STATE OF MICHIGAN
DEPARTMENT OF HEALTH AND HUMAN SERVICES
LANSING

RICK SNYDER
GOVERNOR

NICK LYON
DIRECTOR

April 23, 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 quarterly report for Healthy Michigan Plan. It covers the 1st quarter of federal fiscal year 2015. 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: Ruth Hughes
Angela Garner

Enclosure (2)

Michigan Adult Coverage Demonstration

Section 1115 Quarterly Report

Demonstration Year: 5 (10/1/2013 – 12/31/2014)

Federal Fiscal Quarter: 1 (10/1/2014 – 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 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 third quarter of the program, which is evidence of the high demand for the services offered. 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. MDCH does expect that enrollment will continue to grow as the program matures. Information regarding enrollment and disenrollment is available in the Enrollment Counts for Quarter and Year to Date section of this report.

The following charts detail coverage activity for Healthy Michigan Plan members that were enrolled at any time during the first nine months of the program. Table 1 depicts the January 2015 coverage for the 619,197 unique Healthy Michigan Plan beneficiaries that were enrolled at any point during the first nine months of the program. Once identified, the coverage status for those unique members was queried for the month of January 2015. The following table shows the results of this analysis:

Table 1: January 2015 Coverage for Beneficiaries Enrolled in First Nine Months of Healthy Michigan					
	Healthy Michigan Plan	Medicaid	Spend Down	No Information/Coverage	Total
Count	497,785	34,217	9,153	78,042	619,197
Percent	80%	6%	1%	13%	-

MDCH found that 80 percent of these members continued to receive coverage through the Healthy Michigan Plan in January 2015. MDCH observed 6 percent of the members received coverage from another Medicaid program. Additionally, 1 percent switched from the Healthy Michigan Plan to the Medicaid Spend Down program. Members in this program are above Medicaid income limits to receive benefits, however, are able to qualify for Medicaid during the months that spend down amounts are met. Of the total number of unique Healthy Michigan Plan members, 13 percent disenrolled from Healthy Michigan and did not obtain Medicaid coverage of any kind after disenrollment. MDCH does not have readily available information regarding those members.

MDCH queried the coverage status of these disenrolled members for the month prior to Healthy Michigan Plan implementation. The following table details the March 2014 coverage status of this group:

Table 2: March 2014 Coverage for Healthy Michigan Beneficiaries Without Medicaid Coverage Post Healthy Michigan Disenrollment					
	ABW	Medicaid	Spend Down	No Information/Coverage	Total
Count	14,048	20,291	3,902	39,801	78,042
Percent	18%	26%	5%	51%	-

Overall, out of these 78,042 disenrolled members, 49 percent had Medicaid coverage in the month prior to Healthy Michigan implementation and 51 percent did not. This means that six percent, or roughly 38,000 of the 619,000 unique Healthy Michigan Plan members in the first nine months of the program, did not have coverage prior to Healthy Michigan Plan enrollment and disenrolled without subsequent coverage. Overall, MDCH is encouraged by the high rate of retention of the Healthy Michigan Plan program and the number of members with some form of Medicaid coverage after disenrolling from the Healthy Michigan Plan.

Most Healthy Michigan Plan beneficiaries have elected to choose a health plan rather than being automatically assigned to 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 selected 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 quarter, 5,748 of all Healthy Michigan Plan health plan enrollees changed health plans. This quarter, 3,262 or 57 percent, of beneficiaries that changed plans were previously automatically assigned to a health plan. The remaining beneficiaries were those that changed plans after selecting a health plan.

In this quarter, Health Risk Assessments for 17,683 Healthy Michigan Plan beneficiaries participating in the healthy behaviors incentive program were submitted by the Medicaid Health Plans. Of these, health plans have reported that 14,520 of the incentives earned are gift card incentives, and health plans have begun mailing these gift cards to their members. Additionally, 3,048 reductions in future contribution requirements have been earned. Reductions earned were first applied to the MI Health Account Statements in November 2014. In November, 102 reductions were applied in addition to 1,198 reductions in December. The remaining contribution

reductions that have been earned will be applied when those beneficiaries receive their first quarterly statement. Also in this quarter, one beneficiary received the 50 percent co-pay reduction after reaching the 2 percent of income paid threshold.

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 from March 2014 through December 2014. The initial assessment questions section of the Health Risk Assessments completed through the MDCH 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 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. Beginning October 20, 2014, Medicaid Health Plans have been required to electronically submit Health Risk Assessment files to MDCH for these completed Health Risk Assessments. 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.

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 December 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.

While Healthy Michigan Plan enrollment continued to demonstrate substantial growth, MDCH saw a significant number of disenrollments from the plan as reported in the Monthly Enrollment Reports to CMS. Healthy Michigan disenrollments reflected individuals who were disenrolled during a redetermination of eligibility or switched coverage due to eligibility for other Medicaid program benefits. In most cases when beneficiaries were disenrolled from the Healthy Michigan Plan due to eligibility for other Medicaid programs. This can be a result of MDCH's validation of self-attested information from the beneficiary. After a beneficiary is approved for Healthy Michigan Plan coverage, MDCH performs authentication processes to determine the beneficiary is in fact eligible as attested in the application for benefits. MDCH matches beneficiary information provided with that available through State and Federal databases. Movement between Medicaid programs is not uncommon and MDCH expects that beneficiaries will continue to shift between Healthy Michigan and other Medicaid programs as their eligibility changes.

Table 3: Enrollment Counts for Quarter and Year to Date

Demonstration Population	Total Number of Demonstration Beneficiaries Quarter Ending – 12/2014	Current Enrollees (year to date)	Disenrolled in Current Quarter
ABW Childless Adults	N/A	N/A	N/A
Healthy Michigan Adults	533,830	563,140	53,241

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. This quarter, MDCH added a link that directs beneficiaries to the website accepting online MI Health Account payments. 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 has 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.

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 and will continue to do so at regularly scheduled quarterly meetings. These meetings provide an opportunity for attendees to provide program comments or suggestions. The November 19, 2014 MCAC meeting occurred during the quarter covered by this report. The minutes for this meeting have been 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 quarter, MDCH began using the encounter data to prepare the MI Health Account statements beginning with those mailed in October 2014. 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. The Encounter Quality Initiative will give Medicaid Health Plans the opportunity to qualify for a bonus if the plan delivers a follow-up explanation of variances for each submission and agrees to at least one annual site visit from MDCH staff. 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 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 policies were issued by the State during the quarter covered by this report:

October 9, 2014: A policy bulletin was released regarding the 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 letter was issued by the State during the quarter covered by this report:

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

On January 13, 2015, CMS approved an increase in the Healthy Michigan Plan per member per month limit. This quarter, MDCH did not experience issues with budget neutrality. MDCH has provided a completed budget monitoring table below. 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.

Table 4: 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)	$408.40	-	-	-	-
Total Expenditures (YTD)	$1,495,020,215	-	-	-	-
Total Member Months (YTD)	3,660,674	-	-	-	-

Beneficiary Month Reporting

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

Table 5: Beneficiary Month Reporting				
Eligibility Group	October 2014	November 2014	December 2014	Total for Quarter Ending 12/14
Healthy Michigan Adults	468,179	499,847	533,237	1,501,263

Consumer Issues

Table 6: Healthy Michigan Plan Complaints: October 2014 – December 2014					
	Obtaining Prescriptions	Transportation	Other Covered Services	Other Issues	Total
Count	63	30	20	18	131
Percent	48%	23%	15%	14%	-

This quarter, the total number of Healthy Michigan Plan complaints reported to MDCH was 131. MDCH has now seen two consecutive quarters with decreases in the number of complaints. Issues obtaining prescriptions comprised 48 percent of total complaints received by MDCH. Beneficiaries experiencing issues obtaining transportation consisted of 23 percent of total 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. This quarter, MDCH and the Medicaid Health Plans met and discussed possible improvements. Complaints related to other covered services consisted of 15 percent of total complaints. Complaints on other issues comprised 14 percent of total complaints and included dental and behavioral health services. Overall, with over 1.5 million member months during the quarter, MDCH is encouraged by its low rate of contacts related to Healthy Michigan Plan complaints. 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 specific to the Healthy Michigan Plan will be included in this report. 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.

This quarter, 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 of 2013, MDCH will examine emergency department utilization and evaluate the health plan efforts to encourage its proper use. To qualify, Medicaid Health Plans will be required to demonstrate an understanding of Emergency Department utilization issues, design a method for collecting information from members that use the Emergency Department, and establish a plan for intervention and continual assessment. Submission of project related deliverables will begin in March 2015. Future quarterly reports will include additional information regarding the expectations and progress of the Emergency Department Utilization Improvement Project.

This quarter, Medicaid Health Plans began submitting deliverables as a part of the 2015 Healthy Michigan Plan Pay for Performance Project. Under the Cost Sharing and Incentives category, Medicaid Health Plans had deliverables related to the MI Health Account, member incentives and provider incentives. In October 2014, all 13 Medicaid Health Plans met the performance criteria of signing a contract with the MI Health Account vendor. In December 2014, Medicaid Health Plans were required to submit a policy describing the process through which health plan members receive incentives. As a part of this deliverable, Medicaid Health Plans will have to confirm that members randomly selected by MDCH have received earned incentives. The Medicaid Health Plans also submitted a provider incentives policy that includes the process for tracking Health Risk Assessment completion at the provider and plan level.

Medicaid Health Plans were also required to submit a deliverable under the Access to Care performance category. In December 2014, Medicaid Health Plans submitted documentation demonstrating how the plan promotes and helps members schedule and attend their first primary care appointment. To satisfy this deliverable, Medicaid Health Plans submitted policies, procedures, or reports describing their process.

Medicaid Health Plans submitted several deliverables this quarter within the Health Risk Assessment performance category. The first Health Risk Assessment survey files were submitted to MDCH by October 20, 2014. MDCH has reported Health Risk Assessment data submitted by the Medicaid Health Plans in the Enrollment and Benefits Information section of this report. In December 2014, Medicaid Health Plans were directed to submit policies that detail their process for receiving the Health Risk Assessment file from the vendor, for submitting the file to MDCH, and on handling errors within the file. Additionally, plans submitted policies describing their efforts to provide Health Risk Assessment information to their members. 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 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 has developed processes to collect and report on information for this new population separately from the traditional Medicaid population.

This quarter, applicable Healthy Michigan Plan members received MI Health Account quarterly statements for the first time. Beneficiaries are able to make payments online and by mail. MDCH received reports this quarter from the contractor managing the MI Health Account Call Center. The call volumes for the months in this quarter are detailed in the following table:

Table 7: MI Health Account Call Activity			
Month	**Number of Calls**	**Percent Change**	**Number Change**
Oct. 2014	2,195	-	-
Nov. 2014	1,033	-53%	-1,162
Dec. 2014	1,295	25%	262

The MI Health Account Call Center handles questions regarding the MI Health Account welcome letters and MI Health Account quarterly statements. Commonly asked questions for callers contacting the MI Health Account Call Center relate to general MI Health Account information and payment amounts. Members calling regarding the quarterly statements have asked about amounts owed, requested clarification on the contents of the statement, and reported an inability to pay amounts owed.

During this quarter, Healthy Michigan Plan members began making payments for contributions and copays to the MI Health Account. Members that received a MI Health Account statement in October 2014 had a payment due date of January 15, 2015. For those that received their statement in November 2014, the payment due date was February 15, 2015. December statements have a payment due date of March 15, 2015. The MI Health Account collection activity is detailed in the following tables:

Table 8: MI Health Account Quarterly Statement Collection Activity as of December 2014		
Quarterly Statements Mailed and Payment Received		
Month of Quarterly Statement	**Total Number of Statements Mailed for the Quarter**	**Total Amount of Payments Received for the Quarter**
Oct. 2014	23,679	$8,788.02
Nov. 2014	5,668	$8,754.97
Dec. 2014	53,402	$636.35

Table 9: MI Health Account Quarterly Statement Collection Activity as of December 2014					
Month of Quarterly Statement	Quarterly Statement Mailings Copays & Monthly Contributions				
	Beneficiaries that Owed Copays		Beneficiaries that Owed Monthly Contributions		Total Amount Owed for the Quarter
	Total Amount Owed in Copays	Number of Beneficiaries That Owed Copays	Total Amount Owed in Monthly Contributions	Number of Beneficiaries That Owed Monthly Contributions	
Oct. 2014	$31,998.90	3,974	$0.00	0	$31,998.90
Nov. 2014	$12,160.55	1,574	$40,212.25	721	$52,372.80
Dec. 2014	$130,063.10	17,670	$490,241.18	8,744	$620,304.28

This quarter, MDCH and the Medicaid Health Plans received a MI Health Account Portal demonstration from the MI Health Account vendor. The MI Health Account Portal will give the Medicaid Health Plans access to beneficiary MI Health Account information for customer service and vendor oversight purposes. Additionally, the Medicaid Health Plans and the MI Health Account vendor made significant progress in the development of MI Health Account reports. The Medicaid Health Plans will have the ability to monitor vendor payments and payment explanation using detailed reports electronically delivered from the vendor. The vendor was able to customize oversight reports to meet the complex reporting needs of the Medicaid Health Plans. Additionally, MDCH, Medicaid Health Plans, and the MI Health Account vendor agreed to participate in quarterly vendor oversight meetings beginning in January 2015.

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 quarter in the following tables:

Table 10: Managed Care Organization Appeals: October 2014 – December 2014			
	Decision Upheld	Overturned	Total
Count	28	27	55
Percent	51%	49%	100%

Table 11: Managed Care Organization Grievances: October 2014 – December 2014						
	Access	Quality of Care	Administrative/Service	Billing	Transportation	Total
Count	45	28	34	8	128	243
Percent	19%	12%	14%	3%	53%	100%

From October 2014 to December 2014, there were 55 total appeals among all the Medicaid Health Plans. Medicaid Health Plan decisions were upheld in 51 percent of the appeals. From October 2014 to December 2014 there were a total of 243 grievances. The greatest number of grievances came from the transportation category. As a result of refined data collection processes and instruction to the health plans, MDCH saw an increase in the number of grievances reported. However, out of over 1.5 million member months in this quarter, MDCH is encouraged by the low percentage of members experiencing dissatisfaction with their health plan.

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. Issues reported under the Billing category pertain to billing issues. Transportation grievances relate to issues with the transportation benefit. 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 continues to learn from the experience of launching a program the size and scope of the Healthy Michigan Plan. Collaboration across the department continues to be a key lesson learned from the Healthy Michigan Plan implementation. During this quarter, MDCH sent out its first 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.

Collaboration between MDCH and Medicaid Health Plan contractors has also benefitted Michigan's implementation of the Healthy Michigan Plan. During this quarter, MDCH worked with the Medicaid Health Plans to plan for contractor oversight. MDCH and the Medicaid Health Plans have established quarterly oversight meetings and monthly reporting requirements to monitor the contractor's operation of the MI Health Account. Clear lines of communication are maintained by the involvement of all parties in these oversight meetings. Additionally, open communication has helped MDCH deliver a consistent message to Medicaid Health Plans and contractors.

MDCH also learned this quarter that most of Michigan's primary care physicians are continuing to report the capacity to accept new patients. The Center for Healthcare Research and Transformation (CHRT) in collaboration with the University of Michigan released the results of the 2014 Michigan Physician Survey. CHRT found that physicians accepting new Medicaid patients have increased from 54 percent in 2012 to 64 percent in 2014. While MDCH verified that Michigan primary care physicians had the capacity to accommodate an expanded Medicaid

population prior to Healthy Michigan Plan implementation, MDCH is encouraged verification of this fact through both this study and "real world" experience.

Demonstration Evaluation

MDCH has commissioned the University of Michigan's Institute for Healthcare Policy and Innovation (IHPI) to serve as the Healthy Michigan Plan (HMP) 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 proceed in six domains over the course of the five year evaluation period:

I. An analysis of the impact of the HMP on uncompensated care costs borne by Michigan hospitals;
II. An analysis of the effect of HMP on the number of uninsured in Michigan;
III. The impact of HMP on increasing healthy behaviors and improving health outcomes;
IV. The viewpoints of beneficiaries and providers of the impact of HMP;
V. The impact of HMP's contribution requirements on beneficiary utilization, and;
VI. The impact of the MI Health Accounts on beneficiary healthcare utilization.

Activities for the evaluation have commenced, particularly with regards to Domain IV: Participant Beneficiary Views of the Healthy Michigan Plan. Other domain activities have also begun. A summary of the key activities for the FY 2015 first quarterly report follow this paragraph:

Domain I
Although the interim report for Domain I isn't due until FY 2018, 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 result, IHPI has prepared extracts of Medicare cost report data in this quarter. Ultimately, the activities will afford an assessment of Medicaid expansion on uncompensated care costs.

Domain II
Similar to Domain I, the Domain II interim report is not due until FY 2018. That being said, in this quarter, 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. This analysis will help to formulate a baseline uninsured rate in Michigan.

Domain III
Domain III will look at the impact of HMP on healthy behaviors and health outcomes. The interim report is due in FY 2017. IHPI activities in this quarter included conducting preliminary feasibility assessments of key data fields relative to health behaviors, utilization, and outcomes. Additionally, IHPI is analyzing early utilization patterns to develop a targeted sample for the Domain IV beneficiary survey and participated in meetings to refine their sampling plan.

Domain IV
Domain IV will examine beneficiary and provider viewpoints of HMP through surveys. The interim report is due in FY 2016. Activities for this quarter have included the following:
Primary Care Practitioner (PCP) Survey

- Completed key informant interviews to inform development of interview guides
- Tested, revised, and finalized interview guides for PCPs
- Finalized sampling plan for PCPs
- Began planning for recruitment and scheduling of interviews

Beneficiary Survey

- Began development and testing of enrollee interview guide
- Assembled community advisory team from five community regions in Michigan
- Met with MDCH to develop early evaluation activities related to MI Health Account statements

Domains V/VI
Domains V and VI entail analyzing data to assess the impact of contributions and the MI Health Account statements on beneficiary utilization of health care services, respectively. The interim reports are due in FY 2017. Activities in this quarter 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

Medical Care Advisory Council Minutes

State Contact(s)

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

Jacqueline Coleman, Waiver Specialist

Phone: (517) 241-7172

Carly Todd, Analyst

Phone: (517) 241-8422

Jason Jorkasky, Federal Regulation & Hospital Reimbursement Section Manager

Phone: (517) 335-0215

Brian Keisling, Actuarial Division Director

Phone: (517) 241-7181

Actuarial Division

Bureau of Policy and Actuarial Services

MSA, MDCH, P.O. Box 30479

Lansing, MI 48909-7979

Fax: (517) 241-5112

Date Submitted to CMS

April 23, 2015

Medical Services Administration

Medical Care Advisory Council

Minutes

Date: Wednesday, November 19, 2014

Time: 1:00 pm – 4:30 pm

Where: Michigan Public Health Institute (MPHI)
2436 Woodlake Circle
Okemos, MI

Attendees: **Council Members:** Robin Reynolds, David Herbel, Jan Hudson, Marilyn Litka-Klein, Michael Vizena, Larry Wagenknecht, David Lalumia, Doug Patterson, (for Kim Sibilsky), Alison Hirschel, Cheryl Bupp, Marion Owen, Chris Rodriquez, Rebecca Blake, Andrew Farmer, April Stopczynski, Barry Cargill, Warren White, Katie Linehan (for Elan Nichols), Bill Mayer, Kim Singh, Tawana Robinson (for Kate Kohn-Parrott)

Staff: Steve Fitton, Dick Miles, Jackie Prokop, Cindy Linn, Pam Diebolt, Marie LaPres, Kathy Stiffler, Monica Kwasnik, Kim Hamilton, Debera Eggleston, Cynthia Edwards, Lynda Zeller

Attendees: Abigail Larsen

Welcome and Introductions

Jan Hudson opened the meeting and introductions were made.

ER High Utilizers Project

The draft of the Emergency Room (ER) High Utilizers report was recently issued for comment and distributed to MCAC members. Comments were due by December 3, 2014. The draft report includes the recommendations that were proposed during the ER High Utilizers Project work group that met earlier in the year. These recommendations include: creating standard definitions; developing an advisory committee regarding ER high utilizers; promoting a health information exchange; payment reform; statewide narcotic guidelines; increasing access to primary care; incentivizing providers to see patients immediately after ER visits; educating the public on proper use of the ER; and to promote care coordination. A council member also suggested the creation of guidelines for the disposal of unused narcotics by providers.

Many of the programs for ER high utilizers have been funded through grants, and MDCH has been looking into requesting permanent funding from the legislature. This issue will be included in the report that is due to the legislature December 31, 2014.

Healthy Michigan Plan

Jackie Prokop and Monica Kwasnik gave an update on the implementation of the Healthy Michigan Plan. As of November 17, 2014, the official enrollment in the Healthy Michigan Plan was reported at 459,207 beneficiaries, and enrollment has been increasing at a rate of 1,000 to 1,500 new beneficiaries per day. To bring new meeting attendees up-to-date, Jackie reviewed the eligibility requirements for the Healthy Michigan Plan.

The on-line application process for the Healthy Michigan Plan continues to run quite smoothly; those who complete an application with all information included are able to receive an eligibility determination within 10 seconds. Council members were provided with a handout of a PowerPoint presentation for additional information.

A study is underway at the University of Michigan to review access to primary care.

Eligibility Issues and Fixes

MDCH has experienced a problem with some beneficiaries were being placed into Emergency Services Only (ESO) Medicaid when the Modified Adjusted Gross Income (MAGI) application was unable to immediately verify their citizenship status, even if they did meet federal citizenship requirements. As a solution, MDCH will now grant full Medicaid benefits to applicants who indicated that they are citizens at the time of application, if a check against federal records is not able to immediately verify this information, for a period of 90 days until a final determination of their citizenship status can be made. The Department of Human Services (DHS) is currently in the process of reaching out to applicants who were incorrectly placed into ESO Medicaid in order to grant them the full Medicaid benefits for which they are eligible. Jackie encouraged meeting attendees to share any problems they see with Medicaid eligibility with MDCH so that solutions can continue to be addressed. Issues were also identified with refugees and Plan First!

Changes to Eligibility Determination System

Steve Fitton gave an update on coming changes to the Eligibility Determination System, noting that the Healthy Michigan Plan legislation requires MDCH to submit a report to the legislature by December 31, 2014 about future plans for implementing the Healthy Michigan Plan. Because the Medicaid caseload has more than doubled in the last decade, MDCH is continually looking for ways to improve service to an expanded population of beneficiaries with new technology.

MIHealth Account Statements and Payments

The first round of MIHealth account statements were sent out in mid-October to beneficiaries who were moved to the Healthy Michigan Plan from the Adult Benefits Waiver (ABW). Of these, approximately 3,400 beneficiaries are required to pay copayments. Approximately 20,000 beneficiaries are not required to contribute any payment. Copayment amounts will be recalculated every three months.

Over $5,000 in copayments has already been collected from 821 individuals. Most paid for the full quarter instead of the monthly amount due. The November statements will include those that need to pay both copayments and contributions.

Protocols – Healthy Behaviors

Monica Kwasnik shared an update on the use of Health Risk Assessments (HRAs) by Healthy Michigan Plan beneficiaries enrolled in health plans. As of November 19, 2014, MDCH had received 25,000 completed HRAs. Data collected from these HRAs will be available in future HRA reports, which are released monthly and posted to the Healthy Michigan Plan website at: www.michigan.gov/healthymichiganplan >> Health Risk Assessment. Meeting attendees were provided with a copy of the September 2014 HRA report.

Healthy Michigan Plan beneficiaries who are enrolled in a health plan may complete an HRA and have their contribution amounts reduced. Once the HRA is completed, signed by the beneficiary's Primary Care Physician (PCP) and submitted to the appropriate health plan, the beneficiary will be

eligible to have their contribution amount reduced by half if their income is between 100% and 133% of the Federal Poverty Level (FPL). Beneficiaries with an income at or below 100% of the FPL will receive a $50 gift card for completing an HRA.

The council discussed the impact of the Healthy Michigan Plan on access to primary care and dental care for beneficiaries. Despite the expanded patient population, no significant problems have been reported with new beneficiaries gaining access to a primary care physician, even though some other states reporting problems in this area. One study by the University of Michigan found that because of extensive outreach efforts, access to primary care has actually increased with the implementation of the Healthy Michigan Plan.

Due to problems reported by some dental providers, a council member suggested that many Healthy Michigan Plan beneficiaries who are able to receive dental care for the first time could benefit from education on proper etiquette for dental office visits. MDCH and the health plans currently distribute information to new beneficiaries about their rights and responsibilities in a health plan.

Second Waiver Development

The second waiver for the Healthy Michigan Plan must be submitted by September 30, 2015 and approved by December 31, 2015. Steve Fitton stressed the importance of highlighting the successes of the Healthy Michigan Plan to the incoming members of the legislature in order to ensure continued support for the direction of the program. Steve indicated that the number of people impacted will be relatively small, as the vast majority of Healthy Michigan Plan enrollees have incomes below the Federal Poverty Level.

Managed Care Rebid

Following the August 2014 MCAC meeting, a stakeholder survey for the Managed Care Rebid was administered by the Michigan State University Institute for Health Policy and distributed to 317 different groups, including the MCAC and MSA. As a result of the survey, there were four major pillars for the rebid that were identified, including population health management, pay-for-value, integration of care, and structural transformation. It was acknowledged that each of these pillars may not have a universally-accepted definition, with population health management having the greatest variation in its definition among interested parties. MDCH has been working with independent consultants to gain a better understanding of how to implement the four pillars.

A council member asked if the managed care rebid would provide an opportunity for MDCH to remove the carve-out for the integration of behavioral health and physical health services. In response, Steve assured the member that MDCH is committed to improving the integration of care between behavioral health and physical health. Discussions are ongoing for how to accomplish this goal. Kathy Stiffler added that major changes to the integration of care are needed to make the system work well.

The current Managed Care contract will expire on September 30, 2015, and the Department of Technology, Management and Budget (DTMB) is seeking a new contract effective October 1, 2015 for five years, with three optional one-year extensions. There are no plans to expand or reduce the number of health plans contracted with Managed Care, as the focus will be on having the right number of plans for each region. Health plans may be able to submit a bid for operating in part of a region rather than the whole. The number of regions for the rebid has not yet been finalized. The Request for Proposal is expected by the end of January 2015.

The results of the survey were discussed, including information on the topics that received the most comments. Several stakeholders who participated in the survey commented on the lack of access to transportation for health plan beneficiaries. MDCH staff acknowledged that transportation access is a state-wide problem in Michigan, as many health plans are unable to find vendors to transport beneficiaries. Other topics that received multiple comments on the survey include the complexity of the enrollment system process, concerns about whether there are adequate networks in place for behavioral health and the number of visits, and for greater emphasis to be placed on quality and quality reporting. Council members each received a summary of the survey results.

Medicaid Caseload Decline

Jan Hudson raised concern over the recent decline in Medicaid caseloads, mainly among children and pregnant women. In this category, enrollment has declined from almost 615,000 beneficiaries in October 2013 to 530,000 in September 2014. The possible reasons for this decline in enrollment were discussed at length.

Integrated Care for Dual Eligibles

MDCH now has contracts in place with seven Integrated Care Organizations (ICOs) for the new Integrated Care Demonstration project, called MI Health Link. These ICOs include one located in the Upper Peninsula, two in Southwestern Michigan, and six in the Southeastern region. Implementation will occur in two phases, with implementation planned for the Upper Peninsula and Southwestern Michigan in the beginning of 2015, and for Wayne and Macomb Counties later in the year.

Before implementation can occur, MDCH needs approval of 1915(b) and 1915(c) waivers for the community-based long-term care component of the program, as well as approval of 34 different letters from the Centers for Medicare and Medicaid Services (CMS) to cover multiple aspects of implementation. Additionally, MDCH needs to set up outreach and educational opportunities, ensure provider network adequacy, and take steps to comply with Medicare requirements for the program. All of the health plans have passed their readiness reviews, and MDCH has received a $12 million implementation grant to help launch the program. A council member expressed concern that funds are not being made available to educate and prepare individuals in a reasonable amount of time. Some policies are not yet in place. There are still several contracts that need to be finalized, but Dick Miles expressed encouragement that the program is moving forward.

Policy Updates

A policy handout was given to each attendee.

MSA 14-30 – This policy was issued October 9, 2014. The policy added a new Early and Periodic Screening, Diagnosis and Treatment (EPSDT) chapter in the Medicaid Provider Manual and includes the most recent American Academy of Pediatrics (AAP) Periodicity recommendations.

MSA 14-47 – This policy was issued October 31, 2014. The policy will adopt the American Academy of Pediatric Dentistry (AAPD) recommendations for Pediatric Oral Health Assessment, Preventive Services, and Anticipatory Guidance/Counseling schedule.

Member Terms/Chairperson for 2015

Jan Hudson noted several members of the MCAC whose terms were expiring at the end of 2014, and encouraged the members to indicate their interest in renewing their term via email. Jan accepted the council's nomination for another term as Chairperson.

Medicaid Enactment 50th Anniversary July 30, 2015

The council discussed ideas for commemorating the 50th anniversary of Medicaid enactment. Jan asked council members to share suggestions with her.

4:30 – Adjourn

Next Meeting: To be scheduled