CENTERS FOR MEDICARE AND MEDICAID SERVICES
SPECIAL TERMS AND CONDITIONS

NUMBER: 11-W-00245/5

TITLE: Healthy Michigan Section 1115 Demonstration

AWARDEE: Michigan Department of Health and Human Services

I. PREFACE

The following are the Special Terms and Conditions (STCs) for Michigan's "Healthy Michigan" section 1115(a) Medicaid demonstration (hereinafter referred to as "demonstration") to enable Michigan (hereinafter "state") to operate this demonstration. The Centers for Medicare & Medicaid Services (CMS) has granted waivers of requirements under Section 1902(a) of the Social Security Act (Act), and expenditure authorities authorizing federal matching of demonstration costs not otherwise matchable, which are separately enumerated. These STCs set forth in detail the nature, character, and extent of federal involvement in the demonstration and the state's obligations to CMS during the life of the demonstration. The STCs are effective as of the date of award of the Healthy Michigan amendment unless otherwise specified. This demonstration is approved through December 31, 2018.

The STCs have been arranged into the following subject areas:

I. Preface
II. Program Description And Objectives
III. General Program Requirements
IV. Eligibility for the Demonstration
V. Benefits
VI. Cost Sharing, Contributions and Healthy Behaviors
VII. Delivery System
VIII. Transition of Individuals
IX. General Reporting Requirements
X. General Financial Requirements
XI. Monitoring Budget Neutrality for the Demonstration
XII. Evaluation of the Demonstration
XIII. Measurement of Quality of Care and Access to Care Improvement
XIV. Schedule of State Deliverables During the Demonstration

Additional attachments have been included to provide supplementary information and guidance for specific STCs.

Attachment A: Quarterly Progress Report Content and Format
Attachment B: Demonstration Evaluation Plan

Attachment C: MI Health Accounts Operational Protocol
Attachment D: Healthy Behaviors Incentives Program Operational Protocol
Attachment E: Annual Update of Rural Counties Not Required To Provide a Choice of Managed Care Plans
Attachment F: Final Report Framework

II. PROGRAM DESCRIPTION AND OBJECTIVES

In January 2004, the "Adult Benefits Waiver" (ABW) (21-W-00017/5) was initially approved and implemented as a Title XXI funded Section 1115 demonstration. The ABW provided a limited ambulatory benefit package to previously uninsured, low-income non-pregnant childless adults ages 19 through 64 years with incomes at or below 35 percent of the Federal poverty level (FPL) who are not eligible for Medicaid. The ABW services were provided to beneficiaries through a managed healthcare delivery system utilizing a network of county administered health plans (CHPs) and Public Mental Health and Substance Abuse provider network.

In December 2009, Michigan was granted approval by CMS for a new Medicaid Section 1115 demonstration, entitled "Michigan Medicaid Nonpregnant Childless Adults Waiver (Adult Benefits Waiver)" (11-W-00245/5), to allow the continuation of the ABW health coverage program after December 31, 2009. Section 112 of the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) prohibited the use of Title XXI funds for childless adults' coverage after December 31, 2009, but allowed the states that were affected to request a new Medicaid demonstration to continue their childless adult coverage programs in 2010 and beyond using Title XIX funds. The new "Adult Benefits Waiver" demonstration allowed Michigan to continue offering the ABW coverage program through September 30, 2014, under terms and conditions similar to those provided in the original Title XXI demonstration.

On April 1, 2014, Michigan expanded its Medicaid program to include adults with income up to 133 percent of the FPL. To accompany this expansion, the Michigan "Adult Benefits Waiver" was amended and transformed to establish the Healthy Michigan Plan, through which the state intended to test innovative approaches to beneficiary cost sharing and financial responsibility for care for the new adult eligibility group. The new adult population with incomes above 100 percent of the FPL was required to make contributions equal to two percent of their family income toward the cost of their health care. In addition, all newly eligible adults from 0 to 133 percent of the FPL, regardless of their income, pay required Medicaid copayments through a credit facility operated in coordination with the Medicaid Health Plan. A MI Health Account was established for each enrolled individual to track beneficiaries' contributions and how they were expended. Beneficiaries receive quarterly statements that summarize the MI Health Account funds balance and flows of funds into and out of the account, and the use of funds for health care service copayments. Beneficiaries have opportunities to reduce their regular monthly contributions or average utilization based contributions by demonstrating achievement of recommended Healthy Behaviors. Healthy Michigan Plan beneficiaries receive a full health care benefit package as required under the Affordable Care Act which includes all of the Essential Health Benefits and the requirements for an alternative benefit plan, as required by federal law and regulation, and there are no limits on the number of individuals who can enroll. As of

September 2015, more than 605,000 Michigan citizens receive coverage through the Healthy Michigan Plan. Beneficiaries receiving coverage under the sunsetting ABW program transitioned to the state plan and the Healthy Michigan Plan on April 1, 2014. To reflect its expanded purpose, the name of the demonstration was changed to the Healthy Michigan Plan.

The state reports that the overarching themes used in the benefit design will be increasing access to quality health care, encouraging the utilization of high-value services, promoting beneficiary adoption of healthy behaviors and using evidence-based practice initiatives. Organized service delivery systems will be utilized to improve coherence and overall program efficiency.

The state's goals in creating the Healthy Michigan Plan were to:

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

On September 1, 2015, Michigan submitted an amendment requesting changes to the Healthy Michigan Plan, effective April 1, 2018, 48 months since the inception of the Healthy Michigan Plan. Beginning on April 1, 2018, beneficiaries in the demonstration above 100 percent of the FPL and who are not medically frail will have the opportunity to choose between coverage through the Healthy Michigan Plan, or through a Qualified Health Plan offered on the Marketplace (known as the "Marketplace Option" component of the demonstration). Individuals with incomes at or below 100 percent will remain in the Healthy Michigan Plan.

III. GENERAL PROGRAM REQUIREMENTS

1. **Compliance with Federal Non-Discrimination Statutes.** The state must comply with all applicable Federal statutes relating to non-discrimination. These include, but are not

limited to, the Americans with Disabilities Act of 1990, Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, and the Age Discrimination Act of 1975.

2. **Compliance with Medicaid Law, Regulation, and Policy.** All requirements of the Medicaid program, expressed in law, regulation, and policy statement, not expressly waived or identified as not applicable in the waiver and expenditure authority documents (of which these terms and conditions are part), apply to this demonstration.

3. **Changes in Medicaid Law, Regulation, and Policy.** The state must, within the timeframes specified in law, regulation, or policy statement, come into compliance with any changes in Federal law, regulation, or policy affecting the Medicaid program that occur during this demonstration approval period, unless the provision being changed is expressly waived or identified as not applicable. In addition, CMS reserves the right to amend the STCs to reflect such changes and/or changes as needed without requiring the state to submit an amendment to the demonstration under paragraph 7. CMS will notify the state 30 days in advance of the expected approval date of the amended STCs to allow the state to provide comment. Changes will be considered in force upon issuance of the approval letter by CMS. The state must accept the changes in writing.

4. **Impact of Changes in Federal Law, Regulation, and Policy on the Demonstration.**

    a. To the extent that a change in federal law, regulation, or policy requires either a reduction or an increase in federal financial participation (FFP) for expenditures made under this demonstration, the state must adopt, subject to CMS approval, a modified budget neutrality agreement for the demonstration as necessary to comply with such change. The modified budget neutrality agreement will be effective upon the implementation of the change. The trend rates for the budget neutrality agreement are not subject to change under this subparagraph.

    b. If mandated changes in the Federal law require state legislation, the changes must take effect on the day such state legislation becomes effective, or on the last day such legislation was required to be in effect under the law.

    c. Should there be future changes in federal law related to the FFP associated with the demonstration, the state may seek to end the demonstration (as per STC 9) or seek an amendment (as per STC 7).

5. **State Plan Amendments.** The state will not be required to submit Title XIX state plan amendments (SPAs) for changes affecting any populations made eligible solely through the demonstration. If a population eligible through the Medicaid state plan is affected by a change to the demonstration, a conforming amendment to the appropriate state plan is required, except as otherwise noted in these STCs. In all such cases, the Medicaid state plan governs.

6. **Changes Subject to the Amendment Process.** Changes related to demonstration features, such as eligibility, enrollment, benefits, enrollee rights, delivery systems, cost sharing, evaluation design, sources of non-Federal share of funding, budget neutrality, and other comparable program elements must be submitted to CMS as amendments to the demonstration. All amendment requests are subject to approval at the discretion of the Secretary in accordance with Section 1115 of the Act. The state must not implement or begin operational changes to these elements without prior approval by CMS of the amendment to the demonstration. In certain instances, amendments to the Medicaid state plan may or may not require amendment to the demonstration as well. Amendments to the demonstration are not retroactive and FFP will not be available for changes to the demonstration that have not been approved through the amendment process set forth in paragraph 7.

7. **Amendment Process.** Requests to amend the demonstration must be submitted to CMS for approval no later than 120 days prior to the planned date of implementation of the change and may not be implemented until approved. CMS reserves the right to deny or delay approval of a demonstration amendment based upon non-compliance with these STCs, including but not limited to failure by the state to submit required elements of a viable amendment request as found in these STCs, required reports and other deliverables required in the approved STCs in a timely fashion according to the deadlines specified herein. Amendment requests must include, but are not limited to, the following:

    a. Demonstration of Public Notice 42 CFR 431.408 and tribal consultation: The state must provide documentation of the state's compliance with public notice process as specified in 42 CFR 431.408 and documentation that the tribal consultation requirements outlined in paragraph 15 have been met. Such documentation shall include a summary of public comments and identification of proposal adjustments made to the amendment request due to the public input;

    b. Demonstration Amendment Summary and Objectives: The state must provide a detailed description of the amendment, including what the state intends to demonstrate via this amendment as well as the impact on beneficiaries, with sufficient supporting documentation, the objective of the change and desired outcomes including a conforming Title XIX and/or Title XXI SPA, if necessary;

    c. Waiver and Expenditure Authorities: The state must provide a list waivers and expenditure authorities that are being requested or terminated, along with the reason, need and the citation along with the programmatic description of the waivers and expenditure authorities that are being requested for the amendment;

d. A budget neutrality data analysis worksheet: The state must provide a worksheet which identifies the specific "with waiver" impact of the proposed amendment on the current budget neutrality agreement, including the underlying spreadsheet calculation formulas. Such analysis shall include current total computable "with waiver" and "without waiver" status on both a summary and detailed level through the current approval period using the most recent actual expenditures, as well as summary and detailed projections of the change in the "with waiver" expenditure total as a result of the proposed amendment, which isolates (by Eligibility Group, or feature) the impact of the amendment;

e. Updates to existing demonstration reporting, quality and evaluation plans: A description of how the evaluation design and quarterly and annual reports will be modified to incorporate the amendment provisions, as well as the oversight, monitoring and measurement of the provisions.

8. **Extension of the Demonstration.** States that intend to request demonstration extensions under Sections 1115(e) or 1115(f) are advised to observe the timelines contained in those statutes. Otherwise, no later than 12 months prior to the expiration date of the demonstration, the governor or chief executive officer of the state must submit to CMS either a demonstration extension request or a transition and phase-out plan consistent with the requirements of paragraph 9.

    a. Compliance with Transparency Requirements at 42 CFR 431.412. As part of the demonstration extension requests the state must provide documentation of compliance with the transparency requirements 42 CFR 431.412 and the public notice and Tribal consultation requirements outlined in paragraph 15.

    b. Upon application from the state, CMS reserves the right to temporarily extend the demonstration including making any amendments deemed necessary to effectuate the demonstration extension including but not limited to bringing the demonstration into compliance with changes to federal law, regulation and policy.

9. **Demonstration Transition and Phase Out.** The state may only suspend or terminate this demonstration in whole, or in part, consistent with the following requirements.

    a. Notification of Suspension or Termination. The state must promptly notify CMS in writing of the reason(s) for the suspension or termination, together with the effective date and a transition and phase-out plan. The state must submit its notification letter and a draft transition and phase-out plan to CMS no less than six (6) months before the effective date of the demonstration's suspension or termination. Prior to submitting the draft plan to CMS, the state must publish on its website the draft transition and phase-out plan for a 30-day public comment period. In addition, the state must conduct tribal consultation

in accordance with its approved tribal consultation SPA. Once the 30-day public comment period has ended, the state must provide a summary of each public comment received, the state's response to the comment and how the state incorporated the received comment into the revised phase-out plan.

b. The state must obtain CMS approval of the transition and phase-out plan prior to the implementation of the phase-out activities. Implementation of phase-out activities must be no sooner than 14 days after CMS approval of the phase-out plan.

c. Transition and Phase-out Plan Requirements: The state must include, at a minimum, in its phase-out plan the process by which it will notify affected beneficiaries, the content of said notices (including information on the beneficiary's appeal rights), the process by which the state will conduct administrative reviews of Medicaid eligibility prior to the termination of the program for the affected beneficiaries including any individuals on demonstration waiting lists, and ensure ongoing coverage for those beneficiaries determined eligible for ongoing coverage, as well as any community outreach activities including community resources that are available.

d. Phase-out Procedures: The state must comply with all notice requirements found in 42 CFR 431.206, 431.210, and 431.213. In addition, the state must assure all appeal and hearing rights afforded to demonstration beneficiaries as outlined in 42 CFR 431.220 and 431.221. If a demonstration participant beneficiary requests a hearing before the date of action, the state must maintain benefits as required in 42 CFR 431.230. In addition, the state must conduct administrative renewals for all affected beneficiaries in order to determine if they qualify for Medicaid eligibility under a different eligibility category.

e. Exemption from Public Notice Procedures 42.CFR Section 431.416(g). CMS may expedite the federal and state public notice requirements in the event it determines that the objectives of Title XIX and XXI would be served or under circumstances described in 42 CFR 431.416(g).

f. Federal Financial Participation (FFP): If the project is terminated or any relevant waivers suspended by the state, FFP shall be limited to normal closeout costs associated with terminating the demonstration including services and administrative costs of disenrolling beneficiaries.

10. Expiring Demonstration Authority and Transition. For demonstration authority that expires prior to the overall demonstration's expiration date, the state must submit a demonstration authority expiration plan to CMS no later than 6 months prior to the applicable demonstration authority's expiration date, consistent with the following requirements:

a. **Expiration Requirements:** The state must include, at a minimum, in its demonstration expiration plan the process by which it will notify affected beneficiaries, the content of said notices (including information on the beneficiary's appeal rights), the process by which the state will conduct administrative reviews of Medicaid eligibility for the affected beneficiaries, and ensure ongoing coverage for eligible individuals, as well as any community outreach activities.

b. **Expiration Procedures:** The state must comply with all notice requirements found in 42 CFR 431.206, 431.210 and 431.213. In addition, the state must assure all appeal and hearing rights afforded to demonstration beneficiaries as outlined in 42 CFR 431.220 and 431.221. If a demonstration participant beneficiary requests a hearing before the date of action, the state must maintain benefits as required in 42 CFR 431.230. In addition, the state must conduct administrative renewals for all affected beneficiaries in order to determine if they qualify for Medicaid eligibility under a different eligibility category.

c. **Federal Public Notice:** CMS will conduct a 30-day federal public comment period consistent with the process outlined in 42 CFR 431.416 in order to solicit public input on the state's demonstration expiration plan. CMS will consider comments received during the 30-day period during its review and approval of the state's demonstration expiration plan. The state must obtain CMS approval of the demonstration expiration plan prior to the implementation of the expiration activities. Implementation of expiration activities must be no sooner than 14 days after CMS approval of the plan.

d. **Federal Financial Participation (FFP):** FFP shall be limited to normal closeout costs associated with the expiration of the demonstration including services and administrative costs of disenrolling beneficiaries.

11. **CMS Right to Amend, Terminate or Suspend.** CMS may amend, suspend or terminate the demonstration in whole or in part at any time before the date of expiration, whenever it determines, following a hearing that the state has materially failed to comply with the terms of the project. CMS will promptly notify the state in writing of the determination and the reasons for the suspension or termination, together with the effective date.

12. **Finding of Non-Compliance.** The state does not relinquish its rights to challenge CMS' finding that the state materially failed to comply.

13. **Withdrawal of Waiver Authority.** CMS reserves the right to withdraw waivers or expenditure authorities at any time it determines that continuing the waivers or expenditure authorities would no longer be in the public interest or promote the objectives of Title XIX or Title XXI. CMS will promptly notify the state in writing of the determination and the reasons for the withdrawal, together with the effective date, and afford the state an

opportunity to request a hearing to challenge CMS' determination prior to the effective date. If a waiver or expenditure authority is withdrawn, FFP is limited to normal closeout costs associated with terminating the waiver or expenditure authority, including services and administrative costs of disenrolling beneficiaries.

14. **Adequacy of Infrastructure.** The state must ensure the availability of adequate resources for implementation and monitoring of the demonstration, including education, outreach, and enrollment; maintaining eligibility systems; compliance with cost sharing requirements; and reporting on financial and other demonstration components.

15. **Public Notice, Tribal Consultation, and Consultation with Interested Parties.** The state must comply with the State Notice Procedures set forth in 59 Fed. Reg. 49249 (September 27, 1994). The state must also comply with the Tribal consultation requirements in Section 1902(a)(73) of the Act as amended by Section 5006(e) of the American Recovery and Reinvestment Act (ARRA) of 2009, the implementing regulations for the Review and Approval Process for Section 1115 demonstrations at 42 CFR. 431.408, and the Tribal consultation requirements contained in the state's approved state plan, when any program changes to the demonstration, including (but not limited to) those referenced in paragraph 7, are proposed by the state.

    a. In states with federally recognized Indian Tribes, consultation must be conducted in accordance with the consultation process outlined in the July 17, 2001 letter or the consultation process in the state's approved Medicaid state plan if that process is specifically applicable to consulting with tribal governments on waivers (42 C.F.R. 431.408(b)(2)).

    b. In states with federally recognized Indian Tribes, Indian Health Services programs, and/or Urban Indian Organizations, the state is required to submit evidence to CMS regarding the solicitation of advice from these entities prior to submission of any demonstration proposal, amendment and/or renewal of this demonstration (42 CFR. 431.408(b)(3)).

    c. The state must also comply with the Public Notice Procedures set forth in 42 CFR 447.205 for changes in statewide methods and standards for setting payment rates.

16. **Federal Financial Participation (FFP).** No federal matching for expenditures (administrative or services) for this demonstration will be available until the approval date identified in the demonstration approval letter, or a later date if so identified elsewhere in these STCs or in the lists of waiver or expenditure authorities.

17. **Transformed Medicaid Statistical Information Systems Requirements (T-MSIS).** The state shall comply with all data reporting requirements under Section 1903(r) of the Act, including but not limited to Transformed Medicaid Statistical Information Systems

Requirements. More information on T-MSIS is available in the August 23, 2013 State Medicaid Director Letter.

IV. ELIGIBILITY FOR THE DEMONSTRATION

18. **Eligibility Groups Affected By the Demonstration.** This demonstration affects Medicaid state plan populations, which are outlined in the Eligibility Table at the end of this section. This table shows each specific group of affected individuals; under the authority they are eligible, the name of the eligibility and expenditure group under which expenditures are reported to CMS and the budget neutrality expenditure agreement is constructed, and the corresponding demonstration program under which benefits are provided. State plan groups derive their eligibility through the Medicaid state plan, and are subject to all applicable Medicaid laws and regulations in accordance with the Medicaid state plan, except as expressly waived in this demonstration and as described in these STCs. Any Medicaid eligibility standards and methodologies for these eligibility groups, including the conversion to a modified adjusted gross income standard January 1, 2014, apply to this demonstration. The Medicaid Eligibility Groups (MEGs) listed in the Reporting and the Budget Neutrality Sections of the STCs will be updated upon approval of changes to state plan eligibility and will be considered a technical change to the STCs.

19. **Populations Excluded from "Healthy MI Adults" Group.** The term Healthy MI Adults will be used to refer to Medicaid beneficiaries who are members of the new adult group and who will be affected by this demonstration. The term includes all individuals in the category indicated in the table below.

Eligibility Table

Medicaid State Plan Group Description	Federal Poverty Level and/or Other Qualifying Criteria	Funding Stream	Expenditure Group Reporting Name	Demonstration Specific Program
Adults age 19 through 64 described in §1902(a)(10)(A)(i)(VIII), except as specifically excluded.	Income up to 133 percent FPL receiving ABP benefits, not disabled and not pregnant.	Title XIX	Healthy MI Adults	Healthy Michigan

20. **Delivery System Options.** Beginning April 1, 2018, after the Healthy Michigan Plan has been in operation for 48 months, non-medically frail Healthy Michigan Plan enrollees with incomes at or above 100 percent of the FPL will choose between two delivery system programs based on their health plan eligibility status. The two delivery systems, which will have a separate cost sharing structure, include the Healthy Michigan Plan, available with the completion of a healthy behavior, and a Marketplace Option. Both programs will

provide alternative benefit plan (ABP) benefits. Information about the delivery system, benefits and cost sharing applicable in each of these components are described in Section VII(Delivery System), Section VI(Cost Sharing, Contributions, and Healthy Behaviors), and Section V (Benefits). Individuals who have not yet chosen a Medicaid Health Plan or QHP, and those who are considered members of an exempt or voluntary population (including, but not limited to American Indians/Alaska Natives) for managed care enrollment under the state's approved 1915(b) Comprehensive Health Care Program Waiver (as of December 17, 2015), Michigan state plan, or federal regulations, may receive services through a fee-for-service (FFS) delivery system.

V. BENEFITS

21. **Healthy Michigan Benefit Package.** Healthy Michigan beneficiaries in either the Healthy Michigan Plan or the Marketplace Option will receive the benefits in an approved Alternative Benefit Plan (ABP) SPA.

22. **Marketplace Option Basic Benefit Package.** Healthy Michigan Plan beneficiaries in the Marketplace Option will receive the benefits in an Alternative Benefit Plan (ABP) under an approved state plan that may be specific to the QHP in which the beneficiary is enrolled. Such individuals will receive covered benefits from the defined QHP provider network (except as described in STC 23), and the QHP will pay primary to Medicaid for covered benefits. The QHP payment rate will be payment in full for such benefits.

23. **Marketplace Option Wrap-Around Benefits.** The state will provide or arrange for wrap-around benefits that are included in the ABP but not covered by qualified health plans. These benefits include non-emergency medical transportation (NEMT), early Periodic Screening Diagnosis and Treatment (EPSDT) services for individuals participating in the demonstration who are under age 21, and family planning services and supplies including access to out-of-network family planning providers.

24. **Marketplace Option Early and Periodic Screening, Diagnosis, and Treatment (EPSDT).** The state must fulfill the responsibilities for coverage, outreach, and assistance with respect to EPSDT services that are described in the requirements of sections 1905(a)(4)(b) (services), 1902(a)(43) (administrative requirements), and 1905(r) (definitions).

25. **Marketplace Option Access to Federally Qualified Health Centers and Rural Health Centers.** Marketplace Option enrollees will have access to at least one QHP in each service area that contracts with at least one FQHC and RHC in order to meet ABP requirements at 42 CFR 440.365.

VI. COST SHARING AND CONTRIBUTIONS TO MI HEALTH ACCOUNTS AND HEALTHY BEHAVIORS

26. **Healthy Michigan Plan Contributions to MI Health Accounts and Healthy Behaviors Incentive Components.** The state may require Healthy Michigan Plan beneficiaries to pay premiums and cost sharing that will be reflected in MI Health accounts consistent with the attached protocols. These MI Health accounts will operate to track and record beneficiary payments and liabilities. Beneficiaries will also have the opportunity to receive rewards or incentives for healthy behaviors, which will be represented as credits to the MI Health accounts, as specified in the protocols. These protocols, as currently approved are Attachments C and D. The state may require Healthy Michigan beneficiaries to make contributions and receive rewards or incentives as described below:

    a. Beneficiaries with incomes above 100 percent of the FPL through 133 percent of the FPL will be responsible for copayment liability based upon the prior 6 months of utilization for the beneficiary and a monthly premium that shall not exceed 2 percent of income once the protocol is approved. In addition, reductions for healthy behavior incentives will be applied to the copayment liability, monthly premium, or both. Beneficiaries will be notified of the copayment liability by the provider, but will be billed for such copayments only at the end of quarter, with copayment liability payments due in accordance with the approved protocol. No interest will be due on accrued copayment liability if paid timely. Beneficiary cost-sharing must be compliant with the rules established in 42 CFR 447.56.

    b. Beneficiaries with incomes at or below 100 percent of the FPL will be responsible for copayment liability based upon the prior 6 months of copayment experience for the beneficiary. Beneficiaries will be notified of the copayment liability by the provider, but will be billed for such copayments only at the end of quarter, with payments due in accordance with the approved protocol. No interest will be due on accrued copayment liability if paid timely. In addition, reductions for healthy behavior incentives will be applied to the copayment liability due. No premiums will be paid by this population. Beneficiary cost-sharing must be compliant with the rules established in 42 CFR 447.56.

27. **Cost sharing and contributions in the Healthy Michigan Plan for individuals with incomes at or below 100 percent of the FPL.** All cost sharing must be in compliance with Medicaid requirements that are set forth in federal statute, regulation and policies, except as modified by the waivers and terms and conditions granted for this demonstration. Regarding the protocols described below, once approved, the state may request changes to the protocols, which must be approved by CMS. Such changes will be effective prospectively following approval, on or after a date specified by the state. Changes may be subject to an amendment to the STCs in accordance with paragraph 7, depending upon the nature of the proposed change.

28. **Cost sharing and contributions for individuals above 100 percent of the FPL who, after April 1, 2018, enroll in the Healthy Michigan Plan.** Effective April 1, 2018, beneficiaries in the Healthy Michigan Plan with incomes above 100 percent of the FPL may be subject to an alternative cost sharing model, which requires the completion of healthy behaviors. By July 1, 2017, the state must submit to CMS for approval a revised version of the protocols in Attachments C and D to describe the healthy behaviors that this group of beneficiaries will complete. Every individual in this group must have the opportunity to complete healthy behaviors. The state must afford the individual a reasonable opportunity, including a one year grace period for new enrollees as discussed in STC 35(b), to complete the healthy behaviors, taking into account the individual's current physical and mental health status. The revised healthy behavior(s) must be no more restrictive than those included in the Healthy Behaviors Incentives Program Operational Protocol, as approved on August 29, 2014. The state will work with CMS on an ongoing basis to improve the ability of individuals to complete the Health Risk Assessment and/or other healthy behaviors. Cost-sharing and contribution amounts will be consistent with the Operational Protocol for the MI Health Accounts and STCs 0(a) and STC 30(d).

29. **Cost sharing and contributions for individuals who, after April 1, 2018, choose to enroll the Marketplace Option.** The state shall ensure that cost sharing for such individuals will not exceed the level of cost sharing authorized under Michigan's approved state plan, taking into account the protections for specified populations and services under 42 CFR 447.56. The state may enter into agreements with QHP issuers or other parties to effectuate this responsibility by providing for advance monthly cost-sharing reduction (CSR) payments to cover the costs associated with the reduced cost-sharing for Marketplace Option. Such payments will be subject to reconciliation at the conclusion of the benefit year based on enrollee's actual usage of services. The state's reconciliation process will follow 45 CFR Section 156.430 to the extent possible. Beneficiaries may be charged premiums in amounts that do not exceed 2 percent of household income and beneficiaries shall have the opportunity complete healthy behaviors and have the option to enroll in the Healthy Michigan Plan. The state shall update the Healthy Behaviors Incentives Protocol to include this population.

30. **Healthy Michigan Plan Contribution Protections.**

    a. No individual may lose eligibility for Medicaid or be denied eligibility for Medicaid, be denied enrollment in a Healthy Michigan Managed Care Plan or a QHP, or be denied access to services for failure to pay premiums or copayment liabilities.

    b. Providers may not deny services for failure to receive beneficiary copayments.

    c. Beneficiaries described in 42 CFR 447.56(a)(1) must be exempt from all cost sharing and contribution requirements.

d. Beneficiaries' cost sharing or monthly contributions must be compliant with the rules established in 42 CFR 447.56(f).

e. Copayment amounts will be consistent with federal regulations regarding Medicaid cost sharing and with the state's approved state plan (except for any reductions to copayments due to Healthy Behaviors), including the exceptions from cost sharing for certain services identified in 42 CFR 447.56(a)(2).

f. Beneficiaries' can be billed for copayment liability in any 6-month experience period after the first six months of enrollment. Maximum billed amounts must be equal to or less than the average of the beneficiary's incurred copayments for the previous 6-month period (except for any reductions to copayments due to Healthy Behaviors).

g. A Healthy Michigan Plan, QHP and/or state may attempt to collect unpaid premiums and the related debt from beneficiaries, but may not report the debt to credit reporting agencies, place a lien on an individual's home, refer the case to debt collectors, file a lawsuit, seek a court order to seize a portion of the individual's earnings for enrollees at any income level. The Healthy Michigan Plan, QHP and/or state also may not "sell" the debt for collection by a third-party. The state is permitted to pursue offset of state tax refunds and state lottery winnings for unpaid premiums or contributions and copayments from beneficiaries, as outlined in the Operation Protocol.

h. The state may not pass along the cost of any surcharge associated with processing payments to the beneficiary. Any surcharges or other fees associated with payment processing must be considered an administrative expense by the state.

i. The state will ensure that all payments from the beneficiary, or on behalf of the individual, are accurately and timely credited toward unpaid premiums and related debt, and will provide the beneficiary an opportunity to review and seek correction of the payment history.

31. Contributions Accounts and Payments Infrastructure Operational Protocol. The state must submit an updated Contributions Accounts and Payments Infrastructure Operational Protocol to CMS for review and approval prior to implementing any changes to the MI Health Accounts program within the Healthy Michigan Plan. The protocol must include, at a minimum, the following items:

a. The copayment liability and premium payments strategy and implementation plan, including a phased approach to implementation for beneficiaries beginning six months after enrollment in the Healthy Michigan Plan, that allows for milestones related to successful accounting for funds, data collection for incentives, education and other critical operations to be met prior to inclusion of all Healthy Michigan beneficiaries into the payment and reward program. The

plan must clearly explain when beneficiaries are responsible for payments and how beneficiaries will be engaged in the payment process, including when and under what circumstances payments will be required.

b. A description of how third parties (i.e. the beneficiary's employer, the state, and/or private and public entities) may contribute on the beneficiary's behalf, including how this is operationalized, and how the contributions will be treated in so far as ensuring such funds are not considered beneficiary income or resources. Such contributions will not be considered as matchable expenditures.

c. The strategy, operational and implementation plan to ensure that the beneficiary will not be charged a copayment by a Medicaid healthcare provider when covered benefits are provided.

d. Rules to ensure that account funds may only be disbursed for items or services covered under the individual's Medicaid benefit, and as approved in the Operational Protocol.

e. The strategy and the description of the operational processes to define how and to provide assurances that ensure that account debits and credits will be accurately tracked on a per visit basis, as well as quarterly and annual statements that will be provided to the beneficiary. The purpose of this requirement is to promote beneficiary awareness and understanding of the interaction between health care utilization and potential future copayment obligations or reductions due to healthy behaviors. At a minimum, this must provide for the following: Notices will be required at the time of service, also with quarterly, biannual and annual frequency. The impact of the statements will be considered in the evaluation of the demonstration.

f. A description, strategy and implementation plan of the beneficiary education and assistance process including copies of beneficiary notices, a description of beneficiaries' rights and responsibilities, appeal rights and processes and instructions for beneficiaries about how to interact with state officials for discrepancies or other issues that arise regarding the beneficiaries' MI Health Account.

g. Assurance that the account balances will not be counted as assets for the beneficiary and that funds returned to the beneficiary will not be treated as income, and a plan for whether interest will accrue to account balances.

h. A strategy for educating beneficiaries on how to use the statements, and understand that their health care expenditures will be covered.

i. For beneficiaries that are determined no longer eligible for the demonstration, a method for the remaining balance of the account to either be paid to the beneficiary or used to provide employer-based or Marketplace coverage.

32. **Assurance of Compliance.** Within 90 days of implementation of the MI Health Account, the state shall provide CMS with an accounting for review to verify that the accounts are operating in accord with the approved protocol. Should the program be out of compliance, standard penalties may apply including a corrective action plan, disallowance, or program suspension until all operations are compliant.

33. **Healthy Behaviors Incentives Program.** Following CMS approval of the Healthy Behaviors Incentive program operational protocol, all individuals enrolled in the Healthy Michigan Plan are eligible to receive incentive payments to offset cost sharing liability via reductions in their copayment liability if certain healthy behaviors are maintained or attained. The purpose of this incentive program is to encourage beneficiaries to their improve health outcomes as well as to maintain and implement additional healthy behaviors as identified in collaboration with their health care provider or providers via consultation as well as via a health risk assessment.

34. **Healthy Behaviors Incentives Program Operational Protocol.** The state may not make any changes to the Healthy Behaviors Incentives program without CMS approval. The protocol must, at a minimum, include the following:

    a. The uniform standards for healthy behaviors incentives including, but not limited to, a health risk assessment to identify behavior that the initiative is targeting, for example: routine ER use for non-emergency treatment, multiple comorbities, alcohol abuse, substance use disorders, tobacco use, obesity, and deficiencies in immunization status.

    b. A selection of targeted healthy behaviors that is sufficiently diverse and a strategy to measure access to necessary providers to ensure that all beneficiaries have a meaningful opportunity to receive healthy behavior incentives, taking into account individual physical and mental health status, and including the grace period described in STC 35.b).

    c. A list of stakeholders as well as documentation of the public processes or meetings that occurred during the development of the protocol, the accompanying health risk assessment tool and uniform standards.

    d. The data driven strategy of how healthy behaviors will be tracked and monitored at the enrollee and provider level including standards of accountability for providers. This must include the timeline for development and/or implementation of a systems based approach which shall occur prior to implementing the Healthy Behaviors initiative.

e. A beneficiary and provider education strategy and timeline for completion prior to program implementation.

f. The ongoing structured interventions that will be provided to assist beneficiaries in improving healthy behaviors as identified through the health risk assessment.

g. A description of how the state will ensure that adjustments to premiums or average utilization copayment contributions are accurate and accounted for based upon the success in achieving healthy behaviors.

h. A strategy and implementation plan of how healthy behaviors will be tracked and monitored at the beneficiary and provider levels, including standards of accountability for providers.

i. An ongoing strategy of education and outreach post implementation regarding the Healthy Behaviors Incentives program including strategies related to the ongoing engagement of stakeholders and the public in the state.

j. A description of other incentives in addition to reductions in cost sharing or premiums that the state will implement.

k. The methodology describing how healthy behavior incentives will be applied to reduce premiums or copayments.

VII. DELIVERY SYSTEM

35. Healthy Michigan Plan. Until April 1, 2018, services for Healthy Michigan Plan adults will be provided through a managed care delivery system. After April 1, 2018 when the Healthy Michigan Plan is operational for 48 months, beneficiaries with incomes above 100 percent of the FPL will receive services through a Healthy Michigan Plan or the Marketplace Option.

a. **Exclusions and Exemptions from Enrollment.** The following individuals are not permitted to enroll in the Healthy Michigan Plan: Individuals with incomes above 100 percent of the FPL who have not completed designated healthy behaviors as described in STC 28.

b. **Grace Period**. Individuals who are newly enrolled in the Healthy Michigan Plan on or after April 1, 2018 or who come into the higher income level (above 100 percent of the FPL) on or after April 1, 2018 may have one year of enrollment in the Healthy Michigan Plan in order to allow time for completion of healthy behaviors, before alternative contributions and cost sharing are applicable.

c. **Types of Health Plans.** The state will use two different types of managed care plans to provide the full Alternative Benefit Plan for the demonstration population:

i. Comprehensive Health Plans: These will be Managed Care Organizations (MCOs) (which herein are also referred to as Medicaid Health Plans, or MHPs) that provide acute care, physical health services and most pharmacy benefits on a statewide basis. These MCOs will be the same MCOs that provide acute care and physical health coverage for other Medicaid populations.

ii. Behavioral Health Plans: These will be Pre-paid Inpatient Health Plans (PIHPs) that provide inpatient and outpatient mental health, substance use disorder, and developmental disability services statewide to all enrollees in the demonstration. The PIHPs will be the same entities that serve other Medicaid populations.

36. Healthy Michigan Plan Enrollment Requirements. Before April 1, 2018, the state may require Healthy Michigan Plan adults to enroll in MCOs and PIHPs (with the exception of those beneficiaries who meet the MHP enrollment exemption criteria or those beneficiaries who meet the voluntary enrollment criteria).

a. Mandatory enrollment may occur only when the MCOs or PIHPs have been determined by the state to meet readiness and network requirements to ensure sufficient access, quality of care, and care coordination for beneficiaries as established by the state, consistent with 42 CFR 438 and as approved by CMS.

b. New eligibles will initially be placed in fee-for-service, during which the individual will be responsible for paying all copayments, in amounts that are in accord with the state plan, at the time of service.

c. The state will use an enrollment broker to assist individuals with selection of a MHP managed care organization before relying on auto-assignments.

d. Any individual that does not make an active selection will be assigned, by default, to a participating Healthy Michigan Plan MCO. The state should develop an auto-assignment algorithm which is compliant with 42 CFR 438.50(f).

e. Individuals will have choice of Healthy Michigan Plan MCOs in all areas except the rural counties that are not defined as urban by the Executive Office of Management and Budget. In rural counties, the state will only contract with 1 MCO to serve those beneficiaries, consistent with the standards in section 1932(a)(3)(B) of the Act. In those rural areas that qualify for only one plan, the state will ensure the choice of providers as detailed in 42 C.F.R. 438.52(b)(1). In

all areas of the state, individuals will only be permitted to enroll in the 1 PIHP that serves their area of residence.

f. Upon completion of the 90-day disenrollment period, during which time individuals may choose a different MCO plan, individuals that are mandatorily enrolled into a Healthy Michigan Plan MCO will be locked into that MCO for a period of 12 months, unless they have a for-cause reason for disenrollment, as defined by the state. Individuals that are voluntarily enrolled into a MCO will be permitted to disenroll at any time.

g. All individuals will be automatically assigned to the single PIHP that serves beneficiaries in their area of residence in order to access services in the behavioral health system, provided the PIHP has been determined to meet readiness and network requirements, as described above.

h. Mandatory enrollment cannot include individuals specifically exempted from mandatory enrollment in managed care under section 1932 of the Act. These individuals may elect to receive benefits through a fee-for-service delivery system.

i. Notice Information. The state must provide transition notice to any beneficiaries impacted by a change in delivery system at least 30 days in advance of the change. Notices will be written in simple and understandable terms and in a manner that is accessible to persons who are limited English proficient and individuals living with disabilities.

j. Transition Period. When beneficiaries transition delivery systems, beneficiaries in active treatment (including but not limited to chemotherapy, pregnancy, drug regime or a scheduled procedure) with a non-participating/non-contracted provider shall be allowed to continue receiving treatment from the nonparticipating/non-contracted provider through the duration of their prescribed treatment.

37. Healthy Michigan Plan Managed Care Benefit Package. Individuals enrolled in Healthy Michigan Plan will receive from the managed care program the benefits in the approved Alternative Benefit Plan (ABP) SPA that aligns with the benefit package in the state plan. Covered benefits should be delivered and coordinated in an integrated fashion, using an interdisciplinary care team, to coordinate all physical and behavioral health services. Care coordination and management is a core expectation for these services. MCOs/PIHPs will refer and/or coordinate enrollees' access to needed services that are excluded from the managed care delivery system but available through a fee-for–service (FFS) delivery system (e.g. Home Help services or certain psychotropic medications).

38. Managed Care Requirements. The state must comply with the managed care regulations published at 42 CFR 438, except as waived herein. Capitation rates shall be developed and

certified as actuarially sound, in accordance with 42 CFR 438.6. The certification shall identify historical utilization of services that are the same as outlined in the corresponding Alternative Benefit Plan and used in the rate development process.

39. **Managed Care Contracts.** No FFP is available for activities covered under contracts and/or modifications to existing contracts that are subject to 42 CFR 438 requirements prior to CMS approval of this demonstration authority as well as CMS approval of such contracts and/or contract amendments. The state shall submit any supporting documentation deemed necessary by CMS. The state must provide CMS with a minimum of 60 days to review and approve changes. CMS reserves the right, as a corrective action, to withhold FFP (either partial or full) for the demonstration, until the contract compliance requirement is met.

40. **Public Contracts.** Payments under contracts with public agencies, that are not competitively bid in a process involving multiple bidders, shall not exceed the documented costs incurred in furnishing covered services to eligible individuals (or a reasonable estimate with an adjustment factor no greater than the annual change in the consumer price index).

41. **Network Requirements.** The state must ensure the delivery of all covered benefits, including high quality care. Services must be delivered in a culturally competent manner, and the MCO or PIHP network must be sufficient to provide access to covered services to the low-income population. In addition, the MCO/PIHP must coordinate health care services for demonstration populations. The following requirements must be included in the state's MCO/PIHP contracts:

    a. **Special Health Care Needs.** Enrollees with special health care needs must have direct access to a specialist, as appropriate for the individual's health care condition, as specified in 42 C.F.R. 438.208(c)(4).

    b. **Out of Network Requirements.** Each MCO/PIHP must provide demonstration populations with all demonstration program benefits under their contract and as described within these STCs and must allow access to non-network providers when services cannot be provided consistent with the timeliness standards required by the state.

42. **Demonstrating Network Adequacy.** Annually, each MCO/PIHP must provide adequate assurances that it has sufficient capacity to serve the expected enrollment in its service area and offers an adequate range of providers necessary to provide covered services for the anticipated number of enrollees in the service area.

    a. The state must verify these assurances by reviewing demographic, utilization and enrollment data for enrollees in the demonstration as well as:

i. The number and types of primary care, pharmacy, behavioral health, and specialty providers available to provide covered services to the demonstration population

ii. The number of network providers accepting the new demonstration population; and

iii. The geographic location of providers and demonstration populations, as shown through GeoAccess or similar software.

b. The state must submit the documentation required in subparagraphs i – iii above to CMS with initial MCO/PIHP contract submission as well as at each contract renewal or renegotiation, or at any time that there is a significant impact to each MCO/PIHP's operation, including service area expansion or reduction and population expansion.

43. Managed Care Encounter Data Requirements. All MCO/PIHPs shall maintain an information system that collects, analyzes, integrates and reports data as set forth at 42 CFR 438.242 in a standardized format. Encounter data requirements shall include the following:

a. Encounter Data (MCO/PIHP Responsibilities) – Each MCO/PIHP must collect, maintain, validate and submit data for services furnished to its enrollees as required by state contract.

b. Encounter Data (State Responsibilities) - The state shall develop mechanisms for the collection, reporting, and analysis of these, as well as a process to validate that each plan's encounter data are timely, complete and accurate. The state will take appropriate actions to identify and correct deficiencies identified in the collection of encounter data. The state shall have contractual provisions in place to impose financial penalties if accurate data are not submitted in a timely fashion. Additionally, the state shall contract with its EQRO to validate encounter data through medical record review.

c. Encounter Data Validation Study for New Capitated Managed Care Plans - If the state contracts with new MCOs or PIHPs throughout the lifetime of the demonstration, the state shall conduct a validation study 18 months after the effective date of the contract to determine completeness and accuracy of encounter data. The initial study shall include validation through a sample of medical records of MCO/PIHP enrollees.

44. AI/AN Access to Behavioral Health Services. Native American Indian beneficiaries may elect to obtain Medicaid mental health and substance abuse services directly from Medicaid enrolled Indian Health Service (IHS) facilities and Tribal Health Centers (THCs). For mental health and substance abuse services provided to Native American beneficiaries, the

IHS facilities and THCs will be reimbursed directly for those services by the state in accordance with the applicable rates in the approved state plan and the Michigan Medicaid Provider Manual. Any Native American Indian beneficiary who needs specialty mental health, developmental disability or substance abuse services may also elect to receive such care under this demonstration through the PIHP. The PIHPs have been specifically instructed by MDHHS to assure that Indian health programs are included in the PIHP provider panel, to ensure culturally competent specialty care for the beneficiaries in those areas.

45. **Marketplace Option.** After April 1, 2018, when the Healthy Michigan Plan is operational for 48 months, individuals with income above 100 percent may choose to enroll in the Marketplace Option instead of the Healthy Michigan Plan in accordance with the enrollment process specified in STC 50.

46. **Exclusions and Exemptions from Enrollment.** The following individuals are not permitted to enroll in the Marketplace Option.
    a. Individuals with incomes at or below 100 percent of the FPL
    b. Individuals who are determined to be medically frail.

47. **Marketplace Option Access to Wrap-Around Benefits**. In addition to receiving an insurance card from the applicable QHP issuer, Marketplace Option beneficiaries will be sent a notice and Medicaid card from the Michigan Department of Health and Human Services. The notice will contain information on how enrollees can use their Medicaid card to access wrapped benefits. The notice will include specific information regarding services that are covered directly through a fee-for-service Medicaid delivery system, what phone numbers to call or websites to visit to access wrapped services, and any cost-sharing for wrapped services pursuant to STC 23.

48. **Notices.** Marketplace Option beneficiaries will receive a notice from the state Medicaid agency advising them of the following:

    a. QHP Plan Selection. The notice will include information regarding how Marketplace Option beneficiaries can select a QHP, including guidance on selecting the plan that will best address their needs and information on the state's auto-enrollment process in the event that the beneficiary does not select a plan.

    b. FFS for New Eligibles. New eligibles will initially be placed in fee-for-service, during which the individual will be responsible for paying all copayments, in amounts that are in accord with the state plan, at the time of service.

    c. Access to Services until QHP Enrollment is Effective. The notice will include the Medicaid client identification number (CIN) and Medicaid card. The notice will include information on how beneficiaries can use the CIN number or Medicaid card to access services until their QHP enrollment is effective.

d. Wrapped Benefits. The notice accompanying the Medicaid card will also include information on how enrollees can use the card to access wrapped benefits. The notice will include specific information regarding services that are covered directly through fee-for-service Medicaid, what phone numbers to call or websites to visit to access wrapped services, and any cost-sharing for wrapped services pursuant to STC 23.

e. Appeals. The notice will also include information regarding the grievance and appeals process. Beneficiary safeguards of appeal rights will be provided by the state, including fair hearing rights. No waiver will be granted related to appeals. The state must ensure compliance with all federal and state requirements related to beneficiary appeal rights.

f. Exemption from the Marketplace Option. The notice will include information describing how new adult enrollees who choose to enroll in the Marketplace Option but subsequently complete Healthy Behaviors and elect to move to the Healthy Michigan Plan may do so.

g. Additional Notices. The eligibility determination notice will advise that the Marketplace Option is subject to cancellation upon notice.

49. QHP Selection. The QHPs in which Marketplace Option beneficiaries will enroll will be reviewed by the Michigan Department of Insurance and Financial Services and certified through the Federally Facilitated Marketplace's QHP certification process. The QHP's available for selection by the beneficiary will be determined by the Medicaid agency.

50. Enrollment Process

a. Individuals who are determined to be medically frail based on the definition and process identified in the state's approved alternative benefit plan as well as individuals with incomes at or below 100 percent FPL will be excluded from the Marketplace Option and will continue to receive coverage through the Healthy Michigan Plan as described in the Alternative Benefit Plan that aligns with state plan benefits.

b. Individuals with incomes above 100 percent of the FPL who are not identified as medically frail and who have not chosen to remain in the Healthy Michigan Plan will receive a notice informing them that they must select a QHP for coverage beginning April 1, 2018 and providing guidance on how to select a QHP. The notice will also include information on selecting a QHP and comparisons highlighting the differences between plans with respect to, among other things, networks, access to patient-centered medical homes, and use of care coordination programs.

c. Individuals may select a QHP (1) via the state's online portal, (2) by phone, or (3) in person.

d. New eligibles will initially be placed in fee-for-service, during which the individual will be responsible for paying all copayments, in amounts that are in accord with the state plan, at the time of service.

e. Individuals who elect to enroll in the Marketplace Option but fail to select a QHP within 30 days of an eligibility determination will be auto-assigned. Michigan will send individuals a notice informing them of the QHP to which they have been auto-assigned and that they have the right to select a different plan.

f. Once an individual has either selected a QHP or the time period to select a QHP has ended, Michigan will send an 834 transaction to the issuer. 834 transactions will be sent to carriers daily in batch.

g. Upon receipt of an 834 enrollment transaction, the carrier will send an enrollment package, including the benefit card, to the enrollee.

h. On at least a monthly basis, the carriers will send the state a list of all Marketplace Option enrollees in QHPs, identified by a unique ID number, for the state to reconcile. Upon reconciliation the state will send back an updated list for carriers.

i. The state's MMIS will generate an 820 transaction to pay premiums and cost sharing reductions on behalf of beneficiaries directly to the QHP issuer.

j. State MMIS premium payments will continue to an individual's QHP until the individual is determined to no longer be eligible for Marketplace Option; the individual selects an alternative plan during the next open enrollment period; or the individual is determined to be medically frail; or determined to be eligible for or selects to be enrolled in a Healthy Michigan Plan and excluded from the Marketplace Option.

51. **Auto-assignment Methodology.** The state will work with CMS to develop an approved auto-assignment methodology.

52. **Changes to Auto-assignment Methodology.** The state will advise CMS 60 days prior to implementing a change to the auto-assignment methodology.

53. **Disenrollment.** Enrollees in Marketplace Option may be disenrolled from the QHP if (i) they are determined to be medically frail after they were previously determined eligible or (ii) if they are determined eligible for or elect to be enrolled in a Healthy Michigan Plan, as described in the approved SPA that will be required for the Marketplace Option ABP.

54. **Transition Plan.** No later than April 1, 2017, the state is required to submit or revise a Transition Plan for CMS review that describes the state's process for transitioning individuals from the Healthy Michigan Plan to the Marketplace Option. The Transition Plan will at a minimum address the following:

a. All enrollees who move from the Healthy Michigan Plan to the Marketplace Option will be automatically transitioned without an additional eligibility redetermination. Each transitioned beneficiary will retain his or her original redetermination date;

b. The state must assure the continuity of care for persons transitioning from the Healthy Michigan Plan and the Marketplace Option;

c. The state will explain how it will identify individuals with incomes above 100 percent who choose to enroll in the Marketplace Option instead of the Healthy Michigan Plan when the Healthy Michigan Plan is operational for 48 months. The state will include details explaining how it will provide adequate notice to beneficiaries about the choice between the Healthy Michigan Plan and the Marketplace Option.

IX. GENERAL REPORTING REQUIREMENTS

55. General Financial Requirements. The state must comply with all general financial requirements under Title XIX, including reporting requirements related to monitoring budget neutrality, set forth in Section X of these STCs.

56. Monthly Enrollment Report. Within 20 days following the first day of each month, the state must report demonstration enrollment figures for the month just completed to the CMS Project Officer and Regional Office contact via e-mail, using the table below. The data requested under this subparagraph are similar to the data requested for the Quarterly Progress Report in Attachment A under Enrollment Count, except that they are compiled on a monthly basis.

Demonstration Populations (as hard-coded in the CMS-64)	**Point In Time Enrollment** (last day of month)	**Newly Enrolled Last Month**	**Disenrolled Last Quarter**
Healthy MI Adults			

57. Reporting Requirements Related to Budget Neutrality. The state must comply with all reporting requirements for monitoring budget neutrality set forth in Section XIII of these STCs, including the submission of corrected budget neutrality data upon request.

58. Monitoring Calls. CMS will convene periodic conference calls with the state. The purpose of these calls is to discuss any significant actual or anticipated developments affecting the demonstration. Areas to be addressed include, but are not limited to: transition and implementation activities, MCO operations and performance, enrollment, cost sharing, quality of care, access, the benefit package, audits, lawsuits, financial reporting and budget neutrality issues, progress on evaluations, legislative developments, and any demonstration amendments the state is considering submitting. CMS will provide

updates on any amendments or concept papers under review, as well as federal policies and issues that may affect any aspect of the demonstration. The state and CMS will jointly develop the agenda for the calls.

59. **Post Award Forum.** Within six months of the demonstration's implementation, and annually thereafter, the state will afford the public with an opportunity to provide meaningful comment on the progress of the demonstration. At least 30 days prior to the date of the planned public forum, the state must publish the date, time and location of the forum in a prominent location on its website. The state can use either its Medical Care Advisory Committee, or another meeting that is open to the public and where an interested party can learn about the progress of the demonstration to meet the requirements of these STCs. The state must include a summary of the comments and issues raised by the public at the forum and include the summary in the quarterly progress report, as specified in paragraph 52, associated with the quarter in which the forum was held. The state must also include the summary in its annual report as required in paragraph 53.

60. **Quarterly Progress Reports.** The state must submit quarterly progress reports in accordance with the guidelines in Attachment A no later than 60 days following the end of each quarter. The intent of these reports is to present the state's analysis and the status of the various operational areas. These quarterly progress and annual reports must include the following, but are not limited to:

    a. An updated budget neutrality monitoring spreadsheet;

    b. Events occurring during the quarter or anticipated to occur in the near future that affect health care delivery, including, but not limited to: benefits, enrollment and disenrollment, complaints and grievances, quality of care, and access that is relevant to the demonstration, pertinent legislative or litigation activity, and other operational issues;

    c. Updates on the post award forums required under paragraph 51.

    d. Action plans for addressing any policy, administrative, or budget issues identified;

    e. Monthly enrollment reports for demonstration beneficiaries, that include the member months and end of quarter, point-in-time enrollment for each demonstration population;

    f. Number of beneficiaries who chose an MCO and the number of beneficiaries who change plans after being auto-assigned; and

    g. Information on beneficiary complaints, grievances and appeals filed during the quarter by type including; access to urgent, routine, and specialty services, and a description of the resolution and outcomes. Evaluation activities and interim findings. The state shall include a summary of the progress of evaluation

activities, including key milestones accomplished as well as challenges encountered and how they were addressed. The discussion shall also include interim findings, when available; status of contracts with independent evaluator(s), if applicable; status of Institutional Review Board approval, if applicable; and status of study participant beneficiary recruitment, if applicable.

h. Identify any quality assurance/monitoring activity in current quarter.

61. **Demonstration Annual Report.** The annual report must, at a minimum, include the requirements outlined below. The state will submit the draft Annual Report no later than 90 days after the end of each demonstration year. Within 30 days of receipt of comments from CMS, a final Annual Report must be submitted for the demonstration year (DY) to CMS.

    a. All items included in the Quarterly Progress Report pursuant to paragraph 52 must be summarized to reflect the operation/activities throughout the DY;

    b. Total annual expenditures for the demonstration population for each DY, with administrative costs reported separately

    c. Yearly enrollment reports for demonstration enrollees for each DY (enrollees include all individuals enrolled in the demonstration) that include the member months, as required to evaluate compliance with the budget neutral agreement;

    d. Managed Care Delivery System. The state must document accomplishments, project status, quantitative and case study findings, interim evaluation findings, utilization data, progress on implementing cost containment initiatives and policy and administrative difficulties in the operation of the demonstration. The state must provide the CAHPS survey, outcomes of any focused studies conducted and what the state intends to do with the results of the focused study, outcomes of any reviews or interviews related to measurement of any disparities by racial or ethnic groups, annual summary of network adequacy by plan including an assessment of the provider network pre and post implementation and MCO compliance with provider 24/7 availability, summary of outcomes of any on-site reviews including EQRO, financial, or other types of reviews conducted by the state or a contractor of the state, summary of performance improvement projects being conducted by the state and any outcomes associated with the interventions, outcomes of performance measure monitoring, summary of plan financial performance.

62. **Final Report.** Within 120 days following the end of the demonstration, the state must submit a draft final report to CMS for comments. The state must take into consideration CMS' comments for incorporation into the final report. The final report is due to CMS no later than 90 days after receipt of CMS' comments.

XI. GENERAL FINANCIAL REQUIREMENTS

This project is approved for Title XIX expenditures applicable to services rendered during the demonstration period. This Section describes the general financial requirements for these expenditures.

63. **Quarterly Financial Reports.** The state must provide quarterly Title XIX expenditure reports using Form CMS-64, to separately report total Title XIX expenditures for services provided through this demonstration under Section 1115 authority. This project is approved for expenditures applicable to services rendered during the demonstration period. CMS shall provide Title XIX FFP for allowable demonstration expenditures, only as long as they do not exceed the pre-defined limits on the costs incurred, as specified in Section XIII of the STCs.

64. **Reporting Expenditures under the Demonstration.** The following describes the reporting of expenditures subject to the budget neutrality agreement:

    a. **Tracking Expenditures.** In order to track expenditures under this demonstration, the state will report demonstration expenditures through the Medicaid and State Children's Health Insurance Program Budget and Expenditure System (MBES/CBES); following routine CMS-64 reporting instructions outlined in Section 2500 and Section 2115 of the State Medicaid Manual. All demonstration expenditures subject to budget neutrality limits must be reported each quarter on separate Forms CMS-64.9 WAIVER and/or 64.9P WAIVER, identified by the demonstration project number assigned by CMS (including the project number extension, which indicates the DY in which services were rendered or for which capitation payments were made). For monitoring purposes, cost settlements must be recorded on the appropriate prior period adjustment schedules (Forms CMS-64.9 Waiver) for the Summary Line 10B, in lieu of Lines 9 or l0C. For any other cost settlements (i.e., those not attributable to this demonstration), the adjustments should be reported on lines 9 or 10C, as instructed in the State Medicaid Manual. The term, "expenditures subject to the budget neutrality limit," is defined below in paragraph 65.

    b. **Cost Settlements.** For monitoring purposes, cost settlements attributable to the demonstration must be recorded on the appropriate prior period adjustment schedules (Form CMS-64.9P Waiver) for the Summary Sheet Line 10B, in lieu of Lines 9 or 10C. For any cost settlement not attributable to this demonstration, the adjustments should be reported as otherwise instructed in the State Medicaid Manual.

    c. **Premium and Cost Sharing Contributions.** Premiums and other applicable cost sharing contributions that are collected by the state from enrollees under the demonstration must be reported to CMS each quarter on Form CMS-64 Summary Sheet line 9.D, columns A and B. In order to assure that these collections are

properly credited to the demonstration, premium and cost-sharing collections (both total computable and federal share) should also be reported separately by DY on the Form CMS-64 Narrative. In the calculation of expenditures subject to the budget neutrality expenditure limit, premium collections applicable to demonstration populations will be offset against expenditures. These Section 1115 premium collections will be included as a manual adjustment (decrease) to the demonstration's actual expenditures on a quarterly basis.

d. **Pharmacy Rebates.** The state may propose a methodology for assigning a portion of pharmacy rebates to the demonstration populations, in a way that reasonably reflects the actual rebate-eligible pharmacy utilization of those populations, and which reasonably identifies pharmacy rebate amounts with DYs. Use of the methodology is subject to the approval in advance by the CMS Regional Office, and changes to the methodology must also be approved in advance by the Regional Office. The portion of pharmacy rebates assigned to the demonstration using the approved methodology will be reported on the appropriate Forms CMS-64.9 Waiver for the demonstration and not on any other CMS 64.9 form to avoid double –counting. Each rebate amount must be distributed as state and Federal revenue consistent with the Federal matching rates under which the claim was paid.

e. **Use of Waiver Forms for Medicaid.** For each DY, separate Forms CMS-64.9 Waiver and/or 64.9P Waiver shall be submitted reporting expenditures for individuals enrolled in the demonstration, subject to the budget neutrality limits (Section X of these STCs). The state must complete separate waiver forms for the following Medicaid eligibility groups/waiver names:

    i. MEG 1 – "Healthy MI Adults" (all health care expenditures for Healthy MI Adults, starting April 1, 2014, without regard to actual implementation date for Healthy Michigan)

f. **Demonstration Years.** Demonstration Years (DYs) will be defined as follows:

Demonstration Year 1 (DY 1)	January 1, 2010 – September 30, 2010
Demonstration Year 2 (DY 2)	October 1, 2010 – September 30, 2011
Demonstration Year 3 (DY 3)	October 1, 2011 – September 30, 2012
Demonstration Year 4 (DY 4)	October 1, 2012 – September 30, 2013
Demonstration Year 5 (DY 5)	October 1, 2013 – December 31, 2014
Demonstration Year 6 (DY 6)	January 1, 2015 – December 31, 2015

Demonstration Year 7 (DY 7)	January 1, 2016 – December 31, 2016
Demonstration Year 8 (DY 8)	January 1, 2017 – December 31, 2017
Demonstration Year 9 (DY 9)	January 1, 2018 – December 31, 2018

65. Expenditures Subject to the Budget Neutrality Limits. For purposes of this Section, the term "expenditures subject to the budget neutrality limit" must include:

a. All demonstration medical assistance expenditures (including those authorized through the Medicaid state plan, and through the Section 1115 waiver and expenditures authorities), Eligibility, with dates of services within the demonstration's approval period; and

b. All expenditures that are subject to the budget neutrality agreement are considered demonstration expenditures and must be reported on Forms CMS-64.9 Waiver and /or 64.9P Waiver.

66. Administrative Costs. Administrative costs will not be included in the budget neutrality limit, but the state must separately track and report additional administrative costs that are directly attributable to the demonstration, using Forms CMS-64.10 Waiver and/or 64.10P Waiver, with waiver name "ADM".

67. Claiming Period. All claims for expenditures subject to the budget neutrality limit (including any cost settlements) must be made within 2 years after the calendar quarter in which the state made the expenditures. Furthermore, all claims for services during the demonstration period (including any cost settlements) must be made within 2 years after the conclusion or termination of the demonstration. During the latter 2-year period, the state must continue to identify separately net expenditures related to dates of service during the operation of the Section 1115 demonstration on the Form CMS-64 in order to properly account for these expenditures in determining budget neutrality.

68. Reporting Member Months. The following describes the reporting of member months for demonstration populations:

a. For the purpose of calculating the budget neutrality expenditure cap and for other purposes, the state must provide to CMS, as part of the Quarterly Progress Report required under paragraph 52, the actual number of eligible member months for the demonstration populations defined in paragraph 21. The state must submit a statement accompanying the Quarterly Progress Report, which certifies the accuracy of this information. Member months must be reported for Healthy MI Adults starting April 1, 2014.

b. To permit full recognition of "in-process" eligibility, reported counts of member months may be subject to revisions after the end of each quarter. Member month counts may be revised retrospectively as needed.

c. The term "eligible member months" refers to the number of months in which persons are eligible to receive services. For example, a person who is eligible for 3 months contributes 3 eligible member months to the total. Two individuals who are eligible for 2 months each contribute 2 eligible member months to the total, for a total of 4 eligible member months.

69. **Standard Medicaid Funding Process.** The standard Medicaid funding process must be used during the demonstration. The state must estimate matchable demonstration expenditures (total computable and federal share) subject to the budget neutrality expenditure cap and separately report these expenditures by quarter for each federal fiscal year (FFY) on the Form CMS-37 for both the Medical Assistance Payments (MAP) and State and Local Administration Costs (ADM). CMS will make federal funds available based upon the state's estimate, as approved by CMS. Within 30 days after the end of each quarter, the state must submit the Form CMS-64 quarterly Medicaid expenditure report, showing Medicaid expenditures made in the quarter just ended. The CMS will reconcile expenditures reported on the Form CMS-64 quarterly with federal funding previously made available to the state, and include the reconciling adjustment in the finalization of the grant award to the state.

70. **Extent of FFP for the Demonstration.** Subject to CMS approval of the source(s) of the non-federal share of funding, CMS will provide FFP at the applicable federal matching rate for the demonstration as a whole as outlined below, subject to the limits described in Section XI:

    a. Administrative costs, including those associated with the administration of the demonstration.

    b. Net expenditures and prior period adjustments of the Medicaid program that are paid in accordance with the approved state plan.

    c. Medical Assistance expenditures made under Section 1115 demonstration authority, including those made in conjunction with the demonstration, net of enrollment fees, cost sharing, pharmacy rebates, and all other types of third party liability or CMS payment adjustments.

71. **Sources of Non-Federal Share.** The state must certify that the matching non-federal share of funds for the demonstration is state/local monies. The state further certifies that such funds shall not be used as the match for any other federal grant or contract, except as permitted by law. All sources of non-federal funding must be compliant with Section 1903(w) of the Act and applicable regulations. In addition, all sources of the non-federal share of funding are subject to CMS approval.

a. CMS may review the sources of the non-federal share of funding for the demonstration at any time. The state agrees that all funding sources deemed unacceptable by CMS shall be addressed within the time frames set by CMS.

b. Any amendments that impact the financial status of the program shall require the state to provide information to CMS regarding all sources of the non-federal share of funding.

c. The state assures that all health care-related taxes comport with Section 1903(w) of the Act and all other applicable federal statutory and regulatory provisions, as well as the approved Medicaid state plan.

d. State Certification of Funding Conditions. The state must certify that the following conditions for non-federal share of demonstration expenditures are met:

    ii. Units of government, including governmentally operated health care providers, may certify that state or local tax dollars have been expended as the non-federal share of funds under the demonstration.

    iii. To the extent the state utilizes certified public expenditures (CPEs) as the funding mechanism for Title XIX (or under Section 1115 authority) payments, CMS must approve a cost reimbursement methodology. This methodology must include a detailed explanation of the process by which the state would identify those costs eligible under Title XIX (or under Section 1115 authority) for purposes of certifying public expenditures.

    iv. To the extent the state utilizes CPEs as the funding mechanism to claim federal match for payments under the demonstration, governmental entities to which general revenue funds are appropriated must certify to the state the amount of such tax revenue (state or local) used to satisfy demonstration expenditures. The entities that incurred the cost must also provide cost documentation to support the state's claim for federal match.

e. The state may use intergovernmental transfers to the extent that such funds are derived from state or local tax revenues and are transferred by units of government within the state. Any transfers from governmentally operated health care providers must be made in an amount not to exceed the non-federal share of Title XIX payments.

f. Under all circumstances, health care providers must retain 100 percent of the reimbursement amounts claimed by the state as demonstration expenditures. Moreover, no pre-arranged agreements (contractual or otherwise) may exist between the health care providers and the state and/or local government to return and/or redirect any portion of the Medicaid payments. This confirmation of

Medicaid payment retention is made with the understanding that payments that are the normal operating expenses of conducting business (such as payments related to taxes—including health care provider-related taxes—fees, and business relationships with governments that are unrelated to Medicaid and in which there is no connection to Medicaid payments) are not considered returning and/or redirecting a Medicaid payment.

XI. MONITORING BUDGET NEUTRALITY FOR THE DEMONSTRATION

72. Budget Neutrality for Healthy Michigan.

a. **Limit on Title XIX Funding.** The state shall be subject to a limit on the amount of federal Title XIX funding that the state may receive on selected Medicaid expenditures during the period of approval of the demonstration. The limit is determined by using the per capita cost method described in paragraph 65(c), and budget neutrality expenditure limits are set on a yearly basis with a cumulative budget neutrality expenditure limit for the length of the entire demonstration. The data supplied by the state to CMS to set the annual caps is subject to review and audit, and if found to be inaccurate, will result in a modified budget neutrality expenditure limit. CMS' assessment of the state's compliance with these annual limits will be done using the Schedule C report from the CMS-64.

b. **Risk.** The state will be at risk for the per capita cost (as determined by the method described below) for the Healthy Michigan Plan demonstration populations as defined in paragraph 21, but not at risk for the number of beneficiaries in the demonstration population. By providing FFP without regard to enrollment in the demonstration populations, CMS will not place the state at risk for changing economic conditions that impact enrollment levels. However, by placing the state at risk for the per capita costs of current eligibles, CMS assures that the demonstration expenditures do not exceed the levels that would have been realized had there been no demonstration.

c. **Overall Calculation of the Budget Neutrality Limit for Healthy Michigan Plan.** For the purpose of calculating the overall budget neutrality limit for the demonstration, separate annual budget limits will be calculated for each DY on a total computable basis. The annual limits will then be added together to obtain a budget neutrality limit for the entire demonstration period. The federal share of this limit will represent the maximum amount of FFP that the state may receive during the demonstration period for the types of demonstration expenditures described below. The federal share will be calculated by multiplying the total computable budget neutrality limit by the Composite Federal Share, which is defined in (d) below. The demonstration expenditures subject to the budget neutrality limit are those reported under the Waiver Name "Healthy MI Program."

i. The MEG listed in the table below is included in the calculation of the budget neutrality limit for the Healthy Michigan Plan.

MEG	TREND	DY 5 – PMPM	DY 6 – PMPM	DY7 – PMPM	DY8 – PMPM	–DY9 – PMPM
Healthy MI Adults[1]	5.1%	$667.36[2]	$602.21[3]	$569.80	$598.86	$629.40

ii. If the state's experience of the take up rate for the Healthy MI Adults and other factors that affect the costs of this population indicates that the PMPM limit described above in subparagraph (i) may underestimate the actual costs of medical assistance for the Healthy MI Adults, the state may submit an adjustment to subparagraph (i) for CMS review without submitting an amendment pursuant to paragraph 7. Adjustments to the PMPM limit for a demonstration year must be submitted to CMS no later than the end of the third quarter of the demonstration year for which the adjustment would take effect.

iii. The budget neutrality limit is calculated by taking the PMPM cost projection for the above group in each DY, times the number of eligible member months for that group and DY, and adding the products together across groups and DYs. The federal share of the budget neutrality limit is obtained by multiplying total computable budget neutrality limit by the Composite Federal Share.

iv. The Healthy Michigan Plan budget neutrality test is a comparison between the federal share of the budget neutrality limit and total FFP reported by the state for "Healthy MI Adults."

d. **Composite Federal Share Ratio.** The Composite Federal Share is the ratio calculated by dividing the sum total of FFP received by the state on actual demonstration expenditures during the approval period, as reported through the MBES/CBES and summarized on Schedule C (with consideration of additional allowable demonstration offsets such as, but not limited to, premium collections) by total computable demonstration expenditures for the same period as reported on the same forms. Should the demonstration be terminated prior to the end of the extension approval period (see paragraphs 9 and 11), the Composite Federal Share will be determined based on actual expenditures for the period in which the demonstration was active. For the purpose of interim monitoring of budget neutrality, a reasonable estimate of Composite Federal Share may be developed

[1] The PMPMs for Healthy MI Adults are the sum of a Base Rate and Morbidity Co-factor.
[2] The PMPM for DY 5 was adjusted on January 13, 2015 consistent with the requirements laid out in these STCs.
[3] The PMPM for DY 6 was adjusted on June 7, 2016 consistent with the requirements laid out in these STCs.

and used through the same process or through an alternative mutually agreed upon method.

e. **Lifetime Demonstration Budget Neutrality Limit.** The lifetime (overall) budget neutrality limit for the Healthy Michigan Plan component of the demonstration is the sum of the annual budget neutrality limits calculated in subparagraph (c).

f. **Future Adjustments to the Budget Neutrality Expenditure Limit.** CMS reserves the right to adjust the budget neutrality expenditure limit to be consistent with enforcement of impermissible provider payments, health care related taxes, new federal statutes, or policy interpretations implemented through letters, memoranda, or regulations with respect to the provision of services covered under the demonstration.

g. **Enforcement of Budget Neutrality.** CMS shall enforce budget neutrality over the life of the demonstration rather than on an annual basis. However, if the state's expenditures exceed the calculated cumulative budget neutrality expenditure cap by the percentage identified below for any of the demonstration years, the state must submit a corrective action plan to CMS for approval. The state will subsequently implement the approved corrective action plan.

Year	Cumulative target definition	Percentage
DY 5	Cumulative budget neutrality limit for DY 5 plus:	2.0 percent
DY 6	Cumulative budget neutrality limit for DY 5 and DY 6 plus:	1.5 percent
DY 7	Cumulative budget neutrality limit for DY 5 through DY 7 plus:	1.0 percent
DY 8	Cumulative budget neutrality limit for DY 5 through DY 8 plus:	0.5 percent
DY 9	Cumulative budget neutrality limit for DY 5 through DY 9 plus:	0 percent

73. Impermissible DSH, Taxes or Donations. The CMS reserves the right to adjust the budget neutrality expenditure limit in order to be consistent with enforcement of impermissible provider payments, health care related taxes, new Federal statutes, or with policy interpretations implemented through letters, memoranda, or regulations. CMS reserves the right to make adjustments to the budget neutrality expenditure limit if CMS determines that any health care-related tax that was in effect during the base year, or provider-related donation that occurred during the base year, is in violation of the

provider donation and health care related tax provisions of Section 1903(w) of the Act. Adjustments to the budget neutrality agreement will reflect the phase-out of impermissible provider payments by law or regulation, where applicable.

XII. EVALUATION OF THE DEMONSTRATION

74. **Submission of Draft Evaluation Design Update.** The state must submit to CMS for approval, within 120 days of the approval date of the Healthy Michigan Plan amendment a draft evaluation design update that builds and improves upon the evaluation design that was approved by CMS in 2010. At a minimum, the draft design must include 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 must cover all elements in paragraph 76. The updated design should be described in sufficient detail to determine that it is scientifically rigorous. The data strategy must be thoroughly documented.

    The design should describe how the evaluation and reporting will develop and be maintained to assure its scientific rigor and completion. In summary, the demonstration evaluation will meet all standards of leading academic institutions and academic journal peer review, as appropriate for each aspect of the evaluation, including standards for the evaluation design, conduct, interpretation, and reporting of findings. Among the characteristics of rigor that will be met are the use of best available data; controls for and reporting of the limitations of data and their effects on results; and the generalizability of results.

    The updated design must describe the state's process to contract with an independent evaluator, ensuring no conflict of interest.

    The design, including the budget and adequacy of approach, to assure the evaluation meets the requirements of paragraph 76, is subject to CMS approval. The budget and approach must be adequate to support the scale and rigor reflected in the paragraph above. The rigor also described above also applies as appropriate throughout Section XII.

75. **Cooperation with Federal Evaluators.** Should HHS undertake an evaluation of any component of the demonstration, the state shall cooperate fully with CMS or the evaluator selected by HHS in addition, the state shall submit the required data to HHS or its contractor.

76. **Evaluation Design.**

    a. Domains of Focus – The state must propose as least one research question that it will investigate within each of the domains listed below.

        The state proposes several projects will be conducted to evaluate the success of the Healthy Michigan Plan. These include the following:

i. 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.

ii. Reduction in the Number of Uninsured - The Healthy Michigan Plan 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 insured/uninsured rates in general and more specifically by select population groups (e.g., income levels, geographic areas, and race/ethnicity).

iii. Impact on Healthy Behaviors and Health Outcomes - The Healthy Michigan Plan will evaluate what impact incentives for healthy behavior and the completion of an annual health risk assessment have on increasing healthy behaviors and improving 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.

iv. Participant Beneficiary Views on the Impact of the Healthy Michigan Plan - The Healthy Michigan Plan 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.

v. Impact of Contribution Requirements – The Healthy Michigan Plan will plan 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. The impact of increased communication to beneficiaries about their required contributions (in the form of point of service notices of potential copayment liability and quarterly and annual statements) must be evaluated.

vi. Impact of MI Health Accounts – The Healthy Michigan Plan 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.

vii. Cost-effectiveness – While not the only purpose of the evaluation, one of the core goals of the evaluation is to determine 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. By [insert date], the state must submit to CMS a revised evaluation plan that includes changes made to the demonstration beginning in April 2018.

1. The evaluation will explore and explain through developed evidence the effectiveness of the demonstration for each hypothesis, including total costs in accordance with the evaluation design as approved by CMS.

2. Included in the evaluation will be examinations using a robust set of measures of provider access and clinical quality measures under the Marketplace Option compared to a comparable population enrolled in Medicaid Health Plans.

3. The state will compare total costs under the Marketplace Option to costs that were incurred under the Healthy Michigan Plan. This will include an evaluation of provider rates, healthcare utilization and associated costs, and administrative expenses over time.

4. The state will compare changes in access and quality to associated changes in costs within the Marketplace Option. To the extent possible, component contributions to changes in access and quality and their associated levels of investment in Michigan will be determined and compared to improvement efforts undertaken in other delivery systems.

b. Measures - The draft evaluation design must discuss the outcome measures that shall be used in evaluating the impact of the demonstration during the period of approval, including:

i. A description of each outcome measure selected, including clearly defined numerators and denominators, and National Quality Forum (NQF) numbers (as applicable);

ii. The measure steward;

iii. The baseline value for each measure;

iv. The sampling methodology for assessing these outcomes; and

c. Sources of Measures - CMS recommends that the state use measures from nationally-recognized sources and those from national measures sets (including CMS's Core Set Core Set of Health Care Quality Measures for Medicaid-Eligible Adults).

d. The evaluation design must also discuss the data sources used, including the use of Medicaid encounter data, enrollment data, electronic health record (EHR) data, and consumer and provider surveys. The draft evaluation design must include a detailed analysis plan that describes how the effects of the demonstration shall be isolated from other initiatives occurring in the state. The evaluation designs proposed for each question may include analysis at the beneficiary, provider, and aggregate program level, as appropriate, and include population stratifications to the extent feasible, for further depth and to glean potential non-equivalent effects on different sub-groups.

77. **Final Evaluation Design and Implementation.** CMS shall provide comments on the draft design update and the draft evaluation strategy within 60 days of receipt, and the state shall submit a final design within 60 days of receipt of CMS' comments. The state must implement the evaluation design and submit its progress in each of the Quarterly Progress Reports and Annual Reports.

78. **Interim Evaluation Report.** The state must submit an interim evaluation report to CMS as part of any future request to extend the demonstration, or by June 30, 2018 if no extension request has been submitted by that date. The interim evaluation report will discuss evaluation progress and present findings to date.

79. **Healthy Michigan Plan Final Evaluation Report.** The state must submit to CMS a draft of the Evaluation Final Report by May 1, 2019. The state must submit the Final Evaluation Report within 60 days after receipt of CMS' comments. The final report must include the following:

a. An executive summary;

b. A description of the demonstration, including programmatic goals, interventions implemented, and resulting impact of these interventions;

c. A summary of the evaluation design employed, including hypotheses, study design, measures, data sources, and analyses;

d. A description of the population included in the evaluation (by age, gender, race/ethnicity, etc.);

e. Final evaluation findings, including a discussion of the findings (interpretation and policy context); and

f. Successes, challenges, and lessons learned.

80. Beneficiary Survey. The state shall amend the Healthy Michigan Voices Survey, to be conducted at least once survey per year, to include individuals enrolled in the demonstration, individuals who have been dis-enrolled from the demonstration, and of individuals who are eligible but unenrolled. The survey size must produce statistically significant results, and the design will be described in the evaluation design. The purpose of the survey shall be to determine whether potential applicants and beneficiaries understand the program policies regarding premiums and associated consequences, and whether the premiums affect individuals' decisions about whether to apply for the program.

XIII. MEASUREMENT OF QUALITY OF CARE AND ACCESS TO CARE IMPROVEMENT

81. External Quality Review (EQR). The state is required to meet all requirements for external quality review (EQR) found in 42 C.F.R. Part 438, subpart E. In addition to routine encounter data validation processes that take place at the MCO/PIHP and state level, the state must maintain its contract with its external quality review organization (EQRO) to require the independent validation of encounter data for all MCOs and PIHPs at a minimum of once every three years.

a. The state should generally have available its final EQR technical report to CMS and the public, in a format compliant with Section 508 of the Rehabilitation Act (29 U.S.C. § 794d), by April 30th of each year, for data collected within the prior 15 months. This submission timeframe will align with the collection and annual reporting on managed care data by the Secretary of Health and Human Services each September 30th, which is a requirement under the Affordable Care Act [Sec. 2701 (d)(2)].

b. Consumer Health Plan Report Cards. On an annual basis, the state must create and make readily available to beneficiaries, providers, and other interested stakeholders, a health plan report card, in a format compliant with Section 508 of the Rehabilitation Act (29 U.S.C. § 794d), that is based on performance data on each health plan included in the annual EQR technical report. Each health plan report card must be posted on the state's website and present an easily understandable summary of quality, access, and timeliness regarding the performance of each participating health plan. The report cards must also address the performance of subcontracted dental plans.

82. **Measurement Activities.** The state must ensure that each participating health plan is accountable for metrics on quality and access, including measures to track progress in identified quality improvement focus areas, measures to track quality broadly, and measures to track access. The state must set performance targets that equal or exceed the 75th percentile national Medicaid performance level.

83. **Data Collection.** The state must collect data and information on dental care utilization rates, the CMS Medicaid and CHIP adult and child core measures, and must align with other existing federal measure sets where possible to ensure ongoing monitoring of individual well-being and plan performance. The state will use this information in ongoing monitoring and quality improvement efforts, in addition to quality reporting efforts.

XIV. SCHEDULE OF STATE DELIVERABLES DURING THE DEMONSTRATION

The state is held to all reporting requirements outlined in the STCs; this schedule of deliverables should serve only as a tool for informational purposes only.

Per award letter - Within 30 days of the date of award	Confirmation Letter to CMS Accepting Demonstration STCs
Per paragraph 54	Transition Plan
Per paragraph 74	Submit Draft Evaluation Design
Per paragraph 8	Submit Demonstration Extension Application
Per paragraph 78	Submit Interim Evaluation Report
Per paragraph - Within 6 months of amendment implementation	Post-award Forum Transparency deliverable –
Per paragraph 34	Healthy Behaviors Protocol
Per paragraph 31	MI Health Account Protocol
Monthly	**Deliverable**
Per paragraph 56	Monthly Enrollment Reports
Quarterly	**Deliverable**
Per paragraph 60	Quarterly Progress Reports
Per paragraph 60(e)	Quarterly Enrollment Reports
Per paragraph 63	Quarterly Financial Reports
Annual	**Deliverable**
Per paragraph 59	Annual Forum Transparency deliverable
Per paragraph 61	Draft Annual Report
Renewal/Close Out	**Deliverable**
Per paragraph 62	Final Report
Per paragraph 79	Draft Final Evaluation
Per paragraph 79	Final Evaluation

ATTACHMENT A
Quarterly Progress Report Content and Format

Pursuant to paragraph 52 (Quarterly Progress Report) of these STCs, the state is required to submit Quarterly Progress Reports to CMS. The purpose of the Quarterly Progress Report is to inform CMS of significant demonstration activity from the time of approval through completion of the demonstration. The reports are due to CMS 60 days after the end of each quarter.

The following report guidelines are intended as a framework and can be modified when agreed upon by CMS and the state. A complete Quarterly Progress Report must include an updated budget neutrality monitoring workbook. An electronic copy of the report narrative, as well as the Microsoft Excel workbook must be provided.

NARRATIVE REPORT FORMAT:

Title Line One – Michigan Adult Coverage Demonstration
Title Line Two – Section 1115 Quarterly Report
Demonstration/Quarter Reporting Period:
[Example: Demonstration Year: 7 (1/1/2015 – 12/31/2016)
Federal Fiscal Quarter:
Footer: Date on the approval letter through December 31, 2018

Introduction

Present information describing the goal of the demonstration, what it does, and the status of key dates of approval/operation.

Enrollment and Benefits Information

Discuss the following:

Trends and any issues related to eligibility, enrollment, disenrollment, access, and delivery network.

Any changes or anticipated changes in populations served and benefits. Progress on implementing any demonstration amendments related to eligibility or benefits.

Information about the beneficiary rewards program, including the number of people participating, credits earned, and credits redeemed.

Please complete the following table that outlines all enrollment activity under the demonstration. The state should indicate "N/A" where appropriate. If there was no activity under a particular enrollment category, the state should indicate that by "0".

ATTACHMENT A
Quarterly Progress Report Content and Format

Enrollment Counts for Quarter and Year to Date
Note: Enrollment counts should be unique enrollee counts, not beneficiary months

Demonstration Populations	Total Number of Demonstration beneficiaries Quarter Ending – MM/YY	Current Enrollees (year to date)	Disenrolled in Current Quarter
ABW Childless Adults			
Healthy MI Adults			

IV. Outreach/Innovative Activities to Assure Access
Summarize marketing, outreach, or advocacy activities to potential eligibles and/or promising practices for the current quarter to assure access for demonstration beneficiaries or potential eligibles.

V. Collection and Verification of Encounter Data and Enrollment Data
Summarize any issues, activities, or findings related to the collection and verification of encounter data and enrollment data.

VI. Operational/Policy/Systems/Fiscal Developments/Issues
A status update that identifies all other significant program developments/issues/problems that have occurred in the current quarter or are anticipated to occur in the near future that affect health care delivery, including but not limited to program development, quality of care, approval and contracting with new plans, health plan contract compliance and financial performance relevant to the demonstration, fiscal issues, systems issues, and pertinent legislative or litigation activity.

IX. Financial/Budget Neutrality Development/Issues
Identify all significant developments/issues/problems with financial accounting, budget neutrality, and CMS 64 and budget neutrality reporting for the current quarter. Identify the state's actions to address these issues.

X. Beneficiary Month Reporting
Enter the beneficiary months for each of the MEGs for the quarter.

A. For Use in Budget Neutrality Calculations

Eligibility Group	Month 1	Month 2	Month 3	Total for Quarter Ending XX/XX
Healthy Michigan Adults				

XI. Consumer Issues

A summary of the types of complaints or problems consumers identified about the program or grievances in the current quarter. Include any trends discovered, the resolution of complaints or grievances, and any actions taken or to be taken to prevent other occurrences.

XII. Quality Assurance/Monitoring Activity

Identify any quality assurance/monitoring activity or any other quality of care findings and issues in current quarter.

XIII. Managed Care Reporting Requirements

Address network adequacy reporting from plans including GeoAccess mapping, customer service reporting including average speed of answer at the plans and call abandonment rates; summary of MCO appeals for the quarter including overturn rate and any trends identified; enrollee complaints and grievance reports to determine any trends; and summary analysis of MCO critical incident report which includes, but is not limited to, incidents of abuse, neglect and exploitation. The state must include additional reporting requirements within the Annual Report as outlined in paragraph 53.

XIV. Lessons Learned

Discuss problems encountered, method of identification, and solution implemented. As Section 1115 demonstrations are "learning laboratories" whereby federal and state statutes, regulations, policy, court decisions, and operations are constantly changing and evolving, this Section highlights state actions taken to resolve anticipated and unanticipated challenges encountered in administering the Medicaid demonstration. This Section is not intended to be punitive, but instead highlights the skill and dedication of state personnel to rapidly adapt to new challenges. This Section also serves to inform policy makers and to share these lessons learned with other states seeking to pursue similar programmatic waivers.

XV. Demonstration Evaluation

Discuss progress of evaluation plan and planning, evaluation activities, and interim findings.

XVI. Enclosures/Attachments

Identify by Title the budget neutrality monitoring tables and any other attachments along with a brief description of what information the document contains.

XVII. State Contact(s)

Identify the individual(s) by name, Title, phone, fax, and address that CMS may contact should any questions arise.

XVIII. Date Submitted to CMS

ATTACHMENT B
Demonstration Evaluation Plan

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Section 1115 Demonstration Waiver Amendment Evaluation Proposal

Evaluation Proposal Prepared by
The Institute for Healthcare Policy & Innovation
University of Michigan

October 20, 2014

Centers for Medicare & Medicaid Services
Evaluation Design

ATTACHMENT B
Demonstration Evaluation Plan

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ATTACHMENT B
Demonstration Evaluation Plan

Healthy Michigan Plan Evaluation Proposal
Section 1115 Demonstration Waiver Amendment

Evaluation start date: June 1, 2014
Evaluation end date: September 30, 2019

I. Brief Overview and History of the Demonstration

On December 30, 2013, the Centers for Medicare & Medicaid Services approved amendments to Michigan's existing Section 1115 Demonstration, which had been known as the Adult Benefits Waiver. These amendments to the Section 1115 Demonstration authorize the creation of a new program known as the Healthy Michigan Plan, enacted by the Michigan legislature and signed by Governor Snyder in Public Act 107 of 2013. The Centers for Medicare & Medicaid Services' approval of this plan allows the State to make comprehensive health care coverage available to eligible adults ages 19-64 with incomes at or below 133% of the Federal Poverty Level, who are not currently eligible for Medicare or existing Medicaid programs. An anticipated 300,000-500,000 people are eligible for the Healthy Michigan Plan, including an estimated 60,000 adults previously covered by the Adult Benefits Waiver.

Since 2004, the Adult Benefits Waiver program has provided a limited ambulatory benefit package to previously uninsured, low-income non-pregnant adults ages 19-64, with incomes at or below 35% of the Federal Poverty Level. Adult Benefits Waiver services are provided to beneficiaries primarily through a managed health care delivery system utilizing a network of county-administered health plans and Community Mental Health Services Programs.

The new Healthy Michigan Plan is designed to provide comprehensive health insurance coverage for low-income residents and thereby improve their access to primary care and specialty care when appropriate. Proponents of this plan also anticipate that it will improve the health outcomes and healthy behaviors of newly covered adults and also reduce levels of uncompensated care in the state. Benefits will be provided through existing contracted health plans in the state and will meet the federal benchmark coverage standards, including the 10 essential health benefits. The Healthy Michigan Plan also introduces a number of reforms, including cost-sharing for individuals with incomes above the Federal Poverty Level, the creation of an individual's MI Health Account to record health care expenses and cost-sharing contributions, and opportunities for beneficiaries to reduce their cost-sharing by completing health risk assessments and engaging in healthy behaviors.

This new program became effective April 1, 2014. The transition of current Adult Benefits Waiver beneficiaries and identification and enrollment of newly eligible beneficiaries into the Healthy Michigan Plan is of great importance to the State.

Population groups affected by demonstration

Current Adult Benefits Waiver beneficiaries: Low-income, non-pregnant adults ages 19-64 with income below 35% of the Federal Poverty Level currently enrolled in the Adult Benefits Waiver

Program were transitioned into the Healthy Michigan Plan effective April 1, 2014. As approved by the Centers for Medicare & Medicaid Services, no eligibility redetermination was necessary at the time of transition, though enrollees will need to re-determine eligibility at a later time.

New Healthy Michigan Plan enrollees: Adults ages 19-64 with incomes at or below 133% of the Federal Poverty Level under the Modified Adjusted Gross Income methodology, who do not qualify for existing Medicare or Medicaid programs, are residents of the State of Michigan, and are not pregnant at the time of application will be eligible to receive comprehensive health care coverage through the Healthy Michigan Plan.

II. Objectives & Goals of the Demonstration

The central objective of this demonstration is to improve the health and well-being of Michigan residents by extending health care coverage to low-income individuals who are uninsured or underinsured, and to implement systemic innovations to improve quality and stabilize health care costs.

As approved by the Centers for Medicare & Medicaid Services in the December 30, 2013 Healthy Michigan Plan Section 1115 Demonstration Waiver, the policy goals of the Healthy Michigan Plan are to:

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

Under this demonstration model, the State aims to evaluate the implementation of market-driven principles into a public healthcare insurance program. This evaluation will examine the following six specific domains, as outlined in the Healthy Michigan Plan Section 1115 Demonstration Waiver:

1. "The extent to which the increased availability of health insurance reduces the costs of uncompensated care borne by hospitals;
2. The extent to which availability of affordable health insurance results in a reduction in the number of uninsured/underinsured individuals who reside in Michigan;
3. Whether the availability of affordable health insurance, which provides coverage for preventive and health and wellness activities, will increase healthy behaviors and improve health outcomes;
4. The extent to which beneficiaries feel that the Healthy Michigan Plan has a positive impact on personal health outcomes and financial well-being;
5. Whether requiring beneficiaries to make contributions toward the cost of their health care has no impact on the continuity of their coverage, and whether collecting an average co-pay from beneficiaries in lieu of copayments at the point of service, and increasing

communication to beneficiaries about their required contributions (through quarterly statements) affects beneficiaries' propensity to use services; and

6. Whether providing a MI Health Account into which beneficiaries' contributions are deposited, that provides quarterly statements that include explanation of benefits (EOB) information and details utilization and contributions, and allows for reductions in future contribution requirements, deters beneficiaries from receiving needed health services or encourages beneficiaries to be more cost-conscious."[4]

III. Demonstration Hypotheses

A. Domain I: Uncompensated Care Analysis

Hypothesis I.1: Uncompensated care in Michigan will decrease significantly.

- Hypothesis I.1A: Uncompensated care in Michigan will decrease significantly *relative to the existing trend in Michigan.*
- Hypothesis I.1B: Uncompensated care will decrease more by percentage *for Michigan hospitals with baseline levels of uncompensated care that are above the average for the state than for hospitals with levels that are below the average for the state.*
- Hypothesis I.1C: Uncompensated care will decrease more by percentage *for Michigan hospitals in areas with above average baseline rates of uninsurance in the state than for hospitals with below state average levels.*
- Hypothesis I.1D: Uncompensated care in Michigan will decrease significantly *relative to states that did not expand their Medicaid programs.*
- Hypothesis I.1E: Trends in uncompensated care in Michigan will not differ significantly *relative to other states that did expand their Medicaid programs.*

B. Domain II: Reduction in the Number of Uninsured

Hypothesis II.1: The uninsured population in Michigan will decrease significantly.

- Hypothesis II.1A: The uninsured population in Michigan will decrease significantly *relative to the existing trend within Michigan.*
- Hypothesis II.1B: The uninsured population in Michigan will decrease *more by percentage for subgroups with higher than average baseline rates of uninsurance in the state than for subgroups with lower than state average baseline rates.*
- Hypothesis II.1C: The uninsured population in Michigan will decrease significantly *relative to states that did not expand their Medicaid programs.*
- Hypothesis II.1D: The uninsured population in Michigan will decrease to a similar degree *relative to states that did expand their Medicaid programs.*

Hypothesis II.2: Medicaid coverage in Michigan will increase significantly.

- Hypothesis II.2A: The Medicaid population in Michigan will increase significantly *relative to the existing trend in Michigan.*

[4] CMS Waiver Approval, December 30, 2013.

- Hypothesis II.2B: The Medicaid population in Michigan will increase significantly *more by percentage for subgroups with rates of uninsurance higher than state average baseline than for subgroups with baseline rate lower than the state average.*
- Hypothesis II.2C: The Medicaid population in Michigan will increase significantly *relative to states that did not expand their Medicaid programs.*
- Hypothesis II.2D: The Medicaid population in Michigan will increase to a similar degree *relative to states that did expand their Medicaid programs.*

C. Domain III: Impact on Healthy Behaviors and Health Outcomes

1. Hypothesis III.1: Emergency Department Utilization
    a. Emergency department utilization among the Healthy Michigan beneficiaries will decrease from the Year 1 baseline;
    b. Healthy Michigan Plan beneficiaries who make regular primary care visits (at least once per year) will have lower adjusted rates of emergency department utilization compared to beneficiaries who do not have primary care visits; and
    c. Healthy Michigan Plan beneficiaries who agree to address at least one behavior change will have lower adjusted rates of emergency department utilization compared to beneficiaries who do not agree to address behavior change.
2. Hypothesis III.2: Healthy Behaviors
    a. Receipt of preventive health services among the Healthy Michigan Plan population will increase from the Year 1 baseline;
    b. Healthy Michigan Plan beneficiaries who make regular primary care visits (at least once per year) will have higher rates of general preventive services compared to beneficiaries who do not have primary care visits;
    c. Healthy Michigan Plan beneficiaries who complete an annual health risk assessment will have higher rates of preventive services compared to beneficiaries who do not complete a health risk assessment;
    d. Healthy Michigan Plan beneficiaries who agree to address at least one behavior change will demonstrate improvement in self-reported health status compared to beneficiaries who do not agree to address behavior change; and
    e. Healthy Michigan Plan beneficiaries who receive incentives for healthy behaviors will have higher rates of preventive services compared to beneficiaries who do not receive such incentives.
3. Hypothesis III.3: Hospital Admissions
    a. Adjusted hospital admission rates for Healthy Michigan Plan beneficiaries will decrease from the Year 1 baseline;
    b. Healthy Michigan Plan beneficiaries who make regular primary care visits (at least once per year) will have lower adjusted rates of hospital admissions compared to beneficiaries who do not have primary care visits; and
    c. Healthy Michigan Plan beneficiaries who agree to address at least one behavior change will have lower adjusted rates of hospital admission compared to beneficiaries who do not agree to address behavior change.

D. Domain IV: Participant Beneficiary Views of the Healthy Michigan Plan

1. Aim IV.1: Describe Healthy Michigan Plan enrollees' consumer behaviors and health

insurance literacy, including knowledge and understanding about the Healthy Michigan Plan, their health plan, benefit coverage, and cost-sharing aspects of their plan.

2. Aim IV.2: Describe Healthy Michigan Plan enrollees' self-reported changes in health status, health behaviors (including medication use), and facilitators and barriers to healthy behaviors (e.g. knowledge about health and health risks, engaged participation in care), and strategies that facilitate or challenge improvements in health behaviors.
3. Aim IV.3: Understand enrollee decisions about when, where and how to seek care, including decisions about emergency department utilization.
4. Aim IV.4: Describe primary care practitioners' experiences with Healthy Michigan Plan beneficiaries, practice approaches and innovation adopted or planned in response to the Healthy Michigan Plan, and future plans regarding care of Healthy Michigan Plan patients.

E. Domains V & VI: Impact of Contribution Requirements & MI Health Accounts

1. **Hypothesis V/VI.1:** Cost-sharing implemented through the MI Health Account framework will be associated with beneficiaries making more efficient use of health care services, as measured by total costs of care over time relative to their initial year of enrollment, and relative to trends in the Healthy Michigan Plan's population below 100% of the Federal Poverty Level that face similar service-specific cost-sharing requirements but not additional contributions towards the cost of their care.
2. **Hypothesis V/VI.2:** Cost-sharing implemented through the MI Health Account framework will be associated with beneficiaries making more effective use of health care services relative to their initial year of enrollment, as indicated by a change in the mix of services from low-value (e.g., non-urgent emergency department visits, low priority office visits) to higher-value categories (e.g., emergency-only emergency department visits, high priority office visits), and relative to trends in the Healthy Michigan Plan's population below 100% of the Federal Poverty Level that face similar service-specific cost-sharing requirements but not additional contributions towards the cost of their care. Several questions on the Healthy Michigan Voices Survey also address this hypothesis.
3. **Hypothesis V/VI.3:** Cost-sharing and contributions implemented through the MI Health Account framework will not be associated with beneficiaries dropping their coverage through the Healthy Michigan Plan.
4. **Hypothesis V/VI.4a:** Exemptions from cost-sharing for specified services for chronic illnesses and rewards implemented through the MI Health Account framework for completing a health risk assessment with a primary care provider and agreeing to behavior changes will be associated with beneficiaries increasing their healthy behaviors and their engagement with healthcare decision-making relative to their initial year of enrollment. Several questions on the Healthy Michigan Voices Survey also address this hypothesis.

   Hypothesis V/VI.4b: This increase in healthy behaviors and engagement will be associated with an improvement in enrollees' health status over time, as measured by changes in elements of their health risk assessments and changes in receipt of recommended preventive care (e.g., flu shots, cancer screening) and adherence to prescribed medications for chronic disease (e.g., asthma controller medications).

IV. Information about Evaluation Entity

The University of Michigan Institute for Healthcare Policy and Innovation is an interdisciplinary institute at a premier public research university. The mission of the Institute is to enhance the health and well-being of local, national, and global populations through innovative health services research that effectively informs public and private efforts to optimize the quality, safety, equity, and affordability of health care. The Institute includes more than 400 health services researchers from 14 schools and colleges across the university, as well as 4 nonprofit private-sector partners and the Veterans Health Administration. Institute faculty members participating in the proposed Healthy Michigan Plan evaluation represent the Medical School, School of Public Health, Institute for Social Research, Ross School of Business, Ford School of Public Policy, and School of Social Work.

V. Timeline

Fiscal Year	Deliverable/Milestone	Domain
2015	Initial Baseline Estimate of the Rate of Uninsurance	II
2016	Interim Report: Primary Care Physician Survey (select measures)	IV
2016	Interim Report: Healthy Michigan Voices Survey (select measures)	IV
2017	Interim Report: Healthy Behaviors and Health Outcomes (select measures)	III
2017	Interim Report: Impact of Cost-Sharing/MI Health Accounts (select measures)	V, VI
2018	Interim Report: Uncompensated Care Analysis	I
2018	Interim Report: Rate of Uninsurance	II
2019	Final Evaluation Report	All

ATTACHMENT B
Demonstration Evaluation Plan

Special Terms and Conditions Requirements

The federal approval of the Healthy Michigan Plan Demonstration is conditioned upon compliance with a set of Special Terms and Conditions. Specific to program evaluation, the Special Terms and Conditions outlined six Domains of Focus that the State must investigate, around which Institute for Healthcare Policy and Innovation faculty leads have developed multiple testable hypotheses (listed above). The evaluation design includes a discussion of these goals, objectives, and specific testable hypotheses, including those that focus specifically on target populations for the demonstration, and more generally on beneficiaries, providers, plans, market areas, and public expenditures.

While some members of the University of Michigan evaluation team are practicing clinicians at the University of Michigan, this team will function independently from the system-level clinical operations of the University of Michigan Health System and those who interact with Department officials around Medicaid reimbursement and clinical policies. The University of Michigan research team will continue to maintain this separation throughout the demonstration evaluation to avoid potential conflicts of interest.

A. Scientific Rigor & Academic Standards

The Centers for Medicare & Medicaid Services approval of the Section 1115 waiver for the Healthy Michigan Plan requires that the evaluation be designed and conducted by researchers who will meet the scientific rigor and research standards of leading academic institutions and academic journal peer review. As detailed throughout this proposed evaluation plan, the faculty members and staff of the University of Michigan Institute for Healthcare Policy and Innovation are national leaders in the fields of health services research, health economics, and population health with substantial experience conducting rigorous evaluations of access to care, quality of care, costs of care, and health outcomes.

As further required by the Centers for Medicare & Medicaid Services, the design of the proposed evaluation includes a discussion of the goals, objectives and specific testable hypotheses, including those that focus specifically on target populations for the demonstration, and more generally on beneficiaries, providers, plans, market areas and public expenditures. The analysis plan addresses all six domains specified in paragraph 69 of the waiver approval with a scientifically rigorous data strategy and evaluation plan. The University of Michigan evaluation team will make careful use of the best available data in each of the six required domains; control for and report limitations of these data and their effects on results; and characterize the generalizability of results.

B. Measures Summary

Outcome measures are described in detail in each specific Domain design and reflect key hypotheses. Importantly, because the design of the Healthy Michigan Plan goes beyond the organization of health care to address the personal health behaviors and choices of enrollees, the selected measures are based on established indicators for both clinical care and personal health-

related behaviors. The evaluation team will utilize its significant expertise to refine existing indicators to better match the goals of the Healthy Michigan Plan.

Because most Healthy Michigan Plan enrollees will not have prior Medicaid coverage, there are limitations around baseline values for the selected measures. The University of Michigan evaluation team will take a dual approach to this limitation: 1) Year 1 of the Healthy Michigan Plan will serve as a baseline from which to measure changes over the course of the demonstration project; and 2) comparison data from comparable populations will be gleaned from national data sources when feasible.

C. Data Handling and Management

The evaluation will use a wide variety of data sources (summarized in Appendix B and detailed in specific Domain designs, as noted), including Medicaid enrollment, utilization, encounter and cost data from the Michigan Department of Community Health Data Warehouse, enrollee survey data (the newly-designed Healthy Michigan Voices Survey), hospital cost reports and filings, and provider survey data.

D. Recognition of other initiatives occurring in the state

A fundamental challenge associated with this evaluation is the fact that the Healthy Michigan Plan is being implemented in the context of broader changes to health insurance markets in Michigan and in other states. In particular, the health insurance exchange, the associated premium tax credits, and the individual mandate all affect consumer and firm behavior. An increase in private insurance coverage as people enroll in plans through the newly established health insurance exchange should reduce the amount of uncompensated care provided to uninsured patients. At the same time, the longer-term trend toward private plans with high deductibles will mean more privately insured patients may not be able to pay large out-of- pocket obligations when they are hospitalized, thereby increasing uncompensated care provided to privately insured patients.

In order to address these challenges, our analysis in Domains I and II will compare Michigan to a "control group" of states that are and are not expanding their Medicaid programs, in order to help isolate the impact of the Healthy Michigan Plan on policy problems like uncompensated care, rates of uninsurance, access to appropriate medical services, and trends in health care utilization and health outcomes.

ATTACHMENT B
Demonstration Evaluation Plan

Domain I: Reduction in Uncompensated Care

Uncompensated Care Analysis *– This evaluation project will examine the impact of reducing the number of uninsured individuals on uncompensated care costs to hospitals in Michigan through the expansion of subsidized insurance.*

I. Hypotheses

Hypothesis I.1: Uncompensated care in Michigan will decrease significantly.

- Hypothesis I.1A: Uncompensated care in Michigan will decrease significantly *relative to the existing trend in Michigan.*
- Hypothesis I.1B: Uncompensated care will decrease more by percentage *for Michigan hospitals with baseline levels of uncompensated care that are above the average for the state than for hospitals with levels that are below the average for the state.*
- Hypothesis I.1C: Uncompensated care will decrease more by percentage *for Michigan hospitals in areas with above average baseline rates of uninsurance in the state than for hospitals with below state average levels.*
- Hypothesis I.1D: Uncompensated care in Michigan will decrease significantly *relative to states that did not expand their Medicaid programs.*
- Hypothesis I.1E: Trends in uncompensated care in Michigan will not differ significantly *relative to other states that did expand their Medicaid programs.*

II. Management/Coordination of Evaluation

A. Evaluation Team

The work on Domains I and II of the evaluation will be conducted by a team of researchers led by two University of Michigan faculty members, Thomas Buchmueller Ph.D. and Helen Levy Ph.D. Buchmueller's primary appointment is in the Ross School of Business, where he holds the Waldo O. Hildebrand Endowed Chair in Risk Management and Insurance and currently serves as the Chair of the Business Economics Area. He has a secondary appointment in the Department of Health Management and Policy in the School of Public Health. Levy is a tenured Research Associate Professor, with appointments in the Institute for Social Research, the Ford School of Public Policy and the Department of Health Management and Policy. She is a Co-Investigator on the Health and Retirement Survey, a longitudinal survey supported by the National Institute on Aging. Buchmueller and Levy are experts on the economics of health insurance and health reform. In 2010-2011, Levy served as the Senior Health Economist at the White House Council of Economic Advisers. Buchmueller succeeded her in this position in 2011-2012.

Additional faculty and staff working on this domain are described in Appendix A.

III. Timeline

A. Overview

Initially, our main activities will be related to background research to improve our understanding of the data and to sharpen our hypotheses, the preparation of analytic data files, and an analysis of baseline measures using those files. Once we have sufficient data from the post-Healthy Michigan Plan period, our main focus will be on evaluating trends in uncompensated care and analyses aimed at disentangling the effect of the Healthy Michigan Plan from other factors affecting hospitals and their provision of uncompensated care.

B. Specific Activities: 6/14 to 10/15

The main data sources for this domain are hospital cost reports and Internal Revenue Service filings (see below). Because these data sources were not created for the purposes of research or evaluation, creating data files that can be used for the analysis will require substantial effort. In order to ensure that we are on track to deliver a rigorous evaluation in state fiscal year 2018, it will be important to develop these files well before then. (If it turns out that the cost report and Internal Revenue Service data are not suitable for our purposes, this will give us time to develop other strategies.)

An important part of this process will involve comparing baseline results from the different sources with the goal of representing the distribution of uncompensated care in the state in a clear and consistent fashion. We will also analyze the baseline data from Michigan and other states to identify appropriate comparison groups for the cross-state components of the analysis. This process will involve merging the hospital level data with state and county level data on measures such as the baseline rate of insurance coverage and population demographics.

Another important initial activity will be to review the relevant academic literature on hospital uncompensated care. This review will build on prior reviews conducted by Drs. Lee and Singh who have conducted substantial research on hospital uncompensated care and community benefit.

C. Specific Activities: 10/15 to 10/19

We will conduct most of the analysis in state fiscal year 2018. By December 2017, we expect to have more than a full year of post-implementation data for all hospitals in Michigan and up to two years of post-implementation data for some.

IV. Performance Measures

A. Specific measures and rationale

A number of indicators of uncompensated care will be used to test the research hypotheses outlined above. Our primary indicators will include measures of uncompensated care from hospitals' Medicare and Medicaid cost reports. In particular, we will focus on hospitals' expenditures on charity care and bad debt, measured in terms of cost rather than full charges. Data from Medicare cost reports on these indicators are available for all Medicare-certified hospitals in the U.S. In the Medicare cost report, we will focus on Schedule S-10, which

provides detailed information on hospital uncompensated care and indigent care. Specifically, we will measure charity care costs using the information in line 23 on Schedule S-10. This number represents the cost of care provided to charity and self-pay patients. To distinguish between charity care and self-pay patients, we will further refine our analysis for Michigan hospitals by using data from the Medicaid cost report. In particular, we will estimate true charity care costs by using information on indigent volume and charges reported by Michigan hospitals on their Medicaid cost report. Data from Medicaid cost reports on these indicators are available for all Michigan hospitals. In addition to charity care, we will examine hospitals' bad debt expense. Specifically, we will measure charity care costs using the information in line 29 on Schedule S-10. This number represents a hospital's bad debt expenditures – measured at cost – after accounting for any Medicare bad debt reimbursement.

We will supplement data from the Medicare and Medicaid cost reports with information on community benefits provided from the hospitals' Internal Revenue Service filings. In particular, we will focus on the amount of charity care and bad debt reported by hospitals on their Internal Revenue Service Form 990 Schedule H. In this form, hospitals are required to report their charity care costs net of any direct offsetting revenue. Hospitals are also required to report their bad debt expenses, at cost. We will compare these to the levels of uncompensated care reported in hospitals' Medicare cost reports to validate our primary estimates. Data from the Form 990 is only available for a subset of hospitals, however. More specifically, only federally tax-exempt hospitals that are either free-standing or system-affiliated but report their community benefit at the individual hospital level are required to file Form 990 with the Internal Revenue Service. These data sources are described in more detail below.

B. Methodology and specifications

i. Eligible/target population

The analysis will focus on uncompensated care provided by acute care hospitals. According to Medicare.gov, there are 130 non-Federal hospitals in Michigan.[5] Of these, 85 are federally tax-exempt hospitals that file Form 990 with the Internal Revenue Service at the individual hospital level.[6] As discussed below, hospitals in neighboring states and other states not expanding their Medicaid programs will be used as comparison groups.

ii. Time period of study

The time period of the analysis will vary according to the data used. Data from Schedule H of Form 990 are not available before 2009. Additionally, the Medicare cost report underwent substantial change in data elements reported in 2010. Therefore, for any analyses using these data for the pre-Healthy Michigan Plan period will be 2009/2010 to 2013.

C. Measure steward

[5] https://data.medicare.gov/Hospital-Compare/Michigan-hospitals-April-2011/xmzb-hgc8
[6] Although most hospitals in Michigan are tax-exempt, not all file a Form 990 at the facility level.

As described below, our main data sources are Centers for Medicare & Medicaid Services cost reports, Michigan Medicaid cost reports, and Internal Revenue Service filings.

D. Baseline values for measures

The most recent Medicare cost report data we have is for 2009. Our calculations using those data indicate that the mean level of uncompensated care provided by Michigan hospitals was $8.6 million. This is slightly lower than the mean of $10.3 million for hospitals nationwide. Median amounts for Michigan and the U.S. are more similar: $4.4 million and $4.1 million, respectively. According to the American Hospital Association, in aggregate the cost of uncompensated care provided by community hospitals nationwide was nearly $46 billion in 2012, or 6 percent of total expenses.[7]

The most recent Form 990 data we have is also from 2009. That year non-profit hospitals nationwide reported an average of $3.4 million in charity care costs and an average of $4.3 million in bad debt expense. Non-profit hospitals in Michigan reported an average of $1.3 million in charity care costs and an average of $3.8 million in bad debt expenses. According to the Michigan Hospital Association, in 2011 Michigan hospitals provided a total of more than $882 million in bad debt and charity care.[8]

E. Data Sources

There are several sources of data on hospital uncompensated care, each with particular strengths and weaknesses with respect to this evaluation.

Our primary data source will be Medicare cost reports, which Medicare-certified hospitals are required to submit annually to a Medicare Administrative Contractor. The cost report contains provider information such as facility characteristics, utilization data, cost and charges by cost center (in total and for Medicare), Medicare settlement data, and financial data. As part of the financial data, hospitals are required to provide detailed data on uncompensated care and indigent care provided. These include charity care and bad debt (both in terms of full charges and cost) as well as the unreimbursed cost for care provided to patients covered under Medicaid, the State Children's Health Insurance Program, and state and local indigent care programs. Medicare cost reports (Form CMS-2552-10) for hospitals in Michigan and other states will be obtained from the Centers for Medicare & Medicaid Services website.

We will also use Medicaid cost reports as well as supplementary forms compiled by the Michigan Department of Community Health. These reports have the advantage of providing

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[7] American Hospital Association. 2014. Uncompensated Hospital Care Cost Fact Sheet, http://www.aha.org/research/policy/finfactsheets.shtml

[8] Michigan Health & Hospital Association. 2013. Michigan Community Hospitals, A Healthy Dose of the Facts. http://www.hnjh.org/MHAfactsheet.pdf

more detail than the Centers for Medicare & Medicaid Services reports, but are only available for Michigan hospitals.

A third data source will be the Schedule H of Form 990. Since 2009, federally tax-exempt hospitals have been required to complete the revised Form 990 Schedule H, which requires hospitals to annually report their expenditures for activities and services that the Internal Revenue Service has classified as community benefits. These include charity care (i.e., subsidized care for persons who meet the criteria for charity care established by a hospital), unreimbursed costs for means-tested government programs (such as Medicaid), subsidized health services (i.e., clinical services provided at a financial loss), community health improvement services and community-benefit operations (i.e., activities carried out or supported for the express purpose of improving community health), research, health professions education, and financial and in-kind contributions to community groups. In addition to community benefits, Schedule H asks hospitals to report on their bad debt expenditures.

Hospitals' Internal Revenue Service filings will be obtained from GuideStar, a company that obtains, digitizes, and sells data that organizations report on Form 990 and related Schedules. Data will be obtained for all hospitals that file Form 990 with the Internal Revenue Service at the individual hospital-level. (For 2009 to 2011, Form 990 Schedule H is available for 85 federally tax-exempt hospitals in Michigan.) Members of our research team have previous experience working with these data.[9]

V. Plan for Analysis

A. Evaluation of performance

Our evaluation of the impact of the Healthy Michigan Plan on uncompensated care relies on three types of comparisons: (1) across time; (2) within state; (3) across states.

Comparisons over time

Our initial comparison, looking at changes in Michigan over time, analyzes whether by increasing insurance coverage the Healthy Michigan Plan will reduce the amount of uncompensated care provided by hospitals in Michigan. In technical terms, we will estimate interrupted time series regression models to test for a break in the trend in aggregate uncompensated care amounts at the time the demonstration was implemented.

Comparisons within the state

We expect that the baseline level of uncompensated care to be distributed unevenly across hospitals in Michigan. Some hospitals located in areas with high rates of uninsurance are likely to have high levels of uncompensated care, while other hospitals in areas with lower rates of

[9] Young, G.J., Chou, C, Alexander, J, Lee, S.D. and Raver, E. 2013. "Provision of Community Benefits by Tax-Exempt U.S. Hospitals, *New England Journal of Medicine*, 368(16): 1519-1527.

uninsurance are likely to provide less uncompensated care. To account for these differences we will stratify the analysis by hospital characteristics, including baseline measures of the provision of uncompensated care, size, for-profit status, etc. In doing so, we will test the hypothesis that hospitals that had previously faced a large burden of uncompensated care experienced larger reductions in this burden compared with hospitals that provided less uncompensated care at baseline.

Comparisons across states

We will also compare trends in uncompensated care in Michigan to trends in other states. Cross-state comparisons are useful for two reasons. First, comparisons with trends in neighboring expansion states (Ohio and Illinois) put the effects of the Healthy Michigan Plan in meaningful context. This comparison will provide a sense of whether Michigan's approach to the Medicaid expansion is living up to its potential, gauged relative to what other expansion states are achieving. Second, comparing Michigan with selected states that have not chosen to expand their Medicaid programs allows us to isolate the effect of the Healthy Michigan Plan on uncompensated care outcomes.

In conducting the cross-state analysis, we will also be able to leverage the within-state differences just described. Essentially, we will compare hospitals in Michigan to hospitals in other states that prior to the implementation of the Healthy Michigan Plan provided similar amounts of uncompensated care. This component of the evaluation will use multivariate statistical models that are designed to minimize the impact of other potentially confounding differences between hospitals in Michigan and hospitals in comparison states.

Increased insurance coverage is the primary mechanism by which the Healthy Michigan Plan and other aspects of the Affordable Care Act are expected to reduce uncompensated care. Some cross-state comparisons will directly examine the link between changes in insurance coverage and changes in uncompensated care. As part of the analysis of insurance coverage (Domain II, described below) we will estimate annual rates of uninsurance by sub-state geographic regions (in most cases, counties) for a period spanning several years before the implementation of the Affordable Care Act and the first few years after. We will use these estimates as an independent variable in statistical models that estimate the relationship between changes in market-level rates of insurance coverage and changes in hospital uncompensated care.

B. Outcomes (expected)

We expect total uncompensated care in Michigan to decline as a result of the Healthy Michigan Plan as many currently uninsured individuals gain coverage through Medicaid. Additional currently uninsured individuals will gain coverage through health insurance exchanges. We expect that these gains in coverage will drive declines in uncompensated care that more than offset any increase in uncompensated care that arises as some patients shift from generous employer-sponsored coverage to exchange plans with higher cost-sharing. We expect to observe larger declines in uncompensated care in areas with baseline levels of uncompensated care that are above the state average than in area with levels below the state average. We expect this

pattern to hold for both the within-Michigan analysis and the analysis that uses non-expanding states as a comparison group.

C. Limitations/challenges/opportunities

A fundamental challenge associated with this analysis is the fact that the Healthy Michigan Plan is being implemented in the context of broader changes to health insurance markets in Michigan and in other states. The largest changes will be the result of other provisions of the Affordable Care Act. An increase in private insurance coverage as people enroll in plans through the newly established health insurance exchange should reduce the amount of uncompensated care provided to uninsured patients. In addition, new limits on out-of-pocket payments mean that fewer privately insured patients have large hospital bills that they cannot pay. At the same time, the longer-term trend toward private plans with high deductibles will mean more privately insured patients with large out of pocket obligations.

In order to address this challenge, our cross-state analysis comparing Michigan to a "control group" of states that are and are not expanding their Medicaid programs will help to isolate the impact of the Healthy Michigan Plan on uncompensated care. Still, it will be difficult to precisely isolate the impact of the Healthy Michigan Plan from these other confounding factors.

D. Interpretations/conclusions

The main way that the Healthy Michigan Plan will reduce uncompensated care provided by hospitals is by reducing the number of uninsured patients. Therefore, the results from this analysis will be best interpreted in light of the results concerning the effect of the Healthy Michigan Plan on insurance coverage (Domain II).

ATTACHMENT B
Demonstration Evaluation Plan

Domain II: Reduction in the Number of Uninsured

Reduction in the Number of Uninsured *– The Healthy Michigan Program will test the hypothesis that, when affordable health insurance is made available and the application for insurance is simplified (through both an exchange and the state's existing eligibility process), the uninsured population will decrease significantly. This evaluation will examine the insured/uninsured rates in general and more specifically by select population groups (e.g., income levels, geographic areas, age, gender, and race/ethnicity).*

I. Hypotheses

Hypothesis II.1: The uninsured population in Michigan will decrease significantly.

- Hypothesis II.1A: The uninsured population in Michigan will decrease significantly *relative to the existing trend within Michigan.*
- Hypothesis II.1B: The uninsured population in Michigan will decrease *more by percentage for subgroups with higher than average baseline rates of uninsurance in the state than for subgroups with lower than state average baseline rates.*
- Hypothesis II.1C: The uninsured population in Michigan will decrease significantly *relative to states that did not expand their Medicaid programs.*
- Hypothesis II.1D: The uninsured population in Michigan will decrease to a similar degree *relative to states that did expand their Medicaid programs.*

Hypothesis II.2: Medicaid coverage in Michigan will increase significantly.

- Hypothesis II.2A: The Medicaid population in Michigan will increase significantly *relative to the existing trend in Michigan.*
- Hypothesis II.2B: The Medicaid population in Michigan will increase significantly *more by percentage for subgroups with rates of uninsurance higher than baseline state average than for subgroups with baseline rate lower than state average.*
- Hypothesis II.2C: The Medicaid population in Michigan will increase significantly *relative to states that did not expand their Medicaid programs.*
- Hypothesis II.2D: The Medicaid population in Michigan will increase to a similar degree *relative to states that did expand their Medicaid programs.*

II. Management/Coordination of Evaluation

A. Evaluation Team

The work on Domains I and II of the evaluation will be conducted by a team of researchers led by two University of Michigan faculty members, Thomas Buchmueller Ph.D. and Helen Levy Ph.D. Buchmueller's primary appointment is in the Ross School of Business, where he holds the Waldo O. Hildebrand Endowed Chair in Risk Management and Insurance and currently serves as the Chair of the Business Economics Area. He has a secondary appointment in the Department of Health Management and Policy in the School of Public Health. Levy is a tenured Research Associate Professor, with appointments in the Institute for Social Research, the Ford School of Public Policy and the Department of Health Management and Policy. She is a Co-Investigator

on the Health and Retirement Survey, a longitudinal survey supported by the National Institute on Aging. Buchmueller and Levy are experts on the economics of health insurance and health reform. In 2010-2011, Levy served as the Senior Health Economist at the White House Council of Economic Advisers. Buchmueller succeeded her in this position in 2011-2012.

Additional faculty and staff working on this domain are described in Appendix A.

III. Timeline

A. Overview

The evaluation timeline for this domain is determined by when the necessary data are released by the Census Bureau. Data for both of the main sources used in evaluating insurance coverage—the Current Population Survey (CPS) and the American Community Survey (ACS)—are released annually in September, although the reference periods for the two surveys differ (see below). The data released each fall describe insurance coverage in the prior calendar year. For example, in September 2014 the Census Bureau will release data from the March 2014 Current Population Survey and from the 2013 American Community Survey; both of these sources describe coverage in calendar year 2013. Therefore, we expect to produce the first quantitative estimates of the overall effect of the Healthy Michigan Plan on insurance coverage in fall 2015. In subsequent years, as additional data from both surveys are released, we will update the analysis to evaluate longer-term impacts of the Healthy Michigan Plan on insurance coverage.

B. Specific Activities: 10/15 to 10/19

The report on insurance coverage will be prepared during state fiscal year 2018. The most recent Census data available from that point will provide estimates of coverage in 2016. These data will become available in September 2017. In order to make timely use of these data, it will be important to undertake a number of preliminary tasks in the latter half of state fiscal year 2017.

The two Census Bureau surveys have slightly different questions about health insurance and it will be important to investigate and understand any differences in the estimated coverage rates that each produces. For example, does one survey consistently produce higher rates of insurance coverage than the other? Do the two surveys produce similar differences in insurance coverage across demographic groups?

We will also analyze baseline data in order to determine which states offer the most relevant comparison to Michigan's experience. To understand how the Healthy Michigan Plan affected coverage relative to what would have happened if the state had not expanded Medicaid at all, we will want to compare Michigan to states that did not expand their Medicaid programs. We will therefore need to establish which states are similar to Michigan before 2014, in terms of health insurance, population, and other characteristics such as unemployment rates, as well as monitoring ongoing implementation activities in other states. Our approach for this domain will be similar to the one we will use for Domain I.

IV. Performance Measures:

A. Specific measures and rationale

The outcomes analyzed will be various measures of insurance coverage based on questions in the Current Population Survey and the American Community Survey. The Current Population Survey asks a detailed battery of health insurance questions referring to the respondent's coverage in the prior calendar year; for example, the March 2015 Current Population Survey asks respondents to report coverage during calendar year 2014. These questions make it possible to construct measures of the fraction of the population with Medicaid and the fraction of the population with no coverage – our two main outcome measures. We also plan to look at changes in rates of coverage from other source, such as employer-sponsored coverage and individually-purchased private coverage, since health reform will likely affect those too. The Census Bureau is implementing new health insurance questions in March 2014[10]; we have communicated with Census Bureau staff to get more information about these new measures and will carefully evaluate their usefulness as data become available.

The changes to the Current Population Survey are one rationale for also using data from American Community Survey; another is that the American Community Survey sample is approximately 20 times larger than Current Population Survey (see tables 1 and 2 below) and allows reliable analysis of smaller geographic areas within Michigan.

B. Methodology and specifications

i. Eligible/target population

The population that will gain Medicaid eligibility as a result of the Healthy Michigan Plan consists of non-elderly adults with incomes less than or equal to 133 percent of the Federal Poverty Level. We expect coverage to increase for higher income adults because of other components of the Affordable Care Act, most importantly the availability of premium tax credits for insurance purchased through the new health insurance marketplace and the individual mandate. Therefore, it is important to analyze changes in coverage for non-elderly adults at all income levels. The implementation of the Healthy Michigan Plan is expected to increase Medicaid take-up among people who were eligible for coverage under pre-Affordable Care Act rules (the "welcome mat effect"). Since children make up a large percentage of this group, we will also analyze coverage changes for children.

ii. Time period of study

The Healthy Michigan Plan's implementation date is April 1, 2014. Data covering the years 2006 to 2013 (for the Current Population Survey) and 2010 to 2013 (for the American

[10] Pascale, Joanne, et al. "Preparing to Measure Health Coverage in Federal Surveys Post-Reform: Lessons from Massachusetts." INQUIRY: The Journal of Health Care Organization, Provision, and Financing 50.2 (2013): 106-123.

Community Survey) will be used to establish baseline levels and prior trends in Michigan and other states. The post-implementation period will be defined as 2014 to 2016.

C. Measure steward

The Census Bureau is the measure steward.

D. Baseline values for measures

Please see Tables 1 and 2, which present rates of Medicaid coverage and uninsurance in Michigan and in neighboring states using data from both surveys. We also calculate these rates for respondents in Michigan broken into groups based on race/ethnicity, income, and age. Note that the poverty categories in the Current Population Survey require us to use categories of income relative to poverty of <125%, 125-399%, 400%+ since the underlying continuous measure of income/poverty is not provided on the public use file. In the American Community Survey, in contrast, income/poverty is measured continuously and so our categories better match the Affordable Care Act eligibility categories.

E. Data Sources

The analysis will be based on data from two annual national surveys conducted by the Census Bureau: the Current Population Survey and the American Community Survey. Each survey has specific strengths related to this evaluation. The Current Population Survey is the most commonly cited data source for state-level estimates of insurance coverage. It provides a detailed breakdown by source of coverage. The American Community Survey provides less detail on source of coverage but with a much larger sample size than the Current Population Survey, it provides for precise estimates, even for subgroups defined by geography or demographic characteristics. In each case, our analysis will be based on public use files disseminated by Census.

Each data source is publicly available at no cost from the Census Bureau.

V. Plan for Analysis

A. Evaluation of performance

Our evaluation of the impact of the Healthy Michigan Plan on uninsurance relies on three types of comparisons: (1) across time; (2) within state; (3) across states.

Comparisons across time

Our initial comparison, looking at changes in Michigan over time, analyzes whether the Healthy Michigan Plan reduced the numbers of uninsured both in an absolute sense and relative to the pre-existing trend. In technical terms, we will estimate interrupted time series regression models to test for a break in coverage trends at the time the demonstration was implemented.

Comparisons within the state

As shown in Tables 1 and 2, baseline rates of uninsurance were much higher for some groups within Michigan than for others. We will examine whether the Healthy Michigan Plan effectively reached the groups most in need, reducing disparities in insurance coverage. We will investigate the impact of the Healthy Michigan Plan on disparities within the state across groups defined by income, age, race/ethnicity, sex and geographic location.

Comparisons across states

We will also compare trends in Michigan to trends in other states. Cross-state comparisons are useful for two reasons. First, comparisons with trends in neighboring expansion states (Ohio and Illinois) put the effects of the Healthy Michigan Plan in meaningful context. This comparison will provide a sense of whether Michigan's approach to the Medicaid expansion is living up to its potential, gauged relative to what other expansion states are achieving. Second, comparing Michigan with selected states that have not chosen to expand their Medicaid programs allows us to isolate the effect of the Healthy Michigan Plan on insurance outcomes. This component of the evaluation will use multivariate statistical models that are designed to minimize the impact of other potentially confounding differences between Michigan and comparison states, following current best practices in the program evaluation literature.[11,12]

B. Outcomes (expected)

Our primary outcome measures are uninsurance and health care coverage through the Healthy Michigan Plan. As described above, we hypothesize that uninsurance will decline and Healthy Michigan Plan coverage will increase. We measure uninsurance and Healthy Michigan Plan using the variables described above in both surveys. We are also interested in the interplay between Healthy Michigan Plan and other types of insurance. In particular, some new enrollees in the Healthy Michigan Plan or in Michigan's health insurance exchange will have been uninsured at baseline, while others will have had coverage from another source, such as employer-sponsored coverage or individually purchased private coverage. In order to paint a complete picture of how health reform in Michigan is affecting insurance coverage, we will also analyze coverage from other sources. Both surveys include information on employer-sponsored coverage; other private coverage; and other public coverage (for example, Medicare and Veterans Affairs). We will use these data to analyze how much of the decline in uninsurance can be attributed to increased numbers of Medicaid enrollees and how much to increases in coverage through the exchange or other private sources. We expect to observe larger declines in uninsurance for population subgroups with above average baseline levels of uninsurance, such as racial/ethnic minorities, young adults and low-income families. We will also explore potential

[11] Sommers, Benjamin D., Katherine Baicker, and Arnold M. Epstein. "Mortality and access to care among adults after state Medicaid expansions." New England Journal of Medicine 367.11 (2012): 1025-1034.

[12] Abadie, Alberto, Alexis Diamond, and Jens Hainmueller. "Synthetic control methods for comparative case studies: Estimating the effect of California's tobacco control program." Journal of the American Statistical Association 105.490 (2010).

differences by gender, though currently rates of uninsurance are similar for men and women. We expect this pattern to hold for both the within-Michigan analysis and the analysis that uses non-expanding states as a comparison group.

C. Limitations/challenges/opportunities

A fundamental challenge associated with this analysis is the fact that the Healthy Michigan Plan is being implemented in the context of broader changes to the health insurance market in Michigan associated with the Affordable Care Act. In particular, the health insurance exchange, the associated premium tax credits, and the individual mandate all affect consumer and firm behavior. In order to address this challenge, our cross-state analysis comparing Michigan to a "control group" of states that are not expanding their Medicaid programs will help to isolate the impact of the Healthy Michigan Plan and uninsurance.

D. Interpretations/conclusions

The outcomes associated with this domain of the Healthy Michigan Plan evaluation are fundamental to understanding the demonstration's impact. Without increases in Healthy Michigan Plan enrollment and commensurate reductions in uninsurance, the demonstration cannot achieve the goals of reducing uncompensated care, enhancing access to appropriate medical services, and improving health. Therefore, the conclusions of this domain of the evaluation help to inform the interpretation of other domains of the evaluation.

Table 1
American Community Survey, 2010 - 2012
Baseline measures - Fraction uninsured and fraction with Medicaid
Estimates are weighted using samples weights provided by the Census Bureau

	Uninsured			Medicaid			Unweighted sample size		
	2010	2011	2012	2010	2011	2012	2010	2011	2012
State									
MI	14.6 %	14.1 %	13.8 %	20.3 %	20.9 %	20.6 %	82,340	81,618	80,570
OH	14.4 %	14.2 %	13.8 %	17.4 %	17.7 %	18.4 %	97,998	97,476	95,969
IN	17.5 %	17.1 %	17.1 %	15.8 %	16.2 %	16.2 %	55,381	55,020	55,046
IL	16.0 %	14.7 %	15.0 %	17.8 %	19.1 %	18.7 %	107,140	106,436	106,264
WI	11.4 %	11.0 %	10.9 %	17.9 %	19.1 %	17.7 %	48,554	48,962	47,704
Race/ethnicity (Michigan only)									
White	13.4 %	12.5 %	12.4 %	15.4 %	15.8 %	15.9 %	66,820	65,459	64,526
Black	18.4 %	19.5 %	18.8 %	40.0 %	41.0 %	39.1 %	7,924	8,597	8,427
Other race	13.5 %	14.5 %	14.1 %	22.5 %	25.2 %	23.7 %	4,377	4,176	4,313
Hispanic	23.6 %	21.0 %	20.3 %	33.0 %	33.6 %	33.8 %	3,219	3,386	3,304
Income/poverty (Michigan only)									

<125% FPL	24.8 %	24.1 %	23.6 %	53.0 %	53.7 %	52.2 %	18,071	18,813	18,492
125-399% FPL	15.2 %	14.6 %	14.0 %	13.8 %	14.6 %	14.3 %	35,001	33,874	33,455
>400% FPL	5.1%	4.4%	4.6%	2.5%	2.5%	3.1%	27,504	26,027	25,984
Age (Michigan only)									
0-18	4.6%	4.2%	4.5%	37.7 %	38.7 %	39.3 %	23,412	22,347	22,033
19-34	27.6 %	24.9 %	23.5 %	16.5 %	17.0 %	16.4 %	16,847	17,135	16,895
35-64	14.4 %	14.7 %	14.5 %	11.4 %	12.1 %	11.5 %	42,081	42,136	41,642

Table 2
Current Population Survey, Annual Social and Economic Supplement (March survey), 2010 - 2013
Baseline measures - Fraction uninsured and fraction with Medicaid
Estimates are weighted using samples weights provided by the Census Bureau

	Uninsured				Medicaid				Unweighted sample size			
	2010	2011	2012	2013	2010	2011	2012	2013	2010	2011	2012	2013
State												
MI	15.5 %	14.9 %	14.1 %	12.7 %	16.2 %	18.9 %	19.3 %	18.8 %	4,324	4,134	4,063	3,830
OH	16.4 %	15.5 %	15.9 %	14.4 %	15.3 %	15.5 %	18.3 %	17.9 %	4,981	4,788	4,239	4,485
IN	16.3 %	15.3 %	13.9 %	15.6 %	18.1 %	17.9 %	18.5 %	18.2 %	2,636	2,712	2,681	2,671
IL	16.6 %	16.6 %	16.7 %	15.5 %	17.2 %	18.2 %	19.2 %	17.6 %	5,846	5,651	5,802	5,399
WI	10.9 %	10.9 %	12.0 %	11.2 %	16.8 %	16.8 %	18.5 %	19.7 %	3,398	3,322	3,251	3,330
Race/ethnicity (Michigan only)												
White	15.1 %	13.2 %	13.5 %	11.3 %	12.2 %	14.6 %	13.8 %	14.5 %	3,171	3,000	2,995	2,875
Black	18.8 %	20.8 %	13.4 %	17.7 %	33.5 %	34.5 %	39.0 %	34.7 %	624	584	599	481
Other race	11.3 %	21.0 %	14.4 %	6.5%	19.7 %	17.2 %	24.7 %	25.5 %	291	262	236	266
Hispanic	17.3 %	16.6 %	26.1 %	28.6 %	22.1 %	38.6 %	42.1 %	31.4 %	238	288	233	208
Income/poverty (Michigan only)												
<125% FPL	30.6 %	28.4 %	25.2 %	22.7 %	48.1 %	51.7 %	52.9 %	52.2 %	850	884	874	754

125-399% FPL	16.6%	14.7%	15.6%	15.2%	13.0%	16.2%	16.8%	16.0%	1,945	1,809	1,734	1,663
>400% FPL	6.1%	7.2%	6.2%	4.8%	2.8%	2.6%	3.1%	4.4%	1,529	1,441	1,455	1,413
Age (Michigan only)												
0-18	6.0%	5.2%	5.5%	4.0%	31.1%	35.6%	34.9%	35.8%	1,482	1,419	1,406	1,313
19-34	28.7%	25.5%	24.4%	22.1%	13.0%	16.5%	16.8%	14.1%	931	866	841	797
35-64	14.8%	15.7%	14.3%	13.5%	8.4%	9.6%	11.0%	10.5%	1,911	1,849	1,816	1,720

ATTACHMENT B
Demonstration Evaluation Plan

Domain III: Evaluation of Health Behaviors, Utilization & Health Outcomes

Impact on Healthy Behaviors and Health Outcomes *– The Healthy Michigan Program will evaluate what impact incentives for healthy behavior and the completion of an annual risk assessment have on increasing healthy behaviors and health outcomes. This evaluation will analyze selected indicators, such as emergency room utilization rates, inpatient hospitalization rates, use of preventive services and health and wellness programs, and the extent to which beneficiaries report an increase in their overall health status. Clear milestone reporting on the Healthy Behavior Incentives initiative must be summarized and provided to CMS once per year."*

I. Hypotheses

1. Hypothesis III.1: Emergency Department Utilization
    a. Emergency department utilization among the Healthy Michigan beneficiaries will decrease from the Year 1 baseline;
    b. Healthy Michigan Plan beneficiaries who make regular primary care visits (at least once per year) will have lower adjusted rates of emergency department utilization compared to beneficiaries who do not have primary care visits; and
    c. Healthy Michigan Plan beneficiaries who agree to address at least one behavior change will have lower adjusted rates of emergency department utilization compared to beneficiaries who do not agree to address behavior change.
2. Hypothesis III.2: Healthy Behaviors
    a. Receipt of preventive health services among the Healthy Michigan Plan population will increase over time, from the Year 1 baseline;
    b. Healthy Michigan Plan beneficiaries who make regular primary care visits (at least once per year) will have higher rates of general preventive services compared to beneficiaries who do not have primary care visits;
    c. Healthy Michigan Plan beneficiaries who complete an annual health risk assessment will have higher rates of preventive services compared to beneficiaries who do not complete a health risk assessment;
    d. Healthy Michigan Plan beneficiaries who agree to address at least one behavior change will demonstrate improvement in self-reported health status compared to beneficiaries who do not agree to address behavior change; and
    e. Healthy Michigan Plan beneficiaries who receive incentives for healthy behaviors will have higher rates of preventive services compared to beneficiaries who do not receive such incentives.
3. Hypothesis III.3: Hospital Admissions
    a. Adjusted hospital admission rates for Healthy Michigan Plan beneficiaries will decrease from the Year 1 baseline;
    b. Healthy Michigan Plan beneficiaries who make regular primary care visits (at least once per year) will have lower adjusted rates of hospital admissions compared to beneficiaries who do not have primary care visits; and

c. Healthy Michigan Plan beneficiaries who agree to address at least one behavior change will have lower adjusted rates of hospital admission compared to beneficiaries who do not agree to address behavior change.

II. Management/Coordination of Evaluation

A. Faculty Team

The analysis of administrative data will be led by an existing research team within the Child Health Evaluation and Research (CHEAR) Unit, whose faculty are active members of the Institute for Healthcare Policy and Innovation (IHPI). The core of this team has worked together for over ten years, in collaboration with Michigan Department of Community Health officials, on analyses of administrative data. The team includes Sarah Clark, faculty lead, and Lisa Cohn, lead data analyst. Along with this core analysis team, John Ayanian (General Medicine) and other clinical content experts as needed, will participate in refining data protocols and interpreting results.

III. Timeline

Administrative data will be analyzed throughout the Healthy Michigan Plan demonstration project. Data will be analyzed for baseline measurement, for identification of subpopulations to sample for the Domain IV beneficiary survey, for evaluation of changes related to cost-sharing requirements, and for overall evaluation of changes in health care utilization and other healthy behaviors.

June 1 – September 30, 2014: Development of final data extraction, storage and security protocols; analysis of Adult Benefit Waiver data from state fiscal years 2011-2013 to ascertain potential use as baseline data.

October 1, 2014 – September 30, 2015: Assess rate of primary care visits and health risk assessment completion for persons enrolled in state fiscal year 2014. Analyze early utilization patterns to develop targeted sample for Domain IV beneficiary survey. Provide assistance to the Department in summarizing Healthy Behaviors Incentives initiative.

October 1, 2015 – September 30, 2016: Assess rate of primary care visits and health risk assessment completion for persons enrolled in state fiscal year 2015. Analyze utilization data to support analysis of Domain IV beneficiary survey. Provide assistance to the Department in summarizing Healthy Behaviors Incentives initiative.

October 1, 2016 – September 30, 2017: Calculate measures on emergency department utilization, healthy behaviors/preventive health services, and hospital admissions. Analyze trends over time, and summarize in report to the Centers for Medicare & Medicaid Services. Provide assistance to the Department in summarizing Healthy Behaviors Incentives initiative.

October 1, 2017 – September 30, 2018: Calculate measures on emergency department utilization, healthy behaviors/preventive health services, and hospital admissions for final year of demonstration project. Analyze trends over time, and summarize in final evaluation report to the Centers for Medicare & Medicaid Services.

IV. Performance Measures/Data Sources

A. Overview: Using Medicaid Enrollment & Utilization Data

The Michigan Department of Community Health's Data Warehouse offers an unusually rich data environment for evaluation. For Michigan Medicaid enrollees, the Data Warehouse contains individual-specific information, refreshed daily, on demographic characteristics, enrollment, and health care utilization (including inpatient, outpatient, emergency department, pharmacy, durable medical equipment, immunization, dental and mental health). Data elements unique to the Healthy Michigan Plan will include self-reported health status and other individual-specific data on health risk assessments, incentives for healthy behaviors, and cost-sharing requirements.

The University of Michigan has a longstanding history of collaborating with the Michigan Medicaid program within the Department of Community Health to analyze information from the Data Warehouse to evaluate Medicaid programs and policies. This experience positions the University evaluation team to analyze information in the Data Warehouse to:

- Document trends in key health care utilization (e.g., emergency department use, preventive care services) and Medicaid adult quality measures over time within the Healthy Michigan Plan population, using the first year of implementation as baseline rates and measuring annual changes. This type of analysis addresses federal evaluation requirements.
- Explore associations of health care utilization and Medicaid adult quality measures with major features of the Healthy Michigan Plan, such as receipt of annual visit to a primary care provider, completion of annual health risk assessment, and cost-sharing.
- Identify subgroups of beneficiaries, providers or geographic areas with higher- or lower-than-average utilization, to enable targeted sampling for Domain IV activities exploring beneficiary and provider perspectives.

B. Data Sources

The data source will be the Michigan Department of Community Health Data Warehouse. Under the authority of a Business Associates' Agreement between the Department of Community Health and the University of Michigan, individual-level data for Healthy Michigan Plan enrollees will be extracted from the Data Warehouse, to include enrollment and demographic characteristics; all utilization (encounters in primary care, inpatient, emergency, urgent care; pharmacy); completion of health risk assessments; beneficiary co-pay charges; and vaccine administration data from all providers (including pharmacies). Data will be extracted from the Data Warehouse via an existing secure line, and stored in encrypted files on a secure network with multiple layers of password protection.

The eligible population will include all Healthy Michigan Plan enrollees.

C. Measures

A broad range of measures will be generated each year of the demonstration project, and are noted below for specific focus areas. Measures include established indicators for clinical care (e.g., Healthcare Effectiveness Data and Information Set measures, Adult Core Quality Indicators) with identified measure stewards (e.g., National Quality Forum). Importantly, health plan-based measures offer useful but limited information, as they exclude enrollees who change health plans and do not allow a full assessment of outcomes for the entire population or for a target geographic area with multiple plans; moreover, some measures require a period of identification prior to measurement outcomes, which will be problematic with the Healthy Michigan population. HEDIS criteria for measures of chronic disease populations (Diabetes HbA1c, LDL testing, admission rate; COPD admission rate; CHF admission rate; asthma admission rate) require a year for identification of members who meet the chronic disease definition (i.e., the denominator), followed by a measurement year to assess utilization (i.e., the numerator). However, most HMP enrollees were not covered by Medicaid coverage prior to their HMP start date, and so the MDCH data warehouse will not provide pre-HMP data for identification of chronic disease status. To follow HEDIS criteria strictly, we would need to use the first full year of HMP as the identification year, followed by the second full year of HMP as the measurement year – delaying any results on these key outcome measures until midway through the third year of the demonstration project. Therefore, the evaluation plan will modify identification criteria where necessary, and will go beyond the plan-specific HEDIS measures by generating not only plan-level results, but also results across plans for key subgroups (e.g., by geographic region, urban v. rural, by race/ethnicity, by gender, by age group, and by chronic disease status).

Because most Healthy Michigan Plan enrollees will not have prior Medicaid coverage, baseline values for the selected measures will not be available for most new enrollees. Therefore, Year 1 (April 1, 2014-March 31, 2015) of the Healthy Michigan Plan will serve as a baseline from which to measure changes over the course of the demonstration project; in addition, comparison data from comparable populations will be gleaned from national data sources.

V. Plan for Analysis

Over the 5-year waiver period we will assess a targeted set of performance measures detailed below. Measure stewards are noted, as appropriate. In addition to the performance measures, we will generate annual data on the proportion of Healthy Michigan Plan enrollees who agree to address a behavior change, and the proportion who make at least one primary care visit.

A. Emergency Department (ED) Utilization

We hypothesize that:

1) Emergency department utilization among the Healthy Michigan Plan population will decrease from the Year 1 baseline;

2) Healthy Michigan Plan beneficiaries who make regular primary care visits (at least once per year) will have lower adjusted rates of emergency department utilization compared to beneficiaries who do not make primary care visits; and
3) Healthy Michigan Plan beneficiaries who agree to address at least one behavior change will have lower adjusted rates of emergency department utilization compared to beneficiaries who do not agree to address behavior change.

To evaluate these hypotheses, we will calculate the following measures for the overall Healthy Michigan Plan population, by plan, by gender (where appropriate), by race/ethnicity, by county/geographic region, by chronic disease subgroups (diabetes, COPD, CHF, asthma), for beneficiaries who do vs. do not make regular primary care visits, for those who do vs. do not complete a health risk assessment, and for those who do vs. do not agree to address at least one behavior change. We will calculate measures for each year of the Healthy Michigan Plan demonstration period, and analyze trends over time. In addition, data from these analyses will be used to evaluate the association between emergency department utilization and the presence of cost-sharing requirements (Domain V/VI).

- **Healthcare Effectiveness Data and Information Set (HEDIS) Emergency Department Measure**: We will calculate the rate of emergency department visits per 1000 member months, and will calculate incidence rate ratios to assess the relative magnitude of emergency department utilization rates for subgroup comparisons. To provide additional information, we will calculate subgroup rates for key chronic disease populations (e.g., asthma, COPD, diabetes, CHF) at the plan level and by geographic region; this information will help the state to evaluate disease management programs and other services intended to encourage outpatient visits over emergency department use.
- **Emergency Department High-Utilizer Measure**: We will calculate the proportion of Healthy Michigan Plan beneficiaries who demonstrate high emergency department utilization (e.g., ≥5 emergency department visits within a 12-month period).

B. Healthy Behaviors/Preventive Health Services

We hypothesize that:
1) Receipt of preventive health services among the Healthy Michigan Plan population will increase from the Year 1 baseline;
2) Healthy Michigan Plan beneficiaries who make regular primary care visits (at least once per year) will have higher rates of general preventive services compared to beneficiaries who do not have primary care visits; and that
3) Healthy Michigan Plan beneficiaries who complete an annual health risk assessment will have higher rates of preventive services compared to beneficiaries who do not complete a health risk assessment.
4) Healthy Michigan Plan beneficiaries who agree to address at least one behavior change will demonstrate improvement in self-reported health status compared to beneficiaries who do not agree to address behavior change.

5) Healthy Michigan Plan beneficiaries who are eligible to receive incentives for healthy behaviors will have higher rates of preventive services compared to beneficiaries who are not eligible to receive such incentives.

To evaluate these hypotheses, we will calculate the following measures for the overall Healthy Michigan Plan population, by plan, by gender (where appropriate), by race/ethnicity, by county/geographic region, for beneficiaries who do vs. do not make regular primary care visits for those who do vs. do not complete a health risk assessment, and for those who do vs. do not receive healthy behavior incentives. We will calculate measures for each year of the Healthy Michigan demonstration period, and analyze trends over time. In addition, data from these analyses will be used to evaluate the association between healthy behaviors and the presence of cost-sharing requirements (Domain V/VI).

- **Flu Shots for Adults**: We will calculate the proportion of beneficiaries aged 50-64 and aged 18-49 who received an influenza vaccine between July 1 and April 30. To supplement Consumer Assessment of Healthcare Providers and Systems self-reported data from a small sample of beneficiaries (NQF 0039), we will take advantage of Michigan's unique data environment by combining Medicaid utilization data with information found in the statewide immunization registry (Michigan Care Improvement Registry) to document rates of influenza vaccine receipt for the Healthy Michigan Plan population, and for individuals at high risk for influenza-related complications, such as those with diabetes, COPD, CHF, or asthma.
- **Colon Cancer Screening** (NQF 0034, measure steward NCQA): We will calculate the proportion of beneficiaries aged 50-64 who received colon cancer screening by high-sensitivity fecal occult blood test, sigmoidoscopy with FOBT, or colonoscopy (recommendation USPSTF).
- **Hemoglobin A1c Testing** (NQF 0057; measure steward NCQA): We will calculate the proportion of beneficiaries aged 18-64 with type 1 or type 2 diabetes who had hemoglobin a1c testing at least once during the measurement year.
- **LDL-C Screening** (NQF 0063; measure steward NCQA): We will calculate the proportion of beneficiaries aged 18-64 with type 1 or type 2 diabetes who had an LDL-C screening performed at least once during the measurement year.
- **Breast Cancer Screening** (modified NQF 0031; measure steward NCQA): We will calculate the proportion of women 40-64 who had a mammogram to screen for breast cancer. Modifications from the NQF standard include **age range** (NQF includes 40-69 years; we will use 40-64 years, to be consistent with Healthy Michigan Plan eligibility); **measurement time period** (NQF includes two years; initially, we will calculate this measure for a one-year period, to allow for early results, rather than wait until enrollees have 2 years of data, and then subsequently will use both a one-year and two-year measurement period).
- **Cervical Cancer Screening** (NQF 0032; measure steward NCQA): Among those women who have 3 or more years of continuous enrollment in the Healthy Michigan Plan, we will calculate the proportion of women 21-64 years of age who received a Pap test to screen for cervical cancer.

- **Smoking and Tobacco Use Cessation, Medical Assistance** (NQF 0037; measure steward NCQA): Among beneficiaries who report on smoking or tobacco use on their Health Risk Assessment (HRA), we will calculate the proportion who received tobacco cessation counseling or assistance.
- **Self-Reported Health Status:** As part of the Health Risk Assessment (HRA) to be completed annually, beneficiaries will rate their health status using a commonly used and validated tool. We will calculate the proportion of beneficiaries who rate their health status as Excellent or Very Good vs. Good or Fair or Poor. In addition, we will analyze each beneficiary's change in self-reported health status over time.

C. Hospital Admissions

We hypothesize that:

1) Adjusted hospital admission rates for Healthy Michigan Plan beneficiaries will decrease from the Year 1 baseline.
2) Healthy Michigan Plan beneficiaries who make regular primary care visits (at least once per year) will have lower adjusted rates of hospital admissions compared to beneficiaries who do not have primary care visits.
3) Healthy Michigan Plan beneficiaries who agree to address at least one behavior change will have lower adjusted rates of hospital admission compared to beneficiaries who do not agree to address behavior change.

To evaluate these hypotheses, we will calculate the following measures for the overall Healthy Michigan Plan population, by plan, by gender, by race/ethnicity, by county/geographic region, urban/rural, for beneficiaries who do vs. do not make regular primary care visits, and for those who are vs. are not eligible to receive healthy behavior incentives. We will calculate measures for each year of the Healthy Michigan demonstration period, and analyze trends over time. In addition, data from these analyses will be used to evaluate the association between hospital admission and the presence of cost-sharing requirements (Domain V/VI).

- **Overall Admission Rate**: We will calculate the proportion of enrollees with any inpatient admission, as well as the rate of inpatient admissions per 1000 member months. We will make the same calculations for medical admissions and surgical admissions.
- **Diabetes, Short-term Complications Admission Rate** (NQF 0272; measure steward AHRQ): We will calculate the number of discharges for diabetes short-term complications per 100,000 Healthy Michigan Plan enrollees age 18-64.
- **Chronic Obstructive Pulmonary Disease (COPD) Admission Rate** (NQF 0275; measure steward AHRQ): We will calculate the number of discharges for COPD per 100,000 Healthy Michigan Plan enrollees age 18-64.
- **Congestive Heart Failure Admission Rate** (NQF 0277; measure steward AHRQ): We will calculate the number of discharges for CHF per 100,000 Healthy Michigan Plan enrollees age 18-64.
- **Adult Asthma Admission Rate** (NQF 0283; measure steward AHRQ): We will calculate the number of discharges for asthma per 100,000 Healthy Michigan Plan enrollees age 18-64.

D. Baseline Data

Baseline data on prior healthcare utilization for Healthy Michigan Plan enrollees are not available except for those who were previously enrolled in the Adult Benefits Waiver (state fiscal years 2011-2013); therefore, direct comparison of performance measures pre- and post-implementation will not be possible for most Healthy Michigan Plan enrollees. Rather, Year 1 of the Healthy Michigan Plan will largely serve as baseline data, setting up an evaluation of changes over time.

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ATTACHMENT B
Demonstration Evaluation Plan

Domain IV: Participant Beneficiary Views of the Healthy Michigan Program

Participant Beneficiary Views on the Impact of the Healthy Michigan Program *– The Healthy Michigan Program will evaluate whether access to a low-cost (modest co- payments, etc.) primary and preventive health insurance benefit will encourage beneficiaries to maintain their health through the use of more basic health care services in order to avoid more costly acute care services.*

I. Aims

1) Aim IV.1: Describe Healthy Michigan Plan enrollees' consumer behaviors and health insurance literacy, including knowledge and understanding about the Healthy Michigan Plan, their health plan, benefit coverage, and cost-sharing aspects of their plan.
2) Aim IV.2: Describe Healthy Michigan Plan enrollees' self-reported changes in health status, health behaviors (including medication use), and facilitators and barriers to healthy behaviors (e.g. knowledge about health and health risks, engaged participation in care), and strategies that facilitate or challenge improvements in health behaviors.
3) Aim IV.3: Understand enrollee decisions about when, where and how to seek care, including decisions about emergency department utilization.
4) Aim IV.4: Describe primary care practitioners' experiences with Healthy Michigan Plan beneficiaries, practice approaches and innovation adopted or planned in response to the Healthy Michigan Plan, and future plans regarding care of Healthy Michigan Plan patients.

II. Management/Coordination of Evaluation

Domain IV will be led by Susan Dorr Goold, Professor of Internal Medicine and Health Management and Policy, with community co-director Zachary Rowe, Executive Director, Friends of Parkside and Founding Member of the board of Detroit Urban Research Center and the MICH-R Community Engagement Coordinating Council. Dr. Goold and Mr. Rowe co-direct two projects that engage members of underserved and minority communities in deliberations about health research priorities, including a statewide project funded by the National Institute on Aging and led by a Steering Committee of community leaders from throughout the state (deciderspproject.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. <u>Primary Care Practitioner Survey (PCPS)</u>

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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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.

ATTACHMENT B
Demonstration Evaluation Plan

Appendix A: Researcher Bios

I. Faculty Leadership Profiles

Project Director: John Z. Ayanian, M.D., M.P.P.

John Z. Ayanian, M.D., M.P.P., Director of the University of Michigan Institute for Healthcare Policy & Innovation, will lead the interdisciplinary team of faculty members and staff conducting the Healthy Michigan Plan evaluation. In addition to serving as the Institute's director, Dr. Ayanian is the Alice Hamilton professor of medicine in the University of Michigan Medical School, professor of health management and policy in the School of Public Health, and professor of public policy in the Gerald R. Ford School of Public Policy. Dr. Ayanian's research focuses on the effects of race, ethnicity, gender, and insurance coverage on access to care and clinical outcomes, and the impact of physician specialty and organizational characteristics on the quality of care for cardiovascular disease, cancer, diabetes, and other major health conditions. He has published over 200 studies and over 50 editorials and chapters assessing access to care, quality of care, and health care disparities.

Dr. Ayanian joined the University of Michigan in 2013 from Harvard Medical School, where he served as professor of medicine and of health care policy. He also was a professor in health policy and management at the Harvard School of Public Health, and a practicing primary care physician at Brigham and Women's Hospital in Boston. From 2008-2013, he directed the Health Disparities Research Program of Harvard Catalyst (Harvard's National Institutes of Health-funded Clinical and Translational Sciences Center), Outcomes Research Program of the Dana-Farber/Harvard Cancer Center, and Harvard Medical School Fellowship in General Medicine and Primary Care.

Elected to the Institute of Medicine, the American Society for Clinical Investigation and the Association of American Physicians, he is also a Fellow of the American College of Physicians. In 2012, he received the John M. Eisenberg Award for Career Achievement in Research from the Society of General Internal Medicine, and his past honors include the Generalist Physician Faculty Scholar Award from the Robert Wood Johnson Foundation, Alice Hersch Young Investigator Award from AcademyHealth, and Best Published Research Article of the Year from the Society of General Internal Medicine in 2000 and in 2008.

Project Co-Director: Sarah J. Clark, M.P.H.

Sarah J. Clark, M.P.H., is Associate Research Scientist in the Department of Pediatrics, and Associate Director of the Child Health Evaluation and Research (CHEAR) Unit at the University of Michigan. She also serves as Associate Director of the C.S. Mott Children's Hospital National Poll on Children's Health.

Since joining the University of Michigan faculty in 1998, Ms. Clark has worked closely with Michigan Medicaid Program Staff on projects evaluating Medicaid programs and policies, utilizing both the analysis of Medicaid administrative data and/or primary data collection

involving Medicaid beneficiaries and providers. Areas of inquiry have included trends in emergency department visits after implementation of Medicaid managed care; trends in dental visits associated with expansion of a dental demonstration project; availability of appointments with medical specialists for Medicaid-enrolled children; and the impact of auto-assignment on children's receipt of primary care services. Under her leadership, the Child Health Evaluation and Research Unit researchers have published more than 30 manuscripts related to the Michigan Medicaid program and more than 25 reports to Department of Community Health officials.

II. Faculty Leads, Domains I & II: Thomas Buchmueller, Ph.D. and Helen Levy, Ph.D.

The work on Domains I and II of the evaluation will be conducted by a team of researchers co-led by two University of Michigan faculty members, Thomas Buchmueller Ph.D. and Helen Levy Ph.D. Buchmueller's primary appointment is in the Ross School of Business, where he holds the Waldo O. Hildebrand Endowed Chair in Risk Management and Insurance and currently serves as the Chair of the Business Economics Area. He has a secondary appointment in the Department of Health Management and Policy in the School of Public Health. Levy is a tenured Research Associate Professor with appointments in the Institute for Social Research, Ford School of Public Policy and Department of Health Management and Policy at the School of Public Health. She is a co-investigator on the Health and Retirement Survey, a national longitudinal survey supported by the National Institute on Aging. Buchmueller and Levy are experts on the economics of health insurance and health reform. In 2010-2011, Levy served as the Senior Health Economist at the White House Council of Economic Advisers. Buchmueller succeeded her in this position in 2011-2012.

Domains I & II: Sayeh Nikpay (M.P.H; Ph.D. expected 2014), a Research Investigator at the UM Institute for Healthcare Policy and Innovation (IHPI), will serve as evaluation manager and lead data analyst for Domains I and II. In 2010-2011, Nikpay served as a Staff Economist at the White House Council of Economic Advisers (Levy was her supervisor). In addition to collaborating with Buchmueller and Levy on the design of the evaluation analysis, her responsibilities will include managing the acquisition and maintenance of large data sets, conducting periodic interim analyses and generating reports based on these analyses, and coordinating activities among team members.

Domain I: Professors Daniel Lee, Ph.D. and Simone Singh, Ph.D. from the Department of Health Management and Policy in the University of Michigan School of Public Health will participate in the evaluation activities related to Domain I. Professors Lee and Singh are experts in hospital organization and finance and have conducted research on the determinants of uncompensated care. Their expertise will be essential for compiling the necessary data resources and designing the analysis.

A graduate student researcher will also assist the faculty team.

III. Faculty Leads, Domain III: Sarah Clark, John Ayanian

The work on Domain III will be led by Sarah Clark, M.P.H., and John Ayanian, M.D., M.P.P.as described in Section I of Appendix A above.

IV. Faculty Lead, Domain IV: Susan Goold, M.D., M.H.S.A., M.A.

The work on Domain IV will be led by Susan Dorr Goold, M.D., M.H.S.A., M.A., Professor of Internal Medicine and Health Management and Policy at the University of Michigan. Dr. Goold studies the allocation of scarce healthcare resources, especially the perspectives of patients and citizens. The results from projects using the CHAT (Choosing Healthplans All Together) allocation game, which she pioneered, have been published and presented in national and international venues. CHAT won the 2003 Paul Ellwood Award, and Dr. Goold's research using CHAT received the 2002 Mark S. Ehrenreich Prize for Research in Healthcare Ethics. CHAT has been used by educators, community-based organizations, employer groups, and others in over 20 U.S. states and several countries to engage the public in deliberations on health spending priorities. Dr. Goold serves on several editorial boards and as Chair of the American Medical Association Council on Ethical and Judicial Affairs. She has also held leadership positions in the American Society for Bioethics and Humanities and the International society on Healthcare Priority Setting.

Edith Kieffer (Social Work) brings extensive experience using longitudinal epidemiological studies, qualitative formative research, intervention research, CBPR and CHW-led approaches to design, conduct and evaluate programs addressing health disparities.

Jeffrey Kullgren (Internal Medicine) brings expertise in behavioral economics and experience conducting research on decision making, cost-related access barriers, financial incentives for patients and cost transparency.

Adrianne Haggins (Emergency Medicine) brings knowledge and experience related to patient decision-making about when and where to seek care. She has experience analyzing national data on the impact of expansion of insurance coverage on use of emergency department and non-emergency outpatient services and has completed a review of the state-level effects of healthcare reform initiatives on utilization of outpatient services.

Renuka Tipirneni (Internal Medicine) studies the impact of health care reform on access to and quality of care for low-income and other vulnerable populations, and is currently conducting a study of access to primary care practices for Medicaid enrollees in the state of Michigan.

Ann-Marie Rosland (Internal Medicine) brings experience studying self-management and organization of clinical care for chronic diseases.

Eric Campbell (Mongan Institute for Health Policy), will consult on the project, and will bring extensive experience and expertise with high-profile surveys of physicians on health policy topics.

V. Faculty Lead, Domains V & VI: Richard Hirth, Ph.D.

Richard Hirth, Ph.D. will lead a team of researchers on the work of Domains V and VI. Dr. Hirth is Professor and Associate Chair of Health Management and Policy at the School of Public Health and Professor of Internal Medicine. His expertise includes health insurance and healthcare costs, and his research interests include the role of not-for-profit providers in health care markets, health insurance, the relationship between managed care and the adoption and utilization of medical technologies, long-term care, and the economics of end stage renal disease care.

Dr. Hirth has received several awards, including the Kenneth J. Arrow Award in Health Economics, awarded annually by the American Public Health Association and the International Health Economics Association to the best paper in health economics (1993); the Excellence in Research Award in Health Policy from the Blue Cross/Blue Shield of Michigan Foundation (1998 and 2009); and the Thompson Prize for Young Investigators from the Association of University Programs in Health Administration (1999); Listing in Top 20 Most Read Articles of 2009, Health Affairs (2010); Outstanding abstract (consumer decision-making theme), AcademyHealth Annual Meeting (2007); and Outstanding abstract (long-term care theme), Academy for Health Services Research and Health Policy Annual Meeting (2001).

Most recently, Dr. Hirth received the 2014 AcademyHealth Health Services Research Impact Award for his work on designing the renal dialysis bundled payment system adopted by Medicare for the End-Stage Renal Disease Program in 2011.

Jeff Kullgren, M.D., M.S., M.P.H., is an Assistant Professor of Internal Medicine at the University of Michigan Medical School and a Research Scientist in the VA Ann Arbor HSR&D Center for Clinical Management Research. His research aims to improve patient decisions about healthcare utilization and health behaviors. Most recently his work has examined decision-making and cost-related access barriers among families enrolled in high-deductible health plans as well as the growth of state-based initiatives to publicly report health care prices to consumers. He currently leads a project examining the potential value of state prescription drug price comparison tools for patients who take commonly prescribed prescription drugs and face high levels of out-of-pocket expenditures. In another study, he is testing a provider-focused intervention to decrease overuse of low-value health care services that can often trigger high out-of-pocket expenditures for patients. He has studied the effects of community-based programs to improve access for low-income uninsured adults and the relationship between financial and nonfinancial access barriers, and studies the effects of financial incentives for healthy behaviors such as weight loss, physical activity, and colorectal cancer screening.

A. Mark Fendrick, M.D. is a Professor of Internal Medicine and Professor of Health Management and Policy at the University of Michigan. He directs the Center for Value-Based Insurance Design at the University of Michigan [www.vbidcenter.org], the leading advocate for development, implementation, and evaluation of innovative health benefit plans. Dr. Fendrick's research focuses on how financial incentives impact care-seeking behavior, clinical outcomes and health care costs. Dr. Fendrick is the Co-editor in chief of the *American Journal of Managed Care*. He serves on the Medicare Coverage Advisory Committee and has won numerous awards

for his role for the creation and implementation of value-based insurance design. Dr. Fendrick remains clinically active in the practice of general internal medicine.

Additional staff will include a part time programmer/analyst and a 0.5 FTE Graduate Student Research Assistant, to be identified.

ATTACHMENT B
Demonstration Evaluation Plan

Appendix B: Description of Data Sources

1. Michigan Department of Community Health Data Warehouse

A key data source for the Healthy Michigan Plan evaluation will be the Michigan Department of Community Health Data Warehouse. Components of the data warehouse that will contain data for the Healthy Michigan Plan population include Medicaid beneficiary eligibility, enrollment and demographic characteristics; Medicaid provider enrollment; managed care encounters, payments and provider networks; Medicaid fee-for-service claims; pharmacy claims, including National Drug Codes; community mental health, including managed mental health plans; substance abuse; immunizations; third-party liability; and vital records. A unique client identifier links person-level records across Department of Community Health program areas. The Data Warehouse also links to the statewide Enterprise Data Warehouse, which contains records for human services, corrections, treasury, secretary of state, federal-state programs, and other program areas. The Enterprise Data Warehouse is the nation's most sophisticated and highly utilized state government data warehouse, supporting evaluation of state policies across programmatic lines.

For nearly 15 years, the University of Michigan's Child Health Evaluation and Research (CHEAR) Unit has utilized the Data Warehouse for numerous collaborative projects with Department officials. A Business Associates' Agreement between the Department and the University was enacted to allow CHEAR to extract and analyze information from the Data Warehouse in response to requests from MDCH officials; for other project types, specific Data Use Agreements are prepared and approved by the MDCH Privacy Office, as well as the MDCH Institutional Review Board. CHEAR data analysts participate in training and educational sessions related to the Data Warehouse, and communicate frequently with MDCH staff on data quality issues.

As part of the University's Institute for Healthcare Policy and Innovation (IHPI), the CHEAR Unit will play a central role in the Healthy Michigan Plan evaluation, bringing its experience in extracting and analyzing Medicaid data from the MDCH Data Warehouse. Data extraction will be conducted via VPN connection using a RSA SecurID password token. Using a second password, CHEAR analysts will access data models using Open Text BI-Query, writing specific queries to download demographic, eligibility, health care utilization and provider information records. To protect enrollee confidentiality, CHEAR analysts encrypt the beneficiary IDs using SAS, and use the encrypted datasets for data analysis. The analytic datasets are stored on password protected external hard drives, which are stored in locked cabinets at night. Office doors are locked when unoccupied during the day. The raw data and final analytic files are backed up to a server location that is only accessible to CHEAR analysts and specific faculty leads through secured network sign-on. The server folders are reviewed periodically and data files not accessed in over 5 years are removed unless a longer storage timeframe is requested by MDCH officials.

2. Public Use Data Sets

Hospital Cost Reports & Filings (Domain I)

We intend to use Medicare cost reports, which Medicare-certified hospitals are required to submit annually to a Medicare Administrative Contractor. The cost report contains provider information such as facility characteristics, utilization data, cost and charges by cost center (in total and for Medicare), Medicare settlement data, and financial data. As part of the financial data, hospitals are required to provide detailed data on uncompensated care and indigent care provided. These include charity care and bad debt (both in terms of full charges and cost) as well as the unreimbursed cost for care provided to patients covered under Medicaid, SCHIP, and state and local indigent care programs. Medicare cost reports (Form CMS-2552-10) for hospitals in Michigan and other states will be obtained from the CMS website.

We will also use Medicaid cost reports as well as supplementary forms compiled by the Michigan Department of Community Health. These reports have the advantage of providing more detail than the CMS reports, but are only available for Michigan hospitals.

We also plan to use Schedule H of IRS Form 990. Since 2009, federally tax-exempt hospitals have been required to complete the revised IRS Form 990 Schedule H, which requires hospitals to annually report their expenditures for activities and services that the IRS has classified as community benefits. These include charity care (i.e., subsidized care for persons who meet the criteria for charity care established by a hospital), unreimbursed costs for means-tested government programs (such as Medicaid), subsidized health services (i.e., clinical services provided at a financial loss), community health improvement services and community-benefit operations (i.e., activities carried out or supported for the express purpose of improving community health), research, health professions education, and financial and in-kind contributions to community groups. In addition to community benefits, Schedule H asks hospitals to report on their bad debt expenditures.

Hospitals' IRS filings will be obtained from GuideStar, a company that obtains, digitizes, and sells data that organizations report on IRS Form 990 and related Schedules. Data will be obtained for all hospitals that file Form 990 with the IRS at the individual hospital-level. (For 2009 to 2011, Form 990 Schedule H is available for 85 federally tax-exempt hospitals in Michigan.) Members of our research team have extensive experience working with these data.[13]

US Census Bureau Surveys (Domain II)

The analysis of insurance coverage will be based on data from two annual national surveys conducted by the Census Bureau: the Current Population Survey (CPS) and the American Community Survey (ACS). Each survey has specific strengths related to this evaluation. The CPS is the most commonly cited data source for state-level estimates of insurance coverage. It provides a detailed breakdown by source of coverage. The ACS provides less detail on source of coverage but with a much larger sample size than the CPS. The larger sample size means it is possible to make estimates for subgroups not supported by the CPS, such as geographic areas

[13] Young, G.J., Chou, C, Alexander, J, Lee, S.D. and Raver, E. 2013. "Provision of Community Benefits by Tax-Exempt U.S. Hospitals, *New England Journal of Medicine*, 368(16): 1519-1527.

within a state. In each case, our analysis will be based on public use files disseminated by Census.

3. Primary Data Collection

Healthy Michigan Voices Survey (Domains II, III, IV, V, VI)

Evaluation of the impact of the Healthy Michigan Plan requires tracking the experience of those who enroll: Do they establish primary care? Do they access care appropriately? Do they gain knowledge about health risks and healthy behaviors? Do their health behaviors improve? Identifying trends, assessing the impact of strategies to overcome barriers, and understanding the overall health and economic impact of the Healthy Michigan Plan at a personal level requires learning about the experiences of participant beneficiaries. Tools typically used to track population experiences generally do not include a comprehensive list of items necessary to measure for the purposes of this evaluation.

Researchers at the University of Michigan have established that measuring public experiences, attitudes, and actions through longitudinal population surveys is a timely and informative way to track progress and identify challenges. Such efforts provide objective evaluations of the impact of health programs, and offer timely results that enable stakeholders to identify the need for targeted action. We propose the **Healthy Michigan Voices** (HMV) project, a survey of Healthy Michigan enrollees on key topics related to the Healthy Michigan program.

The Healthy Michigan Voices survey will be limited to those enrolled in the Healthy Michigan Plan, and will include one cohort of approximately 4500 participants, recruited at strategic intervals after enrollment opens in April 2014. The survey will be fielded during state fiscal year 2016, administered by telephone. The survey methodology and specifications are described in greater detail in Domain IV.

Primary Care Practitioner Survey (Domain IV)

To measure primary care practitioners' expectations, experiences, and innovative responses for caring for the Healthy Michigan Plan population, we propose the Primary Care Practitioner Survey (PCPS) to obtain empirically valid and timely data from a small, but generalizable sample of primary care practitioners in Michigan. This will be accomplished through the use of multiple, short surveys (10 items or less) administered during state fiscal year 2015, asking relevant questions about the Healthy Michigan Plan. The surveys will be self-administered and distributed via Priority Mail (with an option to complete online).

As described in greater detail in Domain IV, we will identify primary care practitioners using the Michigan Department of Community Health Data Warehouse, drawing a random sample of 2400 practitioners actively engaging in primary care in Michigan, anticipating we can obtain agreement from at least 1000 primary care practitioners for participation. The surveys will be administered by CHEAR, which has extensive experience in physician studies. All data will be stored in secure, password-protected files.

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 Department of Community Health ("Department"), the Department's contracted health plans, and Department's selected MI Health Account vendor[14] as further described below.

II. Background

All individuals enrolled in the Healthy Michigan Plan through the Department's contracted 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 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 that 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). 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 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

[14] There is a single vendor that all of the Department's contracted health plans will use for the MI Health Account function. This vendor is designated as a mandatory subcontractor for the health plans, and each of the plans will 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.

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 generic prescription for antibiotics at the pharmacy ($1). 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 $2.00 ($6 in expenditures divided over a 3 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 $2.00 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 2014, which will be based on the beneficiary's copayments from July, August, and September of 2014. The beneficiary will then be notified of her new monthly copayment obligation in January 2015, which will be 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) in April of 2014; a visit to an endocrinologist to assess and control her diabetes in May of 2014($0); and finally, she fills a diabetes related prescription ($0) 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 3 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 use the date of payment of the claim 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 grievance process described in Section X. The Department is in the process of working with the MI Health Account vendor to develop a sample account statement that contains all relevant financial information and sufficient encounter level detail, while being respectful of varying levels of health literacy. The Department has shared a copy of a proposed statement with the Centers for Medicare & Medicaid Services (CMS). Because the Department is committed to ensuring that the format and content of the account statement are both responsive to the needs of the beneficiary and support the purpose of the demonstration as a whole, the Department reserves the right to modify the account statement at any time, in consultation with 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 two percent 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. 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.

The contribution amount will not exceed two percent of the amount that represents the beneficiary's percentage of the Federal Poverty Level, though 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 federal poverty level. The contribution for both will be $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 Federal Poverty Level, each would be required to pay $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 Federal Poverty Level, 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 Federal Poverty Level (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 health plans 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 plan.

A beneficiary has a monthly contribution requirement of $25, which he remits as required. The beneficiary receives no services for the first 9 months he is in the health plan. Therefore, the beneficiary has contributed $75 (no contributions for the first 6 months, followed by 3 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 9 months she is in the health plan. Therefore, the beneficiary has contributed $60 (no contributions for the first 6 months plus 3 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 plans 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 3 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 3 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. First, 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 plans with a list of services, which includes 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 this list, 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 list must be approved in advance by CMS.

Co-pays and contributions may also be reduced if certain healthy behaviors are being addressed, though co-pays must reach 2 percent of the beneficiary's income before this specific reduction can occur.[15] The evaluation period for determining satisfaction of the two percent threshold for co-pays will be the beneficiary's enrollment year. This means that the beneficiary will have one year to make progress toward the 2 percent 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. The health plans, along with the MI Health Account vendor and the Department, are responsible for ensuring that the calculation and collection of all cost-sharing amounts is performed in accordance with the Healthy Behaviors Incentives Operational Protocol

[15] While the Healthy Behaviors Incentives Operational Protocol contains the relevant details of the incentives program, for purposes of the MI Health Account protocol, all individuals are eligible for a reduction in copays once the 2 percent threshold is met. Only those individuals who pay a contribution (those above 100 percent of the Federal Poverty Level) will be eligible for a contribution reduction. Those individuals under 100 percent of the Federal Poverty Level are eligible to receive a gift card.

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. Testing of these interfaces will occur prior to the first group of beneficiaries using the MI Health Account (slated to begin October 1, 2014), with adequate testing and demonstrated success required prior to implementation. See the Healthy Behaviors Incentives Operational Protocol for further information.

VI. Account Administration

The Healthy Michigan Plan's unique cost-sharing framework means that the MI Health Account will become operational on October 1, 2014 for the initial group of beneficiaries (who are below 100 percent of the Federal Poverty Level) enrolled in the Healthy Michigan Plan. Testing of the MI Health Account will occur in late summer 2014, with demonstrated success (as evidenced through appropriate testing outcomes) required prior to implementation. The Department has finalized both the initial Statement of Work for the MI Health Account vendor and the initial system and design requirements. 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 an appropriate claims run-off period (120 days is the planned 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 any State health care program, the balance of any funds contributed by the beneficiary will be issued to the beneficiary for the purchase of private health insurance coverage. The Department will work closely with the MI Health Account vendor to implement this requirement. 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 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 of Human Services and the MI Health Account statement. Neither the Department nor the MI Health Account vendor may serve as the system of record for these changes, but the MI Health Account

vendor will receive updated information via the Department's eligibility system shortly after these changes are reported.

- 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 is responsible for tracking all cost sharing (in cooperation with the claims information provided via the Department and the health plans) to ensure that beneficiaries' cost sharing (which includes co-pays and contributions as described herein) is consistent with 42 CFR 447.56(f).

- 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, after an appropriate claims run off period.

- 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 copay 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 $1000.00. 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.

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 from the MI Health Account for health plan 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 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 the health plans and their trade association generally on a monthly basis. In addition, a beneficiary survey, which will include questions regarding the operation of the MI Health Account, will be performed as part of the program evaluation process required by the Special Terms and Conditions, and is planned for 2015. 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. This measure will be monitored through the Department's annual health plan compliance review process, 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. However, the Department will not initiate consequences for beneficiaries owing less than $3.00 to the MI Health Account.

In addition to the consequences described herein, the Department is in the process of evaluating limitations to potential reductions for those who fail to pay required cost-sharing (as this consequence is required by State law). As described in the Healthy Behaviors Incentives Protocol, a member who has earned a reduction but was found to be in "consistently fail to pay" status will lose that reduction for the remained of the year in which it was earned.

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. The Department will work with the MI Health Account vendor to implement this process, which may include but is not limited to, template development for written communications and scripting for any telephone communications.

In addition, State law requires the Department to work with the State's Department of Treasury to garnish state tax returns, and access lottery winnings when applicable, for beneficiaries who consistently fail to meet payment obligations. The Department is pursuing a formal arrangement with the Department of Treasury to provide garnishment services 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 appropriate due process, including as outlined in Section VIII, prior to the initiation of any collection or garnishment 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 specific reports required are still under development, however, the following information is expected to be available and shared as described herein:

- By December 1, 2014, 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 quarterly basis, the MI Health Account vendor will provide the Department with information on co-pays and contributions due, reductions applied, and collections by enrollee.

In addition, the timing of interfaces among the plans, the Department and the MI Health Account vendor is currently being finalized. The timeline for the proposed interface deadlines is attached as **Appendix 3**.

X. Grievances

Healthy Michigan Plan beneficiaries will have the opportunity to contest various facets of the MI Health Account function through the grievance processes operated by the health plans and in accordance with federal law and regulations. Any dispute arising over amounts paid or owed 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. Given that no individual may lose eligibility or have their benefits curtailed for failure to pay co-pays or contributions, the Department expects that all MI Health Account related complaints will move through the grievance process.

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, and information on how to contest amounts paid or owed will be provided on the MI Health Account Statement.

ATTACHMENT D
Healthy Behaviors Incentives Program Protocol

The Michigan Department of Community Health (the Department, or DCH), in consultation with stakeholders, has developed an incentives program specific to the Healthy Michigan Plan Managed care population. As required by the Centers for Medicare & Medicaid Services (CMS), the following operational protocol describes each section of the program as outlined. Please note that responses to the following sections are written together: (a) and (b), (d) and (h), (e) and (i).

a. *The uniform standards for healthy behaviors incentives including, but not limited to, a health risk assessment to identify behavior that the initiative is targeting, for example: routine ER use for non-emergency treatment, multiple comorbidities, alcohol abuse, substance use disorders, tobacco use, obesity, and deficiencies in immunization status.*

   See b.

b. *A selection of targeted healthy behaviors that is sufficiently diverse and a strategy to measure access to necessary providers to ensure that all beneficiaries have an opportunity to receive healthy behavior incentives.*

   The Department has created the Healthy Behaviors Incentives Program to reward Healthy Michigan Plan Managed Care members for their conscientious use of services. Incentives, which the Department defines as both reductions in cost-sharing responsibilities and select financial rewards, can be earned by Healthy Michigan Plan managed care members on the basis of their active, appropriate participation in the health care delivery system. Uniform standards have been developed to ensure that all Healthy Michigan Plan managed care members will have the opportunity to earn incentives and that those incentives are applied properly by the managed care plans or their vendor. Further operational details of these MI Health Accounts and incentives are found in Attachment C.

   As detailed below, each Healthy Michigan Plan managed care member will have the opportunity to earn incentives for their successful engagement with their new health care system. Members who acknowledge the need for behavior change and agree to address those behaviors will earn a reduction in cost-sharing. The Department has developed a Health Risk Assessment (Appendix 4) 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
   - Flu vaccination

   The health risk assessment will be available for completion by all Healthy Michigan Plan managed care members. Members will complete a portion of the assessment on their own, with the assistance of the enrollment broker, MIEnrolls, or with assistance from their selected health plan. The enrollment vendor, health plans, and provider offices must

convey consistent messages to beneficiaries regarding the completion of the health risk assessment. To ensure consistency, member engagement scripts with healthy behaviors incentives program information have been developed and shared with the enrollment vendor and the health plans. Members may call any of those entities to request assistance in filling out the health risk assessment. This portion includes assessment of engagement in healthy behaviors. Members answer questions that indicate how much assistance they may need to achieve health in regards to particular issues. The final portion of the health risk assessment will be done in the primary care provider office and includes attestations by the provider that the member 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 those who may have unmet health needs. For Healthy Michigan Plan managed care members, this initial appointment will 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 PCP within 60 days of enrollment or the date of this approved protocol to schedule a well care appointment and complete the HRA, though there is no penalty on beneficiaries for their failure to do so. When this initial appointment is kept and a Health Risk Assessment is completed for a new member (which includes provider attestations of healthy behaviors and/or changes), that member may be eligible for incentives. The Department will develop 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 plan. This measure will be based on encounter data extracted from the data warehouse and will be tracked by region, health plan, and as a state overall. In SFY2016, this measure will be included in the Performance Bonus for the managed care plans. Healthy Michigan Plan managed care members who complete an appointment along with an HRA after the 150-day timeframe are still eligible to receive incentives described in Appendix 5.

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 enrollees are in FFS before enrollment in a plan, the Department expects there to be relatively few instances of a FFS provider completing the initial appointment and the HRA. When it does occur, the managed care plans will be responsible for either working directly with the FFS provider to obtain the HRA or assisting the member in getting the necessary HRA 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 HRA to their health plan after enrollment. Beneficiaries who complete the HRA during the FFS period are eligible for the incentives upon enrollment into a managed care plan. The eligibility criteria are the same as described in Appendix 5.

The Department also requires each Healthy Michigan managed care plan to pay an incentive to providers who complete the HRA with their Healthy Michigan Plan members. Details of the provider incentive and payment mechanism are plan-specific and will be made available to providers by the health plans with which they participate. Providers who work with patients to complete the HRA during the FFS period will also be eligible for the managed care plan provider incentives once the member has enrolled in the health plan. In order to receive the provider incentive, the PCP must submit the completed HRA to the health plan using a secure method, as designated by the health plan. The provider incentive is paid for completion of the HRA, not for the member choosing to address a healthy behavior.

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 will rely to earn their incentives. Upon 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. Given our estimates of potential enrollment, there were no counties that required an increased network to fall within the Department's required primary care provider to member ratio of 1:750. In the future, if enrollment into the Healthy Michigan Plan is greater than expected in a particular county and the required primary care provider to member ratio of 1:750 is no longer attainable, the Department will open that county for service area expansion. Managed care plans would have the opportunity to request expansion into that county if they can demonstrate that their provider network would create increased access.

c. *A list of stakeholders as well as documentation of the public processes or meetings that occurred during the development of the protocol, the accompanying health risk assessment tool and uniform standards.*

The Department began planning the incentive program in December 2013. Since then, the Department has held a bi-weekly meeting with managed care plans to discuss the health risk assessment, incentive program, cost-sharing, and the MI Health account. The Michigan State Medical Society and the Michigan Osteopathic Association participated in several meetings throughout the development of the program as well. In February 2014, the healthy behaviors program including the Health Risk Assessment and uniform standards was discussed with the Medical Care Advisory Committee. See the February 2014 meeting agenda (Appendix 6). This meeting includes staff from the Department, Medicaid Health Plans, local health departments, medical, oral, and mental health providers, various advocacy groups, and Medicaid beneficiaries. Discussion was held at the meeting and comments received in writing will be considered in the final program design.

Informational presentations have been made to stakeholder and advocacy groups, as well as Tribal partners. The Department published the Healthy Behaviors Incentives Operational Protocol on its website and allowed for public comment during the period of May 2- May 27, 2014. Comments were received from various individuals, advocacy

organizations, and stakeholder groups. The Department considered each comment and made changes and clarifications to the protocols as appropriate. The Department also published responses to public comments on the Departmental website (michigan.gov/healthymichiganplan) on August 7, 2014.

d. The data driven strategy of how healthy behaviors will be tracked and monitored at the enrollee and provider level including standards for accountability for providers. This must include the timeline for development and/or implementation of a systems based approach which shall occur prior to implementing the Healthy Behaviors initiative.

The Department began planning how Health Risk Assessment data would be tracked and monitored in January 2014. All of the Health Risk Assessment data will be put into electronic file formats and stored in the State's data warehouse. The identification of appropriate IT systems and the file format to securely transfer the data from the enrollment broker to the data warehouse and health plans were finalized in February 2014. The file format to securely transfer Health Risk Assessment data from the plans back to DCH has been developed and testing was completed in August 2014. Because beneficiary data from the Health Risk Assessments will be shared only with partners that participate in the treatment, payment, or operations of healthcare benefits, no separate authorization for data exchange is required.

The files include member name and ID number, the member's Medicaid Health 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 enrollee, provider and plan level. The development of queries to pull Health Risk Assessment data monthly already began with the department's data warehouse vendor, Optum, in January 2014. These queries will allow the department to track enrollee and plan level data over time. It will be possible to query on all aspects of the Health Risk Assessment data, and to cross-reference this with care provided to beneficiaries through encounter data. Testing of these systems began in spring 2014 and was implemented in August 2014. Cross-referencing with encounter data will also assist with monitoring provider accountability. Managed care plans will be required to set standards for accountability for their provider networks.
Healthy Michigan Plan managed care members will have the opportunity to contest any information reported on the Health Risk Assessment. Any dispute arising between the beneficiary and the primary care provider and/or health plan regarding information reported on the Health Risk Assessment or appropriate application of earned incentives will be treated as a grievance. The managed care plans are contractually obligated to inform their members of the grievance process at the time of enrollment. Instructions on how to file a grievance are detailed in the Member Handbook for each managed care plan. If a member has questions or concerns about services, charges, or incentives related to the MI Health Account or listed on the quarterly statement, the beneficiary helpline telephone number will be listed on each page of the statement in English, Spanish, and Arabic. Beneficiary helpline staff can also inform members on how to file a grievance.

e. A beneficiary and provider education strategy and timeline for completion prior to program implementation.

Consistent, uniform standards for eligibility and distribution of incentives are paramount to appropriate outreach and education efforts. 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 MIEnrolls, the Department, managed care plans, and providers), members will receive information about the incentives program including eligibility requirements.

The Department has included language in the Healthy Michigan Plan handbook to inform beneficiaries about potential reductions in their cost-sharing based on their engagement in healthy behaviors. This language will be included in Healthy Michigan Plan brochures and other member communications as well.

The Department's enrollment broker, MIEnrolls, will facilitate member questions on the Health Risk Assessment, and will inform beneficiaries about the incentives for members who engage in healthy behaviors. Members are able to choose their primary care provider at the time of enrollment into a managed care Plan. As required in the managed care contract, plans must offer enrollees freedom of choice in selecting a primary care provider. If a member does not pick a primary care provider at the time of enrollment into the plan, the plan may assign the member to a primary care provider. All plans have written policies and procedures describing how enrollees choose and are assigned to a primary care provider, and how they may change their primary care provider. These materials are sent by the health plan to each new Healthy Michigan Plan member in the new member packet, along with a health plan identification card. MIEnrolls will furnish new members with contact information for their new 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 will include information about the incentives program. During these calls, 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 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. The detailed contents of the MI Health Account statement are discussed in the MI Health Account Operational Protocol.

The Department will work with the Michigan State Medical Society, the Michigan Osteopathic Association, and the Michigan Primary Care Association to hold educational

trainings for their members about the Healthy Michigan Plan Healthy Behaviors Incentives program. These partners will include the information in their newsletters and on their websites. They will hold trainings in assessing readiness to change, and provide their members with consistent messaging on the incentives program. The Department sent a letter to all practitioners, Federally Qualified Health Centers, Tribal Health Centers, Rural Health Centers, and health plans on June 13, 2014. This letter included detailed information about the Healthy Behaviors incentives program so that a consistent message will be heard by beneficiaries from providers across the state of Michigan. A policy bulletin (14-39) was distributed to all providers on August 28 , 2014 with similar clarifying information. Not only will this ensure that providers are adequately educated on the incentives program, but that they are able to share a consistent message with members.

The Department is also in the process of developing a voluntary, web-based training for providers on the Healthy Michigan Plan Health Risk Assessment, incentives, and associated processes. The training will be available for completion online and will have continuing education units associated with it. The Department will monitor usage and success rates for providers participating in the online training.

The Department will continue to elicit feedback from managed care plans, providers and other stakeholders about the Healthy Behaviors Incentives program. Results from data analysis will be discussed annually during both the Clinical Advisory Committee and Medical Care Advisory Council meetings and stakeholder input will be considered for any program changes.

The Department received approval from CMS to move forward with the state's planned messaging strategy for the incentives program on 4/11/2014. Since then, MIEnrolls, all managed care plans and the DCH call center have been sharing the same message about the incentives program including eligibility requirements and potential rewards. Providers have received the same messaging to share with beneficiaries. The educational messaging will continue as more Michigan residents apply for the Healthy Michigan Plan.

f. The ongoing structured interventions that will be provided to assist beneficiaries in improving healthy behaviors as identified through the health risk assessment.

Beneficiaries will have structured ongoing support in their efforts to improve healthy behaviors as identified through the Health Risk Assessment.
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 plans to determine suitability for member enrollment into this type of program, or for referral for other covered-services that will assist the member in changing unhealthy behaviors or maintaining current healthy activities.

All 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. This includes counseling (individual, telephone, and group), over-the-counter and prescription medications, and combination therapy.

Addressing obesity is a priority in Michigan. In 2012, Governor Rick Snyder, with support from the Department, launched Michigan's strategic plan to fight obesity, commonly referred to as the 4x4 plan. The plan includes a robust public outreach campaign which includes messaging on four specific healthy behaviors that are all included in the Health Risk Assessment (diet, exercise, annual physical, and avoiding tobacco use) and a 'know your numbers' component that focuses on knowing four clinical values--blood pressure, cholesterol, blood glucose, and body mass index. Influenza vaccination and treatments for alcohol use, substance use disorder and mental health issues are covered services under the Healthy Michigan Plan. Once a member has been identified as in need of any of these services, plans will coordinate care with necessary providers to ensure that timely, appropriate services are rendered. The Department expects health plans to adhere to recognized clinical practice guidelines for the treating Healthy Michigan Plan members.

Financial barriers to appropriate care can influence the health-seeking behaviors of low-income populations. 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 copays 'to promote greater access to services that prevent the progression of and complications related to chronic diseases'. The Department believes that by eliminating copays for services related to chronic disease and the associated pharmaceuticals, members will be better able to achieve their health goals. A list of these chronic disease and associated codes is attached (Appendix 2).
Healthy Michigan Plan members will have access to all of the supports currently available from managed care plans.

g. A description of how the state will ensure that adjustments to premiums or average utilization copayment contributions are accurate and accounted for based upon the success in achieving healthy behaviors.

Attestations from primary care providers are the basis for eligibility for incentives. The provider will return the completed Health Risk Assessment to the Managed Care Plan, which will share member level details on provider attestations with the Department. If a beneficiary disputes the information reported on the health risk assessment, they may utilize their health plan's existing procedures for the resolution of a grievance. This procedure is explained in the member handbook that is sent to members upon enrollment in the health plan.

The Department will also receive from the MI Health Account vendor the amount of cost-sharing expected and received by each Healthy Michigan Plan member. On a quarterly basis, the Department will cross reference a sample of beneficiaries who earned a reduction based on the attestation on their Health Risk Assessment with beneficiaries

who had reductions processed. A sample of each managed care plan's population will be pulled. Results will be processed and reports will be developed to determine the accurate application of cost-sharing reductions. Plans found to be in non-compliance with processes and procedures related to application of cost-sharing reductions will be subject to established remedies and sanctions, per the managed care contract.

The Department is currently developing an interface for the managed care plans to submit member level Health Risk Assessment and cost-sharing data to the data warehouse. Data transfer will be tested extensively prior to implementation to ensure the fidelity and confidentiality of the data.

h. A strategy and implementation plan of how healthy behaviors will be tracked and monitored at the beneficiary and provider levels, including standards of accountability for providers.

See d.

i. An ongoing strategy of education and outreach post implementation regarding the Healthy Behaviors Incentives program including the strategies related to the ongoing engagement of stakeholders and the public in the state.

See Section e., which relates to implementation, and is meant to be the ongoing strategy section of the document.

The Department intends to continue education and outreach efforts on the incentives program for the duration of the demonstration. As long as there are new beneficiaries coming onto the Healthy Michigan Plan managed care program, they will be eligible to incentives if they meet the established criteria. The Department will continue to monitor feedback on the program from the beneficiary helpline, provider helpline, and all advocacy and stakeholder groups. 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 incentives program each year to our stakeholder groups. Through the formal evaluation, the department will publish reports on increased access to care, improvements in self-reported health status, and other relevant measures of success and engagement.

j. A description of other incentives in addition to reductions in cost sharing or premiums that the state will implement.

For those beneficiaries who are not required to pay monthly contributions (because their income is at or below 100 percent of the federal poverty level, or FPL), a $50 gift card will be distributed instead of a 50 percent reduction in monthly contributions. The eligibility requirements to earn this incentive are the same as those beneficiaries earning between above 100 percent of the FPL. They must attend an appointment with their primary care provider, complete the health risk assessment, and agree to address or

maintain a healthy behavior. Once the beneficiary has paid 2 percent of their income in copays, they will also be eligible for a 50 percent reduction in their copays. This process is described in Appendix 5.

k. The methodology describing how healthy behavior incentives will be applied to reduce premiums or copayments.

Healthy Michigan Plan Managed Care members will be rewarded for addressing behaviors necessary for improving health. Completion of an initial appointment with a primary care provider (along with requisite attestations) is necessary to be eligible for reductions in cost-sharing. While the Department encourages the managed care plans to work with their provider networks to ensure timely access for Healthy Michigan Plan members, there is no 'window of opportunity' in which the initial appointment and HRA needs to be done for the beneficiary to be eligible for the incentive. Once the initial appointment and HRA are complete the primary care provider will send a copy of the Health Risk Assessment and attestations to the managed care plans, which will apply incentives/reductions to cost-sharing in accordance with Appendix 5.

The Department has worked with a behavioral economist to develop an innovative approach to incentivizing members to complete the initial appointment and agree to address/maintain healthy behaviors. The Department believes that this approach will serve as an innovative model that rewards members for appropriate use of their new health care benefits.

Appendix 5 graphically describes the following recommendations of the Department: 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. All individuals receiving an incentive are eligible for a reduction in copays once the 2 percent threshold is met. Those individuals who pay a contribution (those above 100 percent of the FPL) will also be eligible for a 50 percent reduction in their monthly contribution. Those individuals at or below 100 percent of the FPL will receive a $50 gift card. Members who do not complete the Health Risk Assessment or who complete it but decline to engage in healthy behaviors will not be eligible for any reductions or incentives.
Members who complete an assessment and initial appointment 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.

Note: 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 (either a gift card or a reduction in contributions) begins when the

member completes the initial appointment and assessment. If a member never visits their primary care provider and does not complete the HRA, the member will not be eligible for the incentives. All Healthy Michigan Plan Managed Care members, regardless of income, who agree to maintain healthy behaviors or address at least one behavior change will be eligible for a reduction in copays. The administration of the MI Health Account, through which the cost-sharing reductions will be applied, is detailed in the MI Health Account Operational Protocol. Consistent with State law, the Department is in the process of evaluating limitations to potential reductions based on a members' failure to pay required cost-sharing. That is, a member who has earned a reduction in cost-sharing, but is subsequently found to be in 'consistent failure to pay' status, will lose that reduction for the remainder of year in which it was earned. 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. This limitation is required by State law. However, a member will not be found in consistent failure to pay status when the amount owed to the MI Health Account is less than $3.

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Appendix 1: MI Health Account Operation Timeline

Appendix 1

MI Health Account Operation Timeline

Beneficiary Cost Sharing Obligations

HEALTHY MICHIGAN PLAN

DRAFT

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Appendix 1: MI Health Account Operation Timeline

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Appendix 2: Chronic Conditions ICD-9

Condition	ICD-9 Codes	Comments
Alcohol Use Disorder	291	
	303	
	305.0	
	571.0-571.3, 535.3	
Asthma	493	
Chronic Kidney Disease	016.0	
	095.4	
	249.4	
	250.4	
	274.10	
	283.11	
	403.01, 403.11, 403.91	
	404.02, 404.03, 404.12, 404.13, 404.92, 404.93	
	440.1	
	442.1	
	572.4	
	580.0, 580.4, 580.81, 580.89, 580.9	
	581-583	
	584.5-588	
	591	
	753.12-753.2	
Chronic Obstructive Pulmonary Disease and Bronchiectasis	490-492	
	494	
	496	
Deep Venous Thrombosis (DVT) (while on anticoagulation)/Pulmonary Embolism (PE) (chronic anticoagulation)	415.1	To meet the chronic anticoagulation requirement, the diagnosis codes provided would need to be reported with V58.61.
	416.2	
	451.1	
	453.4-453.5	
Depression	296.2-296.3	
	296.51-296.56	
	296.6	
	296.89	
	298.0	
	300.4	
	309.1	

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Condition	ICD-9 Codes	Comments
	311	
Diabetes Mellitus	249-250	
	357.2	
	362.0	
	366.41	
Heart Failure	398.91	
	402.01, 402.11, 402.91, 404.01, 404.03, 404.11, 404.13, 404.91, 404.93	
	428	
HIV	042	
	V08	
Hyperlipidemia	272.0-272.4	
Hypertension	362.11	
	401-405	
	437.2	
Ischemic Heart Disease	410-413	
	414.0	
	414.12, 414.2, 414.3, 414.8, 414.9	
Obesity	278.0	
Schizophrenia	295	
Stroke/Transient Ischemic Attack	430-431	
	433.01, 433.11, 433.21, 433.31, 433.81, 433.91	
	434.00, 434.01, 434.10, 434.11, 434.90, 434.91	
	435.0, 435.1, 435.3, 435.8, 435.9	
	436	
	997.02	
Substance Use Disorder	292	
	304	
	305.2-305.9	
Tobacco Use Disorder	305.1	

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Appendix 2: Chronic Conditions ICD-10

Condition	ICD-10 Code	Comments
Alcohol Use Disorder	F10.1-F10.2	
	K29.2	
	K70	
Asthma	J45	
Chronic Kidney Disease	A18.11	
	A52.75	
	B52.0	
	D59.3	
	E08.2, E09.2, E10.2, E11.2, E13.2	
	I12.0, I13.11, I13.2	
	I70.1	
	I72.2	
	K76.7	
	M10.3	
	M32.14-M32.15	
	N00-N08	
	N13.1-N13.3	
	N14	
	N15	
	N16	
	N17-N19	
	N25	
	N26.1, N26.9	
	Q61.02	
	Q61.11	
	Q61.19	
	Q61.2	
	Q61.3	
	Q61.4	
	Q61.5	
	Q61.8	
	Q62.0	
	Q62.1	
	Q62.2	
	Q62.3	

Chronic Obstructive Pulmonary Disease and Bronchiectasis	J40-J42	
	J43	
	J44	
	J47	
Condition	**ICD-10 Code**	**Comments**
Deep Venous Thrombosis (DVT) (while on anticoagulation)/Pulmonary Embolism (PE) (chronic anticoagulation)	I26	
	I27.82	
	I80.1-I80.2	To meet the chronic anticoagulation requirement, the diagnosis codes provided would need to be reported with Z79.01.
	I82.4	
	I82.5	
Depression	F31.3-F31.6	
	F31.75-F31.78	
	F31.81	
	F32	
	F33	
	F34.1	
	F43.21	
Diabetes Mellitus	E08-E13	
Heart Failure	I09.81	
	I11.0, I13.0, I13.2	
	I50	
HIV	B20	
	Z21	
Hyperlipidemia	E78.0-E78.5	
Hypertension	H35.03	
	I10-I15	
	I67.4	
Ischemic Heart Disease	I20-I22	
	I24	
	I25.1	
	I25.2	
	I25.42	
	I25.5	
	I25.6	
	I25.7	
	I25.81-I25.83, I25.89, I25.9	
Obesity	E66	
Schizophrenia	F20	

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Condition	ICD-10 Code	Comments
Stroke/Transient Ischemic Attack	G45	
	G46.0-G46.2	
	I60-I61	
	I63	
	I66	
	I67.84, I67.89	
	I97.81-I97.82	
Substance Use Disorder	F11-F16	
	F18-F19	
Tobacco Use Disorder	F17	
	Z72.0	

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Appendix 2: Chronic Conditions Copay Exempt Drug Class Codes

Treatment Category	**Drug Class**	**Description**	**Chronic Condition(s) Treated**
Behavioral Health/Substance Abuse	C0D	Anti Alcoholic Preparations	Alcohol Dependence
	H2D	BARBITURATES	Anxiety
	H2E	SEDATIVE-HYPNOTICS,NON-BARBITURATE	Alcohol Dependence and Depression
	H2F	ANTI-ANXIETY DRUGS	Alcohol Dependence and Depression
	H2G	ANTI-PSYCHOTICS,PHENOTHIAZINES	Schizophrenia
	H2H	MONOAMINE OXIDASE(MAO) INHIBITORS	Depression
	H2M	BIPOLAR DISORDER DRUGS	Depressiion
	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
	H3T	NARCOTIC ANTAGONISTS	Alcohol Dependence
	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

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Appendix 2: Chronic Conditions Copay Exempt Drug Class Codes

Treatment Category	Drug Class	Description	Chronic Condition(s) Treated
	H7O	ANTIPSYCHOTICS,DOPAMINE ANTAGONISTS,BUTYROPHENONES	Schizophrenia
	H7P	ANTIPSYCHOTICS,DOPAMINE ANTAGONISTS, THIOXANTHENES	Schizophrenia
	H7S	ANTIPSYCHOTICS,DOPAMINE ANTAGONST,DIHYDROINDOLONES	Schizophrenia
	H7T	ANTIPSYCHOTICS,ATYPICAL,DOPAMINE,& SEROTONIN ANTAG	Schizophrenia and Depression
	H7U	ANTIPSYCHOTICS, DOPAMINE & SEROTONIN ANTAGONISTS	Schizophrenia
	H7X	ANTIPSYCHOTICS, ATYP, D2 PARTIAL AGONIST/5HT MIXED	Schizophrenia and Depression
	H7Z	SSRI & ANTIPSYCH,ATYP,DOPAMINE&SEROTONIN ANTAG CMB	Depression
	H8P	SSRI & 5HT1A PARTIAL AGONIST ANTIDEPRESSANT	Depression
	H8T	SSRI & SEROTONIN RECEPTOR MODULATOR ANTIDEPRESSANT	Depression
Chronic Cardiovascular Disease	A1A	DIGITALIS GLYCOSIDES	Heart Failure
	A1C	INOTROPIC DRUGS	Heart Failure
	A2C	ANTIANGINAL & ANTI-ISCHEMIC AGENTS,NON-HEMODYNAMIC	Ischemic Heart Disease
	A4A	ANTIHYPERTENSIVES, VASODILATORS	Hypertension
	A4B	ANTIHYPERTENSIVES, SYMPATHOLYTIC	Hypertension
	A4C	ANTIHYPERTENSIVES, GANGLIONIC BLOCKERS	Hypertension
	A4D	ANTIHYPERTENSIVES, ACE INHIBITORS	Hypertension, Ischemic Heart Disease and Heart Failure
	A4F	ANTIHYPERTENSIVES, ANGIOTENSIN RECEPTOR ANTAGONIST	Hypertension, Ischemic Heart Disease and Heart Failure

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Appendix 2: Chronic Conditions Copay Exempt Drug Class Codes

Treatment Category	Drug Class	Description	Chronic Condition(s) Treated
	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
	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
	A7B	VASODILATORS,CORONARY	Ischemic Heart Disease and Heart Failure
	A7C	VASODILATORS,PERIPHERAL	Ischemic Heart Disease and Stroke/Transient Ischemic Attack
	A7H	VASOACTIVE NATRIURETIC PEPTIDES	Hypertension and Heart Failure
	A7J	VASODILATORS, COMBINATION	Heart Failure
	A9A	CALCIUM CHANNEL BLOCKING AGENTS	Hypertension, Ischemic Heart Disease and Heart Failure

Treatment Category	Drug Class	Description	Chronic Condition(s) Treated
	C4A	ANTIHYPERGLY.DPP-4 INHIBITORS &HMG COA RI(STATINS)	Ischemic Heart Disease
	C6N	NIACIN PREPARATIONS	Hyperlipidemia
Chronic Cardiovascular Disease (cont.)	D7L	BILE SALT SEQUESTRANTS	Hyperlipidemia
	J7A	ALPHA/BETA-ADRENERGIC BLOCKING AGENTS	Hypertension and Heart Failure
	J7B	ALPHA-ADRENERGIC BLOCKING AGENTS	Hypertension
	J7B	ALPHA-ADRENERGIC BLOCKING AGENTS	Hypertension
	J7C	BETA-ADRENERGIC BLOCKING AGENTS	Heart Failure and Ischemic Heart Disease
	J7E	ALPHA-ADRENERGIC BLOCKING AGENT/THIAZIDE COMB	Hypertension
	J7H	BETA-ADRENERGIC BLOCKING AGENTS/THIAZIDE & RELATED	Hypertension
	M4D	ANTIHYPERLIPIDEMIC - HMG COA REDUCTASE INHIBITORS	Hyperlipidemia and Ischemic Heart Disease
	M4E	LIPOTROPICS	Hyperlipidemia and Ischemic Heart Disease
	M4E	LIPOTROPICS	Ischemic Heart Disease
	M4I	ANTIHYPERLIP - HMG-COA&CALCIUM CHANNEL BLOCKER CB	Hyperlipidemia, Hypertension, Ischemic Heart Disease
	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
	M9D	ANTIFIBRINOLYTIC AGENTS	Ischemic Heart Disease
	M9E	THROMBIN INHIBITORS,SEL.,DIRECT,&REV.-HIRUDIN TYPE	DVT and Ischemic Heart Disease

ATTACHMENT D
Healthy Behaviors Incentives Program Protocol
Appendix 2: Chronic Conditions Copay Exempt Drug Class Codes

Treatment Category	**Drug Class**	**Description**	**Chronic Condition(s) Treated**
	M9F	THROMBOLYTIC ENZYMES	DVT and Stroke/Transient Ischemic Attack
	M9K	HEPARIN AND RELATED PREPARATIONS	DVT and Ischemic Heart Disease
	M9L	ANTICOAGULANTS,COUMARIN TYPE	DVT and Ischemic Heart Disease
	M9P	PLATELET AGGREGATION INHIBITORS	Ischemic Heart Disease and Stroke/Transient Ischemic Attack
	M9T	THROMBIN INHIBITORS,SELECTIVE,DIRECT, & REVERSIBLE	DVT and Ischemic Heart Disease
	M9V	DIRECT FACTOR XA INHIBITORS	DVT
	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
Chronic Pulmonary Disease	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
	Z2F	MAST CELL STABILIZERS	Asthma
	Z2X	PHOSPHODIESTERASE-4 (PDE4) INHIBITORS	COPD
	Z4B	LEUKOTRIENE RECEPTOR ANTAGONISTS	Asthma

ATTACHMENT D
Healthy Behaviors Incentives Program Protocol
Appendix 2: Chronic Conditions Copay Exempt Drug Class Codes

Treatment Category	**Drug Class**	**Description**	**Chronic Condition(s) Treated**
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

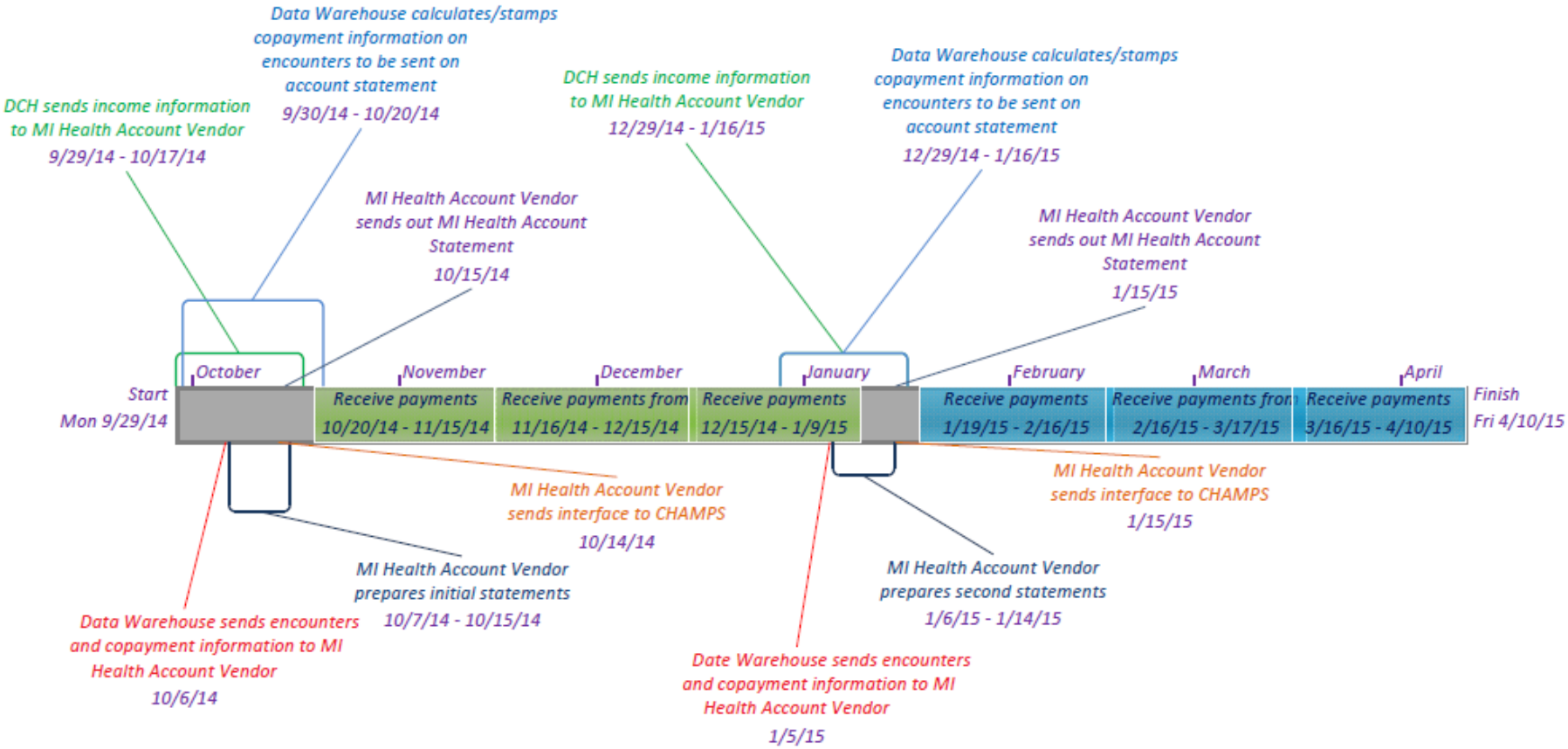
ATTACHMENT D
Healthy Behaviors Incentives Program Protocol
Appendix 2: Chronic Conditions Copay Exempt Drug Class Codes

Treatment Category	Drug Class	Description	Chronic Condition(s) Treated
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
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
Smoking Cessation	J3A	SMOKING DETERRENT AGENTS (GANGLIONIC STIM,OTHERS)	Tobacco Use Disorder

ATTACHMENT D
Healthy Behaviors Incentives Program Protocol
Appendix 2: Chronic Conditions Copay Exempt Drug Class Codes

Treatment Category	Drug Class	Description	Chronic Condition(s) Treated
	J3C	SMOKING DETERRENT-NICOTINIC RECEPT.PARTIAL AGONIST	Tobacco Use Disorder

ATTACHMENT D
Healthy Behaviors Incentives Program Protocol
Appendix 3: Interface Timeline



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 and 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. Take this form with you when you go. 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. 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.

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.

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.

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 ٣١٩٥-٦٤٢-٨٠٠-١

ATTACHMENT D
Healthy Behaviors Incentives Program Protocol
Appendix 4: Health Risk Assessment

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. **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.

3. **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.

4. **In the last 7 days, how often did you have (5 or more for men, 4 or more for women) alcoholic drinks at one time?** ☐ 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.

5. **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

6. **In the last 30 days, how often have you felt tense, anxious or depressed?**
   ☐ Almost every day ☐ Sometimes ☐ Rarely ☐ Never

7. **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.

8. **The flu vaccine can be a shot in the arm or a spray in the nose. Have you had a flu shot or flu spray in the last year?** ☐ Yes ☐ No

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

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

ATTACHMENT D
Healthy Behaviors Incentives Program Protocol
Appendix 4: Health Risk Assessment

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

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.

hat month did you first schedule this appointment? _____ (Month)

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.

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. Look at the list below and **CHOOSE ONE or MORE**:

- ☐ Exercise regularly, eat better, and/or lose weight
- ☐ Cut back or quit smoking or using tobacco
- ☐ Get a flu shot
- ☐ Return to the doctor to get tested for high blood pressure, high cholesterol and diabetes OR if I already have any of them, return to the doctor for check-ups for these conditions
- ☐ Cut back or quit drinking alcohol
- ☐ Seek treatment for drug or substance abuse
- ☐ I will commit to keep up all of the healthy things I do now
- ☐ Other:

Changes like drinking water rather than soda or walking every day can help you stay healthy or help you better control illnesses you may already have. You can learn new ways to handle stress or quit smoking. Remember, even small changes can be difficult and take a long time. It may be helpful to get support from your family, friends, community or your doctor. Your health plan may have programs that can help you.

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

1. **Thinking about your healthy behavior(s), do you want to make some small**

☐	☐	☐	☐	☐	☐
0	**1**	**2**	**3**	**4**	**5**

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?	☐ **0**	☐ **1**	☐ **2**	☐ **3**	☐ **4**	☐ **5**
	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?	☐ **0**	☐ **1**	☐ **2**	☐ **3**	☐ **4**	☐ **5**
	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	

ATTACHMENT D
Healthy Behaviors Incentives Program Protocol
Appendix 4: Health Risk Assessment

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

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 Member Results, select a Healthy Behavior statement in discussion with the member, and sign the Primary Care Provider Attestation. Blood pressure, BMI and tobacco use status will be known from the appointment. For all other Member Results, marking the result as unknown and indicating whether the screening or immunization is recommended satisfies the requirements for a complete Health Risk Assessment. All three parts of Section 4 must be filled in for the attestation to be considered complete.

Member Results

Blood Pressure	(xxx/xxx mmHg)	Patient diagnosed with hypertension? ☐ Yes ☐ No
BMI	_____Ht _____Wt. BMI _____ (xx.x)	In the context of all relevant clinical factors, does this BMI indicate need for weight management? ☐ Yes ☐ No
Tobacco Use Status	☐ Never used tobacco ☐ Previous tobacco user ☐ Current tobacco cessation ☐ Starting tobacco cessation ☐ Tobacco user	
Cholesterol	Cholesterol known? ☐ Yes ☐ No	Patient diagnosed with high cholesterol? ☐ Yes ☐ No
	If cholesterol known is **Yes**: Date of most recent test results:	Total cholesterol: _____ LDL: _____ HDL: _____ Triglycerides:
	If cholesterol known is **No**:	☐ Screening not recommended ☐ Screening Ordered
Blood Sugar	Blood sugar known? ☐ Yes ☐ No	Patient diagnosed with diabetes? ☐ Yes ☐ No
	If blood sugar known is **Yes**: Date of most recent test results:	FBS (xxx mg/dl): _____ A1C (xx.x%): _____

	If blood sugar known is **No**:	☐ Screening not recommended	☐ Screening Ordered
Influenza Vaccine	Annual Influenza Vaccination? ☐ Yes ☐ No		
	If Influenza vaccination is **Yes**:	Date of most recent vaccination:	
	If Influenza vaccination is **No**:	☐ Vaccination not recommended	☐ Vaccination recommended

ATTACHMENT D
Healthy Behaviors Incentives Program Protocol
Appendix 4: Health Risk Assessment

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

Healthy Behaviors - Choose one of the following statements (**1 - 4**)

☐ **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***
- ☐ ***Agrees to follow-up appointment for screening or management (if necessary) of hypertension, cholesterol and/or diabetes***
- ☐ ***Reduce/quit alcohol consumption***
- ☐ ***Treatment for Substance Use Disorder***
- ☐ ***Other:***
  explain _____

☐ **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.**

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.

Print Name (First Name, Last Name)	National Provider Identifier (NPI)
Signature	Date

Submission Instructions:

- Submit completed forms in the secure manner specified by the member's Managed Care Plan.

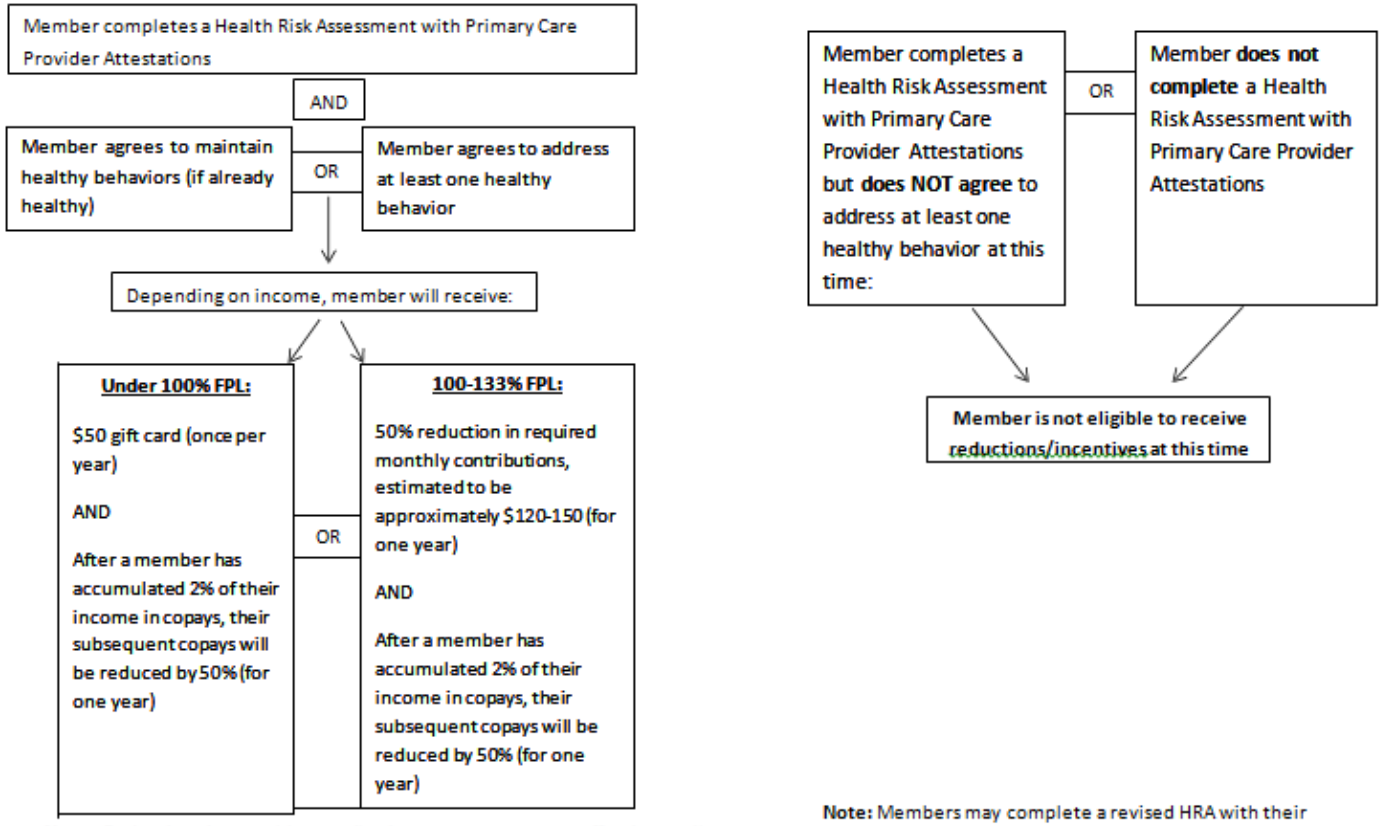
ATTACHMENT D
Healthy Behaviors Incentives Program Protocol
Appendix 4: Health Risk Assessment

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

Completion: Of this form provides information to better meet the health needs of Healthy Michigan Plan beneficiaries in Managed Care Plans.

Michigan Department of Community Health is an equal opportunity employer.

ATTACHMENT D
Healthy Behaviors Incentives Program Protocol
Appendix 5: Healthy Michigan Plan Healthy Behaviors Incentives Eligibility and Distribution



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

Note: Members may complete a revised HRA with their primary care provider at any time during the year to become eligible for the incentives program.

Note: Members who complete an assessment and initial appointment 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.

08/14/14

Michigan Department of Community Health
MDCH
Rick Snyder, Governor
James K. Haveman, Director

Health

Michigan Department of Community
Appendix 6
Medical Services Administration

MEMORANDUM

Medical Care Advisory Council
AGENDA

DATE: **Tuesday February 11, 2014**
TIME: **1:30 pm – 4:30 pm (NOTE LATER START TIME)**
WHERE: **Michigan Public Health Institute (MPHI)**
2436 Woodlake Circle
Okemos, MI
517-324-8326

1. Welcome and Introductions …….……..……...…….Jan Hudson
2. Affordable Care Act Implementation
   a. Healthy Michigan Plan...…… Staff
      i. Waiver Status – Terms and Conditions
      ii. Outreach and Enrollment Plans
      iii. Coordination with DHS
      iv. MAGI Implementation Update
      v. Symposium on High Emergency Room Utilizers – Follow-up
   b. Dual Eligibles Integration Project – Update
   c. SIM Update
3. FY2015 Executive Budget Recommendation ……..……..…… Staff
4. Mental Health Commission Recommendations ……. Staff
5. Policy Updates …….…...……. Staff

4:30 – Adjourn

Next Meeting: May 14, 2014

ATTACHMENT E
Annual Update of Rural Counties Not Required to Provide a Choice of Managed Care Plans

Health Plan Choice
The state will comply with Section 1932(a)(3) of the Social Security Act and the Code of Federal Regulations at 42 CFR 438.52, which requires beneficiaries to enroll in a Medicaid Health Plan, but gives the choice of at least two entities, with some exceptions. In rural counties, the state will employ the "rural exception" where beneficiaries will only have one choice of a Medicaid Health Plan, but given the choice of individual providers. The state will use the rural exception in the following counties:

1. Alger;
2. Baraga;
3. Chippewa;
4. Delta;
5. Dickinson;
6. Gogebic;
7. Houghton;
8. Iron;
9. Keweenaw;
10. Luce;
11. Mackinac;
12. Marquette;
13. Menominee;
14. Ontonagon; and
15. Schoolcraft.

Healthy Michigan Program beneficiaries will be given their choice of plans and providers consistent with federal law and regulation. For those populations who are currently voluntary or exempt from enrollment into a Medicaid Health Plan (e.g., Native Americans, beneficiaries who have other Health Maintenance Organization or Preferred Provider Organization coverage, etc.), they will remain a voluntary or exempt population from managed care under this demonstration.

ATTACHMENT F
Final Report Framework

The final Demonstration Evaluation (draft report), in accord with the Special Terms and Conditions, should accompany the Final Report (draft) for CMS review.

The Final Report is the same as the final annual report if the document addresses:

Introduction
- Summarize history and state's experience
- Waivers (rationale and impact)
- Timeline for renewals, amendments, and other significant changes

Objectives, goals and hypotheses of the demonstration
- Description
- How met/not met

Lessons learned
Operational/policy developments and issues
Challenges/problems encountered and how addressed
- Rationale for amendments and other significant changes
- Innovative activities and/or promising practices
- Examples: including ABD individuals in managed care;
  pros/cons of a single MCO;
  transition to multiple MCOs (challenges/lessons learned)
  methodology
  number of beneficiaries transitioned out and returning to Passport

Beneficiaries
- Who was enrolled
- Enrollment numbers charted over time
- Outreach and enrollment efforts (success and challenges)

Benefits
- Variations from state plan
- Utilization data and trends over time
- Consumer issues (types of complaints or problems identified; trends; resolution of complaints and any actions taken to prevent other occurances)

Delivery system
- Providers – working with and monitoring providers
  - FQHCs/RHCs - role and impact
- Health Plans – working with and monitoring providers
- Performance improvement focus(es) and changes over time

Cost sharing
- Variations from state plan
- Changes that occurred during the demonstration
- Impact of any changes

ATTACHMENT F
Final Report Framework

Quality
- Quality Assurance and monitoring activities
- Quality Reports (names, dates and how to access reports)
  - Selections of quality indicators and data reporting
  - Quality improvement focus(es) and outcomes over time
- Beneficiary surveys and findings
- Provider surveys and findings

Other influences – actions and impact
- Legislature
- Advocates and other stakeholders
- Other (environmental, economic, etc.)

Budget Neutrality
- Actual budget neutrality (based on claim paid as of a specified date)
- Estimated final budget neutrality
  - Expenditure estimates for the demonstration based on historical data
  - Methodology for determining expenditure estimates

(Note: For temporary extension periods, use PMPM and trend rates from the last formal renewal)