

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-25-26
Baltimore, Maryland 21244-1850



State Demonstrations Group

July 15, 2021

Kate Massey
Director
State of Michigan, Medical Services Administration
400 South Pines Street
Lansing, MI 48913

Dear Ms. Massey:

The Centers for Medicare & Medicaid Services (CMS) completed its review of the Evaluation Design, which is required by the Special Terms and Conditions (STC), specifically, STC #49, of Michigan's section 1115 demonstration, "Healthy Michigan Plan" (Project No: 11-W-00245/5), effective through December 31, 2023. CMS has determined that the Evaluation Design, which was submitted on August 12, 2019 and revised on May 27, 2021, meets the requirements set forth in the STCs and our evaluation design guidance, and therefore, approves the state's Evaluation Design.

CMS has added the approved Evaluation Design to the demonstration's STCs as Attachment F. A copy of the STCs, which includes the new attachment, is enclosed with this letter. In accordance with 42 CFR 431.424, the approved Evaluation Design may now be posted to the state's Medicaid website within thirty days. CMS will also post the approved Evaluation Design as a standalone document, separate from the STCs, on Medicaid.gov.

Please note that an Interim Evaluation Report, consistent with the approved Evaluation Design, is due to CMS one year prior to the expiration of the demonstration, or at the time of the extension application, if the state chooses to extend the demonstration. Likewise, a Summative Evaluation Report, consistent with this approved Evaluation Design, is due to CMS within 18 months of the end of the demonstration period. In accordance with 42 CFR 431.428 and the STCs, we look forward to receiving updates on evaluation activities in the demonstration monitoring reports.

We appreciate our continued partnership with Michigan on the Healthy Michigan Plan section 1115 demonstration. If you have any questions, please contact your CMS demonstration team.

Sincerely,

Danielle Daly
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Danielle Daly
Director
Division of Demonstration
Monitoring and Evaluation

Andrea Casart
Director
Division of Eligibility and
Coverage Demonstrations

cc: Keri Toback, State Monitoring Lead, CMS Medicaid and CHIP Operations Group

**CENTERS FOR MEDICARE & MEDICAID SERVICES
SERVICES WAIVER LIST**

NUMBER: 11-W-00245/5

TITLE: Healthy Michigan Plan Section 1115 Demonstration

AWARDEE: Michigan Department of Health and Human Services

All requirements of the Medicaid program expressed in law, regulation and policy statement, not expressly waived, shall apply to the demonstration project effective January 1, 2019 through December 31, 2023. In addition, these waivers may only be implemented consistent with the approved Special Terms and Conditions (STCs).

Under the authority of section 1115(a)(1) of the Social Security Act (the Act), the following waivers of state plan requirements contained in section 1902 of the Act are granted subject to the STCs for the Healthy Michigan Plan section 1115 demonstration.

1. Premiums

**Section 1902(a)(14) insofar as it
incorporates Sections 1916 and
1916A**

To the extent necessary to enable the state to require monthly premiums for individuals eligible in the adult population described in section 1902(a)(10)(A)(i)(VIII) of the Act, who have incomes between 100 and 133 percent of the federal poverty level (FPL).

2. Statewideness

Section 1902(a)(1)

To the extent necessary to enable the state to require enrollment in managed care plans only in certain geographical areas for those eligible in the adult population described in section 1902(a)(10)(A)(i)(VIII) of the Act.

3. Freedom of Choice

Section 1902(a)(23)(A)

To the extent necessary to enable the state to restrict freedom of choice of provider for those eligible in the adult population described in section 1902(a)(10)(A)(i)(VIII) of the Act. No waiver of freedom of choice is authorized for family planning providers.

4. Proper and Efficient Administration

Section 1902(a)(4)

To the extent necessary to enable the state to limit beneficiaries to enrollment in a single prepaid inpatient health plan or prepaid ambulatory health plan in a region or region(s) and restrict disenrollment from them.

5. Comparability

Sections 1902(a)(10)(B) and 1902(a)(17)

To the extent necessary to enable the state to vary the premiums, cost-sharing and healthy behavior reduction options as described in these terms and conditions.

6. Provision of Medical Assistance

Section 1902(a)(8) and 1902(a)(10)

To the extent necessary to enable Michigan to disenroll, and not make medical assistance available to, HMP beneficiaries with incomes above 100 percent of the FPL who have had 48 months of cumulative HMP eligibility and who do not complete a health risk assessment (HRA) or have not completed a healthy behavior, as described in these STCs, within the past twelve months.

7. Eligibility

Section 1902(a)(10)

To the extent necessary to enable Michigan to disenroll, prohibit re-enrollment, and deny eligibility to HMP beneficiaries with income above 100 percent of the FPL who have had 48 months of cumulative HMP eligibility and who do not complete a HRA or have not completed a healthy behavior, as described in these STCs, within the past twelve months.

To the extent necessary to enable Michigan to disenroll, prohibit re-enrollment, and deny eligibility to HMP beneficiaries with income above 100 percent of the FPL who have had 48 months of cumulative HMP eligibility and who do not pay the monthly five percent premium, as described in these STCs.

**CENTERS FOR MEDICARE & MEDICAID SERVICES
SPECIAL TERMS AND CONDITIONS**

NUMBER: 11-W-00245/5

TITLE: Healthy Michigan Plan Section 1115 Demonstration

AWARDEE: Michigan Department of Health and Human Services

I. PREFACE

The following are the Special Terms and Conditions (STCs) for the “Healthy Michigan Plan” section 1115(a) Medicaid demonstration (hereinafter demonstration) to enable the Michigan Department of Health and Human Services (state) to operate this demonstration. The Centers for Medicare & Medicaid Services (CMS) has granted waivers of requirements under section 1902(a) of the Social Security Act (Act), which are separately enumerated. These STCs set forth in detail the nature, character, and extent of federal involvement in the demonstration and the state’s obligations to CMS related to this demonstration. The Healthy Michigan Plan (HMP) demonstration will be statewide and is approved for a 5-year period, from January 1, 2019 through December 31, 2023. The demonstration provides approval for the state to require, beginning no sooner than January 1, 2020, (1) beneficiaries who have been enrolled in the demonstration more than 48 months to pay a monthly premium of five percent of income for continued eligibility, and (2) beneficiaries who have been enrolled in the demonstration more than 48 months to complete a health risk assessment (HRA) at redetermination or complete a healthy behavior in the previous 12 months, as a condition of eligibility.

The STCs have been arranged into the following subject areas:

- I. Preface
- II. Program Description And Objectives
- III. General Program Requirements
- IV. Eligibility for the Demonstration
- V. Benefits
- VI. Cost Sharing, Contributions, and Healthy Behaviors
- VII. Delivery System
- VIII. General Reporting Requirements
- IX. General Financial Requirements
- X. Monitoring Budget Neutrality for the Demonstration
- XI. Evaluation of the Demonstration

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

- Attachment A: Developing the Evaluation Design
- Attachment B: Preparing the Interim and Summative Evaluation Reports
- Attachment C: Implementation Plan
- Attachment D: Monitoring Protocol
- Attachment E: Healthy Behaviors List
- Attachment F: Evaluation Design

II. PROGRAM DESCRIPTION AND OBJECTIVES

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

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

On April 1, 2014, Michigan expanded its Medicaid program to include adults with income up to 133 percent of the FPL. To accompany this expansion, the Michigan “Adult Benefits Waiver” was amended and transformed to establish the HMP, through which the state intended to test innovative approaches to beneficiary cost sharing and financial responsibility for care for the new adult eligibility group, which was authorized under section 1902(a)(10)(A)(i)(VIII) of the Act (the “adult group”). Beneficiaries receiving coverage under the sunseting ABW program transitioned to the state plan and the Healthy Michigan Plan on April 1, 2014. Individuals in the new adult population with incomes above 100 percent of the FPL are required to make contributions equal to two percent of their family income toward the cost of their health care. In addition, all newly eligible adults with income from 0 to 133 percent of the FPL are required to pay copayments through an account operated in coordination with the Medicaid Health Plan (MHP). A MI Health Account was established for each enrolled individual to track beneficiaries’ contributions and how they were expended. Beneficiaries receive quarterly statements that summarized the MI Health Account funds balance and flows of funds into and

out of the account, and the use of funds for health care service copayments. Beneficiaries have opportunities to reduce their regular monthly contributions or average utilization based contributions by demonstrating achievement of recommended Healthy Behaviors. HMP beneficiaries receive a full health care benefit package as required under the Affordable Care Act, which includes all of the Essential Health Benefits and the requirements for an alternative benefit plan, as required by federal law and regulation, and there are no limits on the number of individuals who can enroll.

In September 2015, the state sought CMS approval of an amendment to HMP to implement additional directives contained in the state law (Public Act 107 of 2013). CMS approved the amendment on December 17, 2015, which effectuated the Marketplace Option, a premium assistance program for a subset of HMP eligible beneficiaries. However, the Marketplace Option was never implemented.

In December 2017, the state submitted an application to extend the HMP demonstration. In September 2018, the state submitted an additional application to amend certain elements of the HMP to comply with new state law provisions, and changes to eligibility for health care coverage and cost-sharing requirements for certain beneficiaries. The state also requested to end the Marketplace Option program. As approved, beneficiaries in the demonstration between 100 percent and 133 percent of the FPL who have had 48 months of cumulative eligibility for health care coverage through HMP will be required to pay premiums of five percent of income and have completed a health risk assessment (HRA) at their next redetermination or have engaged in specified healthy behaviors within the twelve- month period prior to the annual redetermination deadline as conditions of eligibility.

III. GENERAL PROGRAM REQUIREMENTS

- 1. Compliance with Federal Non-Discrimination Laws.** The state must comply with applicable federal civil rights laws relating to non-discrimination in services and benefits in its programs and activities. These include, but are not limited to, the Americans with Disabilities Act of 1990 (ADA), Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973 (Section 504), the Age Discrimination Act of 1975, and Section 1557 of the Affordable Care Act (Section 1557). Such compliance includes providing reasonable modifications to individuals with disabilities under the ADA, Section 504, and Section 1557 in eligibility and documentation requirements, to ensure they understand program rules and notices, necessary to obtain and maintain benefits.
- 2. Compliance with Medicaid Law, Regulation, and Policy.** All requirements of the Medicaid program, expressed in federal law, regulation, and written policy, not expressly

waived or identified as not applicable in the waiver and expenditure authority documents (of which these terms and conditions are part), apply to the demonstration.

- 3. Changes in Medicaid Law, Regulation, and Policy.** The state must, within the timeframes specified in federal law, regulation, or written policy, come into compliance with any changes in federal law, regulation, or policy affecting the Medicaid program that occur during this demonstration approval period, unless the provision being changed is expressly waived or identified as not applicable. In addition, CMS reserves the right to amend the STCs to reflect such changes and/or changes of an operational nature without requiring the state to submit an amendment to the demonstration under STC 7. CMS will notify the state 30 calendar days in advance of the expected approval date of the amended STCs to allow the state to provide comment.
- 4. Impact on Demonstration of Changes in Federal Law, Regulation, and Policy.**
 - a. To the extent that a change in federal law, regulation, or policy requires either a reduction or an increase in federal financial participation (FFP) for expenditures made under this demonstration, the state must adopt, subject to CMS approval, a modified budget neutrality agreement for the demonstration as necessary to comply with such change. Further, the state may seek an amendment to the demonstration (as per STC 7 of this section) as a result of the change in FFP.
 - b. If mandated changes in the federal law require state legislation, unless otherwise prescribed by the terms of the federal law, the changes must take effect on the day such state legislation becomes effective, or on the last day such legislation was required to be in effect under federal law, whichever is sooner.
- 5. State Plan Amendments.** The state will not be required to submit title XIX state plan amendments (SPAs) for changes affecting any populations made eligible solely through the demonstration. If a population eligible through the Medicaid state plan is affected by a change to the demonstration, a conforming amendment to the appropriate state plan may be required, except as otherwise noted in these STCs. In all such instances, the Medicaid state plan governs.
- 6. Changes Subject to the Amendment Process.** If not otherwise specified in these STCs, changes related to eligibility, enrollment, benefits, beneficiary rights, delivery systems, cost sharing, sources of non-federal share of funding, budget neutrality, and other comparable program elements must be submitted to CMS as amendments to the demonstration. All amendment requests are subject to approval at the discretion of the Secretary in accordance with section 1115 of the Act. The state must not implement changes to these elements without prior approval by CMS either through an approved amendment to the Medicaid state plan or amendment to the demonstration. Amendments to the demonstration are not retroactive and no FFP of any kind, including for administrative or medical assistance

expenditures, will be available under changes to the demonstration that have not been approved through the amendment process set forth in STC 7, except as provided in STC 3.

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

 - a. A detailed description of the amendment, including impact on beneficiaries, with sufficient supporting documentation;
 - b. A data analysis worksheet which identifies the specific “with waiver” impact of the proposed amendment on the current budget neutrality agreement. Such analysis shall include total computable “with waiver” and “without waiver” status on both a summary and detailed level through the current approval period using the most recent actual expenditures, as well as summary and detail projections of the change in the “with waiver” expenditure total as a result of the proposed amendment, which isolates (by Eligibility Group) the impact of the amendment;
 - c. An explanation of the public process used by the state consistent with the requirements of STC 13; and,
 - d. If applicable, a description of how the Evaluation Design will be modified to incorporate the amendment provisions.
- 8. Extension of the Demonstration.** States that intend to request a demonstration extension under sections 1115(e) or 1115(f) of the Act must submit extension applications in accordance with the timelines contained in statute. Otherwise, no later than twelve (12) months prior to the expiration date of the demonstration, the Governor or Chief Executive Officer of the state must submit to CMS either a demonstration extension request that meets federal requirements at 42 CFR 431.412(c) or a transition and phase-out plan consistent with the requirements of STC 9.
- 9. Demonstration Phase Out.** The state may only suspend or terminate this demonstration in whole, or in part, consistent with the following requirements:

 - a. Notification of Suspension or Termination. The state must promptly notify CMS in writing of the reason(s) for the suspension or termination, together with the effective date and a transition and phase-out plan. The state must submit a

notification letter and a draft transition and phase-out plan to CMS no less than six (6) months before the effective date of the demonstration's suspension or termination. Prior to submitting the draft transition and phase-out plan to CMS, the state must publish on its website the draft transition and phase-out plan for a 30-day public comment period. In addition, the state must conduct tribal consultation in accordance with STC 13, if applicable. Once the 30-day public comment period has ended, the state must provide a summary of the issues raised by the public during the comment period and how the state considered the comments received when developing the revised transition and phase-out plan.

- b. Transition and Phase-out Plan Requirements. The state must include, at a minimum, in its transition and phase-out plan the process by which it will notify affected beneficiaries, the content of said notices (including information on the beneficiary's appeal rights), the process by which the state will conduct administrative reviews of Medicaid eligibility prior to the termination of the demonstration for the affected beneficiaries, and ensure ongoing coverage for eligible beneficiaries, as well as any community outreach activities the state will undertake to notify affected beneficiaries, including community resources that are available.
- c. Transition and Phase-out Plan Approval. The state must obtain CMS approval of the transition and phase-out plan prior to the implementation of transition and phase-out activities. Implementation of transition and phase-out activities must be no sooner than 14 calendar days after CMS approval of the transition and phase-out plan.
- d. Transition and Phase-out Procedures. The state must comply with all applicable notice requirements found in 42 CFR, part 431 subpart E, including sections 431.206, 431.210, 431.211, and 431.213. In addition, the state must assure all applicable appeal and hearing rights are afforded to beneficiaries in the demonstration as outlined in 42 CFR, part 431 subpart E, including sections 431.220 and 431.221. If a beneficiary in the demonstration requests a hearing before the date of action, the state must maintain benefits as required in 42 CFR 431.230. In addition, the state must conduct administrative renewals for all affected beneficiaries in order to determine if they qualify for Medicaid eligibility under a different eligibility category prior to termination as discussed in October 1, 2010, State Health Official Letter #10-008 and as required under 42 C.F.R. 435.916(f)(1). For individuals determined ineligible for Medicaid, the state must determine potential eligibility for other insurance affordability programs and comply with the procedures set forth in 42 CFR 435.1200(e).
- e. Exemption from Public Notice Procedures 42 CFR Section 431.416(g). CMS may expedite the federal and state public notice requirements under circumstances described in 42 CFR 431.416(g).

- f. Enrollment Limitation during Demonstration Phase-Out. If the state elects to suspend, terminate, or not extend this demonstration, during the last six months of the demonstration, enrollment of new individuals into the demonstration must be suspended. The limitation of enrollment into the demonstration does not impact the state's obligation to determine Medicaid eligibility in accordance with the approved Medicaid state plan.
- g. Federal Financial Participation (FFP). FFP will be limited to normal closeout costs associated with the termination or expiration of the demonstration including services, continued benefits as a result of beneficiaries' appeals, and administrative costs of disenrolling beneficiaries.

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

- a. Expiration Requirements. The state must include, at a minimum, in its demonstration authority expiration plan the process by which it will notify affected beneficiaries, the content of said notices (including information on the beneficiary's appeal rights), the process by which the state will conduct administrative reviews of Medicaid eligibility prior to the termination of the demonstration authority for the affected beneficiaries, and ensure ongoing coverage for eligible beneficiaries, as well as any community outreach activities.
- b. Expiration Procedures. The state must comply with all applicable notice requirements found in 42 CFR, part 431 subpart E, including sections 431.206, 431.210, 431.211, and 431.213. In addition, the state must assure all applicable appeal and hearing rights are afforded to beneficiaries in the demonstration as outlined in 42 CFR, part 431 subpart E, including sections 431.220 and 431.221. If a beneficiary in the demonstration requests a hearing before the date of action, the state must maintain benefits as required in 42 CFR 431.230. In addition, the state must conduct administrative renewals for all affected beneficiaries in order to determine if they qualify for Medicaid eligibility under a different eligibility category prior to termination as discussed in October 1, 2010, State Health Official Letter #10-008 and as required under 42 CFR 435.916(f)(1). For individuals determined ineligible for Medicaid, the state must determine potential eligibility for other insurance affordability programs and comply with the procedures set forth in 42 CFR 435.1200(e).
- c. Federal Public Notice. CMS will conduct a 30-day federal public comment period consistent with the process outlined in 42 CFR 431.416 in order to solicit public input on the state's demonstration authority expiration plan. CMS will consider

comments received during the 30-day period during its review of the state's demonstration authority expiration plan. The state must obtain CMS approval of the demonstration authority expiration plan prior to the implementation of the expiration activities. Implementation of expiration activities must be no sooner than fourteen (14) calendar days after CMS approval of the demonstration authority expiration plan.

- d. Federal Financial Participation (FFP). FFP will be limited to normal closeout costs associated with the expiration of the demonstration authority including services, continued benefits as a result of beneficiaries' appeals, and administrative costs of disenrolling beneficiaries.

11. Withdrawal of Waiver or Expenditure Authority. CMS reserves the right to withdraw waivers and/or expenditure authorities at any time it determines that continuing the waivers or expenditure authorities would no longer be in the public interest or promote the objectives of title XIX. CMS must promptly notify the state in writing of the determination and the reasons for the withdrawal, together with the effective date, and afford the state an opportunity to request a hearing to challenge CMS' determination prior to the effective date. If a waiver or expenditure authority is withdrawn, FFP is limited to normal closeout costs associated with terminating the waiver or expenditure authority, including services, continued benefits as a result of beneficiary appeals, and administrative costs of disenrolling beneficiaries.

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

13. Public Notice, Tribal Consultation, and Consultation with Interested Parties. The state must comply with the state notice procedures as required in 42 CFR 431.408 prior to submitting an application to extend the demonstration. For applications to amend the demonstration, the state must comply with the state notice procedures set forth in 59 Fed. Reg. 49249 (September 27, 1994) prior to submitting such request.

The state must also comply with tribal and Indian Health Program/Urban Indian Health Organization consultation requirements at section 1902(a)(73) of the Act, 42 CFR 431.408(b), State Medicaid Director Letter #01-024, or as contained in the state's approved Medicaid State Plan, when any program changes to the demonstration, either through amendment as set out in STC 7 or extension, are proposed by the state.

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

14. Federal Financial Participation (FFP). No federal matching for state expenditures under this demonstration, including for administrative and medical assistance expenditures, will be available until the effective date identified in the demonstration approval letter, or if later, as expressly stated within these STCs.

15. Common Rule Exemption. The state shall ensure that the only involvement of human subjects in research activities that may be authorized and/or required by this demonstration is for projects which are conducted by or subject to the approval of CMS, and that are designed to study, evaluate, or otherwise examine the Medicaid program – including procedures for obtaining Medicaid benefits or services, possible changes in or alternatives to Medicaid programs and procedures, or possible changes in methods or levels of payment for Medicaid benefits or services. The Secretary has determined that this demonstration as represented in these approved STCs meets the requirements for exemption from the human subject research provisions of the Common Rule set forth in 45 CFR 46.101(b)(5).

IV. ELIGIBILITY FOR THE DEMONSTRATION

16. Eligibility Groups Affected By the Demonstration. Only beneficiaries eligible for Medicaid under an eligibility group listed in Table 1 are subject to the provisions within this demonstration; these beneficiaries will be referred to as “HMP beneficiaries.” State plan groups derive their eligibility through the Medicaid state plan, and coverage for this group is subject to all applicable Medicaid laws and regulations in accordance with the Medicaid state plan, except as expressly waived in this demonstration and as described in these STCs.

Table 1. Medicaid Eligibility Groups Affected by the Demonstration	
Eligibility Group	Citations
New Adult Group	1902(a)(10)(A)(i)(VIII) 42 CFR 435.119

17. Beneficiaries with income above 100 percent through 133 percent of the FPL and 48 Months of Eligibility. In order to maintain eligibility for HMP, HMP beneficiaries enrolled in MHPs with income between 100 percent and 133 percent of the FPL, who have had 48 months of cumulative HMP eligibility since April 1, 2014, must:

- a. Complete all required questions on a HRA or have completed a healthy behavior in the prior 12 months, as described in STC 24; and

- b. Pay a premium of five percent of income (in lieu of copayments, coinsurance, and similar payments), not to exceed limits defined in 42 CFR 447.56(f), as described in STC 23(a).

18. Beneficiaries with income at or below 100 percent of the FPL and 48 months of Eligibility. HMP beneficiaries with income at or below 100 percent of the FPL who have had 48 months of cumulative HMP eligibility from April 1, 2014 will continue to be subject to the cost-sharing responsibilities as described in STC 22(d).

V. BENEFITS

19. Healthy Michigan Plan Benefits. HMP beneficiaries will receive benefits as provided in the state's approved Alternative Benefit Plan for HMP.

VI. COST SHARING, CONTRIBUTIONS, AND HEALTHY BEHAVIORS

20. Cost Sharing: General Requirements. All cost sharing must be in compliance with Medicaid requirements that are set forth in federal statute, regulation, the state plan, and policies, except as modified by the waivers and STCs granted for this demonstration.

21. MI Health Account. The state may require each HMP beneficiary to have a MI Health Account that tracks and records beneficiary payments and liabilities.

22. Cost Sharing for Beneficiaries with Fewer than 48 Cumulative Months in the HMP. All HMP beneficiaries with fewer than 48 months of cumulative HMP eligibility from April 1, 2014, are subject to the following cost-sharing requirements:

- a. Copayments. All HMP beneficiaries with fewer than 48 months of cumulative eligibility in HMP are required to pay nominal copayment requirements as specified in the Medicaid state plan.
 - i. Copayments during the initial six months of enrollment. During a beneficiary's first six months of enrollment in a MHP, there will be no copayments collected at the point of service for health plan covered services.
 - ii. Quarterly copayments. At the end of the initial six-month enrollment period, the state will calculate an average monthly co-payment for the beneficiary, based on the beneficiary's first six months of enrollment. The beneficiary will be billed for his or her average monthly copayments only at the end of each quarter. Beneficiaries can be billed for copayment liability in any six month period after the first six months of enrollment. Maximum billed amounts must be equal to or less than the average of the beneficiary's incurred copayments for the previous six month period

(except for any reductions to copayments due to Healthy Behaviors, described in STC 22(b)). Beneficiary cost-sharing must be compliant with the rules established in 42 CFR 447.56.

- b. Healthy Behaviors: Cost sharing reductions. Beneficiaries in this category are eligible to receive incentive payments to offset cost sharing liability via reductions in their copayment liability and a 50 percent reduction in their monthly contribution if certain healthy behaviors are maintained or attained (described in STC 24).
- c. Cost-sharing: beneficiaries with income above 100 percent of the FPL through 133 percent of the FPL. Beneficiaries in this category will be responsible for copayment liability based upon the prior six months of utilization for the beneficiary (see STC 22(b)) and a monthly contribution that shall not exceed two percent of income. In addition, reductions for healthy behavior incentives will be applied to the copayment liability (after the beneficiary has reached two percent of income in copayments), monthly contribution, or both, through the MI Health Account. Beneficiaries will be notified of the copayment liability by the provider, but will be billed for such copayments only at the end of quarter. No interest will be due on accrued copayment liability. Beneficiary cost-sharing must be compliant with the rules established in 42 CFR 447.56. No beneficiary with income from 100 percent of the FPL through 133 percent of the FPL and fewer than 48 cumulative months in the HMP may lose eligibility for Medicaid or be denied eligibility for Medicaid, be denied enrollment in a MHP or be denied access to services for failure to pay premiums or copayment liabilities.
- d. Cost-sharing: beneficiaries with income at or below 100 percent of the FPL. Beneficiaries in this category will be responsible for copayment liability based upon the prior six months of copayment experience for the beneficiary (see STC 22(b)). Beneficiaries will be notified of the copayment liability by the provider, but will be billed for such copayments only at the end of quarter. No interest will be due on accrued copayment liability. In addition, reductions for healthy behavior incentives will be applied to the copayment liability due after the beneficiary has reached two percent of income in copayments. No premiums will be paid by this population. Beneficiary cost-sharing must be compliant with the rules established in 42 CFR 447.56. No beneficiary with income at or below 100 percent of the FPL will lose eligibility for Medicaid or be denied eligibility for Medicaid, be denied enrollment in a MHP or be denied access to services for failure to pay copayment liabilities.

23. Cost sharing for Beneficiaries with 48 or More Cumulative Months in the HMP.

Effective on or after January 1, 2020 all HMP beneficiaries with 48 or more months of cumulative eligibility are subject to the following cost-sharing requirements:

- a. Cost-sharing: beneficiaries with income above 100 percent of the FPL through 133 percent of the FPL. Beneficiaries in this category are not subject to the copayment requirements specified in the Medicaid state plan and are not eligible for any cost-sharing reductions related to healthy behavior completion incentives. Instead, beneficiaries in this category are subject to a monthly premium requirement that shall not exceed five percent of income beginning the first day of the calendar month following the beneficiary's 48th month of cumulative HMP eligibility, but no earlier than January 1, 2020. Sixty days before a beneficiary reaches 48 months of cumulative enrollment, (or, for beneficiaries who have already reached 48 months of cumulative enrollment by January 1, 2020, 60 days prior to January 1, 2020), the beneficiary will be noticed of the five percent premium requirement. No sooner than 60 days after the invoice date of the missed premium, beneficiaries who fail to pay the monthly contribution will be terminated from coverage after proper notice. Disenrolled beneficiaries must pay the missed premium payment(s) accumulated by the beneficiary while enrolled prior to being re-enrolled, at which point the individual will be eligible to re-apply and begin receiving coverage, so long as the individual is otherwise eligible. Beneficiaries who are disenrolled as a result of non-payment of premiums but who, during that disenrollment, would become exempt from premiums or otherwise become eligible for Medicaid under an eligibility group not subject to the premium requirement, may re-enroll with an effective date consistent with the beneficiary's eligibility category without paying owed premiums.
- b. Cost-sharing: beneficiaries with income at or below 100 percent of the FPL. Beneficiaries in this category will continue to be subject to the cost-sharing requirements described in STC 22(a) and 22(d).

24. Healthy Behaviors Incentives Program. The Healthy Behaviors Incentives Program incentivizes beneficiaries to engage in certain healthy behaviors. Beneficiaries who complete a HRA and agree to address or maintain healthy behaviors will receive an incentive described below. Incentives are reflected in a beneficiary's MI Health Account statement (as described in STC 21).

- a. Beneficiaries with incomes at or below 100 percent of the FPL. Beneficiaries in this category who have paid two percent of their income in copayments are eligible for a 50 percent reduction in their copayment liability if certain healthy behaviors are maintained or attained.
- b. Beneficiaries with incomes above 100 percent of the FPL through 133 percent of the FPL with less than 48 cumulative months in HMP. Beneficiaries in this category who have paid two percent of their income in copayments are eligible for a 50 percent reduction in their copayment liability. In addition,

beneficiaries are eligible for a 50 percent reduction in their monthly contribution if certain healthy behaviors are maintained or attained.

- c. Beneficiaries with income above 100 percent of the FPL through 133 percent of the FPL with 48 or more cumulative months in HMP. Beneficiaries with 48 months of eligibility in this category must complete the required questions on a HRA or complete a healthy behavior prior to beneficiary's next redetermination as a condition of continued eligibility. Responses to questions on the HRA will not impact an individual's Medicaid eligibility. Beneficiaries will be sent individual written notices about the requirement 60 days before the beneficiary reaches 48 months cumulative enrollment. If a beneficiary does not complete an HRA or if the state cannot confirm completion of a healthy behavior (see Attachment E for the complete list of qualifying healthy behaviors) in the 12 months preceding the beneficiary's annual redetermination, then the beneficiary will be disenrolled from HMP and must complete an HRA prior to being re-enrolled, at which point the beneficiary will be eligible to re-enroll and begin receiving coverage the first day of the month in which the beneficiary applied. If a beneficiary fails to answer all required questions on the HRA, eligibility for the demonstration will be denied. Beneficiaries who are disenrolled as a result of non-completion of an HRA or a healthy behavior, but who, during that disenrollment, would become exempt from the healthy behavior requirement or otherwise become eligible for Medicaid under an eligibility group not subject to the healthy behavior requirement, may re-enroll with an effective date consistent with the beneficiary's eligibility category without completing a HRA or healthy behavior. Beneficiaries in this category will not receive any reductions in copayment liability or monthly contributions for completion of healthy behaviors.

25. Beneficiaries Exempt from the 48 Month Cost-Sharing and Healthy Behaviors Requirements.

- a. American Indian/Alaska Natives and children under 21 years of age are exempt from paying premiums pursuant to 42 CFR 447.56(a), but will still be required to complete an HRA or complete an annual healthy behavior in order to remain on HMP.
- b. Pregnant women are exempt from paying premiums pursuant to 42 CFR 447.56(a), and while they are encouraged to participate in the Healthy Behavior Incentives Program, they will not be subject to loss of eligibility for failure to comply with the HRA or annual healthy behavior requirement.
- c. Beneficiaries who are identified or self-report as medically frail, as described in 42 CFR 440.315, will be exempt from paying premiums and from the requirement to complete an HRA or complete an annual healthy behavior.
- d. Beneficiaries who are not enrolled in a MHP are exempt from the premiums and from the requirement to complete an HRA or complete an annual healthy behavior.

- e. Beneficiaries who are enrolled in the Flint Michigan section 1115 demonstration are exempt from the premiums and from the requirement to complete an HRA or complete an annual healthy behavior.

26. Premiums: State Assurances. The state shall:

- a. Permit the state's premium vendor to attempt to collect the unpaid premiums from the beneficiary, but the state's premium vendor may not report the premium amount owed to credit reporting agencies, place a lien on a beneficiary's home, refer the case to debt collectors, file a lawsuit, or seek a court order to seize a portion of the beneficiary's earnings for enrollees at any income level. The state will not "sell" the obligation for collection by a third-party. Further, while the amount is collectible by the state, re-enrollment is not conditioned upon repayment, except for beneficiaries described in STC 23(a);
- b. Monitor that beneficiaries do not incur household cost sharing and premiums that, combined, exceed five percent of the aggregate household income, in accordance with 42 CFR 447.56(f);
- c. Ensure that the state, or its designee, does not pass along the cost of any surcharge associated with processing payments to the beneficiary. Any surcharges or other fees associated with payment processing are considered an administrative expense by the state;
- d. Ensure that all payments from the beneficiary, or on behalf of the beneficiary, are accurately credited toward unpaid premiums in a timely manner, and provide the beneficiary an opportunity to review and seek correction of the payment history;
- e. Ensure that the state has a process to refund any premiums paid for a month in which the beneficiary is ineligible for Medicaid services for that month;
- f. Ensure that a beneficiary will not be charged a higher premium the following month due to nonpayment or underpayment of a premium in the previous month/s, except that amounts outstanding and due from the previous month/s may be reflected separately on subsequent invoices;
- g. Ensure the state ends monthly billing of premiums to beneficiaries who have been disenrolled for failure to meet the HRA/healthy behaviors requirements, and provide written notice to prevent overpayment of premiums;
- h. Conduct outreach and education to beneficiaries to ensure that they understand the program policies regarding premiums and associated consequences for nonpayment. Beneficiaries must be provided individual written notice of how premium payments should be made; the potential impact of a change in income on premium payments owed; the consequences of failure to report a change in income or circumstances that affect eligibility; the time period over which income is calculated (e.g., monthly income); the deadline for reporting changes in circumstances; and how to re-enroll if disenrolled for non-payment of premiums;
- i. Provide opportunities to demonstrate good cause for failure to pay premiums that would allow beneficiaries to avoid the consequences for non-payment described

in STC 23(a). Good cause circumstances must include, at a minimum, the following:

- i. The beneficiary was hospitalized, otherwise incapacitated, or has a disability as defined by the ADA, section 504 of the Rehabilitation Act, or section 1557 of the Patient Protection and Affordable Care Act and as a result is unable to pay premiums, or is a person with a disability who was not provided with reasonable modifications needed to pay the premium, or is a person with a disability and there were no reasonable modifications that would have enabled the individual to pay premiums;
- ii. A member of the beneficiary's immediate family who was living in the home with the beneficiary was institutionalized or died or the immediate family member has a disability as defined by the ADA, section 504 of the Rehabilitation Act, or section 1557 of the Patient Protection and Affordable Care Act and caretaking or other disability-related responsibilities resulted in an inability to pay the premiums;
- iii. The birth of a family member living with the beneficiary;
- iv. The beneficiary experienced a family emergency;
- v. The beneficiary experienced a life changing event (e.g., divorce, domestic violence);
- vi. The beneficiary experienced a temporary illness or injury.
- vii. The beneficiary was evicted from their home or experienced homelessness, or
- viii. The beneficiary was the victim of a natural disaster, such as a flood, storm, earthquake, or serious fire.
- j. Provide all applicants and beneficiaries with timely and adequate written notices of any decision affecting their eligibility, including an approval, denial, termination, or suspension of eligibility or a denial or change in benefits and services pursuant to 42 CFR 435.917. The state will also make program information available and accessible in accordance with 42 CFR 435.901 and 435.905. The state will provide beneficiaries with 10 days advance notice for any adverse action prior to the date of action pursuant to 42 CFR 431.211;
- k. Provide notice to beneficiaries, prior to adverse action, about the disenrollment, and explaining what this status means, including but not limited to: their right to appeal, their opportunity to cure, their right to apply for Medicaid on a basis not affected by this status, what this status means with respect to their ability to access other coverage (such as coverage in a qualified health plan through the Exchange, or access to premium tax credits through the Exchange), what they should do if their circumstances change such that they may be eligible for coverage in another Medicaid category, as well as any implications with respect to whether they have minimum essential coverage;
- l. Provide beneficiaries with written notice of the rights of people with disabilities to receive reasonable modifications related to premium payment; and

- m. Maintain a system that identifies, validates, and provides reasonable modifications related to the obligation to pay premiums to beneficiaries with disabilities protected by the ADA, section 504 of the Rehabilitation Act, and section 1557 of the Patient Protection and Affordable Care Act.

27. Healthy Behaviors: State Assurances. The state shall:

- a. Develop uniform standards for healthy behavior incentives including, but not limited to, a health risk assessment to identify behavior that the initiative is targeting. Such targeted behaviors could include: routine ER use for non-emergency treatment, multiple co-morbidities, alcohol abuse, substance use disorders, tobacco use, obesity, and deficiencies in immunization status.
- b. Include a selection of targeted healthy behaviors that is sufficiently diverse and a strategy to measure access to necessary providers to ensure that all beneficiaries have a meaningful opportunity to receive healthy behavior incentives, taking into account individual physical and mental health status.
- c. Implement a comprehensive pre-implementation education and outreach strategy regarding the Healthy Behaviors Incentive Program including strategies related to the ongoing engagement of stakeholders and the public in the state;
- d. Provide written notice to beneficiaries regarding:
 - i. The rights of people with disabilities to receive reasonable modifications related to engaging in healthy behaviors;
 - ii. What specific healthy behaviors will qualify to meet the requirement;
 - iii. How beneficiaries can report engagement in healthy behaviors, in accordance with 42 CFR 435.907(a); and
 - iv. Prior to adverse action, information about disenrollment from HMP and an explanation of what this status means, including but not limited to: their right to appeal, their right to cure, their right to apply for Medicaid on a basis not affected by this status, what this status means with respect to their ability to access other coverage (such as coverage in a qualified health plan through the Exchange, or access to premium tax credits through the Exchange), what they should do if their circumstances change such that they may be eligible for coverage in another Medicaid category, as well as any implications with respect to whether they have minimum essential coverage.
- e. Develop a data driven strategy of how healthy behaviors will be tracked and monitored at the beneficiary and provider level, including standards of accountability for providers. This must include the timeline for development and/or implementation of a systems based approach which shall occur prior to implementing the Healthy Behaviors initiative.
- f. Develop a beneficiary and provider education strategy and timeline for completion prior to program implementation.
- g. For beneficiaries who complete the HRA, provide those beneficiaries with information about ongoing structured interventions that will assist beneficiaries in improving health outcomes.

- h. Maintain ongoing education and outreach post implementation regarding the Healthy Behaviors Incentive Program including strategies related to the ongoing engagement of stakeholders and the public in the state;
- i. Determine how the MHP will coordinate with the beneficiaries and the state in ensuring the beneficiaries understand the impact of failing to engage in healthy behaviors, including the impact on cost-sharing and the potential for disenrollment;
- j. Develop a description of other incentives in addition to reductions in cost sharing or premiums that the state will implement;
- k. Develop a process to inform beneficiaries how to remedy not answering all the required questions on the HRA and the consequences if they do not;
- l. Provide opportunities to demonstrate good cause for failure to pay complete the HRA or healthy behavior that would allow beneficiaries to avoid the consequences for that failure described in STC 24(c). Good cause circumstances must include, at a minimum, the following; and:
 - i. The beneficiary was hospitalized, otherwise incapacitated, or has a disability as defined by the ADA, section 504 of the Rehabilitation Act, or section 1557 of the Patient Protection and Affordable Care Act and as a result is unable to pay premiums, or is a person with a disability who was not provided with reasonable modifications needed to pay the premium, or is a person with a disability and there were no reasonable modifications that would have enabled the individual to pay premiums;
 - ii. A member of the beneficiary's immediate family who was living in the home with the beneficiary was institutionalized or died, or the immediate family member has a disability as defined by the ADA, section 504 of the Rehabilitation Act, or section 1557 of the Patient Protection and Affordable Care Act and caretaking or other disability-related responsibilities resulted in an inability to pay the premiums;
 - iii. The birth of a family member living with the beneficiary;
 - iv. The beneficiary experienced a family emergency;
 - v. The beneficiary experienced a life changing event (e.g., divorce, domestic violence);
 - vi. The beneficiary experienced a temporary illness or injury.
 - vii. The beneficiary was evicted from their home or experienced homelessness, or
 - viii. The beneficiary was the victim of a natural disaster, such as a flood, storm, earthquake, or serious fire that occurred.
- m. Ensure that this healthy behaviors feature of the demonstration is implemented in a way that does not discriminate against people with disabilities on the basis of disability in violation of the ADA, Section 504, Section 1557 or any other federal civil rights laws

VII. DELIVERY SYSTEM

28. Healthy Michigan Plan. Services for Healthy Michigan Plan adults will be provided through a managed care delivery system.

- a. **Types of Health Plans.** The state will use two different types of managed care plans to provide the full Alternative Benefit Plan for the demonstration population:
 - i. **Comprehensive Health Plans:** MHPs that provide acute care, physical health services and most pharmacy benefits on a statewide basis. These MHPs will be the same MHPs that provide acute care and physical health coverage for other Medicaid populations.
 - ii. **Behavioral Health Plans:** These will be Pre-paid Inpatient Health Plans (PIHPs) that provide inpatient and outpatient mental health, substance use disorder, and developmental disability services statewide to all enrollees in the demonstration. The PIHPs will be the same entities that serve other Medicaid populations.

29. Healthy Michigan Plan Enrollment Requirements. The state may require HMP beneficiaries to enroll in MHPs and PIHPs (with the exception of those beneficiaries who meet the MHP enrollment exemption criteria or those beneficiaries who meet the voluntary enrollment criteria).

- a. Mandatory enrollment may occur only when the MHPs or PIHPs have been determined by the state to meet readiness and network requirements to ensure sufficient access, quality of care, and care coordination for beneficiaries as established by the state, consistent with 42 CFR 438 and as approved by CMS.
- b. Newly eligible beneficiaries will initially be placed in fee-for-service (FFS), during which the individual will be responsible for paying all copayments, in amounts that are in accord with the state plan, at the time of service.
- c. The state will use an enrollment broker to assist individuals with selection of a MHP before relying on auto-assignments.
- d. Any individual that does not make an active selection will be assigned, by default, to a participating MHP.
- e. Individuals will have choice of MHPs in all areas except the rural counties that are not defined as urban by the Executive Office of Management and Budget. In rural counties, the state will only contract with one MHP to serve those

beneficiaries, consistent with the standards in section 1932(a)(3)(B) of the Act. In those rural areas that qualify for only one plan, the state will ensure the choice of providers as detailed in 42 CFR. 438.52(b)(1). In all areas of the state, individuals will only be permitted to enroll in the one PIHP that serves their area of residence.

- f. Upon completion of the 90-day disenrollment period, during which time individuals may choose a different MHP, individuals that are mandatorily enrolled into a MHP will be locked into that MHP for a period of no longer than 12 months, unless they have a for-cause reason for disenrollment, as defined by the state. Individuals that are voluntarily enrolled into a MHP will be permitted to disenroll at any time.
- g. All individuals will be automatically assigned to the single PIHP that serves beneficiaries in their area of residence in order to access services in the behavioral health system, provided the PIHP has been determined to meet readiness and network requirements, as described above.
- h. Mandatory enrollment cannot include individuals specifically exempted from mandatory enrollment in managed care under section 1932 of the Act. These individuals may elect to receive benefits through a FFS delivery system.
- i. Notice Information. The state must provide transition notice to any beneficiaries impacted by a change in delivery system at least 30 days in advance of the change. Notices will be written in simple and understandable terms and in a manner that is accessible to persons who are limited English proficient and individuals living with disabilities.
- j. Transition Period. When beneficiaries transition delivery systems, beneficiaries in active treatment (including but not limited to chemotherapy, pregnancy, drug regime or a scheduled procedure) with a non-participating/non-contracted provider shall be allowed to continue receiving treatment from the nonparticipating/non-contracted provider through the duration of their prescribed treatment.

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

31. Managed Care Requirements. The state must comply with the managed care regulations published at 42 CFR 438, except as waived herein. Capitation rates shall be developed and certified as actuarially sound, in accordance with 42 CFR 438.5. The certification shall identify historical utilization of services that are the same as outlined in the corresponding Alternative Benefit Plan and used in the rate development process.

- 32. Managed Care Contracts.** No FFP is available for activities covered under contracts and/or modifications to existing contracts that are subject to 42 CFR 438 requirements prior to CMS approval of this demonstration authority as well as CMS approval of such contracts and/or contract amendments. The state shall submit any supporting documentation deemed necessary by CMS. The state must provide CMS with a minimum of 60 days to review and approve changes. CMS reserves the right, as a corrective action, to withhold FFP (either partial or full) for the demonstration, until the contract compliance requirement is met.
- 33. Public Contracts.** Payments under contracts with public agencies, that are not competitively bid in a process involving multiple bidders, shall not exceed the documented costs incurred in furnishing covered services to eligible individuals (or a reasonable estimate with an adjustment factor no greater than the annual change in the consumer price index).
- 34. AI/AN Access to Behavioral Health Services.** American Indian/Alaska Native beneficiaries may elect to obtain Medicaid mental health and substance abuse services directly from Medicaid enrolled Indian Health Service (IHS) facilities and Tribal Health Centers (THCs). For mental health and substance abuse services provided to Native American beneficiaries, the IHS facilities and THCs will be reimbursed directly for those services by the state in accordance with the applicable rates in the approved state plan and the Michigan Medicaid Provider Manual. Any Native American Indian beneficiary who needs specialty mental health, developmental disability or substance abuse services may also elect to receive such care under this demonstration through the PIHP. The PIHPs have been specifically instructed by the state to assure that Indian health programs are included in the PIHP provider panel, to ensure culturally competent specialty care for the beneficiaries in those areas.

VIII. GENERAL REPORTING REQUIREMENTS

- 35. Deferral for Failure to Submit Timely Demonstration Deliverables.** CMS may issue deferrals in accordance with 42 CFR part 430 subpart C, in the amount of \$5,000,000 per deliverable (federal share) when items required by these STCs (e.g., required data elements, analyses, reports, design documents, presentations, and other items specified in these STCs (hereafter singularly or collectively referred to as “deliverable(s)”) are not submitted timely to CMS or are found to not be consistent with the requirements approved by CMS. A deferral shall not exceed the value of the federal amount for the current demonstration period. The state does not relinquish its rights provided under 42 CFR part 430 subpart C to challenge any CMS finding that the state materially failed to comply with the terms of this agreement.

The following process will be used: 1) Thirty (30) days after the deliverable was due if the state has not submitted a written request to CMS for approval of an extension as described

in subsection (b) below; or 2) Thirty (30) days after CMS has notified the state in writing that the deliverable was not accepted for being inconsistent with the requirements of this agreement and the information needed to bring the deliverable into alignment with CMS requirements.

- a. CMS will issue a written notification to the state providing advance notification of a pending deferral for late or non-compliant submission of required deliverable(s).
- b. For each deliverable, the state may submit to CMS a written request for an extension to submit the required deliverable that includes a supporting rationale for the cause(s) of the delay and the state's anticipated date of submission. Should CMS agree to the state's request, a corresponding extension of the deferral process can be provided. CMS may agree to a corrective action as an interim step before applying the deferral, if corrective action is proposed in the state's written extension request.
- c. If CMS agrees to an interim corrective process in accordance with subsection (b), and the state fails to comply with the corrective action steps or still fails to submit the overdue deliverable(s) that meets the terms of this agreement, CMS may proceed with the issuance of a deferral against the next Quarterly Statement of Expenditures reported in Medicaid Budget and Expenditure System/State Children's Health Insurance Program Budget and Expenditure System (MBES/CBES) following a written deferral notification to the state.
- d. If the CMS deferral process has been initiated for state non-compliance with the terms of this agreement for submitting deliverable(s) and the state submits the overdue deliverable(s), and such deliverable(s) are accepted by CMS as meeting the standards outlined in these STCs, the deferral(s) will be released.
- e. As the purpose of a section 1115 demonstration is to test new methods of operation or service delivery, a state's failure to submit all required reports, evaluations, and other deliverables will be considered by CMS in reviewing any application for an extension, amendment, or for a new demonstration.

36. Submission of Post-Approval Deliverables. The state must submit all deliverables as stipulated by CMS and within the timeframes outlined within these STCs.

37. Compliance with Federal Systems Updates. As federal systems continue to evolve and incorporate additional 1115 demonstration reporting and analytics functions, the state will work with CMS to:

- a. Revise the reporting templates and submission processes to accommodate timely compliance with the requirements of the new systems;

- b. Ensure all 1115, T-MSIS, and other data elements that have been agreed to for reporting and analytics are provided by the state; and
- c. Submit deliverables to the appropriate system as directed by CMS.

38. Implementation Plan. The state must submit an Implementation Plan to CMS no later than ninety (90) calendar days after approval of the demonstration. The Implementation Plan must cover at least the key policies being tested under this demonstration, including but not limited to, cost-sharing and healthy behaviors. Once determined complete by CMS, the Implementation Plan will be incorporated into the STCs, as Attachment C. At a minimum, the Implementation Plan must include definitions and parameters of key policies, and describe the state's strategic approach to implementing the policies, including timelines for meeting milestones associated with these key policies. Other topics to be discussed in the Implementation Plan include application assistance, reporting, and processing; notices; coordinated agency responsibilities; coordination with other insurance affordability programs; appeals; renewals; coordination with other state agencies; beneficiary protections; and outreach.

39. Monitoring Protocol. The state must submit to CMS a Monitoring Protocol no later than one hundred fifty (150) calendar days after approval of the demonstration. Once approved, the Monitoring Protocol will be incorporated into the STCs, as Attachment D.

At a minimum, the Monitoring Protocol will affirm the state's commitment to conduct quarterly and annual monitoring in accordance with CMS' template. Any proposed deviations from CMS' template should be documented in the Monitoring Protocol. The Monitoring Protocol will describe the quantitative and qualitative elements on which the state will report through quarterly and annual monitoring reports. For quantitative metrics (e.g., performance metrics as described in STC 40(b) below), CMS will provide the state with a set of required metrics, and technical specifications for data collection and analysis covering the key policies being tested under this demonstration, including but not limited to, cost-sharing and healthy behaviors. The Monitoring Protocol will specify the methods of data collection and timeframes for reporting on the state's progress as part of the quarterly and annual monitoring reports. For the qualitative elements (e.g., operational updates as described in STC 40(a) below), CMS will provide the state with guidance on narrative and descriptive information which will supplement the quantitative metrics on key aspects of the demonstration policies. The quantitative and qualitative elements will comprise the state's quarterly and annual monitoring reports.

40. Monitoring Reports. The state must submit three (3) Quarterly Reports and one (1) Annual Report each DY. The fourth-quarter information that would ordinarily be provided in a separate quarterly report should be reported as distinct information within the Annual Report. The Quarterly Reports are due no later than sixty (60) calendar days following the end of each demonstration quarter. The Annual Report (including the fourth-quarter information) is due no later than ninety (90) calendar days following the

end of the DY. The reports will include all required elements as per 42 CFR 431.428, and should not direct readers to links outside the report. Additional links not referenced in the document may be listed in a Reference/Bibliography section. The Monitoring Reports must follow the framework to be provided by CMS, which will be organized by milestones. The framework is subject to change as monitoring systems are developed/evolve, and will be provided in a structured manner that supports federal tracking and analysis.

- a. Operational Updates. The operational updates will focus on progress towards meeting the milestones identified in CMS's framework. Additionally, per 42 CFR 431.428, the Monitoring Reports must document any policy or administrative difficulties in operating the demonstration. The reports shall provide sufficient information to document key challenges, underlying causes of challenges, how challenges are being addressed, as well as key achievements and to what conditions and efforts successes can be attributed. The discussion should also include any issues or complaints identified by beneficiaries; lawsuits or legal actions; unusual or unanticipated trends; legislative updates; and descriptions of any public forums held. The Monitoring Report should also include a summary of all public comments received through post-award public forums regarding the progress of the demonstration.
- b. Performance Metrics. The performance metrics will provide data to demonstrate how the state is progressing towards meeting the milestones identified in CMS's framework which includes the following key policies under this demonstration, including but not limited to --, cost-sharing and healthy behaviors. The performance metrics will also reflect all other components of the state's demonstration. For example, these metrics will cover enrollment, disenrollment or suspension by specific demographics and reason, , access to care, and health outcomes.

Per 42 CFR 431.428, the Monitoring Reports must document the impact of the demonstration in providing insurance coverage to beneficiaries and the uninsured population, as well as outcomes of care, quality and cost of care, and access to care. This may also include the results of beneficiary satisfaction surveys, if conducted, and grievances and appeals.

The required monitoring and performance metrics must be included in the Monitoring Reports, and will follow the CMS framework provided by CMS to support federal tracking and analysis.

- c. Budget Neutrality and Financial Reporting Requirements. Per 42 CFR 431.428, the Monitoring Reports must document the financial performance of the demonstration. The state must provide an updated budget neutrality workbook with every Monitoring Report that meets all the reporting requirements for

monitoring budget neutrality set forth in the General Financial Requirements section of these STCs, including the submission of corrected budget neutrality data upon request. In addition, the state must report quarterly and annual expenditures associated with the populations affected by this demonstration on the Form CMS-64. Administrative costs for this demonstration should be reported separately on the CMS-64.

- d. Evaluation Activities and Interim Findings. Per 42 CFR 431.428, the Monitoring Reports must document any results of the demonstration to date per the evaluation hypotheses. Additionally, the state shall include a summary of the progress of evaluation activities, including key milestones accomplished, as well as challenges encountered and how they were addressed.

41. Corrective Action. If monitoring indicates that demonstration features are not likely to assist in promoting the objectives of Medicaid, CMS reserves the right to require the state to submit a corrective action plan to CMS for approval. This may be an interim step to withdrawing waivers or expenditure authorities, as outlined in STC 11.

42. Close Out Report. Within 120 calendar days after the expiration of the demonstration, the state must submit a draft Close Out Report to CMS for comments.

- a. The draft report must comply with the most current guidance from CMS.
- b. The state will present to and participate in a discussion with CMS on the Close-Out report.
- c. The state must take into consideration CMS' comments for incorporation into the final Close Out Report.
- d. The final Close Out Report is due to CMS no later than thirty (30) calendar days after receipt of CMS' comments.
- e. A delay in submitting the draft or final version of the Close Out Report may subject the state to penalties described in STC 39.

43. Monitoring Calls. CMS will convene periodic conference calls with the state.

- a. The purpose of these calls is to discuss ongoing demonstration operation, to include (but not limited to), any significant actual or anticipated developments affecting the demonstration. Examples include implementation activities, trends in reported data on metrics and associated mid-course adjustments, budget neutrality, and progress on evaluation activities.

- b. CMS will provide updates on any pending actions, as well as federal policies and issues that may affect any aspect of the demonstration.
- c. The state and CMS will jointly develop the agenda for the calls.

44. Post Award Forum. Pursuant to 42 CFR 431.420(c), within six (6) months of the demonstration's implementation, and annually thereafter, the state shall afford the public with an opportunity to provide meaningful comment on the progress of the demonstration. At least thirty (30) days prior to the date of the planned public forum, the state must publish the date, time, and location of the forum in a prominent location on its website. The state must also post the most recent Annual Report on its website with the public forum announcement. Pursuant to 42 CFR 431.420(c), the state must include a summary of the comments in the Monitoring Report associated with the quarter in which the forum was held, as well as in its compiled Annual Report.

IX. GENERAL FINANCIAL REQUIREMENTS

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

45. General Financial Requirements. The state must comply with all general financial requirement under Title XIX, as well as any applicable reporting requirement related to monitoring budget neutrality, set forth in Section XI of these STCs.

X. MONITORING BUDGET NEUTRALITY FOR THE DEMONSTRATION

46. Budget Neutrality. Consistent with the August 22, 2018, State Health Official Letter #18-009, CMS has determined that this demonstration is budget neutral based on CMS's assessment that the waiver authorities granted for the demonstration are unlikely to result in any increase in federal Medicaid expenditures for medical assistance, and that no expenditure authorities are associated with the demonstration. The state will not be allowed to obtain budget neutrality "savings" from this demonstration. The demonstration will not include a budget neutrality expenditure limit, and no further test of budget neutrality will be required. CMS reserves the right to request budget neutrality worksheets and analyses from the state whenever the state seeks a change to the demonstration, per STC 7.

XI. EVALUATION OF THE DEMONSTRATION

47. Cooperation with Federal Evaluators. As required under 42 CFR 431.420(f), the state shall cooperate fully and timely with CMS and its contractors in any federal evaluation of the demonstration or any component of the demonstration. This includes, but is not limited to: commenting on design and other federal evaluation documents; providing data and

analytic files to CMS; entering into a data use agreement that explains how the data and data files will be exchanged; and providing a technical point of contact to support specification of the data and files to be disclosed, as well as relevant data dictionaries and record layouts. The state shall include in its contracts with entities that collect, produce, or maintain data and files for the demonstration, a requirements that they make data available for the federal evaluation as is required under 42 CFR 431.420(f) to support federal evaluation. The state may claim administrative match for these activities. Failure to comply with this STC may result in a deferral being issued as outlined in STC 39.

48. Independent Evaluator. Upon approval of the demonstration, the state must begin to arrange with an independent party to conduct an evaluation of the demonstration to ensure that the necessary data is collected at the level of detail needed to research the approved hypotheses. The state must require the independent party to sign an agreement that the independent party will conduct the demonstration evaluation in an independent manner in accord with the CMS-approved Evaluation Design. When conducting analyses and developing the evaluation reports, every effort should be made to follow the approved methodology. However, the state may request, and CMS may agree to, changes in the methodology in appropriate circumstances.

49. Draft Evaluation Design. The state must submit, for CMS comment and approval, a draft Evaluation Design, no later than one hundred eighty (180) calendar days after approval of the demonstration.

Any modifications to an existing approved Evaluation Design will not affect previously established requirements and timelines for report submission for the demonstration, if applicable.

The draft Evaluation Design must be developed in accordance with the following CMS guidance (including but not limited to):

- d. All applicable Evaluation Design guidance, including but not limited to guidance about, cost-sharing and healthy behaviors. Hypotheses for cost-sharing and healthy behaviors will include (but not be limited to): effects on access to care; and health outcomes. Hypotheses applicable to the demonstration as a whole, and to all key policies referenced above, will include (but will not be limited to): the effects of the demonstration on health outcomes; the financial impact of the demonstration (for example, such as an assessment of medical debt and uncompensated care costs); and the effect of the demonstration on Medicaid program sustainability.
- e. Attachment A (Developing the Evaluation Design) of these STCs, technical assistance for developing SUD Evaluation Designs (as applicable, and as

provided by CMS), and all applicable technical assistance on how to establish comparison groups to develop a draft Evaluation Design.

- 50. Evaluation Design Approval and Updates.** The state must submit a revised draft Evaluation Design within sixty (60) calendar days after receipt of CMS' comments. Upon CMS approval of the draft Evaluation Design, the document will be included as an attachment to these STCs. Per 42 CFR 431.424(c), the state will publish the approved Evaluation Design within thirty (30) calendar days of CMS approval. The state must implement the Evaluation Design and submit a description of its evaluation progress in each of the Monitoring Reports. Once CMS approves the Evaluation Design, if the state wishes to make changes, the state must submit a revised Evaluation Design to CMS for approval if the changes are substantial in scope; otherwise, in consultation with CMS, the state may include updates to the Evaluation Design in monitoring reports.
- 51. Evaluation Questions and Hypotheses.** Consistent with Attachments A and B (Developing the Evaluation Design and Preparing the Evaluation Reports) of these STCs, the evaluation documents must include a discussion of the evaluation questions and hypotheses that the state intends to test. Each demonstration component should have at least one evaluation question and hypothesis. The hypothesis testing should include, where possible, assessment of both process and outcome measures. Proposed measures should be selected from nationally-recognized sources and national measures sets, where possible. Measures sets could include CMS's Core Set of Health Care Quality Measures for Children in Medicaid and CHIP, CMS's measure sets for eligibility and coverage, Consumer Assessment of Health Care Providers and Systems (CAHPS), the Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults, and/or measures endorsed by National Quality Forum (NQF).
- 52. Evaluation Budget.** A budget for the evaluation shall be provided with the draft Evaluation Design. It will include the total estimated cost, as well as a breakdown of estimated staff, administrative, and other costs for all aspects of the evaluation such as any survey and measurement development, quantitative and qualitative data collection and cleaning, analyses, and report generation. A justification of the costs may be required by CMS if the estimates provided do not appear to sufficiently cover the costs of the design or if CMS finds that the design is not sufficiently developed, or if the estimates appear to be excessive.
- 53. Interim Evaluation Report.** The state must submit an Interim Evaluation Report for the completed years of the demonstration, and for each subsequent renewal or extension of the demonstration, as outlined in 42 CFR 431.412(c)(2)(vi). When submitting an application for renewal, the Evaluation Report should be posted to the state's website with the application for public comment.
- f. The Interim Evaluation Report will discuss evaluation progress and present findings to date as per the approved Evaluation Design. For demonstration authority that expires prior to the overall demonstration's expiration date, the

Interim Evaluation Report must include an evaluation of the authority as approved by CMS.

- g. If the state is seeking to renew or extend the demonstration, the draft Interim Evaluation Report is due when the application for renewal is submitted. If the state made changes to the demonstration in its application for renewal, the research questions and hypotheses, and how the design was adapted, should be included. If the state is not requesting a renewal for a demonstration, an Interim Evaluation report is due one (1) year prior to the end of the demonstration. For demonstration phase outs prior to the expiration of the approval period, the draft Interim Evaluation Report is due to CMS on the date that will be specified in the notice of termination or suspension.
- h. The state must submit a revised Interim Evaluation Report sixty (60) calendar days after receiving CMS comments on the draft Interim Evaluation Report. Once approved by CMS, the state must post the final Interim Evaluation Report to the state's website.
- i. The Interim Evaluation Report must comply with Attachment B (Preparing the Interim and Summative Evaluation Reports) of these STCs.

54. Summative Evaluation Report. The draft Summative Evaluation Report must be developed in accordance with Attachment B (Preparing the Interim and Summative Evaluation Reports) of these STCs. The state must submit a draft Summative Evaluation Report for the demonstration's current approval period within eighteen (18) months of the end of the approval period represented by these STCs. The Summative Evaluation Report must include the information in the approved Evaluation Design.

- j. Unless otherwise agreed upon in writing by CMS, the state shall submit a revised Summative Evaluation Report within sixty (60) calendar days of receiving comments from CMS on the draft.
- k. Upon approval from CMS, the final Summative Evaluation Report must be posted to the state's Medicaid website within thirty (30) calendar days of approval by CMS.

55. Corrective Action Plan Related to Evaluation. If evaluation findings indicate that demonstration features are not likely to assist in promoting the objectives of Medicaid, CMS reserves the right to require the state to submit a corrective action plan to CMS for approval. These discussions may also occur as part of a renewal process when associated with the state's Interim Evaluation Report. This may be an interim step to withdrawing waivers or expenditure authorities, as outlined in STC 11.

State Presentations for CMS. CMS reserves the right to request that the state present and participate in a discussion with CMS on the Evaluation Design, the Interim

Evaluation Report, and/or the Summative Evaluation Report.

- 56. Public Access.** The state shall post the final documents (e.g., Monitoring Reports, Close-Out Report, approved Evaluation Design, Interim Evaluation Report, and Summative Evaluation Report) on the state's Medicaid website within thirty (30) calendar days of approval by CMS.
- 57. Additional Publications and Presentations.** For a period of twelve (12) months following CMS approval of the final reports, CMS will be notified prior to presentation of these reports or their findings, including in related publications (including, for example, journal articles), by the state, contractor, or any other third party directly connected to the demonstration over which the state has control. Prior to release of these reports, articles, or other publications, CMS will be provided a copy including any associated press materials. CMS will be given ten (10) business days to review and comment on publications before they are released. CMS may choose to decline to comment or review some or all of these notifications and reviews. This requirement does not apply to the release or presentation of these materials to state or local government officials.

Attachment A: Developing the Evaluation Design

Introduction

For states that are testing new approaches and flexibilities in their Medicaid programs through section 1115 demonstrations, evaluations are crucial to understand and disseminate what is or is not working and why. The evaluations of new initiatives seek to produce new knowledge and direction for programs and inform Medicaid policy for the future. While a narrative about what happened during a demonstration provides important information, the principal focus of the evaluation of a section 1115 demonstration should be obtaining and analyzing data on the process (e.g., whether the demonstration is being implemented as intended), outcomes (e.g., whether the demonstration is having the intended effects on the target population), and impacts of the demonstration (e.g., whether the outcomes observed in the targeted population differ from outcomes in similar populations not affected by the demonstration). Both state and federal governments need rigorous quantitative and qualitative evidence to inform policy decisions.

Expectations for Evaluation Designs

CMS expects Evaluation Designs to be rigorous, incorporate baseline and comparison group assessments, as well as statistical significance testing. Technical assistance resources for constructing comparison groups and identifying causal inferences are available on Medicaid.gov: <https://www.medicaid.gov/medicaid/section-1115-demonstrations/1115-demonstration-monitoring-evaluation/1115-demonstration-state-monitoring-evaluation-resources/index.html>. If the state needs technical assistance using this outline or developing the Evaluation Design, the state should contact its demonstration team.

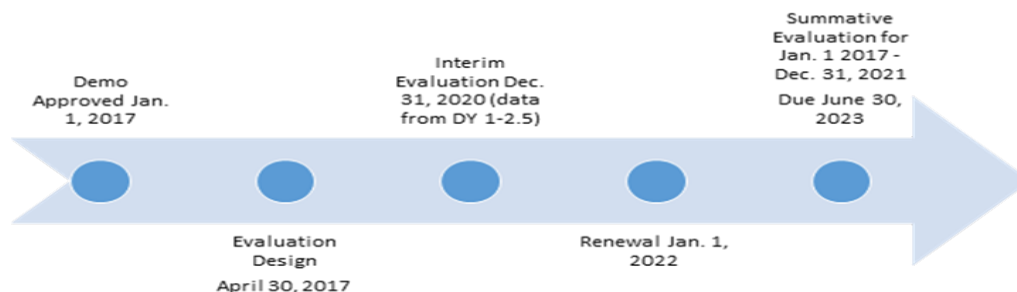
All states with Medicaid section 1115 demonstrations are required to conduct an evaluation, and the Evaluation Design is the roadmap for conducting the evaluation. The roadmap begins with the stated goals for the demonstration followed by the measurable evaluation questions and quantifiable hypotheses, all to support a determination of the extent to which the demonstration has achieved its goals. When conducting analyses and developing the evaluation reports, every effort should be made to follow the approved methodology. However, the state may request, and CMS may agree to, changes in the methodology in appropriate circumstances.

The format for the Evaluation Design is as follows:

- A. General Background Information;
- B. Evaluation Questions and Hypotheses;
- C. Methodology;
- D. Methodological Limitations;
- E. Attachments.

Submission Timelines

There is a specified timeline for the state's submission of Evaluation Design and Reports. (The graphic below depicts an example of this timeline for a 5-year demonstration). In addition, the state should be aware that section 1115 evaluation documents are public records. The state is required to publish the Evaluation Design to the state's website within 30 days of CMS approval, as per 42 CFR 431.424(e). CMS will also publish a copy to the Medicaid.gov website.



Required Core Components of All Evaluation Designs

The Evaluation Design sets the stage for the Interim and Summative Evaluation Reports. It is important that the Evaluation Design explain the goals and objectives of the demonstration, the hypotheses related to the demonstration, and the methodology (and limitations) for the evaluation. A copy of the state's Driver Diagram (described in more detail in paragraph B2 below) should be included with an explanation of the depicted information.

A. General Background Information – In this section, the state should include basic information about the demonstration, such as:

- 1) The issue/s that the state is trying to address with its section 1115 demonstration and/or expenditure authorities, the potential magnitude of the issue/s, and why the state selected this course of action to address the issue/s (e.g., a narrative on why the state submitted an 1115 demonstration proposal).
- 2) The name of the demonstration, approval date of the demonstration, and period of time covered by the evaluation.
- 3) A brief description of the demonstration and history of the implementation, and whether the draft Evaluation Design applies to an amendment, extension, renewal, or expansion of, the demonstration.
- 4) For renewals, amendments, and major operational changes: A description of any changes to the demonstration during the approval period; the primary reason or reasons for the change; and how the Evaluation Design was altered or augmented to address these changes.
- 5) Describe the population groups impacted by the demonstration.

B. Evaluation Questions and Hypotheses – In this section, the state should:

- 1) Describe how the state's demonstration goals are translated into quantifiable targets for improvement, so that the performance of the demonstration in achieving these targets could be measured.
- 2) Include a Driver Diagram to visually aid readers in understanding the rationale behind the cause and effect of the variants behind the demonstration features and intended outcomes. A driver diagram is a particularly effective modeling tool when working to improve health and health care through specific interventions. The diagram includes information about the goal of the demonstration, and the features of the demonstration. A driver diagram depicts the relationship between the aim, the primary drivers that contribute directly to achieving the aim, and the secondary drivers that are necessary to achieve the primary drivers for the demonstration. For an example and more information on driver diagrams:
<https://innovation.cms.gov/files/x/hciatwoaimsdrvrs.pdf>
- 3) Identify the state's hypotheses about the outcomes of the demonstration:
 - a. Discuss how the evaluation questions align with the hypotheses and the goals of the demonstration;
 - b. Address how the research questions / hypotheses of this demonstration promote the objectives of Titles XIX and/or XXI.

C. Methodology – In this section, the state is to describe in detail the proposed research methodology. The focus is on showing that the evaluation meets the prevailing standards of scientific and academic rigor, and the results are statistically valid and reliable, and that where appropriate it builds upon other published research (use references).

This section provides the evidence that the demonstration evaluation will use the best available data; reports on, controls for, and makes appropriate adjustments for the limitations of the data and their effects on results; and discusses the generalizability of results. This section should provide enough transparency to explain what will be measured and how. Specifically, this section establishes:

- 1) *Evaluation Design* – Provide information on how the evaluation will be designed. For example, will the evaluation utilize a pre/post comparison? A post-only assessment? Will a comparison group be included?
- 2) *Target and Comparison Populations* – Describe the characteristics of the target and comparison populations, to include the inclusion and exclusion criteria. Include information about the level of analysis (beneficiary, provider, or program level), and if populations will be stratified into subgroups. Additionally discuss the sampling methodology for the populations, as well as support that a statistically reliable sample size is available.
- 3) *Evaluation Period* – Describe the time periods for which data will be included.

- 4) *Evaluation Measures* – List all measures that will be calculated to evaluate the demonstration. Include the measure stewards (i.e., the organization(s) responsible for the evaluation data elements/sets by “owning”, defining, validating; securing; and submitting for endorsement, etc.) Include numerator and denominator information. Additional items to ensure:
- a. The measures contain assessments of both process and outcomes to evaluate the effects of the demonstration during the period of approval.
 - b. Qualitative analysis methods may be used, and must be described in detail.
 - c. Benchmarking and comparisons to national and state standards, should be used, where appropriate.
 - d. Proposed health measures could include CMS’s Core Set of Health Care Quality Measures for Children in Medicaid and CHIP, Consumer Assessment of Health Care Providers and Systems (CAHPS), the Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults and/or measures endorsed by National Quality Forum (NQF).
 - e. Proposed performance metrics can be selected from nationally recognized metrics, for example from sets developed by the Center for Medicare and Medicaid Innovation or for meaningful use under Health Information Technology (HIT).
 - f. Among considerations in selecting the metrics shall be opportunities identified by the state for improving quality of care and health outcomes, and controlling cost of care.
- 5) *Data Sources* – Explain where the data will be obtained, and efforts to validate and clean the data. Discuss the quality and limitations of the data sources.

If primary data (data collected specifically for the evaluation) – The methods by which the data will be collected, the source of the proposed question/responses, the frequency and timing of data collection, and the method of data collection. (Copies of any proposed surveys must be reviewed with CMS for approval before implementation).

- 6) *Analytic Methods* – This section includes the details of the selected quantitative and/or qualitative measures to adequately assess the effectiveness of the demonstration. This section should:
- a. Identify the specific statistical testing which will be undertaken for each measure (e.g., t-tests, chi-square, odds ratio, ANOVA, regression). Table A is an example of how the state might want to articulate the analytic methods for each research question and measure.
 - b. Explain how the state will isolate the effects of the demonstration (from other initiatives occurring in the state at the same time) through the use of comparison groups.

- c. A discussion of how propensity score matching and difference in differences design may be used to adjust for differences in comparison populations over time (if applicable).
- d. The application of sensitivity analyses, as appropriate, should be considered.

7) *Other Additions* – The state may provide any other information pertinent to the Evaluation Design of the demonstration.

Table A. Example Design Table for the Evaluation of the Demonstration

Research Question	Outcome measures used to address the research question	Sample or population subgroups to be compared	Data Sources	Analytic Methods
Hypothesis 1				
Research question 1a	-Measure 1 -Measure 2 -Measure 3	-Sample e.g. All attributed Medicaid beneficiaries -Beneficiaries with diabetes diagnosis	-Medicaid fee-for-service and encounter claims records	-Interrupted time series
Research question 1b	-Measure 1 -Measure 2 -Measure 3 -Measure 4	-sample, e.g., PPS patients who meet survey selection requirements (used services within the last 6 months)	-Patient survey	Descriptive statistics
Hypothesis 2				
Research question 2a	-Measure 1 -Measure 2	-Sample, e.g., PPS administrators	-Key informants	Qualitative analysis of interview material

D. Methodological Limitations – This section provides detailed information on the limitations of the evaluation. This could include the design, the data sources or collection process, or analytic methods. The state should also identify any efforts to minimize the limitations. Additionally, this section should include any information about features of the demonstration that effectively present methodological constraints that the state would like CMS to take into consideration in its review.

E. Special Methodological Considerations – CMS recognizes that there may be certain instances where a state cannot meet the rigor of an evaluation as expected by CMS. In these instances, the state should document for CMS why it is not able to incorporate key components of a rigorous evaluation, including comparison groups and baseline data analyses. Examples of considerations include:

When the demonstration is considered successful without issues or concerns that would require more regular reporting, such as:

- a. Operating smoothly without administrative changes; and
- b. No or minimal appeals and grievances; and
- c. No state issues with CMS 64 reporting or budget neutrality; and

- d. No Corrective Action Plans (CAP) for the demonstration.

F. Attachments

- 1) **Independent Evaluator.** This includes a discussion of the state's process for obtaining an independent entity to conduct the evaluation, including a description of the qualifications that the selected entity must possess, and how the state will assure no conflict of interest. Explain how the state will assure that the Independent Evaluator will conduct a fair and impartial evaluation, prepare an objective Evaluation Report, and that there would be no conflict of interest. The Evaluation Design should include a "No Conflict of Interest" statement signed by the independent evaluator.
- 2) **Evaluation Budget.** A budget for implementing the evaluation shall be provided with the draft Evaluation Design. It will include the total estimated cost, as well as a breakdown of estimated staff, administrative, and other costs for all aspects of the evaluation. Examples include, but are not limited to: the development of all survey and measurement instruments; quantitative and qualitative data collection; data cleaning and analyses; and reports generation. A justification of the costs may be required by CMS if the estimates provided do not appear to sufficiently cover the costs of the draft Evaluation Design or if CMS finds that the draft Evaluation Design is not sufficiently developed.
- 3) **Timeline and Major Milestones.** Describe the timeline for conducting the various evaluation activities, including dates for evaluation-related milestones, including those related to procurement of an outside contractor, if applicable, and deliverables. The Final Evaluation Design shall incorporate an Interim and Summative Evaluation. Pursuant to 42 CFR 431.424(c)(v), this timeline should also include the date by which the Final Summative Evaluation report is due.

Attachment B: Preparing the Interim and Summative Evaluation Reports

Introduction

For states that are testing new approaches and flexibilities in their Medicaid programs through section 1115 demonstrations, evaluations are crucial to understand and disseminate what is or is not working and why. The evaluations of new initiatives seek to produce new knowledge and direction for programs and inform Medicaid policy for the future. While a narrative about what happened during a demonstration provides important information, the principal focus of the evaluation of a section 1115 demonstration should be obtaining and analyzing data on the process (e.g., whether the demonstration is being implemented as intended), outcomes (e.g., whether the demonstration is having the intended effects on the target population), and impacts of the demonstration (e.g., whether the outcomes observed in the targeted population differ from outcomes in similar populations not affected by the demonstration). Both state and federal governments need rigorous quantitative and qualitative evidence to inform policy decisions.

Expectations for Evaluation Reports

Medicaid section 1115 demonstrations are required to conduct an evaluation that is valid (the extent to which the evaluation measures what it is intended to measure), and reliable (the extent to which the evaluation could produce the same results when used repeatedly). To this end, the already approved Evaluation Design is a map that begins with the demonstration goals, then transitions to the evaluation questions, and to the specific hypotheses, which will be used to investigate whether the demonstration has achieved its goals. States should have a well-structured analysis plan for their evaluation. With the following kind of information, states and CMS are best poised to inform and shape Medicaid policy in order to improve the health and welfare of Medicaid beneficiaries for decades to come. When conducting analyses and developing the evaluation reports, every effort should be made to follow the approved methodology. However, the state may request, and CMS may agree to, changes in the methodology in appropriate circumstances. When submitting an application for renewal, the Interim Evaluation Report should be posted on the state's website with the application for public comment. Additionally, the Interim Evaluation Report must be included in its entirety with the application submitted to CMS.

Intent of this Attachment

Title XIX of the Social Security Act (the Act) requires an evaluation of every section 1115 demonstration. In order to fulfill this requirement, the state's submission must provide a comprehensive written presentation of all key components of the demonstration, and include all required elements specified in the approved Evaluation Design. This Attachment is intended to assist states with organizing the required information in a standardized format and understanding the criteria that CMS will use in reviewing the submitted Interim and Summative Evaluation Reports.

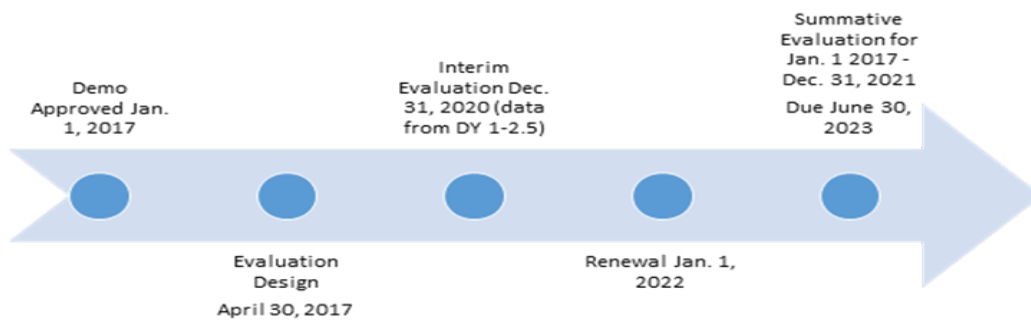
The format for the Interim and Summative Evaluation reports is as follows:

- A. Executive Summary;
- B. General Background Information;
- C. Evaluation Questions and Hypotheses;

- D. Methodology;
- E. Methodological Limitations;
- F. Results;
- G. Conclusions;
- H. Interpretations, and Policy Implications and Interactions with Other State Initiatives;
- I. Lessons Learned and Recommendations; and
- J. Attachment(s).

Submission Timelines

There is a specified timeline for the state's submission of Evaluation Designs and Evaluation Reports. These dates are specified in the demonstration Special Terms and Conditions (STCs). (The graphic below depicts an example of this timeline for a 5-year demonstration). In addition, the state should be aware that section 1115 evaluation documents are public records. In order to assure the dissemination of the evaluation findings, lessons learned, and recommendations, the state is required to publish the Evaluation Design and Reports to the state's website within thirty (30) calendar days of CMS approval, as per 42 CFR 431.424(d). CMS will also publish a copy to the Medicaid.gov website.



Required Core Components of Interim and Summative Evaluation Reports

The section 1115 Evaluation Report presents the research about the section 1115 Demonstration. It is important that the report incorporate a discussion about the structure of the Evaluation Design to explain the goals and objectives of the demonstration, the hypotheses related to the demonstration, and the methodology for the evaluation. A copy of the state's Driver Diagram (described in the Evaluation Design Attachment) must be included with an explanation of the depicted information. The Evaluation Report should present the relevant data and an interpretation of the findings; assess the outcomes (what worked and what did not work); explain the limitations of the design, data, and analyses; offer recommendations regarding what (in hindsight) the state would further advance, or do differently, and why; and discuss the implications on future Medicaid policy. Therefore, the state's submission must include:

- A. Executive Summary** – A summary of the demonstration, the principal results, interpretations, and recommendations of the evaluation.

B. General Background Information about the Demonstration – In this section, the state should include basic information about the demonstration, such as:

- 1) The issues that the state is trying to address with its section 1115 demonstration and/or expenditure authorities, how the state became aware of the issue, the potential magnitude of the issue, and why the state selected this course of action to address the issues.
- 2) The name of the demonstration, approval date of the demonstration, and period of time covered by the evaluation.
- 3) A brief description of the demonstration and history of the implementation, and if the evaluation is for an amendment, extension, renewal, or expansion of, the demonstration.
- 4) For renewals, amendments, and major operational changes: A description of any changes to the demonstration during the approval period; whether the motivation for change was due to political, economic, and fiscal factors at the state and/or federal level; whether the programmatic changes were implemented to improve beneficiary health, provider/health plan performance, or administrative efficiency; and how the Evaluation Design was altered or augmented to address these changes.
- 5) Describe the population groups impacted by the demonstration.

C. Evaluation Questions and Hypotheses – In this section, the state should:

- 1) Describe how the state's demonstration goals were translated into quantifiable targets for improvement, so that the performance of the demonstration in achieving these targets could be measured. The inclusion of a Driver Diagram in the Evaluation Report is highly encouraged, as the visual can aid readers in understanding the rationale behind the demonstration features and intended outcomes.
- 2) Identify the state's hypotheses about the outcomes of the demonstration;
 - a. Discuss how the goals of the demonstration align with the evaluation questions and hypotheses;
 - b. Explain how this Evaluation Report builds upon and expands earlier demonstration evaluation findings (if applicable); and
 - c. Address how the research questions / hypotheses of this demonstration promote the objectives of Titles XIX and XXI.

D. Methodology – In this section, the state is to provide an overview of the research that was conducted to evaluate the section 1115 demonstration consistent with the approved Evaluation Design. The Evaluation Design should also be included as an attachment to the report. The focus is on showing that the evaluation builds upon other published research (use references), and meets the prevailing standards of scientific and academic rigor, and the results are statistically valid and reliable.

An interim report should provide any available data to date, including both quantitative and qualitative assessments. The Evaluation Design should assure there is appropriate

data development and collection in a timely manner to support developing an interim evaluation.

This section provides the evidence that the demonstration evaluation used the best available data and describes why potential alternative data sources were not used; reported on, controlled for, and made appropriate adjustments for the limitations of the data and their effects on results; and discusses the generalizability of results. This section should provide enough transparency to explain what was measured and how. Specifically, this section establishes that the approved Evaluation Design was followed by describing:

- 1) *Evaluation Design*—Will the evaluation be an assessment of: pre/post, post-only, with or without comparison groups, etc?
- 2) *Target and Comparison Populations*—Describe the target and comparison populations; include inclusion and exclusion criteria.
- 3) *Evaluation Period*—Describe the time periods for which data will be collected.
- 4) *Evaluation Measures*—What measures are used to evaluate the demonstration, and who are the measure stewards?
- 5) *Data Sources*—Explain where the data will be obtained, and efforts to validate and clean the data.
- 6) *Analytic Methods*—Identify specific statistical testing which will be undertaken for each measure (t-tests, chi-square, odds ratio, ANOVA, regression, etc.).
- 7) *Other Additions* – The state may provide any other information pertinent to the evaluation of the demonstration.

E. Methodological Limitations –This section provides sufficient information for discerning the strengths and weaknesses of the study design, data sources/collection, and analyses.

F. Results – In this section, the state presents and uses the quantitative and qualitative data to show to whether and to what degree the evaluation questions and hypotheses of the demonstration were achieved. The findings should visually depict the demonstration results (tables, charts, graphs). This section should include information on the statistical tests conducted.

G. Conclusions – In this section, the state will present the conclusions about the evaluation results.

- 1) In general, did the results show that the demonstration was/was not effective in achieving the goals and objectives established at the beginning of the demonstration?
- 2) Based on the findings, discuss the outcomes and impacts of the demonstration and identify the opportunities for improvements. Specifically:
 - a. If the state did not fully achieve its intended goals, why not? What could be done in the future that would better enable such an effort to more fully achieve those purposes, aims, objectives, and goals?

H. Interpretations, Policy Implications and Interactions with Other State Initiatives –

In this section, the state will discuss the section 1115 demonstration within an overall Medicaid context and long range planning. This should include interrelations of the demonstration with other aspects of the state’s Medicaid program, interactions with other Medicaid demonstrations, and other federal awards affecting service delivery, health outcomes and the cost of care under Medicaid. This section provides the state with an opportunity to provide interpretation of the data using evaluative reasoning to make judgments about the demonstration. This section should also include a discussion of the implications of the findings at both the state and national levels.

I. Lessons Learned and Recommendations – This section of the Evaluation Report involves the transfer of knowledge. Specifically, the “opportunities” for future or revised demonstrations to inform Medicaid policymakers, advocates, and stakeholders is just as significant as identifying current successful strategies. Based on the evaluation results:

- 1) What lessons were learned as a result of the demonstration?
- 2) What would you recommend to other states which may be interested in implementing a similar approach?

J. Attachment

- 1) Evaluation Design: Provide the CMS-approved Evaluation Design

Attachment C: Implementation Plan
[To be incorporated after CMS approval.]

Attachment D: Monitoring Protocol
[To be incorporated after CMS approval.]

Attachment E: Healthy Behaviors List

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

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

Q2039	NA
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ANNUAL PREVENTIVE VISIT	
PROCEDURE	DIAGNOSIS CODE
99385	NA
99386	NA
99395	NA
99396	NA
99401	NA
99402	NA

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

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

CANCER SCREENING: COLORECTAL	
PROCEDURE	DIAGNOSIS CODE
45330	Z1211, Z1212, Z1213, Z800, Z8371,
45331	Z1211, Z1212, Z1213, Z800, Z8371,
45333	Z1211, Z1212, Z1213, Z800, Z8371,
45338	Z1211, Z1212, Z1213, Z800, Z8371,
45346	Z1211, Z1212, Z1213, Z800, Z8371,
45378	Z1211, Z1212, Z1213, Z800, Z8371,
45380	Z1211, Z1212, Z1213, Z800, Z8371,
45384	Z1211, Z1212, Z1213, Z800, Z8371,

45385	Z1211, Z1212, Z1213, Z800, Z8371,
45388	Z1211, Z1212, Z1213, Z800, Z8371,
81528	NA
82270	NA
82274	Z1211, Z1212, Z1213, Z800, Z8371,
G0104	NA
G0105	NA
G0121	NA
G0328	NA

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

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

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

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

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

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

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

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

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

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

Healthy Michigan Plan Final Evaluation Design – June 2021

June 24, 2021

**University of Michigan
Institute for Healthcare Policy & Innovation**



Healthy Michigan Plan Evaluation Design Narrative

A. General Background Information about the Demonstration and Evaluation

The Centers for Medicare & Medicaid Services (CMS) approved the renewal of the Healthy Michigan Plan (HMP) Section 1115 Demonstration Waiver (Project No. 11-W-00245/5) on December 21, 2018, for the period January 1, 2019-December 31, 2023. The waiver provided approval for the State to require the following:

- (1) Beneficiaries age 19-62 to complete and report 80 hours per month of community engagement as a condition of eligibility, and
- (2) Beneficiaries with incomes $>100\%$ of the Federal Poverty Level (FPL) who have been enrolled in the demonstration ≥ 48 months to (a) pay a monthly premium of 5% of income, and (b) complete a Health Risk Assessment (HRA) at redetermination or complete a healthy behavior in the previous 12 months as conditions of eligibility.

The community engagement policy was implemented on January 1, 2020. On March 4, 2020, the U.S. District Court vacated CMS approval of Michigan's community engagement waiver. The 48-month policy, consisting of the monthly premium and HRA/healthy behavior requirements, was slated to begin October 1, 2020, but was delayed due to the maintenance of effort requirements of Section 6008 of the Families First Coronavirus Response Act during the public health emergency (FFCRA) related to the COVID-19 pandemic.

This updated evaluation design reflects these modifications to the State's implementation plan. As a result, this evaluation design focuses on current HMP policies (cost-sharing and Healthy Behaviors Incentives program) and requirements expected to be implemented later in this waiver period (48-month policy). Activities to evaluate the impact of the community engagement requirement have been removed in response to the U.S. District Court decision as noted above. Activities to evaluate the impact of the 48-month policy are included, with a delayed timeline to reflect the uncertain date of implementation; these activities will be limited to descriptive trend analyses of administrative data to characterize enrollment patterns in individuals affected by the policy if the new 48-month policy is implemented after January 2023 because there otherwise would be insufficient time to complete the evaluation activities related to surveys of HMP beneficiaries affected by this policy for the summative report to be submitted to MDHHS in July 2024.

A.1. Overview and history of the demonstration

On April 1, 2014, Michigan expanded its Medicaid program under the Affordable Care Act (ACA) to include adults with incomes up to 133% FPL. To accompany this expansion, the Michigan Adult Benefits Waiver (ABW) was amended and transformed to establish HMP, through which the State intended to test innovative approaches to beneficiary cost-sharing and personal responsibility. HMP is administered through the Michigan Department of Health and Human Services (MDHHS). HMP beneficiaries receive a full health care benefit package, which includes all of the ACA-mandated essential health benefits. Most are enrolled in a managed care benefit (HMP-MC) and choose or are assigned a primary care provider through one of the State's Medicaid Health Plans.

Since 2014, to encourage beneficiary engagement and personal responsibility, HMP-MC beneficiaries with incomes above 100% FPL have been required to pay a monthly fee (formerly known as contributions) equal to 2% of their household income, similar to an insurance premium. In addition, all beneficiaries with incomes from 0 to 133% FPL have been required to pay service-related co-payments. Each HMP-MC beneficiary has a MI Health Account that tracks fees, co-pays, and health care expenditures. This cost-sharing policy was modified effective January 1, 2020, when medically frail beneficiaries became exempt from both fees and service-related co-payments.

To promote seeking preventive care, adopting healthy behaviors, and making responsible decisions about health care use, beneficiaries have opportunities to reduce their cost-sharing by participating in the Healthy Behaviors Incentives program, designed to encourage beneficiaries to maintain and implement healthy behaviors in collaboration with their primary care provider via a standardized Health Risk Assessment (HRA). Additional mechanisms to document healthy behaviors through claims/encounter data were later added to include beneficiaries who completed healthy behavior activities but did not submit an HRA.

In December 2017, MDHHS submitted an application to extend the HMP demonstration for an additional five years. In September 2018, the State applied to amend certain elements of HMP to comply with new provisions in state law, and these policy changes were approved by CMS in December 2018. Under the 48-month policy, beneficiaries with household incomes between 100% and 133% FPL and cumulative HMP enrollment of ≥ 48 months would be required to meet two conditions to maintain HMP eligibility. The first condition requires monthly premiums of 5% of their income in order for beneficiaries to become more familiar with how commercial coverage operates; the premiums would represent the beneficiary's full obligation, with no additional co-payments. Because the 5% premium is designed as a requirement to maintain eligibility, the evaluation team expects it will lead to higher rates of premium payment among those who are subject to this requirement. The second condition is completion of an HRA or documented engagement in a specified healthy behavior (e.g., cancer screening, influenza vaccination) within the twelve-month period prior to the annual eligibility re-determination deadline. Beneficiaries exempt from the new 48-month requirements include pregnant women, beneficiaries identified or self-attested as medically frail, beneficiaries not enrolled in a Medicaid Health Plan, and beneficiaries enrolled in the Flint Michigan Section 1115 demonstration. American Indian/Alaska Natives and children under 21 years of age are exempt from paying premiums but they will still be required to meet the HRA/healthy behavior requirement.

Implementation of the 48-month policy has been delayed, as noted above. Until implementation, HMP beneficiaries continue to be subject to the cost-sharing and HRA/healthy behavior policies described above.

A.2. Population groups impacted by the demonstration

HMP beneficiaries enrolled in managed care, unless otherwise exempt, will continue to be subject to the cost-sharing responsibilities and HRA/healthy behavior incentives as described in the HMP Special Terms & Conditions (STC 22(d)) from CMS.

HMP beneficiaries with incomes 100-133% FPL and cumulative HMP enrollment of ≥ 48 months, unless otherwise exempt, will be subject to the new policy of monthly 5% premiums and annual HRA/healthy behavior requirements, as approved by CMS.

A.3. Goals of the demonstration

As stated by MDHHS, the overarching goals of the HMP demonstration are to increase access to quality health care, encourage the utilization of high-value services, promote beneficiary adoption of healthy behaviors, and implement evidence-based practice initiatives.

The main objectives for HMP stated by MDHHS include:

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

A.4. Other relevant contextual factors

HMP was initially implemented in April 2014 in the context of broader changes to health insurance markets in Michigan and in other states under the Affordable Care Act. In particular, the health insurance exchange, associated premium tax credits, and individual mandate all affected consumer and employer behavior. An increase in private insurance coverage as people enrolled in the health insurance Marketplace established in 2013 also reduced the number of uninsured individuals in the state.¹ However, the longer-term trend toward private plans with high deductibles has meant that more privately insured patients face large out-of-pocket obligations when they are hospitalized, which may increase hospital uncompensated care for patients who are unable to pay hospital charges not covered by their private insurance.

The HMP community engagement requirement was implemented January 1, 2020, following months of beneficiary and stakeholder education. The implementation process gave MDHHS valuable experience in broad communication of policy changes, development of efficient methods of identifying policy exemptions, and modifying information systems to track policy compliance. From the perspective of beneficiaries, the rapid changes, from policy implementation to suspension, may have introduced confusion. A prior version of the evaluation plan included a randomized controlled trial to understand the impact of the community engagement requirement, and beneficiary surveys had begun as part of this effort.² These

¹ Kaiser Family Foundation. [Marketplace Enrollment 2014-2019](#).

² [Evaluation of the Healthy Michigan Plan Section 1115 Community Engagement Requirement Waiver](#)

activities were discontinued after the March 2020 ruling that vacated CMS approval for the community engagement provision.

The first individuals diagnosed with COVID-19 in Michigan were identified in March 2020. Since that time, the COVID-19 pandemic has had a dramatic effect on health care utilization and costs and financial well-being for people in Michigan and across the country, including HMP beneficiaries. In particular, HMP enrollment, which had been quite stable in recent years, has grown substantially from approximately 670,000 individuals in March 2020 to over 874,000 individuals as of February 1, 2021. This substantial increase in enrollment can be attributed both to people becoming newly eligible for the program and also to the state's implementation of the maintenance of effort provisions of Section 6008 of the FFCRA.

B. Logic Model, Evaluation Questions, and Hypotheses

B.1. Logic model

Please see the evaluation logic models at the end of this document (pages 45-46).

B.2. Evaluation questions and hypotheses

The evaluation questions and hypotheses are organized around three HMP policies and four broad goals of the overall demonstration that reflect the MDHHS objectives outlined in Section A.3 above. The seven components of the evaluation are: (1) Healthy Behaviors Incentives program, (2) cost-sharing, (3) 5% premium cost-sharing and HRA/healthy behavior requirements (48-month policy), (4) reduce uninsurance and uncompensated care, (5) promote primary care/responsible use of services, (6) support financial well-being, and (7) support coordinated strategies to address social determinants of health. Within each area, we have identified key evaluation questions that explore how HMP promotes the objectives of Titles XIX and XXI by improving access, continuity, and quality of care for low-income adults in Michigan. Because the MDHHS objectives for HMP are stated in qualitative terms, we have framed our hypotheses below to assess directional change without associated quantitative targets. The analysis plan is designed to identify both positive outcomes and potential adverse consequences.

1. Healthy Behaviors Incentives Program

Evaluation question 1.1: How has the health and healthy behavior engagement among Michigan adults changed since introduction of HMP and its Healthy Behaviors Incentives Program?

Hypothesis 1.1: Health status will improve and healthy behaviors will increase over time among income-eligible adults in Michigan compared with similar adults in comparison states.

Evaluation question 1.2: What is the association between beneficiary knowledge of the Healthy Behaviors Incentives program and efforts to maintain or improve health?

Hypothesis 1.2: Engagement in efforts to maintain or improve health will be higher among beneficiaries who report knowledge of the HMP Healthy Behaviors Incentives Program.

Evaluation question 1.3: Is HRA completion associated with improved health status and health behaviors?

Hypothesis 1.3: Beneficiaries who complete an HRA will report improvement in health status and health behaviors compared to beneficiaries who do not complete an HRA.

Evaluation question 1.4: Is HRA completion associated with higher rates of preventive service use?

Hypothesis 1.4: Beneficiaries who complete at least one HRA will demonstrate higher rates of preventive service use compared to beneficiaries who have similar primary care utilization but who have not completed an HRA.

Evaluation question 1.5: How has the Healthy Behaviors Incentives program, and HMP as a whole, affected beneficiaries' engagement in health behaviors and other efforts to maintain or improve health over time?

Hypothesis 1.5: Beneficiaries will describe assistance from primary care providers in setting health goals and engaging in behavior change to meet those goals.

Evaluation question 1.6: How do primary care providers use the HRA to assist in patient engagement and health promotion?

Hypothesis 1.6: Primary care providers will describe that they have become more knowledgeable over time about how to use the HRA to engage patients enrolled in HMP.

2. Cost-Sharing

Evaluation question 2.1: Do beneficiaries understand cost-sharing and other consumer-oriented features of HMP coverage?

Hypothesis 2.1: Beneficiaries who are aware of healthy behavior financial incentives will demonstrate a better understanding of cost-sharing obligations and connections between service utilization and amount owed.

Evaluation question 2.2: What factors are associated with beneficiaries' compliance with cost-sharing obligations?

Hypothesis 2.2: Beneficiaries with MI Health Account fees will have better payment compliance than their counterparts with service-based cost-sharing only.

Evaluation question 2.3: Are beneficiaries able to understand the MI Health Account statement?

Hypothesis 2.3: Beneficiaries will understand where to find the amount they owe, but may not understand how that amount is calculated.

Evaluation question 2.4: What are barriers and facilitators for beneficiaries to pay the amount owed?

Hypothesis 2.4: Beneficiaries will report financial barriers more often than logistical barriers to paying the amount owed.

3. 5% Premium Cost-Sharing & HRA/Healthy Behavior Requirements (48-month policy)

Evaluation question 3.1: Do beneficiaries subject to the new 48-month policy understand the requirements and consequences for noncompliance?

Hypothesis 3.1: Beneficiary literacy level will be associated with understanding of specific provisions of the new 48-month policy.

Evaluation question 3.2: Is the penalty of disenrollment for failure to complete the HRA/healthy behavior requirement stronger than the incentive of cost-sharing reduction for HRA/healthy behavior completion?

Hypothesis 3.2: Among beneficiaries subject to the new 48-month policy, HRA/healthy behavior completion will increase for beneficiaries with income >100% FPL who are subject to disenrollment, with no change for beneficiaries with income <100% FPL who are not subject to disenrollment.

Evaluation question 3.3: Among beneficiaries with income above 100% FPL, how does payment compliance change with the new cost-sharing requirements (from 2% fee and service-related co-payments to a flat 5% premium)?

Hypothesis 3.3: Payment compliance will be higher among those subject to the 5% monthly premium requirement than under the previous cost-sharing requirements.

Evaluation question 3.4: To what extent is the 5% monthly premium requirement associated with disenrollment?

Hypothesis 3.4a: The rate of disenrollment will be higher after implementation of the 5% monthly premium requirement compared to before implementation.

Hypothesis 3.4b: Disenrollment will disproportionately occur among beneficiaries with low utilization in the 24 months prior to implementation of the 5% monthly premium requirement.

4. Overall demonstration: Reduce uninsurance

Evaluation question 4.1: How have insurance coverage rates in the state changed since the implementation of HMP, compared with states that did not expand Medicaid and with states that expanded Medicaid without a waiver?

Hypothesis 4.1a: The decline in uninsurance among non-elderly adults in Michigan compared to other states that did not expand Medicaid that was observed in 2013-2017 will be sustained through subsequent years.

Hypothesis 4.1b: The decline in uninsurance among non-elderly adults in Michigan compared to other states that expanded without a waiver that was observed in 2013-2017 will be sustained through subsequent years.

5. Overall demonstration: Promote primary care/responsible use of services

Evaluation question 5.1: Does HMP's facilitation of primary care access (e.g., through managed care PCP assignment) influence beneficiary engagement in health and maintenance or improvement in physical and mental health?

Hypothesis 5.1a: Beneficiaries who report no barriers to primary care will be more likely to report improved health status and ability to take action to improve or maintain their health.

Hypothesis 5.1b: Beneficiaries who make regular primary care visits will be more likely to report improved health status and ability to take action to improve or maintain their health.

Evaluation question 5.2: What factors influence beneficiaries' decisions about seeking care in the emergency department?

Hypothesis 5.2: Beneficiaries who report barriers to care will be more likely to report an emergency department visit without first attempting to contact their primary care provider.

Evaluation question 5.3: Is use of the emergency department related to continuity of primary care?

Hypothesis 5.3: Beneficiaries with higher continuity of primary care will have lower rates of emergency department utilization and lower odds of being high-frequency ED utilizers.

Evaluation question 5.4: Does HMP promote more consistent use of services to manage chronic conditions over time?

Hypothesis 5.4: Beneficiaries with chronic conditions will demonstrate better rates of medication management and primary care utilization, and lower rates of ED visits and hospitalizations, over time compared to their initial year of HMP enrollment.

Evaluation question 5.5: How has HMP impacted beneficiaries' physical, mental, and oral health and their use of health care services over time?

Hypothesis 5.5: Beneficiaries will describe HMP as allowing them to receive services that have a significant positive impact on their health and well-being.

6. Overall demonstration: Support financial well-being

Evaluation question 6.1: What impact has HMP had on beneficiaries' levels of employment and ability to work?

Hypothesis 6.1: Beneficiaries will report sustained or increased employment and decreased health-related barriers to employment over time.

Evaluation question 6.2: How is HMP enrollment related to individual beneficiaries' financial outcomes during and after HMP enrollment?

Hypothesis 6.2: HMP enrollment will be associated with improved credit report outcomes for beneficiaries over time.

Evaluation question 6.3: How has HMP affected beneficiaries' financial and material well-being over time?

Hypothesis 6.3: Beneficiaries will describe examples of how HMP has improved their financial and material well-being.

7. Overall demonstration: Sustain the safety net and support coordinated strategies to address social determinants of health

Evaluation question 7.1: What are the categories and estimated amounts of the State’s costs to administer key HMP demonstration policies (e.g., Healthy Behaviors Incentives program, cost-sharing)?

Hypothesis 7.1: Administrative costs to implement demonstration policies will remain stable during the current Section 1115 waiver period.

Evaluation question 7.2: How do trends over time in Medicaid expenditures per member-month for HMP enrollees compare to those for beneficiaries in traditional Medicaid managed care?

Hypothesis 7.2: Annual trends in age- and sex-adjusted expenditures per member-month will demonstrate a lower rate of increase over time for enrollees in HMP managed care than for enrollees in traditional Medicaid managed care.

Evaluation question 7.3: How have uncompensated care costs in the state changed since the implementation of HMP, compared with states that did not expand Medicaid and with states that expanded Medicaid without a waiver?

Hypothesis 7.3a: The decline in hospital uncompensated care and the fraction of hospital discharges among non-elderly adults in Michigan for whom the primary payer was uninsured/self-pay compared with states that did not expand Medicaid that was observed between 2013 and 2017 will be sustained in subsequent years.

Hypothesis 7.3b: The decline in hospital uncompensated care and the fraction of hospital discharges among non-elderly adults in Michigan for whom the primary payer was uninsured/self-pay compared with states that expanded Medicaid without a waiver that was observed between 2013 and 2017 will be sustained in subsequent years.

Evaluation question 7.4: How does HMP support new or broadened initiatives to address social determinants of health for low-income adults in Michigan?

Hypothesis 7.4: State officials and safety-net providers will describe specific examples of health-promoting initiatives that build on HMP’s continuity, breadth of coverage, and primary care emphasis.

C. Methodology

C.1. Evaluation design summary

This new evaluation builds on key findings from the summative report prepared by the HMP evaluation team at the University of Michigan Institute for Healthcare Policy and Innovation for the initial five years of HMP (2014-2018) that was submitted to CMS by MDHHS in May 2019 and finalized in March 2020.

This evaluation design responds to the evaluation requirements outlined in the new HMP Special Terms and Conditions (STCs) (Section XII. Evaluation of the Demonstration) and related guidance provided by CMS in Attachment A: Developing the Evaluation Design.³ The HMP evaluation team has also followed subsequent guidance released by CMS in March 2019 in its report, *Evaluation Design Guidance for Section 1115 Eligibility and Coverage Demonstrations*,

³ [Healthy Michigan Plan Section 1115 Demonstration Standard Terms and Conditions \(2018\)](#)

and guidance released in August 2020 in its report, *Implications of COVID-19 for Section 1115 Demonstration Evaluations: Considerations for States and Evaluators*.⁴

The evaluation will use multiple approaches, including analysis of state administrative data, publicly available data, and primary data collected through interviews and surveys. These data sources are described in detail in this evaluation narrative.

Institutional Review Board (IRB) Review and Considerations

Federal regulations governing human subjects protection specify categories of human subjects research that are exempt from the standard regulatory process, per the 2018 Common Rule (45CFR46 subpart A). Exemption category 5 includes:

1. Research and demonstration projects that are conducted or supported by a Federal department or agency, or otherwise subject to the approval of department or agency heads (or the approval of the heads of bureaus or other subordinate agencies that have been delegated authority to conduct the research and demonstration projects), and that are designed to study, evaluate, improve, or otherwise examine public benefit or service programs, including procedures for obtaining benefits or services under those programs, possible changes in or alternatives to those programs or procedures, or possible changes in methods or levels of payment for benefits or services under those programs. Such projects include, but are not limited to, internal studies by Federal employees, and studies under contracts or consulting arrangements, cooperative agreements, or grants. Exempt projects also include waivers of otherwise mandatory requirements using authorities such as sections 1115 and 1115A of the Social Security Act, as amended.
 - i. Each Federal department or agency conducting or supporting the research and demonstration projects must establish, on a publicly accessible Federal Web site or in such other manner as the department or agency head may determine, a list of the research and demonstration projects that the Federal department or agency conducts or supports under this provision. The research or demonstration project must be published on this list prior to commencing the research involving human subjects.

The evaluation plan has been reviewed and deemed exempt by the University of Michigan Medical School IRB under Exemption 5. The evaluation plan has also been reviewed and determined to be exempt by the MDHHS IRB, with approval of a HIPAA Privacy Waiver to use protected health information.

C.2. Target and comparison populations

The evaluation plan does not include a broad experimental design that covers all data sources. Rather, the specific target and comparison populations are described for each data source and corresponding hypotheses in the accompanying table.

C.3. Evaluation period

⁴ [CMS 1115 Demonstration State Monitoring & Evaluation Resources](#)

The evaluation period will include the current waiver demonstration period (January 1, 2019, to December 31, 2023). As specified in the descriptions of analytic methods, the period prior to January 1, 2019, will be used as a baseline comparison period when data from this period are available. The specific time periods to be utilized for each data source are described below.

C.4. Data sources, evaluation measures, and analytic approach

The following sources of data will be used in the evaluation:

- State administrative data
- Beneficiary survey (Healthy Michigan Voices)
- Interviews with beneficiaries
- Interviews with providers
- Interviews with key informants
- Credit data
- Behavioral Risk Factor Surveillance System (BRFSS)
- American Community Survey (ACS)
- HCUP Fast Stats inpatient discharge data
- Medicare cost reports

Descriptions of these data sources and how they will be included in the evaluation are presented below. Analyses related to the 48-month policy are included in italics given that they are contingent on implementation by January 2023. If the 48-month policy is implemented between January 2023 and June 2023, descriptive trend analyses of administrative data will be conducted, when feasible.

C.4.1. State administrative data

Data source

Administrative data will be used in a variety of ways to document changes over time in program enrollment, engagement and utilization, and compliance with cost-sharing requirements. Administrative data allow for multivariate modeling that adjusts for both beneficiary characteristics (e.g., age, sex, region) and programmatic characteristics (managed care vs fee-for-service coverage, cost-sharing requirements) to understand patterns in different subgroups of beneficiaries; this information may be used by policymakers to understand the differential engagement in and benefit from HMP features across subgroups. Administrative data also will be used to describe trends over time in expenditures, with the ability to generate expenditure trends by service type, adjusted estimates by beneficiary characteristics, and comparisons to expenditure trends for other Medicaid benefit plans (e.g., traditional Medicaid).

The state of Michigan offers a rich data environment for evaluation. The backbone of the data environment is the state's Enterprise Data Warehouse. The Data Warehouse maintains individual-level, identifiable data for numerous programs within MDHHS, including:

- Medicaid enrollment files include eligibility dates for different benefit plans, enrollment start and end dates, contact information (address, phone, email), key demographic characteristics (gender, race/ethnicity), and third-party liability coverage.
- Medicaid administrative claims include service-level data on paid claims (fee-for-service)

and encounters (Managed Care), with accompanying billing and reimbursement information (e.g., CPT and ICD-10 diagnosis codes, billing modifiers, billing/rendering provider, paid amount) for inpatient, outpatient, pharmacy, durable medical equipment, dental, lab, and other services.

- Specialty behavioral health administrative claims include individual-level data on services provided through Michigan's behavioral health system.
- Michigan Care Improvement Registry houses individual-level immunization history including vaccine product, date of administration, and provider.
- HRA tables include individual-level data on administration of HRAs (e.g., dates of completion, whether HRA completion was facilitated by a provider, answers to individual HRA questions, and eligibility for HRA-related incentives (e.g., cost-share reduction)).
- Cost-share tables include individual-level data on charges for HMP fees, premiums and co-pays, cost-sharing reductions, and payment history.
- Other tables house data related to specific Medicaid initiatives, such as indicators of medical frailty and other exemptions from program requirements, eligibility for supplementary or pilot programs, and compliance actions.

Each beneficiary has a unique Medicaid ID number that enables linkages across data files within the Data Warehouse. The Data Warehouse houses data from other components of state government, such as the Department of Corrections, Department of Treasury, and Department of Licensing and Regulatory Affairs. The State has implemented a Master Person Indicator that allows linkages across departments once authorization has been obtained.

The HMP evaluation team has a longstanding history of working with MDHHS staff on projects utilizing the state Data Warehouse. A Business Associates Agreement executed between MDHHS and the University of Michigan authorizes direct access to the Data Warehouse via an existing secure portal. The HMP evaluation team has established data storage protocols that comply with MDHHS regulations, including the use of encrypted files, secure networks, and multiple layers of password protection. The evaluation team has extensive experience processing the administrative claims data into analytic data files.

This data source will be used to examine evaluation questions 1.4, 2.2, 3.2, 3.3, 3.4, 5.3, 5.4, and 7.2.

Measures

Data from the state Data Warehouse will be extracted and processed to derive an array of variables.

Enrollment-related variables will include:

- Cumulative months of HMP enrollment (overall, in HMP-Managed Care)
- Enrollment disruptions (number of disruptions, length of enrollment gaps)
- Disenrollment/noncompliance actions
- Timing of initial HMP enrollment (2014-2018 vs. 2019-2023)
- Change from HMP to another Medicaid benefit plan

Demographic variables will include:

- Age at initial HMP enrollment
- Race ethnicity as categorized in data warehouse
- Geographic region, based on prosperity region
- Income level (% FPL) as documented in the data warehouse
- Medicaid Health Plan for months enrolled in HMP-Managed Care
- Medical frailty indicators

HRA-related variables will include:

- Number and timing of initial and subsequent HRA completions
- Target behavior selected, and self-reported health status on initial and subsequent HRAs
- HRA-related incentives

Cost-sharing variables will include:

- Quarterly/annual amount owed (fees, premiums, co-pays)
- Amount and frequency of payments
- Evidence of cost-share reductions
- Non-compliance determinations

Utilization-related variables will be derived from claims data using established measures from the Healthcare Effectiveness Data and Information Set (HEDIS) and from the CMS Core Set of Adult Quality Measures for Medicaid. We will apply modifications as appropriate (e.g., to incorporate state-specific billing codes and/or data sources, to adjust age ranges to be consistent with HMP eligibility). We will calculate utilization-related measures that reflect HMP policies regarding use of primary care/preventive services, avoiding overuse of the emergency department, and effective management of chronic conditions. Specific outcome measures include:

Primary Care and Preventive Services

- Flu Vaccinations for Adults (NQF 0039; measure steward NCQA): percentage of beneficiaries who received an influenza vaccine between July 1 and June 30 (annual measure, modified to use immunization documentation from the MCIR and Medicaid claims rather than self-report)
- Colon Cancer Screening (NQF 0034, measure steward NCQA): percentage of beneficiaries aged 50-64 who received colon cancer screening by high-sensitivity fecal occult blood test, sigmoidoscopy with FOBT, or colonoscopy.
- Breast Cancer Screening (NQF 2372; measure steward NCQA): percentage of women 40-64 who had a mammogram to screen for breast cancer at least once in a two-year period
- Cervical Cancer Screening (NQF 0032; measure steward NCQA): percentage of women 21-64 years of age who received a Pap test to screen for cervical cancer at least once in a three-year period
- Adults' Access to Preventive/Ambulatory Health Services (HEDIS AAP; measure steward HEDIS): percentage of beneficiaries who made an ambulatory or preventive care visit
- Annual Dental Visit (HEDIS ADV; measure steward HEDIS): percentage of beneficiaries who made at least one dental visit, modified to include a sub-measure for preventive dental services

Emergency Department Utilization

- Overall ED utilization (HEDIS EDU; measure steward HEDIS): rate of ED visits per 1,000 member months
- High Frequency ED utilization: proportion of beneficiaries who make >5 ED visits within a 12-month period

Management of Chronic Conditions

- Pharmacotherapy Management of COPD Exacerbation (HEDIS PCE; measure steward HEDIS): percentage of COPD exacerbations for members 40 years of age and older who had an acute inpatient discharge or ED visit and who were dispensed appropriate medications.
- Medication Management for People with Asthma (HEDIS MMA; measure steward HEDIS): percentage of members identified as having persistent asthma who were dispensed appropriate medications that they remained on during the treatment period.
- Statin Therapy for Patients with Cardiovascular Disease (HEDIS SPC; measure steward HEDIS): percentage of members who were identified as having clinical atherosclerotic cardiovascular disease and who (a) were dispensed at least one high- or moderate-intensity statin medication and (b) remained on a statin medication for at least 80% of the treatment period.
- Statin Therapy for Patients with Diabetes (HEDIS SPD; measure steward HEDIS): percentage of members with diabetes who do not have clinical atherosclerotic cardiovascular disease who (a) were dispensed at least one high- or moderate-intensity statin medication and (b) remained on a statin medication for at least 80% of the treatment period.
- Follow-Up After Emergency Department Visit for People with Multiple High-Risk Chronic Conditions (HEDIS FMC; measure steward HEDIS): percentage of ED visits for members who have multiple high-risk chronic conditions that had a follow-up service within 7 days of the ED visit.
- Diabetes, Short-term Complications Admission Rate (NQF 0272; measure steward AHRQ): number of discharges for diabetes short-term complications per 100,000 beneficiaries.
- Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate (NQF 0275; measure steward AHRQ): number of discharges for COPD or asthma per 100,000 beneficiaries.
- Heart Failure Admission Rate (NQF 0277; measure steward AHRQ): number of discharges for CHF per 100,000 beneficiaries.

Analytic approach

For hypotheses based on utilization of health services and completion of HRAs, we first will identify the populations of interest based on the relevant evaluation timeframe (e.g., pre vs. post-implementation of the 5% premium), and beneficiary enrollment duration (e.g., cumulative enrollment of ≥ 48 months). We will also identify each beneficiary's enrollment dates in 12-month increments from initial enrollment, to facilitate longitudinal measures. We will apply measure specifications regarding age, diagnostic and utilization-based inclusion and exclusion criteria.

We will use paired t-tests to compare outcome measures across subgroups. We will employ multivariate negative binomial regression models controlling for demographic characteristics to

generate stratified results (e.g., beneficiaries with and without chronic conditions, those who did vs. did not complete an HRA). For beneficiaries with extended HMP enrollment, we will examine utilization over time (e.g., primary care continuity) and identify characteristics associated with suboptimal patterns (e.g., multiyear pattern of high-frequency ED use).

We will conduct three sets of sensitivity analyses: (1) examining the impact of enrollment disruptions by generating parallel measure results that maintain vs. relax HEDIS/NQA enrollment requirements; (2) examining the impact of managed care plan performance by generating parallel measure results for beneficiaries who do vs. do not remain in the same Medicaid Health Plan throughout their enrollment; and (3) examining the impact of data incompleteness by generating parallel measure results for beneficiaries who have evidence of other insurance in the Third-Party Liability fields.

For hypotheses related to compliance with cost-sharing obligations, we will use logistic regressions (any payment vs. no payment, full payment vs. partial payment) and ordered logistic regression (no payment, partial payment, full payment) analyses to examine differences in payment behavior for beneficiaries subject to fees vs. co-pays only. Analyses will adjust for age, gender, health conditions, race/ethnicity, urban/rural, income, length of HMP enrollment, and total cost-share liability.

Across all areas, we will conduct supplemental analyses, appropriate to each hypothesis, that address the impact of the COVID-19 public health emergency. For example, for measures that reflect a specific timeframe in the beneficiary's enrollment history, we will compare results for those whose measurement period occurred before, during or after the public health emergency. In addition, we will consider the impact of the public health emergency in the interpretation of results; for example, for measures tracking utilization rates over time, we will expect a larger decrease for services that require in-person care (e.g., flu vaccine, cancer screening) compared to services that can be delivered via telehealth (e.g., primary care visit, medication management) during the public health emergency.

The results of these analyses will be included in the interim report, with updated analyses included in the summative report.

Analyses related to the 48-month policy will incorporate three key characteristics: HRA/healthy behavior completion, payment compliance and maintenance of enrollment. Because the 48-month policy includes disenrollment for beneficiaries who do not meet the requirements, we expect that compliance will be higher among those who are subject to the requirements than it was for this group before the 48-month policy took effect. We will test these hypotheses and identify other factors associated with compliance, by estimating bivariate logistic regression models predicting HRA/healthy behavior completion, payment compliance and maintenance of enrollment as a function of beneficiary characteristics, income (above or below 100% FPL), and enrollment period (≥ 48 vs. < 48 months of cumulative HMP enrollment). We will conduct stratified analyses to compare beneficiaries with higher vs. lower utilization in the 24 months prior to implementation of the new requirements, including number of primary care visits, dental visits, ED visits, inpatient stays, and medication fills.

The results of analyses focused on the 48-month policy will be included in the summative report if this policy takes effect by January 2023. If the 48-month policy is implemented between January 2023 and June 2023, descriptive trend analyses of these administrative data will be conducted, when feasible.

C.4.2. Beneficiary survey

Data source

The Healthy Michigan Voices (HMV) beneficiary survey will be conducted from July 2021 to April 2022 to understand the experience and impact of HMP structures and policies. *HMV surveys focused on the 48-month policy will be conducted 6-12 months after implementation of that policy.* Surveys supplement administrative data by documenting beneficiary knowledge of key policies such as of the Healthy Behaviors Incentives program and cost-sharing obligations; eliciting barriers that impede beneficiaries from responsible use of health services; describing lifestyle behaviors that impact health status; and understanding the extended impact of HMP on beneficiary financial well-being.

The HMV target population will be beneficiaries with at least 12 months of enrollment in HMP's managed care benefit, through which key HMP features are administered including the primary care provider assignment, HRA, healthy behavior incentives, and cost-sharing.

The beneficiary survey will include two groups: beneficiaries who participated in prior HMV surveys (Longitudinal Cohort), and a refresher sample of more recently enrolled HMP beneficiaries (New Cohort). Recontacting existing cohorts allows for a more thorough understanding of the experiences of beneficiaries over time, while adding new respondents allows for broader representation of the HMP population and understanding the experiences and impact of the program for those who enrolled more recently.

This data source will be used to examine evaluation questions 1.2, 1.3, 2.1, 3.1, 5.1, 5.2, and 6.1.

Survey cohorts & sample size

The Longitudinal Cohort will be drawn from two prior HMV target populations:

- Cohort I included beneficiaries with initial HMP enrollment between April 2014 and October 2015. Cohort I completed their initial HMV surveys in 2016 (N=4,106), when beneficiaries had cumulative HMP enrollment of 13-28 months. Follow-up surveys were done in 2017 (N=3,104) and 2018 (N=2,608).
- Cohort II included beneficiaries with initial HMP enrollment between January 2016 and December 2017. Cohort II completed HMV surveys in 2018 (N=2,602) when beneficiaries had cumulative HMP enrollment of 13-24 months.

Inclusion criteria for initial selection into Cohorts I and II were enrollment in HMP-Managed Care in the month selected and at least 9 of the prior 12 months in managed care; preferred language of English, Arabic or Spanish; and having complete contact information (phone, address) in the MDHHS Data Warehouse. To ensure broad representation across income levels and geographic regions, stratified sample selection was done according to the following proportions:

Federal Poverty Level	Prosperity Region				
	UP/NW/NE	W/EC/E	SC/SW/SE	DET	Total
0-35%	7.0%	12.0%	8.0%	12.8%	39.9%
36-99%	6.0%	10.5%	7.0%	11.2%	34.8%
≥100%	4.9%	7.5%	5.0%	8.0%	25.5%
Total	17.9%	30.0%	20.0%	32.0%	100.0%

Eligibility for the Longitudinal Cohort will be based on enrollment in HMP-Managed Care in the month selected, regardless of any gaps in HMP coverage; and agreement to recontact on the prior HMV survey. As of October 2020, roughly 2,800 beneficiaries from HMV Cohorts I and II meet these criteria. We will target 2,000 completed surveys with the Longitudinal Cohort.

The New Cohort will be newly drawn from beneficiaries with initial HMP enrollment between August 2019 and December 2020; with the expected timing for data collection, beneficiaries will have cumulative HMP enrollment of 13-24 months. The New Cohort will be drawn using parallel inclusion criteria: enrollment in HMP-Managed Care in the month selected and at least 9 of the prior 12 months in managed care; preferred language of English, Arabic or Spanish; and having complete contact information (phone, address) in the MDHHS Data Warehouse. Stratified sample selection of the New Cohort will be done by income level and region using the same proportions as shown above. We will target 2,000 completed surveys with the New Cohort.

For two-tailed hypothesis testing with Type I error of 5% ($p < 0.05$), this sample size is designed to provide 80% statistical power to detect a 5 percentage-point difference (i.e. 50% vs. 55% or 45%) between those with excellent/very good/good vs. fair/poor health. This sample size also allows for reliable outcome estimates by FPL, region, length of enrollment, and gender.

Sampling for evaluation of the 48-month policy: We anticipate that the Longitudinal Cohort will yield about 400 beneficiaries who would be subject to the 5% premium and HRA/healthy behavior requirements, as verified by information from the state Data. If the Longitudinal Cohort yields fewer than 400, we will sample additional beneficiaries who have not participated in prior HMV surveys, in order to achieve a target number of at least 400 surveys with beneficiaries subject to the 48-month policy.

Measures

Key outcome measures will be based on validated items and scales used in prior HMV surveys. Health-related items will be drawn from national surveys, including the National Health and Nutrition Exam Survey (NHANES),⁵ Health Tracking Household Survey (HTHS),⁶ National Health Interview Survey (NHIS),⁷ Behavioral Risk Factor Surveillance System (BRFSS)⁸ and

⁵ [NHANES \(National Health and Nutrition Exam Survey, CDC\)](#)

⁶ [HTHS \(Health Tracking Household Survey\)](#)

⁷ [NHIS \(National Health Interview Survey, CDC\)](#)

⁸ [BRFSS \(Behavioral Risk Factor Surveillance System, CDC\)](#)

MiBRFSS⁹), Short Form Health Survey (SF-12),¹⁰ Food Attitudes and Behaviors Survey,¹¹ Consumer Assessment of Healthcare Providers and Systems (CAHPS),¹² Employee Benefit Research Institute Consumer Engagement in Healthcare Survey (CEHCS),¹³ Commonwealth Fund Health Care Quality Survey,¹⁴ and Patient Activation Measure.¹⁵

Specific health-related outcome measures to be used in the analysis include:

- Physical, mental, oral health status (Excellent, Very good, Good, Fair, Poor)
- Number of days in past 30 days with poor physical health; with poor mental health; where poor physical or mental health kept you from usual activities
- Engagement in healthy lifestyle behaviors (physical activity/exercise, fruit/vegetable consumption, other attempts at healthy eating)
- Engagement in unhealthy lifestyle behaviors (smoking, binge drinking, substance use)
- Engagement in efforts to address unhealthy behaviors (smoking cessation, substance use treatment, diet change)
- Participation in health-supporting programs (peer support, wellness or disease management programs)
- Usual source of primary care
- Availability of primary care advice after hours
- Barriers to accessing primary care, other services
- Patient activation (confidence in ability to take action to maintain or improve health)
- Reason for ED visit in past 12 months
- Attempted contact with primary care provider prior to ED visit

Survey items that address specific HMP features will draw on questions that were developed and used for prior HMP surveys by the evaluation team.^{16,17,18,19,20} If new policies are implemented or modified, items exploring those features (e.g., understanding of new requirements) will undergo pre-testing to assess clarity of wording and appropriateness of response choices. Additional items may be drawn from emerging topics identified during qualitative interviews with beneficiaries. Specific measures based on HMP policies will include:

- Knowledge of HRA/healthy behaviors and cost-share reduction incentive
- Completion of an HRA, engagement with primary care provider around HRA
- Knowledge of cost-sharing obligations and link between service utilization and amount owed
- Recall of MI Health Account statement

⁹ [MiBRFSS \(Michigan Behavioral Risk Factor Surveillance System, MDHHS\)](#)

¹⁰ [SF-12 \(Short Form Health Survey, RAND\)](#)

¹¹ [FAB \(Food Attitudes and Behaviors Survey, NCI\)](#)

¹² [CAHPS \(Consumer Assessment of Healthcare Providers and Systems\)](#)

¹³ [Consumer Engagement in Health Care Survey \(EBRI: CEHCS\)](#)

¹⁴ [Commonwealth Fund Health Care Quality Survey](#)

¹⁵ [PAM \(Patient Activation Measure\)](#)

¹⁶ Goold, S. D., & Kullgren, J. (2018). [Report on the 2016 Healthy Michigan Voices Enrollee Survey.](#)

¹⁷ Goold, S. D., & Kullgren, J. (2018). [Report on the 2016 Healthy Michigan Voices Enrollee Survey: Supplemental Analyses.](#)

¹⁸ Clark, S. J. & Goold, S. D. (2018). [Report on the Healthy Michigan Voices 2016-17 Survey of Individuals No Longer Enrolled in the Healthy Michigan Plan.](#)

¹⁹ Goold, S. D., Kullgren, J., Beathard, E., Kirch, M., & Bryant, C. (2018). [2017 Healthy Michigan Voices New Enrollee Survey Report.](#)

²⁰ Goold, S. D., Kullgren, J., Beathard, E., Kirch, M., Bryant, C., Tipirneni, R., Ayanian, J. Z. (2018). [2017 Healthy Michigan Voices Follow-Up Survey Report.](#)

- *Knowledge of new 48-month requirements and consequences for noncompliance*

Measures of employment and social determinants of health, used in previous HMP surveys, will be largely drawn from national surveys, such as the American Community Survey (ACS),²¹ the Current Population Survey (CPS),²² and the Health Reform Monitoring Survey (HRMS).²³ Items addressing the impact of the pandemic on employment and social determinants of health will be drawn from the NIH PhenX toolkit.²⁴ Specific measures related to employment and social determinants of health to assess the goals of the overall demonstration will include:

- Employment status (full/part time, number of hours worked)
- Health-related barriers to employment
- Other barriers to employment (inconsistent work hours, transportation, caregiving responsibilities, discrimination, homelessness in past 12 months)

Survey administration

HMP survey administration will build on strategies used successfully in previous HMP surveys. The evaluation team will utilize a Computer-Assisted Telephone Interviewing (CATI) system to administer surveys. Survey questions will be programmed into the CATI system, allowing for branching of survey items based on characteristics known prior to the survey and responses given during the survey. The CATI system will integrate individual characteristics (e.g. gender, name of Medicaid Health Plan) to allow for tailored question wording, as well as tailored branching based on identified characteristics (e.g., subject to 48-month policy). Interviewers will be trained on the survey instrument, including prompts and definitions, pronunciation of terms, and appropriate response to questions about coverage or services. Interviewers will engage in practice interviews and supervisor review of initial interviews until their proficiency is confirmed. Supervisors will conduct ongoing quality assessment checks to ensure fidelity to the interview protocol.

Sampled individuals will be mailed an introductory packet containing a letter explaining the project and a simple-language brochure with key information. The letter and brochure will provide phone, text and email options for individuals to indicate a preferred time/day for the interview or refusal to participate.

For sampled individuals who do not refuse to participate, interviewers will place phone calls between the hours of 9:00 AM and 8:30 PM. Non-respondents will receive two additional mailings with a brief letter and brochure encouraging participation. At the outset of the survey, interviewers will explain the purpose of the project, emphasize the confidentiality of responses, and obtain agreement to participate. Interviewers will note that completion of the survey is voluntary that questions can be skipped for any reason. Interviewers will also note that only aggregate data will be reported. Interviewers will ask if the interview can be recorded; in the prior HMP evaluation, over 95% of respondents agreed to be recorded. At the end of the survey, interviewers will ask if the respondent agrees to be re-contacted for future surveys and interviews and, if yes, the preferred phone, email, and text information to use. Individuals who complete the

²¹ [ACS \(American Community Survey\)](#)

²² [CPS \(Current Population Survey\)](#)

²³ [HRMS \(Health Reform Monitoring Survey\)](#)

²⁴ [NIH PhenX Toolkit](#)

survey will be mailed a gift card in an amount commensurate with the expected time for participation (e.g., \$25 for an interview of 20-30 minutes); incentives will be administered through the University of Michigan research incentive system, to allow for tracking and replacement of lost cards.

Initial data files will be generated from the CATI system. Trained research assistants will review recordings to verify the accuracy of coding and to categorize responses to open-ended questions. Variables describing respondents' demographic and health services utilization characteristics will be generated from Medicaid administrative data for use in analysis of survey data.

Analytic approach

Survey weights

Sample design and survey nonresponse will be handled through weights as well as adjustments to the weights. From the sample design, we will have base weights that account for over- or under-sampling based on the income and region stratification. Because the New Cohort will be drawn from the HMP enrollee list ("frame"), we will use a wide range of characteristics available in the frame to examine nonresponse patterns. A response propensity score model will be developed with multiple predictors. Using the estimated response propensity scores, we will develop weighting classes that include both respondents and nonrespondents and compensate for the potential nonresponse bias by adjusting the base weights of respondents. A similar procedure will be used for the Longitudinal Cohort sample with a wider range of characteristics available from the survey data. Once nonresponse adjustment is completed, we will combine the two samples and post-stratify to the known current beneficiary characteristics ascertained from the Data Warehouse (e.g., the population count of minority beneficiaries).

Note that weight adjustment addresses potential biases using the observed data from both the frame and the survey.

Overall analysis

The design of the survey cohorts allows for three types of analyses.

Cross-sectional analyses of data collected in this evaluation period will include descriptive analysis with subgroup analyses by key beneficiary characteristics (age, gender, race/ethnicity, urban/rural, income, chronic condition, and cumulative HMP enrollment). As appropriate to the hypothesis, cross-sectional analyses may include bivariate comparisons based on survey response patterns (e.g., comparing beneficiaries who do vs. do not report HRA completion).

Comparison of an individual beneficiary's responses over time will be done only for the Longitudinal Cohort. For many items, respondents from Cohort I will have a total of four data points while respondents from Cohort II will have two data points. Comparisons over time will use mixed effects logistic regression models, adjusting for age, gender, race/ethnicity, region, income level, and chronic disease status.

Comparison of aggregate responses for cohorts at a similar point in their HMP enrollment (13-24 months of cumulative enrollment) will be operationalized by comparing responses from the initial HMV Cohort I survey vs. the initial HMV Cohort II survey (both included in the

Longitudinal Cohort) vs. the New Cohort. We will use independent sample t-tests and multivariate regression models adjusting for age, gender, race/ethnicity, income, and chronic disease status within each cohort.

High-level findings from these analyses will be included in the interim report and findings from more detailed analyses (e.g. multivariate, longitudinal) will be included in the summative report.

Analyses related to the 48-month policy will include descriptive analysis with subgroup analyses by key beneficiary characteristics (age, gender, race/ethnicity, urban/rural, income).

The results of analyses focused on the 48-month policy will be included in the summative report if this policy takes effect by January 2023, which would allow a sufficient period for survey data collection from enrollees affected by this policy through the end of the current waiver period in December 2023 and for data analysis between January and April 2024 to be included in the final summative report that will be finalized in May and June and submitted to MDHHS in July 2024.

C.4.3. Interviews with beneficiaries

Data source

Interviews with beneficiaries will be used to gain a richer understanding of the multifaceted ways that beneficiaries interact with and benefit from HMP coverage. We will conduct in-depth longitudinal qualitative interviews by telephone, with a purposive sample of approximately 30 beneficiaries who have completed a prior HMP survey and agreed to be recontacted. Sampling will reflect diversity of geographic region, income, age, gender, race/ethnicity, length of HMP enrollment, and health conditions. This design will allow us to conduct both cross-sectional and longitudinal mixed-methods analyses, using qualitative and survey data. The first round of interviews will be conducted from June to September 2021 and the second round of interviews will be conducted from November 2022 to March 2023.

We will send participants a \$25 gift card in recognition of their time (approximately 30-45 minutes per interview). We will request permission to record the interview and will generate verbatim transcriptions of those recordings.

This data source will be used to examine evaluation questions 1.5, 2.3, 2.4, 5.5, and 6.3.

Measures

We will develop a structured interview guide to explore:

- How HMP has affected beneficiaries' engagement in health behaviors and other efforts to maintain or improve health
- Beneficiaries' understanding and perceptions of the MIHA statement, including terminology, layout, and description of payment options
- Barriers and facilitators to making payments
- How HMP has impacted beneficiaries' physical, mental, and oral health over time and their use of health care services
- How HMP has affected beneficiaries' financial and material well-being, including out-of-pocket costs for medical care and ability to work

Analytic approach

We will use an inductive approach to analysis, coding iteratively using standard qualitative analysis techniques and Dedoose software (<https://www.dedoose.com>). For the first stage of the process, immediately post-interview interviewers will complete a summary of major themes that arose during the interview that are relevant to the project aims. These summaries will be used to develop an initial codebook while data collection is still in progress. We will modify or add new codes to capture emerging themes. Then two team members will independently code the interviews, with differences in coding resolved by consensus in team meetings.

A cross-sectional analysis of initial interview data will be conducted for the whole group of beneficiaries, and in subgroups with shared experiences, e.g., those with cost-sharing obligations; those with chronic conditions. Case profiles will allow us to capture individual narratives in a reduced form that allows both within interviewee and between interviewee comparisons at the group level. Change over time at the individual level will be explored for specific research questions by analyzing responses to questions that remind interviewees of earlier responses and ask them to describe changes during the interval between interviews. Change over time at the group level will be assessed by comparing the overall key themes that emerged during the initial interviews to those that emerge from the follow-up interviews.

High level results from the initial interview data will be included in the interim report. This results of the longitudinal analysis of interview data will be included in the summative report.

C.4.4. Interviews with providers

Data source

Interviews with providers will offer a complementary perspective on how HMP, particularly the HRA process, facilitates beneficiary engagement with healthy behaviors. We will conduct 20-25 in-depth qualitative telephone interviews with a purposive sample of primary care providers from September-November 2021 who are the PCP of record for at least 5 HMP beneficiaries, based on information in the Data Warehouse from January to June 2021. The selected sample will reflect diversity of geographic region, setting (private practice, FQHC, health system-affiliated), and assigned number of HMP beneficiaries.

We will recruit providers via mailed invitation, with telephone and email follow-up. We will conduct 30-minute individual interviews via phone or Zoom, scheduled at the provider's convenience. We will offer a \$50 reimbursement for participation, an amount shown in prior projects to be sufficient to achieve recruitment goals. We will request permission to record the interview and will generate transcriptions of those recordings.

This data source will be used to examine evaluation question 1.6.

Measures

We will develop a structured interview guide to explore providers' knowledge of HRA processes, including variation between health plans; perceptions of HMP beneficiaries' awareness of HRA processes and incentives; use of HRAs to facilitate conversations about

health risks and healthy behaviors; and knowledge of and referral to support services (e.g., peer support groups, gym memberships, online tools).

Analytic approach

We will conduct a thematic analysis of the provider interviews. We will review transcriptions to identify key themes and illustrative quotations.

High-level findings from this analysis will be included in the interim report and findings from more detailed analyses will be included in the summative report.

C.4.5. Interviews with key informants

Data source

Interviews with key informants will provide insight and information about how Medicaid officials calculate and monitor the state cost impacts of HMP. These interviews will explore the costs of implementation and ongoing operations for specific demonstration policies, with a particular focus on components related to HRA/healthy behavior incentives and cost-sharing/premiums. This will include the costs of contracts to implement, monitor and evaluate demonstration policies, as well as staff time estimates to implement, administer, and communicate with beneficiaries. These interviews will also explore the short- and long-term effects of eligibility and coverage policies on Medicaid health service expenditures.

Interviews with key informants will also allow us to gain a broader understanding of how HMP has contributed to the development, facilitation, and maintenance of innovative approaches to system development and service delivery, including efforts to address social determinants of health. These innovations targeted to HMP and other Medicaid beneficiaries, and to the systems that serve them, are aimed at reducing barriers to care and improving connection, continuity, and coordination of care for beneficiaries. An example is the partnership between MDHHS and the Michigan Department of Corrections to initiate application for HMP prior to release of returning citizens from prison, facilitating transition to covered status upon release, and connection to primary care and behavioral health services. Other examples include the Michigan Opioids Task Force; Michigan's State Innovation Model and Health Homes initiatives; and use of community health workers by Medicaid health plans to facilitate outreach to beneficiaries, and coordination and connections to resources to address the social determinants of health. We expect to identify additional innovations during the interviews.

From December 2021 to March 2022, we will conduct 20-25 key informant interviews with two groups. The first group will focus on individuals familiar with Medicaid program administration, rate setting, budgeting, and operations, including the directors and/or key staff of Medicaid Policy, Operations and Actuarial Services, Managed Care Plan Division, and Customer Service Division. The second group will focus on administrators and service providers involved in developing and/or implementing state and local initiatives and services for HMP beneficiaries and HMP-eligible individuals, such as representatives from Medicaid health plans, Behavioral Health, and Public Health Administration; officials from other state departments, such as Michigan Department of Corrections; officials from provider organizations, such as the Michigan Primary Care Association (representing federally qualified health centers), the

Michigan Opioid Task Force and the Michigan State Medical Society; and representatives from relevant advocacy groups, such as the Michigan League for Public Policy.

Key informant interviews will be conducted, by telephone and are expected to take approximately 30-45 minutes. Interviews will be digitally recorded and transcribed.

This data source will be used to examine evaluation questions 7.1 and 7.4.

Measures

We will develop structured interview guides for each research question. For key informants who are familiar with Medicaid program administration, staffing and budgeting, we will discuss the state's calculation of the incremental costs associated with administering the distinctive policies of the Section 1115 waiver, including the Healthy Behaviors Incentives program, 5% premium cost-sharing requirement and HRA/healthy behavior requirement, and other cost-sharing provisions. For key informants involved in innovative approaches to system development and service delivery, including efforts to address social determinants of health, we will explore whether and how HMP facilitated or supported new or expanded initiatives, including; identifying eligible participants, how the initiatives facilitated connection, continuity and quality of care and addressing social determinants of health; barriers and facilitators to initiation, implementation over time focusing on the linkage to HMP; financing; and developing a model for sustainability for these initiatives.

Analytic approach

For key informant interviews pertaining to administrative costs, we will identify major themes related to monitoring and controlling costs. We will review documents shared by interview participants to identify changes in HMP costs over the period of HMP (2014-2023).

For key informant interviews related to programs to address social determinants of health, we will conduct a thematic analysis of the key informant interviews. Immediately following the interview, interviewers will complete a summary of major themes that arose. Subsequently, the interviewer will review the recording to confirm themes and identify illustrative quotations. These summaries will be used by evaluation team members to identify themes that emerged between interviews and quotes that exemplify these themes. This approach is designed to provide rapid but rigorous information to foster understanding of the contributions of HMP policy to systems and service system changes.

An overview of findings from this analysis will be included in the interim report and findings from more detailed analyses will be included in the summative report.

C.4.6. Credit data

Data source

Analysis of linked credit report data from commercial credit agencies presents a unique opportunity to examine the impact of several different aspects of the HMP program on financial outcomes for beneficiaries.

To estimate the effect of HMP on household financial outcomes, we will link HMP administrative data to data on consumer credit histories provided by a credit reporting agency (TransUnion, Experian, or Equifax). Our data linkage procedure will closely follow that used in a previous study led by a U-M faculty member in IHPI that examined financial outcomes for HMP beneficiaries.²⁵ Data from the credit reporting agency will be matched with the HMP administrative data using name, address, and Social Security number. To preserve the confidentiality of HMP beneficiaries' identities, the matching process will utilize a double-blind procedure. Evaluation team members at U-M will extract the identifying information on HMP beneficiaries and append to this dataset a randomly selected sample of approximately one million Michigan residents drawn from an unrelated state health database. These additional observations will serve as "masking" observations. A file consisting of personal information for both HMP beneficiaries and the masking observations will then be provided to the credit reporting agency, which will perform the final step of the data linkage, and then deliver the data to our team with all identifying information removed. Because of the masking procedure, the credit reporting agency will be unable to distinguish which observations are associated with HMP beneficiaries. In the prior study, approximately 98% of HMP beneficiaries were successfully matched to the credit reporting data. We will obtain semi-annual snapshots of credit report data for HMP beneficiaries and comparison groups in low-income zip codes of states that have not expanded Medicaid, beginning in 2013 through 2022 (the most recent data we anticipate being available for analysis).

This data source will be used to examine evaluation question 6.2.

Measures

The credit reporting agency data include several measures that have been used in previous studies of financial distress. Our analysis will be informed by this previous research. One measure is the total amount of debt that has been sent by an original creditor to a third-party collection agency. This debt could represent unpaid bills or severely derogatory credit accounts, such as a credit card bill that is over 180 days late. The credit reporting agency data provide details on the type of third-party collections. Medical bills are reported separately from other sources of debt and are of particular interest. Another indicator of financial distress is credit accounts that are 30 days or more past due but not yet sent to a collection agency. The amount of credit that is in collections and the amount past due but not yet in collections can be summed to form the total amount of debt on which a consumer is delinquent. Another marker of financial difficulties that we will examine is the number of months a consumer is overdrawn on his or her credit card out of the last 12 months. While being overdrawn is not a measure of delinquency *per se*, it is a sign that the consumer is having difficulty spending less than their card limit. This may be a precursor to delinquent debt. We will also analyze financial judgments from court proceedings, including evictions from housing and personal bankruptcies, as measures of severe financial distress.

Finally, we will examine credit score or similar summary of creditworthiness. Lenders use this measure when evaluating whether to extend credit and at what price. As such, it is a concise summary of an individual's access to credit markets. We will analyze the credit score as a

²⁵ Miller, S., Hu, L., Kaestner, R., Mazumder, B., & Wong, A. (2018). [The ACA Medicaid Expansion in Michigan and Financial Health](#). NBER Working Paper No. 25053.

continuous variable. We will also examine the probability that an individual has a credit score in the “subprime” (≤ 600) range, as well as in the “deep subprime” (< 500) range.

Analytic approach

We will construct several different cohorts of HMP beneficiaries with an appropriate comparison group for each cohort and examine credit report outcomes for all cohorts.

Early beneficiary cohort: Individuals who enrolled in HMP in 2014-2015 and have at least one year of total enrollment in HMP. *Comparison group:* Randomly selected individuals from low-income zip codes in states that have not expanded Medicaid.

Later beneficiary cohort: Individuals who enrolled in HMP in 2018-2019 and have at least one year of total enrollment in HMP. *Comparison groups:* (a) Randomly selected individuals from low-income zip codes in states that have not expanded Medicaid; (b) early beneficiary cohort.

2020 beneficiary cohort: Individuals who enrolled in HMP between March 2020 and March 2021 and have at least one year of total enrollment in HMP. *Comparison groups:* Randomly selected individuals from low-income zip codes in states that have not expanded Medicaid.

Disenrollment cohort: Individuals who disenrolled from HMP after at least one year of enrollment. *Comparison group:* Individuals matched on age, zip code, and initial enrollment period who remain enrolled in HMP.

For all analyses, we will use an event study framework to test for a break in trend from 2013 through 2022 within the cohort. We will also use standard difference-in-differences techniques using the comparison groups specified above, including using an evaluation of pre-trends in each cohort and its comparison group(s). If there is not good matching of the pre-trends between treatment and comparison groups, we will consider propensity score weighting or synthetic control methods combined with difference-in-differences analysis.

The results of the early beneficiary cohort and later beneficiary cohort analyses will be included in the interim report. The results of the 2020 beneficiary cohort and the disenrollment cohort will be included in the summative report.

C.4.7. Behavioral Risk Factor Surveillance System (BRFSS)

Data source

We will use national survey data from the Behavioral Risk Factor Surveillance System (BRFSS)²⁶ to estimate changes in health behaviors and health status at the population level. The BRFSS is a nationally representative telephone survey of U.S. adults conducted at the state level and overseen by the Centers for Disease Control & Prevention. Its state-based sampling will allow us to compare changes in health behaviors and health status among low-income Michigan residents to low-income residents in Medicaid expansion states without a healthy behavior incentive or requirement, and to low-income residents in states that did not expand Medicaid.

²⁶ [BRFSS \(Behavior Risk Factor Surveillance System, CDC\)](#)

Household income as a proportion of FPL for each respondent will be estimated from income and household variables available in the BRFSS.

This data source will be used to examine evaluation question 1.1.

Measures

Health outcome variables to be used in the analysis include [variable names]:

- General health status (Excellent, Very good, Good, Fair, Poor) [GENHLTH]
- Poor physical health days per month [PHYSHLTH]
- Poor mental health days per month [MENTHLTH]
- Poor physical or mental health keeping from doing usual activities [POORHLTH]

Health behavior variables to be used in the analysis [variable names] can be grouped into three categories:

Unhealthy lifestyle behaviors

- Smoking status, frequency, and cessation attempts [SMOKE100, SMOKDAY2, STOPSMK2]
- Alcohol use (unhealthy alcohol levels, binge drinking) [ALCDAY5, AVEDRNK3, DRNK3GE5, MAXDRNKS]

Healthy lifestyle behaviors

- Physical activity/exercise [EXERANY2, EXEROFT1, EXERHMM1]
- Fruit and vegetable consumption [FRUIT2, FVGREEN1, VEGETAB2]

Preventive health services

- Cholesterol screening [CHOLCH2]
- HIV screening [HIVTST7]
- Cancer screening: (e.g., colonoscopy, mammogram, Pap smear) [HADSIGM3, HADSGCO1, LASTSIG3, BLDSTOO, LSTBLDS3, HADMAM, HOWLONG, HADPAP2, LASTPAP2]
- Immunizations: Flu vaccine [FLUSHOT7]

Analytic approach

To focus on individuals who are likely to be eligible for HMP, the target group will include low-income Michigan adults between the ages of 19 and 64 with incomes less than or equal to 138 percent of the FPL. Similar to our prior work,²⁷ we will assess this group against two comparison groups: 1) low-income adults between the ages of 19 and 64 with incomes less than or equal to 138 percent of the FPL who reside in demographically or geographically similar states that expanded Medicaid as of the penultimate year of analysis (2019 for the interim report, 2021 for the summative report) but did not include a provision for a healthy behavior incentive or requirement; 2) low-income adults between the ages of 19 and 64 with incomes less than or equal to 138 percent of the FPL who reside in demographically or geographically similar states that did not expand Medicaid as of the penultimate year of analysis. Thus, states other than Michigan that expanded Medicaid with a healthy behavior provision (e.g., Indiana, Iowa) will be excluded from analysis.

²⁷ Nelson, D.B., Sommers, B.D., Singer, P.M., Arntson, E.K., & Tipirneni, R. (2020). [Changes in Coverage, Access, and Health Following Implementation of Healthy Behavior Incentive Medicaid Expansions vs. Traditional Medicaid Expansions](#). *J Gen Intern Med*, 35, 2521–2528.

We will use a difference-in-differences analytic approach, comparing trends in health and health behavior outcomes in Michigan to trends in expansion states without a similar waiver and to non-expansion states. The pre-period will include the years 2011-2014 (prior to implementation of the first HMP waiver in 2014), and the post-period will include the years 2015-2022. The regression model will include fixed effects for state and quarter and also control for covariates, such as age, gender, race/ethnicity, marital status, education, income, employment status, and whether the respondent was part of the BRFSS cell phone sample. We will apply the BRFSS survey weights to all analyses. To meet the assumptions of the difference-in-differences analytic approach, we will assess for parallel trends between target and comparison groups among all outcomes in the pre-period. If the parallel trends assumption is not met for any outcome, we will minimize confounding by using propensity score matching based on inverse probability of treatment weights. These weights will be formed by estimating a logistic model of Medicaid enrollment for a sample of Michigan residents in the years before the implementation of the HMP healthy behavior program features and then applying the estimated parameter models to observations from Michigan and the comparison states.

A confounder of secular trends in Michigan and comparison states will be the coronavirus disease 2019 (COVID-19) pandemic experienced by all states in 2020 and 2021. The inclusion of time fixed effects in our models may partially but not completely mitigate this potential bias. Given higher enrollment during the economic downturn in 2020, sample selection may also be changed before and after the pandemic, despite using the same sample inclusion criteria. We will assess this by examining target and comparison group characteristics before and after 2020. We will also conduct sensitivity analyses assessing trends in health and health behaviors before and after 2020 to ensure the parallel trends assumption of difference-in-differences analysis is met, incorporating quarters in calendar years 2020 and 2021 as a confounding covariate in analyses, and consider dropping calendar year 2020 and some or all of 2021 from analyses.

The results of this analysis using BRFSS data from 2015 to 2020 will be included in the interim report and the results of this analysis using BRFSS data from 2015 to 2022 will be included in the summative report.

C.4.8. American Community Survey (ACS)

Data source

The American Community Survey (ACS) is a nationally representative survey conducted annually by the Census Bureau. The sample size in the ACS public release is approximately 3 million individuals in each year. Our analysis will be limited to adults ages 19 through 64 since this is the group potentially eligible for HMP.

Focusing on observations for individuals from ages 19 to 64 yields approximately 1.8 million observations in each year. Of these individuals, approximately 58,000 in each year are in Michigan, while about 1.1 million observations are in other states that have expanded their Medicaid programs and about 690,000 are in states that have not expanded Medicaid. Based on

prior work with these data in the prior waiver evaluation,²⁸ we anticipate having to drop approximately 4 percent of all observations because they are missing data on family income.

This data source will be used to examine evaluation question 4.1.

Measures

Since 2008, the ACS has included a question about health insurance that asks respondents to indicate sources of current health insurance for every household member. Respondents may mark more than one option. We use these data (variable names HINS1 through HINS6) to create binary indicators of four different measures reflecting insurance outcomes: (1) Medicaid or related public coverage, (2) private non-group coverage, (3) employer-sponsored coverage (including TRICARE), and (4) uninsured. With the exception of uninsured, these outcomes are not mutually exclusive; someone might have, for example, both private non-group coverage and Medicaid; however, this is relatively unusual. Our primary outcomes of interest are Medicaid, private coverage, and uninsurance; trends in employer-sponsored coverage will also be reported. These data will be used to assess insurance coverage among non-elderly low-income adults ages 19 through 64 in Michigan relative to other states.²⁹

Analytic approach

To evaluate the effect of HMP on insurance coverage we will use data from the ACS to compare trends in Michigan with trends in demographically or geographically similar non-expansion states and in demographically or geographically similar expansion states without a similar waiver. Comparing trends in Michigan with trends in non-expansion states extends the analysis we did in the original waiver evaluation. Comparing trends in Michigan with trends in other expansion states without similar waiver provisions will shed light on the impact of Michigan's waiver policies. Our analysis of insurance coverage will separately test for effects on the percentage of people with private health insurance, Medicaid, and uninsured.

We will apply standard difference-in-differences techniques. In the analysis of individual-level data from the ACS we will control for a standard set of individual demographic variables and variables that capture economic conditions measured at the state and sub-state level. These control variables include age, race/ethnicity (white non-Hispanic, black non-Hispanic, other non-Hispanic, Asian non-Hispanic, and Hispanic [any race]), education, gender, and marital status. To account for differences in labor market conditions, we will merge unemployment rate data from the Bureau of Labor Statistics to ACS observations at the state-year level.

We plan also to run analyses that minimize the influence of observed confounders on estimates of program effect by limiting the analysis sample to low-income adults with incomes less than or equal to 150% FPL.

The results of this analysis using ACS data from 2008 to 2020 will be included in the interim report and the results of this analysis using ACS data from 2008 to 2022 will be included in the summative report.

²⁸ Levy, H. & Buchmueller, T. (2019). [Report on Reduction in the Number of Uninsured](#).

²⁹ ACS data are released annually in late September for the previous year. So, for example, 2023 ACS microdata would not be released until September 2024.

C.4.9. HCUP Fast Stats inpatient discharge data

Data source

The Healthcare Cost & Utilization Project (HCUP) sponsored by the federal Agency for Healthcare Research and Quality (AHRQ) provides the Fast Stats database (<https://www.hcup-us.ahrq.gov/faststats/landing.jsp>) as a timely source of state-level inpatient discharge data. These data include demographic variables, diagnoses, and payer for patients discharged from non-federal acute-care hospitals.

This data source will be used to examine evaluation question 7.3.

Measures

Outcomes of interest in the HCUP data include the fraction of hospital discharges for adults ages 19 through 64 for whom the primary payer is Medicaid or uninsured/self-pay. Additional outcomes include the fraction with private coverage or Medicare as primary payer.

Analytic approach

To evaluate the effect of HMP on hospital payer mix for non-elderly adults, we will use data from the Medicare cost reports to compare trends in Michigan with trends in demographically or geographically similar non-expansion states and in demographically or geographically similar expansion states without a similar waiver. Comparing trends in Michigan with trends in non-expansion states extends the analysis we did in the original waiver evaluation. Comparing trends in Michigan with trends in other expansion states without similar waiver provisions will shed light on the impact of Michigan's waiver policies. Payer mix for inpatient hospital stays, which is an important determinant of hospital uncompensated care

The results of this analysis using HCUP data from 2010 to 2021 will be included in the interim report and the results of this analysis using HCUP data from 2010 to 2023 will be included in the summative report.

C.4.10. Medicare cost reports

Data source

We will compare trends in uncompensated care provided by acute care hospitals in Michigan to trends for hospitals in other states using data from the Medicare Hospital cost reports. These data are available for all Medicare-certified hospitals in the U.S. Hospitals report data on a fiscal year basis. Information on uncompensated care comes from Schedule S-10 of the cost reports. The analysis in the prior waiver evaluation used cost report data corresponding to fiscal years 2011 to 2015. For the new waiver evaluation, we will extend the analysis period through 2024.

This data source will be used to examine evaluation question 7.3.

Measures

As in the prior waiver evaluation and consistent with the research literature,³⁰ we will focus on uncompensated care, which equals the sum of charity care and bad debt. Both types of uncompensated care can arise from patients who are uninsured or from those who have private insurance but are unable to afford the cost-sharing required by their insurance plan. The amounts of charity care and bad debt that hospitals report to CMS represent the *charges* corresponding to the care provided. The *cost* of this care can be calculated by applying the hospital's cost-to-charge ratio, which is another measure that hospitals provide in their cost reports. We will analyze the cost of uncompensated care measured in dollars and as a percentage of total operating expenses.

Before analyzing these data, it will be necessary to complete several data cleaning steps. In some cases, hospitals submit multiple cost reports, often for periods that are shorter than 12 months. In these cases, we will combine multiple reports to create a single fiscal year observation for the hospital. We will also check the data for infeasible entries in key fields. Where such outliers are found, we will check for consistency within the set of submissions for a particular hospital. A hospital that consistently reports extremely high values in certain fields is less of a concern than a hospital that reports extreme values in one year, but not others.

Analytic approach

To evaluate the effect of HMP on uncompensated care, we will use data from the Medicare cost reports to compare trends in Michigan with trends in demographically or geographically similar non-expansion states and in demographically or geographically similar expansion states without a similar waiver. Comparing trends in Michigan with trends in non-expansion states extends the analysis we did in the original waiver evaluation. Comparing trends in Michigan with trends in other expansion states without similar waiver provisions will shed light on the impact of Michigan's waiver policies. In regression analyses, we will include hospital and area-level control variables obtained from other sources, including the American Hospital Association annual survey, the Health Resources and Service Administration, and the Bureau of Labor Statistics. These covariates will include hospital ownership status, teaching status, bed count, participation in the 340B prescription drug program, and the county unemployment rate where the hospital is located.

The results of this analysis using Medicare cost report data from 2010 to 2021 will be included in the interim report and the results of this analysis using Medicare cost report data from 2010 to 2023 will be included in the summative report.

D. Methodological Limitations

The statewide implementation of the HMP waiver precludes the conduct of a randomized controlled trial. Where possible, we will rely on quasi-experimental designs (e.g., comparing statewide HMP trends to trends from other states; analyzing trends over time) using difference-in-differences or other appropriate methods to conduct more rigorous analyses of the main outcomes of interest. However, we will not be able to draw definitive causal inferences about specific features of HMP.

³⁰ See, for example, Rhodes, J. H., Buchmueller, T. C., Levy, H. G., & Nikpay, S. S. (2019). [Heterogeneous Effects of the ACA Medicaid Expansion on Hospital Financial Outcomes](#). *Contemporary Economic Policy*.

Several HMP features are complementary, notably the enrollment of beneficiaries into managed care with a specific primary care provider and the encouragement to complete an annual health risk assessment with the primary care provider. It may not be possible to separate the effects of these complementary features. However, state Medicaid officials have expressed interest in understanding the additive benefit of an HRA requirement; as such, the evaluation includes several analyses that attempt to understand the contribution of HRA completion in both changes in health status and engagement in healthy behaviors.

The COVID-19 pandemic has had profound effects the availability and delivery of health care services for Medicaid beneficiaries in Michigan and throughout the country. These effects will impact the evaluation by disrupting trends in patterns of enrollment, utilization of services, employment, and financial stability. We will incorporate sensitivity and supplemental analyses throughout the evaluation, based on the timing of the federal COVID-19 public health emergency, to interpret the impact on evaluation results.

During Michigan's COVID-19 public health emergency, HMP enrollment increased by 30% over a one-year period. It is difficult to estimate the proportion of the enrollment increase due to people becoming newly eligible vs. the proportion due to the lack of disenrollment related to the maintenance of effort provisions of Section 6008 of the FFCRA. This will affect the calculation of claims-based outcomes (e.g., HEDIS, NQF measures) that rely on the number of beneficiaries or member-months for a denominator. We will address this limitation by recalculating outcomes after maintenance of effort provisions expire and enrollment corrections are implemented.

Evaluation activities that utilize administrative data rely on complete and accurate information in the state Data Warehouse. For longitudinal measures, we anticipate some challenges due to modifications in the data structure, particularly for the cost-sharing and HRA tables. We will address these challenges by working with state partners to understand changes in definitions and data management procedures, and employing sensitivity analyses to assess how differential categorization may impact results.

Nonresponse bias can affect evaluation results based on beneficiary surveys. We will address this limitation by employing strategies used in the prior evaluation period, including colorful and engaging recruitment brochures, varying the timing of contact attempts, using email addresses of beneficiaries when listed in the Data Warehouse, and allowing unscheduled call-in surveys as well as scheduled appointments. In addition, we will incorporate nonresponse into our weighting of results. Beneficiary surveys include some measures of self-reported health care utilization (e.g., ED visits in prior year, completion of an HRA), which may suffer from recall bias. When possible, we will validate self-report with claims and encounter data from the Data Warehouse.

Finally, data sources that reflect multi-state or national datasets will use income variables to represent the HMP population. Invariably, this data will include some individuals who are eligible but not enrolled in HMP, which may dampen potential observable effects.

F. Attachments

Independent evaluator

The CMS approval of the Section 1115 waiver for the Healthy Michigan Plan requires that the evaluation be designed and conducted by researchers who will meet the scientific rigor and research standards of leading academic institutions and academic journal peer review. The University of Michigan Institute for Healthcare Policy and Innovation (IHPI) is an interdisciplinary university-wide institute at a premier public research university. The mission of the Institute is to improve the quality, safety, equity, and affordability of health care. The Institute includes more than 650 health services researchers from 15 schools and colleges across the university. IHPI faculty members and staff are national leaders in health services research, health economics, and population health with substantial experience conducting rigorous evaluations of access to care, quality of care, costs of care, and health outcomes.

The Institute for Healthcare Policy and Innovation faculty members participating on the HMP evaluation team represent the University of Michigan Medical School, School of Public Health, Institute for Social Research, Ross School of Business, Ford School of Public Policy, and School of Social Work. They conducted the independent evaluation of the Healthy Michigan Plan during the first five years of the Section 1115 demonstration waiver that authorized this program from April 2014 through December 2018.

A summary of the HMP evaluation reports and articles published in peer-reviewed journals by the evaluation team is available on the Institute for Healthcare Policy and Innovation [website](#).

Brief biographies of evaluation team

John Z. Ayanian, MD, MPP, is the Alice Hamilton Distinguished University Professor of Medicine and Healthcare Policy and Director of the Institute for Healthcare Policy and Innovation at the University of Michigan. He has led the team of faculty and staff conducting the CMS-authorized evaluation of the Healthy Michigan Plan in collaboration with MDHHS since 2014. He is a primary care physician and health services researcher whose research focuses on access to care, quality of care, and health care disparities, including the effects of insurance coverage on health services and outcomes. He is the lead author of three articles on the Healthy Michigan Plan published in the *New England Journal of Medicine*. Dr. Ayanian is an elected member of the National Academy of Medicine, a Master of the American College of Physicians, and the founding Editor of *JAMA Health Forum*.

Nora V. Becker, MD, PhD, is an Assistant Professor in the Department of Internal Medicine, Division of General Medicine, and at the Institute for Healthcare Policy and Innovation at the University of Michigan. Dr. Becker's research focuses on the impact of changes in health policy and health insurance coverage on health care utilization and health outcomes among women and economically disadvantaged populations. As a member of the HMP evaluation team, she brings expertise in health economics and working with insurance claims and financial data.

Thomas C. Buchmueller, PhD, is the Waldo O. Hildebrand Professor of Risk Management and Insurance at the University of Michigan's Stephen M. Ross School of Business. From 2012 to 2019 he served as the Chair of the School's Business Economics and Public Policy area. Buchmueller is an expert on the economics of health insurance and related public policies. His

areas of expertise on the HMP evaluation team include the impact of the expansion on health insurance coverage and on hospital uncompensated care. Other research on the Affordable Care Act includes studies on the law's effects on insurance coverage, hospital utilization and finances and labor market outcomes. In 2011-12 he served as Senior Health Economist to the President's Council of Economic Advisers.

Sarah J. Clark, MPH, is a Research Scientist in the Department of Pediatrics, based in the Susan B. Meister Child Health Evaluation and Research (CHEAR) Center at the University of Michigan. She also serves as Co-Director of the C.S. Mott Children's Hospital National Poll on Children's Health. Since joining the University of Michigan faculty in 1998, Ms. Clark has worked closely with Michigan Medicaid and other MDHHS units on projects evaluating programs and policies related to managed care, children with special health needs, substance use disorder, and provision of dental care, and others. She led the utilization analyses in the initial HMP evaluation, and oversaw data collection for the HMP beneficiary surveys.

Susan Dorr Goold, MD, MHSA, MA, is a Professor of Internal Medicine and Health Management and Policy. She engages patients and communities, particularly minority and underserved communities, in research on health policy. She served as the lead on the beneficiary and provider surveys in the initial HMP evaluation. The Healthy Michigan Voices surveys and interviews have become a national model for Medicaid expansion evaluations in numerous other states. She has served on a CMS panel advising state leaders about 1115 waiver evaluations, consulted for Mathematica as they developed guidance for 1115 waiver evaluations and serves on the advisory board for the Medicaid Demonstration Evaluation Learning Collaborative. Dr. Goold is a Fellow of the American College of Physicians and the Hastings Center.

Richard Hirth, PhD, is the S.J. Axelrod Collegiate Professor of Health Management and Policy at the University of Michigan School of Public Health. Dr. Hirth is an economist whose research focuses on healthcare spending, insurance design and payment systems. He led the cost-sharing analyses for the initial HMP evaluation. In that role, he led the analyses and report writing about the effects of HMP cost-sharing and premium contributions on spending, value of care, and program enrollment.

Edith C. Kieffer, MPH, PhD, is Professor Emerita at the University of Michigan School of Social Work. She conducts community-based participatory intervention research addressing disparities in health and health care. She has contributed to survey design, analyses, and development of reports, presentations and publications as part of the HMP evaluation team. She led the qualitative interviews and analyses conducted as part of the initial HMP evaluation which have provided an in-depth understanding of the perceptions and experiences of HMP beneficiaries, health care providers, and individuals who are eligible for HMP but unenrolled, in their own words. In 2015, she led cognitive interviews to assess HMP beneficiaries' understanding of their MI Health Account statements and recommend modifications.

Sunghee Lee, MS, PhD, is an Associate Research Scientist in the Survey Research Center at the University of Michigan's Institute for Social Research. She provides guidance on power analysis and sample design for the HMP evaluation and leads post-survey statistical weighting efforts.

Helen Levy, PhD, is a Research Professor at the University of Michigan's Institute for Social Research, Gerald R. Ford School of Public Policy, and School of Public Health. Her research interests include evaluating the impact of Medicaid expansion at both the state and national levels, the causes and consequences of lacking health insurance, and material hardship among older Americans. Her expertise on the HMP evaluation team includes the impact of the expansion on health insurance coverage and on hospital uncompensated care. She has also conducted research on the impact of Medicaid expansion nationally on economic outcomes including consumption and labor supply, and she co-authored a study of the fiscal impact of Michigan's Medicaid expansion on the state. Levy is also an Associate Director of the Health and Retirement Study, an NIH-funded longitudinal study of health and economic dynamics at older ages. She is a Research Associate at the National Bureau of Economic Research and served as a Senior Economist to the President's Council of Economic Advisers in 2010-11.

Minal Patel, MPH, PhD, is an Associate Professor in the Department of Health Behavior & Health Education at the University of Michigan School of Public Health. Emphases of her work include access to care, health care navigation, health-related financial burden, and team-based care. Dr. Patel has led studies focused on improving health insurance literacy in economically disadvantaged communities that are primarily covered under Medicaid/HMP, screening and addressing social determinants of health in clinical settings, and health care provider training in implementing guideline-based care. She contributed to the initial HMP evaluation by providing expertise to the survey team related to individuals with chronic conditions.

Zachary Rowe is Executive Director of Friends of Parkside, a non-profit, community-based organization that concerns itself with the health, education and safety of the residents that live in the Village at Parkside on the eastside of Detroit. He has more than 23 years of experience with community-based participatory research and was a founding member of the Detroit Urban Research Center (URC) Board. He serves on the Health Housing Heatwave Partnership Steering Committee, Healthy Environment Partnership Steering Committee, Community Action Against Asthma Steering Committee, the University of Michigan Clinician Scholars Program Advisory Committee and consults for the Michigan Institute for Clinical and Health Research. He has co-directed several projects with Dr. Goold, including the NIA-funded DECIDERS project.

Renuka Tipirneni, MD, MSc, is an Assistant Professor in the Department of Internal Medicine, Divisions of General Medicine and Hospital Medicine, and at the Institute for Healthcare Policy and Innovation investigating the impact of health reform policies and programs on low socioeconomic status, aging and other vulnerable populations, and on delivery of care in the health care safety net. As a member of the team conducting the initial HMP evaluation, she focused on assessing health and employment-related outcomes among enrollees. Dr. Tipirneni will continue to assist with evaluating these key measures in the next waiver evaluation.

Community Advisory Board. The HMP evaluation team has benefitted from the guidance and insights of a Community Advisory Board composed of leaders from minority and underserved communities across Michigan since 2014. These community leaders consult with the evaluation team to ensure Healthy Michigan Voices surveys and other evaluation activities are reflective of diverse perspectives. The Community Advisory Board has engaged with the University of

Michigan in Michigan-focused health policy projects since 2011 to give voice to these communities in decisions about health policy and health research.

Evaluation budget

The HMP evaluation team has prepared and submitted an evaluation budget which includes the total estimated cost, as well as a breakdown of estimated staff, administrative, and other costs for all aspects of the evaluation.

Evaluation data collection, analysis, and reporting milestones

The interim report will be submitted to MDHHS in July 2022 and will contain initial analyses of Data Warehouse (DW) enrollment and claims data, HMP survey data, beneficiary interview data, provider interview data, key informant interview data, credit report data, BRFSS data, ACS data, HCUP data, and Medicare cost report data, as well as findings from interviews with beneficiaries. The summative report will be submitted to MDHHS in July 2024 and will contain final analyses of administrative data, HMP survey data, beneficiary interview data, provider interview data, key informant interview data, credit report data, BRFSS data, ACS data, HCUP data, and Medicare cost report data, as well as the findings from provider interviews, beneficiary follow-up interviews, key informant interviews, and the HMP beneficiary survey.

The below timeline may be modified based on the duration of the federal declaration of the public health emergency, due to delays in data availability, as a result of any limitations on data collection due to pandemic workforce restrictions, or due to other reasons related to the COVID-19 pandemic. As noted above in Sections C.4.1 and C.4.2, evaluation activities focused on the 48-month policy will be limited to descriptive, trend analyses of administrative data if implementation of the new requirements occurs between January and June 2023.

Evaluation Activities/Reporting Milestones	Date
Initial linkages & analysis of DW data, credit report data, BRFSS data, ACS data, HCUP data, and Medicare cost report data	January 2021 – May 2022
Conduct beneficiary interviews	July 2021 – September 2021
Field HMP beneficiary survey	July 2021 – April 2022
Conduct provider interviews	September 2021 – November 2021
Conduct key informant interviews	December 2021 – March 2022
Conduct initial analyses of survey and interview data	October 2021-May 2022
Interim report submitted to MDHHS	July 2022
Ongoing analysis of HMP survey data, beneficiary interview data, provider interview data, key informant interview data, DW data, credit report data, BRFSS data, ACS data, HCUP data, and Medicare cost report data	August 2022 – May 2024
Conduct follow-up beneficiary interviews	November 2022 – March 2023
Summative report submitted to MDHHS	July 2024

Healthy Michigan Plan Evaluation Tables of Hypotheses & Research Questions

1. Healthy Behaviors Incentives Program

Comparison strategy	Outcome measure(s)	Data sources	Analytic approach
Hypothesis 1.1: Health status will improve and healthy behaviors will increase over time among income-eligible adults in Michigan compared with similar adults in comparison states.			
Research question 1.1: How has the health and healthy behavior engagement among Michigan adults changed since introduction of HMP and its Healthy Behaviors Incentives Program?			
Similar adults in expansion states without a healthy behavior waiver provision	Proportion reporting fair/poor health status	BRFSS	Difference-in-difference regression model of health and health behavior outcomes in Michigan vs. comparison states not implementing similar waivers
	Proportion reporting >5 days in past 30 days with poor physical health, mental health, and physical or mental health keeping from usual activities		
Similar adults in states that did not expand Medicaid under the ACA	Proportion reporting engagement in unhealthy lifestyle behaviors		
	Proportion reporting engagement in healthy lifestyle behaviors		
	Proportion reporting receipt of preventive services		
Hypothesis 1.2: Engagement in efforts to maintain or improve health will be higher among beneficiaries who report knowledge of the HMP Healthy Behaviors Incentives Program.			
Research question 1.2: What is the association between beneficiary knowledge of the Healthy Behaviors Incentives program and efforts to maintain or improve health?			
Beneficiaries who report higher vs. lower knowledge of Healthy Behaviors Incentives program	Proportion reporting engagement in healthy lifestyle behaviors	Beneficiary surveys – longitudinal and new cohorts	Bivariate comparison of cross-sectional survey outcomes; multivariate models adjusting for age, gender, race/ethnicity, income, chronic condition, duration of HMP enrollment
	Proportion reporting that they are able to take actions to maintain or improve their health		
	Proportion reporting participation in health-supporting measures		
Hypothesis 1.3: Beneficiaries who complete an HRA will report improvement in health status and health behaviors compared to beneficiaries who do not complete an HRA.			
Research question 1.3: Is HRA completion associated with improved health status and health behaviors?			
Beneficiaries who do vs. do not report completion of an HRA	Proportion reporting fair or poor physical, mental and oral health status	Beneficiary surveys – longitudinal and new cohorts	Bivariate comparison of cross-sectional survey outcomes; multivariate models adjusting for age, gender, race/ethnicity, income, chronic condition, duration of HMP enrollment
	Proportion reporting >5 days in past 30 days with poor physical health, mental health, and physical or mental health keeping from usual activities		

Comparison strategy	Outcome measure(s)	Data sources	Analytic approach
	Proportion reporting improvement in physical and mental health over past 12 months		Mixed effects logistic regression models of Longitudinal Cohort responses over time, adjusting for age, gender, race/ethnicity, income, and chronic condition
	Proportion reporting engagement in unhealthy lifestyle behaviors		
	Proportion reporting engagement in healthy lifestyle behaviors		
Hypothesis 1.4: Beneficiaries who complete at least one HRA will demonstrate higher rates of preventive service use compared to beneficiaries who have similar primary care utilization but who have not completed an HRA.			
Research question 1.4: Is HRA completion associated with higher rates of preventive service use?			
Beneficiaries who do vs. do not have evidence of a completed HRA	Proportion with evidence of annual primary care and dental visits (HEDIS AAP, ADV)	Medicaid claims and encounter data; HRA tables	Bivariate comparison of outcomes; multivariate models adjusting for primary care continuity patterns; multivariate negative binomial regression controlling for demographic characteristics to generate stratified results for those with chronic conditions (asthma, heart failure, COPD, diabetes)
	Proportion with evidence of flu vaccine, cancer screening (NCQF 0039, 0034, 2372, 0032)		
Hypothesis 1.5: Beneficiaries will describe assistance from primary care providers in setting health goals and engaging in behavior change to meet those goals.			
Research question 1.5: How has the Healthy Behaviors Incentives program, and HMP as a whole, affected beneficiaries' engagement in health behaviors and other efforts to maintain or improve health over time?			
n.a.	Reported impact on engagement in health behaviors	Interviews with beneficiaries	Descriptive cross-sectional and longitudinal qualitative analysis
	Reported impact on other efforts to maintain or improve health		
Hypothesis 1.6: Primary care providers will describe that they have become more knowledgeable over time about how to use the HRA to engage patients enrolled in HMP.			
Research question 1.6: How do primary care providers use the HRA to assist in patient engagement and health promotion?			
n.a.	Reported usefulness of HRA as tool to engage patients	PCP interviews	Descriptive cross-sectional qualitative analysis; assessment of variation by plan participation, volume of HMP-enrolled patients
	Reported understanding of the HRA process and financial incentives		

2. Cost-Sharing

Comparison strategy	Outcome measure(s)	Data sources	Analytic approach
Hypothesis 2.1: Beneficiaries who are aware of healthy behavior financial incentives will demonstrate a better understanding of cost-sharing obligations and connections between service utilization and amount owed.			
Research question 2.1: Do beneficiaries understand cost-sharing and other consumer-oriented features of HMP coverage?			
Beneficiaries who do vs. do not report awareness of healthy behavior financial incentives	Proportion reporting awareness of financial incentives related to Healthy Behaviors Incentives program Proportion reporting correct information about payment obligations, link between service utilization and cost-sharing Proportion who recall receiving a MI Health Account (MIHA) statement	Beneficiary surveys – longitudinal and new cohorts	Bivariate comparison of cross-sectional survey outcomes; multivariate models adjusting for age, gender, race/ethnicity, income, chronic condition, literacy, duration of HMP enrollment
Hypothesis 2.2: Beneficiaries with MI Health Account fees will have better payment compliance than their counterparts with service-based cost-sharing only.			
Research question 2.2: What factors are associated with beneficiaries' compliance with cost-sharing obligations?			
Beneficiaries who are vs. are not subject to fees	Beneficiary-level payments (any payment, full payment) of amount owed	Medicaid cost-share tables	Descriptive quantitative analysis of the average amounts and distribution of cost-sharing obligations and estimating multivariate models adjusting for beneficiary characteristics including time enrolled, and subgroup analyses (such as age, gender, race/ethnicity, urban/rural, income, and length of HMP enrollment)
Hypothesis 2.3: Beneficiaries will understand where to find the amount they owe, but may not understand how that amount is calculated.			
Research question 2.3: Are beneficiaries able to understand the MI Health Account statement?			
n.a.	Understanding of MIHA terminology and layout	Interviews with beneficiaries	Descriptive cross-sectional qualitative analysis
Hypothesis 2.4: Beneficiaries will report financial barriers more often than logistical barriers to paying the amount owed.			
Research question 2.4: What are barriers and facilitators for beneficiaries to pay the amount owed?			
n.a.	Barriers and facilitators to making payments	Interviews with beneficiaries	Descriptive cross-sectional qualitative analysis

3. 5% Premium Cost-Sharing & HRA/Healthy Behavior Requirements (48-month policy)*

Comparison strategy	Outcome measure(s)	Data sources	Analytic approach
Hypothesis 3.1: Beneficiary literacy level will be associated with understanding of specific provisions of the new 48-month policy.			
Research question 3.1: Do beneficiaries subject to the new 48-month policy understand the requirements and consequences for noncompliance?			
n.a.	Proportion reporting knowledge of HRA/healthy behavior requirement	Beneficiary surveys – longitudinal cohort (subject to 48-month policy)	Bivariate comparison of cross-sectional survey outcomes by literacy level; multivariate models adjusting for age, gender, race/ethnicity, chronic condition
	Proportion reporting knowledge of 5% monthly premium requirement		
	Proportion reporting knowledge of consequences for noncompliance		
Hypothesis 3.2: Among beneficiaries subject to the new 48-month policy, HRA/healthy behavior completion will increase for beneficiaries with income >100% FPL who are subject to disenrollment, with no change for beneficiaries with income <100% FPL who are not subject to disenrollment.			
Research question 3.2: Is the penalty of disenrollment for failure to complete the HRA/healthy behavior requirement stronger than the incentive of cost-sharing reduction for HRA/healthy behavior completion?			
Beneficiaries before vs. after implementation of the 48-month policy	Probability of completing an annual HRA or healthy behavior	Medicaid HRA tables	Regression model of HRA completion stratified by income group (</>100%), adjusted for demographic characteristics (gender, age, race/ethnicity, urban/rural)
Hypothesis 3.3: Payment compliance will be higher among those subject to the 5% monthly premium requirement than under the previous cost-sharing requirements.			
Research question 3.3: Among beneficiaries with income above 100% FPL, how does payment compliance change with the new cost-sharing requirements (from 2% fee and service-related co-payments to a flat 5% premium)?			
Beneficiaries before vs. after implementation of the 48-month policy	Rates of any payment, full payment of cost-share obligations	Medicaid cost-share tables	Regression model of payment adjusted for demographic characteristics (such as age, gender, race/ethnicity, urban/rural)
Hypothesis 3.4a: The rate of disenrollment will be higher after implementation of the 5% monthly premium requirement compared to before implementation.			
Hypothesis 3.4b: Disenrollment will disproportionately occur among beneficiaries with low utilization in the 24 months prior to implementation of the 5% monthly premium requirement.			
Research question 3.4: To what extent is the 5% monthly premium requirement associated with disenrollment?			
Beneficiaries with high vs. low utilization prior to implementation of the 48-month policy	Rate of HMP disenrollment	Medicaid enrollment files Medicaid claims and encounter data	Comparison of disenrollment rates for pre- vs. post-implementation period using paired t-tests. Multivariate negative binomial regression controlling for demographic characteristics to generate stratified results for those with high vs. low utilization.
	Utilization in prior 24 months (number of primary care visits, dental visits, ED visits, hospitalizations, medication fills)		

*Contingent on implementation, if implemented between January 2023 and July 2023, all analyses will be descriptive, trend analyses.

4. Overall Demonstration: Reduce uninsurance

Comparison strategy	Outcome measure(s)	Data sources	Analytic approach
Hypothesis 4.1a: The decline in uninsurance among non-elderly adults in Michigan compared to other states that did not expand Medicaid that was observed in 2013-2017 will be sustained through subsequent years.			
Hypothesis 4.1b: The decline in uninsurance among non-elderly adults in Michigan compared to other states that expanded without a waiver that was observed in 2013-2017 will be sustained through subsequent years.			
Research question 4.1: How have insurance coverage rates in the state changed since the implementation of HMP, compared with states that did not expand Medicaid and with states that expanded Medicaid without a waiver?			
Similar adults in states that did not expand Medicaid under the ACA	Proportion of adults who are: <ul style="list-style-type: none"> Uninsured Insured through Medicaid Insured through employer-sponsored coverage Insured through private non-group coverage 	ACS (variables HINS1 through HINS6)	Difference-in-differences regression model of coverage among all non-elderly adults, among low-income adults (e.g. income <200% of FPL), and among adults with characteristics correlated with program eligibility (e.g., low levels of education)
Similar adults in expansion states without a similar waiver			Regression adjusted for observable demographic characteristics (age, gender, race/ethnicity)

5. Overall Demonstration: Promote primary care/responsible use of services

Comparison strategy	Outcome measure(s)	Data sources	Analytic approach
Hypothesis 5.1a: Beneficiaries who report no barriers to primary care will be more likely to report improved health status and ability to take action to improve or maintain their health.			
Hypothesis 5.1b: Beneficiaries who make regular primary care visits will be more likely to report improved health status and ability to take action to improve or maintain their health.			
Research question 5.1: Does HMP's facilitation of primary care access (e.g., through managed care PCP assignment) influence beneficiary engagement in health and maintenance or improvement in physical and mental health?			
Beneficiaries who do vs. do not report difficulty accessing primary care	Proportion reporting it is easy to get advice or an appointment from their primary care provider	Beneficiary surveys – longitudinal and new cohorts	Bivariate comparison of cross-sectional survey outcomes; multivariate models adjusting for age, gender, race/ethnicity, income, chronic condition, literacy, duration of HMP enrollment
Beneficiaries who do vs. do not report regular primary care visits (avg 1 per year)	Proportion reporting fair or poor physical, mental and oral health status		
	Proportion reporting >5 days in past 30 days with poor physical health, mental health, and physical or mental health preventing usual activities		Independent sample t-test comparison of aggregate responses for New Cohort vs. Longitudinal Cohort at a similar point in their HMP enrollment, with multivariate models adjusting for age, gender, race/ethnicity, income, and chronic condition
	Proportion reporting improvement in physical and mental health over past 12 months		
	Proportion reporting that they are able to take actions to maintain or improve their health		Mixed effects logistic regression models of Longitudinal Cohort responses over time, adjusting for age, gender, race/ethnicity, income, and chronic condition
Hypothesis 5.2: Beneficiaries who report barriers to care will be more likely to report an emergency department visit without first attempting to contact their primary care provider.			
Research question 5.2: What factors influence beneficiaries' decisions about seeking care in the emergency department?			
Beneficiaries who do vs. do not report difficulty obtaining needed services	Proportion reporting it is easy to get advice or an appointment from their primary care provider	Beneficiary surveys – longitudinal and new cohorts	Bivariate comparison of cross-sectional survey outcomes; multivariate models adjusting for age, gender, race/ethnicity, income, chronic condition, duration of HMP enrollment
	Proportion reporting medical urgency vs. PCP recommendation vs. other reason for ED visit in the past 12 months		
	Proportion reporting they attempted to contact their primary care provider before going to the ED, among those reporting ED visit		Independent sample t-test comparison of aggregate responses for New Cohort vs. Longitudinal Cohort at a similar point in their HMP enrollment, with multivariate models adjusting for age, gender,

Comparison strategy	Outcome measure(s)	Data sources	Analytic approach
			race/ethnicity, income, and chronic condition
			Mixed effects logistic regression models of Longitudinal Cohort responses over time, adjusting for age, gender, race/ethnicity, income, and chronic condition
Hypothesis 5.3: Beneficiaries with higher continuity of primary care will have lower rates of emergency department utilization and lower odds of being high-frequency ED utilizers.			
Research question 5.3: Is use of the emergency department related to continuity of primary care?			
Beneficiaries with higher vs. lower primary care continuity	Rate of ED visits (HEDIS EDU)	Medicaid claims and encounter data	Comparison of ED outcomes using paired t-tests; multivariate negative binomial regression controlling for demographic characteristics to generate stratified results for those with chronic conditions (asthma, heart failure, COPD, diabetes)
	Proportion of high-frequency ED utilizers		
	Primary care continuity (average number of primary care visits per year)		
Hypothesis 5.4: Beneficiaries with chronic conditions will demonstrate better rates of medication management and primary care utilization, and lower rates of ED visits and hospitalizations, over time compared to their initial year of HMP enrollment.			
Research question 5.4: Does HMP promote more consistent use of services to manage chronic conditions over time?			
n.a	Rate of appropriate medication management (HEDIS PCE, MMA, SPC, SPD)	Medicaid claims and encounter data	Comparison of outcomes in initial vs. subsequent years using paired t-tests; multivariate negative binomial regression controlling for demographic characteristics to generate stratified results by continuity of primary care
	Emergency department visit rate (HEDIS EDU); Follow-up after ED visit for beneficiaries with multiple chronic conditions (HEDIS FMC)		
	Disease-specific hospitalization rates (NQF 0272, 0275, 0277)		
Hypothesis 5.5: Beneficiaries will describe HMP as allowing them to receive services that have a significant positive impact on their health and well-being.			
Research question 5.5: How has HMP impacted beneficiaries’ physical, mental, and oral health and their use of health care services over time?			
n.a.	Reported impact of HMP on health status (physical, mental, oral)	Interviews with beneficiaries	Descriptive cross-sectional and longitudinal qualitative analysis
	Reported impact of HMP on use of health care services		

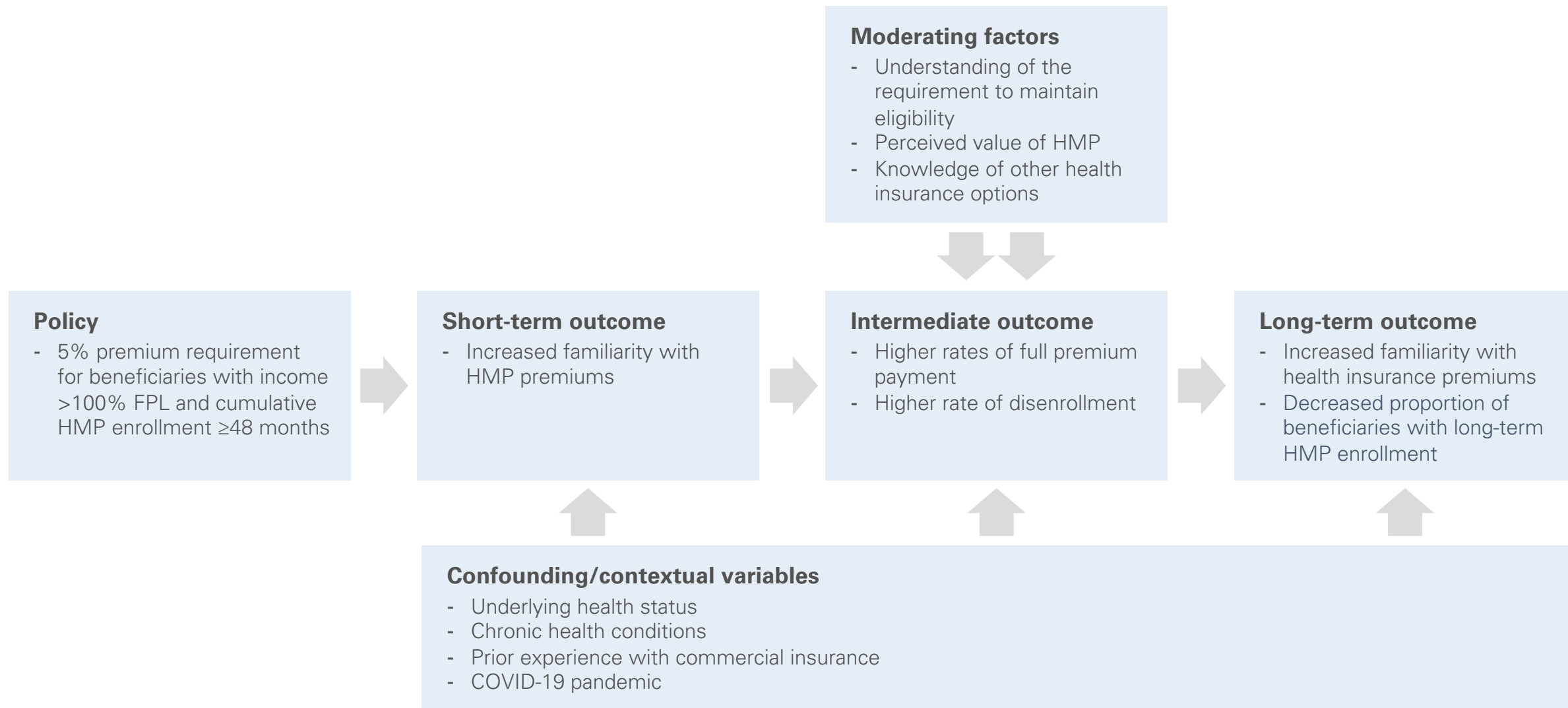
6. Overall Demonstration: Support financial well-being

Comparison strategy	Outcome measure(s)	Data sources	Analytic approach
Hypothesis 6.1: Beneficiaries will report sustained or increased employment and decreased health-related barriers to employment over time.			
Research question 6.1: What impact has HMP had on beneficiaries' levels of employment and ability to work?			
n.a.	Proportion reporting full/part time employment	Beneficiary surveys – longitudinal and new cohorts	Bivariate comparison of cross-sectional outcomes; multivariate models adjusting for age, gender, race/ethnicity, income, chronic condition, duration of HMP enrollment
	Proportion reporting work hours >20 hours/week		
	Proportion reporting health-related barriers to work		
	Proportion reporting other barriers to work (inconsistent work schedule, transportation, caregiving responsibilities, homelessness, discrimination)		Independent sample t-test comparison of aggregate responses for New Cohort vs. Longitudinal Cohort at a similar point in their HMP enrollment; multivariate models adjusting for age, gender, race/ethnicity, income, and chronic condition
			Mixed effects logistic regression models of Longitudinal Cohort responses over time, adjusting for age, gender, race/ethnicity, income, and chronic condition
Hypothesis 6.2: HMP enrollment will be associated with improved credit report outcomes for beneficiaries over time.			
Research question 6.2: How is HMP enrollment related to individual beneficiaries' financial outcomes during and after HMP enrollment?			
Individuals from low-income zip codes in states that have not expanded Medicaid	Total debt past due	Credit report data linked to Medicaid enrollment	Event study regression models to test for break in trend over time
	Bills in collections (all, medical)		
HMP beneficiaries who enrolled in different time periods	Number of months with overdrawn credit cards		Difference-in-difference regression models
	Financial judgments (e.g., evictions, bankruptcies, and wage garnishments)		
	Credit scores		
Hypothesis 6.3: Beneficiaries will describe examples of how HMP has improved their financial and material well-being.			
Research question 6.3: How has HMP affected beneficiaries' financial and material well-being over time?			
n.a.	Reported impact on how HMP has facilitated ability to work	Interviews with beneficiaries	Descriptive cross-sectional and longitudinal qualitative analysis
	Reported impact on financial well-being, including out-of-pocket costs for health services		

7. Overall Demonstration: Sustain the safety net and support coordinated strategies to address social determinants of health

Comparison strategy	Outcome measure(s)	Data sources	Analytic approach
Hypothesis 7.1: Administrative costs to implement demonstration policies will remain stable during the current Section 1115 waiver period.			
Research question 7.1: What are the categories and estimated amounts of the State’s costs to administer key HMP demonstration policies (e.g., Healthy Behaviors Incentives program, cost-sharing)?			
n.a.	Reported HMP administrative costs and staff effort over time	Key informant interviews	Descriptive cross-sectional qualitative analysis
Hypothesis 7.2: Annual trends in age- and sex-adjusted expenditures per member-month will demonstrate a lower rate of increase over time for enrollees in HMP managed care than for enrollees in traditional Medicaid managed care.			
Research question 7.2: How do trends over time in Medicaid expenditures per member-month for HMP enrollees compare to those for beneficiaries in traditional Medicaid managed care?			
HMP-MC vs traditional MA-MC	Total expenditures per member-month	Medicaid claims and encounter data	Year-to-rate change in member-month expenditures, adjusted for enrollee age and sex
Hypothesis 7.3a: The decline in hospital uncompensated care and the fraction of hospital discharges among non-elderly adults in Michigan for whom the primary payer was uninsured/self-pay compared with states that did not expand Medicaid that was observed between 2013 and 2017 will be sustained in subsequent years.			
Hypothesis 7.3b: The decline in hospital uncompensated care and the fraction of hospital discharges among non-elderly adults in Michigan for whom the primary payer was uninsured/self-pay compared with states that expanded Medicaid without a waiver that was observed between 2013 and 2017 will be sustained in subsequent years.			
Research question 7.3: How have uncompensated care costs in the state changed since the implementation of HMP, compared with states that did not expand Medicaid and with states that expanded Medicaid without a waiver?			
States that did not expand Medicaid under the ACA	Proportion of hospital discharges for which primary payer was uninsured/self-pay	HCUP Fast Stats Inpatient Stay data	Comparison of trends in Michigan with other states by payer/age group (Medicaid, 19-64; Medicare, 65+; uninsured, 19-64; private, 19-64)
Expansion states without a similar waiver			
States that did not expand Medicaid under the ACA	Uncompensated care costs	Medicare cost reports (worksheet S-10)	Difference-in-differences regression models of uncompensated care costs comparing changes for Michigan to changes in expansion states that do not have a similar demonstration
Expansion states without a similar waiver			
Regression adjusted for state-level variables			
Hypothesis 7.4: State officials and safety-net providers will describe specific examples of health-promoting initiatives that build on HMP’s continuity, breadth of coverage, and primary care emphasis.			
Research question 7.4: How does HMP support new or broadened initiatives to address social determinants of health for low-income adults in Michigan?			
n.a.	Reported role of HMP in sustaining new or broadened initiatives	Key informant interviews	Descriptive cross-sectional qualitative analysis

Logic model for program goals as stated in HMP Section 1115 demonstration waiver 5% premium requirement (48-month policy)



Logic model for program goals as stated in HMP Section 1115 demonstration waiver HRA/healthy behavior requirement (48-month policy) and Healthy Behaviors Incentives program

