.6%	0.11	22.5%	< 0.01
100+ %	44.3%	< 0.01	22.5%	< 0.01
Age				
Under 30	34.8%		17.3%	
30 to 39	37.5%	< 0.01	20.5%	< 0.01
40 to 49	46.8%	< 0.01	24.7%	< 0.01
Over 50	52.5%	< 0.01	25.5%	< 0.01
Gender				
Male	47.9%		19.4%	
Female	64.2%	< 0.01	25.6%	< 0.01
Race				
White	44.9%		24.1%	
Black	43.9%	< 0.01	20.0%	< 0.01
American Indian	46.9%	0.01	12.8%	< 0.01
Hispanic	45.6%	0.04	22.3%	< 0.01
Asian/Pacific Islander	46.7%	0.02	21.0%	< 0.01
Unknown	44.3%	< 0.01	21.1%	< 0.01
Region				
Upper Peninsula	37.6%	< 0.01	20.9%	< 0.01
Northwest	43.3%	< 0.01	22.0%	< 0.01
Northeast	42.1%	< 0.01	21.7%	< 0.01
West	44.1%	< 0.01	25.1%	< 0.01
East Central	44.1%	< 0.01	19.4%	< 0.01
East	46.4%	0.29	21.2%	< 0.01
South Central	41.1%	< 0.01	21.6%	< 0.01
Southwest	41.6%	< 0.01	18.9%	< 0.01
Southeast	42.3%	< 0.01	23.6%	< 0.01
Detroit Metro	46.6%		24.0%	< 0.01
Other health insurance				0.07
No	44.8%		22.9%	
Yes	39.9%	< 0.01	16.9%	< 0.01
Total observations (Enrollee/periods)	681,530		681,530	

Table 3.1.2a Predicted Copay Exempt and Copay Likely Service Use from Probit Regression Model on Repeated Cross-Sections of Enrollees; With Interactions for Time Period and Above/Below 100% FPL

	Copay exempt service use	*p-value on regression coefficient*	Copay likely service use	*p-value on regression coefficient*
Time period and Federal poverty level				
Months 0-6: Below 100% FPL	56.5%		28.9%	
Months 0-6: Above 100% FPL	57.0%	0.152	27.1%	< 0.01
Months 7-12: Below 100% FPL	43.4%	< 0.01	24.4%	< 0.01
Months 7-12: Above 100% FPL	43.2%	0.145	23.8%	0.026
Months 13-18: Below 100% FPL	46.2%	< 0.01	22.7%	< 0.01
Months 13-18: Above 100% FPL	46.3%	0.493	22.8%	< 0.01
Months 19-24: Below 100% FPL	36.3%	< 0.01	17.1%	< 0.01
Months 19-24: Above 100% FPL	33.9%	< 0.01	17.1%	< 0.01
Months 25-30: Below 100% FPL	33.9%	< 0.01	16.9%	< 0.01
Months 25-30: Above 100% FPL	29.3%	< 0.01	15.3%	0.516
Age				
Under 30	34.8%		17.3%	
30 to 39	37.5%	< 0.01	20.5%	< 0.01
40 to 49	46.7%	< 0.01	24.7%	< 0.01
Over 50	52.4%	< 0.01	25.4%	< 0.01
Gender				
Male	36.4%		19.4%	
Female	51.4%	< 0.01	25.5%	< 0.01
Race				
White	44.8%		24.1%	
Black	43.9%	< 0.01	19.9%	< 0.01
American Indian	46.7%	0.017	12.9%	< 0.01
Hispanic	45.5%	0.076	22.1%	< 0.01
Asian/Pacific Islander	46.7%	0.022	21.3%	< 0.01
Unknown	44.3%	0.017	21.1%	< 0.01
Region				
Upper Peninsula	37.5%	< 0.01	20.9%	< 0.01
Northwest	43.3%	< 0.01	21.9%	< 0.01
Northeast	42.0%	< 0.01	21.6%	< 0.01
West	44.0%	< 0.01	25.1%	< 0.01
East Central	44.0%	< 0.01	19.4%	< 0.01
East	46.3%	0.334	21.2%	< 0.01
South Central	41.0%	< 0.01	21.5%	< 0.01
Southwest	41.4%	< 0.01	18.8%	< 0.01
Southeast	42.3%	< 0.01	23.6%	0.072
Detroit Metro	46.5%		24.0%	

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Other health insurance				
No	44.7%		22.9%	
Yes	39.9%	< 0.01	16.9%	< 0.01
Total observations (Enrollee/periods)	669,398		669,398	

Note: The N here is slightly less than above because this regression excludes those who switch between < 100% FPL and > 100% FPL.

Table 3.1.2b Predicted Average Monthly Spending on Copay Exempt/ Copay Likely Services from Generalized Linear Model Regression

	Copay exempt medications	*p-value on regression coefficient*	Copay likely service spending	*p-value on regression coefficient*
Time period				
Months 0-6	30.54		10.03	
Months 7-12	22.85	*< 0.01*	9.03	*< 0.01*
Months 13-18	24.82	*< 0.01*	8.47	*< 0.01*
Months 19-24	22.75	*< 0.01*	6.66	*< 0.01*
Months 25-30	23.06	*< 0.01*	7.55	*< 0.01*
FPL				
0-35 %	25.87	*< 0.01*	8.92	*< 0.01*
36-99 %	23.96	*< 0.01*	7.98	*< 0.01*
100+ %	23.99	*< 0.01*	7.80	*< 0.01*
Age				
Under 30	17.15		5.47	
30 to 39	18.51	*< 0.01*	6.85	*< 0.01*
40 to 49	26.16	*< 0.01*	9.56	*< 0.01*
Over 50	32.31	*< 0.01*	10.25	*< 0.01*
Gender				
Male	17.74	*0.168*	7.17	*< 0.01*
Female	31.32	*< 0.01*	9.61	*< 0.01*
Race				
White	24.44	*0.121*	9.27	*< 0.01*
Black	26.67	*< 0.01*	7.02	*< 0.01*
American Indian	25.45	*0.458*	3.73	*< 0.01*
Hispanic	28.36	*< 0.01*	7.44	*< 0.01*
Asian/Pacific Islander	23.69	*0.548*	11.36	*0.576*
Unknown	23.90	*0.146*	7.53	*< 0.01*
Region				
Upper Peninsula	15.45	*< 0.01*	6.47	
Northwest	21.64	*< 0.01*	7.78	*0.040*
Northeast	21.31	*< 0.01*	6.47	*0.990*
West	23.47	*< 0.01*	10.10	*< 0.01*
East Central	19.85	*< 0.01*	5.63	*0.054*
East	24.89	*< 0.01*	7.50	*0.047*
South Central	21.89	*< 0.01*	8.79	*0.141*
Southwest	22.53	*< 0.01*	7.58	*0.062*
Southeast	22.57	*< 0.01*	9.90	*< 0.01*
Detroit Metro	28.86		9.12	*0.234*
Other health insurance				
No	25.17		8.57	
Yes	22.37	*< 0.01*	6.09	*< 0.01*
Total Enrollee/periods	681,530		681,530	

Table 3.1.2c Predicted Copay Exempt and Copay Likely Service Use from Probit Regression Model on Repeated Cross-Sections of Enrollees; With Interactions for Time Period and FPL Category

	Copay exempt service use	*p-value on regression coefficient*	Copay likely service use	*p-value on regression coefficient*
Time Period and Federal poverty level				
Months 0-6: Below 35% FPL	56.4%		29.5%	
Months 0-6: 36-99% FPL	56.7%	0.394	27.5%	< 0.01
Months 0-6: Above 100% FPL	57.3%	0.012	27.7%	< 0.01
Months 7-12: Below 35% FPL	43.4%	< 0.01	24.6%	< 0.01
Months 7-12: 36-99% FPL	43.4%	0.616	24.1%	< 0.01
Months 7-12: Above 100% FPL	43.7%	0.264	24.2%	< 0.01
Months 13-18: Below 35% FPL	46.0%	< 0.01	22.6%	< 0.01
Months 13-18: Above 36-99% FPL	46.6%	0.393	22.9%	< 0.01
Months 13-18: Above 100% FPL	46.6%	0.579	23.0%	< 0.01
Months 19-24: Below 35% FPL	36.6%	< 0.01	16.9%	< 0.01
Months 19-24: 36-99% FPL	35.9%	0.026	17.4%	< 0.01
Months 19-24: Above 100% FPL	34.4%	< 0.01	17.3%	< 0.01
Months 25-30: Below 35% FPL	34.7%	< 0.01	17.0%	< 0.01
Months 25-30: 36-99% FPL	31.7%	< 0.01	16.6%	< 0.01
Months 25-30: Above 100% FPL	29.4%	< 0.01	15.4%	0.510
Age				
Under 30	34.8%		17.3%	
30 to 39	37.5%	< 0.01	20.5%	< 0.01
40 to 49	46.8%	< 0.01	24.7%	< 0.01
Over 50	52.5%	< 0.01	25.5%	< 0.01
Gender				
Male	36.5%		19.4%	
Female	51.5%	< 0.01	25.6%	< 0.01
Race				
White	44.9%		24.1%	
Black	43.9%	< 0.01	20.0%	< 0.01
American Indian	46.9%	0.013	12.8%	< 0.01
Hispanic	45.6%	0.039	22.3%	< 0.01
Asian/Pacific Islander	46.7%	0.022	21.0%	< 0.01
Unknown	44.3%	0.016	21.1%	< 0.01
Region				
Upper Peninsula	37.6%	< 0.01	20.9%	< 0.01
Northwest	43.3%	< 0.01	22.0%	< 0.01
Northeast	42.1%	< 0.01	21.7%	< 0.01
West	44.1%	< 0.01	25.1%	< 0.01
East Central	44.1%	< 0.01	19.4%	< 0.01
East	46.4%	0.303	21.2%	< 0.01
South Central	41.1%	< 0.01	21.6%	< 0.01

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Southwest	41.6%	< 0.01	18.9%	< 0.01
Southeast	42.3%	< 0.01	23.6%	0.070
Detroit Metro	46.6%		24.0%	
Other health insurance				
No	44.8%		22.9%	
Yes	39.9%	< 0.01	16.9%	< 0.01
Total observations (Enrollee/periods)	681,530		681,530	

Table 3.1.3 Subset with Cost-Sharing Obligation: Predicted Copay Exempt and Copay Likely Service Use from Probit Regression Model on Repeated Cross-Sections of Enrollees

	Copay exempt service use	*p-value on regression coefficient*	Copay likely service use	*p-value on regression coefficient*
Collection category*				
None collected	43.8%		22.2%	
Partial collection	50.2%	< 0.001	27.1%	< 0.001
Full collection	52.2%	< 0.001	26.3%	< 0.001
Time period				
Months 0-6	60.5%		30.7%	
Months 7-12	46.5%	< 0.001	26.7%	< 0.001
Months 13-18	50.1%	< 0.001	25.0%	< 0.001
Months 19-24	38.2%	< 0.001	18.4%	< 0.001
Months 25-30	33.3%	< 0.001	17.1%	< 0.001
FPL				
0-35 %	49.2%		25.4%	
36-99 %	47.9%	< 0.001	25.1%	0.071
100+ %	45.5%	< 0.001	23.0%	< 0.001
Age				
Under 30	39.3%		20.1%	
30 to 39	40.4%	< 0.001	22.5%	< 0.001
40 to 49	49.3%	< 0.001	26.2%	< 0.001
Over 50	55.7%	< 0.001	27.3%	< 0.001
Gender				
Male	39.1%		21.3%	
Female	52.2%	< 0.001	26.4%	< 0.001
Race				
White	46.7%		25.4%	
Black	50.7%	< 0.001	22.6%	< 0.001
American Indian	51.7%	< 0.001	16.1%	< 0.001
Hispanic	48.8%	< 0.001	23.6%	< 0.001
Asian/Pacific Islander	50.7%	< 0.001	22.7%	0.004
Unknown	47.7%	0.001	22.9%	< 0.001
Region				
Upper Peninsula	40.1%	< 0.001	22.8%	< 0.001
Northwest	45.7%	< 0.001	24.5%	0.001
Northeast	44.3%	< 0.001	22.7%	< 0.001
West	46.7%	< 0.001	27.6%	< 0.001
East Central	46.8%	< 0.001	21.4%	< 0.001
East	48.8%	< 0.001	22.6%	< 0.001
South Central	44.6%	< 0.001	23.6%	< 0.001
Southwest	45.3%	< 0.001	21.2%	< 0.001

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Southeast	45.2%	< 0.001	25.7%	0.460
Detroit Metro	50.6%		25.9%	
Other health insurance				
No	47.9%		24.9%	
Yes	41.7%	< 0.001	18.1%	< 0.001
Total observations (Enrollee/periods)	347,172		347,172	

*Collection category based on aggregate collection over life in program through Q3 2016. Full collection = > 95% of invoice collected

Table 3.1.3a Subset with Cost-Sharing Obligation: Predicted Copay Exempt and Copay Likely Service Use from Probit Regression Model on Repeated Cross-Sections of Enrollees with Interaction of Above/Below 100% FPL and Time Period

	Copay exempt service use	*p-value on regression coefficient*	Copay likely service use	*p-value on regression coefficient*
Collection category				
None collected	43.7%		22.2%	
Partial collection	50.1%	*< 0.001*	27.1%	*< 0.001*
Full collection	52.2%	*< 0.001*	26.3%	*< 0.001*
Time period and Federal poverty level				
Months 0-6: Below 100% FPL	61.2%		31.6%	
Months 0-6: Above 100% FPL	58.5%	*< 0.001*	28.0%	*< 0.001*
Months 7-12: Below 100% FPL	47.2%	*< 0.001*	27.4%	*< 0.001*
Months 7-12: Above 100% FPL	44.2%	*0.757*	24.5%	*0.425*
Months 13-18: Below 100% FPL	50.8%	*< 0.001*	25.7%	*< 0.001*
Months 13-18: Above 100% FPL	47.7%	*0.500*	23.3%	*0.055*
Months 19-24: Below 100% FPL	39.3%	*< 0.001*	18.8%	*< 0.001*
Months 19-24: Above 100% FPL	35.1%	*0.004*	17.5%	*0.001*
Months 25-30: Below 100% FPL	34.6%	*< 0.001*	17.7%	*< 0.001*
Months 25-30: Above 100% FPL	29.8%	*0.001*	15.5%	*0.580*
Age				
Under 30	39.4%	*< 0.001*	20.1%	*< 0.001*
30 to 39	40.4%	*< 0.001*	22.5%	*< 0.001*
40 to 49	49.3%	*< 0.001*	26.2%	*< 0.001*
Over 50	55.6%	*< 0.001*	27.2%	*< 0.001*
Gender				
Male	39.0%		21.3%	
Female	52.2%	*< 0.001*	26.4%	*< 0.001*
Race				
White	46.6%	*0.004*	25.4%	*< 0.001*
Black	50.7%	*< 0.001*	22.5%	*< 0.001*
American Indian	51.6%	*< 0.001*	16.4%	*< 0.001*
Hispanic	48.6%	*< 0.001*	23.5%	*< 0.001*
Asian/Pacific Islander	50.9%	*< 0.001*	23.2%	*0.022*
Unknown	47.8%	*< 0.001*	22.9%	*< 0.001*
Region				
Upper Peninsula	40.0%	*< 0.001*	22.7%	*< 0.001*
Northwest	45.6%	*< 0.001*	24.6%	*0.002*
Northeast	44.1%	*< 0.001*	22.6%	*< 0.001*
West	46.7%	*< 0.001*	27.6%	*< 0.001*
East Central	46.7%	*< 0.001*	21.4%	*< 0.001*
East	48.8%	*< 0.001*	22.6%	*< 0.001*
South Central	44.6%	*< 0.001*	23.5%	*< 0.001*
Southwest	45.2%	*< 0.001*	21.1%	*< 0.001*
Southeast	45.2%	*< 0.001*	25.7%	*0.470*
Detroit Metro	50.5%	*< 0.001*	25.9%	*< 0.001*

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Other health insurance				
No	47.8%		24.8%	
Yes	41.8%	*< 0.001*	18.3%	*< 0.001*
Total observations (Enrollee/periods)	337,131		337,131	

*Collection category based on aggregate collection over life in program through Q3 2016. Full collection = > 95% of invoice collected

Table 3.1.4 Marginal Effects from Fixed Effects Regression of Service Use

	Copay exempt service use	***p-value on regression coefficient***	**Copay likely service use**	***p-value on regression coefficient***
Time period				
Months 0-6				
Months 7-12	-13.2%	< 0.001	-4.9%	< 0.001
Months 13-18	-10.3%	< 0.001	-7.0%	< 0.001
Months 19-24	-20.8%	< 0.001	-13.2%	< 0.001
Months 25-30	-27.1%	< 0.001	-16.8%	< 0.001
FPL				
0-35 %				
36-99 %	2.0%	0.029	3.7%	< 0.001
100+ %	2.8%	0.004	7.1%	< 0.001
Other health insurance				
No	-7.0%		-8.5%	
Yes	-1.5%	< 0.001	-6.2%	< 0.001
Total enrollees	681,789		681,789	

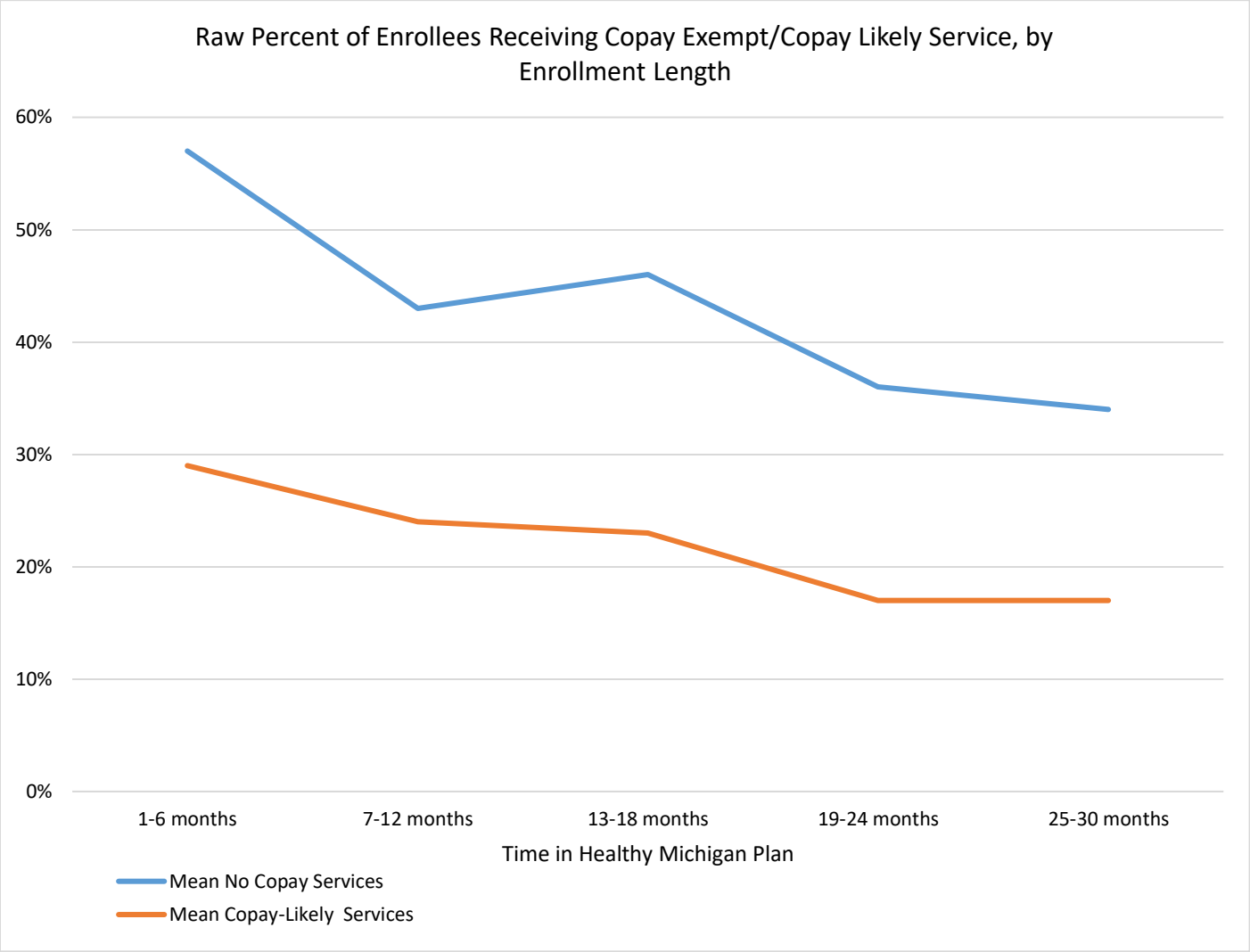
Note: The interpretation on these predictions is as the change in an individual's likelihood of service use compared with the baseline at Months 1-6, 0 to 35% of poverty and with no other health insurance. In this model, any unchanging characteristics of enrollees (gender or region, for example) are held constant.

Table 3.1.4a Marginal Effects from Fixed Effects Regression on Log Spending

	Log spending on no copay	***p-value on regression coefficient***	**Log spending on services with copay**	***p-value on regression coefficient***
Time period				
Months 0-6				
Months 7-12	-0.48	< 0.01	-0.14	< 0.01
Months 13-18	-0.34	< 0.01	-0.19	< 0.01
Months 19-24	-0.63	< 0.01	-0.36	< 0.01
Months 25-30	-0.78	< 0.01	-0.44	< 0.01
FPL				
0-35 %		0.72		
36-99 %	0.06	0.07	0.13	< 0.01
100+ %	0.10	0.01	0.23	< 0.01
Other health insurance				
No				
Yes	-0.57	< 0.01	-0.16	< 0.01
Total enrollees	681,789		681,789	

Notes: 1) The log of healthcare expenditures are often used in research rather than the actual dollar amounts because many people spend very little each month and a few people spend quite a bit. That spread of spending, particularly when a few numbers are much higher than most, has been shown difficult to model mathematically. Instead, using the log of the number, results in more accurate predictions. In this case, the log spending was taken by adding $1 to each spending outcome because the log of $0 is undefined.
2) The interpretation on these predictions is as the change in an individual's likelihood of service use compared with the baseline at Months 1-6, 0 to 35% of poverty and with no other health insurance. In this model, any unchanging characteristics of enrollees (gender or region, for example) are held constant.

Figure 3.1.1 Average Percent of Enrollees Using No Copay/Copay-Likely Services Over Time



Hypothesis 2: Medicaid Service Value – Pharmaceuticals

Table 3.2.1 Predicted Use of Copay-Exempt and Copay-Likely Medications from a Cross-Sectional Probit Regression with Demographic Characteristics

	Predicted percent using copay exempt medications	*p-value on regression coefficient*	Predicted percent using copay likely medications	*p-value on regression coefficient*
FPL				
0-35 %	55.5%		2.4%	
36-99 %	50.9%	< 0.001	1.6%	< 0.001
100+ %	49.7%	< 0.001	1.4%	< 0.001
Age				
Under 30	26.4%		2.5%	
30 to 39	41.3%	< 0.001	2.5%	0.571
40 to 49	60.4%	< 0.001	2.1%	< 0.001
Over 50	70.4%	< 0.001	1.4%	< 0.001
Gender				
Male	51.1%		2.1%	
Female	55.3%	< 0.001	1.9%	0.017
Race				
White	53.4%		2.3%	
Black	54.1%	0.022	1.4%	< 0.001
American Indian	60.2%	< 0.001	0.8%	0.002
Hispanic	52.1%	0.074	1.7%	0.003
Asian/Pacific Islander	48.3%	0.002	2.1%	0.601
Unknown	50.7%	< 0.001	1.6%	< 0.001
Region				
Upper Peninsula	49.5%	< 0.001	2.8%	ref
Northwest	51.1%	0.004	2.3%	0.091
Northeast	52.7%	0.341	1.8%	< 0.001
West	53.9%	0.217	2.3%	0.035
East Central	55.3%	< 0.001	1.9%	< 0.001
East	54.4%	0.011	1.9%	< 0.001
South Central	50.0%	< 0.001	1.7%	< 0.001
Southwest	54.5%	0.027	2.2%	0.012
Southeast	52.7%	0.160	2.1%	0.006
Detroit Metro	53.4%	ref	1.9%	<0.001
Other health insurance				
No	53.2%		2.0%	
Yes	55.1%	< 0.001	2.9%	< 0.001
Total enrollees	158,322		158,322	

Table 3.2.2 Predicted Use of Copay Exempt and Copay-Likely Medications By Time Period from Probit Regression

	Copay exempt medication use	*p-value on regression coefficient*	Copay likely medication use	*p-value on regression coefficient*
Time period				
Months 0-6	39.8%		1.1%	
Months 7-12	41.7%	< 0.01	1.2%	< 0.01
Months 13-18	43.0%	< 0.01	1.1%	0.51
Months 19-24	41.9%	< 0.01	0.8%	< 0.01
Months 25-30	43.4%	< 0.01	0.5%	< 0.01
FPL				
0-35 %	43.4%		1.2%	
36-99 %	39.6%	< 0.01	0.8%	< 0.01
100+ %	39.2%	< 0.01	0.7%	< 0.01
Age				
Under 30	16.3%		1.2%	
30 to 39	27.7%	< 0.01	1.2%	0.70
40 to 49	46.7%	< 0.01	1.0%	< 0.01
Over 50	58.2%	< 0.01	0.7%	< 0.01
Gender				
Male	39.9%		1.0%	
Female	43.3%	< 0.01	0.9%	< 0.01
Race				
White	41.7%		1.1%	
Black	42.5%	< 0.01	0.7%	< 0.01
American Indian	46.9%	< 0.01	0.4%	< 0.01
Hispanic	41.0%	0.05	0.9%	< 0.01
Asian/Pacific Islander	39.6%	0.01	0.9%	0.24
Unknown	40.0%	< 0.01	0.7%	< 0.01
Region				
Upper Peninsula	38.5%	< 0.01	1.6%	< 0.01
Northwest	40.5%	0.02	1.3%	< 0.01
Northeast	41.2%	0.73	0.8%	0.48
West	43.3%	< 0.01	1.2%	< 0.01
East Central	44.2%	< 0.01	0.9%	0.48
East	42.5%	< 0.01	0.9%	0.68
South Central	38.8%	< 0.01	0.7%	0.09
Southwest	42.7%	< 0.01	1.1%	0.95
Southeast	41.4%	0.78	1.1%	0.02
Detroit Metro	41.4%		0.9%	
Other health insurance				
No	41.8%		1.0%	
Yes	42.0%	0.47	1.3%	< 0.01
Total observations (Enrollee/months)	666,582		666,582	

Table 3.2.2a Copay Exempt and Copay-Likely Medication Use, with Time and Above/Below 100% FPL Interaction, Predicted Effects from Probit Regression

	Copay exempt medication use	*p-value on regression coefficient*	Copay likely medication use	*p-value on regression coefficient*
Time period and Federal poverty level				
Months 0-6: Below 100% FPL	40.2%		1.1%	
Months 0-6: Above 100% FPL	36.8%	< 0.001	0.7%	< 0.001
Months 7-12: Below 100% FPL	42.1%	< 0.001	1.3%	0.007
Months 7-12: Above 100% FPL	38.6%	0.705	0.7%	0.788
Months 13-18: Below 100% FPL	43.4%	< 0.001	1.2%	0.595
Months 13-18: Above 100% FPL	39.9%	0.844	0.7%	0.544
Months 19-24: Below 100% FPL	42.4%	< 0.001	0.8%	< 0.001
Months 19-24: Above 100% FPL	38.6%	0.410	0.6%	0.039
Months 25-30: Below 100% FPL	44.1%	< 0.001	0.5%	< 0.001
Months 25-30: Above 100% FPL	39.4%	0.031	0.7%	< 0.001
Age				
Under 30	16.3%		1.2%	
30 to 39	27.6%	< 0.001	1.2%	0.825
40 to 49	46.8%	< 0.001	1.0%	< 0.001
Over 50	58.0%	< 0.001	0.7%	< 0.001
Gender				
Male	40.0%		1.1%	
Female	43.1%	< 0.001	0.9%	< 0.001
Race				
White	41.5%		1.1%	
Black	42.6%	< 0.001	0.7%	< 0.001
American Indian	46.8%	< 0.001	0.4%	< 0.001
Hispanic	40.5%	0.004	0.9%	0.001
Asian/Pacific Islander	38.9%	0.001	0.9%	0.142
Unknown	39.9%	< 0.001	0.7%	< 0.001
Region				
Upper Peninsula	38.1%	< 0.001	1.5%	< 0.001
Northwest	40.2%	0.003	1.2%	< 0.001
Northeast	40.8%	0.195	0.8%	0.394
West	43.2%	< 0.001	1.2%	< 0.001
East Central	44.0%	< 0.001	0.9%	0.472
East	42.3%	< 0.001	0.9%	0.855
South Central	38.6%	< 0.001	0.8%	0.046
Southwest	42.7%	< 0.001	1.1%	< 0.001
Southeast	41.3%	0.996	1.1%	< 0.001
Detroit Metro	41.3%		0.9%	
Other health insurance				
No	41.7%		1.0%	
Yes	41.5%	0.690	1.3%	< 0.001
Total observations (Enrollee/periods)	654,689		654,689	

Table 3.2.2b Predicted Spending on Copay Exempt Medications by Period, Predicted Monthly Spending from GLM Regression

	Copay exempt medications	*p-value on regression coefficient*
Time period		
Months 0-6	29.73	
Months 7-12	36.63	< 0.001
Months 13-18	41.41	< 0.001
Months 19-24	46.75	< 0.001
Months 25-30	54.52	< 0.001
FPL		
0-35 %	41.47	
36-99 %	36.97	< 0.001
100+ %	38.47	< 0.001
Age		
Under 30	19.27	
30 to 39	29.35	< 0.001
40 to 49	46.60	< 0.001
Over 50	50.92	< 0.001
Gender		
Male	48.94	
Female	32.40	< 0.001
Race		
White	36.34	
Black	51.00	< 0.001
American Indian	48.88	0.001
Hispanic	45.93	< 0.001
Asian/Pacific Islander	23.75	< 0.001
Unknown	32.95	< 0.001
Region		
Upper Peninsula	38.62	0.014
Northwest	37.92	0.018
Northeast	33.40	< 0.001
West	47.82	< 0.001
East Central	35.52	< 0.001
East	27.74	< 0.001
South Central	37.67	0.005
Southwest	42.40	0.530
Southeast	44.21	0.051
Detroit Metro	41.71	
Other health insurance		
No	39.98	
Yes	41.35	0.405
Total observations (Enrollee/periods)	666,582	

Notes: Copay-likely medications not included as regression specification was not possible due to computational traction (likely related to overall utilization and spending)

Table 3.2.3 Subset with Cost-Sharing Obligation: Average Medication Use by Time Period, Predictions from Probit Regression

	Copay exempt medication use	*p-value on regression coefficient*	Copay likely medication use	*p-value on regression coefficient*
Collection category*				
None collected	41.0%		0.9%	
Partial collection	43.1%	< 0.001	1.0%	0.003
Full collection	40.7%	0.160	0.8%	0.354
Time period				
Months 0-6	39.6%		0.9%	
Months 7-12	41.5%	< 0.001	0.9%	0.106
Months 13-18	42.8%	< 0.001	1.0%	0.019
Months 19-24	41.8%	< 0.001	0.9%	0.723
Months 25-30	42.5%	< 0.001	0.9%	0.892
FPL				
0-35 %	44.1%		1.2%	
36-99 %	41.1%	< 0.001	0.8%	< 0.001
100+ %	38.9%	< 0.001	0.7%	< 0.001
Age				
Under 30	15.9%		1.2%	
30 to 39	26.3%	< 0.001	1.1%	0.418
40 to 49	45.9%	< 0.001	0.9%	< 0.001
Over 50	60.7%	< 0.001	0.7%	< 0.001
Gender				
Male	41.6%		1.0%	
Female	41.5%	0.391	0.8%	< 0.001
Race				
White	40.7%		1.0%	
Black	45.4%	< 0.001	0.7%	< 0.001
American Indian	46.4%	< 0.001	0.6%	0.085
Hispanic	41.0%	0.569	0.8%	0.147
Asian/Pacific Islander	41.4%	0.496	0.9%	0.821
Unknown	39.9%	0.010	0.7%	< 0.001
Region				
Upper Peninsula	38.7%	< 0.001	1.6%	< 0.001
Northwest	39.6%	< 0.001	1.5%	< 0.001
Northeast	40.4%	0.006	0.7%	0.892
West	42.6%	< 0.001	1.1%	< 0.001
East Central	43.2%	< 0.001	0.9%	0.006
East	41.8%	0.321	0.8%	0.922
South Central	39.1%	< 0.001	0.7%	0.521
Southwest	43.2%	< 0.001	1.0%	< 0.001

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Southeast	40.7%	0.007	0.9%	0.002
Detroit Metro	41.6%		0.7%	
Other health insurance				
No	41.6%		0.9%	
Yes	40.8%	0.041	1.2%	0.001
Total observations (Enrollee/period)	340,254		340,254	

*Collection category based on aggregate collection over life in program through Q3 2016. Full collection = > 95% of invoice collected

Table 3.2.3a Subset with Cost-Sharing Obligation: Average Medication Use, Predictions from Probit Regression with Interaction between Above/Below 100% FPL and Time Period

	Copay exempt medication use	*p-value on regression coefficient*	Copay likely medication use	*p-value on regression coefficient*
Collection category*				
None collected	40.8%		0.9%	
Partial collection	42.9%	< 0.001	1.0%	0.003
Full collection	40.5%	0.225	0.8%	0.389
Time period and Federal poverty level				
Months 0-6: Below 100% FPL	40.3%		0.9%	
Months 0-6: Above 100% FPL	36.6%	< 0.001	0.7%	< 0.001
Months 7-12: Below 100% FPL	42.4%	< 0.001	1.0%	0.100
Months 7-12: Above 100% FPL	38.2%	0.586	0.7%	0.784
Months 13-18: Below 100% FPL	43.7%	< 0.001	1.1%	0.017
Months 13-18: Above 100% FPL	39.5%	0.558	0.7%	0.682
Months 19-24: Below 100% FPL	42.7%	< 0.001	0.9%	0.864
Months 19-24: Above 100% FPL	38.5%	0.502	0.6%	0.493
Months 25-30: Below 100% FPL	43.6%	< 0.001	0.9%	0.917
Months 25-30: Above 100% FPL	39.0%	0.309	0.7%	0.636
Age				
Under 30	15.9%		1.2%	
30 to 39	26.3%	< 0.001	1.1%	0.188
40 to 49	45.9%	< 0.001	0.9%	< 0.001
Over 50	60.4%	< 0.001	0.7%	< 0.001
Gender				
Male	41.4%		1.0%	
Female	41.3%	0.592	0.8%	< 0.001
Race				
White	40.4%		1.0%	
Black	45.4%	< 0.001	0.7%	< 0.001
American Indian	46.4%	< 0.001	0.6%	0.116
Hispanic	40.3%	0.739	0.8%	0.062
Asian/Pacific Islander	40.7%	0.804	0.8%	0.555
Unknown	39.7%	0.026	0.7%	< 0.001
Region				
Upper Peninsula	38.5%	< 0.001	1.6%	< 0.001
Northwest	39.4%	< 0.001	1.4%	< 0.001
Northeast	40.0%	0.002	0.7%	0.978
West	42.5%	< 0.001	1.1%	< 0.001
East Central	42.8%	< 0.001	0.9%	0.002
East	41.5%	0.412	0.8%	0.750
South Central	38.8%	< 0.001	0.7%	0.893

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Southwest	43.1%	< 0.001	1.0%	< 0.001
Southeast	40.4%	0.007	1.0%	< 0.001
Detroit Metro	41.3%		0.7%	
Other health insurance				
No	41.3%		0.9%	
Yes	40.3%	0.021	1.2%	< 0.001
Total observations (Enrollee/periods)	330,382		330,382	

Notes: Collection category based on aggregate collection over life in program through Q3 2016. Full collection = > 95% of invoice collected

Table 3.2.3b Predicted Use of Copay Exempt and Copay Likely Medications from Probit Regression with Interactions on Time Period and FPL

	Copay exempt medication use	*p-value on regression coefficient*	Copay likely medication use	*p-value on regression coefficient*
Time period and Federal poverty level				
Months 0-6: Below 35% FPL	41.3%		1.3%	
Months 0-6: 36-99% FPL	37.7%	< 0.001	0.8%	< 0.001
Months 0-6: Above 100% FPL	37.6%	< 0.001	0.7%	< 0.001
Months 7-12: Below 35% FPL	43.3%	< 0.001	1.4%	0.038
Months 7-12: 36-99% FPL	39.5%	0.674	0.9%	0.690
Months 7-12: Above 100% FPL	39.4%	0.707	0.8%	0.762
Months 13-18: Below 35% FPL	44.6%	< 0.001	1.3%	0.926
Months 13-18: Above 36-99% FPL	40.7%	0.528	0.9%	0.275
Months 13-18: Above 100% FPL	40.5%	0.356	0.7%	0.660
Months 19-24: Below 35% FPL	43.6%	< 0.001	0.9%	< 0.001
Months 19-24: 36-99% FPL	39.8%	0.543	0.8%	< 0.001
Months 19-24: Above 100% FPL	38.9%	0.038	0.6%	0.004
Months 25-30: Below 35% FPL	45.5%	< 0.001	0.4%	< 0.001
Months 25-30: 36-99% FPL	40.8%	0.041	0.7%	< 0.001
Months 25-30: Above 100% FPL	39.5%	0.001	0.6%	< 0.001
Age				
Under 30	16.3%	< 0.001	1.2%	0.141
30 to 39	27.7%	< 0.001	1.2%	0.699
40 to 49	46.7%	< 0.001	1.0%	< 0.001
Over 50	58.2%	< 0.001	0.7%	
Gender				
Male	39.9%		1.0%	
Female	43.3%	< 0.001	0.9%	< 0.001
Race				
White	41.7%		1.1%	
Black	42.5%	< 0.001	0.7%	< 0.001
American Indian	46.9%	< 0.001	0.4%	< 0.001
Hispanic	41.0%	0.048	0.9%	0.004
Asian/Pacific Islander	39.6%	0.006	0.9%	0.247
Unknown	40.0%	< 0.001	0.7%	< 0.001
Region				
Upper Peninsula	38.5%	< 0.001	1.6%	< 0.001
Northwest	40.5%	0.017	1.3%	< 0.001
Northeast	41.2%	0.738	0.8%	0.466
West	43.3%	< 0.001	1.2%	< 0.001
East Central	44.2%	< 0.001	0.9%	0.487
East	42.5%	< 0.001	0.9%	0.963
South Central	38.8%	< 0.001	0.7%	0.022
Southwest	42.7%	< 0.001	1.1%	< 0.001
Southeast	41.4%	0.774	1.0%	< 0.001
Detroit Metro	41.4%		0.9%	

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Other health insurance				
No	41.8%		1.0%	
Yes	42.0%	0.508	1.4%	< 0.001
Total observations (Enrollee/periods)	666,582		666,582	

Table 3.2.4a Marginal Effects of Time and FPL from Fixed Effects Regression of Medication Use

	Copay exempt medications	*p-value on regression coefficient*	Copay likely medications	*p-value on regression coefficient*
Time period				
Months 0-6				
Months 7-12	1.9%	< 0.001	0.08%	< 0.001
Months 13-18	3.2%	< 0.001	-0.02%	0.474
Months 19-24	1.9%	< 0.001	-0.36%	< 0.001
Months 25-30	1.3%	< 0.001	-0.82%	< 0.001
FPL				
0-35 %				
36-99 %	0.5%	0.438	-0.15%	0.413
100+ %	0.7%	0.267	-0.47%	0.004
Other health insurance				
No				
Yes	-2.8%	< 0.001	-0.12%	0.254
Total enrollees	158,366		158,366	

Notes: The interpretation on these predictions is as the change in an individual's likelihood of service use compared with the baseline at Months 1-6, 0 to 35% of poverty and with no other health insurance. In this model, any unchanging characteristics of enrollees (gender or region, for example) are held constant.

Table 3.2.4b Fixed Effects Regression of Spending

	Change in log spending on copay exempt medications	***p-value on regression coefficient***	**Change in log spending on copay likely medications**	***p-value on regression coefficient***
Time period				
Months 0-6				
Months 7-12	0.10	< 0.01	0.07	< 0.01
Months 13-18	0.17	< 0.01	0.13	< 0.01
Months 19-24	0.18	< 0.01	0.13	< 0.01
Months 25-30	0.20	< 0.01	0.13	< 0.01
FPL				
0-35 %				
36-99 %	0.02	0.48	0.00	0.96
100+ %	-0.02	0.38	-0.02	0.38
Other health insurance				
No				
Yes	-0.10	< 0.01	-0.04	< 0.01
Total enrollees	158,366		158,366	

Notes: 1) The log of healthcare expenditures are often used in research rather than the actual dollar amounts because many people spend very little each month and a few people spend quite a bit. That spread of spending, particularly when a few numbers are much higher than most, has been shown difficult to model mathematically. Instead, using the log of the number, results in more accurate predictions. In this case, the log spending was taken by adding $1 to each spending outcome because the log of $0 is undefined.
2) The interpretation on these predictions is as the change in an individual's likelihood of service use compared with the baseline at Months 1-6, 0 to 35% of poverty and with no other health insurance. In this model, any unchanging characteristics of enrollees (gender or region, for example) are held constant.

Figure 3.2.1 Percent of the Population Receiving a High- or Copay- likely Medication

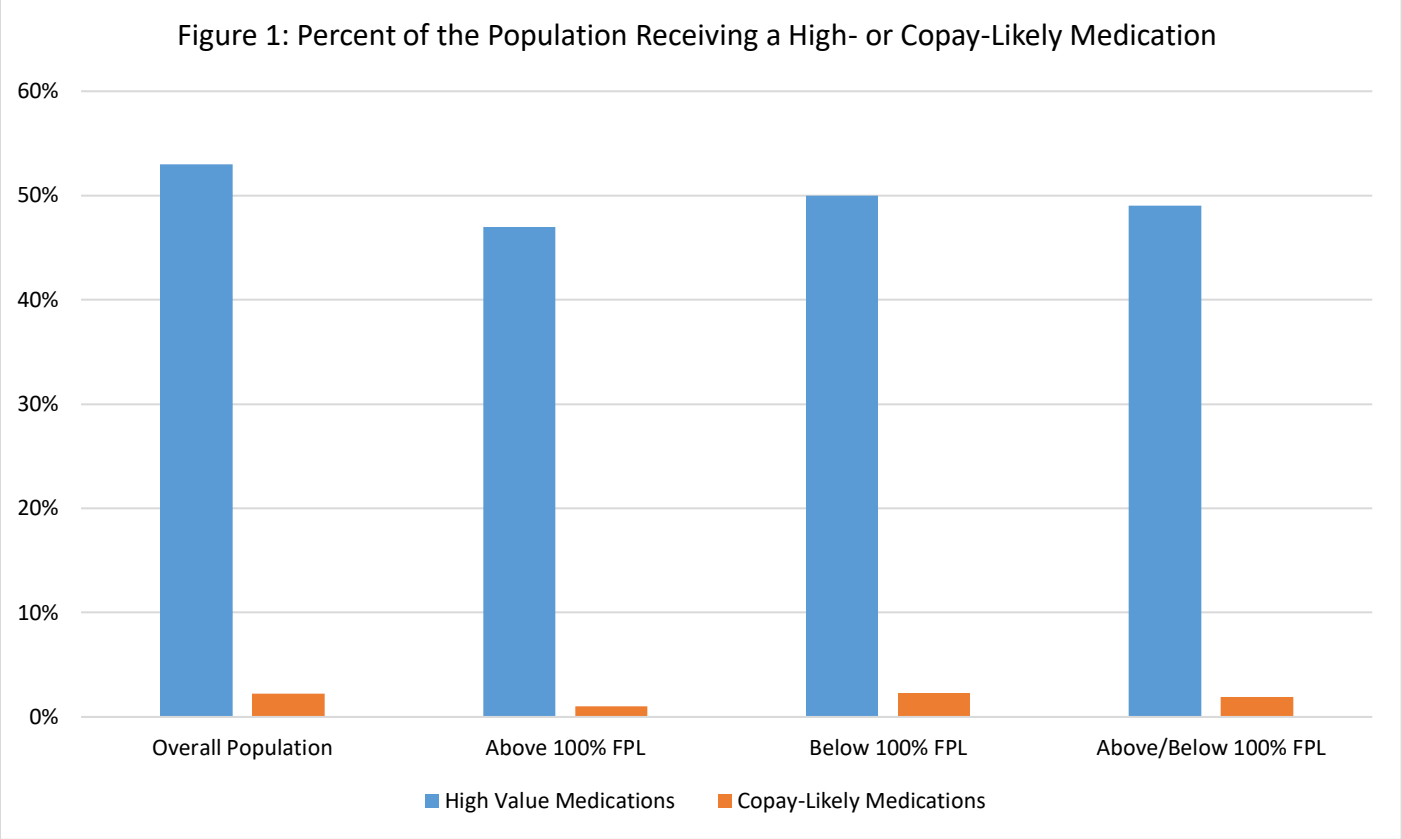
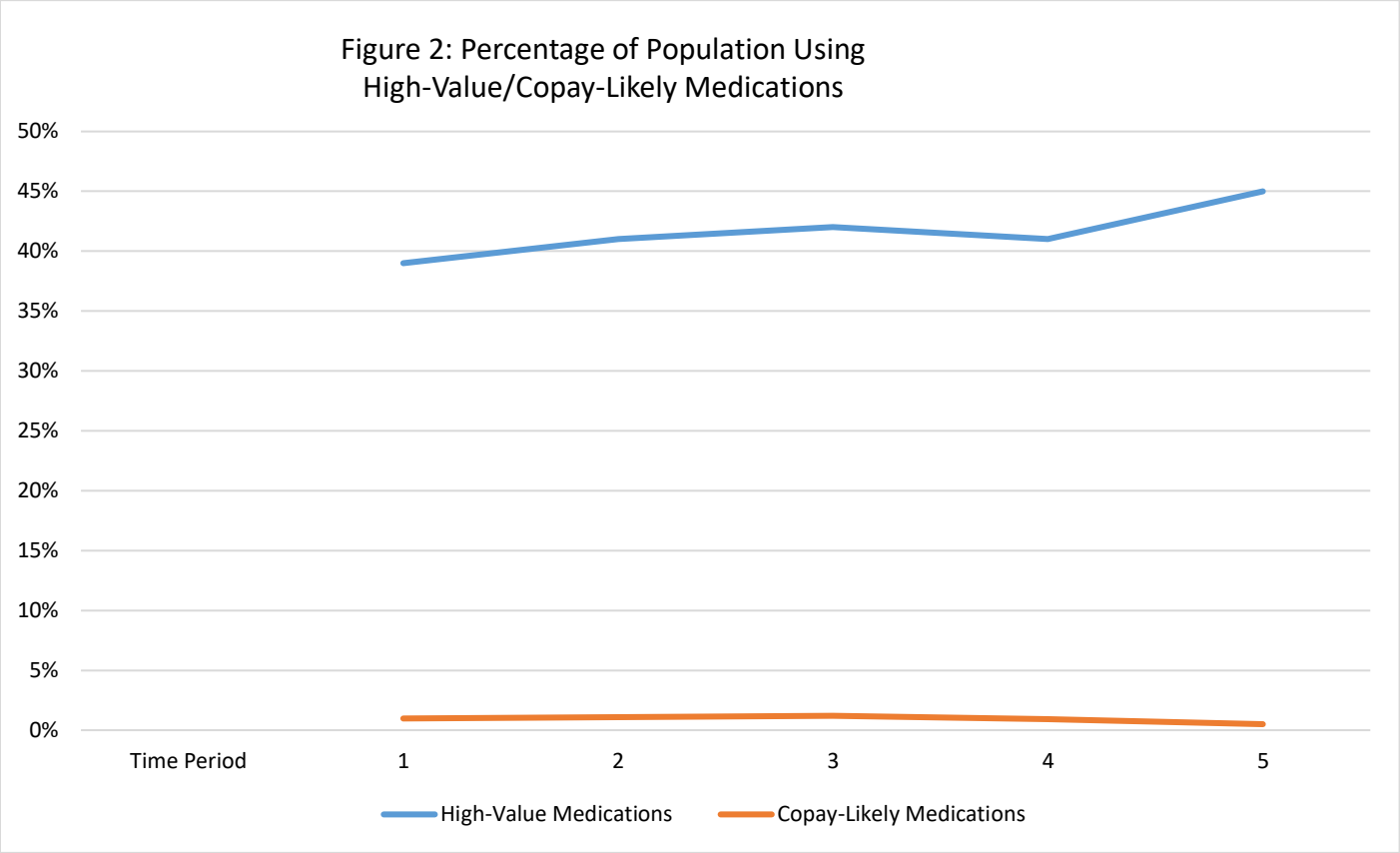


Figure 3.2.2 Percentage of Population Using High-Value/Copay-Likely Medications



Hypothesis 2: Medicaid Service Value – Emergency Department (ED) Use

Table 3.3.1 Number of ED Visits and Likelihood of Copay

	ED type A		ED type B	
	Percent of visits with copay	**Total visits**	**Percent of visits with copay**	**Total visits**
Visit severity				
High	0.01%	209,528	9.76%	1,486
Medium	0.06%	124,082	14.65%	3,645
Low	0.33%	32,264	52.19%	1,667
Total	0.05%	365,874	22.8%	6,798

Table 3.3.2 Predicted Likelihood of Copayment by ED Type and Severity from Probit Regression of Enrollee Month that Includes ED Claim

	No time period effects		Time period effects	
	Copay flag	***p-value on regression coefficient***	**Copay flag**	***p-value on regression coefficient***
Visit severity				
Low	7.8%	< 0.001	7.8%	< 0.001
Medium	0.5%	0.877	0.5%	0.905
High	0.5%		0.5%	
Emergency room type				
24/7 Hospital affiliated (type A)	0.1%		0.1%	
Urgent Care associated with hospital (type B)	22.2%	< 0.001	22.2%	< 0.001
Time period				
Months 0-6			0.8%	
Months 7-12			0.7%	0.328
Months 13-18			0.7%	0.902
Months 19-24			0.7%	0.046
Months 25-30			0.8%	0.584
Total enrollee months with ED claims	229,246		229,246	

Regression level is enrollee/months and this regression is limited to months in which there is an ED claim. So, interpretation is tricky but close to visit level, i.e. 6.2% low severity visits incur a copay, controlling for other things.

Table 3.3.3 Predicted Emergency Department Use over Time from Probit Regression on whether Enrollee had at least one claim in a month

	Predicted total ED use	*p-value on regression coefficient*	Type A visits	*p-value on regression coefficient*	Type B visits	*p-value on regression coefficient*
Time period						
Months 0-6	25.5%		25.2%		1.0%	
Months 7-12	25.0%	0.001	24.7%	0.001	0.9%	0.563
Months 13-18	25.0%	< 0.001	24.6%	< 0.001	0.8%	< 0.001
Months 19-24	19.9%	< 0.001	19.7%	< 0.001	0.5%	< 0.001
Months 25-30	17.3%	< 0.001	17.0%	< 0.001	0.3%	< 0.001
Age						
Under 30	26.8%		26.3%		1.1%	
30 to 39	25.9%	< 0.001	25.4%	< 0.001	0.9%	< 0.001
40 to 49	25.0%	< 0.001	24.6%	< 0.001	0.8%	< 0.001
Over 50	18.9%	< 0.001	18.7%	< 0.001	0.5%	< 0.001
Gender						
Male	21.1%		20.9%		0.6%	
Female	25.2%	< 0.001	24.8%	< 0.001	0.9%	< 0.001
Race						
White	21.6%		21.2%		0.7%	
Black	28.9%	< 0.001	28.7%	< 0.001	1.1%	< 0.001
American Indian	25.6%	< 0.001	25.2%	< 0.001	0.8%	0.267
Hispanic	24.0%	< 0.001	23.6%	< 0.001	0.6%	0.741
Asian/Pacific Islander	12.6%	< 0.001	12.4%	< 0.001	0.3%	0.003
Unknown	20.3%	< 0.001	20.1%	< 0.001	0.6%	0.047
FPL						
0-35 %	25.6%		25.3%		0.8%	
36-99 %	20.6%	< 0.001	20.2%	< 0.001	0.7%	< 0.001
100+ %	19.5%	< 0.001	19.1%	< 0.001	0.8%	0.026
Region						
Upper Peninsula	22.9%	0.224	22.9%	0.013	0.0%	< 0.001
Northwest	22.1%	0.170	20.1%	< 0.001	3.1%	< 0.001
Northeast	20.8%	< 0.001	20.8%	< 0.001	0.1%	< 0.001
West	27.4%	< 0.001	26.1%	< 0.001	2.2%	< 0.001
East Central	24.2%	< 0.001	24.2%	< 0.001	0.0%	< 0.001
East	20.4%	< 0.001	20.2%	< 0.001	0.3%	< 0.001
South Central	21.5%	< 0.001	21.5%	0.007	0.0%	< 0.001
Southwest	27.0%	< 0.001	27.0%	< 0.001	0.0%	< 0.001
Southeast	25.2%	< 0.001	25.3%	< 0.001	0.0%	< 0.001
Detroit Metro	22.5%		22.2%		0.9%	

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Other health insurance						
No	0.8%		23.1%		25.2%	
Yes	0.7%	< 0.001	20.6%	< 0.001	16.8%	0.115
Total observations (Person/period)	681,697		681,697		681,697	

Table 3.3.3a Predicted Average Monthly Spending on Emergency Department Visits, over time using GLM Regression Models

	Spending on all ED visits	*p-value on regression coefficient*	Spending on ED type A visits	*p-value on regression coefficient*	Spending on ED type B visits	*p-value on regression coefficient*
Time period						
Months 0-6	21.93		21.74		0.20	
Months 7-12	22.84	0.002	22.64	0.002	0.20	0.573
Months 13-18	22.95	< 0.001	22.77	< 0.001	0.17	0.072
Months 19-24	21.29	0.041	21.17	0.073	0.12	< 0.001
Months 25-30	20.72	0.003	20.63	0.007	0.10	< 0.001
Age						
Under 30	24.04		23.79		0.25	
30 to 39	24.58	0.090	24.39	0.061	0.19	< 0.001
40 to 49	24.78	0.026	24.60	0.014	0.17	< 0.001
Over 50	17.76	< 0.001	17.65	< 0.001	0.11	< 0.001
Gender						
Male	18.62		18.49		0.12	
Female	25.07	< 0.001	24.86	< 0.001	0.21	< 0.001
Race						
White	21.41		21.26		0.15	
Black	25.00	< 0.001	24.77	< 0.001	0.24	< 0.001
American Indian	26.94	0.001	26.77	0.001	0.17	0.584
Hispanic	22.61	0.048	22.46	0.048	0.15	0.887
Asian/Pacific Islander	10.80	< 0.001	10.75	< 0.001	0.05	< 0.001
Unknown	19.34	< 0.001	19.22	< 0.001	0.13	0.103
FPL						
0-35 %	25.38		25.20		0.18	
36-99 %	18.07	< 0.001	17.93	< 0.001	0.14	< 0.001
100+ %	16.61	< 0.001	16.43	< 0.001	0.18	0.981
Region						
Upper Peninsula	18.22	< 0.001	18.19	< 0.001	0.03	< 0.001
Northwest	20.92	0.343	20.20	0.065	0.72	< 0.001
Northeast	17.95	< 0.001	17.88	< 0.001	0.07	< 0.001
West	25.28	< 0.001	24.82	< 0.001	0.46	< 0.001
East Central	22.47	0.017	22.46	0.005	0.02	< 0.001
East	20.33	0.001	20.26	0.004	0.07	< 0.001
South Central	21.20	0.553	21.19	0.811	0.01	< 0.001
Southwest	25.89	< 0.001	25.88	< 0.001	0.01	< 0.001
Southeast	24.49	< 0.001	24.47	< 0.001	0.01	< 0.001
Detroit Metro	21.50		21.31		0.19	
Other health insurance						
No	22.17		22.00		0.17	
Yes	20.98	0.201	20.81		0.17	0.821
Total observations (Person/period)	681,697		681,697		681,697	

Table 3.3.3b Average Severity of Visit; Marginal Effects from Linear Regression and Probit Model

	Linear regression	*p-value on regression coefficient*	Probit (Prob medium or high severity visit)	*p-value on regression coefficient*
Time period				
Months 0-6	ref		ref	
Months 7-12	-0.002	0.403	-0.002	0.35
Months 13-18	0.004	0.068	0.003	0.07
Months 19-24	0.108	< 0.01	0.081	< 0.01
Months 25-30	0.184	< 0.01	0.137	< 0.01
Age				
Under 30	ref		ref	
30 to 39	0.004	0.055	0.003	0.01
40 to 49	-0.012	< 0.01	-0.009	< 0.01
Over 50	-0.036	< 0.01	-0.029	< 0.01
Gender				
Male	ref		ref	
Female	0.024	< 0.01	0.019	< 0.01
Race				
White	ref		ref	
Black	-0.007	0.001	-0.004	0.02
American Indian	0.009	0.424	0.011	0.25
Hispanic	-0.002	0.666	-0.002	0.70
Asian/Pacific Islander	-0.029		-0.036	
Unknown	0.003	0.380	0.001	0.65
FPL				
0-35 %	ref		ref	
36-99 %	-0.034	< 0.01	-0.028	< 0.01
100+ %	-0.041	< 0.01	-0.033	< 0.01
Region				
Upper Peninsula	-0.016	0.001	-0.013	< 0.01
Northwest	-0.004	0.455	-0.002	0.72
Northeast	-0.022	< 0.01	-0.016	< 0.01
West	0.010	< 0.01	0.012	< 0.01
East Central	0.012	0.001	0.013	< 0.01
East	0.007	0.035	0.005	0.04
South Central	0.022	< 0.01	0.018	< 0.01
Southwest	0.012	0.001	0.010	< 0.01
Southeast	0.015	< 0.01	0.014	< 0.01
Detroit Metro	ref		ref	
Other health insurance				
No	ref		ref	
Yes	0.008	0.160	0.005	0.19
ED type B visit				
No	ref		ref	
Yes	0.002	0.739	0.002	0.55

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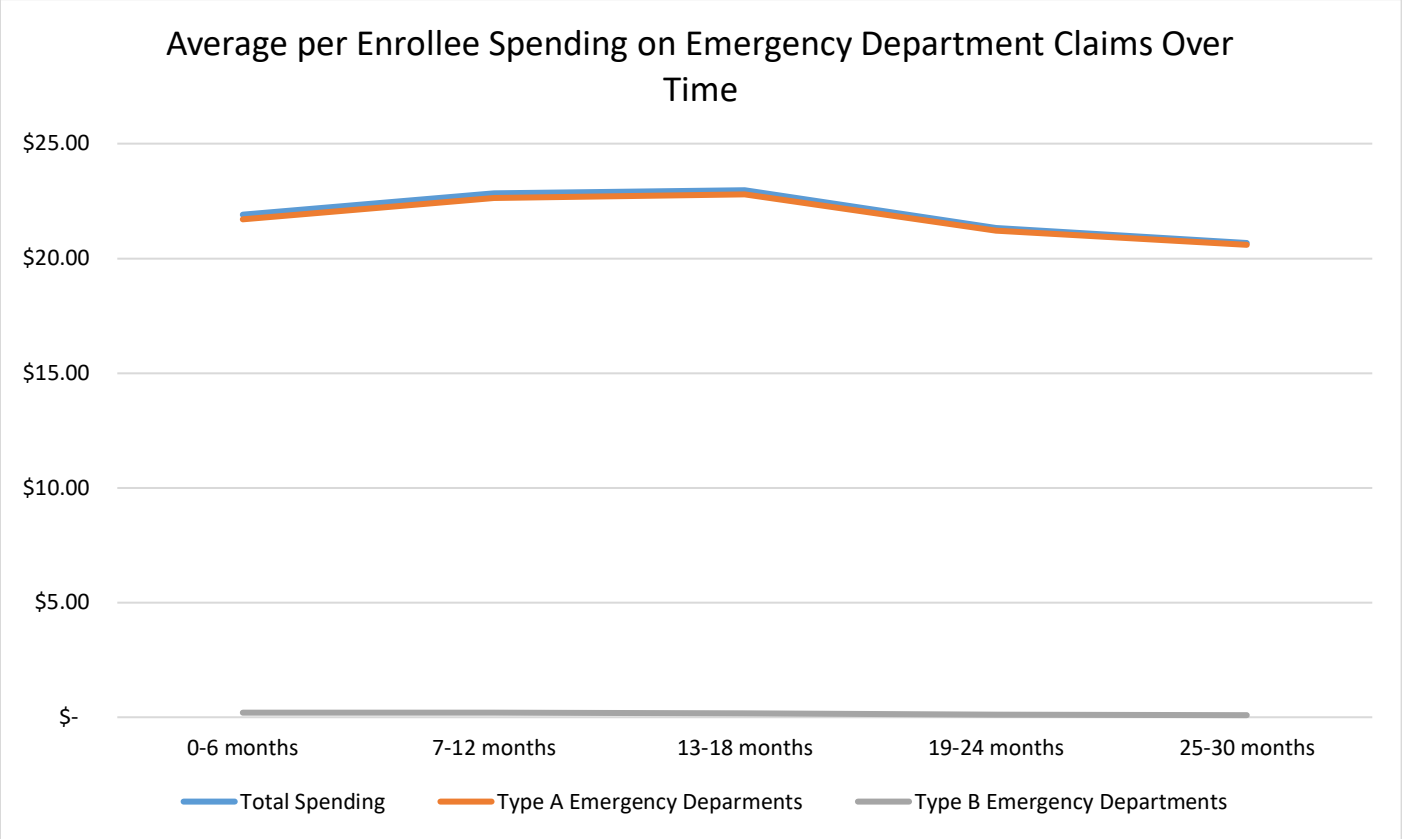
Constant	1.080			
Total observations (Person/period)	159,170		159,170	

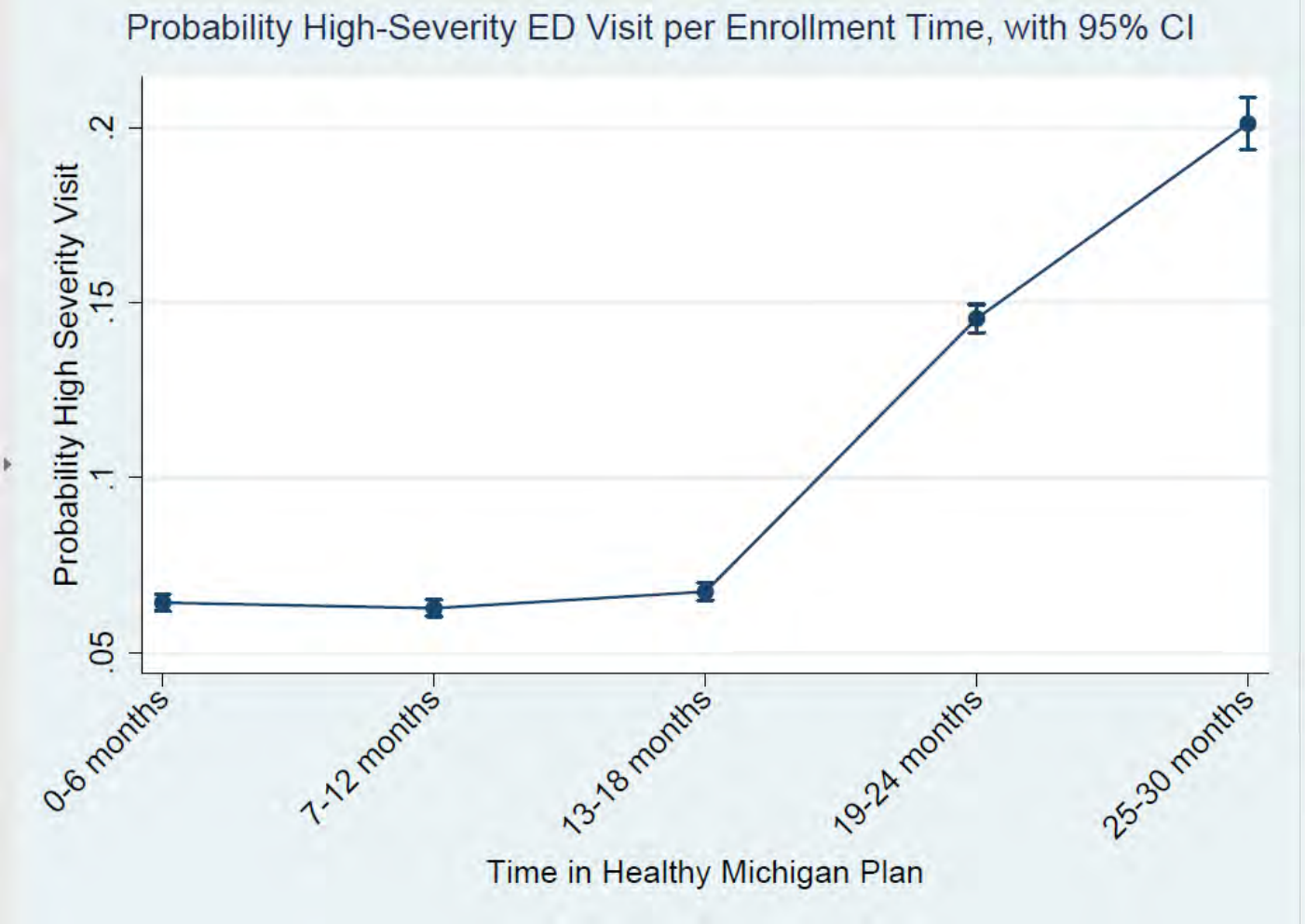
Ordinal logit was tried but no specification was tractable, likely due to low number of high/medium visits compared to low severity. Low severity > 90% of visits

Figure 3.3.1 Average per Enrollee Spending on Emergency Department Claims Over Time



	0-6 months	7-12 months	13-18 months	19-24 months	25-30 months
Total spending	$ 21.90	$ 22.83	$ 22.97	$ 21.33	$ 20.67
Type A emergency departments	$ 21.71	$ 22.62	$ 22.79	$ 21.21	$ 20.59
Type B emergency departments	$ 0.20	$ 0.20	$ 0.18	$ 0.12	$ 0.09

Figure 3.3.2 Probability of Medium/High Severity Visit



Note: Margins from a probit regression of probability of medium or high severity visit on time period, type of ED visit and same set of demographic characteristics as above. All periods are significantly different from baseline except for period 2 (7-12 months).

The hypothesis being tested is whether ED severity goes up over time, a possible indication that lower severity issues are being dealt with in other settings. This graph shows predictive margins from a probit regression of the probability of a visit coded as medium or high severity, conditional on an ED visit.

Hypothesis 3: Disenrollment Analyses

Table 4.1 Demographics of those Without Insurance Compared with Those with Insurance, Post HMP-enrollment, Unadjusted analysis

	Uninsured since HMP	Insured since HMP	*p-value on regression coefficient from adjusted Wald test of difference in proportions*
Age			
Under 30	41.2%	44.6%	0.416
30 to 39	19.7%	17.2%	0.443
40 to 49	19.4%	19.2%	0.952
Over 50	19.7%	19.0%	0.817
Gender			
Male			
Female	34.2%	44.2%	< 0.019
Race			
White	55.2%	58.5%	0.429
Black	21.6%	23.2%	0.672
American Indian	0.9%	0.6%	0.586
Hispanic	4.2%	3.0%	
Asian/Pacific Islander	0.7%	0.8%	0.872
Unknown	17.3%	13.9%	0.278
FPL			
0-35 %	63.6%	60.1%	0.326
36-99 %	23.2%	23.2%	0.996
100+ %	13.2%	16.7%	0.101
Region			
Upper Peninsula	3.1%	3.0%	0.923
Northwest	3.3%	3.3%	0.969
Northeast	1.7%	2.3%	0.294
West	8.3%	12.3%	0.079
East Central	5.0%	7.5%	0.137
East	11.5%	9.7%	0.458
South Central	3.7%	4.5%	0.629
Southwest	7.9%	7.3%	0.773
Southeast	10.9%	7.9%	0.224
Detroit Metro	44.8%	42.2%	0.534
Total enrollees	373	687	

Table 4.2 Predicted Percentage of Insurance Post-HMP from No Longer Enrolled Survey from Probit Regression

	Predicted percent with insurance including average quarterly invoice	*p-value on regression coefficient*	Predicted percent with insurance including flag for cost obligation	*p-value on regression coefficient*	Subset with cost obligation: predicted percent with insurance including compliance with obligation	*p-value on regression coefficient*
Age						
Under 30	64.1%		63.8%		73.2%	
30 to 39	58.7%	0.323	58.8%	0.355	70.1%	0.726
40 to 49	61.5%	0.621	61.8%	0.689	68.4%	0.562
Over 50	57.9%	0.209	58.1%	0.249	57.0%	0.026
Gender						
Male	57.8%		57.9%		67.4%	
Female	66.9%	0.018	66.8%	0.020	68.8%	0.814
Race						
White	62.4%		62.3%		65.1%	
Black	63.9%	0.786	64.0%	0.760	70.9%	0.492
American Indian	48.6%	0.505	48.0%	0.492		
Hispanic	50.1%	0.247	50.6%	0.272	91.1%	0.061
Asian/Pacific Islander	60.5%	0.923	57.9%	0.809	84.7%	0.417
Unknown	57.6%	0.395	57.5%	0.394	73.1%	0.306
FPL						
0-35 %	62.1%		62.6%		77.7%	
36-99 %	57.2%	0.247	58.9%	0.377	64.2%	0.135
100+ %	65.0%	0.598	60.6%	0.683	63.6%	0.106
Region						
Upper Peninsula	61.3%	0.890	59.8%	0.961	62.8%	0.534
Northwest	61.4%	0.870	61.6%	0.844	73.4%	0.815
Northeast	67.7%	0.376	68.3%	0.331	82.9%	0.305
West	71.3%	0.081	71.6%	0.074	80.7%	0.347
East Central	70.3%	0.185	0.705	0.173	63.0%	0.587
East	55.9%	0.503	56.2%	0.539	67.7%	0.755
South Central	66.5%	0.547	65.8%	0.602	62.8%	0.702
Southwest	57.6%	0.746	57.3%	0.721	58.4%	0.356
Southeast	55.2%	0.500	55.3%	0.511	62.4%	0.486
Detroit Metro	60.2%		60.1%		70.7%	

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Category of Average Invoice						
$0	58.5%					
$0.01 - $15	75.2%	< 0.01				
$15.01 +	62.0%	0.569				
Cost Obligation						
No			58.1%			
Yes			69.9%	< 0.014		
Collection category						
None collected					57.5%	
Partial collection					73.0%	0.062
Full collection					84.3%	< 0.01
Total enrollees	1,060		1,060		314	

Adjusted by survey weights and stratum. Results are predicted prevalence of each category, controlling for other covariates in the model

Table 4.3 Predicted Likelihood of Disenrollment in Period

	Cost obligation in prior period	*p-value on regression coefficient*	Invoice amount in prior period	*p-value on regression coefficient*	Invoice amount in prior period (quadratic specification for invoice)	*p-value on regression coefficient*	Invoice amount in prior period (quadratic specification with interactions on above/below 100% FPL)	*p-value on regression coefficient*
FPL								
0-35 %	14.3%		14.5%		14.4%			
36-99 %	12.7%	0.000	11.8%	0.000	11.9%	0.000		
100+ %	16.0%	0.000	16.9%	0.000	17.2%	0.000		
Age								
Under 30	20.3%		20.6%		20.6%		20.4%	
30 to 39	14.6%	0.000	14.7%	0.000	14.7%	0.000	14.6%	0.000
40 to 49	12.1%	0.000	12.1%	0.000	12.1%	0.000	12.1%	0.000
Over 50	10.8%	0.000	10.7%	0.000	10.7%	0.000	10.8%	0.000
Gender								
Male	17.0%		17.2%		17.1%		17.1%	
Female	11.5%	0.000	11.4%	0.000	11.4%	0.000	11.4%	0.000
Race								
White	13.2%		13.1%		13.2%		13.1%	
Black	13.3%	0.281	13.4%	0.009	13.4%	0.027	13.4%	0.002
American Indian	15.3%	0.000	15.8%	0.000	15.8%	0.000	15.7%	0.000
Hispanic	15.0%	0.000	15.0%	0.000	15.0%	0.000	15.0%	0.000
Asian/Pacific Islander	17.1%	0.000	17.1%	0.000	17.1%	0.000	16.8%	0.000
Unknown	22.2%	0.000	22.4%	0.000	22.4%	0.000	22.2%	0.000
Region								
Upper Peninsula	13.1%	0.000	12.9%	0.000	13.0%	0.000	12.9%	0.000
Northwest	15.2%	0.001	15.1%	0.000	15.1%	0.000	15.1%	0.000
Northeast	12.5%	0.000	12.4%	0.000	12.4%	0.000	12.5%	0.000
West	14.7%	0.000	14.7%	0.000	14.7%	0.000	14.7%	0.000
East Central	13.0%	0.000	12.9%	0.000	12.9%	0.000	12.9%	0.000
East	**13.6%**	**0.000**	**13.5%**	**0.000**	**13.5%**	**0.000**	**13.6%**	**0.000**
South Central	15.8%	0.049	15.8%	0.004	15.8%	0.005	15.8%	0.021

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Southwest	**15.9%**	**0.000**	**16.0%**	**0.000**	**16.0%**	**0.000**	**16.0%**	**0.000**
Southeast	15.6%	0.000	15.7%	0.000	15.7%	0.000	15.7%	0.000
Detroit Metro	13.8%	0.000	13.9%	0.000	13.9%	0.000	13.9%	0.000
Cost obligation in prior period								
No	15.8%							
Yes	7.3%	0.000						
Invoice amount in prior period								
$0			15.2%	0.000	15.4%	0.000		0.000
$5			14.9%		14.9%			
$10			14.6%		14.5%			
$15			14.4%		14.1%			
$25			13.8%		13.3%			
$35			13.3%		12.7%			
$50			12.5%		11.7%			
$65			11.8%		10.9%			
$75			11.4%		10.4%			
$85			10.9%		10.0%			
$100			10.3%		9.4%			
$150			8.4%		7.9%			
$200			6.8%		7.0%			
$300			4.4%		6.7%			
Interaction (Always 100 X invoice prior)								
Always Below 100: $0							15.4%	0.000
Always Above 100: $0							15.4%	
Always Below 100: $5							14.1%	
Always Above 100: $5							15.6%	
Always Below 100: $10							13.0%	
Always Above 100: $10							15.9%	
Always Below 100: $15							12.0%	
Always Above 100: $15							16.1%	
Always Below 100: $25							10.2%	
Always Above 100: $25							16.6%	
Always Below 100: $35							8.8%	
Always Above 100: $35							**16.9%**	
Always Below 100: $50							7.1%	

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Always Above 100: $50							**17.2%**	
Always Below 100: $65							5.9%	
Always Above 100: $65							17.4%	
Always Below 100: $75							5.3%	
Always Above 100: $75							17.4%	
Always Below 100: $85							4.8%	
Always Above 100: $85							17.3%	
Always Below 100: $100							4.3%	
Always Above 100: $100							16.9%	
Always Below 100: $150							3.4%	
Always Above 100: $150							14.6%	
Always Below 100: $200							3.7%	
Always Above 100: $200							10.9%	
Always Below 100: $300							10.8%	
Always Above 100: $300							3.7%	
Total observations	879,228		879,228		879,228		879,228	

Notes: 1) Prior period invoice is operationalized as a continuous variable and thus has only 1 p-value indicating the statistical significance of the relationship. In the quadratic specification, both prior invoice and (prior invoice)^2 have $p < 0.001$

2) This is the result of 4 separate regressions run with dependent variable of disenrollment in t+1 (next time period):

a) using cost obligation in t to predict disenrollment (t+1) in first 3 periods

b) using invoice amount (as a continuous variable) to predict disenrollment in (t+1) categories reported were generated using predictive margins

Table 4.3a Predicted Likelihood of Disenrollment in Period--Using Contribution

	Contribution Obligation in Prior Period	p-value	Contribution Amount in Prior Period	p-value	Quadratic in Contribution Amount in Prior Period	p-value	Quadratic in Contribution Amount in Prior Period and Interacting Above/Below 100 FPL	p-value
Federal Poverty Level Category			14.6%		14.7%			
0-35%	10.1%	0.000	11.8%	0.000	11.8%	0.000		
36-99%	8.1%	0.000	16.3%	0.000	16.1%	0.000		
100% +	8.7%							
Age			20.7%		20.7%		20.7%	
Under 30	13.0%	0.000	14.7%	0.000	14.7%	0.000	14.6%	0.000
30 to 39	9.5%	0.000	12.1%	0.000	12.1%	0.000	12.1%	0.000
40 to 49	8.2%	0.000	10.6%	0.000	10.6%	0.000	10.7%	0.000
Over 50	7.3%							
Gender			17.3%		17.3%		17.4%	
Male	11.4%	0.000	11.3%	0.000	11.3%	0.000	11.3%	0.000
Female	7.5%							
Race			13.1%		13.1%		13.1%	
White	8.7%	0.000	13.4%	0.001	13.4%	0.000	13.6%	0.000
Black	9.0%	0.000	16.0%	0.000	16.0%	0.000	16.1%	0.000
American Indian	10.5%	0.000	15.0%	0.000	15.0%	0.000	15.0%	0.000
Hispanic	9.7%	0.000	17.1%	0.000	17.1%	0.000	16.8%	0.000
Asian/Pacific Islander	11.1%	0.000	22.5%	0.000	22.5%	0.000	22.4%	0.000
Unknown	14.2%							
Region			12.9%		12.9%		12.8%	
Upper Penninsula	8.6%	0.000	15.1%	0.000	15.1%	0.000	15.0%	0.000
Northwest	9.7%	0.003	12.3%	0.000	12.3%	0.000	12.3%	0.000
Northeast	8.2%	0.000	14.7%	0.000	14.7%	0.000	14.8%	0.000
West	9.7%	0.000	12.9%	0.000	12.9%	0.000	12.9%	0.000
East Central	8.6%	0.000	13.5%	0.000	13.5%	0.000	13.5%	0.000
East Central	9.0%	0.017	15.8%	0.003	15.8%	0.002	15.8%	0.007

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South Central	10.4%	0.000	16.0%	0.000	16.0%	0.000	16.1%	0.000
Southwest	10.5%	0.000	15.7%	0.000	15.7%	0.000	15.7%	0.000
Southeast	10.2%	0.000	13.9%	0.000	13.9%	0.000	13.9%	2.82E-33
Detroit Metro	9.2%							
Contribution Obligation in Prior Period								
No	9.0%							
Yes	13.2%	0.000						
Invoice Amount in Prior Period			14.8%	0.000	14.7%	0.000		
$0			14.6%		14.6%			
$5			14.4%		14.5%			
$10			14.2%		14.4%			
$15			13.8%		14.2%			
$25			13.4%		13.9%			
$35			12.9%		13.5%			
$50			12.3%		13.0%			
$65			12.0%		12.7%			
$75			11.6%		12.3%			
$85			11.1%		11.8%			
$100			9.6%		9.9%			
$150			8.3%		8.0%			
$200			6.1%		4.4%			0.000
$300								
Interaction Always100 # Invoice Prior								
Always Below 100: $0							14.6%	0.000
Always Above 100: $0							14.6%	
Always Below 100: $5							13.8%	
Always Above 100: $5							15.0%	
Always Below 100: $10							13.1%	
Always Above 100: $10							15.4%	

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Always Below 100: $15							12.5%	
Always Above 100: $15							15.8%	
Always Below 100: $25							11.3%	
Always Above 100: $25							16.5%	
Always Below 100: $35							10.3%	
Always Above 100: $35							17.1%	
Always Below 100: $50							9.0%	
Always Above 100: $50							17.8%	
Always Below 100: $65							8.0%	
Always Above 100: $65							18.2%	
Always Below 100: $75							7.5%	
Always Above 100: $75							18.3%	
Always Below 100: $85							7.0%	
Always Above 100: $85							18.3%	
Always Below 100: $100							6.5%	
Always Above 100: $100							18.0%	
Always Below 100: $150							5.5%	
Always Above 100: $150							15.2%	
Always Below 100: $200							5.6%	
Always Above 100: $200							10.6%	
Always Below 100: $300							9.6%	
Always Above 100: $300							2.5%	
Total Observations			879,228		879,228		879,228	
	1,327,596							

Table 4.3b Predicted Likelihood of Disenrollment in the Period--Using Copay

	Copay Obligation in Prior Period	p-value	Copay Amount in Prior Period	p-value	Quadratic in Copay Amount in Prior Period	p-value	Quadratic in Copay Amount in Prior Period and Interacting Above/Below 100 FPL	p-value
Federal Poverty Level Category								
0-35%	9.9%		14.3%		14.2%			
36-99%	8.0%	0.000	12.9%	0.000	13.0%	0.000		
100% +	9.7%	0.015	15.8%	0.000	15.9%	0.000		
Age								
Under 30	12.9%		20.0%		20.0%		20.0%	
30 to 39	9.5%	0.000	14.5%	0.000	14.5%	0.000	14.5%	0.000
40 to 49	8.2%	0.000	12.2%	0.000	12.2%	0.000	12.2%	0.000
Over 50	7.4%	0.000	10.9%	0.000	10.9%	0.000	11.0%	0.000
Gender								
Male	11.3%		16.8%		16.8%		16.8%	
Female	7.6%	0.000	11.6%	0.000	11.7%	0.000	11.7%	0.000
Race								
White	8.8%		13.2%		13.3%		13.3%	
Black	8.9%	0.015	13.2%	0.817	13.2%	0.610	13.2%	0.000
American Indian	10.3%	0.000	15.3%	0.000	15.2%	0.000	15.2%	0.000
Hispanic	9.7%	0.000	14.9%	0.000	14.9%	0.000	14.9%	0.000
Asian/Pacific Islander	11.1%	0.000	17.0%	0.000	17.0%	0.000	17.0%	0.000
Unknown	14.1%	0.000	22.2%	0.000	22.2%	0.000	22.2%	0.000
Region								
Upper Penninsula	8.7%		12.9%		12.9%		13.0%	
Northwest	9.8%	0.002	15.1%	0.000	15.1%	0.000	15.1%	0.000
Northeast	8.3%	0.000	12.5%	0.000	12.6%	0.000	12.6%	0.000
West	9.7%	0.000	14.5%	0.000	14.5%	0.000	14.6%	0.000
East Central	8.6%	0.000	13.0%	0.000	13.0%	0.000	13.0%	0.000
East	9.0%	0.000	13.6%	0.000	13.6%	0.000	13.6%	0.000

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South Central	10.4%	0.067	15.9%	0.021	15.9%	0.026	15.9%	0.007
Southwest	10.5%	0.000	15.9%	0.000	15.9%	0.000	15.9%	0.000
Southeast	10.2%	0.000	15.6%	0.000	15.6%	0.000	15.6%	0.000
Detroit Metro	9.2%	0.000	13.9%	0.000	13.9%	0.000	13.9%	
Cost Obligation in Prior Period								
No	9.5%							
Yes	9.0%	0.000		0.000				
Invoice Amount in Prior Period								
$0			15.9%		16.1%	0.000		
$5			12.8%		12.3%			
$10			10.2%		9.4%			
$15			8.0%		7.3%			
$25			4.9%		4.6%			
$35			3.0%		3.1%			
$50			1.4%		2.0%			
$65			0.6%		1.5%			
$75			0.4%		1.4%			
$85			0.2%		1.4%			
$100			0.1%		1.7%			
$150			0.0%		11.3%			
$200			0.0%		87.8%			
$300								
Interaction Always100 # Invoice Prior								
Always Below 100: $0							16.1%	0.000
Always Above 100: $0							16.1%	
Always Below 100: $5							12.0%	
Always Above 100: $5							12.9%	
Always Below 100: $10							9.1%	
Always Above 100: $10							10.4%	
Always Below 100: $15							6.9%	
Always Above 100: $15							8.4%	

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Always Below 100: $25							4.2%	
Always Above 100: $25							5.6%	
Always Below 100: $35							2.8%	
Always Above 100: $35							3.9%	
Always Below 100: $50							1.8%	
Always Above 100: $50							2.5%	
Always Below 100: $65							1.4%	
Always Above 100: $65							1.7%	
Always Below 100: $75							1.3%	
Always Above 100: $75							1.5%	
Always Below 100: $85							1.4%	
Always Above 100: $85							1.3%	
Always Below 100: $100							1.7%	
Always Above 100: $100							1.2%	
Always Below 100: $150							15.7%	
Always Above 100: $150							2.3%	
Always Below 100: $200							95.0%	
Always Above 100: $200							14.9%	
Always Below 100: $300							n/a	
Always Above 100: $300							n/a	
Total Observations	1,327,596		879,228		879,228		879,228	

Table 4.4 Detailed Statistical Summary of Average Quarterly Invoice

	Values at Each Percentile of Distribution
1%	0
5%	0
10%	0
25%	0
50%	0
75%	0
90%	26
95%	72
99%	145

Measure	Values
Observations	1,328,015
Mean	9.08
Std. Dev.	27.58
Variance	760.58
Smallest 4 values	0, 0, 0, 0
Largest 4 values	294, 317, 318, 336

Table 4.4a Marginal Effects from a Logit Disenrollment Model that Includes Invoice and Number of Chronic Disease Claims

Marginal Effects from a Logit Disenrollment Model that Includes Invoice and Number of Chronic Disease Claims		
	Marginal Effects	p-value on coefficient
Prior Period Invioce Amount (in dollars)	-0.08%	0.000
Total Chronic Disease Claims (# of claims): 0	ref	
Total Chronic Disease Claims (# of claims): 1-3	-5.00%	0.000
Total Chronic Disease Claims (# of claims): 4-10	-7.92%	0.000
Total Chronic Disease Claims (# of claims): 11+	-10.50%	0.000
Age		
Under 30	ref	
30 to 39	-4.81%	0.000
40 to 49	-6.40%	0.000
Over 50	-7.40%	
Federal Poverty Level Category		
0-35%	ref	0.000
36-99%	-2.98%	0.000
100% +	2.16%	0.000
Gender		
Male	ref	
Female	-5.20%	0.000
Race		
White	ref	
Black	0.02%	0.793
American Indian	3.06%	0.000
Hispanic	1.66%	0.000
Asian/Pacific Islander	3.14%	0.000
Unknown	8.71%	0.000
Region		
Upper Penninsula	-1.32%	0.000
Northwest	1.30%	0.000
Northeast	-1.44%	0.000
West	0.90%	0.000
East Central	-0.70%	0.000
East Central	-0.21%	0.099
South Central	1.68%	0.000
Southwest	2.17%	0.000
Southeast	1.59%	0.000
Detroit Metro	ref	
Total Observations	879,228	

Table 4.5 Predicted Disenrollment by Chronic Disease Claims and Total Spending (Plan and Cost Sharing)

	Any Claim in Prior Period	p-value	Conditional on Chronic Disease Claim: Amount of Claims	p-value	Any Spending in Prior Period	p-value	Amount of Spending	p-value on regression coefficient
Federal Poverty Level Category								
0-35%	10.1%		10.5%		9.9%		15.1%	
36-99%	7.8%	0.000	8.7%	0.000	8.0%	0.000	11.8%	0.000
100% +	9.4%	0.000	11.3%	0.000	9.6%	0.000	14.4%	0.000
Age								
Under 30	11.6%		15.1%		12.3%		19.1%	
30 to 39	9.1%	0.000	10.9%	0.000	9.3%	0.000	14.2%	0.000
40 to 49	8.6%	0.000	9.1%	0.000	8.4%	0.000	12.6%	0.000
Over 50	8.2%	0.000	8.5%	0.000	7.7%	0.000	11.4%	0.000
Gender								
Male	11.0%		12.1%		10.6%		16.3%	
Female	7.8%	0.000	8.7%	0.000	8.1%	0.000	12.1%	0.000
Race								
White	8.8%		9.6%		8.9%		13.4%	
Black	8.8%	0.868	9.2%	0.001	8.6%	0.000	13.0%	0.000
American Indian	11.1%	0.000	11.7%	0.000	11.0%	0.000	17.2%	0.000
Hispanic	9.7%	0.000	10.7%	0.000	9.7%	0.000	14.8%	0.000
Asian/Pacific Islander	10.5%	0.000	12.3%	0.000	10.7%	0.000	16.2%	0.000
Unknown	14.0%	0.000	16.8%	0.000	14.0%	0.000	21.8%	0.000
Region								
Upper Penninsula	8.2%	0.000	9.1%	0.000	8.6%	0.000	12.5%	
Northwest	10.0%	0.000	10.8%	0.001	9.9%	0.000	15.0%	0.000
Northeast	8.4%	0.000	9.2%	0.001	8.4%	0.000	12.3%	0.000
West	9.8%	0.000	10.6%	0.005	9.9%	0.000	15.0%	0.000
East Central	8.9%	0.000	9.3%	0.000	8.7%	0.000	12.9%	0.000
East Central	9.2%	0.008	9.9%	0.000	9.2%	0.000	13.6%	0.000

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South Central	10.2%	0.672	11.2%	0.676	10.3%	0.809	15.4%	0.002
Southwest	10.6%	0.000	11.6%	0.000	10.4%	0.000	15.9%	0.000
Southeast	10.0%	0.000	10.9%	0.000	10.2%	0.000	15.5%	0.000
Detroit Metro	9.2%	0.000	10.0%	0.000	9.2%	0.000	13.9%	0.000
Claim in Prior Period								
No	18.1%							
Yes	5.3%	0.000						
Conditional on Claim: Number of Claims								
1			11.5%	0.000				
5			10.1%					
15			7.2%					
25			5.1%					
35			3.6%					
50			2.1%					
65			1.2%					
75			0.8%					
100			0.3%					
Any Spending in Prior Period								
No					24.3%			
Yes					7.5%	0.000		
Total Spending in Prior								
No Spending							23.6%	
$1 - $19							16.9%	0.000
$20-$40							15.5%	0.000
$50 - $99							13.5%	0.000
$100 - $349							11.0%	0.000
$350 +							8.1%	0.000
Total Observations	1327596		463634		1327596		879226	

Table 4.6 Descriptive Table of Population Used in Regression Discontinuity Regressions (up to 13 Months Follow-up)

Descriptive Statistics -- 13 Months Follow-up			
	Disenroller	Continuously Enrolled	P-value from two-sample ttest
Female (%)	51.1	63.1	<0.001
Age (mean)	37.6	40.4	<0.001
First enrollment month	Nov-14	Oct-14	<0.001
FPL percent	85	76.4	<0.001
Region			
Northern Michigan	9.9	10.4	0.003
Central Michigan	30.9	31.1	0.451
Southern Michigan	22.9	19.4	<0.001
Detroit	36.3	39.1	<0.001
Race			
White	61.8	66.6	<0.001
Black	17.7	19.8	<0.001
Other	20.5	13.5	<0.001
Monthly medical spending (mean $)	165.67	296.51	<0.001
Monthly number of chronic disease claims (mean)	0.24	0.42	<0.001
Received contribution statement (%)	24.5	20.1	<0.001
Received copay statement (%)	27.4	40.4	<0.001
Contribution Invoice (mean $)	3.17	2.09	<0.001
Copay Invoice (mean $)	0.35	0.54	<0.001
Total Number	39,289	156,206	
Notes:			
Inclusion Criteria: 1) Not part of special population 2) Between 22 and 62 years of age 3) Enrolled in HMP-MC before Sept 2015, so that we have at least 13 months of potential observation 4) At least 7 months of continuous HMP-MC enrollment 5) Income between 1% and 133% FPL			
Disenroller: Drops HMP-MC after a spell of at least 7 months in the program up to 13 months in program. Disenrollers must not come back to any Michigan Medicaid program for at least 6 months. Must have dropped from HMP-MC, i.e. not switched into another program and then dropped.			

Table 4.7 Basic Statistics for RD Population

13-month total follow-up		
	Percent	Total Number in Group
Percent with Contribution with FPL rounded to nearest 1…..		
99 to 100	22.8	1766
100 to 101	41.2	1791
Contribution Amount	Mean	
Overall	2.31	195,495
90 to 100	1.56	18,411
100 to 110	4.49	20,970
95 to 100	1.81	9,067
100 to 105	4.36	11,810
Percent Disenroller	Percent	
Overall	20.1	195,495
< 100 % FPL	17.9	131,120
>= 100% FPL	24.6	64,375
100 to < 115 FPL	22.8	28,121
85 to < 100 FPL	20.6	28,457
100 to < 105	22.7	9,977
95 to < 100	19.5	9,067
Subgroup with Lower than Median Medical Spending (1st 7 Months)		
Overall	25.9	98,203
< 100 % FPL	23.5	64,582
>= 100% FPL	30.6	33,621
100 to < 115 FPL	28.4	14,788
85 to < 100 FPL	25.5	14,858
100 to < 110	27.8	10,159
90 to < 100	24.3	9,623
Subgroup with Higher than Median Medical Spending (1st 7 Months)		
Overall	14.2	97292
< 100 % FPL	12.4	66538
>= 100% FPL	18.1	30754
100 to < 115 FPL	16.5	13333
85 to < 100 FPL	15.2	13599
100 to < 110	16.1	9038
90 to < 100	15.1	8788
Subgroup with No Chronic Disease Claims (1st 7 Months)		
Overall	25.1	92359
< 100 % FPL	22.8	61181
>= 100% FPL	29.8	31178
100 to < 115 FPL	27.5	13799

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85 to < 100 FPL	**25.0**	**14161**
100 to < 110	27.1	9505
90 to < 100	24.3	9177
Subgroup with at least 1 Chronic Disease Claim (1st 7 Months)		
Overall	15.6	103,136
< 100 % FPL	13.6	69,939
>= 100% FPL	19.8	33,197
100 to < 115 FPL	18.2	14,322
85 to < 100 FPL	16.2	14,296
100 to < 110	17.6	9,692
90 to < 100	15.6	9,234

Table 4.8 Regression Discontinuity Estimates, 13 Month

Population followed 13 Months						
Total sample N=195495; Income sample (85 – 115%: 56,578						
Bandwidth selector: linear sharp: MSERD (12.4) CER (6.7); quadratic, sharp: MSERD: 11.1, CER: 5.5)						
Bandwidth selector: linear fuzzy: MSERD (8.3) CER (4.5); quadratic fuzzy: MSERD: (16.3) CER: (8.1)						
RUNNING VARIABLE: AVERAGE FPL PERCENT						
Specification	Bandwidth (equal on both sides)	Covariates?	Estimate (in percentage points)	p-value	First stage coefficient (ppts)	p-value
SHARP: rdrobust, linear	6.749 (CER optimal, triangular kernel	Y	0.8	>0.1		
SHARP: rdrobust, linear	6.5 (CER optimal, uniform kernel)	Y	2.9	<0.01		
SHARP: rdrobust, linear	7	Y	1.02	0.378		
SHARP: rdrobust, linear	10	Y	2.3	0.015		
SHARP: rdrobust, linear	12	Y	2.6	0.002		
SHARP: rdrobust, linear	15	Y	2.5	0.001		
SHARP: rdrobust, linear	12.4	Y	2.7	<=0.01		
SHARP: rdrobust, quadratic	6	Y	-7.6	0.001		
SHARP: rdrobust, quadratic	10	Y	-0.87	0.558		
SHARP: rdrobust, quadratic	12	Y	0.36	0.786		
SHARP: rdrobust, quadratic	15	Y	2.02	0.079		
SHARP: regress, linear	10	Y	4.6	<0.001	p-value on coefficient plus100	
SHARP: regress, linear	15	Y	4.4	0.228	p-value on coefficient plus100	
FUZZY: rdrobust, linear	4.5 (CER optimal, triangular kernel)	Y	-17.6	<=0.1	16	<0.01
FUZZY: rdrobust, linear	4.5 (CER optimal, uniform kernel)	Y	-6.7	>0.1	19	<0.01
FUZZY: rdrobust, linear	5	Y	-14.7	0.086	17	<0.001
FUZZY: rdrobust, linear	8.3	Y	9.4	<=0.1	19.1	<0.001
FUZZY: rdrobust, linear	10	Y	11.6	0.016	19	<0.001
FUZZY: rdrobust, linear	12	Y	13.2	0.002	20	<0.001
FUZZY: rdrobust, linear	15	Y	12.4	0.001	20.3	<0.001
FUZZY: rdrobust, quadratic	8	Y	-25.3	0.02	16	<0.001
FUZZY: rdrobust, quadratic	10	Y	-5.1	0.556	17	<0.001

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FUZZY: rdrobust, quadratic	**12**	**Y**	**2**	**0.787**	**18**	**<0.001**
FUZZY: rdrobust, quadratic	15		11	0.084	18	<0.001
FUZZY: rdrobust, quadratic	16	y	11	0.068	18	<0.001
FUZZY: 2sls, linear	none	Y	4.3	<0.001		
RUNNING VARIABLE: MINIMUM REPORTED FPL						
Bandwidth selector: linear sharp: MSERD (9) CER (5); quadratic, sharp: MSERD: (9), CER: (4)						
Bandwidth selector: linear fuzzy: MSERD (7) CER (4); quadratic fuzzy: MSERD: (12) CER: (6)						
SHARP: rdrobust, linear	5	Y	-3.7	0.021		
SHARP: rdrobust, linear	9	Y	1.6	0.134		
SHARP: rdrobust, linear	10	Y	2	0.54		
SHARP: rdrobust, linear	12	Y	2.5	0.007		
SHARP: rdrobust, quadratic	10	Y	-1.8	0.29		
SHARP: rdrobust, quadratic	12	Y	-0.39	0.79		
FUZZY: rdrobust, linear	5	Y	-18.8	0.02	20	<0.001
FUZZY: rdrobust, linear	7	Y	2.6	0.649	22	<0.001
FUZZY: rdrobust, linear	10	Y	8.5	0.056	23	<0.001
FUZZY: rdrobust, linear	12	Y	10.6	0.008	23	<0.001
FUZZY: rdrobust, quadratic	10	Y	-8.8	0.286	20	<0.001
FUZZY: rdrobust, quadratic	12	Y	-1.8	0.79	21	<0.001
FUZZY: rdrobust, quadratic	15	Y	10.2	0.003	24	<0.001
FUZZY: 2sls, linear	none	N	-9.3	<0.001		

Table 4.9 Subgroup Analyses on RD Estimates, Medical Claims

	Specification	Bandwidth (equal on both sides)	Covariates?	Estimate (in percentage points)	p-value	First stage coefficient	p-value
Chronic Disease Claims							
No Chronic Disease Claims (n=92,359)							
	Sharp: rdrobust linear	10	Y	3.4 (0.014)	0.013		
	Sharp: rdrobust linear	10.73 (mse chosen)	Y	3.5 (0.013)	0.008		
	Fuzzy: rdrobust linear	10	Y	14.6 (0.060)	0.015	0.23 (0.014)	<0.001
	Fuzzy: rdrobust linear	12	Y	15.0(0.053)	0.005	0.24 (0.013)	<0.001
	Fuzzy: rdrobust linear	8.4 (mse; chosen)	Y	14.1 (0.068)	0.038	.23 (0.016)	<0.001
Chronic Disease Claims (n=103,136)							
	Sharp: rdrobust linear	5.66 (mse chosen)	Y	-2.4 (0.017)	0.169		
	Sharp: rdrobust linear	6	Y	-2.21 (0.017)	0.221		
	Sharp: rdrobust linear	10	Y	0.72 (0.012)	0.555		
	Fuzzy: rdrobust linear	6	Y	-14.3 (0.12)	0.219	0.15 (0.020)	<0.001
	Fuzzy: rdrobust linear	10	Y	4.8 (0.081)	0.56	0.15 (0.014)	<0.001
	Fuzzy: rdrobust linear	12	Y	8.1 (0.073)	0.267	0.15 (0.013)	<0.001
	Fuzzy: rdrobust linear	8.5mse; chosen	Y	1.1 (0.090)	.902	0.15 (0.015)	<0.001
Using Contribution Amount							
No Chronic Disease Claims	Contribution Amount (FPL at 100)	8.93 (mse chosen)	Y	1.23 (0.0055)	.027	2.71 (0.0177)	<0.001
	Contribution Amount (FPL at 100)	10	Y	1.24 (.0051)	0.015	2.75 (0.17)	<0.001
Chronic Disease Claims	Contribution Amount (FPL at 100)	8.65 (mse chosen)	Y	0.14 (0.0078)	.863	1.70 (0.18)	<0.001
	Contribution Amount (FPL at 100)	10	Y	0.42 (0.0072)	.588	1.71 (0.164)	<0.001

Table 4.10 Estimates Using Monthly Contribution Statement Amounts

Estimates Using Monthly Contribution Statement Amount (not just indicator)								
Specification	Outcome	Independent variable (Instrument)	Estimate (ppts)	Covariates	p-value	Bandwidth (Imputed?)	First Stage Estimate	P-value
Sharp: rdrobust	contribution amount	FPL	2.22	N	<0.001	7.7 (N)		
Sharp: rdrobust	contribution amount	FPL	2.03	N	<0.001	5 (Y)		
Sharp: rdrobust	contribution amount	FPL	2.25	N	<0.001	10 (Y)		
Sharp: rdrobust	contribution amount	FPL	2.02	Y	<0.001	5 (Y)		
Sharp: rdrobust	contribution amount	FPL	2.25	Y	<0.001	10 (Y)		
Fuzzy: rdrobust	disenroller	Contribution Amount (FPL at 100)	0.97	N	0.03	9.162 (N)	2.23	<0.001
Fuzzy: rdrobust	disenroller	Contribution Amount (FPL at 100)	0.803	Y	0.088	8.244(N)	2.22	<0.001
Fuzzy: rdrobust	disenroller	Contribution Amount(FPL at 100)	1.044	N	0.013	10 (Y)	2.25	<0.001
Fuzzy: rdrobust	disenroller	Contribution Amount (FPL at 100)	1.007	Y	0.016	10(Y)	2.25	<0.001
Fuzzy: rdrobust	Disenrollller	Contribution Amount (FPL at 100)`	1.1	Y	<=0.05	15(Y)	2.31	<0.001
Regress	disenroller	Contribution Amount	0.65	Y	<0.001			
Subgroup Analyses								
Below Median Spending	Disenroller	Contribution Amount (FPL at 100)	1.15	Y	0.048	7.867 (N)	2.834	<0.001
	Disenroller	Contribution Amount (FPL at 100)	1.251	Y	0.008	10(Y)	2.917	<0.001
Above Median Spending	Disenroller	Contribution Amount (FPL at 100)	0.568	Y	.448	11.889(N)	1.48	<0.001
	Disenroller	Contribution Amount (FPL at 100)	0.367	Y	.659	10(Y)	1.47	<0.001
No Chronic Disease Claims	Disenroller	Contribution Amount (FPL at 100)	1.29	Y	.020	8.937(N)	2.720	<0.001
	Disenroller	Contribution Amount (FPL at 100)	1.453	Y	.005	10(Y)	2.77	<0.001

Chronic Disease Claims	Disenroller	Contribution Amount (FPL at 100)	0.089	Y	.910	8.607(N)	1.70	<0.001
	Disenroller	Contribution Amount (FPL at 100)	0.389	Y	.589	10(Y)	1.71	<0.001

Table 4.11 Alternative Specifications and Sensitivity Checks

	Effect of exceeding cutoff on				Treatment effect of	
	Any contribution (1/0)	Contribution Amount ($)	Disenrolled		Any Contribution (1/0)	Contribution Amount ($)
	(percentage points)		(percentage points)		(percentage points)	(percentage points)
Standard errors in italics						
CER Bandwidth (triangular kernel)	16*** (4.6) *0.016*	2.03*** (5.0) *0.18*	0.71 (6.7) *0.012*		-16.2* (4.6) *0.090*	-1.4* (4.6) *0.0076*
CER Bandwidth (uniform kernel)	19*** (4.6) *0.015*	2.26*** (4.6) *0.17*	2.9*** (6.5) *0.11*		-6.5 (4.6) *0.072*	-0.54 (4.6) *0.0061*
Global linear (2sls)	36*** *0.0021*	4.34*** *0.028*			5.7*** *0.0099*	0.83*** *0.00082*
Retaining Average FPL 0% (n=410,295)						
MSE-Optimal Bandwidth (in brackets)	19*** (7.8) *0.012*	2.21*** (7.7) *0.13*	-4.0** (3.8) *0.017*		8.1 (7.8) *0.057*	0.67 (7.7) *0.0049*
BW = 10	19*** *0.010*	2.24*** *0.12*	2.2** *0.0093*		11.3** *0.049*	0.98 *0.0042*
BW = 15	20*** *0.0081*	2.31*** *0.095*	2.4*** *0.0075*		12*** *0.037*	1.1*** *0.0033*
Using 12-month follow up (MSE-optimal) (n=166,014)	20*** (7.0) *0.015*	2.31 (8.9) *0.14*	1.9* (10.1) *0.011*		3.4 (7.0) *0.067*	0.7 (8.9) *0.0050*
Using 12-month follow up, BW=10	22*** *0.012*	2.35*** *0.14*	1.9* *0.011*		8.6* *0.050*	0.81* *0.0046*
Using 12-month follow up, BW=15	23*** *0.0098*	2.45*** *0.11*	1.8** *0.0086*		7.8** *0.038*	0.73** *0.0036*
Running variable of minimum reported FPL, MSE-optimal bandwidth	22*** (7.5) *0.012*	2.62*** (7.3) *0.14*	1.8* (9.6) *0.010*		4.6 (7.5) *0.054*	0.35 (7.3) *0.0047*
Running variable of minimum reported FPL, BW=10	23*** *0.010*	2.68*** *0.12*	1.9* *0.010*		8.3* *0.045*	0.71* *0.0038*

Notes: Each row shows estimates using a different bandwidth. Columns 1-3 present estimates of a "sharp" regression discontinuity design on the probability an enrollee faces any premium (column 1), the amount of premium they are asked to contribute (column 2), and the probability that they disenroll (column 3). Columns 4 and 5 scale the disenrollment effect by the probability of receiving a premium (column 4) or the premium amount (column 5), presenting the "treatment on the treated" effect of these measures. Significance levels: *=0.10, **=0.05, ***=0.01.

Table 4.12 Sensitivity Check: Descriptive Statistics for Population Followed up to 19 Months

	Disenroller	Continuously Enrolled	P-value from two-sample ttest
Female (%)	52	63.4	<0.001
Age (mean)	38.2	40.4	<0.001
First enrollment month	Aug-14	Aug-14	<0.001*
FPL percent	81.3	71.9	<0.001
Region			
Northern Michigan	10.2	10.3	0.64
Central Michigan	31.7	31.2	0.095
Southern Michigan	23	19.3	<0.001
Detroit	35.1	39.2	<0.001
Race			
White	62.2	66.1	<0.001
Black	18.5	20.8	<0.001
Other	19.4	13.1	<0.001
Monthly medical spending (mean)	186.52	296.19	<0.001
Monthly number of chronic disease claims (mean)	0.26	0.42	<0.001
Received contribution statement (%)	22.7	25.4	<0.001
Received copay statement (%)	29.8	50.9	<0.001
Contribution Invoice (mean)	2.75	2.36	<0.001
Copay Invoice (mean)	0.37	0.62	<0.001
Total Number	35,283	130,731	
Notes:			
Inclusion Criteria: 1) Not part of special population 2) Between 22 and 62 years of age 3) Enrolled in HMP-MC before March 2015, so that we have at least 19 months of potential observation 4) At least 7 months of continuous HMP-MC enrollment 5) Income between 1% and 133% FPL			
Disenroller: Drops HMP-MC after a spell of at least 7 months in the program up to 13 months in program. Disenrollers must not come back to any Michigan Medicaid program for at least 6 months. Must have dropped from HMP-MC, i.e. not switched into another program and then dropped.			
*These are different because disenrollers tend to enroll toward end of month (6.5) while enrollers are toward beginning of month (6.1) likely suggesting more enrollers in earlier parts of program			

Table 4.13 Sensitivity Check--Basic Statistics 19 Months Enrollment

19 month total follow up		
	Percent	Total Number in Group
Percent with Contribution with FPL rounded to nearest 1…..		
99 to 100	31.8	1352
100 to 101	48.1	1394
Percent Disenroller		
Overall	19.4	166,014
< 100 % FPL	16.6	118,252
>= 100% FPL	26.2	47,762
100 to < 115 FPL	23.6	21,308
85 to < 100 FPL	21.3	22, 373
100 to < 105	23	7,664
95 to < 100	20.4	7,011

Table 4.14 Sensitivity Check: RD Estimates from Population Followed for up to 19 Months

Sample followed 19 Months						
Total sample N=166,014						
Bandwidth selector: linear sharp: MSERD (10) CER (6); quadratic, sharp: MSERD: 13, CER: 7)						
Bandwidth selector: linear fuzzy: MSERD (7) CER (4); quadratic fuzzy: MSERD: (16) CER: (8)						
RUNNING VARIABLE: AVERAGE FPL PERCENT						
Specification	Bandwidth (equal on both sides)	Covariates?	Estimate (in percentage points)	p-value	First stage coefficient	p-value
SHARP: rdrobust, linear	7	Y	0.65	0.627		
SHARP: rdrobust, linear	10	Y	1.9	0.077		
SHARP: rdrobust, linear	12	Y	2	0.038		
SHARP: rdrobust, linear	15	Y	1.8	0.035		
SHARP: rdrobust, quadratic	5	Y	-0.14	0.68		
SHARP: rdrobust, quadratic	10	Y	-0.85	0.626		
SHARP: rdrobust, quadratic	12	Y	0.46	0.766		
SHARP: rdrobust, quadratic	15	Y	1.8	0.178		
SHARP: regress, linear	10	Y	4.5	<0.001		
SHARP: regress, linear	15	Y	4.5	0.545		
FUZZY: rdrobust, linear	5	Y	-9.5	0.337	0.168	<0.001
FUZZY: rdrobust, linear	8	Y	5.9	0.315	0.21	<0.001
FUZZY: rdrobust, linear	10	Y	8.6	0.082	0.22	<0.001
FUZZY: rdrobust, linear	12	Y	9	0.041	0.224	<0.001
FUZZY: rdrobust, linear	15	Y	7.9	0.038	0.231	<0.001
FUZZY: rdrobust, quadratic	5	Y	-22.2	0.673	0.061	0.094
FUZZY: rdrobust, quadratic	10	Y	-4.9	0.623	0.174	<0.001
FUZZY: rdrobust, quadratic	12	Y	2.33	0.767	0.195	<0.001
FUZZY: rdrobust, quadratic	15		8.75	0.186	0.204	<0.001
FUZZY: 2sls, linear	none	Y	4	<0.001		

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RUNNING VARIABLE: MINIMUM REPORTED FPL						
Bandwidth selector: linear sharp: MSERD (11) CER (6); quadratic, sharp: MSERD: (12), CER: (6)						
Bandwidth selector: linear fuzzy: MSERD (6) CER (4); quadratic fuzzy: MSERD: (14) CER: (7)						
SHARP: rdrobust, linear	5	Y	-3.1	0.106		
SHARP: rdrobust, linear	9	Y	1.6	0.221		
SHARP: rdrobust, linear	10	Y	1.8	0.131		
SHARP: rdrobust, linear	12	Y	1.9	0.074		
SHARP: rdrobust, quadratic	10	Y	-1.2	0.535		
SHARP: rdrobust, quadratic	12	Y	0.29	0.866		
FUZZY: rdrobust, linear	5	Y	-14.5	0.1	0.21	<0.001
FUZZY: rdrobust, linear	7	Y	2.7	0.667	0.24	<0.001
FUZZY: rdrobust, linear	10	Y	6.9	0.136	0.26	<0.001
FUZZY: rdrobust, linear	12	Y	7.2	0.078	0.27	<0.001
FUZZY: rdrobust, quadratic	10	Y	-5.7	0.531	0.21	<0.001
FUZZY: rdrobust, quadratic	12	Y	1.2	0.867	0.23	<0.001
FUZZY: rdrobust, quadratic	15	Y	6.3	0.072	0.28	<0.001
FUZZY: 2sls, linear	none	N				

Table 4.15 Effect of Premiums on Medicaid Disenrollment

	Effect of exceeding cutoff on				Treatment effect of	
	Any contribution (1/0) (percentage points)	**Contribution Amount ($)**	**Disenrolled (percentage points)**		**Any contribution (1/0) (percentage points)**	**Contribution Amount ($) (percentage points)**
Full Sample						
MSE-Optimal BW	19.1***	2.22***	2.6***		9.4*	0.82*
(in brackets)	(8.3)	(8.4)	(12.3)		(8.3)	(8.4)
	0.011	0.13	0.0083		0.055	0.0046
BW=10	19***	2.24***	2.2**		11.6**	0.98**
	0.010	0.12	0.0093		0.049	0.0042
BW=15	20***	2.31***	2.4***		12.4***	1.1***
	0.0081	0.095	0.0075		0.037	0.0033
Sample Split by Spending in first 7 months enrollment						
Above Median Spending (>$77/month)						
MSE-Optimal BW	14***	1.48***	.023		2.1	0.60
(in brackets)	(9.2)	(11.9)	(8.4)		(9.2)	(11.9)
	0.015	0.16	0.013		0.092	0.0075
BW=10	14***	1.48***	0.57		4.1	0.41
	0.015	0.18	0.012		0.088	0.0084
Below Median Spending (<$77/month)						
MSE-Optimal BW	24***	2.82***	-1.9†		12.8*	1.06*
(in brackets)	(8.0)	(7.9)	(4.2)		(8.0)	(7.9)
	0.016	0.18	0.023		0.067	0.0056
BW=10	24***	2.90***	3.4***		14.3***	1.19***
	0.014	0.16	0.14		0.058	
Means of Dependent Variable below/above cutoff, full sample (FPL split in brackets)	22.8/41.2 (99/100-101)	1.81/4.36 (95-99/100-105)	19.5/22.7 (95-99/100-105)			

Notes: Each row shows estimates using a different bandwidth. Columns 1-3 present estimates of a "sharp" regression discontinuity design on the probability an enrollee faces any premium (column 1), the amount of premium they are asked to contribute (column 2), and the probability that they disenroll (column 3). Columns 4 and 5 scale the disenrollment effect by the probability of receiving a premium (column 4) or the premium amount (column 5), presenting the "treatment on the treated" effect of these measures. BW=bandwidth. Significance levels: *<=0.10, **<=0.05, ***<=0.01. †This number is sensitive to kernel specification around the cutoff. Estimate shown, like others, uses a triangular kernel density specification. With a uniform kernel, the MSE-optimal bandwith is 7.5, estimate is 3.7 and statistically significant (p=0.01).

Table 4.16 Donut Estimator Using MSE-Optimal Bandwidths

	All Eligible					
Dropped FPL	First Stage Estimate	Standard Error	P-value	Treatment Estimate	Standard Error P-value	p-value
95	0.181	0.013	0.000	0.021	0.066	0.753
96	0.186	0.013	0.000	0.053	0.064	0.400
97	0.183	0.013	0.000	0.019	0.066	0.773
98	0.192	0.015	0.000	-0.025	0.071	0.729
99	0.203	0.016	0.000	0.251	0.081	0.002
100	0.204	0.014	0.000	-0.039	0.062	0.525
101	0.189	0.013	0.000	0.247	0.067	0.000
102	0.177	0.012	0.000	-0.039	0.063	0.537
103	0.193	0.012	0.000	0.098	0.057	0.084
104	0.189	0.012	0.000	0.079	0.058	0.172
105	0.189	0.012	0.000	0.074	0.058	0.198
98/99	0.349	0.035	0.000	0.235	0.109	0.032
101/102	0.167	0.015	0.000	0.094	0.082	0.248

Table 4.17 Donut Estimator, Using MSE-Optimal Bandwidths, Split by Medical Spend

	Lower than Median Spend					
Dropped FPL	First Stage Estimate	Standard Error	P-value	Treatment Estimate	Standard Error P-value	P-value
95	0.238	0.014	0.000	0.148	0.061	0.016
96	0.236	0.017	0.000	0.124	0.073	0.087
97	0.231	0.016	0.000	0.117	0.069	0.087
98	0.241	0.015	0.000	0.100	0.064	0.115
99	0.257	0.017	0.000	0.328	0.072	0.000
100	0.253	0.019	0.000	-0.016	0.073	0.827
101	0.242	0.015	0.000	0.305	0.067	0.000
102	0.221	0.017	0.000	0.024	0.076	0.754
103	0.243	0.015	0.000	0.165	0.063	0.010
104	0.237	0.016	0.000	0.129	0.069	0.060
105	0.237	0.016	0.000	0.131	0.068	0.053
98/99	0.277	0.021	0.000	0.377	0.089	0.000
101/102	0.214	0.017	0.000	0.200	0.080	0.012
	Higher than Median Spend					
95	0.133	0.017	0.000	-0.041	0.107	0.705
96	0.135	0.017	0.000	-0.018	0.104	0.865
97	0.124	0.018	0.000	-0.090	0.119	0.451
98	0.150	0.019	0.000	-0.005	0.107	0.959
99	0.142	0.021	0.000	0.157	0.126	0.215
100	0.150	0.021	0.000	-0.083	0.112	0.458
101	0.123	0.022	0.000	-0.026	0.148	0.862
102	0.127	0.018	0.000	-0.168	0.117	0.151
103	0.139	0.016	0.000	0.009	0.098	0.926
104	0.142	0.015	0.000	0.034	0.087	0.694
105	0.139	0.015	0.000	0.029	0.090	0.743
98/99	0.235	0.025	0.000	0.359	0.108	0.001
101/102	0.114	0.019	0.000	-0.034	0.136	0.805

Table 4.18 Donut Estimator, Using MSE-Optimal Bandwidths, Split by Chronic Disease Diagnosis

No Chronic Disease Diagnoses						
Dropped FPL	First Stage Estimate	Standard Error	P-value	Treatment Estimate	Standard Error P-value	P-value
95	0.217	0.018	0.000	0.092	0.084	0.270
96	0.230	0.016	0.000	0.145	0.068	0.034
97	0.222	0.016	0.000	0.122	0.074	0.102
98	0.233	0.017	0.000	0.112	0.073	0.127
99	0.244	0.020	0.000	0.322	0.089	0.000
100	0.242	0.019	0.000	0.060	0.075	0.424
101	0.237	0.016	0.000	0.302	0.070	0.000
102	0.214	0.018	0.000	0.019	0.083	0.823
103	0.229	0.016	0.000	0.154	0.072	0.033
104	0.231	0.015	0.000	0.150	0.067	0.025
105	0.226	0.016	0.000	0.131	0.073	0.072
98/99	0.310	0.030	0.000	0.407	0.121	0.001
101/102	0.211	0.021	0.000	0.165	0.097	0.089
Chronic Disease Diagnoses						
95	0.150	0.015	0.000	0.027	0.085	0.752
96	0.150	0.016	0.000	0.002	0.090	0.985
97	0.138	0.016	0.000	-0.061	0.103	0.549
98	0.161	0.017	0.000	0.000	0.094	0.998
99	0.157	0.023	0.000	0.171	0.133	0.199
100	0.156	0.017	0.000	-0.078	0.092	0.393
101	0.144	0.017	0.000	0.182	0.108	0.090
102	0.137	0.018	0.000	-0.166	0.113	0.141
103	0.162	0.014	0.000	0.080	0.074	0.284
104	0.151	0.016	0.000	0.011	0.089	0.906
105	0.150	0.015	0.000	0.018	0.088	0.840
98/99	0.236	0.023	0.000	0.369	0.098	0.000
101/102	0.122	0.020	0.000	0.003	0.143	0.981

Table 4.19 Estimated Change at 100 percent FPL for Demographic Covariates (MSE-optimal bandwidths; triangular kernel)

Estimate of jump at 100% FPL	Standard error	p-value	Bandwidth
0.77	0.28	0.005	9.228
-0.29	0.010	0.004	11.773
-0.0098	0.0084	0.25	14.663
0.0020	0.0074	0.79	12.444
0.0053	0.0068	0.44	14.548
-0.011	0.0073	0.140	8.941
0.0127	0.010	0.220	10.416
0.0052	0.0089	0.561	10.548
-0.0076	0.0100	0.444	11.115
Estimated from RD local linear equations where each covariate is a dependent variable and covariates not in the same demographic category are covariates in regressions.			

Table 4.20 Total Spending Regressions; Predicted Monthly Spending by Covariates

	Total Spending		**Medical Spending**		**Rx Spending**		**Total Spending: Disenroller interacted with Above 100**	
	Estimate	pvalue	Estimate	pvalue	Estimate	pvalue	Estimate	pvalue
Disenroller								
No	$ 293.15		$ 215.74		$ 77.86			
Yes	$ 175.84	0.000	$ 132.46	0.000	$ 43.57	0.000		
Gender								
Male	$ 242.83		$ 167.99		$ 75.01		$ 242.83	
Female	$ 289.20	0.000	$ 220.80	0.000	$ 69.13	0.000	$ 289.20	0.000
Age in Bands (under 30 reference)								
30 to 39	$ 296.86	0.036	$ 204.95	0.647	$ 98.10	0.000	$ 296.84	0.033
40 to 49	$ 378.60	0.000	$ 261.50	0.000	$ 125.63	0.000	$ 378.61	0.000
over 50	$ 422.99	0.000	$ 303.95	0.000	$ 128.00	0.000	$ 423.00	0.000
Region of Residence (Detroit reference)								
UP/Northern Michigan	$ 237.90	0.000	$ 175.68	0.000	$ 63.39	0.000	$ 237.90	0.000
Region: Central Mich.	$ 257.67	0.000	$ 193.98	0.017	$ 65.34	0.000	$ 257.67	0.000
Region: Southern Mich.	$ 318.91	0.002	$ 245.65	0.001	$ 72.74	0.487	$ 318.92	0.002
Race (White reference)								
Black	$ 243.26	0.000	$ 172.52	0.000	$ 69.62	0.301	$ 243.28	0.000
Other	$ 239.57	0.000	$ 177.93	0.005	$ 61.94	0.000	$ 239.55	0.000
FPL_percent		0.000		0.000		0.000		0.000
25	$ 463.78		$ 387.43		$ 90.88		$ 467.40	
50	$ 366.13		$ 291.27		$ 81.24		$ 367.86	
75	$ 289.05		$ 218.97		$ 72.61		$ 289.52	
100	$ 228.19		$ 164.62		$ 64.91		$ 227.87	
125	$ 180.15		$ 123.76		$ 58.02		$ 179.34	
Disenroller								
No: Above 100% FPL							$ 291.66	0.933
No: Below 100% FPL							$ 293.90	
Yes: Above 100% FPL							$ 174.53	0.959
Yes: Below 100% FPL							$ 176.54	0.000

Notes: Spending reflects both plan and patient payments to medical providers and pharmacies adjudicated through the claims process. Regression specified as a generalized linear model with a log link and gamma family. Predictions obtained using marginal effects at acutal values through the *margins* command in Stata 14.2

Figure 4.1 Unadjusted Probability of Disenrollment by Prior Period Invoice Amount

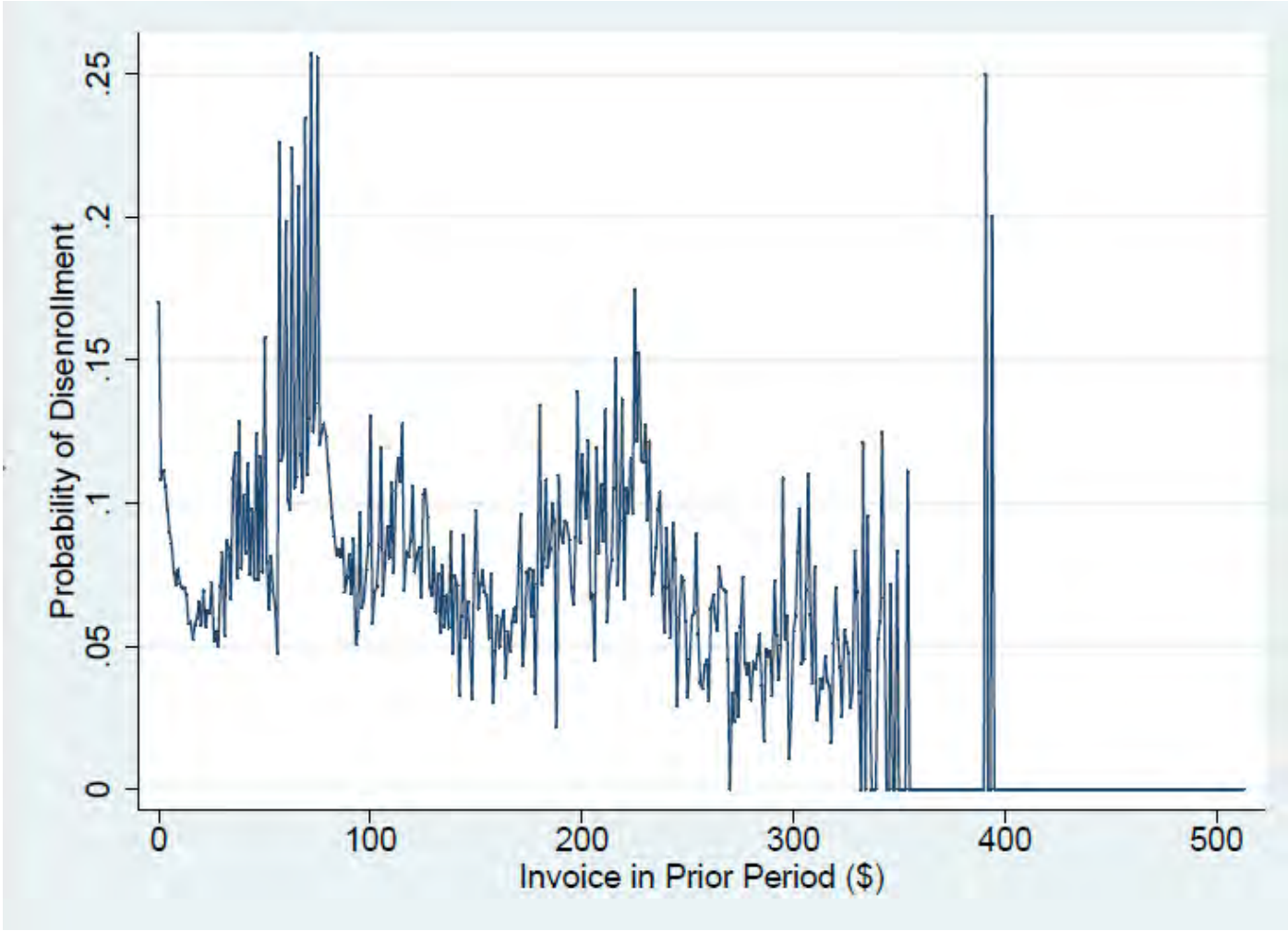


Figure 4.1a Unadjusted Probability of Disenrollment by Prior Period Invoice Amount, Invoice <= $150

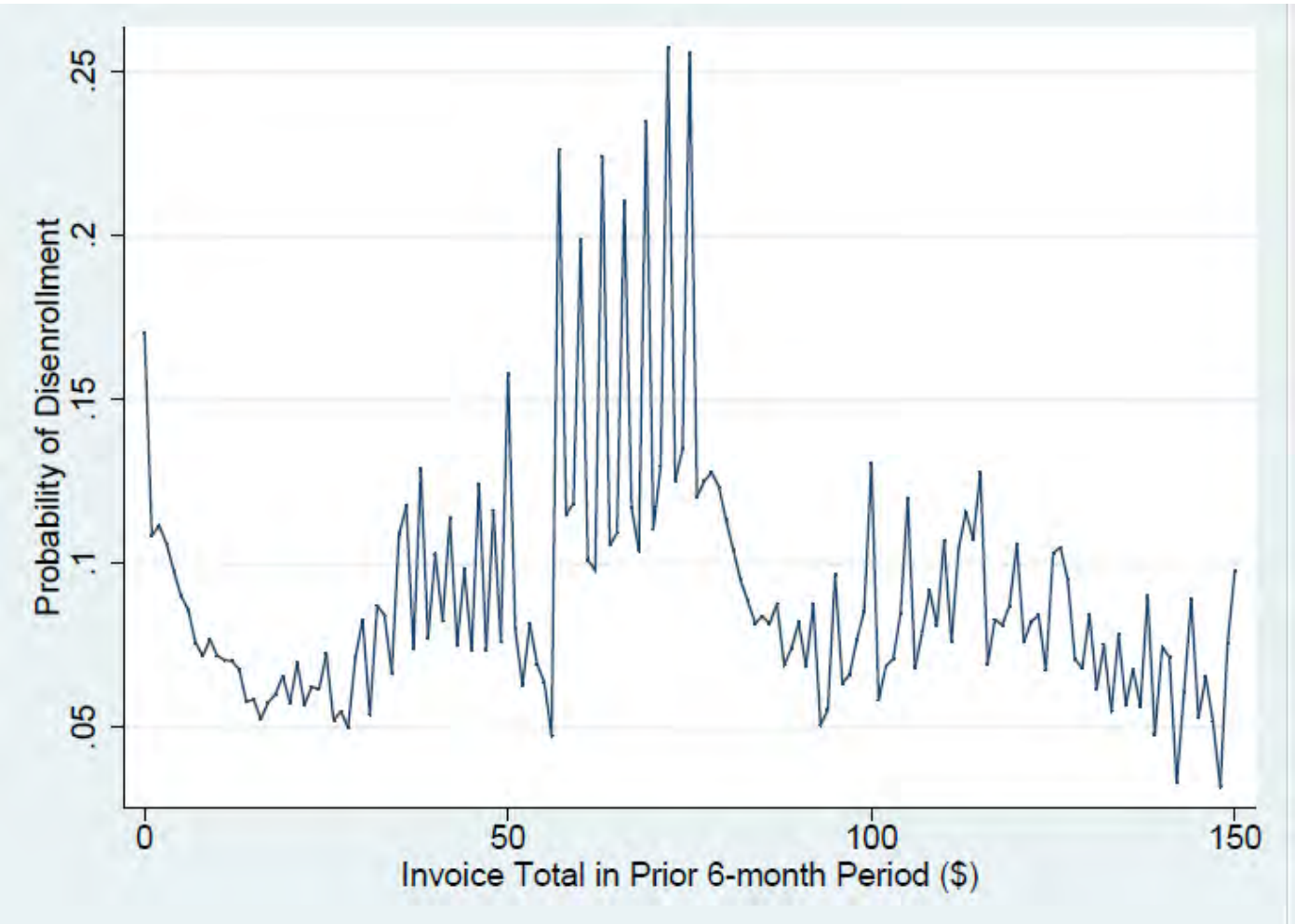


Figure 4.2 Predicted Probability of Disenrollment by Prior Period Invoice Amount, Logit Regression with Invoice Specified Linearly

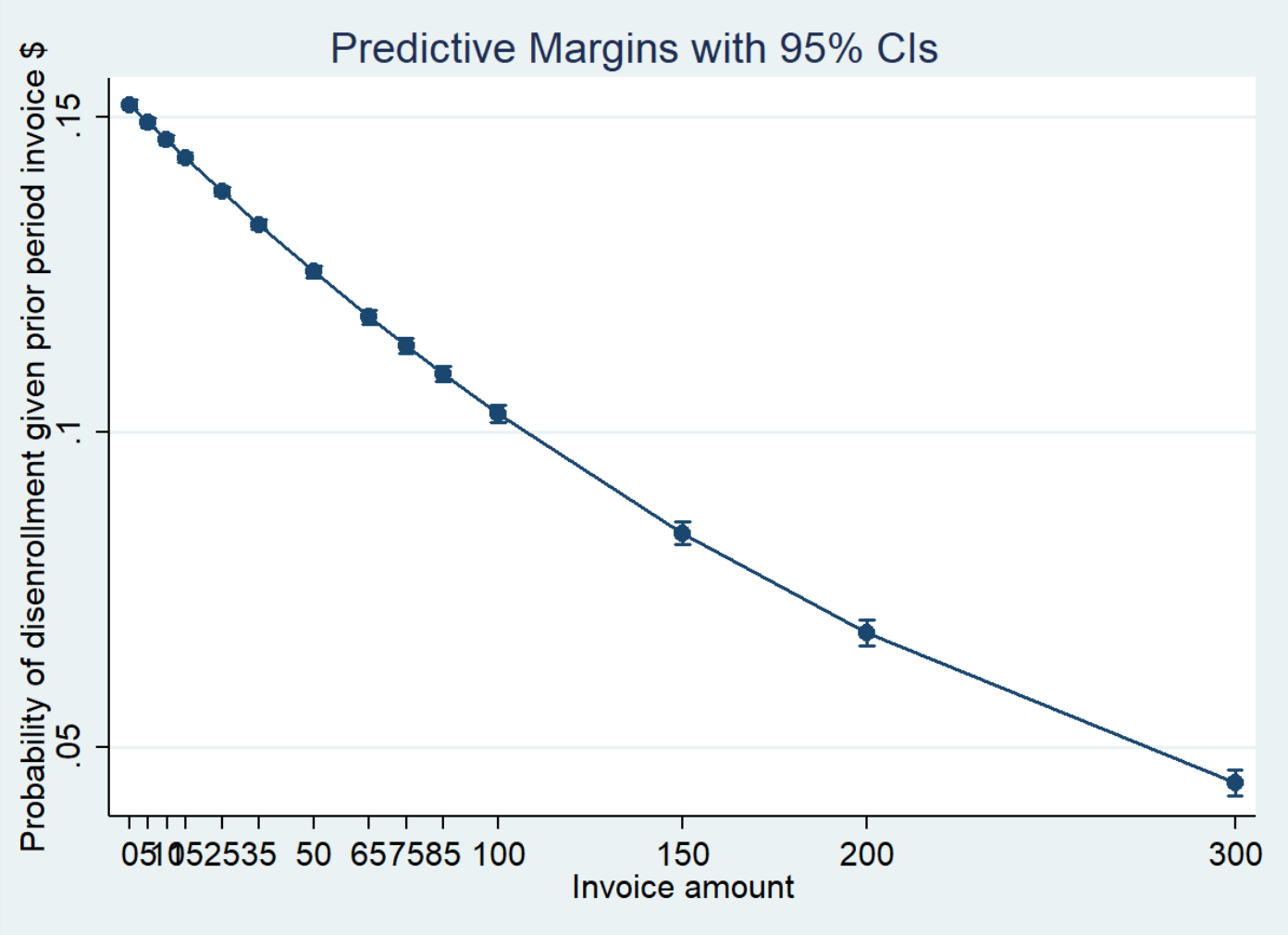


Figure 4.2a Predicted Probability of Disenrollment by Prior Period Invoice Amount Logit Regression with Invoice Specified Quadratically

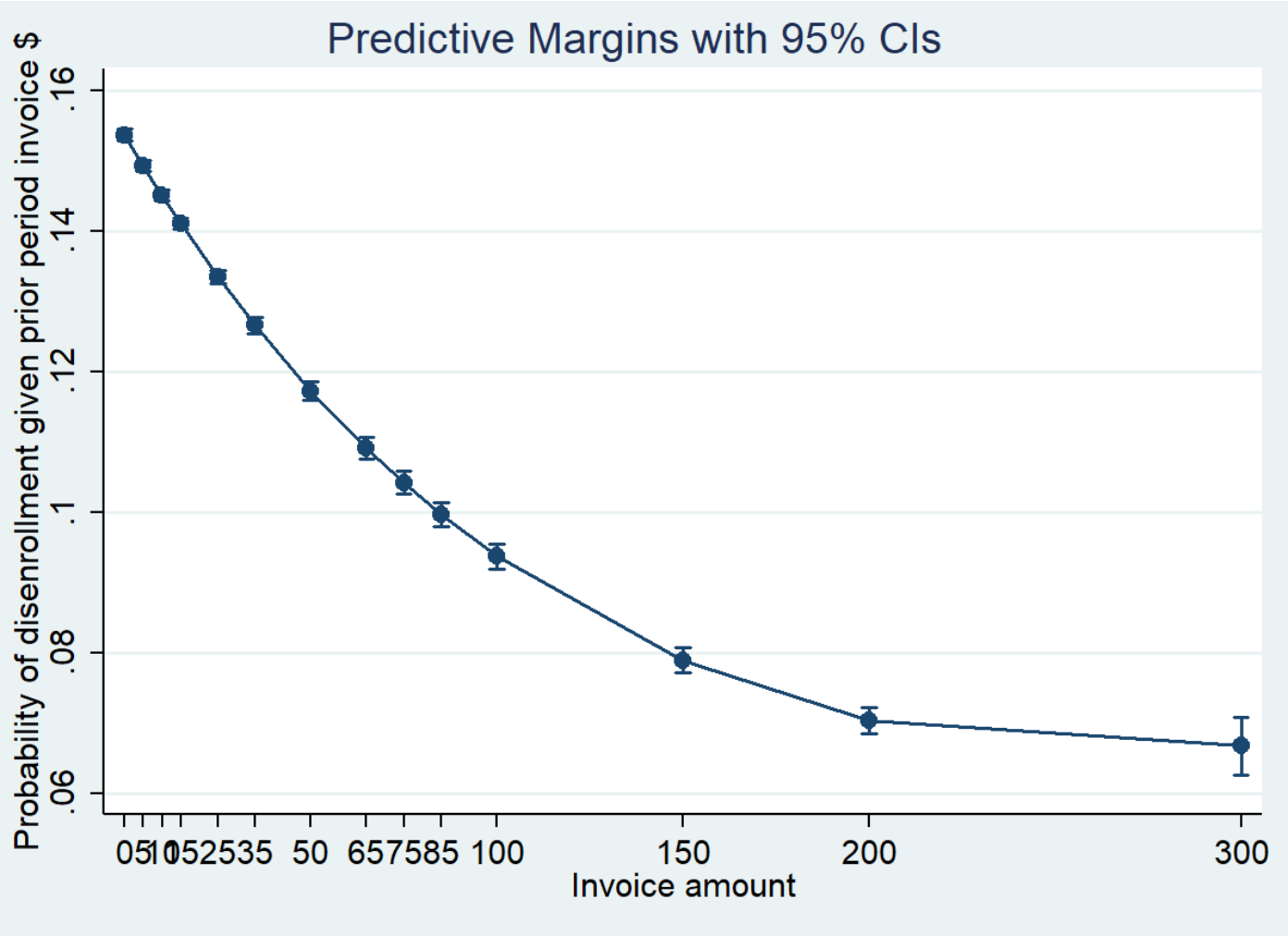


Figure 4.2b Predicted Probability of Disenrollment by Prior 6-11 Period Invoice Amount Interacted with FPL Above/Below 100%, Logit Regression with Invoice Specified Quadratically

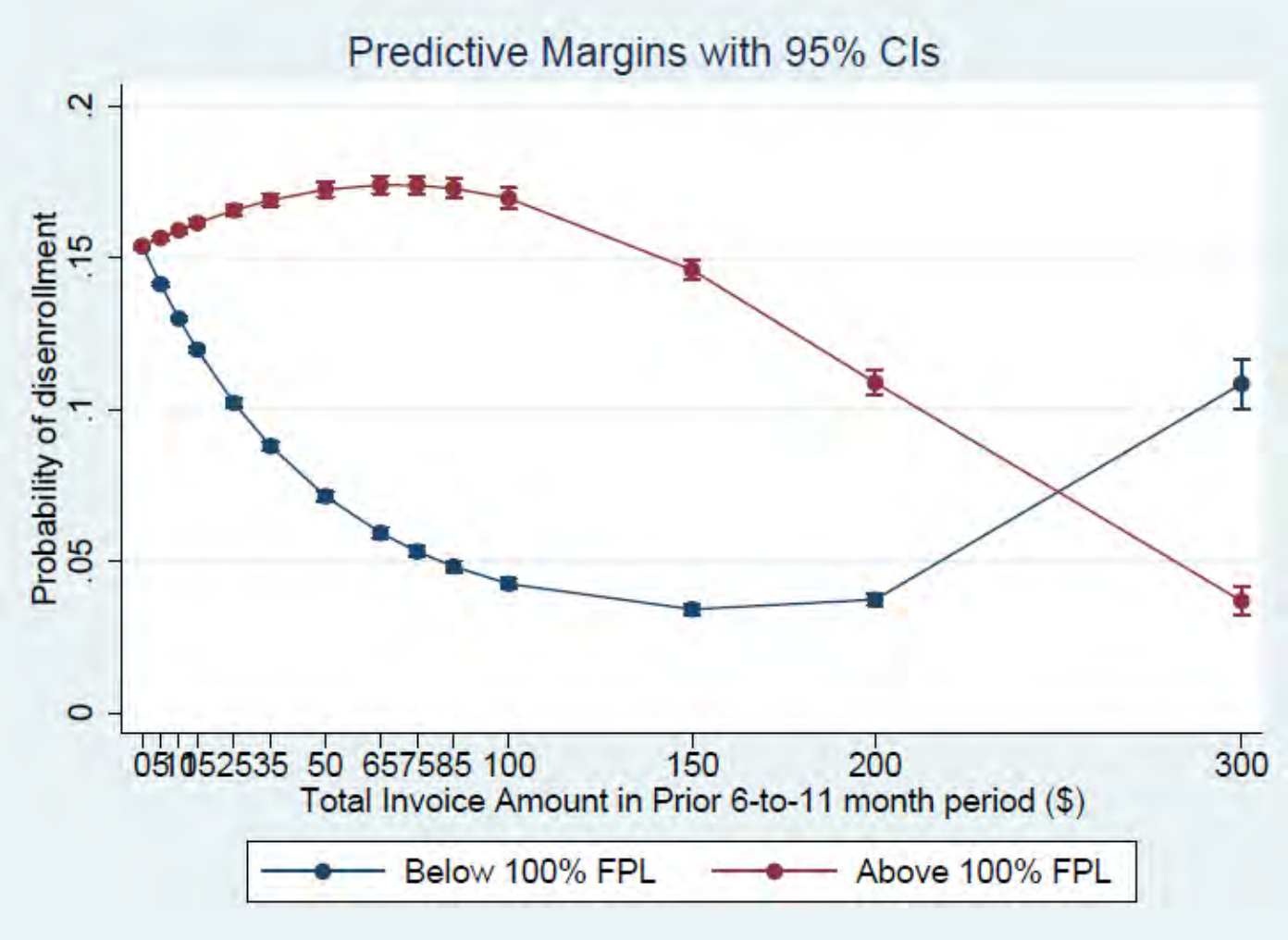


Figure 4.2c Predicted Probability of Disenrollment by Prior 6-11 Month Contribution Amount Interacted with FPL Above/Below 100%, Logit Regression with Invoice Specified Quadratically

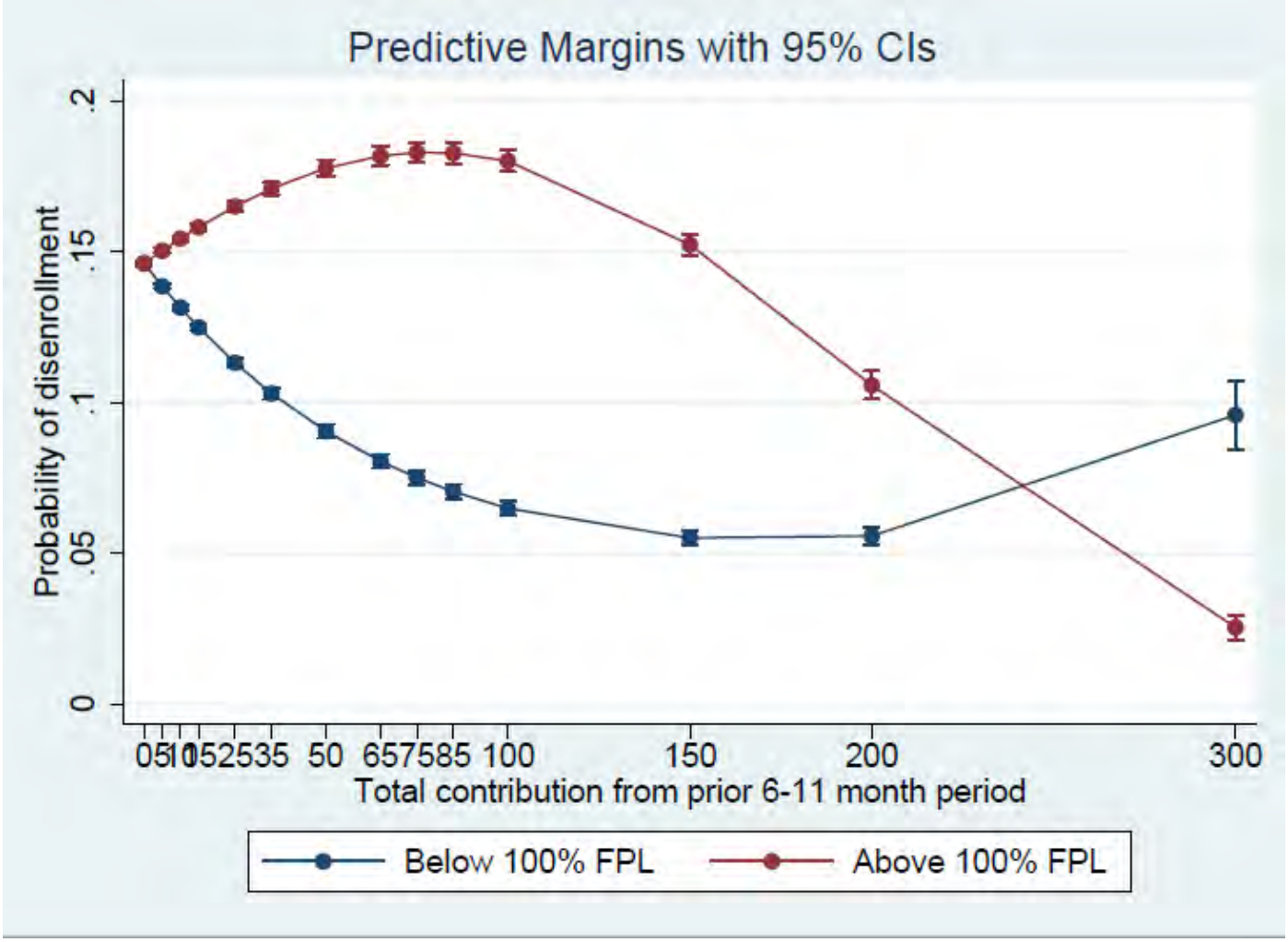


Figure 4.2d Predicted Probability of Disenrollment by Prior 6-11 Month Copay Amount Interacted with FPL Above/Below 100%, Logit Regression with Invoice Specified Quadratically

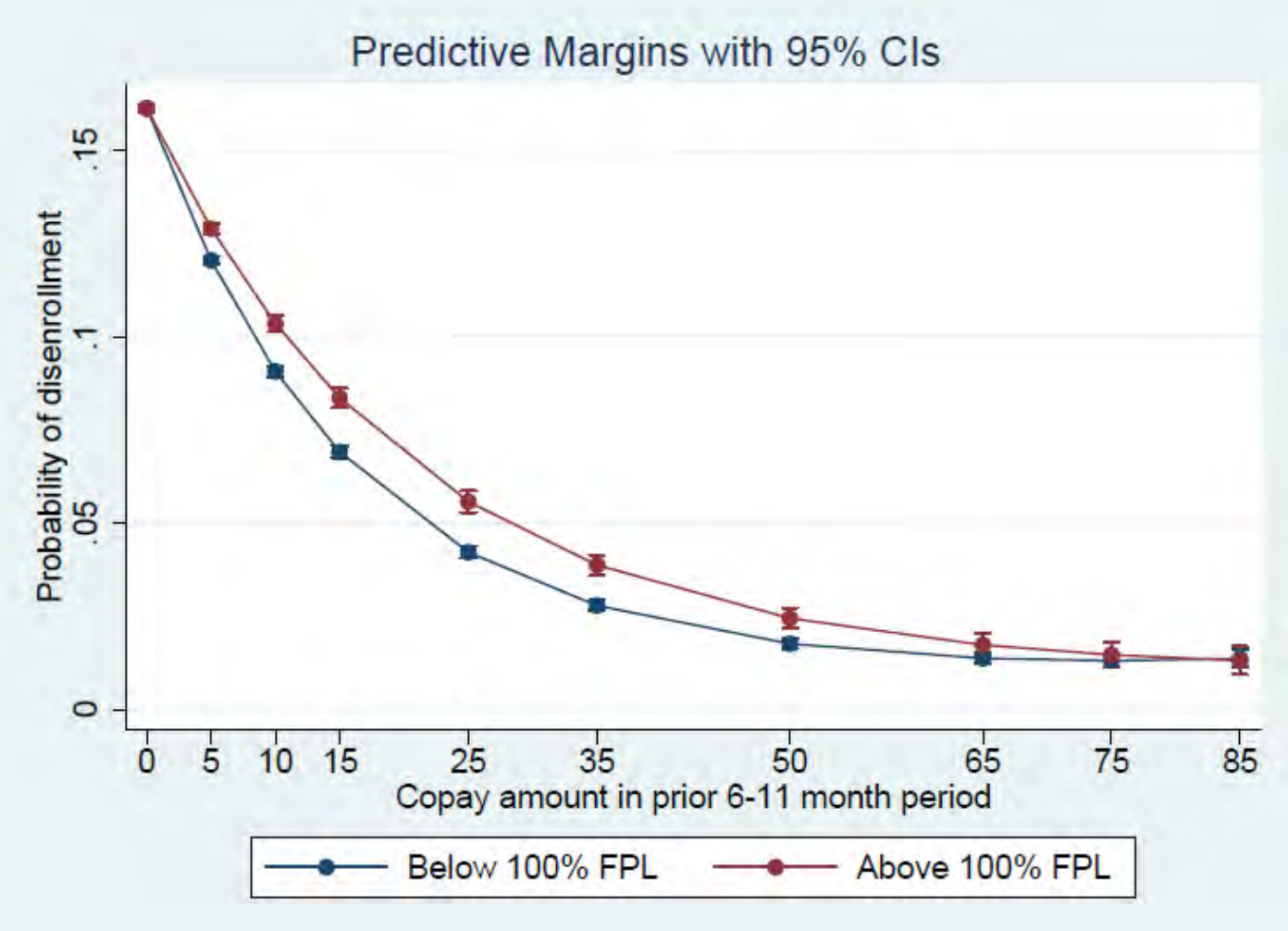


Figure 4.3 Histogram of FPL

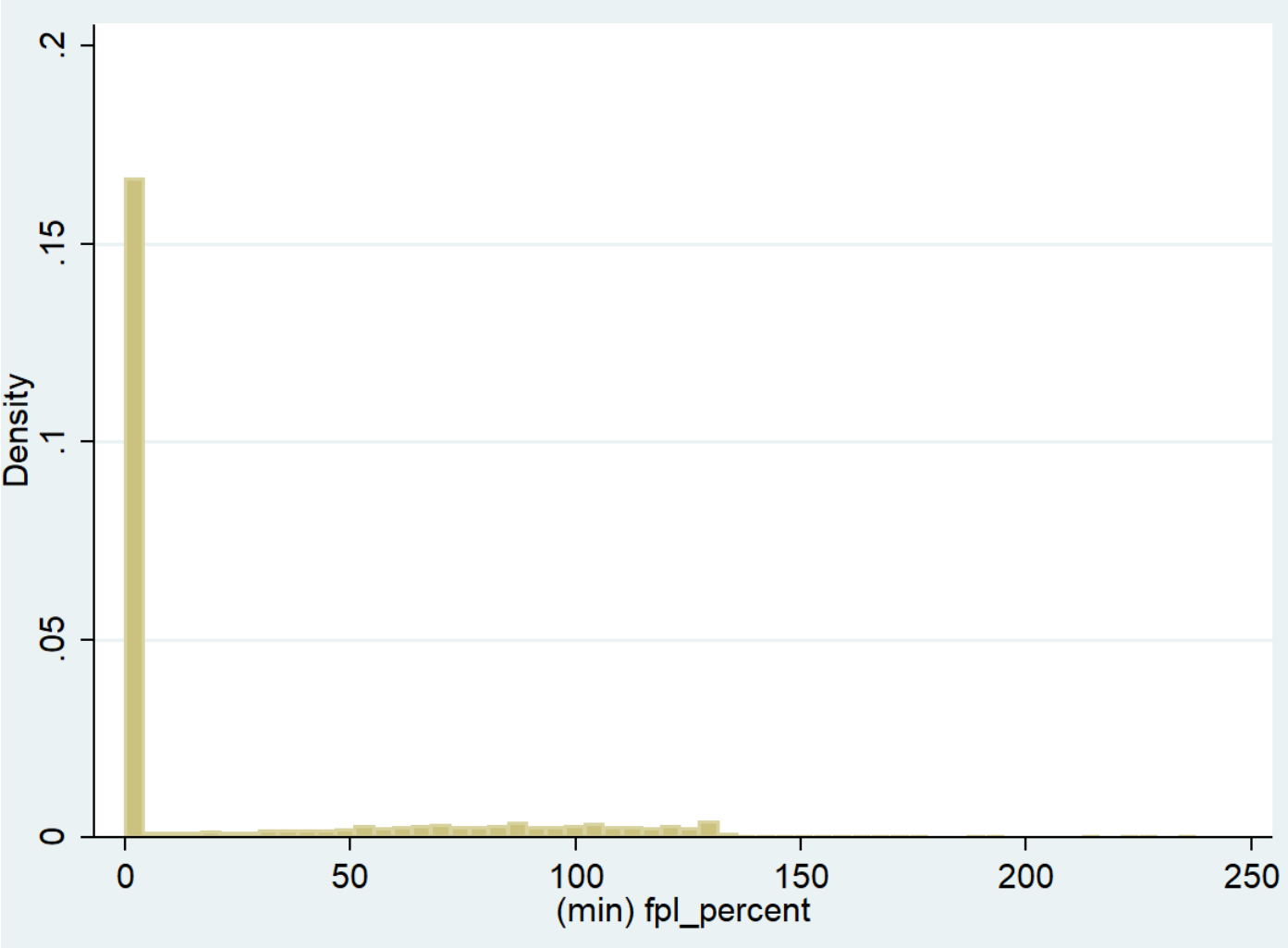


Figure 4.3a Histogram of Federal Poverty Level (>0% FPL to 133% FPL, rounded to nearest whole percent, from RD analysis (n=195,495)

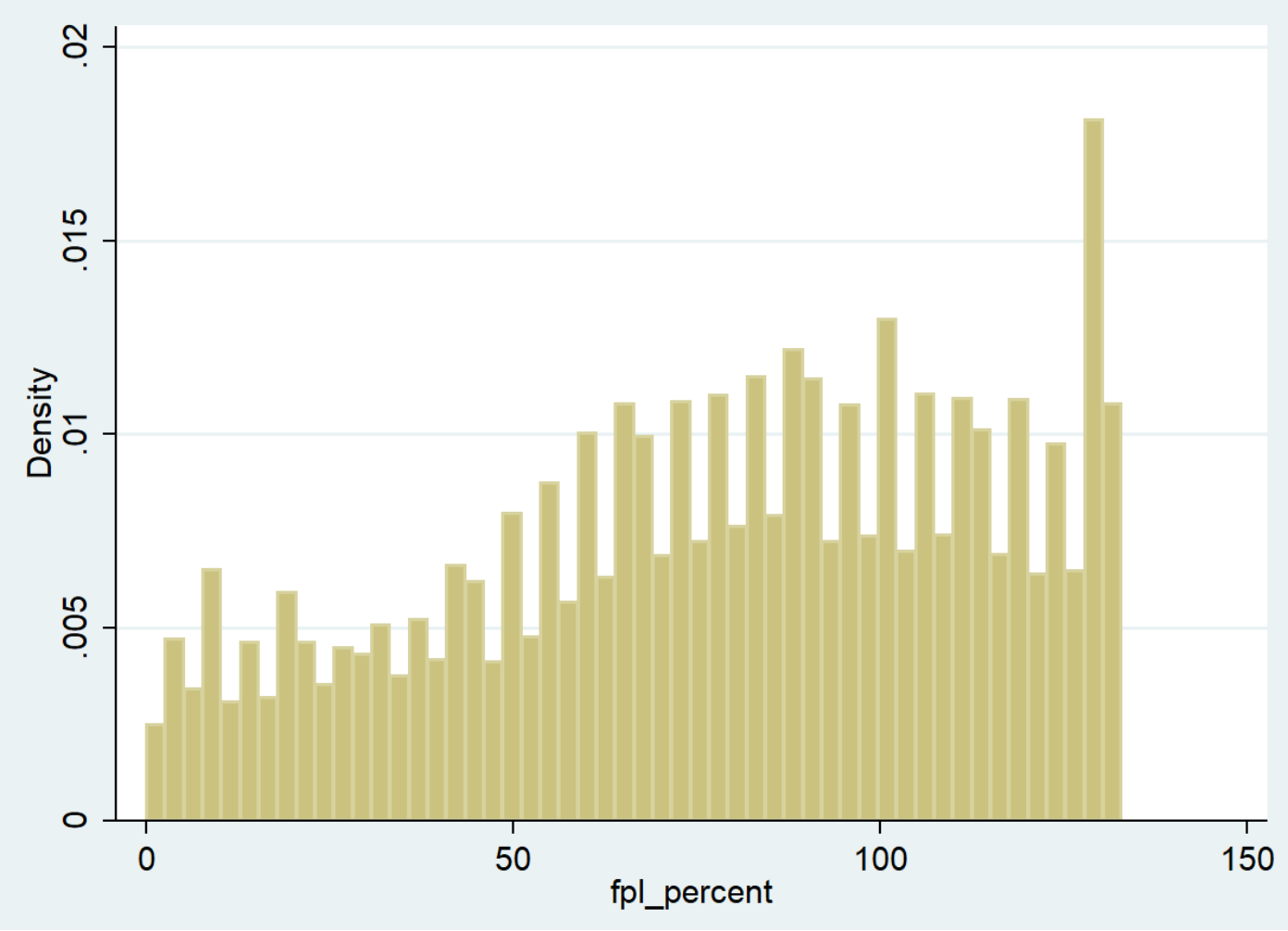


Figure 4.3b Histogram of FPL > 70% and <130%, from RD analysis

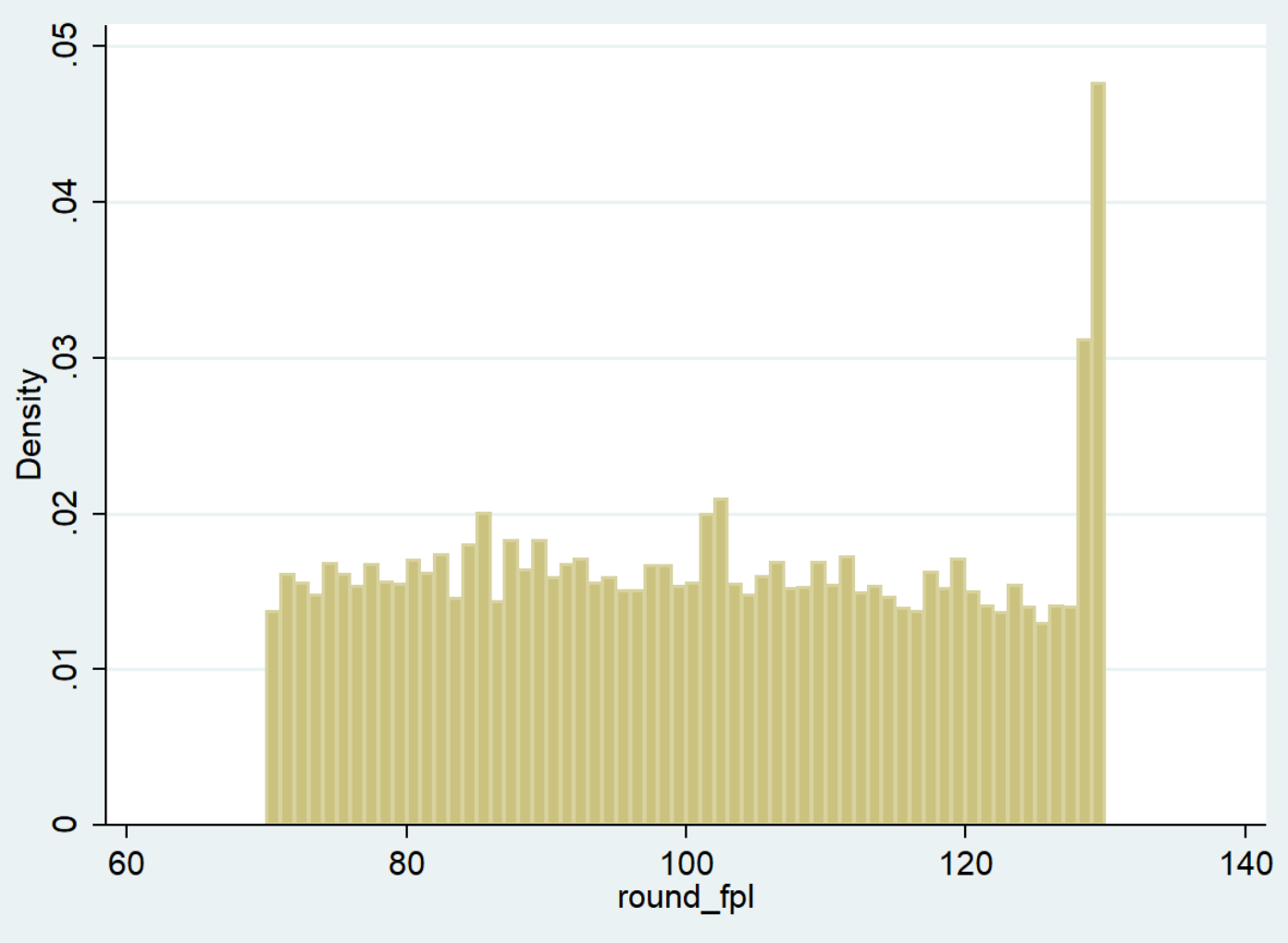


Figure 4.3c Histogram of FPL > 90% and <110%, from RD analysis

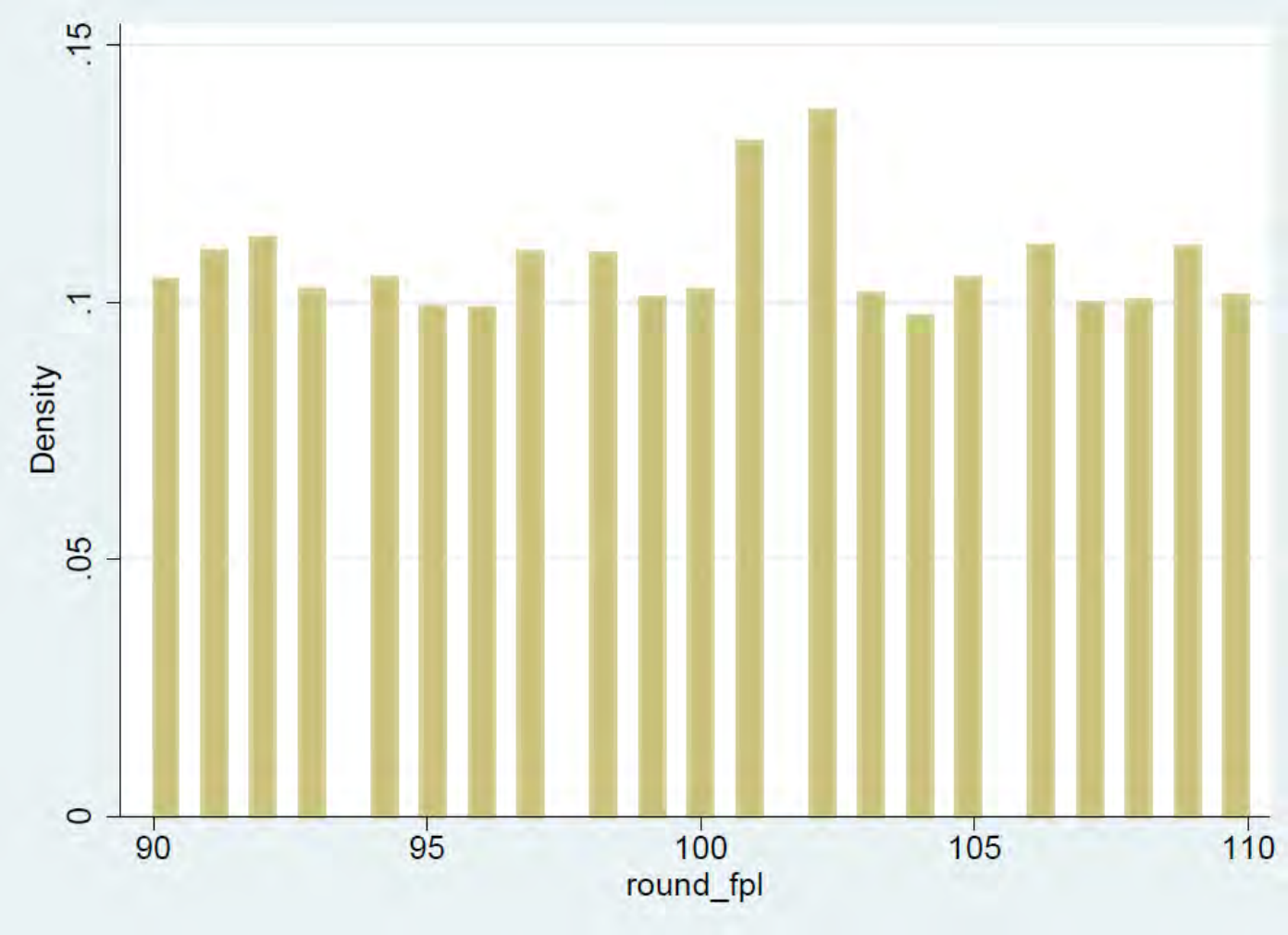
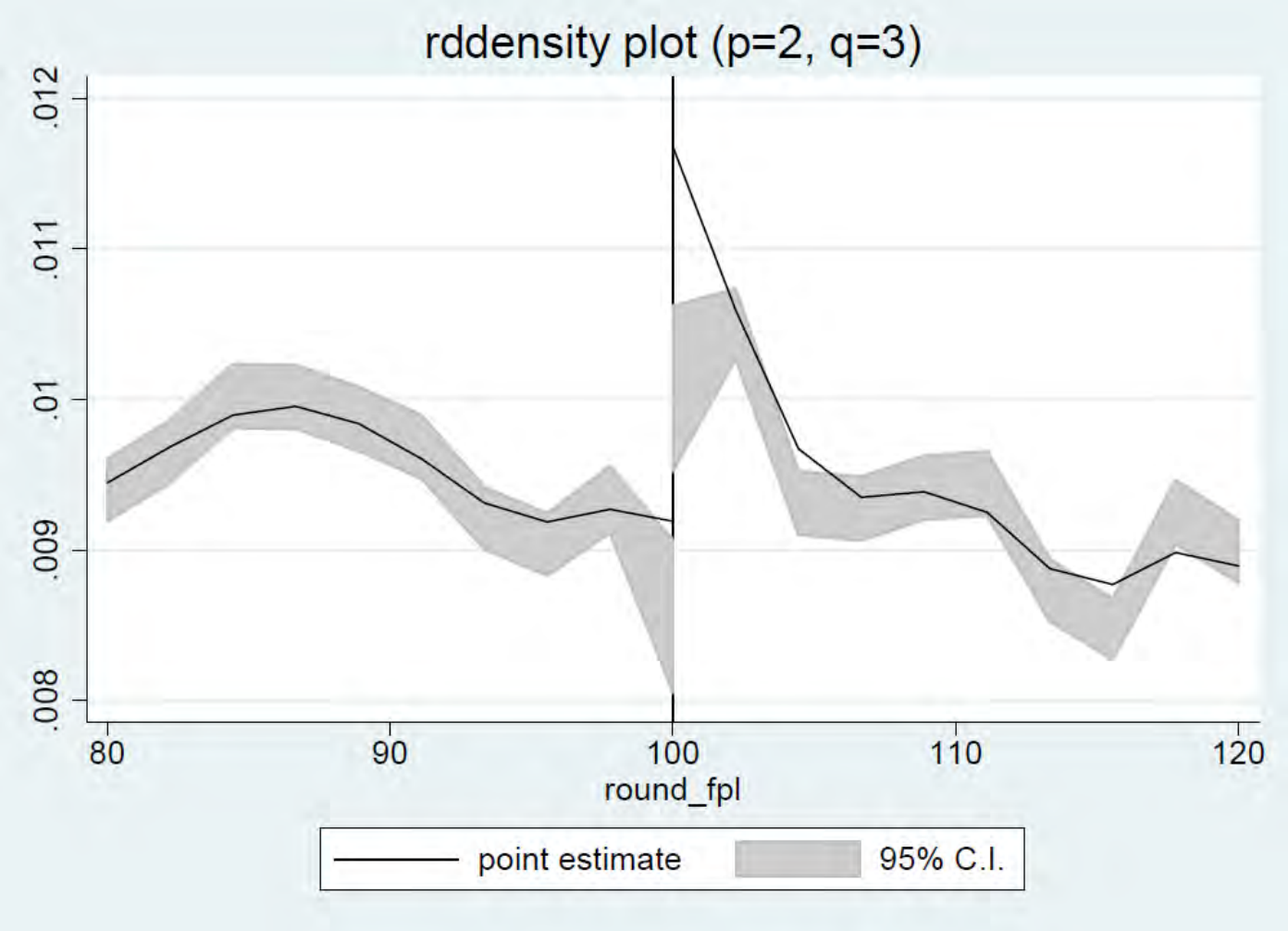
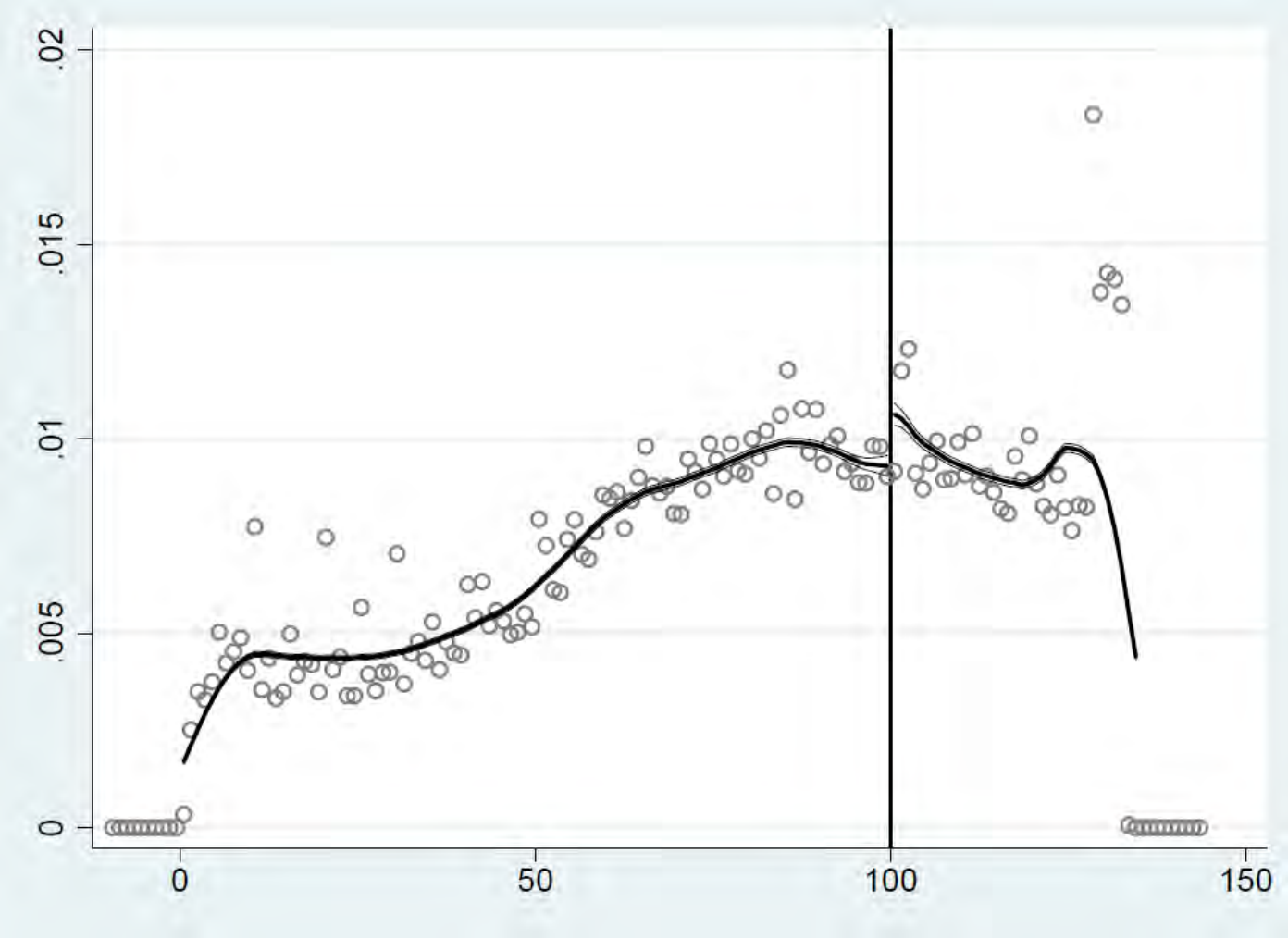


Figure 4.3d CCT RD Density Plot



Notes: The T-statistic estimating the degree of difference in density on either side of the cutoff line is 2.5642. The p-value of the confidence with which we can reject the null that this difference is not different than 0 is 0.0103. At conventional levels, then, we see there is a difference in density, here the density is higher on the right side of the cutoff (>100% FPL).

Figure 4.3e McCrary Density Plot



Notes: Output from the McCrary density test looks like this Discontinuity estimate (log difference in height): .143254085 (.022192522). I believe this rejects the null of no difference with a confidence level of p=0.022, though I couldn't find much documentation on the output.

I also ran density tests on a break at 85 FPL [(log difference in height).0633405 (.021863919)]; 90 FPL [(log difference in height): -.073934225 (.022139484)] and 110 [(log difference in height): .026855361 (.023011226)].

Figure 4.4 Histogram of Time to First Invoice

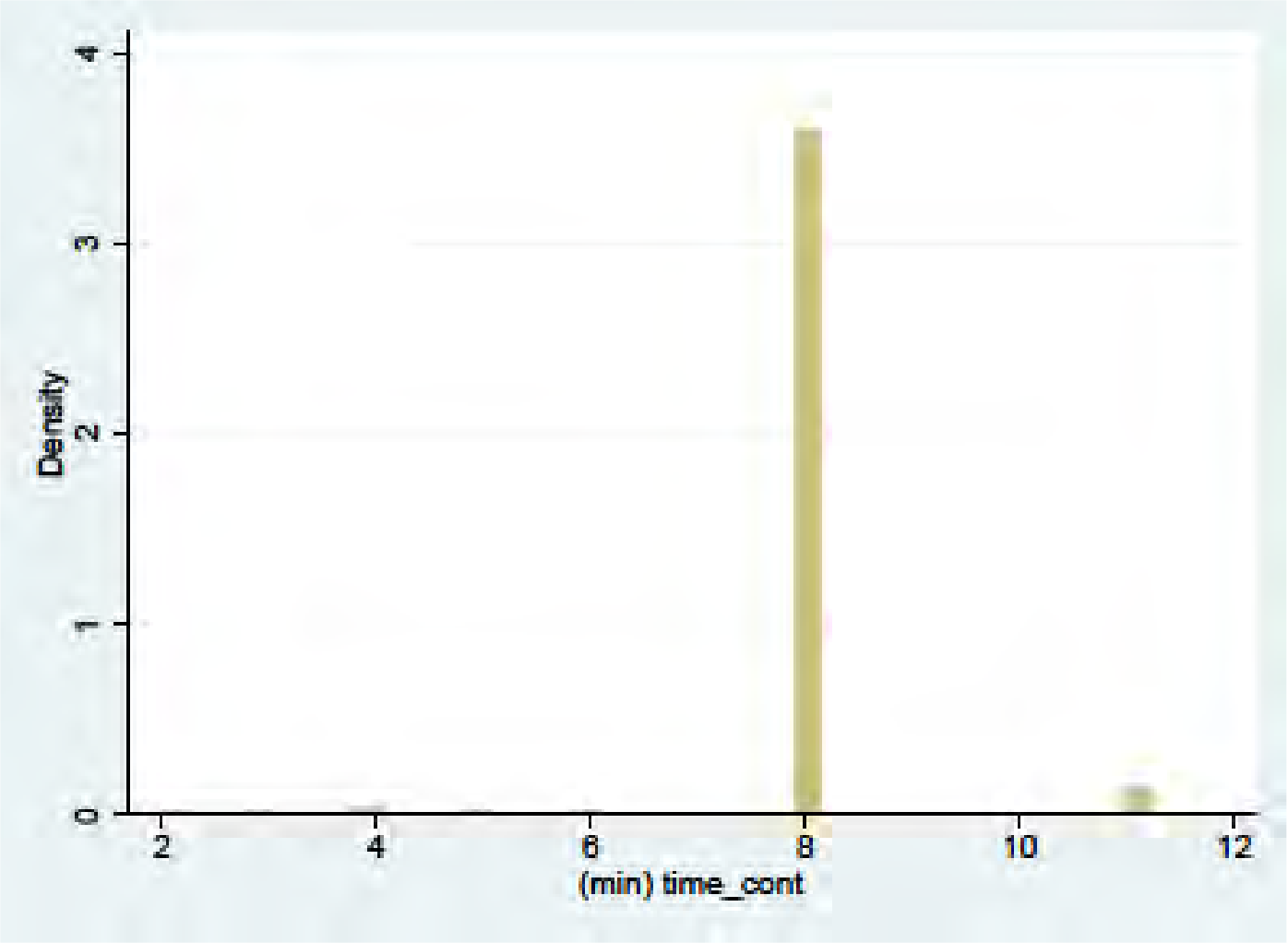


Figure 4.4a Time to First Contribution Invoice

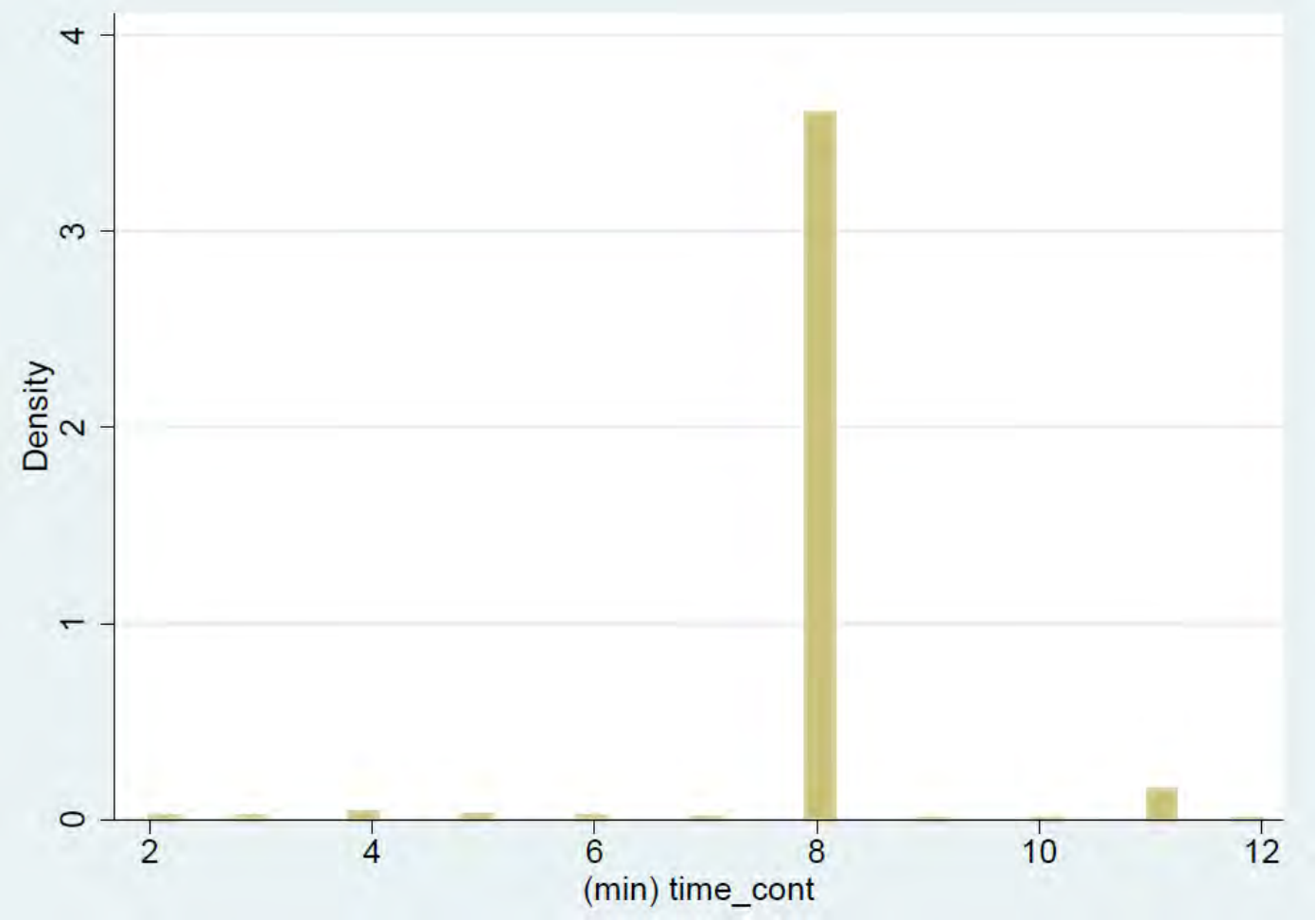


Figure 4.5 Time of Disenrollment

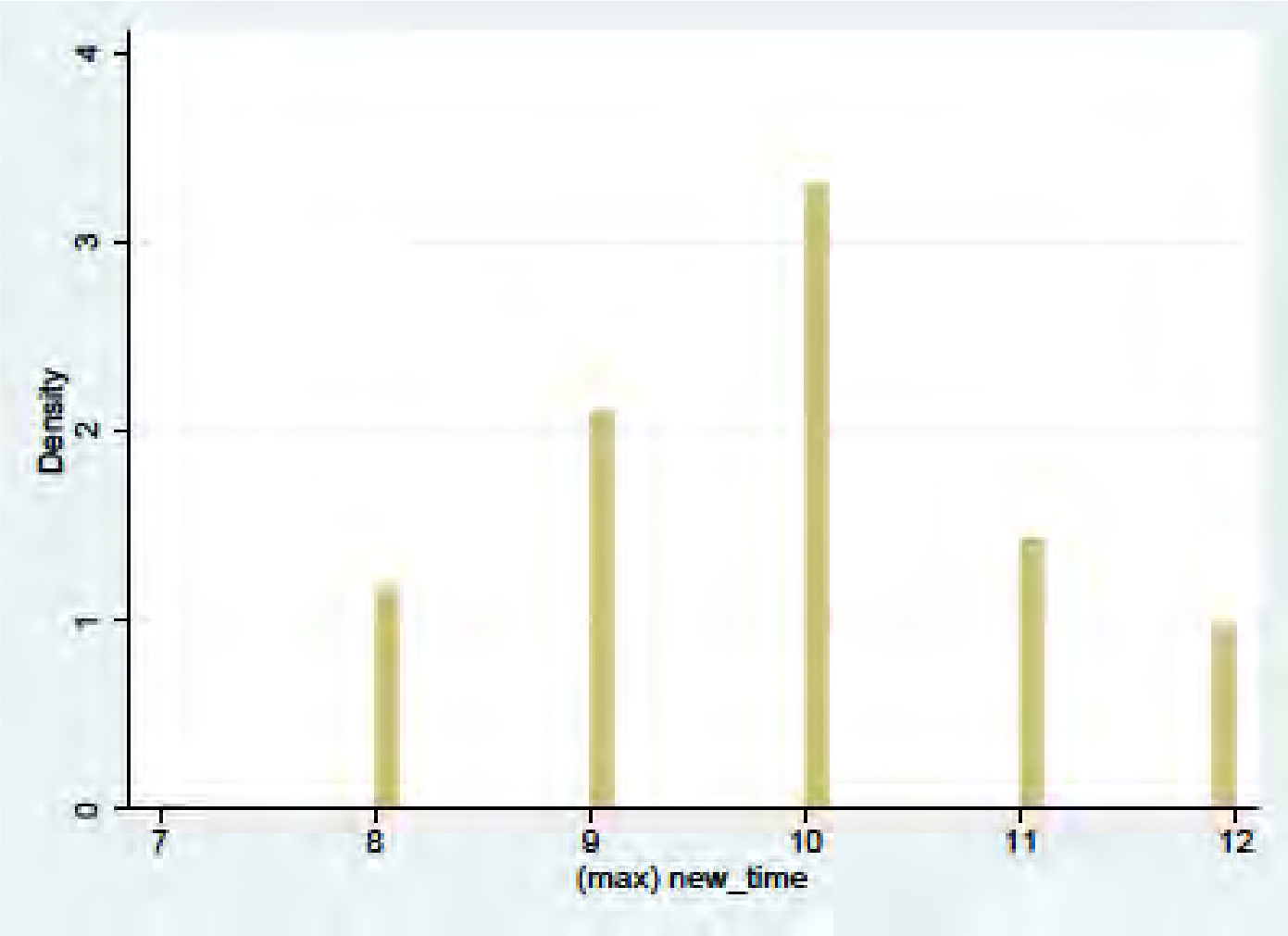


Figure 4.5a Percent of Beneficiaries who Drop by Number of Months Enrolled

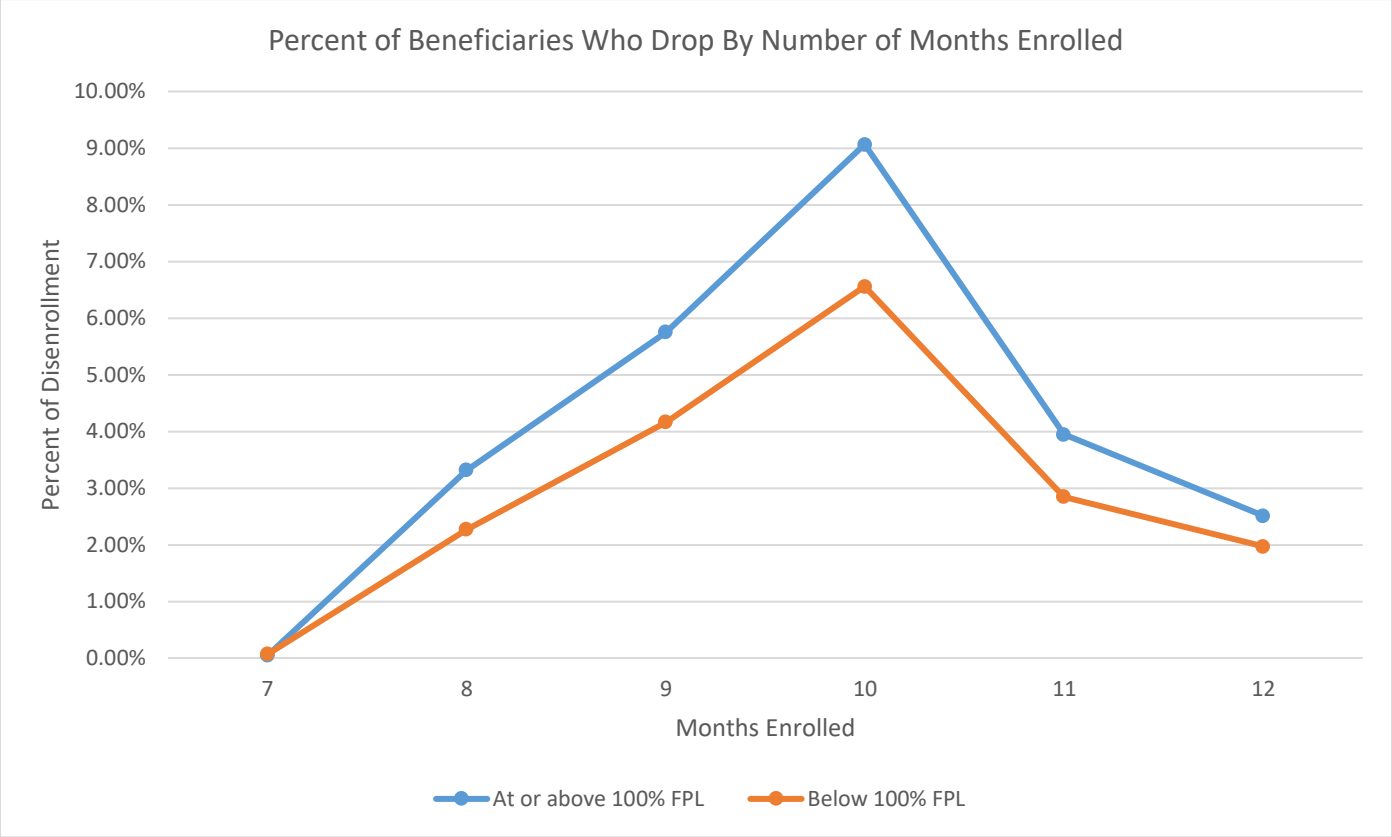


Figure 4.6 Likelihood of Contribution and FPL Scatterplot

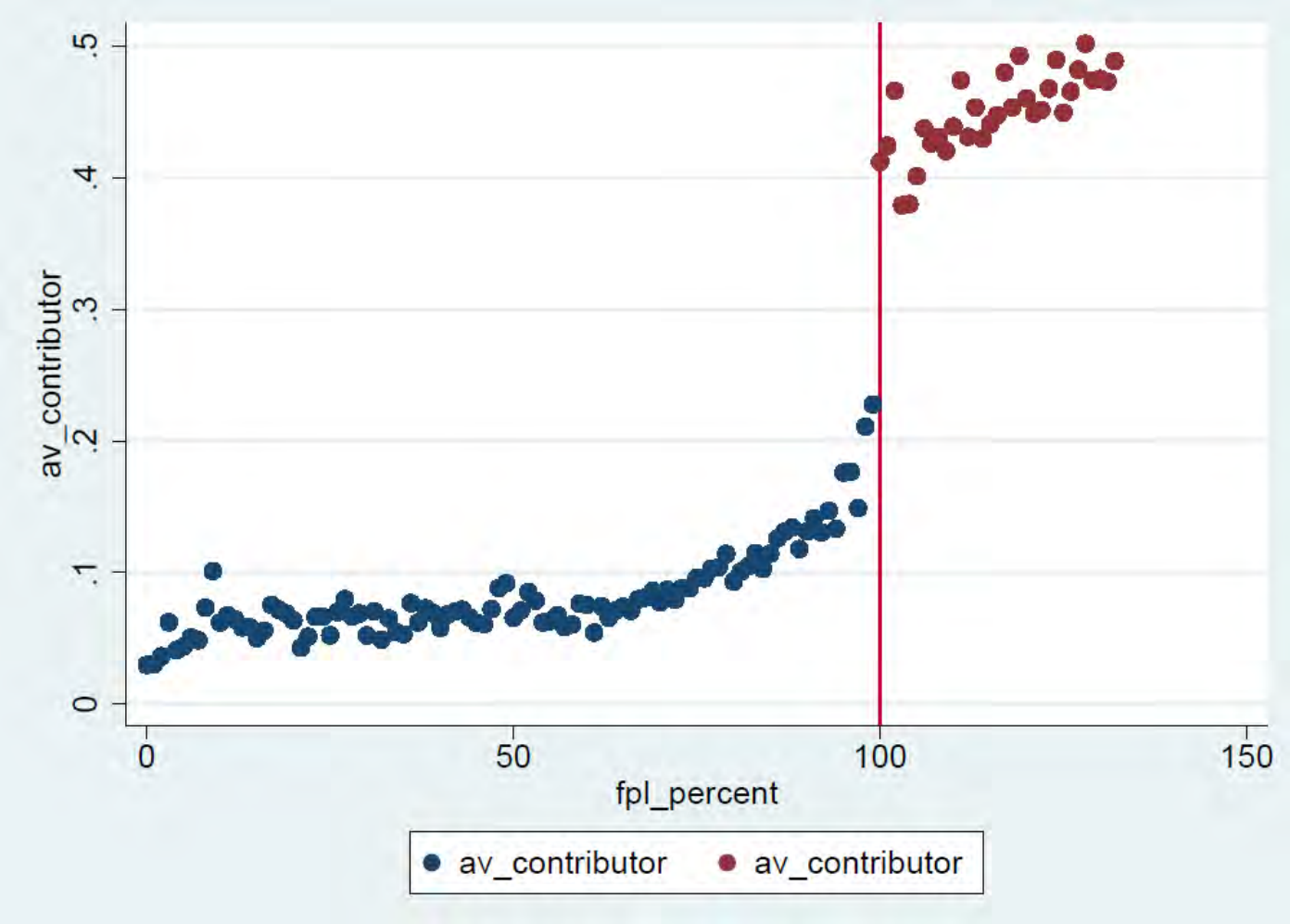


Figure 4.6a Contribution Amount and FPL

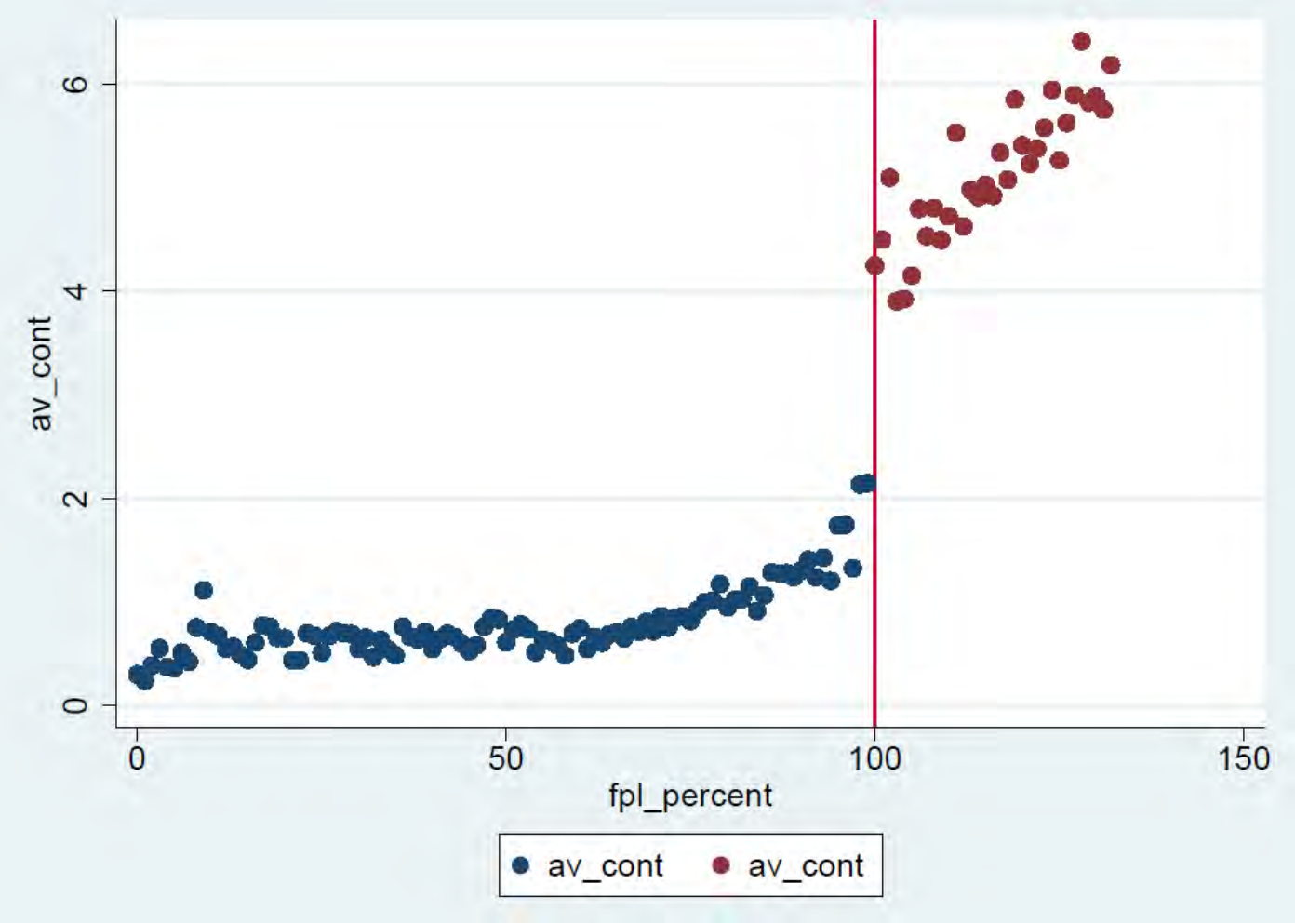


Figure 4.6b Contribution Amount and FPL: RDPlot

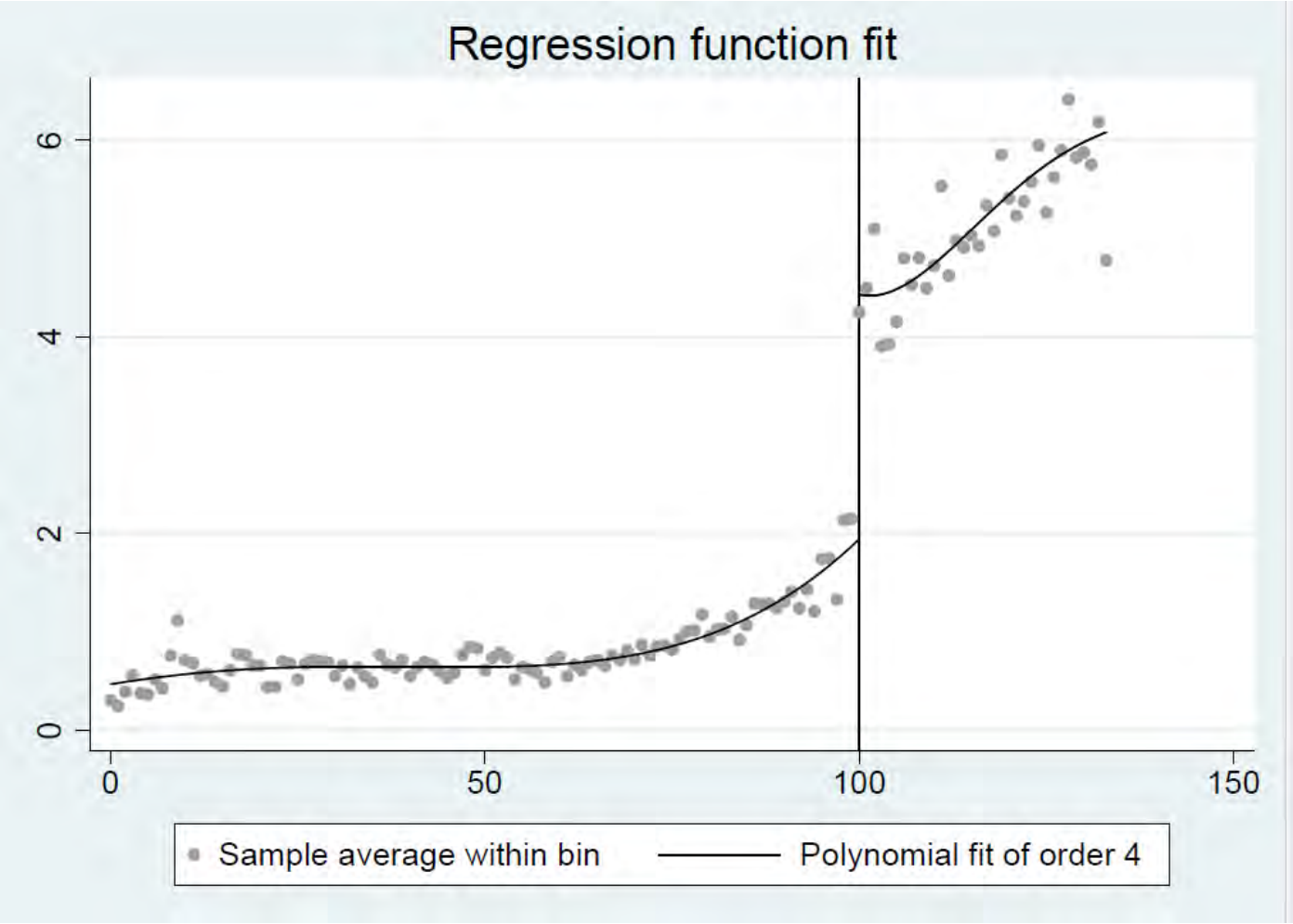


Figure 4.7 Likelihood of Copayment and FPL

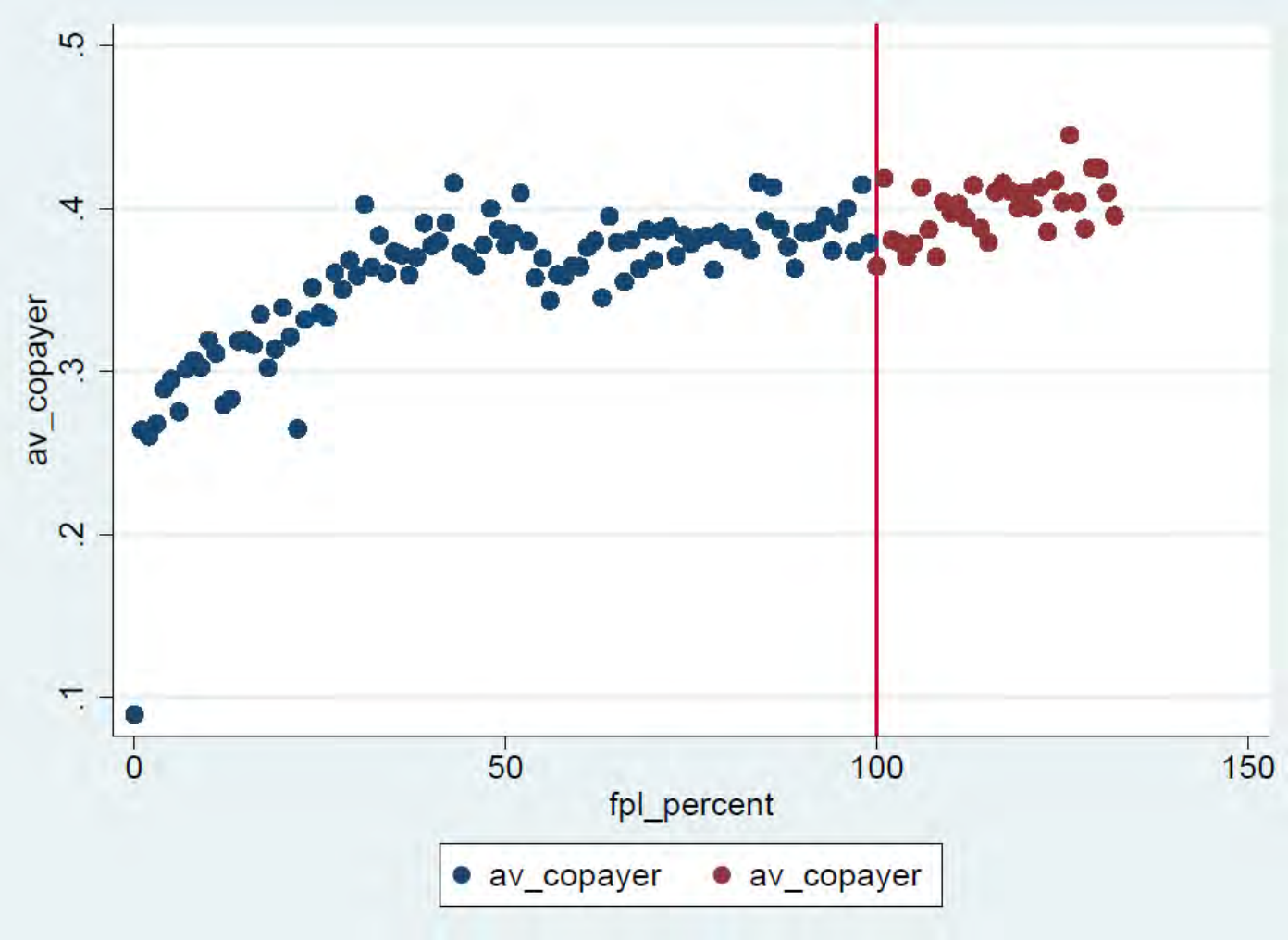


Figure 4.7a Copayment Amount and FPL

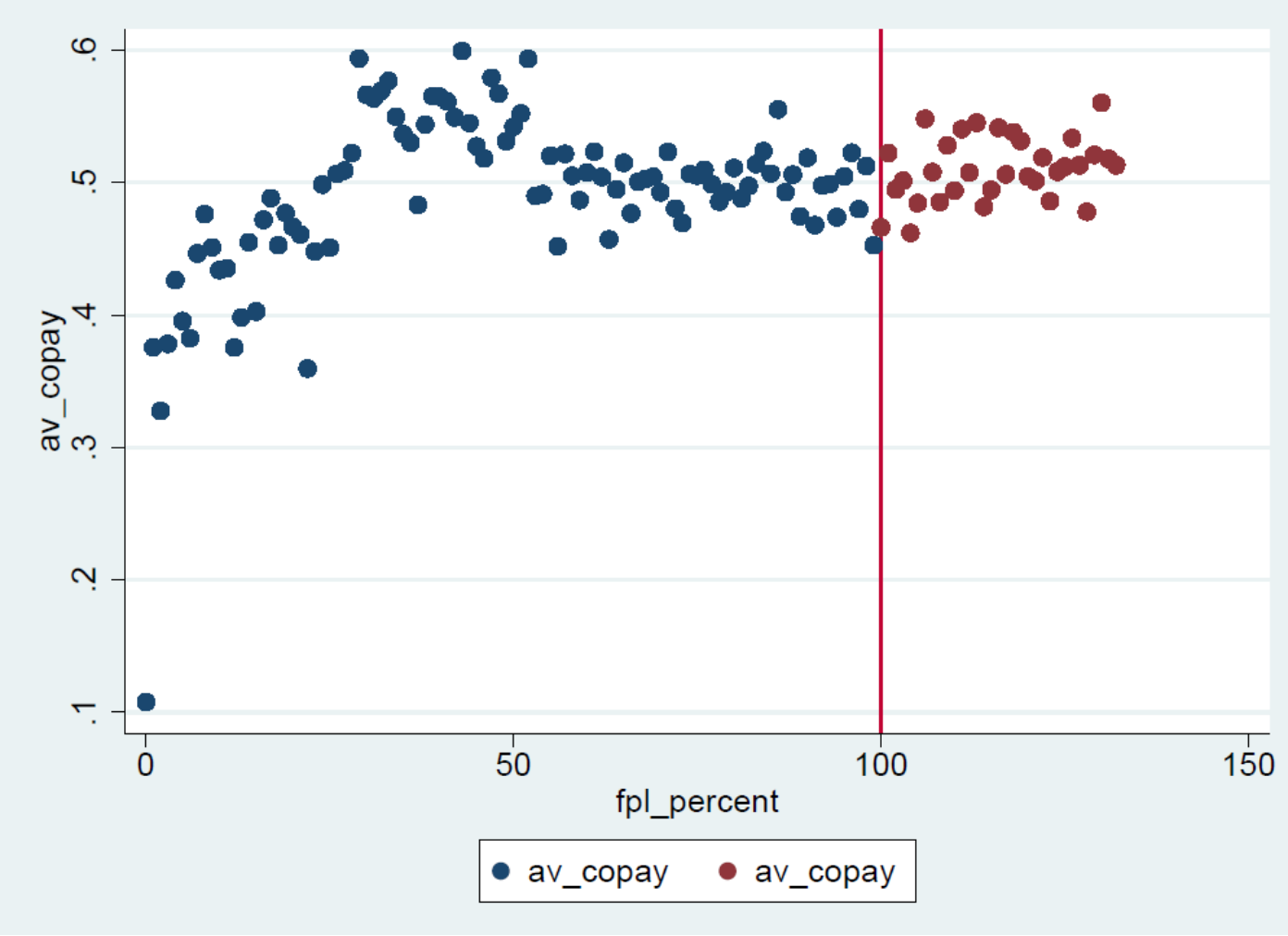


Figure 4.8 Likelihood of Disenrollment by FPL

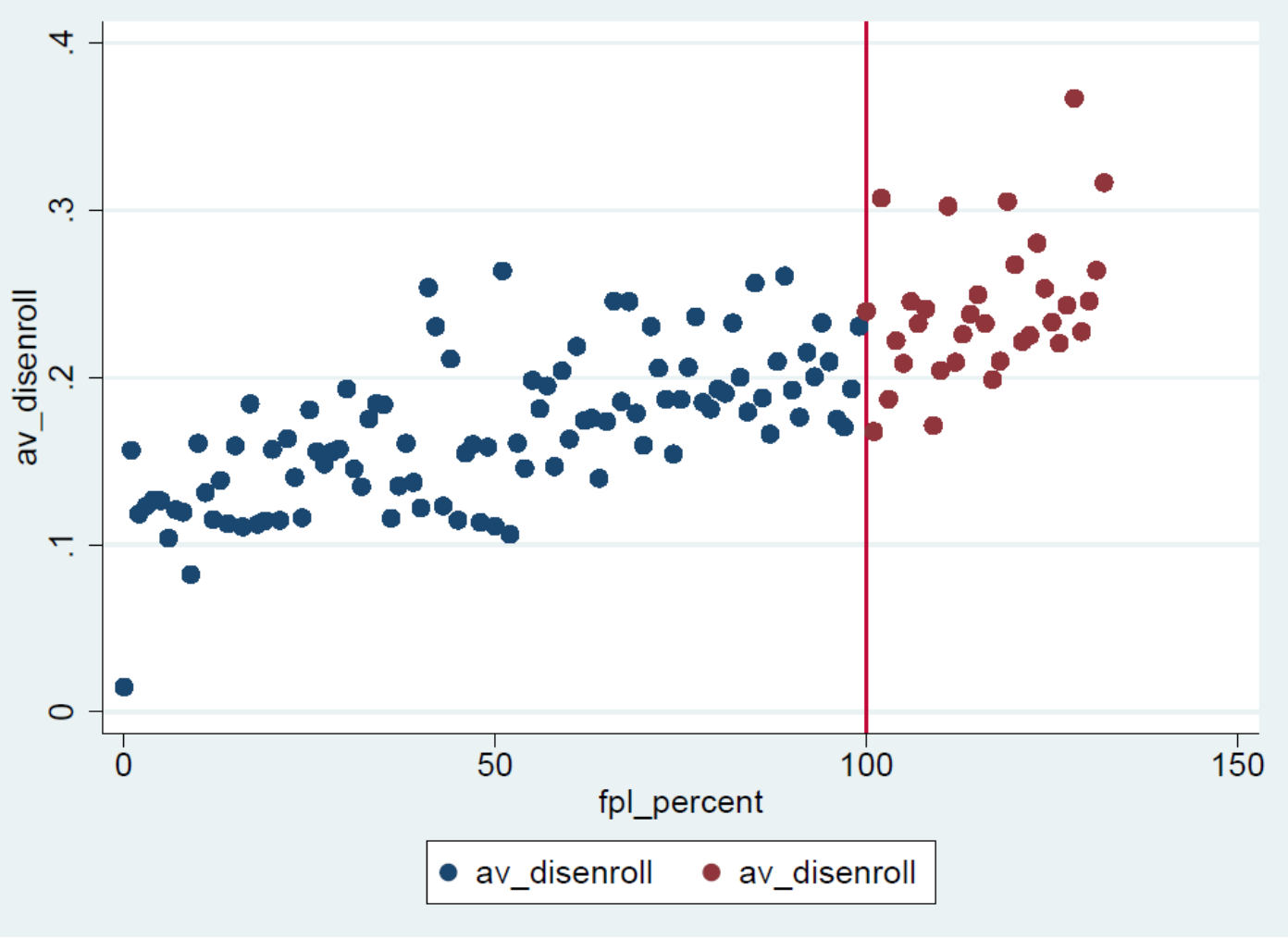


Figure 4.8a Likelihood of Disenrollment, FPL in bins of 7

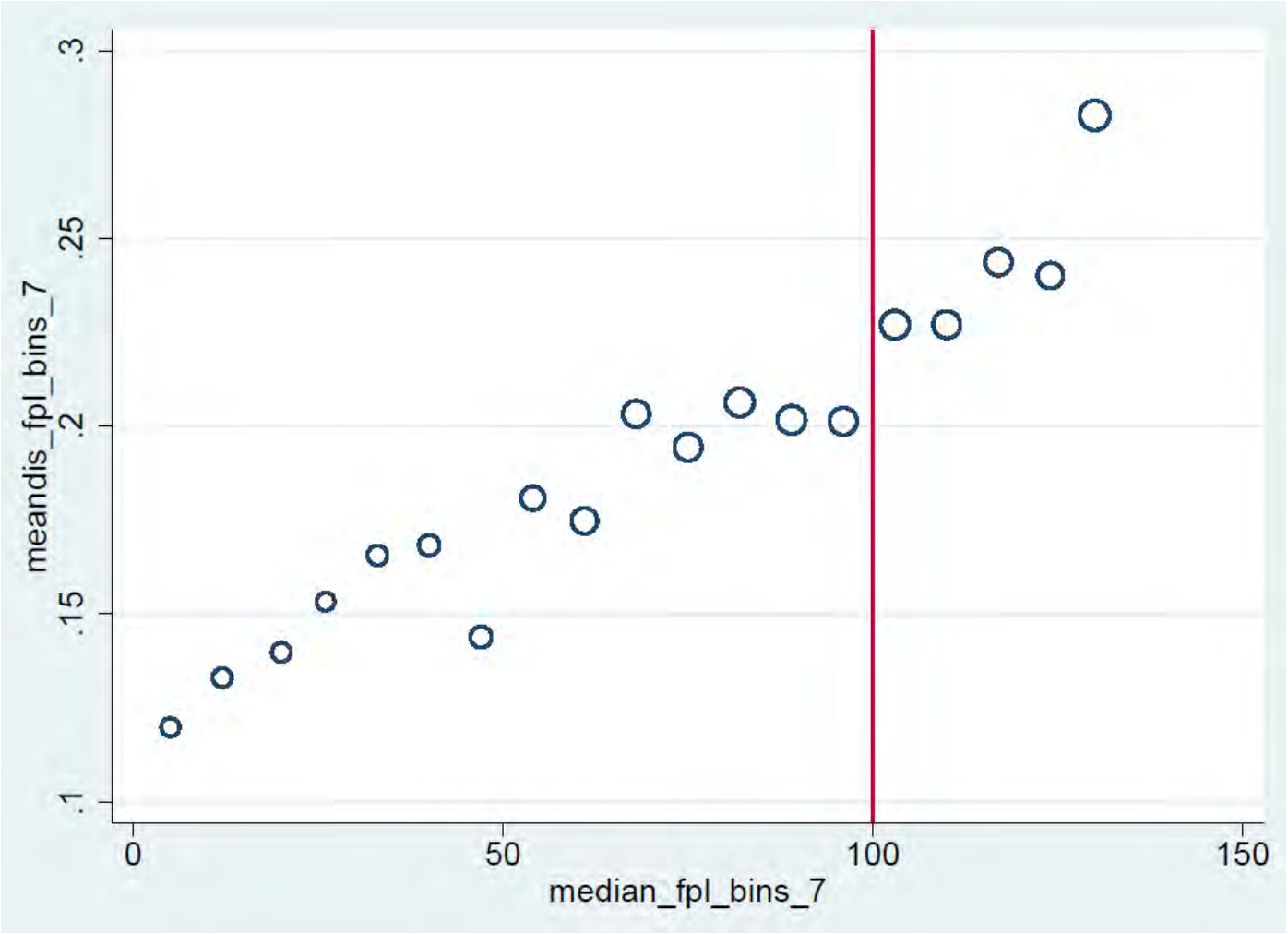


Figure 4.8b Likelihood of Disenrollment, FPL in bins of 5

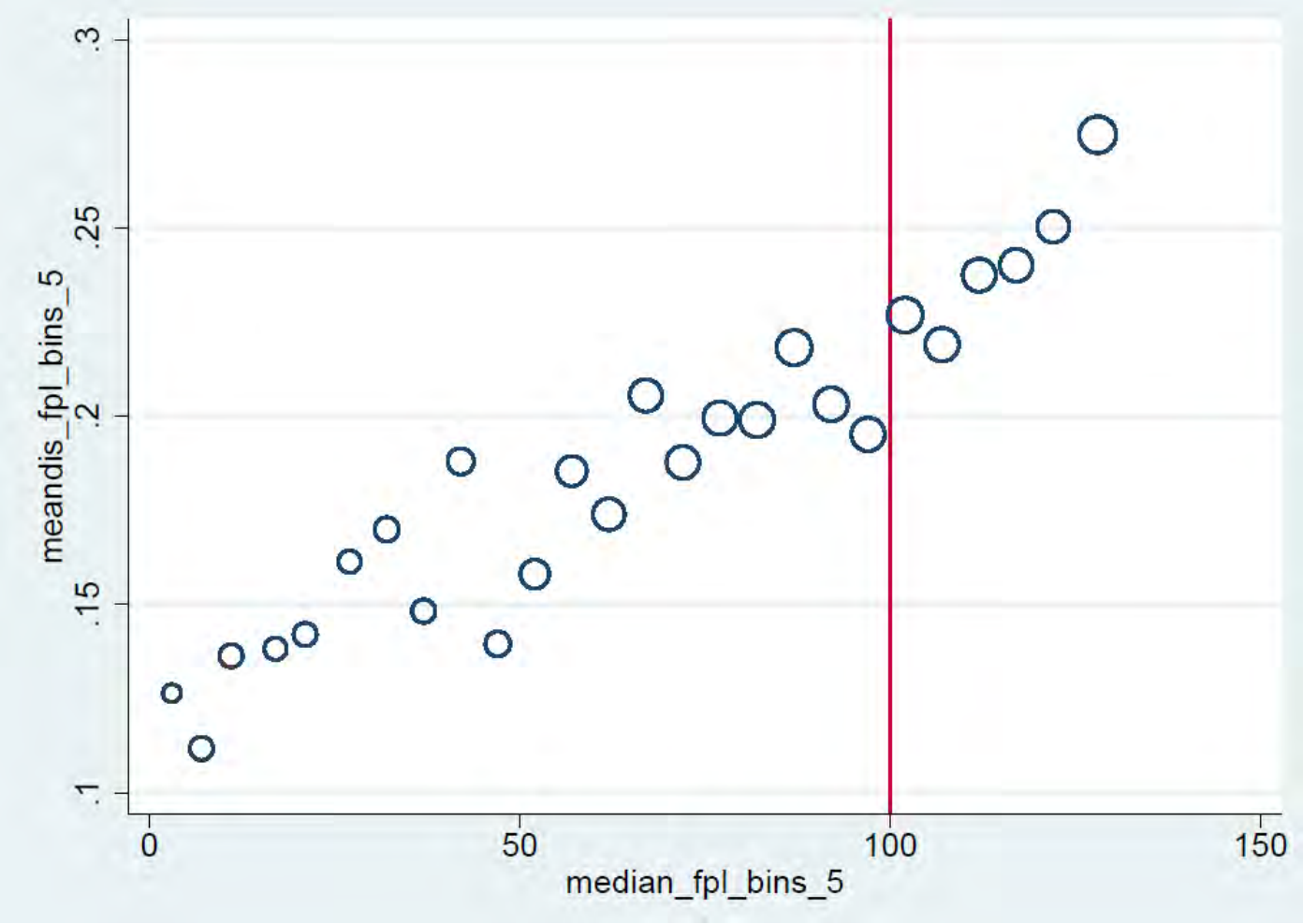


Figure 4.8c Likelihood of Disenrollment, FPL in bins of 4

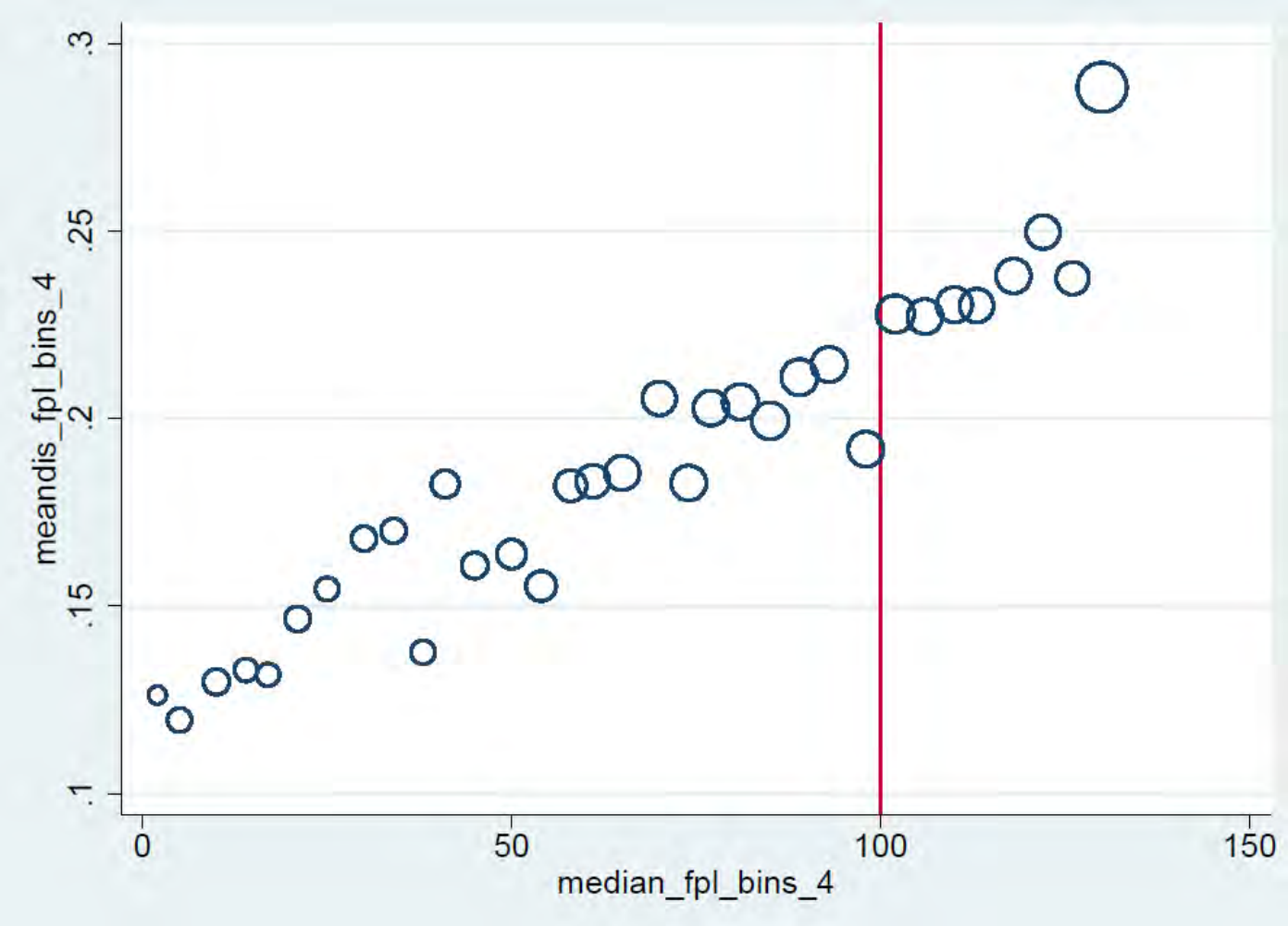


Figure 4.9 RD Plot Sharp, Mean FPL Percent

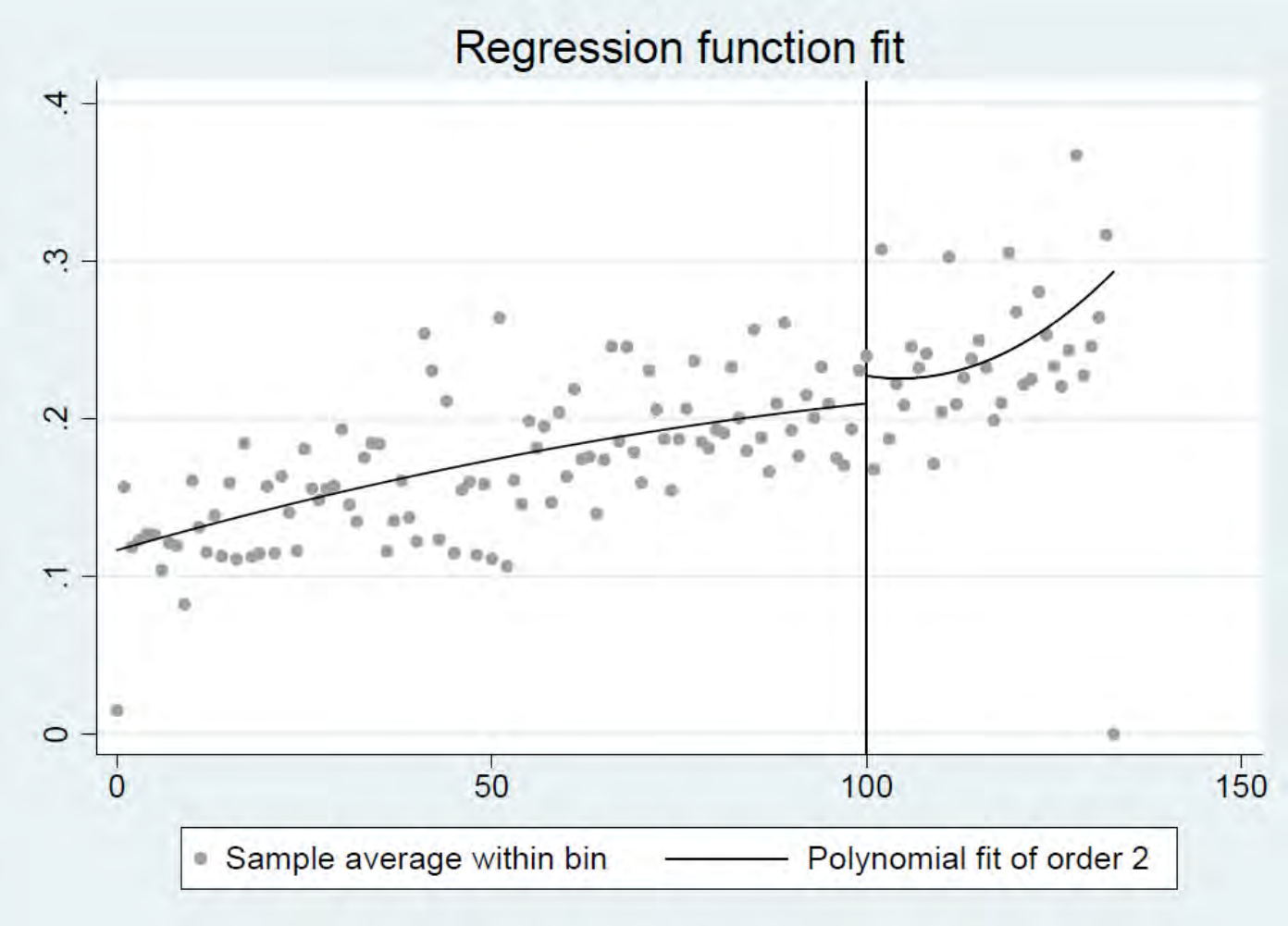


Figure 4.9a RD Plot on minimum reported FPL

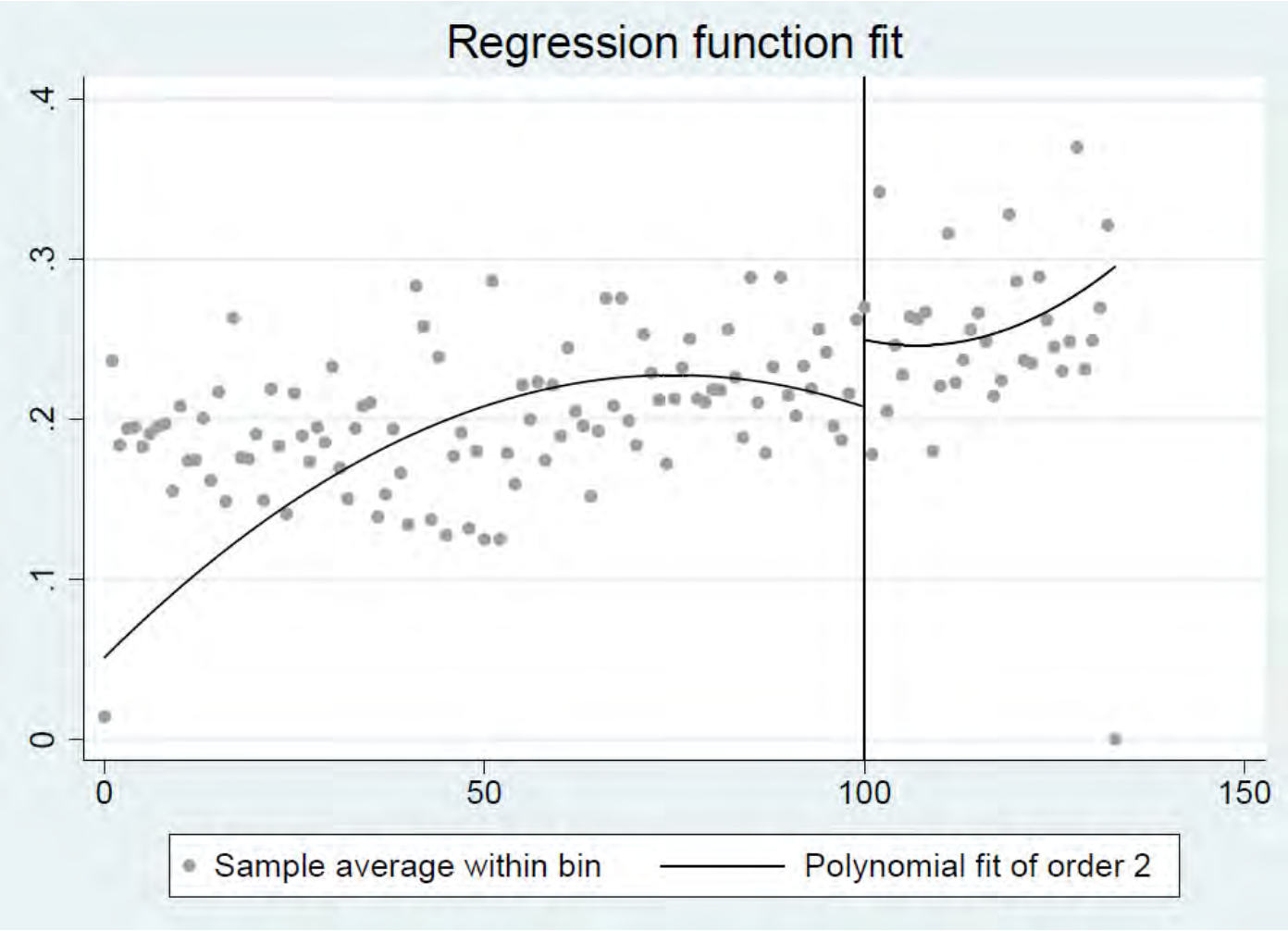


Figure 4.10 RD Plot of Disenrollment for Bottom Half of Spenders (including $0; 1st 7 months enrollment)

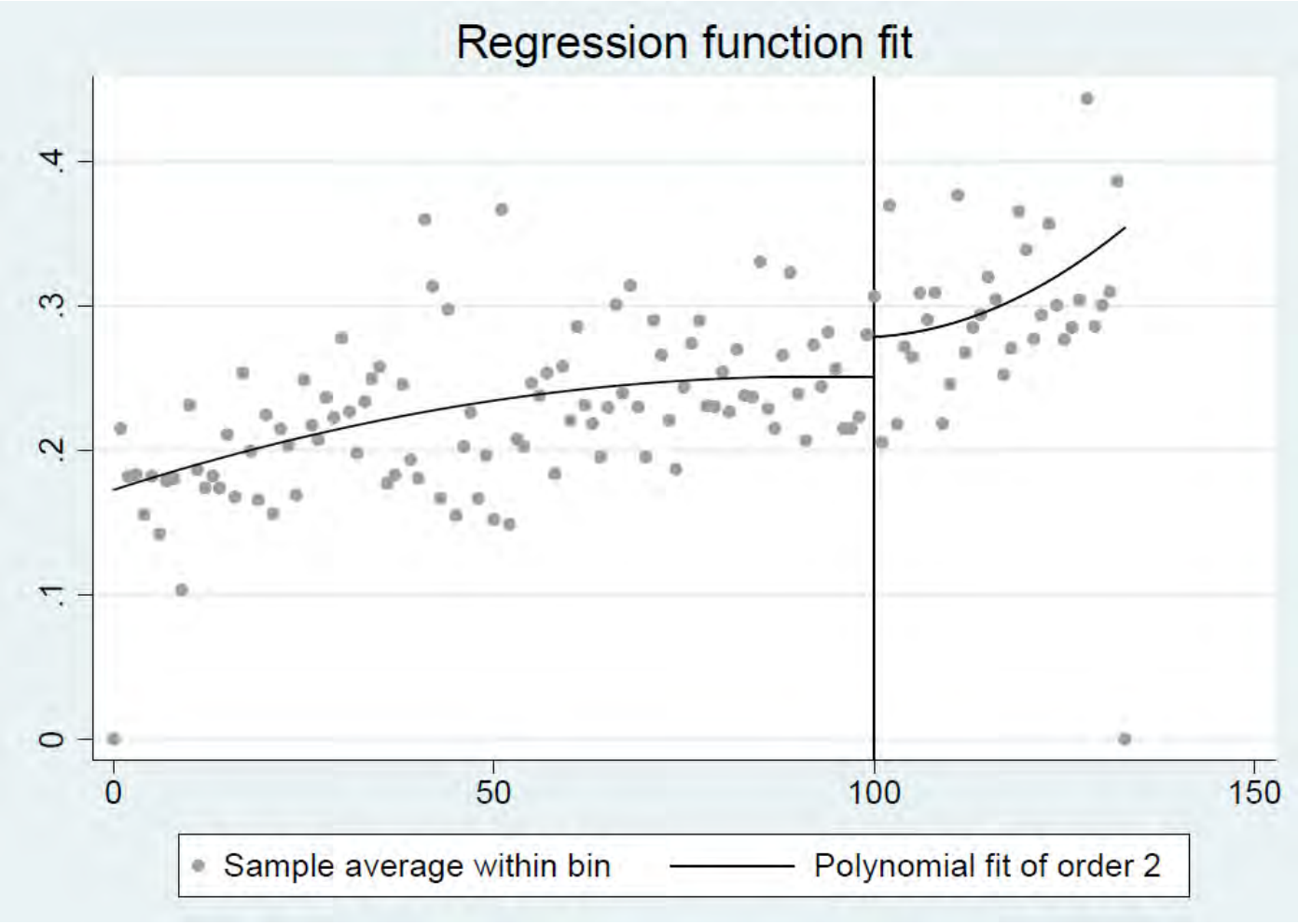


Figure 4.10a RD Plot of Disenrollment for Top Half of Spenders (no truncation; 1st 7 months enrollment)

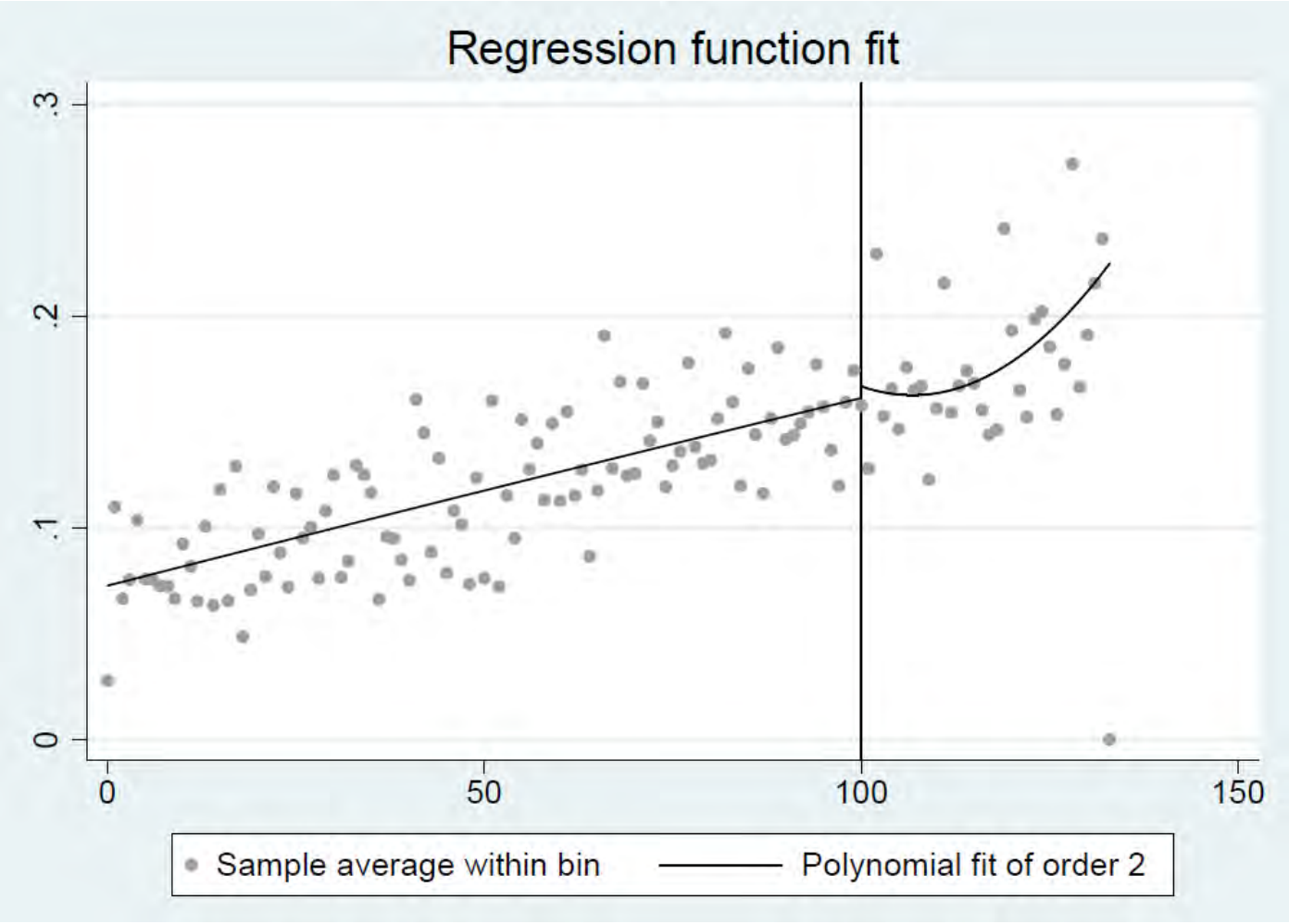


Figure 4.11 RD Plot of Disenrollment for People with No Chronic Disease Claims (1st 7months enrollment)

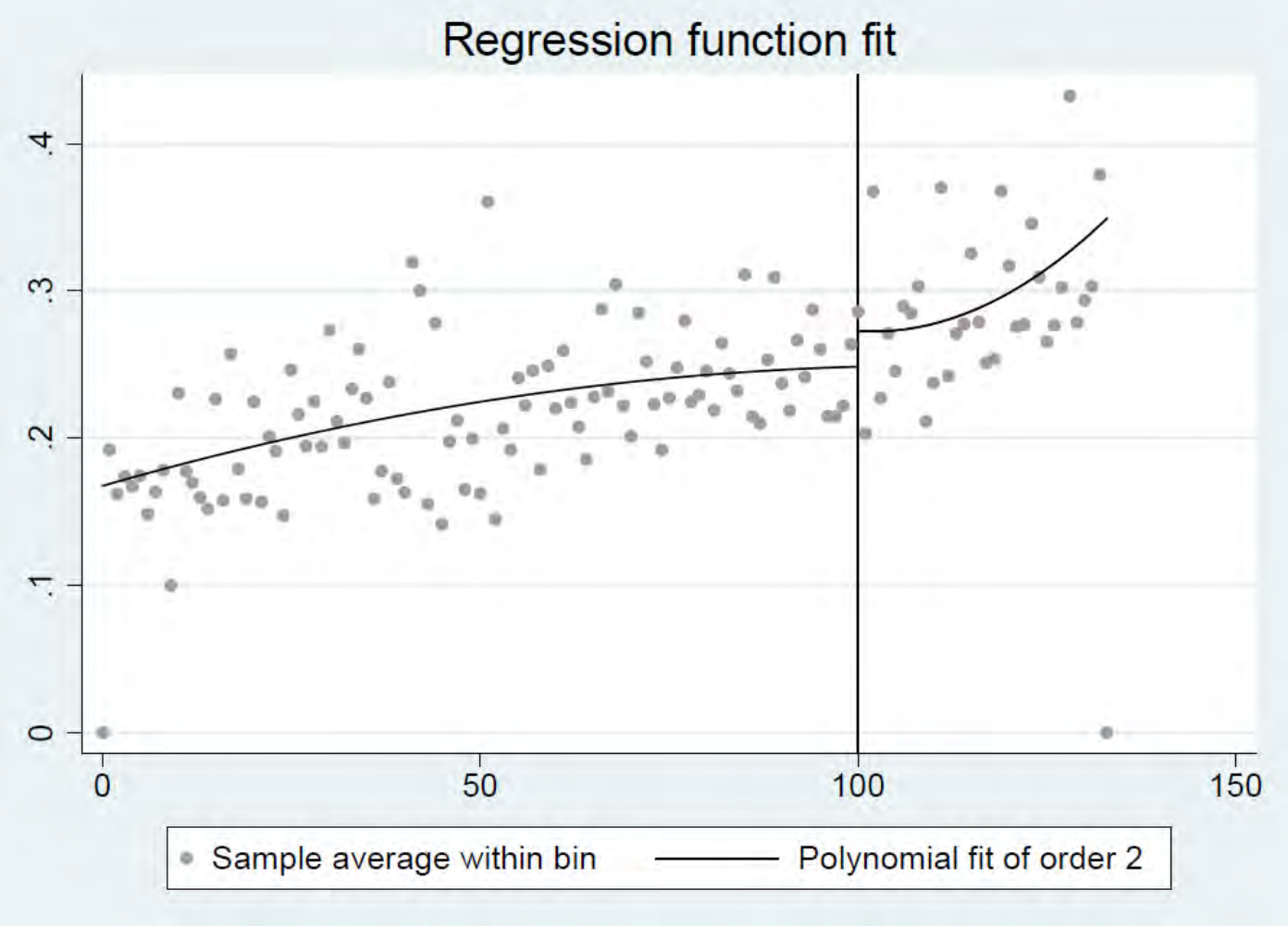


Figure 4.11a RD Plot of Disenrollment for People with Any Chronic Disease Claims (1st 7months enrollment)

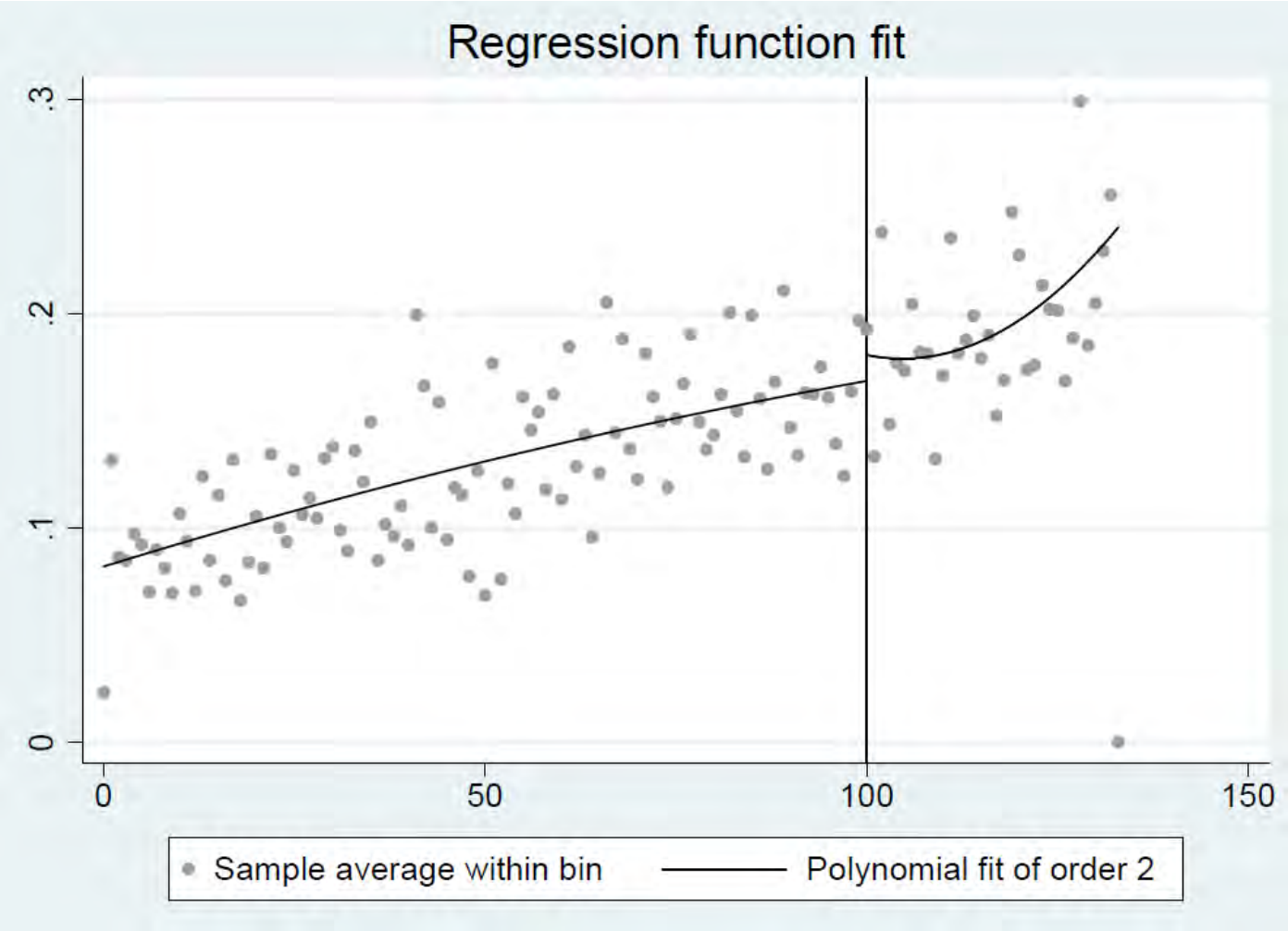


Figure 4.12 Sensitivity Check: Qfit and Scatter of Age on FPL

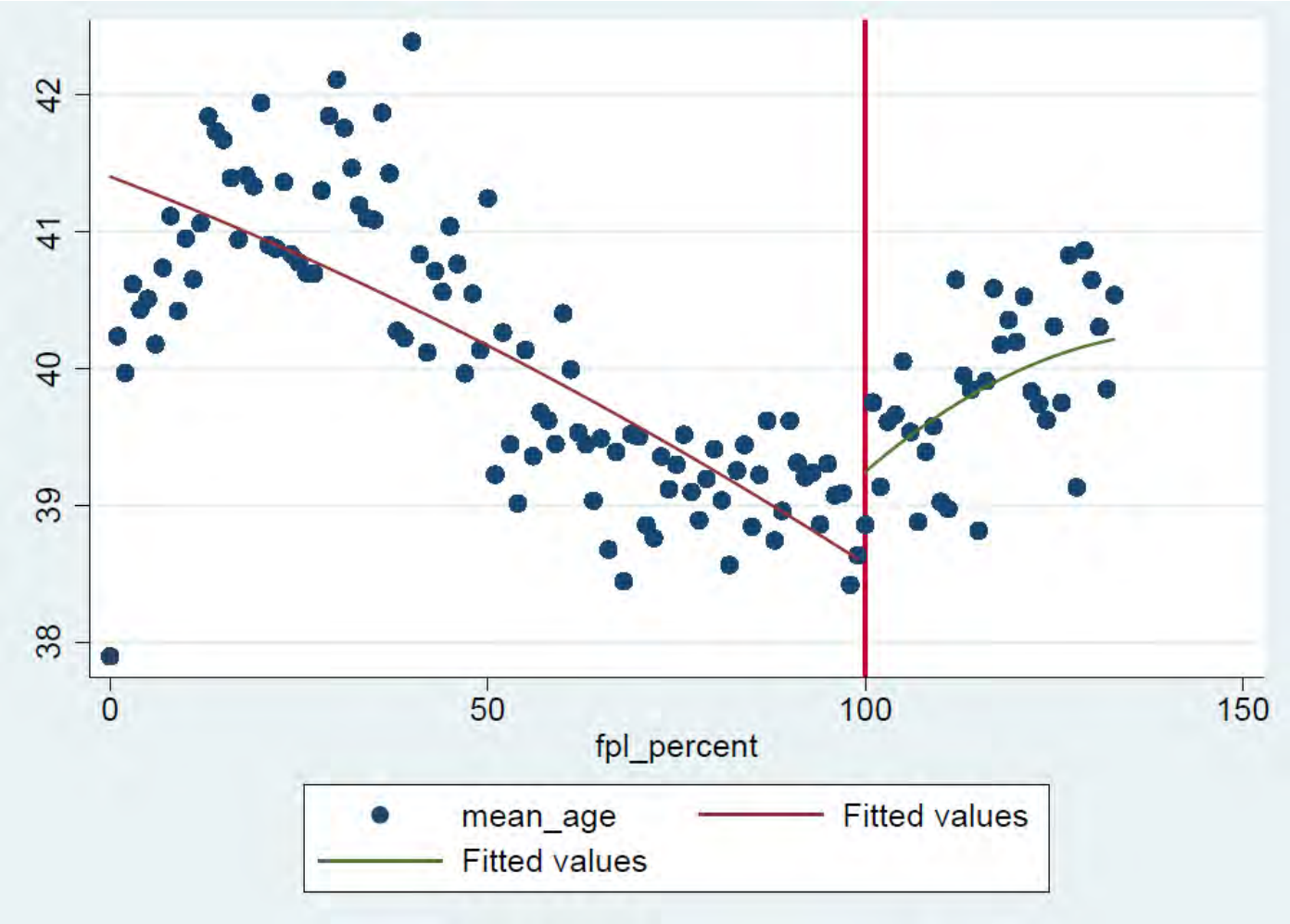


Figure 4.12a Sensitivity Check: RD Plot of Age on FPL

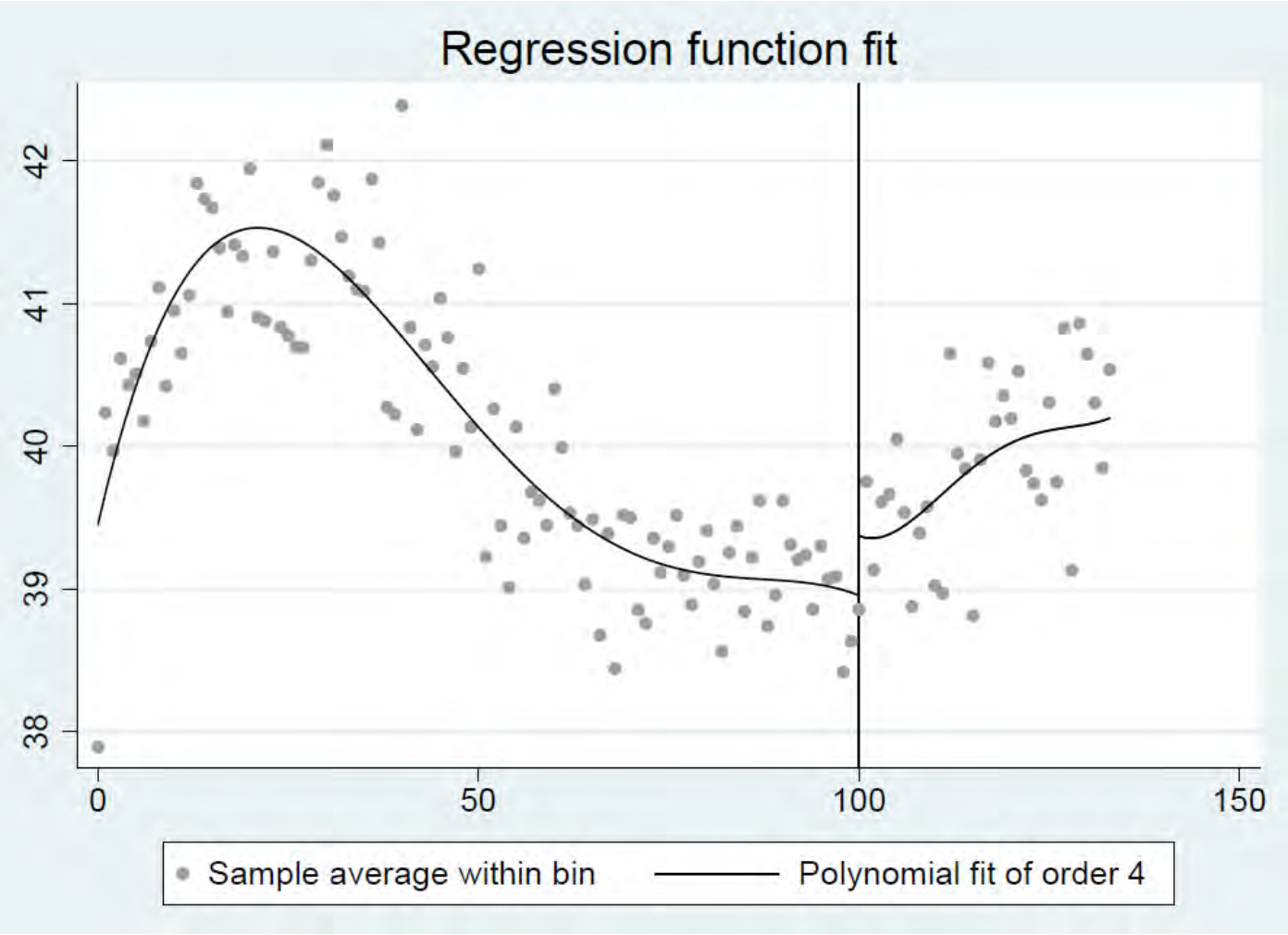


Figure 4.13 Sensitivity Check: Qfit and Scatter of Female on FPL

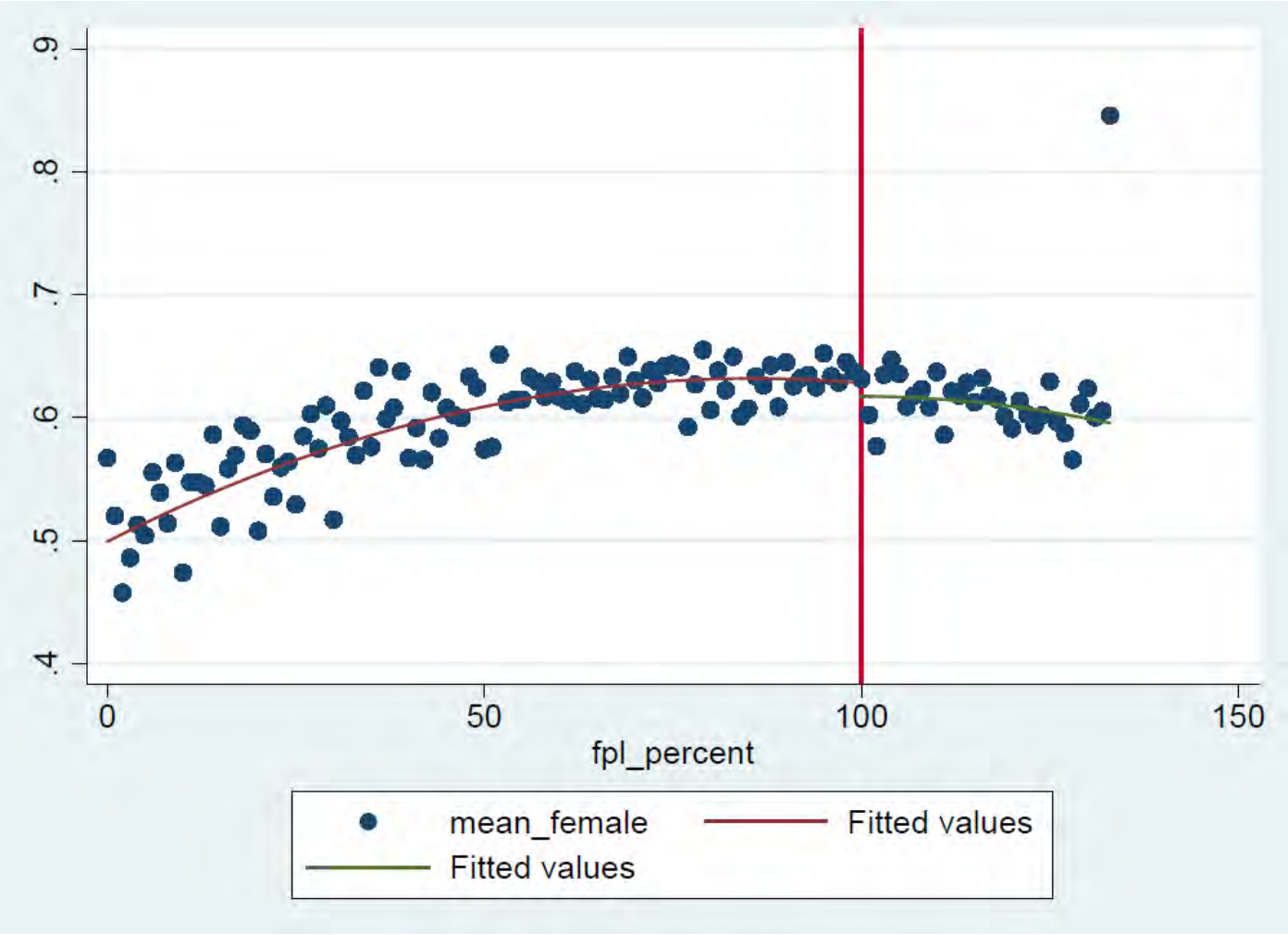


Figure 4.13a Sensitivity Check: RD Plot of Female on FPL

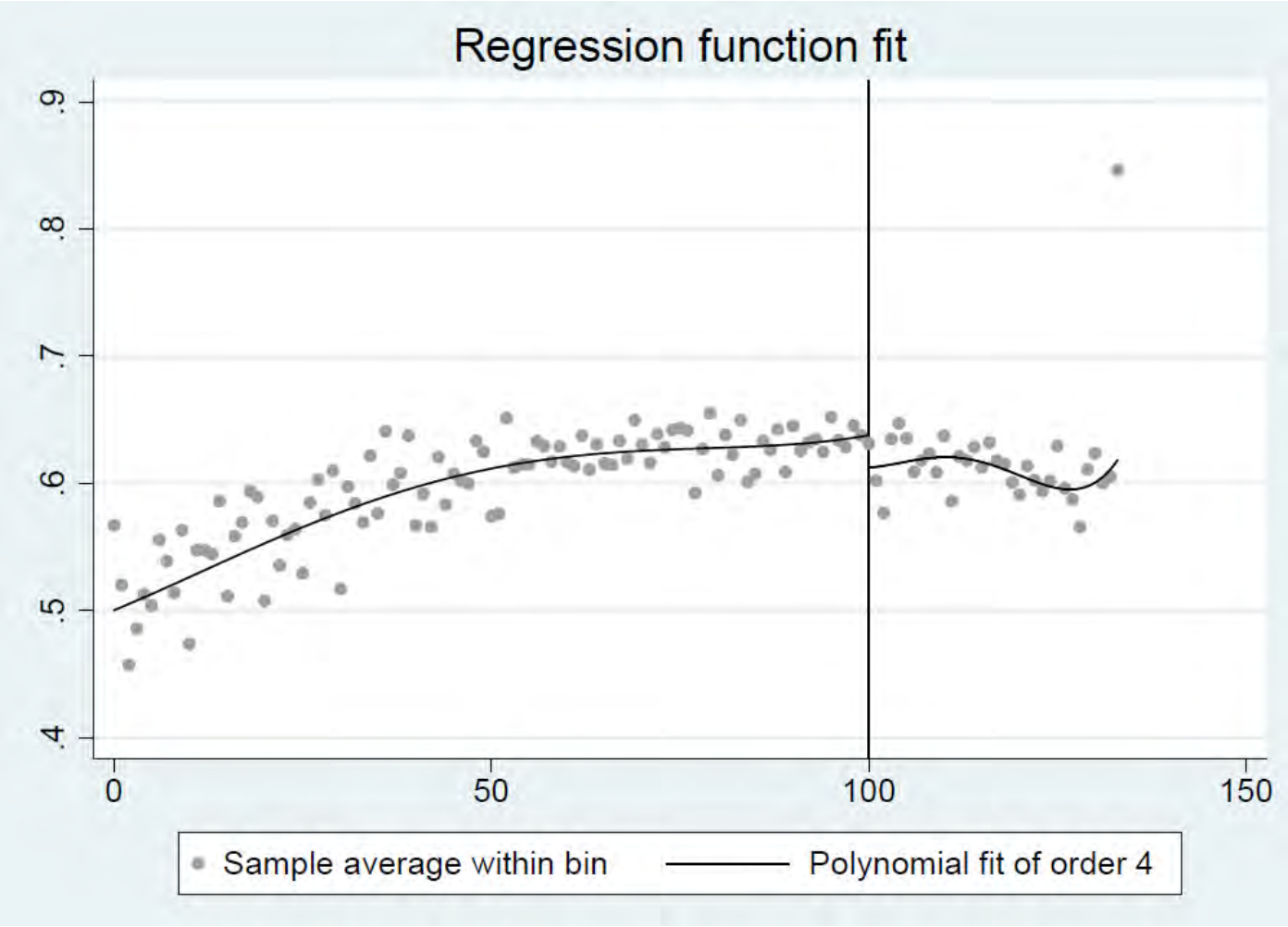
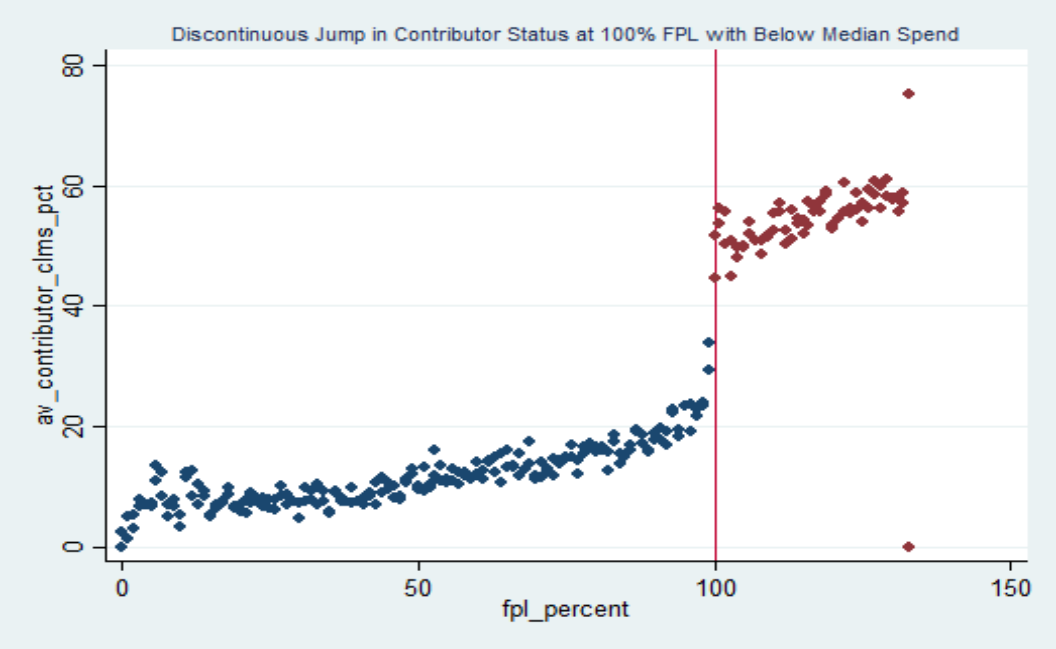


Figure 4.14 Scatter Plot, Contribution Percentage and Average Contribution Amount, Below Median Spending



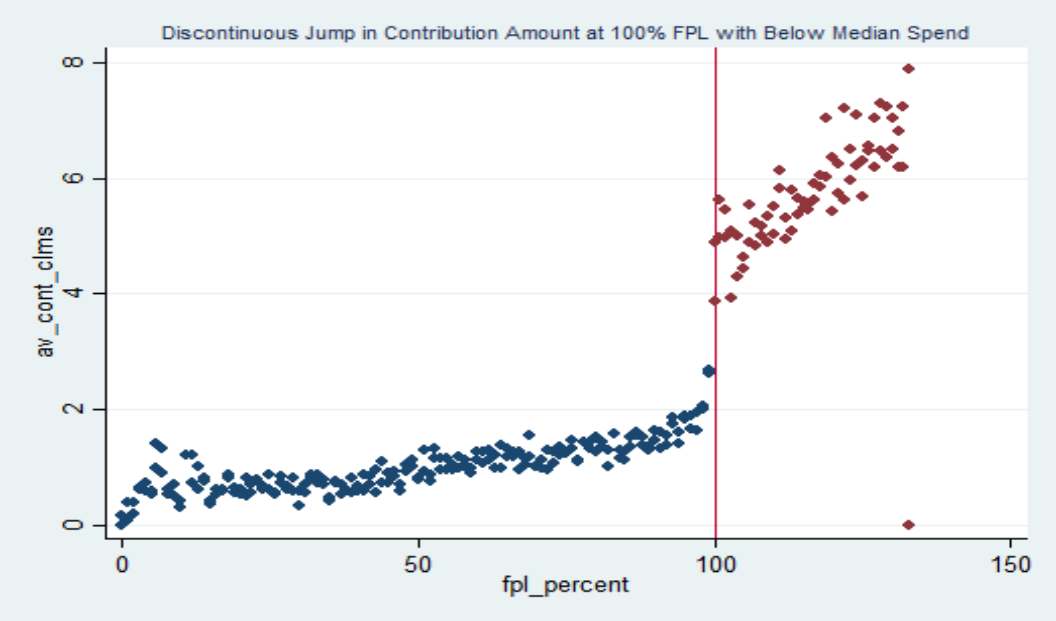
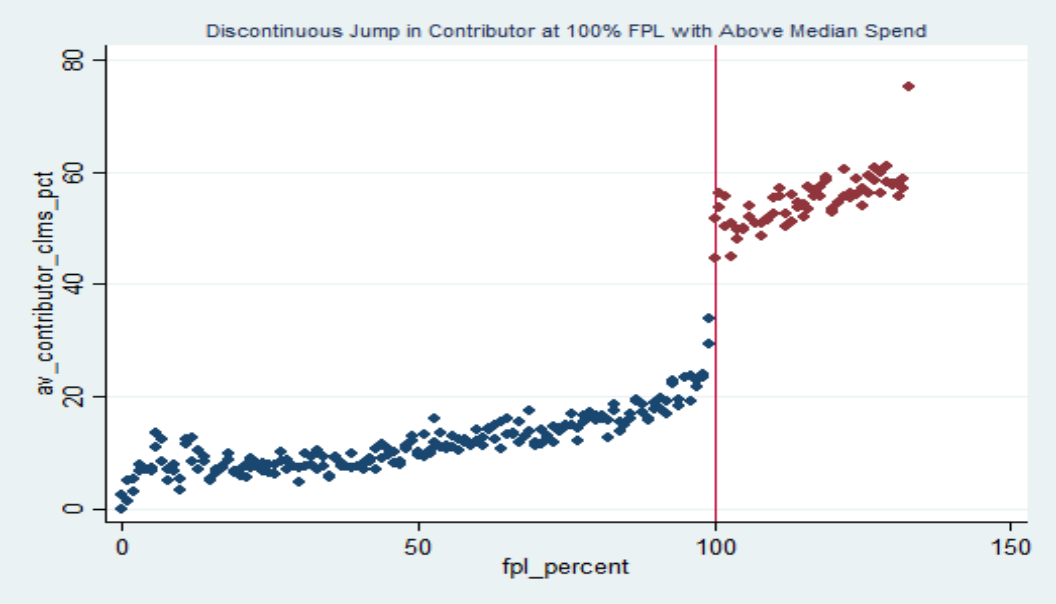


Figure 4.15 Scatter Plot, Contribution Percentage and Average Contribution Amount, Above Median Spending



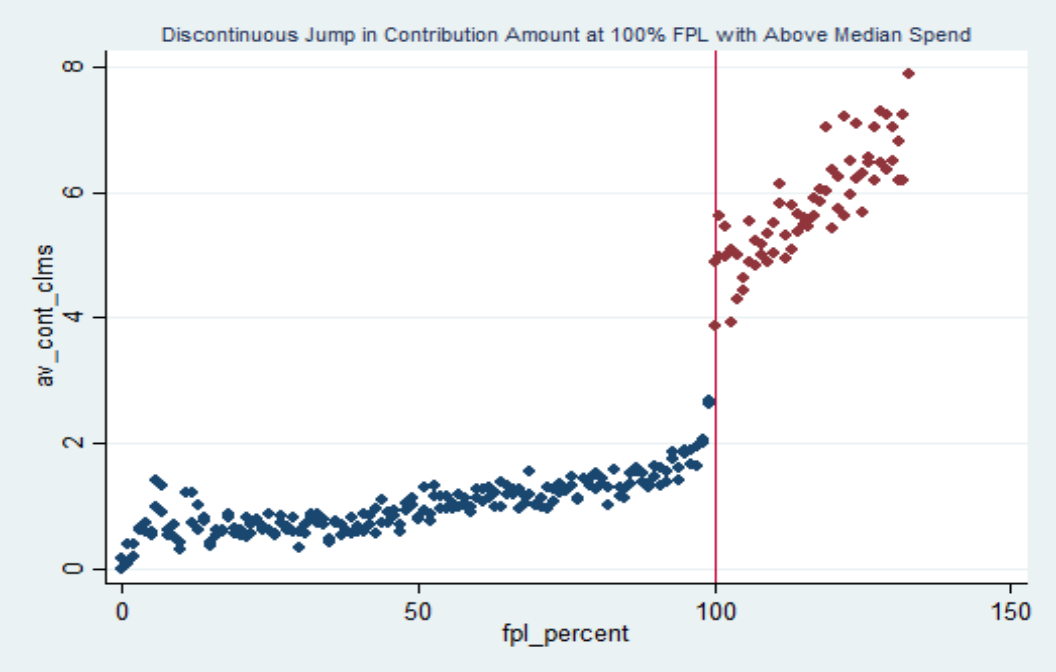
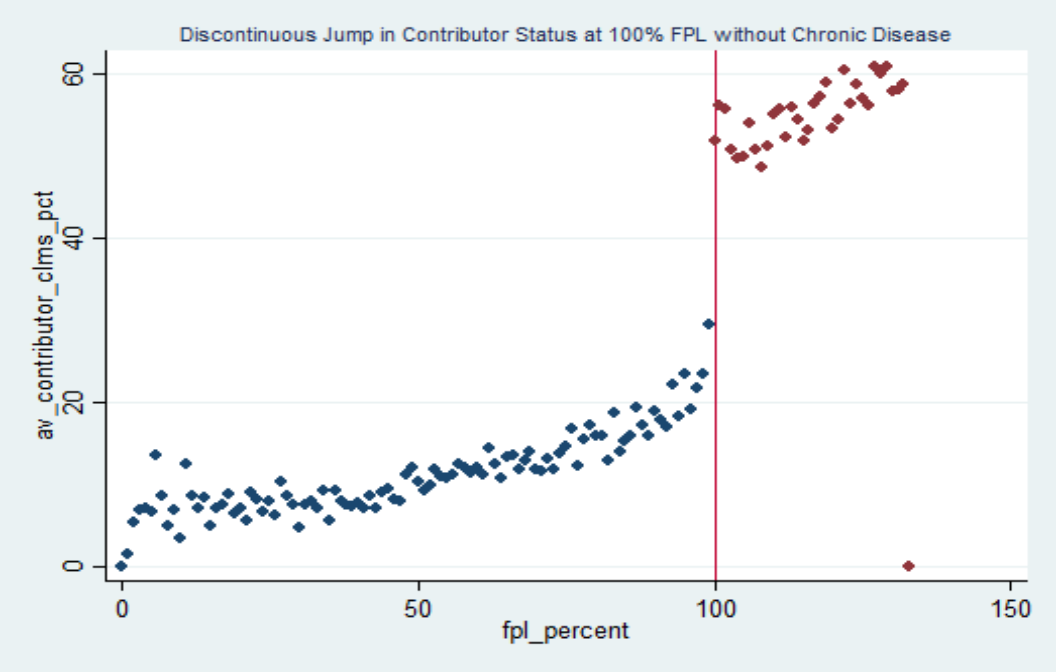


Figure 4.16 Scatter Plot, Contribution Percentage and Average Contribution Amount, No Chronic Disease Claims



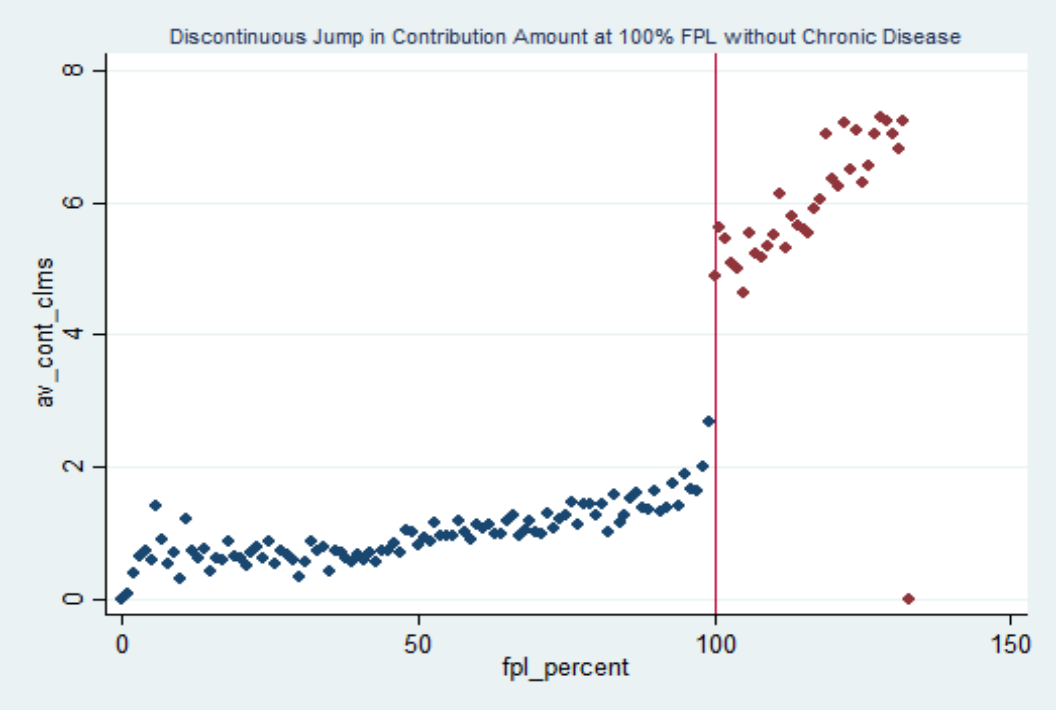
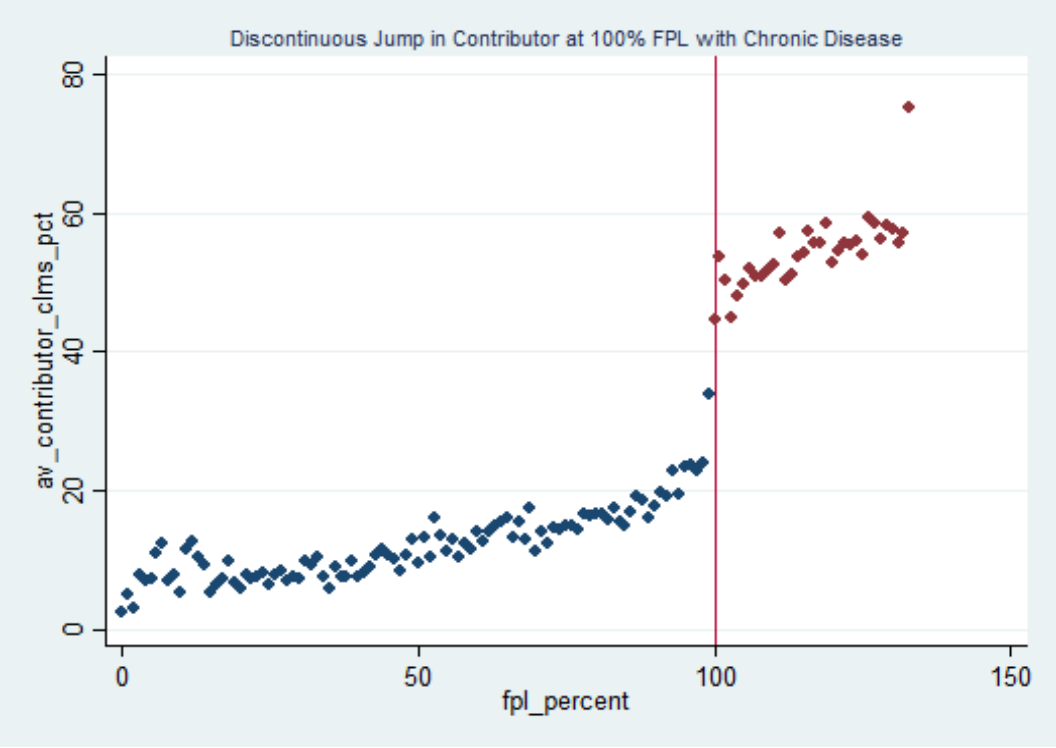


Figure 4.17 Scatter Plot, Contribution Percentage and Average Contribution Amount, Chronic Disease Claims



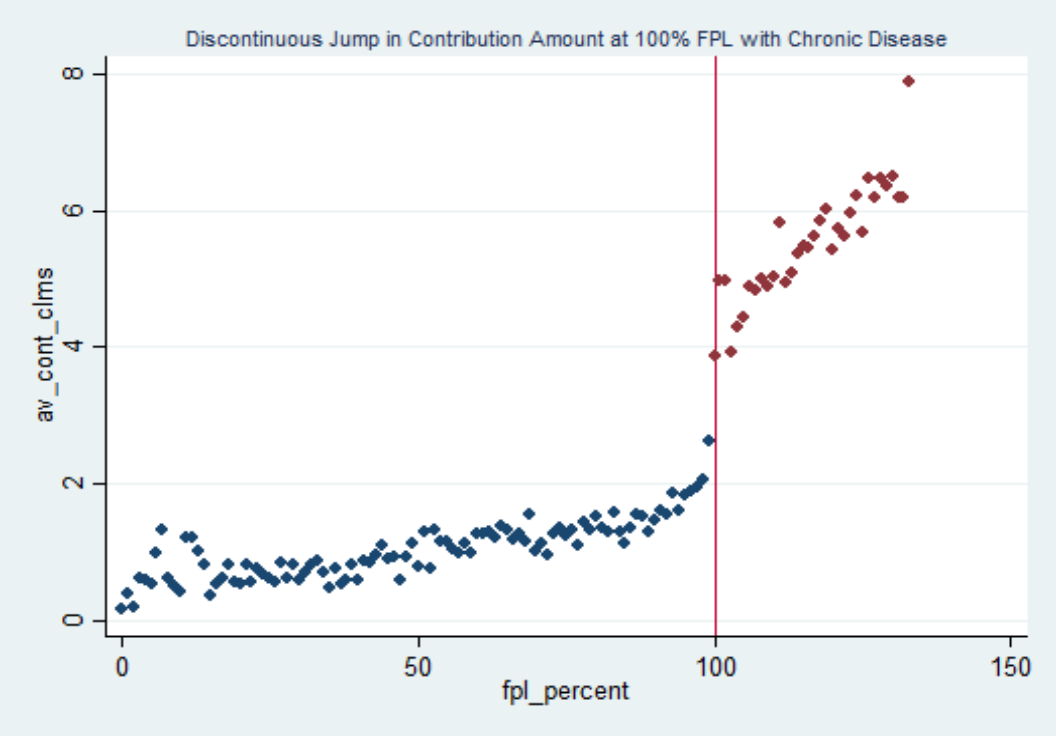


Figure 4.18 Disenrollment Percent by FPL with cutoffs at FPL 20% to FPL 115%, MSE-optimal bandwidths, triangular kernel

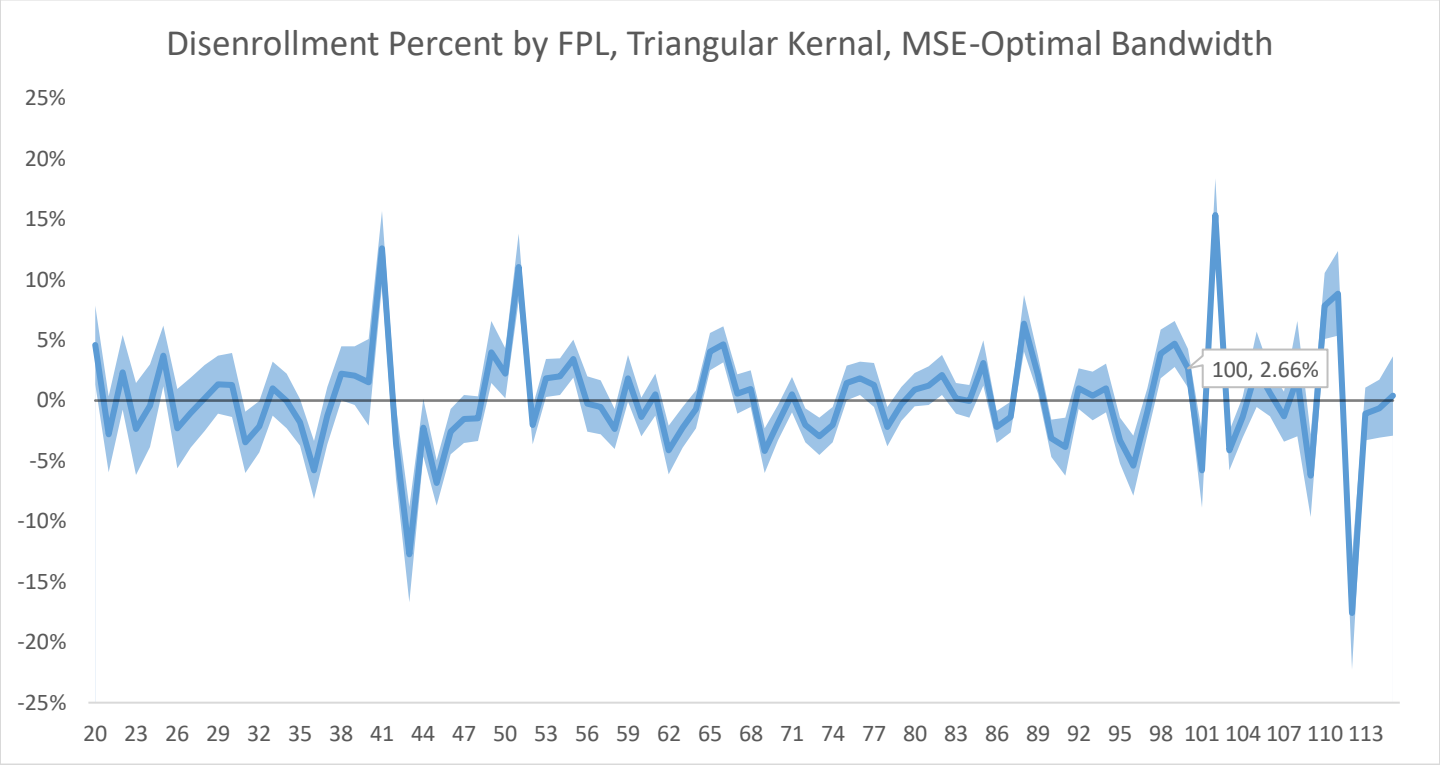
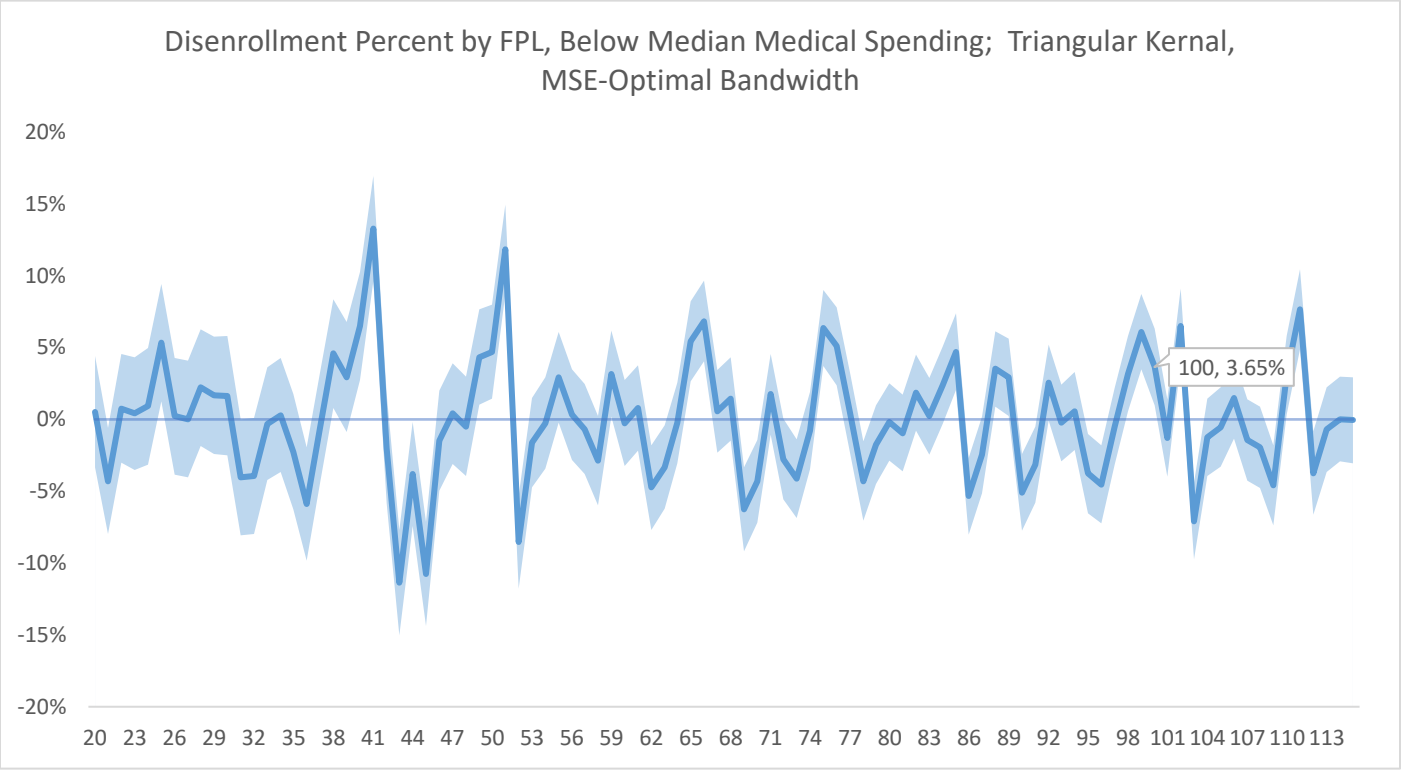


Figure 4.19 Disenrollment Percent by FPL with cutoffs at FPL 20% to FPL 115%, MSE-optimal bandwidths, triangular kernel, Below and Above Median Spending



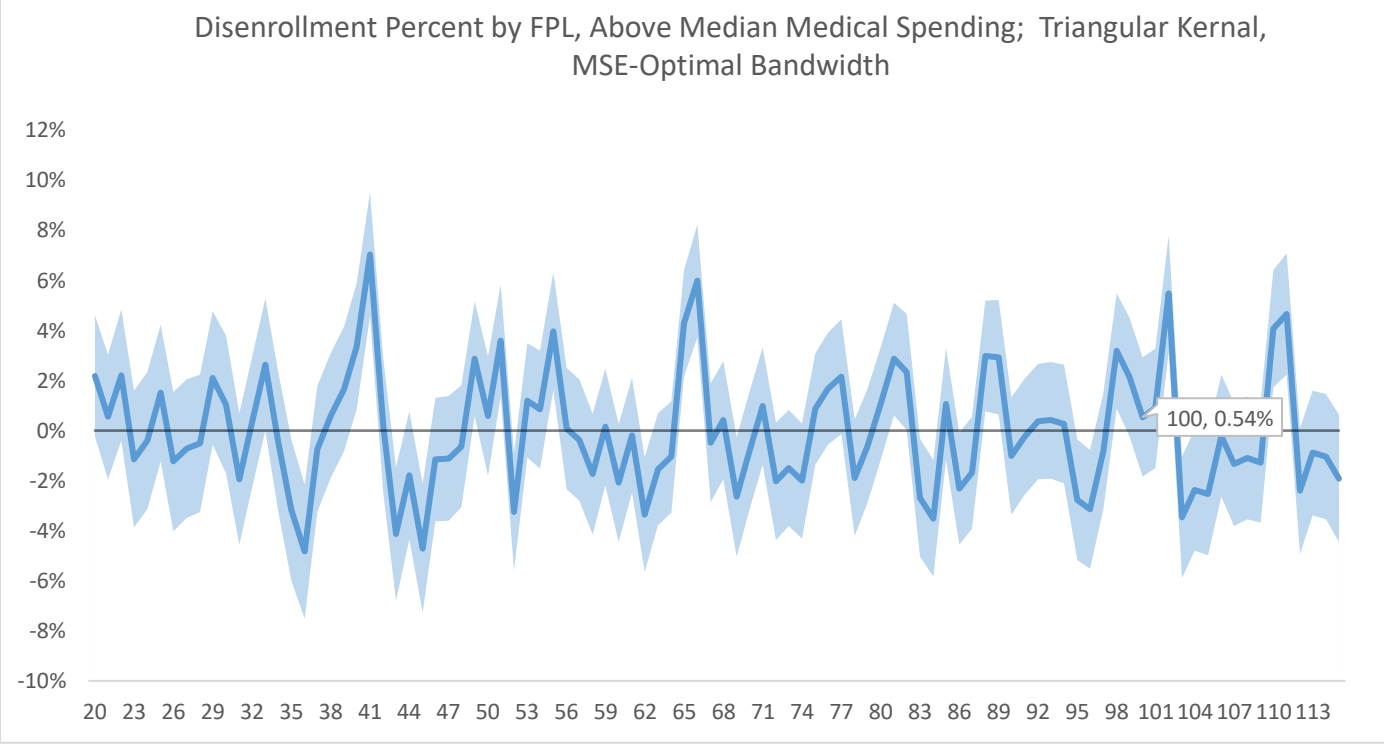
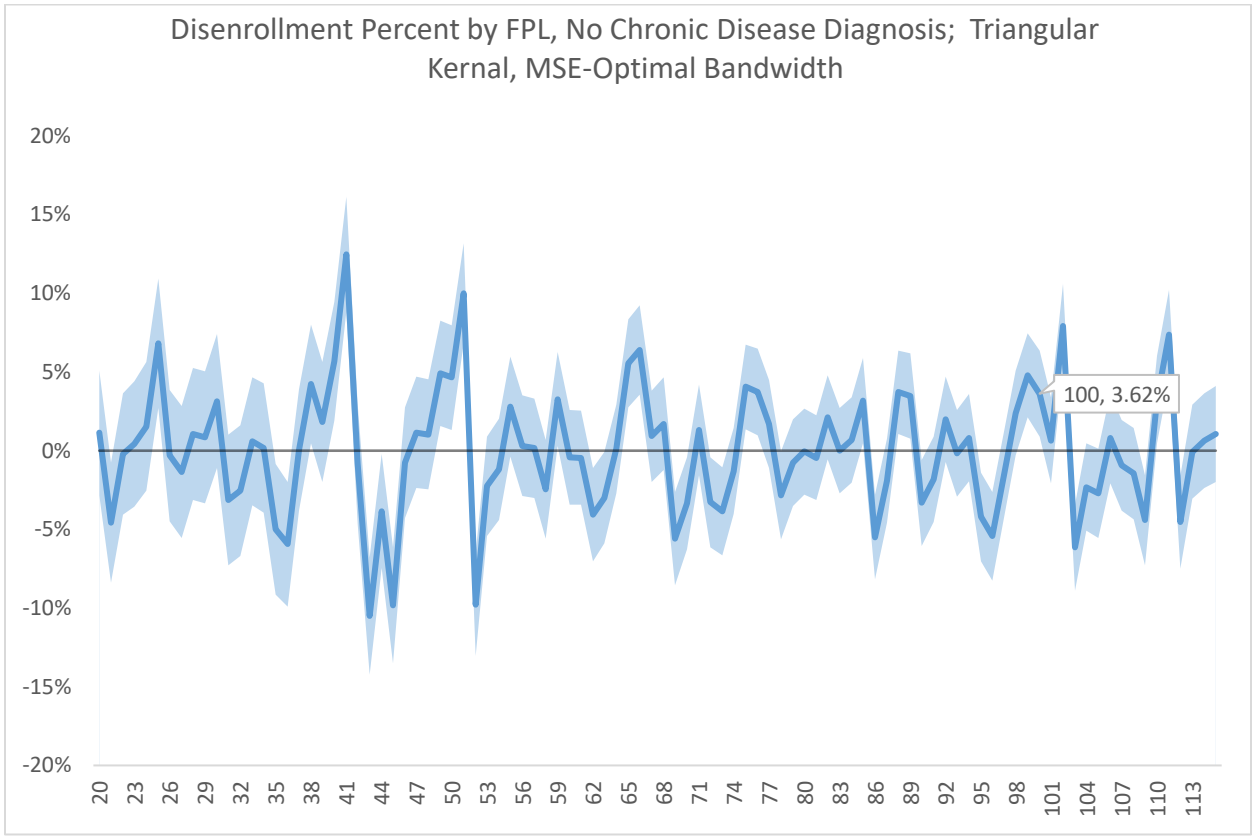


Figure 4.20 Disenrollment Percent by FPL with cutoffs at FPL 20% to FPL 115%, MSE-optimal bandwidths, triangular kernel, Chronic and No Chronic Diagnoses



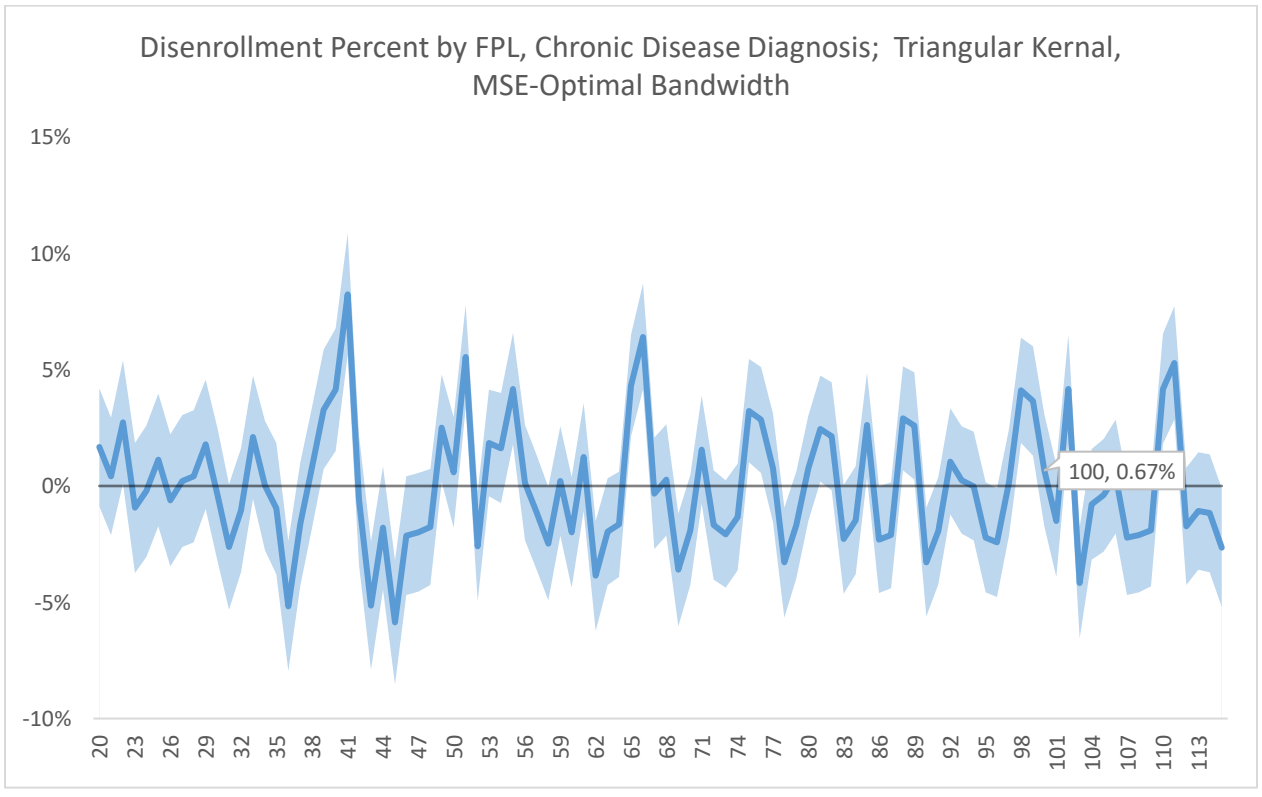


Figure 4.21 Overall density of number of months enrolled among disenrollers, all FPL and all Medicaid programs, sample of enrollees in HMP-MC or HMP-FFS >1 month

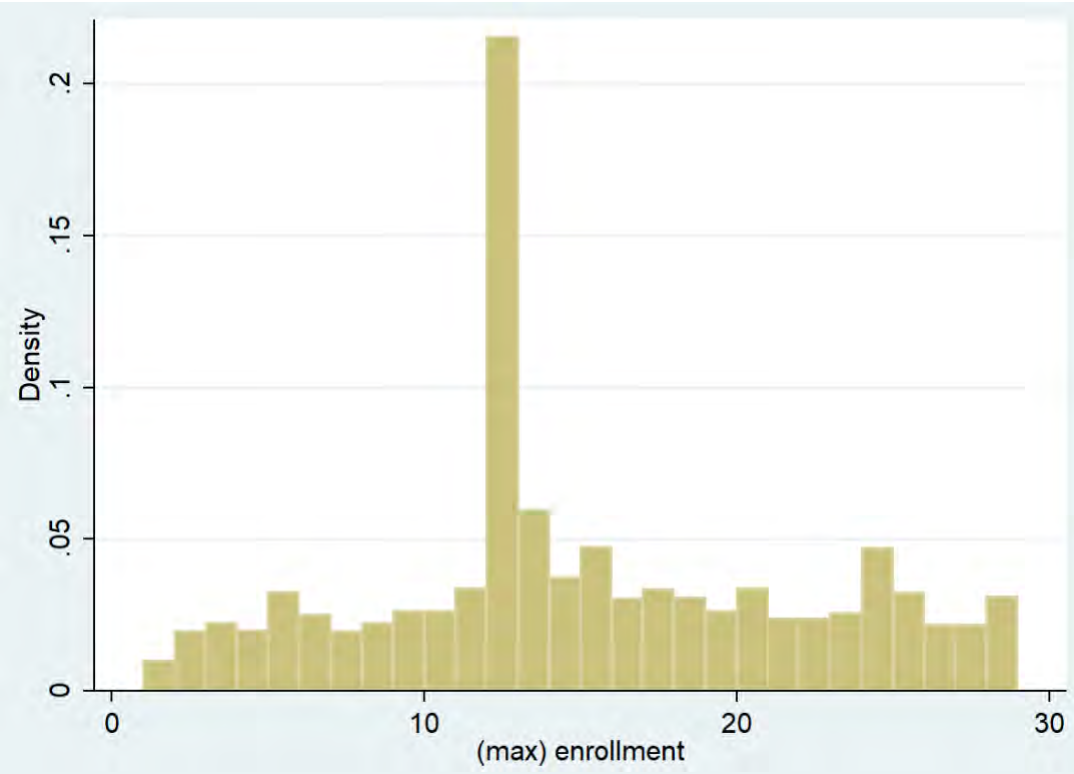
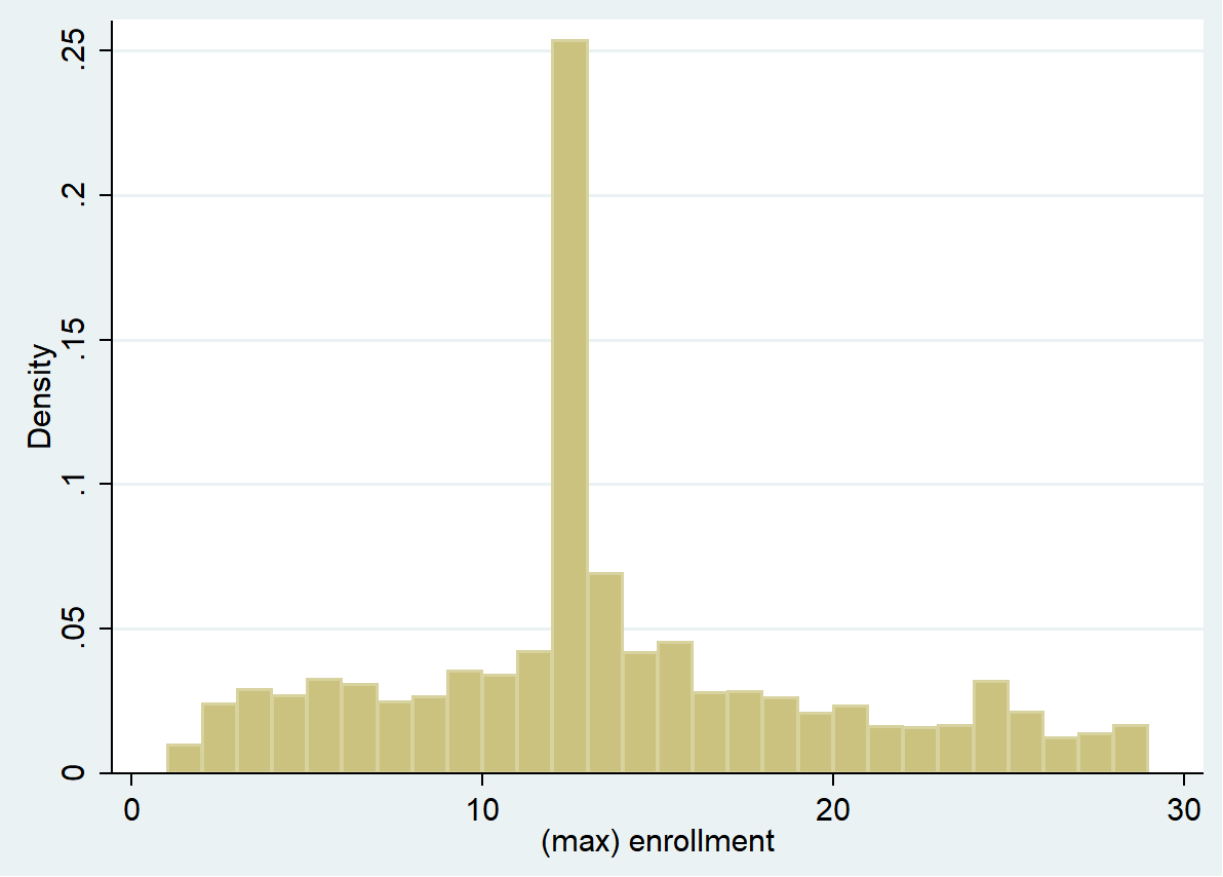


Figure 4.22 Overall density of number of months enrolled among disenrollers, FPL 100%+ and all Medicaid programs, sample of enrollees in HMP-MC or HMP-FFS >1 month



Hypothesis 4: Healthy Behavior Rewards and Healthy Behaviors

Table 5.1 Predictors of Healthy Behaviors, Predicted Prevalence Numbers Based on Probit Regression

	Lost weight in past 12 months (n=4,030)	*p-value on regression coefficient*	Among smokers, trying to quit smoking (n=1,513)	*p-value on regression coefficient*	Got flu shot this year (n= 4,030)	*p-value on regression coefficient*
Healthy behavior reward						
No	30.5%		79.9%		35.3%	
Yes	34.5%	0.047	87.8%	0.005	42.8%	< 0.001
Age						
19-34	31.6%		77.5%		34.0%	
35-50	33.7%	0.365	82.9%	0.117	37.5%	0.142
51-64	29.0%	0.240	86.7%	0.003	43.0%	< 0.001
Gender						
Male	29.4%		79.6%		36.5%	
Female	33.7%	0.023	85.2%	0.028	38.6%	0.297
Race						
White	30.1%		80.8%		37.0%	
Black	36.8%	0.011	87.2%	0.089	37.3%	0.904
Other	26.8%	0.354	76.4%	0.453	43.7%	0.075
Mixed	32.7%	0.589	80.6%	0.979	34.5%	0.615
FPL						
0-35 %	30.8%		82.5%		38.3%	
36-99 %	32.7%	0.345	83.6%	0.699	36.7%	0.473
100+ %	32.4%	0.465	78.0%	0.162	37.0%	0.596
Region						
UP/NW/NE	34.7%	0.489	81.8%	0.854	39.7%	0.493
W/E Central/E	29.7%	0.215	81.1%	0.685	36.1%	0.528
SW/S Central/SE	30.6%	0.418	82.8%	0.945	38.5%	0.771
Detroit Metro	32.7%		82.6%		37.7%	

*p-value on regression coefficient from probit regression coefficient

Table 5.2 Predicted Prevalence of Healthy Behavior Based on Healthy Behavior Reward and Demographic Characteristics from Probit Regressions of flags for Behavior

	Preventive visit	*p-value on regression coefficient*	Preventive screening	*p-value on regression coefficient*	Using copay exempt medication	*p-value on regression coefficient*
Time Period and Federal poverty level						
0-6 Months: No Reward	24.8%		44.3%		35.8%	
0-6 Months: Reward	15.4%	< 0.001	36.0%	< 0.001	37.8%	< 0.001
7-12 Months: No Reward	17.4%	< 0.001	37.3%	< 0.001	38.9%	< 0.001
7-12 Months: Reward	12.4%	< 0.001	29.0%	< 0.001	37.7%	0.238
13-18 Months: No Reward	10.9%	< 0.001	26.2%	< 0.001	38.8%	< 0.001
13-18 Months: Reward	54.7%	< 0.001	67.2%	< 0.001	47.2%	0.854
19-24 Months: No Reward	26.2%	< 0.001	47.6%	< 0.001	48.9%	< 0.001
19-24 Months: Reward	33.6%	< 0.001	53.1%	< 0.001	50.5%	0.113
25- 30 Months: No Reward	21.9%	< 0.001	41.1%	< 0.001	49.7%	< 0.001
25- 30 Months: Reward	19.2%	< 0.001	38.2%	< 0.001	50.8%	0.348
FPL						
0-35 %	21.5%		40.3%		42.7%	
36-99 %	22.0%	< 0.001	40.6%	0.023	39.1%	< 0.001
100+ %	21.6%	0.460	40.2%	0.692	38.6%	< 0.001
Age						
Under 30	20.3%		31.3%		16.4%	
30 to 39	20.8%	0.001	33.7%	< 0.001	28.4%	< 0.001
40 to 49	22.3%	< 0.001	42.5%	< 0.001	46.8%	< 0.001
Over 50	22.4%	< 0.001	47.5%	< 0.001	57.3%	< 0.001
Gender						
Male	16.7%		32.3%		39.6%	
Female	25.8%	< 0.001	47.1%	< 0.001	42.5%	< 0.001
Race						
White	22.3%		40.2%		41.0%	
Black	20.3%	< 0.001	40.4%	0.165	42.0%	< 0.001
American Indian	22.5%	0.778	41.6%	0.075	46.3%	< 0.001
Hispanic	20.0%	< 0.001	42.4%	< 0.001	40.5%	0.165
Asian/Pacific Islander	22.9%	0.411	42.4%	0.007	38.4%	0.001
Unknown	21.2%	< 0.001	40.1%	0.604	39.3%	< 0.001
Region						
Upper Peninsula	18.0%	< 0.001	35.1%	< 0.001	38.8%	< 0.001
Northwest	22.5%	< 0.001	37.3%	< 0.001	39.2%	< 0.001
Northeast	18.2%	< 0.001	37.7%	< 0.001	40.1%	0.001
West	19.8%	< 0.001	40.5%	< 0.001	43.0%	< 0.001
East Central	17.3%	< 0.001	37.2%	< 0.001	41.9%	0.001
East	20.6%	< 0.001	39.0%	< 0.001	39.7%	< 0.001
South Central	17.7%	< 0.001	38.6%	< 0.001	38.8%	< 0.001

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Southwest	19.3%	< 0.001	38.9%	< 0.001	43.2%	< 0.001
Southeast	19.7%	< 0.001	39.6%	< 0.001	41.7%	0.010
Detroit Metro	25.0%	< 0.001	42.6%	< 0.001	41.1%	< 0.001
Total observations (Enrollee/months)	681,697		681,697		681,697	

Table 5.3 Marginal Effects of Fixed Effect Regressions on Healthy Behaviors (Diff in Diff Framework)

	Preventive visit	***p-value on regression coefficient***	**Preventive screening**	***p-value on regression coefficient***	**Using copay exempt medication**	***p-value on regression coefficient***
Healthy behavior reward						
Year 1						
Year 2+	-8.21%	< 0.001	-3.53%	< 0.001	0.73%	< 0.001
Time period						
0-6 Months						
7-12 Months	-14.92%	< 0.001	-11.46%	< 0.001	1.87%	< 0.001
13-18 Months	-8.95%	< 0.001	-7.94%	< 0.001	2.93%	< 0.001
19-24 Months	-16.05%	< 0.001	-17.46%	< 0.001	1.59%	< 0.001
25-30 Months	-19.47%	< 0.001	-23.15%	< 0.001	1.00%	< 0.001
FPL						
0-35 %						
36-99 %	0.99%	0.222	2.29%	0.011	0.62%	0.309
100+ %	2.36%	0.006	3.27%	0.001	0.93%	0.132
Total enrollees	158,366		158,366		158,366	

Table measures likelihood of preventive visit. Rows (except for constant) are change in percent likelihood from baseline, measured by constant.

Figure 5.1 Predictive Margins of Percentage of Enrollees Who Engaged in a Preventive Visit by Period and Healthy Behavior Reward; Predicted Percentages, Probit Regression with Interactions on Period and Reward.

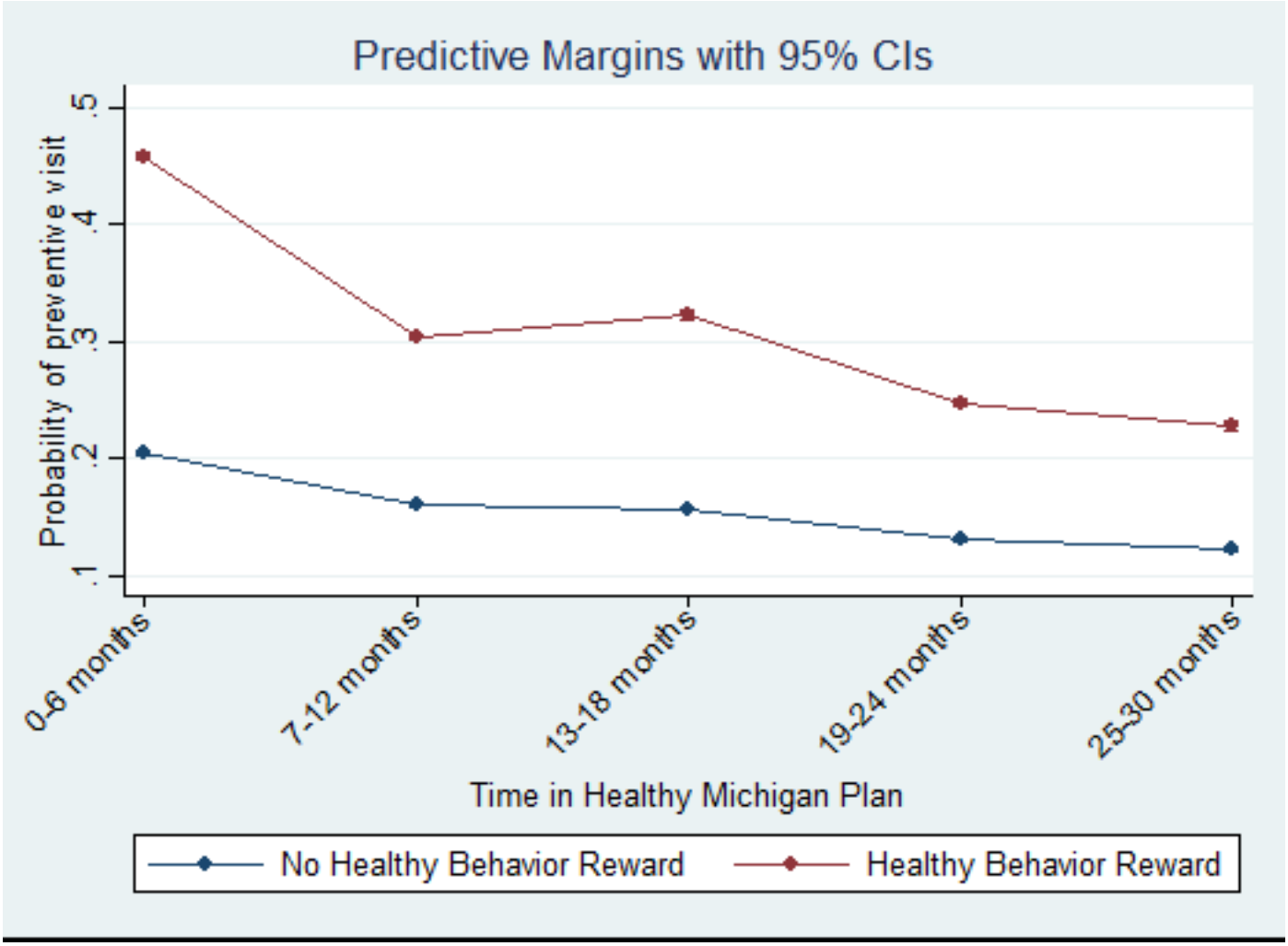


Figure 5.2 Predictive Margins of Percentage of Enrollees Who Engaged in a Preventive Screening by Period and Healthy Behavior Reward; Predicted Percentages, Probit Regression with Interactions on Period and Reward.

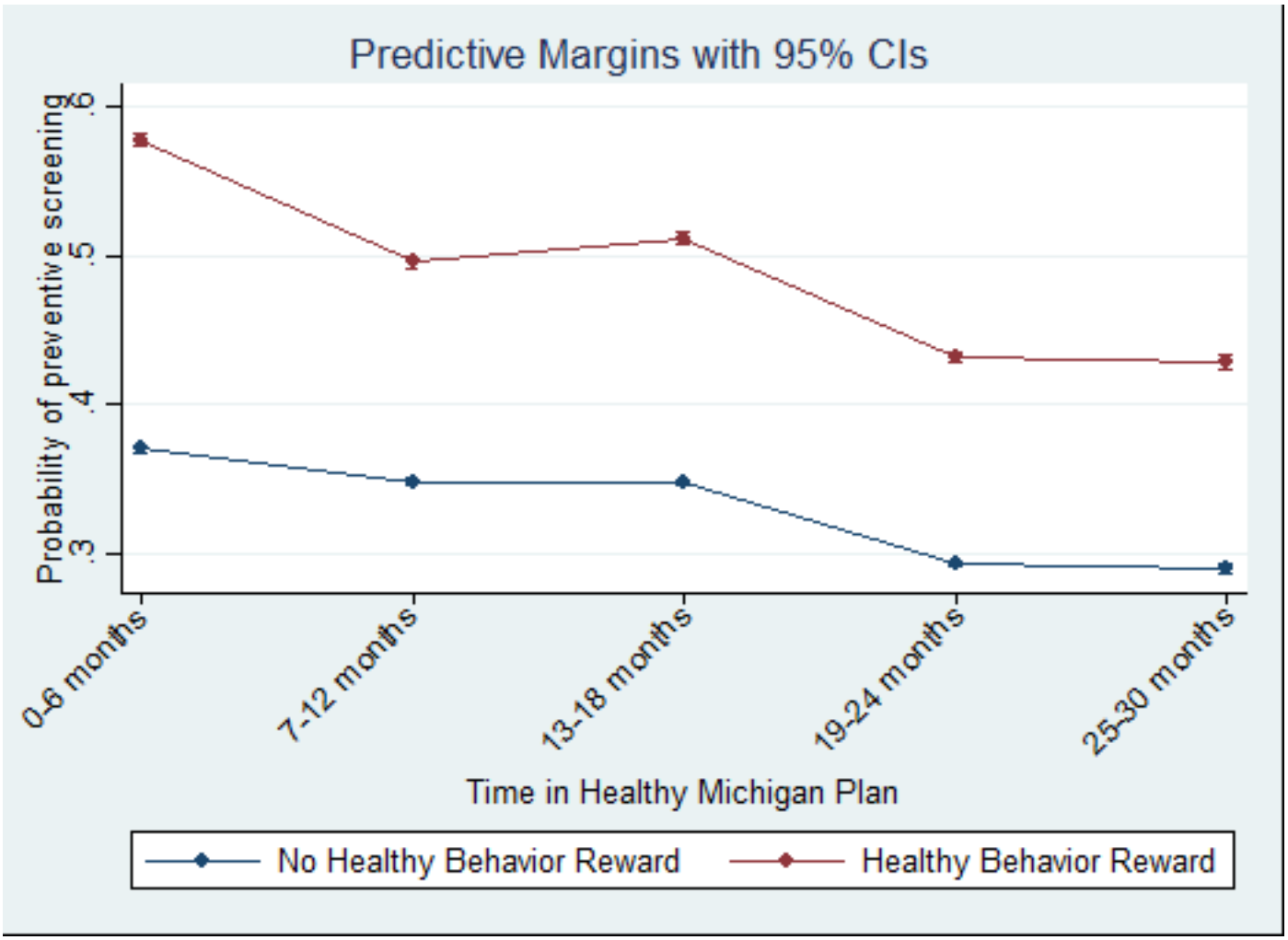
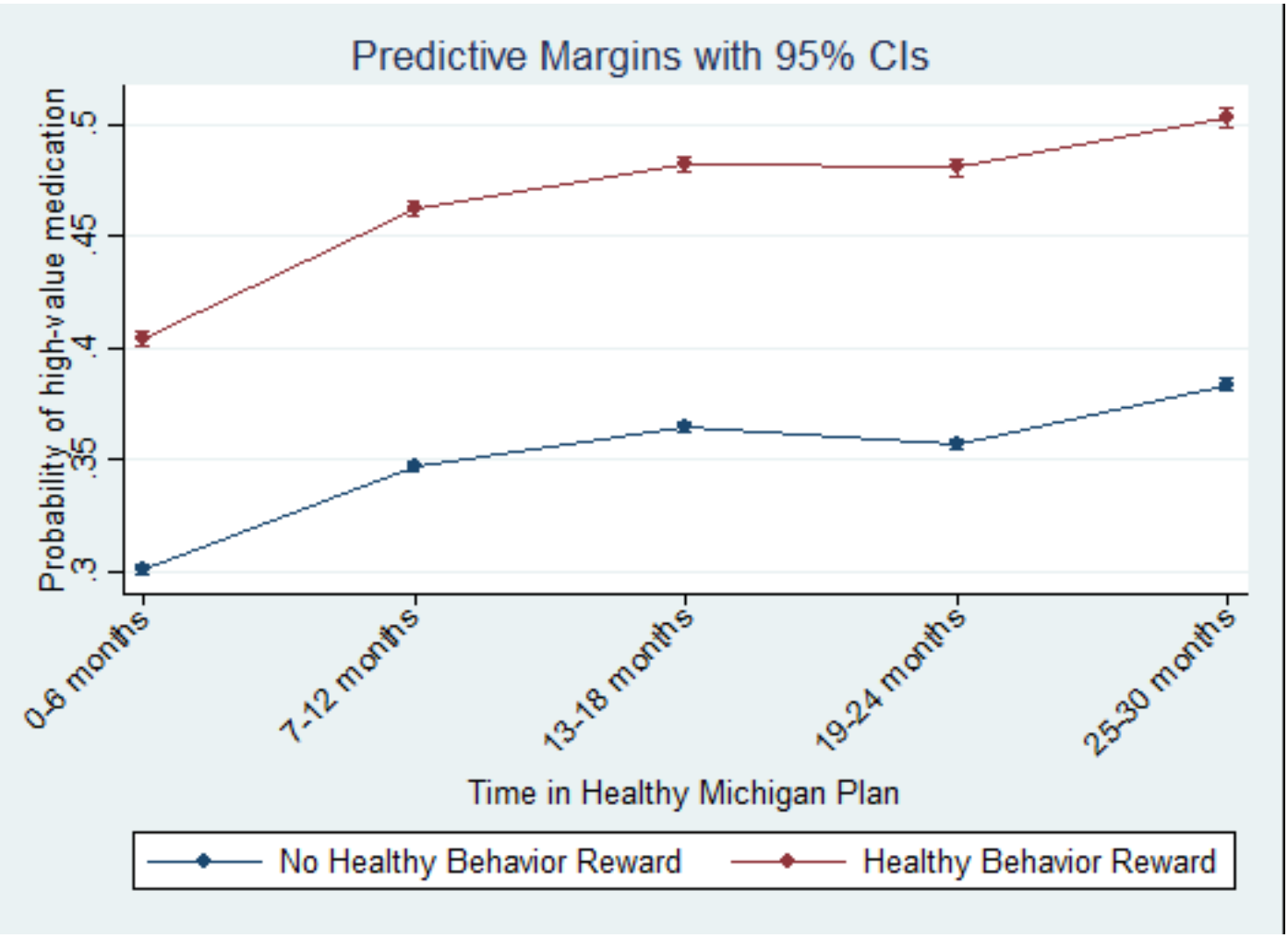


Figure 5.3 Predictive Margins of Percentage of Enrollees Who Use a High-Value Medication by Period and Healthy Behavior Reward; Predicted Percentages, Probit Regression with Interactions on Period and Reward.



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

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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	---

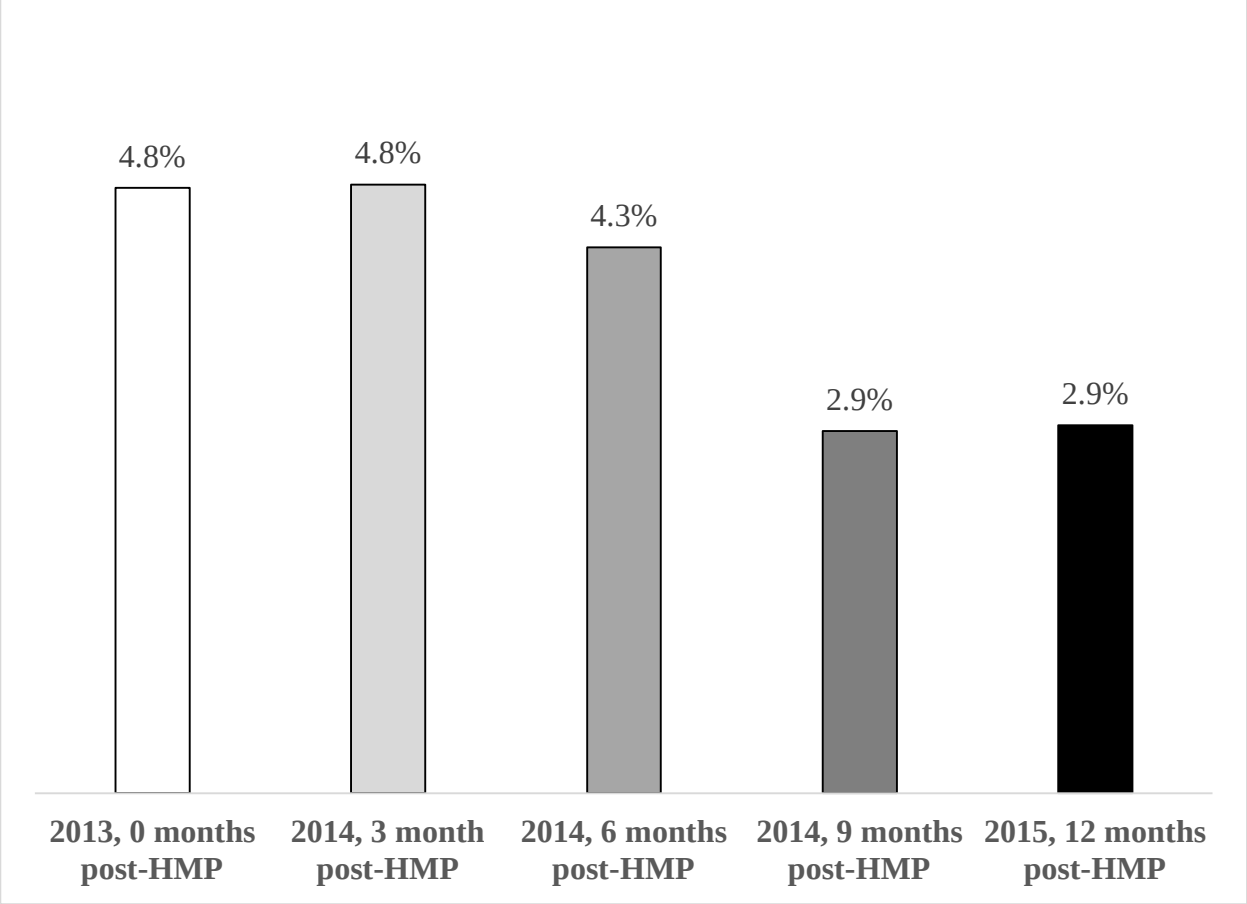
Notes: Hospitals are categorized according to the timing of the fiscal years. The first row in panel gives the number of hospitals in the category reporting data for each fiscal year. Because hospitals submit data with a lag, for hospitals with fiscal years ending in the fourth quarter, the 2015 submission 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%

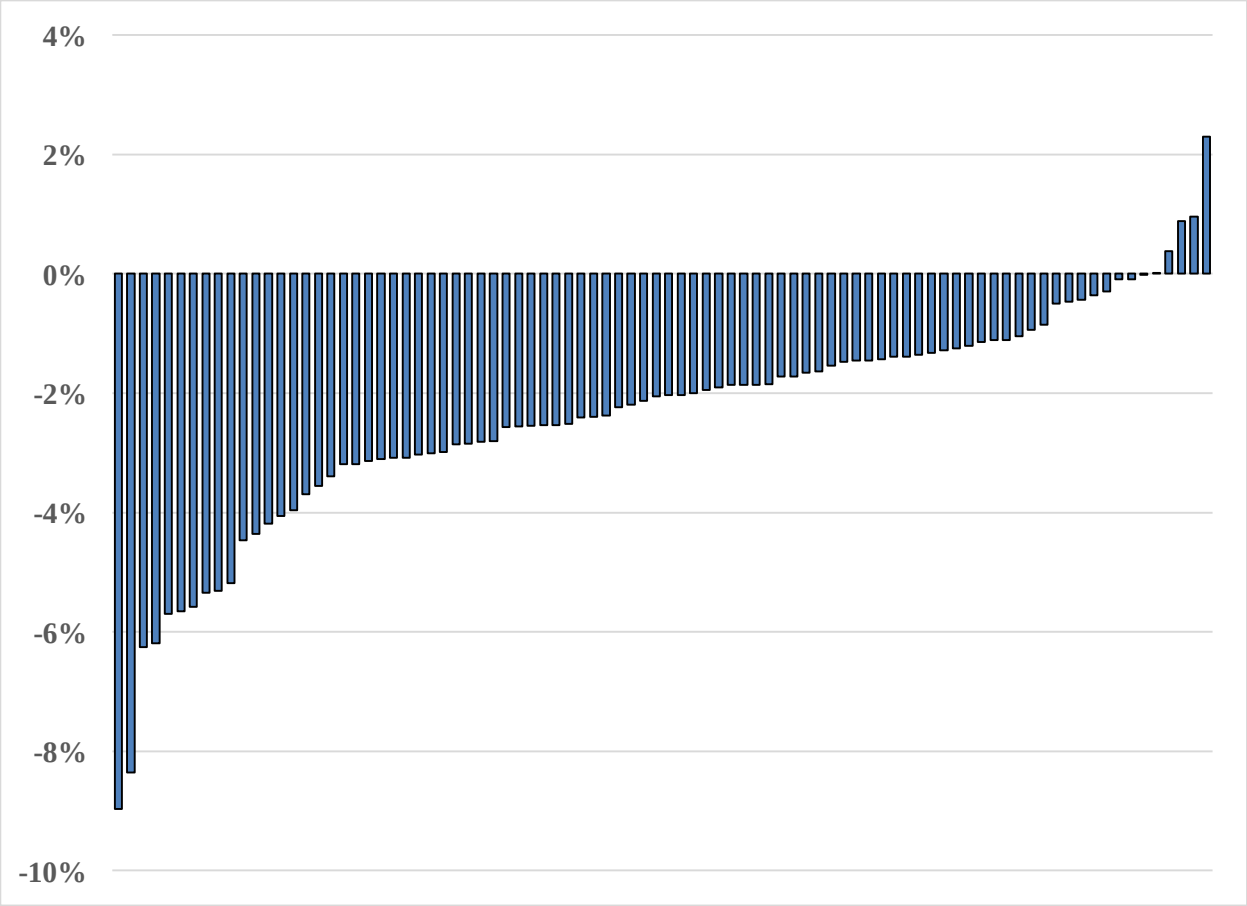
Notes: The figures for uncompensated care as a percentage of total hospital costs represent unweighted means.

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

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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.

<u>Theoretical understandings of cost shift</u>
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

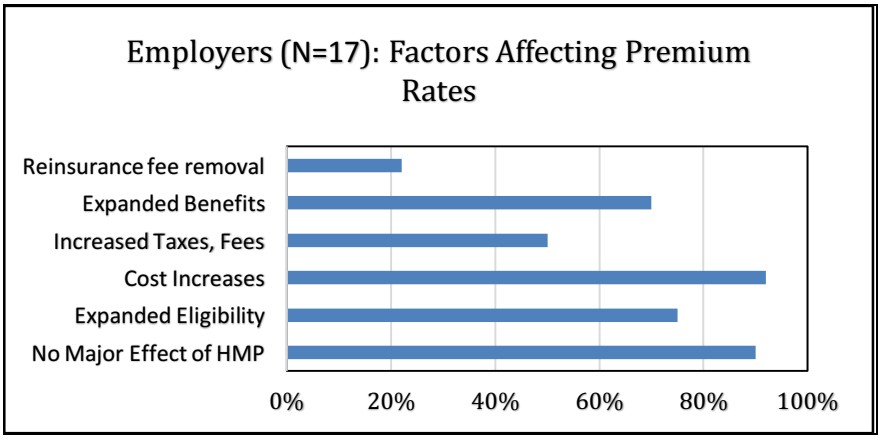
Large Group Plans (for those who have coverage through an employer with more than 50 employees):

- 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 …"

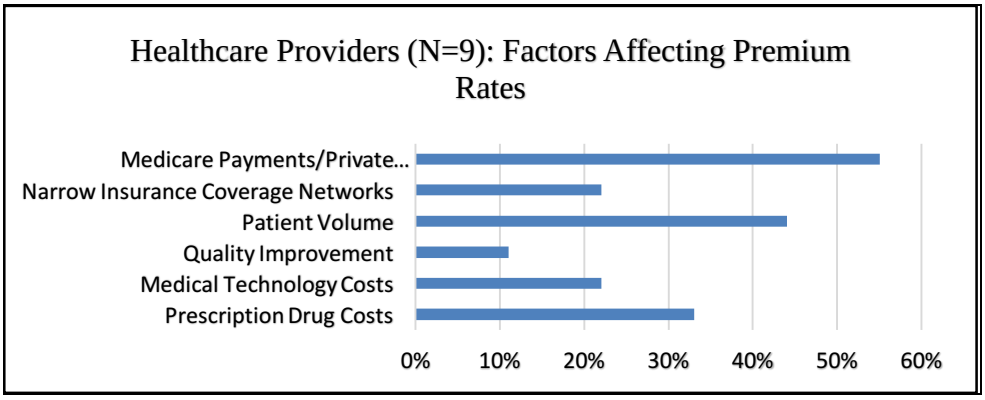
"Decision-making for benefits and ACA has seen the biggest changes…"

"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…"

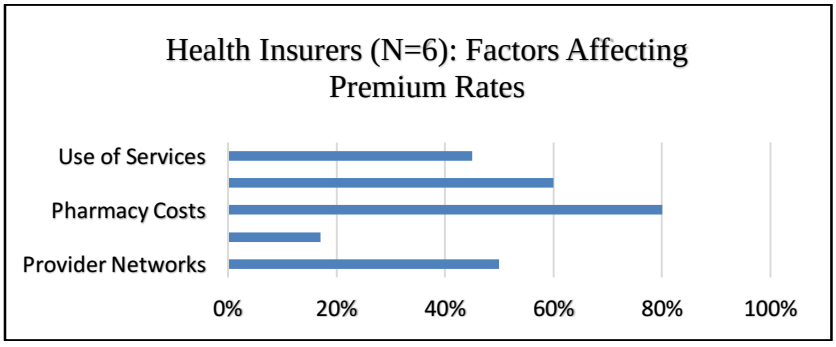
"Volume is critical, and so is the role of consumerism…the dynamics have changed where it is not just the payers making the payments, a key piece is coming from the patient …"

"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

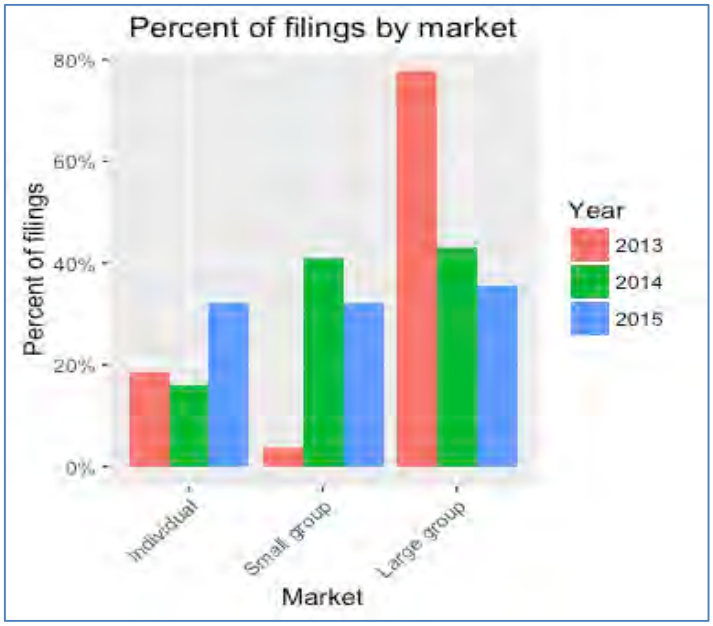
Year	Market	Decrease	Increase
2013	Individual	1	9
	Small group	0	2
	Large group	3	39
2014	Individual	1	6
	Small group	1	17
	Large group	6	13
2015	Individual	3	16
	Small group	4	15
	Large group	0	21

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

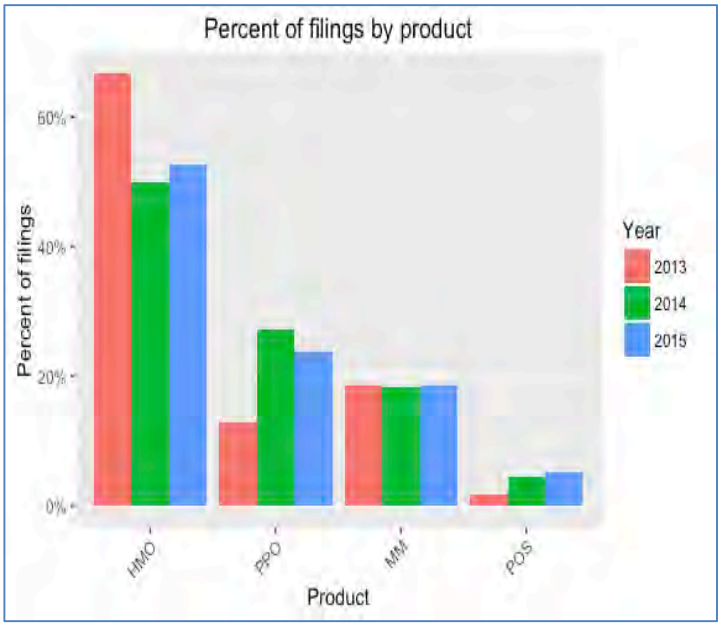
Percent of Filings Requesting Rate Change, by Market, by Year

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

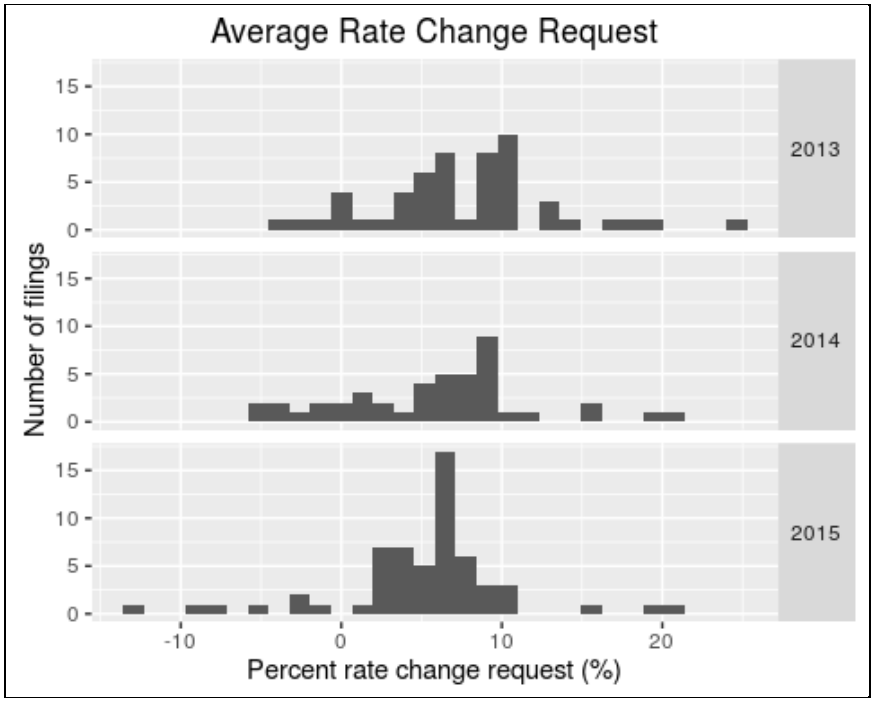
Year	HMO	PPO	MM	POS
2013	66.7%	13.0%	18.5%	1.9%
2014	50.0%	27.3%	18.2%	4.5%
2015	52.5%	23.7%	18.6%	5.1%



B. Magnitude of the Premium Rate Requested

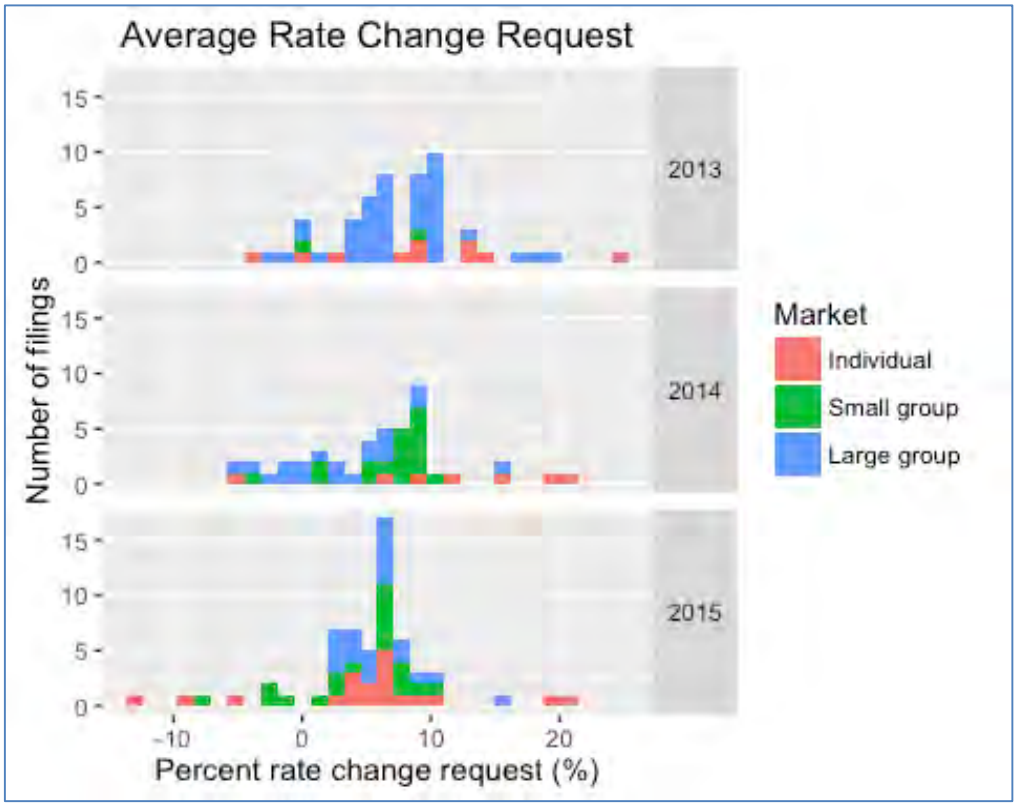
Percent Rate Change Request by Year (%)

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



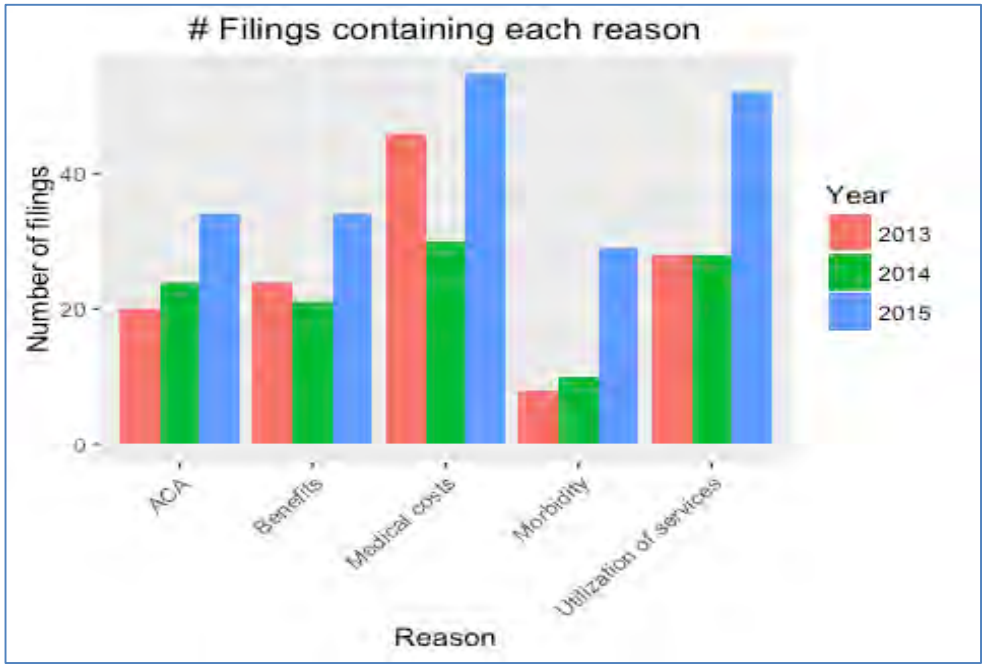
Percent Rate Change Request, by Product, by Year

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

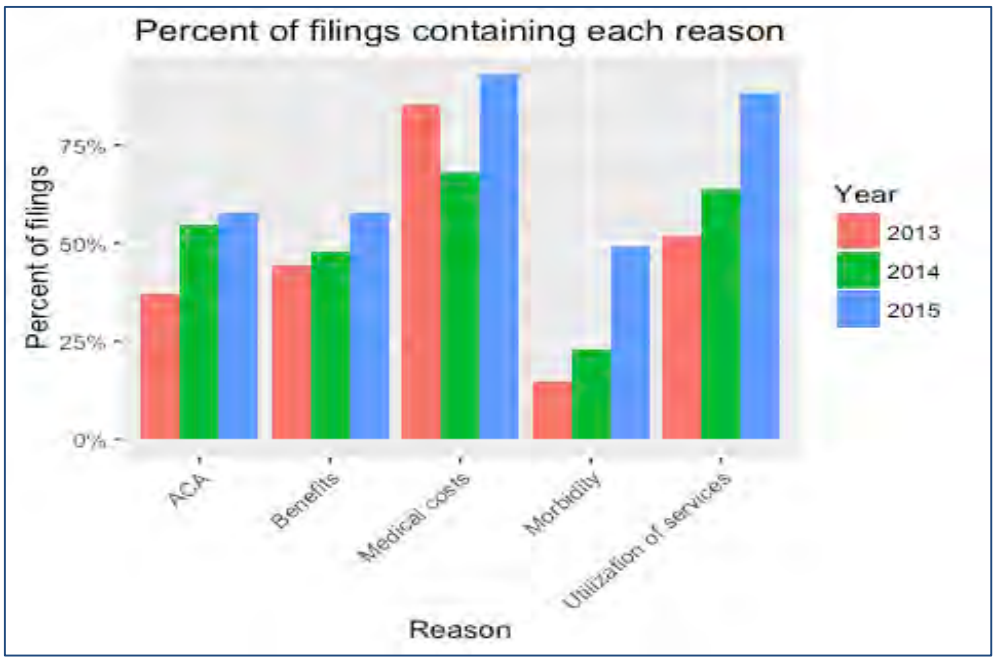
Number of Filings by Reasons for Rate Change Request, by Year

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



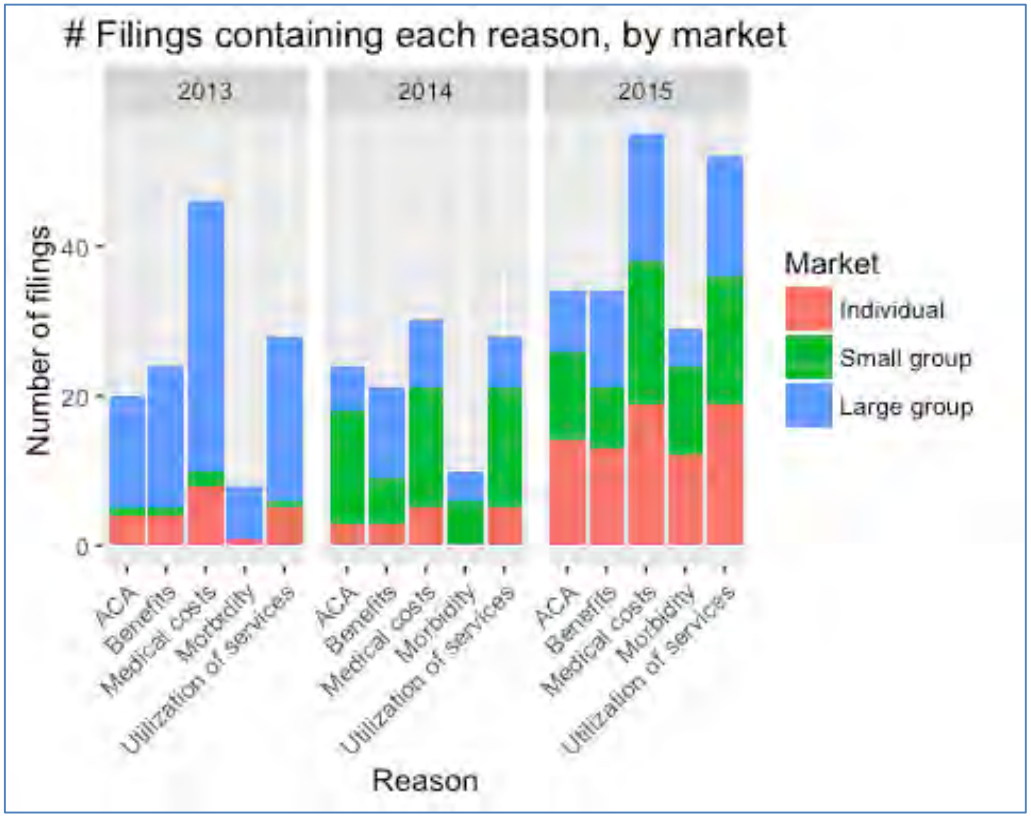
Percent of Filings by Reason for Rate Change Request, by Year

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%



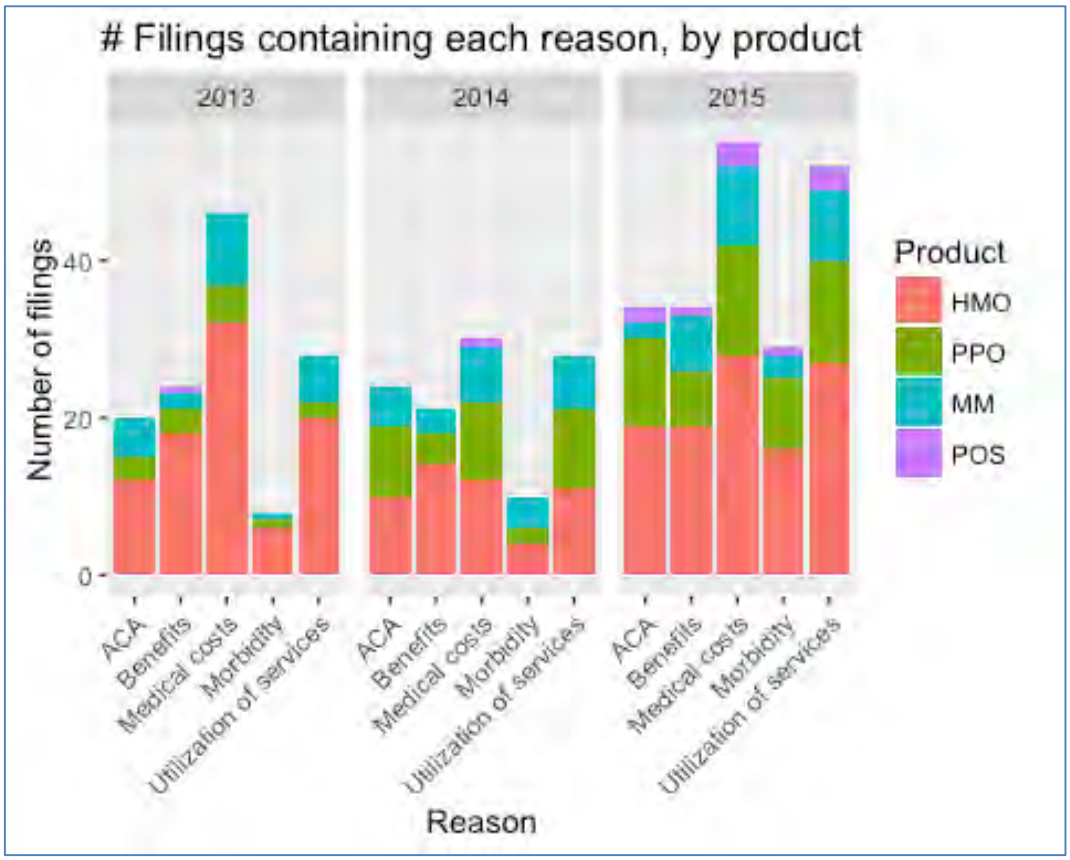
Number of Filings Noting Selected Reasons for Changes in Premium Rates, by Market, by Year

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

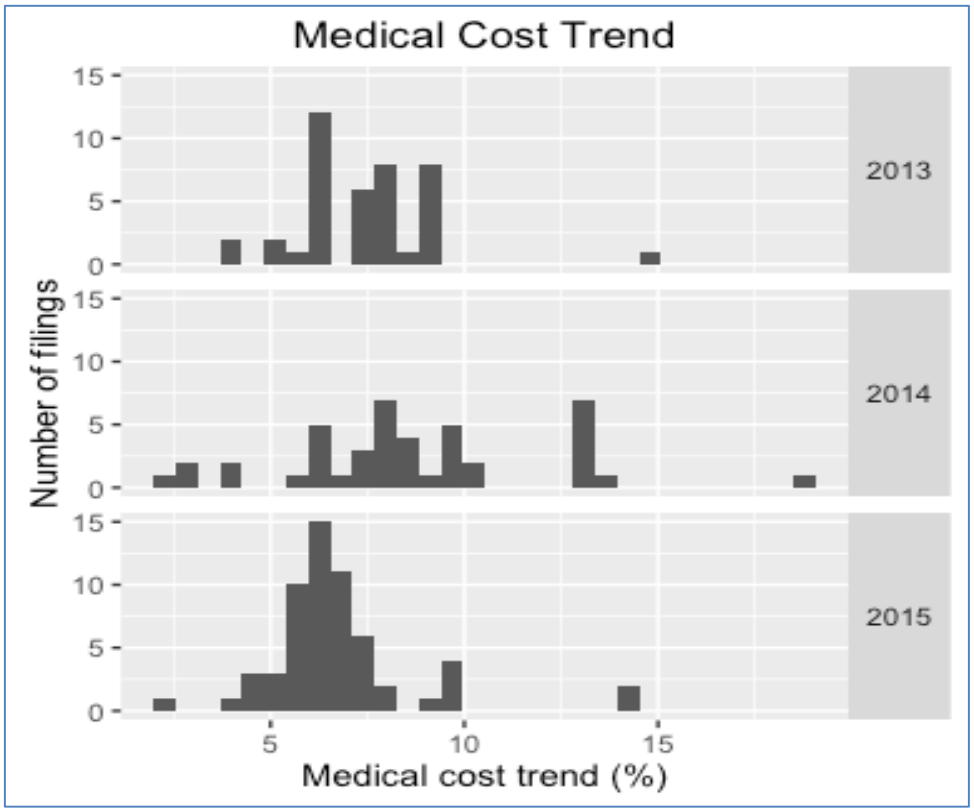
Year	Product	ACA	Benefits	Medical costs	Morbidity	Utilization of services
2013	HMO	12	18	32	6	20
	PPO	3	3	5	1	2
	MM	5	2	9	1	6
	POS	0	1	0	0	0
2014	HMO	10	14	12	4	11
	PPO	9	4	10	2	10
	MM	5	3	7	4	7
	POS	0	0	1	0	0
2015	HMO	19	19	28	16	27
	PPO	11	7	14	9	13
	MM	2	7	10	3	9
	POS	2	1	3	1	3



D. Medical/ RX Cost Trend Rates Noted in Filings (Actuarial memos)

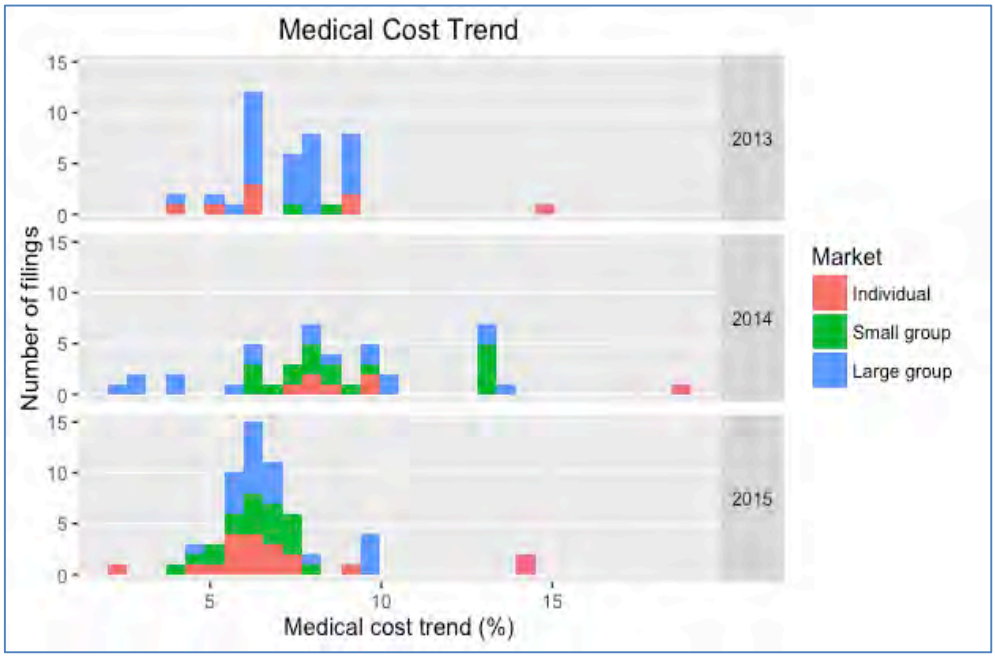
Medical/RX Cost Trend Rate, by Year

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



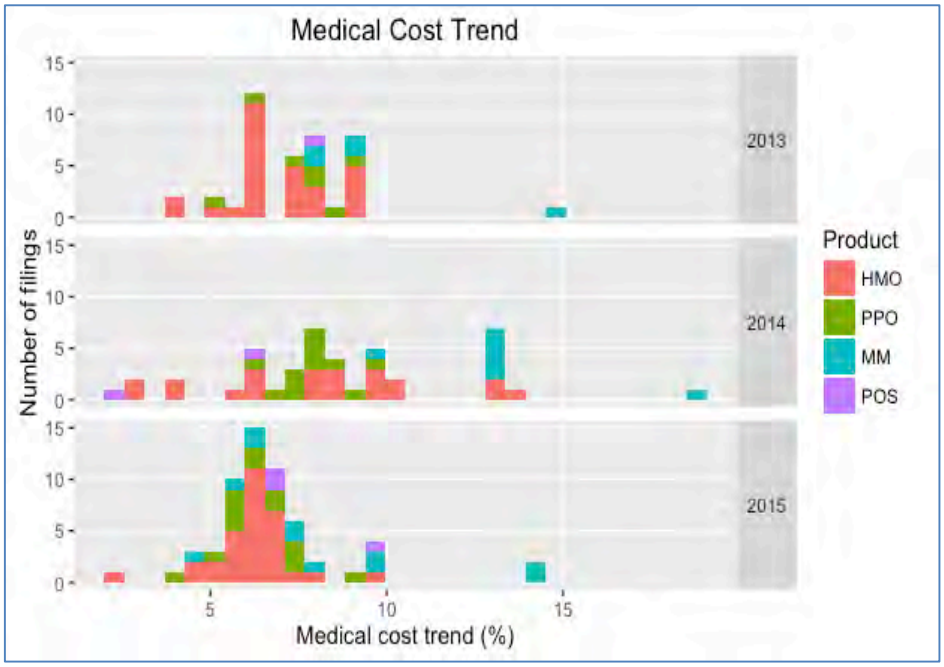
Medical/RX Cost Trend Rate, by Market, by Year

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



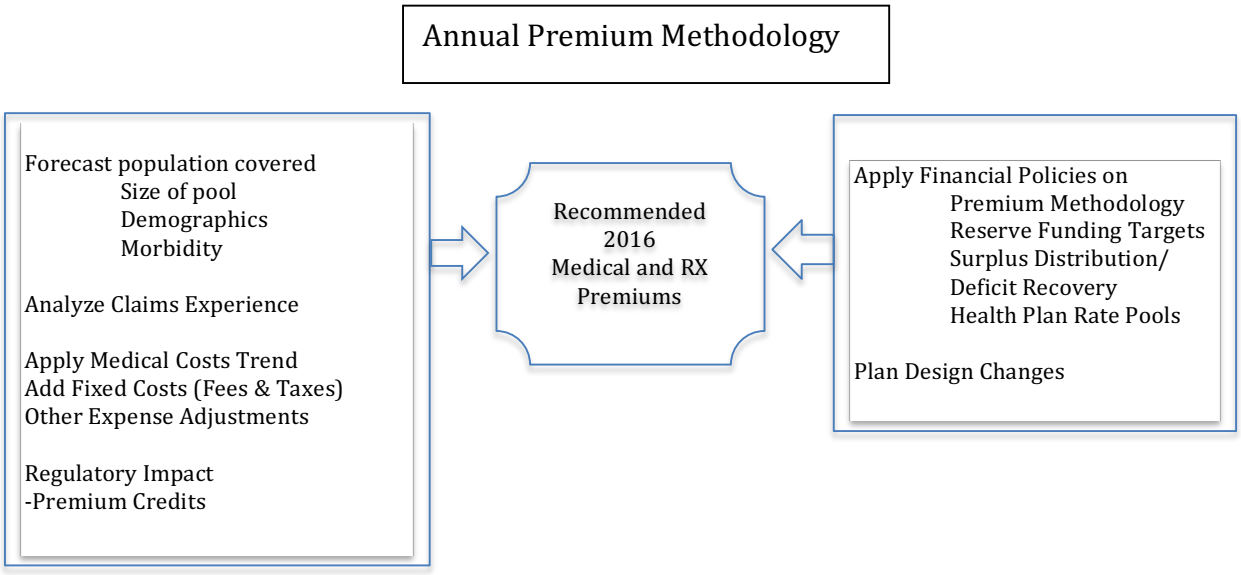
Medical/RX Cost Trend Rate, by Product, by Year

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.

PUBLIC NOTICE
Michigan Department of Health and Human Services
Healthy Michigan Plan §1115 Demonstration Extension Application Amendment

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 extension application amendment to the Centers for Medicare & Medicaid Services (CMS) in compliance with Michigan Public Act 208 of 2018. MDHHS is seeking to amend its Medicaid Expansion §1115 Demonstration extension application, known as the Healthy Michigan Plan (HMP) which expires December 31, 2018. Approval of this request would allow the MDHHS to continue to provide comprehensive health care coverage while incorporating new innovative approaches and structural incentives to increase beneficiary engagement in healthy behaviors and to promote personal responsibility. Consistent with the HMP Special Terms and Conditions, the following is a description of MDHHS's proposed amendment.

HMP Demonstration Description and Objectives - MDHHS began and administered HMP under the §1115 Demonstration Waiver authority on April 1, 2014. Through HMP, MDHHS has extended health care coverage to over 1,000,000 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: usage 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. MDHHS anticipates a decrease in enrollment may occur as a result of this amendment. The total predicted number is unknown.

HMP Demonstration Program Overview - Michigan residents ages 19-64 with incomes at or below 133% of the federal poverty level (FPL), and who do not qualify for or are not enrolled in Medicare or another Medicaid program, are eligible for comprehensive HMP healthcare coverage. Beneficiaries can complete healthy behaviors, which rewards them for conscientious use of health care services. Applicable beneficiary cost-sharing provisions, including co-payments and contributions are outlined in the HMP waiver protocols.

Rescind Marketplace Option Authority – Pursuant to PA 208 of 2018, MDHHS will not be implementing the Marketplace Option benefit.

HMP Changes After 48 Months of Eligibility - As part of this extension application amendment for HMP, MDHHS seeks approval to continue the existing waiver provisions for individuals with an income at or below 100% of the FPL. HMP beneficiaries at or below 100% of the FPL will continue to have eligibility coverage and cost-sharing responsibilities consistent with the process outlined in the HMP waiver protocols.

In addition, the state seeks to amend the HMP waiver eligibility and cost-sharing requirements for individuals with incomes between 100% and 133% of the FPL. To maintain eligibility for HMP, individuals with incomes between 100% and 133% of the FPL who have had 48 months of cumulative eligibility coverage must: (1) Complete or commit to an annual healthy behavior

with effort given to making the healthy behaviors in subsequent years incrementally more challenging; and (2) Pay a premium of 5% of their income, not to exceed limits defined in 42 CFR 447.56(f). Beneficiaries who have not met the healthy behavior or cost-sharing requirements will have their eligibility suspended until they come into compliance. The anticipated effective date of the HMP eligibility changes is July 1, 2019.

Medically frail beneficiaries described in 42 CFR 440.315 will be exempt from the 48 months cumulative enrollment suspension of coverage and from the 5% premium provision. Individuals will have the opportunity to self-report his or her medically frail status. Hardship exemptions for paying the increase cost-sharing or from suspension of coverage will be considered by MDHHS.

Individuals who are exempt from premiums and cost-sharing pursuant to 42 CFR 447.56 will be exempt from the 48 months cumulative enrollment requirement (e.g. pregnant women, under age 21, Native Americans).

HMP Workforce Engagement Requirements - The purpose of adding workforce engagement requirements to HMP is to assist, encourage, and prepare able-bodied adults for a life of self-sufficiency and independence from government interference. Beneficiaries between the ages of 19 and 62 will be required to participate in an average of 80 hours per month of qualifying activities and self-attest to compliance with, or exemption from, workforce engagement requirements to MDHHS on a monthly basis. A beneficiary is allowed three months of noncompliance within a 12-month reporting period, after which a noncompliant recipient's coverage will be suspended until they comply. If a beneficiary misrepresents their compliance with the workforce engagement requirements as identified in PA 208 of 2018, they shall not be allowed to participate in HMP for a one-year period.

Qualifying Activities include (1) employment, self-employment, or having income consistent with being employed or self-employed (makes at least minimum wage for an average of 80 hours per month); (2) education directly related to employment (i.e., high school equivalency test preparation, postsecondary education); (3) job training directly related to employment; (4) vocation training directly related to employment; (5) unpaid workforce engagement directly related to employment (i.e., internship); (6) tribal employment programs; (7) participation in a substance use disorder treatment (court ordered, prescribed by a licensed medical professional, or a Medicaid-funded Substance Use Disorder (SUD) treatment; (8) community service completed with a non-profit 501(c)(3) or 501(c)(4) organization (can only be used as a qualifying activity for up to 3 months in a 12-month period); and (9) job search directly related to job training.

Exemptions from workforce engagement requirements include (1) a caretaker of a family member under 6 years of age (only one parent at a time can claim this exemption); (2) beneficiaries currently receiving temporary or permanent long-term disability benefits from a private insurer or from the government; (3) full-time student who is not a dependent or whose parent/ guardian qualifies for Medicaid; (4) pregnant women; (5) a caretaker of a dependent with a disability who needs full-time care based on a licensed medical professional's order (this exemption is allowed one time per household); (6) a caretaker of an incapacitated individual

even if the incapacitated individual is not a dependent of the caretaker; (7) beneficiaries who meet a good cause temporary exemption (as defined in PA 208 of 2018); (8) beneficiaries designated as medically frail; (9) beneficiaries with a medical condition resulting in a work limitation according to a licensed medical professional order; (10) beneficiaries who have been incarcerated within the last 6 months; (11) beneficiaries currently receiving unemployment benefits from the State of Michigan; and (12) beneficiaries under 21 years of age who had previously been in foster care placement in this state.

Additionally, beneficiaries in compliance with or exempt from the work requirements of the Supplemental Nutrition Assistance Program or Temporary Assistance for Needy Families program are deemed compliant with or exempt from the workforce engagement requirement. The anticipated effective date of the workforce engagement requirements is January 1, 2020.

HMP Demonstration Evaluation - In addition to the HMP Demonstration's program objectives and hypotheses identified in the original waiver Special Terms and Conditions, MDHHS plans to evaluate the following hypotheses for the demonstration extension application amendment: (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; (7) whether a possible suspension of HMP eligibility coverage encourages beneficiaries to complete a healthy behavior and comply with cost-sharing requirements; and (8) the extent to which workforce engagement requirements impact beneficiaries who transition from Medicaid obtain employer sponsored or other health insurance coverage, and how such transitions affect health and well-being.

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: (a) Premiums, § 1092(a)(14), insofar as it incorporates § 1916 and 1916A, (b) State-wideness § 1902(a)(1), (c) Freedom of Choice § 1902(a)(23)(A), (d) Proper and Efficient Administration § 1902(a)(4), (e) Comparability § 1902(a)(17), (f) Provision of Medical Assistance §1902(a)(8) and § 1902(a)(10), (g) Eligibility §1902(a)(10) or § 1902(a)(52), and (h) Reasonable Promptness §1902(a)(3) and § 1902(a)(8). MDHHS seeks the continuation of the CMS-

approved expenditure authorities for expenditures for Healthy Behaviors Program incentives that offset beneficiary cost sharing liability.

Public Hearing, Review of Documents, and Comment Submission - A public hearing will be held on July 31, 2018, from 2:00 p.m. to 3:00 p.m. at the Michigan Library and Historical Center located at 702 W Kalamazoo St, Lansing, MI 48933. A second public hearing will be held August 1, 2018, from 2:00 p.m. to 3:00 p.m. at the Cadillac Place located at 3068 West Grand Boulevard Detroit, MI 48202. The public hearing in Lansing will have webinar capability and both public hearings will have telephone capability (sign interpretation available for those present). The public hearings will provide an overview and discussion of the demonstration extension application amendment. Public hearing call-in numbers and webinar links are available on the Healthy Michigan Plan webpage: www.michigan.gov/healthymichiganplan.

Copies of information related to the proposed demonstration extension application amendment, as well as written comments regarding the proposed demonstration waiver renewal amendment may be reviewed by the public at Capitol Commons Center, 400 South Pine Street, Lansing, Michigan. Additionally, copies of information related to the demonstration extension application amendment are available on the Healthy Michigan Plan webpage: 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 Extension Application Amendment” reference somewhere in the written submission, or in the subject line, if email is used. Comments will be accepted until **August 12, 2018**.

Public Comment Summary

August 2018

The Michigan Department of Health and Human Services (MDHHS) began its 30-day public comment process by posting the Healthy Michigan Plan (HMP) Section 1115 Demonstration extension application amendment and supporting documents on the MDHHS web page and by publishing a notice in newspapers across the state. The public comment period began July 9, 2018 and ended August 12, 2018. During this time, over 1,000 comments were received from many organizations and individuals. MDHHS also received multiple comments during the public hearings. All comments were reviewed and considered by MDHHS in the development of the final waiver amendment. Below is a summary of the public comments received. Copies of all written comments are included in this attachment.

Many of the commenters expressed concern regarding the impact of implementation on beneficiaries, leading to a loss of coverage and increasing the administrative burden associated with these changes. While 84% of the comments expressed concern or opposition to one or more provisions of the waiver amendment, and another 15% expressed general support for Medicaid and/or HMP, approximately 1% of the comments received were in support of the waiver amendment. Over 25% of the comments were related to adding certain diagnoses to the list of medically exempt conditions. In general, the comments reflected the following themes:

1. General comments regarding the impact of the waiver amendment and the intent of Medicaid and the HMP program
    a. The waiver amendment conflicts with objectives of Medicaid and the intent of HMP
    b. Failure to meet Section 1115 demonstration requirements
2. Concerns with the 48-month cumulative enrollment provisions
    a. 5% Premiums
3. Concerns and opposition for implementing workforce engagement requirements
    a. Loss of coverage and access to healthcare
    b. Administrative burden
    c. Impact on uncompensated care
    d. Providing support services
    e. Associated costs
    f. IT system changes
4. Suggestions to add certain diagnosis codes to the medically frail list
5. Support for workforce engagement requirements

1. General comments regarding the impact of the waiver amendment and the intent of Medicaid and the HMP program

a. The waiver amendment conflicts with objectives of Medicaid and the intent of HMP

Comments: Many commenters indicated the provisions of the waiver amendment conflict with the objectives of the Medicaid program and the goals of HMP. With many stating the primary goal of Medicaid and HMP is to increase access to quality healthcare, but MDHHS acknowledges there will be a potential loss of coverage due to the new requirements.

MDHHS Response*: The primary goal of the waiver amendment is to maintain and increase access to quality healthcare. In order to sustain the HMP program, Michigan's Public Act (PA) 208 of 2018 requires MDHHS to submit a waiver amendment to add workforce engagement requirements and to require individuals who are over 100% of the Federal Poverty Level and have 48 months of cumulative eligibility to complete a healthy behavior and pay a 5% premium to maintain coverage. Pursuant to state statute, the HMP program will end if MDHHS is unable to obtain approval of the waiver amendment or if the annual state savings and other nonfederal net savings associated with the implementation of the HMP program are not sufficient to cover the program's state match requirements.*

Comments: Commenters asserted that work requirements were found to be illegal because they do not improve health. Furthermore, commenters stated that removing health support networks is counterproductive to promoting work and self-sufficiency; the waiver amendment proposal undermines healthcare and is contrary to the objectives of Medicaid.

MDHHS Response: *The Centers for Medicare & Medicaid Services (CMS) has issued support for Medicaid work and community engagement requirements, and their guidance indicates that the workforce engagement requirements are not contrary to federal law. The MDHHS workforce engagement requirements, which are mandated by state law, are designed to promote better mental, physical, and emotional health and to help individuals and families rise out of poverty and attain independence. MDHHS believes this is in furtherance of federal Medicaid program objectives as stated by CMS.*

Comments: Many commenters expressed opposition to the workforce engagement requirements indicating the requirements will do nothing to help the people of Michigan connect to good-paying, quality jobs. Commenters stated that people who can work are already working and expressed their belief that Medicaid is not a jobs program, but rather a healthcare program.

MDHHS Response**:** *The purpose of the waiver amendment is to strengthen the HMP program and ensure its sustainability. By providing access to healthcare and encouraging engagement in healthy behaviors, able-bodied Medicaid recipients will be better prepared for a life of self-sufficiency and independence from governmental interference.*

b. Failure to meet Section 1115 demonstration requirements

Comments: Several commenters suggested the waiver amendment is contrary to the purpose of Section 1115 demonstrations and fails to meet federal public notice requirements. They indicated that the waiver amendment document neglected to identify the number of individuals impacted and did not provide updated budget neutrality figures. Additionally, MDHHS received several comments indicating the HMP program evaluation would not adequately test the program hypotheses due to overlapping outcomes.

MDHHS Response*: The Healthy Michigan Plan currently provides coverage to 655,000 individuals. MDHHS has determined that approximately 400,000 individuals may be impacted in some way by the waiver amendment changes, such as now having to obtain work or engage in other qualifying activities, report these activities monthly and timely, and maintain records to document these activities to provide should supporting documentation be requested by MDHHS as part of the compliance review process. Given the scope of this waiver amendment, MDDHS has added this information in response to these comments and will actively monitor enrollment over the course of the demonstration. MDHHS will also be working with CMS to establish an updated evaluation plan that is useful and accurately measures the hypotheses identified.*

2. Concerns with the 48-month cumulative enrollment provisions

a. 5% Premiums

Comments: Several commenters stated that the 5% premiums incurred by beneficiaries will not contribute to the funding of the Medicaid program and alternatively, will cost the state money to implement. Concerns were also raised about how the changes could double the premium amount a beneficiary must pay.

MDHHS Response: *The imposition of the 5% premium is a provision of PA 208 of 2018. The premiums are not intended to fund the state's Medicaid program, but rather are intended to promote personal responsibility and better align the cost of Healthy Michigan Plan coverage with that of non-Medicaid or commercial coverage. MDHHS acknowledges there may be a nominal increase in costs associated with implementing the 5% premium, however, MDHHS plans to leverage existing system processes that are used to collect payments from other MDHHS administered programs.*

3. Concerns and opposition for implementing workforce engagement requirements

a. Loss of coverage and access to healthcare

Comments: Many commenters voiced concerns that the implementation of work requirements will result in a loss of beneficiary healthcare coverage, and that the waiver exemptions do not sufficiently address all individuals who might not meet work requirements for health and social reasons. Additionally, it was noted that there are some obstacles that people encounter which are often not obvious but may include mental or emotional challenges, lack of education or experience,

child care issues, family violence, homelessness, criminal records, or even a loss of hope that they could ever succeed.

***MDHHS Response**: Through this waiver amendment, MDHHS has incorporated the many provisions of PA 208 of 2018 that provide beneficiaries relief from the workforce engagement requirements. The law includes an array of exemptions and provides up to three months of non-compliance in a 12-month period. Additionally, MDHHS has created a robust process to identify medically frail individuals who are exempt from the workforce engagement requirements. Individuals who feel they are unable to meet the workforce engagement requirements have the option of completing an MDHHS Medical Exemption Request form. The form requires the signature of a healthcare provider, attesting to the beneficiary's inability to meet the workforce engagement requirements.*

Comments: Several commenters expressed concern regarding whether beneficiaries who lose coverage from the HMP program due to non-compliance with the workforce engagement requirement will be afforded appeal rights and if their healthcare coverage will continue during the appeals process. There is also concern that the loss of coverage for non-payment of the premiums will create a burden on beneficiaries which would lead to disruptions in care.

MDHHS Response: *Beneficiaries will be afforded appeal rights, with the option for continuation of benefits, consistent with federal law and regulation. MDHHS will monitor the waiver amendment's impact on beneficiaries through the Section 1115 Demonstration Monitoring and Evaluation process.*

b. Administrative burden

Comments: A commenter suggested that MDHHS better define the verification process to be used and to make sure processes are fair and reliable. Other comments questioned whether new verification rules will slow down application approval. Comments included opinions that processes may be burdensome for beneficiaries and MDHHS staff.

***MDHHS Response:** MDHHS is in the preliminary stages of assessing and planning system updates to accommodate the changes required by PA 208 of 2018. The state has requested approval for this extension amendment request effective January 1, 2019 with up to 6 months to implement the 48 months of cumulative coverage change in cost-sharing and healthy behaviors, and up to 12 months to implement the workforce engagement provisions. This timeline allows for a significant planning period, during which MDHHS will work diligently toward implementing a system with as few barriers as possible, providing comprehensive training for all applicable staff, and engaging in robust beneficiary and stakeholder outreach efforts to mitigate issues whenever possible.*

c. Impact on uncompensated care

Comments: Several commenters mentioned that work requirements will cause an increase in uncompensated care.

MDHHS Response: *Due to a multitude of factors, some known and some yet to be identified, that may have an impact on the number of potentially affected individuals, MDHHS is not able to predict potential changes in levels of uncompensated care at this time. MDHHS will implement every strategy possible to enable beneficiaries to meet these new requirements to mitigate the loss of coverage and prevent an increase in uncompensated care.*

d. Providing support services

Comment: Several commenters identified additional qualifying activities that could be added to the waiver amendment to satisfy a beneficiary's work requirements. PA 208 of 2018 offers the option of participating in unpaid work activities such as, but not limited to, internships. It was also suggested that MDHHS include voluntary participation in case management services designed to overcome barriers to self-sufficiency in helping individuals to reach their maximum potential. It was also suggested that extending case management services to those unable to meet their work requirements could prove to be highly cost effective.

MDHHS Response: *MDHHS acknowledges that state law does allow some flexibility regarding the definition for qualifying activities related to unpaid workforce engagement directly related to employment and for education directly related to employment. MDHHS appreciates the comments and will continue to work with stakeholders in further defining such activities that meet the intent of the law.*

e. Associated costs

Comments: Several commenters expressed concern regarding amount of money that would be spent each year to administer the requirements. PA 208 of 2018 does not direct any new money to workforce development programs or employment projects in underserved parts of the state.

MDHHS Response: *MDHHS is currently conducting a needs assessment to determine what additional resources will be required to implement and maintain the program. Michigan intends to provide supportive measures to assist individuals with meeting and sustaining the work requirements as identified in the law. As part of the needs assessment, MDHHS will be exploring the feasibility of leveraging existing services and supports to assist HMP beneficiaries in meeting the workforce engagement requirements. In addition, MDHHS plans to submit a grant proposal to The Michigan Health Endowment Fund to seek funding for additional supportive resources prior to implementation of the workforce engagement requirements in January 2020.*

Comments: One commenter noted that funding would be diverted from beneficiary care to cover these new, unnecessary administrative costs.

MDHHS Response*: No funds will be diverted from beneficiary care to cover the cost of administering these new requirements.*

f. IT system changes

Comments: Comments indicated concerns regarding implementation costs, including additional staff and training requirements. Commenters posed questions to MDHHS regarding what system changes will be required, how long system implementation will take, costs to state and federal

governments, and whether new bids for contracted services will be needed. Questions were also asked related to modifying the healthcare exchange.

***MDHHS Response**: MDHHS anticipates making modifications to several IT systems, including the eligibility and Medicaid Management Information Systems, and is in the process of completing a needs assessment of the required changes. Costs related to such changes are eligible for federal matching dollars.*

4. Suggestions to add certain diagnosis codes to the medically frail list

Comments: Many commenters suggested that people with cystic fibrosis, HIV, certain behavioral health diagnoses, chronic conditions, and those individuals waiting to receive substance use disorder services should be defined as medically frail and exempt from the work requirements.

***MDHHS Response:** In response to public comments, MDHHS has reviewed diagnosis codes and has amended the list to include cystic fibrosis, HIV, and several other diagnoses to the list of health conditions that will be considered as meeting the medically frail definition. MDHHS agrees that beneficiaries with complex chronic conditions may have difficulty meeting the workforce engagement requirement. As part of the Medically Frail Identification Process, MDHHS has provided multiple methods of identifying individuals who meet medically frail exemption criteria, including a beneficiary's self-identification or via an exemption form.*

5. Support for workforce engagement requirements

Comments: Several commenters provided their support for the workforce engagement requirements of the waiver amendment as a condition of HMP coverage.

***MDHHS Response**: MDHHS appreciates the comments.*

Conclusion

In summary, MDHHS appreciates the large volume of comments received as part of the public comment period for the waiver extension amendment. As a result, MDHHS will continue to explore and work to identify resources that can help support beneficiaries in meeting the workforce engagement qualifying activities. MDHHS recognizes the significance of ongoing stakeholder input and the importance of a robust communication strategy for the providers, staff, and beneficiaries. MDHHS endeavors to implement and ensure that appropriate beneficiary supports and protections will be made available. Additionally, MDHHS intends to actively assess and measure through the demonstration evaluation process the influence of the waiver amendment on the impacted population.

In response to the information solicited during the public comment process, MDHHS made the following updates to its waiver extension amendment:

- Updated language related to the objectives of the Medicaid program.

- Provided additional information to address identified needs to provide supports and services to assist individuals with meeting cost-sharing, healthy behaviors, and workforce engagement requirements.
- Clarified that this program only applies to individuals on HMP and is not applicable to other Medicaid programs.
- Provided information related to the number of beneficiaries who may be impacted by the waiver amendment.
- Clarified how MDHHS intends to modify the evaluation activities.
- Updated the public comment activities.
- Performed a review of the Medically Frail Identification Process and added many diagnosis codes to the list of medically exempt conditions in response to the public comments received.

MDHHS will continue to accept and review comments from the public throughout the demonstration extension application amendment submission and implementation process. Continued stakeholder input will be key in working through various HMP program details and to help ensure a smooth implementation process. All waiver related information was provided at the public hearings and remains available on the MDHHS webpage.

From: Mario Azzi
To: HealthyMichiganPlan
Subject: Comments on MDHHS's Amended Section 1115 Demonstration Application for the Healthy Michigan Plan
Date: Wednesday, July 18, 2018 4:41:05 PM
Attachments: Comments on MDHHS's Amended Section 1115 Demonstration Application by Mario Azzi.pdf

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In response to the Department's request for public comment on the amendment to the Healthy Michigan Plan §1115 Demonstration Waiver Extension Request, I would like to submit the attached comments and observations. Thank you for your consideration.

Comments on MDHHS's Amended Section 1115 Demonstration Application For the Healthy Michigan Plan (as Amended July 9, 2018)

In response to the Department's request for public comment on the amendment to the Healthy Michigan Plan §1115 Demonstration Waiver Extension Request, I would like to submit the following comments and observations:

- Current evaluation results suggest that the efficacy with which the amendment's changes to HMP achieve the Department's aims will be impossible to adequately test due to overlapping outcomes with the current impact of the program. In Section II, Part A, the Department states, "it is believed that the changes [to HMP] will more effectively encourage beneficiaries to engage in healthy behaviors and increase awareness of personal responsibility."

  However, in Section VI, part D, the Department references the 2016 Healthy Michigan Voices Enrollee Survey, the findings of which are used to conclude that HMP, in its current form, has reduced the incidence of uncompensated care and improved the ability of enrollees to work and seek jobs. The Department also notes that chronic health conditions (some of which would presumably prevent potential beneficiaries from working) are common among enrollees and that many of these conditions were undiagnosed prior to those individuals receiving HMP coverage.

  It seems likely that the proposed amendments to HMP would, at best, muddy the waters in regards to which outcomes are resulting as a result of workforce engagement and cost sharing, and which are simply consistent with what has already been achieved by the current iteration of HMP.

- In Section II, part B, one of the Department's listed goals for the Healthy Michigan Plan (HMP) demonstration is to "increase access to quality health care." This seems to be inconsistent with the Department's projection in Section V, where the Department predicts that annual HMP enrollment will decrease by an unknown number of beneficiaries, presumably due to the amendments made to the demonstration. Given the Department's stated objective of increasing access to health care, the lack of a detailed analysis of the amended demonstration's impact on program enrollment appears to constitute a serious oversight.

- In Section II, part B, the final evaluation bullet point states:

  > "The extent to which workforce engagement requirements impact beneficiaries who transition from Medicaid obtain employer sponsored or other health insurance coverage, and how such transitions affect health and well-being."

The above text is grammatically inconsistent, resulting in possible confusion as to what the Department intends to evaluate. This may be due to an omission or typographical error. In Section VI, part A, the text of the ninth (*sic*) listed evaluation domain contains the same error.

- While the Department contemplates an updated evaluation design that incorporates the changes made in the amended waiver extension request, no methodology is included in the amendment or any of its attachments. Furthermore, the only item specifically detailed for evaluation by the Department is the impact of increased cost sharing on utilization of HMP. The Department makes no mention of evaluation methods and criteria for the new workforce engagement requirements. The amendment and its attachments provide no basis for projection or evaluation of implementation costs. Ultimately, the entire amendment seems to fail to provide any form of hypothesis as to the impact of its additions to HMP, much less any method by which such hypotheses could be practically tested. This runs contrary to the purpose of Section 1115 demonstrations.

In conclusion, I believe that the Department's haste to comply with the requirements of Public Act 208 and meet the deadline imposed by the end-of-year expiration date on the current HMP waiver has left the amendments made to the waiver extension request lacking the thorough and detailed analysis needed for reasoned approval by the Centers for Medicare and Medicaid Services.

Comments submitted July 18, 2018

By: Mario Azzi
Public Benefits Law Attorney
Center for Civil Justice

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Tuesday, July 17, 2018 8:11:36 AM

Hello,

My name is [redacted] and I write as a consumer. I support Medicaid because it is a critical program in our state that has helped cover hundreds of thousands of individuals in need of care that cannot afford it. Medicaid has saved lives and created new jobs, and it is imperative that we protect this program. I oppose Medicaid work requirements because they inevitably lead to coverage losses and will do nothing to help the people of Michigan connect to good-paying, quality jobs. People who can work are already working. And at the end of the day, Medicaid is not a jobs program. It's a healthcare program.

Thank you,
--
[redacted]

From: Hannah Green
To: HealthyMichiganPlan
Subject: Health Groups Letter to Director Lyon Re: Demonstration Extension Application Amendment
Date: Monday, July 16, 2018 5:16:51 PM
Attachments: Health Groups Letter to MI Director Lyon 7.16.18 (FINAL).pdf

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Hello,

Attached please find a letter from 13 organizations to Director Lyon regarding the public notice and comment requirements for Section 1115 waivers.

Thanks,

Hannah Green
National Director | Health Policy
American Lung Association
1331 Pennsylvania Avenue NW, Suite 1425 | Washington, DC 20004
O: 202-715-3448
Lung HelpLine: 1-800-LUNGUSA
Lung.org | Hannah.Green@Lung.org

July 16, 2018

Nick Lyon
Director
Michigan Department of Health and Human Services (MDHHS)
333 S. Grant Avenue
Lansing, MI 48913

Dear Director Lyon:

Our organizations write to ask you to revise and reopen the public comment period for 30 days for the Section 1115 Demonstration Extension Application for the Healthy Michigan Plan (HMP) released on July 9, 2018, as it fails to meet federal public notice and comment requirements for Section 1115 waivers.

The undersigned organizations represent millions of individuals facing serious, acute and chronic health conditions across the country and in Michigan. Our organizations have a unique perspective on what individuals need to prevent disease, cure illness and manage serious and chronic health conditions. The diversity of our groups and of those we represent enables us to draw upon a wealth of knowledge and expertise and serve as an invaluable resource regarding any decisions affecting the Medicaid program and the people that it serves.

The federal rules at 431.408 pertaining to state public comment process require at (a)(1)(i)(C) that a state include an estimate of the expected increase or decrease in annual enrollment and expenditures if applicable. The intent of this section of the regulations is to allow the public to comment on a Section 1115 proposal with adequate information to assess its impact. However, on pages 14-15 of this demonstration proposal, the Department reuses budget neutrality estimates from an earlier proposal that are no longer relevant and states that “MDHHS expects

annual HMP enrollment to decrease but the total number of beneficiaries who will be impacted is unknown at this time." However, in order to meet these transparency requirements, Michigan must include these projections and their impact on budget neutrality provisions.

Again, we request that you revise the waiver and include this information so that the public has an opportunity to comment on this important issue with adequate information.

Sincerely,

American Cancer Society Cancer Action Network
American Diabetes Association
American Heart Association
American Lung Association
Chronic Disease Coalition
Epilepsy Foundation in Michigan
Hemophilia Federation of America
Hemophilia Foundation of Michigan
Leukemia and Lymphoma Society
Lutheran Services in America
National Multiple Sclerosis Society
National Organization for Rare Disorders
March of Dimes

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Thursday, July 12, 2018 3:32:37 PM

Dear MDHHS:

- Healthy Michigan Plan work requirements are unnecessary and contrary to the purposes of a health insurance program.
- Research has repeatedly demonstrated that most people that have Medicaid and can work, already do work.
- Research has also shown that the 5% premium charged to these low-income HMP recipients will not contribute to funding this program. In fact, the cost of monitoring these work requirements will cost the State hundreds of thousands of dollars and we all know that the MDHHS computer systems are not set up to capture this information.
- These work requirements were already found to be illegal by the court because they do not promote health. People need health insurance to be healthy and if they are healthy, then they can work.
- The legislators that introduced the legislation to submit this ridiculous waiver seem to think that if people have a job, their employer will pay for their health insurance. That is so not true.
- The reality is that when our successful HMP program fails, thousands of Michiganders will not have health coverage again.

[redacted]

From:	Prokop, Jackie (DHHS)
To:	Diebolt, Pamela J. (DHHS); Green, Kellie (DHHS); Boyce, Craig (DHHS); LaPres, Marie (DHHS)
Subject:	FW: Medicaid Waiver Ideas
Date:	Monday, July 30, 2018 2:05:30 PM
Attachments:	Medicaid Waiver Comments (1) (1) (1).docx ATT00001.htm

More comments.

From: Stiffler, Kathleen A. (DHHS)
Sent: Monday, July 30, 2018 2:00 PM
To: Emerson, Erin (DHHS) <EmersonE@michigan.gov>; Prokop, Jackie (DHHS) <prokopj@michigan.gov>
Cc: Larner, Trena (DHHS) <larnert@michigan.gov>
Subject: Fwd: Medicaid Waiver Ideas

Please decide how best to handle this and follow up with Allan with a cc to me. Thanks!

K.

Sent from my iPad

Begin forwarded message:

> **From:** "Wachendorfer, Allan" <awachendorfer.naswmi@socialworkers.org>
> **Date:** July 30, 2018 at 12:31:33 PM CDT
> **To:** "StifflerK@michigan.gov" <StifflerK@michigan.gov>
> **Cc:** david berns <dberns46@gmail.com>, "Thome, Maxine" <mthome.naswmi@socialworkers.org>
> **Subject: Medicaid Waiver Ideas**
>
> Director Stiffler,
>
> I want to bring to your attention and offer the input of one of our members that I think you will find quite helpful in submitting a request for waiver regarding work requirements for Medicaid. Please NOTE: we are not intending to try and convince you that work requirements are a bad idea – which they are – but rather offer an opportunity to make the program into something quite beneficial for beneficiaries in Michigan while also drawing down Federal dollars to pay for it.
>
> Mr. Berns, cc'ed, was a former county services director and then child welfare director here in Michigan. After retiring, he moved on to Colorado implementing welfare-to-work programs on the county level, then Arizona at the state level. Most recently, he was running the DC HHS office implementing the Affordable Care Act. His 44 years of background in this arena gives him an "insider" perspective that I urge you to consider.
>
> Mr. Berns will be attending the public hearing tomorrow in Lansing and I will attend

Wednesday in Detroit. We will both try and make contact with you or your staff there for further discussion. His comments are attached for your review.

Allan Wachendorfer, LMSW-Macro
Director of Public Policy
National Association of Social Workers – Michigan Chapter
517-487-1548 ex. 11
www.nasw-michigan.org

MICHIGAN MEDICAID WAIVER: COMMENT ON DEMONSTRATION EXTENSION APPLICATION AMENDMENT

My name is David Berns, LCSW. I am currently retired but worked in Human Services for about 44 years. In my career, I determined eligibility for various programs such as Medicaid, provided supportive services for families, served as a County Social Services Director in Marquette County for 11 years, and was Director of the Office of Children's Services in the Michigan Family Independence Agency. I retired from the State of Michigan and worked in various other states including Colorado, Arizona and Washington DC. In those positions I administered various programs including Medicaid eligibility. I served as the Director of the Arizona Department of Economic Security with a staff of over 10,000 employees and a multibillion dollar budget. In Washington DC, I was the Director of the Department of Human Services which included in part, implementation of the Medicaid portions of the Affordable Care Act in the District of Columbia.

Removing people from medical assistance due to non compliance with work requirement is a bad idea. People need to be accountable and involved in their own self sufficiency, but removing their support network is shortsighted and counterproductive. In my years of experience, I rarely saw people who chose to remain in poverty when they had legitimate alternatives. They remained in poverty due to various obstacles to their self sufficiency. Those obstacles often are not obvious but may include mental or emotional challenges, lack of education or experience, child care issues, family violence, homelessness, criminal records, or even a loss of hope that they could ever succeed. The proposed waiver exempts some of these individuals from work requirements but most will not meet the criteria in Michigan's waiver request.

At times, the system discourages self improvement because people may lose coverage and supports if their earnings exceed a certain threshold. The coverage provided to Medicaid recipients is often more comprehensive and less costly than private insurance through the health care exchange. But the solution is not to remove essential benefits from the most vulnerable but rather to strengthen supports and subsidies to those in the middle. All agree that our health care system especially for those low income people with private insurance needs improvement. The current proposal does nothing to improve their care but rather undermines health care for even more people.

When drafting their waiver request, the Michigan Department of Health and Human Services (MDHHS) needs to fully address the following concerns:

1. MDHHS should fully explain what will happen to people who lose eligibility for non compliance. I know of no research or studies that demonstrate that most people will get jobs or obtain health insurance through employers. If it were that simple, most would already have taken that option. The Department should explain how many recipients are likely to establish eligibility based on other criteria such as disabilities. How many will seek care through hospital emergency rooms and at what additional cost? How many will become more disabled because of lack of preventive care? How much more will it cost to pay for crisis care for conditions that could have been handled through routine health services?

2. MDHHS should better define the verification processes they will use. Are the processes fair and reliable? How many additional staff will be required? Have the staff been requested and authorized? How and when will the staff be hired and trained? Can MDHHS attest that the staff will be hired and

trained before the new process go into effect? Will other programs require more staff when former recipients need more support due to a lack of health coverage?

3. What Impact will the new rules have on timeliness and accuracy of Medicaid eligibility and re determination? Will new verification rules slow down approvals not only for those with work requirements but also for those who are exempted? Will the new processes be an unmanageable burden for recipients and for staff?

4. I believe that Michigan uses a multi state computer system for their health care exchange. What computer system changes will be required? Will the changes have any effect on other states using the multi state exchange? How long will it take to make the programming changes? How will the changes be tested to make sure the system works and that it does not crash or have other unintended consequences?

5. The computer changes may be extensive and costly. Will the changes trigger a new or revised Advance Planning Document (APD)? What percentage of the cost will the federal government cover? How long will it take to develop and approve the APD? Will new bids be required or will the existing contracts be modified?

6. How much federal participation will Michigan's health care system lose as a result of the work requirements? How many health care jobs will be lost? What is the economic impact of these losses on our health care system and on Michigan's economy in general?

7. Over the long run, will the net savings to the state for the work requirements outweigh the net increase in cost resulting from increased administrative expenses? More importantly will the economic impact from the loss of health care jobs and from poorer health care outcomes demonstrate the shortsightedness of this waiver proposal?

8. If this misguided proposal is approved, how will the evaluation examine the true effects of the changes and assure prompt revisions or termination of the waiver if warranted?

Although I oppose the waiver in general, if it is implemented, at least one additional option should be added under the qualifying activities that would satisfy the recipient's work requirements. The Michigan law that directed MDHHS to request the waiver, (Michigan Public Act 208 of 2018) allows recipients to satisfy their work requirements in a number of different ways. Section 107 a (2) (g) offers the option of participating in unpaid work connections such as but not limited to internships. The state should clarify that this option includes voluntary participation in case management services designed to overcome barriers to self sufficiency.

Medicaid funded case management services should be available to any participant consistently unsuccessful in meeting their work requirements. Modifications to the health risk assessment or other tools may be incorporated into the program allowing for screening, diagnosis and treatment designed to overcome barriers to self sufficiency. Recipients could meet their requirements by developing a plan, working on barriers and engaging services that the case manager facilitates for their success.

Numerous studies have shown that poverty is the single biggest factor contributing to poor health outcomes. It is a greater predictor of health problems than smoking, alcohol abuse, obesity or drug addiction. By adding this case management option rather than terminating Medicaid eligibility, low

income individuals may have a fighting chance of overcoming barriers to self sufficiency and to escaping from poverty.

Similar case management approaches have been used in vocational rehabilitation services, TANF, SNAP, ex offender programs, and services to people with a variety of issues such as developmental disabilities and mental health conditions. Many of these are already funded through Medicaid. A case management approach rather than mandatory work requirements was recently implemented in Montana and is showing promising results. Expanded supports are effective tools in helping individuals to reach their maximum potential. In the long run, the expansion of services to those unable to otherwise meet their work requirements will prove to be highly cost effective.

I appreciate the opportunity to comment on the proposed waiver. I know that the Department is required by law to submit this waiver request, and I hope the above questions and suggestions help the Department to better meet the health care needs of low income adults in Michigan.

Respectfully submitted,

David A. Berns, LCSW
327 Monroe St
Manistee MI 49660

231 510-5895
dberns46@gmail.com

From: [redacted]
To: HealthyMichiganPlan
Subject: Comments on Medicaid Work Requirements
Date: Wednesday, July 25, 2018 4:29:36 PM

Hello-This is my comment for the comment period on Medicaid Work Requirements. I work with people living with HIV and persons with HIV should be categorically defined as medically frail and therefore exempt from the requirements. There are times where someone living with HIV can be very sick and unable to work and treatment can not be interrupted or they will get sicker. Please contact me with any questions.Thanks [redacted]

--

[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Wednesday, July 25, 2018 9:33:07 PM

People with HIV should be categorically defined as medically frail and therefore exempt from the requirements to obtain Medicaid.

For God’s sake, let’s take care of our people.

MDHHS received the following comment on 7/29/2018:

As a person living with HIV and working with others, I am asking that persons living with HIV should be categorically defined as medically frail and therefore exempt from the requirements to work.

Please consider this in your waiver amendment discussion and you may contact me if you have any questions.

We have not included a copy of the actual e-mail in our compilation due to confidentiality concerns.

From: Rep. Sam Singh (District 69)
To: HealthyMichiganPlan
Cc: Aaron Keel; Sarah Schillio
Subject: Demonstration Extension Application Amendment: House Democrats Comment
Date: Monday, July 30, 2018 4:52:41 PM
Attachments: House Democrats Comments on Demonstration Extension Application Amendment.pdf

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Please see attached for formal comments submitted on behalf of the Michigan House Democratic Caucus. We ask that these comments be published on the state's waiver website as part of the public record.

Thank you!

Sam Singh
House Democratic Leader
69th House District

69TH DISTRICT
STATE CAPITOL
P.O. BOX 30014
LANSING, MI 48909-7514

MICHIGAN HOUSE OF REPRESENTATIVES

SAM SINGH

HOUSE DEMOCRATIC LEADER

PHONE: (517) 373-1786
FAX: (517) 373-5717
E-MAIL: samsingh@house.mi.gov

July 30, 2018

The Honorable Rick Snyder, Governor
The State of Michigan
P.O. Box 30013
Lansing, MI 48909

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

Dear Governor Snyder and Director Lyon:

On behalf of the House Democratic Caucus and the millions of constituents we represent across this state, including thousands that will lose health coverage under this waiver proposal, we are providing comment regarding the Department's proposed extension of its Healthy Michigan Section 1115 Medicaid Demonstration. The proposal includes provisions from Senate Bill 897 that would take Medicaid coverage away from people who don't meet a strict work requirement or are unable to afford higher premiums (which the waiver would impose on certain beneficiaries with incomes just above the poverty line). We strongly oppose this proposal, which the House Fiscal Agency projects will cause up to 54,000 Michiganders to lose their health coverage.

For decades, Medicaid has provided low-income families with improved security and the freedom to maintain employment. Specifically in Michigan, Medicaid expansion is working and remains this Administration's greatest achievement, and one that we were pleased to be a partner on. The University of Michigan's reports have consistently shown that expansion has saved the state money, increased health coverage, and connected Michiganders with needed care. And a recent report found Michigan hospitals saw a 57 percent decrease in uncompensated care costs as a share of their budgets as expansion took effect.

This waiver proposal, however, will take Michigan in the opposite direction from the progress we have made, would reduce coverage and worsen access to care for a range of low-income Michiganders. Some of the groups who are likely to be harmed by this proposal that our offices have heard from include:

- **People with disabilities and other serious health needs.** In theory, the proposal exempts people who are medically frail. But in practice, some people with disabilities and serious illnesses would inevitably fall through the cracks because they don't meet the criteria for exemptions, don't understand that they qualify for an exemption, or can't provide the documentation proving they do.

- **Older people.** The proposal would apply a work requirement to Healthy Michigan beneficiaries up to 62 years old. This is despite the fact older people are less likely to be working, in part because many have serious health conditions. Losing health coverage will only exacerbate these conditions.

- **Working Michiganders.** Among enrollees who would be subject to work requirements, most already work, but in industries like health care services, restaurant and food services, construction, or tourism, where hours are volatile and people often end up with gaps between jobs, it is likely many workers would fall short of the requirement for multiple months and would lose their coverage, often times at no-fault of their own.

- **Persons of color.** Medicaid expansion has been found to have reduced disparities by race in access to health care. Persons of color make up more than a third of Healthy Michigan beneficiaries, and this proposal will make it harder for them to access needed care.

Rather than improve employment outcomes for individuals seeking jobs, Senate Bill 897 threatens the health care coverage of the many already employed beneficiaries who may fall short of the monthly requirement. Our concerns are supported by growing evidence that a Medicaid work requirement will harm the most vulnerable beneficiaries and those who are already working. A recent report from the Kaiser Family Foundation found that if a Medicaid work requirement similar to Michigan's were imposed nationwide, 1.4 to 4 million people, or 6 to 17 percent of those potentially subject to the policy, would lose coverage. The researchers warn that "most disenrollment would be among individuals who would remain eligible but lose coverage due to new administrative burdens or red tape."[1] And in Arkansas, where the state began implementing its Medicaid work requirement in June, *more than a quarter* of expansion beneficiaries so far subject to the new requirements are in danger of losing their Medicaid coverage in the coming months because they did not file the necessary paperwork in the first month of the program. Thus, this requirement will likely even impact those who qualify for an exemption but end up losing their coverage due to red-tape, paperwork, and additional bureaucracy.

Further, this proposal more than doubles monthly premiums on certain individuals to 5 percent of their household income. These premiums would make Michigan's plan the most expensive in the nation, and much higher than what those with comparable incomes pay in the ACA marketplace for health care coverage in states that have not expanded Medicaid. Research clearly indicates that premiums as high as this are a barrier to obtaining and maintaining Medicaid for low-income individuals. It should not be our state's objective to place unnecessary barriers and financial burdens on our citizens who will likely be priced out of receiving medical assistance under this proposal.

Finally, this proposal will force the state to spend tens of millions of dollars each year on new bureaucracy to administer the requirements, and Michigan's hospitals are likely to see an increase in their uncompensated care costs as people lose their Medicaid coverage. Meanwhile, SB 897 does not direct any new money to workforce development programs or employment projects in underserved parts of the state. And at the end of the day, this multi-million dollar system SB 897 attempts to assemble will result in nothing more than the loss of medical coverage for approximately 54,000 Michigan residents based on conservative estimates.

Put simply, this waiver proposal poses a substantial threat to the health and well-being of Michigan's low-income workers, its most vulnerable residents, and its economy.

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[1] Rachel Garfield, Robin Rudowitz, and MaryBeth Musumeci, "Implications of a Medicaid Work Requirement: National Estimates of Potential Coverage Losses," Kaiser Family Foundation, June 27, 2018, https://www.kff.org/medicaid/issue-brief/implications-of-a-medicaid-work-requirement-national-estimates-of-potential-coverage-losses/.

Thank you for your time and consideration. We look forward to working with your administration and the Department of Health and Human Services to ensure the gains in health coverage and access to care Michigan has experienced since it expanded Medicaid are not jeopardized. Finally, we ask that these comments be published on the state's waiver website as part of the public record.

Sincerely,

Sam Singh
House Democratic Leader
69th House District

Christine Greig
House Democratic Floor Leader
37th House District

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Tuesday, July 31, 2018 2:24:28 PM

To Whom it May Concern,

Medicaid is critical to ensuring the basic health and security of the most vulnerable of Michigan's residents. The Medicaid extension in Michigan has been a success on this front, and I'm writing with comments to oppose the state's requests to add restrictions making it harder for residents to participate in the program.

The workforce engagement and cost sharing requirements are both concerning, and likely to cause more harm than good. I urge you to reject these. While these elements are focused on adults in the program, they will most certainly have a negative impact on the most vulnerable children in our state, whose parents may be left with huge debts and no health insurance.

A resident who either cannot afford, or loses eligibility for health insurance, will likely not seek treatment for easily treatable conditions, until such point as the health consequences are dire and irreversible. This makes it less likely that these residents will be able to work in the future, and more likely that they will face serious, debilitating health outcomes. Obviously this is negative on multiple levels. These provisions are likely to have the exact opposite effect to what the state intends, ultimately costing the state more and causing serious harm.

Again, I urge you to reject the workforce engagement and cost sharing requirements proposed. Thank you for your consideration.

[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Wednesday, August 1, 2018 1:30:58 PM

I am writing to discourage any red tape that could threaten the health of thousands of Michigan people. Please do not change the Healthy Michigan Plan. Work requirements have been shown to discourage participation without benefit to those who need it -- the sick and elderly. We should do more to protect our vulnerable citizens, not less.

I'd like my comments to be published on the state's waiver website as part of the public record.

Thank you,
[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: "Demonstration Extension Application Amendment."
Date: Wednesday, August 1, 2018 1:56:32 PM

I am a disabled veteran, we deserve a simple Michigan Single Payer System, NOT something with all kinds of READ (R) TAPE.
Just do it for the thousands of disabled veterans in MI.
STOP trying to make it NOT work for us.

--
[redacted]

"Make the injustice visible." Ghandi

269-345-1414

From: Asraa Alhawli
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Thursday, August 2, 2018 9:27:17 AM

Dear Secretary Azar, Senior Advisor Huber, and Deputy Assistant Secretary Foley:

I am writing on behalf of ACCESS in response to request for public comment on the proposed act entitled, "An act to protect the welfare of the people of this state; to provide general assistance, hospitalization, infirmary and medical care to poor or unfortunate persons; to provide for compliance by this state with the social security act; to provide protection, welfare and services to aged persons, dependent children, the blind, and the permanently and totally disabled; to administer programs and services for the prevention and treatment of delinquency, dependency and neglect of children; to create a state department of social services; to prescribe the powers and duties of the department; to provide for the interstate and intercounty transfer of dependents; to create county and district departments of social services; to create within certain county departments, bureaus of social aid and certain divisions and offices thereunder; to prescribe the powers and duties of the departments, bureaus and officers; to provide for appeals in certain cases; to prescribe the powers and duties of the state department with respect to county and district departments; to prescribe certain duties of certain other state departments, officers, and agencies; to make an appropriation; to prescribe penalties for the violation of the provisions of this act; and to repeal certain parts of this act on specific dates," published June 22, 2018. ACCESS is a 501©3 organization whose vision is to create a just and equitable society with the full participation of Arab Americans, and whose mission is to empower communities to improve their economic, social, and cultural well-being.

This proposed act would significantly alter and undermine the Healthy Michigan Plan, a Medicaid expansion program. It is estimated that, through this act, approximately 540,000 Healthy Michigan enrollees will be subject to the 80-hour per month work requirement and project a 5-10% decline in enrollment, or up to 54,000 coverage losses. This implementation will act to deny vital services to patients who rely on the Healthy Michigan Plan to live a healthy life.

The proposed act would threaten the ability for people to work along with their ability to stay healthy. If those on the Healthy Michigan Plan must work, then they cannot seek a healthcare provider when they do fall ill – and should they fall ill, they cannot work. As a result, Michiganders must sacrifice their health, in one way or another. Let it be reminded that Healthy Michigan is a Medicaid expansion program, not a jobs program, and should be treated as such.

The proposed act would exacerbate the challenges that many patients already face in getting

timely and high-quality health care. The proposed changes to the Healthy Michigan Plan would disproportionately affect those who work seasonally, new business owners, parents who work part-time in order to take care of their children, and caregivers to multiple children or disabled persons – just to name a small few – thereby increasing health disparities. We urge the administration to withdraw the proposed act because of the serious harm it would do to patients in our community and across the state of Michigan.

The ACCESS community, in particular, serves many new citizens who rely on Medicaid in order to stay healthy enough to start their new lives in America off right. An ACCESS client, who would like to be identified as Hussein, owes not only his life, but his young daughter's life, to Medicaid. Before Medicaid, Hussein was working as a truck driver, and was comfortably providing for his family. Hussein and his family had no medical history and were leading healthy lives. They had no apparent need for healthcare.

In 2016, Hussein was shot in the head and survived his injuries. His slow recovery resulted in an inability to work and the eventual loss of his job. After the medical expenses kept piling up, Hussein was forced to sell my house to help pay for the bills. A few months later, while shopping with his family at Wal-Mart, Hussein collapsed and started having a seizure. A bystander rushed to his side and began dialing 911. He tried to get her attention to stop, knowing that he could not afford the medical bills that would follow. However, she assured his family that she would help in find assistance to pay for the bills. As the ambulance arrived, she gave Hussein's wife the phone number for Eva, a Health Care Navigator at ACCESS. A few days after the incident, Hussein and his family had an appointment with Eva. She assisted in securing Medicaid as well as other benefits to help the family get by. Hussein began seeing a specialist for his head injury and could afford the medications that were prescribed.

Several months later, Hussein's daughter was diagnosed with diabetes. Without Medicaid, seeking treatment for his daughter would have been near impossible. The Medicaid coverage Hussein's family has continued to be the difference between life and death. Medicaid has been a positive resource in the family's life during their most difficult times. Medicaid made it possible for Hussein to go back to work, provide for his family, and even purchase a condominium. None of this would have been possible, Hussein says, without the assistance of Medicaid.

Another one of our clients, Mike, fled Iraq as a refugee in 2014 and settled in Sterling Heights, Michigan. With limited access to regular healthcare treatment in Iraq, Mike hoped to attend to his medical concerns in the United States. As a 66-year-old living with diabetes and high blood pressure, he knew that the proper care was critical to a healthy lifestyle moving forward. After visiting a doctor, he was diagnosed with high cholesterol and found a malignant tumor. Being retired and not eligible for social security benefits, the limited resources he had

would not be sufficient enough to cover the out-of-pocket expenses for treatments and medications for my conditions.

Mike was directed to ACCESS and met with Eva, as well, for assistance to find health coverage. During their first meeting, he described his medical conditions and his inability to pay for his accumulating medical expenses. She immediately helped Mike fill out and submit an application for Medicaid. Through the support of ACCESS, his application was approved after a few weeks. This allowed Mike to schedule the necessary surgery to remove his tumor, and to begin taking medications for my conditions without straining his resources. The Medicaid coverage he

received has given me an overall better quality of life. Mike is dependent on Medicaid, and otherwise would not be able to afford the medications and doctor visits that keep him healthy. Fortunately, he is able to visit his doctors regularly and has been adhering to his medications. This would not have been possible without the assistance of Medicaid.

Medicaid has very clearly impacted our clients' and our community's lives in the most positive of ways. Medicaid has allowed for our friends, family, and neighbors to live the American dream. This proposed act would very clearly hinder that very ability of our clients.

Sincerely,

Asraa Alhawli
Advocacy Specialist
ACCESS Community

From: Rep. Patrick Green (District 28)
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Thursday, August 2, 2018 1:27:33 PM

August 2, 2018

To whom it may concern,

Below, please find my formal comment about the Department's proposed extension of its Healthy Michigan Section 1115 Medicaid Demonstration, including the Medicaid work requirements put forward by Senate Bill 897. I request that my comments be published on the state's waiver website as part of the public record.

I stand with the people of Michigan and my Democratic colleagues in opposition to the provisions put forward by Senate Bill 897 and the Department of Health and Human Services' waiver application. The expansion of Healthy Michigan in 2013 extended health care coverage to nearly 690,000 Michigan adults who previously were forced to choose between putting food on the table and taking their loved ones to the doctor. Work requirements will pull this health care coverage from tens of thousands of Michiganders, simply because they live on a limited income or have fallen on hard times. It is not our place to determine who is and who is not deserving of quality health care, and I refuse to turn my back on the tens of thousands of Michiganders who will suffer the consequences of SB 897. If the goal is to reduce the cost of social assistance programs in our state, we need to start by taking care of Michigan's workers from the get-go; we need to increase wages and provide wraparound social services to support working class families and help elevate them into the middle class.

Thank you for your time and consideration.

Sincerely,

Patrick Green
State Representative
Assistant Minority Floor Leader
Michigan House of Representatives
28th District
(O) (517)373-1772

P.O. Box 30014
Lansing, MI 48909-7514

Website: green.housedems.com

American Heart Association | American Stroke Association
life is why

Recd 7/31/18 BD

July 31, 2018

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

Re: Healthy Michigan Plan Waiver

Dear Director Lyon:

On behalf of the American Heart Association (AHA) and the American Stroke Association (ASA), I would like to thank you for the opportunity to provide written comments on the proposed Healthy Michigan Plan Section 1115 demonstration waiver.

The AHA represents over 100 million patients with cardiovascular disease (CVD) including many who rely on Medicaid as their primary source of care.[1] In fact, twenty-eight percent of adults with Medicaid coverage have a history of cardiovascular disease.[2] Medicaid provides critical access to prevention, treatment, disease management, and care coordination services for these individuals. Low-income populations are disproportionately affected by CVD – with these adults reporting higher rates of heart disease, hypertension, and stroke – Medicaid is the coverage backbone for the healthcare services these individuals need.

The connection between health insurance and health outcomes is clear and well documented. Americans with CVD risk factors who lack health insurance, or are underinsured, have higher mortality rates[3] and poorer blood pressure control than their insured counterparts.[4]
Further, uninsured stroke patients suffer from greater neurological impairments, longer hospital stays,[5] and higher risk of death[6] than similar patients covered by health insurance.

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[1] RTI. Projections of Cardiovascular Disease Prevalence and Costs: 2015–2035, Technical Report. http://www.heart.org/idc/groups/heart-public/@wcm/@adv/documents/downloadable/ucm_491513.pdf Accessed June 19, 2017.
[2] Kaiser Family Foundation. The Role Of Medicaid For People With Cardiovascular Diseases. 2012. Available at: https://kaiserfamilyfoundation.files.wordpress.com/2013/01/8383_cd.pdf. Accessed August 15, 2016.
[3] McWilliams JM, Zaslavsky AM, Meara E, Ayanian JZ. Health insurance coverage and mortality among the near-elderly. Health Affairs 2004; 23(4): 223-233.
[4] Duru OK, Vargas RB, Kerman D, Pan D, Norris KC. Health Insurance status and hypertension monitoring and control in the United States. Am J Hypertens 2007;20:348-353.
[5] Rice T,LaVarreda SA,Ponce NA, Brown ER. The impact of private and public health insurance on medication use for adults with chronic diseases. Med Care Res Rev 2005; 62(1): 231-249.
[6] McWilliams JM, Meara E, Zaslavsky AM, Ayanian JZ. Health of previously uninsured adults after acquiring Medicare coverage. JAMA. 2007; 298:2886 –2894.

Cardiovascular disease is also costly and burdensome for the individual, their families, and for communities. While the AHA/ASA understands the need to address poverty and control costs, we are concerned that the proposed changes will require a substantial state investment in infrastructure that does not align with, and could detract from, the Medicaid program's goal of providing access to care. The 2017 Federal Budget cut Labor Department funding by 21%, shifting the responsibility to states for certain job placement programs. In addition, CMS has made it clear that it will not provide states with the authority to use Medicaid funding to finance employment related services for individuals. We are concerned that Michigan's 1115 waiver application has not demonstrated how it will provide sufficient job training, child care, transportation, and other supportive programs to enable its affected Medicaid beneficiaries to meet the proposed requirement.

Lastly, the federal rules pertaining to state public comment process require that a state include an estimate of the expected increase or decrease in annual enrollment and expenditures if applicable. The intent of this is to allow the public to comment on a Section 1115 proposal with adequate information to assess its impact. However, in the current demonstration proposal, the Department reuses budget neutrality estimates from an earlier proposal that are no longer relevant and states that "MDHHS expects annual HMP enrollment to decrease but the total number of beneficiaries who will be impacted is unknown at this time." In order to meet these transparency requirements, Michigan must include the projections and their impact on budget neutrality provisions.

Our organization is willing to be helpful and work with you in protecting patient access to care as you implement the proposal mandated by the Michigan legislature. Without addressing these concerns, we believe that the work requirements will not in fact result in more able-bodied adults working, nor produce positive health outcomes—a lose-lose for Michigan.

Respectfully,

Dave J. Hodgkins
Government Relations Director
American Heart Association—Michigan

From: Andrew Schepers
To: HealthyMichiganPlan
Subject: ACS CAN Comments to Waiver Amendment
Date: Friday, August 3, 2018 8:07:08 AM
Attachments: image004.png
FINAL ACS CAN MI 1115 Comments.pdf

Good Morning,

Please find the comments to the amendment of the 1115 waiver attached. As always don't hesitate to reach out if you have any questions. Thank you for the opportunity to comment on the amendments.

Andrew Schepers

Andrew Schepers | Michigan Government Relations Director
American Cancer Society Cancer Action Network, Inc.
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August 3, 2018

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

Re: Health Michigan Plan Project No. 11-W-00245/5 – Section 1115 Demonstration Extension Application

Dear Director Lyon:

The American Cancer Society Cancer Action Network (ACS CAN) appreciates the opportunity to comment on Michigan's proposal to extend the Healthy Michigan Plan (HMP) demonstration waiver. ACS CAN, the nonprofit, nonpartisan advocacy affiliate of the American Cancer Society, supports evidence-based policy and legislative solutions designed to eliminate cancer as a major health problem. As the nation's leading advocate for public policies that are helping to defeat cancer, ACS CAN ensures that cancer patients, survivors, and their families have a voice in public policy matters at all levels of government.

ACS CAN supports Michigan's goal to improve access to healthcare for uninsured or underinsured low-income Michigan residents through the HMP program. Nearly 57,000 Michigan residents are expected to be diagnosed with cancer this year[1] – many of whom are receiving health care coverage through the HMP program. Research has demonstrated that individuals who lack health insurance coverage are more likely to be diagnosed with advanced-stage cancer, which is costly and often leads to worse outcomes.[2,3] Additionally, individuals enrolled in Medicaid prior to their diagnosis have better survival rates than those who enroll after their diagnosis.[4]

It is imperative that low-income Michigan residents continue to have access to comprehensive health care coverage under the HMP program, and that specific requirements do not create barriers to care for low-income cancer patients, survivors, and those who will be diagnosed with cancer during their lifetime. We are concerned with many of the proposals included in the Michigan waiver extension, as detailed below. We urge the Michigan Department of Health and Human Services ("the Department") to reconsider moving forward with the proposed waiver until these issues can be addressed.

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[1] American Cancer Society. *Cancer Facts & Figures 2018*. Atlanta, GA: American Cancer Society; 2018.
[2] Ward E, Halpern M, Schrag N, et al. Association of insurance with cancer care utilization and outcomes. *CA Cancer J Clin*. 2008; 58(1):9-31.
[3] American Cancer Society. *Cancer Prevention & Early Detection Facts & Figures 2016-2017*. Atlanta: American Cancer Society; 2017.
[4] Adams E, Chien LN, Florence CS, et al. The Breast and Cervical Cancer Prevention and Treatment Act in Georgia: effects on time to Medicaid enrollment. *Cancer.* (2009); 115(6):1300-9.

Workforce Engagement Requirements

The requirement that all able-bodied HMP enrollees be employed, receive job training, be in school, or participate in community engagement activities for at least 80 hours per month as a condition of eligibility could unintentionally disadvantage patients with complex chronic conditions, including cancer patients and recent survivors. We understand the intent of the proposal is to incentivize employment, but many cancer patients in active treatment are often unable to work or require significant work modifications due to their treatment.[5,6,7] ACS CAN opposes tying access to affordable health care for lower income persons to work or participation in community engagement requirements because cancer patients, survivors, and those who will be diagnosed with the disease - as well as those with other complex chronic conditions - could find themselves without Medicaid coverage. Research suggests that between 40 and 85 percent of cancer patients stop working while receiving cancer treatment, with work absences ranging from 45 days to six months depending on the treatment.[8] If workforce engagement is required as a condition of eligibility, many cancer patients, recent survivors, and those with other chronic illnesses could find that they are ineligible for the lifesaving care and treatment services provided through the State's Medicaid program.

We appreciate the Department's acknowledgement that not all people are able to work and the decision to include several exemption categories and good cause exemptions from the workforce engagement requirement and associated lock-out period. However, the waiver does not go far enough to protect vulnerable individuals, including recent cancer survivors, and individuals with other serious chronic diseases, some of which are linked to cancer treatments.[9] Additionally, the increase in administrative requirements for enrollees to attest to their working status on a monthly-basis would likely decrease the number of individuals with Medicaid coverage, regardless of whether they are exempt.

Lock-Out Period

We are deeply concerned about the proposed lock-out period or suspension of coverage for non-compliance with the workforce engagement requirement; particularly the proposed one-year lock-out period if the Department believes an individual has misrepresented his or her compliance with the requirement or an exemption. The Department offers individuals who have failed to participate in the requirement "good cause" exemptions, but it is unclear how long the appeals process would take and whether the beneficiary would lose health coverage during the process. It is also unclear from the

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[5] Whitney RL, Bell JF, Reed SC, Lash R, Bold RJ, Kim KK, et al. Predictors of financial difficulties and work modifications among cancer survivors in the United States. *J Cancer Surviv.* 2016; 10:241. doi: 10.1007/s11764-015-0470-y.

[6] de Boer AG, Taskila T, Tamminga SJ, et al. Interventions to enhance return to work for cancer patients. *Cochrane Database Syst Rev.* 2011; 16(2): CD007569. doi: 10.1002/14651858.CD007569.pub2.

[7] Stergiou-Kita M, Pritlove C, van Eerd D, Holness LD, Kirsh B, Duncan A, Jones J. The provision of workplace accommodations following cancer: survivor, provider, and employer perspectives. *J Cancer Surviv*. 2016; 10:480. doi:10.1007/s11764-015-0492-5.

[8] Ramsey SD, Blough DK, Kirchhoff AC, et al. Washington State Cancer Patients Found to be at Greater Risk for Bankruptcy then People Without a Cancer Diagnosis," Health Affairs, 32, no. 6, (2013): 1143-1152.

[9] Mehta LS, Watson KE, Barac A, Beckie TM, Bittner V, Cruz-Flores S, et al. Cardiovascular disease and breast cancer: Where these entities intersect: A scientific statement from the American Heart Association. *Circulation*. 2018; 137(7): CIR.0000000000000556.

waiver if individuals that are determined by the Department to have misrepresented his or her compliance will be given an appeals process. If individuals are locked out of coverage for the one-month period, one-year period, or during any appeals process they will likely have no access to health care coverage, making it difficult or impossible for a cancer patient to continue treatment or pay for their maintenance medication until they come into compliance with the requirement or it is determined that they have "good cause." For those cancer patients who are mid-treatment, a loss of health care coverage could seriously jeopardize their chance of survival. Being denied access to one's cancer care team could be a matter of life or death for a cancer patient or survivor and the financial toll that the lock-out or suspension period would have on individuals and their families could be devastating.

Workforce Engagement Requirement Does Not Meet CMS Criteria
We note that Michigan's proposed waiver does not appear to meet the criteria established by the Centers for Medicare and Medicaid Service (CMS) for approval of work and community engagement proposals under the guidance that CMS sent to state Medicaid Directors on January 11, 2018. The guidance specifically states that "…states will need to link these community engagement requirements to those outcomes and ultimately *assess the effectiveness of the demonstration in furthering the health and wellness objectives* of the Medicaid program [emphasis added]."[10] In contrast, the State's reported objective of the workforce engagement requirement is to "promote work and community engagement…and further the positive physical and mental health benefits associated with work" and to determine the "extent to which workforce engagement requirements impact individuals who transition from Medicaid obtain employer sponsored or other health insurance coverage and how such transitions affect health and wellbeing." The State's reported hypotheses used to evaluate the outcomes of the requirement do not address health and wellness of the Medicaid enrollees in the program itself or those who may lose Medicaid eligibility due to noncompliance.

Further, the Department has neglected to provide projections of the number of beneficiaries who may be impacted by the workforce requirement or the entire demonstration waiver. Instead, the Department states that "MDHHS expects annual HMP enrollment to decrease but the total number of beneficiaries who will be impacted is unknown at this time." Federal rules for the state public notice process for 1115 waivers require states to include, "an estimate of the estimated increase or decrease in annual enrollment" and expenditures for the demonstration requested by the State.[11] This allows stakeholders and CMS to adequately assess the impact the demonstration waiver may have on state residents. Therefore, we strongly urge the State to include these projections, as required by federal law, so that the public has an opportunity to comment on the impact of the proposed waiver demonstration with adequate information.

Patient Cost Sharing and the MI Health Accounts
ACS CAN opposes the proposed premiums of five percent of income – and associated mandatory completion of an annual healthy behavior – for individuals with incomes above 100 percent of the Federal Poverty Level (FPL) who have had 48 months of cumulative HMP eligibility coverage. We are

[10] Centers for Medicare & Medicaid Services. Opportunities to promote work and community engagement among Medicaid beneficiaries. Baltimore, MD. Department of Health and Human Services. SMD: 18-002. Published January 11, 2018. Accessed January 2018.
[11] 42 CFR 431.408 (a)(1)(i)(C).

concerned the cost sharing and related lock-out period for non-payment will create administrative burdens for enrollees, will likely deter enrollment or result in a high number of disenrollment, and will cause significant disruptions in care, especially for cancer survivors and those newly diagnosed. Studies have shown that imposing even modest premiums on low-income individuals is likely to deter enrollment in the Medicaid program.[12,13,14] Imposing copayments or out-of-pocket costs on low-income populations has been shown to decrease the likelihood that they will seek health care services, including preventive screenings.[15,16,17] Cancers that are found at an early stage through screening are less expensive to treat and lead to greater survival.[18] Uninsured and underinsured individuals already have lower screening rates resulting in a greater risk of being diagnosed at a later, more advanced stage of disease.[19] Proposals that place greater financial burden on low-income residents create barriers to care and will negatively impact HMP enrollees – particularly those individuals who are high service utilizers with complex medical conditions.

It is unclear from the waiver whether the premiums of five percent of income will be based on a family's monthly or annual income. Low-income populations are more likely to have an inconsistent income throughout the calendar year. Therefore, if Michigan were to move forward with this proposal, we recommend that the premium contribution be based on monthly household income, as it is a more accurate indicator of an individual's income and ability to consistently meet cost sharing requirements – particularly for seasonal workers or individuals who must spend down before meeting the Medicaid eligibility criteria.

The Healthy Behaviors Incentives Program

ACS CAN supports Michigan's goal of encouraging HMP beneficiaries to seek preventive care and encourage the adoption of health behaviors through the *Healthy Behaviors Incentives Program,* as a substantial proportion of cancers could be prevented or caught at an earlier, more treatable stage through preventive care and screening.[20] However, we strongly advise against the Department's decision to use a mandatory, outcomes-based program that requires beneficiaries with incomes between 100 and 133 percent of FPL and who have had 48 months of HMP eligibility coverage to

[12] Hendryx M, Onizuka R, Wilson V, Ahern M. Effects of a Cost-Sharing Policy on Disenrollment from a State Health Insurance Program. *Soc Work Public Health*. 2012; 27(7): 671-86.
[13] Wright BJ, Carlson MJ, Allen H, Holmgren AL, Rustvold DL. Raising Premiums and Other Costs for Oregon Health Plan Enrollees Drove Many to Drop Out. *Health Affairs*. 2010; 29(12):2311-16.
[14] Office of the Assistant Secretary for Planning and Evaluation. Financial Condition and Health Care Burdens of People in Deep Poverty. Published July 16, 2015. Accessed April 21, 2016. http://aspe.hhs.gov/basic-report/financial-condition-and-health-care-burdens-people-deep-poverty.
[15] Solanki G, Schauffler HH, Miller LS. The direct and indirect effects of cost-sharing on the use of preventive services. *Health Services Research.* 2000; 34: 1331-50.
[16] Wharam JF, Graves AJ, Landon BE, Zhang F, Soumerai SB, Ross-Degnan D. Two-year trends in colorectal cancer screening after switch to a high-deductible health plan. *Med Care.* 2011; 49: 865-71.
[17] Trivedi AN, Rakowsi W, Ayanian JA. Effect of cost sharing on screening mammography in Medicare health plans. *N Eng J Med.* 2008; 358: 375-83.
[18] American Cancer Society. *Cancer Prevention & Early Detection Facts & Figures 2016-2017*. Atlanta: American Cancer Society; 2017.
[19] Ibid.
[20] Ibid.

complete or commit an annual healthy behavior assessment – and associated cost sharing requirements – to maintain eligibility for HMP. We are also opposed to the decision to phase out cost sharing reductions related to healthy behavior completion incentives after 48 months of cumulative HMP eligibility coverage, as beneficiaries would still be required to meet the healthy behavior assessment without the associated incentive. Penalizing enrollees for non-compliance or failing to meet outcomes dictated by a Health Risk Assessment (HRA) (or the state) will not likely generate cost savings or improve the health of low-income HMP enrollees. Instead, State residents would be better served by a comprehensive, evidence-based participatory wellness program based on incentives that provides adequate and comprehensive coverage of preventive services (including tobacco cessation, weight loss, and cancer screenings) and that emphasizes evidence-based interventions to educate, promote, and encourage patients to participate in prevention, early detection, and wellness. Evidence shows that unhealthy behaviors can be changed or modified by modest incentives, rather than penalties, as long as they are combined with adequate medical services and health promotion programs.[21]

A mandatory, outcomes-based program will not improve the health of low-income Michigan residents. Nationally, significant disparities exist in the prevalence of healthy behaviors by income. For example, adults living below the poverty level are more than one and a half times as likely to smoke cigarettes as those with higher incomes[22] and individuals with incomes less than 100 percent of poverty are 30 percent more likely to be obese than people with much higher incomes (above 400 percent of poverty).[23] Low-income individuals and families often face multiple structural barriers to addressing health behaviors, including lack of access to evidence-based tobacco cessation support, few safe places for physical activity in their neighborhoods, lack of access to affordable healthy foods, and lower health literacy.[24] Providing enrollees incentives could lead to a change in behavior whereas penalties do little to improve health, and could reduce access to necessary health care services, including preventive care.

We urge the Department to consider the impact a mandatory, outcomes-based wellness program will have on low-income State residents, because it could unfairly penalize individuals managing complex, chronic diseases, like cancer. Although the Department exempts individuals determined to be medically frail from the 48-month cumulative enrollment suspension of coverage, the increase in administrative requirements for enrollees to attest to their exemption status on a yearly basis could decrease the number of individuals with Medicaid coverage, regardless of whether they are exempt or not. We also ask the Department to clarify the criteria the State intends to use when determining how to assess efforts beneficiaries must take to make their healthy behaviors "incrementally more challenging" in

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[21] Consensus statement of the Health Enhancement Research Organization, American College of Occupational and Environmental Medicine, American Cancer Society and American Cancer Society Cancer Action network, American Diabetes Association, and American Heart Association. Guidance for a reasonably designed, employer-sponsored wellness program using outcomes-based incentives. *JOEM.* 2012; 54(7): 889-96.

[22] Centers for Disease Control and Prevention. Cigarette smoking and tobacco use among people of low socioeconomic status. Updated February 3, 2017. Accessed July 2018. https://www.cdc.gov/tobacco/disparities/low-ses/index.htm.

[23] National Center for Health Statistics. *Health, United States, 2015: with special feature on racial and ethnic health disparities*. Hyattsville, MD. 2016. https://www.cdc.gov/nchs/data/hus/hus15.pdf.

[24] Centers for Disease Control and Prevention – Division of Community Health. *A Practitioner's Guide for Advancing Health Equity: Community Strategies for Preventing Chronic Disease*. Atlanta, GA: US Department of Health and Human Services; 2013.

subsequent years. Greater specification would be helpful in assessing the possible effects this type of incrementally-based measurement would have on HMP enrollees, particularly how it may affect eligibility and enrollment.

Although, overall, we were glad to see the positive health outcomes reported in the State's HMP Primary Care Practitioner Report and Enrollee Survey, we do have some concerns with the findings. Specifically, that only 36 percent of providers reported being very/somewhat familiar with health behavior incentives for patients, only 28.1 percent of enrollees were aware they could reduce the amount they owed by completing an HRA, and that only 45.9 percent of enrollees actually completed an HRA.[25] These numbers are extremely concerning if an enrollee's eligibility is predicated on whether they receive an HRA and perform a healthy behavior determined by that HRA. Educating, encouraging, and raising HMP provider and enrollee awareness of the benefits, services, and incentive program requirements through targeted outreach is extremely important to ensure greater participation and health amongst HMP enrollees, while also preventing individuals from being disenrolled due to lack of proper education of the wellness program requirements.

Suspension of Eligibility Coverage and Continuity of Care
The Michigan 1115 waiver amendment states that Medicaid coverage for beneficiaries who have not met the program's cost-sharing or healthy behavior requirements will be suspended until the individual comes into compliance with the requirements, at which point they will be re-enrolled the first day of the next available month. The waiver appears to imply that some individuals may be exempt from this requirement. We seek further clarification and remind the Department that failure to consider the care delivery and/or treatment regimen of patients, especially those individuals managing a complex, chronic condition like cancer or cancer survivorship, could have devastating effects on patients, their families, and providers.

Cancer patients undergoing an active course of treatment for a life-threatening health condition need uninterrupted access to the providers and facilities from whom they receive treatment. Disruptions in primary cancer treatment care, as well as longer-term adjuvant therapy, such as hormone therapy, can result in negative health outcomes. Additionally, recent cancer survivors often require frequent follow-up visits and maintenance medications as part of their survivorship care plan to prevent recurrence,[26] and suffer from multiple comorbidities linked to their cancer treatments.[27] Ensuring both cancer patients and recent survivors receive the care they need is critical to positive health outcomes.

If Michigan were to move forward with these provisions, we ask the Department to provide a clear appeals process and additional continuity of care provisions that would minimize disruptions in coverage and care for individuals in active treatment for life-threatening illnesses and individuals with chronic

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[25] Michigan Department of Health and Human Services. *Section 1115 demonstration extension application: Health Michigan Plan Project No. 11-W-00245/*5. Lansing, MI.
[26] National Cancer Institute. *Coping with cancer: Survivorship, follow-up medical care*. Accessed July 2018. https://www.cancer.gov/about-cancer/coping/survivorship/follow-up-care.
[27] Mehta LS, Watson KE, Barac A, Beckie TM, Bittner V, Cruz-Flores S, et al. Cardiovascular disease and breast cancer: Where these entities intersect: A scientific statement from the American Heart Association. *Circulation*. 2018; 137(7): CIR.0000000000000556.

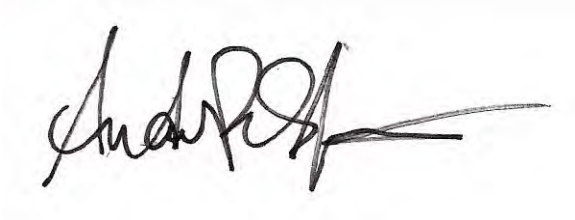
conditions that require frequent follow-up, such as recent cancer survivors. Additionally, the State should establish a clearly defined process through which HMP enrollees or their physician can inform the Department that they are in active treatment or have a serious chronic condition; allowing them to maintain their treatment regimen through any appeals process.

Conclusion

We appreciate the opportunity to provide comments on the Michigan demonstration waiver extension request. The preservation of eligibility, coverage, and access to HMP remains critically important for many low-income Michigan residents who depend on the program for cancer prevention, early detection, diagnostic, and treatment services. As the Department considers its final waiver application, we ask that you weigh the impact these proposals could have on Michigan residents access to lifesaving health care coverage, particularly those individuals with cancer, cancer survivors, and those who will be diagnosed with cancer during their lifetime.

Maintaining access to quality, affordable, accessible, and comprehensive health care coverage and services is a matter of life and survivorship for thousands of low-income cancer patients and survivors, and we look forward to working with the Michigan Department of Health and Human Services to ensure that all Americans are positioned to win the fight against cancer. If you have any questions, please feel free to contact me at andrew.schepers@cancer.org or 517.664.1312.

Sincerely,



Andrew Schepers
Michigan Government Relations Director
American Cancer Society Cancer Action Network

From: Emily Eckert
To: HealthyMichiganPlan
Subject: Healthy Michigan Demonstration Plan
Date: Friday, August 3, 2018 2:45:08 PM
Attachments: ACOG Comments (state)_Healthy Michigan_Final.pdf

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Re-sending with the appropriate subject line. Apologies for the inconvenience.

From: Emily Eckert
Sent: Friday, August 3, 2018 2:40 PM
To: 'healthymichiganplan@michigan.gov' <healthymichiganplan@michigan.gov>
Subject: MI Section of ACOG Comments on Healthy Michigan Plan

Hello,

The attached comments on the Healthy Michigan Plan are submitted on behalf of the Michigan Section of the American College of Obstetricians and Gynecologists (ACOG), representing 1,357 practicing obstetrician-gynecologists. Please do not hesitate to reach out to me if you have any questions, or would like to discuss these recommendations further.

Best,

Emily

Emily Eckert
Health Policy Analyst
American College of Obstetricians and Gynecologists
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Washington, DC 20024
P: 202.863.2485
E: eeckert@acog.org

The American College of Obstetricians and Gynecologists
WOMEN'S HEALTH CARE PHYSICIANS

Michigan Section

August 3, 2018

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

RE: Michigan ACOG's Comments on Healthy Michigan Plan Extension Application

Dear Director Lyon:

The Michigan Section of the American College of Obstetricians and Gynecologists (ACOG), representing 1,357 practicing obstetrician-gynecologists (ob-gyns), welcomes the opportunity to comment on the Michigan Department of Health and Human Services' Section 1115 Waiver Extension Application: Healthy Michigan Plan. As physicians dedicated to providing quality care to women, we are concerned that some of the proposed amendments would place Medicaid beneficiaries at risk for financial harm and deter our patients from seeking necessary care. We believe a number of changes should be made before this extension application is submitted for consideration by the Centers for Medicare and Medicaid Services (CMS).

Eligibility

The State's extension application is ambiguous regarding how it would treat a woman who has been locked out of the Medicaid program for administrative noncompliance (not completing a healthy behavior and/or failing to fulfill the cost-sharing requirement), but then becomes pregnant. Women who do not receive prenatal care are three to four times more likely to die from pregnancy-related complications.[1] Moreover, lack of prenatal care may put some women at higher risk for preterm birth. Infants born preterm are at higher risk for hospitalization and illness than babies born full-term.[2] Most of these births are covered by Medicaid.[3] Based on the evidence that prenatal care improves maternal and infant health outcomes, we strongly recommend that a childless adult woman who becomes pregnant while locked out of the program be immediately made eligible for Medicaid, if she would otherwise qualify.

Cost-Sharing

While we appreciate that the State exempts pregnant women from cost-sharing requirements, ACOG is apprehensive of the overall cost-sharing structure proposed in the extension

application. Research demonstrates that increased cost-sharing has an adverse effect on lower-income populations, particularly those who are eligible for Medicaid.[4] In a review of 65 papers published between 2000 and 2017, the Kaiser Family Foundation found that premiums and other forms of cost-sharing in the Medicaid program are a barrier to receiving and maintaining coverage over the long term.[5] This effect is further compounded for women because of their increased health needs compared to men.[6] Moreover, premiums totaling five percent of annual household income, like what the State is proposing, are unprecedented in the Medicaid program and will be cost-prohibitive for many of our patients.[7]

If implemented, these premiums would be well above the amount allowed in the Affordable Care Act's (ACA) individual market for individuals receiving advanced premium tax credits.[8] We are concerned that women who are required to pay these high premium amounts [those earning between 100 and 133 percent of the federal poverty level (FPL) that have had 48 months of cumulative eligibility coverage], may be dropped from their coverage solely because of an inability to pay. Further, since Michigan chose to adopt the ACA's Medicaid expansion, individuals targeted by this premium policy do not have the option to purchase a Marketplace plan; their income requires that they enroll in Medicaid. These lower-income beneficiaries should not be penalized with higher premiums. The degree of cost-sharing Michigan is requesting is antithetical to the purposes of the Medicaid program, and we urge the State to reconsider its proposed premium policy. If the state insists on implementing a premium policy for its Medicaid beneficiaries, we recommend that the amount be no more than two percent of annual household income.

Workforce Engagement

ACOG does not support the State's work requirement provision, despite the exemption proposed for pregnant women. We believe imposing a work requirement will be burdensome on Medicaid patients with limited resources. Indeed, as demonstrated by the experience of the Temporary Assistance for Needy Families (TANF) program, imposing work requirements on Medicaid beneficiaries would lead to the loss of health care coverage for substantial numbers of people who are unable to work or face major barriers to finding and retaining employment.[9]

Most people on Medicaid who can work, do so, and arbitrary requirements like those proposed in the extension application will not help those who face major obstacles to employment overcome them. Nearly eight in 10 non-disabled adults with Medicaid coverage live in working families, and 60 percent are working themselves.[10] Of those not working, more than one-third reported that illness or a disability was the primary reason, 30 percent reported that they were taking care of home or family, and 15 percent were in school.[11] In addition, these types of work requirements would disproportionately and adversely impact the women currently enrolled in Michigan Medicaid. According to an April 2017 article in *Health Affairs*, if work requirements, like the Michigan proposal in question, were implemented nationwide, almost two-thirds (63 percent) of those at risk of losing coverage are women.[12] We believe it will be incredibly burdensome for beneficiaries to report compliance with the requirements and for Medicaid employees to track whether participants are meeting the program rules. As women's health care physicians, we must advocate against any policy that would jeopardize our patients' ability to access care.

The complexity of the work requirement and how it interplays with the exceptions will likely increase the State's administrative burdens and costs without increasing employment rates. The experiences of TANF and federal housing assistance demonstrate that imposing such requirements on Medicaid beneficiaries would result in few, if any, long-term gains in employment rates.[13] In addition to being ineffective in increasing employment over time, these types of requirements would add considerable complexity and costs to Michigan's Medicaid program. State experience in implementing similar TANF requirements suggests that adding such requirements to Medicaid could cost Michigan thousands of dollars per beneficiary.[14] TANF caseworkers must spend significant amounts of time tracking and verifying clients' work activities and hours, and there is little indication that this 1115 waiver extension application would result in any less burden for the State's Medicaid staff.[15] These additional costs would detract significantly from any anticipated savings and would divert much-needed funds from beneficiary care to cover these new, unnecessary administrative costs.

In addition, we are troubled by the likelihood that physicians will have to provide documentation that proves our patients meet the exemption that they are physically or mentally unable to work in order to maintain their coverage. Increasing the paperwork burden for ob-gyns and other health care providers detracts from our ability to provide patient care and is antithetical to CMS' "Patients Over Paperwork" initiative. At a time when there is increasing reports of physician burnout, placing more administrative burdens on Michigan's health care workforce may make it more difficult to attract and retain qualified medical professionals in the State.[16] We believe that policymakers should be working to reduce barriers for ob-gyns to practice in our State and care for Michigan's Medicaid patients, not placing more in our way.

While we are pleased to see that pregnant women are exempt from the work requirement, and that participation in substance use disorder (SUD) treatment is considered a qualifying activity, we are deeply concerned that the extension application does not include an exemption for individuals with SUDs who may be waiting to receive treatment. SUD is a chronic disease of the brain that requires a coordinated, long-term treatment regimen. Evidence suggests that the longer an individual must wait to get into treatment after their initial contact with the health care system, the less likely they are to attend their first appointment.[17] This is particularly alarming as overdose and suicide linked to opioid-misuse become the leading cause of maternal mortality in a growing number of states.[18,19,20,21]

Many factors contribute to long wait times for SUD services in Medicaid. These include lack of access to qualified providers, lack of reimbursement for Medication Assisted Treatment (MAT), prior authorization requirements, and other federally-mandated prescriber limits. Indeed, the National Survey on Drug Use and Health estimates that in 2016, about 15 percent of all unemployed U.S. adults needed SUD treatment, but only 2.5 percent could access care.[22] Overall, of the 20 million adults who needed treatment in 2016, only 2 million got the help they needed.[23] Imposing a workforce engagement requirement on individuals waiting to receive treatment for SUDs would undermine the mission of the Medicaid program and erode access to SUD coverage for the most vulnerable populations Medicaid was designed to protect. We urge the State to amend the extension application and include an exemption to the workforce

engagement requirement for individuals with SUD who are in or waiting to receive SUD treatment.

Program Financing

According to federal regulations, states must give the public notice of any 1115 waiver application, and that notice must contain "a sufficient level of detail to ensure meaningful input from the public, including…an estimate of the expected increase or decrease in annual enrollment."[24] Similarly, the waiver application is required to include "an estimate of the expected increase or decrease in annual enrollment," as well as "enrollment projections expected over the term of the demonstration for each category of beneficiary whose health care coverage is impacted by the demonstration."[25] Michigan fails to provide this information in its waiver application, and instead states that they expect annual enrollment to decrease, but that "the total number of beneficiaries who will be impacted is unknown." Omitting this data effectively limits the public's opportunity to truly assess the impact of the proposals in the State's extension application. This data must be provided, followed by another state-level, 30-day public comment period, before this waiver is submitted to CMS.

Michigan ACOG Recommendations:

- Revise the waiver to clarify that women who become pregnant while "locked out" will be deemed eligible for Medicaid so long as they otherwise qualify.
- Do not request to impose premiums of five percent of annual household income for beneficiaries earning between 100 and 133 percent FPL.
- Do not request to implement a work requirement.
- Revise the waiver to add an exemption to the workforce engagement and cost-sharing requirements for individuals with SUD who are in or waiting to receive SUD treatment.
- Revise the waiver to include an estimate of the total number of beneficiaries impacted by the policy changes, and begin a new state-level, 30-day public comment period.

Thank you for the opportunity to provide comments on the Michigan Section 1115 Waiver Extension Application. We hope you have found our comments useful. We would be happy to work with your office to develop solutions that both improve health outcomes and reduce the costs in the Medicaid program. To discuss these recommendations further, please contact Matthew Allswede, MD, Michigan ACOG Chair, at Matthew.Allswede@sparrow.org, or Emily Eckert, ACOG Health Policy Analyst, at eeckert@acog.org or 202-863-2485.

Sincerely,

Matthew Allswede, MD, FACOG
Chair, Michigan Section

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[24] 42 CFR 431.408(a)(1)(i)(C).
[25] Ibid.

From: Ryan Burtka
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Monday, August 6, 2018 1:20:38 PM
Attachments: DaVita Comment Letter on Michigan Medicaid Waiver (signed).pdf

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Please see the attached comment letter on the Michigan Medicaid waiver from DaVita Inc.

Ryan Burtka
Kandler Reed Khoury & Muchmore
124 W. Allegan Street, Suite 1700
Lansing, MI 48933
Office: 517/485-4044
Mobile: 313/605-3878

August 12, 2018

Director Nick Lyon
Michigan Department of Health and Human Services
Medical Services Administration
Bureau of Medicaid Policy and Health System Innovation
Attention: Medicaid Policy
P.O. Box 30479
Lansing, Michigan 48909-7979

Re: Healthy Michigan Plan §1115 Demonstration Waiver Extension Request Amendment

Dear Director Lyon:

We respectfully submit the following comments regarding the State of Michigan's Section 1115 Demonstration Waiver Extension Request Amendment, dated July 9, 2018. The DaVita patient population includes more than 194,600 patients who have been diagnosed with end-stage renal disease (ESRD), a group representing approximately one-third of all Americans receiving dialysis services. Spanning all 50 States and the District of Columbia, the DaVita Kidney Care network includes more than 2,445 locations. In Michigan, 1,427 DaVita teammates (employees) have the privilege of serving 6,082 patients. Our comprehensive, in-center care team includes nephrologists, nephrology nurses, patient care technicians, pharmacists, clinical researchers, dieticians, social workers, and other highly-trained kidney care specialists.

BACKGROUND

End Stage Renal Disease (ESRD), or kidney failure, is the last stage (stage five) of chronic kidney disease (CKD). This stage is reached when an individual's kidneys are functioning at 10%–15% of their normal capacity or below and, therefore, cannot sustain life. Kidneys are vital organs that remove toxins from the blood and perform other functions that support the body, such as balancing fluid and electrolytes, and producing certain hormones. When kidneys fail, they cannot effectively perform these functions, and renal replacement therapy, such as dialysis or a kidney transplant, is necessary to sustain life.

The most common type of dialysis is hemodialysis, which is predominantly performed in specialized outpatient facilities. Hemodialysis is a therapy that filters waste products, removes extra fluid, and balances electrolytes (sodium, potassium, bicarbonate, chloride, calcium, magnesium and phosphate), replacing the mechanical functions of the kidney. Traditional in-center hemodialysis is generally performed a minimum of three times a week for approximately four hours each session. Due to the significant impact of dialysis treatment on the body, the resulting fragility of those with the disease, and the amount of time involved in treatment, the proper treatment of ESRD patients under the Healthy Michigan Plan is of critical importance.

ESRD PATIENTS ARE INHERENTLY "MEDICALLY FRAIL" AND SHOULD BE AUTOMATICALLY EXEMPT FROM WORK REQUIREMENTS

As the Michigan Department of Health and Human Services (MDHHS) indicates in its Waiver Extension Request Amendment, the Healthy Michigan Plan (HMP) has extended health care coverage to over 1,000,000 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. In addition to promoting the overall health and well-being of Michigan residents, the program contains structural incentives for healthy behaviors and personal responsibility. Under the Amendment, MDHSS seeks to add workforce engagement requirements as a condition of HMP eligibility for able-bodied adults age 19 to 62. Importantly, however, individuals not impacted by this workforce engagement requirement are those who are "medically frail" in accordance with 42 CFR 440.315.

Federal regulation 42 CFR §440.315(f) provides that a person is "medically frail" if, among other things, the individual has a "serious and complex medical condition." For the reasons noted above, ESRD is a "serious and complex medical condition" and such patients are inherently "medically frail." We are grateful, therefore, that the State of Michigan has set forth an exceptionally patient friendly approach to allow vulnerable patients, such as those with ESRD, to be exempted from the HMP.

Under the Amendment, through a Medically Frail Identification Process, individuals (1) may self-report medically frail status or (2) be identified through a retrospective claims analysis as follows:

- **Self-Reporting of Medically Frail Status**
  - MDHHS would allow individuals to self-attest to their medically frail status through an application. Answering "yes" to either of the following questions would designate an individual as "medically frail":
    - 1) Does the applicant "have a physical, mental, or emotional health condition that causes limitations in activities (like bathing, dressing, daily chores, etc.) or live in a medical facility or nursing home?" (Paper Application)
    - 2) Does the applicant: a) "have a physical disability or mental health condition that limits their ability to work, attend school, or take care of their daily needs?" or b) "need help with activities of daily living (like bathing, dressing, and using the bathroom), or live in a medical facility or nursing home?" (Online Application)
- **Retrospective Claims Analysis**
  - When available, MDHHS will review health care claims data available within its Community Health Automated Medicaid Processing System (CHAMPS) from the preceding 12 months for the presence of select diagnosis codes to identify individuals considered medically frail.
    - Among the list of diagnosis codes that would identify an individual as "medically frail" are N184 (Chronic Kidney Disease Stage 4), N185 (Chronic Kidney Disease Stage 5), and N186 (End-Stage Renal Disease).

We have review several other Medicaid Waiver proposals relating to work requirements for Medicaid beneficiaries – and the "medically frail" exemption processes thereto – and we find Michigan's proposal to be a model in this regard. **We are pleased to support the "medically frail" exemption process in the HMP Demonstration Waiver Extension Request Amendment.**

We appreciate Michigan's efforts to transform the Medicaid program while appropriately taking into account the needs of medically frail individuals. Our comments reflect our sincere desire to make sure that the Michigan Medicaid program is updated through the waiver in a way that best serves the disparate needs of its enrollees. Once again, we thank you for providing the opportunity to provide comments on the Amendment and we look forward to continuing to work with the Department to ensure high-quality Medicaid coverage.

Sincerely,

Michael J. Such, Esq.
Sr. Director, State Government Affiars
DaVita, Inc.
(612) 916-0922

From: Lisa Ruby
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Tuesday, August 7, 2018 1:19:05 PM
Attachments: Healthy Michigan Plan amendment comments to DHHS.pdf

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Hello -

I am attaching my comments on the Healthy Michigan Plan §1115 Demonstration Waiver Extension Request Amendment.

Please let me know if you have any questions.

Lisa Ruby
Michigan Poverty Law Program
220 E. Huron #600A
Ann Arbor, MI 48104
734-998-6100 ext.617

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August 7, 2018

Re: Comments on Healthy Michigan Plan §1115 Demonstration Waiver

To Whom It May Concern:

I am the public benefits attorney at the Michigan Poverty Law Program (MPLP). MPLP is the statewide support center for Legal Services programs in Michigan. As the public benefits attorney, I provide research, training, and litigation support to Legal Services offices statewide and engage in legislative and administrative advocacy. In providing support to attorneys throughout the state, I regularly come in contact with those working with recipients of food, medical and cash assistance and am familiar with the challenges these families face on a daily basis. The purpose of my comments here is to express some of my concerns with the state's proposal to amend the Healthy Michigan Plan.

MPLP supports programs that encourage and assist individuals to work. However, according to an article in the Journal of American Medical Association (JAMA), the majority of individuals who are enrolled in the Healthy Michigan Plan are already working, or they are not able to.[1] The study found that:

- 48.8 percent are employed or self-employed full or part time -- though their incomes were all below 133 percent of the federal poverty level, about $15,800 for an individual and $32,300 for a family of four.
- 27.6 percent are out of work
    - Of these, one-third said they were in fair or poor health
    - Two thirds of those out of work said they had a chronic physical illness, and 35 percent said they had been diagnosed with a mental illness.
    - One-quarter of those out of work said they had a physical or mental impairment that interfered with their ability to function at least half the days in the last month.

- 11.3 percent said they were unable to work. Of these, 73.4 percent reported being in fair or poor health.
- 2.5 percent said they were retired
- 5.2 percent said they were students
- 4.5 percent said they were homemakers

If the majority of Healthy Michigan Plan recipients are already meeting the work requirement or satisfy an exemption, what is the concern? Paperwork. Individuals will be subject to additional reporting and verification requirements, inevitably leading to wrongful cessation of benefits. In my experience, this happens on a regular basis within the existing assistance program structures. Documents are submitted, lost, and then recovered only after a recipient's benefits have been cut off. In addition, Bridges is not a perfect screening system. For instance, Bridges is currently programmed to terminate eligible individuals from Medicaid when there is a change in coding from the Social Security Administration. DHHS is aware of this problem and has attempted, unsuccessfully, to fix it. Impacted recipients have lost their Medicaid despite being eligible. Even wrongful terminations require months of advocacy before benefits are reinstated. In the meantime, access to health care is denied. It is reasonable to conclude that increasing eligibility and verification requirements will lead to more people losing Medicaid and that their health will suffer.

In order for people to be successful reporters, people need to reliably access the verification system. Wage earners making less than 133% of the federal poverty level are low income; they are struggling to meet their obligations on a day-to-day basis. They are less likely to have resources that assist in complying with additional reporting requirements, things like reliable transportation and internet access. In addition, low-wage workers are more likely to have unreliable and inconsistent work hours, making it difficult to consistently meet the 80 hours per

[1]http://ihpi.umich.edu/news/most-who-enrolled-michigan%E2%80%99s-medicaid-expansion-either-already-work-or-can%E2%80%99t-work-study-shows

month work requirement. Hours can fluctuate above and below that 80-hour mark from month to month. But if someone fails to accurately report their hours, regardless of intent, Medicaid will be lost for 12 months.

Reporting requirements alone will lead to thousands of eligible people losing coverage. If the state is truly interested, as it has stated, in growing its workforce, it can invest more resources in the Workforce Development Agency. The proposed amendments to the Healthy Michigan Plan will not incentivize people to seek work; they will simply shrink the current Medicaid rolls. Most residents who signed up for the Healthy Michigan Plan say their health insurance helped them do a better job at work, or made it easier for them to seek a new or better job, in the first year after they enrolled.[2] This is the intended outcome of access to Medicaid. The assertion that work requirements lead to better health outcomes is difficult to grasp when it is clear that it is access to health care that results in a more robust workforce.

The current Healthy Michigan Plan is meeting its goal of increasing access to quality health care, which is in line with the stated purpose of Medicaid. The proposed amendments will do just the opposite, creating an obstacle course for those impacted. Work requirements serve only to remove individuals from Medicaid. It is misplaced to assert, as the state and the director of CMS do, that people who are removed from the Healthy Michigan Plan due to non-compliance with reporting or work requirements don't need the program anymore and/or will "transition" to private health insurance. Most will simply go without insurance.

Thank you for the opportunity to submit these comments. Please contact me if you have any questions.

Lisa Ruby
Staff Attorney

[2] http://ihpi.umich.edu/news/medicaid-expansion-helped-enrollees-do-better-work-or-job-searches

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Wednesday, August 8, 2018 2:03:02 PM

To Whom It May Concern:

My name is [redacted] and I am a mental health care provider in Wayne County. I am writing to you today to voice my opposition to the State of Michigan's changes proposed in its Healthy Michigan Plan §1115 Demonstration Waiver Extension Request Amendment. I believe the proposed changes will have a detrimental effect on those I serve, members of my community, and the State of Michigan as a whole.

Medicaid was enacted over 50 years ago with the goal of expanding access to affordable healthcare to our most vulnerable populations. Now, five years after the Michigan's successful Medicaid expansion, Michigan is considering erecting barriers to care instead of breaking them down.

Lawmakers have crafted the workforce engagement policy with the goal of incentivizing employment among enrollees of the Healthy Michigan Plan (HMP) by adding work requirements to the eligibility requirements. Creating opportunities that help able-bodied people work is admirable, but this bill will not succeed in this aim. Most HMP enrollees (60%) are already working, and only roughly 3% of HMP enrollees could be characterized as choosing not to work. The proposed policy change is similar to the "welfare to work" laws created under the Temporary Assistance for Needy Families (TANF) program. Now, two decades after TANF was enacted, outcomes show that policy changes to that program did not meet their goals because unemployed recipients did not enter, and remain in, the workforce as supporters originally claimed. According to research done by the Kaiser Family Foundation, this is because barriers to employment were not adequately addressed, and these barriers are not adequately addressed for HMP enrollees in the waiver amendment either.

According to a recent U of M study, the majority of unemployed people enrolled in HMP are unable to work due to poor health or chronic health and/or mental health conditions that impair their functioning. Although they may be too sick to work, they may not qualify for exemptions under these proposed changes, or they may face barriers to ensuring they are meeting the exemption requirements. Taking away their access to health care is the last thing these people need. In fact, 69% of HMP enrollees reported that they performed better at work once they got Medicaid coverage, and 55% of expansion enrollees who were unemployed said having Medicaid coverage made them better able to look for work. Ensuring people have access to affordable health care when they need it provides people the solid foundation they need in order to secure and maintain a job.

Finally, these proposed changes will be an economic disaster for Michigan. Because the federal government reimburses 90% of program costs for Medicaid expansion, removing people from the HMP will only save an average of $600 per person each year. Meanwhile, since Medicaid expansion, Michigan hospitals have experienced a $300 million decrease in unreimbursed care costs. The savings is primarily due to Medicaid expansion – people enrolling in the HMP. Because patients receive care covered by Medicaid, and often in less acute settings rather than emergency rooms, they are able to live healthier, more productive lives and save taxpayer money. Lawmakers should focus on policy that helps people stay healthy and contribute to society, rather than remain sick and contribute to expensive unreimbursed healthcare costs, all of which negatively impacts Michigan families and taxpayers.

Please register my comment in opposition to changes proposed in the State of Michigan's Healthy Michigan Plan §1115 Demonstration Waiver Extension Request Amendment.

Sincerely,

[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Oppose Changes to Healthy Michigan Plan
Date: Wednesday, August 8, 2018 2:56:28 PM

To Whom It May Concern:

My name is [redacted] and I am a mental health care provider in Wayne County. I am writing to you today to voice my opposition to the State of Michigan's changes proposed in its Healthy Michigan Plan §1115 Demonstration Waiver Extension Request Amendment. I believe the proposed changes will have a detrimental effect on those I serve, members of my community, and the State of Michigan as a whole.

Medicaid was enacted over 50 years ago with the goal of expanding access to affordable healthcare to our most vulnerable populations. Now, five years after the Michigan's successful Medicaid expansion, Michigan is considering erecting barriers to care instead of breaking them down.

Lawmakers have crafted the workforce engagement policy with the goal of incentivizing employment among enrollees of the Healthy Michigan Plan (HMP) by adding work requirements to the eligibility requirements. Creating opportunities that help able-bodied people work is admirable, but this bill will not succeed in this aim. Most HMP enrollees (60%) are already working, and only roughly 3% of HMP enrollees could be characterized as choosing not to work. The proposed policy change is similar to the "welfare to work" laws created under the Temporary Assistance for Needy Families (TANF) program. Now, two decades after TANF was enacted, outcomes show that policy changes to that program did not meet their goals because unemployed recipients did not enter, and remain in, the workforce as supporters originally claimed. According to research done by the Kaiser Family Foundation, this is because barriers to employment were not adequately addressed, and these barriers are not adequately addressed for HMP enrollees in the waiver amendment either.

According to a recent U of M study, the majority of unemployed people enrolled in HMP are unable to work due to poor health or chronic health and/or mental health conditions that impair their functioning. Although they may be too sick to work, they may not qualify for exemptions under these proposed changes, or they may face barriers to ensuring they are meeting the exemption requirements. Taking away their access to health care is the last thing these people need. In fact, 69% of HMP enrollees reported that they performed better at work once they got Medicaid coverage, and 55% of expansion enrollees who were unemployed said having Medicaid coverage made them better able to look for work. Ensuring people have access to affordable health care when they need it provides people the solid foundation they need in order to secure and maintain a job.

Finally, these proposed changes will be an economic disaster for Michigan. Because the federal government reimburses 90% of program costs for Medicaid expansion, removing people from the HMP will only save an average of $600 per person each year. Meanwhile, since Medicaid expansion, Michigan hospitals have experienced a $300 million decrease in unreimbursed care costs. The savings is primarily due to Medicaid expansion – people enrolling in the HMP. Because patients receive care covered by Medicaid, and often in less acute settings rather than emergency rooms, they are able to live healthier, more productive lives and save taxpayer money. Lawmakers should focus on policy that helps people stay healthy and contribute to society, rather than remain sick and contribute to expensive unreimbursed healthcare costs, all of which negatively impacts Michigan families and taxpayers.

Please register my comment in opposition to changes proposed in the State of Michigan's Healthy Michigan Plan §1115 Demonstration Waiver Extension Request Amendment.

Sincerely,

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Wednesday, August 8, 2018 3:00:42 PM

To Whom It May Concern:

My name is [redacted], and I am a student at the University of Michigan School of Social Work and a mental health care provider in Wayne County. I am writing to you today to voice my opposition to the State of Michigan's changes proposed in its Healthy Michigan Plan §1115 Demonstration Waiver Extension Request Amendment. I believe the proposed changes will have a detrimental effect on those I serve, members of my community, and the State of Michigan as a whole.

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Sincerely,

[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Wednesday, August 8, 2018 8:30:17 PM

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My name is [redacted] and I am a mental health care provider in Wayne County. I am writing to you today to voice my opposition to the State of Michigan's changes proposed in its Healthy Michigan Plan §1115 Demonstration Waiver Extension Request Amendment. I believe the proposed changes will have a detrimental effect on those I serve, members of my community, and the State of Michigan as a whole.

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Sincerely,

[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Thursday, August 9, 2018 10:46:09 AM

To Whom It May Concern:

My name is [redacted] and I am a mental health care provider in Wayne County. I am writing to you today to voice my opposition to the State of Michigan's changes proposed in its Healthy Michigan Plan §1115 Demonstration Waiver Extension Request Amendment. I believe the proposed changes will have a detrimental effect on those I serve, members of my community, and the State of Michigan as a whole.

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Please register my comment in opposition to changes proposed in the State of Michigan's Healthy Michigan Plan §1115 Demonstration Waiver Extension Request Amendment.

Sincerely,

[redacted]

From: Elyssa Koidin Schmier
To: HealthyMichiganPlan
Subject: Comments on Healthy Michigan/Medicaid work requirements plan
Date: Wednesday, August 8, 2018 3:31:05 PM
Attachments: MI DHHS letters.docx

To Whom It May Concern,

Attached you will find the comments from 191 Michigan moms, dads, and concerned Michiganders on the Medicaid work requirements plan proposed by Governor Snyder and passed by the Michigan Legislature.

Please feel free to reach out with any questions.

-Elyssa

--
Elyssa Koidin Schmier
MomsRising
Senior Campaign Director, National Early Learning and Budget
781-608-8795
@ElyssaK
www.MomsRising.org
MamásConPoder

Dear Michigan Department of Health and Human Services,

Plans like those passed by the Michigan Legislature on Medicaid work requirements goes against 50 years and nine presidencies of bipartisan support for the vital Medicaid program. This move could complicate and even eliminate life-saving healthcare for Michiganders on Medicaid, especially the 675,000-plus that are enrolled in the state's Medicaid expansion program for residents with low incomes, the Healthy Michigan Plan. This would put at risk parents, caretakers, and low-income individuals.

Imposing unnecessary and unhelpful barriers to vital health care only sets our families and economy back. This would disproportionately affect low-income families who are just trying to get by and pull themselves out of poverty. No one should be punished for caring for a loved one, being unemployed, going to school, or having an irregular work schedule that prevents them from working more than a certain amount of hours a week. Our children will be affected as well as our economy.

Instead we should be funding job creation and training programs, raising wages, ensuring high-quality, affordable childcare, and passing paid family and medical leave so we can care for ourselves and our loved ones when they need us most and strengthening health care programs so all Michiganders can live to their fullest potential.

Stand with me and protect the healthcare of millions of Michiganders by rejecting Medicaid work requirements!

Elyssa Schmier
645 N. 4th Ave. Unit D
Ann Arbor, MI
48104

Dear Michigan Department of Health and Human Services,

Since it is fact that most recipients of Medicaid who work are paid so little that they still qualify and most of the remainder of eligible people are children and/or the elderly and ill, it seems very harsh to make recipients jump through hoops to get what they are entitled to.

Dear Michigan Department of Health and Human Services,

Please do not enact the Medicaid work requirements bill! This bill would result in lost health care coverage and burdensome red tape for recipients as well as added bureaucracy for Michigan's Department of Health and Human Services. The 675,000 Michiganders on the Healthy Michigan Plan are most at risk of losing their health care if they are unable to abide by the strict work requirements - this includes parents, caretakers, and low-income people.

Dear Michigan Department of Health and Human Services,

This is just inhumane....these people already work and some are unable too! They give tax cuts to rich who do not need it and take from poor....Just what Jesus would do! Right?

[redacted]

Dear Michigan Department of Health and Human Services,

Health care should be free to all.

Medicaid is a necessity for many Michigan people.

Many can't work, many can't even walk.

Once again republicans are adding pain to the American people in exchange for saving money. Money that goes into the pockets of the rich in exchange for the pain of the poor and under privileged. Governor and other republicans, you know no shame. But we the people are ashamed of you and your kind.

Dear Michigan Department of Health and Human Services,

Requiring those who apply for Medicaid to meet work requirements is asking people going into the hospital to run an obstacle course first. Its purpose is not to help but hinder and punish the poor. The work requirement is nothing but a return to the days when poverty was considered a moral failing needing correction, preferably by hurting those in need. It's time to discard this harmful and obstructionist policy. This is the 21st Century. Have we learned nothing in two hundred years?

Dear Michigan Department of Health and Human Services,

I disagree with work requirements to receive health insurance; it is unfair to so many Michigan families who deserve Medicaid as a stop-gap measure to preserve their health needs.

Dear Michigan Department of Health and Human Services,

Medicaid work requirements place an unnecessary hardship on those who can least afford it.

Dear Michigan Department of Health and Human Services,

I depend on Medicaid for my medicine and doctors. I cannot handle working much due to anxiety and depression. The work requirement would hurt many people including myself. I have been on Medicaid for years and it helps pay for things like therapy which I need. Some people may be able to work but I think there are those who cannot. Or at least, cannot manage the number of hours Governor Snyder is proposing. This is a dangerous law that would harm people who depend on Medicaid. I have several health issues in addition to psychological ones. Please, do not approve this law. Thank you.

Dear Michigan Department of Health and Human Services,

Why are the underprivileged in Michigan and elsewhere, that are below the poverty level, being punished for the lumps received in their lives? We ALL know it actually costs higher to take care of the health of these unfortunates when it becomes catastrophic, rather than coverage under Medicaid to help keep them healthy....especially the children, whose whole future is in the balance, and this bad Bill could make or break these people and their children. Why do the people with the power always seem to look down upon and judge those who need a helping hand the most. Deplorable.

Dear Michigan Department of Health and Human Services,

Please protect the 675,000 Michiganders on the Healthy Michigan Plan, who are most at risk of losing their health care if they are unable to abide by the strict work requirements, including parents, caretakers, and low-income people.

Dear Michigan Department of Health and Human Services,

My patients - ill, too mentally ill to work, too cognitively disabled, or elderly and in pain but not old enough for Medicare - will all lose their Medicaid by the work requirements bill. In the past few years, I have helped countless patients to control their diabetes, blood pressure, weight, fatty liver disease. How is post-infart heart disease, renal failure from uncontrolled diabetes or hypertension, or liver cirrhosis cheaper to treat than preventive services? This law is just shifting the financial burden and worsening people's health is the consequence.

Dear Michigan Department of Health and Human Services,

Save medicaid services. I know I need medicaid because I Got sick after retiring. I spent my whole life savings on home care, hospital bills, medical, dr. Bills, supplies, ambulence srvcs, prescriptions, etc. Now, I have nothing left. Medicaid is my last hope. I'm sure others have similar situations, too; and need help as well. We have to really help people that need it.

Dear Michigan Department of Health and Human Services,

Stop hurting the children and women with families who try and take care of them. A lot of women are left on their own to care for their families and not everyone has a high paying job with benefits.

Dear Michigan Department of Health and Human Services,

Medicaid MUST be kept in place for families in need. We are the richest country in the world and healthcare for those who need it shouldn't even be debated.

Dear Michigan Department of Health and Human Services,

My field provides critical home-based services, through Medicaid, for overburdened families of infants and young children, many of whom have experienced multiple traumas and toxic stress (high ACE scores). The support that this Medicaid-funded program affords helps to ameliorate those ACEs and prevent serious (and expensive) problems down the road such as the need special education, health interventions, criminal justice involvement, etc. I urge MDHHS to make it easier NOT harder to obtain/keep Medicaid coverage. The babies would ask you for this if they could!

Dear Michigan Department of Health and Human Services,

Health care is important to our entire population--not just the rich. Do not skimp on health care opportunities for our entire population! Everyone counts.

Dear Michigan Department of Health and Human Services,

Parenting is most important job. There must be no Medicaid work requirements. Parents' work is raising children!

Dear Michigan Department of Health and Human Services,

I disagree on work requirements for Medicaid. This will cause thousands to lose their health insurance.

Dear Michigan Department of Health and Human Services,

Medicaid is there to help those who need help. If it were possible for them to work they would not need the program. Improving the health of all of the most vulnerable helps insure the health of all of us.

Dear Michigan Department of Health and Human Services,

Parenting is most important job. There must be no Medicaid work requirements. Parents' work is raising children!

Dear Michigan Department of Health and Human Services,

A work requirement in order to receive Medicaid? If you're going to require that I work, then you had better give me a job as well, because no one else seems to want to. I've looked for a job, of any sort, for many years and no one has wanted to hire me. Probably because of my physical condition (metal pins in one elbow and missing the tip of one finger, and suffering from diabetic neuropathy). Now I'm 62 and so also have the perceived "disability" of advanced age to contend with. So, tell me again that I'm just a lazy dead beat if I need the assistance of Medicaid, because that's what you're saying with this work requirement.

Dear Michigan Department of Health and Human Services,

Please do not allow red tape to hinder needy Michigander's ability to keep/receive Medicaid insurance. Thank you.

Dear Michigan Department of Health and Human Services,

Its a fact. Stay home if you are sick so you don't give it to your co-workers. Of course if you have something really awful you are not able to work, But those republicant's don't care. If you could make it to some kind of job that would probably kill you and then you wouldn't need Medicaid any more. The perfect republicant solution. I can see the republicant's are all GOOD Christians and practice what they preach. Screw them while they are down!

Dear Michigan Department of Health and Human Services,

Do not impose a work requirement on Medicaid recipients. It is short-sighted and punitive. We all benefit when people get the medical care they need.

Dear Michigan Department of Health and Human Services,

There are too many of us on the fringe income. Special needs seniors we need all the help we can get.

Dear Michigan Department of Health and Human Services,

At some point people have to stand up for what's right, especially those who are charged with carrying out the immoral choices of the state.

Dear Michigan Department of Health and Human Services,

I am opposed to the suggested strict work requirements being proposed by Michigan legislators. It would eliminate necessary help for thousands of Michigan citizens, particularly many elderly people, from getting the help which they so desperately need.

Dear Michigan Department of Health and Human Services,

Please stop the law that would require many Medicaid recipients to work at least 80 hours a month or risk losing their health care. Many people would be unable to fulfill this requirement, often because of situations beyond their control. When more people don't have health care, more people die. Thank you for your consideration.

Dear Michigan Department of Health and Human Services,

How are people supposed to work if they are sick they is a trap just a way to kick people off of Medicaid.

Dear Michigan Department of Health and Human Services,

I disapprove the work requirements for Michigan Medicaid because most recipients are old, disabled, children, or already working jobs that pay minimum wages and don't offer sufficient hours or benefits. This requirement is regressive and harms the most vulnerable while adding oppressive red tape. It's basically a political ploy to blame the poor for poverty. I urge you to disallow it.

Dear Michigan Department of Health and Human Services,

Many low income people, like my daughter, are perfectly willing to work 40 + hours a week. However, employers, such as Wendy's, schedule her to work 25 hours a week or less. Willing workers should not be penalized because employers refuse to give them an adequate work schedule.

Dear Michigan Department of Health and Human Services,

I completely disagree with work requirements in order to receive health insurance. Working poor already have enough challenges. Mediciad is for the most at risk members of our communities. This is harmful to thousands of Michigan families and the fact that the architects of this bill are among the most privileged members of society with jobs that give tremendous security and health insurance is a disgusting testament to the problems of how America views human health services with respect to life, liberty and the pursuit of happiness.

My American neighbor who was a nurse strickened with Lymphoma had to return to work after chemotherapy...too soon...but she could not afford to be thrown off the hospital health insurance for being sick too long. Michigan and American as a whole should be strengthening the Affordable Care Active.

I am an American living abroad for 12 years in The Netherlands and I testify that basic mandatory Healthcare insurance not tied to any employer makes for a better society and community.

Dear Michigan Department of Health and Human Services,

This bill is a haughty and demeaning action against the poor of Michigan. To absolutely take away any medical care for the poor and unable to work, is NOT an act of a Democracy. This extremely cruel bill must be removed from "Healthy Michigan" as Michigan is NOT healthy with it!! Prove that this state does not have tyrannical bill protecting the rich and denying help to the needy.

It makes Michigan look terrible and removes any goodness of "Healthy Michigan"

Dear Michigan Department of Health and Human Services,

As a retired health care practitioner, the plan to force medicaid recipients to work is cold hearted at best and evil at it's worst.

It is still a game of the haves and the have-nots. The haves want to give more public money to their corporate friends by throwing the poor to the streets. You cannot call yourself a good & spiritual human being and do this.

Without compassion, we as a society have lost out way.

Dear Michigan Department of Health and Human Services,

wow employers are only hiring part-time employees which means it is very hard to get in even 24hours per week at minimum wage. NOW you want to require 80hours a month to have health coverage.

THANK You Republicans for giving us little guys the shaft again.

Dear Michigan Department of Health and Human Services,

Medicaid work requirements are a big mistake. Many of those most in need of Medicaid help are unable to workdue to various handicaps or family care responsibilities or to find work.

Dear Michigan Department of Health and Human Services,

People spending Medicaid dollars are often too ill to work. Requiring something from them that may be too difficult or impossible for them to actually do is cruel and may contribute to to their further loss of health. Not to mention the expense of increased bureaucracy and red tape.

Dear Michigan Department of Health and Human Services,

Most people are on Medicaid because they cannot work or can't find work. If they could work they would, but ... Making a work requirement would just negate the whole premise of Medicaid and hurt so many people. If the government thinks people are cheating the system, then investigate and kick off the ones who really do not deserve this help. Don't hurt a lot of people because of a few bad apples.

Dear Michigan Department of Health and Human Services,

Please don't put work requirements on Medicaid! Health is a basic building block that enables people to be able to work, not a privilege!

Dear Michigan Department of Health and Human Services,

PAY CHECKS AT MINIMUM!!!PEOPLE NEED MEDICAID and HEALTH CARE!!!!!

Dear Michigan Department of Health and Human Services,

The Medicaid work requirements shouldn't ever be passed as they will eliminate coverage for families living in need .

Dear Michigan Department of Health and Human Services,

I moved to Michigan to take care of a 57-year-old disabled woman who was too sick to work, and whose retail worker wages did not permit her to afford medical treatment for years before that. Consequently, she was forced into emergency hospital care with lengthy stays four times just to survive. It took an appeal to MDHHS and a judge's intervention for her to qualify for Medicaid in 2014. She is still too ill to work, but may have a chance at returning to the workplace in the future if she continues to be properly treated through Medicaid. Without ongoing treatment toward hopeful recovery, she will not survive due to the almost certainly fatal nature of her condition without proper treatment.

It was a nightmare getting this patient Medicaid coverage back in 2014, but we managed to do it for her through legal process. She was far too sick to manage qualifying on her own, and too sick to manage her daily living needs without ongoing live-in assistance. Getting Medicaid coverage has literally saved her life. The care she's received with Medicaid makes it possible for her to at least participate in Michigan's economy at a very limited level, and have some hope for improvement in her condition, slow and difficult as any improvement has been. I could not have managed to successfully keep her alive in her circumstances and properly care for her without Medicaid and her doctors. Michigan's current ill-founded attempt to demand work requirements for many thousands of people who need Medicaid to survive and stay out of hospitals, but who are too sick to work and too impoverished to afford medical care by any other means will cause a large number of unnecessary deaths, a large increase in homelessness, and a large increase in burdens on their families.

Ultimately, the economic drain on the state will be more burdensome than retaining the current system, as has been shown in studies and reviews by other states.

This is not the economic outcome Michiganders want. The severely burdensome hardships it will create for hundreds of thousands of residents here will have severe deleterious ripple effects, plus additional negative economic consequences Michigan can ill afford while the state continues working to recover from the damage to Its economy wreaked after the last financial crisis and years of manufacturing job losses here.

Dear Michigan Department of Health and Human Services,

as a volunteer at a free medical clinic that assists those in need to apply for and get coverage through the ACA, I have seen the joy people have when they finally get coverage - please allow life with insurance to the thousands in need.

Dear Michigan Department of Health and Human Services,

This is unfair and just wrong because there are many people out there who can't work (and don't qualify for disability). Plus, there are people out there who are already working, but their job limits how many hours they work. Also, there are others who have to stay home with the kids because they can't afford a babysitter.

Dear Michigan Department of Health and Human Services,

Special needs people can'tt work to meet this requirement. This is rediculous and must be stopped.

Dear Michigan Department of Health and Human Services,

Please protect access to Medicaid for all those who need it! Removing coverage based on work requirements does not help people find a job, it puts them more at risk for serious health issues which creates a bigger burden on social services and healthcare.

Dear Michigan Department of Health and Human Services,

This is unworkable, humiliating, unnecessary. This is a program that helps more people than the entire new tax cuts(?). When did stop helping people and only help big corporations? Democracy or corporate state?

Dear Michigan Department of Health and Human Services,

I personally do not use Medicaid but I KNOW IT IS EXTREMELY helpful for family members and people I know. We are supposedly living in one of the wealthiest countries (is that REALLY true!? Maybe for the millionaires and billionaires) ... EVERY CITIZEN and immigrant deserves to receive good quality health care ...To NOT have that available is just a very criminal and cruel practice. We NEED to look to our "Better Angels" in this day and age. AND THE WORK REQUIREMENTS ARE JUST SO UNFAIR AND UNNECESSARY AND, QUITE FRANKLY, SHAMEFUL. Most people would rather be working! But just are not able to because of medical issues.

Dear Michigan Department of Health and Human Services,

I have uncontrolled unconscious seizures and I also have Fibromyalgia and I cannot take care of my self. Let alone keep a job. I used to volunteer for the Arc of Livingston for over 6 years and I loved it; now I am asking the Arc for help; for me.

Dear Michigan Department of Health and Human Services,

675,000 people in Michigan are in danger of losing their health care coverage because people need to work in order to be covered. Is this right and Just? Is this fair? To make people work because some people think there are people who are slacking or being lazy. This is just wrong. What about all the tax breaks the government gives to rich people who do not work either?

Dear Michigan Department of Health and Human Services,

It is a sad state of affairs. Some folks have no one to lean on in times of trouble. They are stressed beyond belief now. This reminds me of throwing out a net to catch fish and having the act kill those varieties we should be protecting. It is so expensive to survive today. These are the very people why don't need more hoops to try to catch them. I am thankful that I was born white, have a college degree and friends and family to sustain me. Women especially are hard pressed to do it all by themselves. Cars and the insurance to cover them are expensive. I can afford a nice car every so many years and the ins. but so many can't. They are screwed. Our politicians have no idea what it is like to live on meager amts of money.

Dear Michigan Department of Health and Human Services,

These suggested changes strike me as being punitive. They hearken back to a racist theme I heard back in the last millennium, that of the "Welfare Queen" who abused the system.

We need to leave that theme behind us in this new millennium and recognize that America needs to fulfill the needs of all.

I am unequivocally against these revisions.

Dear Michigan Department of Health and Human Services,

If they could find a job then things would be good but it is difficult for many to find a job and they need help.

Dear Michigan Department of Health and Human Services,

Depending on someone's record or abilities, healthcare should not come with strings. Many job positions are not full time with benefits~help create a healthier society and encourage employers to offer more benefits as health insurance.

Dear Michigan Department of Health and Human Services,

All the disabled and low income people need this for their healthcare!!!!

Dear Michigan Department of Health and Human Services,

Everyone deserves to have health care coverage. Work requirements are discriminator and hurt the lower income. It is a penalty exposed on people that can't afford health coverage.

Dear Michigan Department of Health and Human Services,

We need to provide support for families who need it, especially those with young children. Support for children is cost effective as well as the right thing to do.

Dear Michigan Department of Health and Human Services,

Medicaid helped me when I was unemployed, and it helps others in that situation.

Dear Michigan Department of Health and Human Services,

WWJD?

Even the Republicans can figure it out. They're just hoping to slither on by. Sleeve.

Dear Michigan Department of Health and Human Services,

I disagree with the work requirements! Health care for parents is vital. Without healthy parents, our children will ultimately suffer.

Dear Michigan Department of Health and Human Services,

Most able people on Medicaid already have gainful employment, additional work requirements will only hurt people who are unable to work. This is not how the richest country is supposed to treat it's citizens. It is cruel, unfair and not the will of the people who sent you to Lansing to represent us.

Dear Michigan Department of Health and Human Services,

All persons deserve to be covered under the ACA. Adding work requirements for persons who are disabled or mentally impaired only hurts Michigan residents who deserve to be covered. The entire community, state, and nation is bettered by more health care not less and we will not accept the dark ages of medical insurance corporations controlling who gets care or not and deciding who dies or not based on corporate greed. America will stand for equality and liberty not death by the almighty dollar. Not in 1776 and not in 2018.

Dear Michigan Department of Health and Human Services,

Medicaid work requirements are antithetical to the whole purpose of the program - to provide coverage for those who are unable, for whatever reason. I am more than happy for my taxes to go to support and provide a decent quality of life for everyone. The financial cost of enforcing such a terrible program would cost far more, and disenfranchise many of our fellow citizens. I very strongly urge that this policy be overturned.

Dear Michigan Department of Health and Human Services,

This is a terrible idea that will cost the state money by adding more bureaucracy and imposing additional hardship on the most vulnerable people. Most people accepting Medicaid are already working at low-paying jobs, or have small children or elderly parents to care for. Those who are unemployed can't just "go out and get a job!" if they are sick or disabled. As already said, any job they find will be low-paying. STOP THIS HORRIBLE LAW PUNISHING POOR PEOPLE.

Dear Michigan Department of Health and Human Services,

The most vulnerable among us do not need additional barriers to getting basic social services. We should be going out of our way to provided additional care to our least fortunate neighbors, not attaching strings.

Dear Michigan Department of Health and Human Services,

As a full time student in college coming from a struggling background, Medicaid work requirements would greatly impact my coverage in a negative way

Dear Michigan Department of Health and Human Services,

Let's be kind to people and spend money where it counts. Don't restrict access to healthcare. We are all humans.

Dear Michigan Department of Health and Human Services,

The health of people should be a right no matter what. We need to worry about the health of citizens as much as we worry about the health of corporations.

Dear Michigan Department of Health and Human Services,

Work requirements must not be required for all Medicaid participants. Many have young children to take care of and can not afford to pay for child care. If they have to pay for child care, that takes away from what they are making at their job. It defeats the purpose of the requirement. Yes they need to be able to eventually be able to work and make money without needing assistance. But with the lack of full time jobs with benefits this not going to happen.

Dear Michigan Department of Health and Human Services,

Work requirements for Medicaid are ridiculous and unnecessary. The majority of folks who work and use Medicaid already work, and those that don't work are either unable to work or take care of their disabled family members. The purpose of Medicaid expansion was to INCREASE the number of people with health coverage. This proposal will certainly DECREASE the number of insured people and increase the burden on hospitals. Please rescind this utterly shameful proposal.

Dear Michigan Department of Health and Human Services,

People should not lose health care because they don't happen to work enough official hours during a particular time period. What happens if a single mom has to stay home with her kids? A caregiver has to spend a week in the hospital with his charge? An employer lays off all of its employees? Michigan should not place administrative hurdles in the way of helping people get health care. I certainly don't want my hard-earned tax dollars going to creating more bureaucracy designed to stop people from getting health care. Study after study from health policy think tanks show that adding work requirements to Medicaid is a penny-wise and pound-foolish strategy and will have real costs for health-care systems, communities, and people's lives.

Dear Michigan Department of Health and Human Services,

No work requirements for Medicaid recipients Please. Those most in need often cannot meet work requirements due to handicaps, family care responsibilities, inability to find or qualify for jobs, etc.

Dear Michigan Department of Health and Human Services,

Do not victimize people who need health insurance. It will cause more bad health in MI. It should be a basic human right.

Dear Michigan Department of Health and Human Services,

It's difficult for me to truly gauge the potential impact of the Medicaid work requirements on individuals, but if someone is disabled to the point that they cannot work it would be cold and cruel to withdraw their medical coverage. Thank you very much.

Dear Michigan Department of Health and Human Services,

The push to remove vital Healthcare access to vulnerable people is disgusting deplorable. These people depend on this service and the idea that someone feels like they don't "deserve" it because of an arbitrary measure of work is misguided.

Dear Michigan Department of Health and Human Services,

Adding work requirements to the Healthy Michigan Plan (our version of expanded Medicaid) would be inefficient and expensive to administer. Adding red tape would leave vulnerable low-income families without heathcare.

Monitoring work requirements is expensive for the state. Keeping track of required paper work (or on-line forms) sets up barriers to healthcare for many low-income people.

Please do not deprive low-income people of healthcare. Healthy Michigan is successful as a health insurance program. Most recipients already have jobs. More red tape would damage this successful Michigan program.

Dear Michigan Department of Health and Human Services,

We disagree with work requirements in order to receive health insurance in Michigan. These requirements would be harmful and could result in loss of health care for thousands if they can't abide by the strict work requirements.

Dear Michigan Department of Health and Human Services,

Discrimination at its worst. Who gets to decide who has to work and who doesn't? What happens if you can't get enough hours? What happens if you are truly to ill or disabled to work? Snyder expanded Medicare for a reason. This is absolutely reprehensible.

Dear Michigan Department of Health and Human Services,

I vehemently oppose keeping people from qualifying for Medicaid if they don't work 40 hours per week. What if they can't find a job? What if their employer won't hire them for 40 hours per week? Many employers refuse to hire full time workers. What if they are a caregiver for another person? What if they are mentally ill? There are too many reasons that disadvantaged people might not be able to work consistent 40 hour work weeks. They should not lose their Medicaid if they cannot. This policy is cruel and wrong. I will not vote for anyone who supports it.

Dear Michigan Department of Health and Human Services,

Medicaid work requirements will inevitably lead to people being denied healthcare coverage who shouldn't be.

Dear Michigan Department of Health and Human Services,

Don't take healthcare away from the people who need it the most. Having healthcare should not be contingent on how many hours you work, or whether you work at all. Healthcare is a human right!

Dear Michigan Department of Health and Human Services,

As citizens we need to ensure the health and well-being of all future citizens.

Dear Michigan Department of Health and Human Services,

I strongly disagree with work requirements in order to receive health insurance. Medicaid work requirements will be very harmful to thousands of Michigan families who will lose access to health care.

Medicaid is health care NOT a work program!

[redacted]

Dear Michigan Department of Health and Human Services,

I completely disagree with these work requirements in order to receive health care. Now to get cash assistance from the state the requirement makes total sense. But for health care? Really? I know way too many good people that this would seriously damage. Myself and my 2 children included.

Dear Michigan Department of Health and Human Services,

I am a nephrologist in Berrien County. Many of my dialysis patients have Medicaid in addition to Medicare. It happens very frequently that their Medicaid is interrupted by paperwork snafus. Many of them struggle with the burden of their disease, poverty, and poor literacy. It is very hard for them to keep up with all the somewhat arbitrary documentation requirements. When they lose their Medicaid, they lose their transportation to dialysis, and end up in the hospital. This wastes resources and places them at risk of dying. The legislature's own evaluation of the work requirement bill shows it will lead to many people losing coverage. I can guarantee from my experience that some will lose coverage they are in fact entitled to simply because of paperwork mistakes. This will hurt the patients and also lead to increased costs to the healthcare system.

Dear Michigan Department of Health and Human Services,

It hurts the person who only can get part-time work, you shouldn't penalize anyone that is trying to work they are trying to do better.

Dear Michigan Department of Health and Human Services,

As a physician who takes care of patients who often are too sick to work, yet don't meet official disability status, I am very worried that this will reduce people's ability to get healthcare when they need it most. Most people would prefer to work over be dependent for healthcare but have extenuating circumstances. The burden of proving they're trying to work will likely be too much for them to navigate. In the end we'll have people without insurance who still need healthcare and either get more in debt paying for Care, put off their care until it becomes an emergency, or end up shifting costs and burdens to the few places that will still Care for the uninsured. My concern is that many will just never get the care at all and their health will suffer from it-making them even less likely to become employed in the future.

Dear Michigan Department of Health and Human Services,

I have a friend near 60 years of age. He has been on Medicaid for 8 years. He is not in good shape, however, he might be dead without the Medicaid helping him with his several surgeries, ER visits, physical therapy for lymphedema, chemotherapy, radiation, regularly scheduled doctor appointments, blood work and prescribed medications. He has a family member who helps him with his transportation and paper work.

MEDICAID IS ESSENTIAL for people who are not physically able to work.

Dear Michigan Department of Health and Human Services,

There was a time when if it hadn't been for Medicaid, I couldn't have gotten the mental health care I needed so that I'd be able to get and hold a job. Not all people with disabilities are ON disability, and under these new requirements, I never would have gotten that help.

Dear Michigan Department of Health and Human Services,

I is interesting that the poorest people in the state are people that they are going after. This is the way the state works, go after the defenseless. Flint, Detroit, Saginaw, Highland Park. All these cities were under State Emergency Management. The Corp. took the best assets, the people were left more impoverished and sicker by mass water shutoffs. Nobody can be healthy without life giving water. Now they want to cut healthcare. It is clear that people don't have transportation or childcare witch the state does not provide. Some people don't even have a supermarket the can get to buy healthy food. This is they way the state set it up. Now they say we need more workers and the only place to get them is work requirements. There is no bottom.

Dear Michigan Department of Health and Human Services,

Everyone should have a right to healthcare regardless of the situation they are in. This would be extremely damaging to many people in Michigan. Please don't let this happen.

Dear Michigan Department of Health and Human Services,

Gov. Snyder fails Michiganders yet again.

Dear Michigan Department of Health and Human Services,

Most people receiving Medicaid are seniors, the disabled and working poor. You're imposing work requirements on those already working and on people who are not able to work.

Dear Michigan Department of Health and Human Services,

Work requirements for Medicaid are BAD! Do not promote legislation that would require them. I have an 88 year old, unemployed father who, due to dementia, would not be eligible for employment anywhere. Do away with work requirements for Medicaid.

Dear Michigan Department of Health and Human Services,

The Michigan Legislature needs to get it's act together. Lost health care coverage is not an option.

Dear Michigan Department of Health and Human Services,

I think that requiring Medicaid recipients to work in order to continue receiving their benefits is shocking, thoughtless, and unjust. So many people with disabilities rely on Medicaid for their treatment, and they are unable to work, not unwilling. Many of them have disability (SSD) payments that are too low to support their medical care! Medicare leaves a 20% copay on every medical treatment, and so many people are unable to afford it.

Please reconsider this Medicaid work requirements bill! It will cause thousands of Michigan residents to lose access to health care that they desperately need and cannot work to afford!

Dear Michigan Department of Health and Human Services,

The mandatory work requirements for Medicaid will put more of a burden on people who are caregivers for children, the sick and the elderly. There will be unintended consequences for strict work requirements that must be explored before implementation.

Dear Michigan Department of Health and Human Services,

Healthcare is a human right. Work requirements are just to make healthcare harder to obtain.

Dear Michigan Department of Health and Human Services,

This is horrible

Let's hope it pans out

[redacted]

Dear Michigan Department of Health and Human Services,

Medicaid is an essential program that helps struggling families and individuals get back on their feet.

Dear Michigan Department of Health and Human Services,

I have lost my insurance due to work requirements I am unable to fulfill. I am physically unable to work and am waiting on a disability hearing, and am now unable to get the ongoing treatment I need to keep my pain levels down and my level of ADL function up. This loss of insurance has been very hard on me, and I have had to stop taking some of my medications because I can't afford them. I feel abandoned by Michigan and have no idea what's going to happen as I have no foreseeable options for obtaining insurance any time soon.

Dear Michigan Department of Health and Human Services,

While the requirements may seem superficially a good idea, as a health care provider I feel undue burden will be placed on recipients. I have seen nothing but positive health impact since Medicaid expanded in Michigan. I anticipate a slip backwards if these requirements are implemented with loss of gains made and impact on some of our most vulnerable.

Dear Michigan Department of Health and Human Services,

We can have a single-payer system in Michigan (and every state) if we would stop giving tax breaks to the wealthy and corporations.

This is NOT rocket science.

Dear Michigan Department of Health and Human Services,

I strongly oppose Medicaid work requirements. Keeping parents, caretakers and low-income people, and their children, healthy benefits all Michigan citizens. Imposing burdensome red tape work requirements as a condition for Medicaid coverage is unethical and creates unnecessary expenses not only for people who are already struggling but also in bureaucracy that must be supported by Michigan taxpayers. As a lifelong Michigan resident, I do not want my tax dollars going for such a bureaucracy. Nor do I want the added costs that will show up in my own health insurance premiums as a result of preventing people from having Medicaid. I find it appallingly unethical to create a harmful system that takes healthcare away from people who need it and cannot afford to get it any other way.

Dear Michigan Department of Health and Human Services,

I understand the impulse to try to reduce the costs of government programs. That's why imposing work requirements on Medicaid recipients makes no sense. Experience in Kentucky proves that imposing work requirements costs government more!

Let's treat our Michigan families and the working poor with respect and stop this needless, expensive assault on their basic human rights.

Dear Michigan Department of Health and Human Services,

I oppose the work requirements to Medicaid. They don’t work, they cost more money and administration than they save, and they harm a vital government program. Stop with the terrible ideas!

Dear Michigan Department of Health and Human Services,

This is cruel, to add a work burden to people who are already suffering or too ill for a job requirement.

Dear Michigan Department of Health and Human Services,

As you add more unnecessary requirements/red tape for Medicare recipients, the increase cost to monitor this will negatively impact individuals that rely on this important benefit.

Michiganders do not need this bill.

Dear Michigan Department of Health and Human Services,

this is immoral

Dear Michigan Department of Health and Human Services,

I can't understand why politicians want to make it MORE difficult for parents and children who cannot afford health insurance to receive healthcare - and in many cases it will cause Americans to LOSE what little healthcare they are now receiving. That is just shameful & disgraceful & immoral. Why punish poor Americans?! Does it make any sense? NO!!!! PLEASE don't do this to people who need help. PLEASE?!

Dear Michigan Department of Health and Human Services,

We do not agree with the Medicaid work requirements because they will in the end cost Michigan taxpayers a lot more than what we pay for Medicaid now, with worse coverage for our citizens. This is simply another case of Republicans hating the poor and does nothing to make our state better or a more desirable place to live.

Dear Michigan Department of Health and Human Services,

Medicaid work requirements will hurt people and cost our communities more money. While some people may game the system, the vast majority of people who use medicaid are doing their best. Let's make Michigan successful instead of hurting people to look tough.

Dear Michigan Department of Health and Human Services,

imagine if you had a 44 year old son who became an alcoholic, only had occasional minimal wage jobs with no health care benefits, and would relapse and end up in an emergency room.

Dear Michigan Department of Health and Human Services,

Medicaid should not have a work requirement for many reasons. First let me start by pointing out that there are people who either are fighting for disability or unable to receive disability who need medical coverage the most but cannot work. Next, there are people like me who suffer from disorders that will allow me to work 40 hours one week and 0 the next. The last point I would like to make is PFAS. I haven't researched where it is popping up but this week I learned that Parchment is at 20 times the acceptable levels and no one knows how long it has been this way. If it dates back to the paper mill I could have been ingesting this my entire life. I now have thyroid issues (no one else in my family does) as well as a slew of anxiety disorders that could have been caused by this poison. We need our healthcare without restriction... it should be a human right.

Dear Michigan Department of Health and Human Services,

Medicaid work requirements have been empirically proven to harm recipients, even those who are able to find jobs. They are often "last hired, first fired."

They often do not make enough to afford child care. They often do not have access to reliable transportation.

This plan is not well-designed to have the intended effect. It IS well-designed to make Americans sicker and more disabled.

Dear Michigan Department of Health and Human Services,

Making a Person with a Medical condition,WORK, is Cruel and Unreasonable! Not all people on Medicaid are SCAMMERS like MOST REPUBLICANS think!

Dear Michigan Department of Health and Human Services,

Medicaid is a health program, not a work program. Some people cannot work even 20 hours per week because of unresolved health issues. If we cannot take care of the weakest among us, what does that say about our society? This bill is a moral issue.

Dear Michigan Department of Health and Human Services,

Medicaid makes a big difference to low income people. I had it for twenty years. My income went up slightly and I ended up with a huge deductible, now I'm rationing my health care. Uninsured medical expenses, regardless of how important they are, don't go toward your deductible.

Dear Michigan Department of Health and Human Services,

Medicaid work requirements are a terrible idea, and counter to the very nature of the program. Medicaid should be there to help the most vulnerable: the sick, the disabled, and those who can't work. Anyone on Medicaid has value as a person, regardless of whether they work. Work requirements will waste resources that could otherwise go towards helping people, rather than punishing them.

Dear Michigan Department of Health and Human Services,

Requiring that people work to receive health care is a bad idea, and will harm everyone in the State of Michigan. When people don't have access to healthcare they delay or avoid treatments they can’t afford, lowering their quality of life and in the end costing all Michiganders more in the form of emergency services. Access to health care obviously results in a healthier community.

Dear Michigan Department of Health and Human Services,

I think they have taken in accout why some cannot work 30 hours a week

Dear Michigan Department of Health and Human Services,

I strongly disagree with instituting work requirements in order to receive health insurance. The requirement would disproportionately burden and harm people in the northern Upper Peninsula, where I live. In an area with few available jobs, finding employment is likely to be impossible for some people; thus, despite their efforts, they will be punished by losing their health insurance. In addition, child care can be expensive and difficult to find, again penalizing families with young children, who need health insurance the most.

Dear Michigan Department of Health and Human Services,

I think these requirements are arbitrary, capricious, and founded on a fundamental misunderstanding about the impact of health conditions on recipients' ability to work. I also believe they violate the equal protection clause of the 14th amendment to the US constitution, since they impose different requirements on Medicaid recipients based on where they live.

Dear Michigan Department of Health and Human Services,

Medicaid has been a literal lifeline for our low-income fellow citizens. I have a friend who was recently able to get Medicaid and as a result is now getting treatment for her diabetes and routine dental care. She's in a stable relationship with a good family practice doctor instead of using emergency rooms the way she had to in the past. When she came back from her last visit to the dentist she was practically crying because it was the first time in her life that she'd gone to the dentist and didn't have a tooth that had to be pulled or even any new cavities

She has significant physical and mental disabilities, including PTSD from a series of sexual assaults, but none with enough medical documentation to qualify her for benefits. She has worked in the past, but she is now in her 50s and has not been able to even get an interview for a job she might be able to handle in the last ten years. There is no question that a Medicaid work requirement would trim Michigan's Medicaid rolls because she is one who would just drop out, convinced that it's hopeless. She would be back to using emergency rooms and would lose what teeth she has left. If she survives to 65 she will come back to Medicaid in much worse health for whatever years she may have remaining at that point.

I won't get into the arguments about whether creating another bureaucracy to enforce the work requirements is economically sensible. As far as I can tell, no one is even trying to justify this on economic grounds. But let me plead, on behalf of my friend, on humanitarian grounds. Our crazy economic times have left far too many of our friends and families behind. While we can work toward a state where there is productive work for everyone able to work, in the meantime we must be sure that our safety net is secure and strong.

Dear Michigan Department of Health and Human Services,

This is an attack on women, who are the caregivers for multiple generations and for sick relatives and are not rewarded with Social Security for their work at home. More cruelty from this gerrymandered state legislature; taking their lead from the Abuser-in-Chief ! Stop the madness now.

Dear Michigan Department of Health and Human Services,

Medicaid helps children and low-income adults get the care they need. Isn't that all you need to know?

Dear Michigan Department of Health and Human Services,

I don't agree with work requirements to receive health insurance. It's an unnecessary burden on people who need this type of health insurance.

Dear Michigan Department of Health and Human Services,

Michigan is STRONGER with Medicaid. Our people need it!

Dear Michigan Department of Health and Human Services,

My children are going to be on this due to medical disabilities. The fact that the rich feel they deserve to have their cake and eat it too, while the rest take it in the shorts is just plain wrong.
Stop cutting and gutting just so some rich waste of flesh can laugh his/her way to the bank for another million dollar withdraw.

Dear Michigan Department of Health and Human Services,

I disagree with the Medicaid work requirements bill that was recently passed. I believe this bill will lead to people losing their health care coverage--a bad idea for both the people involved and the society. It also involves unneeded bureaucracy. I would much rather my tax dollars go to providing health care than to checking to see if someone is working--which a large proportion of able-bodied Medicaid recipients are anyway.

Dear Michigan Department of Health and Human Services,

Stop cutting aid for poor people. It's mean and stupid.

Dear Michigan Department of Health and Human Services,

Healthcare is a basic right. We are all better when our society and our state takes care of the basic responsibilities of seeing that our citizens are healthy. It is arrogant at best to make a law that is burdensome just to ease your mind that someone out there somewhere is taking advantage of the system. As if you do not use every thing at your disposal to ride that line between legal and illegal whether it driving over the speed limit or doing your taxes.

Dear Michigan Department of Health and Human Services,

It is shameful that injured or otherwise disabled individuals should have a mandate placed on their eligibility for a program we all pay to support. This set of bills will inflate government and create more waste as they require more agents to check backgrounds and police recipients. Individuals do not choose to go on public assistance, regardless of what is reported by so-called conservatives. And they would gladly get health insurance from their employers if it were available or accessible. Time and treasure would be better spent on checking the massive overreach into private lives, providing health care and education to all people so that we can all grow to our maximum potential without hindrance.

Do not add a work/school requirement to Medicaid availability.

Thank you for your attention.

Dear Michigan Department of Health and Human Services,

In a country with the largest GDP in the world, every person should have access to health care. And in a country built on the Constitution and Bill of Rights, every person deserves health care. Even the poor and disadvantaged among us. Most people are doing their best with what they have. Don't put more onerous burdens on those who already face enormous odds in our country.

Dear Michigan Department of Health and Human Services,

My husband works full time and I stay home to care for our children. Our family depends on our health insurance through medicaid for vaccinations, and prescriptions, dental care, and emergency room visits when things go wrong. Years ago a family like ours wouldn't have struggled so much. What at happened to the American dream that a working family can afford to pay for their needs a mother can be home with her babies?! Please protect the American working family trying to live a normal life.

Dear Michigan Department of Health and Human Services,

No work requirements for Medicaid recipients

Dear Michigan Department of Health and Human Services,

I strongly disagree with having work requirements to receive Medicaid in Michigan. So many families, some with young children, rely on Medicaid to take care of themselves. Some people simply cannot work or cannot find work and these people deserve to be able to see a doctor when they're sick too.

Dear Michigan Department of Health and Human Services,

Able bodied people not participating in the traditional workforce are frequently doing other things of value to the community. I have friends and family who have provided meals and services to the homeless, rescued dogs, and cared for neighbors' children or elders. Health care should be available to all, not only to people getting a regular paycheck. Please reconsider work requirements for Medicaid- a healthy community benefits everyone.

Dear Michigan Department of Health and Human Services,

The recent work requirements placed on Medicaid recipients is too horrible, dangerous and inhumane for words. What was supposed to be a safety net has turned into a just plain net that will catch up vulnerable people in it if it is allowed to put into action. It is a burden for the administration of health care in the way of more paperwork and bureaucracy and affects individuals who are caretakers for other individuals; work for those who are already working as caretakers! There are many, many reasons why so-called healthy individuals don't have paying jobs, because they already have obligations. And the unskilled labor market here is already abominable. Should a person have to work two or three low paying jobs to keep healthcare? It is lack of union protection that put many of them in that situation in the first place. Right to work, my foot. Right to work for less. Wake up!

Dear Michigan Department of Health and Human Services,

A healthy population is a productive and strong population.

Dear Michigan Department of Health and Human Services,

I really disagree with work requirements in order to receive health insurance.

Dear Michigan Department of Health and Human Services,

Please help the people who need this plan to survive!

Dear Michigan Department of Health and Human Services,

This harmful bill would result in lost health care coverage and burdensome red tape for recipients as well as added bureaucracy for Michigan's Department of Health and Human Services. The 675,000 Michiganders on the Healthy Michigan Plan are most at risk of losing their health care if they are unable to abide by the strict work requirements this includes parents, caretakers, and low-income people. Please don't penalize those who need Medicaid benefits the most. I disagree with and vehemently oppose adding strict work requirements to Medicaid. Health insurance is a right and those who need it most should have access to it without ridiculous hoops to jump through or red tape to navigate. Thank you.

Dear Michigan Department of Health and Human Services,

I am horrified that this Medicaid work requirement bill has passed and been signed into law. This bill would result in lost health care coverage and burdensome red tape for recipients as well as added bureaucracy for Michigan’s Department of Health and Human Services. Most Medicaid recipients *already* work (and work harder than many of us who don't utilize it); this is such a misguided piece of legislation.

Dear Michigan Department of Health and Human Services,

I am against the terrible changes in Michigan Medicaid laws, because they would unfairly impact minority and low income eoe.

Dear Michigan Department of Health and Human Services,

I believe the Michigan Medicaid work requirement is a mean-spirited, punitive law that will penalize many who are not fit to be employed. If Michigan insists on walking down this road, then the legislation must be set up in such a way that work requirements are waived for those for whom satisfying a work requirement is impossible.

Dear Michigan Department of Health and Human Services,

It is so short-sighted to cut medical care for our citizens, not to mention unethical. People need to have access to health care to be contributing members to society. Many jobs are just not paying enough, or providing health care coverage,for their employees to have access to health care. We are falling behind as a nation with our failure to look after our more vulnerable citizens.

Dear Michigan Department of Health and Human Services,

Plenty of finger pointing and lots of blame, but no one wants to walk a mile in the shoes of the poor and disenfranchised. For one reason or another there is a reason. It is our to understand. Leave it to the Have's to place blame and pressures on the Have Not's. Taking care and helping one another is Biblical in Origin and from that we can take hope. No Government and no Politics can ever shelter from our human responsibilities. Stop and ask yourself, WHAT WOULD JESUS DO.

Dear Michigan Department of Health and Human Services,

Most people who can work, do work. This is only going to punish people who already have it rough.

Dear Michigan Department of Health and Human Services,

Some people are unable to work and medicad is from Medicare money leave my money alone and all hard working people

Dear Michigan Department of Health and Human Services,

I disagree with the work requirements in order to receive health insurance. This will be harmful to thousands of Michigan families.

Dear Michigan Department of Health and Human Services,

People who are on Medicaid are on because for some reason or another they CANNOT work! Don’t penalize them for that!

Dear Michigan Department of Health and Human Services,

My adult daughter became pregnant unexpectedly. She was not covered by our health insurance. Thanks to Medicaid she received excellent prenatal care and delivered A healthy child. She and her partner have recently purchased their own home, and she will transfer to his excellent health insurance as soon as they marry. It's simple: do you want to health for our future as a nation? Do the right thing .

Dear Michigan Department of Health and Human Services,

My MIL with Alzheimer's obviously cannot work, yet needs Medicaid for treatment.

My disabled sister can only work a small amount, and needs Medicaid for things that Medicare won't cover.

My developmentally impaired niece is on Medicaid, to cover her therapies that she needs and does not get at their small-town school.

My parents are retired and beginning to show the weaknesses of age; they use Medicaid to pay for some of their health care when Medicare won't cover it.

DO NOT allow this work requirements bill to ruin their lives. They do not have the energy and time to push through red tape proving that they are genuinely unable to work -- why would anyone put that burden on an old woman with Alzheimer's, a severely disabled woman, a little girl who will never mentally grow up, and kindhearted grandparents who worked so hard during their prime that they're now old and worn out? It's cruel, and it will ruin people's lives.

On behalf of my family, and other Michigan families, strike this "work requirement" policy down!

Dear Michigan Department of Health and Human Services,

As a Michigander, it gives me great pride to live in a state with a strong history of providing social services for our citizens. Other states that have added work requirements for obtaining health insurance have not had positive outcomes - it does not support our neediest citizens. I firmly disagree with work requirements for obtaining health insurance and hope DHHS will fight this law.

Dear Michigan Department of Health and Human Services,

As a retired R.N. I've had the unfortunate experience of seeing the effects of families having to choose between seeking treatment for a medical problem for which they have no insurance coverage and hoping it will go away. The severity of the health problem when treatment MUST be sought and its cost far outweighs the expense of routine care and prevention. No parent should be forced to make these decisions.

Dear Michigan Department of Health and Human Services,

Cutting Medicaid would be devastating!!! Because of the ever increasing cost of healthcare, losing Medicaid would be fatal for far too many. Instead of cutting Medicaid it would be far better to cut what the medical field is charging rather than allowing elderly and poor to die in the street.

Dear Michigan Department of Health and Human Services,

I strongly OPPOSE work requirements for Medicaid. They will serve only for force people in need out of Medicaid. Medicaid is a health care program NOT a work program. NO work requirements should get in the way of low-income people getting health care.

Dear Michigan Department of Health and Human Services,

Protect Medicaid for all You have already made serous cuts to life saving medications shakes for eldrrs and hypoglycemia everyone is one step close to homeless if you look at the statistics

[redacted]

Dear Michigan Department of Health and Human Services,

I disagree with a requirement for work to receive Medicaid benefits. It is insensitive and ignorant. As a counselor I know that this is undue hardship for many people with untreated trauma that date back to childhood. Absolutely no!

Dear Michigan Department of Health and Human Services,

I do not even have a family to help care for me. I have severe arthritis and a replaced hip. What if I just plain cannot ambulate? Work requirements are insane and especially cruel in the shadow of the gross upward transfer of wealth to the wealthy by GOP tax legislation (which they want paid for by this and other cuts of benefits to anyone not a millionaire).

Dear Michigan Department of Health and Human Services,

Medicaid work requirements for disabled people is cruel. My older sister is a dialysis patient and cannot work, she needs Medicare/Medicaid to receive life-saving medicines and her treatments. Passing this horrible bill only hurts people, not help them.

Dear Michigan Department of Health and Human Services,

I strongly oppose work requirements to receive Medicaid. In many cases, the person requires Medicaid for the same reasons that work is prohibited. I am appalled my state would play with people's health this way. Shame on the Legislature.

Dear Michigan Department of Health and Human Services,

My 2 adult developmentally disabled adult children are on Medicaid. My daughter was left severely brain damaged from her birth parent's abuse, and my son has Down Syndrome. Do you really think someone is going to hire them? Where do these jobs come from when even physically and mentally whole people are unable to find work? What about the over 60% of our vulnerable seniors in Nursing Homes? Are they supposed to get jobs to qualify? There are states that have already sent out eviction notices to some seniors in nursing homes. Are unprepared and overwhelmed families supposed to care for these seniors suddenly and unceremoniously dumped on their doorstep? Who stays home with them and gives up THEIR job, putting them in danger of needing health coverage assistance? Have you ever cared for someone with dementia 24/7? No rotating shifts, no relief, no help. Too many families already face this reality because they're unable to afford assisted living. Medicaid is their only potential rescue. Back to my personal plea. People with Down Syndrome have a wide range of abilities. Some are TV stars and some struggle to make themselves understood and make themselves learn simple life skills. Also, many on Medicaid already have two and three jobs, none of which offer insurance and they don't make enough to buy insurance. Please find your compassion and humanity when considering work for Medicaid requirements. The percentage of people trying to defraud the system is actually very low, check out the actual facts. Thank you for your time.

Dear Michigan Department of Health and Human Services,

Once you have provided Medicaid recipients with the education to get a job, child care/caregiving, and transportation to get to the job, only then can you think about a work requirement.

Dear Michigan Department of Health and Human Services,

I think the work requirements are an added burden on people already struggling just to get by. While I don't reveive public assistance, I know people who do, and if they were able to find work, they would do so!

Dear Michigan Department of Health and Human Services,

Our families need health care. A healthy beginning gives children a good start in life. They do better in school. They will b healthier adults. All of this makes for a stronger adult population. Don’t be penny wise and pound foolish.

Dear Michigan Department of Health and Human Services,

THIS IS BEING USED TO HURT THE VERY PEOPLE IT SHOULD BE HELPING -
THE MAJORITY OF THE PEOPLE WHO CAN WORK ARE WORKING -

Dear Michigan Department of Health and Human Services,

The state of Michigan should be HELPING not punishing its most vulnerable citizens.

Dear Michigan Department of Health and Human Services,

Low and mid income families need healthcare insurance. Is work necessary? Yes - but there are times when it isn't possible. Keep medicaid in place for all Michigan citizens who need it!

Dear Michigan Department of Health and Human Services,

Hard working, low income people are in need of good health care. The Medicaid expansion made that possible.

Do not chip away at this crucial benefit. Children are covered by health insurance, their parents need to be covered as well. The Medicaid work requirements are cruel, unncessary and costly. Some reports show that it

woudld cost the state more money to monitor this program than the state would save from taking low income working people off the health care rolls.

Dear Michigan Department of Health and Human Services,

Michigan Medicaid work requirements are problematic for a number of reasons. I would like to comment on two.

One, they have the potential to compromise healthcare even for those eligible for exemptions, as it requires recipients to prove they are eligible. I have a mother currently receiving Medicaid who is eligible for exemption under multiple criteria. But she is an older woman with chronic health issues who struggles with basic computer knowledge. Even now she has to battle through red tape to receive services. These work requirements create more red tape--undermining the purpose of Medicaid to increase access. Two, these work requirements require a government infrastructure to manage it. Our governor and state legislators already struggle to maximize the budget as it is. It does not make sense to add more administrative work that costs money that could be used instead to increase residents' access to healthcare. I urge MDHHS to take these issues into consideration.

Dear Michigan Department of Health and Human Services,

I'm writing to urge you to drop work requirements in order to receive Medicaid health insurance benefits in Michigan. Even in a healthy economy, there are many people who are unable to find work. Health or family problems may necessitate solving those issues before obtaining employment. I prefer to give people the option of having Medicaid pay for medical expenses instead of just going to the emergency room for treatment (and thus having the public pay for their services anyway).

Dear Michigan Department of Health and Human Services,

Medicaid is the health insurance that makes it possible for 2.4 million low income people to access health care. They can go to a doctor or hospital, as well as buying medications. This health care is now at risk for this population. In June Governor Snyder signed a rush bill that asks the federal government to allow Michigan to cut coverage for who can least afford health insurance out of pocket. In addition the state wants to impose red tape and 80 hours of work monthly or lose their insurance. Such requirements are for only low income people. I hope that this unconscionable bill dies and the Healthy Michigan Plan will live.

Dear Michigan Department of Health and Human Services,

Stop the strict & harmful changes to Medicaid.

Dear Michigan Department of Health and Human Services,

There are too many p who need the assistance of Medicaid. One if my oldest Son's got Juevenile Diabetes at 16 yrs old. He was covered by CSHC at that time back in 1999-2000. Well, as he turned 18 it was hard for him to continue his on going health care visits, screenings, etc. Medicaid(MDHHS) kept denying & cutting him off. It's sad and embarrassing when our own Government WILL NOT help our own citizen's with lifetime illnesses that really depends on the assistance of health care and LONG term medication to live...How can they work and have life threatening illnesses ? It's like leaving people to die ! How long can they work without proper care, meds, maintenance ? They end up sick, calling off work because they're too sick, hospitalized constantly, etc. They'll lose a job before getting the help they really need. I feel like our Government is just letting people die or in their eyes people are just allowing self destruction to get attention... Who really wants to sit and die ? But when people feel they have NO choices, No help, what are they to do ? And who is going to help them ? Especially the young and Elderly people. America has to do better than that. America used to be a proud, Strong Country who cared for ALL Americans, and ALL people....I feel our country has weakened and been broken by self destruction with our Government. We need the right people in the right places to strengthen our country once again for ALL mankind,the human race, and Justice for all. To soley and proudly do what's right for longevity of life. Thank you !

Dear Michigan Department of Health and Human Services,

Low-income people do all they can to earn a living and sometimes have to work multiple jobs just to barely get on! And often they cannot find suitable or affordable child care so that they can work all those hours at outrageously low pay! To add this work burden in order for people to obtain much-needed medical care is immoral!

Dear Michigan Department of Health and Human Services,

Being poor and/ or disabled is not a crime. Punishing people who need assistance is abhorrent. Many people on.Medicaid already work. It's due to their low wages that they need the extra help.

Healthcare should be a right in this wealthy country.

Dear Michigan Department of Health and Human Services,

It's difficult for people with disabilities to find a job period, let alone a full time position that fulfills the work requirements.

Dear Michigan Department of Health and Human Services,

The Michigan Legislature has passed their terrible, horrible, harmful, and unnecessary Medicaid work requirements bill, which was signed into law by Governor Snyder in June. This bill would result in lost health care coverage and burdensome red tape for recipients as well as added bureaucracy for Michigan's Department of Health and Human Services. The 675,000 Michiganders on the Healthy Michigan Plan are most at risk of losing their health care if they are unable to abide by the strict work requirements, this includes parents, caretakers, and low-income people. This is UNACCEPTABLE and SHAMEFUL!

Dear Michigan Department of Health and Human Services,

Keep Medicaid for all children and disability and oldest ppl too they need their supportive through their keep Medicaid health ins it's important for them cause they can't afford any medical of their low income ... thank you

Dear Michigan Department of Health and Human Services,

People who are unable to work at all most often suffer from mental illness and/or are victims of the opioid crisis. They are the ones who need medical assistance most. Cutting Medicaid for these - the poorest, most unfortunate and vulnerable members of our society is not only cruel and inhumane, but it shifts the entire financial responsibility to the hospitals. In addition, treating these patients only when they present to the emergency room in life-threatening situations ends up being expensive and inefficient.

Dear Michigan Department of Health and Human Services,

Medicaid coverage is critical to a very large number of low income families and individuals with disability conditions. Those who do not work, do so because they are unable to work. Rather than punishing large categories of medicaid recipients, add investigators and refine procedures to determine scofflaws. Adding work requirements would cruel and some cases life-threatening.

Dear Michigan Department of Health and Human Services,

I think it's a war on the poor and middle class and we should do everything in our power to help those who need assistance than make it impossible to get the help they need!

Dear Michigan Department of Health and Human Services,

The government created illness in Flint. Now you're stopping protection of the sick. Callous. callous. A denial of the Right to Life, which your party hypocritically pretends to support. Are you going to provide union wages for those on the work requirement? If not this will give employers (who are dunsing your campa8gns an incentive to fire more peole, expanding unemployment). Let public officials dig ditches before they get government pensions.

Dear Michigan Department of Health and Human Services,

Medicaid is an incredibly important for so many, as is Medicare and Social Security. I know the ultearich don't want to pay taxes, but we ALL need to pay OUR share

I do it, as someone who is definitely paying my fair share with pleasure. One NEVER knows when a person might just need it!

Dear Michigan Department of Health and Human Services,

I think that the 675,000 Michiganders on the Healthy Michigan Plan are unemployed not because they chose not to work. They are unable to get a job because most of them have mental disorders. Because of these mental disorders they are also unable to claim disability benefits. in my opinion, the passing of this bill will have therefore, a devastating effect on this vulnerable group.

Dear Michigan Department of Health and Human Services,

I truly believe that all people have the right to have affordable health care. If we expect that Medicaid recipients work more hours for this right, we need to be sure that they have quality affordable day care and transportation. Also, that they have the emotional and physical health to work. I don't see enough support for these challenges. Most people want to work. We can not take their health care away.

Dear Michigan Department of Health and Human Services,

My greatest concern is that the imposition of these strict work requirements will result in the denial of healthcare to our most vulnerable citizens. Access to healtjcare is a human right, NOT a privilege reserved for the middle amd upper classes.

A government with vision recognizes that healthy citizens who are treated with respect are much more productive than they would be if their access to healthcare is denied and they are assigned to a 2nd class status. Why would any elected official think this is right?

Dear Michigan Department of Health and Human Services,

There was a time when we were asked to respond to Health Care Plans for Michigan Families. We would read the requirements and put our "Stamp of Approval" on the Plan. Recently, however, the tables seem to have turned for the most needy of Michigan Citizens. The Legislature and Governor have attached a series of requirements in order to receive Health 'Benefits. These "work requirements" are unnecessary and harmful and appear to be so strict as to make one wonder if the Governor and the Legislature are interested at all in making decent Health Care possible for Michigan families, or just giving the outward appearance of actually caring for the Citizens of Michigan.

This "Plan" is an insult to the People of Michigan. The Legislature should be ashamed to even put forth such a plan full of RED TAPE and ADDED BUREAUCRACY TO WHAT COULD HAVE BEEN A WORKABLE PLAN FOR THE PEOPLE OF MICHIGAN! The "Work Requirements" in this plan are a slap-in-the-face to all residents and send the message, "We really don't care about you--just ourselves!"

I sincerely trust that the Michigan Department of Health and Human Services will make the necessary changes to this Medicaid Bill that would honor each person touched by this bill and offer Medical Care that is feasible, and easily attainable by the good people of Michigan.

From: [redacted]
To: HealthyMichiganPlan
Subject: Ccomment on work rule
Date: Thursday, August 9, 2018 10:02:55 AM

As a former recipient of medicaid who is currently responsible for two young ladies aged 21 I want you to understand that until you have a fairly decent public transportation system AND fix the catastrophic cost of auto insurance, you cannot ethically institute a work rule.
Even though we happen to live [redacted] from the main bus route [redacted] the bus makes very few deviations from that road.
That means for any destination that is not within a block of that road you are looking at walking to get to any job--very few of which want to locate near Saginaw (with the exception of Grand Blanc and Mt Morris) because the area looks like a war zone (I'm not exaggerating).
Both girls work, one luckily about a block away at Subway in Mt. Morris. The other at [redacted], 3.5 miles away. Due to problems with her growth when she was young she has issues with her knees--not enough to be disabled, but enough that she certainly couldnt walk that distance.
Not that it's safe for a 21 year old young lady to walk that distance alone. Are you kidding me? Have you heard of human trafficking? Not to mention the increase in hit and run accidents, again due to the catastrophic cost of insurance.
These are two typical kids who dont earn enough to afford cars and gas much less insurance for work transportation. The average cost of a used car is edging up around $30,000 (again, no exaggeration, heard it on the radio yesterday).
The daughter who works at Subway also goes to Mott. She regularly plans to catch the bus 60-90 minutes prior to needing to be there because that is how long it takes to make the trip the mere 8.2 miles from here to there. Now factor in that amount of time for any job, PLUS walking time and its completely unreasonable to assume that people have transportation available to and from work. Some of these people will have small children who will need day care. How will they work that into the schedule if they have to take the bus? Just think about the logistics of it--it's staggering to imagine how that could possibly happen? Factor in getting to the grocery store a couple times a week? Impossible.
Now this is in a metro area like Flint that actually has a transportation system. Implementing the work rule in a rural are without one is just asking for disaster--there is now way it's going to work.
I hope you will seriously consider the many factors that go into having a job before you legislate what is impossible for people to do.
Sincerely

[redacted]

From:	HealthyMichiganPlan
To:	Boyce, Craig (DHHS); Prokop, Jackie (DCH) (prokopj@michigan.gov); Green, Kellie (DHHS); LaPres, Marie (DHHS); Prokop, Jackie (DHHS)
Subject:	FW: Demonstration Extension Application Amendment
Date:	Thursday, August 9, 2018 9:33:32 AM
Attachments:	Image08-08-2018-075003.pdf

Comments from Henry Ford Health System…

From: Kutter, Elizabeth <ekutter1@hfhs.org>
Sent: Thursday, August 9, 2018 9:11 AM
To: HealthyMichiganPlan <HealthyMichiganPlan@michigan.gov>
Cc: Valade, Diane K. <DVALADE1@hfhs.org>; Corriveau, Marc R. <Marc.Corriveau@hfhs.org>
Subject: Demonstration Extension Application Amendment

To Whom it May Concern,

Attached please find comments on behalf of Henry Ford Health System regarding the §1115 Demonstration Waiver Extension Request Amendment.

Should you have questions, comments, or concerns feel free to reach out.

Thank you in advance for your consideration,

Elizabeth

Elizabeth Kutter
Manager, State and Federal Government Affairs
Henry Ford Health System
ekutter1@hfhs.org
313-574-1375

August 8, 2018

MDHHS
Medical Services Administration
Bureau of Medicaid Policy and Health System Innovation
Attention: Medicaid Policy
P.O. Box 30479
Lansing, Michigan 48909-7979

Re: Healthy Michigan Plan §1115 Demonstration Waiver Extension Request Amendment

Submitted electronically to healthymichiganplan@michigan.gov

Dear Sir or Madam,

On behalf of the more than 30,000 employees of Henry Ford Health System (HFHS), I am writing to express our concerns with the Healthy Michigan Plan (HMP) §1115 Demonstration Waiver Extension Request Amendment. HFHS actively advocated for many policy changes to Senate Bill 897 (now Public Act 208 of 2018), which gave rise to the §1115 amendment. While several of our policy suggestions were incorporated into the final bill, we remain concerned that the Medicaid work requirements for the HMP (expanded Medicaid) will have an adverse impact on the most vulnerable patients we serve.

As one of the nation's leading academic and integrated health systems, HFHS, headquartered in Detroit, Michigan, serves patients across Southeastern and South Central Michigan, with five acute-care hospitals, one inpatient psychiatric hospital, and an extensive network of medical centers, emergency rooms and outpatient services. Our over 1,900 affiliated physicians, comprised of the employed Henry Ford Medical Group (HFMG) and the extended Henry Ford Physician Network (HFPN), focus on delivering high quality care while reducing medical costs through collaborative best practices, evidence-based medicine and improved efficiency.

Across our healthcare system, almost 20% of the patients we serve have Medicaid coverage (Traditional or HMP). Medicaid and the HMP have been successful in improving access to health care coverage and reducing Michigan's uninsured rate among low-income individuals. Access to health care coverage is associated with an array of beneficial effects: having a regular doctor; receiving timely preventive care services; better management of chronic health conditions; improved health status, particularly among people with chronic health problems; greater workforce participation; and longer life-expectancy. By the end of 2015, enrollment in HMP reached 613,000 statewide, and total Medicaid enrollment (both traditional Medicaid and HMP) was over 2.37 million, an increase from 1.93 million in April 2014 when HMP launched. In Wayne County, headquarters of HFHS, Medicaid enrollment grew from 28.9% to 36.4% following Medicaid expansion in the state.

Given the magnitude of the proposed change, we believe the work requirements should be introduced with careful consideration of the impacts on the most vulnerable people in Michigan. While we support the underlying concept that able-bodied individuals who receive government-sponsored health care coverage should make an effort to work, we are concerned that the addition of work requirements to the HMP

program, as required by PA 208 of 2018, will reduce the number of vulnerable people enrolled who would otherwise be eligible for HMP coverage. This will have the unfortunate effect of increasing the number of uninsured in the state, slow down the gains in health coverage we have experienced, and negatively impact access to health care services for people who may be most in need.

Our specific concerns with the proposed HMP amendment are provided below.

- Mandating work activities represents a dramatic departure from Medicaid policy over the past 50 years. The Kaiser Family Foundation analysis of the March 2017 Current Population Survey finds that, among non-elderly Medicaid adults: 42% are working full-time, 18% are working part-time, 12% are not working due to caregiving, 6% are not working due to school attendance, 14% are not working due to illness or disability, and 7% are not working for other reasons.[1] Given that about 60% of people on Medicaid already work at least part-time, and only 7% may actually be subject to the requirement as proposed, it is not clear that adding work requirements will result in a measurable improvement in the number of people working, once exemptions for such things as health conditions, disability, caregiving, and school attendance are considered. Given this uncertainty, we suggest that the work requirements be implemented as a pilot or demonstration project that is time-limited and includes population and potentially geographic targets. As part of the pilot/demonstration evaluation, we believe a cost-benefit analysis should be conducted to determine if the costs to implement, administer and evaluate the work requirements exceed the Medicaid program savings and other potential program benefits such as getting people to work.

- The work requirements will increase administrative burdens of the Medicaid program for the state, HMP beneficiaries, and health care providers. The state will need to pay additional staff to develop, implement, and monitor compliance with the new work requirements. People on Medicaid who are already working, in addition to people who newly meet qualifying activities or qualify for an exemption, will have to document and verify compliance on a monthly basis. This increases the burden on HMP beneficiaries to meet reporting requirements, in addition to the actual work requirements. HFHS is concerned that some eligible HMP enrollees will lose coverage due to the complexity of meeting administrative requirements, including individuals with serious health conditions or disabilities that qualify for an exemption. The loss of HMP coverage for noncompliance with the work *reporting* requirements may be disruptive to a HMP beneficiary's health care treatment. This will also be a burden for health care providers, who will have to figure out how to manage care for patients who move in and out of the HMP program, potentially disrupting continuity of care for serious medical conditions, including substance use disorders. Health care providers may also have to absorb the cost of care when these individuals lose their coverage. Loss of HMP coverage for people in these situations is not an acceptable outcome for a program whose primary purpose is to improve access to health care and coverage.

  For health care providers like HFHS, we expect that many patients will show up at our doors, thinking they have HMP coverage, but have a lapse in coverage that they were not aware of. This adds an administrative burden to providers, to help these patients sort through the HMP eligibility requirements and enrollment requirements, when we should be focusing resources on their care. Also, as a result of treating more uninsured patients, HFHS and other healthcare providers across the state will see a rise in the amount of uncompensated care provided.

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[1] Musumeci, MB, Garfield, R. and Rudowitz, R. Medicaid and Work Requirements: New Guidance, State Waiver Details and Key Issues. Issue Brief. January 2018. Kaiser Family Foundation Issue Brief. Retrieved on March 23, 2018 from http://files.kff.org/attachment/Issue-Brief-Medicaid-and-Work-Requirements-New-Guidance-State-Waiver-Details-and-Key-Issues.

To avoid these potential complications, we recommend that enrollment rules and documentation and reporting requirements be simplified and streamlined to ensure that barriers to enrollment are not created for people who are eligible, and who may be suffering disabilities and severe health conditions.

- HFHS is concerned about the impact of changes to the cost-sharing requirements for enrollees who have had 48 months of cumulative eligibility. Research indicates that requiring individuals on Medicaid and CHIP to pay a premium creates additional barriers to access, often results in additional administrative burden on states to collect owed premiums, and most importantly has resulted in reduced use of care – particularly necessary services.[2] Further, individuals are frequently found to utilize more high-cost health care alternatives because they often let treatable acute or chronic conditions spiral out of control. HFHS believes in the importance of accessible health care, and we promote healthy behaviors in the communities we serve. Instituting changes to the cost-sharing requirements for enrollees beyond the 48 month limit could jeopardize the continuum of care our patients receive now.

- HFHS is deeply concerned about the implications a denial of the §1115 amendment by CMS could have on the program. Michigan has seen great growth in the number of people with healthcare coverage since the inception of the HMP and we do not want this successful program put at risk of being eliminated if the work requirement waiver is not approved. The HMP is often cited as a model for successful expansion of Medicaid to working people who cannot afford to buy private health care coverage. We do not support any plan amendment that could put those covered lives at risk.

We would be happy to discuss our concerns with you in more detail, and are committed to continuing to work with the department and other stakeholders to find solutions. Please contact Marc Corriveau, Vice President, Government Affairs at 248-921-2003 or marc.corriveau@hfhs.org to arrange a meeting or conference with the HFHS team if you are interested in discussing our concerns in more detail.

Thank you.

Sincerely,

Robert G. Riney

Robert G. Riney
President, Healthcare Operations & Chief Operating Officer
Henry Ford Health System

[2] Artiga, Samantha et al., The Effects of Premiums and Cost Sharing on Low-Income Populations, http://files.kff.org/attachment/Issue-Brief-The-Effects-of-Premiums-and-Cost-Sharing-on-Low-Income-Populations

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Thursday, August 9, 2018 9:13:10 AM

Healthy citizens are more likely to be productive citizens in the long term. In the short term, maintaining health or addressing health issues should not be contingent upon immediate availability for work, nor for seeking employment and/or education.

Healthy citizens should be a priority for many reasons important to the economic health of our state and country, such as the cost of untreated health issues and overuse of emergency rooms. Further, if the legislature were truly committed to filling the workforce gap in Michigan they would concentrate on improving skilled trade education, public transportation, quality and affordability of childcare, and raising the minimum wage. Not to mention reinstating the prevailing wage law and passing an infrastructure bill.

Until Michigan (and the country at large) can address these chronic barriers to work for many families - adding the burden of losing healthcare is counter-productive, not to mention mean spirited.

[redacted]

Sent from my iPhone

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Thursday, August 9, 2018 9:26:26 AM

I disagree with the premise that forcing people to work for 20 hrs a week, on average, should be the entitlement for Medicaid benefits.

Most people who earn between 100% and 133% of the HMP eligibility probably work in jobs that do not offer health insurance, or the cost is so high that they can't afford it. A single person earning $16,000 or less makes $307.69 each week before taxes, or essentially minimum wage for 40 hrs if they can get 40 hrs. After taxes it's barely enough to survive on. If they have children they can't even afford day care or babysitting costs on top of health insurance. THEY ARE ALREADY WORKING and can't improve their lives with the low minimum wage in Michigan.

Medicaid expansion in our state brought health insurance to over 600,000 people. Do you think those people now don't still need an affordable health care plan?

This is not a "hand up" nor is it a "hand out". Without any additional sources of affordable health insurance in Michigan you will simply be moving the state back to where it was before the expansion of Medicaid.....a lot of uninsured citizens who cannot afford health insurance for themselves or their children, including the preventive care they need to stay healthy.

From: [redacted]
To: HealthyMichiganPlan
Subject: no problem
Date: Thursday, August 9, 2018 9:39:54 AM

I have no problem with requiring able bodied adults enrolled in the Healthy Michigan Plan to work for an average of 80 hours per month to keep benefits or participate in job training, education, internships, or community service and certainly not actively job searching.

Some of these people might actually find they are employable, they can work, they can earn a living. Question is will it be more than they are raking in now.

[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Medicaid work rules
Date: Thursday, August 9, 2018 9:52:37 AM

I do NOT favor changing the Medicaid eligibility rules to require recipients to work....unless you are at the same time planning to increase job training, transportation, child care and workshop opportunities for people with disabilities. Most of the people on Medicaid are children. Many of the others are unable to work for physical or mental health reasons, or because they are poorly trained and have no way to get to a bare-bones job, or if they accept a minimum-wage job, they won't be able to afford decent child care. Almost all of those not already covered are willing and able to work, if they could find a job. This is a cruel and heartless bunch of legislation.

[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: "Healthy Michigan" Plan
Date: Thursday, August 9, 2018 9:53:30 AM

I was a welfare recipient as a child of divorce and as the 3 years' married mother of a 3-month old whose husband left and never paid a penny of support. Back in 1970, I was able to finish my remaining 9 months of a degree while on ADC (not allowed since) and get a job as an ADC caseworker! I am certain that the taxes I paid on the next year's income easily repaid every penny of the welfare.

As a caseworker, I found more recipients trying to work when they physically should not have than the maybe one person trying to "milk the system." One woman wanted a factory job, but no, the system wanted to train women for cutting hair or LPN, neither of which could ever get anyone with even one child out of poverty. And the system has not been improved and now the ax is out again.

Instead of requiring, how about inviting? How about having the Chamber of Commerce to list specifically all of the jobs it says are going begging and to work with organizations to recruit (that "invitation" again) from the handful of "able-bodied" remaining after exclusions and to provide the necessary counseling, training, transportation and child care to enable that result.

Article I, section 8 **of the U. S. Constitution** gave Congress the power to "lay and collect Taxes, Duties, Imposts, and Excises, to pay the Debts and provide for the common defense and **general Welfare of the United States**." When "welfare" had a positive meaning and included health and safety.

[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Thursday, August 9, 2018 9:54:04 AM

I am a 55-year-old widow who receives Medicaid. After my husband passed away, I couldn't afford the COBRA. This proposal to make Medicaid recipients work at least 30-hour weeks will cause me to lose my Medicaid. If I could work, I wouldn't need Medicaid. I am housebound, I have no family to help me, I try and find work-from-home jobs but they aren't enough to even support me and they don't offer health insurance.

This proposal doesn't make sense and is antithetical. Shame on our legislators for putting a burden on people who are already trying their best to make it through each day while they most likely live comfortably on their large taxpayer funded salaries and health insurance.

I recently read the following comment online and I agree with it:

[redacted]

While I have generally supported some type of work/training/public service requirement for adults receiving cash benefits, I am concerned that this is a different situation. Individuals who are eligible for Medicaid do not get a cash benefit, the beneficiary is the doctor or hospital that provides care if they are ill or injured... if we remove lower income individuals from medicaid, we still pay for their health services when they can't, just in the form of higher medical bills and health insurance premiums. Medicaid is not just for the recipients, it is for health care providers and hospitals that care for low income individuals.

[redacted]

From: [redacted]
To: [redacted]
Subject: Demonstration Extension Application Amendment
Date: Thursday, August 9, 2018 10:02:27 AM

This is a terrible idea. To make requirements on recipients of Medicaid is a terrible idea. Please, let us look at civilized societies around the world and emulate them. Let's move forward, not backward in time.

[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Thursday, August 9, 2018 10:25:57 AM

I'm shocked that some people still think medicaid recipients don't deserve help if they don't work. How can we forget kindergartner [redacted] killed by classmate [redacted] mother had to work to qualify for benefits. She couldn't care for her son. Her brother agreed to watch him. [redacted] got his uncle's gun and killed his classmate. Two families plunged into grief and shame and tragedy because politicians thought only the workers deserve benefits.

Thank you for considering this comment.

Sincerely,

[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Thursday, August 9, 2018 10:15:17 AM

As a person who worked for DHS for five years, I see this program as a system to set people up to fail. For people who've never worked in that system, I can see where this would make sense, but if you've ever had to get something accomplished like getting forms in on time or making an appointment that someone else made for you, as is what happens in the DHS system, you know that many people are not going to stay insured just because you have a worker that is not able to manage their overwhelming workload. I personally feel that this program is a waste of state money and is only adding more layers to the already confusing system. It's going to create hardship for people who are just trying to survive in some cases in their particular current situations. My experience was that most people that came in weren't happy to be in the situation they were in, were extremely frustrated by the whole process and were made to feel less than what they were. This program will only reinforce that and unfortunately take healthcare aware from our most vulnerable citizens because of the red tape.

Thank you for allowing input.

[redacted]

Sent from my iPhone

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Thursday, August 9, 2018 10:28:39 AM

Medicaid in Michigan should not have a work requirement for a variety of reasons. Among those:

- Michigan citizens who are eligible for Medicaid already face daunting life situations. I believe most of them would work if they could.
- My siblings and I would have been hard pressed to take care of our mother without Medicaid. And at 96 years old, Mom couldn't work. Families like ours need Medicaid to help care for the people we love.
- Simply because a job is open doesn't mean a Medicaid recipient is qualified or able to do it. I am retired and would love to find a part-time job, but I can't stand for long periods of time so my opportunities are limited. I expect situations like that are true for many people.
- Medicaid is not – and should not be – a work recruitment program.
- When did taking care of our most vulnerable citizens become a partisan issue?
- If funding is the primary issue, raise taxes. I, and I expect more people than you think, am willing to pay more in taxes to help people who need help.

[redacted]

She who has a garden and a library wants for nothing. ~ Cicero (mildly edited)

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Thursday, August 9, 2018 10:28:53 AM

I strongly oppose the proposed “work rules” for Medicaid recipients.

1. There is no justification to implement these rules. They are based on an invalid assumption that recipients are “gaming” the system in some way.
2. The requirements will have an out-sized impact on communities of color, the elderly, and disabled recipients for the following reasons:
    a. Lack of available jobs in these communities.
    b. Lack of available jobs that offer accommodations for people with disabilities.
    c. The documented fact that employers are hesitant to hire older workers. And when they do, the pay scale offered is far less than what they would offer to a younger worker.
    d. Lack of transportation resources to get members of these communities out to where the jobs are located. Many Medicaid recipients have limited income with little to no access to public transportation.
    e. Excessive paperwork to “prove” that recipients are actually working and eligible.

[redacted]

Thank you.

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Thursday, August 9, 2018 10:33:25 AM

Work requirements are a terrible idea. They don’t save the state any money, they only hurt people that Medicaid was supposed to help. Please make them as loose as possible so that it doesn’t hurt the disabled.

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment"
Date: Thursday, August 9, 2018 10:33:50 AM

I agree overall with a 20-hour work requirement as long as it includes provisions for the following

Unemployed but healthy job seekers show 20 hours of job search. Logs similar to the UIA (unemployment insurance agency) would be helpful. Allow time in the 20 hour requirement for research, travel time to and from applying or interviews, preparing cover letters/resumes and job testing requirements by employers, travel time for drug tests, and completing applications.

Tie into the work requirement after 12 weeks of job search, that they must begin applying for a job on the listing of area employers needing workers.

Also, my biggest concern are for situations where a recipient is unable to work. What happens when a person is required to be off work for medical care?. Issues such as maternity leave, surgery, etc.

What about situations where the person is a full-time caregiver for a person that medically needs around the clock care?

Will those factors be taken into consideration?

[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Thursday, August 9, 2018 10:43:23 AM

Thank you for requesting feedback.

I am all for having work requirements to receive free healthcare. Government (state and local) do such an excellent job of enabling people. Make people get out there and get a job in order to receive free stuff. My husband, myself, and my two adult children work very hard and have to pay for our healthcare.

Many of these people getting free healthcare are working under the table or are being supported by their parents and they have no desire to work. The economy is thriving so make them work for healthcare....just like myself and everyone reading this comment.

Enough is enough! They get food stamps, free medical, free housing through MSHDA, their utility bills paid for, etc. The list is endless and it's the working people that are paying for their lack of ambition and laziness.

I'd like to see the work requirements expanded to adults with minor children also for food stamps, healthcare, and MSHDA housing also. There are so many single parents sitting home getting free rent, food stamps, and free healthcare. Where is the incentive to get off of welfare? There is none!

These should not be entitlement programs.

Thank you,
A very concerned taxpayer and working adult.

From: [redacted]
To: HealthyMichiganPlan
Subject: Comment on Medicaid work requirement
Date: Thursday, August 9, 2018 11:00:25 AM

After reading through the proposed work requirement, I have the following concerns/questions:

Who defines "able bodied"? I looked at the medically frail diagnostic codes and felt that there were many debilitating conditions missing from that list, including depression, anxiety, and the hidden diseases such as fibromyalgia, lupus, etc.

This proposal doesn't take into account those who lack reliable transportation, which is especially problematic in places that don't have public transportation options. These requirements would cause undue hardship to people who are already struggling.

Is this even a real issue that needs addressing? How many individuals are "taking advantage" of the system? Will we be wasting time and financial resources enforcing rules on something that wouldn't even have a significant impact?

[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Medicaid work requirements
Date: Thursday, August 9, 2018 11:07:59 AM

If you are going to make work/volunteerism a requirement, then you have the responsibility to create the jobs and volunteer opportunities so the poor can fulfill this requirement. But, first provide them with new teeth, clothes and people skills so they can succeed. You and I both know the unemployed are not about to be qualified for a skilled job just because you are taking away their healthcare. I am not against them working, just give them the job. Some of them might be able to supervise these make do jobs. It is going cost the State money and most of the current unemployed will never become middle class workers, but we will be able to quit hating them for being poor, lazy, fat, sick, and toothless. A win win for all.

Sent from my iPad

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Thursday, August 9, 2018 11:11:33 AM

Dear MDHHS,

Healthy Michigan Plan §1115 Demonstration Waiver Extension Request Amendment would cause Medicaid recipients several problems. Since Medicaid recipients typically are disabled, children, or caring for disabled/children, requiring them to work to continue to receive benefits will cause these people harm. Since the requirement is most likely to hit carers, this will cause people to neglect their disabled relatives and children. In the long run, this will force more children into foster care (which is already well past its limit in Michigan) and dump families onto the streets homeless without health care.

This change will be extremely expensive to the State of Michigan and I want you to stop wasting our money with harmful nonsense. Paying for basic public services to struggling families up front is much cheaper than having to pay for foster children and families bouncing in and out of ERs without insurance.

Sincerely,

[redacted]

[redacted]

[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Thursday, August 9, 2018 11:45:37 AM

Thank you for allowing public comment on this proposed public policy change.

I believe this would be an irresponsible policy for so many reasons, not the least of which is that we don't really know what its impact would be on the health and well-being of families already living on the edge of survival. While workforce development is a worthwhile goal, there are much better mechanisms and incentives to employ toward that end. This policy seems likely to require more state expenditures in record-keeping, tracking, enforcement, and reporting than it would save in benefit avoidance…all while creating more hoops for participants to jump through. This seems like a giant waste of human energy and puts the health and welfare of our citizens at risk.

Respectfully yours,

[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Thursday, August 9, 2018 11:50:25 AM

I live and work in a small town in the Upper Peninsula that is full of people unwilling to work. There are dozens of open jobs that yes, maybe only pay minimum wage or so, but there is tons of work. Our local businesses are suffering because of the lack of manpower. In Iron County, we have a very high percentage of the population on disability/welfare-- 12.5% compared to the state average of 8.6%. I know my community and the people in it and I'm frustrated to no end seeing the welfare/Medicaid system being abused by people who are very much able to work but don't.The mentality is "why get a job and work 40 hours a week when I can claim welfare/Medicaid/food stamps and come out close to the same pay and not have to work".

This abuse of the system is making it hard for people who actually need help to get it. For example, in my early 20's (I'm currently 30), I was living on $8/hour. Because I "made too much money", I did not qualify for HUD or any other type of assistance when I inquired about it. I couldn't afford more than a Tracfone, couldn't afford internet, and with heat bills over $300/month, I couldn't afford gas to drive to work (so I would bike) and would have a grocery budget of about $15/week. I made it work and I've been able to work my way out of that situation, but when I needed help with groceries (I would often eat plain rice or pasta because I couldn't afford anything to put on it), I was denied help. The woman I spoke to said if I quit my job, I'd qualify for all of it-- HUD, food stamps, Medicaid, and cash assistance. I got a CNA Certificate and started working about 65-70 hours a week and made it out of that situation, but when I needed help buying something more than plain pasta and watering down a half-gallon of milk to make it a gallon, I was denied that help. I have an acquaintance who literally times her pregnancies so she can stay on WIC and other assistance.

All that being said, I don't mind tax dollars going to help those who really need it. But the welfare system is meant to be a temporary crutch, not a lifestyle. And those who took the advice of quitting a job so you can have more money than if you work should ABSOLUTELY have to work for those benefits. If I have to work for my money, so can they.

Thank you and I hope someone actually reads this.[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: "Demonstration Extension Application Amendment"
Date: Thursday, August 9, 2018 12:32:41 PM

Thank you for letting citizens comment on the Medicaid work requirements being implemented in Michigan. I think they are a big mistake. We do not have data about how many Medicaid recipients work now or about why those who do not work cannot do so. We should collect the relevant data before enacting a policy change.

I am also concerned about the bureaucracy we would need to pay for in order to spy on and police Medicaid recipients to make sure they are working the mandatory 20 hrs/week. This bureaucracy would be expensive and would cost more than simply letting those eligible for Medicaid receive its benefits without work requirements.

I truly oppose the Medicaid Work Requirements for Michigan.

[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Thursday, August 9, 2018 1:02:00 PM

I object to the work requirement for health benefits.

[redacted]

From: [redacted]
To: HealthyMichiganPlan; MSAPolicy
Cc: GovernorsOffice; info@gretchenwhitmer.com
Subject: Demonstration Extension Application Amendment-Healthy Michigan Plan
Date: Thursday, August 9, 2018 1:07:27 PM

Suggestion to the Healthy Michigan Plan

Is it possible to offer a low monthly premium as an alternate option to the new work requirement? It would be easier/cheaper for the State to collect the premiums than to monitor work requirements. If there is a small premium policy holders may take part time jobs to cover the cost, but they could decide that.

My Story

I'm 55 and retired early a few years ago. I was laid off my long term job of 20 years doing print/graphic design work. Jobs in that industry have dried up, plus I have minor carpal tunnel that prevents me from doing computer work. My biggest concern about retiring was health insurance so I was very thankful to get on the Healthy MI Plan. I do not have health issues so I'm not a burden on the system, I just need something to cover unexpected emergencies. I cannot get a plan on the ACA since I don't have an income, if I didn't have the Healthy MI Plan I would fall into the "coverage gap". Please consider offering an alternative to the 20 hour work requirement so folks can "buy-into" the plan for a small premium (under $100 month). I would gladly pay it for the coverage.

Suggestion for a new 'Healthy Michigan Limited Plan'

Perhaps MI could offer a new 'Healthy Michigan Limited Plan' with a 'buy-in option' for limited coverage only (emergency/catastrophic care). It could be similar to Medicare Part A. Many MI citizens (retirees, low income, self-employed) would benefit from this option and it would add funds to the Medicaid system. The plan could offer advice/direction on where to find free/low-cost local community health services. Folks with greater needs could apply for the full plan, or buy this with supplemental plans. It would offer citizens more options in choosing what they want and need from health insurance.

Thank You,

[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Thursday, August 9, 2018 2:20:49 PM

I definitely believe “able bodied”, as referred to in the bill, participants should be required to work to retain these health care benefits.
A large portion of our society has digressed to the belief that they are owed free hand outs and are therefor not at all motivated to better themselves and become contributing members of said society.
Requiring government aid participants to work (or train, go to school, etc…) to EARN some of these benefits, to the extent of their abilities, will result in a more success orientated attitude and should encourage
Government aid participants to become as self-sufficient as they are able to be, rather than simply sitting back with their hands out.
Government assistance is great for what it was intended, assistance to help people in difficult situations get back on their feet, but our policies on it have changed that mindset to a culture where these same
Individuals look at the assistance as a way of life, with no intention of succeeding on their own.

From:	Rep. William Sowerby (District 31)
To:	HealthyMichiganPlan
Subject:	Demonstration Extension Application Amendment Public Comment
Date:	Thursday, August 9, 2018 2:48:08 PM
Attachments:	Medicaid Work Requirments Public Comment.pdf

Hello,

Attached you will find my public comment on the Healthy Michigan Plan §1115 Demonstration Waiver Extension Request Amendment. I wish to have my comments published on the state's waiver website as part of the public record.

Sincerely,

Bill Sowerby
State Representative
House District 31

August 9, 2018

The Honorable Rick Snyder, Governor
The State of Michigan
P.O. Box 30013
Lansing, MI 48909

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

Dear Governor Snyder and Director Lyon:

I wish to offer my comments regarding the Department's proposed extension of its Healthy Michigan Section 1115 Medicaid Demonstration. The proposal includes the provisions from Senate Bill 897 that would strip Medicaid coverage away from those who fail to meet strict monthly work requirements. I am strongly opposed to this proposal, which poses a serious threat to Michigan families, children, and seniors who rely on quality health care to get ahead.

It is backward and unfair to strip individuals of their health care simply because their boss cut their hours or shortened their shift. Health care is a right and creating more hoops to jump through to preserve your access to it is wrong. For people who are battling serious medical conditions, like cancer, any interruption in medical treatment could be devastating. These people need comprehensive care, not health care that could be taken away from them just because they couldn't work due to their illness or because of a paperwork issue with state government bureaucracy.

Furthermore, SB 897 is projected to cost the state tens of millions of dollars in administrative costs to implement. This money would be much more effectively spent actually helping people improve their health or increasing access to jobs. Instead, this legislation uses taxpayer dollars to create new administrative and bureaucratic processes.

This legislation will not make people healthier, improve our economy, or create more jobs. I am opposed to the provisions from Senate Bill 897 because I believe everyone should have access to the quality, affordable health care they deserve.

Thank you for your time and attention. I ask that these comments be published on the state's waiver website as part of the public record.

Sincerely,

William J. Sowerby

Bill Sowerby
State Representative
House District 31

From: [redacted]
To: HealthyMichiganPlan
Subject: New rules for Medicaid
Date: Thursday, August 9, 2018 3:14:26 PM

My daughter has EDS, Ehlers-Denlos Syndrome. She has been diagnosed by DeVos Medical staff. But Social Security does not yet recognize her disease. It has no category for her, therefore she has been denied disability income. Unless you believe in reincarnation as a healthcare treatment, to work that many hours will kill her. She is 44.

Sent from my iPhone

From: [redacted]
To: HealthyMichiganPlan
Subject: Work requirements
Date: Thursday, August 9, 2018 4:09:40 PM

I feel that this is a bad idea! It'll cost the state more money to enforce than it would ever save. Plus extenuating circumstances will not be considered. Thus driving off worthy families. The uninsured as a result of the program will be a burden to the health care system, especially hospitals!
[redacted]

Sent from my iPhone

From: [redacted]
To: HealthyMichiganPlan
Subject: Medicaid work requirements
Date: Thursday, August 9, 2018 4:22:16 PM

I support a qualification of work for receiving benefits. There will obviously be exceptions but as I work in the industry (pharmacy) I see way too many that I think are abusing the system. Kids under 19 and elderly over retirement age should have benefits. And I unfortunately see some elderly suffering without coverage.

From: [redacted]
To: HealthyMichiganPlan
Subject: Work requirements for Medicaid.
Date: Thursday, August 9, 2018 4:28:00 PM

While to many people, the idea of requiring people to work in order to receive any assistance with healthcare may sound reasonable, it can be disastrous for many, including taxpayers.

Often those needing help are too sick to work. Does it make sense to take their healthcare away? NO!!!

Others may want to work, but childcare costs more than they make. So taking their healthcare away is only making sick families.

With all these people lacking healthcare, they will be avoiding preventive care, getting sicker and going the emergency room. This will be more expensive, the hospitals will shift these unpaid costs to others.

Please reject this cruel plan.

[redacted]

Sent from my iPhone

From: Gary Dougherty
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Thursday, August 9, 2018 2:44:45 PM
Attachments: ADAComments-MIWorkRequirementsStateComments-final.pdf

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Please accept the attached comments from the American Diabetes Association regarding the Section 1115 Demonstration Extension Application and publish them on the state's waiver website as part of the public record.

Thank you.

Gary Dougherty
Director – State Government Affairs and Advocacy
(IL, IN, KY, MD, MI, OH, TN, VA, WI, WV)

American Diabetes Association.

Phone: 1-800-676-4065 x 4832 (office)
Mobile: 614-726-0801
diabetes.org
1-800-DIABETES (800-342-2383)

American Diabetes Association®

August 9, 2018

Nick Lyon
Director
Michigan Department of Health and Human Services
Medical Services Administration
Bureau of Medicaid Policy and Health System Innovation
P.O. Box 30479
Lansing, Michigan 48909-7979

Attention: Medicaid Policy

Dear Director Lyon:

On behalf of the more than 30 million Americans living with diabetes and the 84 million more with prediabetes, the American Diabetes Association (ADA) provides the following comments based on the information available in the State of Michigan's Department of Health and Human Services' (Department) Section 1115 Demonstration Waiver for the Healthy Michigan Plan (HMP).

As the global authority on diabetes, the ADA funds research to better understand, prevent and manage diabetes and its complications; publishes the world's two most respected scientific journals in the field, Diabetes and Diabetes Care; sets the standards for diabetes care; holds the world's most respected diabetes scientific and educational conferences; advocates to increase research funding, improve health care, enact public policies to stop diabetes, and end discrimination against those denied their rights because of the disease; and supports individuals and communities by connecting them with the resources they need to prevent diabetes and better manage the disease and its devastating complications.

According to the Centers for Disease Control and Prevention, over 9.5% of adults in Michigan have diagnosed diabetes.[1] Access to affordable, adequate health coverage is critically important for all people with, and at risk for, diabetes. Adults with diabetes are disproportionally covered by Medicaid.[2] For low-income individuals, access to Medicaid coverage is essential to managing their health. As a result of inconsistent access to Medicaid across the nation, these low-income populations experience great disparities in access to care and health status, which is reflected in geographic, race and ethnic differences in morbidity and mortality from preventable and treatable conditions.

Medicaid expansion made available through the Affordable Care Act (ACA) offers promise of significantly reducing these disparities. Specifically, in Medicaid expansion states, more individuals are being screened for and diagnosed with diabetes than states that haven't expanded.[3] Additionally, a new study found expansion states have a higher rate of prescription fills for diabetes medications than non-expansion states.[4] Regular medication use with no gap in health insurance coverage leads to fewer hospitalizations and use of acute care facilities.[5,6] As such, the ADA continues to support Michigan's expanded Medicaid coverage. However, we have concerns regarding some of the provisions of the state's Healthy Michigan Plan, and provide the following comments and recommendation to help ensure the needs of low income individuals with diabetes and prediabetes are met by Michigan's Medicaid program.

Lack of Information on Impact of Waiver

During a public comment period, the federal rules require the state include within the proposal an estimate of increase or decrease in enrollment and expenditures. The proposal presented by the Department does not provide any prediction of potential impact of the waiver on enrollment or cost over the next five years. Based on the information provided by the Department, the public does not have adequate information to comment and assess the potential impact of the Healthy Michigan Plan. In order to meet these transparency requirements, the Department must include updated projections of the impact on budget neutrality and the coverage. If the Department intends to move ahead with the proposal, it should at minimum provide the required information to the public and reopen the comment period for an additional 30 days.

Work Requirements

The ADA is deeply concerned by the Department's proposal to limit or revoke certain Medicaid beneficiaries' enrollment if they do not meet proposed work or community engagement standards. This type of coverage limit is in direct conflict with the Medicaid program's objective to offer health coverage to those without access to care. Most people with Medicaid who can work, do so. Nearly 8 in 10 non-disabled adults with Medicaid coverage live in working families, and nearly 60% are working themselves. Of those not working, more than one-third reported that illness or disability was the primary reason, 28% reported they were taking care of home or family, and 18% were in school.[7] For people who face major obstacles to employment, harsh Medicaid requirements will not help to overcome them. In addition, research shows work requirements are not likely to have a positive impact on long-term employment.[8] Instead, instituting a work requirement would lead to higher uninsured rates and higher emergency room visits by uninsured individuals who would have been eligible for Medicaid coverage, and increase the administrative burden for the state and its Medicaid managed care plans.[9,10]

A study by the National Bureau of Economic Research concluded Medicaid coverage increases utilization of primary and preventative services, lowers out-of-pocket medical spending and medical debt, and results in better self-reported physical and mental health.[11] In addition, Medicaid enrollees are 15% more likely to be screened for diabetes than someone who is uninsured.[12] CDC data show prevention

programs and early detection can prevent the onset of type 2 diabetes and reduce state spending.[13] Michigan's proposal to limit access to Medicaid services through the implementation of work requirements will decrease access to care for low-income Michigan residents with diabetes and increase state health care costs.

Premiums

The ADA has great concern with the Department's proposal to impose premiums for Michigan's Medicaid expansion population. Under this proposed waiver, Michigan seeks to require new cost-sharing requirements for individuals enrolled in Medicaid expansion for at least 48 months whose income is between 100 percent and 133 percent of the poverty level. These individuals would be required to complete a "health behavior assessment" with incrementally challenging healthy behavior requirements, and they would have to pay 5 percent of their income in premiums. Coverage will be suspended for those individuals who do not complete the healthy behavior assessment or who do not pay the 5 percent premium. Although CMS has approved premiums for low-income individuals, premiums totaling 5 percent of a household income are unprecedented in Medicaid. In the same income bracket, the ACA limits premiums on the Marketplace to 2 percent of the household's income.

When people are not able to afford the tools and care necessary to manage their diabetes, they scale back or forego the care they need. A Kaiser Family Foundation review of research related to cost-sharing and premiums in state Medicaid and CHIP programs found that "[f]or individuals with low income and significant health care needs, cost sharing can act as a barrier to accessing care, including effectiveness and essential services, which can lead to adverse health outcomes."[14] In addition, premiums can prevent individuals from enrolling in and maintaining coverage. [15] Requiring low-income Michigan residents with diabetes to pay monthly premiums to maintain Medicaid coverage puts their ability to manage the disease at risk, which could result in significantly increased health care costs for the state in the long-term. The ADA strongly urges the Department to remove this unprecedentedly high premium requirement.

Administrative Burden

Under this proposed waiver, individuals will need to either prove they meet certain exemptions or provide evidence of the number of hours they have worked as well as other monthly milestones they have met, all of which significantly increases the administrative burden of health care. Even though the Department has not provided an estimate of the impact the Healthy Michigan Plan will have on enrollment, it is highly likely that increasing the administrative requirements to maintain eligibility will result in fewer individuals with Medicaid coverage, even for those who meet the requirements or qualify for an exemption. An analysis of expected Medicaid disenrollment rates after implementation of work requirements shows most disenrollment would be due to administrative burdens or red tape.[16] Medicaid enrollees who are working may experience difficulty obtaining the required documentation from their employer on a timely basis. Furthermore, Michigan plans to impose a lock out from the Medicaid program for one year if any discrepancy or "misrepresentation of compliance" is found with an

American Diabetes Association®

individual's work requirement reporting. Even though they meet the proposed requirements, their inability to provide timely documentation could result in them losing Medicaid coverage. Diabetes is a complex, chronic illness that requires continuous medical care,[17] so Medicaid enrollees with diabetes cannot afford a sudden gap in health insurance coverage. A recent study found that patients with type 1 diabetes who experience a gap or interruption in coverage, are five times more likely to use acute care services (i.e. urgent care facilities or emergency departments).[18] Through adding administrative barriers and burdens, this waiver proposal will impede access to health services that Michigan residents with diabetes need.

Conclusion

Research shows work requirements are not likely to have a positive impact on long-term employment.[19] Instead, instituting a work requirement would lead to higher uninsured rates and higher emergency room visits by uninsured individuals who would have been eligible for Medicaid coverage, and increase the administrative burden for the state and its Medicaid managed care plans. In addition, high monthly premiums are a barrier for obtaining and maintaining Medicaid coverage. **We strongly urge the state to retract and modify the 1115 Demonstration Waiver for the Healthy Michigan Plan as it creates barriers to accessible, affordable, and adequate healthcare for low-income Michiganders with diabetes who rely on the program.**

The ADA appreciates the opportunity to comment on the Department's Waiver. Our comments include numerous citations to supporting research, including direct links to the research for the benefit of the Department in reviewing our comments. We direct the Department to each of the studies cited – made available through active hyperlinks – and we request that the full text of each of the studies cited, along with the full text of our comments, be considered part of the administrative record in this matter for purposes of the Administrative Procedure Act. If you have any questions, please contact Gary Dougherty, Director of State Government Affairs and Advocacy at GDougherty@diabetes.org or 800-676-4065 x4832.

Sincerely,

Gary Dougherty
Director, State Government Affairs and Advocacy

[1] Center for Disease Control and Prevention, Diagnosed Diabetes. Available at: https://gis.cdc.gov/grasp/diabetes/DiabetesAtlas.html

[2] Kaiser Commission on Medicaid and the Uninsured, The Role of Medicaid for People with Diabetes, November 2012. Available at http://kaiserfamilyfoundation.files.wordpress.com/2013/01/8383_d.pdf.

[3] Kaufman H., Chen Z., Fonseca V. and McPhaul M., "Surge in Newly Identified Diabetes Among Medicaid Patients in 2014 Within Medicaid Expansion States Under the Affordable Care Act," Diabetes Care, March 2015. Available at: http://care.diabetesjournals.org/content/early/2015/03/19/dc14-2334

[4] [4] Myerson R., Tianyi L., Tonnu-Mihara I., and Huang E.S., Health Affairs, Medicaid Eligibility Expansions May Address Gaps in Access to Diabetes Medications, August 2018. Available at: https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.2018.0154

[5] Id.

[6] Rogers M, Lee J, Tipirneni R, Banerjee T, and Kim C, Health Affairs, Interruptions in Private Health Insurance and Outcomes In Adults with Type 1 Diabetes: A Longitudinal Study. July 2018. Available at: https://www.healthaffairs.org/doi/10.1377/hlthaff.2018.0204

[7] Garfield R, Rudowitz R and Damico A, Understanding the Intersection of Medicaid and Work, Kaiser Family Foundation, February 2017. Available at: http://files.kff.org/attachment/Issue-Brief-Understanding-the-Intersection-of-Medicaid-and-Work

[8] Kaiser Family Foundation, Are Uninsured Adults Who Could Gain Medicaid Coverage Working?, February 2015. Available at: https://www.kff.org/medicaid/fact-sheet/are-uninsured-adults-who-could-gain-medicaid-coverage-working/

[9] Rector R, Work Requirements in Medicaid Won't Work. Here's a Serious Alternative, Heritage Foundation, March 2017. Available at: https://www.heritage.org/health-care-reform/commentary/work-requirements-medicaid-wont-work-heres-serious-alternative

[10] Katch H, Medicaid Work Requirements Would Limit Health Care Access Without Significantly Boosting Employment, Center on Budget and Policy Priorities, July 2016. Available at: https://www.cbpp.org/research/health/medicaid-work-requirement-would-limit-health-care-access-without-significantly

[11] National Bureau of Economic Research, The Medicaid Program, July 2015, available at: http://www.nber.org/papers/w21425.pdf.

[12] Kaiser Family Foundation, The Role of Medicaid for People with Diabetes, November 2012, available at: https://kaiserfamilyfoundation.files.wordpress.com/2013/01/8383_d.pdf

[13] Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, At A Glance 2016, available at: https://www.cdc.gov/chronicdisease/resources/publications/aag/pdf/2016/nccdphp-aag.pdf

[14] Kaiser Family Foundation, Premiums and Cost-Sharing in Medicaid: A Review of Research Findings, Kaiser Commission on Medicaid and the Uninsured, February 2013. Available at: https://www.kff.org/medicaid/issue-brief/premiums-and-cost-sharing-in-medicaid-a-review-of-research-findings/

[15] Id.

[16] Kaiser Family Foundation, Implications of Work Requirements in Medicaid: What Does the Data Say?, June 2018, available at: https://www.kff.org/medicaid/issue-brief/implications-of-work-requirements-in-medicaid-what-does-the-data-say/

[17] American Diabetes Association, Standards of Medial Care in Diabetes – 2018, Diabetes Care, January 2018, available at: http://care.diabetesjournals.org/content/41/Supplement_1.

[18] Rogers M, Lee J, Tipirneni R, Banerjee T, and Kim C, Health Affairs, Interruptions in Private Health Insurance And Outcomes In Adults with Type 1 Diabetes: A Longitudinal Study. July 2018. Available at: https://www.healthaffairs.org/doi/10.1377/hlthaff.2018.0204

[19] Kaiser Family Foundation, Are Uninsured Adults Who Could Gain Medicaid Coverage Working?, February 2015, available at: http://kff.org/medicaid/fact-sheet/are-uninsured-adults-who-could-gain-medicaid-coverage-working/.

From: Holly Kilness Packett
To: HealthyMichiganPlan
Cc: Cindy Snyder
Subject: Demonstration Extension Application Amendment
Date: Thursday, August 9, 2018 5:10:29 PM
Attachments: image003.png
ViiV Healthcare Comments - Healthy Michigan Plan §1115 Demonstration Waiver Extension Request Amendment _FINAL.pdf

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Dear Director Lyon,

ViiV Healthcare appreciates the opportunity to submit comments to The Michigan Department of Health and Human Services (MDHHS) Bureau of Medicaid Policy and Health System Innovation regarding the "Healthy Michigan Plan §1115 Demonstration Waiver Extension Request Amendment," and its proposed changes to the Michigan Medicaid expansion program, known as the Healthy Michigan Plan (HMP). Please feel free to contact Cindy Snyder, Community Government Relations Director, ViiV Healthcare at (919) 323-9084 or Cindy.C.Snyder@viivhealthcare.com with any questions.

Sincerely,

Holly Kilness Packett
Manager, HIV Policy
Public Policy US

GlaxoSmithKline (GSK)
1050 K Street NW, Washington, DC 20001
holly.k.packett@gsk.com
phone: 1-202-715-1073
work cell: 1-202-339-2385

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August 9, 2018

Submitted via: healthymichiganplan@michigan.gov

Nick Lyon, Director
MDHHS
Medical Services Administration
Bureau of Medicaid Policy and Health System Innovation
Attention: Medicaid Policy
P.O. Box 30479
Lansing, Michigan 48909-7979

Re: Healthy Michigan Plan §1115 Demonstration Waiver Extension Request Amendment

Dear Director Lyon,

ViiV Healthcare appreciates the opportunity to submit comments to The Michigan Department of Health and Human Services (MDHHS) Bureau of Medicaid Policy and Health System Innovation regarding the "Healthy Michigan Plan §1115 Demonstration Waiver Extension Request Amendment," and its proposed changes to the Michigan Medicaid expansion program, known as the Healthy Michigan Plan (HMP).

ViiV Healthcare is the only pharmaceutical manufacturer devoted exclusively to supporting the needs of people living with or affected by HIV. From ViiV Healthcare's inception in 2009, we have had a singular focus to improve the health and quality of life of people affected by this disease, and have worked to address significant gaps and unmet needs in HIV care. In collaboration with the HIV community, ViiV Healthcare remains committed to developing meaningful treatment advances, improving access to our HIV medicines, and supporting the HIV community to facilitate enhanced care and treatment.

As a manufacturer of HIV medicines, we are proud of the scientific advances in the treatment of this disease. These advances have transformed HIV from a terminal illness to a manageable chronic condition. Effective HIV treatment can help people living with HIV (PLWH) to live longer, healthier lives, and has been shown to reduce HIV-related morbidity and mortality at all stages of HIV infection.[1, 2] Furthermore, effective HIV treatment can also prevent the transmission of the disease. In a sponsored study by the National Institutes of Health (NIH) (published in 2016), the investigators reported that when treating the HIV-positive partner in a serodiscordant couple with antiretroviral therapy,[3] there were no linked infections observed when the infected partner's HIV viral load was below the limit of detection.

[1] Severe P, Juste MA, Ambroise A, et al. Early versus standard antiretroviral therapy for HIV-infected adults in Haiti. *N Engl J Med*. Jul 15 2010;363(3):257-265. Available at http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=PubMed&dopt=Citation&list_uids=20647201

[2] Kitahata MM, Gange SJ, Abraham AG, et al. Effect of early versus deferred antiretroviral therapy for HIV on survival. *N Engl J Med.* Apr 30 2009;360(18):1815-1826. Available at http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=PubMed&dopt=Citation&list_uids=19339714

[3] Cohen MS, Chen YQ, McCauley M, et al. Prevention of HIV-1 infection with early antiretroviral therapy. *N Engl J Med* 2011;365:493-505. See also http://www.cdc.gov/hiv/prevention/research/art/.

Medicaid has played a critical role in HIV care since the epidemic began, and it is the largest source of coverage for PLWH.[4] In 2015, there were 14,615 people living with HIV in Michigan.[5] Of those, approximately 78 percent were men, and 22 percent were women. [6] In 2015, there were 747 new HIV diagnoses in the state. [7] Michigan is near CDC prevention goals for 2016, with 81 percent of individuals aware of their HIV status, an 85 percent increase in HIV linkage to care, and an overall 82 percent rate of viral suppression.[8] These are notable accomplishments.

ViiV Healthcare wishes to share with CMS its comments on some of possible ramifications the proposed Section waiver amendment will have for PLWH in the Healthy Michigan Plan (HMP). ViiV Healthcare respectfully submits the following comments:

Effective HIV Treatment

Treatment of HIV is a dynamic area of scientific discovery, and treatment protocols are constantly changing and being updated to reflect advances in medical science. PLWH often face a variety of medical challenges that impede access to, retention in, and adherence to HIV care and treatment.

Strict adherence to ART – taking HIV medicines every day and exactly as prescribed – is essential to sustained suppression of the virus, reduced risk of drug resistance, and improved overall health.[9] The Health Resources and Services Administration (HRSA) stated in its *Guide for HIV/AIDS Clinical Care* that "adherence to ART is the major factor in ensuring the virologic success of an initial regimen and is a significant determinant of survival."[10] Nonadherence – or skipping HIV medicines – may lead to drug-resistant strains of the virus for which HIV medicines are less effective.[11] In fact, the World Health Organization (WHO) recently reported that resistance among people retained on ART ranged from four to 28 percent, while among people with unsuppressed viral load on first-line ART regimens, resistance ranged from 47 to 90 percent.[12]

Federal HIV clinical treatment guidelines (DHHS Guidelines for the Use of Antiretroviral Agents in HIV-1-Infected Adults and Adolescents[13]) emphasize the importance of adherence to ensure long-term treatment success.[14] The effective treatment of HIV is highly individualized and accounts for a patient's size, gender, treatment history, viral resistance, comorbid conditions, drug interactions, immune status, and side effects[15]. Aging beneficiaries who are living with HIV often experience non-HIV related comorbidities.[16] Clinically significant drug interactions have been reported in 27 to 40 percent of HIV patients taking antiretroviral therapy requiring regimen changes or dose modifications.[17] Medical challenges for PLWH also include an increased risk for, and prevalence of, comorbidities such as depression and substance use disorders,[18] as well as cardiovascular disease, hepatic and renal disease, osteoporosis, metabolic

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[4] Kaiser Family Foundation. Medicaid and HIV, http://www.kff.org/hivaids/fact-sheet/medicaid-and-hiv/.
[5] AIDS Vu, Michigan: https://aidsvu.org/state/michigan/
[6] AIDS Vu, Michigan: https://aidsvu.org/state/michigan/
[7] AIDS Vu, Michigan: https://aidsvu.org/state/michigan/
[8] AIDS Vu, Michigan: https://aidsvu.org/state/michigan/
[9] Chesney MA. The elusive gold standard. Future perspectives for HIV adherence assessment and intervention. J Acquir Immune Defic Syndr. 2006;43 Suppl 1:S149-155, http://www.ncbi.nlm.nih.gov/pubmed/17133199.
[10] HRSA, Guide for HIV/AIDS Clinical Care (April 2014), https://hab.hrsa.gov/sites/default/files/hab/clinical-quality-management/2014guide.pdf. Accessed October 13, 2017.
[11] AIDS Info, HIV Treatment Fact Sheet (March 2, 2017), https://aidsinfo.nih.gov/understanding-hiv-aids/fact-sheets/21/56/drug-resistance. Last accessed October 13, 2017.
[12] WHO, HIV Drug Resistance Report 2017, http://apps.who.int/iris/bitstream/10665/255896/1/9789241512831-eng.pdf?ua=1. Accessed October 13, 2017.
[13] DHHS Guidelines for the Use of Antiretroviral Agents in HIV-1-Infected Adults and Adolescents, NIH.gov https://aidsinfo.nih.gov/contentfiles/lvguidelines/adultandadolescentgl.pdf accessed: Dec. 5, 2017
[14] DHHS guidelines for the use of antiretroviral agents in adults and adolescents living with HIV. May 30, 2018. Accessible at https://aidsinfo.nih.gov/guidelines (accessed June 2018)
[15] HHS, Panel on Antiretroviral Guidelines for Adults and Adolescents. Guidelines for the Use of Antiretroviral Agents in HIV-1-Infected Adults and Adolescents, p. 183, https://aidsinfo.nih.gov/guidelines/html/1/adult-and-adolescent-treatment-guidelines/0. Accessed October 13, 2017.
[16] Schouten J, et al. Clin Infect Dis. 2014 Dec 15;59(12):1787-97.
[17] Evans-Jones JG et al. Clin Infect Dis 2010;50:1419–1421; Marzolini C et al. Antivir Ther 2010;15:413–423.
[18] CDC, Medical Monitoring Project, United States, 2013 Cycle (June 2013–May 2014

disorders, and several non–AIDS-defining cancers.[19,20] The most common non-infectious co-morbidities of HIV are hypertension, hyperlipidemia, and endocrine disease.[21]

Prevention

Effective treatment of HIV also helps to prevent new transmissions of the virus. Broad access to life-saving HIV treatments is equally important to reduce transmission rates. According to the Centers for Disease Control and Prevention (CDC), however, less than half of diagnosed PLWH are virally suppressed.[22] Viral load suppression means that the virus has been reduced to an undetectable level in the body.[23]

A 2011 clinical study from the National Institutes of Health (NIH), found that treating HIV-positive people with ART reduces the risk of transmitting the virus to HIV-negative sexual partners by 93 percent.[24] Reduced transmissions not only improve public health but also save money. It is estimated PLWH who are not retained in medical care may transmit the virus to an average of 5.3 additional people per 100-person years.[25] Other studies estimate that each HIV positive patient may approach $338,400 in additional costs to the healthcare system over his or her lifetime even if diagnosed early and retained in care.[26] Successful treatment with an antiretroviral regimen results in virologic suppression and virtually eliminates secondary HIV transmission to others. As a result, it is possible to extrapolate that successful HIV treatment and medical care of each infected patient may save the system up to $1.79 million by preventing[27] further transmission to others. These savings can only occur, however, if PLWH are diagnosed, have access to medical care, receive treatment, and remain adherent to their prescribed therapy.

HIV & Medical Frailty

ViiV Healthcare encourages the state to protect HIV patients from potential disruptions in care and treatment under the HMP. One way to do this is through designation of all PLWH as "medically frail." Uninterrupted access to medical care and drug treatment benefits is directly linked to the health and wellness of PLWH covered by public health programs. In a study, PLWH who faced drug benefit design changes were found to be nearly six times more likely to face treatment interruptions than those with more stable coverage, which can increase virologic rebound, drug resistance, and increased morbidity and mortality.[28] For this reason, PLWH should be exempted from penalties that create potential disruptions in access to necessary medications or care, similar to other complex medical conditions through a designation of medical frailty.

Eligibility Requirements

ViiV Healthcare appreciates the state's goals under the HMP to "assist, encourage, and prepare an able-bodied adult for a life of self-sufficiency and independence from governmental interference," through

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[19] Joel Gallant, Priscilla Y Hsue, Sanatan Shreay, Nicole Meyer; Comorbidities Among US Patients With Prevalent HIV Infection—A Trend Analysis, The Journal of Infectious Diseases, Volume 216, Issue 12, 19 December 2017, Pages 1525–1533, https://doi.org/10.1093/infdis/jix518

[20] Rodriguez-Penney, Alan T. et al. "Co-Morbidities in Persons Infected with HIV: Increased Burden with Older Age and Negative Effects on Health-Related Quality of Life." AIDS Patient Care and STDs 27.1 (2013): 5–16. PMC. Web. 21 June 2018. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3545369/

[21] Joel Gallant, Priscilla Y Hsue, Sanatan Shreay, Nicole Meyer; Comorbidities Among US Patients With Prevalent HIV Infection—A Trend Analysis, The Journal of Infectious Diseases, Volume 216, Issue 12, 19 December 2017, Pages 1525–1533, https://doi.org/10.1093/infdis/jix518

[22] CDC. MMWR. Vol 67 No.4 Feb. 2, 2018. https://www.cdc.gov/mmwr/volumes/67/wr/pdfs/mm6704a2-H.pdf.

[23] National Institutes of Health (NIH) "Ten things to Know about HIV Suppression" https://www.niaid.nih.gov/news-events/10-things-know-about-hiv-suppression. Accessed July 7, 2018

[24] Cohen MS, Chen YQ, McCauley M, et al. Prevention of HIV-1 infection with early antiretroviral therapy. *N Engl J Med* 2011;365:493-505, http://www.nejm.org/doi/full/10.1056/NEJMoa1600693#t=article.

[25] Skarbinski, et al. *JAMA Intern Med*. 2015;175(4):588-596.

[26] Schackman BR, Fleishman JA, Su AE, Berkowitz BK, Moore RD, Walensky RP, et al. The lifetime medical cost savings from preventing HIV in the United States. Medical care. 2015;53(4):293–301, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4359630/

[27] Schackman BR, Fleishman JA, Su AE, Berkowitz BK, Moore RD, Walensky RP, et al. The lifetime medical cost savings from preventing HIV in the United States. Medical care. 2015;53(4):293–301, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4359630/

[28] Das-Douglas, Moupali, et al. "Implementation of the Medicare Part D prescription drug benefit is associated with antiretroviral therapy interruptions." AIDS and Behavior 13.1 (2009): 1

workforce and community engagement requirements, and to create "structural incentives to increase beneficiary engagement in healthy behaviors and to promote personal responsibility in maintaining health care coverage." (p.4)[29]

ViiV Healthcare's prevailing concern is the proposed penalty for failing to meet these requirements is loss of eligibility for the program, and therefore loss of covered benefits such as medical care and treatment. According to the proposal (p.7):

> *"Beneficiaries who have not met the program's healthy behavior or cost-sharing requirements will be notified 60 days before the end of their 48th month that their coverage under the HMP program will be ending. Their HMP eligibility will be suspended until the individual comes into compliance with the healthy behavior and cost-sharing requirements, at which point they will be re-enrolled the first day of the next available month."*[30]

For PLWH, adherence to antiretroviral medication is paramount in maintaining their health, avoiding viral resistance, and preventing medical complications and co-morbidities. Access to qualified medical care providers is also highly important for PLWH in order to monitor disease progression and screen for signs of viral resistance.

Although the proposal exempts medically frail individuals from these penalties, it is not specified in the proposal that all PLWH would be included in this definition or exempt from these penalties. ViiV Healthcare encourages the state to consider including specific provisions to designate PLWH as medically frail.

Medically Frail Designation

- **Self-Attestation**

ViiV Healthcare values the state's proposal to allow individuals to self-report medically frail status. (p.12) However, Attachment L[31] of the proposal amendment specifies that an individual must attest that he/she has *"a physical, mental, or emotional health condition that causes limitations in activities (like bathing, dressing, daily chores, etc.) or live in a medical facility or nursing home"* in order to self-identify as medically frail.

Many PLWH may not be able to attest to these qualifications as stated. However, given the fact that their health and wellness is entirely dependent on uninterrupted access to medical care and treatment, they should be exempted from penalties that would threaten this important coverage. Therefore, ViiV Healthcare encourages the state to consider expanding the self-attestation proposal to allow individuals with HIV/AIDS to also be exempted through self-attestation.

- **Retrospective Claims Analysis**

The state proposes, as outlined in Attachment L,[32] to also identify medically frail populations through diagnosis codes, including ICD-10 diagnosis codes that identify individuals with "serious and complex medical conditions."[33] Consistent with the state's efforts to identify these individuals who should be

[29] Section 1115 Demonstration Extension Application, Healthy Michigan Plan, Project No. 11-W-00245/5, AMENDED: JULY 9, 2018
[30] Section 1115 Demonstration Extension Application, Healthy Michigan Plan, Project No. 11-W-00245/5, AMENDED: JULY 9, 2018
[31] Attachment L, "Medically Frail Identification Process Proposed Amendment: Revised July 9, 2018"
https://www.michigan.gov/documents/mdhhs/Attachment_L_Medically_Frail_Process_DRAFT_070518_627125_7.pdf
[32] Attachment L, "Medically Frail Identification Process Proposed Amendment: Revised July 9, 2018"
https://www.michigan.gov/documents/mdhhs/Attachment_L_Medically_Frail_Process_DRAFT_070518_627125_7.pdf
[33] Attachment L, "Medically Frail Identification Process Proposed Amendment: Revised July 9, 2018"
https://www.michigan.gov/documents/mdhhs/Attachment_L_Medically_Frail_Process_DRAFT_070518_627125_7.pdf

automatically designated as medically frail, ViiV Healthcare recommends that ICD codes related HIV and AIDS should be included in the state's list.

There are two main ICD-10 categories for coding HIV and they have subsequent clarifying details with extra digits added to the category number. These two main codes are:

B20 – Human immunodeficiency virus [HIV] disease resulting in infectious and parasitic diseases

Z21 – Asymptomatic human immunodeficiency virus [HIV] infection status[34]

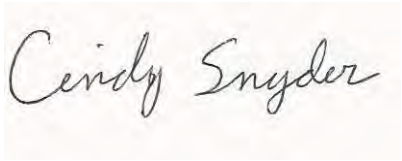
ViiV Healthcare recommends that at a minimum, the state include both codes within its list of automatic designations. These codes would include many PLWH whose condition is well controlled through medications; therefore, these patients are not easily identified through codes for more severe comorbidities and conditions. However, these individuals are dependent on uninterrupted access to medical treatment due to the complexity of the disease, and should be included in the state's efforts to define medical complexity through claims analysis.

Conclusion

ViiV thanks the state for its consideration of its comments and applauds the commitment to improving health outcomes for most vulnerable patients. The state has clearly been successful in getting individuals tested, linking PLWH to care, and achieving an overall 82 percent rate of viral suppression. As indicated above, ViiV Healthcare requests that the state maintain Medicaid coverage for PLWH by including HIV in the medically frail designation. ViiV Healthcare looks forward to working with the MDHHS, and other stakeholders to ensure that Michigan's public programs continue to ensure PLWH have access to quality care and to improve health outcomes.

Please feel free to contact me at (919) 323-9084 or Cindy.C.Snyder@viivhealthcare.com with any questions.

Sincerely,



Cindy Snyder
Community Government Relations Director
ViiV Healthcare

[34] ICD-10 codes for HIV https://www.ncbi.nlm.nih.gov/books/NBK236995/bin/annex2-m1.pdf

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Thursday, August 9, 2018 5:38:40 PM

As a mother and grandmother, I am very concerned about the bill passed by the Michigan Legislators requiring Medicaid recipients to work 20 hours per week.
I believe this bill is grossly unfair to single parents, especially those with no support system to help with childcare. I believe they make accommodations for children who are not in school, however no child is school 24/7. Also, you are assuming there are employers who will grant hours only when children are normally in school. It may be very difficult to find such a job. You are also assuming that this poor person has reliable transportation, which also may not be true. Daycare is also very expensive and would wipe out any earnings this person would make. I live in a rural area with the closest city being 15 miles away, which would add close to an hour of travel time each day, adding up to 25 hours per week of paying for childcare.
A few years back I recall a case of a single mother leaving her children alone while she worked because she had no childcare that day. A tragedy happened and she was charged with neglect, lost custody of her children and jailed. This is the type of desperate situation you are creating!
This bill is based on the premise that Michigan has a shortage of workers. We all know why this is true! When hundreds of thousands of undocumented immigrants are being deported, they leave a huge vacuum in the work force. Not to mention the tax base. However, experience tells us that you cannot solve one problem by creating another!
I believe this bill creates a huge burden on poor people just struggling to survive and my prayer is that it will be rescinded!
Sincerely,
[redacted]

Sent from my iPhone

From: [redacted]
To: HealthyMichiganPlan
Subject: bill to require people to work for benefits
Date: Thursday, August 9, 2018 6:53:50 PM

---

to whom it may concern:

both of my adult children have autism, ADHD, and general problems with brain organization; each struggle with everyday activities typical people take for granted.

Due to their disorganized brains and other differences in their personhood it is hard for them to get work and easy for them to lose a job due to no transportation (neither drive) being late, forgetful, perhaps not as thorough or as complete (follow through) with some tasks or not handling a situation as others might.

one of my children works 15 hours a week and that is about all he can handle at the present and the other child who is managing to live independently has been without a job now for several months but is currently and actively seeking employment.
ironically the one who lives alone may be evicted and lose her housing subsidy because she forgot to attend a meeting and submit that she is not making any money outside of my husband's social security disability. this is so typical of her disability.

Considered to have an invisible disability, because of their high function and no outward physical impairment (they are able to do many things and are enjoyable people) they are often judged harshly and cruely by others for what they are unable to do.

My kids do not need harder lives. they do need better program assistance to be successful in the world.
we are very active in their lives and try to help as much as we can but sadly fall short, and we are not getting any younger. I only hope we don't die before they can take care of themselves.

sincerely,
[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Medicaid Work Requirements
Date: Thursday, August 9, 2018 8:51:28 PM

I am against these proposed requirements. Further strain on our system and going after some of our most vulnerable people- Why? For the first time, many people who can't work steady jobs 12 months a year have a prayer of getting medical help when they need it with coverage.

Many people all ready work. Some have irregular schedules and may not get their required hours in a month so they loose their medical coverage? I have seen the exemptions- not enough. Just don't do it!

Terrible idea! Will be difficult to manage and track and make poor people even more stressed and limit their care options.

[redacted]

Sent from my iPhone

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Thursday, August 9, 2018 9:00:41 PM

To whom it may concern,

I strongly believe (as a working mother, college student, home-owning, Medicaid recipient) that the bill requiring Medicaid receipts to work is an attack on our states most vulnerable population.

I vote NO to senate bill 897.

[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Friday, August 10, 2018 5:44:22 AM

I am against the idea of forcing recipients of Medicaid to work for the benefits.
It will add another layer of government administration to investigate and make sure the work requirement is happening. I do not want to see that happen.
Many folks who are getting Medicaid are working! They are the working poor and don't need any additional hardship. The infirm and elderly cannot have more stress added to their lives by the idea of needing to work.
Please do not allow this rule to pass.
[redacted]

Sent from my iPhone

From:	Diebolt, Pamela J. (DHHS)
To:	HealthyMichiganPlan
Subject:	FW: Comment in opposition to Michigan Medicaid work requirement waiver
Date:	Friday, August 10, 2018 8:40:35 AM
Attachments:	Medicaid waiver comment Rabbi.pdf ATT00001.htm

From: Emerson, Erin (DHHS)
Sent: Wednesday, August 8, 2018 7:17 PM
To: Prokop, Jackie (DHHS) <prokopj@michigan.gov>; Diebolt, Pamela J. (DHHS) <DieboltP@michigan.gov>
Cc: Stiffler, Kathleen A. (DHHS) <StifflerK@michigan.gov>
Subject: Fwd: Comment in opposition to Michigan Medicaid work requirement waiver

Sent from my iPhone

Begin forwarded message:

> **From:** "Lyon, Nick (DHHS)" <LyonN2@michigan.gov>
> **Date:** August 8, 2018 at 7:13:01 PM EDT
> **To:** "Stiffler, Kathleen A. (DHHS)" <StifflerK@michigan.gov>, "Emerson, Erin (DHHS)" <EmersonE@michigan.gov>
> **Subject: Fwd: Comment in opposition to Michigan Medicaid work requirement waiver**
>
> Please incorporate.
>
> Begin forwarded message:
>
> > **From:** "Rep. Yousef Rabhi (District 53)" <YousefRabhi@house.mi.gov>
> > **Date:** August 8, 2018 at 2:24:13 PM PDT
> > **To:** "scotta12@michigan.gov" <scotta12@michigan.gov>, "Rick.Snyder@michigan.gov" <Rick.Snyder@michigan.gov>, "LyonN2@michigan.gov" <LyonN2@michigan.gov>
> > **Cc:** "SchuetteB@michigan.gov" <SchuetteB@michigan.gov>, "Seema.Verma@cms.hhs.gov" <Seema.Verma@cms.hhs.gov>
> > **Subject: Comment in opposition to Michigan Medicaid work requirement waiver**
> >
> > Governor Rick Snyder
> > P.O. Box 30013
> > Lansing, Michigan 48909

Nick Lyon
Director, Michigan Department of Health and Human Services
333 S. Grand Avenue
P.O. Box 30195
Lansing, Michigan 48909

Dear Governor Snyder and Director Lyon:

I am writing on behalf of my constituents to oppose adding work requirements to Michigan Medicaid. Please publish these comments on the state's Section 1115 waiver website as part of the public record. Since 1965, Medicaid has provided access to healthcare for some of our most vulnerable citizens. Recently, Michigan has proposed imposing a work requirement that is incompatible with the intent of Medicaid. This bureaucratic barrier would keep tens of thousands of Michiganders from accessing needed care, including many who are simply unable to document that they are meeting the requirement or qualify for an exemption. The House Fiscal Agency estimates that 54,000 Michiganders would lose coverage. Many of them would suffer as a result, and about 50 of them would die every year due to reduced access to care.

Administering a work requirement will inevitably divert resources from providing healthcare to expanding bureaucracy. In Kentucky, the first state to be approved for a Medicaid work requirement, **Medicaid administration costs increased by 40 percent**. The work requirement also incurred legal costs for Kentucky; their waiver's approval was struck down by a federal judge because it was not in keeping with the purpose of Medicaid—to pay for the health care of vulnerable people. Michigan should learn from this example and avoid wasting taxpayer resources on a failed attempt to take away our citizens' healthcare.

Medicaid expansion has been hugely successful in extending health coverage to over 680,000 Michiganders, a legacy of which the Snyder administration can be justifiably proud. I strongly urge you not to undermine that progress with this hastily constructed and ill-conceived Medicaid waiver application. Please act in the best interests of the people of our state by protecting their access to healthcare from bureaucratic interference.

Sincerely,
Yousef Rabhi

CC: Attorney General Bill Schuette, CMS Administrator Seema Verma

Yousef Rabhi
Representative, 53rd District (Ann Arbor)

517-373-2577
To subscribe to my enewsletter, please email me at
YousefRabhi@house.mi.gov

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FAX: (517) 373-5808
E-MAIL: yousefrabhi@house.mi.gov

MICHIGAN HOUSE OF REPRESENTATIVES

YOUSEF RABHI

STATE REPRESENTATIVE

August 7th, 2018

Governor Rick Snyder
P.O. Box 30013
Lansing, Michigan 48909

Nick Lyon
Director, Michigan Department of Health and Human Services
333 S. Grand Avenue
P.O. Box 30195
Lansing, Michigan 48909

Dear Governor Snyder and Director Lyon:

I am writing on behalf of my constituents to oppose adding work requirements to Michigan Medicaid. Please publish these comments on the state's Section 1115 waiver website as part of the public record. Since 1965, Medicaid has provided access to healthcare for some of our most vulnerable citizens. Recently, Michigan has proposed imposing a work requirement that is incompatible with the intent of Medicaid. This bureaucratic barrier would keep tens of thousands of Michiganders from accessing needed care, including many who are simply unable to document that they are meeting the requirement or qualify for an exemption. The House Fiscal Agency estimates that 54,000 Michiganders would lose coverage. Many of them would suffer as a result, and about 50 of them would die every year due to reduced access to care.

Administering a work requirement will inevitably divert resources from providing healthcare to expanding bureaucracy. In Kentucky, the first state to be approved for a Medicaid work requirement, **Medicaid administration costs increased by 40 percent**. The work requirement also incurred legal costs for Kentucky; their waiver's approval was struck down by a federal judge because it was not in keeping with the purpose of Medicaid—to pay for the health care of vulnerable people. Michigan should learn from this example and avoid wasting taxpayer resources on a failed attempt to take away our citizens' healthcare.

Medicaid expansion has been hugely successful in extending health coverage to over 680,000 Michiganders, a legacy of which the Snyder administration can be justifiably proud. I strongly urge you not to undermine that progress with this hastily constructed and ill-conceived Medicaid waiver application. Please act in the best interests of the people of our state by protecting their access to healthcare from bureaucratic interference.

Sincerely,

Yousef Rabhi

CC: Attorney General Bill Schuette, CMS Administrator Seema Verma

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Friday, August 10, 2018 9:13:38 AM

On behalf of a Michigan resident...

"I have family members that are disabled, unable to hold down a job, and cannot afford healthcare. Medicaid expansion is the only reason they receive the care they do right now."

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Friday, August 10, 2018 9:16:47 AM

On behalf of a Michigan resident...

"People need help... no one chooses to have these issues and the belief that people are abusing the system is wrong"

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Friday, August 10, 2018 9:17:55 AM

On behalf of a Michigan resident...

"Healthcare costs are overall better when people can see a primary care doctor for preventative care, or at least before they are so sick that they require an emergency room visit or hospitalization. The community does better when everyone is healthier."

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Friday, August 10, 2018 9:19:09 AM

On behalf of a Michigan resident...

"I work with people living with HIV and Healthy Michigan has been so helpful for them in their other health needs too."

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Friday, August 10, 2018 9:20:38 AM

On behalf of a Michigan resident...

"My daughter, who is 24, cannot receive coverage under my husbands insurance (state of MI retiree). She attends college and works part time. With Medicaid we don't have to worry about her health needs while she works to continue her education. Though she is a healthy young woman, like all people she occasionally gets ill (sinus infection, strep, etc.), when that happens she can see a doctor w/o fear of the cost. Also her regular checkups and birth control are covered so that there does not need to be a disruption to education.

Also, this program briefly covered our son, who has Type 1 diabetes, when he was done with college, but had not yet found a teaching position. The cost of his insulin would have been impossible for us to manage without Healthy Michigan Medicaid."

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Friday, August 10, 2018 9:22:14 AM

On behalf of a Michigan resident...

"After being without insurance for many years, Medicaid allowed me to receive care for a chronic issue that adversely affected my life for many years. I was able to work function but at a limited level. Healthy Mi allowed me to get constant care and raise my health level."

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Friday, August 10, 2018 9:23:40 AM

On behalf of a Michigan resident...

"It's very important to provide assistance to the community. Not everyone has the same opportunities provided as others. Not everyone gets their start in the same place. Providing assistance is crucial to a better economy to allow the less fortunate a chance to catch up where others are just starting."

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Friday, August 10, 2018 9:24:45 AM

On behalf of a Michigan resident...

"My father was covered by Medicaid when he had life saving surgery for an aortic aneurysm and at the end of his life when he was hospitalized for over a month. These conditions would have bankrupted all of his children (myself and my 2 siblings)."

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Friday, August 10, 2018 9:25:37 AM

On behalf of a Michigan resident...

" When I left my job to become a full time law student I was placed on Medicaid. Without it I could not have afforded insurance. It saved me!"

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Friday, August 10, 2018 9:26:48 AM

On behalf of a Michigan resident...

"Many members of my community have benefited from Medicaid coverage. It has allowed them to see doctors and get medical care outside of emergency rooms. This kind of health care allows people to take care of their families, to go to school, to work. Medicaid helps hospitals survive, especially in rural areas, because uncompensated care costs are reduced."

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Friday, August 10, 2018 9:27:53 AM

On behalf of a Michigan resident...

"Healthy Michigan has effectively eliminated the uninsured population in Southeast Michigan, with the exception of some outlying populations. This has been a major first step toward reducing health disparities and creating health equity within the region. It will take considerable time to create healthy behaviors that will lead to better management of chronic disease and health promotion."

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Friday, August 10, 2018 9:29:17 AM

On behalf of a Michigan resident...

" My brother-in-law has struggled with mental health and addiction issues his entire adult life. Without Medicaid, he often would not have any healthcare at all. His life is already overwhelming for him most of the time. Adding more hurdles will not help his situation."

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Friday, August 10, 2018 9:30:28 AM

On behalf of a Michigan resident...

"People are now able to access needed medical services that otherwise they haven't been able to. Healthier people lead to a healthier community."

From: [redacted]
To: HealthyMichiganPlan
Subject: “Demonstration Extension Application Amendment”
Date: Friday, August 10, 2018 9:30:30 AM

These seemingly arbitrary work requirements are only going to harass and stress out those who are least able to deal with bureaucratic red tape!

Legislators seem to have no idea, or don't care, about the daily grind that low income people experience, or how capricious employers are with hours, seasonal work, etc. These new requirements would cause many people to lose health care EVEN if they are working, which only makes them more likely to be unemployable when they can't get treatment and must miss work because if injury of illness.

My husband and I oppose this proposal.

[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Friday, August 10, 2018 9:32:30 AM

On behalf of a Michigan resident...

"I no longer have fear of cost to seek medical care and it has helped with high cost of medications such as Insulin"

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Friday, August 10, 2018 9:33:42 AM

On behalf of a Michigan resident...

"My brother is severely disabled. He has been able to enjoy a full and happy life because of his access to Medicaid. Many if my coworkers would not even be able to work if they didn't have Medicaid."

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Friday, August 10, 2018 9:35:28 AM

On behalf of a Michigan resident...

"I am 36 years old, with a Master's degree. I had been unable to work any kind of regular job because of multiple health issues, including narcolepsy, fibromyalgia, arthritis, and liver disease. I worked as a independent contractor, editing and publishing, piecing together just enough money to pay bills. I received food benefits, but made "too much money" to qualify for Medicaid. I seldom went to the doctor and unsuccessfully attempted to self-treat my pain and overwhelming fatigue.

After the Medicaid expansion, I was eligible for the Healthy Michigan Plan. As a result, I found doctors who helped me devise a treatment plan, including lifestyle changes, physical therapy, as well as medications to treat symptoms. In the fall if 2016, I was able to return to work as an adjunct English professor. Since then, I've continued work, found purpose in my life again, and have contributed to my health plan as my income has risen."

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Friday, August 10, 2018 9:36:36 AM

On behalf of a Michigan resident...

" My husband has multiple health issues that preclude employment. He's tried several times. It hasn't worked out because of his health."

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Friday, August 10, 2018 9:38:25 AM

On behalf of a Michigan resident...

"My sister is a person with a developmental disability who receive Medicaid behavioral services and supports. Her direct support staff rely on Medicaid since the direct support positions do not offer benefits. These hardworking individuals also receive wages that make it difficult to pay insurance premiums."

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Friday, August 10, 2018 9:40:33 AM

On behalf of a Michigan resident...

"Healthy Michigan has slowed people from using ER as a PCP and provided stability for those without access to insurance and given them dignity in seeking ongoing care"

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Friday, August 10, 2018 9:42:05 AM

On behalf of a Michigan resident...

"Healthy population, less stress on health system."

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Friday, August 10, 2018 9:44:15 AM

On behalf of a Michigan resident...

"Individuals with disabilities qualify for services that give them more independence and equity in their lives."

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Friday, August 10, 2018 9:46:07 AM

On behalf of a Michigan resident...

"It has helped my children because we don't have insurance available for them through our workplace."

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Friday, August 10, 2018 9:47:14 AM

On behalf of a Michigan resident...

"Healthcare creates a more robust community."

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Friday, August 10, 2018 9:48:39 AM

On behalf of a Michigan resident...

"I used to work for the Welfare office...I KNOW how it's helped, by keeping people HEALTHY"

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Friday, August 10, 2018 9:49:47 AM

On behalf of a Michigan resident...

"I have Medicaid because I am a single mom, a student, and I have Multiple Sclerosis. Without Medicaid, I would not have insurance PERIOD. Without insurance, I would not have access to my MS medication which retails for $75 per pill. I take two pills per day. This medication keeps my disease from progressing. So Medicaid is preventing my disease from progressing so I can continue my education and become a graphic designer."

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Friday, August 10, 2018 9:50:48 AM

On behalf of a Michigan resident...

"Medicaid has allowed people with disabilities to live meaningful lives with access to support staff and transportation. Without these Medicaid benefits, people would be living in institutions. "

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Friday, August 10, 2018 9:52:00 AM

On behalf of a Michigan resident...

"My husband passed away at age 60. At the time I was 51 and hadn't worked in 14 years. I couldn't afford to pay COBRA. Thank goodness I applied and was approved for the Healthy Michigan Plan. If I could work outside the home, I wouldn't need Medicaid. I am housebound, I have no family to help me, I try and find work-from-home jobs but they aren't enough to even support me and they don't offer health insurance. S.B. 897 doesn't make sense and is antithetical."

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Friday, August 10, 2018 9:55:27 AM

On behalf of a Michigan resident...

" Medicaid and Healthy Michigan coverage has been a huge stress relief for our family. Thankfully we have no chronic health issues, but to have health care during this low income time in our life means that there is one less thing to keep us up at night."

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Friday, August 10, 2018 9:56:46 AM

On behalf of a Michigan resident...

"I am taking care of my husband who is disabled and I have health issues as well. Healthy Michigan is helping me get the medical attention I need right now that I can't afford being on a fixed income."

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Friday, August 10, 2018 9:57:58 AM

On behalf of a Michigan resident...

"My father was diagnosed with prostate cancer in 2014. Without Medicaid expansion he would not have had any medical insurance upon his diagnosis and would never have been able to afford insurance or his treatments."

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Friday, August 10, 2018 10:00:30 AM

On behalf of a Michigan resident...

"My fiance has been able to see a doctor for the first time in years! She only ever saw a doctor when her illnesses got too severe, and she hadn't been to a doctor for a regular checkup since she was a child."

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Friday, August 10, 2018 10:26:25 AM

On behalf of a Michigan resident...

" My brother developed grand mal seizures and is unable to work. His employer fired him because he has seizures at any time of the day without warning and has actually hurt himself while at work. Without Medicaid he cannot receive the diagnosis and treatment necessary to prevent the seizures from occurring. He applied for disability but that could take years to get approved. He is unable to work. His seizures make him unable to drive."

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Friday, August 10, 2018 11:06:15 AM

On behalf of a Michigan resident...

"I help people every day who are able to receive mental health care and home health care support and needs through Medicaid waiver program."

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Friday, August 10, 2018 11:06:46 AM

On behalf of a Michigan resident...

" My father is in a long term care facility and is unable to live on his own. If it wasn't for his Medicaid coverage, I don't know what we would do."

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Friday, August 10, 2018 11:07:54 AM

On behalf of a Michigan resident...

"The Medicaid expansion helped me get through law school."

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Friday, August 10, 2018 11:09:31 AM

On behalf of a Michigan resident...

"Many people are now back in workforce as their health needs addressed. Complications from chronic conditions reduced as they are getting early intervention and management. Not using emergency room when really sick, can get care early. Charity care and bad debt reduced at hospitals. More people getting vital dental care to prevent sepsis. Supports employers in health care to hire more people-created jobs where I work."

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Friday, August 10, 2018 11:10:23 AM

On behalf of a Michigan resident...

" Medicaid helped my mom, a single parent, put herself through nursing school. The shaming associated with Medicaid needs to stop- listen to the nurses!"

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Friday, August 10, 2018 11:11:20 AM

On behalf of a Michigan resident...

" My son has a congenital disability and he needs expensive medical equipment in order to function in society. Without coverage, he would not be able to be independent in the community."

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Friday, August 10, 2018 11:12:39 AM

On behalf of a Michigan resident...

"I had a stroke a year ago. Without the medications and medical care I get now through Healthy Michigan, I'll just keep having strokes and going to the E.R. without being able to pay for it. The medications I take keep my blood pressure under control. I was also able to get a surgery that fixed an issue that hindered my ability to work for almost 10 years."

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Friday, August 10, 2018 11:13:35 AM

On behalf of a Michigan resident...

"Medicaid allows persons who previously had little or no healthcare to receive fuller healthcare coverage."

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Friday, August 10, 2018 11:15:39 AM

On behalf of a Michigan resident...

"Medicaid expansion means members of the community receive health care and that reduces the likelihood of spreading communicable diseases. It also reduces the financial burden on hospitals of providing care to the poor."

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Friday, August 10, 2018 11:16:35 AM

On behalf of a Michgian resident...

" My two adult daughters suffer from anxiety. They are unable to work full time. The Medicaid has helped them to receive necessary medical care and support for doctor visits and medication."

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Friday, August 10, 2018 11:17:32 AM

On behalf of a Michigan resident...

"All people deserve to have a basic level of health care available to them"

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Friday, August 10, 2018 11:18:44 AM

On behalf of a Michigan resident...

"Medicaid coverage allows my children access to the medical care and medications they need to be healthy and successful without us going bankrupt as a family."

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Friday, August 10, 2018 11:19:47 AM

On behalf of a Michigan resident...

"I am a single foster mom with medically fragile children who need this. It is nice to know I have insurance too so that I can stay healthy for them."

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Friday, August 10, 2018 11:21:10 AM

On behalf of a Michigan resident...

" After the ACA was passed, I was able to quit my government job and start my own businesses. A younger person was able to take my position and I am able to provide services in my community that no one ever has before. It's pretty amazing! I would never have been able to become a small business owner without Medicaid. "

[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Friday, August 10, 2018 11:22:21 AM

On behalf of a Michigan resident...

" I believe that everyone should have some basic level of healthcare so that people don’t have to chose between their health and a job. I know people who have jobs who can’t afford to use their insurance because it’s too expensive."

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Friday, August 10, 2018 11:29:53 AM

On behalf of a Michigan resident...

" Medicaid is so important to my brother because when he was diagnosed with cancer, Blue Cross dropped him. He needs Medicaid to stay alive."

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Friday, August 10, 2018 11:31:23 AM

On behalf of a Michigan resident...

"I have never needed this service but have seen it save lives"

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Friday, August 10, 2018 11:33:23 AM

On behalf of a Michigan resident...

"Medicaid is an important program in our community. We all benefit when healthcare is accessible for all people."

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Friday, August 10, 2018 11:34:36 AM

On behalf of a Michigan resident...

" I have had rough times with low income and have personally seen the relief Medicaid has provided. This allowed me to advance my personal goal so I no longer need Medicaid."

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Friday, August 10, 2018 11:35:32 AM

On behalf of a Michigan resident...

" My little sister is autistic and my older brother has several medical issues. Neither of them can work. Medicaid allows them both to live independent lives but still have necessary care."

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Friday, August 10, 2018 11:37:12 AM

On behalf of a Michigan resident...

" After my husband left & we divorced, he actively sought work with no health benefits, leaving my children without health insurance. In addition, he consistently has not earned enough to pay his full spousal or child support, leaving me no option to work full-time due to childcare costs (he surely would not pay). Also without the help I receive, our cost of living expenses would overwhelm me throwing me into bankruptcy. Without Medicaid, myself & my children would be without Medical coverage. There is no job waiting for me at $50-60,000 per year. I an active job searching. I am a college degreed, white, divorced suburban single parent. I am not an urban poor person. I am what Americans don't believe exists. I am stuck right now, in financial limbo, until both my children attend school fulltime."

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Friday, August 10, 2018 11:40:18 AM

On behalf of a Michigan resident...

"My sister is Autistic and is unable to work due to the severe depression and anxiety that comes along with her autism. Healthy Michigan allowed her to be able to maintain health insurance after she turned 26 and allows her to be able to see her mental health professionals, as well as other healthcare providers. She would not be able to do this if it weren't for the current Healthy Michigan program."

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Friday, August 10, 2018 11:41:10 AM

On behalf of a Michigan resident...

" My spouse and I both work directly with low income or special needs populations that depend on Medicaid for their healthcare. Without Medicaid, our clientele would have no access to healthcare."

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Friday, August 10, 2018 11:42:55 AM

On behalf of a Michigan resident...

"I have been able to maintain health through regular check-ups and address injuries when they occurred, instead of having to wait until they develop into something worse."

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Friday, August 10, 2018 11:44:07 AM

On behalf of a Michigan resident...

" People that are struggling financial have been able to rely on this form of welfare. The whole community benefits from good health, including those that are struggling financially."

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Friday, August 10, 2018 11:44:56 AM

On behalf of a Michigan resident...

"When our community is healthier, we all benefit."

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Friday, August 10, 2018 11:46:29 AM

On behalf of a Michigan resident...

" Healthy Michigan enables us to have good healthcare even though, as self-employed small business owners and freelancers, our income often fluctuates."

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Friday, August 10, 2018 11:47:42 AM

On behalf of a Michigan resident...

" Without it I would have no coverage and would probably die from diabetes."

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Friday, August 10, 2018 11:48:37 AM

On behalf of a Michigan resident...

" Due to financial difficulty, I enrolled in Medicaid in March. To date, I have not needed to use it. However, it's nice to know that in case of emergency I have health insurance to fall back on and I can seek medical treatment if needed. It's reassuring to know that I won't go bankrupt due to a medical emergency."

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Friday, August 10, 2018 11:49:31 AM

On behalf of a Michigan resident...

" People in my community can continue to work in jobs that offer lower pay and hours while keeping in better health. Many of these folks work in direct service with people in need or food service. They need care and coverage. Prevents the spread of disease."

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Friday, August 10, 2018 11:50:19 AM

On behalf of a Michigan resident...

" If it wasn't for Medicaid by suicidal father wouldn't have received the mental health help he needed."

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Friday, August 10, 2018 11:52:52 AM

On behalf of a Michigan resident...

" Medicaid was there when we needed it, everyone should be able to get healthcare if they need it, especially if their employer won't pay them a decent wage."

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Friday, August 10, 2018 11:58:14 AM

On behalf of a Michigan resident...

" People have been able to receive preventive care. People haven't had to go to the ER for routine care."

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Friday, August 10, 2018 11:59:23 AM

On behalf of a Michigan resident...

"Medicaid expansion has allowed my mother to have medical care without going bankrupt."

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Friday, August 10, 2018 12:00:26 PM

On behalf of a Michigan resident...

"I get access to a Doctor, and don't have to go through ER."

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Friday, August 10, 2018 12:01:23 PM

On behalf of a Michigan resident...

"Our daughter has been underemployed (mental health issues) and would not have health coverage without this program"

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Friday, August 10, 2018 12:02:16 PM

On behalf of a Michigan resident...

" I'm a psychologist who works sick kids and changes under the ACA have significantly improved my patients access to mental healthcare!"

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Friday, August 10, 2018 12:03:25 PM

On behalf of a Michigan resident...

" I believe it benefits those most in need of medical assistance due to their age, health, or educational/career/social disadvantages in our society. I believe by uplifting those at the bottom, we create safer, healthier communities for all. The expansion of the coverage provided options for those most in need, and it does so in a more equitable gender manner."

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Friday, August 10, 2018 12:04:38 PM

On behalf of a Michigan resident...

"It has helped me through several health issues that could have been potentially life threatening!"

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Ammendment
Date: Thursday, August 9, 2018 9:11:02 AM

To Michigan legislators,

There will come a day before I am 65 years old, that I will have to quit my job in order to take care of my aging mother. I would like to feel free to do that, knowing that I can apply for state sponsored health insurance and be covered while I care for her. I do not want work requirements for anyone over the age of 55. Parents of baby boomers are aging rapidly. We need to be able to care for them! If my mother ends up in a nursing home because I cannot care for her, it will cost my state a heck of a lot more to pay for that care than to pay for mine!!

Respectfully submitted,

[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Medicaid expansion work requirements
Date: Thursday, August 9, 2018 9:04:24 AM

Love this! Great idea about time

Sent from my iPhone

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Thursday, August 9, 2018 9:01:55 AM

I don't support the proposed Medicaid work requirements that are being proposed. I think it's draconian and that it's, once
again, punishing people for being poor.

We have a family member with a long history of mental illness. He's "able bodied" but not "able minded." Is this even being
taken into account?

And adding even a small percentage to their fees can make this care inaccessible. Plus what's paying for the additional staff,
administration and computer costs to monitor the program.

This is mean-spirited and not well thought.

[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Thursday, August 9, 2018 8:56:03 AM

As a Christian, I believe there's only one Person's input we need on this:

Then the King will say to those on his right, "Come, you who are blessed by my Father; take your inheritance, the kingdom prepared for you since the creation of the world. For I was hungry and you gave me something to eat, I was thirsty and you gave me something to drink, I was a stranger and you invited me in, I needed clothes and you clothed me, ***I was sick and you looked after me****, I was in prison and you came to visit me."*

Then the righteous will answer him, "Lord, when did we see you hungry and feed you, or thirsty and give you something to drink? When did we see you a stranger and invite you in, or needing clothes and clothe you? When did we see you sick or in prison and go to visit you?"

The King will reply, "Truly I tell you, ***whatever you did for one of the least of these brothers and sisters of mine, you did for me****."*

Then he will say to those on his left, "Depart from me, you who are cursed, into the eternal fire prepared for the devil and his angels. For I was hungry and you gave me nothing to eat, I was thirsty and you gave me nothing to drink, I was a stranger and you did not invite me in, I needed clothes and you did not clothe me, ***I was sick*** *and in prison* ***and you did not look after me****."*

They also will answer, "Lord, when did we see you hungry or thirsty or a stranger or needing clothes or sick or in prison, and did not help you?"

He will reply, "Truly I tell you, ***whatever you did not do for one of the least of these, you did not do for me****."*

Then they will go away to eternal punishment, but the righteous to eternal life.

Please note that the King made no mention of work requirements. If we claim to be Christians, our choice is clear.

[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Application Extension Amendment
Date: Thursday, August 9, 2018 8:53:35 AM

The barriers to being able to successfully “enforce” and support individuals to comply with this mandate is to remove the barriers that interfere with an ability to work:

Here are the top three (although there are many more):

1. Affordable childcare (more likely most will be unable to pay for any childcare since most jobs available are, at most, minimum wage).
2. Affordable and available transportation. Again, since most likely these jobs will be, at most, minimum wage, recipients will not be able to afford their own transportation.
3. Work skills and ethics. This is not innate. Mentors and resources must be tangible and readily available and consistent over a period of time . This is not a quick fix.

Without addressing barriers, as well as identifying and providing supports and resources, just requiring someone to work does nothing but exacerbate continued poverty and reliance on the system. Systemic changes over a long period of time must be what drives any possibility of success) from a systemic point of view as well as a personal point of view).

Unfortunately, I have seen no evidence of any of these considerations attached to this published mandate.

Sent from my iPhone

From: [redacted]
To: HealthyMichiganPlan
Subject: "Demonstration Extension Application Amendment
Date: Thursday, August 9, 2018 8:43:38 AM

To whom it may concern,

Please do not Implement work requirements for Medicaid. There are many many people who encounter barriers to employment who still deserve Health Care! If we want to have a society, we have to care about the other members in it. That means doing what we can to keep them healthy. Everyone knows that getting Health Care is not affordable without insurance. And for many people, insurance is not an option. My partner cannot afford insurance because it cost $700 a month, and he only makes $3000. When he goes to see his family physician, the charge is $175. A required 20-minute appointment to get medication costs more than he makes in a day. And he has to take a day off just to go to the appointment, losing that income. Legislators who have never had to bear the burden of paying healthcare costs without sufficient income have no business restricting the health care of people who go through a daily struggle just to survive. the proposal to implement work requirements is based on a theoretical idea that putting pressure on people will help them improve. This is been shown again and again by data to be untrue. If you want people to improve, support them and give them the tools they need.

Thank you for your consideration.

[redacted]

From:	Ken Fletcher
To:	HealthyMichiganPlan
Cc:	Hannah Green; Erika Sward
Subject:	Demonstration Extension Application Amendment
Date:	Wednesday, August 8, 2018 4:52:26 PM
Attachments:	Lung Association in Michigan Medicaid Sec 1115 Waiver Comments.pdf

Good Afternoon,

Please find the American Lung Association in Michigan's comments to the demonstration extension application amendment of the 1115 waiver attached. As always don't hesitate to reach out if you have any questions. Thank you for the opportunity to comment on the amendments.

Kenneth Fletcher
Director of Advocacy
American Lung Association in Michigan and Ohio
PO Box 70031 | Lansing, MI 48908-0031
O: 248-220-5213 | C: 517-582-7688
Lung HelpLine: 1-800-LUNGUSA
Lung.org | Ken.fletcher@Lung.org

AMERICAN LUNG ASSOCIATION.
IN MICHIGAN

August 8, 2018

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

Re: Section 1115 Demonstration Extension Application

Dear Director Lyon:

The American Lung Association in Michigan appreciates the opportunity to submit comments on Michigan's Section 1115 Demonstration Extension Application.

The American Lung Association is the oldest voluntary public health association in the United States, currently representing the 33 million Americans living with lung diseases including asthma, lung cancer and COPD, including nearly 1.5 million Michiganders. The Lung Association is the leading organization working to save lives by improving lung health and preventing lung disease through research, education and advocacy.

The American Lung Association in Michigan believes healthcare should be affordable, accessible and adequate. The Lung Association strongly supports the Healthy Michigan Program, which has extended coverage to 680,000 low-income individuals and families in the state.[1] This coverage helps lung disease patients access asthma medications to help them breathe, preventive services like tobacco cessation and lung cancer screening, and many other treatments to manage their conditions and stay healthy.

The purpose of the Medicaid program is to provide affordable healthcare coverage for low-income individuals and families. Unfortunately, Michigan's application does not meet this objective and will instead create new financial and administrative barriers that jeopardize access to healthcare for patients with asthma, COPD, lung cancer, and other lung diseases. According to one estimate by the Michigan House Fiscal Agency, up to 54,000 Michiganders will lose their coverage as a result of this waiver.[2] The American Lung Association in Michigan therefore opposes this proposal.

Under the waiver, individuals with incomes between 100 and 138 percent of the federal poverty level (approximately $1,372/month to $1,893/month for a family of two) would face new barriers to coverage after receiving 48 cumulative months of coverage through the Healthy Michigan program. These individuals would be required to pay monthly premiums equal to five percent of their income and complete or commit to an annual healthy behavior, unless they can demonstrate that they qualify for an exemption. Individuals who cannot meet this requirement will lose their coverage. A premium of five percent of monthly income will range from approximately $50 to $67 for an individual, a sizable cost for this low-income population. Research has shown that even relatively low levels of cost-sharing for low-income populations limit the use of necessary healthcare services.[3] This means that patients with lung disease may cut back on the healthcare that they need to manage their condition and stay healthy. Additionally, the Lung Association is concerned that, instead of incentivizing healthy behaviors, conditioning coverage on completing an annual healthy behavior will reduce coverage for individuals in need of care. Ensuring that Medicaid enrollees have access to comprehensive health coverage that includes all of the treatments and services that they need to live healthy lives would likely be a more effective approach to improving health in Michigan.

Also under this waiver, individuals between the ages of 19 and 62 would be required to either demonstrate that they work at least 80 hours per month or meet exemptions. One major consequence of this proposal will be to increase the administrative burden on all patients. Individuals will need to attest that they meet certain exemptions or have worked the required number of hours on a monthly basis. Increasing administrative requirements will likely decrease the number of individuals with Medicaid coverage, regardless of whether they are exempt or not. For example, after Washington state changed its renewal process from every twelve months to every six months and instituted new documentation requirements in 2003, approximately 35,000 fewer children were enrolled in the program by the end of 2004.[4] Battling administrative red tape in order to keep coverage should not take away from patients' or caregivers' focus on maintaining their or their family's health.

Failing to navigate these burdensome administrative requirements could have serious – even life or death – consequences for people with serious, acute and chronic diseases, including lung diseases. If the state finds that individuals have failed to comply with the new requirements for three months, they will be locked out of coverage for *at least* one month. Additionally, if the state finds that individuals have misrepresented their compliance, these individuals will be locked out of coverage for one year. People who are in the middle of treatment for a life-threatening disease, rely on regular visits with healthcare providers or must take daily medications to manage their chronic conditions cannot afford a sudden gap in their care.

The American Lung Association in Michigan is also concerned that the current exemption criteria may not capture all individuals with, or at risk of, serious and chronic health conditions that prevent them from meeting these requirements. While the Lung Association is pleased that patients will have the option to demonstrate that they qualify for an exemption through self-attestation, the reporting process still creates opportunities for administrative error that could jeopardize coverage. No exemption criteria can circumvent this problem and the serious risk to the coverage and health of the people we represent.

Administering these requirements will be expensive for Michigan. The Michigan House Fiscal Agency estimates that the state's administrative costs will be approximately $20 million, in addition to one-time information technology costs of up to $10 million.[5] States such as Kentucky, Tennessee and Virginia have also estimated that setting up the administrative systems to track and verify exemptions and work activities will cost tens of millions of dollars.[6] These costs would divert resources from Medicaid's core goal – providing health coverage to those without access to care – as well from other important initiatives in the state of Michigan.

Ultimately, the requirements outlined in this waiver do not further the goals of the Medicaid program or help low-income individuals improve their circumstances without needlessly compromising their access to care. Most people on Medicaid who can work already do so.[7] A recent study, published in *JAMA Internal Medicine*, looked at the employment status and characteristics of Michigan's Medicaid enrollees.[8] The study found only about a quarter were unemployed (27.6 percent). Of this 27.6 percent of enrollees, two thirds reported having a chronic physical condition and a quarter reported having a mental or physical condition that interfered with their ability to work.

The American Lung Association in Michigan also wishes to highlight that the federal rules at 431.408 pertaining to state public comment process require at (a)(1)(i)(C) that a state include an estimate of the expected increase or decrease in annual enrollment and expenditures if applicable. The intent of this section of the regulations is to allow the public to comment on a Section 1115 proposal with adequate information to assess its impact. However, on pages 14-15 of this proposal, the Department reuses budget neutrality estimates from an earlier proposal that are no longer relevant and

states that "MDHHS expects annual HMP enrollment to decrease but the total number of beneficiaries who will be impacted is unknown at this time." We urge the Administration to release updated enrollment and expenditures data and include this analysis in its application to the federal government to ensure the application meets federal requirements.

The American Lung Association in Michigan believes everyone should have access to quality and affordable healthcare coverage. Michigan's Section 1115 Demonstration Extension Application does not advance that goal. Thank you for the opportunity to provide comments.

Sincerely,

Ken Fletcher
Director of Advocacy
American Lung Association in Michigan

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[1] Michigan Department of Health and Human Services, Healthy Michigan Plan Enrollment Statistics, July 31, 2018. Available at https://www.michigan.gov/mdhhs/0,5885,7-339-71547_2943_66797---,00.html.

[2] Michigan House Fiscal Agency, Legislative Analysis of Healthy Michigan Plan Work Requirements and Premium Payment Requirements, June 6, 2018. Available at: http://www.legislature.mi.gov/documents/2017-2018/billanalysis/House/pdf/2017-HLA-0897-5CEEF80A.pdf.

[3] Samantha Artiga, Petry Ubri, and Julia Zur, "The Effects of Premiums and Cost Sharing on Low-Income Populations: Updated Review of Research Findings," Kaiser Family Foundation, June 2017, https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/.

[4] Tricia Brooks, "Data Reporting to Assess Enrollment and Retention in Medicaid and SCHIP," Georgetown University Health Policy Institute Center for Children and Families, January 2009.

[5] Michigan House Fiscal Agency, Legislative Analysis of Healthy Michigan Plan Work Requirements and Premium Payment Requirements, June 6, 2018. Available at: http://www.legislature.mi.gov/documents/2017-2018/billanalysis/House/pdf/2017-HLA-0897-5CEEF80A.pdf.

[6] Misty Williams, "Medicaid Changes Require Tens of Millions in Upfront Costs," Roll Call, February 26, 2018, https://www.rollcall.com/news/politics/medicaid-kentucky.

[7] Rachel Garfield, Robin Rudowitz, and Anthony Damico, "Understanding the Intersection of Medicaid and Work," Kaiser Family Foundation, February 2017, http://kff.org/medicaid/issue-brief/understanding-the-intersection-of-medicaid-and-work/.

[8] Renuka Tipirneni, Susan D. Goold, John Z. Ayanian. Employment Status and Health Characteristics of Adults With Expanded Medicaid Coverage in Michigan. *JAMA Intern Med.* Published online December 11, 2017. doi:10.1001/jamainternmed.2017.7055

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Friday, August 10, 2018 1:15:11 PM

On behalf of a Michigan resident...

" My grandparents are currently using Medicaid to pay for required nursing care for their advanced age, my cousin's son is severely disabled due to illness as an infant and Medicaid helps with his medication and periodic surgeries "

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Friday, August 10, 2018 1:17:05 PM

On behalf of a Michigan resident...

" If someone has the need for care then Medicaid needs to be there."

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Friday, August 10, 2018 1:18:15 PM

On behalf of a Michigan resident...

" I have multiple cousins that work part time who are currently unable to work full time that are having positive health outcomes as a result of inclusion in Medicaid since the implementation of ACA. For one, this has meant access to a gynecologist for the first time in her life. For another, it means physical therapy to address a years-old back injury."

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Friday, August 10, 2018 1:19:40 PM

On behalf of a Michigan resident...

"My partner has chronic kidney disease and extreme congenital hypertension. He is a classical musician, which is not a highly paid career. He needs medicine and care from specialists just to stay alive. He discovered his disease when his kidneys failed and he almost died. He was uninsured and terrified. U of M covered him under a county-level charity program, otherwise he would have died. This program no longer exists. Healthy MI is the only thing keeping him alive."

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Friday, August 10, 2018 1:22:07 PM

On behalf of a Michigan resident...

"The State of Michigan is aware of the benefits of wellness/preventative healthcare services. Medicaid provides my family that service."

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Friday, August 10, 2018 1:29:21 PM

On behalf of a Michigan resident...

" I do in-home daycare and I am not eligible for unemployment. I can’t justify charging low income families half of their paycheck to watch their children. I am low income and rely on Medicaid for my medical needs"

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Friday, August 10, 2018 1:30:31 PM

On behalf of a Michigan resident...

" Medicaid has helped keep low income individuals and families in good health, which supports my community."

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Friday, August 10, 2018 1:32:00 PM

On behalf of a Michigan resident...

"More coverage allows people to sustain a certain level of heath, enabling them to pursue their dreams and improve their lives and the lives of the people they love. What better benefit could we ask for?"

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Friday, August 10, 2018 1:33:19 PM

On behalf of a Michigan resident...

" We had Medicaid when I was pregnant with my daughter and it was a lifesaver. We now are lucky enough to have blue cross blue shield but I will never forget that Medicaid was there when I needed it. Also, I'm a stay at home mom."

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Friday, August 10, 2018 1:34:44 PM

On behalf of a Michigan resident...

" **More people have access to healthcare. Thus, more people can have fulfilling lives which includes employment."**

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Friday, August 10, 2018 1:35:49 PM

On behalf of a Michigan resident...

" These changes do not apply to me because I am disabled and will exceed the age limit by the time it goes into effect, but without expanded Medicaid to begin with, I would have been unable to have the tests and Doctor visits necessary to get disability."

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application
Date: Friday, August 10, 2018 1:40:08 PM

On behalf of a Michigan resident...

" Before losing health coverage from a clerical error my partner saw a doctor for the first time in 10 years! That is not an exaggeration. Now they have a serious health issue and CANT WORK but we are terrified by what it's going to cost now to just find out what is going on. "

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Friday, August 10, 2018 1:41:11 PM

On behalf of a Michigan resident

" Medicaid pays for ongoing psychiatrist visits and medication which would be unaffordable without Medicaid."

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Friday, August 10, 2018 1:42:29 PM

On behalf of a Michigan resident...

" For my family, Medicaid has allowed affordable coverage for my son, who has an intellectual and developmental disability, maintain a healthy life into adulthood. I had to leave my job when he finished school to ensure proper care for him. When I left my job, my family lost its health benefits. Now we pay $1,200 per month premium with a $13,000 deductible from the ACA Exchange. My son, who has Medicaid coverage, has significant health needs. To maintain a healthy life, without Medicaid, we would be paying that $13,000+ every year, in addition to the premium. It is important for our legislators and communities to note, that for people with I/DD, Medicaid is far more than just health care. Most don't understand that, and they should be more knowledgeable."

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Friday, August 10, 2018 1:43:38 PM

On behalf of a Michigan resident...

" Everyone has benefited from Medicaid coverage, because a healthy community is a strong community that can do more."

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Friday, August 10, 2018 1:44:33 PM

On behalf of a Michigan resident...

" By keeping families in our community healthy. By providing some reimbursement to hospitals for necessary care and helping to keep people out of the emergency room. "

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Friday, August 10, 2018 1:46:07 PM

On behalf of a Michigan resident...

" My best friend just broke her foot badly and needed surgery, she cannot work with the injury and may lose her job but needs medical care. Medicaid was there for her."

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Friday, August 10, 2018 1:47:08 PM

On behalf of a Michigan resident...

" Medicaid provides essential health care access to thousands of Michigan residents. The expansion of Medicaid under the ACA was a great step forward in moving towards providing affordable health care to all Americans. This is a moral question."

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Friday, August 10, 2018 1:49:14 PM

On behalf of a Michigan resident...

" I am able to get adequate healthcare to be able to continue my education and become a productive citizen"

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Friday, August 10, 2018 1:54:07 PM

On behalf of a Michigan resident...

" Everyone I know who has used Medicaid has been going through legitimate hardship and that last bit of safety net has protected them as fellow Michiganders. One friend lost her job coinciding with a diagnosis of MS. Medicaid allowed her to take care of herself and she now is a co-owner of her own small business. Two others were struggling with addiction and depression from the death of those close to them. One is now employed full time, one is employed full time and taking classes at the same time. When they were on the edge of everything Medicaid allowed them to get treatment and ultimately recover. They obviously wanted to work, but needed medical care to do so."

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Friday, August 10, 2018 1:55:18 PM

On behalf of a Michigan resident...

" Both a family member and I have received treatment through Medicaid that we would not have otherwise been able to receive. This allowed us to contribute back to society in valuable ways. I am generally very healthy and use very little that Medicaid provides, but I was able to care for my father during the end of his life without the additional fear of what would happen if something happened to me. In other, poorer developed countries around the world, this peace of mind is simply taken for granted. Surely the United States as the richest country in history and a country that finds enough money to fund a military bigger than the next twelve combined can provide what these other countries can."

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Friday, August 10, 2018 1:56:28 PM

On behalf of a Michigan resident...

" My son, who is a University of Michigan graduate, ran into problems in Chicago after doing Cancer Research for 6 years immediately after graduation. He moved home for a few months with a need to regroup and he wanted to move out west. He is ADHD, has anxiety and depression. Medicaid gave us a stop gap for 4 or five months where he could get his medicine again and was able to secure another job in Seattle at the University of Washington. He was not really able to function when he moved home. Medicaid made it so he could see a physician and find a new job. "

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Friday, August 10, 2018 1:57:54 PM

On behalf of a Michigan resident...

" My children attend a title 1 public school and I know how much the parents and sometimes the entire families struggle with food insecurity. The Medicaid program has helped so many people who are trying to keep their heads above water."

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Friday, August 10, 2018 1:59:32 PM

On behalf of a Michigan resident...

" Providing access to health care enables low income residents to concentrate on other economic necessities, such as housing, childcare, transportation, and saving for the future."

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Friday, August 10, 2018 2:04:07 PM

On behalf of a Michigan resident...

" It is the right thing to do morally. I feel proud to live in a state that is trying to help its residents most in need."

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Friday, August 10, 2018 2:05:30 PM

On behalf of a Michigan resident...

" A healthy society helps everyone. Less recourse to emergency rooms. Less contagion (especially among children in school). I disapprove of work requirements."

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Friday, August 10, 2018 2:07:01 PM

On behalf of a Michigan resident...

" Medicaid is the stop-gap that prevents situations Michiganders experience at a specific time and place in their lives from defining their futures.

Without Medicaid, individuals that find themselves without access to affordable healthcare have to make choices about their immediate needs at the expense of their long term health. By ignoring a health issue today, a person can find themselves permanently disabled. As a state that means that we save money on Medicaid costs at the expense of lifetime support costs when an individual becomes incapacitated. This isn't good for our communities and it isn't the right way to treat people in crisis.

Without Medicaid, the pathway out of poverty is difficult, unlikely.

As a young adult and mother, I found myself relying on Medicaid to stay afloat after having major surgeries to preserve my ability to walk. Working three jobs I was able to provide housing, food and safe childcare for my family while working through school and trainings to prepare for a better future. Because of Medicaid, I knew that I didn't have to sacrifice my home, or my health, to make ends meet. While I am forever grateful for the three years that Medicaid provided for my family, I can now safely say that I don't ever expect to need any type of state assistance again. I have a great job (thanks to being able to finish my education), I pay for my healthcare, I own my home, I have savings in the bank, I have significant retirement savings and I have saved nearly $100,000 for my children to attend college - so they never find themselves in my shoes.

Making Medicaid less accessible has long lasting consequences that far surpass any perceived savings. Medicaid is not the tool to force people into jobs that can't and won't ever be able to provide."

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Friday, August 10, 2018 2:07:55 PM

On behalf of a Michigan resident...

" My husband was under-employed and seriously ill (cardiac and renal issues) with no coverage whatsoever until Healthy Michigan was put in place. If not for this program, he would either be dead or we would be on the street - there was no way we would be able to pay the horrendously high medical bills."

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Friday, August 10, 2018 2:09:36 PM

On behalf of a Michigan resident...

" I had a mental health crisis, was hospitalized, and chose to resign from my job because I did not qualify for FMLA or short term disability since I had not worked there for an entire year. Medicaid has filled the gap for me, and I'm about to enter a PhD program as a funded Graduate Teaching Assistant where I will be able to get health care through the University. Without Medicaid, I would be bankrupt and potentially dead from not being able to afford mental health care."

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Friday, August 10, 2018 2:10:51 PM

On behalf of a Michigan resident...

" More people have been insured and help support our local small hospitals"

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Friday, August 10, 2018 2:13:14 PM

On behalf of a Michigan resident...

" Medicaid coverage reduces unpaid care at local hospitals and providers, keeps my neighbors healthier, too. "

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Friday, August 10, 2018 2:14:02 PM

On behalf of a Michigan resident...

" I have had chronic and severe asthma for my entire life. This condition forces me to attend the emergency room 3-4 times per year. I attend the Urgent Care at least as many times per year. My asthma prescriptions as well as other prescriptions that I receive are covered. "

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Friday, August 10, 2018 2:14:55 PM

On behalf of a Michigan resident...

" Medicaid has enabled so many families in Michigan to have health insurance. No one should experience a financial crisis because they get sick and no sick person should be turned away when seeking treatment. This is the richest country in the world. We can afford to take care of our own."

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Friday, August 10, 2018 2:15:49 PM

On behalf of a Michigan resident...

" My children are on Medicaid and it has made the difference in being able to schedule routine appointments and checkups and get support when needed. "

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Friday, August 10, 2018 2:16:57 PM

On behalf of a Michigan resident...

" My disabled son has independent living supports that are effective. Appropriate job training supports would be great but they don't exist yet. "

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Friday, August 10, 2018 2:17:55 PM

On behalf of a Michigan resident...

"**I'm a social worker and most of my clients are covered by Medicaid, many through Medicaid expansion. Medicaid coverage helps alleviate some negative health impacts of poverty (lead poisoning in children), besides covering necessary healthcare it is also a gateway through which many are identified and connected with additional resources they need- providers discover a patient is homeless, providers discover a disabled patient doesn't know how to apply for social security or even that they can, et cetera. "**

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Friday, August 10, 2018 2:18:48 PM

On behalf of a Michigan resident...

" I work with a large number of individuals who have received Medicaid coverage. This coverage has increased the health of the family as a whole, which has lessened stress for parents and allowed them to parent more effectively. Lowered stress and better health are directly correlated with lower rates of child abuse and neglect. Lower rates of abuse and neglect are directly correlated with lower long-term healthcare needs. So Medicaid coverage now saves the government significant amounts of money in the future. Medicaid should not be made more difficult to access. "

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Friday, August 10, 2018 2:21:22 PM

On behalf of a Michigan resident...

" Members of my community have been able to see a doctor and obtain medical evidence necessary to apply for Disability due to medicaid coverage. They have been able to lead healthier lives, and work towards improvements leading to becoming productive members of society."

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Friday, August 10, 2018 2:22:54 PM

On behalf of a Michigan resident...

" Medicaid supported my family in the time of need during transition to new jobs (for about a year) and currently supports a disabled family member. "

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Friday, August 10, 2018 2:24:14 PM

On behalf of a Michigan resident...

" Children and their families have health care leading to positive health outcomes. Kids and families will suffer if parents lose coverage due to work requirements."

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Friday, August 10, 2018 2:25:13 PM

On behalf of a Michigan resident...

" As a primary care physician, I have seen Medicaid allow disadvantaged people become more productive members of society. "

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Friday, August 10, 2018 2:26:37 PM

On behalf of a Michigan resident...

" In the past year I ended up in the hospital 6 times and then needed to see several different types of specialists to finally determine why I had such a high blood pressure and risk of stroke even while on medication and eating properly. It took 6 months of continuous appointments to finally find the underlying medical condition and start to treat that so my blood pressure could improve. I missed numerous days of work in order to accomplish this and could barely pay my share of rent and buy enough gas to get to and from the appointments and work. During part of this time I was not working because I quit the job that was causing my blood pressure to spike so high that my vision went black and the paramedics worried I might have a stroke before making it to the hospital. During that 2 months I needed to not work while I began recovery and had doctors appointments several times per week. Under the new plan I would have been dealing with the stress of the work requirements while dealing with stress-induced risk of stroke. My toddlers might not have a mother any more if I had not been permitted to be off of work while reducing my risk of stroke. And the medical appointments continued once I was back to work, slightly over poverty income. So the 5% would have made me choose between electricity and medical. I already don't have frivolous expenses like pets or cable TV or parties, or even recent clothes despite my existing clothes being almost worn through and no longer fitting. There was nothing to get the 5% from. So I would not have insurance and who knows if my boys would be orphaned if I hadn't gotten the medical care I needed. "

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Friday, August 10, 2018 2:27:32 PM

On behalf of a Michigan resident...

" I work with Medicaid recipients and most are very vulnerable and need support and resources."

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Friday, August 10, 2018 2:30:44 PM

On behalf of a Michigan resident...

" My daughter & her 2 children currently have Medicaid coverage. My daughter have been working for the same child care provider for 13 yrs and unable to afford their medical benefits after the kids. I'm struggling trying to afford health care for me & my son and I have been told my coverage is pretty good through my company."

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Friday, August 10, 2018 2:31:41 PM

On behalf of a Michigan resident...

" I know so many people that depend on Healthy Michigan Coverage to make their everyday lives work. This program saves lives and tax payer dollars when looking at the BIG PICTURE."

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Friday, August 10, 2018 2:32:27 PM

On behalf of a Michigan resident...

" Communities that have access to healthcare are more productive."

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Friday, August 10, 2018 2:33:30 PM

On behalf of a Michigan resident...

" As an oncology nurse for over 40 years I have seen financial hardship including bankruptcy for the uninsured/under-insured and have at least 4 head and neck cancer patients in my practice area alone who are cancer-free due to Healthy Michigan (admitted they would not have sought care if they were uninsured). "

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Friday, August 10, 2018 2:36:32 PM

On behalf of a Michigan resident...

" Medicaid helps keep my severely disabled daughter alive. Despite being disabled she brings joy to everyone who comes into contact with her. She makes the world a better place."

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Friday, August 10, 2018 2:37:18 PM

On behalf of a Michigan resident...

" I was on the Healthy Michigan plan when it was first implemented. I've since incomed out of it. I was able to get a toothache fixed because of it. Now I pay about $100/month through my employer for worse coverage that I don't use."

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Friday, August 10, 2018 2:38:30 PM

On behalf of a Michigan resident...

" Healthy Michigan prevented unnecessary hospitalization and personal bankruptcy."

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Friday, August 10, 2018 2:39:23 PM

On behalf of a Michigan resident...

" People with low incomes can get health care. That's a good in itself."

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Friday, August 10, 2018 2:40:09 PM

On behalf of a Michigan resident...

" A family member has been able to have access for the care of her daughter and for herself which she would otherwise not be able to afford."

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Friday, August 10, 2018 2:41:01 PM

On behalf of a Michigan resident...

" My son, who has multiple severe disabilities (both physical and developmental) has been on Medicaid since he turned 18. Medicaid has covered many costs of his health care which we would have been unable to afford "

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Friday, August 10, 2018 2:42:39 PM

On behalf of a Michigan resident...

" Keeping people healthy in school or work and enhancing the health of the community as a whole...improving social terminates of health outcomes"

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Friday, August 10, 2018 2:43:18 PM

On behalf of a Michigan resident...

" Medicaid has lifted so many out of dire circumstances. This is a public good I gladly pay for."

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Friday, August 10, 2018 2:44:27 PM

On behalf of a Michigan resident...

" I served as the director of a free clinic in our community for 15 years. The HMP changed lives for the better. As I signed individuals up for HMP, I saw tears of joy, sighs of relief and determined individuals who intended to make healthy choices and take charge of their lives. It was heart breaking and heart warming all at once. Health care SHOULD be a right for all Michiganders not just the privileged."

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Friday, August 10, 2018 2:45:19 PM

On behalf of a Michigan resident...

" Family member had serious back infection that could have been deadly if not for access to health care."

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Friday, August 10, 2018 2:46:04 PM

On behalf of a Michigan resident...

" My family had medical coverage though my husband's job, but he has recently become unemployed and is having trouble finding a new job. I'm very grateful that are kids can be covered by Medicaid during this challenging time. They need checkups with vaccinations for school registration."

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Friday, August 10, 2018 2:46:48 PM

On behalf of a Michigan resident...

" We are the only civilized country without universal care. It is cruel and barbaric that we have to struggle to pay care costs like this. Losing our homes, etc. "

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Friday, August 10, 2018 2:48:14 PM

On behalf of a Michigan resident...

" We are a stronger community when we care for the vulnerable."

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Friday, August 10, 2018 2:49:05 PM

On behalf of a Michigan resident...

" Thankfully, my family has never had to rely on Medicaid coverage. I realize that not everyone is as blessed as we are. A healthy community benefits us all. "

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Friday, August 10, 2018 2:50:01 PM

On behalf of a Michigan resident...

" While we do not have Medicaid at this time, several years ago my children did and when my son had to have surgery, our primary (commercial) insurance would have left us with an $8,000 copay, which would have crippled us. Medicaid covered the rest, which allowed us to not be trapped by a bill we couldn't pay."

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Friday, August 10, 2018 2:51:11 PM

On behalf of a Michigan resident...

" I believe everyone has a right to health care. The Medicaid expansion in Michigan has allowed low income folks to get needed care and are healthier. They are better able to care for themselves and others and seek employment. "

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Friday, August 10, 2018 2:52:16 PM

On behalf of a Michigan resident...

" In addition to providing care for many of our elders in nursing homes or through home health services, the Medicaid expansion has meant that thousands of our community members have received important health care benefits enabling them to look for work - or remain at work. This is a positive for everyone in Michigan! "

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Friday, August 10, 2018 2:53:08 PM

On behalf of a Michigan resident...

" I work hard to ensure that those who are not able to work (either permanently or temporarily) can get the care they need. Healthcare for ALL. It’s the morally correct thing to do. "

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Friday, August 10, 2018 2:56:51 PM

On behalf of a Michigan resident...

" I would have no other way of getting or staying on my medications for PTSD, major depressive disorder, and anxiety. My children would not have their medications for asthma, chronic acid reflux, and multiple allergies. Loss of insurance would have a severely negative impact on my family."

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Friday, August 10, 2018 2:58:04 PM

On behalf of a Michigan resident...

" Insuring the most vulnerable in our communities. Providing life saving and chronic disease management services for those who would likely go without. Many people on Medicaid already are working. The percent who do not and are physically, emotionally, economically able is a very small minority and there are many barriers in rural areas making gainful employment very difficult. In addition, Michigan Right to Work Laws provide workers in Michigan with little protection. I think the right way to approach this is to remove the income restriction for qualifying for Medicaid and open it up to every resident in the state of Michigan as a viable option for health insurance coverage. Each person will pay 3% of their gross income to fund the program. For example, someone making 24,000 per year would pay $720 per yr; someone making $240000 per year would pay $7200 per yr. no copays, deductibles or out of pocket expenses. In this way every Michigan resident can benefit from, if they so choose, the program which our tax $$ help to support."

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Friday, August 10, 2018 2:58:49 PM

On behalf of a Michigan resident...

" A family member on profoundly developmentally disabled, while another is severely limited by physical disability and another by a mental health issue. Their access to Medicaid has provided irreplaceable support for their conditions. "

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Friday, August 10, 2018 2:59:53 PM

On behalf of a Michigan resident...

" I have off and on struggles with keeping work due to PTSD/Anxiety, and have used Medicaid quite a bit. Under the VA, I don't have traditional emergent care and used it for that."

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Friday, August 10, 2018 3:00:46 PM

On behalf of a Michigan resident...

" My grand son is a full time college student, his parents cannot afford to carry him on their health insurance. He works part time which does not qualify him for employee health insurance. Being able to obtain Medicaid has been a blessing! "

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Friday, August 10, 2018 3:01:43 PM

On behalf of a Michigan resident...

" We are able to get the medical help we need as senior citizens. Without it we would have no money to pay for the coverage we would need having preexisting conditions. It has allowed me to get my diabetic medicine and my husband's high blood pressure medication. Without the coverage we could not afford to pay for the medicine."

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Friday, August 10, 2018 3:04:03 PM

On behalf of a Michigan resident...

" Yes, Medicaid does help a lot of people. My daughter was on it and her daughter has it. Child care was an issue for them to work. Anyone working with insurance pays 30% of the premium, so I think 5% is reasonable."

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Friday, August 10, 2018 3:05:04 PM

On behalf of a Michigan resident...

" It has literally saved my life by allowing me to get an expensive test that showed that an organ was rotting in my body. Without coverage, I could not have gotten the test."

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Friday, August 10, 2018 3:05:57 PM

On behalf of a Michigan resident...

" A number of my family members are hardworking and industrious, but unable to find or hold jobs for multiple reasons. They have medical conditions that would go undiagnosed and treated without Medicaid."

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Friday, August 10, 2018 3:06:51 PM

On behalf of a Michigan resident...

" Individuals who have never had healthcare coverage now have the opportunity to manage their health."

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Friday, August 10, 2018 3:07:57 PM

On behalf of a Michigan resident...

" Healthy Michigan Plan has provided community members an opportunity to afford healthcare coverage for the first time in a long time. They are able to get comprehensive medical care and preventive services which will save them and the State a lot of money. We need to find ways to lower premiums and deductibles instead of adding additional work requirements. It is our duty to take care of ALL Michiganders, especially those who are most vulnerable."

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Friday, August 10, 2018 3:09:02 PM

On behalf of a Michigan resident...

" Medicaid was never designed to be a workforce development program. One great benefit to our community is that people who need it can continue to live and function with dignity. How many more people would be completely dependent on charitable resources that are already stretched thin should these new rules apply? These new, Republican-sponsored work rules are another attempt at weakening the “safety net” for low-income citizens. Such actions are reprehensible, especially in view of rising healthcare costs."

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Friday, August 10, 2018 3:09:54 PM

On behalf of a Michigan resident...

" Important mental health and surgery was possible because of Medicaid."

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Friday, August 10, 2018 3:10:00 PM

On behalf of a Michigan resident...

" I have been able to have my chronic conditions treated, so I have been able to stay healthy and contribute within my community, by advocating for others who are disabled. This is an issue of Humanity (i.e. being humane) and we all need to take care of each other. We NEED universal healthcare; Medicare for all! Do the right thing! NO CHANGES TO MEDICAID! Let compassion rule the day!"

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Friday, August 10, 2018 3:11:20 PM

On behalf of a Michigan resident...

" Medicaid provides behavioral health care to our daughter in a manner that supports her to be included in the community and employed part time. "

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Friday, August 10, 2018 3:12:14 PM

On behalf of a Michigan resident...

" I work in a Physical Therapy clinic. Our patients that are covered by Medicaid are able to be treated for injuries that they weren't able to take care of without Medicaid. This allows them to stay healthy so they can move. This reduces the burden in other areas of healthcare, if they aren't sedentary and getting diseases related to that. "

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Friday, August 10, 2018 3:13:10 PM

On behalf of a Michigan resident...

" I'm a single mom working 2 jobs, well over full time hours. But the pay is low and no benefits are offered. Medicaid is the only insurance we have and couldn't afford anything else."

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Friday, August 10, 2018 3:14:10 PM

On behalf of a Michigan resident...

" It covers my sister and her wife who both have serious health issues and are disabled, but not disabled by Social Security standards. One has mental health issues and would probably kill herself without it. The other has some mental issues too but also physical ones. For me, I have 3 degrees but no job because I cannot find work, plus I have an infant, and a teenager who's disabled. This work requirement will do serious damage to many and throw us all under the bus again. People will lose their jobs because the health care facilities won't be able to afford them any longer. "

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Friday, August 10, 2018 3:15:04 PM

On behalf of a Michigan resident...

" The Healthy Michigan Plan has kept my family alive. Without our health care coverage, we would lose our home. I do not know how we would survive without the Healthy Michigan Plan."

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Friday, August 10, 2018 3:16:17 PM

On behalf of a Michigan resident...

" Feels good being in a community where there is a safety net of a sorts for those in my community who need it."

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Friday, August 10, 2018 3:17:16 PM

On behalf of a Michigan resident...

" I am a single mother and full time student. Most places will only hire for thirty hours and below. I have a bachelor's and make just over minimum wage. I also have an internship, which is twenty free hours a week. I don't have time to get help when I'm sick. Added stress means I will never go. "

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Friday, August 10, 2018 3:18:26 PM

On behalf of a Michigan resident...

" My parents have benefited from the Healthy Michigan Plan/Medicaid. They are older, have put in their years of work and are able to live a simple life on minimal income. These programs have helped them to keep up on their health issues without forcing them out of their home. Without these programs, they may have ignored serious health issues and may not be here today. My brother and his family of 6 has also benefited from these programs which helps keep them from bankruptcy for the second time. I have employee sponsored healthcare, pay premiums, co-pays, and deductibles. However, I still support Medicaid and the Healthy Michigan Plan 100%!"

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Friday, August 10, 2018 3:19:13 PM

On behalf of a Michigan resident...

" It benefits mostly individuals and families with children who do not have little or no medical insurance."

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Friday, August 10, 2018 4:00:23 PM

On behalf of a resident of Michigan...

" I don't want my daughter to have to change her education track because someone has decided that what she is studying isn't "job related". I don't want people to lose coverage because they missed reporting their work or educational activities one month. I don't want people to lose their coverage because the only work they can find will not cover the cost of their childcare. I don't want people to lose their coverage because they don't have access to transportation."

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Friday, August 10, 2018 4:01:17 PM

On behalf of a Michigan resident...

" More people would go bankrupt from using the hospital, people may die earlier than necessary due to lack of treatment. Medical facilities will lay off staff because of funding woes. It’s a snowball action. Please keep Healthy Michigan"

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Friday, August 10, 2018 4:02:43 PM

On behalf of a Michigan resident...

" When looking at other first world countries, America is the only country putting people in debt in paying medical bills. We are supposed to be the greatest country in the world and yet our citizens are not being given basic Heath care without large debts. This needs to change. Biblically, Jesus took care of the broken. The same should be said for our government. It's hypocritical for some of these religious rights to want to abandon the poor then citing the Bible when doing it."

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Friday, August 10, 2018 4:03:27 PM

On behalf of a Michigan resident...

" Work requirements will cause members of my community to lose their health coverage. That will force people needing care to go emergency rooms, rather than to a doctor who knows them and their health needs. Without access to good healthcare they will find it harder to take care of their children, to go to school and to look for work."

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Friday, August 10, 2018 4:04:26 PM

On behalf of a Michigan resident...

" Efforts to create a law limiting access to the Healthy Michigan Medicaid program is of great concern to organizations like ours who are committed to ensuring access to health services for all as a foundation for promoting health equity in our communities. Employment and educational attainment are values we espouse and believe are essential determinants of health. However, as punitive tools designed to exclude those who have been chronically unemployed or disconnected to the education system, this is a misdirected, if not malicious effort.

If work and educational requirements are deemed necessary – and we hope Gov. Snyder will use reason in his assessment of this legislation – we strongly recommend that community engagement, increased job readiness resources, and educational counseling be included as part of the package.

Michigan was a leader among states in establishing a strong Healthy Michigan program. It will take time to demonstrate its ultimate value to the disenfranchised population of our state. This is not the time to be reducing access to our vulnerable population."

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Friday, August 10, 2018 4:05:11 PM

On behalf of a Michigan resident...

" My brother is not the only one in Michigan that faces major challenges. Show some basic human decency for the people in our community."

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Friday, August 10, 2018 4:08:08 PM

On behalf of a Michigan resident...

" The proposal now being considered may result in many currently out of work people becoming physically unable to obtain and maintain gainful employment because of poor health due to lost Medicaid."

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Friday, August 10, 2018 4:09:19 PM

On behalf of a Michigan resident...

" I am working. Adjunct professors, which make up approximately 60-70% of the faculty in universities and colleges across the country, are given courses to teach based on availability. We are paid per course we teach, and there are not many courses available in the summer. For example, last school year, I taught 5 courses in Fall (60 hours/week), 4 (48 hours/week) in Winter, and only 1 (12 hours/week) in the summer. This means that I've fallen far below the proposed required work hours. If I were penalized for keeping my job, and only working what is available, it would be unjust and severely counterproductive for both my career and my health."

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Friday, August 10, 2018 4:10:15 PM

On behalf of a Michigan resident...

" It only further complicates the lives of direct support staff. This will add one more factor to the ongoing challenge of finding qualified individuals to serve as direct support staff "

-

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Friday, August 10, 2018 4:11:24 PM

On behalf of a Michigan resident...

" It will push the struggles back to ED for care and mental health care back to county responsibility for payments when general funds are not provided, causing programs to be cut. Idiocy in the work's, provide universal care medicare to all people. The state and the US is a world wide embarrassment with neglecting health needs, including mental health, prisons are not and should not be pipeline for mental health care, they do a pathetic job trying, homelessness increases, veterans also left out."

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Friday, August 10, 2018 4:12:09 PM

On behalf of a Michigan resident...

" Required work without transportation is just setting people up for failure"

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Friday, August 10, 2018 4:13:02 PM

On behalf of a Michigan resident...

" People with disabilities are 2.5 times more likely to live in poverty, those who receive benefits lose part of their benefits for earning too much! Forcing people to work is not the answer! How about an economy where jobs pay a wage that allow for independence and ability to get off entitlements. This mindset to mandate work can only point to a GOP philosophy that all people are takers - a white person's warped sense of those in need. "

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Friday, August 10, 2018 4:13:56 PM

On behalf of a Michigan resident...

" I feel people should work. But you can not work at fast food and pay for day care. Day care needs to be higher quality. Let’s break the cycle by offering job training , quality care"

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Friday, August 10, 2018 4:14:49 PM

On behalf of a Michigan resident...

" People will suffer because of these changes."

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Friday, August 10, 2018 4:15:50 PM

On behalf of a Michigan resident...

" Healthy people are folks that give back...keep the community going, provide jobs, work jobs, contribute to community shops/stores, economy works better, others get jobs too: day care providers, etc...It's good all the way around."

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Friday, August 10, 2018 4:17:03 PM

On behalf of a Michigan resident...

" Personally, I would not meet the work requirement. I do not attend school for 80 hours per month. Due to my degree program availability, I can only attend just enough to make it impossible to find a job to accommodate my school schedule. The work requirement will cause me to lose my Medicaid. Without it, I will lose my medication. For people with Multiple Sclerosis, if they do not take a medication, their disease progresses. MS progression could lead to paralysis requiring a wheelchair, blindness, incontinence, cognitive issues including memory loss, and pain among other symptoms. If I were allowed to finish school and keep my Medicaid, I will have a career and no longer need Medicaid. If I lose my Medicaid, I will no longer be able to work ever again and end up on Medicare and disability."

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Friday, August 10, 2018 4:18:00 PM

On behalf of a Michigan resident...

" Changes to the Medicaid program would remove the necessary supports for people to live independently and participate in their community to the fullest extent possible."

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Friday, August 10, 2018 4:18:59 PM

On behalf of a Michigan resident...

" I believe the lawmakers proposed these changes because they think everyone on Medicaid is a lazy bum. The truth is that families are already struggling enough and now the lawmakers (who already have the best healthcare thanks to taxpayers) want to makes families suffer even more by making recipients jump through hoops of red tape causing even more stress and anxiety and struggling. "

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Friday, August 10, 2018 4:20:02 PM

On behalf of a Michigan resident...

" Having to pay 5% of our income would be devastating and unsustainable. The current living wage for Michigan for a family of 3 with one person working/one caregiver is $43,287. (http://livingwage.mit.edu/states/26) The numbers don't add up - if we make $25,000 a year, where does that $1250 come from? Food? Housing? Transportation?

We are also in a catch 22 - our income is likely to go up this year, which is great. But once we are out of Healthy Michigan, healthcare costs become unaffordable. Last time I checked a catastrophic plan had a $12,000 deductible and costs $120/month. How is that affordable on an income of $30,000-$35,000? If this is still the case, I will forgo insurance (now that there is no penalty) and risk bankruptcy if there is a medical emergency. It doesn't make sense to pay almost $1500 a year for a checkup and then have to pay $12,000 out of pocket before my deductible is met.

The answer to ALL of these issues, in my opinion, is a single payer system or national healthcare system. People forgo healthcare, switch jobs, get married and stay married because of healthcare coverage. It's not just a poor people issue, it's a middle class issue too, speaking as one who flits between the two demographics. It's ridiculous that we as a society have to worry about healthcare so much. "

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Friday, August 10, 2018 4:21:24 PM

On behalf of a Michigan resident...

" It's going to make a lot of people who need help but can't work go without any health care. Congress and state officials are punishing the elders and the poor. While they continue to get wealthier. Not everyone one Medicaid is on it to take advantage of the system. They are on it to survive."

From: Emily Schwarzkopf
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Friday, August 10, 2018 4:29:17 PM
Attachments: MLPP Public Comment - HMP.pdf

Attached you will find the Michigan League for Public Policy's written comments.

Thank you,

--
Emily Schwarzkopf
Policy Analyst
Michigan League for Public Policy
Office: 517-487-5436 Cell: 517-507-6934
mlpp.org

MICHIGAN LEAGUE FOR PUBLIC POLICY

August 10, 2018

Governor Rick Snyder
P.O. Box 30013
Lansing, MI 48909

Nick Lyon, Director
Michigan Department of Health and Human Services
333. S. Grand Ave.
P.O. Box 30195
Lansing, MI 48909

Dear Governor Snyder and Director Lyon,

I write today to express my concerns about the waiver amendment to the Healthy Michigan Plan which would require those on the program to meet a stringent work requirement and a requirement that certain individuals pay substantial premiums in order to maintain coverage. We continue to have the same concerns today as we did when the legislation that triggered this process moved through the Legislature and onto Governor Snyder for approval.

If you look very plainly at the intention of the Medicaid program, the program was designed to give people with low incomes health insurance and improve their health. Nowhere in the Medicaid statute does it say that work could and can be used as a determination of eligibility[1]. From that view, Medicaid is a health insurance program, not a jobs program. And while we believe fundamentally that work requirements do nothing to improve the health of our fellow Michiganders, are likely to cause excessive costs to our state budget, burdensome paperwork for doctors, beneficiaries, and state workers and may cost people their health coverage if they struggle to qualify for exemptions or get a job – today, I would like to focus on three main areas of concern regarding Michigan's Section 1115 waiver request.

[1] 42 U.S.C. 1396a(a)(10), which states that Medicaid is for "making medical assistance available" for all eligible populations, including the expansion population.

We are deeply concerned about the coverage losses that may occur as a result of these changes. And while we believe all enrollees in Healthy Michigan will be impacted in some way – it is important for us to know if people will lose coverage because of these restrictions, whether it be through non-compliance, the inability to find a job and therefore meet the requirements, an inability to pay their premiums, or even if they no longer receive coverage because they did find a job that offered health coverage. The nonpartisan House Fiscal Agency estimated that 54,000 could lose coverage[2] but this did not take into account people that may lose coverage due to inability to pay the 5% premium after 48 months and assumes that everyone eligible for an exemption is able to secure one. Given these qualifiers, it is our belief that the coverage losses could be much greater. We implore the department to do what it can to provide advocates and beneficiaries an accurate picture of the number of people that may be harmed from these new provisions.

In our letter urging Governor Snyder to veto the legislation[3], we highlighted another major concern and that is the lack of resources for people to comply with these requirements. If this is the path that Michigan is going to take, we need to ensure that people have the resources to meet these requirements. As written, the department would need only to direct individuals to existing resources for job training, transportation, and child care – many of these resources are significantly lacking.

The debate around transit has been raging in Michigan for years and to date there has been no significant progress on this in any part of our state. In its 2018 report, the America Society of Civil Engineers graded Michigan's transit system a C- stating that "the reliability and availability of these services to many areas is inadequate, and some of the urban systems are unable to adequately meet transit demands."[4]

Affordable child care is also essential to ensuring that individuals can take care of their families. But research shows that child care remains unaffordable to parents with low or moderate wages. The average cost of care for one infant in a licensed child care center in Michigan exceeds $10,000, dropping only to $7,300 for a four year old – these costs would be significantly difficult to overcome in families that have more than one child. In the Midwest, annual child care expenses for two children ($19,728) rival the costs of a college education and far exceed housing costs ($17,188).[5] The truth of the matter is that families may find that the cost of child care is too great of a burden and may choose not to work because affordable care is not available.

Transportation, affordable child care, and job training are essential investments that the state can make to ensure that those who must meet these stringent requirements can. We would urge the next administration and the next Legislature to look at ways to invest in these important work supports. The entire state would ultimately benefit from these investments.

Finally, we have grave concerns about the decision to rescind the state's marketplace option and move instead to a requirement that individuals above 100% of the federal poverty line pay a 5% premium plus participate in increasingly challenging healthy behaviors in order to maintain coverage.

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[2] Kevin Koorstra, *Healthy Michigan Plan Work Requirement and Premium Payment Requirements*, House Fiscal Agency, June 2018, http://www.legislature.mi.gov/documents/2017-2018/billanalysis/House/pdf/2017-HLA-0897-78EF78F9.pdf

[3] *Letter from Michigan League for Public Policy President and CEO urging Governor Snyder to veto SB 897,* https://mlpp.org/wp-content/uploads/2018/08/snyder-letter-sb-897-veto-clean.pdf (June 1, 2018)

[4] *Report Card for Michigan's Infrastructure,* https://www.infrastructurereportcard.org/wp-content/uploads/2016/10/FullReport-MI_2018-FINAL-1.pdf American Society of Civil Engineers (2018)

[5] *Parents and the High Cost of Child Care,* Child Care Aware of Michigan (2017)

In Judge Boasberg's opinion in *Stewart vs. Azar* he concluded that the objective of Medicaid is not only to provide coverage, but also to reduce the costs of healthcare for low-income individuals and families.[6] There is no doubt that these premium rates may make coverage unaffordable, especially for families with low-incomes. Five percent premium payments are unprecedented and have never been approved in any state. Premiums may significantly reduce enrollment and health coverage, rather than strengthen engagement in an individual's healthcare. It is also of concern regarding the requirement to participate in increasingly more challenging healthy behaviors. I worry that these individuals may not have easy access to options that would meet this definition.

The Michigan League for Public Policy has long advocated for the Healthy Michigan program and believes strongly that it has been of benefit to those that receive coverage through it and it has also benefitted the fiscal health of our state. Nearly 680,000 of our fellow Michiganders have received coverage through the program – that includes annual physicals, dental visits, cancer screenings, and prescription drugs. We are understanding of the limitations afforded to the department by ways of Public Act 208 of 2018 but we believe that for the reasons listed above and from the many comments you will receive that you should look closely at how these changes will impact the very people that have benefitted from the current success of the Healthy Michigan program.

Respectfully submitted,

Gilda Z. Jacobs
President and CEO

[6] See *Stewart v. Azar*, page 46, https://ecf.dcd.uscourts.gov/cgi-bin/show_public_doc?2018cv0152-74

From: MARK MCWILLIAMS
To: HealthyMichiganPlan
Cc: ELMER CERANO
Subject: Comments on Healthy Michigan Waiver Extension Request
Date: Friday, August 10, 2018 10:27:55 AM
Attachments: HM Work Requirements waiver amendment comments 7-18.doc

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Greetings!

Here are written comments from Michigan Protection & Advocacy Service, Inc. (MPAS) on the proposed Healthy Michigan Medicaid waiver amendment.

Please feel free to contact me if you have any questions.

Mark McWilliams, Attorney
Director, Public Policy and Media Relations
Michigan Protection & Advocacy Service, Inc.
4095 Legacy Parkway, Suite 500
Lansing, MI 48911-4263
(517) 487-1755/(800) 288-5923
Fax: (517) 487-0827
mmcwilliams@mpas.org

MICHIGAN
MP&AS
"PROTECTING THE RIGHTS OF PERSONS WITH DISABILITIES"
PROTECTION & ADVOCACY SERVICE, INC.

Elmer L. Cerano, *Executive Director*

July 31, 2018

Comments by Michigan Protection & Advocacy Service, Inc. (MPAS) on Healthy Michigan Waiver Amendment 7/9/18

Michigan Protection & Advocacy Service, Inc. (MPAS) is a private, nonprofit corporation mandated to advocate for people with disabilities in Michigan. MPAS appreciates the opportunity to comment on the July 9, 2018, Healthy Michigan Plan Waiver Amendment, particularly Section VI as it relates to the "workforce engagement" provisions. MPAS understands that MDHHS has been required to submit these amendments by state law, so we will not comment here on the merits of the workforce engagement provisions themselves or how they relate to the intent of the Healthy Michigan waiver, that is, "improving access to healthcare for uninsured or underinsured low-income Michigan residents" (p.5).

In Section VI, the initial program evaluations report specific improvements in mental health services under the waiver. Primary care providers noted that "coverage for … mental health services [is a] previously unmet need being addressed by the Healthy Michigan Program" (p. 18). Among enrollees, 32.1% reported that they had at least one mental health condition, 56% knew that the Healthy Michigan Plan covered counseling for mental and emotional problems, and 38.2% said their mental health had improved (pp. 19-21).

The waiver amendment should specifically provide for evaluation of how these gains in mental health services will be affected by the changes in the waiver and the likely reduction in the number of people served (as noted in Section V). Michigan is currently experiencing a crisis in the provision of community mental health services and continues to experience problems with achieving mental health parity in private insurance. In this environment, maintaining gains in providing mental health services is crucial progress that should not be surrendered lightly.

Please contact Mark McWilliams, mmcwilliams@mpas.org, at (517) 487-1755 if you have any questions.

Main Office:
4095 Legacy Parkway, Suite 500 • Lansing, MI 48911-4263
517.487.1755 (Voice or TTY)
800.288.5923 (Information and Referral
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906.228.5910
866.928.5910 (Toll Free)
906.228.9148 (Fax)

MPAS web site: www.mpas.org

From: Darla Jackson
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Friday, August 10, 2018 10:29:45 AM
Attachments: Medicaid work requirements.pdf

Hello,

Attached is a letter to be included in the public comments for the Healthy Michigan Plan 1115 Demonstration Waiver Extension Request Amendment. Please let me know if you have any trouble opening the attachment.

Thank you for the opportunity to provide feedback.

Darla Jackson
Human Services Specialist
jackson@meridian.mi.us
Phone 517.853.4204
Fax 517.853.4251
5151 Marsh Road | Okemos, MI 48864

Meridian Township
5151 Marsh Road
Okemos, MI 48864

P 517.853.4000
F 517.853.4096

August 10, 2018

MDHHS
Medical Services Administration
Bureau of Medicaid Policy and Health System Innovation
Attention: Medicaid Policy
P.O Box 30479
Lansing, MI 48909

To whom it may concern:

The Meridian Township Community Resources Commission opposes the portions of the proposed Michigan Section 1115 Medicaid waiver that mandates citizens to work in order to receive health care and to pay 5% of their income toward Medicaid premiums.

The University of Michigan Institute for Healthcare Policy and Innovation, Michigan League for Public Policy, and Citizens Research Council have all researched the issue and have come to the same conclusion: imposing a work requirement for Medicaid will create an unnecessary deterrent and result in poorer health for low-income residents. This research has been echoed by national organizations such as the Urban Institute and the Kaiser Family Foundation. The data indicates that the majority of current Medicaid enrollees are already working or have health conditions that prevent them from working, instituting a work requirement would cause an undue burden on those that are unable to work, and the state would incur a great expense to enforce the policy.

As a group of volunteers who are charged with helping ensure the human services safety net works as well as possible, we view Medicaid as a successful tool in getting and keeping households out of poverty and receiving cost-effective, life-saving health care. We urge you to preserve the current system and not mandate citizens to work or pay 5% of their income toward premiums in order to receive Medicaid.

Thank you for your consideration. Please feel free to contact me if you need any further information.

Sincerely,

Suzanne Brouse

Suzanne Brouse
Chair
Meridian Township Community Resources Commission

From:	HealthyMichiganPlan
To:	Prokop, Jackie (DCH) (prokopj@michigan.gov); Boyce, Craig (DHHS); LaPres, Marie (DHHS); Green, Kellie (DHHS); Prokop, Jackie (DHHS)
Subject:	FW: Section 1115 Demonstration Extension Application Comments
Date:	Saturday, August 11, 2018 12:42:01 PM
Attachments:	8-10-18 Work Requirements L.docx

From: Jill Gerrie <jill.gerrie@arcmi.org>
Sent: Friday, August 10, 2018 12:58 PM
To: HealthyMichiganPlan <HealthyMichiganPlan@michigan.gov>
Subject: Section 1115 Demonstration Extension Application Comments

Hi,
Please see attached for comments regarding the Section 1115 Demonstration Extension Application for the Healthy Michigan Plan from the Arc Michigan.
Thank you,
Jill

Jill Gerrie
Project Coordinator
The Arc Michigan
1325 S. Washington Ave
Lansing, MI 48910
Direct Line: (517) 492-5029
Toll Free: (800) 292-7851 x 114
Fax: (517) 487-0303
Email: jill.gerrie@arcmi.org

The Arc Michigan

1325 South Washington Avenue
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(517) 487-5426 or 1-800-292-7851
Fax: (517) 487-0303
Website: www.arcmi.org

Ron Kimball, President

Sherri Boyd, Executive Director

August 10, 2018

Dear Medical Services Administration,

The following are comments from The Arc Michigan regarding the Section 1115 Demonstration Extension Application for the Healthy Michigan Plan.

While we applaud the outcomes of the Healthy Michigan Plan and believe it should continue without change, the new work requirements are mean-spirited and are expected to increase the number of Michiganders without health insurance. Health care coverage should not be used as an employment program. The complexity of the requirements will increase administrative costs in a department that already lacks an adequate number of personnel and costs to administer and monitor will be excessive.

The new requirements for those with income between 100%-133% of the Federal Poverty Level after 48 months of coverage are punitive and misguided. That the State would require completion of a "healthy behavior" for continued coverage illustrates the lack understanding of the complex issues people face. It will also be nearly impossible to implement and verify without substantial additional costs.

Allowing people to lose health coverage with no viable alternative is not in the best interest of people with disabilities or without disabilities in the state of Michigan. Michigan should be waiting to see the outcome of the lawsuit in Kentucky and the modifications of the waiver needed for it to be legal before they begin implementing what is a very similar program. Michigan cannot and should not be tying insurance coverage to employment. Medicaid is a health insurance program NOT A WORK PROGRAM.

Sincerely,

Sherri Boyd
Executive Director

From:	HealthyMichiganPlan
To:	Prokop, Jackie (DCH) (prokopj@michigan.gov); Boyce, Craig (DHHS); LaPres, Marie (DHHS); Green, Kellie (DHHS); Prokop, Jackie (DHHS)
Subject:	FW: Alcona Citizens for Health, Inc. - Healthy Michigan Plan Waiver Extension Amendment
Date:	Saturday, August 11, 2018 12:43:19 PM
Attachments:	image003.png Alcona Citizens for Health - HMP Waiver Extension Amendment.pdf
Importance:	High

From: Mary DeCaire <mdecaire@alconahc.org>
Sent: Friday, August 10, 2018 1:28 PM
To: HealthyMichiganPlan <HealthyMichiganPlan@michigan.gov>
Cc: Nancy Spencer <NSpencer@alconahc.org>; Loretta Bush <LBush@mpca.net>
Subject: Alcona Citizens for Health, Inc. - Healthy Michigan Plan Waiver Extension Amendment
Importance: High

Dear Ms. Prokop,

Please accept the attached letter of support regarding comments submitted by the Michigan Primary Care Association in response to the Healthy Michigan Plan waiver extension request amendment.

Respectfully,

Mary DeCaire
Administrative Projects Director
Alcona Health Center
989-358-3942
mdecaire@alconahc.org

alcona citizens for health, inc
AHC alcona health center "Your family health center"

Administrative Annex

August 10, 2018

MDHHS
Medical Services Administration
Bureau of Medicaid Policy and Health System Innovation
ATTN: Medicaid Policy
P.O. Box 30479
Lansing, MI 48909

Submitted via email: healthymichiganplan@michigan.gov

Subject: Healthy Michigan Plan § 1115 Demonstration Waiver Extension Request Amendment

Dear Ms. Prokop:

The Alcona Citizens for Health, Inc. appreciates the opportunity to comment on the Michigan Department of Health and Human Services' (MDHHS) request for public comment on the Healthy Michigan Plan § 1115 Demonstration Waiver Extension Request Amendment.

Alcona Citizens for Health, Inc. is a Federally Qualified Health Center (FQHC) that provided care to 31,694 unduplicated patients in 2017 of which 11,137 were Medicaid patients. We have 14 clinics in a seven counties in Northern Michigan. We also provide Behavioral Health Therapy to students in 18 area schools. Alcona Citizens for Health, Inc. provides a full range of quality, affordable, comprehensive primary health care services, including medical, dental, and behavioral health services, either through direct care or through community referrals, regardless of insurance status or ability to pay for services.

Northern Michigan is an underserved rural area and in many cases we are their only access to medical care for these patients. With Medicaid expansion many families are able to have coverage and are receiving regular preventive care for the first time in many years. This has improved their overall health and helped to reduce Emergency Department utilization.

Alcona Citizens for Health, Inc. is writing to express our support for the comments submitted by the Michigan Primary Care Association (MPCA) in response to the Healthy Michigan Plan waiver extension request amendment. A summary of these comments is as follows:

Definition of medically frail
Federal statute allows states to create a unique medically frail definition to meet the state's needs under 42 CFR 440.315(f). Although being supportive of the process MDHHS proposes to use to identify medically frail individuals, MPCA is very concerned that the current list of ICD-10 diagnoses codes included in Appendix A, Attachment L, fails to include conditions such as clinical depression or anxiety that could prevent an individual from working. Penalizing an individual who cannot work but does not qualify for an exemption would contribute to a dangerous cycle of failure and worsening health outcomes.

MDHHS has the authority to include additional diagnosis codes. MPCA urges MDHHS to include diagnoses related to depression, anxiety, and other mental health conditions that are not otherwise included in the proposed waiver extension amendment. Specifically, MPCA requests MDHHS add diagnoses related to ICD-10 codes F063, F064, F309-F339, F410-F4312, F440, F600-F609, and F6381 to the state's definition of medically frail. MPCA strongly urges MDHHS to use this broadened definition of medically frail for both the workforce engagement and the cost-sharing requirements articulated in the waiver extension application.

Suspension of coverage for noncompliance with cost-sharing requirements

MPCA is extremely concerned by the lack of details relative to suspension of coverage for noncompliance with cost-sharing requirements for individuals with income between 100 and 133 percent of the federal poverty limit. Individuals covered by HMP make daily decisions on how to make ends meet, which makes careful consideration of cost-sharing compliance mandates important. MPCA encourages MDHHS to use its authority to specify how it will operationalize the suspension of coverage for noncompliance with the program's cost-sharing requirements.

MPCA recommends that MDHHS align compliance with cost-sharing requirements with the proposed workforce engagement requirements and allow an individual up to six consecutive months of the year to be noncompliant relative to cost-sharing. MDHHS should suspend eligibility only for individuals who have consistently failed to pay cost-sharing contributions for six consecutive months before the outstanding balance is sent to the Michigan Department of Treasury for garnishment of tax returns or lottery winnings. Additionally, MPCA urges MDHHS to develop and publicize the process by which individuals can restore HMP benefits. We believe this process should include a provision restoring coverage once an individual agrees to an outstanding balance payment plan and has made the first monthly payment. The state should accept the first payment on a mutually agreed upon payment plan as a good faith effort to be in compliance with the cost-sharing requirements.

§ 1115 demonstration waiver evaluation design

A core component of the § 1115 demonstration waiver is the inclusion of an appropriate evaluation component to assess the relevant hypotheses the demonstration plans to test. MPCA believes the stated objectives in the evaluation overview section of the amended waiver extension proposal falls short of fully evaluating this statutory mission statement. Specifically, MPCA strongly urges MDHHS to include evaluating the following components to test additional hypotheses supported by the statute's mission statement:

- The extent to which beneficiaries believe that workforce engagement requirements as a condition of HMP eligibility has a positive impact on personal health outcomes and financial well-being;
- The extent to which workforce engagement requirements improve health outcomes while covered by HMP; and
- Whether the costs in uncompensated care increase or decrease as a result of individuals losing coverage for noncompliance with workforce engagement requirements.

The Healthy Michigan Plan has been a large success in no small part due to the leadership of MDHHS to ensure all individuals have access to affordable coverage to improve health outcomes. Continued access to health coverage for all families currently enrolled in the HMP is critical. The HMP has allowed many Community Health Center patients to receive preventive services and make healthy lifestyle changes,

such as smoking cessation and weight loss. They also have the opportunity to receive critical services, such as dental, behavioral health and vision care. In the past, uninsured health center patients have been forced to choose between paying for health care and buying food for their family. With HMP coverage, these patients can see their primary care provider, follow through on referrals, and engage in their own care without having to make painful choices.

Alcona Citizens for Health, Inc. strongly believes MDHHS should use its authority to ensure the HMP remains a health coverage program and work in partnership with stakeholders to implement a fair, Michigan-based approach to workforce engagement requirements.

In closing, we appreciate the opportunity to comment on this issue. If you require any clarification on our comments, please contact me at nspencer@alconahc.org or at 989-358-3916.

Sincerely,

Nancy Spencer

Nancy Spencer
Chief Executive Officer
Alcona Citizens for Health, Inc.

From:	HealthyMichiganPlan
To:	Prokop, Jackie (DCH) (prokopj@michigan.gov); Boyce, Craig (DHHS); LaPres, Marie (DHHS); Green, Kellie (DHHS); Prokop, Jackie (DHHS)
Subject:	FW: NMSS 1115 Comments
Date:	Saturday, August 11, 2018 12:43:54 PM
Attachments:	Michigan Medicaid 1115 Comment LetterFINAL[2001].pdf

From: Holly Pendell <Holly.Pendell@nmss.org>
Sent: Friday, August 10, 2018 1:39 PM
To: HealthyMichiganPlan <HealthyMichiganPlan@michigan.gov>
Subject: NMSS 1115 Comments

Please find attached comments from the National MS Society on the proposed 1115 waiver.

Holly Pendell
Director, Advocacy & Activist Engagement
National Multiple Sclerosis Society
614.515.4622 Holly.Pendell@NMSS.org

National Multiple Sclerosis Society

August 10, 2018

MDHHS
Medical Services Administration
Bureau of Medicaid Policy and Health System Innovation
Attention: Medicaid Policy
P.O. Box 30479
Lansing, Michigan 48909-7979
Re: Demonstration Extension Application Amendment

To Whom it May Concern:

The National MS Society appreciates the opportunity to submit comments on Michigan's Section 1115 Demonstration Extension Application.

Multiple sclerosis is an unpredictable, often disabling disease of the central nervous system that disrupts the flow of information within the brain, and between the brain and body. Symptoms range from numbness and tingling to blindness and paralysis. The progress, severity and specific symptoms of MS in any one person cannot yet be predicted but advances in research and treatment are leading to better understanding MS and moving us closer to a world free of MS.

The Society believes everyone, including Medicaid enrollees, should have access to quality and affordable healthcare coverage. While we are pleased MS is listed as an exempt condition on the medically frail list, so many other chronic and often debilitating conditions have not been included. The Society still opposes imposing work requirements and the administrative burden it places on Medicaid beneficiaries. Unfortunately, the proposed waiver will jeopardize access to care and will have harmful implications for patients.

The purpose of the Medicaid program is to provide affordable healthcare coverage for low-income individuals and families. Unfortunately, Michigan's application does not meet this objective and will instead create new financial and administrative barriers that jeopardize access to healthcare for patients with multiple sclerosis. According to one estimate by the Michigan House Fiscal Agency, up to 54,000 Michiganders will lose their coverage as a result of this proposal.[i]

Under the waiver, individuals with incomes between 100 and 138 percent of the federal poverty level (approximately $1,372/month to $1,893/month for a family of two) would face new barriers to coverage after receiving 48 cumulative months of coverage through the Healthy Michigan program. Under the waiver proposal, these individuals would be required to pay monthly premiums equal to five percent of their income and complete or commit to an annual

healthy behavior, unless they can demonstrate that they qualify for an exemption. Individuals who cannot meet this requirement will lose their coverage. A premium of five percent of monthly income will range from approximately $50 to $67 for an individual, a sizable cost for this low-income population. Research has shown that even relatively low levels of cost-sharing for low-income populations limit the use of necessary healthcare services.[ii] This means that patients with multiple sclerosis may cut back on the healthcare that they need to manage their condition and stay healthy. Additionally, the Society is concerned that, instead of incentivizing healthy behaviors, conditioning coverage on completing an annual healthy behavior will reduce coverage for individuals in need of care. Ensuring that Medicaid enrollees have access to comprehensive health coverage that includes all of the treatments and services that they need to live healthy lives would likely be a more effective approach to improving health in Michigan.

Also, under this waiver, individuals between the ages of 19 and 62 would be required to either demonstrate that they work at least 80 hours per month or meet exemptions. One major consequence of this proposal will be to increase the administrative burden on all patients. Individuals will need to attest that they meet certain exemptions or have worked the required number of hours on a monthly basis. Increasing administrative requirements will likely decrease the number of individuals with Medicaid coverage, regardless of whether they are exempt or not. For example, after Washington state changed its renewal process from every twelve months to every six months and instituted new documentation requirements in 2003, approximately 35,000 fewer children were enrolled in the program by the end of 2004.[iii] Battling administrative red tape in order to keep coverage should not take away from patients' or caregivers' focus on maintaining their or their family's health.

Failing to navigate these burdensome administrative requirements could have serious – even life or death – consequences for people with serious, acute and chronic diseases, including multiple sclerosis. If the state finds that individuals have failed to comply with the new requirements for three months, they will be locked out of coverage for *at least* one month. Additionally, if the state finds that individuals have misrepresented their compliance, these individuals will be locked out of coverage for one year. People who are in the middle of treatment for a life-threatening disease, rely on regular visits with healthcare providers or must take daily medications to manage their chronic conditions cannot afford a sudden gap in their care.

The Society is also concerned that the current exemption criteria, while including MS, may not capture all individuals with, or at risk of, serious and chronic health conditions that prevent them from meeting these requirements, including individuals in the process of acquiring a MS diagnosis. While the Society is pleased that patients will have the option to demonstrate that they qualify for an exemption through self-attestation, the reporting process still creates opportunities for administrative error that could jeopardize coverage. No exemption criteria can circumvent this problem and the serious risk to the coverage and health of the people we represent.

Administering these requirements will be expensive for Michigan. The Michigan House Fiscal Agency estimates that the state's administrative costs will be approximately $20 million, in addition to one-time information technology costs of up to $10 million.[iv] States such as Kentucky, Tennessee and Virginia have also estimated that setting up the administrative systems to track and verify exemptions and work activities will cost tens of millions of dollars.[v] These

costs would divert resources from Medicaid's core goal – providing health coverage to those without access to care – as well from other important initiatives in the state of Michigan.

Ultimately, the requirements outlined in this waiver do not further the goals of the Medicaid program or help low-income individuals improve their circumstances without needlessly compromising their access to care. Most people on Medicaid who can work already do so.[vi] A recent study, published in *JAMA Internal Medicine*, looked at the employment status and characteristics of Michigan's Medicaid enrollees.[vii] The study found only about a quarter were unemployed (27.6 percent). Of this 27.6 percent of enrollees, two thirds reported having a chronic physical condition and a quarter reported having a mental or physical condition that interfered with their ability to work.

The Society also wishes to highlight that the federal rules at 431.408 pertaining to state public comment process require at (a)(1)(i)(C) that a state include an estimate of the expected increase or decrease in annual enrollment and expenditures if applicable. The intent of this section of the regulations is to allow the public to comment on a Section 1115 proposal with adequate information to assess its impact. However, on pages 14-15 of this proposal, the Department reuses budget neutrality estimates from an earlier proposal that are no longer relevant and states that "MDHHS expects annual HMP enrollment to decrease but the total number of beneficiaries who will be impacted is unknown at this time." We urge the Administration to release updated enrollment and expenditures data and include this analysis in its application to the federal government to ensure the application meets federal requirements.

The Society believes everyone should have access to quality and affordable healthcare coverage. Michigan's Section 1115 Demonstration Extension Application does not advance that goal. Thank you for the opportunity to provide comments.

Sincerely,

Holly Pendell
Director, Advocacy and Activism Engagement
National MS Society

---

[i] Michigan House Fiscal Agency, Legislative Analysis of Healthy Michigan Plan Work Requirements and Premium Payment Requirements, June 6, 2018. Available at: http://www.legislature.mi.gov/documents/2017-2018/billanalysis/House/pdf/2017-HLA-0897-5CEEF80A.pdf.

[ii] Samantha Artiga, Petry Ubri, and Julia Zur, "The Effects of Premiums and Cost Sharing on Low-Income Populations: Updated Review of Research Findings," Kaiser Family Foundation, June 2017, https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/.

[iii] Tricia Brooks, "Data Reporting to Assess Enrollment and Retention in Medicaid and SCHIP," Georgetown University Health Policy Institute Center for Children and Families, January 2009.

[iv] Michigan House Fiscal Agency, Legislative Analysis of Healthy Michigan Plan Work Requirements and Premium Payment Requirements, June 6, 2018. Available at: http://www.legislature.mi.gov/documents/2017-2018/billanalysis/House/pdf/2017-HLA-0897-5CEEF80A.pdf.

[v] Misty Williams, "Medicaid Changes Require Tens of Millions in Upfront Costs," Roll Call, February 26, 2018, https://www.rollcall.com/news/politics/medicaid-kentucky.

[vi] Rachel Garfield, Robin Rudowitz, and Anthony Damico, "Understanding the Intersection of Medicaid and Work," Kaiser Family Foundation, February 2017, http://kff.org/medicaid/issue-brief/understanding-the-intersection-of-medicaid-and-work/.

[vii] Renuka Tipirneni, Susan D. Goold, John Z. Ayanian. Employment Status and Health Characteristics of Adults With Expanded Medicaid Coverage in Michigan. *JAMA Intern Med.* Published online December 11, 2017. doi:10.1001/jamainternmed.2017.7055

From: Jared Burkhart
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Friday, August 10, 2018 2:16:04 PM
Attachments: 2471_0001.pdf

Please see the attached comments regarding the Michigan Work Requirement Medicaid Waiver. A hard copy has also been sent via USPS.

Jared Burkhart
Executive Director
Michigan Chapter American Academy of Pediatrics
106 W. Allegan, Suite 310
Lansing, MI 48933
P: 517-484-3013
C: 517-403-8533

American Academy of Pediatrics

DEDICATED TO THE HEALTH OF ALL CHILDREN™

Michigan Chapter

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President
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Sharon Swindell, MD, MPH, FAAP
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sswindell8286@gmail.com

Executive Director
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106 W. Allegan
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(517) 484-3013
Fax: (517) 575-6285
jared.burkhart@miaap.org

August 10, 2018

MDHHS
Medical Services Administration
Bureau of Medicaid Policy and Health System Innovation
Attention: Medicaid Policy
P.O. Box 30479
Lansing, MI 48909-7979

Dear Director Lyon,

The Michigan Chapter of the American Academy of Pediatrics (MIAAP), a nonprofit organization representing over 1100 pediatricians from across the state, dedicated to the health, safety and well-being of all Michigan infants, children, adolescents and young adults, thanks you for the opportunity to provide comments on the proposed Michigan Department of Health and Human Services (MDHHS) Section 1115 Demonstration Extension Application.

We write today to express our concerns with this proposed application, which would create significant barriers for some low-income adults to access health coverage. These changes could have a negative effect on the health of our state and halt the significant progress we have made in decreasing our uninsured rate, which dropped from 12.1% in 2013 to 7.4% in 2016.[1]

We are concerned with the following provisions in this proposed wavier extension application:

- **The work requirement, including a 1-year lockout period**. As proposed this provision would require Healthy Michigan Plan (HMP) Medicaid beneficiaries to work or participate in qualifying activities for an average of 80 hours per month to access health care. While we appreciate there are several populations that would be exempt from these requirements such as children and pregnant women, we remain concerned that Medicaid coverage might be punitively denied for those who are unable to otherwise meet this requirement.

[1] http://files.kff.org/attachment/Fact-Sheet-Key-Facts-about-the-Uninsured-Population

Studies have shown that 8 in 10 Medicaid eligible adults live in working families and almost 60% work themselves.[2] In regard to HMP, the University of Michigan published a study regarding the employment status of the adult Medicaid expansion population in the state and found that 48.8% of enrollees were either employed or self-employed and 5.2% were students. Another 11.3% of enrollees described themselves as being unable to work, citing significant barriers to employment, such as chronic conditions like cancer, diabetes, or asthma, and other functional limitations. This study concludes, "...the proportion of Medicaid expansion enrollees overall who were not working and possibly able to work if employment were available remained small".[3]

Therefore, it is not clear how the proposed work requirement will serve Medicaid enrollees or increase their access to medically necessary coverage and care. Moreover, the resultant coverage losses may not only harm the individual but children in the family as well. Research shows that when a parent does not have health coverage, a child is less likely to be insured.[4]

The waiver proposal would require that all beneficiaries attest to either meeting or being exempt from the new requirements monthly but does not indicate how individuals will accomplish this. Even those individuals who are meeting the work requirement could face obstacles in complying with this onerous reporting requirement. Thirty percent of Medicaid adults report they never use a computer, 28% do not use the internet, and 41% do not use e-mail.[5] Additionally, Michigan is currently ranked 38th in the country for access to the internet.[6] If reporting compliance with these rules is only to be done via an online tool, as is currently being done in Arkansas, this could result in many eligible individuals losing much needed coverage.

Additionally, this proposal would lock individuals out of Medicaid coverage for a period of 1 year "if a beneficiary is found to have misrepresented his or her compliance with the...requirements". Will beneficiaries have a means to appeal a decision that they have not complied with the program prior to losing coverage? What data sources will the state use to determine non-compliance? A yearlong lockout could not only interrupt an existing course of medically necessary treatment, but also block coverage when a significant diagnosis is reached, or injury occurs and may result in uncovered visits to emergency rooms.

Medicaid is in place to provide needed coverage to low-income residents—the majority of whom already work—who cannot afford private insurance. Adding an onerous work and documentation requirement of this sort counters the very nature of Medicaid as a health care lifeline for those most in need.

- **Inclusion of some former foster care youth.** While we appreciate that many former foster care youths are exempt from the work requirement, we do note the exemption is only for those under 21 years of age. Under the Affordable Care Act (ACA), all former foster care youth to age 26 are eligible for Medicaid coverage, making them a traditionally eligible group. Limiting access to coverage for this group could have serious implications. Former foster care youth are a particularly vulnerable population that have disproportionately high rates of both physical and behavioral health issues. Between 35-60% of youth entering foster care have at least one chronic or acute health condition that requires treatment, while

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[2] http://kff.org/medicaid/issue-brief/understanding-the-intersection-of-medicaid-and-work
[3] https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/2664514
[4] https://www.cbpp.org/sites/default/files/atoms/files/10-20-06health.pdf
[5] https://www.kff.org/medicaid/issue-brief/implications-of-work-requirements-in-medicaid-what-does-the-data-say/
[6] https://www.usnews.com/news/best-states/rankings/infrastructure/internet-access

between 50-75% have a behavioral health issue that may require mental health treatment.[7] Putting up barriers to needed care for this population would result in both medical and financial hardships for those with the most need, many of whom are just starting the transition to adulthood.

- **Premiums for individuals between 100% and 133% of federal poverty level (FPL).** As proposed, Michigan's Medicaid extension waiver would require individuals earning between 100% and 138% (133%, with 5% disregard) of FPL to pay a premium of 5% of their income. While premium payments on the surface can seem nominal, research has demonstrated that cost sharing for individuals with low-incomes can prevent those eligible for programs from seeking coverage, and those enrolled in coverage from seeking care. [8] While the state may see initial cost savings as people lose coverage due to lack of ability to pay, the state could see increases in uncompensated care costs as more people seek care in emergency departments. Additionally, this type of provision is likely to incentivize people to limit their incomes for fear of losing insurance coverage, as they likely will not be receiving insurance from their low-wage jobs. A 2014 study showed that only 28% of employees of private firms with low average wages obtain health insurance through their jobs, and 42% are not even eligible for employer sponsored coverage.[9] This proposal only serves to punish individuals who are meeting the work requirement and obstruct the goal of increasing levels of employment of those living in poverty.

- **Increased administrative costs to the state.** We are concerned about added costs to the state that may result from these proposed work requirements. Work requirements do not only increase the administrative burden for enrollees, but for the state as well. As there is no information in the application regarding the administrative cost associated with the proposed waiver amendment, it is not clear what additional costs may be incurred by the state with respect to implementation. The exact costs to implement a tracking system and/or hire new staff to track compliance with the new requirements are yet unknown, however recent reports from Kentucky indicate administrative costs have jumped in that state by as much as 40% as it implements a work requirement there.[10] Where would additional funding of this amount come from in Michigan? We are concerned that this additional administrative burden to the state could result in fewer resources to provide health care services and improve outcomes.

Thank you for the opportunity to provide comments on this Medicaid extension application. We hope the state takes the thoughts of Michigan's pediatricians into consideration as it contemplates serious changes to the Medicaid program. If you have questions regarding our concerns, please contact me at jared.burkhart@miaap.org or 517-484-3013.

Sincerely,

Jared Burkhart

Jared Burkhart
Executive Director

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[7] http://childwelfaresparc.org/wp-content/uploads/2014/07/3-The-Affordable-Care-Act-and-Youth-Aging-Out-of-Foster-Care.pdf

[8] https://www.kff.org/medicaid/issue-brief/premiums-and-cost-sharing-in-medicaid-a-review-of-research-findings/

[9] https://meps.ahrq.gov/mepsweb/survey_comp/Insurance.jsp

[10] https://www.forbes.com/sites/brucejapsen/2018/07/22/trumps-medicaid-work-rules-hit-states-with-costs-and-bureaucracy/#71daf9f866f5

From:	HealthyMichiganPlan
To:	Prokop, Jackie (DCH) (prokopj@michigan.gov); Boyce, Craig (DHHS); LaPres, Marie (DHHS); Green, Kellie (DHHS); Prokop, Jackie (DHHS)
Subject:	FW: MPCA Comments on 2nd Waiver Extension Amendment
Date:	Saturday, August 11, 2018 12:39:23 PM
Attachments:	MPCA_HMP Revised 2nd Waiver Public Comments_Final.pdf

Comments from MPCA..

From: Ryan Grinnell-Ackerman <rgrinnell@mpca.net>
Sent: Friday, August 10, 2018 2:16 PM
To: HealthyMichiganPlan <HealthyMichiganPlan@michigan.gov>
Subject: MPCA Comments on 2nd Waiver Extension Amendment

Good afternoon,
Please accept the attached letter from Michigan Primary Care Association detailing our public comments on the Healthy Michigan Plan 2nd waiver extension amendment.

Ryan Grinnell-Ackerman, MPA
Policy and Government Affairs Manager
517.827.0884 (Office)
rgrinnell@mpca.net

mpca THE VOICE OF COMMUNITY HEALTH CENTERS

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101 SOUTH WASHINGTON SQUARE, SUITE 820
LANSING, MI 48933

August 9, 2018

Michigan Department of Health and Human Services
Medical Services Administration
Bureau of Medicaid Policy and Health System Innovation
ATTN: Medicaid Policy
P.O. Box 30479
Lansing, MI 48909

Submitted via email: healthymichiganplan@michigan.gov

Subject: Healthy Michigan Plan § 1115 Demonstration Waiver Extension Request Amendment

Dear Ms. Prokop:

The Michigan Primary Care Association (MPCA) appreciates the opportunity to comment on the Michigan Department of Health and Human Services' (MDHHS) request for public comment on the Healthy Michigan Plan § 1115 Demonstration Waiver Extension Request Amendment.

MPCA is the voice for 45 health center organizations in Michigan, including Federally Qualified Health Centers (otherwise known as community health centers or CHCs), FQHC Look-Alikes, and Tribal Health Centers. Michigan community health centers serve as the health home for more than 700,000 medically underserved Michigan residents, including more than 377,000 Medicaid beneficiaries, at over 300 sites throughout Michigan. Sixty-nine percent of CHC patients live below the federal poverty level and face multiple social and environmental factors that affect their health and ability to access health care services. MPCA's members provide a full range of quality, affordable, comprehensive primary health care services, including medical, dental, and behavioral health services, either through direct care or through community referrals, regardless of insurance status or ability to pay for services.

MPCA supports MDHHS's overall effort to comply with Public Act 208 of 2018 to ensure continuation of the Healthy Michigan Plan §1115 Demonstration Waiver through the amended waiver extension request. MPCA believes that to achieve better health in the state, the continued access to health insurance coverage for all 683,000 Michiganders currently enrolled in the Healthy Michigan Plan (HMP) is critical. The HMP has allowed many CHC patients to receive preventive services and make healthy lifestyle changes, such as smoking cessation and weight loss. They also have the opportunity to receive critical services, such as dental and vision care. In the past, uninsured health center patients have been forced choose between paying for health care and buying food for their family. With HMP coverage, these patients can see their primary care provider, follow through on referrals, and engage in their own care without having to make painful choices.

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MPCA strongly urges MDHHS to carefully design all elements of HMP that are not expressed in statute so as to limit the number of individuals that could be inadvertently harmed due to administrative complexities. MPCA's comments focus on the list of conditions qualifying individuals as medically frail; the suspension and the process to reactivate coverage for individuals struggling with the cost-sharing requirements of the amended waiver extension; and the details of the evaluation required as part of any § 1115 demonstration project.

Definition of medically frail

Federal statute allows states to create a unique medically frail definition to meet the state's needs under 42 CFR 440.315(f). MPCA supports MDHHS's proposed process to identify individuals who are medically frail using three methods: self-identification, claims analysis, and health care provider referral. MPCA believes this is the optimal approach to ensure continuity of care for individuals who require exemptions from the cost-sharing or workforce engagement requirements included in the waiver amendment.

Despite our support of the process for identifying medically frail, MPCA is concerned that the current list of ICD-10 diagnoses codes included in Appendix A, Attachment L, fails to include conditions such as clinical depression or anxiety that could prevent an individual from working. Penalizing an individual who cannot work but does not qualify for an exemption would contribute to a dangerous cycle of failure and worsening health outcomes. Medicaid, including the Medicaid expansion, was created to be a health program. Taking actions that have the potential to lead to worse health outcomes is contradictory to the spirit and intent of the law.

Because the statutory language allows the state to define medically frail, MPCA believes MDHHS has the authority to include additional diagnosis codes. MPCA urges MDHHS to include diagnoses related to depression, anxiety, and other mental health conditions that are not otherwise included in the proposed waiver extension amendment. Specifically, MPCA requests that MDHHS add diagnoses related to ICD-10 codes F063, F064, F309-F339, F410-F4312, F440, F600-F609, and F6381 to the state's definition of medically frail. MPCA strongly urges MDHHS to use this broadened definition of medically frail for both the workforce engagement and the cost-sharing requirements articulated in the waiver extension application.

Suspension of coverage for noncompliance with cost-sharing requirements

As part of the extension application for HMP, MDHHS is seeking to amend the eligibility and cost-sharing requirements for individuals with income between 100 and 133 percent of the federal poverty limit. Although these provisions are intended to comply with state statute, MPCA is extremely concerned by the lack of details relative to implementation of this provision.

Individuals covered by HMP make daily decisions on how to make ends meet, which makes careful consideration of cost-sharing compliance mandates important. MPCA encourages MDHHS to use its authority to specify how it will operationalize the suspension of coverage for noncompliance with the program's cost-sharing requirements. PA 208 of 2018 contains few specifics on the definition of noncompliance, nor does it specify the process by which a noncompliant individual can restore their eligibility. In the proposed workforce engagement requirements, individuals are allowed up to three months of noncompliance before a suspension of eligibility. Additionally, an individual is allowed up to three months of unpaid volunteer activity to count toward meeting the workforce engagement requirements, bringing the total to six consecutive months where an individual can maintain eligibility for HMP while not receiving compensation.

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MPCA recommends that MDHHS align compliance with cost-sharing requirements with the proposed workforce engagement requirements and allow an individual up to six consecutive months of the year to be noncompliant relative to cost-sharing. MDHHS should suspend eligibility only for individuals who have consistently failed to pay cost-sharing contributions for six consecutive months before the outstanding balance is sent to the Michigan Department of Treasury for garnishment of tax returns or lottery winnings. Additionally, MPCA urges MDHHS to develop and publicize the process by which individuals can restore HMP benefits. We believe this process should include a provision restoring coverage once an individual agrees to an outstanding balance payment plan and has made the first monthly payment. The state should accept the first payment on a mutually agreed upon payment plan as a good faith effort to be in compliance with the cost-sharing requirements.

§ 1115 demonstration waiver evaluation design

A core component of the § 1115 demonstration waiver is the inclusion of an appropriate evaluation component to assess the relevant hypotheses the demonstration plans to test. According to the statute authorizing the workforce engagement requirements of HMP, the goal is to leverage Medicaid to "assist, encourage, and prepare an able-bodied adult for a life of self-sufficiency and independence from government interference." MPCA believes the stated objectives in the evaluation overview section of the amended waiver extension proposal falls short of fully evaluating this statutory mission statement. Specifically, MPCA strongly urges MDHHS to include evaluating the following components to test additional hypotheses supported by the statute's mission statement:

- The extent to which beneficiaries believe that workforce engagement requirements as a condition of HMP eligibility has a positive impact on personal health outcomes and financial well-being;
- The extent to which workforce engagement requirements improve health outcomes while covered by HMP; and
- Whether the costs in uncompensated care increase or decrease as a result of individuals losing coverage for noncompliance with workforce engagement requirements.

The Healthy Michigan Plan has been a large success in no small part due to the leadership of MDHHS to ensure all individuals have access to affordable coverage to improve health outcomes. MPCA strongly believes MDHHS should use its authority to ensure the HMP remains a health coverage program and work in partnership with stakeholders to implement a fair, Michigan-based approach to workforce engagement requirements. In closing, we appreciate the opportunity to comment on this issue. If you require any clarification on our comments, please contact me at lbush@mpca.net or at 517.381.8000.

Sincerely,

Loretta V. Bush, MSHA
Chief Executive Officer
Michigan Primary Care Association

7215 WESTSHIRE DRIVE
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101 SOUTH WASHINGTON SQUARE, SUITE 820
LANSING, MI 48933

From:	HealthyMichiganPlan
To:	Prokop, Jackie (DCH) (prokopj@michigan.gov); Boyce, Craig (DHHS); LaPres, Marie (DHHS); Green, Kellie (DHHS); Prokop, Jackie (DHHS)
Subject:	FW: Demonstration Extension Application Amendment
Date:	Saturday, August 11, 2018 12:46:34 PM
Attachments:	Representative Camilleri Medicaid Public Comment.pdf

From: Rep. Darrin Camilleri (District 23) <DarrinCamilleri@house.mi.gov>
Sent: Friday, August 10, 2018 3:06 PM
To: HealthyMichiganPlan <HealthyMichiganPlan@michigan.gov>
Subject: Demonstration Extension Application Amendment

Good afternoon,

Attached you will find my comments on the Department's proposed extension of its Healthy Michigan Section 1115 Medicaid Demonstration. I ask that these comments be published on the state's waiver website as part of the public record. Thank you for your consideration.

Sincerely,

Darrin Camilleri
State Representative—23rd District

23RD DISTRICT
STATE CAPITOL
P.O. BOX 30014
LANSING, MI 48909-7514
PHONE: (517) 373-0855
FAX: (517) 373-5922
E-MAIL: darrincamilleri@house.mi.gov

MICHIGAN HOUSE OF REPRESENTATIVES

DARRIN CAMILLERI

STATE REPRESENTATIVE

August 10, 2018

The Honorable Rick Snyder, Governor
The State of Michigan
P.O. Box 30013
Lansing, MI 48909

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

Dear Governor Snyder and Director Lyon:

On behalf of the 90,000+ constituents I represent in the Downriver area, including thousands served by the Medicaid program, I write in opposition to the Department's proposed extension of its Healthy Michigan Section 1115 Medicaid Demonstration. The proposal includes strict work requirements for recipients and would more than double premiums for certain individuals with incomes barely above the poverty line. These changes will effectively shut thousands of families out of accessing healthcare, posing a significant threat to the health and livelihoods of Michigan families as well as Michigan's economy.

For 50 years, Medicaid has successfully enabled families to access healthcare when they are struggling to make ends meet, treating patients with dignity by putting their lives and their health before their financial status. Medicaid was never intended to be a jobs program, and this proposal fundamentally undercuts the program's mission of improving health outcomes. It is, instead, likely to undo many of the gains we've made as a result of Medicaid expansion, especially for Michigan seniors, low income residents, and people with serious health conditions.

Further, this proposal will hurt Downriver's economy and in turn, Downriver families. Almost half a million people in Wayne County receive Medicaid, including almost 200,000 individuals receiving healthcare through Healthy Michigan. A work requirement with no accompanying attention to job training is likely to drive down wages for Downriver workers, especially those in the service industry and construction. At the same time, Michigan taxpayers will bear the brunt of the enormous administrative and uncompensated care costs caused by this proposal. In short, not only will health outcomes suffer, but this proposal threatens to negatively impact workers and families across Michigan.

Thank you for your time and consideration. I look forward to working with you to ensure all Michiganders can continue to access the healthcare they need. Finally, I ask that these comments be published on the state's waiver website as part of the public record.

Sincerely,

Darrin Camilleri
State Representative
23rd House District

From:	HealthyMichiganPlan
To:	Prokop, Jackie (DCH) (prokopj@michigan.gov); Boyce, Craig (DHHS); LaPres, Marie (DHHS); Green, Kellie (DHHS); Prokop, Jackie (DHHS)
Subject:	FW: Demonstration Extension Application Amendment
Date:	Saturday, August 11, 2018 12:47:15 PM
Attachments:	CFF comments Michigan 1115 waiver.pdf

From: Pudeler, Meghan <mpudeler@cff.org>
Sent: Friday, August 10, 2018 3:13 PM
To: HealthyMichiganPlan <HealthyMichiganPlan@michigan.gov>
Subject: Demonstration Extension Application Amendment

To whom it may concern:

Please find attached a written submission from the Cystic Fibrosis Foundation on Michigan's Healthy Michigan Plan Section 1115 Demonstration Waiver Extension Request Amendment. Thank you, please consider us a resource now and in the future.

Best,

Meghan Pudeler
State Policy Specialist
Cystic Fibrosis Foundation
(240) 482-2872
mpudeler@cff.org

CYSTIC FIBROSIS FOUNDATION
ADDING TOMORROWS

MDHHS
Medical Services Administration
Bureau of Medicaid Policy and Health System Innovation
Attention: Medicaid Policy
P.O. Box 30479
Lansing, Michigan 48909-7979

August 10, 2018

Re: Healthy Michigan Plan Section 1115 Demonstration Waiver Extension Request Amendment

To whom it may concern:

Thank you for the opportunity to comment on Michigan's Section 1115 Demonstration Waiver Extension Request Amendment. On behalf of people with cystic fibrosis (CF), we write to express our concern that work and community engagement requirements, lockout periods, and increased premiums are barriers to accessing the high-quality care that people with CF need. As such, we ask the state to specifically and automatically exempt people with cystic fibrosis from these requirements.

Cystic fibrosis (CF) is a life-threatening genetic disease that affects 1,111 people in Michigan and 30,000 children and adults in the United States. CF causes the body to produce thick, sticky mucus that clogs the lungs and digestive system, which can lead to life-threatening infections. As a complex, multi-system condition, CF requires targeted, specialized treatment and medications. Medicaid plays an important role in helping this patient population access the high-quality care and treatment necessary to maintain or improve health.

Continuous access to high-quality, specialized CF care is essential to the health and well-being of people with cystic fibrosis. Making work a condition of Medicaid eligibility threatens access to care for people with CF, as their ability to work can vary with changes in health status. Implementing lock-out periods for those who failed to meet reporting requirements further penalizes those who need care the most. Declines in health status due to pulmonary exacerbations, infections, and other events can arise quickly and can take someone out of the workforce for significant periods of time. Patients bear a significant treatment burden as well, amounting to hours of chest physiotherapy, delivery of nebulized treatments, administration of intravenous antibiotics, and/or other activities required to maintain or improve their health. Maintaining sustained employment may not be possible due to the time required to undergo necessary treatment, which includes an intense and time-consuming daily regimen.

Furthermore, we are concerned with the proposal to require individuals between 100%-133% of the federal poverty level to pay premiums of 5% of an individual's income. While we understand that the state currently has a cost sharing component for these individuals, more than doubling premiums costs may impose unmanageable health care costs on financially vulnerable and medically complex adults. Our research shows that while 99% of people with CF have insurance, one-quarter of people delay or

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skip care due to cost concerns. Therefore, increasing premiums for this population could jeopardize their ability to maintain coverage and access care.

We appreciate the state's decision to exempt a person who is "medically frail" or has a medical condition that results in a work limitation from these requirements —which reflects the important reality that health status can significantly affect an individual's ability to search for and sustain employment. We strongly urge the state to include cystic fibrosis in list of conditions that will be automatically exempt from work requirements, lock-out periods and premiums.

As experts in cystic fibrosis care and research, please consider us a resource during the rulemaking and implementation process to minimize unintended errors and ensure our population is exempt. In particular, should the state decide to exempt people with cystic fibrosis, we can provide clinical expertise on service utilization, co-morbidities, and other factors that may help the state ensure people with CF are accurately captured by the state's algorithm.

The Cystic Fibrosis Foundation appreciates the opportunity to provide input on these important policy changes. As the health care landscape continues to evolve, we look forward to working with the state of Michigan to ensure access to high-quality, specialized CF care and improve the lives of all people with cystic fibrosis.

Sincerely,

Mary B. Dwight
Senior VP of Policy & Advocacy
Cystic Fibrosis Foundation

Lisa Feng, DrPH
Senior Director of Policy & advocacy
Cystic Fibrosis Foundation

Martin E. Hurwitz, MD
Director, Pediatric Cystic Fibrosis Program
Michigan State University
East Lansing, MI

Richard H. Simon, MD
Director, Adult Cystic Fibrosis Program
University of Michigan
Ann Arbor, MI

Ibrahim Abdulhamid, MD
Director, Pediatric Cystic Fibrosis Program
Children's Hospital of Michigan
Detroit, MI

Dana Kissner, MD
Director, Adult Cystic Fibrosis Program
Wayne State University Harper University Hospital
Detroit, MI

Samya Nasr, MD
Director, Cystic Fibrosis Program
University of Michigan Health System
Ann Arbor, MI

Myrtha Gregoire-Bottex, MD
Director, Cystic Fibrosis Program
Western Michigan University School of Medicine Affiliate
Kalamazoo, MI

John Schuen, MD
Director, Cystic Fibrosis Program
Helen DeVos Women and Children's Center
Grand Rapid, MI

From: Wachendorfer, Allan
To: HealthyMichiganPlan
Subject: Medicaid Waiver Extension Application Amendment
Date: Saturday, August 11, 2018 12:33:27 AM
Attachments: Medicaid Waiver Comments.doc
Importance: High

Greetings,

Attached, please find my organizations comments on the Medicaid waiver extension amendment. Thank you.

Allan Wachendorfer, LMSW-Macro
Director of Public Policy
National Association of Social Workers – Michigan Chapter
517-487-1548 ex. 11
awachendorfer.naswmi@socialworkers.org
www.nasw-michigan.org

741 North Cedar Street, Suite 100, Lansing, MI 48906
517.487.1548 » nasw-michigan.org

NASW MICHIGAN CHAPTER
National Association of Social Workers

Date: August 10, 2018
To: Michigan Department of Health and Human Services Medicaid Services Administration
From: National Association of Social Workers – Michigan Chapter
Subject: Michigan Medicaid Demonstration Extension Application Amendment

The National Association of Social Workers – Michigan Chapter is a membership organization of 6,000 social workers that works to grown and improve the profession of social work, support social work professionals in their work and continuing education, and improve the quality of life for all people. We have members in every county in Michigan – many of whom work for organizations or in private practices where they serve Medicaid clients, develop or run programs that benefit Medicaid clients, or see the impacts of barriers to health and human services on their clients.

Removing people from medical assistance due to non-compliance with work requirements is a bad idea. People need to be accountable and involved in their own self sufficiency, but removing their support network is shortsighted and counterproductive. People do not choose the remain in poverty if they have legitimate alternatives. They remain in poverty due to various obstacles to their self-sufficiency. Those obstacles often are not obvious but may include mental or emotional challenges, lack of education or experience, child care issues, family violence, homelessness, criminal records, or even a loss of hope that they could ever succeed. The proposed waiver exempts some of these individuals from work requirements but many will not meet the criteria in Michigan's waiver request.

At times, the system discourages self-improvement because people may lose coverage and supports if their earnings exceed a certain threshold. The coverage provided to Medicaid recipients is often more comprehensive and less costly than private insurance through the health care exchange. But the solution is not to remove essential benefits from the most vulnerable, but rather to strengthen supports and subsidies to those in the middle. All agree that our health care system - especially for those low income people with private insurance - needs improvement. The current proposal does nothing to improve their care but rather undermines health care for even more people.

There are a number of implementation concerns that should be addressed, including:

- explaining what will happen to people who lose eligibility;
- defining the verification process;
- examining the new rules' impact on timeliness standards for eligibility;
- considering technology upgrades and changes that will be required including cost;
- evaluating the impact of the program on Michigan's workforce, economy, budget and the overall effectiveness of the program.

Although NASW-Michigan oppose the concept of work requirements in general, if it is implemented, at least one additional option should be added under the qualifying activities that would satisfy the recipient's work requirements: The Michigan law that directed MDHHS to request the waiver (Michigan Public Act 208 of 2018) allows recipients to satisfy their work requirements in a number of different ways. Section 107 a (2) (g) offers the option of participating in unpaid work connections such as but not limited to internships. The state should clarify that this option includes voluntary participation in case management services designed to overcome barriers to self-sufficiency.

Medicaid funded case management services should be available to any participant consistently unsuccessful in meeting their work requirements. Modifications to the health risk assessment or other tools may be incorporated into the program allowing for screening, diagnosis and treatment designed to overcome barriers to self-sufficiency. Recipients could meet their requirements by developing a plan, working on barriers and engaging services that the case manager facilitates for their success.

Numerous studies have shown that poverty is the single biggest factor contributing to poor health outcomes. It is a greater predictor of health problems than smoking, alcohol abuse, obesity or drug addiction. By adding this case management option rather than terminating Medicaid eligibility, low income individuals may have a fighting chance of overcoming barriers to self-sufficiency and escaping from poverty.

Similar case management approaches have been used in vocational rehabilitation services, TANF, SNAP, ex offender programs, and services to people with a variety of issues such as developmental disabilities and mental health conditions. Many of these are already funded through Medicaid. A case management approach rather than mandatory work requirements was recently implemented in Montana and is showing promising results. Expanded supports are effective tools in helping individuals to reach their maximum potential. In the long run, the expansion of services to those unable to otherwise meet their work requirements will prove to be highly cost effective.

We appreciate the opportunity to comment on the proposed waiver. We know that the Department is required by law to submit this waiver request, and we hope the above questions and suggestions help the Department to better meet the health care needs of low income adults in Michigan.

Respectfully submitted,

Allan Wachendorfer, LMSW
Director of Public Policy
NASW-Michigan
517-487-1548 ex11
policy@nasw-michigan.org

From:	Stacy Skiba
To:	HealthyMichiganPlan
Cc:	Michelle Styma
Subject:	Healthy Michigan Plan - Request
Date:	Saturday, August 11, 2018 9:23:39 AM
Attachments:	HMP Waiver Extension Request.pdf
Importance:	High

Hello,

Please find our comments related to the Healthy Michigan Plan attached. Don't hesitate to reach out with any questions.

Thank you,

Stacy Skiba
Administrative Director
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ONAWAY
21258 W. M-68 Hwy.
P.O. Box 722
Onaway, MI 49765
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PH. 989-733-7037
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ONAWAY SCHOOL BASED HEALTH CENTER
4549 M-33 Hwy.
Onaway, MI 49765
PH. 989-733-4980
FAX 989-733-7064

This Institution is an equal opportunity provider and employer.

August 12, 2018

MDHHS
Medical Services Administration
Bureau of Medicaid Policy and Health System Innovation
ATTN: Medicaid Policy
P.O. Box 30479
Lansing, MI 48909

Submitted via email: healthymichiganplan@michigan.gov

Subject: Healthy Michigan Plan § 1115 Demonstration Waiver Extension Request Amendment

Dear Ms. Prokop:

Thunder Bay Community Health Service, Inc. (TBCHS) appreciates the opportunity to comment on the Michigan Department of Health and Human Services' (MDHHS) request for public comment on the Healthy Michigan Plan § 1115 Demonstration Waiver Extension Request Amendment.

Thunder Bay is a Federally Qualified Health Center (FQHC) that provides care to approximately 15,000 patients of which nearly 5,200 are Medicaid beneficiaries. Our organization has 4 primary care sites, 2 school-based health centers, and 14 additional schools which provide behavioral health services across 6 counties. Thunder Bay provides a full range of quality, affordable, comprehensive primary health care services, including medical, dental, and behavioral health services, either through direct care or through community referrals, regardless of insurance status or ability to pay for services.

The Medicaid expansion has allowed TBCHS to reach out to patients in need in our rural communities. We have increased the number of Medicaid beneficiaries who visit our health center and have been able to provide additional services to those patients who have not had previous access to care. Our goal is to build healthier communities and empower our patients to be accountable for their care and the Healthy Michigan Plan has allowed us to work toward achieving these goals.

TBCHS is writing to express our support for the comments submitted by the Michigan Primary Care Association (MPCA) in response to the Healthy Michigan Plan waiver extension request amendment. A summary of these comments is as follows:

Thunder Bay
COMMUNITY HEALTH SERVICE, INC.

Administrative Office &
HILLMAN
15774 State St.
P.O. Box 427
Hillman, MI 49746
PH. 989-742-4583
FAX 989-742-4298

ATLANTA
11899 M-32 West
P.O. Box 850
Atlanta, MI 49709
PH. 989-785-4855
FAX 989-785-2267

Thunder Bay Pharmacy Atlanta
989-785-5535
FAX 989-785-5267

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Definition of medically frail

Federal statute allows states to create a unique medically frail definition to meet the state's needs under 42 CFR 440.315(f). Although being supportive of the process MDHHS proposes to use to identify medically frail individuals, MPCA is very concerned that the current list of ICD-10 diagnoses codes included in Appendix A, Attachment L, fails to include conditions such as clinical depression or anxiety that could prevent an individual from working. Penalizing an individual who cannot work but does not qualify for an exemption would contribute to a dangerous cycle of failure and worsening health outcomes.

MDHHS has the authority to include additional diagnosis codes. MPCA urges MDHHS to include diagnoses related to depression, anxiety, and other mental health conditions that are not otherwise included in the proposed waiver extension amendment. Specifically, MPCA requests MDHHS add diagnoses related to ICD-10 codes F063, F064, F309-F339, F410-F4312, F440, F600-F609, and F6381 to the state's definition of medically frail. MPCA strongly urges MDHHS to use this broadened definition of medically frail for both the workforce engagement and the cost-sharing requirements articulated in the waiver extension application.

Suspension of coverage for noncompliance with cost-sharing requirements

MPCA is extremely concerned by the lack of details relative to suspension of coverage for noncompliance with cost-sharing requirements for individuals with income between 100 and 133 percent of the federal poverty limit. Individuals covered by HMP make daily decisions on how to make ends meet, which makes careful consideration of cost-sharing compliance mandates important. MPCA encourages MDHHS to use its authority to specify how it will operationalize the suspension of coverage for noncompliance with the program's cost-sharing requirements.

MPCA recommends that MDHHS align compliance with cost-sharing requirements with the proposed workforce engagement requirements and allow an individual up to six consecutive months of the year to be noncompliant relative to cost-sharing. MDHHS should suspend eligibility only for individuals who have consistently failed to pay cost-sharing contributions for six consecutive months before the outstanding balance is sent to the Michigan Department of Treasury for garnishment of tax returns or lottery winnings. Additionally, MPCA urges MDHHS to develop and publicize the process by which individuals can restore HMP benefits. We believe this process should include a provision restoring coverage once an individual agrees to an outstanding balance payment plan and has made the first monthly payment. The state should accept the first payment on a mutually agreed upon payment plan as a good faith effort to be in compliance with the cost-sharing requirements.

§ 1115 demonstration waiver evaluation design

Thunder Bay
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A core component of the § 1115 demonstration waiver is the inclusion of an appropriate evaluation component to assess the relevant hypotheses the demonstration plans to test. MPCA believes the stated objectives in the evaluation overview section of the amended waiver extension proposal falls short of fully evaluating this statutory mission statement. Specifically, MPCA strongly urges MDHHS to include evaluating the following components to test additional hypotheses supported by the statute's mission statement:

- The extent to which beneficiaries believe that workforce engagement requirements as a condition of HMP eligibility has a positive impact on personal health outcomes and financial well-being;
- The extent to which workforce engagement requirements improve health outcomes while covered by HMP; and
- Whether the costs in uncompensated care increase or decrease as a result of individuals losing coverage for noncompliance with workforce engagement requirements.

The Healthy Michigan Plan has been a large success in no small part due to the leadership of MDHHS to ensure all individuals have access to affordable coverage to improve health outcomes. Healthy Michigan has been such a great asset to our patients who previously lacked access to care. TBCHS strongly believes MDHHS should use its authority to ensure the HMP remains a health coverage program and work in partnership with stakeholders to implement a fair, Michigan-based approach to workforce engagement requirements.

In closing, we appreciate the opportunity to comment on this issue. If you require any clarification on our comments, please contact me at mstyma@tbchs.org or at (989)742-5002.

Sincerely,

Michelle Styma, CEO
Thunder Bay Community Health Service, Inc.

From: [redacted]
To: HealthyMichiganPlan
Subject: Work Requirement for Medicaid
Date: Friday, August 10, 2018 10:04:16 AM

I am strongly opposed to a work requirement for Medicaid recipients. This regulation is unnecessary, as many Medicaid beneficiaries already work and the overwhelming majority of Medicaid fraud comes not from individuals but from companies making claims. Additionally, with a minimum wage of $9.25/hour, many individuals would face strong barriers to even break even while working to even pay for transportation and childcare arrangements to allow them to hold a position. This law would only hurt the must vulnerable among us, and then we (the taxpayers) would simply end up paying MORE for their emergency care than we would for their Medicaid.

From: [redacted]
To: HealthyMichiganPlan
Subject: Public Comment: Demonstration Extension Application Amendment
Date: Friday, August 10, 2018 10:24:15 AM

I am a resident of Grand Rapids, a Michigan taxpayer, and a regular voter. I would like to comment on Michigan's Medicaid work rules. I strongly oppose these work rules and think they are bad for the State of Michigan for the following reasons:

1) In the rest of the rich, industrialized countries of the world (EU, Canada, etc.) all citizens have access to universal healthcare. America is the only shameful exception to this pattern. Elsewhere in the world, ensuring access to health services for citizens is considered a key responsibility of government and denying access to healthcare is regarded as an infringement on human rights. This is why other countries have much better health outcomes than we have in America and much lower maternal and infant mortality rates.

2) Imposing work rules on Medicaid will add enormous administrative costs to the budget and expand bureaucracy. I thought Republicans wanted to give us smaller government and more efficiency. But this would add enormous inefficiencies into the system. The administrative cost per insured individual will go up at the same time that health outcomes worsen.

3) Most Medicaid recipients already work.

4) Many Medicaid recipients would run into child care and transportation barriers trying to comply with the work mandate.

Some people who are not in the workforce are at home taking care of children so that other people can be in the workforce. For example, a woman in her late 50s may be staying home to watch grandchildren during the day so her daughter can work. If that grandmother needs to get a job, the child care issues will become a crisis for that family and put them in an economic tailspin. There is a

lot of very real but unpaid work performed in our society by women. It is invisible and unpaid, but it's also adding value to our economy by reducing the need for employers or government services to supply affordable child care. Medicaid work requirements will be a blunt instrument that has numerous negative unforeseen consequences for families that have members at home doing vital caretaking work both for children and seniors.

Please implement public policy that leads to human flourishing! Our goal should be to make it easier for families to climb out of poverty, not give them more hoops to jump through.

From: MSADraftPolicy
To: HealthyMichiganPlan
Subject: FW: Work requirements
Date: Friday, August 10, 2018 10:44:49 AM

[redacted]
Sent: Friday, August 10, 2018 10:11 AM
To: MSADraftPolicy <MSADraftPolicy@michigan.gov>
Subject: Work requirements

Please do not change the rules, there are so many people in the world that medicad has has helped and changed lives and have given a second chance to.we the people are blessed to have a program like this. My mother in law lost her husband to a stroke. She also had some serious health problems that caused her not to be able to work. When her husband passed away she became homeless. She started receiving medicad to help her with the water on her brain and then2knee surgreys and the back problems and all the other Heath issues she was going threw due to bone detereation . With your help she is now back on her feet and is a certified to help in foster homes. Still to this day she has tears of joy and worry in her eyes. This is only one story there are alot more. Please keep Americans, michiganders heathy! You have saved my mom's life thank you.

[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment Comment
Date: Friday, August 10, 2018 11:33:14 AM

Once again people at the bottom take a hit, and are now required to work to receive help. This while we give away our water almost for free to a multinational company that cares only for it's bottom line. So here is an idea,charge a reasonable rate for this water say what we pay, and give some of it to these people.
[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Medicaid work requirements
Date: Friday, August 10, 2018 12:11:10 PM

This is ABSOLUTELY needed. Those who are truly disabled will be able to get a waiver.
Working in the ER, we see the contrast daily between those people and the medicaid recipients who have no health problems and brazenly tell me “thank you for working so I don’t have to”.
I have been working since I was 12 (nearly 50 years), this is an ethic taught by our parents. It is way past time to begin demonstrating such behaviors to the kids via example.
The current setup is NOT SUSTAINABLE.

[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment"
Date: Friday, August 10, 2018 12:24:38 PM

I am against imposing a work requirement on Medicaid recipients. Many are poor, or have health issues that make working (or even getting hired) problematic.

I have a family member who received Healthy Michigan benefits in 2014. He is an addict, lost his job, and clearly was in no condition to work. He needed medical care to pay for his doctor visits, two hospitalizations, and his medications. Benefits did NOT cover addiction rehab, which he went through twice.

Healthy Michigan saved his life, I am convinced. He is now in recovery, and successfully working at a full time job with health benefits.

Everyone deserves help when they have serious health problems. Addiction is a medical condition, and needs to be treated if a person is to get back into society.

Ours is just one story. Health care for everyone should be the goal, and there should be no judgment involved.

[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: "Demonstration Extension Application Amendment
Date: Friday, August 10, 2018 12:38:50 PM

Sir/Madam:

Instituting a work requirement for people using the Medicare system is not in the best interest of Michigan residents. Many people have health issues that are not conducive to being able to work outside of their homes or, in some cases, perform any type of work at all.

Diabetes, Multiple Sclerosis, Psychiatric issues, severe asthma, etc. are health issues that may not manifest themselves in easily observed ways, yet, they can be crippling for those suffering from those conditions. Withholding their health care because they aren't working is not the solution for those people.

Please do not support this plan for Michigan residents. Sick individuals deserve health care whether they are able work or not work.

[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: "Demonstration Extension Application Amendment"
Date: Friday, August 10, 2018 12:38:54 PM

I am 100 perecent for the work requirement for able boddied people. I work for my insurance doubled I and have a huge deductable ever since the affordable care act was put in place. It's not fair that someone who is able boddied can get free healthcare with no deductable. I just had to take out a loan to pay my $4,500 copay for a back surgery. How is this fair to the working people paying for all of this free healthcare? You should help those that work hard enough to get health care, not those who do not have g to support themselves.
[redacted]

Sent from Yahoo Mail on Android

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Friday, August 10, 2018 1:11:09 PM

In my work experience with employees I find there are only two things. One is willingness and the other is ability. If someone is medically unable to work Medicaid is fine. Yet, if willingness is the issue then they need to be given motivation to work. Limiting their Medicaid is a good start.

From: [redacted]
To: HealthyMichiganPlan
Subject: Healthy Michigan Plan 1115
Date: Friday, August 10, 2018 1:22:23 PM

I want to go on record as opposing this entire legislation. We do not need to get involved in a complicated to administer program that would yield a little money and a lot of hardship and resentment. This is not progressive but transparently designed to “encourage” people to work. Most of these people are truly unable to work, and, I fear, won’t qualify for a waiver. As a retired pediatric nurse, I know there are young adults out there who would be in jeopardy if their health care were interrupted for any reason. I am also concerned about mentally ill individuals who Just are not desirable employees. Don’t bother with this horrendous law.
Sent from my iPhone

From: [redacted]
To: HealthyMichiganPlan
Subject: Medicaid work requirement
Date: Friday, August 10, 2018 2:40:37 PM

I'm saddened that Governor Snyder signed a bill that treats different people differently based on the unemployment rate in each county. I'm against it. Seems racist and unconstitutional to me.

[redacted]

Sent from my iPad

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Ammendment
Date: Friday, August 10, 2018 2:41:42 PM

I think the most important point to remember is Do No Harm. Each person's case needs to be considered individually and monitored monthly to make sure someone's health and safety is not compromised. What barriers are there for individuals besides their health, mental disability, child care responsibilities, education level, or transportation? If they are obese are they getting help with nutrition choices? Is there healthy food even accessible? Are they living in a safe and stable environment? If they do find a job, will they lose their benefits? These are complex issues that need to be considered.

Sent from my iPad

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Friday, August 10, 2018 3:13:28 PM

Scenario: Working TWO part time jobs with NO benefits (because you can't FIND a full time benefited job in your field, in which you have a masters degree) and have student loans which take 1/3 of monthly income or more....then as a result of working more than 20 hours/week you don't even qualify for Medicaid anymore. Now you pay over $100/month for a catastrophic plan only, since the deductible is over $6,000 a year. This is one example of why this change is a disaster. There are plenty of part time jobs, but few that are actually full time benefitted career positions. Until this changes, there will be many many young adults who are one illness or accident away from financial ruin before they can even get started.

Sent from my iPhone

From: [redacted]
To: HealthyMichiganPlan
Subject: medicaid
Date: Friday, August 10, 2018 3:15:32 PM

I have worked and had insurance my whole life now at 58 I am struggling with a back issue and only thing I could go is get Medicaid –but due to working retail always and know that I am not able to work right now due to pain and having to see surgeon –it would be so painful to try and work let alone unfair to all others working there if I can't perform my job –do I like this NO but after 14 years of heavy lifting and loading at McSports (banckrupt) I now have horrible mess plus I have RA and that is not curable

Thank you

[redacted]

From: [redacted]
To: HealthyMichiganPlan
Date: Friday, August 10, 2018 3:18:39 PM

I think there are too many little loop holes in this. Nothing really is spelled out specifically and too many open ended possibilities. I really hope this doesn't pass
Sent from Yahoo Mail on Android

From: [redacted]
To: HealthyMichiganPlan
Subject: About work requirements for the Healthy Michigan Plan!
Date: Friday, August 10, 2018 3:28:21 PM

It's reprehensible that we're even considering putting work requirements on Healthy Michigan. We are the wealthiest nation in the world. We are perfectly capable of taking care of our poorest and most destitute, no matter their personal stories or backgrounds. If someone is sick, they should be taken care of. I work full time. I am on the Healthy Michigan Plan. It has changed my life for the better, and all I want is the same for others, whether they work or not. We should not be valuing people solely on their work performance. We are nominally not a meritocracy and should not treat our citizens like we are one.

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Friday, August 10, 2018 3:28:40 PM

I would like to make a comment on the work requirements Michigan is looking to put into effect for Medicaid eligibility. I have a 6 year old daughter who I have sole custody of. Her father is in and out of rehab/jail, and basically not part of her life.

I have been on Medicaid for two years. I lost my job in February at a retail store and decided to get into substitute teaching in order to spend more time with my daughter and have a schedule that was flexible enough to be fully involved in her life since her father is not.

Substitute teaching is a field that desperately needs employees. However, the demand is not consistently there. Some weeks I could probably get 3-5 days of work but not always. And not always in locations that make it worth the drive. Some weeks I might know my schedule ahead of time, other weeks I'm getting phone calls in the morning for a job in the same day. I have a degree, but unfortunately not in education. So, as a substitute I can only work 90 days in a school year. This work requirement for Medicaid while on the surface may seem like a good idea, in reality you will be pushing people out of fields that NEED employees. I love being a substitute teacher. I found my niche, but I may have to choose between a job I love or whether I can afford to go to the doctor when I'm sick.

With this work requirement, I will have to either marry my boyfriend to get on his insurance (which is something no human should be forced in to just so they can afford to go to the doctor) or I will have to find a new job that can guarantee me 20 hours (or 29, because the requirements keep changing and nobody can keep up).

I am active in the PTO at my daughter's school. I take her to swimming lessons. I put her on the bus. I take her to dance. I do everything for her, but I may lose my insurance because I have employment that is on demand versus consultant and the millions of different things that I do as a single parent doesn't suffice for "Work requirements".

When a teacher can't be in the classroom, it's important that someone is able to be there that is a good fill in. It would be a shame for our school systems, as well as similar seasonal/on call fields to lose good employees because health and survival have to be put first.

[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Friday, August 10, 2018 3:34:19 PM

Hi, I am a widow mother of two. Before my husband died we had health insurance. Unfortunately, now I have Meridian. I suffer with a medical condition. The Ortho Dr I see is not certified to perform surgery through Mercy and the insurance doesn't cover the procedure done at the surgery clinic where he can perform the surgery. So, I am stuck and will be for awhile until I get treatment covered. I may also be facing blood clots. With the cost of daycare and my kiddos schedule I cannot work. With my son being 12 daycares will not except his age and by that he is not mature to stay home alone. He has some anger issues. I need my health care so I can stay healthy for my kids. They lost their father ...they don't need to loose their mother. No employer is going to hire the minium work hours. I believe mothers and their kids should automatically be included until their kiddos reach a certain age where the parent could actually leave their kids home to go to work. Daycare all summer and out of all the breaks....most single parents have trouble paying bills, now to add daycare too. Keep the medical insurance for the women and children and those who need it most.
Thank you!

From: Robert Dorigo Jones
To: HealthyMichiganPlan
Subject: Healthy Michigan Plan Application Public Comment
Date: Friday, August 10, 2018 3:36:42 PM
Attachments: Healthy Michigan Public Comment Michigan"s Children.pdf

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Hello,

I'm writing to submit public comment from the organization Michigan's Children regarding the changes to the Healthy Michigan Plan. Thank you!

Best,

Robert Dorigo Jones
Policy and Outreach Associate
Michigan's Children
(517) 648-5072

Michigan's Children

Public policy in the best interest of children

Date: August 10, 2018

To: Michigan Department of Health and Human Services
Bureau of Medicaid Policy and Health System Innovation

From: Matt Gillard, President & CEO
matt@michiganschildren.org or (517) 485-3500

Re: Healthy Michigan Application Public Comment

Thank you for the opportunity to provide comment on the Healthy Michigan Plan's policy changes. Michigan's Children is the only statewide and independent voice working to ensure that public policies are made in the best interest of children and youth, from cradle to career, and their families, with a focus on policy solutions that improve equitable outcomes for children.

We know from over two decades of work with children, youth, and families; decades of overwhelming research; as well as common sense, that people are more likely to learn, and more likely to earn, when their basic needs are met. Children and youth who receive regular physical and behavioral health care services reap lifelong benefits: they attend school ready to learn, have stronger health outcomes, are more likely to attend college, and generate more tax contributions as adults. Healthy parents are more likely to be able to keep their children healthy, help in their communities and keep a job. We are concerned that the changes to the Healthy Michigan Plan will adversely impact child and family outcomes and do not support the changes.

We are concerned over the potential negative impact the changes could have on children and youth's access to primary health care services, despite exemptions for children and parents of children under age 6. Regardless of whether they themselves are covered, children and youth are far more likely to receive physical and mental health services when their parents have health care coverage. According to Johns Hopkins University researchers, when their parents are covered, kids are always more likely to see a medical professional for preventive care, which reduces both the need for future services and long-term state costs. When parents can go to the doctor, they're more likely to bring their kids, be they age three, seven or seventeen.

If their parents lose health care, not only will children and youth see fewer check-ups, out-of-pocket costs during emergencies may skyrocket, putting their families at financial risk. Medicaid enrollees borrow less money to pay for medical costs, a benefit that kids feel when their parents are more able to afford healthful food or new, safe housing. As a result of the proposed changes, children's health could be compromised not only through lost access to services, but also because their family resources will be spread even thinner.

The Healthy Michigan changes would also exempt pregnant mothers, but research finds the health of a child depends on pre-conception parental health in addition to the mother's health during pregnancy. About half of pregnancies are unplanned, meaning at any point a young woman's health status could have implications for that of a baby. A parent's young adult years are critical for a baby's health: in Michigan, the average age of a mother at first birth is about 26 years old. Unfortunately, our statewide unemployment rate for young adults aged 20-24 in 2016, a year of robust economic health, was 8.4%. For 18- and 19-year-olds, the rate was closer to 16%. These double during economic recession, when older, more qualified workers compete for lower-paying jobs. Policymakers have already agreed that young adults deserve protection from market forces when it comes to health care: the Affordable Care Act guarantees young adults can remain on their parents' insurance until 26. In the face of economic challenges, rescinding health care coverage would place young adults, and their own future families, in a precarious position.

The policy could also have unintended consequences for youth who are transitioning out of the foster care system and working to establish themselves economically and educationally. Foster-affiliated youth often negotiate trauma and other needs. Current work and education requirements for other programs have been crafted around the unique challenges that these young people face far beyond the age of 21. Existing supports include fewer required hours than exist in this bill, as well as grace periods, recognizing the personal circumstances that might arise to pull young people temporarily off track without compromising services for the longer term. There is a lack of clarity regarding how existing protections for youth transitioning out of foster care will be reconciled with the proposed Healthy Michigan changes, and significant risk for this population.

Finally, Michigan's child care system lacks the capacity to guarantee quality care for every eligible parent or caregiver: state business practices and a history of low investment have driven hundreds of providers out of the system, to the point that 48% of low-inome people, including including the Healthy Michigan population, live in a child care desert, lacking access to licensed care. While many adults are already subject to work requirements and entitled to child care support, and although the plan exempts sole caretakers of children under 6 from work requirements, eligible two-parent families and families with children over the age of six already fall through the cracks, and they will continue to do so without systemic child care reforms.

A child's health ultimately relies upon the health of those around them. While exemptions from work requirements can protect some people, many will fall through the cracks. Hundreds of working families and young adults who will soon be starting families face barriers that could cost them coverage under the Healthy Michgan Plan changes, putting that cornerstone of a healthy life – regular health care services – in jeopardy for many children and youth.

Sincerely,

Matt Gillard

From: Brenda F. Jackson
To: HealthyMichiganPlan
Subject: Healthy Michigan Plan Program - Comments Letter
Date: Friday, August 10, 2018 3:41:16 PM
Attachments: Healthy Michigan Plan Program - Comments Letter.doc

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Sent on behalf of Mr. Anthony King, CEO and Executive Director, The Wellness Plan Medical Centers.

Brenda Jackson
Executive Assistant
Office of the CEO & Executive Director
Anthony V. King, FACHE, MHSA
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Health, Wellness and Quality of Life

August 12, 2018

MDHHS
Medical Services Administration
Bureau of Medicaid Policy and Health System Innovation
ATTN: Medicaid Policy
P.O. Box 30479
Lansing, MI 48909

Submitted via email: healthymichiganplan@michigan.gov

Subject: Healthy Michigan Plan § 1115 Demonstration Waiver Extension Request Amendment

Dear Ms. Prokop:

The Wellness Plan Medical Centers appreciates the opportunity to comment on the Michigan Department of Health and Human Services' (MDHHS) request for public comment on the Healthy Michigan Plan § 1115 Demonstration Waiver Extension Request Amendment.

The Wellness Plan Medical Centers is a Federally Qualified Health Center (FQHC) founded 45 years ago and operates six medical centers in Wayne, Oakland and Macomb counties. We provide care to 24,198 patients of which 16,983 are Medicaid patients. The Wellness Plan Medical Centers provides a full range of quality, affordable, comprehensive primary health care services, including medical, dental, and behavioral health services, either through direct care or through community referrals, regardless of insurance status or ability to pay for services.

Through the expansion of Healthy Michigan we were able to provide services to an additional 2,000 patients. This provided additional access to services they would otherwise not have received.

The Wellness Plan Medical Centers is writing to express our support for the comments submitted by the Michigan Primary Care Association (MPCA) in response to the Healthy Michigan Plan waiver extension request amendment. A summary of these comments is as follows:

Definition of medically frail
Federal statute allows states to create a unique medically frail definition to meet the state's needs under 42 CFR 440.315(f). Although being supportive of the process MDHHS proposes to use to identify medically frail individuals, MPCA is very concerned that the current list of ICD-10 diagnoses codes

included in Appendix A, Attachment L, fails to include conditions such as clinical depression or anxiety that could prevent an individual from working. Penalizing an individual who cannot work but does not qualify for an exemption would contribute to a dangerous cycle of failure and worsening health outcomes.

MDHHS has the authority to include additional diagnosis codes. MPCA urges MDHHS to include diagnoses related to depression, anxiety, and other mental health conditions that are not otherwise included in the proposed waiver extension amendment. Specifically, MPCA requests MDHHS add diagnoses related to ICD-10 codes F063, F064, F309-F339, F410-F4312, F440, F600-F609, and F6381 to the state's definition of medically frail. MPCA strongly urges MDHHS to use this broadened definition of medically frail for both the workforce engagement and the cost-sharing requirements articulated in the waiver extension application.

Suspension of coverage for noncompliance with cost-sharing requirements
MPCA is extremely concerned by the lack of details relative to suspension of coverage for noncompliance with cost-sharing requirements for individuals with income between 100 and 133 percent of the federal poverty limit. Individuals covered by HMP make daily decisions on how to make ends meet, which makes careful consideration of cost-sharing compliance mandates important. MPCA encourages MDHHS to use its authority to specify how it will operationalize the suspension of coverage for noncompliance with the program's cost-sharing requirements.

MPCA recommends that MDHHS align compliance with cost-sharing requirements with the proposed workforce engagement requirements and allow an individual up to six consecutive months of the year to be noncompliant relative to cost-sharing. MDHHS should suspend eligibility only for individuals who have consistently failed to pay cost-sharing contributions for six consecutive months before the outstanding balance is sent to the Michigan Department of Treasury for garnishment of tax returns or lottery winnings. Additionally, MPCA urges MDHHS to develop and publicize the process by which individuals can restore HMP benefits. We believe this process should include a provision restoring coverage once an individual agrees to an outstanding balance payment plan and has made the first monthly payment. The state should accept the first payment on a mutually agreed upon payment plan as a good faith effort to be in compliance with the cost-sharing requirements.

§ 1115 demonstration waiver evaluation design
A core component of the § 1115 demonstration waiver is the inclusion of an appropriate evaluation component to assess the relevant hypotheses the demonstration plans to test. MPCA believes the stated objectives in the evaluation overview section of the amended waiver extension proposal falls short of fully evaluating this statutory mission statement. Specifically, MPCA strongly urges MDHHS to include evaluating the following components to test additional hypotheses supported by the statute's mission statement:

- The extent to which beneficiaries believe that workforce engagement requirements as a condition of HMP eligibility has a positive impact on personal health outcomes and financial well-being;

- The extent to which workforce engagement requirements improve health outcomes while covered by HMP; and
- Whether the costs in uncompensated care increase or decrease as a result of individuals losing coverage for noncompliance with workforce engagement requirements.

The Healthy Michigan Plan has been a large success in no small part due to the leadership of MDHHS to ensure all individuals have access to affordable coverage to improve health outcomes. The Wellness Plan Medical Centers strongly believes MDHHS should use its authority to ensure the HMP remains a health coverage program and work in partnership with stakeholders to implement a fair, Michigan-based approach to workforce engagement requirements.

In closing, we appreciate the opportunity to comment on this issue. If you require any clarification on our comments, please contact me at aking@wellplan.com or at 313-202-8550.

Sincerely,

Anthony King
CEO and Executive Director

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Friday, August 10, 2018 3:44:59 PM

I drive Uber. I don't make enough money to afford health insurance. I can't even afford to take 20 percent of my earnings and give them to the government. I'm super broke all the time, my car's suspension and steering components are worn pretty good and my tires cost 500 dollars to replace every 8 - 10 months. I can't work 20 hours a week sometimes because of what a car's suspension does to my brain and body. It compresses my spine, hurts my legs and lower back and sometimes at 33 years old I have to force myself up stairs to get into my apartment. My apartment costs 1100 dollars a month. Just about what I make in a month driving Uber after gas, food, oil changes, and many other things. Food costs 11 or 12 dollars for one meal. It costs upwards of 30 dollars a day to feed myself decent food and not McDonald's crap that hurts my body and brain. Healthy food is very expensive.. Especially when you're constantly on the go. I really need healthcare. I can't afford to pay out of pocket myself for doctor visits and the healthy Michigan plan has helped me incredibly. I wouldn't be able to seek physical therapy for my aching body.. I often feel much older than I am because of my physical issues.. I fell off a bike before I was driving Uber when I had no job. Someone played a dirty trick on me and others by covering the bike path with wood chips so my bike slid out from underneath me. I hit my head pretty good and ended up with a traumatic brain injury. Michigan healthy plan was there for me. I could have died.. My mother would have been an absolute wreck. She never tells anyone, but I'm her favorite son. ;o) out of three boys. Can you imagine raising three sons? I've been homeless in Michigan because I screw up a lot at work with things, never because of irresponsibility. Always on time to jobs. They just let me go very often because I can't get things down.. It makes me sad, really sad that I can't do things like other people. They'll call me slow at work, I try to pick it up but it's just not good enough. I got let go before from Value World because despite my efforts I could not sort by color and pattern of womens clothing.. Being a man I never took pride in clothing. I buy cheap clothes and wear em out until I can find more cheap clothes.. I really need the healthy Michigan plan and don't think I could work 20 hours a week.. I hurt constantly. I try to force myself to get out there and work but I seem to have failure written across my forehead. It's so disheartening.. I want to be like everyone else, but I'm held back by an unknown force.. I wish I could seek help for this but people I've seen therapists say I'm a failure themselves and that I need to try harder. I try very hard. They don't see the struggle. They don't know what's holding me back, I don't know what's holding me back except for body pains maybe. I wish there was something I could be successful at.. I'm constantly struggling to eat and pay my rent and car loan and car insurance.. My family is always so so mad at me for not being able to pay my car insurance. They threaten me.. I just want to be normal.. Like everyone else..

From: Darrel Thompson
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Friday, August 10, 2018 3:50:45 PM
Attachments: CLASP MI Waiver Comments State.pdf

Hello Director Nick Lyon,

Attached are comments on the Healthy Michigan Plan §1115 Demonstration Waiver Extension Request Amendment from the Center for Law and Social Policy (CLASP).

Best regards,

Darrel Thompson
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CLASP
Policy solutions that work for low-income people

August 10, 2018

Michigan Department of Health and Human Services
Medical Services Administration
Bureau of Medicaid Policy and Health System Innovation
Attention: Medicaid Policy
P.O. Box 30479
Lansing, Michigan 48909-7979

Re: Demonstration Extension Application Amendment

Dear Director Nick Lyon,

I am writing on behalf of the Center for Law and Social Policy (CLASP). CLASP is a national, nonpartisan, anti-poverty nonprofit advancing policy solutions for low-income people. We work at both the federal and state levels, supporting policy and practice that makes a difference in the lives of people living in conditions of poverty. In particular, these comments draw on CLASP's deep experience with Temporary Assistance for Needy Families (TANF) and the Supplemental Nutrition Assistance Program (SNAP), two programs where many of the policies proposed in this proposal have already been implemented – and been shown to be significant barriers to low-income people getting and retaining benefits. These comments also draw on CLASP's experience in working with six states under the Work Support Strategies (WSS) project, where these states sought to dramatically improve the delivery of key work support benefits to low-income families, including health coverage, nutrition benefits, and child care subsidies through more effective, streamlined, and integrated approaches. From this work, we learned that reducing unnecessary steps in the application and renewal process both reduced burden on caseworkers and made it easier for families to access and retain the full package of supports that they need to thrive in work and school.

CLASP submits the following comments in response to Michigan's Demonstration Extension Application Amendment and raises serious concerns about the effects of the amendment, as proposed, on the coverage and health outcomes of low-income Medicaid beneficiaries in Michigan. Medicaid plays a critical role in supporting the health and well-being of low-income adults and children and is not a government "interference," as suggested by Michigan. In fact, many Medicaid enrollees work in low-wage jobs where employer-sponsored health care is not offered or is prohibitively expensive. Others may have health concerns that threaten employment stability, and without Medicaid, would be denied access to the medical supports they need to hold a job, such as access to critical medications.

The Medicaid statute is clear that the purpose of the program is to furnish medical assistance to individuals whose incomes are not enough to meet the costs of necessary medical care and furnish such assistance and services to help these individuals attain or retain the capacity for independence and self-care. States are allowed in limited circumstances to request to "waive" provisions of the rule but the Secretary of Health and Human Services (HHS) may only approve a project which is "likely to assist in

promoting the objectives" of the Medicaid Act.[1] A waiver that does not promote the provision of affordable health care would not be permissible.

Among the state's professed goals for the proposal is to increase access to health care and reduced uncompensated care. However, this proposal's attempt to transform Medicaid and reverse its core function will result in Medicaid enrollees losing needed coverage, poor health outcomes, and higher costs. There is extensive and strong literature that shows, as a recent New England Journal of Medicine review concludes, "Insurance coverage increases access to care and improves a wide range of health outcomes."[2] Moreover, losing health coverage will also make achieving work and education goals significantly more difficult for beneficiaries. This amendment is therefore inconsistent with the Medicaid purpose of providing medical assistance and should be rejected. It is also inconsistent with improving health and increasing employment.

Proposal to increase cost-sharing and participation requirements for individuals enrolled for 48 cumulative months

CLASP does not support Michigan's proposal to require a monthly premium equal to 5% of income and eliminate eligiblity for cost-sharing reductions for persons enrolled for 48 cumulative months. No rational is provided for the changes in eligiblity and cost-sharing to persons with 48 months of cumulative coverage. This proposed policy is essentially a punishment for maintaining employment with income between 100 and 138 percent of poverty but not increasing your earnings.

The reality of low-wage work is that many people work for poverty-level wages and do not substantially increase their earnings from year to year. In one study that followed a group of women who received welfare in an urban county in Michigan, the share of respondents who were working in "good jobs" (defined by a combination of wages, hours, and health benefits) increased from 8.3% in 1997 to just 29% in 2001. This is in spite of a historically strong labor market that resulted in labor force participation rates for single mothers that have not been seen since. As would be expected, the probability of holding a good job is higher for former recipients who worked steadily. However, even exceptionally regular employment did not guarantee progression to a good job; of the small fraction of respondents who had worked in every month of the past five years, only 55% were employed in good jobs in 2001.[3]

Proposals to Take Health Coverage Away from Individuals Who Do Not Meet New Work Requirements

CLASP does not support Michigan's proposal to take away health coverage from individuals who do not meet new work requirements. Our comments focus on the harmful impact the proposed work requirements will have on Michiganders and the state. Michigan is proposing to implement a work requirement for beneficiaries who are between the ages of 19-62, unless they qualify for an exemption. Those who are subject to the work requirement will have to work or participate in other qualifying activities for 80 hours per month to stay enrolled in Medicaid. Medicaid enrollees will also be required to demonstrate that they are compliant with the work requirements through monthly verification. The penalty for not complying with the work requirement is disenrollment from Medicaid.

CLASP strongly opposes work requirements for Medicaid beneficiaries and urges Michigan to reconsider their approach to workforce development. Work requirements—and disenrollment for failure to comply—are inconsistent with the goals of Medicaid because they would act as a barrier to access to

health insurance, particularly for those with chronic conditions and disabilities, but also for those in areas of high unemployment or who work the variable and unpredictable hours characteristic of many low-wage jobs. The reality is that denying access to health care makes it less likely that people will be healthy enough to work. This provision would also increase administrative costs of the Medicaid program and reduce the use of preventive and early treatment services, ultimately driving up the costs of care while also leading to worse health outcomes.

Proposals to Take Health Coverage Away from Individuals Who Do Not Meet New Work Requirements Do Not Promote Employment

Lessons learned from TANF, SNAP, and other programs demonstrate that work requirement policies are not effective in connecting people to living-wage jobs that provide affordable health insurance and other work support benefits, such as paid leave.[4] A much better focus for public policy is to develop skills training for jobs that are in high demand and pay living wages, help people get the education they need to climb their career ladder, and foster an economy that creates more jobs.

Another consequence of a work requirement could be, ironically, making it harder for people to work. When additional red tape and bureaucracy force people to lose Medicaid, they are less likely to be able to work. People must be healthy in order to work, and consistent access to health insurance is vital to being healthy enough to work.[5] As reported by the University of Michigan, Medicaid expansion helped low-income Michigan residents look for employment and stay employed. In particular, the study highlights that most (55 percent) of those who were out of work said that coverage made them better able to look for a job and, among those who had jobs, 69 percent said they did better at work once they got covered.[6] Making Medicaid more difficult to access could have the exact opposite effect on employment that supporters of work requirements claim to be pursuing.

Proposals to Take Health Coverage Away from Individuals Who Do Not Meet New Work Requirements Grow Government Bureaucracy and Increase Red Tape

Taking away health coverage from Medicaid enrollees who do not meet new work requirements would add new red tape and bureaucracy to the program and only serve as a barrier to health care for enrollees. Michigan's proposal would require Medicaid enrollees subject to new work requirements to demonstrate that they are meeting the requirements through monthly verification. Not only will this create considerable paperwork for Medicaid enrollees, but also significantly increase administrative costs. Tracking work hours, reviewing proof of work, and keeping track of who is and is not subject to the work requirement every month is a considerable undertaking that will be costly and possibly require new technology expenses to update IT systems.

One of the key lessons of the Work Support Strategies initiative is that every time that a client needs to bring in a verification or report a change adds to the administrative burden on caseworkers and increases the likelihood that clients will lose benefits due to failure to meet one of the requirements. In many cases, clients remain eligible and will reapply, which is costly to families who lose benefits as well as to the agencies that must process additional applications. The WSS states found that reducing administrative redundancies and barriers used workers' time more efficiently and helped with federal timeliness requirements.

Lessons from the WSS initiative is that the result of Michigan's new administrative complexity and red tape is that ***eligible*** people will lose their health insurance because the application, enrollment, and on-going processes to maintain coverage are too cumbersome. Additional evidence from Arkansas' first month of implementing work requirements also suggests that they create bureaucratic barriers for individuals who already work or qualify for an exemption. Over 7,000 Medicaid beneficiaries now have one month of non-compliance of the new requirement and will lose coverage if they have two more. As reported by the Center on Budget and Policy Priorities, many of those who failed to report likely didn't understand the reporting requirements, lacked internet access or couldn't access the reporting portal through their mobile device, couldn't establish an account and login, or struggled to use the portal due to disability.[7]

Proposals to Take Health Coverage Away from Individuals Who Do Not Meet New Work Requirements Do Not Reflect the Realities of Our Economy

Proposals to take away health coverage from Medicaid enrollees who do not work a set number of ours per month do not reflect the realities of today's low-wage jobs. For example, seasonal workers may have a period of time each year when they are not working enough hours to meet a work requirement and as a result will churn on and off the program during that time of year. Or, some may have a reduction in their work hours at the last minute and therefore not meet the minimum numbers of hours needed to retain Medicaid. Many low-wage jobs are subject to last-minute scheduling, meaning that workers do not have advance notice of how many hours they will be able to work.[8] This not only jeopardizes their health coverage if Medicaid has a work requirement but also makes it challenging to hold a second job. If you are constantly at the whim of random scheduling at your primary job, you will never know when you will be available to work at a second job.

Proposals to Take Health Coverage Away from Individuals Who Do Not Meet New Work Requirements are Likely to Increase Churn

Michigan's proposal to take away health coverage from Medicaid enrollees who do not meet new work requirements is likely to increase churn. As people are disenrolled from Medicaid for not meeting work requirements, possibly because their hours get cut one week or they have primarily seasonal employment (like construction work), they will cycle back on Medicaid as their hours increase or the seasons change. People may be most likely to seek to re-enroll once they need healthcare and be less likely to receive preventive care if they are not continuously enrolled in Medicaid.

Disenrollment and lock out would lead to worse health outcomes, higher costs

After three months of non-compliance within a 12-month reporting period, Medicaid enrollees subject to new work requirements will be disenrolled from Medicaid. If they are not able to comply within 30 days following disenrollment, they will continue to be without coverage until they meet new work requirements. If a beneficiary is found to have misrepresented his or her compliance, the Medicaid enrollee would be locked out of coverage for a one-year period.
The lock-out period serves no purpose other than to be punitive and does not encourage work. The broadness of this lanugage raises concern that beneficiaires who mistakenly and unintentionally provide inaccurate information may be locked out of having health insurance for a year. Given the unavoidable complexity that must exist to navigate the bureaucracy and red tape created by Michigan's proposal, it is

not unreasonable that beneficiaries may make errors on their paperwork.

Once terminated from Medicaid coverage, beneficiaries will likely become uninsured. Needed medical services and prescription drugs, including those needed to maintain positive health outcomes, may be deferred or skipped. Because people without health coverage are less likely to have regular care, they are more likely to be hospitalized for avoidable health problems and to experience declines in their overall health.[9] Further, during the lock-out period, these now-uninsured patients present as uncompensated care to emergency departments, with high levels of need and cost—stretching already overburdened hospitals and clinics. This will only lead to poorer health outcomes and higher uncompensated costs for providers.

The impact of even short-term gaps in health insurance coverage has been well documented. In a 2003 analysis, researchers from the Urban Institute found that people who are uninsured for less than 6 months are less likely to have a usual source of care that is not an emergency room, more likely to lack confidence in their ability to get care and more likely to have unmet medical or prescription drug needs.[10] A 2006 analysis of Medicaid enrollees in Oregon found that those who lost Medicaid coverage but experienced a coverage gap of fewer than 10 months were less likely to have a primary care visit and more likely to report unmet health care needs and medical debt when compared with those continuously insured.[11]

The consequences of disruptions in coverage are even more concerning for consumers with high health needs. A 2008 analysis of Medicaid enrollees in California found that interruptions in Medicaid coverage were associated with a higher risk of hospitalization for conditions such as heart failure, diabetes, and chronic obstructive disorders. In addition to the poorer health outcomes for patients, these avoidable hospitalizations are also costly for the state.[12] Similarly, a separate 2008 study of Medicaid enrollees with diabetes who experienced disruptions in coverage found that the per member per month cost following reenrollment after a coverage gap rose by an average of $239, and enrollees were more likely to incur inpatient and emergency room expenses following reenrollment compared to the period of time before the enrollee lost coverage.[13]

When the beneficiary re-enrolls in Medicaid—or qualifies for Medicare—after the lock-out period, they will be sicker and have higher health care needs. Studies repeatedly show that the uninsured are less likely than the insured to get preventive care and services for major chronic conditions.[14] Public programs will end up spending more to bring these beneficiaries back to health.

Children will also be harmed by the proposal

It is important to recognize that limiting parents' access to health care will have significant negative effects on their children as well. Children do better when their parents and other caregivers are healthy, both emotionally and physically.[15] Adults' access to health care supports effective parenting, while untreated physical and mental health needs can get in the way. For example, a mother's untreated depression can place at risk her child's safety, development, and learning.[16] Untreated chronic illnesses or pain can contribute to high levels of parental stress that are particularly harmful to children during their earliest years.[17] Additionally, health insurance coverage is key to the entire family's financial stability, particularly because coverage lifts the burdens of unexpected health problems and related costs. These findings were reinforced in a new study, which found that when parents were enrolled in

Medicaid their children were more likely to have annual well-child visits.[18]

Further, research shows that when parents have health insurance their children are more likely to have health insurance.[19] Michigan's proposal to disenroll Medicaid enrollees from health coverage for not meeting a work requirement will reduce the number of parents with health insurance, which the evidence suggests will lead to children becoming uninsured. Michigan's plan would only exempt one parent of a child under 6 years of age, putting at risk the health care of all parents and their children 6 years of age and older.

Support services will be inadequate

Child care is a significant barrier to employment for low-income parents. Many low-income jobs have variable hours from week to week and evening and weekend hours, creating additional challenges to finding affordable and safe child care. Under Michigan's proposal, parents whose children are older than 5 years are subject to the work requirements. Finding affordable and safe child care for children is difficult and a barrier to employment. Requiring employment in order to maintain health care, but not providing adequate support services such as child care, sets a family up for a no-win situation. Even with the recent increase in federal child care funding, Michigan does not have enough funding to ensure all eligible families can access child care assistance.[20]

Proposals to Take Health Coverage Away from Individuals Who Do Not Meet New Work Requirements Will Harm Persons with Illness and Disabilities

Many people who are unable to work due to disability or illness are likely to lose coverage because of the work requirement. Although Michigan proposes to exempt individuals who currently receive temporary or permanent long-term disability benefits from a private insurer or the government or designated as unfit to work or medically frail, in reality many people who are not able to work due to disability or unfitness are likely to not receive an exemption due to the complexity of paperwork. A Kaiser Family Foundation study found that 36 percent of unemployed adults receiving Medicaid—but who are not receiving Disability/SSI—reported illness or disability as their primary reason for not working. In Michigan, this rate increases to 39 percent. [21]

New research shows a correlation between Medicaid expansion and an increased employment rate for persons with disabilities.[22] In states that have expanded Medicaid, such as Michigan, persons with disabilities no longer have to qualify for SSI in order to be eligible for Medicaid. This change in policy allows persons with disabilities to access health care without having to meet the criteria for SSI eligibility, including an asset test. Other research that shows a drop in SSI applications in states that have expanded Medicaid supports the theory that access to Medicaid is an incentive for employment.[23] Jeopardizing access to Medicaid for persons with disabilities by the policies proposed in Michigan's proposal will ultimately create a disincentive for employment among persons with disabilities.

Further, an Ohio study found that one-third of the people referred to a SNAP employment program that would allow them to keep their benefits reported a physical or mental limitation. Of those, 25 percent indicated that the condition limited their daily activities,[24] and nearly 20 percent had filed for Disability/SSI within the previous 2 years. Additionally, those with disabilities may have a difficult time navigating the increased red tape and bureaucracy put in place to administer a work requirement,

including proving they are exempt. The end result is that many people with disabilities will in fact be subject to the work requirement and be at risk of losing health coverage.

Proposals to Take Health Coverage Away from Individuals Who Do Not Meet New Work Requirements Will Harm Returning Citizens

Having a criminal record can make it extremely difficult to find a job and meet work requirements. Research shows that roughly half of returning citizens are still unemployed one year after release.[25] These individuals face many legal and social impediments to finding and retaining employment which can build stability and reduce the risk of recidivism. Taking away health coverage for not working a set number of hours per month only exacerbates this challenge. People with criminal records face many more legal barriers to employment such as occupational licensing bans that preclude them from obtaining even low skilled and entry level positions. Even an arrest record can be a long-term barrier to finding and keeping employment since many businesses conduct background checks; a recent survey found that 96 percent of employers conduct background checks on job applicants that include a criminal history search.[26]

Michigan's proposal would subject returning citizens after only six months of release to work a set number of hours per month. Many people with criminal records need more time, training, and hands-on assistance to find adequate employment. Access to benefits, such as Medicaid can mean the difference between an individual successfully reintegrating into society, or recidivating.

Former foster youth are likely to lose coverage

The Affordable Care Act (ACA) included a provision to help improve the health of young adults who often have significant health care needs and are more likely to be uninsured than their peers –youth up to age 26 previously in foster care and enrolled in Medicaid. This provision was also intended to reduce disparities in access to health insurance between former foster youth and other young adults who can stay on their parents' private insurance until age 26.

For youth who enter into foster care, between 35 and 60 percent have at least one chronic or acute health condition that needs treatment.[27] The chronic health issues that impact youth involved in the foster care system continue to be problematic for youth who ultimately age out of the foster care system. Youth who have aged out of foster care are more likely than their general peers to have a health condition that limits their daily activities.[28] Despite the intention of the ACA and the evidence surrounding the health of these youth, Michigan's proposal takes away health coverage from former foster youth who are older than 21 years of age and do not work a set number of hours per month, jeopardizing their general health and well-being over time.[29]

Budget neutrality information is insufficient

The state's proposal does not include budget neutrality information that is necessary to evaluate the anticipated impact of the proposal. The proposal does not provide any estimate of the number of people who are expected to become disenrolled from Medicaid. The proposal states, "[Michigan] expects the annual HMP enrollment to decrease but the total number of beneficiaries who will be impacted is unknown at this time." Michigan should provide details about the anticipated change in enrollment in

the state and corresponding budget implications. Without this detail, it is impossible to fully understand the impact of the proposal.

Conclusion

Our comments include citations to supporting research and documents for the benefit of Michigan's Department of Health and Human Services in reviewing our comments. We direct the Department of Health and Human Services to each of the items cited and made available to the agency through active hyperlinks, and we request that these, along with the full text of our comments, be considered part of the formal administrative record on this proposal.

Thank you for considering CLASP's comments. Contact Suzanne Wikle (**swikle@clasp.org**) with any questions.

All sources accessed August 2018.

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[27] Dina Emam and Olivia Golden "The Affordable Care Act and Youth Aging Out of Foster Care: New Opportunities and Strategies for Action" State Policy Advocacy and Refrom Center, April 2014 **https://www.clasp.org/sites/default/files/public/resources-and-publications/publication-1/The-Affordable-Care-Act-and-Youth-Aging-Out-of-Foster-Care.pdf**.

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From: Hassan Jaber
To: HealthyMichiganPlan
Subject: Healthy Michigan Plan §1115 Demonstration Extension Application Amendment
Date: Friday, August 10, 2018 4:01:04 PM
Attachments: ACCESS Public Comment_HJaber.pdf

Good afternoon,

I am writing on behalf of ACCESS in response to the request for public comment on the proposed Healthy Michigan Plan Medicaid Section §1115 Demonstration Waiver Extension Request Amendment - please see the attached letter. I would like these comments published on the state's waiver website as part of the public record.

Thank you.

Hassan

Hassan Jaber
Executive Director & Chief Executive Officer

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National Network for Arab American Communities | Center for Arab American Philanthropy

ACCESS
assisting. improving. empowering.

August 10th, 2018

Mr. Nick Lyon, Director
Michigan Department of Health and Human Services
Medical Services Administration
Bureau of Medicaid Policy and Health System Innovation
Attention: Medicaid Policy
P.O. Box 30479
Lansing, Michigan 48909-7979

RE: Healthy Michigan Plan §1115 Demonstration Extension Application Amendment

Dear Director Lyon:

I am writing on behalf of ACCESS, the largest Arab American community nonprofit organization in the United States, whose vision is to create a just and equitable society with the full participation of Arab Americans, in response to request for public comment on the proposed Healthy Michigan Plan Medicaid Section 1115 Demonstration Waiver Extension Request Amendment (hereafter referred to as "the waiver"). We serve to share the impacts that this proposal would have on the communities we serve with respect to their economic, social, and cultural well-being.

Over the past 5 years, the ACCESS Navigator Program has been able to connect thousands in our community to health care such as Medicaid and the Marketplace, and it provides a wide variety of enrollment-related services. Access to coverage has improved the health and wellbeing of our community and has made a lasting impact on them. Medicaid has made it possible for our clients to reach their lifelong goals of pursuing higher education, finding and retaining employment, and ultimately leading empowered and fulfilled lives. A work requirement will compromise the health of these individuals, making it more difficult for them to work or go to school.

At the ACCESS Medical Center, we see a large patient population dealing with chronic health conditions, substance abuse and mental health disorders that rely on consistent medications and treatment. Because of their conditions, these populations face additional barriers in gaining consistent and fulltime employment. This waiver will cause these populations, along with many others, to move in and out of eligibility for Healthy Michigan, potentially locking them out of coverage and treatment, posing a risk far too large for their health and wellbeing. We are also concerned about the bureaucratic process associated with the waiver including paperwork submission, and fear that many clients who indeed qualify for an exemption will also be at risk of losing their coverage regardless of their eligibility.

This proposed act would significantly alter and undermine the Healthy Michigan Plan, a Medicaid expansion program. It is estimated that, through this act, approximately 540,000 Healthy Michigan enrollees will be subject to the 80-hour per month work requirement and project a 5-10% decline in enrollment, or up to 54,000 coverage losses. This implementation will act to deny vital services to patients who rely on the Healthy Michigan Plan to live a healthy life.

The proposed act would threaten the ability for people to work along with their ability to stay healthy. If those on the Healthy Michigan Plan should fall ill, their ability to work would be significantly hindered and this could very well lock them out of coverage. As a result, Michiganders must sacrifice

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Dearborn, Michigan 48120
www.accesscommunity.org

their health, in one way or another. Let it be reminded that the Medicaid program is aimed at providing health care coverage and improving health outcomes. It is not a jobs program, and should not be treated as such.

One of hundreds of stories we hear at ACCESS is that of Jordan, a 30-year-old man from Ferndale. He has been working since the age of 18, as a teacher and later as a recruiter. In 2014, he began to suffer from a chronic and life-threatening throat infection which prevented him from working. He previously had insurance through his employer, but he lost his job in 2017 due to extended hospital stays and sick days. Uninsured and out of work, Jordan would not be able to treat this condition that almost cost his life on multiple occasions. Jordan visited ACCESS where he was able to obtain Medicaid coverage. Medicaid has already saved his life through emergency room visits and continued treatment. Coverage will also allow him to undergo surgery and finally put an end to this ongoing issue. Now that he's able to afford treatment, he can begin to rebuild his life after unemployment.

Another one of our clients, Mary, was involved in a car accident in 2016, where she hit her head on the dashboard. After she received scans at the hospital, she was told she had a brain tumor that had been growing for two years. She immediately visited one of our Navigators at ACCESS to apply for Medicaid, since she was not insured before then. Once on Medicaid, Mary began intensive chemotherapy treatment and had to quit her job. Unable to take care of herself, her daughter stepped in to help. Her daughter was a Detroit police officer, but due to the unpredictability of her career, she resigned and found employment closer to home to both pay her mother's medical bills and to get home as quickly as possible. Since this job was a huge step down from being part of the Detroit Police Department, Mary's daughter was left without healthcare – she came to ACCESS, as well, to apply for Medicaid. When Mary heard about the Work Requirement Bill potentially being passed, she began working at a bakery out of fear that her Medicaid would be stripped from her. A woman who is having poison dripped into her body is working a job that requires her to be on her feet and near ovens – fearing that if she doesn't, she will not have healthcare. We acknowledge that Mary would qualify for an exemption from the work requirement, but without submitting the right type or amount of paperwork by the right deadline, she may not receive one. Mary is at risk of losing Medicaid, her lifeline, as a result of the waiver's policies, despite the fact that she's currently working.

Not every case is going to be as severe as Mary's or Jordan's. However, there will be likely be many others who are working and eligible for an exemption, like Mary, or unable to work but ineligible for an exemption, like Jordan, who will slip through the cracks and suffer should this waiver be implemented. It is evident that Medicaid has impacted our clients' and community members' lives in the most positive of ways. Medicaid has allowed for our community to build dignified lives and live the American Dream. This proposed act would severely hinder that very ability of our clients.

Sincerely,

Hassan Jaber
ACCESS Executive Director & CEO

ACCESS

From: Chelsey Moon
To: HealthyMichiganPlan
Subject: Healthy Michigan Plan § 1115 Demonstration Waiver Extension Request Amendment
Date: Friday, August 10, 2018 4:03:49 PM
Attachments: Public comment on the Healthy Michigan Plan § 1115.docx

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Please view the attached letter

Chelsey Moon
Health Care Outreach and Enrollment Specialist
Certified Application Counselor
Bay Mills Health Center
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Brimley, MI, 49715
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clmoon@baymills.org

Bay Mills Health Center
12124 W Lakeshore Drive
Brimley, MI 49715

August 12, 2018

MDHHS
Medical Services Administration
Bureau of Medicaid Policy and Health System Innovation
ATTN: Medicaid Policy
P.O. Box 30479
Lansing, MI 48909

Submitted via email: healthymichiganplan@michigan.gov

Subject: Healthy Michigan Plan § 1115 Demonstration Waiver Extension Request Amendment

Dear Ms. Prokop:

The Bay Mills Health Center appreciates the opportunity to comment on the Michigan Department of Health and Human Services' (MDHHS) request for public comment on the Healthy Michigan Plan § 1115 Demonstration Waiver Extension Request Amendment.

Bay Mills Health Center is a Federally Qualified Health Center (FQHC) that provides primary care to one out of every ten residents of Chippewa County. In 2017, 24 percent of our patients were beneficiaries of Medicaid and Healthy Michigan Plan. Bay Mills Health Center provides a full range of quality, affordable, comprehensive primary health care services, including medical, dental, and behavioral health services, either through direct care or through community referrals, regardless of insurance status or ability to pay for services. We are the only dental provider in Chippewa County that accepts Medicaid patients.

Bay Mills Health Center is also an Indian Health Service facility. As more tribal people enrolled in Healthy Michigan Plan, claims in the Indian Health Service Purchased Referred Care (PRC) program decreased by 15 percent compared to 2013. When more tribal people have health coverage, limited funds in PRC become available to tribal people without options for health coverage. In addition, Bay Mills Health Center has extended hours of operation and expanded services due to a 26 percent increase of patients served compared to 2013.

Bay Mills Health Center is writing to express our support for the comments submitted by the Michigan Primary Care Association (MPCA) in response to the Healthy Michigan Plan waiver extension request amendment. A summary of these comments is as follows:

Definition of medically frail
Federal statute allows states to create a unique medically frail definition to meet the state's needs under 42 CFR 440.315(f). Although being supportive of the process MDHHS proposes to use to identify medically frail individuals, MPCA is very concerned that the current list of ICD-10 diagnoses codes

included in Appendix A, Attachment L, fails to include conditions such as clinical depression or anxiety that could prevent an individual from working. Penalizing an individual who cannot work but does not qualify for an exemption would contribute to a dangerous cycle of failure and worsening health outcomes.

MDHHS has the authority to include additional diagnosis codes. MPCA urges MDHHS to include diagnoses related to depression, anxiety, and other mental health conditions that are not otherwise included in the proposed waiver extension amendment. Specifically, MPCA requests MDHHS add diagnoses related to ICD-10 codes F063, F064, F309-F339, F410-F4312, F440, F600-F609, and F6381 to the state's definition of medically frail. MPCA strongly urges MDHHS to use this broadened definition of medically frail for both the workforce engagement and the cost-sharing requirements articulated in the waiver extension application.

Suspension of coverage for noncompliance with cost-sharing requirements

MPCA is extremely concerned by the lack of details relative to suspension of coverage for noncompliance with cost-sharing requirements for individuals with income between 100 and 133 percent of the federal poverty limit. Individuals covered by HMP make daily decisions on how to make ends meet, which makes careful consideration of cost-sharing compliance mandates important. MPCA encourages MDHHS to use its authority to specify how it will operationalize the suspension of coverage for noncompliance with the program's cost-sharing requirements.

MPCA recommends that MDHHS align compliance with cost-sharing requirements with the proposed workforce engagement requirements and allow an individual up to six consecutive months of the year to be noncompliant relative to cost-sharing. MDHHS should suspend eligibility only for individuals who have consistently failed to pay cost-sharing contributions for six consecutive months before the outstanding balance is sent to the Michigan Department of Treasury for garnishment of tax returns or lottery winnings. Additionally, MPCA urges MDHHS to develop and publicize the process by which individuals can restore HMP benefits. We believe this process should include a provision restoring coverage once an individual agrees to an outstanding balance payment plan and has made the first monthly payment. The state should accept the first payment on a mutually agreed upon payment plan as a good faith effort to be in compliance with the cost-sharing requirements.

§ 1115 demonstration waiver evaluation design

A core component of the § 1115 demonstration waiver is the inclusion of an appropriate evaluation component to assess the relevant hypotheses the demonstration plans to test. MPCA believes the stated objectives in the evaluation overview section of the amended waiver extension proposal falls short of fully evaluating this statutory mission statement. Specifically, MPCA strongly urges MDHHS to include evaluating the following components to test additional hypotheses supported by the statute's mission statement:

- The extent to which beneficiaries believe that workforce engagement requirements as a condition of HMP eligibility has a positive impact on personal health outcomes and financial well-being;
- The extent to which workforce engagement requirements improve health outcomes while covered by HMP; and
- Whether the costs in uncompensated care increase or decrease as a result of individuals losing coverage for noncompliance with workforce engagement requirements.

The Healthy Michigan Plan has been a large success in no small part due to the leadership of MDHHS to ensure all individuals have access to affordable coverage to improve health outcomes. Tribal people and surrounding community members have gained access to health care and we have been able to offer patients more services. Bay Mills Health Center strongly believes MDHHS should use its authority to ensure the HMP remains a health coverage program and work in partnership with stakeholders to implement a fair, Michigan-based approach to workforce engagement requirements.

In closing, we appreciate the opportunity to comment on this issue. If you require any clarification on our comments, please contact me at abreakie@baymills.org or at (906)248-8327.

Sincerely,

Audrey Breakie
Health Center Director
Bay Mills Health Center

From:	Cooper, Lisa Dedden
To:	HealthyMichiganPlan; Stiffler, Kathleen A. (DHHS)
Cc:	MSAPolicy
Subject:	Demonstration Extension Application Amendment
Date:	Friday, August 10, 2018 4:05:17 PM
Attachments:	AARP.Comments.Sec1115Waiver.8.10.2018.pdf

Dear Acting Director Stiffler,

Attached please find AARP Michigan's comments regarding the State of Michigan's proposed amendment to its Section 1115 Demonstration Extension Application.

As always, we appreciate the opportunity to work with the Department in support of the Healthy Michigan Plan.

If you have any questions or if there is further information we can provide, please feel free to contact me or AARP Michigan State Director Paula Cunningham directly.

Thank you.

Lisa Dedden Cooper | **AARP Michigan** | **Manager of Advocacy**
309 North Washington Square | Suite 110 | Lansing, MI 48933
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https://twitter.com/LDeddenCooper
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August 10, 2018

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

Re: §1115 Demonstration Waiver Extension Application Amendment - Healthy Michigan Plan

Dear Director Lyon,

AARP Michigan welcomes the opportunity to submit these comments regarding the State of Michigan's proposed amendment dated July 9, 2018, to its Section 1115 Demonstration Extension Application.

AARP is the nation's largest nonprofit, nonpartisan organization dedicated to empowering people age 50 and over to choose how they live as they age. With approximately 1.4 million members in Michigan, AARP advocates on issues that matter most to people age 50+ and their families with a focus on health care, financial security and personal fulfillment.

First and foremost, AARP Michigan strongly supports the long-term continuation of the State of Michigan's Section 1115 Demonstration Program known as the Healthy Michigan Plan. Healthy Michigan has been successful at bringing health coverage including primary care to nearly 700,000 people in Michigan, and approximately 36% of Healthy Michigan enrollees – an estimated 243,000 people – are ages 45-64.

Our intention in submitting these comments is to urge the Michigan Department of Health & Human Services (MDHHS) to interpret the *exemptions* to the work engagement requirements set forth by Public Act 208 of 2018 as broadly as possible to minimize the risk that older adults who rely on Healthy Michigan will lose their primary care health coverage, and to interpret the *qualifying activities* as broadly as possible in recognition of the obstacles to employment that are disproportionately faced by older adults in Michigan.

Chronic Health Conditions in Older Adults

Older adults are particularly vulnerable to deterioration in function and health status if they don't have health coverage. As AARP and AARP Foundation described in our amicus brief filed on April 6, 2018, in the ongoing *Stewart v. Azar* federal lawsuit over the State of Kentucky's Section 1115 waiver request:

> *Prevalence of chronic conditions, including both physical and mental health conditions, increases significantly with age. Based on health care expense data, the Agency for Healthcare Research and Quality found that 57% of persons from ages 55 through 64 have at least two chronic conditions. An additional 20.3% of these persons have one chronic condition, and only 22.7% have no chronic condition.*

Since its launch in 2014, Healthy Michigan has begun to create better health outcomes for older adults in Michigan who would lack primary care without it. Many older adults – particularly those in their 50s and 60s – have chronic conditions or functional limitations that hinder their ability to work but may not rise to a programmatic definition of disability. Having access to primary care means people can access medicine to manage chronic conditions such as diabetes, asthma and arthritis, which allows them to continue to lead productive lives. On the other hand, people in their 50s and 60s who do not have access to health care to manage chronic conditions become less able to maintain their family's financial security through work as their health declines, and they ultimately end up requiring more costly health care due to complications from health conditions left unmanaged.

In particular, AARP urges the MDHHS to broadly interpret the exemptions for "Beneficiaries who are designated as medically frail" and "Beneficiaries with a medical condition that results in a work limitation according to a licensed medical professional order" to protect against older adults with chronic health conditions losing the Healthy Michigan coverage they need to manage their conditions.

Older Adults in the Michigan Workforce

Older adults who are unemployed face additional obstacles to finding new work, and it typically takes them longer to do so compared with younger workers. The average time an unemployed person spends looking for work is 36.2 weeks for people ages 55 to 64 and 32.9 weeks for people ages 65 and over, compared to 24.8 weeks on average for workers generally. Jobseekers ages 55 and older are also more likely than younger jobseekers to experience long-term unemployment. In March 2018, 29 percent of jobseekers ages 55 and older were long-term unemployed (looking for work for 27 weeks or more) compared with 19.4 percent of jobseekers in the 16 to 54 age group. Other obstacles that older workers may face include:

- Displaced or laid off older workers may need to learn new skills to transfer from one sector to another, and may even need help learning to search and apply for jobs online.
- Older adults are more likely to be serving as a family caregiver for an aging spouse or parent.
- Two out of three workers between ages 45 and 74 say they have seen or experienced age discrimination at work.

AARP urges the MDHHS to broadly interpret the qualifying activity described as "Job search directly related to job training" to recognize the extended period of time that unemployed older adults are likely to need to find a new job. Additionally, AARP urges the MDHHS to interpret the exemption for "A caretaker of an incapacitated individual even if the incapacitated individual is not a dependent of the caretaker" to encompass the experience of Michiganders serving as a family caregiver for an aging spouse, parent or other relative whether in their own home or in their loved one's home. Michigan's family caregivers devote an estimated 1.2 billion hours in unpaid care to loved ones at a total value of about $15 billion a year. The average family caregiver is a 49-year-old female taking care of her mother for nearly 20 hours per week.

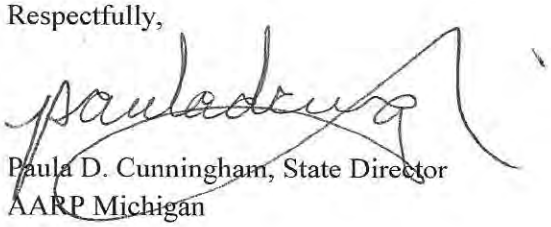
Workforce Engagement Requirements

One concern we would like to raise is with respect to the workforce engagement provision in Section II of the waiver application. This provision would require beneficiaries between the ages of 19-62 to work or engage in specified educational, job training, or community service activities for at least 80 hours per month to remain covered through the HMP unless they qualify for an exemption.

AARP believes that this provision seeking to impose a work requirement is not authorized by Section 1115 of the Social Security Act because it is not "likely to assist in promoting the objectives" of the Medicaid Act. 42 U.S.C. § 1315(a). Specifically, this provision is not likely to assist in promoting the objective of enabling the State of Michigan "to furnish medical assistance [to individuals and families] whose income and resources are insufficient to meet the costs of necessary medical services and rehabilitation and other services to help such families and individuals attain or retain capability for independence or self-care." 42 U.S.C. § 1396-1(1). It would also present an unnecessary barrier to health coverage for a sector of Michigan's population that is most in need of coverage. This includes the many individuals who have recurring periods of illness due to chronic and behavioral health conditions who may not be exempt from the work or job search/training requirements. Moreover, the recent court ruling in the *Stewart v. Azar* case reaffirmed these concerns, stating that work requirements would not help to furnish medical coverage consistent with Medicaid program objectives.

Thank you for the opportunity to express these comments on behalf of AARP and Michigan's older adult population. If you have any questions or if there is further information we can provide, please feel free to contact Lisa Dedden Cooper, Manager of Advocacy for AARP Michigan, at 517-267-8923 or LCooper@AARP.org.

Respectfully,



Paula D. Cunningham, State Director
AARP Michigan

From: Nicole Felix
To: HealthyMichiganPlan
Cc: Bragg, Darryl (DHHS); Tara O"Neil; Samantha Dane
Subject: Demonstration Extension Application Amendment
Date: Friday, August 10, 2018 5:19:27 PM
Attachments: MER_Healthy Michigan Plan 1115 Demonstration Waiver Extension Request Amendment Feedback.docx

Good Afternoon,

Please see attached for Meridian's feedback on the Demonstration Extension Application Amendment due on or before August 12, 2018.

Thank you,

Nicole

Nicole M. Felix
Sr. Manager of Operations
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Document Name: Healthy Michigan Plan 1115 Demonstration Waiver Extension Request Amendment Feedback
Date: 8/10/2018

Document	Topic	Feedback/Questions/Recommendations
Section 1115	Hardship Exemption	• How will "Hardship Exemption" be tracked, by whom, and how will plans be notified? How will this be operationalized and within what timeframe would this exemption go live? Is this exemption currently present in any other assistance program in MI? • What is defined as "family emergency" are these instances self-reported by the members as work requirements as being reported? More elaboration needed here • With the recent denial of work requirements as proposed by other states, how will this request be amended to adjust for the reasoning for the declined waiver in other state programs?
Attachment D	Healthy Behavior Goals	• Attachment D outlines the expectation that the health behavior goals become more challenging year over year. o Are challenges being defined by the providers via the office visit, etc.? Is the Healthy Behavior goals section that was added to the 2018 HRA still applicable? More clarification is needed surrounding this expectation to avoid manual, last minute, administrative efforts to be undertaken by the MHPs. o What evidence/guidance was used in outlining this requirement? It also states that goals must be reviewed with PCPs and that an attestation must be obtained.
Attachment C	Disqualified/Member has exceeded months allowed	• Attachment C outlines that once a member who falls between 100-133% FPL has been on HMP for a cumulative 48 months, their MIHA will no longer be utilized. o Who will be tracking this? o Will the MIHA vendor be overseeing this piece?
Attachment C	Cost Sharing Reduction Changes- Post 48 Months Cumulative Enrollment	• "Complete or commit to an annual healthy behavior with effort given to making the healthy behaviors in subsequent years incrementally more challenging." o Who is going to monitor this? o How is, "incrementally more challenging" defined? Will they receive different healthy behavior options? Will this prompt another HRA change?
Attachment D	Health Risk Assessment	• "Existing enrollees will also be encouraged to make subsequent year healthy behaviors incrementally more challenging, working with their primary care provider to build on the goals of previous years."

		○ Many Medicaid members do not consistently see the same PCP. In the event that a member sees a different PCP annually, how will this be accounted for?
Attachment D	Cost-Sharing Obligations	• Attachment D, p. 9: says that this is the case of members "have had 48 months of cumulative eligibility coverage will not be eligible for incentives and will be suspended from HMP if they fail to complete a health behavior or pay cost-sharing obligations". ○ Does this mean that it only applies when a member doesn't complete a healthy behavior option/falls into CFP or is it for any member who exceeds the 48 months of cumulative eligibility coverage?
Attachment D	Tobacco Cessation	• Attachment D outlines that existing members must review their progress on their previous years goals with their PCP to track if the member achieves or has made significant progress. ○ How is this to be tracked? ○ Who does this need to be reported to and how often? ○ Will previous HRAs be made available for the PCP? ○ If the beneficiary has changed PCP since last HRA completion, is there a barrier in this requirement? ○ Will the health plans be responsible to compare previous responses via the goals process?
Attachment D	Wellness Programs	• Attachment D, p. 4: States "MDHHS will work with the managed care plans to ensure uniform standards are applied for determining annual improvement through these activities". ○ Does this mean that all Wellness Programs across plans will be the same? If not, how will uniformity be determined?
Attachment L	Medical Exemption Request Forms	• Attachment L, p 1: There are questions similar to that noted for the Application for Health Coverage and Help Paying Costs/Medical Exemption Request form on the HMP HRA. ○ Will these be pulled from the HPs' 5944 and used as well?

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Friday, August 10, 2018 4:02:34 PM

I can understand the work/education idea for some people but can see where it would be an issue for many people in my situation.

I am 60 and have a health issue that requires a quarterly injection of medicine that costs $7500.00 for each injection. If I am required to work, two things could happen: #1- I would make too much money to qualify for Healthy MI Insurance (my spouse receives social security) so I would be in jeopardy of not being able to afford the medication.
#2- I would have difficulty working due to my medical condition (I retired 3 years ago).
I work hard at keeping my body moving to keep the disease from progressing rapidly. Some days are better than others. But, who decides when a person is considered medically frail? What would those guidelines be? One person may see qualifying medical issues completely different than another. This is very concerning to me.

Thank you for the opportunity to voice my concerns.

[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstation extension Application Amendment
Date: Friday, August 10, 2018 4:06:03 PM

I am very much against work requirements for Medicaid recipients. I work with the poorand I feel I have some experience with Medicaid recipients and their struggles. For the most part, our clients do work at least 20 hours, many of them have full time jobs. Sometimes they are at the mercy of life events, a car that dies, an injury or illness, the illness of a child or family member and suddenly they cannot work. Or their employer decides to cut their hours because things are slow that month. You are giving employers a lot of power here. And a requirement of 30 hours is too much.

This sounds like a record keeping nightmare, and a very expensive one at that. Healthcare is not something we should be playing games with. These can literally cause the death of our people here in Michigan.

If you really want to get people off the Medicaid rolls, they need good paying jobs. No one can support themselves working 40 hours for $10 or $11, much less their families. They also need reliable public transportation, quality childcare and safe, affordable housing. If you want to spend lots of money, spend it there, instead on record keeping for a punitive program. These are not lazy people trying to live off the state, stop treating them as such.

[redacted]

Sent from my iPad

From: [redacted]
To: HealthyMichiganPlan
Subject: Medicaid
Date: Friday, August 10, 2018 4:09:37 PM

I am a permanently disabled woman in Jackson County Michigan. I was working two jobs when I became ill. I couldn't continue to work. I lost my health insurance and had to rely on medicaid to receive life saving treatment. It took 2 years to qualify for Medicare. I think this law was written by someone who has no idea what it's like to become deathly ill out of nowhere and I believe that people who want to work but are too sick will end up suffering a great deal. In short, it's a terrible idea.
[redacted]

Happy Connecting. Sent from my Sprint Samsung Galaxy S® 5

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration extension application amendment
Date: Friday, August 10, 2018 4:25:07 PM

Why is it always the knee jerk reaction to assume poor people are lazy, welfare queens? Does it make us all feel better about ourselves as we flaunt our privilege like some shiny badge of honor? I have some money and I work. Therefore since you don't have money must mean you don't work, so I'm going to punish you for being poor.

The facts don't support this assumption. The fact is that a majority of benefit recipients are children.

Being poor isn't a crime. It IS damned hard work, however. I'm opposed to this draconian measure.

[redacted]

Get Outlook for Android

From: [redacted]
To: HealthyMichiganPlan
Subject: Medicare working requirement
Date: Friday, August 10, 2018 4:36:03 PM

This is cruel and unjust. My son suffers from mental and physical disabilities and stress from this requirement just adds to his daily suffering! Much of the public needing this benefit qualify because of illness or disabilities that make it difficult for them to work and you are attacking this group with this insensitive and criel requirement. Thses people are suffering to be on this and you have to punish them too. How cruel! I protest this requirement.

[redacted]

Sent from Yahoo Mail on Android

From: [redacted]
To: HealthyMichiganPlan
Subject: demonstration extension application amendment
Date: Friday, August 10, 2018 4:40:11 PM

I am opposed to requiring Medicaid recipients to work to be eligible for benefits.Here are some of my reasons:

How is someone who has nothing supposed to suddenly have childcare and transportation available to get to a job that is not necessarily near them?

If a job is available, and isn't nearby, where do the resources come from for that person to move to the area where it is? This would also mean leaving/losing any support system they have in place where they currently live.

Once someone is trained for a job, and there is no opening for them, what then? That sounds like they will either be tossed away, or live in a limbo where they are told over and over that they have to learn to do this or that, then get nothing for it.

The whole proposition sounds like creating an underclass that has to prove they aren't stupid or lazy. In comparison, the schemes to drug-test people applying for assistance have weeded out offenders with numbers akin to 1 in 1,000,000.

[redacted]

From: Pat Clark
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Friday, August 10, 2018 5:10:14 PM

Persons living with HIV should be categorically defined as medically frail and therefore exempt from the requirements.

I have numerous clients who are dependent on the life-saving medications to treat HIV but whose access to these may be denied due to the work requirement you are looking at enacting.

Many people have numerous issues and some side effects but those are not always significant enough to qualify them for disability. They are often accepting jobs at fast food or similar types of employment that can come and go easily. When they are experiencing the effects of living with HIV it may impact their ability to make it to work that day causing them to lose the job. Finding another can be daunting.

Please consider people living with HIV, regardless of their disability status, to be categorically defined as medically frail and therefore exempt from the requirements to work.

Please feel free to reach out if you have questions or need more information.
Pat

Pat Clark
Director of Client Services
EIS, NMCM, HOPWA, Tobacco & QM Supervisor
CARES
(269)-210-7577

Language Matters in Reducing Stigma!

People before their diagnosis: **"person living with HIV"** instead of HIV+ or infected
Stage 3 HIV or AIDS diagnosis rather than "full-blown AIDS"
Transmission, diagnosed, acquired, or contracted not infected or caught

From: [redacted]
To: HealthyMichiganPlan
Subject: "Demonstration Extension Application Amendment"
Date: Friday, August 10, 2018 5:12:54 PM

It seems foolish to implement work requirements for the state's Medicaid expansion recipients without knowing the consequences. How many people will this impact? How much will it cost to implement? What will happen to the people who fall through the cracks? This seems nothing more than a political effort by the those looking to appeal to their base in the fall election. The cost of living has increased and yet wages have not, so many people look to state and federal programs to help make up for this gap. Please, instead of penalizing those who need help, why not raise the minimum wage and implement programs that actually help people. [redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Opinion on work requirements for HIV positive people
Date: Friday, August 10, 2018 5:44:06 PM

Persons living with HIV should be categorically defined as medically frail and therefore exempt from the requirement.

I sit on the board at Community AIDS Resources and Education Services in Kalamazoo. I see so many of our clients that need this exemption.

[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Friday, August 10, 2018 6:37:58 PM

I think even entertaining the thought of work requirement is stupid. Most users are already working for [redacted] poor wages and the rest are either elderly or disabled and cannot work.

Just my two cents but the few that might be able bodied are probably just between jobs. Unless you are actively finding them work, you should not punish them for needing help.

Please reconsider your requirement.

Thank you!

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Friday, August 10, 2018 6:43:38 PM

"Demonstration Extension Application Amendment"

Hello,

I am an employer in a economically depressed county in the Upper Penninsula. I oppose your work requirement proposal for expanded Medicaid, because, from my experience as an employer, I can tell you that it is virtually impossible for workers in this area, even those with two jobs, to count on receiving 80 hours of work every single month of the year.

In a tourism and education dependent employment area like ours, there are months, specifically November and May, as well as potentially December and June, in which business dips so drastically, that a worker who may even significantly exceed 40 hours per week during the busy season, simply will not be able to work 80 hours per month. This is also due to the dramatic seasonal variation, and would be further magnified if our area were tourism only dependent, as many areas of Michigan are.

Most of Michigan north of Grand Rapids, Lansing and the broad Detroit area, is tourism dependent, and therefor susceptible to dramatic swings in demand for labor hours. This clearly indicates that Michigan is a poor fit for a work requirement designed as this one.

Sincerely,

[redacted]

[redacted]

[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Friday, August 10, 2018 7:31:07 PM

I am concerned about the addition of work requirements in order to receive benefits. There are people receiving these health care benefits that cannot work. How would you separate them out? Will you require a physician's evaluation? (I apologize if this is covered in your attachments, but I could not get them to download.)

Some people have become disabled before they qualified for Social Security disability, or never got a chance in the work force due to disability. This is their only hope.

People in general do not WANT to receive a hand out. Contrary to what some politicians seem to believe, people prefer to work. However, physical or mental conditions could exist to keep them from working. Yes, even 20 hours a week could be too much.

I see a need to create a separate program for job training and a "talent pipeline for employers". People WANT to work, but cannot afford to live on minimum wage jobs. But this is a different issue.

Please pay attention...if "enrollment exceeded initial expectations", then there is a need for better health care options. With the gutting of The Affordable Care Act, people cannot get the insurance they need. Those with disabilities or other extenuating circumstances are even less able to get any other coverage.

Quotes above taken from https://na01.safelinks.protection.outlook.com/?url=https%3A%2F%2Fwww.bridgemi.com%2Fpublic-sector%2Fhave-opinion-michigans-medicaid-work-rules-weigh-quickly&data=02%7C01%7Chealthymichiganplan%40michigan.gov%7Ccfb0e796eec246c840c908d5ff195849%7Cd5fb7087377742ad966a892ef47225d1%7C0%7C1%7C636695406673158281&sdata=zwm4gm9kpBHIGqT%2FxzDoVkydE5D717VyHGdCEzmWyZM%3D&reserved=0

Thank you,
[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Medicaid
Date: Friday, August 10, 2018 7:49:32 PM

I am against the 20hr week or 80 hr month work requirement if it puts people just over the income limit to qualify for Medicaid, and they can't afford other health insurance.
Sent from my iPhone

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Friday, August 10, 2018 8:18:15 PM

I believe that for each and every single program to help Michigan citizens that there will be people who abuse that system. You can fill loopholes all you want, but they will find others and take advantage of the situation. I don't like it and I wish they'd spend their energies in some other way. But it is, in my view, a fact that will happen no matter what.

But I also believe that the majority of recipients of assistance or any other program intended to help citizens truly need and benefit by the assistance. I'm a believer in a hand-up and not a hand-out, but sometimes the hand-out is what they need right then to gather their energies to start again or simply to keep on living the kind of life the rest of us take for granted.

I always use this example: Remember in elementary school that time the teacher punished the entire class for what one or maybe two kids did? Remember that feeling in your stomach and the shouting in your mind "I didn't do anything wrong, why am I being punished?" Imagine instead, now, that you are an adult who has complied with all that the state of Michigan has asked of you in order to receive the money or assistance that lets you eat every day, get the medical care you need every day, lets you go to school, lets you keep your child or grandchild in an educational daycare program, whatever. We provide so much for so many. Why do we want to let a few wreck it for the many? Yeah, those people don't deserve it and they may get away with it for their entire lives and teach their children to abuse the system as well. But I'd rather spend my extra energy on finding more ways to help the people who need the help, will use the help wisely, and that many of them will someday find a way beyond needing that help and stand on their own. That gives them dignity. It gives the people who, though ill and confined in their movements, dignity to make it as best they can on their own.

Don't punish the good, deserving people because of the despicable ones who abuse the system. The good, deserving people will be thankful for the dignity we help them keep; the despicable couldn't care less about us or anyone else.

Make all of them work? No! Make some of them work? No! Provide dignity-enhancing work opportunities without it being a requirement to get help

and NOT reduce their assistance until they want you to reduce it? YES! I believe the good, deserving people will be glad and proud to do what they can to give back. I shout NO to any law or program that requires people to work or struggle at something in order to receive their assistance. Would I like to see those lazy-asses and system-abusers caught and forced to work? Oh, yeah! Just like anyone else (except them!) would. But not at the expense of causing more misery to even one good and deserving person.

Thank you for reading. I'm sure this commentary will only end up as a check mark in the "against" column, but I hope that you, the reader, and anyone you might share it with will feel the sincerity and humanity behind my words. If nothing else, I'd like you to agree with me that there will always be abusers but the good people shouldn't be punished because of them.

Thank you,

From: [redacted]
To: HealthyMichiganPlan
Subject: Public Comment on Demonstration Extension Application Amendment
Date: Friday, August 10, 2018 8:23:57 PM

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dTo: MDHHS
Re: Demonstration Extention Application Amendment\

From: [redacted]

To whom it may concern,

I am writing to oppose the waiver and 80 hour/month work requirement for Medicaid recipients for the following reasons:

Medicaid was not created as a work program, and the requirement of work to receive Medicaid violates Federal law, and will instigate costly court cases which the State will lose.

Only a small percentage of "able-bodied" people who are on Medicaid do not work. The costs of extra paperwork, and the stress the paperwork will provoke does not justify a work requirement. The expansion of the ACA already served to help people work while they are on Medicaid.

There are many people on Medicaid who serve as support to their family members who do work, or who are parents of small children, or who are caregivers to people who can not live independently. I understand that caregivers would be exempt under the new rules, but it still adds more paperwork, more stress and worry about qualifying to an already stressed population of people. Caregivers have particular challenges, are vastly underpaid, yet are essential servants in the healthcare system. In the US the millions of caregivers lose 3 trillion in retirement, wages and benefits, and their personal health suffers, making them more likely to become disabled/chronically ill and impoverished themselves. The state of MI should be streamlining health services, eliminating paperwork, and providing extra support (even a livable income) for caregivers due to the essential role they play and the long and short term sacrifices they make for our healthcare system. This waiver does the opposite.

Anecdotally, I have family members who are chronically ill but not sick enough to be considered disabled by the Social Security Administration. One family member has just survived cancer. Another has severe generalized anxiety disorder and social phobia. Still another has chronic IBS, and another has Neurofibromitosis. They are limited in their ability to work even 20 hours a week. Because healthcare in the US is tied to employment, and they can not work full time, they have resorted to Medicaid in order to receive the important life-saving care they require. Some of these individuals would most likely be considered "able-bodied" by the new requirements and would thus lose their healthcare, which would aggravate their conditions and cause them to become fully disabled.

Personally, I have been a caregiver my entire adult life. I have worked to help family members manage their healthcare with medications, doctor's visits, managing appointments and applications, coordinating services with caseworkers and health professionals. I have been in

the roles of counselor, mentor, home nurse, advocate and receptionist day and night. Our system is paperwork heavy when it doesn't need to be, complicated when it can be simple, and it seems to me, designed to discourage sick people from accessing care rather than the opposite. After years of working, and watching my health decline due to the pressures of caring for the sick 24/7, I have just recently been diagnosed with an autoimmune disorder. I fear for my own future. Will I, too, lose my Medicaid health coverage-after years of sacrifice and service? Should my health take a further turn for the worse, who will be my caregiver? I, and people like me, have been champions of the forgotten sick, the workhorse underlings of the health system, underpaid or not paid anything at all and with little thanks and recognition. I gave up personal happiness and a career to help others. I gave up financial security and retirement. And now I am being told by my government that I am lazy, no good, not worth having insurance because I now don't have a regular job? I believe I am justified in being angry. ***It is just possible, you know, to be a valuable member of a community, a charitable person who works hard and yet not be rich, and not be employed.***

Thank you for taking the time to read this. Please do not enact this policy change.
Sincerely

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Friday, August 10, 2018 10:17:03 PM

Hello my name is [redacted] I am writting to comment in reguards to the proposed amendments requiring medicade recipients to work or go to school. I am 32 years old with 3 children who all as well as myself depend on this insurance. I have fibromyalgia, asthma, clots in my lungs (from unknown causes), thrombocytopenia. The last two of which I have been diagnosed with in the last year. The fibromyalgia affects my nerves and muscles as well as my brain causing memory lapses, severe pain which most days makes it very hard to move. There is no cure or pill that helps my fibromyalgia symtoms. The muclee relaxers I do take to attempt to help ease the pain are not much but are the best they can do for me. Those alone are $65+ a month. The clots and asthma affect my breathing. I am on blood thinners and an inhaler for those and those alone would cost me $120. The thrombocytopenia is a blood disorder that causes my.platelets and my.immune system to attack themselves. I have to go get weekly lab work and infusions that cost well over $1000 each. I have tried to work over the years but my health always gets in the way and employers never seem to understand or want to work with a person as I'll as I am. I don't know how a person like me would survive working let alone being without the important things/my insurance. I have to use a walker to get around most days. The fear of loosing my insurance because I can't meet the requirements scares me not only for myself but my children as well. I realize this is fairly long so I will stop here but please feel free to email me.back with any questions or concerns and thank you for you time.

Reguards,

[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Comments on work requirement for Medicaid recipients
Date: Friday, August 10, 2018 10:17:55 PM

This change in the law concerns me. I am a beneficiary of the state's Medicaid plan. I am divorced with 2 children. Currently I do have a job but it is part-time. Employers keep part-time workers to less than 20 hrs weekly because then they do not need to offer health insurance. My job is at my son's school which is ideal for commuting, the hours enable me to work without loss of pay to childcare. My 2 children have an age difference of 5 yrs, which means they attend different schools neither of which we qualify for bus service. They are too young to stay home alone, childcare costs would eat a substantial portion of any pay, and I do not have family near in the area to "help". I work hard and transport them and raise them on my own. The one thing I've needed is health insurance which thankfully helps me stay healthy to care for my kids. If a work requirement has minimum hours attached to it, it realistically needs to be under 20 hrs. Employers of part-time employees aren't going to give 24hrs or such per week because they would have to offer health insurance. They hire under 20hrs or full-time. And fulltime employees obviously get company health insurance. I don't think health insurance should be attached to a work requirement. Perhaps food stamps should be. But please give people like me peace of mind that if I'm injured or I'll be taken care of... years ago I had an episode of major chest pain.. I had no insurance at the time, having lost it in divorce and being a college student. My daughter was 18 months old. I took a chance and did not go to ER because the cost would have broken me. Luckily I wasn't having a heart attack... but no one should feel they can't see a doctor because of insurance.

[redacted]

From: [redacted]
To: HealthyMichiganPlan
Date: Friday, August 10, 2018 10:42:03 PM

Please pass the bill requiring recipients to work for benefits. Also please put a cap on how long people can be on assistance. It is an assistance program not a life-long benefit. Tax payers are tired of giving out free rides. Everyone should work unless disabled which should be investigated to ensure that is the case.

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration extension application amendment
Date: Friday, August 10, 2018 11:01:30 PM

I'm a stay at home mom of three, while their father works full time. We can't afford day care, nor do I trust to put my kids in day care. And I will continue to be a stay at home mom until my youngest starts school full time. It's unfair to assume that because I don't work outside the home that I'm sitting around doing nothing.

Sent from Yahoo Mail on Android

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Friday, August 10, 2018 11:14:46 PM

Public Comment on Medicaid Work Requirements:

I do not support the policy that Medicaid recipients be required to work to receive health benefits. Health benefits should not be conditional. In addition, the cost of tracking and maintaining this requirement would better be spent improving workers' wages and employment training programs. Most adults who are able to work do so. Many have poor wages or limited hours.

Thank you,
[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Work for medicaid
Date: Friday, August 10, 2018 11:19:16 PM

A bad plan. There should be no connection between employment and receiving Medicaid.

[redacted]

[redacted]
[redacted]

[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Friday, August 10, 2018 11:21:35 PM

I am a person who benefits from expanded Medicaid. Without this health coverage, I would have died several times over. It is my Medicaid coverage that allows me to even CONSIDER working in the first place. Without it, I would not be able to work and I'd have to apply for disability, something I have been desperately trying to avoid. Because of the Healthy Michigan program I have been able to get access to medical care that has changed my life.
I am happy to say that I'm starting EMT training in September, a goal that I wouldn't even dream of if not for my health coverage. I'm going to be a Paramedic, to give back to the community and the state that has supported me.

Without the Healthy Michigan program and expanded Medicaid, people are going to die. Not just a few people here and there, but thousands.
I am utterly sickened by politicians who push for death by legislation. If politicians really care about the poor, they need to put their money where their mouth is. Either that, or those politicians should have the courage to publicly admit that they strive to purposefully kill thousands of American citizens just because they are poor.

Please do everything you can to keep the program (and the people of Michigan) alive.

Thank you,
[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Saturday, August 11, 2018 12:04:06 AM

Hello,

I am writing to voice my objection to work requirements for people getting medical coverage under the Medicaid Expansion.

I lost my sales job at 51. Turns out, not only does no one want to hire you at that age, it was impossible for me to get an interview. I tried to get hired in my field (biotech sales) for 7 years. I also went without health insurance for that time. The Medicaid Expansion finally allowed me to see a doctor again, and I am grateful for that.

I am now 63 years old. I cannot get Medicare for 2 more years. Please don't make me be uninsured again.

Sincerely,

[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Saturday, August 11, 2018 12:27:53 AM

To whom it may concern:

I am firmly in opposition to the Michigan Section 1115 Medicaid waiver that mandates citizens to work in order to receive Medicaid and to pay 5% of their income toward Medicaid premiums. I believe that the measure is unnecessarily harsh and will result in devastating outcomes to an already vulnerable population.

In working with low-income populations for the past eleven years it has become abundantly clear that access to healthcare is essential to keeping lower income households healthy and housed. Many of the households that I have worked with face one or more barriers to overall success, from mental health issues to transportation and child care challenges to lack of access to affordable housing, and the ability of those households to be enrolled in Medicaid has been instrumental in keeping them financially stable. To impose work requirements and require the households to pay 5% of their income toward Medicaid premiums would wreak havoc on households that are already struggling to stay afloat financially.

The proposed Medicaid waiver was reportedly enacted to save the state money, and as a tax-paying Michigan resident, I understand the need for fiscal responsibility; however I do not support a measure that will do so at the cost of the health of low-income people. Please consider preserving the existing system and not impose work requirements or the 5% Medicaid premium.

Thank you for your consideration.

[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Saturday, August 11, 2018 1:43:56 AM

To whom it may concern,

I spent nearly two years in various parts of Michigan for a 501(c)3 trying to explain the Affordable Care Act and Healthy Michigan plan to a variety of groups and individuals willing to listen. It was my experience that what the public needed, and continues to need to this day, is not a work requirement, but rather an education on how to access affordable health care through either channel, but especially through Healthy Michigan.

Most of the citizens of our state eligible for the Healthy Michigan plan likely would be exempted with this proposal, but those who are not are going to suffer. This proposal seems based on the idea that there are perfectly healthy people withdrawing from the workforce for no reason other than personal choice, though framed now as though they're needed workers in a healthy economy. Though anecdotal, this was not my experience.

Those affected are those on the margins, and in the absence of Healthy Michigan, they'll be forced to either purchase a lesser plan in the marketplace or continue to go without healthcare, which is the most likely outcome, and which will likely harm them in the near term and all of us in the long term. They've ended up in this situation much more likely due to a lack of viable opportunity rather than choice.

In my time with them, again, it was understanding the insurance scenarios and options, the necessity of coverage, and the responsibility that accompanies Healthy Michigan that are needed more than any work requirement.

Healthy Michigan has been a success of which we should all be proud. This work requirement would be a shame upon us for no reason.

Regards,
[redacted]

Sent from my iPhone

From: [redacted]
To: HealthyMichiganPlan
Subject: [redacted]
Date: Saturday, August 11, 2018 5:08:48 AM

Work rules re: Medicaid would impact the most vulnerable individuals covered by the program. Many already work and the Medicaid was never intended to be a workforce program. I strongly oppose this requirement. [redacted]

Sent from my iPad

From: [redacted]
To: HealthyMichiganPlan
Subject: Working requirements for Medicaid
Date: Saturday, August 11, 2018 7:32:14 AM

I am vehemently against this, LBJ signed Medicaid into LAW FOR THE POOR,not for those able bodes etc. what about all the kids under 8 not pulling their weight ? This states going to turn into the south quick! The Supreme Court will block this , and you should be ashamed of yourself yourselves. Most places are having trouble trying to hire and your going to pimp out temps on the federal govt assisted MEDICAID plan? What's next making the elderly work 60 hr if their in public housing or on food stamps? Too many ethical points and makes Michigan my state look like Mitch McConnells Kentucky where people have amputated legs and are missing teeth cause they deny them Medicaid. [redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Saturday, August 11, 2018 7:32:59 AM

Ask Gretchen Whitmer, she helped get the original extension for the Obamacare bill . She wouldn't endorse this with a ten foot pole
I am totally against this, remember this wasn't designed for the POOR ya know the people we be helping to be washing toilets, if so then every government contractors family should do community service cause WE the tax payers pay for them . We just passed massive tax cuts that could've prevented this .
LBJ signed Medicaid into LAW FOR the POOR,not for those rich enough to buy human or Aetna etc. you think people like whipping out their cards places? There's zero fraud and 80hours a week is 880.00 a month! That is illegal, you don't define age gender or anything when defining hours! This ain't Kentucky nor will it ever be!
what about all the kids not pulling their weight ? Or you u going to go Deep South and make them work too?
This states going to turn into the south quick! The Michigan Supreme Court will can block this , and you should be ashamed of yourself yourselves. Most places are having trouble trying to hire and your going to pimp out temps on the federal govt assisted MEDICAID plan? What's next making the elderly work 60 hr if their in public housing or on food stamps? Too many ethical points and makes Michigan my state look like Mitch McConnells Kentucky where people have amputated legs and are missing teeth cause they deny them Medicaid. [redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Saturday, August 11, 2018 8:50:28 AM

The proposed Healthy Michigan Plan §1115 Demonstration Waiver Extension Request Amendment is arbitrary and capricious. It includes more exceptions than applications, increases bureaucratic intervention in people's daily lives and threatens their health and well being based on, among other things, insurance codes that can easily be mistaken and can jeopardize access to care with little recourse or ability to correct the mistake. It unduly increases the administrative burden placed on recipients, likely will cost a grossly excessive amount of money to implement and maintain, and is based on bias and fears of misuse rather than genuine public good. It assumes malice and indolence in Michigan's citizenry, whom the state is meant to serve, and thus codifies malicious retribution for perceived and unsubstantiated claims of misuse. Further, it masks penalization of need as incentive for good health, when that incentive is a threat and blackmail device putting access to care in the line and nothing more.

This amendment is in absolute bad faith and should not be enacted.

Sincerely,
[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Comment: Healthy Michigan Plan §1115 Demonstration Waiver Extension Request Amendment
Date: Saturday, August 11, 2018 9:57:59 AM

Hello,

I am a citizen of Michigan, resident in Lansing.

I strongly OPPOSE the Medicaid work requirements amendment. Study after study demonstrates that work requirements do not work, as recipients are now required to find and pay for child care while they make poverty-level wages. But you know that. You know that you are merely trying to prolong the suffering of people of color. We know you are nothing but racists.

These requirements are nothing more than thinly-veiled racist policies to "punish" people of color who already live under institutionalized racism and centuries of abuse and legal discrimination from white republicans. Disgusting. You have no idea what it is like to be poor. Meanwhile, you are more than happy to give out government handouts to your white friends in agricultural counties all over the state. SHAME ON YOU, THIS IS CLEARLY ANOTHER RACIST POLICY FROM THE MICHIGAN RACIST REPUBLICANS.

[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Saturday, August 11, 2018 10:07:10 AM

I am a type one diabetic and am on the Medicaid. I am an 38 year old artist and designer and am in the process of building my own design business that is slowly gaining traction and not quite profitable yet. I work at minimum 50 hours a week- some of that work results in income, other times its R and D and pro bono work that will hopefully lead to income in the future. Medicaid has allowed me to take the risk and quit my full time corporate job to follow my dream and while feeling secure that my diabetes will be able to be controlled. I am healthy thanks to my daily medication and regular doctor visits. I dont have a lot of money presently and am incredibly grateful for the assistance I am receiving while I'm working towards a place where I will not longer need any.

I would ask that the changes to Michigan Medicaid take in to account people like me who are working for themselves to achieve higher goals.

Thank you

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Saturday, August 11, 2018 10:57:22 AM

Regarding work requirements for Medicaid recipients:

I have a niece with chronic drug abuse and psychiatric problems. She has three children aged 9, 4, and 1 and is a high school dropout. Historically, she has been unable to maintain employment for very long. She also struggles to push paper when it is required to maintain eligibility for services.

We, the members of the family without these challenges, are already waist-deep and decades into efforts to help her get and stay clean and address her ongoing psychiatric issues. We are already heavily impacted by the need to protect the kids (to the degree this is possible). Much time and effort goes into day-to-day care and support: roof over the head, food in the kids' tummies, rides to the methadone clinic, encouragement to get back into rehab. Battles and anxiety about how much help is too much, and whose turn it is to step up.

Rules like this are not going to make her more functional than she is. What they will do is increase the burden on family, impacting our health, workforce participation, and ability to care for our own children and seniors. I expect it will also cause further turmoil in the medical system insofar as hospitals will be unable to turn her away for emergency care and she will lose access to other, less costly providers.

The unstated assumption of such rules is that people receiving Medicaid are able to work, or volunteer, or seek work, and are choosing not to. I would not hire my niece, who lacks a diploma, transportation, or child care, and who is not at all easy to get along with. Jobs for workers without education are so very limited, and public transportation is spotty and at times unreliable. I expect that even if my niece is able to get out to volunteer, she will create problems, or will be unable to maintain the required documentation.

There are some very troubled people in our society and I have one such person in my family. Social insurance programs like Medicaid don't only protect the person with the immediate need – they affect all the others around that individual. Many families include a heroin addict, and based on what I have seen, this rule needs fine tuning for them, and for those with psychiatric conditions. It is not at all realistic to expect the rule to affect their choices and capacities and opportunities.

Regards,

[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Saturday, August 11, 2018 1:59:06 PM

On behalf of a Michigan resident...

" My fiance may lose her coverage. It's hard enough to convince her to make a doctor's appointment, and without coverage, I'm afraid she'll put off seeing a doctor until she's too sick to function (like she used to), and she'll probably get me sick, too. Affordable, quality health care is absolutely a right - and a societal necessity."

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Saturday, August 11, 2018 1:59:58 PM

On behalf of a Michigan resident...

" If my brother were forced to work for health insurance he would be unable to do so and he would lose his health insurance, which means he would not be able to receive his medical treatment needed. He should be considered disabled."

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Saturday, August 11, 2018 2:00:56 PM

On behalf of a Michigan resident...

" Medicaid work requirements would limit the ability for individuals and families caring for school-aged children, sick, or elderly family members and present significant challenges for transportation and community child care. Additionally, as the Lansing community is very diverse, lack of training in language and skills, could present significant issues in the hiring process. Medicaid work requirements only make life harder for the working poor and add an unnecessary and thoughtless layer of bureaucracy to the state."

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Saturday, August 11, 2018 2:01:42 PM

On behalf of a Michigan resident...

" The work requirement will cause individuals to lose healthcare and healthcare professionals will lose much needed dollars!"

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendmet
Date: Saturday, August 11, 2018 2:02:59 PM

On behalf of a Michigan resident...

"I believe the work requirement will create a barrier to people seeking health coverage. I also feel it will further stigmatize the poor."

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Saturday, August 11, 2018 2:04:14 PM

On behalf of a Michigan resident...

" I work with people and their families who are part of the Medicaid Waiver program. Just the idea of this gives them great concern and anxiety as they care for their family members or are disabled themselves. I am concerned who is going to track all these "Exemptions" or how it will be tracked. Many of these folks are already some of our most vulnerable and in need of care. I am a full time employed person who does have to pay for my health care. 5% to some of these folks is a LOT of money. "

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Saturday, August 11, 2018 2:05:36 PM

On behalf of a Michigan resident...

"I'm worried about negative health outcomes and bankruptcy for my patients"

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Saturday, August 11, 2018 2:06:37 PM

On behalf of a Michigan resident...

" It will cost the state money to track. People would not get care they need. More will return to getting really ill and forced to use ED for care. People will lose health care jobs."

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Saturday, August 11, 2018 2:07:28 PM

On behalf of a Michigan resident...

" Ask hospitals and ERs how they will accommodate these changes."

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Saturday, August 11, 2018 2:08:43 PM

On behalf of a Michigan resident...

" Decreased health of any one person negatively affects the health and welfare of others, whether family members, classmates, coworkers, or others using a shared public space!!"

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Saturday, August 11, 2018 2:09:49 PM

On behalf of a Michigan resident...

" The possible loss of health care coverage due to failure to work increases risk of serious health consequences or risk of financial ruin. "

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Saturday, August 11, 2018 2:10:47 PM

On behalf of a Michigan resident...

" The changes would negatively impact individuals ability to receive health care and medication that they could afford to access"

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Saturday, August 11, 2018 2:11:36 PM

On behalf of a Michigan resident...

" I worry about children being left home alone, or with abusive/neglectful caregivers while the parents are fulfilling the work requirement."

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Saturday, August 11, 2018 2:12:56 PM

On behalf of a Michigan resident...

" I'm the only private doula and childbirth educator in my city, so I wouldn't be able to continue providing those services because I would have to stop being self-employed and find a job with benefits. In order to do that, I'd most likely have to sell my house and leave the city, if not the state. This would provide a lot of disruption in my family, as I'm the only daughter of my elderly father who lives in town. I'm also a single parent of a toddler, who would lose contact with the rest of her family in the state. I'd also have to shut down the hostel I've been running since 2015 that attracts hundreds of tourists to my small city every year. It's one of only 2 hostels in the state. I also just enrolled in graduate school and that wouldn't be possible if I lost my Medicaid, either."

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Saturday, August 11, 2018 2:13:57 PM

On behalf of a Michigan resident...

" My clients would have enormous bills if they didn't have Medicaid. They are on fixed incomes and Medicare doesn't cover enough of the cost."

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Saturday, August 11, 2018 2:15:12 PM

On behalf of a Michigan resident...

" In my brothers instance, these changes would be devastating to his health."

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Saturday, August 11, 2018 2:19:03 PM

On behalf of a Michigan resident...

" Changes would increase untreated medical conditions. Concerns this will increase need for police response and increase in crime in all areas of the state"

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Saturday, August 11, 2018 2:19:57 PM

On behalf of a Michigan resident...

" The work requirements are unrealistic demands of people who are already at a vulnerable point in their lives financially."

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Saturday, August 11, 2018 2:20:51 PM

On behalf of a Michigan resident...

" My brother would definitely lose his health care if work requirements were put into place. Because of his medical issues (anxiety, ADHD and Lupus) as well as lack of access to transportation where he lives, it's very difficult for him to hold a steady job. "

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Saturday, August 11, 2018 2:22:48 PM

On behalf of a Michigan resident...

" I cannot work 20 hours a week. My children are traveling & in school from 8-4:30p Monday through Thursday September to June. Friday my preschooler has no school whatsoever. I would have to first find before & after school care, with one full day on Friday. Then I have to secure employment to solely pay for it as I'm certain my deadbeat ex would only add more debt to the support he owes. I would need a job that allows me to work within the parameters of my children's school hours, or afford childcare. The math isn't hard. It just doesn't add up. "

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Saturday, August 11, 2018 2:24:10 PM

On behalf of a Michigan resident...

" My sister would be without coverage and she would not be able to manage her mental health disorders in any realistic way, thereby making her worse off."

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Saturday, August 11, 2018 2:24:43 PM

On behalf of a Michigan resident...

" Members of my community would lose their access to healthcare, causing a decline in the overall health of my community and an increase to overall costs."

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Saturday, August 11, 2018 2:25:18 PM

On behalf of a Michigan resident...

" Some employers will pray on those needing to work by paying little (unlivable) wages."

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Saturday, August 11, 2018 2:26:10 PM

On behalf of a Michigan resident..

" We lack public transportation in many parts of Michigan, and all of Michigan lacks reliable public transport. Also over the summer, who will watch children of parents that are forced to work? These problems will lead to more than just financial struggle among those on Medicaid."

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Saturday, August 11, 2018 2:26:49 PM

On behalf of a Michigan resident..

" I bet more people will use the emergency room for routine matters, increasing costs on all of us."

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Saturday, August 11, 2018 2:29:00 PM

On behalf of a Michigan resident...

" We need to find employers who would be willing to hire those in our community whom have difficulty obtaining jobs due to being out of the workforce for many years/have had a criminal record."

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Saturday, August 11, 2018 2:29:23 PM

On behalf of a Michigan resident...

" I'm concerned that these requirements will cause many people who desperately need health insurance to lose it."

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Saturday, August 11, 2018 2:30:49 PM

On behalf of a Michigan resident...

" People in my community will lose health care making for an unhealthy community. Causing poorer performances in school, work and other places."

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Saturday, August 11, 2018 2:32:26 PM

On behalf of a Michigan resident..

" My young adult child will not be receiving a diploma. She may not be approved by SSI. So how will she support herself and get an employer to train and have a job coach by her side while also providing her health insurance. She has many pre existing conditions."

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Saturday, August 11, 2018 2:32:56 PM

On behalf of a Michigan resident...

" It’s the right thing to do for my community, people shouldn’t die because their employer won’t pay them a living wage. My tax money can help support them until the government holds them accountable. They are hardworking people that deserve to be treated with dignity and respect."

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Saturday, August 11, 2018 2:33:35 PM

On behalf of a Michigan resident...

" These changes affect all of us, as overflowing emergency rooms because people can't fulfil work requirements to keep insurance has proven a costly and inefficient way to attempt healthcare cost reductions-it also decreases quality of care to anyone in the community and increases premium pricing in effort to offset the enormous cost."

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Saturday, August 11, 2018 2:34:16 PM

On behalf of a Michigan resident...

" The work requirements would force people unable to work due to disability, depression, mental illness, to take jobs that would put their health and well-being at risk."

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Saturday, August 11, 2018 2:35:14 PM

On behalf of a Michigan resident...

" Many in the community might not receive the care they need. Consequently, this could also create more cost to the public and public health concerns."

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Saturday, August 11, 2018 2:36:03 PM

On behalf of Michigan resident...

" Child care, transportation, and job training are all necessary for recipients to meet this work requirement. These essential elements do not appear to be part of the proposal."

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Saturday, August 11, 2018 2:36:51 PM

On behalf of a Michigan resident...

" Lack of day care would make it nearly impossible to comply."

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Saturday, August 11, 2018 2:37:40 PM

On behalf of a Michigan resident..

" Too many people would lose the only healthcare they have."

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Saturday, August 11, 2018 2:38:31 PM

On behalf of a Michigan resident...

" Any change in Medicaid that reduces benefits, requires burdensome paperwork or increases co pays or out of pocket charges will greatly impact the quality of life for my loved ones"

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Saturday, August 11, 2018 2:39:40 PM

On behalf of a Michigan resident...

" My mom works, but hours are fluctuating all the time, so my concern is if she goes below your threshold will she be [expletive]?"

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Saturday, August 11, 2018 2:40:48 PM

On behalf of a Michigan resident...

" Both of my cousins are at a level of income where paying for insurance would have negative affects. One takes care of her mother and cannot work full time; adding work requirements would be an additional expense if she had to switch to the exchange. For my other cousin who does not work full time, the lack of care would exacerbate his back problems and he would be able to work even less and/or have sharply reduced quality of life."

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Saturday, August 11, 2018 2:41:29 PM

On behalf of a Michigan residnet...

"My partner is a highly trained classical musician. He makes money but not enough to afford health insurance. He plays for Ann Arbor symphony orchestra, the Michigan Philharmonic, Fint, Saginaw and Dearborn. He teaches private students. He works 70+ hours a week not including practicing. Because he is not paid hourly he would have to quit his music career and go to work at some low-paid wage job, work LESS than he does now, just to meet an hourly wage requirement. He will be forced to choose between staying alive or giving up music, which is his entire life. This is cruelty and may wind up driving us both out of state (and I will take my company with me).

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Saturday, August 11, 2018 2:42:15 PM

On behalf of a Michigan resident...

" Work is not easy to come by with 1000 people applying for the same job. If I'm out of work it's because I can't find work, not because I'm lazy. If I find work, that doesn't guarantee Healthcare coverage"

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Saturday, August 11, 2018 2:43:30 PM

On behalf of a Michigan resident...

> **" I work up to 24 hours a week so I have no problem with the work part. I also am 62 and in good health now, but I have had health issues before that I needed help paying large medical bills with"**

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Saturday, August 11, 2018 2:44:18 PM

On behalf of a Michigan resident...

" My daughters father and a friend never had steady health care until the expanded ACA Medicaid. They would wait and use the ER which is vet expensive and their health has suffered"

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Saturday, August 11, 2018 2:45:16 PM

On behalf of a Michigan resident...

" If I or anyone in my family or community were to become seriously ill and unable to work, should we just lie down and die? What would be the point of the Medicaid program?"

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Saturday, August 11, 2018 2:48:20 PM

On behalf of a Michigan resident...

" I don’t see work requirements as beneficial. I think it will cost more than what Republicans think it will save. It's like drug testing welfare recipients. It’s a gimmick for votes but the math doesn’t add up."

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Saturday, August 11, 2018 2:50:40 PM

On behalf of a Michigan resident...

" I work a limited number of hours each week, it will be difficult to find another source to count as hours each week."

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Saturday, August 11, 2018 2:51:22 PM

On behalf of a Michigan resident...

" If we ever needed Medicaid as a safety net again it would not be there for us because I refuse to do anything other than stay home with my children. I'm sure many people will lose their health insurance coverage under these new policies and it's going to cost the state and hospitals more money."

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Saturday, August 11, 2018 2:52:10 PM

On behalf of a Michigan resident...

" I think it would cause bankruptcy for some in my community, but the worst impact would be death due to neglected health issues"

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Saturday, August 11, 2018 2:53:12 PM

On behalf of a Michigan resident...

" So many people don't have a car or access to public transportation or childcare. Especially in the city, there are no jobs for people who haven't been employed in a long time and have no skills."

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Saturday, August 11, 2018 2:53:56 PM

On behalf of a Michigan resident...

" We will get sick, lose our jobs and not be able to work then lose everything and die. I’m guessing this is totally acceptable in Lansing."

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Saturday, August 11, 2018 2:54:58 PM

On behalf of a Michigan resident...

" Keeping a job and required work hours is impossible and no way could meet these requirements due to anxiety, depression and Aspergers."

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Saturday, August 11, 2018 2:55:48 PM

On behalf of a Michigan resident...

" While it is my understanding that persons with I/DD are exempt from these changes, I interact with people in our community who have little access to reliable private or public transportation. Our busing service is very limited. There is no Uber driver. They have food and housing insecurities and AFFORDABLE child care is out of reach. Quality mental health care is rare. All of these factors can affect a person's ability for long term training and employment without a VERY compassionate and dedicated employer."

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Saturday, August 11, 2018 2:56:55 PM

On behalf of a Michigan resident...

" Implementing these unfair and arbitrary work rules would force many to lose their health insurance, which is a basic human right. If a woman has a child and is unable to find or afford child care, she does not deserve to lose healthcare. If the family car breaks down and we are so impoverished we cannot afford to fix it so we lose transportation to work and thus work, we do not want to also lose our healthcare. A healthy Michigan is a strong Michigan. Without healthcare, the entire system crumbles and leaves the poor in the dust."

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Saturday, August 11, 2018 2:57:38 PM

On behalf of a Michigan resident...

" Hospitals would quit getting some of their reimbursement and people in our community would not get needed care."

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Saturday, August 11, 2018 2:58:35 PM

On behalf of a Michigan resident...

" People will go without coverage, negative health outcomes, more ER visits, lack of prevention."

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Saturday, August 11, 2018 2:59:32 PM

On behalf of a Michigan resident...

" The measure of a state is the way it treats the least advantaged. These proposals punish the poor and create unmanageable bureaucratic burdens for the state. Decouple health care from work! Let's do what most of our peers have managed to do and treat health care as a basic right owed to all. It will save us money in the long run. Yes there will be disruption, but our current path is unsustainable and stupid."

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Saturday, August 11, 2018 3:00:36 PM

On behalf of a Michigan resident...

" I already spend so much time trying to interpret Medicaid documents for friends who are still learning English as resettled refugees. As a native speaker with a college degree I can barely navigate through the documentation or a phone call on their behalf as it is (so many hours on hold only to be passed back and forth...). It's already incredibly burdensome for Mom working as fast and hard as she can to learn English and find a job (with a disabled husband and 4 children). This ironically will make it more difficult for her to find work with the additional time (and headache and stress) of dealing with another level of bureaucracy - a completely unnecessary one. Please take the money it would take to implement this needless program and put it into direct assistance. Thank you."

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Saturday, August 11, 2018 3:01:40 PM

On behalf of a Michigan resident...

" I'm afraid we'll see more negative health outcomes and medical bankruptcies."

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Saturday, August 11, 2018 3:02:12 PM

On behalf of a Michigan resident...

" Seems like an excellent way to have people rely on expensive ER visits to take care of minor health-related concerns"

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Saturday, August 11, 2018 3:02:46 PM

On behalf of a Michigan resident...

" My daughter who is disabled lives in a different state. I thank God she does not have to deal with this sort of barrier to the services she needs. She is barely able to handle the paperwork already required to receive needed help. Sick people, seriously disabled people should NOT have to deal with another level of bureaucracy."

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Saturday, August 11, 2018 3:03:31 PM

On behalf of a Michigan resident...

" These changes to Medicaid act as an additional barrier for individuals in crisis. As a community, we need to remove the barriers and empower and prepare individuals to be able to meet their own needs."

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Saturday, August 11, 2018 3:04:56 PM

On behalf of a Michigan resident...

" My community will be affected by the long term consequences that will results from individuals losing medical care when they are unable to complete the requirements due to lack of transportation, education or any of the other many factors that make it difficult for individuals in crisis to add additional burdens to their plates."

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Saturday, August 11, 2018 3:05:35 PM

On behalf of a Michigan resident...

" For the moment, we are both covered: my husband through Medicare and myself through my workplace. But who knows what the future may bring? It would be reassuring to know that this essential safety net is in place for ALL Michiganders."

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Saturday, August 11, 2018 3:06:44 PM

On behalf of a Michigan resident...

" I want my neighbors and community members to have access to health care. It’s a right everyone should have."

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Saturday, August 11, 2018 3:07:31 PM

On behalf of a Michigan resident...

" I believe it would increase poverty in my community. Most people on Medicaid are in desperate need of help and need more opportunities for support, not more rules that would require more paperwork and communication with the government. I consider myself an intelligent and well-supported individual, and it was very difficult for me to navigate finding Medicaid services that were covered under my plan. If I had had to do this when I had a mental health crisis (I was covered by other insurance at the time) I do not think I would have been able to. For those with mental health issues, even those who seem to function well with these issues as I did, having to file more paperwork with the government or having to try to find a job or volunteer opportunity would be extremely stressful and I think a lot of people would fall through the cracks and lose their insurance. This would only encourage a greater downward spiral that would lead to more sick people in poverty, and these are people who need and deserve the most help."

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Saturday, August 11, 2018 3:08:31 PM

On behalf of a Michigan resident...

" There will be more people without insurance. People will go back to using the local Hospital Emergency room for medical care. Of course, this will be a huge burden to our hospital, but the STATE will save money. I believe health care is a right not a luxury item that only wealthy people can afford to have. Before the expansion many of the people I worked with had full time jobs but were still eligible for Medicaid. This subject makes me so mad that this State of Michigan just wants people to die if they can't afford insurance. If Michigan had a LIVING WAGE there would be no need of Medicaid or food stamps."

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Saturday, August 11, 2018 3:09:21 PM

On behalf of a Michgain resident...

"People in areas where there are few jobs nearby will suffer. Most people on Medicaid are unable to work. "

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Saturday, August 11, 2018 3:18:28 PM

On behalf of a Michigan resident..

" I want to live in a community where people look out for each other, not where people are left to fend for themselves."

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Saturday, August 11, 2018 3:19:25 PM

On behalf of a Michigan resident...

" I am enrolled full-time in school as well as working 20 hours per week and interning another 15-20 hours per week. Work requirements as a concept would not affect me in particular because I have no children and I have access to reliable transportation. I am concerned about the paperwork requirements, and that I may miss a form or someone may not properly document my forms and I would be penalized."

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Saturday, August 11, 2018 3:20:08 PM

On behalf of a Michigan resident...

" Individuals on Medicaid will be negatively affected by these changes because it simply is not that easy to meet the work requirements. If people could work and find a job to sustain themselves and their families, they would. These proposed changes assume that people on Medicaid are less than and that is insulting. Again, we can afford to take care of our sick. We have to."

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Saturday, August 11, 2018 3:20:49 PM

On behalf of a Michigan resident...

" Undoubtedly, this will lead to fewer people having health coverage which affects the health and wellbeing of an entire community."

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Saturday, August 11, 2018 3:21:39 PM

On behalf of a Michigan resident...

" I believe kicking people off of this minimal form of health insurance impairs the economic and social development of all residents of Michigan. Who is going to care for us old people in the many ways we will need assistance, or work in our businesses, industry, schools, etc if the incoming work force is undereducated because of chronic health issues so often associated with life in poverty? This idea of work requirements instead of work supports is to make some politician look like he's a tough guy, instead of a stupid guy."

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Saturday, August 11, 2018 3:22:23 PM

On behalf of a Michigan resident...

" Without it, many wouldn't receive care they need, some would die, those who received any care would only get emergency care from hospitals with bills they can't pay back. Especially for clients who are homeless, the last thing they need is more barriers."

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Saturday, August 11, 2018 3:23:03 PM

On behalf of a Michigan resident...

" These changes will negatively impact my community. Most of the time, the families I work with are doing everything they can to keep their heads above water. They are looking for work or are working as much as they are able to. Imposing even more restrictions and requirements will result in wasted hours of time as individuals fill out paperwork (which is difficult on its own, let alone if the individual has a disability or low level of schooling) and spend their limited time and resources on transportation to a job that might not be a good fit simply to fulfill the requirement. Also consider the vast amount of resources that will have to be spent by the state government in order to track all of this. I'd much rather spend that money on a family needing healthcare."

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Saturday, August 11, 2018 3:25:35 PM

On behalf of a Michigan resident...

" These changes could hurt individuals who cannot locate employment, and those who should receive disability benefits, but cannot due to lack of medical evidence."

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Saturday, August 11, 2018 3:26:13 PM

On behalf of a Michigan resident...

" These changes will negatively affect the already stressed disabled family member and his family caregivers, adding more anxiety, more paperwork, etc."

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Saturday, August 11, 2018 3:26:56 PM

On behalf of a Michigan resident...

" My husband is an adjunct professor at various colleges. Only a handful of full-time positions become available each year. My field was decimated in 2008 and has not recovered in this past decade. Regardless of this, both of us have not stopped looking for work."

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Saturday, August 11, 2018 3:27:44 PM

On behalf of a Michigan resident...

" A healthy community is a productive community. The less trouble people have staying alive, the more they can contribute to society, and so it is worth it for everyone in the country to ensure that their neighbors have access to good health care. Based on this, I am generally opposed to creating barriers to receiving low-cost treatment when an individual is unable to financially support themselves due to life circumstances, and subsidized preventative care is just cost effective vs the likely alternative."

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Saturday, August 11, 2018 3:28:40 PM

On behalf of a Michigan resident...

" Would increase spread of communicable diseases with no adequate treatment available, seen at this time with more resistant strains of gonorrhea. Would also increase inadequacies of community support for families under stress of poor educational opportunities, lack of adequate transportation, childcare, housing at low income levels"

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Saturday, August 11, 2018 3:29:48 PM

On behalf of a Michigan resident...

" Medicaid allows the healthcare system to "come alongside" people who are marginalized in every other aspect of their lives so that they can become contributing members of society... isn't that what we all want?"

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Saturday, August 11, 2018 3:30:19 PM

On behalf of a Michigan resident...

" My community feels better that we can assist others that are falling through the cracks which appear to be an ever increasing population. Our communities would also be less safe due to desperate people."

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Saturday, August 11, 2018 3:36:32 PM

On behalf of a Michigan resident...

" I think it will make people have to jump through hoops and do more paperwork, losing insurance even if they are qualified, and then we all pay when they go to the ER and the costs can not be recouped."

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Saturday, August 11, 2018 3:37:18 PM

On behalf of a Michigan resident...

" If people do not have access to healthcare they cannot work or be productive members of society."

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Saturday, August 11, 2018 3:38:08 PM

On behalf of a Michigan resident...

" I live in a community with no effective mass transit, limited affordable day care. I personally lost a job in 2006 my department went from 4 full-time RNs to 1 after cut backs were made to off-set financial losses incurred by the healthcare system due to uncompensated care."

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Saturday, August 11, 2018 3:39:09 PM

On behalf of a Michigan resident...

"I hope my daughter would meet an exception. However I'm not sure. She does attend a workshop but it isn't Medicaid certified, and it isn't 80 hours a month. And whether or not she meets an exception I am afraid you are chipping away at the system that helps keep her alive."

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Saturday, August 11, 2018 3:40:16 PM

On behalf of a Michigan resident...

" Michigan's family caregivers are the foundation of Michigan's long-term care system, caring for the majority of Michigan's seniors who require assistance. According to the Family Caregiver Alliance National Center on Caregiving, family caregivers provide billions of dollars in uncompensated care each year:
• At $470 billion in 2013, the value of unpaid caregiving exceeded the value of paid home care and total Medicaid spending in the same year, and nearly matched the value of the sales of the world's largest company, Wal-Mart ($477 billion). [AARP Public Policy Institute. (2015). Valuing the Invaluable: 2015 Update.]
• The economic value of the care provided by unpaid caregivers of those with Alzheimer's disease or other dementias was $217.7 billion in 2014. [Alzheimer's Association. (2015). 2015 Alzheimer's Disease Facts and Figures.]

These statistics demonstrate the tremendous monetary value of uncompensated caregiving. This could be lost Under Senate Bill 897 if a care recipient cannot meet the strict medical guidelines outlined. Family caregivers who currently receive Medicaid benefits would be forced to make a no-win choice. That choice is between providing uncompensated care for their care recipient and dropping out of Medicaid or staying in Medicaid and meeting the work requirements that preclude them from providing uncompensated care. Leaving caregiving to maintain Medicaid coverage could lead to placement of the care recipient into a much costlier institutional setting such as a nursing home. If the caregiver chooses to forgo Medicaid coverage for their own healthcare needs, it could cause them to have significantly poorer health outcomes due to lack of access to medically necessary services. That has negative cost implications as well."

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Saturday, August 11, 2018 3:41:13 PM

On behalf of a Michigan resident...

" I am the director of a small free health clinic in southern Michigan, which is open one night a week. Prior to HMP we were seeing about an average of 65 patients a week. Since HMP our numbers have drastically dropped. If these changes happen I expect our numbers to grow, which is not what we want to happen. The goal of every free clinic is to put themselves out of work, wouldn't it be wonderful for everyone in your community to have health coverage? In the past few years our donor base has decreased as we don't have the high need. But, I do not see the community stepping up if our need goes back to where it was 15 years ago when we opened."

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Saturday, August 11, 2018 3:42:24 PM

On behalf of a Michigan resident...

" Tells the individual/family/community that the State really "doesn't care" about those who are already suffering and who are truly in need!"

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Saturday, August 11, 2018 3:43:04 PM

On behalf of a Michigan resident...

" Work requirements pervert the purpose of Medicaid. They are intrusive and unreasonable and are designed to push people off Medicaid, plain and simple, as part of the right-wing Republican agenda of undoing the social safety net."

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Saturday, August 11, 2018 3:43:43 PM

On behalf of a Michigan resident...

" Our community will suffer under these new rules. Employers will balk, prospective users will be afraid and overwhelmed. We need a healthy society!"

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Saturday, August 11, 2018 3:44:48 PM

On behalf of a Michigan resident...

" I have a number of friends whose children are on Medicaid, I don't know if they could meet the work requirements in hours, but not a single one of their children should lose coverage because they don't have the money to pay for daycare so that they can work. I recently heard that the Grand Rapids area is short about 4,000 daycare spots. I don't know if that is accurate, but I know that I stopped working when I had a second child because the cost of childcare nearly outpaced my wages.'

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Saturday, August 11, 2018 3:54:48 PM

On behalf of a Michigan resident...

" People will lose needed health care coverage. Some may actually die as a result."

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Saturday, August 11, 2018 3:55:34 PM

On behalf of a Michigan resident...

" I believe a lot of Medicaid recipients do in fact, work. Why burden those who are trying to do the best that they can with unnecessary requirements?"

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Saturday, August 11, 2018 3:56:14 PM

On behalf of a Michigan resident...

" I believe they would have a negative impact on the most vulnerable of people. While there are many who have a bus they can take, or a bike to ride - there are just as many who do not. Those barriers are probably impacting their ability to find and maintain employment in the first place. I also think that it would create a huge amount of confusion to begin charging a premium. Saying 5% - 5% of what ? That's a completely ambiguous amount that might be far more than a person in poverty can afford. Secondly - it creates more paperwork for DHHS and an already overburdened system. Who will process all of that paperwork? Will it cost more than we save?"

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Saturday, August 11, 2018 3:57:23 PM

On behalf of a Michigan resident...

" Our area has no public transportation for folks to get to work or to training they might need. The paperwork for the recipients, the social services workers, the healthcare employees and employers would be unmanageable."

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Saturday, August 11, 2018 3:58:14 PM

On behalf of a Michigan resident...

"If work requirements are implemented many in my area will be forced to take entry level and very low pay jobs just to keep basic insurance. The additional transportation and child care costs make this an endless cycle of poverty.

Why should a human have to beg for such a basic level of dignity in the richest country in the world?"

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Saturday, August 11, 2018 3:59:37 PM

On behalf of a Michigan resident...

" I worry that a work requirement will mean that thousands will lose their health benefits, that the costs to public health and hospital systems will increase dramatically, and that all of Michigan will suffer from the effects of medical bankruptcy, increased homelessness, and an increase in unemployment as workers will need to leave jobs to care for ill loved ones."

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Saturday, August 11, 2018 4:00:23 PM

On behalf of a Michigan resident...

" Adding more regulations only makes it more difficult and more costly."

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Saturday, August 11, 2018 4:01:12 PM

On behalf of a Michigan resident...

" I believe the proposed changes would have a negative effect on the very small percentage of those on Medicaid who are not already working or would otherwise be exempt under the proposal. I believe the cost to monitor and these changes far exceeds any potential benefits as access to work, the availability of work In rural communities is both scarce or too far away to make it practical or realistic."

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Saturday, August 11, 2018 4:02:06 PM

On behalf of a Michigan resident...

" They would simply not be able to comply due to the severity of their conditions, at least not without accommodations that would be more costly to supply than were worth. It makes no sense, fiscal or otherwise."

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Saturday, August 11, 2018 4:03:12 PM

On behalf of a Michigan resident...

" It would not change my current situation, but would negatively impact the community at large by putting excessive burdens on low- lower-middle income families."

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Saturday, August 11, 2018 4:03:59 PM

On behalf of a Michigan resident...

" I work with women who are trying to get back on their feet. The barriers they already face just trying to feed their families, hold down a job with a sick child or being sick themselves, get to work if they can find a job that pays enough to feed their families and if the family is trying to get out of a violent household, work with the legal system are enough! These changes are another way to punish someone for being poor. This program no track of success in any other state and it won't here in Michigan."

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Saturday, August 11, 2018 4:04:55 PM

On behalf of a Michigan resident...

" Making a complicated system more complicated. Managing new requirements may disrupt coverage"

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Saturday, August 11, 2018 4:05:47 PM

On behalf of a Michigan resident...

" My grandson is worried that he will no longer qualify since he is not always able to meet the required amount of work hours. Finishing college in the 18 months is his priority, so he can become a well functioning member of society!"

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Saturday, August 11, 2018 4:06:27 PM

On behalf of a Michigan resident...

" The changes to the coverage would affect us as my husband and I are not able to work. We both have medical conditions. I can't drive so I would need transportation to and from a job. Also who is going to hire someone with certain medical conditions?"

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Saturday, August 11, 2018 4:07:13 PM

On behalf of a Michigan resident...

" I think health care shouldn’t put people out of their homes and they have enough to worry about without being frightened to get health care because of the cost."

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Saturday, August 11, 2018 4:07:58 PM

On behalf of a Michigan resident...

" Fewer people would get vaccines. More people would use the emergency room for primary care."

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Saturday, August 11, 2018 4:09:18 PM

On behalf of a Michigan resident...

" Those who have kids or have transportation barriers would be unfairly burdened by the work requirements. Members of my community work very hard to get by and losing their health coverage would be disastrous to their livelihoods. Losing Medicaid will lead to people not getting preventive health services and increased use of emergency rooms. Ultimately, this will lead to higher costs for the state and its taxpayers. This issue is of concern to all Michiganders, not just those who are on Medicaid."

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Saturday, August 11, 2018 4:10:01 PM

On behalf of a Michigan resident...

" I am almost at retirement age, and I fear that these changes will adversely impact my ability to qualify for and receive Medicaid."

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Saturday, August 11, 2018 4:10:41 PM

On behalf of a Michigan resident...

" My brother is on the autism spectrum and has never been able to work outside the home but doesn't qualify for disability. He had no training, no transportation and no one would hire him. I have severe Generalized Anxiety Disorder. What I make from in home child care I'm sure wouldn't be enough to meet requirements but working outside the home results in panic attacks."

From: Almeida, Dave (National Office)
To: HealthyMichiganPlan
Subject: Comment Letter, The Leukemia & Lymphoma Society
Date: Sunday, August 12, 2018 3:21:53 PM
Attachments: Comment Letter, The Leukemia & Lymphoma Society-HMP Section 1115 Demonstration Extension Application.pdf

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The Leukemia & Lymphoma Society submits the attached comments regarding the HMP 1115 Demonstration Extension Application

J. DAVID ALMEIDA | Regional Director, Government Affairs – Midwest Region
The Leukemia & Lymphoma Society | Office of Public Policy | 10 G Street, NE, Suite 400 Washington, DC 20002
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LEUKEMIA &
LYMPHOMA
SOCIETY"

12 August 2018

Nick Lyon
Director
Michigan Department of Health and Human Services
333 South Grant Avenue
Lansing, Michigan 48913

Re: Healthy Michigan Plan Project No. 11-W-00245/5 - Section 1115 Demonstration Extension Application

Dear Director Lyon:

The Leukemia & Lymphoma Society (LLS) appreciates the opportunity to submit comments on the proposal put forward by the Michigan Department of Health & Human Services to extend the Healthy Michigan Plan (HMP) demonstration waiver. At LLS, our mission is to cure leukemia, lymphoma, Hodgkin's disease and myeloma, and improve the quality of life of patients and their families. LLS exists to find cures and ensure access to treatments for blood cancer patients. In light of that mission, LLS urges the Department to reconsider moving forward with its waiver amendment until the Department has been able to resolve the serious concerns LLS raises below.

The Department proposes that as a condition of eligibility for HMP, individuals between the ages of 19 and 62 must be employed or engage in specified educational, job training, or community services activities for at least 80 hours per month, unless they qualify for an exemption. A lock-out period of at least one month (with no maximum) will result if an individual fails to meet his or her workforce engagement requirement. Further, individuals whom the Department believes to have misrepresented his or her compliance with the requirement will face a lock-out period of one year.

The Department also proposes that individuals with incomes between 100 and 133 percent of the federal poverty level be required to pay monthly premiums equal to five percent of their income, unless they can demonstrate that they qualify for an exemption. A lock-out period will result until the individual comes into compliance, at which point he or she **will** be re-enrolled the first day of the next available month.

LLS believes firmly that all patients and consumers should have access to high quality, stable coverage to ensure that they are able to receive appropriate and timely care. Medicaid serves a vital role in making sure that no one is left without access to such coverage. While LLS appreciates the importance of the flexibility offered by the Section 1115 waiver process, LLS believes that changes authorized through that process should not cause fewer people to receive or retain coverage or make it harder to obtain necessary health care.[1] It's on those grounds that LLS urges the Department to reconsider moving

[1] Judith Solomon and Jessica Schubel, "Medicaid Waivers Should Further Program Objectives, Not Impose Barriers to Coverage and Care," Center on Budget and Policy Priorities, August 29, 2017, https://www.cbpp.org/sites/default/files/atoms/files/8-28-17health.pdf

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LEUKEMIA & LYMPHOMA SOCIETY*

forward with its waiver amendment until the Department has been able to resolve the serious concerns LLS raises.

MEDICAID: A VITAL SOURCE OF COVERAGE

Medicaid guarantees access to life-saving care for low-income Americans

As the nation's public health insurance program for low-income children, adults, seniors, and people with disabilities, Medicaid covers 1 in 5 Americans,[2] including the 680,000[3] Michigan residents served by HMP. Many of them have complex and costly health care needs, making Medicaid a critical access point for disease management and care for many of the poorest and sickest people in our nation.[4]

Thanks to Medicaid coverage, enrollees have access to screening and preventive care, which translates into well-child care and earlier detection of health and developmental problems in children, earlier diagnosis of cancer, diabetes, and other chronic conditions in adults, and earlier detection of mental illness in people of all ages.[5] Medicaid also ensures access to physician care, prescription drugs, emergency care, and other services that - like screening and prevention - are critical to the health and well-being of any American.

Medicaid is a crucial source of coverage for specialty care too, including cancer care. Evidence suggests that public health insurance has had a positive impact on cancer detection: researchers have determined that states that expanded Medicaid experienced a 6.4 percent increase in early detection of cancer from pre-Affordable Care Act (ACA) levels.[6] Evidence also shows better survival rates among individuals who were enrolled in Medicaid prior to being diagnosed with cancer, relative to those who enroll in Medicaid after their diagnosis.[7] In Michigan, 44,415 people are living with blood cancer and, last year alone, an estimated 5,680 received a new diagnosis of blood cancer.[8] For many of them, HMP will be their only source of affordable coverage.

WORKFORCE ENGAGEMENT

Making coverage contingent on work status will disrupt access to care

The Department proposes that individuals between the ages of 19 and 62 be employed or engage in specified educational, job training, or community services activities for at least 80 hours per month as a condition of receiving coverage through HMP, unless they qualify for an exemption.

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2 Rachel Garfield, Robin Rudowitz, and Anthony Damico, "Understanding the Intersection of Medicaid and Work," Kaiser Family Foundation, January 2018, https://www.kff.org/medicaid/issue-brief/understanding-the-intersection-of-medicaid-and-work/.

3 Michigan Department of Health and Human Services, Healthy Michigan Plan Enrollment Statistics, July 31, 2018. Available at https://www.michigan.gov/mdhhs/0,5885,7-339-71547_2943_66797---,00.html.

4 Julia Paradise, "Data Note: Three Findings about Access to Care and Health Outcomes in Medicaid," March 23, 2017, https://www.kff.org/medicaid/issue-brief/data-note-three-findings-about-access-to-care-and-health-outcomes-in-medicaid/.

5 Ibid.

6 A Soni, K Simon, J Cawley, L Sabik, Effect of Medicaid expansions of 2014 on overall and early-state cancer diagnoses [published online December 21, 2017]. *Am J Public Health,* doi: 10.2105/AJPH.2017.304166.

7 E Adams, LN Chien, CS Florence, et al. The Breast and Cervical Cancer Prevention and Treatment Act in Georgia: effects on time to Medicaid enrollment. *Cancer.* 2009; IIS(G):1300-9.

8 The leukemia & lymphoma Society: LLS Mission & Impact. 2017.

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Medicaid's core mission is to provide comprehensive coverage to low-income people so they can obtain the health care services they need.[9] In service of that mission, the ACA streamlined Medicaid enrollment and renewal processes across all states.[10] The intent was to reduce the number of uninsured and keep individuals covered over time by reducingthe burden of paperwork. But in contrast, Michigan's proposed work requirement will initiate a return to increased bureaucracy and paperwork and, in turn, coverage losses. It'sbecause of those losses that LLS firmly opposes making Medicaid coverage contingent on work requirements.

The State of Kentucky, for example, projected that its Section 1115 waiver will yield a 15 percent drop (95,000 beneficiaries) in adult Medicaid enrollment by the waiver's fifth year of implementation and that well over 100,000 people will experience gaps in coverage due to lock-outs for failing to meet work requirements, report changes, or renew coverage in a timely manner.11

Indeed, work requirements wilt result in some enrollees losing coverage not because they failed to maintain employment but because of difficulty navigating compliance processes or satisfying the burden of additional paperwork. When Washington State required increased reporting as part of its Medicaid renewal process, approximately 35,000 fewer children were enrolled in the program, despite the fact that many remained eligible. Families reported that they had simply lost track of the paperwork.12 It ' s important to note that many in the M edicaid population face barriers associated with disability, mental illness, insecure work, frequent moves, and homelessness - all factors that pose significant challenges to successfully navigating any system.

Early reports from Arkansas on their work requirement validate concerns over widespread confusion and significant coverage losses. In the first month of implementationof its"Arkansas Works" program, nearly 75% of beneficiaries who were required to take action online to report their work hours or an exemption failed to do so.[13] This is not surprising given that Arkansas ranks 46th in the nation with respect to internet access[1;4] in fact, 31% of Arkansas Medicaid beneficiaries who are likely to not be exempt from the work requirement and are not currently working have no access to the internet in their household[1.5] It is also highly likely that many people simply did not receive the notices stating that they would be subject to a work requirement, given that low income households move at twice the rate of higher income

9 42 U.S.C. 1396.
1 Kaiser Family Foundation, "Implic ation of Emerging Waivers on Stre amlined Medicaid Enrollment and Rene wa l Processes," Febru ary 2018, htt ps://www .kff.org/ medicaid/ fact-sheet/implications-of-emerging-waivers-on-streamlined -medicaid-enrollment-and -renewal-processe.s/
11 Judith Solomon, "Kentucky Waiver Will Harm Medicaid Beneficiaries," Center on Budget and Policy Priorities, January 16, 2018, htt ps:// www.cbpp.org/research/health/kentucky -waiver-will-harm-medicaid-beneficiaries.
12 Margot Sanger-Katz, "Hate Paperwork? Medicaid Recipients Will Be Drowning In It ," *The New York Times,* January 18, 2018.
13 Joan Alker and Maggie Clark, "One Month into Medicaid Work Requirement in Arkansas, Warning Lights are Already Flashing." July 20, 2018, Georgetown University Health Policy Institute: Center for Children and Families, https://ccf.georgetown.edu/2018/07/ 20/one-mont-h into-arkansas-medicaid-work-requirement-the-wa rning-Hghts-are -alre ady-flashing/
14 U.S. News & World Report, Internet Access Ratings, htt ps:// www.usnews.com /news/best-states/rankings/ infrastructure/inte rnet -access
15 Anuj Gangopadhyaya, Genevieve Kenney, Rachel Burton , and Jeremey Marks, "Medicaid Work Requirements in Arkansas: Who Could Be Affected, and What Do We Know About Them?" May 24, 2018, Urban Institut e Research Report , (htt ps:/ / www.urban.org/ research/publication/ medicaid-work-requirements -arkansas.

households.[16] Because Arkansas plans to terminate eligibility after three months of not meeting the new work requirement rules, the more than 7,000 beneficiaries who were unable to report their work hours or an exemption in the first month of implementation are now one step closer to losing coverage.17

This effect has been borne out in other contexts too: data shows that inTemporary Assistance for Needy Families (TANF), for example, many people who were working or should have qualified for exemptions from work requirements lost benefits because they didnot complete required paperwork or were unable to document their eligibility for exemptions.[18]

The fact is loss of coverage is a grave prospect for anyone, in particular a patient living with a serious disease or condition. People in the midst of cancer treatment, for example, rely on regular visits with healthcare providers, and many of those patients must adhere to frequent, if not daily, medication protocols. Thus LLS is seriously concerned that individualswho are unable to satisfy work requirements may end up going without necessary care, perhaps for an extended period of time.

It's important to note that exempting some beneficiaries from having to comply with work requirements willnot sufficiently mitigate the access barriers that willresult from making coverage contingent on work. Under commercial health insurance, exemption and exceptions procedures have a long track record of limiting or delaying access to care for patients living with serious medical needs. At times this is due to the slow pace of the determination process. At other times, the challenge is simply understanding the exemption process itself or having the time and resources to pursue appeals. It's highly likely that, where it concerns exemptions from work requirements, Medicaid enrollees will find it similarly complicated, time-consuming, and expensive to secure and maintain an exemption.

Implementation will strain already-limited government resources

Implementation of work requirements will obligate the state to devote significant resourcesto tracking work program participation and compliance or, alternatively, incur the cost of contracting out that function.[19] A draft operational protocol prepared for the implementation of Kentucky's proposed waiver illustrates the costs involved: nearly $187 million in the first six months alone.[20] Similarly, Tennessee estimates that the implementation of a Medicaid work requirement would cost the state an estimated $18.7 million each year.[21]

"Brett Theodos, Sara McTarnaghan, and Claudia Coulton, " amily Ria,id,rntial Instability: What Can States and Localities Do?" May 2018, Urban Institute, https://www.urban.org/sites/default/files/publication/98286/family_residential_instability_what_can_states_and_localities_do_1.pdf

17 Alker and Clark.

18 Judith Solomon, "Kentucky Waiver Will Harm Medicaid Beneficiaries," January 16, 2018, Center on Budget and Policy Priorities https://www.cbpp.org/research/health/kentucky-waiver-will-harm-medicaid-beneficiaries.

19 MaryBeth Musumeci and Julia Zur, "Medicaid Enrollees and Work Requirements: Lessons from the TANF Experience," Kaiser Family Foundation, August 2017, https://www.kff.org/medicaid/issue-brief/medicaid-enrollees-and-work-requirements-lessons-from-the-tanf-experience/.

20 *RollCall,* "Medicaid Changes Require Tens of Millions in Upfront Costs," Feb. 26, 2018, https://www.rollcall.com/news/politics/medicaid-kentucky.

21 Ibid.

Administering these requirements will be expensive for Michigan as well: the Michigan House Fiscal Agency estimates that the state's administrative costs alone will be approximately $20 million, in addition to one-time information technology costs of up to $10 milli on.[22] If the state is willing to increase its spending on HMP, those additional dollars ought to be prioritized for uses that are directly related to access to care, not the creation of a work requirements bureaucracy.

INCREASED PREMIUMS

Increased enrollee costs will limit access to care

The Department proposes that individuals with 48 cumulative months of enrollment in HMP whose incomes fall between 100 and 133 percent of the federal poverty level (approximately $1,372/month to $1,893/month for a family of two) be required to pay monthly premiums equal to five percent of their income, unless they're able to secure an exempt ion. While the federal government has previously approved the use of premiums in Medicaid, no state has received approval for premiums at a level as high as this.

The Department's proposed premium increase will almost certainly cause HMP enrollees to lose access to coverage, decrease their adherence to t reat ment, or simply not enroll in the program, as five percent of household income represents a serious burden for people living at or near the poverty level. Indeed, evidence shows that modest premiums deter enrollment in Medicaid.[23] Similarly, research shows that even relatively small co-payments of $1 to $5 reduce people's utilization of necessary healthcare services among people who are low-income.[24]

In short, LLS believes that patients should not be made to choose between affording treatment and other basic necessities and thus opposes financial burdens that will erect barriers to accessing Medicaid for low-income, vulnerable populations.

LOCK-OUT PERIODS

Cancelling coverage will disrupt essential care

The Department proposes to penalize individuals who fail to meet workforce engagement requirements with a tock-out peri od of at least one month, with no maximum. Furt her, individuals whom the Department believes to have misrepresented his or her compliance with the requirement will face a lock-out period of one year. Similarly, the Depart ment proposes lock-out periods as penalty for non-payment of premium increases, with benefits suspended under the individual has come into compliance.

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22 Michigan House Fiscal Agency, Legislative Analysis of Healthy Michigan Plan Work Requirements and Premium Payment Requiremen ts, June 6, 2018. Available at: http://www.legislature.mi.gov/_documents/2017-2018/billanalysis/House/pdf/2017-HLA-0897-SCEEFSOA.pdf.

23 BJ Wright. MJ Carlson, H Allen. Al Holmgren, Ol Rustvold, " Raising Premium s and Other Costs for Oregon Health Plan Enrollees Drove Many to Drop Out," *Hea lth Affairs,* 2010; 29(12):2311-16.

24 Judith Solomon , "Kent ucky Waiver Will Harm Medicaid Beneficiaries," January 16, 2018, Center on Budget and Policy Priorities, https://www.cbpp.org/research/health/kentucky-waiver-will-harm-medicaid-beneficiarie s

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Evidence suggests that restricting or terminating coverage or access to services as a penalty for failing to pay premiums or cost-sharing reduces access to necessary care, disrupts continuity of care, and increases the likelihood of emergency department (ED) utilization.[25] For example, when Oregon introduced a six month lock-out in 2003, enrollees who lost coverage were three times as likely to not fill a prescription, and four to five times more likely to use the ED as a source of care than people who remained enrolled.[26]

For those reasons, LLS opposes Michigan's proposal to utilize lock-outs, in all instances proposed. Simply put, these lock-out periods will have the effect of preventing access to critical healthcare services. LLS believes that Medicaid enrollees should be afforded the peace of mind that they will not lose coverage if they fall behind on their bills or experience challenges navigating the processes to prove eligibility for exemptions. Even if it is temporary, coverage loss can be catastrophic for enrollees, including those with cancer or other serious and/or chronic health conditions.

To be clear, LLS's concern here extends to HMP enrollees who today have blood cancer as well as those who do not currently live with a blood cancer diagnosis; if during a lock-out period an individual develops blood cancer, it's likely the disease won't be diagnosed early enough to ensure the best possible health outcomes.

DISCLOSURE OF ENROLLMENT & EXPENDITURES

Federal rules at 431.408 pertaining to the state public comment process require at (a)(l)(i)(C) that a state publish an estimate of the expected increase or decrease in annual enrollment and expenditures associated with its Section 1115 waiver proposals. The intent of this section of the regulations is to allow the public to comment fully on a Section 1115 proposal, with the information in hand that is critical to understanding the full extent of a proposal's impact.

However, on pages 14-15 of this proposal, the Department reuses budget neutrality estimates from an earlier proposal that are no longer relevant and states that "MDHHS expects annual HMP enrollment to decrease but the total number of beneficiaries who will be impacted is unknown at this time." As LLS has already communicated to the Department, LLS and patient organizations across the state urge the Snyder Administration to release updated enrollment and expenditures data and to include this analysis in its application to the federal government to ensure that federal requirements have been satisfied and to enable stakeholders to assess the full impact of the Department's proposal.

Ultimately, the requirements outlined in the Department's waiver amendment do not further the goals of the Medicaid program. Instead, they needlessly compromise access to care for a very vulnerable population. Again, LLS urges the Department to reconsider its proposed amendments to its HMP demonstration waiver until such time that the issues detailed above have been addressed. LLS urges the

[25] Melinda J. Beeuwkes Buntin, John Graves, Nikki Viverette, "State Medicaid Lessons for Federal Health Reform," *Health Affairs,* June 7, 2017, https://www.healthaffairs.org/do/10.1377/hblog20170607.060481/full/

[26] Ibid.

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Department to focus on solutions that can promote adequate, affordable, and accessible HMP coverage for all Michiganders.

Thank you for your consideration of LLS's comments on this important matter. If we can address any questions or provide further information, please don't hesitate to contact me at dave.almeida@lls.org or 803-546-6379.

Regards,

J. David Almeida

J. David Almeida
Regional Director, Government Affairs - Midwest Region
The Leukemia & Lymphoma Society

National Office
3 International Drive
Suite 200
Rye Brook, NY 10573
main 914.949.5213
www.LLS.org

BEATING CANCER IS IN OUR BLOOD.

From: Prokop, Jackie (DHHS)
To: HealthyMichiganPlan
Subject: FW: Comments regarding the work requirements for Medicaid recipients
Date: Monday, August 13, 2018 10:41:36 AM

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in forwarded message:

From: [redacted]
Date: August 12, 2018 at 5:29:43 PM EDT
To: "richardsd@michigan.gov" <richardsd@michigan.gov>
Subject: Comments regarding the work requirements for Medicaid recipients
Reply-To: [redacted]

Dear Department of Health and Human Services,

If I have not sent these comments to the correct person/ address, would you please forward this email. Thank you.

Just today, I learned that I am permitted to comment on the proposed work requirements for those of us who need Medicaid. I am a Medicaid recipient. I am 58 years-old. I am bi-lingual (I speak both French and English.). I have two university degrees. I am completely debt-free, and I have a near-perfect credit score. I also have a serious health condition called Epstein-Barr that causes chronic, extreme fatigue. Nevertheless, I work as an independent contractor and I generally teach English and U.S. cultural practices to business executives, their spouses, and their children who have either moved permanently to live and work in the U.S., or the family is here on an exchange program to learn more about American business operations. I have also had occasion to teach French grammar, spelling, reading, and writing to native French children to prepare them for their return to the French school system once their exchange stay was finished. The work I do is quite sophisticated and interesting, but it is not stable. If a student cancels a lesson, I am not paid. The pay is low and all expenses for materials, travel, etc. are at my own cost.

For me, it is outrageous that Senator Shirkey and Governor Snyder, who receive health insurance and other lifetime benefits at taxpayer expense (I am a taxpayer!), assume that Medicaid recipients are automatically taking advantage of public benefits simply because we are poor. Obviously, they have not spent enough time among us to become aware of our daily realities! These politicians are wealthy. They do not need to be supported by taxpayer money. Why are they not purchasing their personal health insurance and other benefits on the private market?! The work requirements for Medicaid are just wrong, ignorant, and heartless. This policy needs to be stopped immediately.

Sincerely,

From: DuBuc, Kyle
To: HealthyMichiganPlan
Cc: Hare, Cassie
Subject: Demonstration Extension Application Amendment
Date: Sunday, August 12, 2018 2:28:41 PM
Attachments: Public Comments re Michigan Medicaid Waiver 8-12-18, FINAL.pdf

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Please see the attached comments submitted on behalf of United Way for Southeastern Michigan. Please let me know if there is any problem with this format or if you have any questions.

Thank you,

Kyle DuBuc
Director, Advocacy & Government Relations
United Way for Southeastern Michigan

United Way
United Way
for Southeastern Michigan
660 Woodward Ave., Suite 300
Detroit, MI 48226
www.UnitedWaySEM.org

August 12, 2018

MDHHS, Medical Services Administration
Bureau of Medicaid Policy and Health System Innovation
Attention: Medicaid Policy
P.O. Box 30479
Lansing, Michigan 48909-7979

Re: Demonstration Extension Application Amendment, Proposed Amendment to Michigan's Medicaid Waiver

Dear Sir or Madam,

United Way for Southeastern Michigan (hereinafter, "United Way") is dedicated to improving the health, education, and economic prosperity of all families in Southeastern Michigan which includes Wayne County, Oakland County, and Macomb County. Our organization has direct experience working with struggling and low-income families across the region. This experience gives us significant insight regarding the impact of access to health services as well as the importance of programs that assist individuals in finding sustainable employment. In light of our experience in these areas, we are very concerned about the proposed Healthy Michigan Plan §1115 Demonstration Waiver Extension Request Amendment (hereinafter, the "Waiver").

The primary objective of Medicaid, as noted by Judge James E. Boasberg in *Maurice v. Azar*, is to furnish medical assistance to a state's citizens.[1] In fact, the United States Secretary of Health and Human Services agreed that the "purpose of Medicaid is to provide medical assistance to certain specified populations as far as practicable under the conditions in those states."[2] For a section 1115 Waiver, the "statute required that the Secretary examine two criteria before doing so: First, whether the project is an 'experimental, pilot, or demonstration project'; and second, whether the project is 'likely to assist in promoting the objectives' of the Act".[3]

It is clear that this Waiver does not promote that objective. While United Way has many concerns about this waiver, we have highlighted three primary concerns below: 1) Reduction in recipients due to new work requirements, 2) Reduction in recipients due to new mandatory premiums, and 3) Reduction in recipients due to reporting requirements.

[1] Stewart v. Azar, Civil Action No. 18-152 (JEB) at 3. (D.D.C April 10, 2018), Retrieved from https://ecf.dcd.uscourts.gov/cgi-bin/show_public_doc?2018cv0152-74
[2] Stewart v. Azar, At 35
[3] Stewart v. Azar, at 23.

Reduction in Recipients Due to Work Requirements

In its analysis of Michigan's Senate Bill 897 which amended the Medicaid Expansion known as the Healthy Michigan Plan, the Michigan House Fiscal Agency estimated a decline in the range of 5-10% of recipients, citing other states forecasting declines of 5-15% of recipients.[4] This anticipated reduction is due to current Healthy Michigan recipients not meeting the new work requirements of 80 hours per month. However, the Michigan Senate Fiscal Agency noted that because implementation of such a work requirement had not yet occurred, it is impossible to determine with any degree of certainty the number of people who will no longer be eligible.[5] Assuming that 10% is a correct estimate, with 670,000 Healthy Michigan recipients this would mean that 67,000 Michigan recipients will no longer have access to Medicaid. This alone violates the requirement that a §1115 Waiver promote the objectives of Medicaid.

Reduction Due to the New Mandatory Premiums

This Waiver includes a requirement that Healthy Michigan recipients who have an income between 100% and 133% of the federal poverty level and who have received coverage under the Healthy Michigan Plan for 48 cumulative months will now have to pay a premium of 5% of their income. Neither the House Fiscal nor Senate Fiscal analyses of this new requirement could provide any insight into the impact of this requirement on Michigan families. Instead, the Senate Fiscal Analysis simply notes that those who are unable to pay this premium will be unenrolled from the Healthy Michigan Plan, leading to greater cost savings for the State. However, the objective of Medicaid is to furnish medical assistance to a state's citizens, not to reduce access or save a state money.

The Michigan Association of United Ways has released a report known as the ALICE Report, which stands for Asset Limited Income Constrained Employed.[6] The ALICE Report looks at the cost of basic necessities, including healthcare, in each county and provides a thorough analysis of the amount an individual or family must make in order to meet their basic needs. We know from this report that 40% of Michigan residents struggle to make ends meet as is.[7] Many of these residents fall above the Federal Poverty Level and will be subject to the 5% premiums. For families who are already struggling, this could mean choosing between access to healthcare services and putting food on the table. This is not a decision any family should be forced to make.

Since families receiving healthcare coverage through the Healthy Michigan Plan are low-income, many will not be able to pay the 5% premium and will lose their coverage. This provision will lead to an even greater decrease in the number of people who participate in the Healthy Michigan Plan.

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[4] Koostra, K. (2018, June 7). Healthy Michigan Plan Work Requirements and Premium Payment Requirements, *House Fiscal Agency*, p. 6.
[5] Angelotti, S. (2018, June 27). Medicaid Workforce Engagement, *Senate Fiscal Agency*, p. 7.
[6] United Ways of Michigan (2017) ALICE: Asset Limited Income Constrained Employed.
[7] United Ways of Michigan (2017) ALICE: Asset Limited Income Constrained Employed, p. 5.

Reduction in Recipients Due to Reporting Requirements

The proposed Waiver includes a requirement that recipients provide monthly verification that they meet the work requirements or an exemption. However, the Waiver does not address how an individual will be required to provide this information. Any method of monthly reporting can create an unsurmountable burden for recipients. First, if the reporting and verification must be done in person, many recipients may fail to meet the requirements do to work schedule, child care access, or lack of transportation. Second, if the reporting and verification must be done online, many recipients may not be able to comply due to lack of or inconsistent internet access. Michigan ranks 38th in the country for access to internet,[8] indicating that many families will struggle to report and may lose their healthcare coverage despite being eligible and meeting all of the requirements.

This issue was clearly demonstrated by Arkansas on July 1. Arkansas recently implemented a similar Medicaid work requirement law that requires reporting under which recipients were required to report their information online by July 1. After the individuals who were automatically exempted, there were 10,304 people who were required report online.[9] Of those people, 72% did not take any action to report.[10] One factor that is responsible for this is the lack of access to internet. Arkansas ranks 46th in the nation with regard to access to internet[11] and the Urban Institute found that up to 31% of those required to report had no access to the internet in their homes.[12] Another factor that is likely responsible for the overwhelming majority of recipients not reporting is that they had not received notice.[13] Low income households have higher rates of residential instability, making it difficult to provide them with advanced notice that reporting requirements have changed.[14]

Michigan's access to the internet is only marginally better than Arkansas's, and Michigan stands to face the same problems locating and providing notice to recipients of the changes to Healthy Michigan reporting requirements. Therefore, Michigan is also likely to see a dramatic decrease in the number of recipients accessing Healthy Michigan, not because many are ineligible, but because they do not report. Once again, this provision fails to promote the primary objective of Medicaid, furnishing medical assistance to its citizens.

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[8] Internet Access Rankings, *US News*, Retrieved from https://www.usnews.com/news/best-states/rankings/infrastructure/internet-access.
[9] Alker, J. and Maggie Clark. (2018, July 20). One Month Into Medicaid Work Requirement in Arkansas, Warning Lights are Already Flashing, *Georgetown University Health Policy Institute: Center for Children and Families*, Retrieved from https://ccf.georgetown.edu/2018/07/20/one-month-into-arkansas-medicaid-work-requirement-the-warning-lights-are-already-flashing/.
[10] Alker.
[11] Internet Access Rankings.
[12] Alker.
[13] Alker.
[14] Alker.

Conclusion

This Waiver does not serve to promote the primary objective of Medicaid. In fact, it is contrary to the purpose of Medicaid because it is likely to decrease access to medical services dramatically. Therefore, we request that this proposed Waiver not be sent to the Center for Medicare and Medicaid Services unless changes are made that will ensure that access to healthcare services is not reduced.

In addition, this Waiver fails to provide a clear understanding of how recipients will be required to report. Therefore, we urge MDHHS to revise this amendment to include a description of the reporting requirements and the steps that will be taken to ensure all recipients are able to access the reporting structure and are provided adequate notice of the reporting requirements.

If you have any questions regarding these comments or if you would like additional data and information about the negative impacts of the changes proposed in this Waiver, please contact Kyle DuBuc, Director of Advocacy & Government Relations at United Way for Southeastern Michigan at Kyle.DuBuc@liveunitedsem.org or Cassie Hare, Policy & Advocacy Specialist at Cassie.Hare@liveunitedsem.org.

Sincerely,

Darienne B. Driver, Ed.D.
President & CEO
United Way for Southeastern Michigan

From:	Deema Tarazi
To:	HealthyMichiganPlan
Cc:	Miriam Goldstein; sprocario@hfmich.org
Subject:	Demonstration Extension Application Amendment
Date:	Sunday, August 12, 2018 4:28:47 PM
Attachments:	Demonstration Extension Application Amendment Letter.pdf

Dear Whomever It May Concern:

Attached is a letter from both the Hemophilia Federation of America and Hemophilia Foundation of Michigan regarding the Michigan's Section 1115 Demonstration Extension Application.

Please let us know if you need anything additional.

Thanks,

Deema Tarazi

August 12, 2018

Nick Lyon
Director
Michigan Department of Health and Human Services (MDHHS)
333 S. Grant Avenue
Lansing, MI 48913

Re: Demonstration Extension Application Amendment

Dear Director Lyon:

Hemophilia Federation of America (HFA) and Hemophilia Foundation of Michigan (HFM) appreciate the opportunity to submit comments on Michigan's Section 1115 Demonstration Extension Application.

HFA is a national non-profit organization that represent individuals with bleeding disorders across the United States. Our mission is to ensure that individuals affected by hemophilia and other inherited bleeding disorders have timely access to quality medical care, therapies, and services, regardless of financial circumstances or place of residence. HFM is the only agency in Michigan that provides education, advocacy and supportive services for those affected by bleeding disorders, including family members and caregivers. HFM strives to improve the quality of life for all people affected by hemophilia, von Willebrand disease, other coagulation disorders and related complications, including HIV/AIDS and hepatitis.

HFA and HFM believe healthcare should affordable, accessible and adequate. HFA and HFM strongly support the Healthy Michigan Program, which has extended coverage to 680,000 low-income individuals and families in the state.[i] We do not know how many people with hemophilia are covered by the Healthy Michigan Program, but we do know that nationally, about thirty percent of the bleeding disorders population depends on Medicaid.

The purpose of the Medicaid program is to provide affordable healthcare coverage for low-income individuals and families. Unfortunately, Michigan's application does not meet this objective and will instead create new financial and administrative barriers that jeopardize access to healthcare for Michigan residents, including patients with bleeding disorders. According to one estimate by the Michigan House Fiscal Agency, up to 54,000 Michiganders will lose their coverage as a result of this proposal.[ii]

Under the waiver, individuals with incomes between 100 and 138 percent of the federal poverty level (approximately $1,372/month to $1,893/month for a family of two) would face new barriers to coverage after receiving 48 cumulative months of coverage through the Healthy Michigan program. Under the waiver proposal, these individuals would be required to pay monthly premiums equal to five percent of their income and complete or commit to an annual healthy behavior assessment, unless they can demonstrate that they qualify for an exemption. Individuals who cannot meet this requirement will lose their coverage. A premium of five percent of monthly income will range from approximately $50 to $67 for an individual, a sizable cost for this low-income population. Research has shown that even relatively low levels of cost-sharing for low-income populations limit the use of necessary healthcare services.[iii] Additionally, HFA and HFM are concerned that, instead of incentivizing healthy behaviors, conditioning coverage on completing an annual healthy behavior assessment will reduce coverage for individuals in

need of care. Ensuring that Medicaid enrollees have access to comprehensive health coverage that includes all of the treatments and services that they need to live healthy lives would likely be a more effective approach to improving health in Michigan.

Also, under this waiver, individuals between the ages of 19 and 62 would be required to either demonstrate that they work at least 80 hours per month or meet exemptions. One major consequence of this proposal will be to increase the administrative burden on all patients. Individuals will need to attest that they meet certain exemptions or have worked the required number of hours on a monthly basis. Increasing administrative requirements will likely decrease the number of individuals with Medicaid coverage, regardless of whether they are exempt or not. For example, after Washington state changed its renewal process from every twelve months to every six months and instituted new documentation requirements in 2003, approximately 35,000 fewer children were enrolled in the program by the end of 2004.[iv] Battling administrative red tape in order to keep coverage should not take away from patients' or caregivers' focus on maintaining their or their family's health.

Failing to navigate these burdensome administrative requirements could have serious – even life or death – consequences for people with serious, acute and chronic diseases, including bleeding disorders. If the state finds that individuals have failed to comply with the new requirements for three months, they will be locked out of coverage for *at least* one month. Additionally, if the state finds that individuals have misrepresented their compliance, these individuals will be locked out of coverage for one year. People with bleeding disorders rely on essential medications to manage their condition: to prevent bleeding, and to treat acute breakthrough bleeding episodes. They cannot afford to experience a gap in their care.

HFA and HFM are also concerned that the current exemption criteria may not capture all individuals with, or at risk of, serious and chronic health conditions that prevent them from meeting these requirements. While HFA and HFM are pleased that patients will have the option to demonstrate that they qualify for an exemption through self-attestation, the reporting process still creates opportunities for administrative error that could jeopardize coverage. No exemption criteria can circumvent this problem and the serious risk to the coverage and health of the people we represent.

Administering these requirements will be expensive for Michigan. The Michigan House Fiscal Agency estimates that the state's administrative costs will be approximately $20 million, in addition to one-time information technology costs of up to $10 million.[v] States such as Kentucky, Tennessee and Virginia have also estimated that setting up the administrative systems to track and verify exemptions and work activities will cost tens of millions of dollars.[vi] These costs would divert resources from Medicaid's core goal – providing health coverage to those without access to care – as well from other important initiatives in the state of Michigan.

Ultimately, the requirements outlined in this waiver do not further the goals of the Medicaid program or help low-income individuals improve their circumstances without needlessly compromising their access to care. Most people on Medicaid who can work already do so.[vii] A recent study, published in *JAMA Internal Medicine*, looked at the employment status and characteristics of Michigan's Medicaid enrollees.[viii] The study found only about a quarter were unemployed (27.6 percent). Of this 27.6 percent of enrollees, two thirds reported having a chronic physical condition and a quarter reported having a mental or physical condition that interfered with their ability to work.

HFA and HFM also wish to highlight that the federal rules at 431.408 pertaining to state public comment

process require at (a)(1)(i)(C) that a state include an estimate of the expected increase or decrease in annual enrollment and expenditures if applicable. The intent of this section of the regulations is to allow the public to comment on a Section 1115 proposal with adequate information to assess its impact. However, on pages 14-15 of this proposal, the Department reuses budget neutrality estimates from an earlier proposal that are no longer relevant and states that "MDHHS expects annual HMP enrollment to decrease but the total number of beneficiaries who will be impacted is unknown at this time." We urge the Administration to release updated enrollment and expenditures data and include this analysis in its application to the federal government to ensure the application meets federal requirements.

HFA and HFM believe everyone should have access to quality and affordable healthcare coverage. Michigan's Section 1115 Demonstration Extension Application does not advance that goal. Thank you for the opportunity to provide comments.

Sincerely,

Sarah Procario
Advocacy/Communications Manager
Hemophilia Foundation of Michigan

Miriam Goldstein
Associate Director, Policy
Hemophilia Federation of America

[i] Michigan Department of Health and Human Services, Healthy Michigan Plan Enrollment Statistics, July 31, 2018. Available at https://www.michigan.gov/mdhhs/0,5885,7-339-71547_2943_66797---,00.html.

[ii] Michigan House Fiscal Agency, Legislative Analysis of Healthy Michigan Plan Work Requirements and Premium Payment Requirements, June 6, 2018. Available at: http://www.legislature.mi.gov/documents/2017-2018/billanalysis/House/pdf/2017-HLA-0897-5CEEF80A.pdf.

[iii] Samantha Artiga, Petry Ubri, and Julia Zur, "The Effects of Premiums and Cost Sharing on Low-Income Populations: Updated Review of Research Findings," Kaiser Family Foundation, June 2017, https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/.

[iv] Tricia Brooks, "Data Reporting to Assess Enrollment and Retention in Medicaid and SCHIP," Georgetown University Health Policy Institute Center for Children and Families, January 2009.

[v] Michigan House Fiscal Agency, Legislative Analysis of Healthy Michigan Plan Work Requirements and Premium Payment Requirements, June 6, 2018. Available at: http://www.legislature.mi.gov/documents/2017-2018/billanalysis/House/pdf/2017-HLA-0897-5CEEF80A.pdf.

[vi] Misty Williams, "Medicaid Changes Require Tens of Millions in Upfront Costs," Roll Call, February 26, 2018, https://www.rollcall.com/news/politics/medicaid-kentucky.

[vii] Rachel Garfield, Robin Rudowitz, and Anthony Damico, "Understanding the Intersection of Medicaid and Work," Kaiser Family Foundation, February 2017, http://kff.org/medicaid/issue-brief/understanding-the-intersection-of-medicaid-and-work/.

[viii] Renuka Tipirneni, Susan D. Goold, John Z. Ayanian. Employment Status and Health Characteristics of Adults With Expanded Medicaid Coverage in Michigan. *JAMA Intern Med.* Published online December 11, 2017. doi:10.1001/jamainternmed.2017.7055

From: Amanda West
To: HealthyMichiganPlan
Subject: PPAM Comments on Healthy Michigan Plan
Date: Sunday, August 12, 2018 5:31:47 PM
Attachments: PPAM Healthy MI Plan Comments_08.12.18.pdf

Please find attached our comments on the Healthy Michigan Plan Section 1115 Demonstration Waiver Extension Request Amendment.

Amanda West (*she/her/hers*)
Director of Government Relations
Planned Parenthood Advocates of Michigan | Planned Parenthood of Michigan
115 W. Allegan, Suite 500 | Lansing, MI 48933
Ph: (517) 482-1080 Ext. 3 | Cell: (517) 214-7529

You can support our work at www.miplannedparenthood.org

August 12, 2018

VIA ELECTRONIC SUBMISSION - healthymichiganplan@michigan.gov

Kathy Stiffler
Acting Deputy Director
Medical Services Administration
Bureau of Medicaid Policy & Health System Innovation
Attention: Medicaid Policy
P.O. Box 30479
Lansing, MI 48909

Re: Comments on the Healthy Michigan Plan Section 1115 Demonstration Waiver Extension Request Amendment

Dear Ms. Stiffler:

Planned Parenthood Advocates of Michigan ("Planned Parenthood") submits these comments regarding the Michigan Department of Health and Human Services ("the State" or "the Department") Healthy Michigan Plan Section 1115 Demonstration Waiver Extension Request Amendment.

Planned Parenthood Advocates of Michigan is the state's leading women's health advocacy organization. We are committed to ensuring that women, young people, and men across the state of Michigan are able to access affordable, quality reproductive health care services, and as such, believe that expansion of Medicaid coverage under the Affordable Care Act (ACA) has been critical for making great strides toward improving health equity and health care access. In fact, we are proud that the Healthy Michigan Plan has provided coverage to over 670,000 low-income Michigan residents.

We support Michigan's commitment to expand Medicaid under the Affordable Care Act (ACA) in order to provide needed health care coverage to more women and families. Medicaid is a vital part of the health care system and plays a major role in ensuring access to essential primary and preventive care services for women, men, and young people. With greater access to coverage, women across the state have been able to obtain women's health services that are critical to their health and well-being, including birth control, life-saving cancer screenings, and testing and treatment for sexually transmitted infections.

However, we are concerned that Michigan's latest proposal to condition Medicaid coverage on mandatory participation in work or work-like activities will undermine health care access for individuals with low incomes in Michigan, including many of the patients that we serve. While the State claims that the goals of this Section 1115 demonstration waiver are to promote economic stability and improve health outcomes, we fear the result will be the exact opposite and people's health will suffer. Unfortunately, women of color will be harmed the most by efforts to roll back Medicaid coverage since, due to the intersections of race, poverty, and gender in our country, women of color are most likely to be low-income and have Medicaid coverage.

We urge the State to reconsider its proposal as such requirements are inconsistent with and contrary to the requirements of Section 1115 waivers. Finally, we want to remind Michigan to

ensure that the Medicaid program in our state reflects women's unique health needs and enables women to access the health care services they need without barrier or delay.

1. ***The State of Michigan Should Rescind its Proposal that Requires Employment or Other Work-Like Activities as a Condition to Medicaid Coverage.***

Planned Parenthood is aware that CMS has already issued guidance supporting Medicaid enrollment restrictions, including conditioning Medicaid coverage on compliance with work activities.[1] However, Michigan seeking to move such proposal is not only misguided and dangerous, but will threaten access to critical health coverage for many women and families with low incomes. For over 50 years, Medicaid has provided benefits for all eligible individuals—with eligibility being determined by income and/or special characteristic (e.g., pregnancy, being a child under 19, or having a disability). Under Michigan's proposed waiver, the state would be allowed to narrow eligibility and limit enrollment for adults under the age of 50 based on a person's participation in state-approved work activities, with limited exceptions. This proposal clearly contravenes the objectives of Medicaid and does not serve a legitimate experimental purpose.

First, in order to be approved pursuant to Section 1115 of the Social Security Act, Michigan's application must:

- propose an "experiment[], pilot or demonstration";
- waive compliance only with requirements in 42 U.S.C. § 1396a;
- be likely to promote the objectives of the Medicaid Act; and
- be approved only "to the extent and for the period necessary" to carry out the experiment.[2]

The purpose of Medicaid is to enable states to furnish medical assistance to individuals with low incomes who are unable to meet the costs of medical care and to furnish such assistance and services to help these individuals attain or retain the capacity for independence and self-care.[3] Conditioning Medicaid eligibility on participation in work activities would block access to care and services that help individuals attain and retain independence or self-care and, as a result, be able to work. [4] Research confirms that Medicaid coverage helps individuals to obtain and maintain employment. In a recent study of Ohio's Medicaid program, 74.8 percent of unemployed Medicaid expansion enrollees reported Medicaid made it easier to secure and maintain employment.[5] As an example, Medicaid coverage helped an Ohio woman who was suffering from a severe hernia and was previously unable to get out of bed to receive the surgery she needed to improve her health and go back to work.[6] Medicaid enrollees also report less financial stress and depression, and greater financial security than individuals who are uninsured.[7]

Second, imposing Medicaid work requirements is a policy proposal to address a non-existent problem, as the vast majority of people with Medicaid coverage work or have a reason for not working. According to the Kaiser Family Foundation, a majority of non-elderly adults with Medicaid coverage (more than 6 in 10) are already working. Among adults with Medicaid coverage who did not work, it was likely because they were: going to school (15%); taking care of their home or family (14%); retired (2%); unable to find full-time work (10%) or facing slack business conditions (11%); or dealing with illness (35%) or disability (31%).[9] Further, almost two-thirds (62%) of those who could lose Medicaid coverage due to work requirements are women.[10] Women will be disproportionately harmed by the state's proposal, as they are more likely to provide informal and undervalued caregiving to family members—including spouses and parents—work that typically would not fulfill the work requirement.[11] Creating burdensome

administrative hurdles and red tape to getting Medicaid coverage will inevitably result in eligible people losing needed coverage, causing the health of Michiganders across the state to suffer.

Experience has shown that imposing work requirements as a condition of receipt of public benefits is particularly harmful for women and families and does nothing to help people secure employment. For example, work requirements were a key feature of the 1996 Temporary Assistance for Needy Families (TANF) legislation. Rigorous review of data over the last several decades found that TANF employment mandates did not boost the job prospects of low-income women;[12] rather, they led to women losing TANF benefits and more children living in poverty.[13] Further, mandatory work requirements could also have harmful spillover effects for children whose parents or caretakers lose coverage. Research shows that expanding coverage to parents and caretakers is associated with increased receipt of recommended pediatric preventive care for their children.[14] That study noted an "independent relationship between parental Medicaid enrollment and children's primary care use in low-income families" and cautions that "our results reveal the potential for reductions in adult Medicaid coverage to have unintended spillover effects on children's health care use."[15]

Rather than imposing these harmful requirements on Medicaid enrollees, the state of Michigan should instead focus on voluntary, evidence-based anti-poverty efforts that will provide legitimate and equitable opportunities for women and families, such as family planning access, educational assistance, job training, and affordable child care.[16] We urge the State of Michigan to rescind its proposal to impose work requirements as it will have the impact of making people lose needed health coverage, thus threatening their economic circumstances.

***

Thank you for the opportunity to comment on the proposed waiver. If you have any questions, please do not hesitate to contact me at (734)926-4815.

Respectfully submitted,

Lori Carpentier
President & CEO
Planned Parenthood Advocates of Michigan

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[1] SMD 18-002, "Opportunities to Promote Work and Community Engagement Among Medicaid Beneficiaries," (Jan. 11, 2018). https://www.medicaid.gov/federal-policy-guidance/downloads/smd18002.pdf.

[2] 42 U.S.C. § 1315(a).

[3] 42 U.S.C. § 1396a-1.

[4] By contrast, as far back as the 1970s, states obtained § 1115 waivers to test work requirements in the AFDC program (which, unlike Medicaid, does have work promotion as a purpose of the program). These waivers required states to conduct "rigorous evaluations of the impact," typically requiring the random assignment of one group to a program operating under traditional rules and another to a program using

the more restrictive waiver rules. United States Dep't of Health & Human Servs., *State Welfare Waivers: An Overview*, http://aspe.hhs.gov.hsp/isp/waiver2/waivers.htm.

[5] The Ohio Department of Medicaid. Ohio Medicaid Group VIII Assessment. http://medicaid.ohio.gov/Portals/0/Resources/Reports/Annual/Group-VIII-Assessment.pdf.

[6] The Ohio Department of Medicaid. Ohio Medicaid Group VIII Assessment. http://medicaid.ohio.gov/Portals/0/Resources/Reports/Annual/Group-VIII-Assessment.pdf.

[7] The Commonwealth Fund. *Does Medicaid Make a Difference?* http://www.commonwealthfund.org/publications/issue-briefs/2015/jun/does-medicaid-make-a-difference.

[8] Leighton Ku & Erin Brantley, *Medicaid Work Requirements: Who's At Risk?*, Health Affairs Blog (April 12, 2017). https://www.healthaffairs.org/do/10.1377/hblog20170412.059575/full/.

[9] Rachel Garfield et. al., *Implications of Work Requirements in Medicaid: What Does the Data Say?,* Kaiser Family Foundation (June 2018), https://www.kff.org/medicaid/issue-brief/implications-of-work-requirements-in-medicaid-what-does-the-data-say/.

[10] Rachel Garfield, *Understanding the Intersection of Medicaid and Work,* Kaiser Family Foundation (2017), http://files.kff.org/attachment/Issue-Brief-Understanding-the-Intersection-of-Medicaid-and-Work.

[11] *Id.*

[12] Elizabeth Lower-Basch. *Adding Stumbling Blocks in the Path to Health Care*, CLASP (March 2017). http://www.clasp.org/resources-and-publications/publication-1/Adding-Stumbling-Blocks-in-the-Path-to-Health-Care.pdf.

[13] Ladonna Pavetti, *Work Requirements Don't Cut Poverty, Evidence Shows*, Center on Budget and Policy Priorities (June 2016), https://www.cbpp.org/research/poverty-and-inequality/work-requirements-dont-cut-poverty-evidence-shows.

[14] Maya Venkataramani, Craig Evan Pollack, Eric T. Roberts, *Spillover Effects of Adult Medicaid Expansions on Children's Use of Preventive Services*, 140 Pediatrics 1 (Dec. 2017), http://pediatrics.aappublications.org/content/140/6/e20170953.

[15] *Id.*

[16] Studies show that voluntary employment programs increase employment and income among low-income individuals. Howard Bloom et al., MDRC, *Promoting Work in Public Housing: The Effectiveness of Jobs-Plus* (2005), https://www.doleta.gov/research/pdf/jobs_plus_3.pdf; James A. Riccio, MDRC, *Sustained Earnings Gains for Residents in a Public Housing Jobs Program: Seven-Year Findings from the Jobs-Plus Demonstration* (2010), http://files.eric.ed.gov/fulltext/ED514703.pdf.

From:	Zachary Fichtenbaum
To:	HealthyMichiganPlan
Cc:	Carol A. Bailey (carol.bailey@tenethealth.com); David Katz (dkatz@dmc.org); Tom A. Smith (tom.smith@tenethealth.com); Timothy [Tim] J. Miner (tim.miner@tenethealth.com); Catherine Kirkland; Jim Frizzera
Subject:	DMC Comments to 1115 Waiver Extension Amendment
Date:	Sunday, August 12, 2018 5:43:30 PM
Attachments:	DMC Comments re. Proposed 1115 Waiver Amendment - August 2018 (00170264xBD172).pdf

On behalf of Detroit Medical Center, please find attached comments to Michigan's proposed 1115 Waiver Extension Amendment.

Thank you,

Zach Fichtenbaum, Attorney
GJERSET & LORENZ, LLP
Phone: (512) 899-3995
Fax: (512) 899-3939
www.gl-law.com

August 12, 2018

Ms. Jackie Prokop
Michigan Department of Health and Human Services
Medical Services Administration
Bureau of Medicaid Policy and Health System Innovation
Attention: Medicaid Policy
P.O. Box 30479
Lansing, Michigan 48909-7979
Via email: healthymichiganplan@michigan.gov

RE: Michigan's proposed Section 1115 Waiver Extension

Dear Ms. Prokop,

As one of Michigan's largest Medicaid providers, the Detroit Medical Center ("DMC") is invested in improving access to quality health care in Michigan and appreciates the opportunity to comment on Michigan's proposed Section 1115 Waiver Extension published on July 9, 2018 (the "Waiver Extension"). DMC understands that the legislature required work requirements be included in the Waiver Extension as imposed by Senate Bill 897, now known as Public Act 208.

Our questions and comments fall within three categories: 1) implications of the D.C. federal district court's decision regarding Kentucky's Section 1115 Waiver work requirements; 2) implementation and administration of the new requirements; and 3) the Department's interpretation of the Healthy Michigan Plan ("HMP") termination clause contained within Public Act 208.

How does the Department plan to address the recent Federal Court decision regarding Kentucky's Medicaid work requirements?

On June 22, 2018, the Governor signed into law Senate Bill 897, which required the Department to include work requirements and other "healthy behavior" criteria for Medicaid expansion enrollees in the Waiver Extension.

Seven days later, on June 29, 2018, a D.C. federal district court invalidated nearly identical work requirements in Kentucky's 1115 Waiver.[1] The Court held that HHS acted arbitrarily or capriciously in concluding that the new requirements would achieve the Medicaid Act's objectives of 1) furnishing medical assistance, and 2) providing services to help individual attain or retain independence. Specifically, the Court determined that HHS never "adequately" analyzed the loss of coverage that would occur because of the requirements and never considered whether the new requirements would help promote healthcare coverage. For example, the Court stated that HHS "never provided a bottom-line estimate for how many people would lose Medicaid" coverage.

[1] *Stewart v. Azar*, CV No. 18-152 (JEB), 2018 WL 3203384 (D.D.C. June 29, 2018).

In light of this opinion, DMC has the following questions:

- Does the Department plan to work with the Legislature to revise the Waiver Extension in accordance with the federal court opinion, or, does the Department intend to pursue the Waiver Extension as-is?
- What is the Department's position on how the new requirements contained within the Waiver Extension promote the objectives of the Medicaid Act?
- Has the Department quantified (a "bottom-line estimate") how many people will lose Medicaid coverage under the new requirements?

How does the Department plan to address the loss of Medicaid coverage?

As mentioned above, it is unknown how many people will lose Medicaid coverage as a result of the new requirements.

- What is the Department's plan to address the loss in Medicaid coverage and the corresponding increase in uninsured patients?
- As uninsured patients increase, hospitals will experience an increase in uninsured costs. How does the Department intend to address increased uninsured costs for hospitals?
- Has the Department modeled the long-term impact of the new requirements on loss of Medicaid coverage and provider payments?

How does the Department intend to design, implement, and administer the new requirements?

The Waiver Extension imposes reporting requirements upon beneficiaries to demonstrate either compliance with the new conditions of eligibility, or qualification for one of the exemptions. DMC is concerned about the vulnerability of compliant or exempted individuals who face disenrollment merely as a result of not meeting the documentation requirements.

- How does the Department plan to communicate the changes in eligibility requirements to beneficiaries?
- What are the Department's plans to implement the reporting and documentation requirements?
- How will the Department administer the coverage suspension appeals process, referenced during the Department's public hearing on August 1, 2018, to prevent coverage lapses for Healthy Michigan beneficiaries solely due to documentation and reporting issues?

DMC requests the Department's interpretation of the HMP termination clause contained within Public Act 208.

Public Act 208 includes a clause that terminates the Health Michigan Program if any of the following events occur: a) CMS does not approve the Waiver Extension within 12 months of the Department's submission; b) CMS denies the Waiver Extension, and fails to approve a new or replacement Waiver Extension within 12 months; c) CMS cancels the Waiver Extension, and fails to approve a new or replacement Waiver Extension within 12 months;

d) the Waiver Extension is otherwise invalidated, and CMS fails to approve a new or replacement Waiver Extension within 12 months; or e) CMS approves the Waiver Extension, but the Waiver Extension fails to comply with the requirements of the applicable statutory section.

- Which requirements does the HMP termination clause cover?
- What is the Department's interpretation of the HMP termination clause in light of the Kentucky federal court opinion?
- It is DMC's understanding that if the requirements are invalidated, the Department will still have 12 months for CMS to approve a new Waiver Extension. Is this the Department's understanding?

Conclusion

If approved, the proposed Waiver Extension will have a considerable impact on Michigan's Medicaid population. DMC respectfully requests the Department's response on the above questions and comments and also urges the Department to work with CMS to arrive at a Waiver Extension that upholds the goals of the Medicaid Act. DMC appreciates this opportunity to ask questions and submit comments. Thank you for your consideration.

Sincerely,

Carol Bailey
Vice President of Operations/Reimbursement
Tenet Healthcare Corporation

From: Laura Appel
To: HealthyMichiganPlan
Subject: Comment on MDHHS Healthy Michigan Plan 1115 Demonstration Extension Application Amendment
Date: Sunday, August 12, 2018 9:23:37 PM
Attachments: 18 aug work requirement comment letter.pdf

MHA Michigan Health & Hospital Association | Leading Healthcare

August 12, 2018

Michigan Department of Health and Human Services
Program Policy Division
Bureau of Medicaid and Health System Innovation
Attention: Medicaid Policy

Thank you for the opportunity to comment on the Michigan Department of Health and Human Services (MDHHS) Healthy Michigan Plan §1115 Demonstration Extension Application Amendment.

The Michigan Health & Hospital Association (MHA) represents all acute care hospitals in Michigan, as well as their parent health systems. The MHA opposed the legislation to adopt a work requirement for certain people who qualify for the Healthy Michigan Plan throughout the legislative debate on this matter. On behalf of its members, the MHA remains concerned that the work requirement will not increase self-sufficiency, but will lead to the loss of coverage for people who need care, and potentially disrupt the economic progress of people who are gaining ground on poverty.

The Kaiser Family Foundation conservatively estimated for the Kentucky Medicaid work requirement plan that 5 to 15 percent of those eligible, and in compliance with their work requirement, would lose coverage. This is due to the burden of online or paper reporting being incomplete or not done at all. A smaller but significant number of people would lose coverage because they fail to claim the exemptions to which they are entitled.

Having a healthcare benefit may actually be a key to increasing self-sufficiency and financial independence. As Kaiser Family Foundation researchers concluded from a comprehensive review of the available evidence, “access to affordable health insurance has a positive effect on people’s ability to obtain and maintain employment,” while lack of access to needed care, especially mental healthcare and substance use treatment, impedes employment.[i]

Despite the lack of evidence for work requirements improving economic security and the risk of causing loss of coverage for people who are ill or will become ill during this demonstration, the MHA recognizes that PA 208 of 2018 requires MDHHS to implement the Healthy Michigan Plan (HMP) work requirement. The MHA offers the following comments specific to the MDHHS waiver amendment.

1. Under Section V, Program Financing, MDHHS states it “expects the annual HMP enrollment to decrease, but the total number of beneficiaries who will be impacted is unknown at this time.”

   Estimates are made on the potential coverage loss in other states imposing work requirements. Kentucky’s work requirement, which is the subject of a federal lawsuit,

Brian Peters, *Chief Executive Officer*
2112 University Park Drive | Okemos, MI 48864 | (517) 323-3443 | www.mha.org

MHA Michigan Health & Hospital Association | Leading Healthcare

puts coverage for 95,000 people at risk. The arbitrary nature of this risk, and the failure of the state of Kentucky to demonstrate why this coverage loss advances the goals of the Medicaid program are the subject of the debate in the federal court. MDHHS should put forth a good-faith estimate of how many people are likely to lose coverage under this policy, and explain how this coverage loss will not undermine the improvements the HMP is currently demonstrating for the state of Michigan.

2. Under Section VI, Evaluation Report, the list of domains should be expanded to include:
    a. The number of people who lose coverage due to their failure or inability to directly comply with the work, training, or volunteer requirements of PA 208 of 2018.
    b. The number of people who are working or are otherwise in compliance, but lose coverage due to their failure or inability to demonstrate they are working.
    c. The impact of coverage loss on people who were eligible and who have acute illness (cancer, organ failure) and/or chronic illness (diabetes, heart disease).
3. Under Attachment L, Medically Frail Identification Process, the MDHHS should amend this part to include a plan to notify all existing HMP-eligible people of their opportunity to seek an exemption for medical frailty, and include in that notice a more complete description of what qualifies as medically frail. This same notice should be delivered to all primary care clinicians identified by these patients. This can be accomplished using the claims history available through the Medicaid managed care plans.

Again, the MHA appreciates both the opportunity to provide this comment and to continue its working relationship with the leadership and staff at the MDHHS to maximize the effectiveness and value of the HMP. As you are aware, MHA member hospitals were required to take substantial Medicare reductions to help provide funding for coverage expansion. Between 2010, four years before HMP expansion began, and 2019, these payment reductions total $7 billion for Michigan hospitals. In exchange, Michigan hospitals were in support of expanding Medicaid and providing coverage through the private coverage insurance exchange system. Michigan hospitals will continue to sustain these Medicare reductions. The HMP must continue to sustain its promise of coverage for those in Michigan who are at, below and barely above the federal poverty line.

If you have any questions or care to discuss this letter, please contact me at your convenience at 517-703-8606 or lappel@mha.org.

Sincerely,

Laura Appel
SVP and Chief Innovation Officer

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[i] https://www.kff.org/medicaid/issue-brief/the-relationship-between-work-and-health-findings-from-a-literature-review/

From: Donna Lasinski
To: HealthyMichiganPlan
Subject: Attention: Medicaid Policy
Date: Sunday, August 12, 2018 9:34:39 PM
Attachments: MedicaidWorkRules_Letter_Lasinski.docx

Dear MDHHS,

Thank you for the opportunity to comment on the Healthy Michigan Plan §1115 Demonstration Waiver Extension Request Amendment.

Please find my comments attached in the letter below.

Best,
Donna

DONNA LASINSKI
State Representative
52nd District

dlasinski@house.mi.gov
O 517.373.0828

52ND DISTRICT
STATE CAPITOL
P.O. BOX 30014
LANSING, MI 48909-7514
PHONE: (517) 373-0828
FAX: (517) 373-5783
E-MAIL: donnalasinski@house.mi.gov

MICHIGAN HOUSE OF REPRESENTATIVES
DONNA LASINSKI
STATE REPRESENTATIVE

COMMITTEES:
ENERGY POLICY,
MINORITY VICE CHAIR
COMMUNICATIONS
AND TECHNOLOGY
INSURANCE

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

Dear Director Lyon,

On behalf of my constituents in the 52nd House District, I am submitting my opposition to the Department's proposed waiver request for the extension of its Healthy Michigan Section 1115 Medicaid Demonstration to be published on the state's website as part of the public record. Known as Medicaid work rules, the House Fiscal Agency estimates that 54,000 Michiganders may lose coverage under this proposal, including many in the 52nd House District.

When Senate Bill 897, from which this waiver proposal takes several provisions, was first introduced I viewed it as a solution looking for a problem. The bill was not about work requirements; it was about restricting access to Medicaid benefits for a small percentage of Michiganders who are struggling to make ends meet. The proposal is both costly and impractical. The administrative costs associated with operating the proposed program have been estimated to be in the tens of millions of dollars with negligible offset savings. I do not support bloated bureaucracy and increased costs at the expense of the health of Michigan families.

In Kentucky, state officials came dangerously close to taking coverage away from 95,000 citizens. The role of the Department of Health and Human Services is to ensure the health and well-being of state residents. Adding work requirements that will ultimately result in thousands of working, low-income Michiganders losing health coverage, without dedicating any new funding to job assistance programs or skills training is in direct opposition to the mission and purpose of the DHHS.

In addition, this proposal will cause premiums to skyrocket for low-income individuals while likely causing even those who qualify under the new work rules to lose coverage due to paperwork and added bureaucratic red tape. We have seen many beneficiaries lose coverage in Arkansas simply for not filling out the necessary forms within the first month of the program. I do not believe that the state should trade the health and well-being of Michigan families for costly and unnecessary burdens to its assistance programs.

Thank you for your consideration. It is my sincere hope that the Department of Health and Human Services will join me in prioritizing the health and wellness of Michigan residents by pursuing policies that help Michiganders *overcome* obstacles to health care coverage. Once

again, I ask that these comments be published on the state's waiver website as a part of the public record.

Sincerely,

Donna Lasinski
State Representative
52nd District

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Saturday, August 11, 2018 4:11:15 PM

On behalf of a Michigan resident...

" Access to health preventative healthcare keeps healthcare costs low for everyone. Negative reinforcement by restricting access to preventative healthcare does not encourage people to get jobs, it makes it more difficult to obtain to employment. If the goal is to increase employment, providing supports for employment will actually benefit individuals. Removing access to healthcare increases the strain on emergency services and makes it more difficult for individuals to access employment. Increasing access to healthcare benefits everyone."

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Saturday, August 11, 2018 4:12:04 PM

On behalf of a Michigan resident...

" The proposed changes to add work restrictions to Medicaid benefits perverts the original mandate of Title XIX of the Social Security Amendments Act of 1965. This Act's objective is to provide aid to people without adequate income or resources to meet the costs of necessary medical services. By threatening recipients with cancellation of benefits if they do not work for three months in a calendar year, these new Republican-backed rules will put more at-risk people at the mercy of the market place. Increasing co-pays by 150% amounts to a tax hike that will place undue financial burdens on communities that will struggle to meet the needs of their people, inevitably resulting in rising local taxes and the exhaustion of local charitable initiatives. Finally, it seems to me that this change in rules is one more political move to get rid of the Healthy Michigan program: the citation that these new rules are a "hand up, not a hand out," reinforces a patronizing attitude that people don't really need welfare. Instead, we should uphold this cost-effective program as a robust government service that provides a safety net to those in need."

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Saturday, August 11, 2018 4:12:50 PM

On behalf of a Michigan resident...

" These changes will increase the death-rate and all of those things in society that are effected when people are sicker and in pain (untreated). Lost hours from work; not being able to work. Homelessness. More crime. Hopelessness will prevail and when people are down and out and in pain, they will do things to just survive. We're better than that as human beings."

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Saturday, August 11, 2018 4:13:43 PM

On behalf of a Michigan resident...

" The process to acquire exemption from work requirements are like to be as challenging as the Medicaid application and redetermination processes which are too difficult for eligible individuals. This will result in the loss of critical behavioral and physical health care coverage."

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Saturday, August 11, 2018 4:14:26 PM

On behalf of a Michigan resident...

" If people face work requirements when they aren't able to work, they will probably just go uninsured. This will result in an increase in sickness and deaths, and put an added burden on our economy and especially hospital emergency rooms. Treating the uninsured will once again pass more healthcare cost to those that have health insurance, which may lead those people to not be able to afford their own health insurance plans."

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Saturday, August 11, 2018 4:15:24 PM

On behalf of a Michigan resident...

My name is [redacted] and I am a retired Social Worker with over 30 years of experience working to help families move out of poverty. Today I will share the story of [redacted] a 60 year old woman living in Flint. I met [redacted] in 2016 as I served as a volunteer going door to door offering families bottled water, water filters, and education on preventing/mitigating the effects of lead exposure.

[redacted] had been serving as an unofficial block captain as many of her neighbors are older than her and have limited mobility. [redacted] began volunteering well beyond her block to help other families affected by the water crisis.

[redacted] is a survivor of childhood abuse. She is also a breast cancer survivor. Yet [redacted] is resourceful, industrious and constantly seeking opportunities to improve her own life and the life of her community. [redacted] is a felon who after serving prison time out of state where she received proper treatment, completely turned her life around. [redacted] then returned to Flint to obtain guardianship of her granddaughter to avoid her entry into the foster care system. Additionally in attempt to break the cycle of poverty, [redacted] volunteers at her granddaughter's school and has sought out tutoring and other affordable enrichment opportunities.

Since [redacted] has returned to Flint she has worked hard to be financially independent. She had no transportation and relied on public transportation and her bicycle. After applying for jobs with out success [redacted] sought out a job training program. She was a star pupil and was asked to give the graduation speech to her peers. Although the program increased [redacted] skills and confidence, finding a job as a felon is not easy. It took several months and a willingness to make arrangements for her granddaughter, so that [redacted] could leave home at 5 a.m. to arrive at work. [redacted] works regularly at her part time job where she is offered 2-3 shifts a week, well short of the 29 hours required to receive Medicaid in SB 0897. She has been in chronic pain for several months and has been waiting for 2 months to see a specialist. Yet she maintains her job.

I do not know if [redacted] is aware of the proposed Medicaid changes. I have not discussed this with her because I am concerned about adding stress to her life as making ends meet currently is a daily struggle. I am hopeful that our legislators will understand that placing such requirements on healthcare does not help move families beyond poverty. In fact it is harmful not only to adults but to children if their parents cannot receive healthcare.

[redacted] story is one of many such families in Michigan. I hope you will really take time to consider the impact of this change.

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Saturday, August 11, 2018 4:16:53 PM

On behalf of a Michigan resident...

" I would be unable to pay premiums and lose coverage."

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Saturday, August 11, 2018 4:17:37 PM

On behalf of a Michigan resident...

" It’ll probably kill my sister and sister in law. Possibly me. It’ll definitely kill many people."

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Saturday, August 11, 2018 4:18:21 PM

On behalf of a Michigan resident...

" The work requirements would make me lose my health care coverage. It would be a death sentence."

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration extension application amendment
Date: Saturday, August 11, 2018 4:19:36 PM

I am opposed to making those “able bodied” persons work or do community service or any other activity to receive Medicaid services.
Many people who are unemployed are such because of chronic diseases and/or mental illness. These people need Medicaid.
The other issue is why they are unemployed. A lack of transportation perhaps or any other many reasons.
To reiterate I oppose the actions to make Medicaid unavailable to those who need it.
[redacted]

Sent from my iPhone

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Saturday, August 11, 2018 4:19:42 PM

On behalf of a Michigan resident...

" I think there would be increased frustration and anger from residents who use and need Medicaid by adding these restrictions. I don’t want negativity and anger to increase in those folks in my community because they feel they are even more out upon. I want to be part of a community which helps build supports and bridges to help folks like that."

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Saturday, August 11, 2018 4:20:25 PM

On behalf of a Michigan resident...

" I work with the homeless community. Most people do not have transportation. If you want them to volunteer somewhere where do they keep their belongings? If they had the ability to work they would. Many of these people have mental illnesses and no social support. If they don't have their medication they will end up in jail."

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Saturday, August 11, 2018 4:21:15 PM

On behalf of a Michigan resident...

" It will affect those individuals greatly. We will have to pay at the end for others who cannot not afford to."

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Saturday, August 11, 2018 4:21:48 PM

On behalf of a Michigan resident...

" If you are disabled or have pre-existing conditions and you are forced to work for a program that is meant to help with the burden of these conditions it doesn’t make any sense."

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Saturday, August 11, 2018 4:22:32 PM

On behalf of a Michigan resident...

" The changes would affect all communities tremendously, because what good does it do anyone to have sick people amongst healthy people in any environment?"

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Saturday, August 11, 2018 4:23:12 PM

On behalf of a Michigan resident...

" Recipients would have to choose between child care, transportation costs and medical coverage when unable to afford all three at once."

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Saturday, August 11, 2018 4:24:15 PM

On behalf of a Michigan resident...

"You can’t believe that everyone that needs help is abusing the system. To take away benefits would make costs rise for every worker without the benefit of a family getting any help needed."

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Saturday, August 11, 2018 4:30:31 PM

On behalf of a Michigan resident...

" My daughter has pre-existing life long conditions. She will never be able to get private insurance let alone hold a job that will afford her to do so."

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Saturday, August 11, 2018 4:31:29 PM

On behalf of a Michigan resident...

" Medicaid has helped me at times when I have been unemployed and I feel no one should have to go without insurance. Make the wealthy that benefits and steal from the poor pay more in taxes to help offset insurance issues."

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Saturday, August 11, 2018 4:32:46 PM

On behalf of a Michigan resident...

" My son has Spectrum Autism. Having Medicaid has allow him to have resources that I couldn’t ever pay for. Please continue to keep service the way they are."

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Saturday, August 11, 2018 4:33:45 PM

On behalf of a Michigan resident...

" I have been able to get needed vaccines for myself and my child without paying the hefty price tag. I have been able to see a doctor as well. I pay a very small copay and don't mind one bit."

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Saturday, August 11, 2018 4:34:40 PM

On behalf of a Michigan resident...

" If I didn't have Medicaid coverage, I wouldn't be able to get the help I need for my chronic illness."

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Saturday, August 11, 2018 4:35:32 PM

On behalf of a Michigan resident...

" My family has not directly benefited from Medicaid coverage, but many in our northern Michigan area have. The proposed changes will by more punitive than helpful, and as far as I can tell would create a management and bureaucratic nightmare. The work requirement is in every respect a bad idea that, more than anything, expresses a disturbing hostility to those who most need the state program as it now stands. Will the state provide jobs for those affected? How about job training? Have the members of the legislature who supported this measure considered the effects on any current recipient who might be disqualified? On the medical resources? Please withdraw the measure; doing so will be both humane and practical."

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Saturday, August 11, 2018 4:36:15 PM

On behalf of a Michigan resident...

" My son has Schizophrenia and must have his medications in order to be sane. Medicaid has made this possible."

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Saturday, August 11, 2018 4:39:14 PM

On behalf of a Michigan resident...

" My son is DMDD, ADHD, and socially impaired. The medication alone would be over 4,000 a month. There is absolutely no way I could provide these medications with out medicaid assistance"

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Saturday, August 11, 2018 4:40:01 PM

On behalf of a Michigan resident...

" One major benefit is being able to afford my child’s epilepsy medication (before insurance and medicaid cost of 7,000 for one month supply last month)."

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Saturday, August 11, 2018 4:40:40 PM

On behalf of a Michigan resident...

" A healthy population is more productive. Preventative medicine is less expensive than emergency care or care postponed until crisis."

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Saturday, August 11, 2018 4:41:24 PM

On behalf of a Michigan resident...

" My 25 year old daughter has mild intellectual and physical disabilities due to epilepsy. She has been employed part time at a fast food restaurant for the past year, but that was only after having tried to find employment since high school. Without Medicaid, I don't know how she will ever have any medical insurance."

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Saturday, August 11, 2018 4:42:18 PM

On behalf of a Michigan resident...

" If it wasn’t for Medicaid, my children wouldn’t have insurance. I have a severely disabled child and she’d be screwed without Medicaid. We depend on it.'

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Saturday, August 11, 2018 4:43:09 PM

On behalf of a Michigan resident...

" Medical services have managed issues that stabilized their life leading to employment."

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Saturday, August 11, 2018 4:43:59 PM

On behalf of a Michigan resident...

" Medicaid is the result of a recognition that, in a country where healthcare is prohibitively expensive, there should at least be a minimum level of public assurance that those facing extreme financial distress can still have some kind of healthcare coverage."

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Saturday, August 11, 2018 4:45:25 PM

On behalf of a Michigan resident...

" A healthy person can be a productive person."

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Saturday, August 11, 2018 4:53:42 PM

On behalf of a Michigan resident...

" If you are disabled or have pre-existing conditions and you are forced to work for a program that is meant to help with the burden of these conditions it doesn't make any sense."

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Saturday, August 11, 2018 4:57:13 PM

On behalf of a Michigan resident...

" Our family would lose our home and transportation, so we could afford our child’s medication"

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Saturday, August 11, 2018 4:58:21 PM

On behalf of a Michigan resident...

" The changes are mostly designed to shame poor people and increase burdens on them, with no significant beneficial effect on the budget or economy."

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Saturday, August 11, 2018 4:59:19 PM

On behalf of a Michigan resident...

" As long as my daughter can maintain employment, she would meet those requirements, but when/if the economy goes bad, I fear she could lose her job and then what?"

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Saturday, August 11, 2018 5:00:06 PM

On behalf of a Michigan resident...

" It would be awful if our family lost Medicaid. And it would also be devastating to the community if lots of families lost health insurance."

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Saturday, August 11, 2018 5:00:48 PM

On behalf of a Michigan resident...

" Adding stress to recipients, additional paperwork, people who are awaiting a determination for disability will be left in limbo"

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Saturday, August 11, 2018 5:01:31 PM

On behalf of a Michigan resident...

"The premium may impose a hardship when earning such low wages, taking away from housing, transportation costs and other life expenses."

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Saturday, August 11, 2018 5:02:26 PM

On behalf of a Michigan resident...

" The primary result of work requirements would be that people who are already the victims of an economy that does not guarantee employment for every person would be punished in the harshest of ways--by having their only access to healthcare coverage stripped from them. This would make my community a less humane world to live in."

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Saturday, August 11, 2018 5:03:07 PM

On behalf of a Michigan resident...

" The only issue I have with the changes is the cost of daycare. Prevents many parents from seeking employment"

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Sunday, August 12, 2018 5:03:00 PM

On behalf of a Michigan resident..

" As a volunteer Navigator, I help people sign up for health insurance. I have helped many people sign up for Medicaid. Many of these people didn't have health insurance for many years before the Healthy Michigan Plan was implemented. A few are unemployable because of mental problems or health problems (although not officially disabled.) Many work, but have difficulty finding jobs that reliably provide enough work hours. Because their part-time employer keeps changing the work schedule, it is hard for them to get a second job to increase their work hours. Some have a prison record that makes it hard for them to get work. My wife volunteers at an church outreach project in Detroit. Many people she meets live in neighborhoods with no available jobs and they don't have transportation to suburban jobs."

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Sunday, August 12, 2018 5:04:02 PM

On behalf of a Michigan resident...

"I help people deal with MDHHS workers who are already overworked. This will provide even more burden on these caseworkers, making it harder for everyone who deals with the benefit system. I think it is inevitable that some people will fall through the cracks: being denied Medicaid when they should be eligible. This will also increase financial stress on hospitals and community health centers."

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Sunday, August 12, 2018 5:05:01 PM

On behalf of a Michigan resident...

"More people have the ability to get their basic health needs met. My costs are lower because people don’t have to go to the ER for things that could be managed through a GP."

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Sunday, August 12, 2018 5:06:15 PM

On behalf of a Michigan resident...

" I believe the MI Medicaid expansion has helped low income MI families get the care they need to stay healthy by receiving appropriate primary and preventative care, rather than more expensive urgent and emergency care"

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Sunday, August 12, 2018 5:07:19 PM

On behalf of a Michigan resident...

" By having medicaid, I am able to focus on my vocational skills, volunteer work, and infirmities without the worry of getting sick or medical condition regressing and thus, prohibiting me from being a productive member of society."

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Sunday, August 12, 2018 5:08:12 PM

On behalf of a Michigan resident...

" Did not know I was Diabetic, Rushed to hospital unconscious, Had no insurance, Was approved for medicaid retroactively, Covered 2 Hospitalizations for Diabetic Ketoacidosis (Diabetes is still very hard to understand!)"

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Sunday, August 12, 2018 5:09:11 PM

On behalf of a Michigan resident...

" My family has what is considered “good” health insurance, but I know that we are all at risk when all do not have healthcare. There but for fortune go you or I."

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Sunday, August 12, 2018 5:09:55 PM

On behalf of a Michigan resident...

" Medicaid coverage has expanded access to necessary health care that helps families be more self-reliant."

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Sunday, August 12, 2018 5:10:39 PM

On behalf of a Michigan resident...

" Michigan’s Medicaid program has been a vital resource for over half-a-million people in our state. Medicaid provides essential health benefits for an at-risk population, which benefits not only the individual but the community as a whole, helping to keep down hospital costs and expenses for the state."

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Sunday, August 12, 2018 5:11:16 PM

On behalf of a Michigan resident...

" Healthcare is a right. Medicaid makes communities stronger."

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Sunday, August 12, 2018 5:12:23 PM

On behalf of a Michigan resident...

" Medicaid has provided cancer treatment for family members who would not had the opportunity to seek proper treatment. It has allowed preventable treatment for loved ones to live a productive life."

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Sunday, August 12, 2018 5:13:14 PM

On behalf of a Michigan resident...

" I have several family members who delayed getting care because of lack of insurance, waiting until they could get coverage through a new job. Some of these family member experienced severe consequences to their health, and at least two of them lost their new job because their health had deteriorated so much in the intervening period. I have a nephew in the hospital right now with a brain tumor that was untreated because he did not have access to care. In addition, the stigma related to accessing Medicaid prevents other family members from applying, which would help them very much in managing chronic illnesses like diabetes. Work requirements and all the unsupported rhetoric around them only make this stigma worse, and make it harder for people to get or stay healthy"

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Sunday, August 12, 2018 5:14:46 PM

On behalf of a Michigan resident...

" More people will not be able to afford their basic needs. More people will get sick and die unnecessarily. This negatively impacts everyone in the community."

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Sunday, August 12, 2018 5:16:17 PM

On behalf of a Michigan resident...

" These changes will not reduce the number of individuals on Medicaid, they will only create new headaches and challenges in providing healthcare. The real "free loaders" in the system are the politicians who earn a good income, but receive free, lifelong healthcare on the taxpayers' dime."

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Sunday, August 12, 2018 5:17:44 PM

On behalf of a Michigan resident...

" Chipping away at the poor will not balance the budget"

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Sunday, August 12, 2018 5:18:53 PM

On behalf of a Michigan resident...

" The bureaucracy, confusion, hardship and shame would force people back into being uninsured"

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Sunday, August 12, 2018 5:20:07 PM

On behalf of a Michigan resident...

" People will suffer, needlessly. This is 100% unacceptable in this richest and most powerful nation in the world"

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Sunday, August 12, 2018 5:20:55 PM

On behalf of a Michigan resident...

" Healthy residents results in higher quality of life for everyone in the community."

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Sunday, August 12, 2018 5:21:56 PM

On behalf of a Michigan resident...

" Michigan's new Medicaid law is a poorly-written piece of legislation that will harm the Medicaid population. Medicaid was never designed to be a workplace development project, which is part of this legislation's intention. The mandatory work requirements will be a burden for many Medicaid recipients. Many already work but will have difficulties Meeting the 20 hour per week requirement, since their work is inconsistent and study hours. Also, accessing child care and transportation Will be difficult for many. Finally, this legislation include some triggers that could actually end benefits for the entire Medicaid expansion population."

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Sunday, August 12, 2018 5:22:42 PM

On behalf of a Michigan resident...

"The potential loss of healthcare coverage due to a person's inability to meet "work requirements" would cause great harm to individuals, families, and our communities."

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Sunday, August 12, 2018 5:23:49 PM

On behalf of a Michigan resident...

" I know that supports for meeting work requirements related to other programs are not accessible to all who need them, especially adequate child care and that computer systems set up to track compliance with work requirements are expensive and often fail even though they are very expensive as they are built upon a software infrastructure that is unsound. Also, the lack of any requirements of employers for any workers in MI related to flexibility around managing health issues and the on-demand scheduling that leaves people vulnerable is especially problematic for low-wage workers who qualify for Healthy Michigan, especially if they have children who require safe care. It is not within the workers' power to ensure they can get the hours they need or that they can do what they need to do to remain healthy. That is already the case, adding work requirements only tightens the screws on people who are already struggling. Finally, the lack of investment in MDHHS to ensure adequate staffing to support compliance is a slap in the face to all the workers who will be saddled with trying to make this untenable system work and even more so to all the families whose health and wellbeing depend on access to care and whose pathway to self-sufficiency depends on reliable work supports. This is a completely irrational and immoral policy for Michigan to pursue."

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Sunday, August 12, 2018 9:41:42 PM

On behalf of a Michigan resident...

" My son benefited from the Healthy Michigan expansion. Without this he would not have been able to go back to school."

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Sunday, August 12, 2018 9:42:48 PM

On behalf of a Michigan resident...

" As a nurse I know these changes would be disastrous to the patients served at my hospital and the hospital's finances."

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Sunday, August 12, 2018 9:43:44 PM

On behalf of a Michigan resident...

" As a worker in healthcare, I regularly see patients who are able to receive care they otherwise would not have without Medicaid. This helps their family remain healthy."

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Sunday, August 12, 2018 9:44:37 PM

On behalf of a Michigan resident...

" The requirement would put undue burdens on already vulnerable populations. How would they get transportation, child care, and job training? The requirement would be on them but, without assistance to address the barriers to employment, their success in getting a job could be out of their control.."

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Sunday, August 12, 2018 9:52:57 PM

On behalf of a Michigan resident...

" It would lead to lack of good, basic healthcare for the disadvantaged community members."

From: [redacted]
To: HealthyMichiganPlan
Subject: The Healthy MI work requirement
Date: Saturday, August 11, 2018 4:35:45 PM

To whom it may concern,

I would as a contracted provider for MDOC contract for people with special needs returning to the community from prison and I have been working in the program since 2006 prior to Healthy MI and Medicaid expansion. Prior to Healthy MI and the Medicaid expansion our program was paying (State of MI - full MDOC dollars) were paying for all of individuals medication, mental health and medical services because people returning to the community from prison do not have income and they were not eligible for Medicaid. If some is mentally ill or mentally fragile it still takes at a min 5-6 months for federal benefits to be approved if they are approved and many times a year or more. In the meantime, the State is paying the full costs of services. Medicaid expansion allowed the federal government to take on some of those costs. It was a win for the recipients and the states. Some of our clients may not meet criteria for federal disability benefits but also have a hard time sustaining any kind of gainful employment.

The work requirement causes more stress on the DHHS workers and the recipients. (Finding a job for someone who has mental health and medical disabilities as well as felonies is extremely difficult) and going without Medicaid only leaves them open to stopping medications and treatment which can lead to less healthy individual and likely increased crime that is often related to individuals not caring for their medical and mental health needs. Please consider these factors in policy making.

The commercial market has a extreme hole in it at this time where our health insurance is tied to our employment. People can have bouts of being uninsured because of this and this leaves the state, hospital and medical providers at risk as well as the patients. To move forward with this will cause the same issues with state Medicaid recipients benefits being tied to employemtn with bouts of people being uninsured depending on with abilities to follow the policy requirements to DHHS in timely matters, how much money people are making, low income jobs where health insurance is now offered and opening more and more cracks in the insurance system.

Please consider these concerns in policy making. Thanks,[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Michigan Medicaid work rules
Date: Saturday, August 11, 2018 4:55:48 PM

Dumb idea. It would be impossible to manage efficiently. We dont need another program that costs more to manage in man hours, policy changes and even lawsuits. We need 100% of our people to have real medical coverage. I have an employee who needs cataract surgery. His sight is limited in both eyes. He needs abput 2 grand per eye for surgery..he doesnt have it. He may go blind because he cant see. I f that happens we lose another tax payer..we lose an employee..we lose all the way around.

Sent from my Samsung Galaxy smartphone.

From: [redacted]
To: HealthyMichiganPlan
Subject: Requiring 80 hrs of work or schooling
Date: Saturday, August 11, 2018 5:32:58 PM

I just hope each individual and their situation will be looked at by the department
My son has been on Medicaid for almost a year but did not actively use until January. He suffers from mental health issues and has not been able to keep a job due to his condition. He has been working with health care professionals and takes medication which is covered under the Medicaid plan.
Therefore I'm asking that he will be assessed individually and not lumped into the whole.
Thank you for listening

[redacted]

Sent from my iPhone

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment.
Date: Saturday, August 11, 2018 8:08:30 PM

I speak against Medicaid work requirements. This extra layer of bureaucracy will cost the state more money and will certainly not do anything to help the people of Michigan who need Medicaid. Please stop making it difficult for people in this state to get the support they need. It's mean spirited and unnecessary. Thank you.[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Saturday, August 11, 2018 10:07:14 PM

Hello,
I live with my three children and their father (My SO). He does not work so he can supervise their online school day (kind of like home school). One of the children especially benefits from doing school at home because of learning and attention problems. My SO has had sever asthma since childhood and relies heavily on three asthma medications. I cannot afford to purchase healthcare through my employer for him, and with out Medicaid we will not be able to pay for his medications OR the Dr visits in between medication refills. It would make me sad if we had to send my children to school, and I fear the difficulties my son would have (with his education and his self esteem) would impact his future as a functioning adult.

[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: comment on Medicaid work requirement
Date: Sunday, August 12, 2018 8:33:39 AM

I have been a medical social worker for over 30 years. I worked for 25 years in a community hospital, and for the last 8 years in an outpatient oncology setting. Putting a work requirement on the healthy Michigan program will surely cost lives. I would like to provide 2 examples, but have many more. When I worked in the hospital, I was summoned to the emergency room many times.

On one occasion, there was a 50 year old man who was deceased from an apparent heart attack. In talking with the grieving family, they told me that he had been having chest pains for weeks, but did not seek treatment because he was uninsured. On another occasion, a 55 year old woman was brought into emergency as her gall bladder had burst. She subsequently died from sepsis. Again, she was not able to access primary care as she was uninsured, and had been having symptoms for weeks. These occurred before the healthy Michigan program was available, and demonstrate how the healthy Michigan program could have saved these lives, and I have may examples of how it is saving lives in its current form.

In my current work in oncology, treatment is time sensitive, and delaying care causes cancer to spread and can costs lives and affect the ability to treat and cure illness. Most of the time, my patients and I can not even get the Department of Human Services workers to answer the phone as they are so understaffed and overworked. Adding another layer of requirements on workers will surely add un needed burden on them, and on our most impoverished citizens. This policy is unthinkable to me, and surely seems to be motivated by the opinions of persons who do not encounter the people who are in my office every day.

I implore you not to add this work requirement. Which of my cancer patients will be exempt? Which will not be? What if someone is exempt but the paperwork is not read by a caseworker in time? I know what will happen, more restriction to access care, and more dire results. Please listen to those of us on the front line here and not to politicians who are trying to score points with their electorate. When patients get their Medicaid cut off, they stop coming for care, they can't fill their scripts. The effects are real and immediate.

[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Sunday, August 12, 2018 8:47:06 AM

What a terrible idea. And how underhanded to say it's about getting more workers to fill the needs of employers. This ill conceived idea is about the budget and saving money. How about doing it on the backs of rich white people instead of sick minorities? The people I know getting Medicaid need it and certainly couldn't do 20 hours of work a week. Is this plan paying for child care and transportation? Of course not. This is a despicable proposal.

[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Medicaid Work Requirements
Date: Sunday, August 12, 2018 9:58:59 AM

As a social worker I have seen the individuals who have struggled to keep themselves and their family healthy. Putting into place a job, school or volunteer component is not helpful because many of these people would do this if they could. I have met people who had to choose between a job that could provide experience and income but kicks them off of assistance, assistance they still need because of the low wages. I have many people who do volunteer their time to a number of organizations because they cannot work due to mental health and/or physical challenges. Many of the people I have met work on social changes, is that the type of volunteerism that would be accepted? Who would decide what was accepted and what and who decides on the criteria for ability to work?

The work requirements puts a perception out there that people who receive Medicaid are lazy and frauds and therefor must be forced into becoming a productive citizen. This is not true, some end up with Medicaid because of a long period of illness and many stabilize and can move forward but it can take years to rebuild your life and you may still need treatment or have period of time when symptoms of the illness are such that you need time off from work, which some employers may not be able to accommodate.

I am opposed to the work requirements.

[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Sunday, August 12, 2018 10:30:32 AM

Dear Healthy Michigan Plan authors:

You have requested public comments.

After reviewing the material concerning the Medicaid extension, I suggest adding a category in the medically fragile section to cover those who have applied and have been denied Social Security or SSI disability benefits with a vocational decision limiting them from any type of physical or mental demands of work.

Though not meeting the severity of preventing all work, this designation is an administrative medical-vocational decision on record that is a clear indicator of medical fragility.

File sharing between SSA and the DDS can confirm this designation through decision codes such as H1, J1, N31 and N32 among others. Accepting these code verifications would eliminate the need for or streamline the applicant's self declaration process.

If you should need clarification or additional discussion, please contact me any time.

[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Sunday, August 12, 2018 10:39:37 AM

I do not support changing the rules to demand that Medicaid recipients work. At best demanding that recipients of Medicaid work is solving a non-existent problem, at worst it will deprive needy people of help they need. Worse, it will likely drive the cost of healthcare up in the state.

As a former psychologist I can say that there are a great many people who are undiagnosed and untreated with many illnesses, from PTSD and schizophrenia to depression that make them unable to find and keep employment. Without Medicaid their healthcare needs will again be met at the emergency rooms, at the highest possible cost to the state and the community.

[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: D.E.A.A.
Date: Sunday, August 12, 2018 11:12:57 AM

To Whom It concerns:

Having only just read about this an hour and 1 minute before deadline closure I am pretty upset, as this was already submitted to the current Governor of Michigan for his rubber stamped approval. Which it received. Back in June! So here we are!! When people are beholden you don't need to also debase them. I am against forcing those in need of help this disrespect of 'work until you drop' thinking!!!

People don't want to be dependent on the state for ANYTHING, this is a fact and they aren't here by choice! People who qualify for assistance in any form are here for a damned good reason but still require respect – especially from those voted into office. The reason for the poor turnout in "Comments" is due to the lack of knowledge of what is going on. A "Big Brother" doesn't care situation, again!
Sent from Mail for Windows 10

From: [redacted]
To: HealthyMichiganPlan
Subject: Work requirements for medicaid
Date: Sunday, August 12, 2018 11:41:34 AM

Greetings,

Requiring labor to receive medical care is a regressive policy straight out of the 19th century, a plantation era mindset, Work or Die.

We provide healthcare for inmates. Why can't we provide the same for someone struggling to find a good job? It's a perverse sign of the times that in order to get healthcare an unemployed person has to commit a crime.

The number of aging Michiganders is growing exponentially and many were profoundly affected by the 2008 recession. That demographic is more likely to need medical treatment and more likely to experience hiring discrimination. This demographic will be affected the most.

Regardless of medicaid expansion, tying work to employment is a bad idea. For small companies providing health care is a significant burden. For large companies it gives the employer way too much power. It's also too many chefs in the kitchen. It's hard enough for the average citizen to navigate the red tape of medical care. Getting employers out of the mix eliminates at least one middle man. Even with the best employers the cost of medical care is unpredictable and inadequate.

The 3 largest government sponsored healthcare agencies are medicare, Veterans affairs and medicaid. Phasing in medicare for the entire population, gradually lowering the eligible age is the best way to start providing health care at a reasonable cost that all Americans deserve.

Thanks for soliciting input on this critical matter.

[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Sunday, August 12, 2018 11:51:26 AM

Dear Michigan Department of Health and Human Services,
Michigan must provide Medicaid to individuals and families in need, without prejudice, to ensure that we have a healthy population. The proposed changes to add work restrictions are reprehensible, as they will will harm those who most need the benefits. Cancelling coverage altogether if recipients do not work for 3 months in a calendar year would create perverse incentives - for example, for individuals to not fill temporary assignments (for fear of not finding another short-term position) or to not take time off of work when sick or to care for family members. Increasing co-pays to 5% of income for those at or just above the poverty threshold is an unfair financial burden and harms those who need government assistance. Provisions that would trigger an end the Healthy Michigan program would cause tremendous harm to Michigan's citizens and the general health of our population. Please overturn this bill in its entirety and, instead, uphold our Healthy Michigan program as a robust government service that provides healthcare coverage to Michiganders in need.
Thank you for taking public comments on proposed changes to Michigan's Medicaid program.

From: [redacted]
To: HealthyMichiganPlan
Subject: Work requirements
Date: Sunday, August 12, 2018 11:51:45 AM

There is often a good reason why come people on Medicaid are not employed. Many who have not been approved for Social Security Insurance for disability are fragile in ways that make them unreliable employees. Migraine headaches, arthritis, a needy child or parent or similar conditions cause frequent absences that are disruptive in many business environments. Others never make it past the screening process because of a criminal record or marginal literacy, or because conditions like anxiety or autism make interviewers uneasy.

It is easy to think that the non-profit world will benefit from the unpaid work these people will be forced to provide to receive Medicaid benefits. The reality is that many of the conditions that limit them as employees also limit them as volunteers.

An example is a wonderful woman who volunteered for a couple of years with me We loved having her around but could never really count on her to cover a shift at the office. She would frequently have to cancel because of health problems and appointments to address them, and to get and maintain the few benefits she and her children received. Then she had to move and the new location was two long bus rides away. If the first bus was late and she missed the connection, she'd be an hour late. That happened often in the winter.

She faces the same challenges getting to her appointments, food banks, stores and so on, making survival pretty close to a full-time job. Adding a 20 hour per week volunteering requirement will likely push her to the necessity of getting on disability.

On the other hand, if she was paid a decent wage for working even 30 hours, she could probably move closer to the bus station and dispense with scouring the food banks for diabetes-friendly foods for her family. She might well then even get a full-time, flexible-hour job in the private sector, especially if she could then afford internet access from her house.

So many of the jobs which don't require a reliable physical presence – blogging, telemarketing, computer programming – all need reliable connectivity. If the state is serious about getting those who could work back into the workforce, they need to provide a realistic bridge to getting there.

A large contribution could be made by developing job-sharing techniques for local and state government office work that could then be adapted to the private sector. For instance, a pool of people could be employed to answer phones, prepare newsletters and file. With several scheduled at a time, at least one would usually be there to cover time-sensitive tasks like answering phones, though a traditional employee would have to be prepared to step in on those occasions where none of the Medicaid-pool workers made it. Landscaping is another field that could work, as is sorting recyclables.

People who show up and work hard deserve to be paid enough to be free from dependency and its morass of regulations. It may well take two or more years for people to build the resources they need to move to conventional employment.

Some never will make that jump. They might survive in a wilderness setting but have personality disorders that prevent them from getting along with others, a basic requirement for any kind of commerce. These are probably also the people who social workers find most unpleasant to deal with, and for whom the general public most resents providing benefits. Consider, though, that these people would change if they could. But they can't, so someone is going to have to be paid to find them solitary tasks and supervise them. If the state wants non-profits to assume this burden, the state

should at least provide monetary support to make this feasible.

Most of the people I know who qualify for welfare benefits find them distasteful, at best. Beyond the stigma, an intrusive government presence becomes part of the recipients' life and the effort to secure them is hardly worth the increasingly stingy return. Many simply do not accept them.

The financial beneficiaries of the Medicaid expansion are those who pay for insurance or medical care. Impoverished people get care at hospital emergency rooms, whether they can pay for it or not. The cost of unpaid visits are added to the fees charged to those who do pay. Emergency room visits are expensive, especially when a condition has escalated.

Since the expansion, hospital social workers have been enrolling all patients who can't pay their bills onto Medicaid and instructing them on how to get preventive primary care services. This is now starting to change the way people who have grown up in poverty understand health care.

It is unfortunate that this behavior-changing policy wasn't given a chance to take hold before additional demands were added. But since the state added the requirement to work or volunteer, it is incumbent on that same body to make it practical for all people to reap the rewards of working.

From: [redacted]
To: HealthyMichiganPlan
Subject: Work Requirements
Date: Sunday, August 12, 2018 11:57:12 AM

Please explain how this is effective without spending millions more on implementation and what does the doctors do? This is STUPID plain and simple. I also wonder if this is more of the Republicans Party racism? Without racism Republicans go away.

Sent from my iPhone

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Sunday, August 12, 2018 12:04:09 PM

Dear Michigan Department of Health and Human Services,

Michigan must provide Medicaid to individuals and families in need, without prejudice, to ensure that we have a healthy population. The proposed changes to add work restrictions are reprehensible, as they will will harm those who most need the benefits. Cancelling coverage altogether if recipients do not work for 3 months in a calendar year would create perverse incentives - for example, for individuals to not fill temporary assignments (for fear of not finding another short-term position) or to not take time off of work when sick or to care for family members. Increasing co-pays to 5% of income for those at or just above the poverty threshold is an unfair financial burden and harms those who need government assistance. Provisions that would trigger an end the Healthy Michigan program would cause tremendous harm to Michigan's citizens and the general health of our population. Please overturn this bill in its entirety and, instead, uphold our Healthy Michigan program as a robust government service that provides healthcare coverage to Michiganders in need.

Thank you for taking public comments on proposed changes to Michigan's Medicaid program.

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Sunday, August 12, 2018 12:05:27 PM

Dear Michigan Department of Health and Human Services,

Michigan must provide Medicaid to individuals and families in need, without prejudice, to ensure that we have a healthy population. The proposed changes to add work restrictions are reprehensible, as they will will harm those who most need the benefits. Cancelling coverage altogether if recipients do not work for 3 months in a calendar year would create perverse incentives - for example, for individuals to not fill temporary assignments (for fear of not finding another short-term position) or to not take time off of work when sick or to care for family members. Increasing co-pays to 5% of income for those at or just above the poverty threshold is an unfair financial burden and harms those who need government assistance. Provisions that would trigger an end the Healthy Michigan program would cause tremendous harm to Michigan's citizens and the general health of our population. Please overturn this bill in its entirety and, instead, uphold our Healthy Michigan program as a robust government service that provides healthcare coverage to Michiganders in need.

Thank you for taking public comments on proposed changes to Michigan's Medicaid program.

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Sunday, August 12, 2018 12:06:04 PM

Hello -

I would like to add my comments to those of my fellow Michiganders regarding the new work requirements for Medicaid.

I would like bring some attention to health issues that aren't visible and remind those making decisions as to what constitues "medically frail" to remember those who have these.

Those with chronic pain diseases have good days and bad days. A string of bad days could drop them below 20 hours. They aren't gaming the system - they can predict when the pain will ease most days.

I would also like to ask decision makers to consider those with mental health issues. From my experience working in a public library, those with access to quality mental health care are those with insurance via their employer, and therefore are not on Medicaid. This becomes an additional stressor for those who can't afford the care they need.

Thank you for allowing me to voice my input.

Sincerely,
[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Sunday, August 12, 2018 12:06:39 PM

Dear Michigan Department of Health and Human Services,

Michigan must provide Medicaid to individuals and families in need, without prejudice, to ensure that we have a healthy population. The proposed changes to add work restrictions are reprehensible, as they will will harm those who most need the benefits. Cancelling coverage altogether if recipients do not work for 3 months in a calendar year would create perverse incentives - for example, for individuals to not fill temporary assignments (for fear of not finding another short-term position) or to not take time off of work when sick or to care for family members. Increasing co-pays to 5% of income for those at or just above the poverty threshold is an unfair financial burden and harms those who need government assistance. Provisions that would trigger an end the Healthy Michigan program would cause tremendous harm to Michigan's citizens and the general health of our population. Please overturn this bill in its entirety and, instead, uphold our Healthy Michigan program as a robust government service that provides healthcare coverage to Michiganders in need.

Thank you for taking public comments on proposed changes to Michigan's Medicaid program.

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Sunday, August 12, 2018 12:50:26 PM

Dear Michigan Department of Health and Human Services,

Michigan must provide Medicaid to individuals and families in need, without prejudice, to ensure that we have a healthy population. The proposed changes to add work restrictions are reprehensible, as they will will harm those who most need the benefits. Cancelling coverage altogether if recipients do not work for 3 months in a calendar year would create perverse incentives - for example, for individuals to not fill temporary assignments (for fear of not finding another short-term position) or to not take time off of work when sick or to care for family members. Increasing co-pays to 5% of income for those at or just above the poverty threshold is an unfair financial burden and harms those who need government assistance. Provisions that would trigger an end the Healthy Michigan program would cause tremendous harm to Michigan's citizens and the general health of our population. Please overturn this bill in its entirety and, instead, uphold our Healthy Michigan program as a robust government service that provides healthcare coverage to Michiganders in need.

Thank you for taking public comments on proposed changes to Michigan's Medicaid program.

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Sunday, August 12, 2018 12:53:53 PM

Working is not always possible for people who receive benefits. Isn't that the point of safety net benefits? To help those unable to work, so they aren't poor beggar homeless on the street ready to pick pocket in order to survive?
I have a friend that suffers from fibromyalgia, she never knows what days if the month she will be unable t get out if bed because of the pain. She relies n Medicaid for the measley medical benefits she receives. She has suffered through many months if pain caused by kidney stones because no one will perform lithotripsy on her with Medicaid.
Please vote down this proposal!
[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment”
Date: Sunday, August 12, 2018 1:05:16 PM

This legislation will hurt those who are most vulnerable and should not be adopted.

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Sunday, August 12, 2018 1:06:52 PM

To whom it may concern,

Please do not add a work requirement. This will radically increase inefficient utilization of the ER for issues that could otherwise be treated less expensively in a regular office visit.

Sincerely,
[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment: Comments
Date: Sunday, August 12, 2018 1:14:25 PM

I wish to comment on the Medicaid work requirements rules currently being drafted as a consequence of recently enacted Michigan legislation.

Requirements for demonstration that work requirements are met should not be overly burdensome on Medicaid recipients. SIMPLE mechanisms MUST be available for recipients to demonstrate continuing eligibility by submitting documentation by mail, electronically and/or in person.

Reasonable requirements for demonstrating eligibility exclusions, such as for disability or caregiving, must be available. For instance:
> Tying the disability exclusion to federal requirement for social security disability will create an unreasonable obstacle: for instance, my brother, suffering from multiple symptoms as a result of Type II diabetes and an inability to walk up more than a few steps at a time, needed to apply for disability twice before acceptance; a good friend suffering from mental illness had to apply three times; in both of these cases, many months were needed for eligibility to be granted. Instead, documented concurrence from a licensed physician should be sufficient to demonstrate disability.
> Having personally provided caregiving for elder parents, I feel it will be unreasonable to expect persons in similar situations to have to go to great lengths to prove their unavailability to work the required number of hours. There are many different circumstances that could contribute to a person's unavailability to have a job outside the home and rules must be flexible to accommodate them. Caregivers may already be under considerable emotional distress and challenging requirements for them to meet will only add to stress.

There should be reasonable provisions allowing continued eligibility for persons who demonstrate honest but unsuccessful efforts to find employment in their community.

I feel strongly that volunteer jobs should be sufficient for demonstrating eligibility. Volunteer jobs also provide additional benefits to local communities and should be strongly encouraged, especially given that paying jobs may be difficult to find for some individuals, or in challenging economic times when fewer paying jobs may be available than at present.

Sincerely,
[redacted]

From: [redacted]
To: HealthyMichiganPlan
Date: Sunday, August 12, 2018 1:19:03 PM

I'm a young partially disabled single mother raising a disabled son, we both have Marfan Syndrome. Marfan Syndrome is a rare genetic mutation that only 200,000 people/year have. This means it's woefully under-researched & understood.
I've worked many jobs in my adult life trying to provide for my family, saving to go to school. Because of my condition, repetitive motion at manual labor jobs (such as farmhand, janitor, prep cook) causes irreparable damage to my body. I have permanent injuries to my arms & back.
Due to the rarity of my condition it isn't listed as a disability in the DSM. Only when my heart ruptures & I almost die will it be considered such.
Living in fear of dying very painfully every single day has taken a huge toll on me. I'm in the hospital twice a year for chest pains (most of which are just dislocated ribs). It must be easy to sign bills like this when you aren't worried about your heart dissecting, but you MUST know: THIS BILL WILL KILL PEOPLE.
Are you ready for death? I'm not.

From: [redacted]
To: HealthyMichiganPlan
Subject: Healthy Michigan Plan
Date: Sunday, August 12, 2018 1:26:06 PM

Hello,

I am extremely concerned regarding the proposed changes to the eligibility changes for Medicaid.

I volunteer running a client choice food pantry in [redacted]. I see over a thousand clients a year. Many of them get Medicaid. Many of those are working poor. Requiring them to work MORE to qualify for Medicaid is outrageous. Many others I see are unable to work - disabled or chronically sick children or other family members prevent them. Cutting them off from coverage is heartless.

please eliminate these proposed changes.

[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Healthy Michigan Medicaid - work requirement public comment
Date: Sunday, August 12, 2018 3:50:30 PM

The philosophy that underlies the change to the work requirement rules for Medicaid is based on assumptions. I challenge those making those assumptions to provide data that supports their beliefs. The first assumption is that people who receive the Healthy Michigan Medicaid are freeloaders who are intentionally avoiding work in order to receive this benefit. The second assumption is that there is enough work available that would allow the current recipients to receive or afford the purchase of health insurance. The third assumption is that taking this benefit away will somehow motivate people to go to work. A fourth assumption is that there will be work or meaningful activity available for all people effected by this change. A fifth assumption is that this change to the law will save the state money. I believe it will be impossible to prove any of these assumptions based on any data driven assessment.

I have been a social worker in Michigan for 30 years. My own experience with the Healthy Michigan Medicaid is that it provided a great benefit to the community and the individuals receiving that entitlement. The people I work with function on that border of able and disabled, often due to mental illness. HMM allowed them the resources to stay on their medications and treatments which enhanced their ability to function at work, as parents, as responsible members of the community. It provided a level of support that helped keep them from total disability. Taking that entitlement away will lead to lapses in medication coverage and treatment. It will lead to loss of functioning and do harm to peoples' ability to work, care for their children and act responsibly in their community. These losses have costs to the individuals effected and the communities where they live. I submit that these costs will be great both financially and by humanitarian standards.

Healthy Michigan Medicaid has been a benefit to the State of Michigan. These mean spirited rule changes are a poorly thought out political ploy. They threaten to cause real harm on an individual, community and state level. If these rules are to be carried out, I request that they be enforced at the lowest possible level and allow those who benefit from receiving Medicaid to continue to receive this support.

Sincerely,

[redacted]

From: NANCY HARMON
To: HealthyMichiganPlan; NANCY HARMON
Subject: Public Comment Medicaid Work requirement
Date: Sunday, August 12, 2018 4:12:14 PM

As the Dental Director for a free dental and medical clinic in Detroit for over 5 years and as the previous coordinator of a school based dental program which included more than 40 schools, I am seeing the result of the failure of Detroit policy makers to have planned for the future.

Whoever thought it was right to defund schools and trades thereby undermining our children's futures?
Whoever thought you could expect someone to do better when the options /opportunities were closed?
Whoever thought we could have good heath for anyone without healthcare for adults?
Whoever thought we could have a good work force without health care for everyone?

Most of the patients I see are not able to work due to illness, injury or mental health issues. I HAVE STORIES AND PHOTOS.

The wonderful patients I see have not had access to health care long enough to gain a level of health to work.

I have seen great gains with some of our patients regarding health and their ability to recover for years of neglect.

But I do not feel we are ready for a work requirmennt.

Most sincerely,

Nancy Harmon RDH , Dental Director
Malta Medical and Dental Clinic
4800 Grand River Ave, Detroit MI 48208
Personal: 313-942-5957
maltadentaldirector@gmail.com

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Sunday, August 12, 2018 4:21:01 PM

Regarding the Extension Application Amendment,

Just because someone is not working doesn't mean that they are not entitled to health care. We are used to the idea that we receive health care as a benefit of our employment. However, this does not mean that the two are necessarily or ethically linked.

Without health care, some people cannot work, even though they may not qualify for disability. Tying health care to employment, education or volunteer work assumes that jobs will be available, that transportation will be available, that child and dependent adult care will be available, that any number of community services will be available for an individual to access. Access to such services is typically not available in many situations and can be the very reason for lack of access to a job and health care benefits in the first place. Requiring employment for health care puts people in a catch-22 position.

Additionally, implementing this new system will cost a substantial amount of extra money, money needed to train people, educate people and administer the new guidelines equitably. This money would be better spent on actually providing the services people need to support their employment.

The new guidelines seem punitive and ignorant of the realities facing millions of poor Michiganders every day. Instead of punishing people for being poor, instead of assuming worst intentions, we should be helping people to be as productive as they really want to be, as they can be, and as they would be with adequate and humane support.

Sincerely,

[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Sunday, August 12, 2018 4:26:24 PM

RE: Demonstration Extension Application Amendment

Just because someone is not working doesn't mean that they are not entitled to health care. We are used to the idea that we receive health care as a benefit of our employment. However, this does not mean that the two are necessarily or ethically linked.

Without health care, some people cannot work, even though they may not qualify for disability. Tying health care to employment, education or volunteer work assumes that jobs will be available, that transportation will be available, that child and dependent adult care will be available, that any number of community services will be available for an individual to access. Access to such services is typically not available in many situations and can be the very reason for lack of access to a job and health care benefits in the first place. Requiring employment for health care puts people in a catch-22 position.

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The new guidelines seem punitive and ignorant of the realities facing millions of poor Michiganders every day. Instead of punishing people for being poor, instead of assuming worst intentions, we should be helping people to be as productive as they really want to be, as they can be, and as they would be with adequate and humane support.

Sincerely,

[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Commentary by Deadline
Date: Sunday, August 12, 2018 5:00:04 PM

Good afternoon

I'd like my voice to be heard on this issue. Requiring these sorts of work and activity stipulations are ableist and short sighted. I am proud of Michigan overall but this would be another stain on us. This measure focuses more on a wallet than someone's health. Please do not pass this.

Thank you

[redacted]

Sent from my iPhone

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Sunday, August 12, 2018 5:11:41 PM

Attention: Medicaid Policy

Attaching work to healthcare has always been a mistake and doing so for those who already struggle is an even bigger one. The times we most need care are the times we are least able to work. Obvious, diagnosed, disability is not the only time this is true. Having a family business means I see daily that we need to fill more jobs, but this is not an efficient way of doing that. And to assume most readily available jobs, to new, untrained workers, would either pay enough to cover medical care or pay low enough to keep them on government care is negligent. Most people are already doing all they can to get by. So while I do agree that helping match people to available work, better work, work fitting to their individual life and situation as well as the needs of Michigan business is honorable this in no way addresses that and muddles workforce and healthcare policy. I must strongly oppose the amendment to Medicaid work rules.

[redacted]

[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Please don"t add work requirements to Medicaid
Date: Sunday, August 12, 2018 6:47:42 PM

This is adds an unnecessary burden of paperwork and bureaucracy to the people currently on Medicaid and extra costs to State government. Even if the ideal is to have everyone working, I believe that cutting of health insurance to those that are not is a poor use of government regulation. Especially with the opiod epidemic in full swing and the cost of auto insurance being so effected by health costs, we need to be increasing the number of people with health insurance, not decreasing it.

Thank you for your consideration,

[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Sunday, August 12, 2018 7:11:19 PM

As a healthcare professional who works with Medicaid recipients, I think that it is a terrible idea to require Medicaid recipients to work in order to continue receiving benefits.

My main objection to the plan is that the requirement is on the individual Medicaid recipient, but success is largely out of his or her control. How would individuals overcome barriers such as transportation, child care, job training, or job shortages? Without direct assistance in those areas, the plan would set up individuals to fail.

Without financial or logistical assistance, a minimum wage job that they could get would not cover transportation and child care. They would be financially worse off as a result.

This measure does not support vulnerable populations. Medicaid was not intended to be a workforce training program.

Regards,

[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Sunday, August 12, 2018 7:14:22 PM

Dear MDEQ,

I am highly against the waiver that would require work or training from Medicaid recipients because it will only further hurt the most vulnerable in our communities. Those who receive Medicaid and are able to work already do so--it is a farce to think otherwise. My father has been on Medicaid for several years now, and badly wishes he could work, though his health prevents him from doing so. He can in no way handle the proposed requirements, and I fear for his wellbeing.

Moreover, Medicaid work requirements shift costs in unacceptable and inefficient ways. Medicaid work requirements which exclude people from public insurance shift costs to other ledgers: households bear costs in basic well-being and stress, non-profits and for-profits absorb the costs of untreated disease, some of the insured may pay more, and hospitals face additional uncompensated care costs.

Sincerely,
[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Sunday, August 12, 2018 7:35:10 PM

Dear State of Michigan,

RE: The proposed work requirements for recipients of Medicaid is terrible legislation.

While in grad school and the University of Michigan School of Public Health, we studied how these programs do not “inspire Medicaid recipients to work,” instead, it ends up costing the state more money. You would think the State of Michigan would have seen the light after the recent initiative to drug test all those Michiganders who were eligible to receive welfare. It was ended after it spent hundreds of thousands of tax payer dollars with out finding any significant amount of welfare recipients testing positive for drugs!

This law is not intended to help any Michiganders get jobs; it is a way to score political points to the right wing donors (many of whom don’t even live in Michigan). The fact is, most Medicaid recipients are already working; many are working full time but still are getting paid so little, they still qualify for benefits. Why don’t you work on changing that? Have any of you tried to buy health insurance making $8 an hour? Instead, Michigan’s leaders give out plenty of benefits, in the shape of tax incentives to huge corporations with out ever making sure they bring the jobs they promise or stay in the state once the incentive period is over. No CEO's need to take drug tests or prove they work a certain amount of hours a week in order to receive millions of dollars in tax write offs. Yet, the people who actually vote for you are the ones suffering.

Also, you sign this horrible legislation into law with out figuring out how you will measure the exceptions (i.e. those who are too "medically frail" to work). All you care about is how this looks politically for the Republican led state legislature and governor's office. You'd rather turn eligible Medicaid recipients away which will push them to stay away from low cost preventative care and turn to hospital emergency rooms when their manageable ailments turn critical and life threatening. This makes everyone’s private and public insurance costs go up. If you really wanted to save money, you’d expand Medicaid to more people.

Have you figured out how you’d administrate these requirements? Who will be keeping tabs on these recipients? If you think MDHHS benefit specialists can just add this on to all the other responsibilities, you haven’t had to wait to talk to someone on your eligibility or get a question answered (may take weeks of leaving messages with out anyone getting back in touch with you). Those DHS specialists don’t even answer their phones and only call back those they “deem worthy” as it is, are you planning on adding hundreds more MDHHS employees? How much will this new hurtle cost the state? How much will the state “save” if everything works as planned (of course, this assumes you have planned this much out).

Lastly, if you really wanted to save the State of Michigan tax payers, let the Medicaid expansion continue to save the state money. The federal government picks up most of the bill and it is one shining part of government that was actually working for the good of Michiganders.

Please, do not implement the work requirement for Medicaid.

Sincerely,

From: Greg Hofman
To: HealthyMichiganPlan
Cc: [redacted]
Subject: Demonstration Extension Application Amendment
Date: Sunday, August 12, 2018 8:01:48 PM

Bureau of Medicaid Policy and Health System Innovation Staff,

On behalf of the Lakeshore Regional Entity (Region 3 PIHP), we would like to thank you for the opportunity to provide input into the Demonstration Extension Application Amendment. The effort to clarify the amendment, particularly as it relates to those at 100% below, or at 100-133% the federal poverty level (FPL), was very helpful in understanding the scope of the document. We support the objectives of self-sufficiency and independence for our consumers who are eligible for Healthy Michigan benefits. Encouraging persons to develop healthy lifestyle choices is a goal we all support for individuals who receive our services.

In addition to reviewing this at the LRE staff level, we had opportunity to spend some time with our Consumer Advisory Committee. The comments we provide below are inclusive of the feedback we received from that committee.

1. It appears to us that the administrative effort required to oversee these work requirements is potentially intensive. Our consumer population will need support to navigate this system, and we worry about individuals dropping off of HM. It is not necessarily a resistance to participation, but lack of knowledge on how to meet all system requirements. The LRE recommends that you review your process and resources to assure that this level of support and interaction is available for consumers.
2. Attachment L addresses Medically Frail Identification Process, and includes a list of medical and behavioral diagnosis that would define the status of medically frail. This level of specificity is lauded, but we are recommending an additional review by your clinical leaders. During our meeting with our Consumer Advisory Committee, input was received that additional diagnosis can also greatly effect the ability to work at the level required in the standards. Examples included major depression, PTSD, and anxiety disorders. I'm sure there are other significant behavioral health diagnosis which impact the ability to work.
3. Our Consumer Advisory Committee also expressed that consumers desire to work, but find one of the biggest barriers to be adequate training. There are some structured programs through the community mental health system, but the LRE recommends that access to additional training resources be considered as a part of you review of the amendment. Encouraging work without providing the proper support may result in outcomes that do not support objectives as stated in this Amendment.

Thank you again for the opportunity to provide input. If you would desire additional dialogue on this, please do not hesitate to contact me.

Sincerely,

Greg Hofman, COO
Lakeshore Regional Entity
231 246-3577
gregh@lsre.org

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment"
Date: Sunday, August 12, 2018 8:02:28 PM

Please reconsider the proposed work requirement for Medicaid recipients. One issue that is a glaring problem everywhere, and certainly in Michigan, is that of untreated mental health. This requirement will aggravate the problem of untreated mental illnesses, since it will be very difficult to prove that a person is not capable of holding down even a part time job. I know of one young person who suffers from severe depression and is able to work only sporadically. This person has survived one (very nearly successful) suicide attempt, and there is no indication it won't happen again. Medicare is this person's only option for health care; the options under the Affordable Care Act are too expensive. I am concerned about what will happen if this individual's Medicaid is reduced or eliminated.

There are many others in the same boat. It is cruel and —if you want to reduce the human element and just talk in terms of money—short sighted and eventually more expensive—to cut off even limited health care to those who are struggling with poverty as well as physical and mental illnesses.

[redacted]

Sent from my iPad

From: [redacted]
To: HealthyMichiganPlan
Subject: Work requirement--public comment
Date: Sunday, August 12, 2018 8:39:30 PM

Healthy Michigan has been a success in getting care to people who couldn't afford insurance. It has been saving the state's medical systems from having to absorb the costs of later treatment and of emergency care, so that those costs don't get passed on to others. The work requirement will likely drive up those costs by making it much more difficult to stay insured, as well as costing massive amounts of money to process the complicated requirements.

Governor Snyder and Michigan lawmakers did the state a service in expanding Medicaid. If it ain't broke, don't fix it.

Sincerely,

[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Sunday, August 12, 2018 8:52:48 PM

Hello,

I am writing to express my significant displeasure and extreme concern about the proposed Healthy Michigan work requirements. This is inhumane, unjust, and unnecessary; there is no justification for this law. It will take away healthcare from the most vulnerable among us for no reason. There is enough of a stigma around Medicaid and other means-tested programs as it is. Please do not allow this to plan to be enacted.

Sincerely,
[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Michigan"s Medicaid Work rules
Date: Sunday, August 12, 2018 8:59:56 PM

Dear Michigan Department of Human Services, thank you for accepting public comments on the new proposed Michigan's Medicaid work rules. I believe that most able-bodied people do work, if they can find a job, which will support their families. People that live in Michigan are struggling to find jobs that will support their families, provide appropriate and affordable health insurance and for some, paying for daycare. I have a bachelor degree and a long work history, but have also faced the challenges of how difficult it is to find a job in Michigan. I do not have health insurance currently. My current employer does not offer health insurance and I cannot afford to purchase it on the marketplace. I am fortunate that my children are grown, but they still face the challenges to provide health insurance for my grandchildren. With this being said, I believe that these new requirements will have a devastating impact for poor income families, disabled individuals, children, individuals that cannot get a job, and worsen Michigan's economy and health care system. Transportation and daycare alone, will be a huge hurdle for individuals to overcome, just to get a new job. In my current position, I work with the Michigan Re-entry program for offenders with special needs. This will directly impact them as well. Many of these individuals are disabled and cannot secure employment, due to their criminal backgrounds. These new rules will most likely increase Michigan's recidivism, depleting the successful recidivism rates that Michigan is known for. I really hope that this can be stopped and redeveloped for something that will promote success and benefit all Michiganders.

Thank you for your time and consideration.

[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Sunday, August 12, 2018 9:01:34 PM

Dear Michigan Department of Health and Human Services,

Michigan must provide Medicaid to individuals and families in need, without prejudice, to ensure that we have a healthy population. The proposed changes to add work restrictions are reprehensible, as they will will harm those who most need the benefits. Cancelling coverage altogether if recipients do not work for 3 months in a calendar year would create perverse incentives - for example, for individuals to not fill temporary assignments (for fear of not finding another short-term position) or to not take time off of work when sick or to care for family members. Increasing co-pays to 5% of income for those at or just above the poverty threshold is an unfair financial burden and harms those who need government assistance. Provisions that would trigger an end the Healthy Michigan program would cause tremendous harm to Michigan's citizens and the general health of our population. Please overturn this bill in its entirety and, instead, uphold our Healthy Michigan program as a robust government service that provides healthcare coverage to Michiganders in need.

Thank you for taking public comments on proposed changes to Michigan's Medicaid program.

[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Healthy Michigan Medicaid - work requirement public comment
Date: Sunday, August 12, 2018 9:06:19 PM

“Unless we put medical freedom into the Constitution the time will come when medicine will organize itself into an undercover dictatorship. To restrict the art of healing to doctors and deny equal privileges to others will constitute the Bastille of medical science. All such laws are un-American and despotic.”

— Benjamin Rush

Medical freedom includes the ability to receive treatment and care no matter one’s financial situation. That Michigan would consider restricting health insurance benefits for its citizens when affordable and good care is very difficult to come by should be a matter of shame. A progressive movement toward health care as a basic human right is the paradigm in many countries—including Cuba.

Please consider this when reviewing the changes to Michigan’s management of Medicaid benefits as proposed by Governor Snyder.

Respectfully,
[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Sunday, August 12, 2018 10:26:30 PM

I'm writing to express my strong opposition to any work requirement for Michigan residents to be able to qualify for Medicaid.

Any such change is fundamentally punitive in nature. There are no studies to support that such a program will be cost-effective. To the contrary, it will push people off of Medicaid and return them -- and us -- to the state of making Emergency Departments the site of last-resort medical care.

It is a cruel mockery of the name "Healthy Michigan" to propose that implementing this plan will do anything but make more Michigan residents sicker, poorer, and more likely to die from otherwise treatable conditions.

I have private insurance myself through my employer and have no family members who would be harmed by such a change. But I still know that it's poor public policy and deserves to be abandoned before it goes any further.

Sincerely,
[redacted]

From: [redacted]
To: HealthyMichiganPlan
Cc: [redacted]
Subject: Demonstration Extension Application Amendment
Date: Sunday, August 12, 2018 10:32:27 PM

This is absolutely critical (but I expect nobody will ever read any of this)!!

There's something that I have not heard _anyone_ discuss regarding "work" requirements in order to receive healthcare: Small businesses are being devastated by soaring healthcare costs, and many small business owners, when their business experiences a downturn, can no longer afford healthcare. Rather than helping these small businesses afford healthcare, it seems the State thinks it's best to effectively destroy these businesses by taking healthcare options away from them, thus forcing the owners and employees to shutdown the business, and hope they can all find jobs quickly enough that they don't suffer serious health consequences without having insurance in place. THIS IS A NET LOSS OF JOBS, PEOPLE!!

The idea that our lawmakers are so incapable of thinking clearly and inventively about _real_ solutions, and simply seem to want to punish people to the point of risking their lives and health is wasteful, immoral, inexcusable and shameful!

In general, it's starkly clear that work requirements for accessing healthcare will cause people to suffer long-term health issues that would otherwise have been easily preventable, and some will even die. This will end up costing Michigan tax payers _more_, than if we were to require that every single person in Michigan have access to the healthcare they need, regardless of their level of employment or income. Not taking care that every single Michigander has healthcare is cruel, immoral, and will cost our society in unimaginably bad ways.

For folks who are self-employed, or members of a small business, the sooner they don't have to worry about whether they suffer serious illness, or even die, because they have true guaranteed access to healthcare, the sooner they can completely focus on keeping their business on track, finish developing new products and services, and growing -- leading to yet more employment opportunities for Michiganders. Without access to healthcare, however, some of them must decide between their business and employees, or healthcare. This a a needlessly disastrous choice to have to make, and one which apparently our lawmakers completely failed to consider, or even worse, completely disregard.

There are far more intelligent and effective ways to assist folks in maintaining their business, or assist others in becoming independent, than threatening them with possible ill-health, financial ruin due to healthcare debt, or death. Not only is holding accessible healthcare hostage to employment requirements going to cause great harm to many individuals, but at the same time, legislators are ignoring many proven, highly effective ways to help train and assist people in gaining independence – without the falsely perceived necessity of cruelly

threatening them with potentially devastating health consequences.

These horribly disastrous policies will cause small businesses and sole proprietorships to fail, and more people to lose their jobs. Many people will be harmed. And again, Michiganders will pay for this in many ways more important than just money.

Just one true example: A small business owner and design engineer, who in the past 20 years has formed 5 companies -- all self-funded with some modest partner investments, and with an employment record of over 100 people – and who has never taken even a dime from the government, hits a point where new products and services have to be developed in order to take advantage of new opportunities with current and potential customers. And to make things more challenging, has recently had to end a major contract with a partner who was found to be disreputable.

This person has the knowledge and skills to design high-tech products, including smart LED lighting, wireless sensor networks, assistive technology to aid persons with disabilities, firmware, software, CAD design, 3D printing and much more, and has taken a number of products from conception to market. The company is actually a spin-off from Wayne State University. This person works at least 14 hours every day in their own high-tech lab that they built and paid for over many years with their own money. This person has chosen to create technology to help people over having a family, vacations, nice cars, or a fancy house. Not that any of that should matter.

Unfortunately, healthcare costs have now risen to the point where, after paying for private healthcare insurance for 20 years (and never even utilizing a dime of services due to fear of possible pre-existing conditions), this person can no longer afford it until the next set of products/services are ready and rolled out – requiring about a year or two of investing yet more retirement savings and putting in continued long hard hours. Possibly tragically, to pull this off, private healthcare insurance has to be dropped, because it is close to $1000/month through Blue Care Network. $12000 in a year is a HUGE amount of money for a self-investing social entrepreneur to afford, in addition to all of the development costs, and in this case is simply too much.

So, this person can either give up the business, which has an extremely high probability of long-term success, or get a job, and accept that the projected 50 to 100 jobs that would likely have been created (again, there is a proven track record at creating jobs in the past), will simply never happen. Former employees will have to look elsewhere for employment. And, all of the training programs that would have been implemented, leading to yet more people gaining employment, will never happen, either. And the myriad of people who could have benefited from the assistive technology developments will never receive the unique technology that could have helped them to be more productive and independent themselves.

On the other hand, if this person sticks with finishing the development of the next phase of the business, this person must choose going without healthcare, at an age where it is really critical to have, and is one accident or illness away from complete financial devastation, ill-health, or death.

If it's not clear that Michigan's way of dealing with this sort of person -- to force them to destroy their business and all of the jobs/training/opportunities it would have created, just to get access to healthcare for a limited period of time, is a bad thing for everyone involved, then clearly Michigan is not the right place to do business anymore, and does not deserve entrepreneurs of this quality and dedication.

This is a terrible choice, thanks to Lansing: either risk one's life and health to continue to put forward training programs, products and services focused on improving the lives and opportunities of those with disabilities, or let that all fail, after 20 years and thousands of dollars of personal business re-investment.

You'd think that Michigan would be seeking out people like this, who have a rare, extremely extensive range of skills and experience in bringing unique products to market and training others to be able to do so as well. But actually the opposite is true. Michigan legislators are actively working against small businesses and sole proprietorships – choosing instead to threaten some of them who may be struggling temporarily, with their very lives and health.

Though I'm sure I'll never receive any response whatsoever – the design engineer has never received any help from Michigan for any of those projects in all these years anyway – here's the bottom line: there are far better ways to get folks employed with meaningful careers than threatening their health, lives, and financial stability.

Shame on all of you who choose to risk harm to others by threatening their very health and life!

I sincerely hope and pray that none of the lawmakers who conceived of, and approved, this ignorantly cruel, short-sighted, unimaginative and ineffectual policy, will ever find themselves in dire need of healthcare they cannot afford, and have to experience the sheer terror and desperation of that situation. I wouldn't wish that on anyone. I now live with that fear every day. I also pray that these policies will be changed as soon as possible, before too many dear people suffer the horrible consequences. In the meantime, we're all going to pay much more in the long run – both financially and morally!

Shame on you, Michigan!

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Sunday, August 12, 2018 10:42:16 PM

I have volunteered for almost ten years doing office work in a community health clinic that serves low-income people. The Healthy Michigan plan has made care available to people who would otherwise not get it. Adding a work requirement into the system is cruel to people who don't have the resources to comply with complicated paperwork. Does the state have lots of funding to set up a system that can help them?

Adding the requirement adds a barrier to getting care--which will make our state less healthy. It is ill-advised policy.

Sincerely,

[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Monday, August 13, 2018 12:00:00 AM

My name is [redacted] and I'm a mom of 2 boys with autism in Grand Rapids, MI. I work part time, volunteer in both my boys' schools, member of 2 PTOs, manage 2 IEPs as well as therapeutic services for both, and beyond this I work hard to take of my home, and participate in community events for accessibility, environmental cleanups, and learning how to code. I do not have medicaid nor do my children, but affordable health care must be available for my fellow citizens, and if we ever need it, I hope Medicaid is there for me and my family too.

Every time I sit down to write to you about what a terrible idea medicaid work requirements are, I have had to stop as I become overwhelmed with all the thoughts swirling around in my head. But here goes.

Proven Success
Our expansion, Healthy Michigan has already proved to be highly successful in improving quality of life, health outcomes. It has provided an additional almost 700,000 people (http://www.michiganradio.org/post/medicaid-work-requirements-could-affect-700000-people) with physical and mental health services, and prescriptions.

Healthy Michigan Saves Money
Healthy people save our health system money because preventive care decreases the cost of reactive care by magnitudes. According to Detroit news: https://www.detroitnews.com/story/news/politics/2018/04/19/michigan-senate-approves-medicaid-work-requirement/33986343/ "The Medicaid work requirements are projected to cost the state about $20 million to $30 million a year in administrative costs, according to the nonpartisan Senate Fiscal Agency, which said it is difficult to estimate how many individual enrollees the legislation could impact."
So if the legislative analysis will only save $7 - $20 Million, and the nonpartisan Senate Fiscal Agency is projected $20-$30 Million in administrative costs, we are actively pursuing a net loss to provide less health care coverage and inflict harm on our most vulnerable populations.
According to a US News article (https://www.usnews.com/news/best-states/michigan/articles/2018-06-22/snyder-signs-law-creating-medicaid-work-requirement), supporters of this expansion say the requirements are necessary to keep the program afloat. However, when we realize the net loss of the program, it is clear their logic is fundamentally flawed.
****

Good Health Policy is a Pillar of a Well Functioning Society
My expectation of the political class is that you are working for the public good. This waiver does not support the public good. It increases the likelihood of significant medical debt, tuition costs, and stress upon our most vulnerable. As a citiizen of Michigan, I want better than this waiver for my community members, friends and family. I want them to be healthy so they can be happy and productive and so my children can benefit from their continued presence in our lives. If a member of my community needs help, I want them to have it. Raise my taxes. Their well being is essential to my well being.

Impact on Children and Schools
Medicaid also supports our public schools by helping to pay for essential of children with special needs. These requirements take even more away from our already devasted public education system,

Nor should a child's right to be with their family be impinged when a parent loses benefits due to work requirement and then becomes unable to care for that child, support the child in school or simply not be able to tuck the child in at night because they are not healthy enough after losing their benefits.

Protecting Our Most Vulnerable Citizens
Medicaid allows disabled individuals to pay the staff that allows them to be productive, involved members our community. Caregivers are already chronically underpaid and removing medicaid dollars deprives the them of even more hard-earned dollars as well as depriving a person in need of the care they so desperately need. The result would be that a person with disabilities is unable to pursue the education, work, or community opportunities without the support of the caregivers. The state community is immeasurably better when all of our citizens are enabled to share their voices, ideas, passions and skills.

Lack of health insurance will Kill people
This policy would be unequivocally harmful. One of the early consequences is delayed health services. Health care delayed is consequentially health care denied. Health care denied is a dead valued, vital citizen robbed of the opportunity to enrich our society. Please don't put my friends' blood on my hands.
"Every one of these reasons to deny you healthcare kills people," Paul Propson, CEO of Covenant Community Care in Detroit, a primary health care provider that sees 20,000 patients with Medicaid benefits or no insurance coverage each year, told me last month. "It might only kill 10 people or 50 people or 100 people, but when there are delays in accessing health care, there are victims." (https://www.freep.com/story/opinion/columnists/nancy-kaffer/2018/05/01/medicaid-work-requirements-gop/569760002/)

Buried Under Paperwork
This Waiver will allow people to apply for exemptions. But how many will have the ability and energy to navigate that on top of their daily challenges? Paperwork and the onerous burden of constantly proving eligibility will deter people from accessing needed services. How many of us actually enjoy putting together the documents needed to do our taxes or apply for a mortgage? Or delay it until the last minute? Now consider someone burdened with a disability, mental health issue, or a caregiver trying to keep up with the administrative requirements…. As a parent of 2 children with special needs, I can assure you, the continued task of evaluation, documentation, and communication is enough to be a job all on its own.

Policy of Systemic Racism and Cruelty
The New York Times pointed out a notable aspect of Michigan's plan in that the 1st iteration was blatantly racist in how the work requirements are enforced. Some of this has been correct3ed, but again. This is not the Michigan I want for my children and my community.
https://www.nytimes.com/2018/05/08/opinion/michigan-medicaid-work-requirement.html
The Metrotimes also describes the inequality perpetrated on poor black citizens in urban areas.
https://www.metrotimes.com/news-hits/archives/2018/05/09/michigans-medicaid-work-requirements-bill-could-have-racist-effects

The Purpose of Medicaid
Medicaid exists to provide health care to the poor. Not jobs, not education, not wifi, just

health care. In Michigan, again, this has worked very well.
In a ruling on the work requirement of Kentucky's expansion,

> 'U.S. District Judge James Boasberg called the Trump administration's approval of the program, Kentucky HEALTH, "arbitrary and capricious."
>
> He writes that in approving Kentucky's work requirement proposal, Health and Human Services Secretary Alex Azar "never adequately considered whether Kentucky HEALTH would in fact help the state furnish medical assistance to its citizens, a central objective of Medicaid.
>
> Instead, he wrote, HHS failed to consider whether the work requirements would do anything to further the program's core mission, which is to provide medical care to the poor.'

It is inconsistent with mission of health policy that health access is to be mandated by job policy. Adding work and education requirements are simply don't align with that goal. Health policy is not jobs policy or education policy. To put it bluntly, we are weaponizing health policy to hurt people who need it most.

Please do not implement these harmful, cruel, and ignorant requirements. Everyone deserves health care.

Thank for reading,
[redacted]

From: MSAPolicy
To: HealthyMichiganPlan
Subject: FW: Work Requirement for Medicaid Proposal
Date: Tuesday, August 14, 2018 12:05:59 PM

From: [redacted]
Sent: Friday, August 10, 2018 3:23 PM
To: MSAPolicy <MSAPolicy@michigan.gov>
Subject: Work Requirement for Medicaid Proposal

My 54 year old brother has inoperable pancreatic cancer, COPD, and Congestive heart failure. He also receives Medicaid insurance. He gets enough hassle from DSS and the Medical Healthcare system to get adequate care as it is, but I can see him now being routinely cut off from his healthcare insurance with the passage of this work requirement because of incompetent beurocrats assigning him fit to work in error just by looking at his age.
You know this is going to happen. This is nothing but red meat thrown to the base an election year and our family member's lives are being played with.
All people deserve health care in this country.
Regards
[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Thursday, August 2, 2018 10:11:29 AM

Dear Acting Deputy Director Stiffler,

As a constituent and someone personally affected by cystic fibrosis (CF), I'm writing to ask you to specifically and automatically exempt people with CF from work and community engagement requirements in Healthy Michigan. Furthermore, I ask that the state use its own data to identify people with CF for exemption to minimize the risk of inappropriate disenrollment and administrative burden on recipients.

CF is a life-threatening genetic disease that causes persistent lung infections and progressively limits the ability to breathe, often leading to respiratory failure. Over 1,100 people in Michigan live with CF. There is no known cure. As a complex, multi-system condition, CF requires targeted, highly specialized treatment and medications.

Medicaid plays an important role in helping people with CF—including 200 adults in the state—access the high-quality care and treatments they need to lead healthy, productive lives. While many Medicaid recipients living with CF are employed, others are unable to due to health status or the amount of time they need to spend on their treatments. To stay healthy, people with CF must endure hours of treatment every day – including receiving chest physiotherapy, taking inhaled treatments, potentially administering IV antibiotics, and other activities. In addition, people with CF commonly deal with pulmonary exacerbations (episodes where the symptoms of CF get worse and often lead to hospitalization), infections, and other events that cause their health to decline rapidly, potentially taking them out of the workforce for significant periods of time.

While I appreciate that the state plans to exempt individuals designated as "medically frail" and those with a medical condition that results in a work limitation according to a licensed medical professional, I am concerned that CF is not included in the list of diagnostic codes that will be automatically exempt. I am asking the state to add CF to this list of conditions that will be specifically and automatically exempt people from this Medicaid work requirement.

Consistent care is a critical component of CF treatment, and any loss or gaps in health coverage, because of failure to comply with these requirements, may put the health of people with CF at risk.

Again, I urge you to specifically and automatically exempt people with CF from the work requirement. Your attention to this matter will help people with CF continue to have access to the high-quality, specialized care they need to live full and healthy lives.

Sincerely,

[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Thursday, August 2, 2018 9:29:53 AM

Dear Acting Deputy Director Stiffler,

As a constituent and someone personally affected by cystic fibrosis (CF), I'm writing to ask you to specifically and automatically exempt people with CF from work and community engagement requirements in Healthy Michigan. Furthermore, I ask that the state use its own data to identify people with CF for exemption to minimize the risk of inappropriate disenrollment and administrative burden on recipients.

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Again, I urge you to specifically and automatically exempt people with CF from the work requirement. Your attention to this matter will help people with CF continue to have access to the high-quality, specialized care they need to live full and healthy lives.

Sincerely,

[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Thursday, August 2, 2018 9:09:38 AM

Dear Acting Deputy Director Stiffler,

As a constituent and someone personally affected by cystic fibrosis (CF), I'm writing to ask you to specifically and automatically exempt people with CF from work and community engagement requirements in Healthy Michigan. Furthermore, I ask that the state use its own data to identify people with CF for exemption to minimize the risk of inappropriate disenrollment and administrative burden on recipients.

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Again, I urge you to specifically and automatically exempt people with CF from the work requirement. Your attention to this matter will help people with CF continue to have access to the high-quality, specialized care they need to live full and healthy lives.

Sincerely,

[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Thursday, August 2, 2018 8:56:57 AM

Dear Acting Deputy Director Stiffler,

As a constituent and someone personally affected by cystic fibrosis (CF), I'm writing to ask you to specifically and automatically exempt people with CF from work and community engagement requirements in Healthy Michigan. Furthermore, I ask that the state use its own data to identify people with CF for exemption to minimize the risk of inappropriate disenrollment and administrative burden on recipients.

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Again, I urge you to specifically and automatically exempt people with CF from the work requirement. Your attention to this matter will help people with CF continue to have access to the high-quality, specialized care they need to live full and healthy lives.

Sincerely,

[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Thursday, August 2, 2018 7:45:48 AM

Dear Acting Deputy Director Stiffler,

As a constituent and someone personally affected by cystic fibrosis (CF), I'm writing to ask you to specifically and automatically exempt people with CF from work and community engagement requirements in Healthy Michigan. Furthermore, I ask that the state use its own data to identify people with CF for exemption to minimize the risk of inappropriate disenrollment and administrative burden on recipients.

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Again, I urge you to specifically and automatically exempt people with CF from the work requirement. Your attention to this matter will help people with CF continue to have access to the high-quality, specialized care they need to live full and healthy lives.

Sincerely,

[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Wednesday, August 1, 2018 10:44:41 PM

Dear Acting Deputy Director Stiffler,

As a constituent and someone personally affected by cystic fibrosis (CF), I'm writing to ask you to specifically and automatically exempt people with CF from work and community engagement requirements in Healthy Michigan. Furthermore, I ask that the state use its own data to identify people with CF for exemption to minimize the risk of inappropriate disenrollment and administrative burden on recipients.

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Again, I urge you to specifically and automatically exempt people with CF from the work requirement. Your attention to this matter will help people with CF continue to have access to the high-quality, specialized care they need to live full and healthy lives.

Sincerely,

[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Wednesday, August 1, 2018 9:47:17 PM

Dear Acting Deputy Director Stiffler,

As a constituent and someone personally affected by cystic fibrosis (CF), I'm writing to ask you to specifically and automatically exempt people with CF from work and community engagement requirements in Healthy Michigan. Furthermore, I ask that the state use its own data to identify people with CF for exemption to minimize the risk of inappropriate disenrollment and administrative burden on recipients.

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Again, I urge you to specifically and automatically exempt people with CF from the work requirement. Your attention to this matter will help people with CF continue to have access to the high-quality, specialized care they need to live full and healthy lives.

Sincerely,

[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Wednesday, August 1, 2018 7:25:28 PM

Dear Acting Deputy Director Stiffler,

As a constituent and someone personally affected by cystic fibrosis (CF), I'm writing to ask you to specifically and automatically exempt people with CF from work and community engagement requirements in Healthy Michigan. Furthermore, I ask that the state use its own data to identify people with CF for exemption to minimize the risk of inappropriate disenrollment and administrative burden on recipients.

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Again, I urge you to specifically and automatically exempt people with CF from the work requirement. Your attention to this matter will help people with CF continue to have access to the high-quality, specialized care they need to live full and healthy lives.

Sincerely,

[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Wednesday, August 1, 2018 7:08:27 PM

Dear Acting Deputy Director Stiffler,

As a constituent and someone personally affected by cystic fibrosis (CF), I'm writing to ask you to specifically and automatically exempt people with CF from work and community engagement requirements in Healthy Michigan. Furthermore, I ask that the state use its own data to identify people with CF for exemption to minimize the risk of inappropriate disenrollment and administrative burden on recipients.

CF is a life-threatening genetic disease that causes persistent lung infections and progressively limits the ability to breathe, often leading to respiratory failure. Over 1,100 people in Michigan live with CF. There is no known cure. As a complex, multi-system condition, CF requires targeted, highly specialized treatment and medications.

Medicaid plays an important role in helping people with CF—including 200 adults in the state—access the high-quality care and treatments they need to lead healthy, productive lives. While many Medicaid recipients living with CF are employed, others are unable to due to health status or the amount of time they need to spend on their treatments. To stay healthy, people with CF must endure hours of treatment every day – including receiving chest physiotherapy, taking inhaled treatments, potentially administering IV antibiotics, and other activities. In addition, people with CF commonly deal with pulmonary exacerbations (episodes where the symptoms of CF get worse and often lead to hospitalization), infections, and other events that cause their health to decline rapidly, potentially taking them out of the workforce for significant periods of time.

While I appreciate that the state plans to exempt individuals designated as "medically frail" and those with a medical condition that results in a work limitation according to a licensed medical professional, I am concerned that CF is not included in the list of diagnostic codes that will be automatically exempt. I am asking the state to add CF to this list of conditions that will be specifically and automatically exempt people from this Medicaid work requirement.

Consistent care is a critical component of CF treatment, and any loss or gaps in health coverage, because of failure to comply with these requirements, may put the health of people with CF at risk.

Again, I urge you to specifically and automatically exempt people with CF from the work requirement. Your attention to this matter will help people with CF continue to have access to the high-quality, specialized care they need to live full and healthy lives.

Sincerely,

[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Wednesday, August 1, 2018 5:16:11 PM

Dear Acting Deputy Director Stiffler,

As a constituent and someone personally affected by cystic fibrosis (CF), I'm writing to ask you to specifically and automatically exempt people with CF from work and community engagement requirements in Healthy Michigan. Furthermore, I ask that the state use its own data to identify people with CF for exemption to minimize the risk of inappropriate disenrollment and administrative burden on recipients.

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Again, I urge you to specifically and automatically exempt people with CF from the work requirement. Your attention to this matter will help people with CF continue to have access to the high-quality, specialized care they need to live full and healthy lives.

Sincerely,

[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Wednesday, August 1, 2018 4:22:46 PM

Dear Acting Deputy Director Stiffler,

As a constituent and someone personally affected by cystic fibrosis (CF), I'm writing to ask you to specifically and automatically exempt people with CF from work and community engagement requirements in Healthy Michigan. Furthermore, I ask that the state use its own data to identify people with CF for exemption to minimize the risk of inappropriate disenrollment and administrative burden on recipients.

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Again, I urge you to specifically and automatically exempt people with CF from the work requirement. Your attention to this matter will help people with CF continue to have access to the high-quality, specialized care they need to live full and healthy lives.

Sincerely,

[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Wednesday, August 1, 2018 4:18:09 PM

Dear Acting Deputy Director Stiffler,

As a constituent and someone personally affected by cystic fibrosis (CF), I'm writing to ask you to specifically and automatically exempt people with CF from work and community engagement requirements in Healthy Michigan. Furthermore, I ask that the state use its own data to identify people with CF for exemption to minimize the risk of inappropriate disenrollment and administrative burden on recipients.

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Again, I urge you to specifically and automatically exempt people with CF from the work requirement. Your attention to this matter will help people with CF continue to have access to the high-quality, specialized care they need to live full and healthy lives.

Sincerely,

[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Wednesday, August 1, 2018 4:15:52 PM

Dear Acting Deputy Director Stiffler,

As a constituent and someone personally affected by cystic fibrosis (CF), I'm writing to ask you to specifically and automatically exempt people with CF from work and community engagement requirements in Healthy Michigan. Furthermore, I ask that the state use its own data to identify people with CF for exemption to minimize the risk of inappropriate disenrollment and administrative burden on recipients.

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Again, I urge you to specifically and automatically exempt people with CF from the work requirement. Your attention to this matter will help people with CF continue to have access to the high-quality, specialized care they need to live full and healthy lives.

Sincerely,

[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Wednesday, August 1, 2018 3:02:47 PM

Dear Acting Deputy Director Stiffler,

As a constituent and someone personally affected by cystic fibrosis (CF), I'm writing to ask you to specifically and automatically exempt people with CF from work and community engagement requirements in Healthy Michigan. Furthermore, I ask that the state use its own data to identify people with CF for exemption to minimize the risk of inappropriate disenrollment and administrative burden on recipients.

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Again, I urge you to specifically and automatically exempt people with CF from the work requirement. Your attention to this matter will help people with CF continue to have access to the high-quality, specialized care they need to live full and healthy lives.

Sincerely,

[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Wednesday, August 1, 2018 2:57:14 PM

Dear Acting Deputy Director Stiffler,

As a constituent and someone personally affected by cystic fibrosis (CF), I'm writing to ask you to specifically and automatically exempt people with CF from work and community engagement requirements in Healthy Michigan. Furthermore, I ask that the state use its own data to identify people with CF for exemption to minimize the risk of inappropriate disenrollment and administrative burden on recipients.

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Sincerely,

[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Wednesday, August 1, 2018 2:47:29 PM

Dear Acting Deputy Director Stiffler,

As a constituent and someone personally affected by cystic fibrosis (CF), I'm writing to ask you to specifically and automatically exempt people with CF from work and community engagement requirements in Healthy Michigan. Furthermore, I ask that the state use its own data to identify people with CF for exemption to minimize the risk of inappropriate disenrollment and administrative burden on recipients.

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Sincerely,

[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Wednesday, August 1, 2018 2:32:51 PM

Dear Acting Deputy Director Stiffler,

As a constituent and someone personally affected by cystic fibrosis (CF), I'm writing to ask you to specifically and automatically exempt people with CF from work and community engagement requirements in Healthy Michigan. Furthermore, I ask that the state use its own data to identify people with CF for exemption to minimize the risk of inappropriate disenrollment and administrative burden on recipients.

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Sincerely,

[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Wednesday, August 1, 2018 2:21:45 PM

Dear Acting Deputy Director Stiffler,

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Sincerely,

[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Wednesday, August 1, 2018 1:57:49 PM

Dear Acting Deputy Director Stiffler,

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Sincerely,

[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Wednesday, August 1, 2018 1:54:40 PM

Dear Acting Deputy Director Stiffler,

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Sincerely,

[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Wednesday, August 1, 2018 1:08:04 PM

Dear Acting Deputy Director Stiffler,

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Sincerely,

[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Wednesday, August 1, 2018 12:11:24 PM

Dear Acting Deputy Director Stiffler,

As a constituent and someone personally affected by cystic fibrosis (CF), I'm writing to ask you to specifically and automatically exempt people with CF from work and community engagement requirements in Healthy Michigan. Furthermore, I ask that the state use its own data to identify people with CF for exemption to minimize the risk of inappropriate disenrollment and administrative burden on recipients.

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Sincerely,

[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Wednesday, August 1, 2018 12:01:02 PM

Dear Acting Deputy Director Stiffler,

As a constituent and someone personally affected by cystic fibrosis (CF), I'm writing to ask you to specifically and automatically exempt people with CF from work and community engagement requirements in Healthy Michigan. Furthermore, I ask that the state use its own data to identify people with CF for exemption to minimize the risk of inappropriate disenrollment and administrative burden on recipients.

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Sincerely,

[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Wednesday, August 1, 2018 11:48:13 AM

Dear Acting Deputy Director Stiffler,

As a constituent and someone personally affected by cystic fibrosis (CF), I'm writing to ask you to specifically and automatically exempt people with CF from work and community engagement requirements in Healthy Michigan. Furthermore, I ask that the state use its own data to identify people with CF for exemption to minimize the risk of inappropriate disenrollment and administrative burden on recipients.

CF is a life-threatening genetic disease that causes persistent lung infections and progressively limits the ability to breathe, often leading to respiratory failure. Over 1,100 people in Michigan live with CF. There is no known cure. As a complex, multi-system condition, CF requires targeted, highly specialized treatment and medications.

Medicaid plays an important role in helping people with CF—including 200 adults in the state—access the high-quality care and treatments they need to lead healthy, productive lives. While many Medicaid recipients living with CF are employed, others are unable to due to health status or the amount of time they need to spend on their treatments. To stay healthy, people with CF must endure hours of treatment every day – including receiving chest physiotherapy, taking inhaled treatments, potentially administering IV antibiotics, and other activities. In addition, people with CF commonly deal with pulmonary exacerbations (episodes where the symptoms of CF get worse and often lead to hospitalization), infections, and other events that cause their health to decline rapidly, potentially taking them out of the workforce for significant periods of time.

While I appreciate that the state plans to exempt individuals designated as "medically frail" and those with a medical condition that results in a work limitation according to a licensed medical professional, I am concerned that CF is not included in the list of diagnostic codes that will be automatically exempt. I am asking the state to add CF to this list of conditions that will be specifically and automatically exempt people from this Medicaid work requirement.

Consistent care is a critical component of CF treatment, and any loss or gaps in health coverage, because of failure to comply with these requirements, may put the health of people with CF at risk.

Again, I urge you to specifically and automatically exempt people with CF from the work requirement. Your attention to this matter will help people with CF continue to have access to the high-quality, specialized care they need to live full and healthy lives.

Sincerely,

[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Wednesday, August 1, 2018 11:29:51 AM

Dear Acting Deputy Director Stiffler,

As a constituent and someone personally affected by cystic fibrosis (CF), I'm writing to ask you to specifically and automatically exempt people with CF from work and community engagement requirements in Healthy Michigan. Furthermore, I ask that the state use its own data to identify people with CF for exemption to minimize the risk of inappropriate disenrollment and administrative burden on recipients.

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Again, I urge you to specifically and automatically exempt people with CF from the work requirement. Your attention to this matter will help people with CF continue to have access to the high-quality, specialized care they need to live full and healthy lives.

Sincerely,

[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Wednesday, August 1, 2018 11:27:30 AM

Dear Acting Deputy Director Stiffler,

As a constituent and someone personally affected by cystic fibrosis (CF), I'm writing to ask you to specifically and automatically exempt people with CF from work and community engagement requirements in Healthy Michigan. Furthermore, I ask that the state use its own data to identify people with CF for exemption to minimize the risk of inappropriate disenrollment and administrative burden on recipients.

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Again, I urge you to specifically and automatically exempt people with CF from the work requirement. Your attention to this matter will help people with CF continue to have access to the high-quality, specialized care they need to live full and healthy lives.

Sincerely,

[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Wednesday, August 1, 2018 11:26:48 AM

Dear Acting Deputy Director Stiffler,

As a constituent and someone personally affected by cystic fibrosis (CF), I'm writing to ask you to specifically and automatically exempt people with CF from work and community engagement requirements in Healthy Michigan. Furthermore, I ask that the state use its own data to identify people with CF for exemption to minimize the risk of inappropriate disenrollment and administrative burden on recipients.

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Consistent care is a critical component of CF treatment, and any loss or gaps in health coverage, because of failure to comply with these requirements, may put the health of people with CF at risk.

Again, I urge you to specifically and automatically exempt people with CF from the work requirement. Your attention to this matter will help people with CF continue to have access to the high-quality, specialized care they need to live full and healthy lives.

Sincerely,

[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Wednesday, August 1, 2018 11:21:41 AM

Dear Acting Deputy Director Stiffler,

As a constituent and someone personally affected by cystic fibrosis (CF), I'm writing to ask you to specifically and automatically exempt people with CF from work and community engagement requirements in Healthy Michigan. Furthermore, I ask that the state use its own data to identify people with CF for exemption to minimize the risk of inappropriate disenrollment and administrative burden on recipients.

CF is a life-threatening genetic disease that causes persistent lung infections and progressively limits the ability to breathe, often leading to respiratory failure. Over 1,100 people in Michigan live with CF. There is no known cure. As a complex, multi-system condition, CF requires targeted, highly specialized treatment and medications.

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While I appreciate that the state plans to exempt individuals designated as "medically frail" and those with a medical condition that results in a work limitation according to a licensed medical professional, I am concerned that CF is not included in the list of diagnostic codes that will be automatically exempt. I am asking the state to add CF to this list of conditions that will be specifically and automatically exempt people from this Medicaid work requirement.

Consistent care is a critical component of CF treatment, and any loss or gaps in health coverage, because of failure to comply with these requirements, may put the health of people with CF at risk.

Again, I urge you to specifically and automatically exempt people with CF from the work requirement. Your attention to this matter will help people with CF continue to have access to the high-quality, specialized care they need to live full and healthy lives.

Sincerely,

[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Wednesday, August 1, 2018 11:20:59 AM

Dear Acting Deputy Director Stiffler,

As a constituent and someone personally affected by cystic fibrosis (CF), I'm writing to ask you to specifically and automatically exempt people with CF from work and community engagement requirements in Healthy Michigan. Furthermore, I ask that the state use its own data to identify people with CF for exemption to minimize the risk of inappropriate disenrollment and administrative burden on recipients.

CF is a life-threatening genetic disease that causes persistent lung infections and progressively limits the ability to breathe, often leading to respiratory failure. Over 1,100 people in Michigan live with CF. There is no known cure. As a complex, multi-system condition, CF requires targeted, highly specialized treatment and medications.

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While I appreciate that the state plans to exempt individuals designated as "medically frail" and those with a medical condition that results in a work limitation according to a licensed medical professional, I am concerned that CF is not included in the list of diagnostic codes that will be automatically exempt. I am asking the state to add CF to this list of conditions that will be specifically and automatically exempt people from this Medicaid work requirement.

Consistent care is a critical component of CF treatment, and any loss or gaps in health coverage, because of failure to comply with these requirements, may put the health of people with CF at risk.

Again, I urge you to specifically and automatically exempt people with CF from the work requirement. Your attention to this matter will help people with CF continue to have access to the high-quality, specialized care they need to live full and healthy lives.

Sincerely,

[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Wednesday, August 1, 2018 11:15:12 AM

Dear Acting Deputy Director Stiffler,

As a constituent and someone personally affected by cystic fibrosis (CF), I'm writing to ask you to specifically and automatically exempt people with CF from work and community engagement requirements in Healthy Michigan. Furthermore, I ask that the state use its own data to identify people with CF for exemption to minimize the risk of inappropriate disenrollment and administrative burden on recipients.

CF is a life-threatening genetic disease that causes persistent lung infections and progressively limits the ability to breathe, often leading to respiratory failure. Over 1,100 people in Michigan live with CF. There is no known cure. As a complex, multi-system condition, CF requires targeted, highly specialized treatment and medications.

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While I appreciate that the state plans to exempt individuals designated as "medically frail" and those with a medical condition that results in a work limitation according to a licensed medical professional, I am concerned that CF is not included in the list of diagnostic codes that will be automatically exempt. I am asking the state to add CF to this list of conditions that will be specifically and automatically exempt people from this Medicaid work requirement.

Consistent care is a critical component of CF treatment, and any loss or gaps in health coverage, because of failure to comply with these requirements, may put the health of people with CF at risk.

Again, I urge you to specifically and automatically exempt people with CF from the work requirement. Your attention to this matter will help people with CF continue to have access to the high-quality, specialized care they need to live full and healthy lives.

Sincerely,

[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Wednesday, August 1, 2018 11:12:58 AM

Dear Acting Deputy Director Stiffler,

As a constituent and someone that treats patients with cystic fibrosis (CF), I'm writing to ask you to specifically and automatically exempt people with CF from work and community engagement requirements in Healthy Michigan. Furthermore, I ask that the state use its own data to identify people with CF for exemption to minimize the risk of inappropriate disenrollment and administrative burden on recipients.

CF is a life-threatening genetic disease that causes persistent lung infections and progressively limits the ability to breathe, often leading to respiratory failure. Over 1,100 people in Michigan live with CF. There is no known cure. As a complex, multi-system condition, CF requires targeted, highly specialized treatment and medications.

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Consistent care is a critical component of CF treatment, and any loss or gaps in health coverage, because of failure to comply with these requirements, may put the health of people with CF at risk.

Again, I urge you to specifically and automatically exempt people with CF from the work requirement. Your attention to this matter will help people with CF continue to have access to the high-quality, specialized care they need to live full and healthy lives.

Sincerely,

[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Wednesday, August 1, 2018 11:08:10 AM

Dear Acting Deputy Director Stiffler,

As a constituent and someone personally affected by cystic fibrosis (CF), I'm writing to ask you to specifically and automatically exempt people with CF from work and community engagement requirements in Healthy Michigan. Furthermore, I ask that the state use its own data to identify people with CF for exemption to minimize the risk of inappropriate disenrollment and administrative burden on recipients.

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Consistent care is a critical component of CF treatment, and any loss or gaps in health coverage, because of failure to comply with these requirements, may put the health of people with CF at risk.

Again, I urge you to specifically and automatically exempt people with CF from the work requirement. Your attention to this matter will help people with CF continue to have access to the high-quality, specialized care they need to live full and healthy lives.

Sincerely,

[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Wednesday, August 1, 2018 11:07:18 AM

Dear Acting Deputy Director Stiffler,

As a constituent and someone personally affected by cystic fibrosis (CF), I'm writing to ask you to specifically and automatically exempt people with CF from work and community engagement requirements in Healthy Michigan. Furthermore, I ask that the state use its own data to identify people with CF for exemption to minimize the risk of inappropriate disenrollment and administrative burden on recipients.

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Again, I urge you to specifically and automatically exempt people with CF from the work requirement. Your attention to this matter will help people with CF continue to have access to the high-quality, specialized care they need to live full and healthy lives.

Sincerely,

[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Wednesday, August 1, 2018 10:59:25 AM

Dear Acting Deputy Director Stiffler,

As a constituent and someone personally affected by cystic fibrosis (CF), I'm writing to ask you to specifically and automatically exempt people with CF from work and community engagement requirements in Healthy Michigan. Furthermore, I ask that the state use its own data to identify people with CF for exemption to minimize the risk of inappropriate disenrollment and administrative burden on recipients.

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Sincerely,

[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Wednesday, August 1, 2018 10:57:56 AM

Dear Acting Deputy Director Stiffler,

As a constituent and someone personally affected by cystic fibrosis (CF), I'm writing to ask you to specifically and automatically exempt people with CF from work and community engagement requirements in Healthy Michigan. Furthermore, I ask that the state use its own data to identify people with CF for exemption to minimize the risk of inappropriate disenrollment and administrative burden on recipients.

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Again, I urge you to specifically and automatically exempt people with CF from the work requirement. Your attention to this matter will help people with CF continue to have access to the high-quality, specialized care they need to live full and healthy lives.

Sincerely,

[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Wednesday, August 1, 2018 10:57:12 AM

Dear Acting Deputy Director Stiffler,

As a constituent and someone personally affected by cystic fibrosis (CF), I'm writing to ask you to specifically and automatically exempt people with CF from work and community engagement requirements in Healthy Michigan. Furthermore, I ask that the state use its own data to identify people with CF for exemption to minimize the risk of inappropriate disenrollment and administrative burden on recipients.

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Again, I urge you to specifically and automatically exempt people with CF from the work requirement. Your attention to this matter will help people with CF continue to have access to the high-quality, specialized care they need to live full and healthy lives.

Sincerely,

[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Wednesday, August 1, 2018 10:55:34 AM

Dear Acting Deputy Director Stiffler,

As a constituent and someone personally affected by cystic fibrosis (CF), I'm writing to ask you to specifically and automatically exempt people with CF from work and community engagement requirements in Healthy Michigan. Furthermore, I ask that the state use its own data to identify people with CF for exemption to minimize the risk of inappropriate disenrollment and administrative burden on recipients.

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Again, I urge you to specifically and automatically exempt people with CF from the work requirement. Your attention to this matter will help people with CF continue to have access to the high-quality, specialized care they need to live full and healthy lives.

Sincerely,

[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Wednesday, August 1, 2018 10:54:46 AM

Dear Acting Deputy Director Stiffler,

As a constituent and someone personally affected by cystic fibrosis (CF), I'm writing to ask you to specifically and automatically exempt people with CF from work and community engagement requirements in Healthy Michigan. Furthermore, I ask that the state use its own data to identify people with CF for exemption to minimize the risk of inappropriate disenrollment and administrative burden on recipients.

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Again, I urge you to specifically and automatically exempt people with CF from the work requirement. Your attention to this matter will help people with CF continue to have access to the high-quality, specialized care they need to live full and healthy lives.

Sincerely,

[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Wednesday, August 1, 2018 10:52:32 AM

Dear Acting Deputy Director Stiffler,

As a constituent and someone personally affected by cystic fibrosis (CF), I'm writing to ask you to specifically and automatically exempt people with CF from work and community engagement requirements in Healthy Michigan. Furthermore, I ask that the state use its own data to identify people with CF for exemption to minimize the risk of inappropriate disenrollment and administrative burden on recipients.

CF is a life-threatening genetic disease that causes persistent lung infections and progressively limits the ability to breathe, often leading to respiratory failure. Over 1,100 people in Michigan live with CF. There is no known cure. As a complex, multi-system condition, CF requires targeted, highly specialized treatment and medications.

Medicaid plays an important role in helping people with CF—including 200 adults in the state—access the high-quality care and treatments they need to lead healthy, productive lives. While many Medicaid recipients living with CF are employed, others are unable to due to health status or the amount of time they need to spend on their treatments. To stay healthy, people with CF must endure hours of treatment every day – including receiving chest physiotherapy, taking inhaled treatments, potentially administering IV antibiotics, and other activities. In addition, people with CF commonly deal with pulmonary exacerbations (episodes where the symptoms of CF get worse and often lead to hospitalization), infections, and other events that cause their health to decline rapidly, potentially taking them out of the workforce for significant periods of time.

While I appreciate that the state plans to exempt individuals designated as "medically frail" and those with a medical condition that results in a work limitation according to a licensed medical professional, I am concerned that CF is not included in the list of diagnostic codes that will be automatically exempt. I am asking the state to add CF to this list of conditions that will be specifically and automatically exempt people from this Medicaid work requirement.

Consistent care is a critical component of CF treatment, and any loss or gaps in health coverage, because of failure to comply with these requirements, may put the health of people with CF at risk.

Again, I urge you to specifically and automatically exempt people with CF from the work requirement. Your attention to this matter will help people with CF continue to have access to the high-quality, specialized care they need to live full and healthy lives.

Sincerely,

[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Wednesday, August 1, 2018 10:51:23 AM

Dear Acting Deputy Director Stiffler,

As a constituent and a parent personally affected by Cystic Fibrosis (CF), I'm writing to ask you to specifically and automatically exempt people with CF from work and community engagement requirements in Healthy Michigan. Furthermore, I ask that the state use its own data to identify people with CF for exemption to minimize the risk of inappropriate disenrollment and administrative burden on recipients. I greatly appreciate your consideration of this request!

CF is a life-threatening genetic disease that causes persistent lung infections and progressively limits the ability to breathe, often leading to respiratory failure. Over 1,100 people in Michigan live with CF. There is no known cure. As a complex, multi-system condition, CF requires targeted, highly specialized treatment and medications.

Medicaid plays an important role in helping people with CF—including 200 adults in the state—access the high-quality care and treatments they need to lead healthy, productive lives. While many Medicaid recipients living with CF are employed, others are unable to due to health status or the amount of time they need to spend on their treatments. To stay healthy, people with CF must endure hours of treatment every day – including receiving chest physiotherapy, taking inhaled treatments, potentially administering IV antibiotics, and other activities. In addition, people with CF commonly deal with pulmonary exacerbations (episodes where the symptoms of CF get worse and often lead to hospitalization), infections, and other events that cause their health to decline rapidly, potentially taking them out of the workforce for significant periods of time.

While I appreciate that the state plans to exempt individuals designated as "medically frail" and those with a medical condition that results in a work limitation according to a licensed medical professional, I am concerned that CF is not included in the list of diagnostic codes that will be automatically exempt. I am asking the state to add CF to this list of conditions that will be specifically and automatically exempt people from this Medicaid work requirement.

Consistent care is a critical component of CF treatment, and any loss or gaps in health coverage, because of failure to comply with these requirements, may put the health of people with CF at risk.

Again, I urge you to specifically and automatically exempt people with CF from the work requirement. Your attention to this matter will help people with CF continue to have access to the high-quality, specialized care they need to live full and healthy lives.

Sincerely,

[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Wednesday, August 1, 2018 10:51:06 AM

Dear Acting Deputy Director Stiffler,

As a constituent and someone personally affected by cystic fibrosis (CF), I'm writing to ask you to specifically and automatically exempt people with CF from work and community engagement requirements in Healthy Michigan. Furthermore, I ask that the state use its own data to identify people with CF for exemption to minimize the risk of inappropriate disenrollment and administrative burden on recipients.

CF is a life-threatening genetic disease that causes persistent lung infections and progressively limits the ability to breathe, often leading to respiratory failure. Over 1,100 people in Michigan live with CF. There is no known cure. As a complex, multi-system condition, CF requires targeted, highly specialized treatment and medications.

Medicaid plays an important role in helping people with CF—including 200 adults in the state—access the high-quality care and treatments they need to lead healthy, productive lives. While many Medicaid recipients living with CF are employed, others are unable to due to health status or the amount of time they need to spend on their treatments. To stay healthy, people with CF must endure hours of treatment every day – including receiving chest physiotherapy, taking inhaled treatments, potentially administering IV antibiotics, and other activities. In addition, people with CF commonly deal with pulmonary exacerbations (episodes where the symptoms of CF get worse and often lead to hospitalization), infections, and other events that cause their health to decline rapidly, potentially taking them out of the workforce for significant periods of time.

While I appreciate that the state plans to exempt individuals designated as "medically frail" and those with a medical condition that results in a work limitation according to a licensed medical professional, I am concerned that CF is not included in the list of diagnostic codes that will be automatically exempt. I am asking the state to add CF to this list of conditions that will be specifically and automatically exempt people from this Medicaid work requirement.

Consistent care is a critical component of CF treatment, and any loss or gaps in health coverage, because of failure to comply with these requirements, may put the health of people with CF at risk.

Again, I urge you to specifically and automatically exempt people with CF from the work requirement. Your attention to this matter will help people with CF continue to have access to the high-quality, specialized care they need to live full and healthy lives.

Sincerely,

[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Wednesday, August 1, 2018 10:48:13 AM

Dear Acting Deputy Director Stiffler,

As a constituent and someone personally affected by cystic fibrosis (CF), I'm writing to ask you to specifically and automatically exempt people with CF from work and community engagement requirements in Healthy Michigan. Furthermore, I ask that the state use its own data to identify people with CF for exemption to minimize the risk of inappropriate disenrollment and administrative burden on recipients.

CF is a life-threatening genetic disease that causes persistent lung infections and progressively limits the ability to breathe, often leading to respiratory failure. Over 1,100 people in Michigan live with CF. There is no known cure. As a complex, multi-system condition, CF requires targeted, highly specialized treatment and medications.

Medicaid plays an important role in helping people with CF—including 200 adults in the state—access the high-quality care and treatments they need to lead healthy, productive lives. While many Medicaid recipients living with CF are employed, others are unable to due to health status or the amount of time they need to spend on their treatments. To stay healthy, people with CF must endure hours of treatment every day – including receiving chest physiotherapy, taking inhaled treatments, potentially administering IV antibiotics, and other activities. In addition, people with CF commonly deal with pulmonary exacerbations (episodes where the symptoms of CF get worse and often lead to hospitalization), infections, and other events that cause their health to decline rapidly, potentially taking them out of the workforce for significant periods of time.

While I appreciate that the state plans to exempt individuals designated as "medically frail" and those with a medical condition that results in a work limitation according to a licensed medical professional, I am concerned that CF is not included in the list of diagnostic codes that will be automatically exempt. I am asking the state to add CF to this list of conditions that will be specifically and automatically exempt people from this Medicaid work requirement.

Consistent care is a critical component of CF treatment, and any loss or gaps in health coverage, because of failure to comply with these requirements, may put the health of people with CF at risk.

Again, I urge you to specifically and automatically exempt people with CF from the work requirement. Your attention to this matter will help people with CF continue to have access to the high-quality, specialized care they need to live full and healthy lives.

Sincerely,

[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Wednesday, August 1, 2018 10:44:05 AM

Dear Acting Deputy Director Stiffler,

As a constituent and someone personally affected by cystic fibrosis (CF), I'm writing to ask you to specifically and automatically exempt people with CF from work and community engagement requirements in Healthy Michigan. Furthermore, I ask that the state use its own data to identify people with CF for exemption to minimize the risk of inappropriate disenrollment and administrative burden on recipients.

CF is a life-threatening genetic disease that causes persistent lung infections and progressively limits the ability to breathe, often leading to respiratory failure. Over 1,100 people in Michigan live with CF. There is no known cure. As a complex, multi-system condition, CF requires targeted, highly specialized treatment and medications.

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While I appreciate that the state plans to exempt individuals designated as "medically frail" and those with a medical condition that results in a work limitation according to a licensed medical professional, I am concerned that CF is not included in the list of diagnostic codes that will be automatically exempt. I am asking the state to add CF to this list of conditions that will be specifically and automatically exempt people from this Medicaid work requirement.

Consistent care is a critical component of CF treatment, and any loss or gaps in health coverage, because of failure to comply with these requirements, may put the health of people with CF at risk.

Again, I urge you to specifically and automatically exempt people with CF from the work requirement. Your attention to this matter will help people with CF continue to have access to the high-quality, specialized care they need to live full and healthy lives.

Sincerely,

[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Wednesday, August 1, 2018 10:43:54 AM

Dear Acting Deputy Director Stiffler,

As a constituent and someone personally affected by cystic fibrosis (CF), I'm writing to ask you to specifically and automatically exempt people with CF from work and community engagement requirements in Healthy Michigan. Furthermore, I ask that the state use its own data to identify people with CF for exemption to minimize the risk of inappropriate disenrollment and administrative burden on recipients.

CF is a life-threatening genetic disease that causes persistent lung infections and progressively limits the ability to breathe, often leading to respiratory failure. Over 1,100 people in Michigan live with CF. There is no known cure. As a complex, multi-system condition, CF requires targeted, highly specialized treatment and medications.

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While I appreciate that the state plans to exempt individuals designated as "medically frail" and those with a medical condition that results in a work limitation according to a licensed medical professional, I am concerned that CF is not included in the list of diagnostic codes that will be automatically exempt. I am asking the state to add CF to this list of conditions that will be specifically and automatically exempt people from this Medicaid work requirement.

Consistent care is a critical component of CF treatment, and any loss or gaps in health coverage, because of failure to comply with these requirements, may put the health of people with CF at risk.

Again, I urge you to specifically and automatically exempt people with CF from the work requirement. Your attention to this matter will help people with CF continue to have access to the high-quality, specialized care they need to live full and healthy lives.

Sincerely,

[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Wednesday, August 1, 2018 10:41:57 AM

Dear Acting Deputy Director Stiffler,

As a constituent and someone personally affected by cystic fibrosis (CF), I'm writing to ask you to specifically and automatically exempt people with CF from work and community engagement requirements in Healthy Michigan. Furthermore, I ask that the state use its own data to identify people with CF for exemption to minimize the risk of inappropriate disenrollment and administrative burden on recipients.

CF is a life-threatening genetic disease that causes persistent lung infections and progressively limits the ability to breathe, often leading to respiratory failure. Over 1,100 people in Michigan live with CF. There is no known cure. As a complex, multi-system condition, CF requires targeted, highly specialized treatment and medications.

Medicaid plays an important role in helping people with CF—including 200 adults in the state—access the high-quality care and treatments they need to lead healthy, productive lives. While many Medicaid recipients living with CF are employed, others are unable to due to health status or the amount of time they need to spend on their treatments. To stay healthy, people with CF must endure hours of treatment every day – including receiving chest physiotherapy, taking inhaled treatments, potentially administering IV antibiotics, and other activities. In addition, people with CF commonly deal with pulmonary exacerbations (episodes where the symptoms of CF get worse and often lead to hospitalization), infections, and other events that cause their health to decline rapidly, potentially taking them out of the workforce for significant periods of time.

While I appreciate that the state plans to exempt individuals designated as "medically frail" and those with a medical condition that results in a work limitation according to a licensed medical professional, I am concerned that CF is not included in the list of diagnostic codes that will be automatically exempt. I am asking the state to add CF to this list of conditions that will be specifically and automatically exempt people from this Medicaid work requirement.

Consistent care is a critical component of CF treatment, and any loss or gaps in health coverage, because of failure to comply with these requirements, may put the health of people with CF at risk.

Again, I urge you to specifically and automatically exempt people with CF from the work requirement. Your attention to this matter will help people with CF continue to have access to the high-quality, specialized care they need to live full and healthy lives.

Sincerely,

[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Wednesday, August 1, 2018 10:40:41 AM

Dear Acting Deputy Director Stiffler,

As a constituent and someone personally affected by cystic fibrosis (CF), I'm writing to ask you to specifically and automatically exempt people with CF from work and community engagement requirements in Healthy Michigan. Furthermore, I ask that the state use its own data to identify people with CF for exemption to minimize the risk of inappropriate disenrollment and administrative burden on recipients.

CF is a life-threatening genetic disease that causes persistent lung infections and progressively limits the ability to breathe, often leading to respiratory failure. Over 1,100 people in Michigan live with CF. There is no known cure. As a complex, multi-system condition, CF requires targeted, highly specialized treatment and medications.

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Consistent care is a critical component of CF treatment, and any loss or gaps in health coverage, because of failure to comply with these requirements, may put the health of people with CF at risk.

Again, I urge you to specifically and automatically exempt people with CF from the work requirement. Your attention to this matter will help people with CF continue to have access to the high-quality, specialized care they need to live full and healthy lives.

Sincerely,

[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Wednesday, August 1, 2018 10:39:29 AM

Dear Acting Deputy Director Stiffler,

As a constituent and someone personally affected by cystic fibrosis (CF), I'm writing to ask you to specifically and automatically exempt people with CF from work and community engagement requirements in Healthy Michigan. Furthermore, I ask that the state use its own data to identify people with CF for exemption to minimize the risk of inappropriate disenrollment and administrative burden on recipients.

CF is a life-threatening genetic disease that causes persistent lung infections and progressively limits the ability to breathe, often leading to respiratory failure. Over 1,100 people in Michigan live with CF. There is no known cure. As a complex, multi-system condition, CF requires targeted, highly specialized treatment and medications.

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Consistent care is a critical component of CF treatment, and any loss or gaps in health coverage, because of failure to comply with these requirements, may put the health of people with CF at risk.

Again, I urge you to specifically and automatically exempt people with CF from the work requirement. Your attention to this matter will help people with CF continue to have access to the high-quality, specialized care they need to live full and healthy lives.

Sincerely,

[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Wednesday, August 1, 2018 10:39:02 AM

Dear Acting Deputy Director Stiffler,

As a constituent and someone personally affected by cystic fibrosis (CF), I'm writing to ask you to specifically and automatically exempt people with CF from work and community engagement requirements in Healthy Michigan. Furthermore, I ask that the state use its own data to identify people with CF for exemption to minimize the risk of inappropriate disenrollment and administrative burden on recipients.

CF is a life-threatening genetic disease that causes persistent lung infections and progressively limits the ability to breathe, often leading to respiratory failure. Over 1,100 people in Michigan live with CF. There is no known cure. As a complex, multi-system condition, CF requires targeted, highly specialized treatment and medications.

Medicaid plays an important role in helping people with CF—including 200 adults in the state—access the high-quality care and treatments they need to lead healthy, productive lives. While many Medicaid recipients living with CF are employed, others are unable to due to health status or the amount of time they need to spend on their treatments. To stay healthy, people with CF must endure hours of treatment every day – including receiving chest physiotherapy, taking inhaled treatments, potentially administering IV antibiotics, and other activities. In addition, people with CF commonly deal with pulmonary exacerbations (episodes where the symptoms of CF get worse and often lead to hospitalization), infections, and other events that cause their health to decline rapidly, potentially taking them out of the workforce for significant periods of time.

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Consistent care is a critical component of CF treatment, and any loss or gaps in health coverage, because of failure to comply with these requirements, may put the health of people with CF at risk.

Again, I urge you to specifically and automatically exempt people with CF from the work requirement. Your attention to this matter will help people with CF continue to have access to the high-quality, specialized care they need to live full and healthy lives.

Sincerely,

[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Wednesday, August 1, 2018 10:33:36 AM

Dear Acting Deputy Director Stiffler,

As a constituent and someone personally affected by cystic fibrosis (CF), I'm writing to ask you to specifically and automatically exempt people with CF from work and community engagement requirements in Healthy Michigan. Furthermore, I ask that the state use its own data to identify people with CF for exemption to minimize the risk of inappropriate disenrollment and administrative burden on recipients.

CF is a life-threatening genetic disease that causes persistent lung infections and progressively limits the ability to breathe, often leading to respiratory failure. Over 1,100 people in Michigan live with CF. There is no known cure. As a complex, multi-system condition, CF requires targeted, highly specialized treatment and medications.

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Consistent care is a critical component of CF treatment, and any loss or gaps in health coverage, because of failure to comply with these requirements, may put the health of people with CF at risk.

Again, I urge you to specifically and automatically exempt people with CF from the work requirement. Your attention to this matter will help people with CF continue to have access to the high-quality, specialized care they need to live full and healthy lives.

Sincerely,

[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Wednesday, August 1, 2018 10:28:47 AM

Dear Acting Deputy Director Stiffler,

As a constituent and someone personally affected by cystic fibrosis (CF), I'm writing to ask you to specifically and automatically exempt people with CF from work and community engagement requirements in Healthy Michigan. Furthermore, I ask that the state use its own data to identify people with CF for exemption to minimize the risk of inappropriate disenrollment and administrative burden on recipients.

CF is a life-threatening genetic disease that causes persistent lung infections and progressively limits the ability to breathe, often leading to respiratory failure. Over 1,100 people in Michigan live with CF. There is no known cure. As a complex, multi-system condition, CF requires targeted, highly specialized treatment and medications.

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Consistent care is a critical component of CF treatment, and any loss or gaps in health coverage, because of failure to comply with these requirements, may put the health of people with CF at risk.

Again, I urge you to specifically and automatically exempt people with CF from the work requirement. Your attention to this matter will help people with CF continue to have access to the high-quality, specialized care they need to live full and healthy lives.

Sincerely,

[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Wednesday, August 1, 2018 10:18:48 AM

Dear Acting Deputy Director Stiffler,

As a constituent and someone personally affected by cystic fibrosis (CF), I'm writing to ask you to specifically and automatically exempt people with CF from work and community engagement requirements in Healthy Michigan. Furthermore, I ask that the state use its own data to identify people with CF for exemption to minimize the risk of inappropriate disenrollment and administrative burden on recipients.

CF is a life-threatening genetic disease that causes persistent lung infections and progressively limits the ability to breathe, often leading to respiratory failure. Over 1,100 people in Michigan live with CF. There is no known cure. As a complex, multi-system condition, CF requires targeted, highly specialized treatment and medications.

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Consistent care is a critical component of CF treatment, and any loss or gaps in health coverage, because of failure to comply with these requirements, may put the health of people with CF at risk.

Again, I urge you to specifically and automatically exempt people with CF from the work requirement. Your attention to this matter will help people with CF continue to have access to the high-quality, specialized care they need to live full and healthy lives.

Sincerely,

[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Wednesday, August 1, 2018 10:13:49 AM

Dear Acting Deputy Director Stiffler,

As a constituent and someone personally affected by cystic fibrosis (CF), I'm writing to ask you to specifically and automatically exempt people with CF from work and community engagement requirements in Healthy Michigan. Furthermore, I ask that the state use its own data to identify people with CF for exemption to minimize the risk of inappropriate disenrollment and administrative burden on recipients.

CF is a life-threatening genetic disease that causes persistent lung infections and progressively limits the ability to breathe, often leading to respiratory failure. Over 1,100 people in Michigan live with CF. There is no known cure. As a complex, multi-system condition, CF requires targeted, highly specialized treatment and medications.

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Consistent care is a critical component of CF treatment, and any loss or gaps in health coverage, because of failure to comply with these requirements, may put the health of people with CF at risk.

Again, I urge you to specifically and automatically exempt people with CF from the work requirement. Your attention to this matter will help people with CF continue to have access to the high-quality, specialized care they need to live full and healthy lives.

Sincerely,

[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Wednesday, August 1, 2018 10:07:05 AM

Dear Acting Deputy Director Stiffler,

As a constituent and someone personally affected by cystic fibrosis (CF), I'm writing to ask you to specifically and automatically exempt people with CF from work and community engagement requirements in Healthy Michigan. Furthermore, I ask that the state use its own data to identify people with CF for exemption to minimize the risk of inappropriate disenrollment and administrative burden on recipients.

CF is a life-threatening genetic disease that causes persistent lung infections and progressively limits the ability to breathe, often leading to respiratory failure. Over 1,100 people in Michigan live with CF. There is no known cure. As a complex, multi-system condition, CF requires targeted, highly specialized treatment and medications.

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Consistent care is a critical component of CF treatment, and any loss or gaps in health coverage, because of failure to comply with these requirements, may put the health of people with CF at risk.

Again, I urge you to specifically and automatically exempt people with CF from the work requirement. Your attention to this matter will help people with CF continue to have access to the high-quality, specialized care they need to live full and healthy lives.

Sincerely,

[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Wednesday, August 1, 2018 10:06:38 AM

Dear Acting Deputy Director Stiffler,

As a constituent and someone personally affected by cystic fibrosis (CF), I'm writing to ask you to specifically and automatically exempt people with CF from work and community engagement requirements in Healthy Michigan. Furthermore, I ask that the state use its own data to identify people with CF for exemption to minimize the risk of inappropriate disenrollment and administrative burden on recipients.

CF is a life-threatening genetic disease that causes persistent lung infections and progressively limits the ability to breathe, often leading to respiratory failure. Over 1,100 people in Michigan live with CF. There is no known cure. As a complex, multi-system condition, CF requires targeted, highly specialized treatment and medications.

Medicaid plays an important role in helping people with CF—including 200 adults in the state—access the high-quality care and treatments they need to lead healthy, productive lives. While many Medicaid recipients living with CF are employed, others are unable to due to health status or the amount of time they need to spend on their treatments. To stay healthy, people with CF must endure hours of treatment every day – including receiving chest physiotherapy, taking inhaled treatments, potentially administering IV antibiotics, and other activities. In addition, people with CF commonly deal with pulmonary exacerbations (episodes where the symptoms of CF get worse and often lead to hospitalization), infections, and other events that cause their health to decline rapidly, potentially taking them out of the workforce for significant periods of time.

While I appreciate that the state plans to exempt individuals designated as "medically frail" and those with a medical condition that results in a work limitation according to a licensed medical professional, I am concerned that CF is not included in the list of diagnostic codes that will be automatically exempt. I am asking the state to add CF to this list of conditions that will be specifically and automatically exempt people from this Medicaid work requirement.

Consistent care is a critical component of CF treatment, and any loss or gaps in health coverage, because of failure to comply with these requirements, may put the health of people with CF at risk.

Again, I urge you to specifically and automatically exempt people with CF from the work requirement. Your attention to this matter will help people with CF continue to have access to the high-quality, specialized care they need to live full and healthy lives.

Sincerely,

[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Wednesday, August 1, 2018 10:05:57 AM

Dear Acting Deputy Director Stiffler,

As a constituent and someone personally affected by cystic fibrosis (CF), I'm writing to ask you to specifically and automatically exempt people with CF from work and community engagement requirements in Healthy Michigan. Furthermore, I ask that the state use its own data to identify people with CF for exemption to minimize the risk of inappropriate disenrollment and administrative burden on recipients.

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Again, I urge you to specifically and automatically exempt people with CF from the work requirement. Your attention to this matter will help people with CF continue to have access to the high-quality, specialized care they need to live full and healthy lives.

Sincerely,

[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Wednesday, August 1, 2018 10:05:52 AM

Dear Acting Deputy Director Stiffler,

As a constituent and someone personally affected by cystic fibrosis (CF), I'm writing to ask you to specifically and automatically exempt people with CF from work and community engagement requirements in Healthy Michigan. Furthermore, I ask that the state use its own data to identify people with CF for exemption to minimize the risk of inappropriate disenrollment and administrative burden on recipients.

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Again, I urge you to specifically and automatically exempt people with CF from the work requirement. Your attention to this matter will help people with CF continue to have access to the high-quality, specialized care they need to live full and healthy lives.

Sincerely,

[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Wednesday, August 1, 2018 10:05:38 AM

Dear Acting Deputy Director Stiffler,

As a constituent and someone personally affected by cystic fibrosis (CF), I'm writing to ask you to specifically and automatically exempt people with CF from work and community engagement requirements in Healthy Michigan. Furthermore, I ask that the state use its own data to identify people with CF for exemption to minimize the risk of inappropriate disenrollment and administrative burden on recipients.

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Again, I urge you to specifically and automatically exempt people with CF from the work requirement. Your attention to this matter will help people with CF continue to have access to the high-quality, specialized care they need to live full and healthy lives.

Sincerely,

[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Wednesday, August 1, 2018 10:03:29 AM

Dear Acting Deputy Director Stiffler,

As a constituent and someone personally affected by cystic fibrosis (CF), I'm writing to ask you to specifically and automatically exempt people with CF from work and community engagement requirements in Healthy Michigan. Furthermore, I ask that the state use its own data to identify people with CF for exemption to minimize the risk of inappropriate disenrollment and administrative burden on recipients.

CF is a life-threatening genetic disease that causes persistent lung infections and progressively limits the ability to breathe, often leading to respiratory failure. Over 1,100 people in Michigan live with CF. There is no known cure. As a complex, multi-system condition, CF requires targeted, highly specialized treatment and medications.

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Consistent care is a critical component of CF treatment, and any loss or gaps in health coverage, because of failure to comply with these requirements, may put the health of people with CF at risk.

Again, I urge you to specifically and automatically exempt people with CF from the work requirement. Your attention to this matter will help people with CF continue to have access to the high-quality, specialized care they need to live full and healthy lives.

Sincerely,

[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Wednesday, August 1, 2018 10:02:31 AM

Dear Acting Deputy Director Stiffler,

As a constituent and someone personally affected by cystic fibrosis (CF), I'm writing to ask you to specifically and automatically exempt people with CF from work and community engagement requirements in Healthy Michigan. Furthermore, I ask that the state use its own data to identify people with CF for exemption to minimize the risk of inappropriate disenrollment and administrative burden on recipients.

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Again, I urge you to specifically and automatically exempt people with CF from the work requirement. Your attention to this matter will help people with CF continue to have access to the high-quality, specialized care they need to live full and healthy lives.

Sincerely,

[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Wednesday, August 1, 2018 10:05:57 AM

Dear Acting Deputy Director Stiffler,

As a constituent and someone personally affected by cystic fibrosis (CF), I'm writing to ask you to specifically and automatically exempt people with CF from work and community engagement requirements in Healthy Michigan. Furthermore, I ask that the state use its own data to identify people with CF for exemption to minimize the risk of inappropriate disenrollment and administrative burden on recipients.

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Again, I urge you to specifically and automatically exempt people with CF from the work requirement. Your attention to this matter will help people with CF continue to have access to the high-quality, specialized care they need to live full and healthy lives.

Sincerely,

[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Wednesday, August 1, 2018 9:57:16 AM

Dear Acting Deputy Director Stiffler,

As a constituent and someone personally affected by cystic fibrosis (CF), I'm writing to ask you to specifically and automatically exempt people with CF from work and community engagement requirements in Healthy Michigan. Furthermore, I ask that the state use its own data to identify people with CF for exemption to minimize the risk of inappropriate disenrollment and administrative burden on recipients.

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Again, I urge you to specifically and automatically exempt people with CF from the work requirement. Your attention to this matter will help people with CF continue to have access to the high-quality, specialized care they need to live full and healthy lives.

Sincerely,

[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Wednesday, August 1, 2018 9:57:08 AM

Dear Acting Deputy Director Stiffler,

As a constituent and someone personally affected by cystic fibrosis (CF), I'm writing to ask you to specifically and automatically exempt people with CF from work and community engagement requirements in Healthy Michigan. Furthermore, I ask that the state use its own data to identify people with CF for exemption to minimize the risk of inappropriate disenrollment and administrative burden on recipients.

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Again, I urge you to specifically and automatically exempt people with CF from the work requirement. Your attention to this matter will help people with CF continue to have access to the high-quality, specialized care they need to live full and healthy lives.

Sincerely,

[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Wednesday, August 1, 2018 9:52:43 AM

Dear Acting Deputy Director Stiffler,

As a constituent and someone personally affected by cystic fibrosis (CF), I'm writing to ask you to specifically and automatically exempt people with CF from work and community engagement requirements in Healthy Michigan. Furthermore, I ask that the state use its own data to identify people with CF for exemption to minimize the risk of inappropriate disenrollment and administrative burden on recipients.

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Sincerely,

[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Wednesday, August 1, 2018 11:23:00 AM

Dear Acting Deputy Director Stiffler,

As the Medical Director of the [redacted] Program that provides care for approximately 50% of all adults with CF in the State, I'm writing to ask you to specifically and automatically exempt people with CF from work and community engagement requirements in Healthy Michigan. Furthermore, I ask that the state use its own data to identify people with CF for exemption to minimize the risk of inappropriate disenrollment and administrative burden on recipients.

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Again, I urge you to specifically and automatically exempt people with CF from the work requirement. Your attention to this matter will help people with CF continue to have access to the high-quality, specialized care they need to live full and healthy lives.

Sincerely,

[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Thursday, August 2, 2018 2:52:53 AM

Dear Acting Deputy Director Stiffler,

As a constituent and someone personally affected by cystic fibrosis (CF), I'm writing to ask you to specifically and automatically exempt people with CF from work and community engagement requirements in Healthy Michigan. Furthermore, I ask that the state use its own data to identify people with CF for exemption to minimize the risk of inappropriate disenrollment and administrative burden on recipients.

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Again, I urge you to specifically and automatically exempt people with CF from the work requirement. Your attention to this matter will help people with CF continue to have access to the high-quality, specialized care they need to live full and healthy lives.

Sincerely,

[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Friday, August 3, 2018 12:16:20 AM

Dear Acting Deputy Director Stiffler,

As a constituent and someone personally affected by cystic fibrosis (CF), I'm writing to ask you to specifically and automatically exempt people with CF from work and community engagement requirements in Healthy Michigan. Furthermore, I ask that the state use its own data to identify people with CF for exemption to minimize the risk of inappropriate disenrollment and administrative burden on recipients.

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Again, I urge you to specifically and automatically exempt people with CF from the work requirement. Your attention to this matter will help people with CF continue to have access to the high-quality, specialized care they need to live full and healthy lives.

Sincerely,

[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Friday, August 3, 2018 8:42:05 AM

Dear Acting Deputy Director Stiffler,

As a constituent and someone personally affected by cystic fibrosis (CF), I'm writing to ask you to specifically and automatically exempt people with CF from work and community engagement requirements in Healthy Michigan. Furthermore, I ask that the state use its own data to identify people with CF for exemption to minimize the risk of inappropriate disenrollment and administrative burden on recipients.

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Again, I urge you to specifically and automatically exempt people with CF from the work requirement. Your attention to this matter will help people with CF continue to have access to the high-quality, specialized care they need to live full and healthy lives.

Sincerely,

[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Sunday, August 5, 2018 4:49:00 PM

Dear Acting Deputy Director Stiffler,

As a constituent and someone personally affected by cystic fibrosis (CF), I'm writing to ask you to specifically and automatically exempt people with CF from work and community engagement requirements in Healthy Michigan. Furthermore, I ask that the state use its own data to identify people with CF for exemption to minimize the risk of inappropriate disenrollment and administrative burden on recipients.

CF is a life-threatening genetic disease that causes persistent lung infections and progressively limits the ability to breathe, often leading to respiratory failure. Over 1,100 people in Michigan live with CF. There is no known cure. As a complex, multi-system condition, CF requires targeted, highly specialized treatment and medications.

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Again, I urge you to specifically and automatically exempt people with CF from the work requirement. Your attention to this matter will help people with CF continue to have access to the high-quality, specialized care they need to live full and healthy lives.

Sincerely,

[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Monday, August 6, 2018 3:30:37 PM

Dear Acting Deputy Director Stiffler,

As a constituent and someone personally affected by cystic fibrosis (CF), I'm writing to ask you to specifically and automatically exempt people with CF from work and community engagement requirements in Healthy Michigan. Furthermore, I ask that the state use its own data to identify people with CF for exemption to minimize the risk of inappropriate disenrollment and administrative burden on recipients.

CF is a life-threatening genetic disease that causes persistent lung infections and progressively limits the ability to breathe, often leading to respiratory failure. Over 1,100 people in Michigan live with CF. There is no known cure. As a complex, multi-system condition, CF requires targeted, highly specialized treatment and medications.

Medicaid plays an important role in helping people with CF—including 200 adults in the state—access the high-quality care and treatments they need to lead healthy, productive lives. While many Medicaid recipients living with CF are employed, others are unable to due to health status or the amount of time they need to spend on their treatments. To stay healthy, people with CF must endure hours of treatment every day – including receiving chest physiotherapy, taking inhaled treatments, potentially administering IV antibiotics, and other activities. In addition, people with CF commonly deal with pulmonary exacerbations (episodes where the symptoms of CF get worse and often lead to hospitalization), infections, and other events that cause their health to decline rapidly, potentially taking them out of the workforce for significant periods of time.

While I appreciate that the state plans to exempt individuals designated as "medically frail" and those with a medical condition that results in a work limitation according to a licensed medical professional, I am concerned that CF is not included in the list of diagnostic codes that will be automatically exempt. I am asking the state to add CF to this list of conditions that will be specifically and automatically exempt people from this Medicaid work requirement.

Consistent care is a critical component of CF treatment, and any loss or gaps in health coverage, because of failure to comply with these requirements, may put the health of people with CF at risk.

Again, I urge you to specifically and automatically exempt people with CF from the work requirement. Your attention to this matter will help people with CF continue to have access to the high-quality, specialized care they need to live full and healthy lives.

Sincerely,

[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Monday, August 6, 2018 4:50:08 PM

Dear Acting Deputy Director Stiffler,

As a constituent and someone personally affected by cystic fibrosis (CF), I'm writing to ask you to specifically and automatically exempt people with CF from work and community engagement requirements in Healthy Michigan. Furthermore, I ask that the state use its own data to identify people with CF for exemption to minimize the risk of inappropriate disenrollment and administrative burden on recipients.

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Sincerely,

[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Monday, August 6, 2018 5:24:48 PM

Dear Acting Deputy Director Stiffler,

As a constituent and someone personally affected by cystic fibrosis (CF), I'm writing to ask you to specifically and automatically exempt people with CF from work and community engagement requirements in Healthy Michigan. Furthermore, I ask that the state use its own data to identify people with CF for exemption to minimize the risk of inappropriate disenrollment and administrative burden on recipients.

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Sincerely,

[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Monday, August 6, 2018 5:55:58 PM

Dear Acting Deputy Director Stiffler,

As a constituent and someone personally affected by cystic fibrosis (CF), I'm writing to ask you to specifically and automatically exempt people with CF from work and community engagement requirements in Healthy Michigan. Furthermore, I ask that the state use its own data to identify people with CF for exemption to minimize the risk of inappropriate disenrollment and administrative burden on recipients.

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Sincerely,

[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Monday, August 6, 2018 6:17:19 PM

Dear Acting Deputy Director Stiffler,

As a constituent and someone personally affected by cystic fibrosis (CF), I'm writing to ask you to specifically and automatically exempt people with CF from work and community engagement requirements in Healthy Michigan. Furthermore, I ask that the state use its own data to identify people with CF for exemption to minimize the risk of inappropriate disenrollment and administrative burden on recipients.

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Again, I urge you to specifically and automatically exempt people with CF from the work requirement. Your attention to this matter will help people with CF continue to have access to the high-quality, specialized care they need to live full and healthy lives.

Sincerely,

[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Monday, August 6, 2018 6:49:13 PM

Dear Acting Deputy Director Stiffler,

As a constituent and someone personally affected by cystic fibrosis (CF), I'm writing to ask you to specifically and automatically exempt people with CF from work and community engagement requirements in Healthy Michigan. Furthermore, I ask that the state use its own data to identify people with CF for exemption to minimize the risk of inappropriate disenrollment and administrative burden on recipients.

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Sincerely,

[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Monday, August 6, 2018 7:20:56 PM

Dear Acting Deputy Director Stiffler,

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Sincerely,

[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Monday, August 6, 2018 7:44:46 PM

Dear Acting Deputy Director Stiffler,

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Sincerely,

[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Monday, August 6, 2018 7:58:05 PM

Dear Acting Deputy Director Stiffler,

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Sincerely,

[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Monday, August 6, 2018 8:14:45 PM

Dear Acting Deputy Director Stiffler,

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Sincerely,

[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Monday, August 6, 2018 8:18:05 PM

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Sincerely,

[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Monday, August 6, 2018 8:37:37 PM

Dear Acting Deputy Director Stiffler,

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Sincerely,

[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Monday, August 6, 2018 8:40:08 PM

Dear Acting Deputy Director Stiffler,

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Sincerely,

[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Monday, August 6, 2018 8:48:34 PM

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Sincerely,

[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Monday, August 6, 2018 9:07:10 PM

Dear Acting Deputy Director Stiffler,

As a constituent and someone personally affected by cystic fibrosis (CF), I'm writing to ask you to specifically and automatically exempt people with CF from work and community engagement requirements in Healthy Michigan. Furthermore, I ask that the state use its own data to identify people with CF for exemption to minimize the risk of inappropriate disenrollment and administrative burden on recipients.

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Sincerely,

[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Monday, August 6, 2018 9:20:26 PM

Dear Acting Deputy Director Stiffler,

As a constituent and someone personally affected by cystic fibrosis (CF), I'm writing to ask you to specifically and automatically exempt people with CF from work and community engagement requirements in Healthy Michigan. Furthermore, I ask that the state use its own data to identify people with CF for exemption to minimize the risk of inappropriate disenrollment and administrative burden on recipients.

CF is a life-threatening genetic disease that causes persistent lung infections and progressively limits the ability to breathe, often leading to respiratory failure. Over 1,100 people in Michigan live with CF. There is no known cure. As a complex, multi-system condition, CF requires targeted, highly specialized treatment and medications.

Medicaid plays an important role in helping people with CF—including 200 adults in the state—access the high-quality care and treatments they need to lead healthy, productive lives. While many Medicaid recipients living with CF are employed, others are unable to due to health status or the amount of time they need to spend on their treatments. To stay healthy, people with CF must endure hours of treatment every day – including receiving chest physiotherapy, taking inhaled treatments, potentially administering IV antibiotics, and other activities. In addition, people with CF commonly deal with pulmonary exacerbations (episodes where the symptoms of CF get worse and often lead to hospitalization), infections, and other events that cause their health to decline rapidly, potentially taking them out of the workforce for significant periods of time.

While I appreciate that the state plans to exempt individuals designated as "medically frail" and those with a medical condition that results in a work limitation according to a licensed medical professional, I am concerned that CF is not included in the list of diagnostic codes that will be automatically exempt. I am asking the state to add CF to this list of conditions that will be specifically and automatically exempt people from this Medicaid work requirement.

Consistent care is a critical component of CF treatment, and any loss or gaps in health coverage, because of failure to comply with these requirements, may put the health of people with CF at risk.

Again, I urge you to specifically and automatically exempt people with CF from the work requirement. Your attention to this matter will help people with CF continue to have access to the high-quality, specialized care they need to live full and healthy lives.

Sincerely,

[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Monday, August 6, 2018 9:21:09 PM

Dear Acting Deputy Director Stiffler,

As a constituent and someone personally affected by cystic fibrosis (CF), I'm writing to ask you to specifically and automatically exempt people with CF from work and community engagement requirements in Healthy Michigan. Furthermore, I ask that the state use its own data to identify people with CF for exemption to minimize the risk of inappropriate disenrollment and administrative burden on recipients.

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Consistent care is a critical component of CF treatment, and any loss or gaps in health coverage, because of failure to comply with these requirements, may put the health of people with CF at risk.

Again, I urge you to specifically and automatically exempt people with CF from the work requirement. Your attention to this matter will help people with CF continue to have access to the high-quality, specialized care they need to live full and healthy lives.

Sincerely,

[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Monday, August 6, 2018 9:24:42 PM

Dear Acting Deputy Director Stiffler,

As a constituent and someone personally affected by cystic fibrosis (CF), I'm writing to ask you to specifically and automatically exempt people with CF from work and community engagement requirements in Healthy Michigan. Furthermore, I ask that the state use its own data to identify people with CF for exemption to minimize the risk of inappropriate disenrollment and administrative burden on recipients.

CF is a life-threatening genetic disease that causes persistent lung infections and progressively limits the ability to breathe, often leading to respiratory failure. Over 1,100 people in Michigan live with CF. There is no known cure. As a complex, multi-system condition, CF requires targeted, highly specialized treatment and medications.

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Consistent care is a critical component of CF treatment, and any loss or gaps in health coverage, because of failure to comply with these requirements, may put the health of people with CF at risk.

Again, I urge you to specifically and automatically exempt people with CF from the work requirement. Your attention to this matter will help people with CF continue to have access to the high-quality, specialized care they need to live full and healthy lives.

Sincerely,

[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Monday, August 6, 2018 9:42:01 PM

Dear Acting Deputy Director Stiffler,

As a constituent and someone personally affected by cystic fibrosis (CF), I'm writing to ask you to specifically and automatically exempt people with CF from work and community engagement requirements in Healthy Michigan. Furthermore, I ask that the state use its own data to identify people with CF for exemption to minimize the risk of inappropriate disenrollment and administrative burden on recipients.

CF is a life-threatening genetic disease that causes persistent lung infections and progressively limits the ability to breathe, often leading to respiratory failure. Over 1,100 people in Michigan live with CF. There is no known cure. As a complex, multi-system condition, CF requires targeted, highly specialized treatment and medications.

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Consistent care is a critical component of CF treatment, and any loss or gaps in health coverage, because of failure to comply with these requirements, may put the health of people with CF at risk.

Again, I urge you to specifically and automatically exempt people with CF from the work requirement. Your attention to this matter will help people with CF continue to have access to the high-quality, specialized care they need to live full and healthy lives.

Sincerely,

[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Monday, August 6, 2018 10:13:17 PM

Dear Acting Deputy Director Stiffler,

As a constituent and someone personally affected by cystic fibrosis (CF), I'm writing to ask you to specifically and automatically exempt people with CF from work and community engagement requirements in Healthy Michigan. Furthermore, I ask that the state use its own data to identify people with CF for exemption to minimize the risk of inappropriate disenrollment and administrative burden on recipients.

CF is a life-threatening genetic disease that causes persistent lung infections and progressively limits the ability to breathe, often leading to respiratory failure. Over 1,100 people in Michigan live with CF. There is no known cure. As a complex, multi-system condition, CF requires targeted, highly specialized treatment and medications.

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While I appreciate that the state plans to exempt individuals designated as "medically frail" and those with a medical condition that results in a work limitation according to a licensed medical professional, I am concerned that CF is not included in the list of diagnostic codes that will be automatically exempt. I am asking the state to add CF to this list of conditions that will be specifically and automatically exempt people from this Medicaid work requirement.

Consistent care is a critical component of CF treatment, and any loss or gaps in health coverage, because of failure to comply with these requirements, may put the health of people with CF at risk.

Again, I urge you to specifically and automatically exempt people with CF from the work requirement. Your attention to this matter will help people with CF continue to have access to the high-quality, specialized care they need to live full and healthy lives.

Sincerely,

[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Monday, August 6, 2018 10:15:15 PM

Dear Acting Deputy Director Stiffler,

As a constituent and someone personally affected by cystic fibrosis (CF), I'm writing to ask you to specifically and automatically exempt people with CF from work and community engagement requirements in Healthy Michigan. Furthermore, I ask that the state use its own data to identify people with CF for exemption to minimize the risk of inappropriate disenrollment and administrative burden on recipients.

CF is a life-threatening genetic disease that causes persistent lung infections and progressively limits the ability to breathe, often leading to respiratory failure. Over 1,100 people in Michigan live with CF. There is no known cure. As a complex, multi-system condition, CF requires targeted, highly specialized treatment and medications.

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While I appreciate that the state plans to exempt individuals designated as "medically frail" and those with a medical condition that results in a work limitation according to a licensed medical professional, I am concerned that CF is not included in the list of diagnostic codes that will be automatically exempt. I am asking the state to add CF to this list of conditions that will be specifically and automatically exempt people from this Medicaid work requirement.

Consistent care is a critical component of CF treatment, and any loss or gaps in health coverage, because of failure to comply with these requirements, may put the health of people with CF at risk.

Again, I urge you to specifically and automatically exempt people with CF from the work requirement. Your attention to this matter will help people with CF continue to have access to the high-quality, specialized care they need to live full and healthy lives.

Sincerely,

[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Monday, August 6, 2018 10:46:07 PM

Dear Acting Deputy Director Stiffler,

As a constituent and someone personally affected by cystic fibrosis (CF), I'm writing to ask you to specifically and automatically exempt people with CF from work and community engagement requirements in Healthy Michigan. Furthermore, I ask that the state use its own data to identify people with CF for exemption to minimize the risk of inappropriate disenrollment and administrative burden on recipients.

CF is a life-threatening genetic disease that causes persistent lung infections and progressively limits the ability to breathe, often leading to respiratory failure. Over 1,100 people in Michigan live with CF. There is no known cure. As a complex, multi-system condition, CF requires targeted, highly specialized treatment and medications.

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While I appreciate that the state plans to exempt individuals designated as "medically frail" and those with a medical condition that results in a work limitation according to a licensed medical professional, I am concerned that CF is not included in the list of diagnostic codes that will be automatically exempt. I am asking the state to add CF to this list of conditions that will be specifically and automatically exempt people from this Medicaid work requirement.

Consistent care is a critical component of CF treatment, and any loss or gaps in health coverage, because of failure to comply with these requirements, may put the health of people with CF at risk.

Again, I urge you to specifically and automatically exempt people with CF from the work requirement. Your attention to this matter will help people with CF continue to have access to the high-quality, specialized care they need to live full and healthy lives.

Sincerely,

[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Monday, August 6, 2018 11:09:50 PM

Dear Acting Deputy Director Stiffler,

As a mother of a daughter personally affected by cystic fibrosis (CF), I'm writing to ask you to specifically and automatically exempt people with CF from work and community engagement requirements in Healthy Michigan. Furthermore, I ask that the state use its own data to identify people with CF for exemption to minimize the risk of inappropriate disenrollment and administrative burden on recipients.

CF is a life-threatening genetic disease that causes persistent lung infections and progressively limits the ability to breathe, often leading to respiratory failure. Over 1,100 people in Michigan live with CF. There is no known cure. As a complex, multi-system condition, CF requires targeted, highly specialized treatment and medications.

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While I appreciate that the state plans to exempt individuals designated as "medically frail" and those with a medical condition that results in a work limitation according to a licensed medical professional, I am concerned that CF is not included in the list of diagnostic codes that will be automatically exempt. I am asking the state to add CF to this list of conditions that will be specifically and automatically exempt people from this Medicaid work requirement.

Consistent care is a critical component of CF treatment, and any loss or gaps in health coverage, because of failure to comply with these requirements, may put the health of my daughter and people with CF at risk.

Again, I urge you to specifically and automatically exempt my daughter and people with CF from the work requirement. Your attention to this matter will help my daughter and people with CF to continue to have access to the high-quality, specialized care they need to live full and healthy lives.

Sincerely,

[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Monday, August 6, 2018 11:22:16 PM

Dear Acting Deputy Director Stiffler,

As a constituent and someone personally affected by cystic fibrosis (CF), I'm writing to ask you to specifically and automatically exempt people with CF from work and community engagement requirements in Healthy Michigan. Furthermore, I ask that the state use its own data to identify people with CF for exemption to minimize the risk of inappropriate disenrollment and administrative burden on recipients.

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Consistent care is a critical component of CF treatment, and any loss or gaps in health coverage, because of failure to comply with these requirements, may put the health of people with CF at risk.

Again, I urge you to specifically and automatically exempt people with CF from the work requirement. Your attention to this matter will help people with CF continue to have access to the high-quality, specialized care they need to live full and healthy lives.

Sincerely,

[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Tuesday, August 7, 2018 12:58:23 AM

Dear Acting Deputy Director Stiffler,

As a constituent and someone personally affected by cystic fibrosis (CF), I'm writing to ask you to specifically and automatically exempt people with CF from work and community engagement requirements in Healthy Michigan. Furthermore, I ask that the state use its own data to identify people with CF for exemption to minimize the risk of inappropriate disenrollment and administrative burden on recipients.

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Consistent care is a critical component of CF treatment, and any loss or gaps in health coverage, because of failure to comply with these requirements, may put the health of people with CF at risk.

Again, I urge you to specifically and automatically exempt people with CF from the work requirement. Your attention to this matter will help people with CF continue to have access to the high-quality, specialized care they need to live full and healthy lives.

Sincerely,

[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Tuesday, August 7, 2018 3:39:39 AM

Dear Acting Deputy Director Stiffler,

As a constituent and someone personally affected by cystic fibrosis (CF), I'm writing to ask you to specifically and automatically exempt people with CF from work and community engagement requirements in Healthy Michigan. Furthermore, I ask that the state use its own data to identify people with CF for exemption to minimize the risk of inappropriate disenrollment and administrative burden on recipients.

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Consistent care is a critical component of CF treatment, and any loss or gaps in health coverage, because of failure to comply with these requirements, may put the health of people with CF at risk.

Again, I urge you to specifically and automatically exempt people with CF from the work requirement. Your attention to this matter will help people with CF continue to have access to the high-quality, specialized care they need to live full and healthy lives.

Sincerely,

[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Tuesday, August 7, 2018 7:00:46 AM

Dear Acting Deputy Director Stiffler,

As a constituent and someone personally affected by cystic fibrosis (CF), I'm writing to ask you to specifically and automatically exempt people with CF from work and community engagement requirements in Healthy Michigan. Furthermore, I ask that the state use its own data to identify people with CF for exemption to minimize the risk of inappropriate disenrollment and administrative burden on recipients.

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Again, I urge you to specifically and automatically exempt people with CF from the work requirement. Your attention to this matter will help people with CF continue to have access to the high-quality, specialized care they need to live full and healthy lives.

Sincerely,

[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Tuesday, August 7, 2018 7:04:19 AM

Dear Acting Deputy Director Stiffler,

As a constituent and someone personally affected by cystic fibrosis (CF), I'm writing to ask you to specifically and automatically exempt people with CF from work and community engagement requirements in Healthy Michigan. Furthermore, I ask that the state use its own data to identify people with CF for exemption to minimize the risk of inappropriate disenrollment and administrative burden on recipients.

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Again, I urge you to specifically and automatically exempt people with CF from the work requirement. Your attention to this matter will help people with CF continue to have access to the high-quality, specialized care they need to live full and healthy lives.

Sincerely,

[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Tuesday, August 7, 2018 7:42:50 AM

Dear Acting Deputy Director Stiffler,

As a constituent and someone personally affected by cystic fibrosis (CF), I'm writing to ask you to specifically and automatically exempt people with CF from work and community engagement requirements in Healthy Michigan. Furthermore, I ask that the state use its own data to identify people with CF for exemption to minimize the risk of inappropriate disenrollment and administrative burden on recipients.

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Consistent care is a critical component of CF treatment, and any loss or gaps in health coverage, because of failure to comply with these requirements, may put the health of people with CF at risk.

Again, I urge you to specifically and automatically exempt people with CF from the work requirement. Your attention to this matter will help people with CF continue to have access to the high-quality, specialized care they need to live full and healthy lives.

Sincerely,

[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Tuesday, August 7, 2018 7:51:06 AM

Dear Acting Deputy Director Stiffler,

As a constituent and someone personally affected by cystic fibrosis (CF), I'm writing to ask you to specifically and automatically exempt people with CF from work and community engagement requirements in Healthy Michigan. Furthermore, I ask that the state use its own data to identify people with CF for exemption to minimize the risk of inappropriate disenrollment and administrative burden on recipients.

CF is a life-threatening genetic disease that causes persistent lung infections and progressively limits the ability to breathe, often leading to respiratory failure. Over 1,100 people in Michigan live with CF. There is no known cure. As a complex, multi-system condition, CF requires targeted, highly specialized treatment and medications.

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Consistent care is a critical component of CF treatment, and any loss or gaps in health coverage, because of failure to comply with these requirements, may put the health of people with CF at risk.

Again, I urge you to specifically and automatically exempt people with CF from the work requirement. Your attention to this matter will help people with CF continue to have access to the high-quality, specialized care they need to live full and healthy lives.

Sincerely,

[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Tuesday, August 7, 2018 7:51:51 AM

Dear Acting Deputy Director Stiffler,

As a constituent and someone personally affected by cystic fibrosis (CF), I'm writing to ask you to specifically and automatically exempt people with CF from work and community engagement requirements in Healthy Michigan. Furthermore, I ask that the state use its own data to identify people with CF for exemption to minimize the risk of inappropriate disenrollment and administrative burden on recipients.

CF is a life-threatening genetic disease that causes persistent lung infections and progressively limits the ability to breathe, often leading to respiratory failure. Over 1,100 people in Michigan live with CF. There is no known cure. As a complex, multi-system condition, CF requires targeted, highly specialized treatment and medications.

Medicaid plays an important role in helping people with CF—including 200 adults in the state—access the high-quality care and treatments they need to lead healthy, productive lives. While many Medicaid recipients living with CF are employed, others are unable to due to health status or the amount of time they need to spend on their treatments. To stay healthy, people with CF must endure hours of treatment every day – including receiving chest physiotherapy, taking inhaled treatments, potentially administering IV antibiotics, and other activities. In addition, people with CF commonly deal with pulmonary exacerbations (episodes where the symptoms of CF get worse and often lead to hospitalization), infections, and other events that cause their health to decline rapidly, potentially taking them out of the workforce for significant periods of time.

While I appreciate that the state plans to exempt individuals designated as "medically frail" and those with a medical condition that results in a work limitation according to a licensed medical professional, I am concerned that CF is not included in the list of diagnostic codes that will be automatically exempt. I am asking the state to add CF to this list of conditions that will be specifically and automatically exempt people from this Medicaid work requirement.

Consistent care is a critical component of CF treatment, and any loss or gaps in health coverage, because of failure to comply with these requirements, may put the health of people with CF at risk.

Again, I urge you to specifically and automatically exempt people with CF from the work requirement. Your attention to this matter will help people with CF continue to have access to the high-quality, specialized care they need to live full and healthy lives.

Sincerely,

[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Tuesday, August 7, 2018 7:52:00 AM

Dear Acting Deputy Director Stiffler,

As a constituent and someone personally affected by cystic fibrosis (CF), I'm writing to ask you to specifically and automatically exempt people with CF from work and community engagement requirements in Healthy Michigan. Furthermore, I ask that the state use its own data to identify people with CF for exemption to minimize the risk of inappropriate disenrollment and administrative burden on recipients.

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Consistent care is a critical component of CF treatment, and any loss or gaps in health coverage, because of failure to comply with these requirements, may put the health of people with CF at risk.

Again, I urge you to specifically and automatically exempt people with CF from the work requirement. Your attention to this matter will help people with CF continue to have access to the high-quality, specialized care they need to live full and healthy lives.

Sincerely,

[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Tuesday, August 7, 2018 8:04:42 AM

Dear Acting Deputy Director Stiffler,

As a constituent and someone personally affected by cystic fibrosis (CF), I'm writing to ask you to specifically and automatically exempt people with CF from work and community engagement requirements in Healthy Michigan. Furthermore, I ask that the state use its own data to identify people with CF for exemption to minimize the risk of inappropriate disenrollment and administrative burden on recipients.

CF is a life-threatening genetic disease that causes persistent lung infections and progressively limits the ability to breathe, often leading to respiratory failure. Over 1,100 people in Michigan live with CF. There is no known cure. As a complex, multi-system condition, CF requires targeted, highly specialized treatment and medications.

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While I appreciate that the state plans to exempt individuals designated as "medically frail" and those with a medical condition that results in a work limitation according to a licensed medical professional, I am concerned that CF is not included in the list of diagnostic codes that will be automatically exempt. I am asking the state to add CF to this list of conditions that will be specifically and automatically exempt people from this Medicaid work requirement.

Consistent care is a critical component of CF treatment, and any loss or gaps in health coverage, because of failure to comply with these requirements, may put the health of people with CF at risk.

Again, I urge you to specifically and automatically exempt people with CF from the work requirement. Your attention to this matter will help people with CF continue to have access to the high-quality, specialized care they need to live full and healthy lives.
I just lost a 24 year old friend to CF right around his golden birthday in June. His name was [redacted]. They thought he wouldnt live past 16. I have another amazing little friend named [redacted] with CF who just turned 4. Who most likely I will outlive. Im 35. I cry just writing that as she is an amazing little girl who deserves everything in life. Please help these people who require special things.

Sincerely,

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Tuesday, August 7, 2018 8:15:22 AM

Dear Acting Deputy Director Stiffler,

As a constituent and someone personally affected by cystic fibrosis (CF), I'm writing to ask you to specifically and automatically exempt people with CF from work and community engagement requirements in Healthy Michigan. Furthermore, I ask that the state use its own data to identify people with CF for exemption to minimize the risk of inappropriate disenrollment and administrative burden on recipients.

CF is a life-threatening genetic disease that causes persistent lung infections and progressively limits the ability to breathe, often leading to respiratory failure. Over 1,100 people in Michigan live with CF. There is no known cure. As a complex, multi-system condition, CF requires targeted, highly specialized treatment and medications.

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While I appreciate that the state plans to exempt individuals designated as "medically frail" and those with a medical condition that results in a work limitation according to a licensed medical professional, I am concerned that CF is not included in the list of diagnostic codes that will be automatically exempt. I am asking the state to add CF to this list of conditions that will be specifically and automatically exempt people from this Medicaid work requirement.

Consistent care is a critical component of CF treatment, and any loss or gaps in health coverage, because of failure to comply with these requirements, may put the health of people with CF at risk.

Again, I urge you to specifically and automatically exempt people with CF from the work requirement. Your attention to this matter will help people with CF continue to have access to the high-quality, specialized care they need to live full and healthy lives.

Sincerely,

[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Tuesday, August 7, 2018 8:48:15 AM

Dear Acting Deputy Director Stiffler,

As a constituent and someone personally affected by cystic fibrosis (CF), I'm writing to ask you to specifically and automatically exempt people with CF from work and community engagement requirements in Healthy Michigan. Furthermore, I ask that the state use its own data to identify people with CF for exemption to minimize the risk of inappropriate disenrollment and administrative burden on recipients.

CF is a life-threatening genetic disease that causes persistent lung infections and progressively limits the ability to breathe, often leading to respiratory failure. Over 1,100 people in Michigan live with CF. There is no known cure. As a complex, multi-system condition, CF requires targeted, highly specialized treatment and medications.

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Consistent care is a critical component of CF treatment, and any loss or gaps in health coverage, because of failure to comply with these requirements, may put the health of people with CF at risk.

Again, I urge you to specifically and automatically exempt people with CF from the work requirement. Your attention to this matter will help people with CF continue to have access to the high-quality, specialized care they need to live full and healthy lives.

Sincerely,

[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Tuesday, August 7, 2018 8:51:21 AM

Dear Acting Deputy Director Stiffler,

As someone personally affected by cystic fibrosis (CF), I'm writing to ask you to specifically and automatically exempt people with CF from work and community engagement requirements in Healthy Michigan. Furthermore, I ask that the state use its own data to identify people with CF for exemption to minimize the risk of inappropriate disenrollment and administrative burden on recipients.

My son has CF and while he's only 4 years old today, his need for medication and ability to stay healthy in order to work one day will be contingent on his receiving Medicaid. He also has a drive, already, to be active and able to help anyone in need. If he does not have health treatments, he won't be able to work and if he's not able to work, he won't have health treatments. There's a cycle here.

CF is a life-threatening genetic disease that causes persistent lung infections and progressively limits the ability to breathe, often leading to respiratory failure. Over 1,100 people in Michigan live with CF. There is no known cure. As a complex, multi-system condition, CF requires targeted, highly specialized treatment and medications.

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Consistent care is a critical component of CF treatment, and any loss or gaps in health coverage, because of failure to comply with these requirements, may put the health of people with CF at risk.

Again, I urge you to specifically and automatically exempt people with CF from the work requirement. Your attention to this matter will help people with CF continue to have access to the high-quality, specialized care they need to live full and healthy lives.

Sincerely,

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Tuesday, August 7, 2018 8:52:27 AM

Dear Acting Deputy Director Stiffler,

As a constituent and someone personally affected by cystic fibrosis (CF), I'm writing to ask you to specifically and automatically exempt people with CF from work and community engagement requirements in Healthy Michigan. Furthermore, I ask that the state use its own data to identify people with CF for exemption to minimize the risk of inappropriate disenrollment and administrative burden on recipients.

CF is a life-threatening genetic disease that causes persistent lung infections and progressively limits the ability to breathe, often leading to respiratory failure. Over 1,100 people in Michigan live with CF. There is no known cure. As a complex, multi-system condition, CF requires targeted, highly specialized treatment and medications.

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Again, I urge you to specifically and automatically exempt people with CF from the work requirement. Your attention to this matter will help people with CF continue to have access to the high-quality, specialized care they need to live full and healthy lives.

Sincerely,

[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Tuesday, August 7, 2018 8:54:45 AM

Dear Acting Deputy Director Stiffler,

As a constituent and someone personally affected by cystic fibrosis (CF), I'm writing to ask you to specifically and automatically exempt people with CF from work and community engagement requirements in Healthy Michigan. Furthermore, I ask that the state use its own data to identify people with CF for exemption to minimize the risk of inappropriate disenrollment and administrative burden on recipients.

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Again, I urge you to specifically and automatically exempt people with CF from the work requirement. Your attention to this matter will help people with CF continue to have access to the high-quality, specialized care they need to live full and healthy lives.

Sincerely,

[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Tuesday, August 7, 2018 9:07:05 AM

Dear Acting Deputy Director Stiffler,

As a constituent and someone personally affected by cystic fibrosis (CF), I'm writing to ask you to specifically and automatically exempt people with CF from work and community engagement requirements in Healthy Michigan. Furthermore, I ask that the state use its own data to identify people with CF for exemption to minimize the risk of inappropriate disenrollment and administrative burden on recipients.

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Again, I urge you to specifically and automatically exempt people with CF from the work requirement. Your attention to this matter will help people with CF continue to have access to the high-quality, specialized care they need to live full and healthy lives.

Sincerely,

[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Tuesday, August 7, 2018 9:43:28 AM

Dear Acting Deputy Director Stiffler,

As a constituent and someone personally affected by cystic fibrosis (CF), I'm writing to ask you to specifically and automatically exempt people with CF from work and community engagement requirements in Healthy Michigan. Furthermore, I ask that the state use its own data to identify people with CF for exemption to minimize the risk of inappropriate disenrollment and administrative burden on recipients.

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Again, I urge you to specifically and automatically exempt people with CF from the work requirement. Your attention to this matter will help people with CF continue to have access to the high-quality, specialized care they need to live full and healthy lives.

Sincerely,

[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Tuesday, August 7, 2018 9:51:57 AM

Dear Acting Deputy Director Stiffler,

As a constituent and someone personally affected by cystic fibrosis (CF), I'm writing to ask you to specifically and automatically exempt people with CF from work and community engagement requirements in Healthy Michigan. Furthermore, I ask that the state use its own data to identify people with CF for exemption to minimize the risk of inappropriate disenrollment and administrative burden on recipients.

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Again, I urge you to specifically and automatically exempt people with CF from the work requirement. Your attention to this matter will help people with CF continue to have access to the high-quality, specialized care they need to live full and healthy lives.

Sincerely,

[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Tuesday, August 7, 2018 10:34:28 AM

Dear Acting Deputy Director Stiffler,

As a constituent and someone personally affected by cystic fibrosis (CF), I'm writing to ask you to specifically and automatically exempt people with CF from work and community engagement requirements in Healthy Michigan. Furthermore, I ask that the state use its own data to identify people with CF for exemption to minimize the risk of inappropriate disenrollment and administrative burden on recipients.

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Again, I urge you to specifically and automatically exempt people with CF from the work requirement. Your attention to this matter will help people with CF continue to have access to the high-quality, specialized care they need to live full and healthy lives.

Sincerely,

[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Tuesday, August 7, 2018 10:46:18 AM

Dear Acting Deputy Director Stiffler,

As a constituent and someone personally affected by cystic fibrosis (CF), I'm writing to ask you to specifically and automatically exempt people with CF from work and community engagement requirements in Healthy Michigan. Furthermore, I ask that the state use its own data to identify people with CF for exemption to minimize the risk of inappropriate disenrollment and administrative burden on recipients.

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Consistent care is a critical component of CF treatment, and any loss or gaps in health coverage, because of failure to comply with these requirements, may put the health of people with CF at risk.

Again, I urge you to specifically and automatically exempt people with CF from the work requirement. Your attention to this matter will help people with CF continue to have access to the high-quality, specialized care they need to live full and healthy lives.

Sincerely,

[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Tuesday, August 7, 2018 10:47:14 AM

Dear Acting Deputy Director Stiffler,

As a constituent and someone personally affected by cystic fibrosis (CF), I'm writing to ask you to specifically and automatically exempt people with CF from work and community engagement requirements in Healthy Michigan. Furthermore, I ask that the state use its own data to identify people with CF for exemption to minimize the risk of inappropriate disenrollment and administrative burden on recipients.

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Again, I urge you to specifically and automatically exempt people with CF from the work requirement. Your attention to this matter will help people with CF continue to have access to the high-quality, specialized care they need to live full and healthy lives.

Sincerely,

[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Tuesday, August 7, 2018 12:06:48 PM

Dear Acting Deputy Director Stiffler,

As a constituent and someone personally affected by cystic fibrosis (CF), I'm writing to ask you to specifically and automatically exempt people with CF from work and community engagement requirements in Healthy Michigan. Furthermore, I ask that the state use its own data to identify people with CF for exemption to minimize the risk of inappropriate disenrollment and administrative burden on recipients.

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Consistent care is a critical component of CF treatment, and any loss or gaps in health coverage, because of failure to comply with these requirements, may put the health of people with CF at risk.

Again, I urge you to specifically and automatically exempt people with CF from the work requirement. Your attention to this matter will help people with CF continue to have access to the high-quality, specialized care they need to live full and healthy lives.

Sincerely,

[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Tuesday, August 7, 2018 12:20:31 PM

Dear Acting Deputy Director Stiffler,

As a constituent and someone whos friends' are personally affected by cystic fibrosis (CF), I'm writing to ask you to specifically and automatically exempt people with CF from work and community engagement requirements in Healthy Michigan. Furthermore, I ask that the state use its own data to identify people with CF for exemption to minimize the risk of inappropriate disenrollment and administrative burden on recipients.

CF is a life-threatening genetic disease that causes persistent lung infections and progressively limits the ability to breathe, often leading to respiratory failure. Over 1,100 people in Michigan live with CF. There is no known cure. As a complex, multi-system condition, CF requires targeted, highly specialized treatment and medications.

Medicaid plays an important role in helping people with CF—including 200 adults in the state—access the high-quality care and treatments they need to lead healthy, productive lives. While many Medicaid recipients living with CF are employed, others are unable to due to health status or the amount of time they need to spend on their treatments. To stay healthy, people with CF must endure hours of treatment every day – including receiving chest physiotherapy, taking inhaled treatments, potentially administering IV antibiotics, and other activities. In addition, people with CF commonly deal with pulmonary exacerbations (episodes where the symptoms of CF get worse and often lead to hospitalization), infections, and other events that cause their health to decline rapidly, potentially taking them out of the workforce for significant periods of time.

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Again, I urge you to specifically and automatically exempt people with CF from the work requirement. Your attention to this matter will help people with CF continue to have access to the high-quality, specialized care they need to live full and healthy lives.

Sincerely,

[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Tuesday, August 7, 2018 12:22:28 PM

Dear Acting Deputy Director Stiffler,

As a constituent and someone personally affected by cystic fibrosis (CF), I'm writing to ask you to specifically and automatically exempt people with CF from work and community engagement requirements in Healthy Michigan. Furthermore, I ask that the state use its own data to identify people with CF for exemption to minimize the risk of inappropriate disenrollment and administrative burden on recipients.

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Again, I urge you to specifically and automatically exempt people with CF from the work requirement. Your attention to this matter will help people with CF continue to have access to the high-quality, specialized care they need to live full and healthy lives.

Sincerely,

[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Tuesday, August 7, 2018 12:28:34 PM

Dear Acting Deputy Director Stiffler,

As a constituent and someone personally affected by cystic fibrosis (CF), I'm writing to ask you to specifically and automatically exempt people with CF from work and community engagement requirements in Healthy Michigan. Furthermore, I ask that the state use its own data to identify people with CF for exemption to minimize the risk of inappropriate disenrollment and administrative burden on recipients.

CF is a life-threatening genetic disease that causes persistent lung infections and progressively limits the ability to breathe, often leading to respiratory failure. Over 1,100 people in Michigan live with CF. There is no known cure. As a complex, multi-system condition, CF requires targeted, highly specialized treatment and medications.

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Consistent care is a critical component of CF treatment, and any loss or gaps in health coverage, because of failure to comply with these requirements, may put the health of people with CF at risk.

Again, I urge you to specifically and automatically exempt people with CF from the work requirement. Your attention to this matter will help people with CF continue to have access to the high-quality, specialized care they need to live full and healthy lives.

Sincerely,

[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Tuesday, August 7, 2018 12:31:35 PM

Dear Acting Deputy Director Stiffler,

As a constituent and someone personally affected by cystic fibrosis (CF), I'm writing to ask you to specifically and automatically exempt people with CF from work and community engagement requirements in Healthy Michigan. Furthermore, I ask that the state use its own data to identify people with CF for exemption to minimize the risk of inappropriate disenrollment and administrative burden on recipients.

CF is a life-threatening genetic disease that causes persistent lung infections and progressively limits the ability to breathe, often leading to respiratory failure. Over 1,100 people in Michigan live with CF. There is no known cure. As a complex, multi-system condition, CF requires targeted, highly specialized treatment and medications.

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Consistent care is a critical component of CF treatment, and any loss or gaps in health coverage, because of failure to comply with these requirements, may put the health of people with CF at risk.

Again, I urge you to specifically and automatically exempt people with CF from the work requirement. Your attention to this matter will help people with CF continue to have access to the high-quality, specialized care they need to live full and healthy lives.

Sincerely,

[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Tuesday, August 7, 2018 12:32:31 PM

Dear Acting Deputy Director Stiffler,

As a constituent and someone invested in the mission to find effective treatments and eventually a cure for cystic fibrosis (CF), I'm writing to ask you to specifically and automatically exempt people with CF from work and community engagement requirements in Healthy Michigan. Furthermore, I ask that the state use its own data to identify people with CF for exemption to minimize the risk of inappropriate disenrollment and administrative burden on recipients.

CF is a life-threatening genetic disease that causes persistent lung infections and progressively limits the ability to breathe, often leading to respiratory failure. Over 1,100 people in Michigan live with CF. There is no known cure. As a complex, multi-system condition, CF requires targeted, highly specialized treatment and medications.

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Consistent care is a critical component of CF treatment, and any loss or gaps in health coverage, because of failure to comply with these requirements, may put the health of people with CF at risk.

Again, I urge you to specifically and automatically exempt people with CF from the work requirement. Your attention to this matter will help people with CF continue to have access to the high-quality, specialized care they need to live full and healthy lives.

Sincerely,

[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Tuesday, August 7, 2018 12:36:01 PM

Dear Acting Deputy Director Stiffler,

As a constituent and someone personally affected by cystic fibrosis (CF), I'm writing to ask you to specifically and automatically exempt people with CF from work and community engagement requirements in Healthy Michigan. Furthermore, I ask that the state use its own data to identify people with CF for exemption to minimize the risk of inappropriate disenrollment and administrative burden on recipients.

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Consistent care is a critical component of CF treatment, and any loss or gaps in health coverage, because of failure to comply with these requirements, may put the health of people with CF at risk.

Again, I urge you to specifically and automatically exempt people with CF from the work requirement. Your attention to this matter will help people with CF continue to have access to the high-quality, specialized care they need to live full and healthy lives.

Sincerely,

[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Tuesday, August 7, 2018 12:41:53 PM

Dear Acting Deputy Director Stiffler,

As a constituent and someone personally affected by cystic fibrosis (CF), I'm writing to ask you to specifically and automatically exempt people with CF from work and community engagement requirements in Healthy Michigan. Furthermore, I ask that the state use its own data to identify people with CF for exemption to minimize the risk of inappropriate disenrollment and administrative burden on recipients.

CF is a life-threatening genetic disease that causes persistent lung infections and progressively limits the ability to breathe, often leading to respiratory failure. Over 1,100 people in Michigan live with CF. There is no known cure. As a complex, multi-system condition, CF requires targeted, highly specialized treatment and medications.

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Again, I urge you to specifically and automatically exempt people with CF from the work requirement. Your attention to this matter will help people with CF continue to have access to the high-quality, specialized care they need to live full and healthy lives.

Sincerely,

[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Tuesday, August 7, 2018 12:48:03 PM

Dear Acting Deputy Director Stiffler,

As a constituent and someone personally affected by cystic fibrosis (CF), I'm writing to ask you to specifically and automatically exempt people with CF from work and community engagement requirements in Healthy Michigan. Furthermore, I ask that the state use its own data to identify people with CF for exemption to minimize the risk of inappropriate disenrollment and administrative burden on recipients.

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Consistent care is a critical component of CF treatment, and any loss or gaps in health coverage, because of failure to comply with these requirements, may put the health of people with CF at risk.

Again, I urge you to specifically and automatically exempt people with CF from the work requirement. Your attention to this matter will help people with CF continue to have access to the high-quality, specialized care they need to live full and healthy lives.

Sincerely,

[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Tuesday, August 7, 2018 12:59:47 PM

Dear Acting Deputy Director Stiffler,

As a constituent and someone personally affected by cystic fibrosis (CF), I'm writing to ask you to specifically and automatically exempt people with CF from work and community engagement requirements in Healthy Michigan. Furthermore, I ask that the state use its own data to identify people with CF for exemption to minimize the risk of inappropriate disenrollment and administrative burden on recipients.

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Again, I urge you to specifically and automatically exempt people with CF from the work requirement. Your attention to this matter will help people with CF continue to have access to the high-quality, specialized care they need to live full and healthy lives.

Sincerely,

[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Tuesday, August 7, 2018 1:01:53 PM

Dear Acting Deputy Director Stiffler,

As a constituent and someone personally affected by cystic fibrosis (CF), I'm writing to ask you to specifically and automatically exempt people with CF from work and community engagement requirements in Healthy Michigan. Furthermore, I ask that the state use its own data to identify people with CF for exemption to minimize the risk of inappropriate disenrollment and administrative burden on recipients.

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Sincerely,

[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Tuesday, August 7, 2018 1:06:52 PM

Dear Acting Deputy Director Stiffler,

As a constituent and someone personally affected by cystic fibrosis (CF), I'm writing to ask you to specifically and automatically exempt people with CF from work and community engagement requirements in Healthy Michigan. Furthermore, I ask that the state use its own data to identify people with CF for exemption to minimize the risk of inappropriate disenrollment and administrative burden on recipients.

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Sincerely,

[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Tuesday, August 7, 2018 1:10:49 PM

Dear Acting Deputy Director Stiffler,

As a constituent and someone personally affected by cystic fibrosis (CF), I'm writing to ask you to specifically and automatically exempt people with CF from work and community engagement requirements in Healthy Michigan. Furthermore, I ask that the state use its own data to identify people with CF for exemption to minimize the risk of inappropriate disenrollment and administrative burden on recipients.

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Again, I urge you to specifically and automatically exempt people with CF from the work requirement. Your attention to this matter will help people with CF continue to have access to the high-quality, specialized care they need to live full and healthy lives.

Sincerely,

[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Tuesday, August 7, 2018 1:22:17 PM

Dear Acting Deputy Director Stiffler,

As a constituent and someone personally affected by cystic fibrosis (CF), I'm writing to ask you to specifically and automatically exempt people with CF from work and community engagement requirements in Healthy Michigan. Furthermore, I ask that the state use its own data to identify people with CF for exemption to minimize the risk of inappropriate disenrollment and administrative burden on recipients.

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Again, I urge you to specifically and automatically exempt people with CF from the work requirement. Your attention to this matter will help people with CF continue to have access to the high-quality, specialized care they need to live full and healthy lives.

Sincerely,

[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Tuesday, August 7, 2018 1:28:33 PM

Dear Acting Deputy Director Stiffler,

As a constituent and someone personally affected by cystic fibrosis (CF), I'm writing to ask you to specifically and automatically exempt people with CF from work and community engagement requirements in Healthy Michigan. Furthermore, I ask that the state use its own data to identify people with CF for exemption to minimize the risk of inappropriate disenrollment and administrative burden on recipients.

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Sincerely,

[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Tuesday, August 7, 2018 1:41:12 PM

Dear Acting Deputy Director Stiffler,

As a constituent and someone personally affected by cystic fibrosis (CF), I'm writing to ask you to specifically and automatically exempt people with CF from work and community engagement requirements in Healthy Michigan. Furthermore, I ask that the state use its own data to identify people with CF for exemption to minimize the risk of inappropriate disenrollment and administrative burden on recipients.

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Consistent care is a critical component of CF treatment, and any loss or gaps in health coverage, because of failure to comply with these requirements, may put the health of people with CF at risk.

Again, I urge you to specifically and automatically exempt people with CF from the work requirement. Your attention to this matter will help people with CF continue to have access to the high-quality, specialized care they need to live full and healthy lives.

Sincerely,

[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Tuesday, August 7, 2018 1:53:23 PM

Dear Acting Deputy Director Stiffler,

As a constituent and someone personally affected by cystic fibrosis (CF), I'm writing to ask you to specifically and automatically exempt people with CF from work and community engagement requirements in Healthy Michigan. Furthermore, I ask that the state use its own data to identify people with CF for exemption to minimize the risk of inappropriate disenrollment and administrative burden on recipients.

CF is a life-threatening genetic disease that causes persistent lung infections and progressively limits the ability to breathe, often leading to respiratory failure. Over 1,100 people in Michigan live with CF. There is no known cure. As a complex, multi-system condition, CF requires targeted, highly specialized treatment and medications.

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Again, I urge you to specifically and automatically exempt people with CF from the work requirement. Your attention to this matter will help people with CF continue to have access to the high-quality, specialized care they need to live full and healthy lives.

Sincerely,

[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Tuesday, August 7, 2018 2:00:20 PM

Dear Acting Deputy Director Stiffler,

As a constituent and someone personally affected by cystic fibrosis (CF), I'm writing to ask you to specifically and automatically exempt people with CF from work and community engagement requirements in Healthy Michigan. Furthermore, I ask that the state use its own data to identify people with CF for exemption to minimize the risk of inappropriate disenrollment and administrative burden on recipients.

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Again, I urge you to specifically and automatically exempt people with CF from the work requirement. Your attention to this matter will help people with CF continue to have access to the high-quality, specialized care they need to live full and healthy lives.

Sincerely,

[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Tuesday, August 7, 2018 2:03:46 PM

Dear Acting Deputy Director Stiffler,

As a constituent and someone personally affected by cystic fibrosis (CF), I'm writing to ask you to specifically and automatically exempt people with CF from work and community engagement requirements in Healthy Michigan. Furthermore, I ask that the state use its own data to identify people with CF for exemption to minimize the risk of inappropriate disenrollment and administrative burden on recipients.

CF is a life-threatening genetic disease that causes persistent lung infections and progressively limits the ability to breathe, often leading to respiratory failure. Over 1,100 people in Michigan live with CF. There is no known cure. As a complex, multi-system condition, CF requires targeted, highly specialized treatment and medications.

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Again, I urge you to specifically and automatically exempt people with CF from the work requirement. Your attention to this matter will help people with CF continue to have access to the high-quality, specialized care they need to live full and healthy lives.

Sincerely,

[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Tuesday, August 7, 2018 2:28:40 PM

Dear Acting Deputy Director Stiffler,

As a constituent and someone personally affected by cystic fibrosis (CF), I'm writing to ask you to specifically and automatically exempt people with CF from work and community engagement requirements in Healthy Michigan. Furthermore, I ask that the state use its own data to identify people with CF for exemption to minimize the risk of inappropriate disenrollment and administrative burden on recipients.

CF is a life-threatening genetic disease that causes persistent lung infections and progressively limits the ability to breathe, often leading to respiratory failure. Over 1,100 people in Michigan live with CF. There is no known cure. As a complex, multi-system condition, CF requires targeted, highly specialized treatment and medications.

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Consistent care is a critical component of CF treatment, and any loss or gaps in health coverage, because of failure to comply with these requirements, may put the health of people with CF at risk.

Again, I urge you to specifically and automatically exempt people with CF from the work requirement. Your attention to this matter will help people with CF continue to have access to the high-quality, specialized care they need to live full and healthy lives.

Sincerely,

[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Tuesday, August 7, 2018 2:30:11 PM

Dear Acting Deputy Director Stiffler,

As a constituent and someone personally affected by cystic fibrosis (CF), I'm writing to ask you to specifically and automatically exempt people with CF from work and community engagement requirements in Healthy Michigan. Furthermore, I ask that the state use its own data to identify people with CF for exemption to minimize the risk of inappropriate disenrollment and administrative burden on recipients.

CF is a life-threatening genetic disease that causes persistent lung infections and progressively limits the ability to breathe, often leading to respiratory failure. Over 1,100 people in Michigan live with CF. There is no known cure. As a complex, multi-system condition, CF requires targeted, highly specialized treatment and medications.

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Consistent care is a critical component of CF treatment, and any loss or gaps in health coverage, because of failure to comply with these requirements, may put the health of people with CF at risk.

Again, I urge you to specifically and automatically exempt people with CF from the work requirement. Your attention to this matter will help people with CF continue to have access to the high-quality, specialized care they need to live full and healthy lives.

Sincerely,

[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Tuesday, August 7, 2018 2:30:32 PM

Dear Acting Deputy Director Stiffler,

As a constituent and someone personally affected by cystic fibrosis (CF), I'm writing to ask you to specifically and automatically exempt people with CF from work and community engagement requirements in Healthy Michigan. Furthermore, I ask that the state use its own data to identify people with CF for exemption to minimize the risk of inappropriate disenrollment and administrative burden on recipients.

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Consistent care is a critical component of CF treatment, and any loss or gaps in health coverage, because of failure to comply with these requirements, may put the health of people with CF at risk.

Again, I urge you to specifically and automatically exempt people with CF from the work requirement. Your attention to this matter will help people with CF continue to have access to the high-quality, specialized care they need to live full and healthy lives.

Sincerely,

[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Tuesday, August 7, 2018 2:31:15 PM

Dear Acting Deputy Director Stiffler,

As a constituent and someone personally affected by cystic fibrosis (CF), I'm writing to ask you to specifically and automatically exempt people with CF from work and community engagement requirements in Healthy Michigan. Furthermore, I ask that the state use its own data to identify people with CF for exemption to minimize the risk of inappropriate disenrollment and administrative burden on recipients.

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Consistent care is a critical component of CF treatment, and any loss or gaps in health coverage, because of failure to comply with these requirements, may put the health of people with CF at risk.

Again, I urge you to specifically and automatically exempt people with CF from the work requirement. Your attention to this matter will help people with CF continue to have access to the high-quality, specialized care they need to live full and healthy lives.

Sincerely,

[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Tuesday, August 7, 2018 2:34:34 PM

Dear Acting Deputy Director Stiffler,

As a constituent and someone personally affected by cystic fibrosis (CF), I'm writing to ask you to specifically and automatically exempt people with CF from work and community engagement requirements in Healthy Michigan. Furthermore, I ask that the state use its own data to identify people with CF for exemption to minimize the risk of inappropriate disenrollment and administrative burden on recipients.

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Again, I urge you to specifically and automatically exempt people with CF from the work requirement. Your attention to this matter will help people with CF continue to have access to the high-quality, specialized care they need to live full and healthy lives.

Sincerely,

[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Tuesday, August 7, 2018 2:34:41 PM

Dear Acting Deputy Director Stiffler,

As a constituent, and with someone dear to me affected by cystic fibrosis (CF), I'm writing to ask you to specifically and automatically exempt people with CF from work and community engagement requirements in Healthy Michigan. Furthermore, I ask that the state use its own data to identify people with CF for exemption to minimize the risk of inappropriate disenrollment and administrative burden on recipients.

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Again, I urge you to specifically and automatically exempt people with CF from the work requirement. Your attention to this matter will help people with CF continue to have access to the high-quality, specialized care they need to live full and healthy lives.

Sincerely,

[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Tuesday, August 7, 2018 2:35:24 PM

Dear Acting Deputy Director Stiffler,

As a constituent and someone personally affected by cystic fibrosis (CF), I'm writing to ask you to specifically and automatically exempt people with CF from work and community engagement requirements in Healthy Michigan. Furthermore, I ask that the state use its own data to identify people with CF for exemption to minimize the risk of inappropriate disenrollment and administrative burden on recipients.

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Again, I urge you to specifically and automatically exempt people with CF from the work requirement. Your attention to this matter will help people with CF continue to have access to the high-quality, specialized care they need to live full and healthy lives.

Sincerely,

[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Tuesday, August 7, 2018 2:37:35 PM

Dear Acting Deputy Director Stiffler,

As a constituent and someone personally affected by cystic fibrosis (CF), I'm writing to ask you to specifically and automatically exempt people with CF from work and community engagement requirements in Healthy Michigan. Furthermore, I ask that the state use its own data to identify people with CF for exemption to minimize the risk of inappropriate disenrollment and administrative burden on recipients.

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Sincerely,

[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Tuesday, August 7, 2018 2:37:47 PM

Dear Acting Deputy Director Stiffler,

As a constituent and someone personally affected by cystic fibrosis (CF), I'm writing to ask you to specifically and automatically exempt people with CF from work and community engagement requirements in Healthy Michigan. Furthermore, I ask that the state use its own data to identify people with CF for exemption to minimize the risk of inappropriate disenrollment and administrative burden on recipients.

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Sincerely,

[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Tuesday, August 7, 2018 2:41:26 PM

Dear Acting Deputy Director Stiffler,

As a constituent and someone personally affected by cystic fibrosis (CF), I'm writing to ask you to specifically and automatically exempt people with CF from work and community engagement requirements in Healthy Michigan. Furthermore, I ask that the state use its own data to identify people with CF for exemption to minimize the risk of inappropriate disenrollment and administrative burden on recipients.

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Again, I urge you to specifically and automatically exempt people with CF from the work requirement. Your attention to this matter will help people with CF continue to have access to the high-quality, specialized care they need to live full and healthy lives.

Sincerely,

[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Tuesday, August 7, 2018 2:46:02 PM

Dear Acting Deputy Director Stiffler,

As a constituent and someone personally affected by cystic fibrosis (CF), I'm writing to ask you to specifically and automatically exempt people with CF from work and community engagement requirements in Healthy Michigan. Furthermore, I ask that the state use its own data to identify people with CF for exemption to minimize the risk of inappropriate disenrollment and administrative burden on recipients.

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Again, I urge you to specifically and automatically exempt people with CF from the work requirement. Your attention to this matter will help people with CF continue to have access to the high-quality, specialized care they need to live full and healthy lives.

Sincerely,

[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Tuesday, August 7, 2018 2:51:45 PM

Dear Acting Deputy Director Stiffler,

As a constituent and someone personally affected by cystic fibrosis (CF), I'm writing to ask you to specifically and automatically exempt people with CF from work and community engagement requirements in Healthy Michigan. Furthermore, I ask that the state use its own data to identify people with CF for exemption to minimize the risk of inappropriate disenrollment and administrative burden on recipients.

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Medicaid plays an important role in helping people with CF—including 200 adults in the state—access the high-quality care and treatments they need to lead healthy, productive lives. While many Medicaid recipients living with CF are employed, others are unable to due to health status or the amount of time they need to spend on their treatments. To stay healthy, people with CF must endure hours of treatment every day – including receiving chest physiotherapy, taking inhaled treatments, potentially administering IV antibiotics, and other activities. In addition, people with CF commonly deal with pulmonary exacerbations (episodes where the symptoms of CF get worse and often lead to hospitalization), infections, and other events that cause their health to decline rapidly, potentially taking them out of the workforce for significant periods of time.

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Consistent care is a critical component of CF treatment, and any loss or gaps in health coverage, because of failure to comply with these requirements, may put the health of people with CF at risk.

Again, I urge you to specifically and automatically exempt people with CF from the work requirement. Your attention to this matter will help people with CF continue to have access to the high-quality, specialized care they need to live full and healthy lives.

Sincerely,

[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Tuesday, August 7, 2018 2:53:13 PM

Dear Acting Deputy Director Stiffler,

As a constituent and someone personally affected by cystic fibrosis (CF), I'm writing to ask you to specifically and automatically exempt people with CF from work and community engagement requirements in Healthy Michigan. Furthermore, I ask that the state use its own data to identify people with CF for exemption to minimize the risk of inappropriate disenrollment and administrative burden on recipients.

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Sincerely,

[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Tuesday, August 7, 2018 2:56:17 PM

Dear Acting Deputy Director Stiffler,

As a constituent and someone personally affected by cystic fibrosis (CF), I'm writing to ask you to specifically and automatically exempt people with CF from work and community engagement requirements in Healthy Michigan. Furthermore, I ask that the state use its own data to identify people with CF for exemption to minimize the risk of inappropriate disenrollment and administrative burden on recipients.

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Sincerely,

[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Tuesday, August 7, 2018 2:56:22 PM

Dear Acting Deputy Director Stiffler,

As a constituent and someone personally affected by cystic fibrosis (CF), I'm writing to ask you to specifically and automatically exempt people with CF from work and community engagement requirements in Healthy Michigan. Furthermore, I ask that the state use its own data to identify people with CF for exemption to minimize the risk of inappropriate disenrollment and administrative burden on recipients.

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Sincerely,

[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Tuesday, August 7, 2018 2:58:34 PM

Dear Acting Deputy Director Stiffler,

As a constituent and someone personally affected by cystic fibrosis (CF), I'm writing to ask you to specifically and automatically exempt people with CF from work and community engagement requirements in Healthy Michigan. Furthermore, I ask that the state use its own data to identify people with CF for exemption to minimize the risk of inappropriate disenrollment and administrative burden on recipients.

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Again, I urge you to specifically and automatically exempt people with CF from the work requirement. Your attention to this matter will help people with CF continue to have access to the high-quality, specialized care they need to live full and healthy lives.

Sincerely,

[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Tuesday, August 7, 2018 3:03:43 PM

Dear Acting Deputy Director Stiffler,

As a constituent and someone personally affected by cystic fibrosis (CF), I'm writing to ask you to specifically and automatically exempt people with CF from work and community engagement requirements in Healthy Michigan. Furthermore, I ask that the state use its own data to identify people with CF for exemption to minimize the risk of inappropriate disenrollment and administrative burden on recipients.

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Again, I urge you to specifically and automatically exempt people with CF from the work requirement. Your attention to this matter will help people with CF continue to have access to the high-quality, specialized care they need to live full and healthy lives.

Sincerely,

[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Tuesday, August 7, 2018 3:04:11 PM

Dear Acting Deputy Director Stiffler,

As a constituent and someone personally affected by cystic fibrosis (CF), I'm writing to ask you to specifically and automatically exempt people with CF from work and community engagement requirements in Healthy Michigan. Furthermore, I ask that the state use its own data to identify people with CF for exemption to minimize the risk of inappropriate disenrollment and administrative burden on recipients.

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Again, I urge you to specifically and automatically exempt people with CF from the work requirement. Your attention to this matter will help people with CF continue to have access to the high-quality, specialized care they need to live full and healthy lives.

Sincerely,

[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Tuesday, August 7, 2018 3:05:18 PM

Dear Acting Deputy Director Stiffler,

As a constituent and someone personally affected by cystic fibrosis (CF), I'm writing to ask you to specifically and automatically exempt people with CF from work and community engagement requirements in Healthy Michigan. Furthermore, I ask that the state use its own data to identify people with CF for exemption to minimize the risk of inappropriate disenrollment and administrative burden on recipients.

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Sincerely,

[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Tuesday, August 7, 2018 3:07:37 PM

Dear Acting Deputy Director Stiffler,

As a constituent and someone personally affected by cystic fibrosis (CF), I'm writing to ask you to specifically and automatically exempt people with CF from work and community engagement requirements in Healthy Michigan. Furthermore, I ask that the state use its own data to identify people with CF for exemption to minimize the risk of inappropriate disenrollment and administrative burden on recipients.

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Sincerely,

[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Tuesday, August 7, 2018 3:10:27 PM

Dear Acting Deputy Director Stiffler,

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Sincerely,

[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Tuesday, August 7, 2018 3:14:56 PM

Dear Acting Deputy Director Stiffler,

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Sincerely,

[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Tuesday, August 7, 2018 3:22:13 PM

Dear Acting Deputy Director Stiffler,

As a constituent and someone personally affected by cystic fibrosis (CF), I'm writing to ask you to specifically and automatically exempt people with CF from work and community engagement requirements in Healthy Michigan. Furthermore, I ask that the state use its own data to identify people with CF for exemption to minimize the risk of inappropriate disenrollment and administrative burden on recipients.

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Sincerely,

[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Tuesday, August 7, 2018 3:43:51 PM

Dear Acting Deputy Director Stiffler,

As a constituent and someone personally affected by cystic fibrosis (CF), I'm writing to ask you to specifically and automatically exempt people with CF from work and community engagement requirements in Healthy Michigan. Furthermore, I ask that the state use its own data to identify people with CF for exemption to minimize the risk of inappropriate disenrollment and administrative burden on recipients.

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Sincerely,

[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Tuesday, August 7, 2018 3:48:05 PM

Dear Acting Deputy Director Stiffler,

As a constituent and someone personally affected by cystic fibrosis (CF), I'm writing to ask you to specifically and automatically exempt people with CF from work and community engagement requirements in Healthy Michigan. Furthermore, I ask that the state use its own data to identify people with CF for exemption to minimize the risk of inappropriate disenrollment and administrative burden on recipients.

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Sincerely,

[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Tuesday, August 7, 2018 4:00:27 PM

Dear Acting Deputy Director Stiffler,

As a constituent and someone personally affected by cystic fibrosis (CF), I'm writing to ask you to specifically and automatically exempt people with CF from work and community engagement requirements in Healthy Michigan. Furthermore, I ask that the state use its own data to identify people with CF for exemption to minimize the risk of inappropriate disenrollment and administrative burden on recipients.

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Sincerely,

[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Tuesday, August 7, 2018 4:16:22 PM

Dear Acting Deputy Director Stiffler,

As a constituent and a physician who cares for patients with cystic fibrosis (CF), I'm writing to ask you to specifically exempt people with CF from work and community engagement requirements in Healthy Michigan. Furthermore, I ask that the state use its own data to identify people with CF for exemption to minimize the risk of inappropriate disenrollment and administrative burden on recipients.

CF is a life-threatening genetic disease that causes persistent lung infections and progressively limits the ability to breathe, often leading to respiratory failure. Over 1,100 people in Michigan live with CF. There is no known cure. As a complex, multi-system condition, CF requires targeted, highly specialized treatment and medications.

Medicaid plays an important role in helping people with CF—including 200 adults in the state—access the high-quality care and treatments they need to lead healthy, productive lives. While many Medicaid recipients living with CF are employed, others are unable to due to health status or the amount of time they need to spend on their treatments. To stay healthy, people with CF must engage in hours of treatment every day – including receiving chest physiotherapy, taking inhaled treatments, potentially administering IV antibiotics, and other activities. In addition, people with CF commonly deal with pulmonary exacerbations (episodes where the symptoms of CF get worse and often lead to hospitalization), infections, and other events that cause their health to decline rapidly, potentially taking them out of the workforce for significant periods of time.

While I appreciate that the state plans to exempt individuals designated as "medically frail" and those with a medical condition that results in a work limitation according to a licensed medical professional, I am concerned that CF is not included in the list of diagnostic codes that will be automatically exempt. I am asking the state to add CF to this list of conditions that will be specifically and automatically exempt people from this Medicaid work requirement.

Consistent care is a critical component of CF treatment, and any loss or gaps in health coverage, because of failure to comply with these requirements, may put the health of people with CF at risk.

Again, I urge you to specifically and automatically exempt people with CF from the work requirement. Your attention to this matter will help people with CF continue to have access to the high-quality, specialized care they need to live full and healthy lives.

Sincerely,

[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Tuesday, August 7, 2018 4:17:50 PM

Dear Acting Deputy Director Stiffler,

As a constituent and someone personally affected by cystic fibrosis (CF), I'm writing to ask you to specifically and automatically exempt people with CF from work and community engagement requirements in Healthy Michigan. Furthermore, I ask that the state use its own data to identify people with CF for exemption to minimize the risk of inappropriate disenrollment and administrative burden on recipients.

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Sincerely,

[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Tuesday, August 7, 2018 4:44:32 PM

Dear Acting Deputy Director Stiffler,

As a constituent and someone personally affected by cystic fibrosis (CF), I'm writing to ask you to specifically and automatically exempt people with CF from work and community engagement requirements in Healthy Michigan. Furthermore, I ask that the state use its own data to identify people with CF for exemption to minimize the risk of inappropriate disenrollment and administrative burden on recipients.

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Again, I urge you to specifically and automatically exempt people with CF from the work requirement. Your attention to this matter will help people with CF continue to have access to the high-quality, specialized care they need to live full and healthy lives.

Sincerely,

[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Tuesday, August 7, 2018 4:44:59 PM

Dear Acting Deputy Director Stiffler,

As a constituent and someone personally affected by cystic fibrosis (CF), I'm writing to ask you to specifically and automatically exempt people with CF from work and community engagement requirements in Healthy Michigan. Furthermore, I ask that the state use its own data to identify people with CF for exemption to minimize the risk of inappropriate disenrollment and administrative burden on recipients.

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Again, I urge you to specifically and automatically exempt people with CF from the work requirement. Your attention to this matter will help people with CF continue to have access to the high-quality, specialized care they need to live full and healthy lives.

Sincerely,

[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Tuesday, August 7, 2018 4:58:01 PM

Dear Acting Deputy Director Stiffler,

As a constituent and someone personally affected by cystic fibrosis (CF), I'm writing to ask you to specifically and automatically exempt people with CF from work and community engagement requirements in Healthy Michigan. Furthermore, I ask that the state use its own data to identify people with CF for exemption to minimize the risk of inappropriate disenrollment and administrative burden on recipients.

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Again, I urge you to specifically and automatically exempt people with CF from the work requirement. Your attention to this matter will help people with CF continue to have access to the high-quality, specialized care they need to live full and healthy lives.

Sincerely,

[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Tuesday, August 7, 2018 4:59:10 PM

Dear Acting Deputy Director Stiffler,

As a constituent and someone personally affected by cystic fibrosis (CF), I'm writing to ask you to specifically and automatically exempt people with CF from work and community engagement requirements in Healthy Michigan. Furthermore, I ask that the state use its own data to identify people with CF for exemption to minimize the risk of inappropriate disenrollment and administrative burden on recipients.

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Sincerely,

[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Tuesday, August 7, 2018 5:00:53 PM

Dear Acting Deputy Director Stiffler,

As a constituent and someone personally affected by cystic fibrosis (CF), I'm writing to ask you to specifically and automatically exempt people with CF from work and community engagement requirements in Healthy Michigan. Furthermore, I ask that the state use its own data to identify people with CF for exemption to minimize the risk of inappropriate disenrollment and administrative burden on recipients.

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Again, I urge you to specifically and automatically exempt people with CF from the work requirement. Your attention to this matter will help people with CF continue to have access to the high-quality, specialized care they need to live full and healthy lives.

Sincerely,

[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Tuesday, August 7, 2018 5:45:27 PM

Dear Acting Deputy Director Stiffler,

As a constituent and someone personally affected by cystic fibrosis (CF), I'm writing to ask you to specifically and automatically exempt people with CF from work and community engagement requirements in Healthy Michigan. Furthermore, I ask that the state use its own data to identify people with CF for exemption to minimize the risk of inappropriate disenrollment and administrative burden on recipients.

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Sincerely,

[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Tuesday, August 7, 2018 5:53:38 PM

Dear Acting Deputy Director Stiffler,

As a constituent and someone personally affected by cystic fibrosis (CF), I'm writing to ask you to specifically and automatically exempt people with CF from work and community engagement requirements in Healthy Michigan. Furthermore, I ask that the state use its own data to identify people with CF for exemption to minimize the risk of inappropriate disenrollment and administrative burden on recipients.

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Sincerely,

[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Tuesday, August 7, 2018 6:17:07 PM

Dear Acting Deputy Director Stiffler,

As a constituent and someone personally affected by cystic fibrosis (CF), I'm writing to ask you to specifically and automatically exempt people with CF from work and community engagement requirements in Healthy Michigan. Furthermore, I ask that the state use its own data to identify people with CF for exemption to minimize the risk of inappropriate disenrollment and administrative burden on recipients.

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Sincerely,

[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Tuesday, August 7, 2018 6:34:52 PM

Dear Acting Deputy Director Stiffler,

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Sincerely,

[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Tuesday, August 7, 2018 6:42:35 PM

Dear Acting Deputy Director Stiffler,

As a constituent and someone personally affected by cystic fibrosis (CF), I'm writing to ask you to specifically and automatically exempt people with CF from work and community engagement requirements in Healthy Michigan. Furthermore, I ask that the state use its own data to identify people with CF for exemption to minimize the risk of inappropriate disenrollment and administrative burden on recipients.

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Sincerely,

[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Tuesday, August 7, 2018 6:43:11 PM

Dear Acting Deputy Director Stiffler,

As a constituent and someone personally affected by cystic fibrosis (CF), I'm writing to ask you to specifically and automatically exempt people with CF from work and community engagement requirements in Healthy Michigan. Furthermore, I ask that the state use its own data to identify people with CF for exemption to minimize the risk of inappropriate disenrollment and administrative burden on recipients.

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Sincerely,

[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Tuesday, August 7, 2018 7:06:06 PM

Dear Acting Deputy Director Stiffler,

As a constituent and someone personally affected by cystic fibrosis (CF), I'm writing to ask you to specifically and automatically exempt people with CF from work and community engagement requirements in Healthy Michigan. Furthermore, I ask that the state use its own data to identify people with CF for exemption to minimize the risk of inappropriate disenrollment and administrative burden on recipients.

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Sincerely,

[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Tuesday, August 7, 2018 7:54:27 PM

Dear Acting Deputy Director Stiffler,

As a constituent and the great aunt of two wo derful young men personally affected by cystic fibrosis (CF), I'm writing to ask you to specifically and automatically exempt people with CF from work and community engagement requirements in Healthy Michigan. Furthermore, I ask that the state use its own data to identify people with CF for exemption to minimize the risk of inappropriate disenrollment and administrative burden on recipients.

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Sincerely, [redacted]

Sincerely,

[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Tuesday, August 7, 2018 7:59:33 PM

Dear Acting Deputy Director Stiffler,

As a constituent and someone personally affected by cystic fibrosis (CF), I'm writing to ask you to specifically and automatically exempt people with CF from work and community engagement requirements in Healthy Michigan. Furthermore, I ask that the state use its own data to identify people with CF for exemption to minimize the risk of inappropriate disenrollment and administrative burden on recipients.

CF is a life-threatening genetic disease that causes persistent lung infections and progressively limits the ability to breathe, often leading to respiratory failure. Over 1,100 people in Michigan live with CF. There is no known cure. As a complex, multi-system condition, CF requires targeted, highly specialized treatment and medications.

Medicaid plays an important role in helping people with CF—including 200 adults in the state—access the high-quality care and treatments they need to lead healthy, productive lives. While many Medicaid recipients living with CF are employed, others are unable to due to health status or the amount of time they need to spend on their treatments. To stay healthy, people with CF must endure hours of treatment every day – including receiving chest physiotherapy, taking inhaled treatments, potentially administering IV antibiotics, and other activities. In addition, people with CF commonly deal with pulmonary exacerbations (episodes where the symptoms of CF get worse and often lead to hospitalization), infections, and other events that cause their health to decline rapidly, potentially taking them out of the workforce for significant periods of time.

While I appreciate that the state plans to exempt individuals designated as "medically frail" and those with a medical condition that results in a work limitation according to a licensed medical professional, I am concerned that CF is not included in the list of diagnostic codes that will be automatically exempt. I am asking the state to add CF to this list of conditions that will be specifically and automatically exempt people from this Medicaid work requirement.

Consistent care is a critical component of CF treatment, and any loss or gaps in health coverage, because of failure to comply with these requirements, may put the health of people with CF at risk.

Again, I urge you to specifically and automatically exempt people with CF from the work requirement. Your attention to this matter will help people with CF continue to have access to the high-quality, specialized care they need to live full and healthy lives.

Sincerely,

[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Tuesday, August 7, 2018 8:32:15 PM

Dear Acting Deputy Director Stiffler,

Please put yourself in the shoes of someone with cystic fibrosis.

As a constituent and someone personally affected by cystic fibrosis (CF), I'm writing to ask you to specifically and automatically exempt people with CF from work and community engagement requirements in Healthy Michigan. Furthermore, I ask that the state use its own data to identify people with CF for exemption to minimize the risk of inappropriate disenrollment and administrative burden on recipients.

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Again, I urge you to specifically and automatically exempt people with CF from the work requirement. Your attention to this matter will help people with CF continue to have access to the high-quality, specialized care they need to live full and healthy lives.

Sincerely,

[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Tuesday, August 7, 2018 8:38:50 PM

Dear Acting Deputy Director Stiffler,

As a constituent and someone personally affected by cystic fibrosis (CF), I'm writing to ask you to specifically and automatically exempt people with CF from work and community engagement requirements in Healthy Michigan. Furthermore, I ask that the state use its own data to identify people with CF for exemption to minimize the risk of inappropriate disenrollment and administrative burden on recipients.

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Again, I urge you to specifically and automatically exempt people with CF from the work requirement. Your attention to this matter will help people with CF continue to have access to the high-quality, specialized care they need to live full and healthy lives.

Sincerely,

[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Tuesday, August 7, 2018 8:44:31 PM

Dear Acting Deputy Director Stiffler,

As a constituent and someone personally affected by cystic fibrosis (CF), I'm writing to ask you to specifically and automatically exempt people with CF from work and community engagement requirements in Healthy Michigan. Furthermore, I ask that the state use its own data to identify people with CF for exemption to minimize the risk of inappropriate disenrollment and administrative burden on recipients.

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Again, I urge you to specifically and automatically exempt people with CF from the work requirement. Your attention to this matter will help people with CF continue to have access to the high-quality, specialized care they need to live full and healthy lives.

Sincerely,

[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Tuesday, August 7, 2018 9:01:24 PM

Dear Acting Deputy Director Stiffler,

As a constituent and someone personally affected by cystic fibrosis (CF), I'm writing to ask you to specifically and automatically exempt people with CF from work and community engagement requirements in Healthy Michigan. Furthermore, I ask that the state use its own data to identify people with CF for exemption to minimize the risk of inappropriate disenrollment and administrative burden on recipients.

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Again, I urge you to specifically and automatically exempt people with CF from the work requirement. Your attention to this matter will help people with CF continue to have access to the high-quality, specialized care they need to live full and healthy lives.

Sincerely,

[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Tuesday, August 7, 2018 9:02:57 PM

Dear Acting Deputy Director Stiffler,

As a constituent and someone personally affected by cystic fibrosis (CF), I'm writing to ask you to specifically and automatically exempt people with CF from work and community engagement requirements in Healthy Michigan. Furthermore, I ask that the state use its own data to identify people with CF for exemption to minimize the risk of inappropriate disenrollment and administrative burden on recipients.

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Again, I urge you to specifically and automatically exempt people with CF from the work requirement. Your attention to this matter will help people with CF continue to have access to the high-quality, specialized care they need to live full and healthy lives.

Sincerely,

[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Tuesday, August 7, 2018 9:15:04 PM

Dear Acting Deputy Director Stiffler,

As a constituent and someone personally affected by cystic fibrosis (CF), I'm writing to ask you to specifically and automatically exempt people with CF from work and community engagement requirements in Healthy Michigan. Furthermore, I ask that the state use its own data to identify people with CF for exemption to minimize the risk of inappropriate disenrollment and administrative burden on recipients.

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Sincerely,

[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Tuesday, August 7, 2018 9:19:53 PM

Dear Acting Deputy Director Stiffler,

As a constituent and someone personally affected by cystic fibrosis (CF), I'm writing to ask you to specifically and automatically exempt people with CF from work and community engagement requirements in Healthy Michigan. Furthermore, I ask that the state use its own data to identify people with CF for exemption to minimize the risk of inappropriate disenrollment and administrative burden on recipients.

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Sincerely,

[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Tuesday, August 7, 2018 9:45:57 PM

Dear Acting Deputy Director Stiffler,

As a constituent and someone personally affected by cystic fibrosis (CF), I'm writing to ask you to specifically and automatically exempt people with CF from work and community engagement requirements in Healthy Michigan. Furthermore, I ask that the state use its own data to identify people with CF for exemption to minimize the risk of inappropriate disenrollment and administrative burden on recipients.

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Sincerely,

[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Tuesday, August 7, 2018 9:50:00 PM

Dear Acting Deputy Director Stiffler,

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Sincerely,

[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Tuesday, August 7, 2018 9:51:31 PM

Dear Acting Deputy Director Stiffler,

As a constituent and someone personally affected by cystic fibrosis (CF), I'm writing to ask you to specifically and automatically exempt people with CF from work and community engagement requirements in Healthy Michigan. Furthermore, I ask that the state use its own data to identify people with CF for exemption to minimize the risk of inappropriate disenrollment and administrative burden on recipients.

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Sincerely,

[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Tuesday, August 7, 2018 10:06:45 PM

Dear Acting Deputy Director Stiffler,

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Sincerely,

[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Tuesday, August 7, 2018 10:19:11 PM

Dear Acting Deputy Director Stiffler,

As a constituent and someone personally affected by cystic fibrosis (CF), I'm writing to ask you to specifically and automatically exempt people with CF from work and community engagement requirements in Healthy Michigan. Furthermore, I ask that the state use its own data to identify people with CF for exemption to minimize the risk of inappropriate disenrollment and administrative burden on recipients.

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Sincerely,

[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Tuesday, August 7, 2018 10:20:04 PM

Dear Acting Deputy Director Stiffler,

As a constituent and someone personally affected by cystic fibrosis (CF), I'm writing to ask you to specifically and automatically exempt people with CF from work and community engagement requirements in Healthy Michigan. Furthermore, I ask that the state use its own data to identify people with CF for exemption to minimize the risk of inappropriate disenrollment and administrative burden on recipients.

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Sincerely,

[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Tuesday, August 7, 2018 10:20:26 PM

Dear Acting Deputy Director Stiffler,

As a constituent and someone personally affected by cystic fibrosis (CF), I'm writing to ask you to specifically and automatically exempt people with CF from work and community engagement requirements in Healthy Michigan. Furthermore, I ask that the state use its own data to identify people with CF for exemption to minimize the risk of inappropriate disenrollment and administrative burden on recipients.

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Sincerely,

[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Tuesday, August 7, 2018 10:43:21 PM

Dear Acting Deputy Director Stiffler,

As a constituent and someone personally affected by cystic fibrosis (CF), I'm writing to ask you to specifically and automatically exempt people with CF from work and community engagement requirements in Healthy Michigan. Furthermore, I ask that the state use its own data to identify people with CF for exemption to minimize the risk of inappropriate disenrollment and administrative burden on recipients.

CF is a life-threatening genetic disease that causes persistent lung infections and progressively limits the ability to breathe, often leading to respiratory failure. Over 1,100 people in Michigan live with CF. There is no known cure. As a complex, multi-system condition, CF requires targeted, highly specialized treatment and medications.

Medicaid plays an important role in helping people with CF—including 200 adults in the state—access the high-quality care and treatments they need to lead healthy, productive lives. While many Medicaid recipients living with CF are employed, others are unable to due to health status or the amount of time they need to spend on their treatments. To stay healthy, people with CF must endure hours of treatment every day – including receiving chest physiotherapy, taking inhaled treatments, potentially administering IV antibiotics, and other activities. In addition, people with CF commonly deal with pulmonary exacerbations (episodes where the symptoms of CF get worse and often lead to hospitalization), infections, and other events that cause their health to decline rapidly, potentially taking them out of the workforce for significant periods of time.

While I appreciate that the state plans to exempt individuals designated as "medically frail" and those with a medical condition that results in a work limitation according to a licensed medical professional, I am concerned that CF is not included in the list of diagnostic codes that will be automatically exempt. I am asking the state to add CF to this list of conditions that will be specifically and automatically exempt people from this Medicaid work requirement.

Consistent care is a critical component of CF treatment, and any loss or gaps in health coverage, because of failure to comply with these requirements, may put the health of people with CF at risk.

Again, I urge you to specifically and automatically exempt people with CF from the work requirement. Your attention to this matter will help people with CF continue to have access to the high-quality, specialized care they need to live full and healthy lives.

Sincerely,

[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Tuesday, August 7, 2018 10:53:32 PM

Dear Acting Deputy Director Stiffler,

As a constituent and someone personally affected by cystic fibrosis (CF), I'm writing to ask you to specifically and automatically exempt people with CF from work and community engagement requirements in Healthy Michigan. Furthermore, I ask that the state use its own data to identify people with CF for exemption to minimize the risk of inappropriate disenrollment and administrative burden on recipients.

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Again, I urge you to specifically and automatically exempt people with CF from the work requirement. Your attention to this matter will help people with CF continue to have access to the high-quality, specialized care they need to live full and healthy lives.

Sincerely,

[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Tuesday, August 7, 2018 11:08:03 PM

Dear Acting Deputy Director Stiffler,

As a constituent and someone personally affected by cystic fibrosis (CF), I'm writing to ask you to specifically and automatically exempt people with CF from work and community engagement requirements in Healthy Michigan. Furthermore, I ask that the state use its own data to identify people with CF for exemption to minimize the risk of inappropriate disenrollment and administrative burden on recipients.

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Again, I urge you to specifically and automatically exempt people with CF from the work requirement. Your attention to this matter will help people with CF continue to have access to the high-quality, specialized care they need to live full and healthy lives.

Sincerely,

[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Tuesday, August 7, 2018 11:12:22 PM

Dear Acting Deputy Director Stiffler,

As a constituent and someone personally affected by cystic fibrosis (CF), I'm writing to ask you to specifically and automatically exempt people with CF from work and community engagement requirements in Healthy Michigan. Furthermore, I ask that the state use its own data to identify people with CF for exemption to minimize the risk of inappropriate disenrollment and administrative burden on recipients.

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Sincerely,

[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Tuesday, August 7, 2018 11:13:44 PM

Dear Acting Deputy Director Stiffler,

As a constituent and someone personally affected by cystic fibrosis (CF), I'm writing to ask you to specifically and automatically exempt people with CF from work and community engagement requirements in Healthy Michigan. Furthermore, I ask that the state use its own data to identify people with CF for exemption to minimize the risk of inappropriate disenrollment and administrative burden on recipients.

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Again, I urge you to specifically and automatically exempt people with CF from the work requirement. Your attention to this matter will help people with CF continue to have access to the high-quality, specialized care they need to live full and healthy lives.

Sincerely,

[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Tuesday, August 7, 2018 11:21:24 PM

Dear Acting Deputy Director Stiffler,

As a constituent and someone personally affected by cystic fibrosis (CF), I'm writing to ask you to specifically and automatically exempt people with CF from work and community engagement requirements in Healthy Michigan. Furthermore, I ask that the state use its own data to identify people with CF for exemption to minimize the risk of inappropriate disenrollment and administrative burden on recipients.

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Sincerely,

[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Tuesday, August 7, 2018 11:21:34 PM

Dear Acting Deputy Director Stiffler,

As a constituent and someone personally affected by cystic fibrosis (CF), I'm writing to ask you to specifically and automatically exempt people with CF from work and community engagement requirements in Healthy Michigan. Furthermore, I ask that the state use its own data to identify people with CF for exemption to minimize the risk of inappropriate disenrollment and administrative burden on recipients.

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Sincerely,

[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Wednesday, August 8, 2018 12:27:12 AM

Dear Acting Deputy Director Stiffler,

As a constituent and someone personally affected by cystic fibrosis (CF), I'm writing to ask you to specifically and automatically exempt people with CF from work and community engagement requirements in Healthy Michigan. Furthermore, I ask that the state use its own data to identify people with CF for exemption to minimize the risk of inappropriate disenrollment and administrative burden on recipients.

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Sincerely,

[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Wednesday, August 8, 2018 7:22:28 AM

Dear Acting Deputy Director Stiffler,

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Sincerely,

[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Wednesday, August 8, 2018 7:35:33 AM

Dear Acting Deputy Director Stiffler,

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Sincerely,

[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Wednesday, August 8, 2018 7:44:55 AM

Dear Acting Deputy Director Stiffler,

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Sincerely,

[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Wednesday, August 8, 2018 8:42:00 AM

Dear Acting Deputy Director Stiffler,

As a constituent and someone personally affected by cystic fibrosis (CF), I'm writing to ask you to specifically and automatically exempt people with CF from work and community engagement requirements in Healthy Michigan. Furthermore, I ask that the state use its own data to identify people with CF for exemption to minimize the risk of inappropriate disenrollment and administrative burden on recipients.

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Sincerely,

[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Wednesday, August 8, 2018 8:48:59 AM

Dear Acting Deputy Director Stiffler,

Dear Acting Deputy Director Stiffler,

As a constituent and someone personally affected by cystic fibrosis (CF), I'm writing to ask you to specifically and automatically exempt people with CF from work and community engagement requirements in Healthy Michigan. Furthermore, I ask that the state use its own data to identify people with CF for exemption to minimize the risk of inappropriate disenrollment and administrative burden on recipients.

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Sincerely,

[redacted]

Sincerely,

[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Wednesday, August 8, 2018 9:04:09 AM

Dear Acting Deputy Director Stiffler,

As a constituent and someone personally affected by cystic fibrosis (CF), I'm writing to ask you to specifically and automatically exempt people with CF from work and community engagement requirements in Healthy Michigan. Furthermore, I ask that the state use its own data to identify people with CF for exemption to minimize the risk of inappropriate disenrollment and administrative burden on recipients.

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Sincerely,

[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Wednesday, August 8, 2018 9:05:23 AM

Dear Acting Deputy Director Stiffler,

As a constituent and someone personally affected by cystic fibrosis (CF), I'm writing to ask you to specifically and automatically exempt people with CF from work and community engagement requirements in Healthy Michigan. Furthermore, I ask that the state use its own data to identify people with CF for exemption to minimize the risk of inappropriate disenrollment and administrative burden on recipients.

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Sincerely,

[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Wednesday, August 8, 2018 9:11:00 AM

Dear Acting Deputy Director Stiffler,

As a constituent and someone personally affected by cystic fibrosis (CF), I'm writing to ask you to specifically and automatically exempt people with CF from work and community engagement requirements in Healthy Michigan. Furthermore, I ask that the state use its own data to identify people with CF for exemption to minimize the risk of inappropriate disenrollment and administrative burden on recipients.

CF is a life-threatening genetic disease that causes persistent lung infections and progressively limits the ability to breathe, often leading to respiratory failure. Over 1,100 people in Michigan live with CF. There is no known cure. As a complex, multi-system condition, CF requires targeted, highly specialized treatment and medications.

Medicaid plays an important role in helping people with CF—including 200 adults in the state—access the high-quality care and treatments they need to lead healthy, productive lives. While many Medicaid recipients living with CF are employed, others are unable to due to health status or the amount of time they need to spend on their treatments. To stay healthy, people with CF must endure hours of treatment every day – including receiving chest physiotherapy, taking inhaled treatments, potentially administering IV antibiotics, and other activities. In addition, people with CF commonly deal with pulmonary exacerbations (episodes where the symptoms of CF get worse and often lead to hospitalization), infections, and other events that cause their health to decline rapidly, potentially taking them out of the workforce for significant periods of time.

While I appreciate that the state plans to exempt individuals designated as "medically frail" and those with a medical condition that results in a work limitation according to a licensed medical professional, I am concerned that CF is not included in the list of diagnostic codes that will be automatically exempt. I am asking the state to add CF to this list of conditions that will be specifically and automatically exempt people from this Medicaid work requirement.

Consistent care is a critical component of CF treatment, and any loss or gaps in health coverage, because of failure to comply with these requirements, may put the health of people with CF at risk.

Again, I urge you to specifically and automatically exempt people with CF from the work requirement. Your attention to this matter will help people with CF continue to have access to the high-quality, specialized care they need to live full and healthy lives.

Sincerely,

[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Wednesday, August 8, 2018 9:13:00 AM

Dear Acting Deputy Director Stiffler,

As a constituent and someone personally affected by cystic fibrosis (CF), I'm writing to ask you to specifically and automatically exempt people with CF from work and community engagement requirements in Healthy Michigan. Furthermore, I ask that the state use its own data to identify people with CF for exemption to minimize the risk of inappropriate disenrollment and administrative burden on recipients.

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Again, I urge you to specifically and automatically exempt people with CF from the work requirement. Your attention to this matter will help people with CF continue to have access to the high-quality, specialized care they need to live full and healthy lives.

Sincerely,

[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Wednesday, August 8, 2018 9:13:44 AM

Dear Acting Deputy Director Stiffler,

As a constituent and someone personally affected by cystic fibrosis (CF), I'm writing to ask you to specifically and automatically exempt people with CF from work and community engagement requirements in Healthy Michigan. Furthermore, I ask that the state use its own data to identify people with CF for exemption to minimize the risk of inappropriate disenrollment and administrative burden on recipients.

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Again, I urge you to specifically and automatically exempt people with CF from the work requirement. Your attention to this matter will help people with CF continue to have access to the high-quality, specialized care they need to live full and healthy lives.

Sincerely,

[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Wednesday, August 8, 2018 9:17:02 AM

Dear Acting Deputy Director Stiffler,

As a constituent and someone personally affected by cystic fibrosis (CF), I'm writing to ask you to specifically and automatically exempt people with CF from work and community engagement requirements in Healthy Michigan. Furthermore, I ask that the state use its own data to identify people with CF for exemption to minimize the risk of inappropriate disenrollment and administrative burden on recipients.

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Again, I urge you to specifically and automatically exempt people with CF from the work requirement. Your attention to this matter will help people with CF continue to have access to the high-quality, specialized care they need to live full and healthy lives.

Sincerely,

[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Wednesday, August 8, 2018 9:20:39 AM

Dear Acting Deputy Director Stiffler,

As a constituent and someone personally affected by cystic fibrosis (CF), I'm writing to ask you to specifically and automatically exempt people with CF from work and community engagement requirements in Healthy Michigan. Furthermore, I ask that the state use its own data to identify people with CF for exemption to minimize the risk of inappropriate disenrollment and administrative burden on recipients.

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Consistent care is a critical component of CF treatment, and any loss or gaps in health coverage, because of failure to comply with these requirements, may put the health of people with CF at risk.

Again, I urge you to specifically and automatically exempt people with CF from the work requirement. Your attention to this matter will help people with CF continue to have access to the high-quality, specialized care they need to live full and healthy lives.

Sincerely,

[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Wednesday, August 8, 2018 9:27:06 AM

Dear Acting Deputy Director Stiffler,

As a constituent and someone personally affected by cystic fibrosis (CF), I'm writing to ask you to specifically and automatically exempt people with CF from work and community engagement requirements in Healthy Michigan. Furthermore, I ask that the state use its own data to identify people with CF for exemption to minimize the risk of inappropriate disenrollment and administrative burden on recipients.

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Again, I urge you to specifically and automatically exempt people with CF from the work requirement. Your attention to this matter will help people with CF continue to have access to the high-quality, specialized care they need to live full and healthy lives.

Sincerely,

[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Wednesday, August 8, 2018 9:32:03 AM

Dear Acting Deputy Director Stiffler,

As a constituent and someone personally affected by cystic fibrosis (CF), I'm writing to ask you to specifically and automatically exempt people with CF from work and community engagement requirements in Healthy Michigan. Furthermore, I ask that the state use its own data to identify people with CF for exemption to minimize the risk of inappropriate disenrollment and administrative burden on recipients.

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Again, I urge you to specifically and automatically exempt people with CF from the work requirement. Your attention to this matter will help people with CF continue to have access to the high-quality, specialized care they need to live full and healthy lives.

Sincerely,

[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Wednesday, August 8, 2018 9:35:34 AM

Dear Acting Deputy Director Stiffler,

As a constituent and someone personally affected by cystic fibrosis (CF), I'm writing to ask you to specifically and automatically exempt people with CF from work and community engagement requirements in Healthy Michigan. Furthermore, I ask that the state use its own data to identify people with CF for exemption to minimize the risk of inappropriate disenrollment and administrative burden on recipients.

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Again, I urge you to specifically and automatically exempt people with CF from the work requirement. Your attention to this matter will help people with CF continue to have access to the high-quality, specialized care they need to live full and healthy lives.

Sincerely,

[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Wednesday, August 8, 2018 9:42:30 AM

Dear Acting Deputy Director Stiffler,

As a constituent and someone personally affected by cystic fibrosis (CF), I'm writing to ask you to specifically and automatically exempt people with CF from work and community engagement requirements in Healthy Michigan. Furthermore, I ask that the state use its own data to identify people with CF for exemption to minimize the risk of inappropriate disenrollment and administrative burden on recipients.

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Again, I urge you to specifically and automatically exempt people with CF from the work requirement. Your attention to this matter will help people with CF continue to have access to the high-quality, specialized care they need to live full and healthy lives.

Sincerely,

[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Wednesday, August 8, 2018 9:44:55 AM

Dear Acting Deputy Director Stiffler,

As a constituent and someone personally affected by cystic fibrosis (CF), I'm writing to ask you to specifically and automatically exempt people with CF from work and community engagement requirements in Healthy Michigan. Furthermore, I ask that the state use its own data to identify people with CF for exemption to minimize the risk of inappropriate disenrollment and administrative burden on recipients.

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Sincerely,

[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Wednesday, August 8, 2018 10:12:40 AM

Dear Acting Deputy Director Stiffler,

As a constituent and someone personally affected by cystic fibrosis (CF), I'm writing to ask you to specifically and automatically exempt people with CF from work and community engagement requirements in Healthy Michigan. Furthermore, I ask that the state use its own data to identify people with CF for exemption to minimize the risk of inappropriate disenrollment and administrative burden on recipients.

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Sincerely,

[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Wednesday, August 8, 2018 10:22:15 AM

Dear Acting Deputy Director Stiffler,

As a constituent and someone personally affected by cystic fibrosis (CF), I'm writing to ask you to specifically and automatically exempt people with CF from work and community engagement requirements in Healthy Michigan. Furthermore, I ask that the state use its own data to identify people with CF for exemption to minimize the risk of inappropriate disenrollment and administrative burden on recipients.

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Again, I urge you to specifically and automatically exempt people with CF from the work requirement. Your attention to this matter will help people with CF continue to have access to the high-quality, specialized care they need to live full and healthy lives.

Sincerely,

[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Wednesday, August 8, 2018 10:28:38 AM

Dear Acting Deputy Director Stiffler,

As a constituent and someone personally affected by cystic fibrosis (CF), I'm writing to ask you to specifically and automatically exempt people with CF from work and community engagement requirements in Healthy Michigan. Furthermore, I ask that the state use its own data to identify people with CF for exemption to minimize the risk of inappropriate disenrollment and administrative burden on recipients.

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Again, I urge you to specifically and automatically exempt people with CF from the work requirement. Your attention to this matter will help people with CF continue to have access to the high-quality, specialized care they need to live full and healthy lives.

Sincerely,

[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Wednesday, August 8, 2018 10:35:11 AM

Dear Acting Deputy Director Stiffler,

As a constituent and someone personally affected by cystic fibrosis (CF), I'm writing to ask you to specifically and automatically exempt people with CF from work and community engagement requirements in Healthy Michigan. Furthermore, I ask that the state use its own data to identify people with CF for exemption to minimize the risk of inappropriate disenrollment and administrative burden on recipients.

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Again, I urge you to specifically and automatically exempt people with CF from the work requirement. Your attention to this matter will help people with CF continue to have access to the high-quality, specialized care they need to live full and healthy lives.

Sincerely,

[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Wednesday, August 8, 2018 10:51:28 AM

Dear Acting Deputy Director Stiffler,

As a constituent and someone personally affected by cystic fibrosis (CF), I'm writing to ask you to specifically and automatically exempt people with CF from work and community engagement requirements in Healthy Michigan. Furthermore, I ask that the state use its own data to identify people with CF for exemption to minimize the risk of inappropriate disenrollment and administrative burden on recipients.

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Sincerely,

[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Wednesday, August 8, 2018 10:53:57 AM

Dear Acting Deputy Director Stiffler,

As a constituent and someone personally affected by cystic fibrosis (CF), I'm writing to ask you to specifically and automatically exempt people with CF from work and community engagement requirements in Healthy Michigan. Furthermore, I ask that the state use its own data to identify people with CF for exemption to minimize the risk of inappropriate disenrollment and administrative burden on recipients.

CF is a life-threatening genetic disease that causes persistent lung infections and progressively limits the ability to breathe, often leading to respiratory failure. Over 1,100 people in Michigan live with CF. There is no known cure. As a complex, multi-system condition, CF requires targeted, highly specialized treatment and medications.

Medicaid plays an important role in helping people with CF—including 200 adults in the state—access the high-quality care and treatments they need to lead healthy, productive lives. While many Medicaid recipients living with CF are employed, others are unable to due to health status or the amount of time they need to spend on their treatments. To stay healthy, people with CF must endure hours of treatment every day – including receiving chest physiotherapy, taking inhaled treatments, potentially administering IV antibiotics, and other activities. In addition, people with CF commonly deal with pulmonary exacerbations (episodes where the symptoms of CF get worse and often lead to hospitalization), infections, and other events that cause their health to decline rapidly, potentially taking them out of the workforce for significant periods of time.

While I appreciate that the state plans to exempt individuals designated as "medically frail" and those with a medical condition that results in a work limitation according to a licensed medical professional, I am concerned that CF is not included in the list of diagnostic codes that will be automatically exempt. I am asking the state to add CF to this list of conditions that will be specifically and automatically exempt people from this Medicaid work requirement.

Consistent care is a critical component of CF treatment, and any loss or gaps in health coverage, because of failure to comply with these requirements, may put the health of people with CF at risk.

Again, I urge you to specifically and automatically exempt people with CF from the work requirement. Your attention to this matter will help people with CF continue to have access to the high-quality, specialized care they need to live full and healthy lives.

Sincerely,

[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Wednesday, August 8, 2018 11:05:29 AM

Dear Acting Deputy Director Stiffler,

As a constituent and someone personally affected by cystic fibrosis (CF), I'm writing to ask you to specifically and automatically exempt people with CF from work and community engagement requirements in Healthy Michigan. Furthermore, I ask that the state use its own data to identify people with CF for exemption to minimize the risk of inappropriate disenrollment and administrative burden on recipients.

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Again, I urge you to specifically and automatically exempt people with CF from the work requirement. Your attention to this matter will help people with CF continue to have access to the high-quality, specialized care they need to live full and healthy lives.

Sincerely,

[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Wednesday, August 8, 2018 12:05:43 PM

Dear Acting Deputy Director Stiffler,

As a constituent and someone personally affected by cystic fibrosis (CF), I'm writing to ask you to specifically and automatically exempt people with CF from work and community engagement requirements in Healthy Michigan. Furthermore, I ask that the state use its own data to identify people with CF for exemption to minimize the risk of inappropriate disenrollment and administrative burden on recipients.

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Again, I urge you to specifically and automatically exempt people with CF from the work requirement. Your attention to this matter will help people with CF continue to have access to the high-quality, specialized care they need to live full and healthy lives.
Thanks very much!!!

Sincerely,

[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Wednesday, August 8, 2018 12:09:13 PM

Dear Acting Deputy Director Stiffler,

As a constituent and someone personally affected by cystic fibrosis (CF), I'm writing to ask you to specifically and automatically exempt people with CF from work and community engagement requirements in Healthy Michigan. Furthermore, I ask that the state use its own data to identify people with CF for exemption to minimize the risk of inappropriate disenrollment and administrative burden on recipients.

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Again, I urge you to specifically and automatically exempt people with CF from the work requirement. Your attention to this matter will help people with CF continue to have access to the high-quality, specialized care they need to live full and healthy lives.

Sincerely,

[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Wednesday, August 8, 2018 12:17:01 PM

Dear Acting Deputy Director Stiffler,

As a constituent and someone personally affected by cystic fibrosis (CF), I'm writing to ask you to specifically and automatically exempt people with CF from work and community engagement requirements in Healthy Michigan. Furthermore, I ask that the state use its own data to identify people with CF for exemption to minimize the risk of inappropriate disenrollment and administrative burden on recipients.

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Again, I urge you to specifically and automatically exempt people with CF from the work requirement. Your attention to this matter will help people with CF continue to have access to the high-quality, specialized care they need to live full and healthy lives.

Sincerely,

[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Wednesday, August 8, 2018 12:45:23 PM

Dear Acting Deputy Director Stiffler,

As a constituent and someone personally affected by cystic fibrosis (CF), I'm writing to ask you to specifically and automatically exempt people with CF from work and community engagement requirements in Healthy Michigan. Furthermore, I ask that the state use its own data to identify people with CF for exemption to minimize the risk of inappropriate disenrollment and administrative burden on recipients.

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Again, I urge you to specifically and automatically exempt people with CF from the work requirement. Your attention to this matter will help people with CF continue to have access to the high-quality, specialized care they need to live full and healthy lives.

Sincerely,

[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Wednesday, August 8, 2018 12:56:40 PM

Dear Acting Deputy Director Stiffler,

As a constituent and someone personally affected by cystic fibrosis (CF), I'm writing to ask you to specifically and automatically exempt people with CF from work and community engagement requirements in Healthy Michigan. Furthermore, I ask that the state use its own data to identify people with CF for exemption to minimize the risk of inappropriate disenrollment and administrative burden on recipients.

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Again, I urge you to specifically and automatically exempt people with CF from the work requirement. Your attention to this matter will help people with CF continue to have access to the high-quality, specialized care they need to live full and healthy lives.

Sincerely,

[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Wednesday, August 8, 2018 1:24:52 PM

Dear Acting Deputy Director Stiffler,

As a constituent and someone personally affected by cystic fibrosis (CF), I'm writing to ask you to specifically and automatically exempt people with CF from work and community engagement requirements in Healthy Michigan. Furthermore, I ask that the state use its own data to identify people with CF for exemption to minimize the risk of inappropriate disenrollment and administrative burden on recipients.

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Sincerely,

[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Wednesday, August 8, 2018 1:28:06 PM

Dear Acting Deputy Director Stiffler,

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Again, I urge you to specifically and automatically exempt people with CF from the work requirement. Your attention to this matter will help people with CF continue to have access to the high-quality, specialized care they need to live full and healthy lives.

Sincerely,

[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Wednesday, August 8, 2018 2:34:43 PM

Dear Acting Deputy Director Stiffler,

As a constituent and someone personally affected by cystic fibrosis (CF), I'm writing to ask you to specifically and automatically exempt people with CF from work and community engagement requirements in Healthy Michigan. Furthermore, I ask that the state use its own data to identify people with CF for exemption to minimize the risk of inappropriate disenrollment and administrative burden on recipients.

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Sincerely,

[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Wednesday, August 8, 2018 2:38:49 PM

Dear Acting Deputy Director Stiffler,

As a constituent and someone personally affected by cystic fibrosis (CF), I'm writing to ask you to specifically and automatically exempt people with CF from work and community engagement requirements in Healthy Michigan. Furthermore, I ask that the state use its own data to identify people with CF for exemption to minimize the risk of inappropriate disenrollment and administrative burden on recipients.

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Sincerely,

[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Wednesday, August 8, 2018 4:04:26 PM

Dear Acting Deputy Director Stiffler,

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Sincerely,

[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Wednesday, August 8, 2018 4:12:01 PM

Dear Acting Deputy Director Stiffler,

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Sincerely,

[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Wednesday, August 8, 2018 4:25:48 PM

Dear Acting Deputy Director Stiffler,

As a constituent and someone personally affected by cystic fibrosis (CF), I'm writing to ask you to specifically and automatically exempt people with CF from work and community engagement requirements in Healthy Michigan. Furthermore, I ask that the state use its own data to identify people with CF for exemption to minimize the risk of inappropriate disenrollment and administrative burden on recipients.

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Sincerely,

[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Wednesday, August 8, 2018 4:26:35 PM

Dear Acting Deputy Director Stiffler,

As a constituent and someone personally affected by cystic fibrosis (CF), I'm writing to ask you to specifically and automatically exempt people with CF from work and community engagement requirements in Healthy Michigan. Furthermore, I ask that the state use its own data to identify people with CF for exemption to minimize the risk of inappropriate disenrollment and administrative burden on recipients.

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Sincerely,

[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Wednesday, August 8, 2018 6:20:02 PM

Dear Acting Deputy Director Stiffler,

As a constituent and someone personally affected by cystic fibrosis (CF), I'm writing to ask you to specifically and automatically exempt people with CF from work and community engagement requirements in Healthy Michigan. Furthermore, I ask that the state use its own data to identify people with CF for exemption to minimize the risk of inappropriate disenrollment and administrative burden on recipients.

CF is a life-threatening genetic disease that causes persistent lung infections and progressively limits the ability to breathe, often leading to respiratory failure. Over 1,100 people in Michigan live with CF. There is no known cure. As a complex, multi-system condition, CF requires targeted, highly specialized treatment and medications.

Medicaid plays an important role in helping people with CF—including 200 adults in the state—access the high-quality care and treatments they need to lead healthy, productive lives. While many Medicaid recipients living with CF are employed, others are unable to due to health status or the amount of time they need to spend on their treatments. To stay healthy, people with CF must endure hours of treatment every day – including receiving chest physiotherapy, taking inhaled treatments, potentially administering IV antibiotics, and other activities. In addition, people with CF commonly deal with pulmonary exacerbations (episodes where the symptoms of CF get worse and often lead to hospitalization), infections, and other events that cause their health to decline rapidly, potentially taking them out of the workforce for significant periods of time.

While I appreciate that the state plans to exempt individuals designated as "medically frail" and those with a medical condition that results in a work limitation according to a licensed medical professional, I am concerned that CF is not included in the list of diagnostic codes that will be automatically exempt. I am asking the state to add CF to this list of conditions that will be specifically and automatically exempt people from this Medicaid work requirement.

Consistent care is a critical component of CF treatment, and any loss or gaps in health coverage, because of failure to comply with these requirements, may put the health of people with CF at risk.

Again, I urge you to specifically and automatically exempt people with CF from the work requirement. Your attention to this matter will help people with CF continue to have access to the high-quality, specialized care they need to live full and healthy lives.

Sincerely,

[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Wednesday, August 8, 2018 8:02:09 PM

Dear Acting Deputy Director Stiffler,

As a constituent and someone personally affected by cystic fibrosis (CF), I'm writing to ask you to specifically and automatically exempt people with CF from work and community engagement requirements in Healthy Michigan. Furthermore, I ask that the state use its own data to identify people with CF for exemption to minimize the risk of inappropriate disenrollment and administrative burden on recipients.

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Again, I urge you to specifically and automatically exempt people with CF from the work requirement. Your attention to this matter will help people with CF continue to have access to the high-quality, specialized care they need to live full and healthy lives.

Sincerely,

[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Wednesday, August 8, 2018 11:49:28 PM

Dear Acting Deputy Director Stiffler,

As a constituent and someone personally affected by cystic fibrosis (CF), I'm writing to ask you to specifically and automatically exempt people with CF from work and community engagement requirements in Healthy Michigan. Furthermore, I ask that the state use its own data to identify people with CF for exemption to minimize the risk of inappropriate disenrollment and administrative burden on recipients.

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Again, I urge you to specifically and automatically exempt people with CF from the work requirement. Your attention to this matter will help people with CF continue to have access to the high-quality, specialized care they need to live full and healthy lives.

Sincerely,

[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Thursday, August 9, 2018 12:02:14 AM

Dear Acting Deputy Director Stiffler,

As a constituent and someone personally affected by cystic fibrosis (CF), I'm writing to ask you to specifically and automatically exempt people with CF from work and community engagement requirements in Healthy Michigan. Furthermore, I ask that the state use its own data to identify people with CF for exemption to minimize the risk of inappropriate disenrollment and administrative burden on recipients.

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Again, I urge you to specifically and automatically exempt people with CF from the work requirement. Your attention to this matter will help people with CF continue to have access to the high-quality, specialized care they need to live full and healthy lives.

Sincerely,

[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Thursday, August 9, 2018 7:34:19 AM

Dear Acting Deputy Director Stiffler,

As a constituent and someone personally affected by cystic fibrosis (CF), I'm writing to ask you to specifically and automatically exempt people with CF from work and community engagement requirements in Healthy Michigan. Furthermore, I ask that the state use its own data to identify people with CF for exemption to minimize the risk of inappropriate disenrollment and administrative burden on recipients.

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Consistent care is a critical component of CF treatment, and any loss or gaps in health coverage, because of failure to comply with these requirements, may put the health of people with CF at risk.

Again, I urge you to specifically and automatically exempt people with CF from the work requirement. Your attention to this matter will help people with CF continue to have access to the high-quality, specialized care they need to live full and healthy lives.

Sincerely,

[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Thursday, August 9, 2018 11:41:11 AM

Dear Acting Deputy Director Stiffler,

As a constituent and someone personally affected by cystic fibrosis (CF), I'm writing to ask you to specifically and automatically exempt people with CF from work and community engagement requirements in Healthy Michigan. Furthermore, I ask that the state use its own data to identify people with CF for exemption to minimize the risk of inappropriate disenrollment and administrative burden on recipients.

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Again, I urge you to specifically and automatically exempt people with CF from the work requirement. Your attention to this matter will help people with CF continue to have access to the high-quality, specialized care they need to live full and healthy lives.

Sincerely,

[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Thursday, August 9, 2018 3:54:31 PM

Dear Acting Deputy Director Stiffler,

As a constituent and someone personally affected by cystic fibrosis (CF), I'm writing to ask you to specifically and automatically exempt people with CF from work and community engagement requirements in Healthy Michigan. Furthermore, I ask that the state use its own data to identify people with CF for exemption to minimize the risk of inappropriate disenrollment and administrative burden on recipients.

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Sincerely,

[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Thursday, August 9, 2018 3:56:50 PM

Dear Acting Deputy Director Stiffler,

As a constituent and someone personally affected by cystic fibrosis (CF), I'm writing to ask you to specifically and automatically exempt people with CF from work and community engagement requirements in Healthy Michigan. Furthermore, I ask that the state use its own data to identify people with CF for exemption to minimize the risk of inappropriate disenrollment and administrative burden on recipients.

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Sincerely,

[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Thursday, August 9, 2018 4:08:49 PM

Dear Acting Deputy Director Stiffler,

As a constituent and someone personally affected by cystic fibrosis (CF), I'm writing to ask you to specifically and automatically exempt people with CF from work and community engagement requirements in Healthy Michigan. Furthermore, I ask that the state use its own data to identify people with CF for exemption to minimize the risk of inappropriate disenrollment and administrative burden on recipients.

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Sincerely,

[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Friday, August 10, 2018 8:37:16 AM

Dear Acting Deputy Director Stiffler,

As a constituent and someone personally affected by cystic fibrosis (CF), I'm writing to ask you to specifically and automatically exempt people with CF from work and community engagement requirements in Healthy Michigan. Furthermore, I ask that the state use its own data to identify people with CF for exemption to minimize the risk of inappropriate disenrollment and administrative burden on recipients.

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Sincerely,

[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Friday, August 10, 2018 10:27:22 AM

Dear Acting Deputy Director Stiffler,

As a constituent and someone personally affected by cystic fibrosis (CF), I'm writing to ask you to specifically and automatically exempt people with CF from work and community engagement requirements in Healthy Michigan. Furthermore, I ask that the state use its own data to identify people with CF for exemption to minimize the risk of inappropriate disenrollment and administrative burden on recipients.

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Sincerely,

[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Friday, August 10, 2018 11:09:31 AM

Dear Acting Deputy Director Stiffler,

As a constituent and someone personally affected by cystic fibrosis (CF), I'm writing to ask you to specifically and automatically exempt people with CF from work and community engagement requirements in Healthy Michigan. Furthermore, I ask that the state use its own data to identify people with CF for exemption to minimize the risk of inappropriate disenrollment and administrative burden on recipients.

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Sincerely,

[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Friday, August 10, 2018 12:00:56 PM

Dear Acting Deputy Director Stiffler,

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Sincerely,

[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Friday, August 10, 2018 12:55:35 PM

Dear Acting Deputy Director Stiffler,

As a constituent and someone personally affected by cystic fibrosis (CF), I'm writing to ask you to specifically and automatically exempt people with CF from work and community engagement requirements in Healthy Michigan. Furthermore, I ask that the state use its own data to identify people with CF for exemption to minimize the risk of inappropriate disenrollment and administrative burden on recipients.

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Sincerely,

[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Friday, August 10, 2018 9:29:06 PM

Dear Acting Deputy Director Stiffler,

As a constituent and someone personally affected by cystic fibrosis (CF), I'm writing to ask you to specifically and automatically exempt people with CF from work and community engagement requirements in Healthy Michigan. Furthermore, I ask that the state use its own data to identify people with CF for exemption to minimize the risk of inappropriate disenrollment and administrative burden on recipients.

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Sincerely,

[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Saturday, August 11, 2018 9:27:32 AM

Dear Acting Deputy Director Stiffler,

As a constituent and someone personally affected by cystic fibrosis (CF), I'm writing to ask you to specifically and automatically exempt people with CF from work and community engagement requirements in Healthy Michigan. Furthermore, I ask that the state use its own data to identify people with CF for exemption to minimize the risk of inappropriate disenrollment and administrative burden on recipients.

CF is a life-threatening genetic disease that causes persistent lung infections and progressively limits the ability to breathe, often leading to respiratory failure. Over 1,100 people in Michigan live with CF. There is no known cure. As a complex, multi-system condition, CF requires targeted, highly specialized treatment and medications.

Medicaid plays an important role in helping people with CF—including 200 adults in the state—access the high-quality care and treatments they need to lead healthy, productive lives. While many Medicaid recipients living with CF are employed, others are unable to due to health status or the amount of time they need to spend on their treatments. To stay healthy, people with CF must endure hours of treatment every day – including receiving chest physiotherapy, taking inhaled treatments, potentially administering IV antibiotics, and other activities. In addition, people with CF commonly deal with pulmonary exacerbations (episodes where the symptoms of CF get worse and often lead to hospitalization), infections, and other events that cause their health to decline rapidly, potentially taking them out of the workforce for significant periods of time.

While I appreciate that the state plans to exempt individuals designated as "medically frail" and those with a medical condition that results in a work limitation according to a licensed medical professional, I am concerned that CF is not included in the list of diagnostic codes that will be automatically exempt. I am asking the state to add CF to this list of conditions that will be specifically and automatically exempt people from this Medicaid work requirement.

Consistent care is a critical component of CF treatment, and any loss or gaps in health coverage, because of failure to comply with these requirements, may put the health of people with CF at risk.

Again, I urge you to specifically and automatically exempt people with CF from the work requirement. Your attention to this matter will help people with CF continue to have access to the high-quality, specialized care they need to live full and healthy lives.

Sincerely,

[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Saturday, August 11, 2018 10:56:58 AM

Dear Acting Deputy Director Stiffler,

As a constituent and someone personally affected by cystic fibrosis (CF), I'm writing to ask you to specifically and automatically exempt people with CF from work and community engagement requirements in Healthy Michigan. Furthermore, I ask that the state use its own data to identify people with CF for exemption to minimize the risk of inappropriate disenrollment and administrative burden on recipients.

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Again, I urge you to specifically and automatically exempt people with CF from the work requirement. Your attention to this matter will help people with CF continue to have access to the high-quality, specialized care they need to live full and healthy lives.

Sincerely,

[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Saturday, August 11, 2018 1:50:22 PM

Dear Acting Deputy Director Stiffler,

As a constituent and someone personally affected by cystic fibrosis (CF), I'm writing to ask you to specifically and automatically exempt people with CF from work and community engagement requirements in Healthy Michigan. Furthermore, I ask that the state use its own data to identify people with CF for exemption to minimize the risk of inappropriate disenrollment and administrative burden on recipients.

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Again, I urge you to specifically and automatically exempt people with CF from the work requirement. Your attention to this matter will help people with CF continue to have access to the high-quality, specialized care they need to live full and healthy lives.

Sincerely,

[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Saturday, August 11, 2018 5:03:26 PM

Dear Acting Deputy Director Stiffler,

As a constituent and someone personally affected by cystic fibrosis (CF), I'm writing to ask you to specifically and automatically exempt people with CF from work and community engagement requirements in Healthy Michigan. Furthermore, I ask that the state use its own data to identify people with CF for exemption to minimize the risk of inappropriate disenrollment and administrative burden on recipients.

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Again, I urge you to specifically and automatically exempt people with CF from the work requirement. Your attention to this matter will help people with CF continue to have access to the high-quality, specialized care they need to live full and healthy lives.

Sincerely,

[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Saturday, August 11, 2018 5:16:43 PM

Dear Acting Deputy Director Stiffler,

As a constituent and someone personally affected by cystic fibrosis (CF), I'm writing to ask you to specifically and automatically exempt people with CF from work and community engagement requirements in Healthy Michigan. Furthermore, I ask that the state use its own data to identify people with CF for exemption to minimize the risk of inappropriate disenrollment and administrative burden on recipients.

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Consistent care is a critical component of CF treatment, and any loss or gaps in health coverage, because of failure to comply with these requirements, may put the health of people with CF at risk.

Again, I urge you to specifically and automatically exempt people with CF from the work requirement. Your attention to this matter will help people with CF continue to have access to the high-quality, specialized care they need to live full and healthy lives.

Sincerely,

[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Saturday, August 11, 2018 8:30:14 PM

Dear Acting Deputy Director Stiffler,

As a constituent and someone personally affected by cystic fibrosis (CF), I'm writing to ask you to specifically and automatically exempt people with CF from work and community engagement requirements in Healthy Michigan. Furthermore, I ask that the state use its own data to identify people with CF for exemption to minimize the risk of inappropriate disenrollment and administrative burden on recipients.

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Again, I urge you to specifically and automatically exempt people with CF from the work requirement. Your attention to this matter will help people with CF continue to have access to the high-quality, specialized care they need to live full and healthy lives.

Sincerely,

[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Sunday, August 12, 2018 9:31:21 AM

Dear Acting Deputy Director Stiffler,

As a constituent and someone personally affected by cystic fibrosis (CF), I'm writing to ask you to specifically and automatically exempt people with CF from work and community engagement requirements in Healthy Michigan. Furthermore, I ask that the state use its own data to identify people with CF for exemption to minimize the risk of inappropriate disenrollment and administrative burden on recipients.

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Again, I urge you to specifically and automatically exempt people with CF from the work requirement. Your attention to this matter will help people with CF continue to have access to the high-quality, specialized care they need to live full and healthy lives.

Sincerely,

[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Sunday, August 12, 2018 7:37:23 PM

Dear Acting Deputy Director Stiffler,

As a constituent and someone personally fighting cystic fibrosis (CF), I'm writing to ask you to specifically and automatically exempt people with CF from work and community engagement requirements in Healthy Michigan. Furthermore, I ask that the state use its own data to identify people with CF for exemption to minimize the risk of inappropriate disenrollment and administrative burden on recipients.

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Again, I urge you to specifically and automatically exempt people with CF from the work requirement. Your attention to this matter will help people with CF continue to have access to the high-quality, specialized care they need to live full and healthy lives.

Sincerely,

[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Sunday, August 12, 2018 8:36:06 PM

Dear Acting Deputy Director Stiffler,

As a constituent and someone personally affected by cystic fibrosis (CF), I'm writing to ask you to specifically and automatically exempt people with CF from work and community engagement requirements in Healthy Michigan. Furthermore, I ask that the state use its own data to identify people with CF for exemption to minimize the risk of inappropriate disenrollment and administrative burden on recipients.

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Again, I urge you to specifically and automatically exempt people with CF from the work requirement. Your attention to this matter will help people with CF continue to have access to the high-quality, specialized care they need to live full and healthy lives.

Sincerely,

[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Sunday, August 12, 2018 9:10:41 PM

Dear Acting Deputy Director Stiffler,

As a constituent and someone personally affected by cystic fibrosis (CF), I'm writing to ask you to specifically and automatically exempt people with CF from work and community engagement requirements in Healthy Michigan. Furthermore, I ask that the state use its own data to identify people with CF for exemption to minimize the risk of inappropriate disenrollment and administrative burden on recipients.

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Sincerely,

[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Sunday, August 12, 2018 9:11:18 PM

Dear Acting Deputy Director Stiffler,

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Sincerely,

[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Sunday, August 12, 2018 9:22:28 PM

Dear Acting Deputy Director Stiffler,

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Sincerely,

[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Sunday, August 12, 2018 9:38:54 PM

Dear Acting Deputy Director Stiffler,

As a constituent and someone personally affected by cystic fibrosis (CF), I'm writing to ask you to specifically and automatically exempt people with CF from work and community engagement requirements in Healthy Michigan. Furthermore, I ask that the state use its own data to identify people with CF for exemption to minimize the risk of inappropriate disenrollment and administrative burden on recipients.

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Sincerely,

[redacted]

From: [redacted]
To: HealthyMichiganPlan
Subject: Demonstration Extension Application Amendment
Date: Sunday, August 12, 2018 9:40:40 PM

Dear Acting Deputy Director Stiffler,

As a constituent and someone personally affected by cystic fibrosis (CF), I'm writing to ask you to specifically and automatically exempt people with CF from work and community engagement requirements in Healthy Michigan. Furthermore, I ask that the state use its own data to identify people with CF for exemption to minimize the risk of inappropriate disenrollment and administrative burden on recipients.

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Sincerely,

[redacted]

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
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
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

STATE OF MICHIGAN
DEPARTMENT OF HEALTH AND HUMAN SERVICES
LANSING

RICK SNYDER
GOVERNOR

NICK LYON
DIRECTOR

July 9, 2018

NAME
TITLE
ADDRESS
CITY STATE ZIP

Dear Tribal Chair and Health Director:

RE: Healthy Michigan Plan §1115 Demonstration Waiver Amendment

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 amendment to the Healthy Michigan Plan (HMP) §1115 Demonstration Extension Application to comply with provisions outlined in Michigan Public Act (PA) 208 of 2018.

Approval of this request would allow the State of Michigan to continue to provide comprehensive health care coverage while incorporating new innovative approaches and structural incentives to increase beneficiary engagement in healthy behaviors and to promote personal responsibility in maintaining health care coverage. The amendment allows Michigan to secure the long-term sustainability of Medicaid expansion, and introduce reforms intended to tailor the program to the able-bodied adult population.

HMP Changes After 48 Months

MDHHS seeks approval to amend the HMP extension application related to the completion of program defined healthy behaviors and cost-sharing responsibilities in accordance with PA 208 of 2018. This includes provisions to address exemptions related to cost-sharing, medically frail individuals, and beneficiary hardship. This portion of the proposed amendment is specifically applicable to individuals between 100% and 133% of the Federal Poverty Level (FPL) who have had 48 months of cumulative eligibility coverage through HMP. Additionally, MDHHS seeks to institute workforce engagement requirements while rescinding the MI Marketplace Option benefit.

To maintain eligibility for HMP, individuals with incomes between 100% and 133% of the FPL who have had 48 months of cumulative eligibility coverage must:

- Complete or commit to an annual healthy behavior with effort given to making the healthy behaviors in subsequent years incrementally more challenging; and
- Pay a premium of 5% of their income (no copays required), not to exceed limits defined in 42 CFR 447.56(f).

After 48 months of eligibility coverage, beneficiaries will not be eligible for any cost-sharing reductions. Beneficiaries who have not met the program's healthy behavior or cost-sharing requirements will receive notice that their HMP eligibility will be suspended. Individuals subject to suspension will be eligible for re-enrollment upon coming into compliance with the healthy behavior and cost-sharing requirements. Re-enrollment will be effective the first day of the next available month.

MDHHS does not expect this portion of the waiver amendment to have a significant 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, since Native American enrollees will continue to have coverage without cost sharing or premium obligations in accordance with 42 CFR 447.56, they will not be subject to the eligibility suspension provisions outlined above. Beneficiaries described in 42 CFR 440.315 will be exempt from the 48 months cumulative enrollment suspension of coverage and from the 5% premium provision. The anticipated effective date of the HMP eligibility changes is July 1, 2019.

Workforce Engagement Requirements

As identified in PA 208 of 2018, the purpose of adding workforce engagement requirements to the Medical Assistance Program is to assist, encourage, and prepare able-bodied adults for a life of self-sufficiency and independence from government interference. Native American beneficiaries are required to comply with the workforce engagement requirements. Workforce engagement requirements applies to beneficiaries between the ages of 19 and 62 and include the following:

- Participate in an average of 80 hours per month of qualifying activities or a combination of any qualifying activities; and
- Self-attest to compliance with, or exemption from, workforce engagement requirements to MDHHS on a monthly basis

The following list identifies qualifying activities:

- Employment, self-employment, or having income consistent with being employed or self-employed (makes at least minimum wage for an average of 80 hours per month);
- Education directly related to employment (i.e., high school equivalency test preparation, postsecondary education);
- Job training directly related to employment;
- Vocation training directly related to employment;
- Unpaid workforce engagement directly related to employment (i.e., internship);

- Tribal employment programs;
- Participation in a substance use disorder treatment (court ordered, prescribed by a licensed medical professional, or a Medicaid-funded Substance Use Disorder (SUD) treatment;
- Community service completed with a non-profit organization (can only be used as a qualifying activity for up to 3 months in a 12-month period); and
- Job search directly related to job training.

A beneficiary is allowed three months of noncompliance within a 12-month reporting period. After three months of noncompliance, recipients who remain noncompliant will not receive coverage for at least one month and will be required to come into compliance before coverage is reinstated. If a beneficiary is found to have misrepresented his or her compliance with the workforce engagement requirements as identified in PA 208 of 2018, he or she shall not be allowed to participate in HMP for a one-year period.

The following individuals are exempt from workforce engagement requirements:

- A caretaker of a family member under 6 years of age (only one parent at a time can claim this exemption);
- Beneficiaries currently receiving temporary or permanent long-term disability benefits from a private insurer or from the government;
- Full-time student who is not a dependent or whose parent or guardian qualifies for Medicaid
- Pregnant women;
- A caretaker of a dependent with a disability who needs full-time care based on a licensed medical professional's order (this exemption is allowed one time per household);
- A caretaker of an incapacitated individual even if the incapacitated individual is not a dependent of the caretaker;
- Beneficiaries who have proven they meet a good cause temporary exemption (as defined in PA 208 of 2018);
- Beneficiaries designated as medically frail;
- Beneficiaries with a medical condition resulting in a work limitation according to a licensed medical professional order;
- Beneficiaries who have been incarcerated within the last 6 months;
- Beneficiaries currently receiving unemployment benefits from the State of Michigan; and
- Beneficiaries under 21 years of age who had previously been in foster care placement in this state.

Additionally, beneficiaries in compliance with, or exempt from, the work requirements of the Supplemental Nutrition Assistance Program or Temporary Assistance for Needy Families program are deemed compliant with or exempt from the workforce engagement requirements. Additional reporting will not be required.

The statutorily required effective date of the workforce engagement requirements is January 1, 2020.

Rescinding MI Marketplace Option

MDHHS seeks to amend the waiver and expenditure authorities related to the states Healthy Michigan Plan and rescind the MI Marketplace Option.

MDHHS expects to make the demonstration extension application amendment available for public comment on July 9, 2018. In addition, MDHHS will have a conference call August 6, 2018 from 1:00 to 2:00 pm for tribal consultation to discuss this §1115 demonstration extension application amendment. 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. The call-in number is 888-808-6929, Access Code: 1129906.

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 August 23, 2018.**

MDHHS appreciates the continued opportunity to work collaboratively with you to care for the residents of our state.

Sincerely,

Kathy Stiffler, Acting Director
Medical Services Administration

cc: Keri Toback, Region V, CMS
Leslie Campbell, Region V, CMS
Kyle Straley, 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 18-45
July 9, 2018

Mr. Bryan Newland, 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. Kathy Mayo, Interim Health Administrator, 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 Stuck, 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. Ronald Ekdahl, 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. Leonid Chugunov, Health Director, Sault Ste. Marie Tribe of Chippewa Indians - Health Center

CC: Keri Toback, Region V, CMS
Leslie Campbell, Region V, CMS
Kyle Straley, 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

Tribal Comment Summary

The Michigan Department of Health and Human Services (MDHHS) sent written notification to the Tribal Chairs and Health Directors on July 9, 2018 informing them of the proposed Healthy Michigan Plan (HMP) Section 1115 Demonstration extension application amendment and offered to have a consultation conference call on August 6, 2018. MDHHS posted the HMP Section 1115 Demonstration extension application amendment and supporting documents on the MDHHS web page and published a notice in newspapers across the state. The initial in-person tribal consultation took place on July 11, 2018 during the Quarterly Tribal Health Director's Association meeting in Watersmeet, Michigan, where the details of the waiver extension amendment application were discussed. A tribal consultation conference call was held on August 6, 2018 that provided detailed information about the proposed HMP changes and how these changes will impact Native Americans. During this call, several tribes requested a follow-up in-person consultation meeting to further discuss the issues.

The follow-up in-person tribal consultation meeting was held in Lansing, MI on August 27, 2018 from 3:00 to 5:00 pm. This meeting included members from various tribes throughout Michigan, MDHHS leadership, and senior members from Governor Snyder's staff. All comments were reviewed and considered by MDHHS in the development of the final waiver amendment. Below is a summary of the comments received. Copies of all written tribal comments are included in this attachment.

Many of the commenters expressed concern regarding the impact of implementation on tribal members, leading to a loss of coverage and increasing the administrative burden on beneficiaries. In general, the comments reflected the following themes:

1. Native Americans should be exempt from the workforce engagement requirements;
2. If workforce engagement requirements are implemented, allow an additional 3 months of non-compliance in counties of high rates of seasonal unemployment;
3. Suggestions to expand the Medically Frail list of diagnosis codes;
4. The comment period should be extended because the tribal consultation requirements were not met;
5. Work requirements will cause a financial burden on the Indian Health System (IHS); and
6. Request for exemption from the healthy behavior 48 months of cumulative eligibility requirement.

1. Native Americans should be exempt from the workforce engagement requirements

Comments: Tribal representatives disagreed with CMS' view that exempting Native Americans from workforce engagement requirements would present civil rights concerns and believe an exemption would be permissible.

MDHHS Response: MDHHS is required to submit the waiver amendment to CMS in compliance with PA 208 of 2018, which does not include an exemption for Native Americans. However, MDHHS intends to continue consultation with the tribes throughout the waiver submission and implementation process and anticipates additional comment from CMS on these issues.

2. If workforce engagement requirements are implemented, allow an additional three months of non-compliance in geographically isolated areas with high rates of seasonal unemployment

Comments: Tribal members voiced concerns during the consultation that they are disproportionally impacted by seasonal unemployment rates in geographically isolated areas and they should be exempt from the workforce engagement requirement. Other tribal members commented that if they are required to participate, they should be allowed to claim an additional three months of non-compliance. Tribal members further noted that the mandatory workforce engagement requirements will create a barrier to Medicaid access that is unique to tribal members as well as those individuals located in the most geographically isolated areas of the State where employment opportunities are limited or seasonal at best. Additionally, tribal members commented that Native American beneficiaries may not be able to meet the work requirements due to lack of connection to State employment programs.

MDHHS Response: During the legislative process, PA 208 of 2018 was revised to grant individuals three months of noncompliance in a 12-month period, which would account for seasonal fluctuations in unemployment. In addition, state law recognizes participation in Tribal Employment Programs as a qualifying activity for the workforce engagement requirements. Finally, as noted above, MDHHS intends to work collaboratively with the tribal community throughout the waiver implementation process to assure that the concerns of tribal members are addressed, whenever possible, in accordance with state law.

3. Suggestions to expand the Medically Frail list of diagnosis codes

Comments: Commenters suggested MDHHS add additional behavioral health diagnosis codes to the medically frail list.

MDHHS Response: MDHHS reviewed the suggested diagnosis codes and has revised the list to incorporate many of the codes. The medically frail process and a complete list of the diagnosis codes can be found on the MDHHS website.

4. The comment period should be extended because the tribal consultation requirements were not met in accordance with the State of Michigan or Michigan Tribal-State Accord

Comments: Tribal representatives asked MDHHS to extend the comment period because they did not believe the conference call on August 6, 2018 satisfied the tribal consultation requirements.

MDHHS Response: Although MDHHS believes that the August 6, 2018 conference call met Medicaid State Plan tribal consultation requirements, per the request of tribal members, MDHHS held an in-person consultation meeting on August 27, 2018 to allow for additional testimony and extended the tribal comment period to August 31, 2018. Any comments received from tribal members by August 31, 2018 are included in waiver documents submitted to CMS.

MDHHS welcomes additional comments from tribal members and is open to further stakeholder input after waiver submission.

5. Work requirements will cause a financial burden on the Indian health system

Comments: Several comments indicated that the imposition of work requirements on Native Americans will cause a financial burden on the IHS system, by shifting funding responsibility from Medicaid to IHS as beneficiaries lose Medicaid coverage due to the work requirements. Furthermore, commenters believe this undermines the federal trust responsibility to provide healthcare to Native Americans.

MDHHS Response: As MDHHS implements the workforce engagement requirements, it will undertake active outreach efforts to beneficiaries and partner with community stakeholders to ensure that beneficiaries understand program requirements and do not lose coverage as a result of noncompliance. MDHHS will include the tribes in subsequent workgroups to implement the proposal as applicable.

6. Request for exemption from the healthy behavior 48 months of cumulative eligibility requirement

Comments: While the tribes do encourage healthy behaviors through their own government programs and traditional practices, a request was made to exempt Native Americans from the 48-month cumulative enrollment requiring the completion of healthy behavior to maintain healthcare coverage.

MDHHS Response: MDHHS did clarify in the waiver extension amendment that Native Americans who are receiving services through a Medicaid health plan are not exempt from this requirement. Native Americans are a voluntary Medicaid health plan population.

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523 Ashmun St.
Sault St. Marie, MI 49783

Aaron A. Payment, MPA, MEd, EdD
Tribal Chairperson

Consultation Testimony
Michigan Department of Health and Human Services
August 27, 2018

Ahneen, BiiWaagajiig, n'dizhnikaaz. Mukwa Megizi Ndodem. Bahweting n'donjaba. My name is Aaron Payment. As the elected Tribal Chairperson of the Sault Ste. Marie Tribe of Chippewa Indians, I am speaking on behalf of the Tribe. As always, my Tribe and I want to work in partnership with you.

Today I am here to explain why Medicaid beneficiary work requirements cannot be applied to Tribal Nations. This is not just a Michigan issue, but one that is national in scope. I'll begin by providing a context for the federal government and any entity carrying out the duty of the federal government to provide "health" care to tribes pursuant to treaties and the supreme law of the land ~ United States Constitution. I will then summarize how the national controversy spread to our state. I'll explain the issues and ramifications the new policy has in regard to the federally recognized Tribes. Then, I will explain how several states have successfully dealt with it and suggest how Michigan should proceed.

The United States has a trust and treaty based responsibility to provide access to health care for American Indians and Alaska Natives, and that responsibility includes ensuring access to federal health programs like Medicaid. Congress has declared that "it is the policy of this Nation, in fulfillment of its special trust responsibilities and legal obligations to Indians ... to ensure the highest possible health status for Indians and urban Indians and to provide all resources necessary to effect that policy."

I serve on the HHS Secretary Tribal Advisory Council and attest that this trust responsibility is highlighted in the Department of Health and Human Services (HHS) Strategic Plan FY 2018 - 2022, Importantly, the Federal Government has a unique legal and political government-to-government relationship with Tribal governments and a special obligation to provide services for American Indians and Alaska Natives based on these individuals' relationship to Tribal governments.

National Controversy Spreads to States:

In January 2018, the Centers for Medicare and Medicaid Services (CMS) announced its new policy to incentivize employment and community engagement among Medicaid beneficiaries.[1] The policy was designed to encourage states to implement work requirements

[1] See copy of the Dear State Medicaid Director Letter, January 11, 2018: https://www.medicaid.gov/federal-policy-guidance/downloads/smd18002.pdf

as a condition of Medicaid eligibility, should a state choose to do that through a 115 Demonstration Waiver.

CMS noted that Tribes would not be exempt from these requirements because of "civil rights issues"[2] and directed states to be open to including Tribal work programs as meeting the state community engagement requirements[3]. Additionally, CMS encouraged states to consult with Tribes prior to submission of a Waiver.[4]

Immediately, Tribes noted 4 major issues:

1. The policy will likely weaken Tribal health care services.
2. The policy undermines Congressional intent regarding Indian Health Service (IHS) funding mechanisms.
3. The policy attempts to delegate the federal trust responsibility to state governments, which cannot happen as it is inconsistent with treaties and the supreme law, the U.S. Constitution.
4. By categorizing Tribes "racially," the policy fails to recognize Tribal governments politically.

At the federal level, Congress reacted. On April 27, 2018, ten members of the United States Senate sent a letter to Department of Health and Human Services Secretary Azar to express "growing concerns" regarding the CMS policy.[5] The Senate letter noted that including Tribes in work requirements is contrary to federal law, the U.S. Constitution, treaties, and the federal trust responsibility. The Senate letter explained that the new policy violates the U.S. Supreme Court ruling *Morton v. Mancari*.[6] The Senate letter also noted that the policy violates legislative intent regarding to the Congressional changes to Sections 1905(b) and 1911 of the *Social Security Act*.

On April 30, 2018, Representative Tom Cole (R OK 4) wrote Secretary Azar and CMS Administrator Verma[7]. He noted his strong opposition to the classification of Native Americans as a "racial group" and noted that the new CMS policy undermines Tribal sovereignty. Congressman Cole argued that the policy goes against specific Congressional intent to ensure stable funding for the Indian Health Service via the changes made to the *Social Security Act*.

On May 15, 2018, fifty-six Congressional members from the House (including three members from the Michigan Delegation) reacted to the CMS policy announcement, expressing "profound concern" and "strong opposition" to Secretary Azar and Administrator

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[2] See copy of the Dear Tribal Leader Letter, January 17, 2018: https://www.indianz.com/News/2018/04/23/dttl011718.pdf

[3] https://www.medicaid.gov/federal-policy-guidance/downloads/smd18002.pdf See page 7.

[4] https://www.medicaid.gov/federal-policy-guidance/downloads/smd18002.pdf See page 8.

[5] A copy of this letter has been provided to Mike McCoy. See August 21, 2018 email from Meghan Starling. The April 27, 2018 letter to Secretary Azar is signed by Senators Chuck Schumer, Lisa Murkowski, Tom Udall, Maria Cantwell, Jeffrey A. Merkley, Heidi Heitkamp, Catherine Cortez-Masto, Martin Heinrich, Tina Smith, and Elizabeth Warren.

[6] *Morton v. Mancari* sets forward the rule of law that federal classifications fulfilling federal obligations to Indian Tribes are not based on race but on the political relationship between the Tribes and the federal government.

[7] A copy of this letter has been provided to Mike McCoy. See August 21, 2018.

Verma. [8] The letter states, "[b]eyond the question of legality of the underlying authority of CMS to allow Medicaid work requirements under Section 1115 of the *Social Security Act*, we strongly oppose CMS's guidance that would deny any exemption of tribal citizens from state Medicaid waiver requests." The letter reaffirms that the United States and Tribal governments interact on a government-to-government basis and that the programs enacted by Congress to benefit Native Americans, such as Medicaid, are provided as a function of that political relationship. Perhaps most importantly, the letter urges the rescission of the "misguided" policy decisions.

At the same time, state government programs were being set up to meet new national policy standards. Here at home, the Michigan state legislature passed Senate bill 897. On June 22, Governor Synder signed it into law. Now known as "Public Act 208 of 2018" the law amends the Social Welfare Act of Michigan by including work requirements for beneficiary recipients. Unfortunately, and just like the national policy, the Michigan law fails to recognize Tribes as sovereigns, it undermines Congressional intent regarding the federal funding of the Indian Health Service, and will likely weaken Tribal health care programs.

Flexibility exists:

Administrator Verma gave a speech to the American Hospital Association Annual Membership meeting on May 7, 2018, and appeared to ease up on the issue of community engagement requirements forced upon Tribal governments. She stated, "*We believe we can give states flexibility and discretion to implement the community engagement requirements with respect to Tribal members. We look forward to working with states and Tribes to try to help them achieve their goals and determine how to best apply community engagement to serve their populations.*"[9]

States Exempting Tribes:

At least three states have exempted Tribes from Medicaid work requirement programs. Arkansas does not require Tribes to meet work requirements.[10] Additionally, the Arkansas plan, submitted March 5, 2018, notes that "[*u]nder the Indian Health Care Improvement Act (IHCAI), I/T/U facilities are entitled to payment notwithstanding network restrictions.*"[11] As another example of a state exempting Tribes from the community

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[8] A copy of this letter has been provided to Mike McCoy. See August 21, 2018 email from Meghan Starling. The letter is signed by: Representatives Tom Cole, Mike Simpson, Walter B. Jones, Don Young, Juan Vargas Steve Pearce, Collin Peterson, Coleen Hanabusa, John B. Larson, Joe Courtney, Duncan Hunter, Tony Cardenas, Debbie Wasserman Schultz, Keith Ellison, Mike Thompson, Ruben Gallego, Raul Ruiz, John Moolenaar, Mark Pocan, Dina Titus, Denny Heck, Ted Deutch, Norma J. Torres, Gregg Harper, Greg Walden, Mark Takano, Jacky Rosen, Paul Mitchell, Betty McCollum, Ken Calvert, Derek Kilmer, Michelle Lujan Grisham, Tim Walz, Grace Napolitano, Elise Stefanik, Peter DeFazio, Jared Huffman, Mario Diaz-Balart, Ben Ray Lujan, Alcee L. Hastings, Erik Paulsen, Kyrsten Sinema, Paul M. Grijalva, Rick Nolan, Pramila Jayapal, Jack Bergman, Charlie Crist, Donald S. Beyer Jr., Martha McSally, Jackie Walorski, Scott Tipton, Daniel T. Kildee, Pete Sessions, Trent Kelly, and Sean Duffy.

[9] For a copy of the speech, go to: https://www.cms.gov/newsroom/fact-sheets/speech-remarks-cms-administrator-seema-verma-american-hospital-association-annual-membership-meeting

[10] See https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ar/ar-works-ca.pdf

[11] https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ar/ar-works-ca.pdf See page 13 of 48.

engagement requirements, see Arizona's plan.[12] The plan, put into effect on August 3, 2018, exempts American Indians from work requirements.

Perhaps most interesting is Utah's treatment of Medicaid work requirements: On August 15, 2017 Utah provided an interesting model that exempts Tribes from work requirements. [13] Within the "Tribal Consultation" section of its plan, it states:

> ***Tribal representatives stated there is a concern with applying the work requirement to American Indian/Alaska Native (AI/AN) population. They felt this requirement would prohibit individuals from completing the application. They added that unemployment rates are high in these areas.***
>
> ***They also felt it would have a direct and negative impact on the 3rd party resources available to the IHS and tribal health programs. In addition, they believe requiring an AI/AN to work in order to access health care is not compliant with federal policy.***
>
> ***In response to these concerns, American Indian/Alaska Natives will be enrolled in the work requirement program but will not have their medical benefits terminated if they fail to complete all required work activities.*** [14]

Next Steps:

On behalf of my Tribe, I urge the State of Michigan to follow the example of Arizona, Arkansas, and Utah. Each of these states have Medicaid work requirements. At the same time, they show respect to Tribal sovereignty, support federal legislative intent regarding Medicaid, and allow Tribal health care facilities to operate as best they can.

Similar to Utah's plan, Michigan Public Act 208 of 2018 includes specific language referring to a "tribal employment program." Sault Ste. Marie Tribe of Chippewa Indians recommends that Michigan include in its Waiver Amendment to CMS, a section regarding Tribal consultation, just as Utah does. The section should include that, "In response to concerns identified by Tribal governments, American Indians and Alaska Natives can be enrolled in their own Tribe's "Tribal Employment Program" but will not have their medical benefits terminated if they fail to complete all required work activities."

Through the ebbs and flows of federal health care policy, it can be confusing and frustrating to States and partners in fulfilling the federal health responsibility, as well as, providing for the promises of the ACA to benefit Michigan citizens. Michigan was not one of the first states to join the Medicaid expansion but once it did, Michigan citizens shared in this promise. I am mindful that through elections, policies shift such that full implementation of the work requirement or any efforts to undermine the ACA (when a full repeal was not tenable in the Senate) may simply be undone. I am also cognizant that

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[12] See https://www.azahcccs.gov/shared/Downloads/News/AHCCCSWorks1115WaiverAmendmentRequest.pdf

[13] Please see: https://health.utah.gov/MedicaidExpansion/pdfs/Utah%201115%20PCN%20Waiver%20Revisions%2015%20Aug%2017.pdf

[14] https://health.utah.gov/MedicaidExpansion/pdfs/Utah%201115%20PCN%20Waiver%20Revisions%2015%20Aug%2017.pdf See page 8.

elections this fall may shift policy once again, such that it would behoove the State of Michigan to not implement unnecessarily drastic changes only to find these undone come January 2019.

Finally, to be clear, the Sault Tribe is opposed to the implementation of work requirements for Native American; especially those residing in desolate or geographically isolated areas of the State. I echo other tribes' testimony and request that the Michigan Department of the Health and Human Services:

1. Consider the addition of a specific exemption from the workforce engagement requirements for Native Americans as well as those who reside in desolate or geographically isolated areas of the State like Michigan's Upper Peninsula.

2. Include the Tribe as a partner at the table during the revision process before submission to CMS in order to ensure the goals of the State/Tribal Accord are met.

3. Include the Tribe in subsequent workgroups developed to implement the Proposal, if applicable.

Thank you for this opportunity to consult. I hope that you will wish to work with us.

If you have any questions, please ask. I stand ready to answer any of your questions.

Sincerely,

Aaron A. Payment

Aaron A. Payment

Lac Vieux Desert Band Of Lake Superior Chippewa Indians
Tribal Government

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Michael Hazen, Jr.
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August 27, 2018

MDHHS
Medical Services Administration
Bureau of Medicaid Policy and Health System Innovation
Attention: Medicaid Policy
P.O. Box 30479
Lansing, Michigan 48909-7979

Re: Lac Vieux Desert Band of Lake Superior Chippewa Indians
Comments Re: Healthy Michigan Plan §1115 Demonstration Waiver Extension Application Amendment

Dear Mr. Wise:

The Lac Vieux Desert Band of Lake Superior Chippewa Indians ("Tribe") appreciates the opportunity to respond to the State of Michigan's ("State") request to amend the Healthy Michigan Plan §1155 Demonstration Waiver Extension Application ("the Proposal"). Like many tribes across the nation, the Tribe runs its own tribal health care facility ("LVD Health Center"), providing health care services to both Native and non-Native patients. The LVD Health Center is a full-service health clinic, offering primary care, walk-in services, dental services, lab and imaging, chiropractic and physical therapy, optical care, acupuncture, behavior health and family services, and pharmacy services. The LVD Health Center has 12 exam rooms with 2 procedure rooms and a care team area, a 9-chair dental suite with lab services, retail pharmacy, an imaging suite, a clinical lab, chiropractic and physical therapy department, an optical department with sales area and two patient exam rooms, behavior health and family services, an administrative suite, and a community gathering room. The LVD Health Center is unique in that it provides services to both Native and non-Native patients and is only one of three providers accepting Medicaid in a four (4) county service area consisting of Dickinson, Gogebic, Ontonagon and Iron counties, making it a valuable resource in the rural and geographically isolated area on the western end of Michigan's Upper Peninsula.

As the Tribe understands it, the State, pursuant to Public Act 208 of 2018 is requesting authority from the Centers for Medicare and Medicaid Services ("CMS") through the Proposal[1] to

[1] It is worth noting that the Proposal was not developed in accordance with the State-Tribal Accord (per Executive Directive 2001-2) entered into between Governor Engler (2002) and extended by both Governors Granholm and

implement changes in cost-sharing requirements for beneficiaries of the Healthy Michigan Plan ("HMP") for individuals with income between 100% and 133% of the federal poverty level as well as implement certain workforce engagement requirements to maintain eligibility.[2] After being presented with notice of the HMP Application Amendment in December 2017 that did not include information as to how the HMP Application would be amended, the Tribe received another notice with more information in July 2018 - the same date the Proposal was made available for public comment. A conference call with the tribes was held on August 6, 2018 but little was dedicated to allowing tribes to address concerns or voice any suggestions, revisions or objections as indicated by the notice. A Tribal/State consultation is scheduled for August 27, 2018.

While the Tribe appreciates that the Proposal recognizes that Native Americans are exempt from the cost-sharing requirements as required by federal law[3], it must be noted that no such exemption has been recognized for Native Americans regarding the work requirements further, it fails to recognize Congress's intent that Medicaid be administered in a manner that supports Indian Health Services ("IHS"'s) provision of health care to Native Americans. Indeed, based on the Tribe's experience and data, three things about the Proposal are abundantly clear, (1) mandatory work requirements will create a barrier to access to Medicaid that is unique to IHS beneficiaries as well as those individuals located in the most geographically isolated areas of the State where employment opportunities are limited or seasonal at best[4]; (2) the Proposal's imposition of additional qualifying requirements for both Native Americans and non-Native Americans served by the LVD

Snyder, which calls for a respectfully government to government relationship when dealing with Michigan Federally Recognized Tribes of which Section V. Implementation, reads:

> For purposes of this accord, "state action significantly affecting tribal interests" is defined as regulations or legislation proposed by executive departments, and other policy statements or actions of executive departments, that have or may have substantial direct effects on one or more tribes, on the relationship between the state and tribes, or on the distribution of power and responsibilities between the state and tribes. State action includes the development of state policies under which the tribe must take voluntary action to trigger application of the policy.

Consultation occurs before or in conjunction with policy, legislative, regulation development, not at the same time it is made available to the public

[2] While the Tribe has been assured that the Proposal affects only those individuals who fall between 100%-133% of the federal poverty level, what happens to those individuals who are unable to become gainfully employed or lose their employment? Notwithstanding the fact that in the Western Upper Peninsula, there are more residents than jobs, where is the line between Medicaid eligibility and Upper Peninsula Health Plan ("UPHP") coverage? And if there is a line, while an individual is in an unemployed situation, don't the additional requirements actually discourage an individual with a chronic health condition who needs medical care not to work in order not to become eligible for the UPHP?

[3] See 42 CFR 447.56

[4] While tribal governments support full employment for their citizens, mandating work requirements through the Medicaid program will not increase employment in Indian Country where unemployment rates remain the highest in the United States. U.S. Census Bureau numbers reflect the unemployment rate among Native Americans nationwide is at least 12% (in some places they are as high at 40% or much higher) well over twice the national average of 4.9%. Moreover, many tribal citizens provide for their families through traditional work outside the formal economy, such as through subsistence fishing, hunting, gathering, offering spiritual support, traditional healing services, and other culturally significant activities in which the exchange of gifts for services is traditionally recognized. How are these activities to be counted to meet workforce engagement requirements? While reference in the Proposal has been made to "tribal employment programs" which may encompass content designed to track such "employment", the existence of such a program assumes the Tribe has the resources available to develop, operate and sustain such a program. That is simply not the case for many tribes.

Health Center will preclude Medicaid reimbursement for the Tribe; and (3) the Proposal lacks a comprehensive list of exemptions to identify an individual as medically frail recognizing the broad spectrum of behavioral health diagnosis encompassed by ICD-10.

It is important to note that Section 1911 of the Social Security Act, enacted over 40 years ago, authorizes IHS and tribally operated programs like the LVD Health Center to bill the Medicaid program and receive reimbursement. Section 1911 was enacted to provide supplemental funding to the Indian health systems and designed to ensure that Medicaid funds would "flow into IHS institutions." Unlike other Medicaid enrollees, IHS beneficiaries have access to the IHS system at no cost to them. Faced with mandatory work requirements, Native American enrollees will simply choose to no longer participate in the Medicaid program. That, in turn, will deprive the LVD Health Center of Medicaid resources that is contrary to the Congressional intent of §1911 of the Social Security Act and thwart the objectives of the Medicaid statute for purposes of Indian health.[5]

Indeed, the Proposal in its current form amounts to nothing more than a condition to the Tribe's access to Medicaid reimbursement funding based on the contingency of an individual Indian's compliance with a State-created "experimental, pilot or demonstration project." Given that an individual Indian would receive the same health care at the Tribe's health clinic or any other IHS facility regardless of his or her qualification under the State's Medicaid plan, it is a certainty the number of such persons who would participate in the State plan that imposed additional qualifying requirements would decline, thus precluding Medicaid reimbursement for the Tribe. This interposition of extra statutory State requirements would therefore result in a decrease in funding to support the LVD Health Center; and importantly, as a matter of law, such decrease would be accomplished through an exercise of administrative discretion (i.e., CMS's approval of a State Medicaid plan waiver applications), not statutory directive or authorization. Moreover, this exercise of discretion would undermine Congress's manifest intent that CMS administer Medicaid in a manner that supports IHS. In fact, Congress has provided that IHS reimbursements from Medicaid be borne entirely by CMS, with no portion paid by any state.[6] Nothing in Congress's provision for IHS reimbursements—a framework that narrowly focuses on "services provided" and the facility providing those services—leaves room for CMS to impose additional requirements on program beneficiaries as a prerequisite to IHS's obtaining Medicaid reimbursements.

It is also important to note that mandatory work requirements for Native Americans is inconsistent with federal treaty and trust obligations. In fact, Congress declared in the Indian Health Care Improvement Act (P.L. 94-437), "that it is the policy of this Nation, in fulfillment of its special trust responsibilities and legal obligations to Indians…to ensure the highest possible health status for Indians and urban Indians and to provide all resources necessary to effect that policy."[7] Despite this commitment, Native Americans still face enormous health disparities and continue to have a lower life expectancy than the overall population. Native Americans are more likely to die of diabetes, unintentional injury, intentional self-harm or suicide, chronic lower respiratory diseases, liver

[5] Between August 1, 2017 and August 1, 2018, Upper Peninsula Health Plan enrollees represented approximately 13% of the total billable medical patient encounters at LVD Health Center. These medical patient encounters constituted over 30% of LVD Health Center revenue during that same period. In addition, these percentages for both patient encounters and revenue are significantly higher when adding in dental and other services currently offered at the LVD Health Center. That information was unavailable at the time of submission of these comments.
[6] 42 U.S.C. § 1396d(b) ("the Federal medical assistance percentage shall be 100 per centum with respect to amounts expended as medical assistance for services which are received through an Indian Health Service facility whether operated by the Indian Health Service or by an Indian tribe or tribal organization").
[7] 25 U.S.C. § 1602(1).

disease, influenza and pneumonia.[8] Yet, the IHS is currently only funded at around 60% of need.[9] Congress intended for Medicaid to help address this funding shortfall when it authorized IHS to bill Medicaid.[10] This is made clear by the legislative history surrounding such authorization which states that "[t]hese Medicaid payments are viewed as a much-needed supplement to a health care program which has for too long been insufficient to provide quality health care to the American Indian."[11] To ensure that Indian health care remained a federal responsibility that was not shifted to the states, Congress also enacted legislation to provide for a 100% federal medical assistance percentage for Medicaid services received through and HIS or tribal facility, like the LVD Health Center.[12] Congress has also amended Medicaid numerous times to accommodate the unique nature of the Indian health system.[13] To be sure, Medicaid has become a critical component of the United States' fulfillment of its trust responsibilities to provide for Native American health care. Additional State mandated requirements on Native Americans which serve as a barrier to Medicaid are fundamentally at odds with the Federal governments treaty and trust responsibilities to the Indian tribes.

Furthermore, failure to include an exemption for desolate and geographical isolated areas undermines the overall purpose of the Social Security Act as it related to the Medicaid program and could prove detrimental to the State as an argument could be made that the State has failed to adequately consider the basic question of whether the Proposal would harm the core Medicaid goal of providing health coverage.[14] The rapid rate at which the Proposal is moving through the Michigan Department of Health and Human Services for submission to CMS[15] and the depressed economic conditions of Michigan's Upper Peninsula reinforces a lack of adequate reflection on the part of the State.[16]

Finally, with over 68,000 ICD-10 codes that identify medical conditions that could lead to a diagnosis that result in an enrollee being diagnosed as medically frail, only 500 codes are specified.

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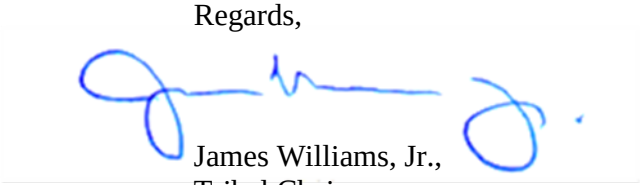
[8] See Indian Health Service, Factsheets: Disparities, https://www.ihs.goc/newsrooms/factsheets/disparities/.
[9] See Indian Health Service, Frequently Asked Questions.
[10] 42 U.S.C. §§ 1395qq, 1396j.
[11] H.R. Rep. No. 94-1026-Part III at 21 (May 21, 1976, reprinted in 1976 U.S.C.C.A.N. 2796).
[12] 42 U.S.C. § 1396(d).
[13] Balanced Budget Act of 1997 (P.L. 105-33)(providing an exception for American Indians/Alaskan Natives and others when allowing states new flexibility to mandate enrollment into managed care systems); 42 U.S.C. §§ 1396o(j), 1396o-1(b)(3)(A)(vii)(prohibited states from imposing premiums or cost sharing on American Indians/Alaskan Natives receiving covered services through HIS or a tribal facility); 42 U.S.C. §§1396a(ff), 1397gg€(1)(H)(ensured that certain trust-related property would be excluded from ineligibility determinations); 42 U.S.C. § 1396p(b)(3)(B)(imposed Medicaid estate recovery protections for American Indians/Alaskan Natives); 42 U.S.C. § 1396u-2(h)(established special rules to ensure Indian health care providers are reimbursed by states using managed care systems).
[14] Cf. Stewart, et. al. v. Azar, Civ. Action No. 1:18-cv-152 (D.C. 2018) (finding the Secretary's approval Kentucky's HEALTH program arbitrary and capricious prohibiting Kentucky from implementing it until HHS makes an assessment of whether the program in fact will help the state furnish medical assistance to its citizens).
[15] P.A.208 of 2018 was signed into law on June 22, 2018. The Proposal was released on July 9, 2018. MDHHS is mandated to submit the Proposal by October 1, 2018. Little more than 90 days will pass between development and submission of the Proposal that could affect hundreds of thousands of Michigan residents.
[16] In March 2018, the Bureau of Labor Statistics report a 6% unemployment rate in Gogebic County and a 10.3% unemployment rate in Ontonagon County. With the recent announcement of the closing of the Ojibway Correctional Facility, the largest and highest paying employer in Gogebic County, those numbers are sure to rise. https://www.mlive.com/news/index.ssf/2018/08/plan_to_close_prison_rocks_up.html. Coupled with transportation issues and inclement weather, workforce engagement requirements are simply out of tune with the State's most geographically isolated areas.

The current list lacks significant behavioral health diagnoses that are likely to affect an enrollee's ability to meet the work requirements. Specifically, the current list of ICD-10 codes fails to include F31-F68.10, all of which may represent significant impairments to an individual's ability to be active 20 hours each week, let alone attain gainful employment. These ICD-10 codes include diagnoses such as severe bi-polar disorder, sever manic depressive disorder, certain adjustment disorders and other significant diagnoses which could very well lead to an individual being determined medically frail. In addition, the language used to describe a medically frail diagnosis seems to require that an individual self-report, a claims analysis, and a health care provider referral. The Tribe submits that the "and" should be revised to an "or" as both would provide adequate evidence of such a determination by a health care professional.

For all the reasons explained herein, the Tribe is opposed to the implementation of work requirements for Native American HMP enrollees and HMP enrollees residing in desolate or geographically isolated areas of the State, and respectfully requests that the Michigan Department of the Health and Human Services:

1. Consider the addition of a specific exemption from the workforce engagement requirements for Native Americans as well as those who reside in desolate or geographically isolated areas of the State like Michigan's Upper Peninsula.
2. Revisit and revise the Proposal to include a more comprehensive list of behavioral health diagnosis when determining whether an individual is medically frail as well as clarify language regarding how such a determination is required to be made.
3. Include the Tribe as a partner at the table during the revision process before submission to CMS in order to ensure the goals of the State/Tribal Accord are met.
4. Include the Tribe in subsequent workgroups developed to implement the Proposal, if applicable.

Regards,



James Williams, Jr.,
Tribal Chairman

Pokégnek Bodéwadmik · Pokagon Band of Potawatomi
Tribal Council

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August 21, 2018

Michigan Department of Health and Human Services
Medical Services Administration
Bureau of Medicaid Policy and Health System Innovation
Attention: Medicaid Policy
P.O. Box 30479
Lansing, Michigan 48909-7979
Attn: Kathy Stiffler, Acting Director

Re. Tribal Comments on Healthy Michigan Plan Demonstration Waiver Amendment

Dear Ms. Stiffler,

The Pokagon Band of Potawatomi Indians (the Tribe) is pleased to provide comments on the State of Michigan's proposed Healthy Michigan Plan §1115 Demonstration Extension Waiver (Amended Waiver). The Tribe is pleased that the State has afforded it the opportunity to submit comments on the Waiver, and appreciates the State's commitment to further tribal consultation. We look forward to working with your staff throughout the consultation process on the waiver proposal.

As discussed below, the Tribe has concerns with parts of the Amended Waiver as they apply to Native Americans. While the Tribe appreciates the Amended Waiver's clear exemption of Native Americans from the cost-sharing provisions, and including other exemptions, overall the Tribe requests MDHHS to include more clear language on exemptions, and to broaden the exemptions for Native Americans. The Amended Waiver, and its actual implementation, may conflict with federal law exempting Native Americans from general Medicaid requirements, including work engagement requirements, healthy behavior incentives, and managed care requirements. Our specific comments, discussed in detail below, can be summarized as follows:

1. We support the exemption from cost-sharing for Native Americans.

2. Native Americans should also be exempt from the healthy behaviors requirement. This appears to be the intent but the application is not clear on this point and should be amended accordingly.

3. Native Americans should be exempted from the work requirements. While the intent behind the requirement is understandable, because Native Americans have access to medical care at no cost through our tribal clinic and other federally-funded clinics, the employment incentive structures created by Medicaid work requirements do not operate in the same way for Native American Medicaid beneficiaries, who may

simply forgo Medicaid coverage and rely instead on the free care offered at federally-funded clinics, which in turn adds significant financial strain on the those clinics.

4. The Application should be amended to clarify that Native Americans are exempt from mandatory enrollment in managed care, which appears to be your intent as stated in your recent letter to tribes.

5. We request consultation on the waiver application, as required by law and CMS policy.

Background

The Tribe is based in Dowagiac, Michigan, and has approximately 5,600 citizens, the majority of whom live in Michigan, and many on the Tribe's reservation. The Tribe provides housing, education and health services to its citizens, both those living on and off the reservation.

The Pokagon Band Department of Health Services serves as a primary care provider for its citizens in Allegan, Van Buren, Berrien and Cass counties in Michigan, and La Porte, St. Joseph, Elkhart, Stake, Marshall and Kosciusko counties in Indiana. Its Contract Health Service Delivery Area (CHSDA) encompasses all of those counties.

The Pokagon Band Department of Health Services is an ambulatory clinic which provides direct patient care in the areas of diagnosis, prevention and treatment of acute and chronic illness, with an emphasis on health and wellness. The Health Department serves Pokagon citizens who live in Michigan and Indiana, providing services including management of acute and chronic illness, routine medical care, laboratory services, minor procedures, immunizations, wellness visits for adults and children, health and medical education, including illness prevention, and conducting periodic health fairs and educational events.

The United States has a federal trust responsibility to provide health care to American Indians and Alaska Natives, which is implemented by federal agencies like CMS. Both the HHS and CMS tribal consultation policies recognize "the unique government to government" relationship between the United States and Tribes, as well as the trust responsibility "defined and established" by "the U.S. Constitution, numerous treaties, statutes, Federal case law, regulations and executive orders."[1] One manifestation of this trust responsibility is that "CMS and Indian Tribes share the goals of eliminating health disparities for American Indians and Alaska Natives (AI/AN) and of ensuring that access to Medicare, Medicaid, the Children's Health Insurance Program (CHIP) and Exchanges is maximized."[2]

Tribal Medicaid Protections

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[1] Centers for Medicare & Medicaid Services Tribal Consultation Policy (Nov. 17, 2011), at 1; U.S. Dep't of Health and Human Services Tribal Consultation Policy (Dec. 14, 2010), at 1.

[2] Centers for Medicare & Medicaid Services Tribal Consultation Policy (Nov. 17, 2011), at 2.

In furtherance of the federal trust responsibility, Congress has enacted a number of provisions in the Medicaid statute that are designed to reduce barriers for Native Americans people to access Medicaid benefits. The Indian health system is unique and has a unique relationship to the Medicaid program. The Indian health system relies primarily on funding provided through appropriations to the Indian Health Service (IHS), but these appropriations are insufficient to fully fund the system. Recognizing this, Congress enacted legislation over 40 years ago to authorize the IHS and tribal health programs to bill the Medicare and Medicaid programs as a way to supplement inadequate IHS funding.[3] The House Committee on Interstate and Foreign Commerce justified its action by stating that "[t]hese Medicaid payments are viewed as a much-needed supplement to a health care program which has for too long been insufficient to provide quality health care to the American Indian."[4] Other Medicaid statute amendments relating to Indians include the following:

- **100 percent FMAP**. An amendment to Section 1905(b) of the Social Security Act, 42 U.S.C. §1396d(b), applied a 100 percent federal medical assistance percentage (FMAP) to Medicaid services provided to an Indian by an IHS or tribally-operated facility. As a result of Section 1905(b), the State is reimbursed at 100 percent FMAP for services provided to Medicaid eligible individuals who receive services at an IHS or tribal facility, resulting in **no cost to the State** for Indian participation in the Medicaid program.[5]

- **No Mandated Managed Care**. An amendment to Section 1932 of the Social Security Act, 42 U.S.C. § 1932(a)(2)(C), provides that States may not require Indians to enroll in managed care entities as a condition of participating in its Medicaid program.

- **No Premiums or Cost Sharing**. Section 5006 of the American Recovery and Reinvestment Act of 2009 (ARRA) added a number of Indian-specific Medicaid

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[3] 42 U.S.C. §1395qq and 42 U.S.C. §1396j.

[4] H.R. REP. No. 94-1026, pt. III, at 21 (1976), as reprinted in 1976 U.S.C.C.A.N. 2782, 2796.

[5] The application of 100 percent FMAP to the Medicaid-covered services provided by these facilities was made in express recognition of the federal government's treaty obligations for Indian health. The House Committee Report stated that since the United States already had an obligation to pay for health services to Indians as *IHS beneficiaries*, it was appropriate for the United States to pay the full cost of their care as *Medicaid beneficiaries:*

> (1) the Federal government has treaty obligations to provide services to Indians; it has not been a State responsibility;
>
> (2) since the 100 percent matching is limited to services in IHS facilities, it is clearly being paid for Indians who are already IHS eligible (and therefore clearly part of the population to which the U.S. Government has an obligation) and who are already eligible for full Federal funding of their services, and
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> (3) States with a large IHS eligible Indian population have a limited tax base because so much of the land is public and not taxable; the higher matching rate under Medicaid simply recognizes this. H.R. REP. No. 94-1026, pt. III, at 21 (1976), as reprinted in 1976 U.S.C.C.A.N. 2782, 2796.

protections, including a provision that provides that States are prohibited from imposing any premium or cost-sharing on an Indian for a covered service provided by the IHS, a health program operated by an Indian tribe, tribal organization or urban Indian organization, or through referral under contract health services. 42 U.S.C. §§1396o(j) and 1396o-1(b)(3)(vii).[6]

- **Disregard of Certain Indian Property from Resources for Medicaid and CHIP Eligibility.** Section 5006(b) of ARRA exempts certain types of Indian property from the resources calculation for Medicaid eligibility. 42 U.S.C. §§1396a(ff) and 1397gg(e)(1)(H).

- **Medicaid Estate Recovery Protections.** Section 5006(c) of ARRA provides an exemption for certain Indian-related income, resources and property held by a deceased Indian from the Medicaid estate recovery requirement. 42 U.S.C. §1396p(b)(3)(B).

- **Special Indian-specific Rules for Medicaid Managed Care.** Section 5006(d) of ARRA provides protections for Indian people and Indian health providers when Indians voluntarily choose to participate in managed care systems. It provides that Indian enrollees have the right choose their Indian health program as their primary care provider, that Indian health providers (IHS, tribal and urban Indian organization programs) have a right to prompt payment from managed care entities, and directs the States to make up the difference in payment to tribal health facilities by a managed care entity that was not what Medicaid would otherwise pay for the service. 42 U.S.C. §1396u-2(h).

Tribal Concerns with Healthy Michigan Plan Extension Waiver

We have reviewed the Tribal Notice sent July 9, 2018, containing information on how the Healthy Michigan Plan §1115 Demonstration Extension Waiver ("Amended Waiver Extension Application" or "Application")), the Section 1115 Demonstration Extension Application amended July 9, 2018,[7] and Public Act 208. We are concerned that the draft waiver application includes detrimental aspects the State should change before submission to CMS.

1. Exemption of Native Americans From Cost-Sharing

The Amended Waiver Extension Application makes clear that Native Americans are not subject to the cost-sharing and premium provisions of the proposed waiver.[8] As discussed above, the Social Security Act specifically exempts American Indians and Alaska Natives from premiums, co-payments, or cost-sharing of any kind in the Medicaid program. 42 U.S.C. 1396o(j). The Tribe supports including the exemption in the waiver application. Additionally, in

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[6] In recognition of the trust responsibility, Indian children have been exempt from cost-sharing in the CHIP program pursuant to regulation at 42 C.F.R. §457.535.

[7] Available online at https://www.michigan.gov/mdhhs/0,5885,7-339-71547_2943_66797-472387--,00.html.

[8] Amended Waiver Extension Application, 8, 9, and Exhibit C at 1.

any discussions with CMS concerning the application, you should insist that this exemption be included in any final waiver that may be granted.

2. Healthy Behavior Requirements

The Amended Waiver Extension Application is not clear as to whether Native Americans are exempted from the healthy behaviors requirement. The Application states that beneficiaries with an income between 100% and 133% of the FPL must complete a healthy behavior to remain eligible after 48 months of eligibility. Application at 7. It further states that Native Americans are exempt from the cost-sharing requirement, Application at 8, 9, but does not expressly state that they are exempt from the healthy behaviors requirement. The July 9 Tribal Notice states, on the other hand, that "Native American enrollees … will not be subject to the eligibility suspension provisions outlined above," (at p. 2), referring to both the cost-sharing and healthy behavior requirements. If it is your intent to exempt Indians from the healthy behavior requirement—as it appears to be—then the Application should be amended to say so expressly.

We encourage healthy behaviors through our own government programs and traditional practices, and encourage an open dialogue with the State to develop healthy behavior incentives within the Tribe and to share our traditional knowledge and practices to help improve healthy behaviors throughout Michigan. However, without a clear exemption of Native Americans from the healthy behavior requirements in the Waiver, the risk of lost health coverage through unforeseen consequences, inaccurate implementation or administrative errors is too great.

While imposing healthy behaviors and other eligibility conditions may be appropriate for Michigan's non-Indian population, they will not work as intended in Indian country because the incentives are not the same. Faced with meeting these requirements as a condition of Medicaid eligibility, American Indians and Alaska Natives will simply elect not to enroll in Medicaid and rely on IHS instead. This will lead to more uncompensated care provided to otherwise Medicaid eligible individuals by the IHS, tribes and non-Indian healthcare providers. Instead of incentivizing healthy behaviors and employment, such requirements will lead to decreased Indian access to the Medicaid program, a result at odds with congressional intent.

3. Work Requirements

Although the Tribe fully supports the goal of increasing employment for its tribal citizens and others, work requirements simply will not accomplish their goal when they are applied to Michigan's Native American population. Native Americans are unique among Medicaid enrollees because they also have access to the IHS, and therefore the employment incentive structures created by Medicaid work requirements do not operate in the same way for Native American Medicaid beneficiaries. Because Native American beneficiaries may simply forgo Medicaid coverage and rely instead on IHS coverage, which in turn adds significant financial strain on the perennially underfunded IHS system.

Additionally, as a practical matter, many Native American Medicaid beneficiaries may not be able to meet Medicaid work requirements due to high on-reservation unemployment and/or lack of connection to State employment programs.

4. Managed Care Requirements

The Tribe requests an explicit exemption in the Application from the Healthy Michigan Plan's (HMP) managed care requirements. Although MDHHS stated in the July 9, 2018 Tribal Notice that that Native Americans may "voluntarily enroll in the managed care delivery system," (p. 2, emphasis added)—making clear that they cannot be required to enroll in managed care—the Application does not expressly exempt them from any requirements to enroll, or to be automatically enrolled into such a system. Express exemption language is essential because the Amended Waiver Extension states "services for HMP beneficiaries are provided through a managed care delivery system, and that "[a]ll HMP eligible beneficiaries are initially mandatorily enrolled in a Medicaid Health Plan (MHP), with the exception of those few beneficiaries who meet the MHP enrollment exemption criteria or those beneficiaries who meet the voluntary enrollment criteria." (p. 9, emphasis added)." The language in the Application is at best unclear. It should be revised to clearly state that Indians are not subject to mandatory enrollment in managed care.[9]

Without this clear exemption language, even with the clear intent to exempt Native Americans from the various additional programs the Amended Waiver creates, the State's proposal would likely result in additional administrative burdens to the State, to the Tribe, and to the Managed Care Entities that are unnecessary and can be easily avoided. By simply adding clear and concise language directly into these Amended Waiver initiatives, then the implementation of the Amended Waiver initiatives will go much more smoothly and without costly errors or misunderstandings of the scope of the exemptions.

5. Request for Tribal Consultation

We appreciate the efforts the State has made in consulting with tribes through its conference call on August 6, 2018, as communicated in the June 9 Tribal Notice letter, and the extended comment deadline of August 23, 2018. However, under federal law and policy, tribal consultation requires more than simply public comment participation and one brief pre-schedule phone call. As CMS's Tribal Consultation Policy explains, Section 5006(e) of the American Recovery and Reinvestment Act (ARRA) requires any State with one or more Indian health providers to obtain advice and input on a regular, ongoing basis prior to submitting a waiver

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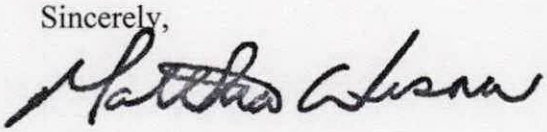
[9] Requiring Indians to enroll in managed care plans would result in additional administrative burdens to the State, to the Tribe, and to the managed care entities that are unnecessary and can be easily avoided. Managed care entities would be in a position of having to administer the program in a manner that allowed Indian enrollees to choose the Pokagon Health Department as their primary health care provider of choice, 42 U.S.C. § 1396u-2(h)(1), to make payments to the Pokagon Health Department whether they were an in-network provider or not, 42 U.S.C. § 1396u-2(h)(2) and 25 U.S.C. § 1621e, and would require the State to make supplemental payments to the Pokagon Health Department to the extent the managed care entities paid less than the rate that applies to the provision of such services under the State plan. 42 U.S.C. § 1396u-2(h)(2)(C)(ii). In addition, the managed care entities (and the State, in its oversight capacity) would have to design Indian-specific plans in order to ensure that Pokagon Band citizens did not have to make any payments or cost-sharing. 42 U.S.C. §§ 1396o(j), 13960-1(b)(3)(A)(vii) and (b)(3)(B)(x).

request or proposal for a demonstration project likely to have a direct effect on Indians and Indian health providers. 42 U.S.C. § 1396a(a)(73).[10] Because of the unique issues arising from the interactions of Medicaid and tribal healthcare, we request further consultation to more sufficiently discuss the health impacts of the waiver and necessary clarifications to ensure a smooth transition for Native Americans. We will follow-up with MDHHS Liaison to the Michigan Tribes, Lorna Elliott-Egan, in order to resolve the ambiguities and ensure the necessary exemptions are included in the finalized demonstration waiver.

Conclusion

We understand the State is eager to move forward with the submission of these waivers and to have CMS begin assessing them. We appreciate the consultation processes already completed, and the changes already made to ensure Native American exemptions from cost-sharing. We believe further progress can be made, and better policy outcomes achieved, by ensuring all aspects of the Amended Waiver programs include sufficient and clear exemptions for Native Americans. This approach will not only expedite this process, but also ensure that the waiver can be implemented in the most efficient and least complicated and burdensome fashion possible.

Sincerely,



Matthew Wesaw
Tribal Council Chairman
Pokagon Band of Potawatomi Indians

Cc: Matt Clay, Director, Pokagon Band Department of Health Services
Elliott Milhollin, Esq., Hobbs, Straus, Dean & Walker, LLP

[10] Federal regulations also require the continued consultation through the submittal of the waiver to CMS when the waiver will have a direct effect on the Tribe. CMS's Tribal Consultation Policy, citing Section 1115 Transparency Regulations at 42 C.F.R. § 431.408(b). Documentation of the State's consultation activities must be included in the demonstration application. 42 C.F.R. § 431.408(b)(3).

Pokégnek Bodéwadmik · Pokagon Band of Potawatomi
Tribal Council

P.O. Box 180 • 58620 Sink Road • Dowagiac, MI 49047 • www.PokagonBand-nsn.gov
(269) 782-6323 • (888) 376-9988 toll free • (269) 782-9625 fax

August 31, 2018

Michigan Department of Health and Human Services
Medical Services Administration
Bureau of Medicaid Policy and Health System Innovation
Attention: Medicaid Policy
P.O. Box 30479
Lansing, Michigan 48909-7979
Attn: Kathy Stiffler, Acting Director

Re. Additional Comments on Healthy Michigan Plan Demonstration Waiver Work Requirements

Dear Ms. Stiffler,

The Pokagon Band of Potawatomi Indians (the Tribe) is writing to follow up on the August 21, 2018 comments we provided to you on the State of Michigan's proposed Healthy Michigan Plan §1115 Demonstration Extension Waiver (Amended Waiver). Tribes are universally opposed to the Amended Waiver's proposal to include work and community engagement requirements as a condition of Medicaid eligibility. As discussed below, CMS lacks the legal authority to approve such requirements, and cannot approve any waiver that would impose such requirements on American Indians and Alaska Natives (AI/ANs).

We understand CMS has expressed concern regarding the approval of a waiver that contains an exemption for AI/ANs from work and community engagement requirements, but CMS's concerns are misplaced and lack any legal basis. As a result, we request that to the extent the State decides to maintain its proposal to impose work and community engagement requirements, it exempt AI/ANs from those requirements. As discussed below, as an alternative, the State should exempt individuals who are not required to enroll in managed care, and/or individuals who are exempt from cost-sharing in the Medicaid program.

Work requirements will not work in Indian country

The Tribe fully supports programs designed to increase employment, and has developed significant economic development, education, and workforce training programs for our citizens. We are concerned, however, that the Amended Waiver's work requirements will not work for AI/ANs. Unlike other Medicaid enrollees, American Indians have a right to access care at IHS and tribal facilities at no cost to them. As a result, they have no incentive to participate in the Medicaid program if meeting the State's work requirements is too burdensome. Imposing work requirements on our citizens will result in many of the patients we serve dropping off of Medicaid or not enrolling in the first place. That, in turn, would deprive the Indian health system of a stream of supplemental funding it needs to survive, and which Congress intended it receive.

CMS may not lawfully approve a waiver that imposes work requirements on our citizens

While Section 1115 grants broad discretion to the Secretary, it only authorizes the waiver of certain enumerated provisions in the Social Security Act. It does not authorize the Secretary to impose new requirements, such as work requirements.

In addition, CMS may only approve demonstration projects that are "likely to assist in promoting the [Act's] objectives." 42 U.S.C. § 1315(a); *Stewart v. Azar* at *5 (No. 18-152 (JEB)) (D.D.C., June 29, 2018). One of the Act's general objectives is to "furnish medical assistance" to individuals whose income and resources are insufficient to meet the costs of necessary medical services. *Stewart* at *33. It is difficult to see how CMS could advance that objective with regard to AI/ANs if the waiver at issue would result in significant incentives for AI/ANs not to enroll in Medicaid to begin with, or for those already enrolled to drop off and rely instead on the IHS.

The Act also sets out unique objectives that are specific to the Indian health system. In 1976, Congress amended the Medicaid statute to authorize IHS and tribally operated facilities to bill the Medicaid program in order to make Medicaid resources available to supplement funding for the chronically underfunded Indian health system.[1] Section 1911 of the Act, 42 U.S.C. §1396j, made IHS and tribal facilities eligible to collect reimbursements from Medicaid, and an amendment to Sec. 1905(b), 42 U.S.C. §1396d(b), ensured States would not bear the burden of costs associated with doing so by applying a 100 percent federal medical assistance percentage (FMAP) to Medicaid services provided to an Indian by an IHS or tribally-operated facility.

Congress's intent in enacting Section 1911 was to ensure that Medicaid funds be made available to help supplement inadequate IHS funding. Section 1911 was enacted "as a much needed supplement to a health care program which for too long has been insufficient to provide quality health care to the American Indian." H.R. Rep. 94-1026 at 21. It was intended "to enable Medicaid funds to flow into IHS institutions." H.R. Rep. 94-1026 at 20. Congress intended these resources be available to enable IHS facilities to meet the conditions of participation in the Medicare and Medicaid programs. *Id.*

Congress also taken additional steps to lower barriers to AI/ANs enrollment and participation in the Medicaid program. Congress amended the Act to authorize IHS, tribal and urban Indian programs to act as express lane agencies, 42 U.S.C. 1396a(e)(13)(F), it exempted AI/AN Medicaid enrollees receiving services through an IHS or through contract health service referral from premiums, co-pays or cost-sharing of any kind, 42 U.S.C. § 1396o(j)(1)(A), and it

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[1] The House Interior and Insular Affairs Committee noted that per capita spending on Indian health in 1976 was 25 percent less than the average American per capita amount. H.R. REP. No. 94-1026, pt. I, at 16 (1976), *reprinted in* 1976 U.S.C.C.A.N. 2652, 2655. According to the U.S. Commission on Civil Rights, IHS per capita spending for Indian medical care in 2003 was 62 percent lower than the U.S. per capita amount. U.S. Commission on Civil Rights, *Broken Promises: Evaluating the Native American Health Care System* (Sept. 2004), at 98.

authorized the Secretary to encourage States to work with tribes to increase AI/AN enrollment,

and required the Secretary to facilitate cooperation between States and tribes in implementing the Medicaid program. 42 U.S.C. § 1320b-9.

Imposing work requirements on AI/ANs works at cross purposes to all of these objectives. It would have the effect of dramatically decreasing enrollment in Medicaid for AI/ANs in Michigan, not increasing it. It would cut off access to Medicaid reimbursement for the Indian health system in the State, not increase access to that funding. Such a result would frustrate, rather than advance, the objectives of the Medicaid statute.

CMS's objections are misplaced and lack any basis in the law

CMS has stated that it cannot approve a waiver that contains an exemption for AI/ANs from work requirements because doing so would raise "civil rights concerns." CMS has not explained what those concerns might be, or provided any legal justification for that statement, because it cannot. CMS has ample legal authority to make accommodations for IHS beneficiaries in administering the Medicaid statute when doing so is rationally related to its unique trust responsibility to Indians. Under familiar provisions of Indian law that are routinely upheld by the courts, such actions are political in nature, and as a result do not constitute prohibited race based classifications. This is well-settled law that tribes and tribal organizations have explained to CMS, and which in the past CMS has relied on when approving other Indian-specific provisions in Section 1115 waivers and CMS Medicaid regulations. Rather than reiterate that authority here, we attach recent comments provided to CMS on this issue by the Tribal Technical Advisory Group to CMS.

Alternatives to Consider

As currently structured, the Amended Waiver would exclude a number of classes of individuals from having to participate in work requirements as a condition of Medicaid eligibility. As discussed above, we request that AI/ANs be included in the list of excluded classes of individuals from such requirements. If CMS cannot back off of its previously stated position, there are several other categories of individuals, which include AI/ANs and non-AI/ANs alike, that the State should exclude as well. These include:

- Exempting individuals who are not required to enroll in managed care in order to access Medicaid services and/or
- Exempting individuals who are exempt from cost-sharing in the Medicaid program.

Conclusion

We would like to thank the State for the opportunity to discuss these issues during our tribal consultation and to provide these additional comments on the Amended Waiver. We understand that Section 1115 Demonstration Waivers often involve an iterative process of discussion between the State and CMS, and we ask that the Tribe be kept informed of any developments on this issue as your discussions with CMS move forward.

Sincerely,

Matthew Wesaw
Chairman
Pokagon Band of Potawatomi Indians

Cc: Matt Wesaw, Chairman, Pokagon Band of Potawatomi Indians
Ed Williams, Esq., Pokagon Band of Potawatomi Indians

American Indian Health and Family Services
Of Southeastern Michigan, Inc.

Mínobínmaadzíwin "A Good Life"

To: State of Michigan
Re: 1115 Waiver Extension Application- Work Requirement Requested Exemption for Tribal Members

American Indian Health and Family Services of Southeastern MI, is a non-profit health center whose mission is to empower and enhance the physical, spiritual, emotional, and mental wellbeing of American Indian/Alaska Native individuals, families and other underserved populations in SE MI through culturally grounded health and family services./

I write this letter today with deep concern regarding the 115 Waiver Extenstion Application and specifically the states lack of exemption for Native Americans. As a general matter, we are concerned that work and community engagement requirements have the potential to significantly limit access to healthcare for the most vulnerable populations.

The Federal Government's trust responsibility for the provision of health care to AI/ANs has long been recognized and applies to all federal agencies.[2] Medicaid is one of the major programs the Federal Government utilizes in its implementation of this responsibility. 27% of nonelderly AI/AN adults, half of AI/AN children, and 40% of urban AI/AN UIHP patients are enrolled in Medicaid.[3] It is thus imperative that states that seek Section 1115 waivers do not impose any undue burdens or requirements on the AI/AN population that would limit their participation in the Medicaid program, including work and community engagement requirements. AIHFS herefore supports the exception for AI/ANs from its work requirement proposal language from Utah, which states that "[i]ndividuals with verified membership in a federally recognized tribe will not be required to participate, but they may participate in the work requirement if they choose. They will not lose eligibility if they fail to participate."[4] AIHFS notes that this should be interpreted as applicable to AI/ANs, including urban AI/ANs seen at UIHP facilities. Imposing this work requirement on the AI/AN population would be a violation of the trust obligation and this exception is therefore necessary for compliance with legal obligations. We thus request that the State of Michigan include this important exemption in their waiver application.

[2] In addition, this responsibility is not restricted to the borders of reservations and follows AI/ANs to urban centers where over 70% of AI/ANs live. *See* S. Rep. 100-508, Indian Health Care Amendments of 1987, Sept. 14, 1988, at 25.
[3] Henry J. Kaiser Family Foundation, Medicaid and American Indians and Alaska Natives (Sept. 2017); Indian Health Service, Office of Urban Indian Health Programs, UDS Summary Report Final – FY2016 (as of May 6, 2018).
[4] State of Utah, 1115 Primary Care Network Demonstration Waiver: Adult Expansion Amendment Request (June 22, 2018) at 6.

Furthermore, AIHFS cautions that any denial of AI/ANs exemption to work requirements on the basis of categorization of AI/ANs as a racial group is misguided and founded on an incorrect understanding of both law and facts.

First, Title VI of the Civil Rights Act of 1964 prohibits programs receiving federal financial assistance from discriminating on the basis of race, color or national origin. But Title VI does not preclude the federal government from requiring states to recognize unique obligations to AI/ANs under federal law. Based upon the unique legal status of Tribes under Federal law, the Federal government's trust and responsibility toward AI/ANs as authorized by Congress, CMS must affirmatively address barriers to healthcare for the AI/AN population.

Since the formation of the Union, the U.S. has recognized Indian Tribes as sovereign nations. This unique government-to-government relationship between Indian Tribes and the Federal Government is grounded in the U.S. Constitution, numerous treaties, statutes, Federal case law, regulations, and executive orders that establish and define a trust relationship with Indian Tribes and AI/AN people. This relationship derives from this political and legal relationship and *is not based upon race.*

Congress has already enacted a statute requiring CMS to support the Indian health system through Medicaid. Section 1911 of the Social Security Act "made clear [Congress's] intent to leverage the Medicaid and Medicare programs for fulfillment of its trust and treaty obligations[.]"[5] These changes to the Social Security Act were political actions – political in nature – not a race-based classification.

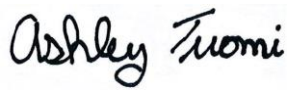
Moreover, the Supreme Court has recognized the principle that CMS has valid legal authority to single out IHS beneficiaries for special treatment in its administration of its programs, and has repeatedly upheld this unique political status and government- to-government relationship. In *Morton v. Mancari*, 417 U.S. 535 (1974), the Supreme Court held that, "[a]s long as the special treatment [for Indians] can be tied rationally to the fulfillment of Congress' unique obligation toward the Indians, such judgments will not be disturbed." *Id.* at 555. This principle has been reaffirmed numerous times both by the Supreme Court and every Federal Appellate Circuit Court of Appeals that has been presented with this issue.

[5] Letter of Bipartisan Senators to Department of Health and Human Services Secretary concerning AI/AN exemptions to Medicaid work requirements (April 27, 2018) [hereinafter "Senate Letter"].

Finally, the U.S. Senate reaffirmed that CMS has both the authority and the trust responsibility to ensure Medicaid is available to AI/ANs. The U.S. Senate Committee on Indian Affairs stated in a letter to CMS that Supreme Court precedent in *Morton* "— combined with a number of statutes, regulations, and additional court decisions – confirms that Tribes are not a racial group but rather political communities."[6] The Senators further state that Congress's extension of Medicaid to IHS beneficiaries rests on the "solid principles . . . [t]hat Congress can extend federal benefits to Indian tribes and their members as a means of fulfilling Congress's unique obligation toward tribes— all while abiding by the Equal Protection clause."[7]

For the aforementioned reasons, AIHFS supports the AI/AN exception from the work requirement that should be included in Michigan's 1115 demonstration waiver. This exception is consistent with Congressional practice and intent as well as Supreme Court precedent and is necessary to comply with the Federal Government's trust obligation to AI/ANs.

Sincerely,



Ashley Tuomi, CEO

Great Lakes Area Tribal Health Board

Resolution No. 18-001

Supporting the Government to Government Relationship Between the United States and Tribes and Protecting Tribal Sovereignty

WHEREAS, the Great Lakes Area Tribal Health Board (GLATHB) is a Tribal Health Board that serves thirty-four (34) Tribes, three (3) Service Units and four (4) Urban Indian Health Programs in Minnesota, Wisconsin, Michigan, Indiana, and Chicago, Illinois; and

WHEREAS, the GLATHB was developed to act as the conduit between the Bemidji Area tribes, tribal organizations, and urban Indian organizations to promote the spirit of self-determination and advocacy of tribal health care to the federal Indian health care system, while monitoring the federal and state legislation that may impact Indian health care; and

WHEREAS, GLATHB has adopted bylaws which authorize the Board of Directors to present and pass resolutions in support of actions that benefit its service area; and

WHEREAS, Since the formation of the Union, the United States has recognized Indian Tribes as sovereign nations; and

WHEREAS, A unique government-to-government relationship exists between Indian Tribes and the federal government and this relationship is grounded in the United States Constitution, numerous treaties, statutes, federal case law, regulations, executive orders evidencing the political and legal relationship that Indian Tribes enjoy with the federal government; and

WHEREAS, As part of its mission, GLATHB will continue to educate States, as well as the federal government, whether it be members of Congress or the Administration about the federal government's Trust Responsibility as well as the resulting provisions and protections afforded to American Indians based on the unique political status of Indian Tribes not on that of race; and

WHEREAS, In recognition of Tribal Sovereignty and the federal government's Trust Responsibility, American Indians are exempt from workforce enhancement and other extra-statutory requirements not otherwise authorized or consistent with federal statute; and

NOW, THEREFORE, BE IT RESOLVED, that the Great Lakes Area Tribal Health Board will continue to advocate for and support the unique government-to-government relationship between Indian Tribes and the federal government to promote and protect Tribal Sovereignty; and

BE IT FURTHER RESOLVED, that the Great Lake Area Tribal Health Board will continue to educate States, as well as the federal government, whether it be members of Congress or the Administration about the federal government's Trust Responsibility as well as the resulting provisions and protections afforded to American Indians based on the unique political status of Indian Tribes not on that of race; and

BE IT FINALLY RESOLVED, that the Great Lakes Area Tribal Health Board will continue to advocate for the unique political status of Indian Tribes, their members, and to take all action necessary and practical to ensure policymaking at both the federal and State level do not misinterpret policies mobilizing the federal Trust Responsibility and recognizing treaty rights on the basis of race.

CERTIFICATION

As Chair of the Great Lakes Area Tribal Health Board (GLATHB), I do hereby certify that the foregoing Resolution No. 18-001 was passed on August 28th, 2018, at a duly called meeting at which a quorum was present with 7 voting for, 0 voting against, and 0 abstaining.

Phyllis Davis, Chair

NOTTAWASEPPI HURON
BAND OF THE POTAWATOMI
A FEDERALLY RECOGNIZED TRIBAL GOVERNMENT

August 30, 2018

Matt Lori
Deputy Director, Policy, Planning and Legislative Services
333 S. Grand Ave
P.O. Box 30195
Lansing, Michigan 48909

Re: Nottawaseppi Huron Band of the Potawatomi
Comments Re: Healthy Michigan Plan §1115 Demonstration Waiver Extension Application Amendment

Dear Mr. Lori:

The Nottawaseppi Huron Band of the Potawatomi ("NHBP") appreciates the face-to-face consultation that was held to address the State of Michigan's ("State") request to amend the Healthy Michigan Plan §1115 Demonstration Waiver Extension Application ("the Proposal"). NHBP also appreciates the opportunity extended by Governor Snyder's Chief of Staff, Richard Posthumus, giving NHBP additional time to submit written comments on the State's Proposal.

Like many tribes across the nation, NHBP operates its own tribal health care facilities ("NHBP Health Clinics") on the Pine Creek Indian Reservation, at the FireKeepers Casino Hotel and in the City of Grand Rapids. The NHBP Health Clinics are full-service health clinics, offering primary care, walk-in services, dental services, behavior health and family services. These facilities provide health care services to both Native American and non-Native American clients. NHBP is the only tribe operating a health clinic in an urban area, City of Grand Rapids, with a large concentration of Native Americans from dozens of different tribes. On average, NHBP provides health services to 1813 patients who are enrolled members or descendants of other tribes each year. Of that number 318 are Medicaid recipients, with an additional 198 NHBP members and descendants who are Medicaid recipients.

NHBP understands, the State, pursuant to Public Act 208 of 2018, is requesting authority from the Centers for Medicare and Medicaid Services ("CMS") through the

Proposal[1] to implement changes in cost-sharing requirements for beneficiaries of the Healthy Michigan Plan ("HMP") for individuals with incomes between 100% and 133% of the federal poverty level as well as implement certain workforce engagement requirements for those individuals to maintain eligibility. NHBP has serious concerns with the State's plan to move forward with this Proposal without any meaningful opportunity for consultation and believes further consultation should take place before the State submits any Proposal that impacts Native Americans and tribal health programs.

The Tribe was first presented with notice of the HMP Application Amendment in December 2017; however, that notification did not include information as to how the HMP Application would be amended. The Tribe received another notice with more information in July 2018 - the same date the Proposal was made available for public comment. A conference call with the tribes was held on August 6, 2018, but little time was dedicated to allowing tribes to address concerns or voice any suggestions, revisions or objections as indicated by the notice. As a result of concerns expressed on the August 6th teleconference, an in-person Tribal/State consultation was held on August 27, 2018 - just 3 days before these written comments were due and little discussion was had regarding the logistics of implementation or tribal member reporting on these new requirements. Tribal Consultation, by agreement of the State, must occur before or in conjunction with policy/legislative/regulation development, not at the same time as the State's initiatives are made public.

While the Tribe appreciates that the Proposal recognizes that Native Americans are exempt by federal law from the cost-sharing requirements, it must be noted that no such exemption has been recognized for Native Americans regarding the work requirements. Furthermore, the Proposal fails to recognize Congress's intent that Medicaid be administered in a manner that supports Indian Health Services' ("IHS") provision of health care to Native Americans. Indeed, based on NHBP's experience and data, three things about the Proposal are abundantly clear, (1) mandatory work requirements will create a barrier to access to Medicaid that is unique to IHS beneficiaries as well as those individuals located in the most geographically isolated areas of the State where employment opportunities are limited or seasonal at best; (2) the Proposal's imposition of additional qualifying requirements for both Native Americans and non-Native Americans served by NHBP's Health Clinics will preclude Medicaid reimbursement for NHBP; and (3) the Proposal lacks a comprehensive list of

[1] The Proposal was not developed in accordance with the State-Tribal Accord (per Executive Directive 2001-2) entered into between Governor Engler (2002) and extended by both Governors Granholm and Snyder, which calls for a respectful government to government relationship when dealing with Michigan's Federally recognized Tribes of which Section V. Implementation reads:

> For purposes of this accord, "state action significantly affecting tribal interests" is defined as regulations or legislation proposed by executive departments, and other policy statements or actions or executive departments, that have or may have substantial direct effects on one or more tribes, on the relationship between the state and tribes, or on the distribution of power and responsibilities between the state and tribes. State action includes the development of state policies under which the tribe must take voluntary action to trigger application of the policy.

Consultation occurs before or in conjunction with policy, legislative, and regulation development, not at the same time as it is made available to the public.

exemptions to identify an individual as medically frail recognizing the broad spectrum of behavioral health diagnosises encompassed by ICD-10.

Crucial to NHBP's position is that Section 1911 of the Social Security Act, enacted over 40 years ago, authorizes IHS and tribally operated programs like NHBP's Health Clinics to bill the Medicaid program and receive reimbursement. Section 1911 was enacted to provide supplemental funding to the Indian health system and designed to ensure that Medicaid funds would "flow into IHS institutions." Unlike other Medicaid enrollees, IHS beneficiaries have access to the IHS system at no cost to them. Faced with mandatory work requirements, Native American enrollees will simply choose to no longer participate in the Medicaid program. That, in turn, will deprive the NHBP Health Clinics of Medicaid resources. This result is contrary to the Congressional intent of §1911 of the Social Security Act and thwarts the objectives of the Medicaid statute for purposes of Indian health.

An individual's eligibility for health care at NHBP's Health Clinic (or at any other IHS facility) is largely determined by federal law and does not depend upon whether that individual is complying with a State-created "experimental, pilot or demonstration project." The Proposal in its current form amounts to nothing more than a condition on NHBP's access to Medicaid reimbursement funding. Since an individual Indian or eligible descendant would be entitled to receive the same health care at NHBP's Health Clinic regardless of his or her qualification under the State's Medicaid plan, it is a certainty that the number of such persons who would participate in the State plan would decline, thus precluding Medicaid reimbursement for the services provided by NHBP. The interposition of this extra statutory State requirement would therefore result in a decrease in funding to support the NHBP Health Clinics. In addition, and importantly, as a matter of law, such decrease would be accomplished through an exercise of administrative discretion (i.e., CMS's approval of a State Medicaid plan waiver applications), not statutory directive or authorization. Finally, this exercise of discretion would undermine Congress's manifest intent that CMS administer Medicaid in a manner that supports IHS and improved health services for Native Americans. In fact, Congress has provided that IHS reimbursements from Medicaid be borne entirely by CMS, with no portion paid by any state.[2] Nothing in Congress's provision for IHS reimbursements—a framework that narrowly focuses on "services provided" and the facility providing those services—leaves room for CMS to impose additional requirements on program beneficiaries as a prerequisite to IHS's obtaining Medicaid reimbursements.

It is also important to note that mandatory work requirements for Native Americans are inconsistent with federal treaty and trust obligations. In fact, Congress declared in the Indian Health Care Improvement Act (P.L. 94-437), "that it is the policy

[2] 42 U.S.C. §1396d(b) "...the Federal medical assistance percentage shall be 100 per centum with respect to amounts expended as medical assistance for services which are received through an Indian Health Service facility whether operated by the Indian Health Service or by an Indian tribe or tribal organization".

of this Nation, in fulfillment of its special trust responsibilities and legal obligations to Indians...to ensure the highest possible health status for Indians and urban Indians and to provide all resources necessary to effect that policy."[3] Despite this commitment in federal law, Native Americans still face enormous health disparities and continue to have a lower life expectancy than the overall population. NHBP conducted a census in 2014 wherein 42% of respondents reported being diagnosed with a chronic disease. Then in 2016 NHBP conducted a Community Health Needs Assessment. This survey revealed that 20% of respondents had been diagnosed with diabetes and 16% of respondents reported no health care coverage at all, including no private health insurance, no prepaid plan such as an HMO and no government plan such as Medicare or Medicaid. NHBP Members identified that cost was the main barrier to access to health care. Yet, the IHS is currently funded at around 60% of need.[4] Congress intended for Medicaid to help address this funding shortfall when it authorized IHS to bill Medicaid.[5] This is made clear by the legislative history surrounding such authorization which states that "[t]hese Medicaid payments are viewed as a much-needed supplement to a health care program which has for too long been insufficient to

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[3] 25 U.S.C. §1602, Declaration of national Indian health policy
Congress declares that it is the policy of this Nation, in fulfillment of its special trust responsibilities and legal obligations to Indians—

(1) to ensure the highest possible health status for Indians and urban Indians and to provide all resources necessary to effect that policy;
(2) to raise the health status of Indians and urban Indians to at least the levels set forth in the goals contained within the Healthy People 2010 initiative or successor objectives;
(3) to ensure maximum Indian participation in the direction of health care services so as to render the persons administering such services and the services themselves more responsive to the needs and desires of Indian communities;
(4) to increase the proportion of all degrees in the health professions and allied and associated health professions awarded to Indians so that the proportion of Indian health professionals in each Service area is raised to at least the level of that of the general population;
(5) to require that all actions under this chapter shall be carried out with active and meaningful consultation with Indian tribes and tribal organizations, and conference with urban Indian organizations, to implement this chapter and the national policy of Indian self-determination;
(6) to ensure that the United States and Indian tribes work in a government-to-government relationship to ensure quality health care for all tribal members; and
(7) to provide funding for programs and facilities operated by Indian tribes and tribal organizations in amounts that are not less than the amounts provided to programs and facilities operated directly by the Service.

[4] See Indian Health Service webpage frequently asked questions at: https://www.ihs.gov/forpatients/faq/
Q: I am eligible for health care from the Indian Health Service, but the local Service Unit will not pay for the [surgery, health care, medicine] that I need? Why?
A: The Indian Health Service is funded each year through appropriations by the U.S. Congress...The Indian Health Service cannot always guarantee that funds are always available. Funds appropriated by the U.S. Congress currently cover an estimated 60% of health care needs of the eligible American Indian and Alaska Native people....

[5] 42 U.S.C. §§ 1395qq, 1396j

provide quality health care to the American Indian."[6] To ensure that Indian health care remained a federal responsibility that was not shifted to the states, Congress also enacted legislation to provide for a 100% federal medical assistance percentage for Medicaid services received through an IHS or tribal facility, like the NHBP Health Clinics.[7] Congress has also amended Medicaid numerous times to accommodate the unique nature of the Indian health system.[8] To be sure, Medicaid has become a critical component of the United States' fulfillment of its trust responsibilities to provide for Native American health care. Additional State mandated requirements on Native Americans which serve as a barrier to Medicaid are fundamentally at odds with the Federal government's treaty and trust responsibilities to the Indian tribes.

Finally, the current list of IDC-10 codes lacks significant behavioral health diagnoses that are likely to affect an enrollee's ability to meet the work requirements. Specifically, the current list of ICD-10 codes fails to include F31-F68.10, all of which may represent significant impairments to an individual's ability to be active 20 hours each week, let alone attain gainful employment. These ICD-10 codes include diagnoses such as severe bi-polar disorder, sever manic depressive disorder, certain adjustment disorders and other significant diagnoses which could very well lead to an individual being determined medically frail. In addition, the language used to describe a medically frail diagnosis seems to require that an individual self-report a claims analysis, and a health care provider referral. NHBP requests that the "and" be revised to an "or" as both would provide adequate evidence of such a determination by a health care professional.

For all the reasons explained herein, the Tribe is opposed to the implementation of work requirements for Native Americans in general and for enrolled members of the Nottawaseppi Huron Band of the Potawatomi specifically, and respectfully requests that the Michigan Department of the Health and Human Services:

1. Consider the addition of a specific exemption from the workforce engagement requirements for all persons who are enrolled members of federally recognized tribes or who receive health care at tribal health clinics.

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[6] H.R. Rep. No. 94-1026-Part III at 21 (May 21, 1976, reprinted in 1976 U.S.C.C.A.N. 2796).

[7] 42 U.S.C. § 1396(d).

[8] Balanced Budget Act of 1997 (P.L. 105-33)(providing an exception for American Indians/Alaskan Natives and others when allowing states new flexibility to mandate enrollment into managed care systems); 42 U.S.C. §§ 1396o(j), 1396o-1(b)(3)(A)(vii)(prohibited states from imposing premiums or cost sharing on American Indians/Alaskan Natives receiving covered services through HIS or a tribal facility); 42 U.S.C. §§1396a(ff), 1397gg€(1)(H)(ensured that certain trust-related property would be excluded from ineligibility determinations); 42 U.S.C. § 1396p(b)(3)(B)(imposed Medicaid estate recovery protections for American Indians/Alaskan Natives); 42 U.S.C. § 1396u-2(h)(established special rules to ensure Indian health care providers are reimbursed by states using managed care systems).

2. Revisit and revise the Proposal to include a more comprehensive list of behavioral health diagnoses when determining whether an individual is medically frail as well as clarify language regarding how such a determination is required to be made.

3. Include NHBP as a partner at the table during the revision process before submission to CMS in order to ensure the goals of the State/Tribal Accord are met.

4. Include NHBP in subsequent workgroups developed to implement the Proposal, if applicable.

Respectfully,

Jamie Stuck
NHBP Tribal Council Chairperson

cc: Richard Posthumus
Nick Lyon
Lorna Elliot Egan
MDHHS Medical Services Administration
Administrator Seema Verma
Hon. Alex M. Azar II

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
MDCH
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
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
MDCH
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.

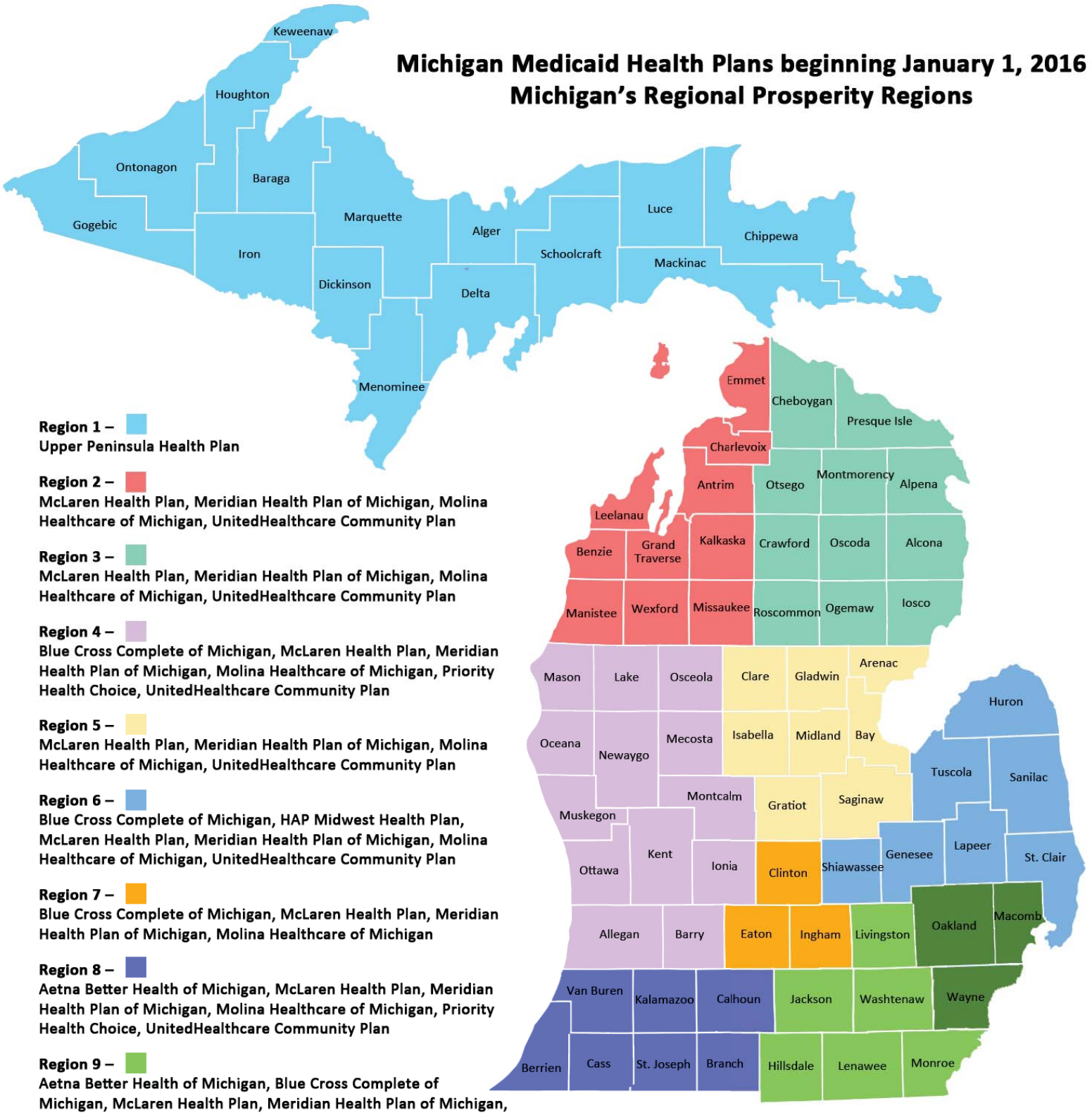
Consumer Representation for 2016 Update

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.

Michigan Department of Health and Human Services
Medical Services Administration

Medical Care Advisory Council

Meeting Minutes

Date: Wednesday, December 6, 2017

Time: 1:00 p.m. – 4:30 p.m.

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

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

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

Other Attendees: Jeff Holm, Jane Pilditch

Welcome, Introductions, Announcements

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

Federal Update

Children's Health Insurance Program (CHIP) Reauthorization

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

Cost Sharing Reductions

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

Budget/Boilerplate Update

2019 Budget Update

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

2018 Supplemental

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

Provider Enrollment Requirements

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

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

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

Integrated Service Delivery (ISD)

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

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

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

Medicaid Managed Care

Healthy Kids Dental Bid Update

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

Member Transportation Survey

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

Dental Services for Pregnant Women

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

Healthy Michigan Plan

Healthy MI Waiver Renewal Update

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

Transition to Marketplace for Healthy Michigan Plan Members

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

Behavioral Health Updates

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

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

Section 298 Update

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

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

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

Section 1115 Waiver Update

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

Long Term Care Updates

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

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

Managed Long Term Care Services and Supports

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

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

Policy Updates

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

MCAC Leadership

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

4:30 – Adjourn

Michigan Department of Health and Human Services
Medical Services Administration

Medical Care Advisory Council

Meeting Minutes

Date: Thursday, February 22, 2018

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:** Emily Schwarzkopf, Deb Brinson, Barry Cargill, Mark Klammer, Alison Hirschel, Amy Zaagman, Bill Mayer, Meghan Swain, Jeff Towns, April Stopczynski, Dan Thompson, Michelle Best (on behalf of Amy Hundley), Travar Pettway, Marion Owen, Dianne Haas, Linda Vail, Vicki Kunz (on behalf of Marilyn Litka-Klein), Melissa Samuel, Karlene Ketola, Lisa Dedden Cooper, Kim Singh, Jane Phillips (on behalf of Jim Milanowski), Bobbi Kuyers (on behalf of Dave Herbel), Stacie Saylor (on behalf of Rebecca Blake)

Staff: Kathy Stiffler, Farah Hanley, Lynda Zeller, Erin Emerson, Dick Miles, Brian Keisling, Jackie Prokop, Marie LaPres, Dave Schneider, Philip Bergquist, Phil Kurdunowicz

Other Attendees: Jane Pilditch, Salli Pung, Mario Azzi, Kelly Bidelman

Welcome, Introductions, Announcements

Emily Schwarzkopf opened the meeting and introductions were made.

Federal Update

Children's Health Insurance Program (CHIP) Reauthorization

Kathy Stiffler announced that congress has reauthorized CHIP for an additional 10 years.

Federal Budget

President Trump has released his FY19 federal budget recommendation, which includes a proposed 22.5% reduction in funding for Medicaid and the provisions of the Affordable Care Act (ACA) by 2028 and a proposed 28% reduction in funding for the Supplemental Nutrition Assistance Program (SNAP), as well as several other proposed reductions in non-defense discretionary spending. Meeting attendees were advised that approval for the proposed budget is a lengthy process, and that the Michigan Department of Health and Human Services (MDHHS) will not take any action on proposed funding levels until they are finalized.

Centers for Medicare & Medicaid Services (CMS) State Medicaid Director Letter – Opportunities to Promote Work and Community Engagement Among Medicaid Beneficiaries

CMS has issued a letter to State Medicaid Directors to indicate that states now have the option to submit Section 1115 waiver requests to implement work requirements as a condition of Medicaid eligibility, a copy of which was distributed to meeting attendees. Ten states have submitted Section 1115 waiver requests under this guidance to date, though MDHHS has no plans to do so at this time pending further direction from department leadership and the state legislature. MDHHS staff and meeting attendees discussed at length the many potential implications of implementing Medicaid work requirements, including concerns about the large staff and resource commitment that would be needed to monitor the employment status of Medicaid beneficiaries.

Budget Update

2019 Budget Update

The FY 2019 executive budget recommendation was released on February 7, 2018 and reflects a 0.6% increase in total statewide spending from FY 2018, including a 0.1% increase in general fund (GF) expenditures. The FY19 executive budget recommendation for MDHHS includes $177 million GF, most of which is allocated to existing programs. The FY19 executive budget recommendation for MDHHS includes:

- $72 million to address Federal Matching Assistance Percentage (FMAP) costs departmentwide;
- $42 million for departmentwide caseload costs;
- $63 million for actuarial soundness costs;
- $29 million for fund shifts;
- $20 million for various Department investments;
- An actuarial soundness increase of 2% for the Prepaid Inpatient Health Plans (PIHPs);
- $1.4 million to increase base salaries for psychiatrists at state psychiatric hospitals;
- Actuarial soundness increases of 1.5% for Medicaid;
- $56 million to account for an FMAP change that reflects a Healthy Michigan Plan adjustment of $30 million GF;
- $7 million GF to support rural hospitals;
- Funding for additional Medical Services Administration support staff;
- $8 million in additional funding for the Department’s per- and polyfluoroalkyl substances (PFAS) initiative;
- $4.8 million ongoing funding for local public health departments to address emerging public health threats;
- $2 per person per month increase (1.2%) in the family independence program cash allowance;

- $4.6 million in funding for information technology in support of the Integrated Service Delivery (ISD) initiative; and
- Funding to support MDHHS' Flint initiatives.

Overall, the FY19 executive budget recommendation for MDHHS includes $19 million in new funding, and $55 million in proposed reductions. In response to a question from a meeting attendee asking how the Medical Care Advisory Council (MCAC) can best show support for the proposed budget, Farah Hanley encouraged council members to contact their legislators to indicate their organization's support for the proposal and emphasize the importance of maintaining proposed funding levels to support the department's programs.

Provider Enrollment Requirements

Kathy Stiffler provided an update on Medicaid provider enrollment requirements by noting that while all providers who render services to Michigan Medicaid fee-for-service (FFS) beneficiaries were required to enroll in CHAMPS beginning in 2009, in May 2016 CMS issued a rule requiring all Managed Care Organization (MCO) providers to enroll with Medicaid beginning for rating periods on or after July 1, 2018. While MDHHS was working to implement this rule by the start of Michigan's fiscal year on October 1, 2018, the federal government enacted the 21st Century Cures Act, which requires that MCO providers be enrolled with their states' Medicaid programs by January 1, 2018. However, CMS has indicated that states may apply the 120-day grace period allowed by the Managed Care Rule for this change, which would extend Michigan's deadline for compliance with the 21st Century Cures Act to May 1, 2018. In addition, MDHHS is also working to require all prescribing providers to enroll with Medicaid.

The department had planned to begin denying claims for non-enrolled MCO providers on March 1, 2018, and for non-enrolled prescribing providers on May 1, 2018. However, due to many providers submitting enrollment applications as these dates approach, MDHHS has decided to indefinitely postpone these actions to allow staff the time to process the new applications. The department is also working to release communication to providers regarding this change, although staff emphasized that while the deadlines for enrollment have been postponed indefinitely, providers should still enroll as soon as possible. MDHHS staff and meeting attendees discussed this issue at length.

Integrated Service Delivery

MDHHS staff provided the following updates on the implementation of ISD:

- On January 22, 2018, the department began using a new paper public benefits application for individuals to apply for multiple MDHHS program benefits with a single form.
- Following a pilot demonstration of the new MI Bridges Self-Service Portal in Muskegon county, MDHHS has expanded the new system to Jackson, Genesee, Clinton and Eaton counties to further test its functionality before beginning to make it available statewide on March 19, 2018. The statewide rollout process is expected to be

completed by April 6, 2018.

- The universal caseload pilot in Gratiot and Shiawassee counties that was discussed at the previous MCAC meeting began on February 20, 2018.

Medicaid Managed Care

Healthy Kids Dental Bid Update

MDHHS has completed the process for selecting new vendors to provide services under the ***Healthy Kids Dental*** program, and has awarded statewide contracts to Blue Cross Blue Shield of Michigan, which will work with DentaQuest to provide dental benefits, and Delta Dental. As part of the new contract, MDHHS has included quality metrics to measure each plan's performance and is working to develop an algorithm to auto-assign new beneficiaries to a plan based on these quality measures. The new contracts will begin on October 1, 2018, and the plans may begin drafting marketing materials for MDHHS approval on April 1, 2018. In response to an inquiry regarding reimbursement rates for dental services, MDHHS staff indicated that no changes have been made, and that the department expects to finalize rates for FY19 by July 1, 2018.

Pregnancy Dental Benefit

MDHHS has received funding to provide dental services for pregnant women through the Medicaid Health Plans (MHPs) and is continuing to work on developing a process to identify Medicaid beneficiaries who are pregnant.

Healthy Michigan Plan

Transition to Marketplace for Healthy Michigan Plan Members

Letters sent out February 16, 2018

On February 16, 2018, MDHHS sent letters to approximately 13,500 Healthy Michigan Plan beneficiaries to inform them that they meet the criteria to transition to health coverage in the Marketplace beginning April 1, 2018 under the terms of the second waiver for the Healthy Michigan Plan. As outlined in the letter, MDHHS staff explained that beneficiaries who receive the letter have the right to appeal the decision and may also stay enrolled in the Healthy Michigan Plan if they attest to being medically frail, are pregnant, or complete a Health Risk Assessment (HRA) and engage in a healthy behavior. Beneficiaries who do not follow these steps and are required to transition to the Marketplace will receive an enrollment packet with information about each Marketplace health plan by early April 2018, and will be required to enroll by May 1, 2018. Those who do not choose a health plan will be auto-assigned. Copies of the letter were distributed to meeting attendees, and MDHHS staff and meeting attendees discussed at length the process for transitioning Healthy Michigan Plan beneficiaries to the Marketplace. Additional information about this process is available on the web at www.michigan.gov/mimarketplaceoption. MDHHS staff also indicated that the department worked with the University of Michigan Institute for Health Policy & Innovation to conduct surveys of beneficiaries and providers involved with the Healthy Michigan Plan. The reports from these surveys can be accessed on the web at www.michigan.gov/healthymichiganplan >>

Healthy Michigan Plan Program Information and History, under "CMS Correspondence."

Pregnant Women

Under the terms of the second waiver for the Healthy Michigan Plan, women who become pregnant after transitioning to the Marketplace from the Healthy Michigan Plan may either choose to stay in the Marketplace or receive coverage through regular Medicaid. MDHHS staff and meeting attendees discussed at length ideas for improving this process, including a suggestion for the department to consider allowing pregnant women to enroll directly into an MHP from the Marketplace.

Aged, Blind and Disabled Eligibility Category

Kathy Stiffler shared that MDHHS is continuing to investigate reports that individuals eligible for coverage under the Aged, Blind and Disabled category are being incorrectly classified for coverage by the department, and as a result, the Prepaid Inpatient Health Plans (PIHPs) do not receive the higher capitation rate for providing services to these beneficiaries. However, data indicate that these beneficiaries are instead voluntarily applying for Healthy Michigan Plan coverage, which is a beneficiary decision. Many are also losing coverage completely.

Healthy MI Waiver Renewal Update

On December 12, 2017, MDHHS submitted a renewal application for the Section 1115 Demonstration Waiver for the Healthy Michigan Plan to CMS, which has been posted on the CMS website at www.medicaid.gov for public comment.

Behavioral Health Updates

Section 298 Update

The Michigan legislature directed MDHHS to conduct up to three pilots to test publicly integrated behavioral health and physical health services, which will focus on financial integration. The department issued a Request for Information (RFI) in December 2017 to select the pilot sites and has received responses from five Community Mental Health Services Programs (CMHSPs) wishing to participate. MDHHS is currently working to evaluate the responses to the RFI with the goal of selecting the location of the three pilot sites by March 9, 2018. To be considered for inclusion in the pilot, a CMHSP must have letters of support from 50% of the MHPs in their region and demonstrate full financial integration of behavioral health and physical health services in their application. MDHHS is also exploring options for how best to serve those with specialty behavioral health needs. The targeted implementation date for the pilot programs is October 1, 2018.

The demonstration model for the Stakeholder 298 Initiative will maintain the current funding mechanism in which physical health services are funded through the Medicaid Health Plans and behavioral health services are funded through the PIHPs. The demonstration will be established in Kent County through the local CMHSP, Network180, in partnership with Priority Health. MDHHS has been actively engaged in discussions with Network180 and Priority Health on the implementation of the demonstration model and expects to receive a detailed project plan from the two entities in mid-March.

Additionally, the University of Michigan Institute for Health Policy & Innovation IHPI is in the process of developing a plan to put together an evaluation of the demonstration model, and will identify comparison sites for their study once the pilot begins. MDHHS is also continuing to work toward implementing the 76 policy recommendations for the integration of behavioral health and physical health services proposed by the Section 298 work group. Updates on this process will be posted on the web at www.michigan.gov/stakeholder298 as they become available.

1115 Waiver Update

MDHHS is continuing to communicate with CMS regarding the Section 1115 waiver application to provide all behavioral health services under a single waiver authority. No action has been taken by CMS on the waiver application since the previous MCAC meeting in December, although MDHHS staff have a call scheduled with CMS on Monday, February 26 to further discuss the waiver.

Other

The Behavioral Health and Developmental Disabilities Administration (BHDDA) is also working with other areas of MDHHS to implement the federal Home and Community Based Services (HCBS) Final Rule and the Electronic Visit Verification (EVV) system for personal care service providers.

Mental Health Parity Update

MDHHS staff provided an update on the department's efforts to comply with the Mental Health Parity and Addiction Equity Act of 2008, which requires that states place no more restrictions on behavioral health/substance use disorder benefits than on medical/surgical benefits. To comply with the law, MDHHS will require that, on a statewide basis, PIHPs can place no greater restrictions in any classification of behavioral health/substance use disorder services than the least restrictive restriction in that classification for medical/surgical benefits. Following the last update on mental health parity at the June 2017 MCAC meeting, MDHHS distributed surveys to all Medicaid Health Plans and PIHPs operating in the State of Michigan to gather data on their coverage standards and is in the process of compiling their findings into an assessment and developing a plan for corrective action. The issues the department will seek to address include: prescription drug copays; inpatient and outpatient prior authorization for behavioral health/substance use disorder services; and services for beneficiaries with intellectual and developmental disabilities. MDHHS plans to complete the assessment and

plan for corrective action by the end of April 2018, at which time it will be submitted to CMS and be made publicly available. In response to an inquiry, MDHHS staff indicated that the state does not anticipate a significant increase in costs as a result of compliance with the Mental Health Parity and Addictions Act of 2008.

Long Term Care Updates

Dick Miles provided an update on the following items related to Long Term Care:

- MDHHS is working to submit a renewal application for the MI Choice Waiver to CMS by October 1, 2018.
- Approximately 39,300 individuals are currently enrolled in the MI Health Link demonstration program for individuals who are dually eligible for Medicare and Medicaid. Enrollment in the demonstration has stabilized, and MDHHS is working to secure approval from CMS for waiver applications related to MI Health Link.
- The department is working to implement an EVV system for providers of in-home personal care services, which must be in place by January 1, 2019 per the 21st Century Cures Act.

Managed Long Term Care Services and Supports

A report containing data on long term care services and supports programs in Michigan and other states was distributed to meeting attendees and the document was discussed.

Policy Updates

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

4:30 – Adjourn

Michigan Department of Health and Human Services
Medical Services Administration

Medical Care Advisory Council

Meeting Minutes

Date: Monday, June 18, 2018

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:** Emily Schwarzkopf, Mark Klammer, Chris George (for Amy Hundley), Dan Thompson, Dianne Haas, William Mayer, Jeff Towns, Rod Auton, Marilyn Litka-Klein, Lisa Dedden Cooper, Karen MacMaster, Linda Vail, Pam Lupo, April Stopczynski, Mario Azzi, Kim Singh, Rebecca Blake, Deb Brinson, Robert Sheehan, Linda Gibson (for Jim Milanowski)

Staff: Kathy Stiffler, Farah Hanley, Dick Miles, Brian Keisling, Jackie Prokop, Pam Diebolt, Marie LaPres, Dave Schneider, Christina Severin, Jon Villasurda, Cindy Linn, Phil Kurdunowicz

Other Attendees: Randy Walainis, Amy Justus, Jane Pilditch

Welcome, Introductions, Announcements

Emily Schwarzkopf opened the meeting and introductions were made.

Budget Update

2019 Budget Update

Farah Hanley reported that the FY 2019 budget has been approved by both houses of the state legislature and forwarded for Governor Snyder's signature. Effective October 1, 2018, the budget includes an appropriation of $26 billion ($4.46 billion general fund [GF]) for the Michigan Department of Health and Human Services (MDHHS), which is $30 million beyond the Executive Budget Recommendation. Ms. Hanley indicated that while funding for legislative and MDHHS priorities is strong overall, some programs received reduced funding in the FY 19 budget, including a $12 million reduction in funding for the department's autism program, which includes a $7 million reduction by switching from a capitation model to a fee schedule model, and $5 million reduction by reducing the behavioral technician hourly rate from $55 to $50. Other highlights from the MDHHS FY19 budget include:

- $14 million for implementation of the Integrated Service Delivery (ISD) system.
- Actuarial soundness adjustment of 1% for the Medicaid Health Plans (MHPs) and 2% for the Prepaid Inpatient Health Plans (PIHPs).
- $10 million hospital payment ($6 million for rural hospitals and $4 million for OB/GYN hospitals).

- $5 million GF to support medical education loan repayment for primary care physicians and other sub-specialties.
- $2.8 million to $3 million to support an increase in Medicaid neonatal rates from 64% of the Medicare rate to 75%.
- $1.6 million to restore funding to dental clinics.
- Funding for a salary increase for psychiatrists at state psychiatric hospitals.
- $5.5 million GF to support non-Medicaid funded Community Mental Health Services Programs (CMHSPs).
- $9.3 million for Local Health Departments (LHDs) to address emerging public health threats.
- An increase of $2.5 million GF for senior services.
- All funding for Flint initiatives that was requested by the governor was included in the FY19 budget.

Ending Gift Cards for Healthy Michigan Plan

Kathy Stiffler explained that as part of the Healthy Michigan Plan, beneficiaries with incomes above 100% of the federal poverty level (FPL) who complete a healthy behavior receive a reduction in their required contribution. Since Healthy Michigan Plan beneficiaries with incomes below 100% FPL are exempt from contributions, MDHHS currently requires the MHPs to provide these individuals with $50 gift cards for completing a healthy behavior. The FY19 budget rescinds this requirement, though MDHHS staff indicated that the department is seeking clarification from the legislature on whether MHPs may continue to provide gift cards using their own administrative dollars.

Healthy Michigan Plan

Review of Bill

MDHHS staff and meeting attendees discussed SB 897 at length, which outlines proposed changes for Healthy Michigan Plan beneficiaries with incomes above 100% FPL who have been enrolled in the program for 48 cumulative months, as well as instituting workforce engagement requirements for non-exempt Healthy Michigan Plan beneficiaries between the ages of 19 and 62. SB 897 has been approved by both houses of the state legislature and is currently pending final approval by the governor. Copies of the bill were distributed to meeting attendees.

48 Months

Healthy Behaviors

As of June 18, 2018, approximately 1,400 Healthy Michigan Plan beneficiaries have incomes above 100% FPL and have been enrolled in the program for 48 cumulative months. Pending approval of SB 897, these individuals will be required to continue engaging in healthy behaviors **and** contribute 5% of their income toward premiums as a condition of continued enrollment in the Healthy Michigan Plan. Participation in one or more healthy behaviors will

not result in a reduction in cost-sharing obligations, and copayments will no longer apply, as beneficiaries may not exceed 5% of their income toward total cost-sharing.

Suspension of Coverage

Healthy Michigan Plan coverage will be suspended for beneficiaries who choose not to engage in a healthy behavior, or who fail to meet their cost-sharing obligations. For these individuals, MDHHS will apply the department's "consistently fail-to-pay" criteria, which means that coverage will be suspended if the beneficiary has not paid any amount toward their premium obligations for one full quarter, or at least half of their total owed after 12 months. Once a beneficiary's coverage is suspended for failure to pay, coverage may be reinstated at which time the beneficiary contributes a minimum amount and agrees to a payment plan determined by MDHHS. Additionally, third-party payers may also assist beneficiaries with meeting their premium obligations.

In response to an inquiry regarding the anticipated timeline for implementation of these requirements, MDHHS staff reported that the legislature is targeting an effective date of July 1, 2019 for the changes to Healthy Michigan Plan cost-sharing and healthy behavior requirements. MDHHS plans to submit an amendment to the Healthy Michigan Plan waiver renewal application that is currently pending before the Centers for Medicare & Medicaid Services (CMS) by October 1, 2018 to request CMS approval for these changes.

Impact on Sending Beneficiaries to the Marketplace

Pending approval of SB 897, the MI Marketplace Option for Healthy Michigan Plan for beneficiaries who choose not to engage in a healthy behavior has been rescinded. Instead, beneficiaries will be required to engage in a healthy behavior as a condition of continued enrollment in the Healthy Michigan Plan. If they choose not to engage in a healthy behavior, Healthy Michigan Plan coverage will be discontinued per the criteria outlined above. In response to an inquiry, MDHHS staff indicated that the federal government will not allow individuals who are income-eligible for the Healthy Michigan Plan to receive a subsidy for coverage on the Federally Facilitated Marketplace (FFM).

Work Requirements

MDHHS staff indicated that the workforce engagement requirements outlined in SB 897 apply to all able-bodied Healthy Michigan Plan beneficiaries (including those below 100% FPL) between the ages of 19 and 62 who do not meet at least one of the 12 exemption criteria included in the legislation. MDHHS expects that a maximum of 400,000 Healthy Michigan Plan beneficiaries may be impacted by the workforce engagement requirements, though staff are working to determine how many additional enrollees may meet exemption criteria. It is unknown at this time how many are likely to lose coverage given the lack of data or experience to estimate this figure.

Beneficiaries who do not meet a qualifying exemption must self-attest to participation in one of the following qualifying events for an average of 80 hours per month to meet the workforce engagement requirements:

1. Employment, self-employment or income consistent with employment;
2. Education directly related to employment;
3. Job training directly related to employment;
4. Vocational training directly related to employment;
5. Unpaid workforce engagement directly related to employment;
6. Tribal employment programs;
7. Participation in Substance Use Disorder (SUD) treatment;
8. Community service (limit of 3 months within a 12-month period with a registered 501[c][3] organization); or
9. Job search directly related to employment.

A beneficiary is allowed three months of noncompliance within a 12-month reporting period. After three months of noncompliance, recipients who remain noncompliant will not receive coverage for at least one month and will be required to come into compliance before coverage is reinstated. If a beneficiary is found to have misrepresented his or her compliance with the workforce engagement requirements as identified in SB 897, he or she shall not be allowed to participate in the Healthy Michigan Plan for a one-year period. A beneficiary is exempt from the workforce engagement requirements if they meet one or more of the following conditions:

1. A recipient is the caretaker of a family member who is under the age of 6 years. This exemption only applies to one parent at a time to be a caretaker, no matter how many children are being cared for.
2. A recipient who is currently receiving temporary or permanent long-term disability benefits from a private insurer or from the government.
3. A recipient who is a full-time student who is not a dependent of a parent or guardian or whose parent or guardian qualifies for Medicaid.
4. A recipient who is pregnant.
5. A recipient who is the caretaker of a dependent with a disability which the dependent needs full-time care based on a licensed medical professional's order.
6. A recipient who is the caretaker of an incapacitated individual even if the incapacitated individual is not a dependent of the caretaker.
7. A recipient who has proven that he or she has met the good cause temporary exemption.
8. A recipient who has been designated as medically frail.
9. A recipient who has a medical condition that results in a work limitation according to a licensed medical professional's order.
10. A recipient who has been incarcerated within the last 6 months.
11. A recipient who is receiving unemployment benefits from this state.
12. A recipient who is under 21 years of age who had previously been in a foster care placement in this state.

In addition, Supplemental Nutrition Assistance Program (SNAP) or Temporary Assistance for Needy Families (TANF) beneficiaries who meet exemption criteria for SNAP or TANF work requirements are also exempt from the Healthy Michigan Plan workforce engagement requirements outlined above with no additional reporting requirements. SB 897 requires that MDHHS implement the workforce engagement requirements for the Healthy Michigan Plan by January 1, 2020 pending approval from CMS.

Communications with Beneficiaries

MDHHS plans to begin the process of communicating the details of the workforce engagement requirements with beneficiaries only after CMS approval of Michigan's amended Healthy Michigan Plan Section 1115 Waiver Renewal Request. MDHHS staff also discussed a pending federal court decision on workforce engagement requirements promulgated by the State of Kentucky and the potential impact the court proceedings could have on the future of the Healthy Michigan Plan. To date, CMS has approved waiver requests from Kentucky, Arkansas, Indiana and New Hampshire to implement workforce engagement requirements for Medicaid recipients, with requests from seven additional states pending.

Behavioral Health Updates

MDHHS staff provided several general updates related to behavioral health, including:

- The department is continuing to work with CMS to gain approval for its Section 1115 Pathways to Integration waiver, which would allow MDHHS to provide all behavioral health services under a single waiver authority.
- A $27.5 million federal non-competitive grant has been allocated to the State of Michigan for its State Opioid Response Team, pending approval of an application from the state that is due August 13, 2018.
- Local communities within the state must now apply individually for funding through the Certified Community Behavioral Health Clinics (CCBHC) grant. MDHHS has provided several letters of support on behalf of communities for this funding.
- The Health Resources & Services Administration (HRSA) within the U.S. Department of Health and Human Services has made grants available to expand services to address the opioid epidemic in rural communities. Eleven counties within northern Michigan meet the eligibility criteria to apply for a grant under this program.
- Congress has appropriated $10 billion in federal funding nationwide for FY19 for opioid use disorder treatment, as well as $2.3 billion for behavioral health services. In addition, congress is currently considering 80 additional bills to address behavioral health issues, including legislation to protect data privacy for individuals receiving treatment for Substance Use Disorder (SUD).
- MDHHS is working to establish an Opioid Health Home (OHH) pilot program in Michigan's PIHP Region 2.
- The department is working with stakeholders and the state legislature on several initiatives aimed at increasing access to inpatient psychiatric services.

Section 298 Update

MDHHS is in the process of establishing pilot programs to financially integrate behavioral health and physical health services, as directed by the state legislature. Four CMHSPs have been selected to participate in the pilot programs with the seven MHPs operating in the three pilot regions. The department is also exploring options for including beneficiaries in the pilot programs who are not currently enrolled in an MHP and receive managed behavioral health services through the local PIHP, as well as continuing to work through various other issues related to implementation. The anticipated implementation date of the Section 298 pilot programs is October 1, 2019. Additional information on the Section 298 process is available on the MDHHS website at www.michigan.gov/stakeholder298.

Mental Health Parity Update

MDHHS staff provided an update on the department's efforts to comply with the Mental Health Parity and Addiction Equity Act of 2008, which requires that states place no more restrictions on behavioral health/substance use disorder benefits than on medical/surgical benefits. As part of these efforts, MDHHS has prepared a Mental Health and Substance Use Disorder Parity Assessment and Corrective Action Plan to report findings of an assessment of compliance with the federal parity rules conducted by the Medical Services Administration (MSA). Copies of the report were distributed to meeting attendees, and the document was discussed at length.

Provider Enrollment Requirements

Kathy Stiffler shared an update on the department's ongoing efforts to comply with federal laws and regulations by requiring all providers in the State of Michigan who provide services to Medicaid beneficiaries to enroll with the state's Medicaid program. Medicaid FFS already denies claims for non-enrolled providers. MDHHS initially planned to require the MHPs to deny claims from non-enrolled providers on March 1, 2018, and FFS and the HMPs were to deny claims (at the point of service) for non-enrolled prescribers on May 1, 2018. The department is now considering extending this deadline. MDHHS staff and meeting attendees discussed the issue at length, including ideas for communicating the requirements to providers.

Long Term Care Updates

Dick Miles provided updates on several MDHHS long term care initiatives, which include the following:

- The department is working to submit a renewal application for the MI Choice waiver, which has been posted for public comment. MDHHS plans to submit the renewal application to CMS in July 2018.
- MDHHS is continuing work to develop an Electronic Visit Verification (EVV) system for in-home personal care services by January 1, 2019 in compliance with the requirements of the 21st Century Cures Act.

- Enrollment in the MI Health Link demonstration is now stable with approximately 40,000 individuals currently enrolled.
- MDHHS has contracts with partnering entities to develop proposed models and to engage with stakeholders in the development of managed long term care supports and services.
- The department is also working to update the nursing facility Level of Care Determination (LOCD) determination business process.

Policy Updates

A policy bulletin list was distributed to attendees and the following updates were discussed:

- Bulletin MSA 18-05 – MI Marketplace Option and Healthy Michigan Plan Updates
- Bulletin MSA 18-10 – Pediatric Outpatient Intensive Feeding Program Services
- Bulletin MSA 18-18 – Expanded Access to Dental Benefits for Pregnant Women
- Proposed Policy 1806-Hospital – Inpatient Long-Acting Reversible Contraception (LARC) Device Reimbursement
- Proposed Policy 1807-BHDDA – Opioid Health Home Pilot Program
- Proposed Policy 1814-Hearing – Reinstatement of Adult Hearing Aid Coverage; Update to Disposable Hearing Aid Batteries and Replacement Earmold Coverage

4:30 – Adjourn

Michigan Department of Health and Human Services
Medical Services Administration

Medical Care Advisory Council

Meeting Minutes

Date: Wednesday, August 8, 2018

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:** Emily Schwarzkopf, Dominick Pallone, Rod Auton, Elmer Cerano, Mark Klammer, Robert Sheehan, Amy Zaagman, April Stopzcynski, Mario Azzi, Rebecca Blake, Karlene Ketola, Jim Milanowski, Lisa Dedden Cooper, David Herbel, Debra Brinson, William Mayer, Marilyn Litka-Klein

Staff: Kathy Stiffler, Lynda Zeller, Erin Emerson, Brian Keisling, Jackie Prokop, Craig Boyce, Leslie Asman, Mary Beth Kern-Collins, Marie LaPres, Dave Schneider, Phil Kurdunowicz

Other Attendees: Salli Pung, Dan Wojciak, Joe Pawluszka, Kellie Bidelman

Welcome, Introductions, Announcements

Emily Schwarzkopf opened the meeting and introductions were made.

Healthy Michigan Plan

Public Act 208 of 2018

Kathy Stiffler provided an overview of Public Act 208 of 2018, which directs the Michigan Department of Health and Human Services (MDHHS) to (1) make changes to the Healthy Michigan Plan for beneficiaries who have been enrolled in the program for 48 cumulative months and have incomes above 100% of the Federal Poverty Level (FPL), and also (2) implement workforce engagement requirements for non-exempt beneficiaries. To implement these changes, MDHHS is working to submit an amendment to its Section 1115 Demonstration Waiver extension application for the Healthy Michigan Plan. The waiver application amendment is currently posted for public comment at www.michigan.gov/healthymichiganplan, and Ms. Stiffler noted that while the formal public comment period officially ends on August 12, 2018, interested parties may continue to submit comments after that date. MDHHS will take comments submitted after August 12 into consideration for future changes to the Healthy Michigan Plan. In addition, public hearings were held to discuss the amendment on July 31, 2018 and August 1, 2018. The waiver application amendment must be submitted to the Centers for Medicare & Medicaid Services (CMS) by October 1, 2018 per the State statute, but the State plans to submit early.

Cumulative 48 months of coverage and over 100% of the federal poverty level (FPL)

PA 208 of 2018 requires that beneficiaries who have been enrolled in the Healthy Michigan Plan for 48 cumulative months and have incomes above 100% of the FPL must engage in a healthy behavior **and** contribute a 5% premium as a condition of continued coverage. Participation in a healthy behavior will no longer result in a reduction in premium obligations, but co-payments will no longer apply, as beneficiaries may not exceed 5% of their income toward total cost-sharing. The targeted implementation date of this change is July 1, 2019.

Rescinds Marketplace Option

PA 208 of 2018 also rescinds the Marketplace Option for Healthy Michigan Plan for beneficiaries who choose not to engage in a healthy behavior. In February 2018, MDHHS notified approximately 15,000 beneficiaries who failed to complete a healthy behavior that they were at risk of transitioning to the Marketplace. At that time, approximately half of those individuals completed a Health Risk Assessment and chose to engage in a healthy behavior. MDHHS has since notified all individuals in this group that the Marketplace Option has been rescinded.

Workforce Engagement Requirements

In addition to the 48 month cumulative enrollment changes and rescinding the Marketplace Option, PA 208 of 2018 requires MDHHS to implement workforce engagement requirements for all beneficiaries ages 19 to 62 as a condition of continued enrollment in the Healthy Michigan Plan. The legislation outlines 10 qualifying events under which individuals can meet workforce engagement requirements, as well as 12 exemption criteria, which were discussed in detail at the previous Medical Care Advisory Council (MCAC) meeting on June 18, 2018. Kathy Stiffler indicated that approximately 400,000 Healthy Michigan Plan beneficiaries may be impacted by the workforce engagement requirements, as this is the number of beneficiaries between the ages of 19-62 who have been identified as not meeting the requirements of current Supplemental Nutritional Assistance Program (SNAP) and Temporary Assistance for Needy Families (TANF) program workforce engagement requirements. This figure includes individuals who may meet exemption criteria, as some exemptions may require continued attestation.

MDHHS plans to begin the process of communicating the workforce engagement requirements with beneficiaries following approval of the waiver amendment by CMS. In response to an inquiry, Ms. Stiffler indicated that it is unknown at this time how many beneficiaries could potentially lose coverage as a result of the implementation of these requirements. MDHHS is also monitoring the implementation process for similar workforce engagement requirements in other states. MDHHS staff and meeting attendees discussed this issue at length, including details related to the exemption criteria and the implications of the federal court decision on Kentucky's waiver on the potential approval of workforce engagement requirements for other states. Meeting attendees also recommended that the state consider allocating resources for job training, transportation and child care for Healthy Michigan Plan beneficiaries to meet the workforce engagement requirements, and Emily Schwarzkopf offered to draft a letter on behalf of the MCAC to MDHHS leadership and the legislature to request these changes.

Healthy Michigan Waiver Renewal Update – Amendment

Public Hearings

Jackie Prokop provided an overview of some of the comments that were shared at the public hearings held on July 31, 2018 and August 1, 2018. Most comments shared at the hearings reflected concern related to the workforce engagement requirements for Healthy Michigan Plan beneficiaries. Many commenters also requested information on exemption criteria and requested clarity on the criteria for an individual to be designated as "medically frail." As a result of the feedback received at the hearings, MDHHS staff plan to meet to discuss the possible addition of certain diagnosis codes under which an individual may be deemed "medically frail."

Impact if waiver extension amendment is not approved

As currently directed by PA 208 of 2018, the Healthy Michigan Plan must end if the Section 1115 Waiver Extension Amendment is not approved by CMS within a year of submission, though MDHHS staff indicated that members of the legislature have expressed a willingness to re-examine the legislation if this occurs.

Behavioral Health Updates

Lynda Zeller shared the following updates related to recent activities of the Behavioral Health and Developmental Disabilities Administration (BHDDA):

- MDHHS is working to implement an Opioid Health Home pilot program in Michigan's Prepaid Inpatient Health Plan (PIHP) Region 2.
- The department is continuing efforts to increase beneficiary access to state psychiatric hospitals. The state convened the Michigan Inpatient Psychiatric Admissions Discussion (MIPAD) workgroup to discuss this issue, and it has now become a nationwide initiative coordinated by the National Association of State Mental Health Program Directors (NASMHPD) known as Beyond Beds. MDHHS staff and meeting attendees discussed this issue at length.

Section 298 update

A leadership group consisting of the Executive Directors of the four Community Mental Health Services Programs (CMHSP) as well as the CEOs of the seven partnering MHPs involved in the Section 298 initiative for the integration of physical health and behavioral health services has been meeting to discuss a financial model and managed care models for the pilot programs. In addition, several sub-groups have been formed to discuss various components of the pilot models, including technology needs, policy updates, reporting, and finance. MDHHS is also working with a team to evaluate the pilot models in order to move forward with the demonstration project, as well as moving forward with implementing the 76 policy recommendations contained in the final report that was submitted to the legislature in 2017. Additional information about this process is also available on the MDHHS website at www.michigan.gov/stakeholder298.

Pharmacy Benefits Manager

MDHHS is in the process of reviewing bids for a new pharmacy benefits manager contract, which is currently held by Magellan. The department expects to announce the contract award winner in the near future. In response to an inquiry, Kathy Stiffler indicated that MDHHS does not currently require MHPs to return supplemental rebates that they receive to the State and will require the MHPs to deny pharmacy claims for non-enrolled providers. The department has no plans at this time to require MHPs to follow the State's formulary for prescription drugs. MDHHS continues to seek public comment on the current Medicaid Health Plan common formulary once per quarter and make changes based on stakeholder input.

Non-emergency Medical Transportation (NEMT)

MDHHS also plans to submit a Request for Proposal (RFP) by October 1, 2018 for a new NEMT contractor to serve Medicaid Fee-for-Service (FFS) beneficiaries in Wayne, Oakland and Macomb counties. The new contract will take effect April 1, 2019. The current contract is held by Logisticare.

Provider Enrollment Requirements

MDHHS currently requires providers billing Medicaid FFS to be enrolled with Medicaid to receive reimbursement for services. This requirement is not in place for MHPs at this time, but MDHHS will require the MHPs to begin denying claims from non-enrolled providers beginning January 1, 2019. MDHHS will also begin denying pharmacy claims from non-enrolled providers billing through Medicaid FFS and MHPs beginning July 1, 2019. In response to an inquiry regarding whether atypical providers will be required to enroll with Medicaid to receive payment for services, MDHHS staff indicated that discussions have taken place on this issue, but no date for implementation has been set.

Policy Updates

A policy bulletin handout was distributed to attendees and the following updates were discussed:

- Bulletin MSA 18-24 – Reinstatement of Adult Hearing Aid Coverage; Update to Disposable Hearing Aid Batteries and Replacement Earmold Coverage
- Bulletin MSA 18-21 – Timely Hearing Requests
- Proposed Policy 1825-HKD – New Dental Health Plan Choice for Healthy Kids Dental Beneficiaries
- Proposed Policy 1822-Pharmacy – Copayment Exemption for Drugs to Treat Mental Health Conditions and Substance Use Disorders
- Proposed Policy 1821-Lab - Ordering of Genetic Laboratory Services by Physician Assistants (PAs), Registered Nurse Practitioners (NPs), and Certified Nurse Midwives (CNMs)

The meeting was adjourned at 3:00 p.m.