STATE OF MICHIGAN
DEPARTMENT OF HEALTH AND HUMAN SERVICES
LANSING

RICK SNYDER
GOVERNOR

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June 30, 2015

Leila Ashkeboussi, Project Officer
Centers for Medicare and Medicaid Services
7500 Security Boulevard
Mail Stop S2-01-16
Baltimore, Maryland 21244-1850

Dear Ms. Ashkeboussi,

Re: Project Number 11-W-00245/5 – Healthy Michigan Plan

Enclosed is the revised version of the first annual report for Healthy Michigan Plan. It covers the first demonstration year of the Healthy Michigan Plan. The report provides operational information, program enrollment, and policy changes related to the waiver as specified in the Special Terms and Conditions.

Should you have any questions related to the information contained in this report, please contact Jacqueline Coleman. She may be reached by phone at (517) 241-7172, or by e-mail at colemanj@michigan.gov.

Sincerely,

[redacted]

Brian Keisling, Director
Actuarial Division

cc: Ruth Hughes, Region V, CMS
Angela Garner, Central Office, CMS
Jacqueline Coleman, MDHHS

Enclosures (10)

Michigan Adult Coverage Demonstration
Section 1115 Annual Report

Demonstration Year: 5 (10/1/2013 – 12/31/2014)
Reporting Period: (04/01/2014 – 12/31/2014)

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

Introduction

In January 2004, the "Adult Benefits Waiver" (ABW) was 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.

In December 2009, Michigan was granted approval by the Centers for Medicare and Medicaid Services (CMS) for a new Medicaid Section 1115 demonstration, entitled "Michigan Medicaid Nonpregnant Childless Adults Waiver (Adult Benefits Waiver)," to allow the continuation of the ABW health coverage program after December 31, 2009 through the use of Title XIX funds. The new ABW 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.

In December 2013, CMS approved Michigan's request to amend the Medicaid demonstration, entitled "Healthy Michigan Plan Section 1115 Demonstration (Project No. 11-W-00245/5)," formerly known as the Medicaid Nonpregnant Childless Adults Waiver [Adult Benefits Waiver (ABW)]. 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 ABW was amended and transformed to establish the Healthy Michigan Plan, through which the Michigan Department of Community Health (MDCH) will test innovative approaches to beneficiary cost sharing and financial responsibility for health care for the new adult eligibility group. The new adult population with incomes above 100 percent of the FPL will be required to make contributions toward the cost of their health care. In addition, all newly eligible adults from 0 to 133 percent of the FPL will be subject to copayments consistent with federal regulations.

In October 2014, the MI Health Account was established for individuals enrolled in managed care plans to track beneficiaries' cost-sharing and service utilization. Healthy Michigan Plan beneficiaries receive quarterly statements that summarize the MI Health Account activity. The quarterly statements provide applicable members with contribution and co-payment amounts. Beneficiaries can meet cost sharing obligations by making monthly payments online or by mail and have the flexibility in the timing of their payments so long as the total payment obligation is met by the end of the quarter. Beneficiaries also have opportunities to reduce their cost-sharing amounts by agreeing to address or maintain certain Healthy Behaviors. Healthy Michigan Plan provides a full health care benefit package as required under the Affordable Care Act including all of the Essential Health Benefits as required by Federal law and regulation. There will not be any limits on the number of individuals who can enroll. Beneficiaries who received coverage under the ABW program transitioned to the Healthy Michigan Plan on April 1, 2014.

To reflect its expanded purpose, the name of the demonstration is changed to Healthy Michigan Plan. The overarching themes used in the benefit design will be:

- Increasing access to quality health care;
- Encouraging the utilization of high-value services; and
- Promoting beneficiary adoption of healthy behaviors and using evidence-based practice initiatives.

Organized service delivery systems will be utilized to improve coherence and overall program efficiency.

MDCH's goals in amending the demonstration are to:

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

Enrollment and Benefits Information

As previously indicated, MDCH's Healthy Michigan Plan began on April 1, 2014. Enrollment into the program happened in two ways. Beneficiaries who were enrolled in the ABW were automatically transitioned into the Healthy Michigan Plan effective April 1, 2014. MDCH began enrolling new beneficiaries into the program beginning April 1. Potential enrollees can apply for the program in one of three ways. They can apply via the Michigan Department of Human Services' (MDHS') website, call a toll-free number or visit their local MDHS office. At this time, MDCH does not anticipate any changes in the population served or the benefits offered. Enrollment surpassed early expectations during the first year of the program, which is evidence of the high demand for the services offered. Information regarding enrollment and disenrollment is available in the Enrollment Counts for Quarter and Year to Date section of this report.

While Healthy Michigan Plan enrollment demonstrated substantial growth, MDCH saw a significant number of disenrollments from the plan as reported in the Monthly Enrollment Reports to CMS. Healthy Michigan disenrollments reflect individuals who were disenrolled during a redetermination of eligibility or switched coverage due to eligibility for other Medicaid

program benefits. In most cases beneficiaries were disenrolled from the Healthy Michigan Plan due to eligibility for other Medicaid programs. This occurs as a result of MDCH's validation of self-attested information from the beneficiary. MDCH matches information provided by the beneficiary with that available through State and Federal databases. Movement between Medicaid programs is common and MDCH expects that beneficiaries will continue to shift between Healthy Michigan and other Medicaid programs as their eligibility changes.

The following table details new Healthy Michigan Plan enrollments by month for the 2014 calendar year as of March 2015 and include retroactive enrollments:

Table 1: 2014 Healthy Michigan Plan: New Enrollments by Month								
April	**May**	**June**	**July**	**August**	**September**	**October**	**November**	**December**
259,620	62,374	42,177	43,859	44,946	47,385	50,429	46,742	54,529

The following table details Healthy Michigan Plan disenrollments by month for the 2014 calendar year as of March 2015:

Table 2: 2014 Healthy Michigan Plan: Disenrollments by Month								
April	**May**	**June**	**July**	**August**	**September**	**October**	**November**	**December**
-	5,719	8,147	12,249	12,589	23,343	19,139	14,247	19,835

This year, most Healthy Michigan Plan beneficiaries elected to choose a health plan rather than be automatically assigned a health plan. As of December 15, 2014, 265,227, or 74 percent, of the State's 357,484 Healthy Michigan Plan health plan enrollees chose a health plan. The remaining managed care enrolled beneficiaries were automatically assigned to a health plan. All Medicaid Health Plan members have an opportunity to change their plan within 90 days of enrollment into the plan. During this year, 13,268 enrollees changed health plans. Of the 13,268 members that changed health plans, 6,977, or 53 percent, were previously automatically assigned to a health plan.

Healthy Michigan Plan members have the opportunity to reduce cost-sharing requirements through the completion of Health Risk Assessments and engaging in healthy behaviors. MDHHS has developed a standard Health Risk Assessment form to be completed annually. Health Risk Assessment forms and reports are located on the MDHHS website: http://www.michigan.gov/mdch/0,4612,7-132-2943_66797-325070--,00.html. The Health Risk Assessment document is intended to be completed in two parts. Healthy Michigan Plan members typically complete the first sections of the form with the assistance of the Healthy Michigan Plan enrollment broker over the phone. Additionally, Medicaid Health Plans mail the Health Risk Assessment form to all new members. New members are also informed that an annual preventative visit is a covered benefit of the Healthy Michigan Plan. The remainder of the form is completed at the initial primary care visit. Members that are automatically assigned to a health plan are not surveyed but can complete the entire Health Risk Assessment at the primary care provider's office.

The initial assessment questions section of the Health Risk Assessments completed through the MDHHS enrollment broker had a completion rate of 96 percent this year. MDHHS is encouraged by the high level of participation by beneficiaries at the initial point of contact.

The following table details that Health Risk Assessment data collected by the enrollment broker:

Table 3: 2014 Health Risk Assessment (HRA) Enrollment Broker Data					
Month	Number of Completed HRAs	Percent of Total	Number of Refused HRAs	Percent of Total	Total Enrollment Calls
March	17,398	97%	482	3%	17,880
April	6,536	97%	178	3%	6,714
May	33,331	97%	1,172	3%	34,503
June	20,611	96%	875	4%	21,486
July	15,336	96%	582	4%	15,918
August	15,480	96%	625	4%	16,105
September	10,866	96%	458	4%	11,324
October	11,765	95%	602	5%	12,367
November	5,513	95%	318	5%	5,831
December	9,325	93%	684	7%	10,009
Total	146,161	96%	5,976	4%	152,137

Completion of the remaining Health Risk Assessment sections (beyond those completed through the State's enrollment broker) requires beneficiaries to schedule an annual appointment, select a Healthy Behavior, and have member results completed by their primary care provider. The primary care provider then securely sends the completed Health Risk Assessment to the appropriate Medicaid Health Plan. Health Risk Assessments for 35,177 Healthy Michigan Plan beneficiaries participating in the healthy behaviors incentive program were submitted by the Medicaid Health Plans this year. Of the 35,177 completed Health Risk Assessments, health plans have reported that 29,552 of the incentives earned were gift card incentives, and health plans began mailing these gift cards to their members. Additionally, 5,381 reductions in contribution requirements were earned. Reductions earned were first applied to the MI Health Account Statements in November 2014. There were 244 Health Risk Assessments where members completed the survey but declined to choose a Healthy Behavior.

The following table details that Health Risk Assessment data submitted by the Medicaid Health Plans:

Table 4: 2014 Quarterly Health Risk Assessment (HRA) Health Plan Data				
	April - June	July - September	October - December	Total
HRAs Submitted	-	17,494	17,683	35,177
Gift Cards Earned	-	15,032	14,520	29,552
Reductions Earned	-	2,333	3,048	5,381
Reductions Applied	-	-	1,300	1,300

The completed Health Risk Assessments submitted by the Medicaid Health Plans are not limited to those where members completed the first section over the phone with the enrollment broker. Members also receive Health Risk Assessments by mail from their health plan and can download the form online. As a result, MDHHS measures Health Risk Assessment completion by the percentage of Healthy Michigan Plan health plan members that complete the Health Risk Assessment within 150 days of health plan enrollment. This includes Health Risk Assessments completed during the fee-for-service period prior to enrollment in a Medicaid Health Plan. This measure is calculated by dividing the number of members that completed the Health Risk

Assessment by the total number of eligible members. This year, 14 percent of Healthy Michigan Plan members completed a Health Risk Assessment within 150 days of health plan enrollment.

Enrollment Counts for Year and Year to Date

The enrollment counts below are for unique beneficiaries for the identified time periods. The unique enrollee count will differ from the count from the Beneficiary Month Reporting section as a result of disenrollment that occurred during the quarter. Disenrollment can occur for a variety of reasons including change in eligibility status, such as an increase in income, or as part of a redetermination cycle, for example.

The following table contains unique enrollment counts for the year and year to date:

Table 5: Enrollment Counts for Year and Year to Date

Demonstration Population	Total Number of Demonstration Beneficiaries Year Ending – 12/2014	Current Enrollees (year to date)	Disenrolled in Demonstration Year
ABW Childless Adults	N/A	N/A	N/A
Healthy Michigan Adults	537,823	586,959	115,268

Outreach/Innovation Activities to Assure Access

On March 20, 2014, Governor Snyder announced to the public that the State would begin taking applications for the new Healthy Michigan Plan effective April 1, 2014. Most program beneficiaries are expected to enroll into one of the State's thirteen licensed Medicaid Health Plans. MDCH monitors the adequacy of the health plans' networks to ensure there is capacity to serve all of the new beneficiaries, and avoid access to care issues. In most cases, beneficiaries are able to choose from at least two health plans to provide their coverage.

MDCH developed a Healthy Michigan Program website with information available to both beneficiaries and providers (http://www.michigan.gov/healthymiplan/). There is a frequently asked question and answer section that provides additional information to users of this site. Beneficiaries also receive informational materials in the form of a member handbook with their enrollment packet. This year, advertisements for the program ran on the radio and television. In addition, MDCH worked closely with provider groups through meetings, Medicaid provider policy bulletins, and various interactions with community partners and provider trade associations. MDCH also created a mailbox, healthymichiganplan@michigan.gov, for questions or comments about the Healthy Michigan Plan. Utilization of this mailbox has decreased as the program has become more established.

An MDCH course on the completion of Healthy Michigan Plan Health Risk Assessment was released to the public August 1, 2014. This two hour course was developed for health care practitioners who are providing care and services to Healthy Michigan Plan beneficiaries. The course has been helpful to the provider community and has received a positive response. MDCH also performed outreach with a webinar catering to community partners on September 18, 2014. Additionally, MDHS field workers received informational material on how to approach beneficiaries that have questions about MI Health Account statements. At the end of September 2014, applicable beneficiaries received MI Health Account welcome letters. These letters described how the account functions, what the beneficiary can expect and contact information for additional assistance.

MDCH held post award forums with the Medical Care Advisory Council (MCAC) to discuss the Healthy Michigan Plan. The purpose of the MCAC is to advise MDCH on policy issues related to Medicaid. In addition, the Council is involved with the issues of access to care, quality of care, and service delivery for managed care and fee-for-service programs. These meetings provide an opportunity for attendees to provide program comments or suggestions. Please see the 2014 meeting minutes attached as an enclosure. MCAC meeting agendas and minutes are also available online at: http://michigan.gov/mdch/0,4612,7-132-2943_4860-55742--,00.html.

Collection and Verification of Encounter Data and Enrollment Data

MDCH has a mature managed care program that began in the late 1990s and has evolved over time to become an efficient healthcare delivery system for Michigan's Medicaid beneficiaries. This same system was expanded on April 1, 2014, to include the Healthy Michigan Plan. Once a beneficiary is determined to be eligible for the new program, the State's enrollment broker provides the beneficiary with an opportunity to select the Medicaid Health Plan into which he/she would like to enroll. If no plan is chosen, the beneficiary is automatically assigned to a plan using an MDCH defined algorithm. Until such time that a person is enrolled in a plan, he/she receives coverage through MDCH's fee-for-service system. On average, beneficiaries spend approximately 40 days in the fee-for-service environment before enrolling into a plan. This same process is used for traditional Medicaid beneficiaries. Enrollment data are readily available and provide useful information regarding characteristics of the new waiver population. These data are used to generate monthly capitation payments to the health plans. As a mature managed care state, all Medicaid Health Plans submit encounter data to MDCH for the services provided to Healthy Michigan Plan beneficiaries following the existing MDCH data submission requirements. This year, MDCH used the encounter data to prepare the MI Health Account statements beginning with those mailed in October 2014.

MDCH has actively engaged in its Encounter Data Quality Initiative (EQI) process for all managed care benefit plans. Data from the MDCH data warehouse and internal data from the Medicaid Health Plans is compared by Milliman, Inc., the State's actuary. Milliman, MDCH and the plans work together in determining data inconsistencies. The plans then take corrective action ensuring submission of quality data. To incentivize Medicaid Health Plans to maintain high quality encounter data, future measures are included in the Health Plans performance metrics pertaining to encounter data quality. MDCH continues to work closely with the plans in reviewing, monitoring and investigating encounter data anomalies. MDCH and the plans then work collaboratively to correct any issues discovered as part of the review process.

Operational/Policy/Systems/Fiscal Development Issues

On December 30, 2013, CMS approved the State's Healthy Michigan Plan, which began on April 1, 2014. Health coverage under this program includes both Federal and State mandated essential health benefits such as ambulatory patient services, emergency services, hospitalization, mental health and substance abuse disorders, prescription drugs, rehabilitative and habilitative services, laboratory services, preventive and wellness services, and pediatric services for 19 and 20 year olds.

During the first year of launching the Healthy Michigan Plan, MDCH encountered systems issues that resulted in the retroactive enrollment of Healthy Michigan Plan members into the Medicaid Health Plans. The information supplied via the Eligibility Verification Systems and the information that the plans received did not match. The Medicaid Health Plans were notified

immediately of the defect and were instructed to recognize the enrollment to remove any barriers to care. However, this defect not only generated member complaints, but required repair to the Eligibility Verification Systems. MDCH systems staff were able to ensure that MI Health Account statement accuracy was not impacted by the retroactive enrollment defect by identifying applicable members and making the appropriate changes.

The following are notable CMS approval dates from this demonstration year:

December 30, 2013: Healthy Michigan Plan Demonstration Approval

August 29, 2014: Healthy Behaviors Incentives Program and Contributions Accounts and Infrastructure Operational Protocols Approval

October 22, 2014: Demonstration Evaluation Plan Approval

The following Healthy Michigan Plan policies were issued by the State during the year covered by this report:

Feb 27, 2014: A policy bulletin was released to provide information to providers regarding eligibility for the Healthy Michigan Plan; describe the transition of ABW beneficiaries into the Healthy Michigan Plan; describe the delivery system of the new program; describe the Health Risk Assessment component of the program; describe the beneficiary cost sharing requirements; and provide a list of the program's covered services.

Feb 27, 2014: A policy bulletin was released to provide information to providers regarding eligibility determinations for the Healthy Michigan Plan, effective April 1, 2014.

August 29, 2014: A policy bulletin was released to provide additional information on the promotion of healthy behaviors, cost-sharing requirements and special coverage provisions.

October 9, 2014: A policy bulletin was released to modify guidance previously provided as it relates to Healthy Michigan Chronic Condition Copay Exemption. The policy clarified that if the beneficiary's visit is related to one of the program-specified chronic conditions, there is no copay for the service.

December 29, 2014: A policy bulletin was released to provide information and policy regarding the Behavioral Health Benefit for the Healthy Michigan Plan.

The following Healthy Michigan Plan Medicaid Provider letters were issued by the State during the year covered by this report:

April 2, 2014: A letter was released to notify all providers of an update on the status of enrollment for the Healthy Michigan Plan.

May 8, 2014: A letter was released to Tribal Chairs and Health Directors as notification of MDCH's intent to submit the MI Health Account Operational Protocol and the Healthy Behaviors Incentives Operational Protocol.

June 13, 2014: A letter was released to provide an update regarding Healthy Michigan Plan Health Risk Assessments completed prior to beneficiary enrollment in a health plan.

September 30, 2014: A letter was released to select providers to clarify the process through which claims from Healthy Michigan Plan members retroactively enrolled in health plans are to be processed.

October 28, 2014: A letter was released to notify all providers and Medicaid Health Plans that Healthy Michigan Plan beneficiaries enrolled in Medicaid managed care plans are required to receive information on potential copays at the point of service.

Financial/Budget Neutrality Development Issues

This year MDCH engaged with CMS staff during the waiver's bi-weekly CMS/Michigan Implementation conference calls to discuss issues surrounding items that were initially excluded from the budget neutrality calculations. On September 30, 2014, MDCH submitted a request to CMS for an increase to its budget neutrality cap. The primary reason for the requested increase was related to the development of actuarially sound capitation rates to the Medicaid Health Plans and Prepaid Inpatient Health Plans occurring after the submission of the original budget neutrality request. On January 13, 2015, CMS approved an increase in the Healthy Michigan Plan per member per month limit.

MDCH will continue to update the Healthy Michigan Plan Budget Neutrality Monitoring Table as expenditures are adjusted over time. MDCH collected the Healthy Michigan Plan expenditures using the information submitted in the CMS 64.9VIII files. Expenditures for Demonstration Year 5 include expenditures that both occurred and were paid in the same quarter in addition to adjustments to expenditures paid in quarters after the quarter of service. Expenditures for all eligible groups within the Healthy Michigan Plan were included. The total annual expenditures for Demonstration Year 5 amounted to $1,495,020,215. This amount is consistent with that reported on the CMS-64 Quarterly Expense Report. Currently administrative costs for the Healthy Michigan Plan are not reported separately. MDCH is working with CMS to report administrative costs separately in future CMS-64 Quarterly Expense Reports. MDCH has provided a complete budget monitoring table below.

Table 6: Healthy Michigan Plan Budget Neutrality Monitoring Table

	DY 5 - PMPM	DY 6 - PMPM	DY 7 - PMPM	DY 8 - PMPM	DY 9 - PMPM
Approved HMP PMPM	$667.36	$542.15	$569.80	$598.86	$629.40
Actual HMP PMPM (YTD)	$407.45	-	-	-	-
Total Expenditures (YTD)	$1,495,020,215	-	-	-	-
Total Member Months (YTD)	3,669,197	-	-	-	-

Beneficiary Month Reporting

The beneficiary counts below include information for each of the designated months during the year, and include retroactive eligibility through December 31, 2014.

Table 7: Healthy Michigan Plan Beneficiary Month Reporting

Eligibility Group	April 2014	May 2014	June 2014	July 2014	August 2014	September 2014	October 2014	November 2014	December 2014	Total for Year Ending 12/2014
Healthy Michigan Adults	259,620	316,275	350,305	381,915	414,272	438,314	469,604	502,099	536,793	3,669,197

Consumer Issues

This year, the total number of Healthy Michigan Plan complaints reported to MDCH was 634. The largest number of complaints stemmed from the previously mentioned retroactive enrollment defect experienced by MDCH. The defect lead to the retroactive enrollment of Healthy Michigan Plan beneficiaries into the managed care plans. As a result of the aforementioned retroactive enrollment issue, some beneficiaries experienced difficulties with health plan enrollment recognition and obtaining prescriptions. The managed care plans were able to recognize the enrollment to remove any barriers to care.

Beneficiaries, especially in rural areas, can experience difficulty in utilizing transportation services due to a lack of drivers. This issue is one that preceded the implementation of the Healthy Michigan Plan. This year, MDCH and the Medicaid Health Plans met and discussed possible improvements. Complaints categorized as Other Issues include contacts related to behavioral health, dental, covered services, and medical supplies. Overall, MDCH is encouraged by its low rate of complaints during the first year of the program. MDCH will continue to monitor calls to the Beneficiary Helpline to identify problems or trends that need to be addressed. The following tables show the number of Healthy Michigan Plan complaints by quarter and by category.

Table 8: Number of Healthy Michigan Plan Complaints By Quarter: April 2014 – December 2014		
April 2014 – June 2014	July 2014 – August 2014	September 2014 – December 2014
356	167	131

Table 9: Healthy Michigan Plan Complaints: April 2014 – December 2014		
Category	**Count**	**Percent**
Eligibility/Enrollment	348	53%
Obtaining Prescriptions	198	30%
Transportation	52	8%
Other Issues	56	9%
Total	654	-

Quality Assurance/Monitoring Activity

MDCH completes Performance Monitoring Reports (PMR) for the thirteen Medicaid Health Plans that are licensed and approved to provide coverage to Michigan's Medicaid beneficiaries. These reports are based on data submitted by the health plans. Health plans submit data for the following items: grievance and appeal reporting, a log of beneficiary contacts, financial reports, encounter data, pharmacy encounter data, provider rosters, primary care provider-to-member ratio reports, and access to care reports. The measures for the Healthy Michigan Plan population will mirror those used for the traditional Medicaid population. In addition, MDCH will monitor trends specific to this new population over time.

MDCH presented its Healthy Michigan Plan Performance Monitoring Specifications to the Medicaid Health Plans at the September 2014 Administrative Issues meeting. Many of the measures for fiscal year 2015 are informational as MDCH continues to refine its data collection and analysis process. Performance areas include Adults' Access to Ambulatory Health Services, Outreach and Engagement to Facilitate Entry to Primary Care, Adults' Generic Drug Utilization, Plan All-Cause Acute 30-Day Readmissions, and Timely Completion of Initial Health

Risk Assessment. Information regarding the 2015 Pay for Performance Project was also presented to the Medicaid Health Plans at the September 2014 Administrative Issues meeting. Medicaid Health Plans will be awarded points in performance categories based on their delivery of performance criteria. Pay for Performance under the Healthy Michigan Plan is calculated using Cost Sharing and Incentives, Access to Care, Health Risk Assessment, and Value Added categories.

During the November Administrative Issues Meeting, MDCH introduced the Fiscal Year 2016 – 2017 Focus Bonus Emergency Department Utilization Improvement Project to the Medicaid Health Plans. In compliance with Michigan's Public Act 107, MDCH will examine emergency department utilization and evaluate the health plan efforts to encourage its proper use. At the end of the year, Medicaid Health Plans began submitting deliverables as a part of the 2015 Pay for Performance Project. MDCH staff members are currently reviewing the deliverables submitted by the Medicaid Health Plans in all performance categories

Managed Care Reporting Requirements

MDCH has established a variety of reporting requirements for the Medicaid Health Plans, many of which are compiled, analyzed and shared with the plans in the PMRs described in the Quality Assurance/Monitoring Activity section of this report. These reports have historically been used for the traditional Medicaid population, and, as indicated above, will also include information for the Healthy Michigan Plan population. This year, MDCH has developed and refined processes to collect and report on information for this new population separately from the traditional Medicaid population.

A Health Risk Assessment Report using data provided from the State's enrollment broker was published in January 2015 and was made available to the public by the Bureau of Medicaid Care Management and Quality Assurance within MDCH. This report included data for Health Risk Assessments completed through December 2014. The initial assessment questions section of the Health Risk Assessments completed through the enrollment broker had a completion rate of 96 percent. MDCH is encouraged by the high level of participation by beneficiaries at the initial point of contact.

Completion of the remaining Health Risk Assessment sections (beyond those completed through the State's enrollment broker) requires beneficiary scheduling of an annual appointment, selecting a Healthy Behavior, and completing of member results by a primary care provider. Data from these Health Risk Assessment files were also published in the January 2015 Health Risk Assessment Report. As of December 2014, among beneficiaries who completed the Health Risk Assessment, 86 percent agreed to address healthy behaviors, and of those, 63 percent chose to address more than one healthy behavior.

During October 2014, MI Health Account quarterly statement activities began and Healthy Michigan Plan members began making payments for contributions and copays to the MI Health Account. Beneficiaries are able to make payments online and by mail. The MI Health Account collection activity was reported in the Healthy Michigan Plan Special Terms and Conditions 31: Assurance of Compliance Report. This document has been enclosed with this report.

MDCH has refined the Managed Care Organization grievance and appeal reporting process to collect Healthy Michigan Plan specific data. Grievances are defined in the MDCH Medicaid Health Plan Grievance/Appeal Summary Reports as an expression of dissatisfaction about any matter other than an action subject to appeal.

Appeals are defined as a request for review of the Health Plan's decision that results in any of the following actions:

- The denial or limited authorization of a requested service, including the type or level of service;
- The reduction, suspension, or termination of a previously authorized service;
- The denial, in whole or in part, of a payment for a properly authorized and covered service;
- The failure to provide services in a timely manner, as defined by the State; or
- The failure of the Health Plan to act within the established timeframes for grievance and appeal disposition.

MDCH has included grievance and appeals data from this year in the following tables:

Table 10: Managed Care Organization Appeals: April 2014 – December 2014			
	Decision Upheld	Overturned	Total
Count	52	43	95
Percent	55%	45%	-

Table 11: Managed Care Organization Grievances: April 2014 – December 2014						
	Access	Quality of Care	Administrative/Service	Billing	Transportation	Total
Count	73	53	55	15	139	335
Percent	22%	16%	16%	4%	41%	-

From April 2014 to December 2014, there were 95 total appeals among all the Medicaid Health Plans. Medicaid Health Plan decisions were upheld in 52, or 55 percent, of the appeals. From April 2014 to December 2014 there were a total of 335 grievances. Grievances reported by the Medicaid Health Plans are equivalent by definition to complaints to the department as referenced above. The greatest number of grievances came from the transportation category. Grievances in this category commonly pertain to the vendor's ability to accommodate member appointments, conditions of vehicles, and driver behavior. MDCH and the Medicaid Health Plans are aware of transportation related issues their members are facing and are taking action. MDCH met with Medicaid Health Plans this year, as described in the Consumer Issues section of this report, to discuss improvements to the transportation benefit.

Access grievances include a primary care physician not accepting new patients, limited specialist availability, the refusal of a primary care physician to complete a referral or write a prescription, a lack of services provided by the primary care physician, long wait times for appointments and denied services. Grievances related to quality of care pertain to the level of care issues experienced by beneficiaries. Administrative/Service grievances range from issues with claims, enrollment, eligibility, out-of-network providers and benefits not covered. MDCH will continue to monitor the Medicaid Health Plans Grievance/Appeal Summary Reports to ensure levels of grievances remain low and resolution of grievances is completed in a timely manner.

Managed Care Delivery System

MDCH reviewed a number of systems and program related processes and procedures related to health plan implementation of the Healthy Michigan Plan. This included a detailed investigation into how the plans operationalized cost sharing and incentive procedures, how well plans facilitated entry into primary care, and their processes to facilitate completion of the Health Risk Assessment and appropriately transmitting those Health Risk Assessment results to MDCH for use in determining eligibility for reductions in cost sharing. MDCH is closely monitoring access to care in the Healthy Michigan Plan program for fee-for-service and health plan members. First quarter enrollment data indicate that 71 percent of Healthy Michigan Plan enrollees have had an ambulatory or preventive care visit within 150 days of enrollment.

MDCH measures racial/ethnic health disparities through three analyses:

1. MDCH performs an internal analysis to investigate how Healthy Michigan Plan enrollment by race/ethnicity compares to estimates modelled by the Urban Institute's Health Policy Center. Results indicate that enrollment of African American Enrollees match estimates, while white and Hispanic enrollment does not. All results were statistically significant at the 99% p-level. This analysis is run on an ad hoc basis.

2. MDCH conducts a Health Equity Analysis which includes quality measures across four health dimensions: Women – Adult Care and Pregnancy Care, Child and Adolescent Care, Access to Care and Living with Illness. This analysis is in its fourth year for the traditional Medicaid Managed Care population, and will include Healthy Michigan Plan enrollees starting in 2016 (Healthcare Effectiveness Data and Information Set (HEDIS) 2015 data). Analyses are conducted for all Medicaid Managed Care Enrollees and for each Medicaid health plan. Health disparity analyses conducted include pair-wise disparity analyses between all non-white populations and the white reference population. Through this analysis for 2013 (most recent data), racial/ethnic disparities have been identified for all fourteen of the quality measures collected, with the largest disparities identified in the Women – Adult Care and Pregnancy Care health dimension. A comparison of racial/ethnic population rates and the HEDIS National Medicaid 50th Percentile is also conducted, where the majority of measures had racial/ethnic populations that fell above and below the HEDIS National Medicaid 50th Percentile each year. Annual trending of rates is also conducted to monitor for statistically significant increases or decreases in rates for specific racial/ethnic populations. Between 2012 and 2013, eight of the fourteen measures show statistical improvement for the African American population, an important trajectory to promote health equity. An Index of Disparity is also calculated for each quality measure. This index is a valuable tool for measuring inequity in health and for setting health equity standards. This analysis is run on an annual basis.

3. MDCH collects race/ethnicity data for internal review for all Adult Core Set and Healthy Michigan Plan measures included in the PMR. The PMR includes both the traditional Medicaid and Healthy Michigan Plan populations. Measures which are stratified by race ethnicity include: Elective Delivery, Postpartum Care, Adults' Generic Drug Utilization, Timely Completion of Initial Health Risk Assessment, Outreach and Engagement to Facilitate Entry to Primary Care, Adults' Access to Ambulatory Health Services, Adult Body Mass Index Assessment, Breast Cancer Screening, Cervical Cancer Screening, Diabetes Short-Term Complications Admission Rate, COPD or Asthma in Older Adults Admission Rate, Heart Failure Admission Rate, Asthma in Younger Adults Admission

Rate, Chlamydia Screening in Women Ages 21 to 24, Comprehensive Diabetes Care: Hemoglobin A1c Testing, Antidepressant Medication Management and Annual Monitoring for Patients on Persistent Medications. This analysis is run on a quarterly basis.

MDCH reviews the provider network submitted by the Medicaid Health Plans quarterly to ensure that networks meet the adequacy criteria specified in the contract. Medicaid Health Plans must maintain a Primary Care Physician to enrollee ratio of at least one full-time Primary Care Physician per 750 members. Pre and post implementation network review indicate that all plans maintain an adequate network and are in contract compliance. Network capacity is used in calculating the automatic assignment algorithm as outlined below and plans are given additional points for exceeding this measure.

MDCH uses the capacity report from the State's enrollment broker (current at time of algorithm development) to determine the Open Primary Care Physician to capacity ratio for each county. When the ratio is less than 1:500, 100 points are added to the plan's score for that county. When the ratio is between 1:500 and 1:750, 50 points are added to the plan's score for that county. Twenty four seven availability is reviewed annually as part of the comprehensive compliance review and took place in January 2015. All thirteen Medicaid Health Plans demonstrated compliance with this criterion.

The External Quality Review (EQR) report includes information on how well plans performed on each aspect of the compliance review, as well as a validation of each plans' HEDIS findings and Performance Improvement Projects. The onsite reviews of plans in 2015 will include components specific to the Healthy Michigan Plan. The final protocol for the visit is under development and can be made available to CMS once complete. The 2013 – 2014 EQR Technical Report was published in February 2015 and is attached to this report.

As part of the EQR process, health plans are required to participate in an annual performance improvement project. In 2014, plans began a new three year cycle for Performance Improvement Projects. Each plan was required to select a special population (e.g. pregnant women, children, etc.). Each plan's proposed project was validated by the MDCH EQR vendor prior to implementation of interventions. Plans are currently in year two of the project and will undergo a review each year of the three year cycle including final evaluation of outcomes in 2016. MDCH is also participating in several Quality Improvement initiatives including the Maternal Infant Health Initiative through the Center for Medicaid and CHIP Services, the Association of State and Territorial Health Officials Million Hearts Learning Collaborative/Quality Improvement Initiative. MDCH is also continuing both of the Quality Improvement projects supported by the Adult Medicaid Quality grant from CMS (Early Elective Delivery and Adult Asthma). Final reports including evaluation of outcomes for both of those projects will be available in January 2016.

MDCH measures health plan performance through annual HEDIS reporting and the revised, internally-derived PMR. All plans are required to undergo the HEDIS reporting process for all members who meet measure-specific eligibility criteria. Healthy Michigan Plan members will be included in these reports as they become eligible for measures. Data for the quarterly PMR comes from the MDCH Data Warehouse and includes rates specific to Healthy Michigan Plan members when, depending on measure criteria, they are eligible. As a result of CMS support via the Adult Medicaid Quality grant, MDCH was able to build queries to run fifteen Adult Core Set measures out of the Data Warehouse, including breakouts by Healthy Michigan Plan and traditional Medicaid. January 2015 was the first time MDCH reported data in the revised PMR. Most measures are Informational Only as MDCH is currently collecting baseline data. Once

sufficient data have been collected, standards will be set for each measure and plan performance will be compared against these standards. The Michigan Medicaid HEDIS 2014 Results Statewide Aggregate Report and January 2015 PMR are attached to this report.

MDCH contracted with Health Services Advisory Group, Inc. to conduct and report results of the Consumer Assessment of Healthcare Providers and Systems (CAHPS) Health Plan Survey for its Medicaid program. MDCH has included the 2014 Adult Medicaid Health Plan CAHPS Report as an attachment. Additionally, health plan financial information is reviewed on a quarterly basis to assure each plan has adequate working capital, their net worth is not at a negative status and the risk based capital is between 150 percent and 200 percent. Financial reports were reviewed in May 2014, August 2014 and November 2014. All thirteen Medicaid Health Plans demonstrated compliance with the contractual financial requirements.

Lessons Learned

MDCH continues to learn, from the experience of launching a program the size and scope of the Healthy Michigan Plan. MDCH established a multidisciplinary response team, comprised of departmental leadership and subject matter experts, who initially met on a daily basis in order to monitor the status of the program and quickly respond to any and all issues. Frequency of these meetings decreased as the program became established. The value of having this team in place to make critical decisions in an expedient manner was an important element of launching the program.

One of the initial challenges faced by the State centered on call volume and wait times in the earliest stages of enrollment. MDCH, in conjunction with its enrollment broker, was able to adapt to high call volume and wait times in a timely manner by closely monitoring call data. The State's enrollment broker also demonstrated the ability to meet the demands of high enrollment with its foresight in increasing staff and cross-training its employees.

In response to this huge undertaking, knowledgeable personnel from many different areas within the department came together to launch the Healthy Michigan Plan. The collaborative spirit has also extended to MDCH's relationship with and between its vendors. Collaboration has also been essential to implementing the Healthy Michigan Plan through Michigan's existing managed care system. Michigan has traditionally fostered close relationships with the Medicaid Health Plans but this partnership has become even more collaborative with the implementation of the Healthy Michigan Plan. MDCH has frequent contact with the Medicaid Health Plans to resolve issues and work together to find new and effective ways to deliver care. Communicating with all the Medicaid Health Plans as a group allows MDCH to deliver a consistent message to the plans while allowing plans to contribute to the implementation process.

MDCH has embraced creativity and innovative thinking in its implementation of the Healthy Michigan Plan. The ingenuity of the MDCH staff was demonstrated in the design and integration of the MI Health Account technical requirements. For example, staff members were able to identify a change in the State Medicaid Management Information System that utilized existing features to ensure that copayment logic operates as intended as is reflected on the MI Health Account statements. To ensure that statement accuracy was not impacted by the previously reported retroactive enrollment defect, MDCH identified beneficiaries impacted by this error and made the appropriate systems changes. Systems staff demonstrated the ability to quickly adapt to the potential issues that this resolved defect posed.

Demonstration Evaluation

MDCH has commissioned the University of Michigan's Institute for Healthcare Policy and Innovation (IHPI) to serve as the Healthy Michigan Plan independent evaluator. The IHPI has developed a comprehensive plan to address the needs of the State and CMS. In accordance with paragraph 67 of the waiver special terms and conditions, the State submitted a draft of its initial evaluation design to CMS on April 28, 2014. After a period of revisions, CMS formally approved the evaluation plan on October 22, 2014.

Demonstration evaluation activities for the Healthy Michigan Plan are utilizing an interdisciplinary team of researchers from the IHPI. The activities of the evaluation will carry in six domains over the course of the five year evaluation period:

I. An analysis of the impact the Healthy Michigan Plan on uncompensated care costs borne by Michigan hospitals;

II. An analysis of the effect of the Healthy Michigan Plan on the number of uninsured in Michigan;

III. The impact of the Healthy Michigan Plan on increasing healthy behaviors and improving health outcomes;

IV. The viewpoints of beneficiaries and providers of the impact of the Healthy Michigan Plan;

V. The impact of the Healthy Michigan Plan's contribution requirements on beneficiary utilization, and;

VI. The impact of the MI Health Accounts on beneficiary healthcare utilization

Activities for the demonstration evaluation began this year and are currently ongoing. Under Domain I, IHPI has engaged in activities to find and compare baseline uncompensated care results from hospital cost reports and IRS filings to understand the distribution of uncompensated care in Michigan. As a part of Domain II, IHPI has prepared extracts of Current Population Survey data and will subsequently prepare extracts of American Community Survey data to help ascertain the difference between these two US Census Bureau data sources. Domain III activities for this year have included conducting preliminary feasibility assessments of key data fields relative to health behaviors, utilization, and outcomes. Under Domain IV, IHPI has made progress on the Primary Care Practitioner Survey and the Beneficiary Survey. Activities in Domains V and VI have entailed IHPI meetings of a designated enrollee survey team to discuss consumer engagement, behavior, and cost sharing measures for inclusion in enrollee surveys.

Enclosures/Attachments

Special Terms and Conditions 31: Assurance of Compliance Report

2014 MCAC Meeting Minutes

2013 – 2014 External Quality Review Technical Report

Michigan Medicaid HEDIS 2014 Results Statewide Aggregate Report

January 2015 Performance Monitoring Report

2014 MDCH Adult Medicaid Health Plan CAHPS Report

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