STATE OF MICHIGAN
DEPARTMENT OF COMMUNITY HEALTH
LANSING

RICK SNYDER
GOVERNOR

NICK LYON
DIRECTOR

December 22, 2014

Megan E. Lepore, Project Officer
Centers for Medicare and Medicaid Services
7500 Security Boulevard
Mail Stop S2-01-16
Baltimore, Maryland 21244-1850

Dear Ms. Lepore,

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

Enclosed is the quarterly report for Healthy Michigan Plan. It covers the 4th quarter of federal fiscal year 2014. 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,

Brian Keisling, Director
Actuarial Division

cc: Alan Freund
Angela Garner

Enclosure

Michigan Adult Coverage Demonstration
Section 1115 Quarterly Report

Demonstration Year: 5 (10/1/2013 – 12/31/2014)
Federal Fiscal Quarter: 4 (7/1/2014 – 9/30/2014)

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.

Beginning October 1, 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 will receive quarterly statements that summarize the MI Health Account activity. Beneficiaries will 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. First, beneficiaries who were enrolled in the ABW were automatically transitioned into the Healthy Michigan Plan effective April 1, 2014. Second, MDCH began enrolling new beneficiaries into the new program beginning April 1. Enrollment has continued to grow steadily during the second quarter 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. 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.

While Healthy Michigan Plan enrollment continued to demonstrate substantial growth, MDCH saw a significant number of disenrollments from the plan as reported in the September Enrollment Report to CMS. This quarter, Healthy Michigan disenrollments reflected individuals who were disenrolled during a redetermination of eligibility or switched coverage due to eligibility for other Medicaid program benefits. Many Healthy Michigan beneficiaries, who were previously eligible under the former Adult Benefits Waiver (ABW), were due for their annual redetermination of eligibility. These closure numbers are consistent with typical monthly ABW redetermination closure numbers from previous periods.

At this time, MDCH does not anticipate any changes in the population served or the benefits offered. MDCH does expect that enrollment will continue to grow as the program matures. During the quarter covered by this report, the State has worked collaboratively with CMS on the Healthy Behaviors Incentives Program and Contributions Accounts and Infrastructure operational protocols. CMS approved these protocols on August 29, 2014.

Most Healthy Michigan Plan beneficiaries have elected to choose a health plan rather than being automatically assigned a health plan. As of September 15, 2014, 209,064, or 74%, of the State's 281,027 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. MDCH made changes to allow for more refinement in the reporting of the number of beneficiaries who change plans after being automatically assigned into a health plan. This information became available in August, and will be incorporated into future quarterly progress reports. During the months of August and September, 4,535 of all Healthy Michigan Plan health plan enrollees, regardless of whether they chose a health plan or were automatically assigned, changed health plans. From August 2014 to September 2014, 2,343 or 52% of beneficiaries that changed plans were previously automatically assigned to a health plan.

In this quarter, Health Risk Assessments for 17,494 Healthy Michigan Plan beneficiaries participating in the healthy behaviors incentive program have been submitted by the Medicaid Health Plans. Of these, health plans have reported that 15,032 of the incentives earned are gift card incentives, and health plans have begun mailing these gift cards to their members. Additionally, 2,333 reductions in future contribution requirements have been earned. The Medicaid Health Plans began sending gift cards this quarter, but reductions are not applied until the November 2014 MI Health Account Statements.

Enrollment Counts for Quarter and Year to Date

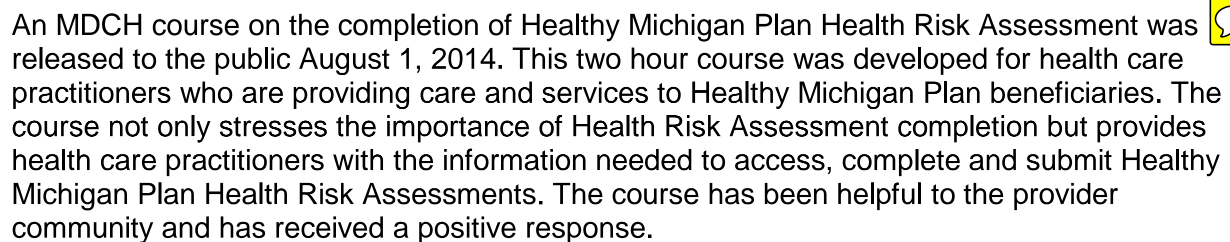
The enrollment counts below are for unique beneficiaries for the identified time periods. The unique enrollee count will differ from the September 2014 count from the Beneficiary Month Reporting section as a result of disenrollment that occurred during the quarter. Disenrollment can occur for a variety of reasons including change in eligibility status, such as an increase in income, or as part of a redetermination cycle, for example.

Demonstration Population	Total Number of Demonstration Beneficiaries Quarter Ending – 09/14	Current Enrollees (year to date)	Disenrolled in Current Quarter
ABW Childless Adults	N/A	N/A	N/A
Healthy Michigan Adults	465,801	486,349	46,058

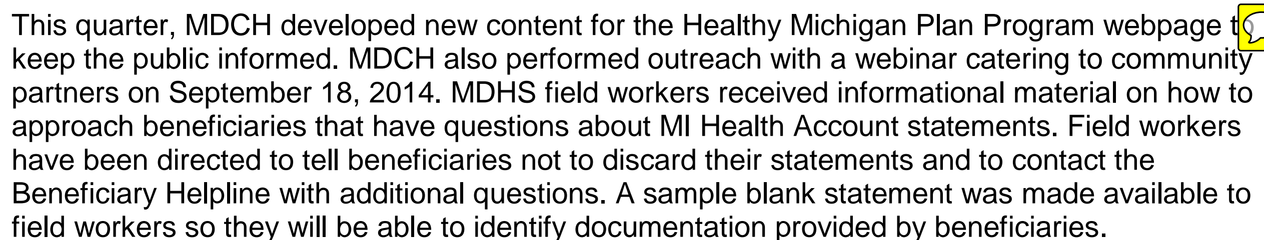
Outreach/Innovation Activities to Assure Access

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 13 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. Advertisements for the program have run on the radio and television. In addition, MDCH has 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. MDCH occasionally sees increases in the use of this mailbox after an event in which Healthy Michigan Plan contact information has been provided.



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 not only stresses the importance of Health Risk Assessment completion but provides health care practitioners with the information needed to access, complete and submit Healthy Michigan Plan Health Risk Assessments. The course has been helpful to the provider community and has received a positive response.



This quarter, MDCH developed new content for the Healthy Michigan Plan Program webpage to keep the public informed. MDCH also performed outreach with a webinar catering to community partners on September 18, 2014. MDHS field workers received informational material on how to approach beneficiaries that have questions about MI Health Account statements. Field workers have been directed to tell beneficiaries not to discard their statements and to contact the Beneficiary Helpline with additional questions. A sample blank statement was made available to field workers so they will be able to identify documentation provided by beneficiaries.

At the end of September 2014, applicable beneficiaries began receiving MI Health Account welcome letters. These letters include how the account functions, what the beneficiary can expect and contact information for additional assistance. On a quarterly basis beneficiaries will receive a MI Health Account Statement detailing healthcare services provided and cost-sharing amounts due. In October 2014 the first MI Health Account statements were sent to applicable beneficiaries. MDCH employees have been directed to refer all questions about the MI Health Account and MI Health Account Statement to the Beneficiary Help Line and the Healthy Michigan Program website.

MDCH has 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.

MDCH has committed to providing the MCAC with an update on the progress of the Healthy Michigan Plan implementation during the MCAC meetings scheduled during 2014 and will continue to do so at regularly scheduled quarterly meetings. Please see the 2014 meeting schedule below. These meetings provide an opportunity for attendees to provide program comments or suggestions.

- February 11, 2014
- May 27, 2014

- August 19, 2014
- November 19, 2014

The August 19, 2014 MCAC meeting occurred during the quarter covered by this report. The MCAC discussed Healthy Michigan Plan enrollment and Healthy Michigan Plan successes and areas for improvement. Additionally, the MCAC reviewed the Healthy Behaviors Incentives Program and Contributions Accounts and Infrastructure operational protocols and the Expedited Enrollment Waiver for Supplemental Nutrition Assistance Program (SNAP) and parents.

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 quarter, MDCH used the encounter data to prepare the MI Health Account statements beginning October 15, 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. Additional information regarding encounter data will be provided in future quarterly reports.

Operational/Policy/Systems/Fiscal Developmental 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.

MDCH holds bi-monthly meetings with the staff of Medicaid Health Plans to address operational issues, programmatic issues, and policy updates and clarifications. Updates and improvements to the Community Health Automated Medicaid Processing System (CHAMPS), the State's Medicaid Management Information System (MMIS) happen continually, and MDCH strives to

keep the health plans informed and functioning at the highest level. At these meetings, Medicaid policy bulletins and letters that impact the program are discussed, as are other operational issues.

The following Healthy Michigan Plan policy was issued by the State during the quarter covered by this report:

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.

Financial/Budget Neutrality Development Issues

MDCH continues to evaluate its budget neutrality calculations and has 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 calculations. The State is committed to this process and is working diligently to ensure all appropriate program costs are included in the budget neutrality numbers. 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 is 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.

In accordance with Paragraph 52, Quarterly Progress Reports, of the Healthy Michigan Special Terms and Conditions, MDCH will provide a completed budget monitoring spreadsheet once its budget neutrality issues have been resolved.

Beneficiary Month Reporting

The beneficiary counts below include information for each of the designated months during the quarter, and include retroactive eligibility through September 30, 2014.

Eligibility Group	July 2014	August 2014	September 2014	Total for Quarter Ending 09/14
Healthy Michigan Adults	361,172	401,669	427,226	1,198,067

Consumer Issues

This quarter, the total number of Healthy Michigan Plan complaints reported to MDCH was 168. The correction of last quarter's retroactive enrollment system defect was remedied, however, complaints related to this issue spilled over into this quarter. Beneficiaries reported difficulty with enrollment recognition and in obtaining prescriptions and other covered services as a result. This complaint generated 59 percent of the 168 total complaints for this quarter. Of the 59 percent, 40 percent of the eligibility/enrollment related complaints occurred in July 2014 while MDCH was still in the process of resolving the system defect.

Issues obtaining prescriptions comprised of 24 percent of complaints received by MDCH. In the previous quarter MDCH saw that the effects of the eligibility/enrollment defect on obtaining prescriptions. This quarter found a slightly lower number of complaints related to obtaining prescriptions. With the resolution of the retroactive enrollment problem, MDCH expects to see a decrease in complaints related to the above complaints.

Beneficiaries experiencing issues obtaining transportation consisted of 12 percent of complaints reported to MDCH. 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. MDCH and the Medicaid Health Plans are aware of transportation related issues their members are facing and are taking action. MDCH has plans to discuss transportation solutions with the Medicaid Health Plans and its transportation vendors. Other complaints that comprised a very small percentage of complaints related to dental and behavioral health services.

Overall, with over one million member months during the quarter, MDCH is encouraged by its low rate of contacts during this quarter of the program. MDCH will continue to monitor calls to the Beneficiary Helpline to identify problems or trends that need to be addressed.

Quality Assurance/Monitoring Activity

MDCH completes Performance Monitoring Reports for the 13 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.

Information for the Healthy Michigan Plan will be included in this report. The program will also be part of any other current monitoring or quality assurance activities. 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. Future Performance Monitoring reports will include Healthy Michigan Plan measures from Michigan's Public Act 107, the State's law that established the program. Many of the measures for fiscal year 2015 are informational as MDCH continues to refine its data collection and analysis process. Performance areas include the following:

- 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
- Timely Completion of Initial Health Risk Assessment

Adults' Access to Ambulatory Health Services is a quarterly measure of the percentage of adults (19 to 64 years old) who had an ambulatory or preventive care visit. The Outreach and Engagement to Facilitate Entry to Primary Care measure is performed quarterly and demonstrates the percentage of Healthy Michigan Plan Health Plan enrollees who had an ambulatory or preventive care visit within 150 days of enrollment into a health plan who had not previously had an ambulatory or preventive care visit since enrollment in Healthy Michigan Plan. Under the Adults' Generic Drug Utilization measurement, the percentage of generic prescriptions filed for adult members of health plans will be collected quarterly. The Plan All-

Cause Acute 30-Day Readmissions measurement is performed annually and includes the percentage of acute inpatient stays that were followed by an acute readmissions for any diagnosis within 30 days. The Timely Completion of Initial Health Risk Assessment performance measure will contain the percentage of Healthy Michigan Plan beneficiaries who had a Health Risk Assessment completed within 150 days of enrollment in a health plan.

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 the following categories:

- Cost Sharing and Incentives
- Access to Care
- Health Risk Assessment
- Value Added

The areas of review in the Cost Sharing and Incentives category include vendor contracts and monitoring, quality and timely reporting of encounter data and informing members of rights and responsibilities. The Access to Care category requires the Medicaid Health Plans to demonstrate how they have assisted beneficiaries in scheduling and attending their first primary care appointment. Additionally, MDCH will utilize data sources to determine adequacy of transportation services provided to new Healthy Michigan plan members and overall network adequacy. Under the Health Risk Assessment category, Medicaid Health Plans are asked to establish policies and/or procedures that ensure member education about the Health Risk Assessment. This includes a Health Risk Assessment in the plan welcome packet, member education about healthy behavior incentives and Health Risk Assessment information in call center scripts to new members. Policies and/or procedures regarding quality and timely reporting of Health Risk Assessments and the level of assistance the plan provides to members with Healthy Behavior goals are also criteria for this category. The Value Added category is intended to reward plans for exceeding expectations in terms of outreach, communication and assistance to members and providers.

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 Performance Monitoring Reports 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. MDCH is in the process of developing processes to collect and report on information for this new population separately from the traditional Medicaid population.

This quarter, a Health Risk Assessment Report using data provided from the State's enrollment broker was published in August 2014 and was made available to the public by the Bureau of Medicaid Care Management and Quality Assurance within MDCH. As of August 2014, the initial assessment questions section of the Health Risk Assessments completed through the enrollment broker had a completion rate of 96.5%. MDCH is encouraged by the high level of participation by beneficiaries at the initial point of contact.

Medicaid Health Plans will be the source of Health Risk Assessment data beyond that of the initial assessment questions. Completion of the remaining Health Risk Assessment sections requires beneficiaries to schedule an annual appointment, select a Healthy Behavior, and completion of member results from a primary care provider. MDCH's Health Risk Assessment file containing health plan submitted data went into production in August of this quarter. Medicaid Health Plans began submitting Health Risk Assessment data prior to the first mandatory submission deadline. Beginning October 20, 2014, Medicaid Health Plans will be required to submit monthly Health Risk Assessment files.

Additionally this quarter, MDCH was able to refine the Managed Care Organization grievance and appeal reporting process to collect Healthy Michigan Plan specific data. For the purposes of reporting grievance and appeal information not available in the last quarterly report, the grievance and appeals data for this report will cover April 2014 to September 2014. 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 April 2014 through September 2014 in the following tables:

Managed Care Organization Appeals: April 2014 - September 2014		
Decision Upheld	Overturned	Total
24	16	40
60%	40%	-

Managed Care Organization Grievances: April 2014 - September 2014					
Access	Quality of Care	Administrative/Service	Billing	Transportation	Total
28	25	21	7	11	92
30%	27%	23%	8%	12%	-

From April 2014 to September 2014, there were 40 total appeals among all the Medicaid Health Plans. Medicaid Health Plan decisions were upheld in 24, or 60 percent of the appeals. From April 2014 to September 2014 there were a total of 92 grievances. The greatest number of grievances came from access, quality of care and administrative/service categories. Access grievances can include a primary care physician not accepting new patients, limited specialist availability, the refusal of a primary care physician to complete a referral or write a prescription,

a lack of services provided by the primary care physician, long wait times for appointments and denied services. Grievances related to quality of care pertain to the level of care issues experienced by beneficiaries. Administrative/Service grievances can range from issues with claims, enrollment, eligibility, out-of-network providers and benefits not covered. 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.

Lessons Learned

MDCH has learned, and continues to learn, from the experience of launching a program the size of the Healthy Michigan Plan. The implementation of the Healthy Michigan Plan has been a collaborative effort across MDCH. In response to this huge undertaking, knowledgeable personnel from many different areas within the department have come together to launch the Healthy Michigan Plan. The collaborative spirit has also extended to MDCH's relationship with and between its vendors. MDCH has maintained good relationships with contractors and remains impressed with their contributions. Teamwork continues to be essential to the successful implementation and growth of the Healthy Michigan Plan.

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 send a consistent message to the plans while allowing the 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 MMIS system that utilized existing features to ensure that copayment logic operates as intended as is reflected on the MI Health Account statements.

Demonstration Evaluation

MDCH has engaged 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, and received formal comments from CMS since that date. After reviewing CMS feedback, MDCH revised the draft demonstration evaluation and submitted a final proposal to CMS on September 29, 2014.

Demonstration evaluation activities for the Healthy Michigan Plan have commenced, particularly with regards to Domain IV: Participant Beneficiary Views of the Healthy Michigan Plan. Aims of this domain include utilizing surveys to ascertain:

- Beneficiary knowledge and understanding of the Healthy Michigan Plan;
- Consumer behaviors including utilization of the Healthy Michigan Plan;

- Self-reported changes in health behaviors, including knowledge of barriers and facilitators to healthy behaviors; and
- Primary care practitioners' experiences with Healthy Michigan Plan beneficiaries.

In light of the preceding, IHPI and MDCH have begun the planning phase of Domain IV and the research team is meeting regularly to gain insight as to how to best develop surveys to achieve the aforementioned aims. This includes a literature and resource review of Healthy Michigan Plan materials and communications to beneficiaries and providers, identification and interviews of key informants/stakeholders, and the identification of five geographic areas for conducting community focus groups. IHPI is also in the process of forming an advisory group of community leaders/key stakeholders that will include representation from the five identified geographic areas.

Enclosures/Attachments

N/A

State Contact(s)

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

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Date Submitted to CMS

December 22, 2014