STATE OF MICHIGAN
DEPARTMENT OF HEALTH AND HUMAN SERVICES
LANSING

GRETCHEN WHITMER
GOVERNOR

ROBERT GORDON
DIRECTOR

April 24, 2020

Jennifer Kostesich, Project Officer
Division of Medicaid and Children's Health
Centers for Medicare & Medicaid Services
233 North Michigan Avenue, Suite 600
Chicago, Illinois 60601

Dear Ms. Kostesich,

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

Enclosed is the quarterly report for Healthy Michigan Plan. It covers the fourth quarter of calendar year 2019. The report provides operational information, program enrollment, and policy changes related to the waiver as specified in the Special Terms and Conditions.

Should you have any questions related to the information contained in this report, please contact Jacqueline Coleman by phone at (517) 284-1190, or by e-mail at colemanj@michigan.gov.

Sincerely,

[redacted]

Penny Rutledge, Director
Actuarial Division

cc: Ruth Hughes
Angela Garner

Enclosure (6)

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1. Title page for the state's eligibility and coverage policies demonstration or eligibility and coverage policies components of the broader demonstration

State	**Michigan**
Demonstration name	**Healthy Michigan Plan** **Project No. 11-W-00245/5**
Approval date	**December 21, 2018**
Approval period	**January 1, 2019 through December 31, 2023**
Implementation date	**January 1, 2020**

2. Executive summary

On April 1, 2014, Michigan expanded its Medicaid program to include adults with income up to 133 percent of the FPL. To accompany this expansion, the Michigan "Adult Benefits Waiver" was amended and transformed to establish the Healthy Michigan Plan (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 sunsetting ABW program transitioned to the state plan and the HMP 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, including a community engagement requirement, 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. Additionally, beneficiaries ages 19 through 62 are required to meet a community engagement requirement as a condition of HMP eligibility. On March 4, 2020, a federal judge ruled that approval of the HMP work requirements was unlawful. This ruling stopped MDHHS' implementation and enforcement of the work rules.

3. Narrative information on implementation, by eligibility and coverage policy

Prompts	Demonstration year (DY) and quarter first reported	Metric(s) (if any)	Summary
CE.Mod_1. Specify community engagement policies			
CE.Mod_1.1 Metric trends			
1.1.1 Discuss any data trends related to the overall community engagement enrollment count. Describe and explain changes (+ or -) greater than two percent.	DY 10 – Q4	CE_1-8	
1.1.2 Discuss any data trends related to community engagement requirement qualifying activities. Describe and explain changes (+ or -) greater than two percent.	DY 10 – Q4	CE_9-14	
1.1.3 Discuss any data trends related to beneficiaries exempt from community engagement requirements. Describe and explain changes (+ or -) greater than two percent.	DY 10 – Q4	CE_15-24	
☒ The state has no metrics related to this reporting topic.			

Prompts	Demonstration year (DY) and quarter first reported	Metric(s) (if any)	Summary
CE.Mod_1.2 Implementation update			
1.2.1 Compared to the demonstration design details outlined in the implementation plan, describe any changes or expected changes to how the state defines: a) Beneficiaries exempt from community engagement requirements b) Qualifying community engagement activities and required hours c) Reporting frequency and hours measurement d) Situations that give rise to good cause e) Compliance actions f) Other policy changes	DY 10 – Q4		
☒ The state has no implementation updates to report for this reporting topic.			

Prompts	Demonstration year (DY) and quarter first reported	Metric(s) (if any)	Summary
CE.Mod_2. Establish beneficiary supports and modifications			
CE.Mod_2.1 Metric trends			
2.1.1 Discuss any data trends related to supports and assistance: a) Overall b) Transportation assistance c) Childcare assistance d) Language supports e) Assistance with placement f) Other supports, including assistance from other agencies and entities complementing Medicaid efforts Describe and explain changes (+ or -) greater than two percent.	DY 10 – Q4	CE 25-30	The State does not have Community Engagement metric trends to report this quarter as those requirements have not begun.
2.1.2 Discuss any data trends related to beneficiaries who request or are granted reasonable modifications to community engagement requirements due to disability. Describe and explain changes (+ or -) greater than two percent.	DY 10 – Q4	CE 31-32	The State does not have Community Engagement metric trends to report this quarter as those requirements have not begun.

Prompts	Demonstration year (DY) and quarter first reported	Metric(s) (if any)	Summary
CE.Mod_2.2 Implementation update			
2.2.1 Compared to the demonstration design details outlined in the implementation plan, describe any changes or expected changes in provided transportation, childcare assistance, language supports, placement assistance, or other supports, including assistance from other agencies and entities complementing Medicaid efforts.	DY 10 – Q4		Michigan is working to identify additional beneficiary supports and will be providing updated information when available.
2.2.2 Compared to the demonstration design details outlined in the implementation plan, describe any changes or expected changes in public programs that the state Medicaid agency is partnering with to leverage existing employment and training supports.	DY 10 – Q4		Michigan will leverage its existing partnerships to provide employment and training supports. The state is working to identify additional beneficiary employment and training supports and will be providing updated information when available.
2.2.3 Describe any other program changes that have impacted the availability and accessibility of community engagement activities.	DY 10 – Q4		The state is continuing to explore ways to support the availability and accessibility of community engagement activities.

Prompts	Demonstration year (DY) and quarter first reported	Metric(s) (if any)	Summary
2.2.4 Compared to the demonstration design details outlined implementation plan, describe any changes or expected changes to how the state provides reasonable modifications for beneficiaries with disabilities or connects beneficiaries with disabilities to needed supports and services.	DY 10 – Q4		MDHHS is working to identify how to connect beneficiaries with disabilities to needed supports and services and will be providing updated information when available. MDHHS will be compliant with ADA requirements.
☒ The state has no implementation updates to report for this reporting topic.			

Prompts	Demonstration year (DY) and quarter first reported	Metric(s) (if any)	Summary
CE.Mod_3. Establish procedures for enrollment, verification and reporting			
CE.Mod_3.1 Metric trends – ***No metric trend analysis is required for this reporting topic.***			
CE.Mod_3.2 Implementation update			
3.2.1 Compared to the demonstration design details outlined in the implementation plan, describe any changes or challenges to the state's: a) Application/enrollment processes to identify beneficiaries subject to or exempt from CE b) Renewal processes for the CE demonstration population c) Other planned modifications to the state's eligibility determination and enrollment processes and operations as a result of implementation of CE requirements.	DY 10 – Q4		Michigan will be making changes to its paper and electronic Medicaid applications to allow exemption attestation and reporting of community engagement compliance for those previously non-compliant. The state is also making changes to its redetermination packets to allow beneficiaries to attest to exemptions. Michigan plans to modify eligibility determination logic to recognize exemptions before enforcing community engagement reporting requirements and/or closures for non-compliance.

Prompts	Demonstration year (DY) and quarter first reported	Metric(s) (if any)	Summary
3.2.2 From the design details outlined in the implementation plan, describe any changes or challenges with the state's procedures for beneficiaries to report community engagement activities**.**	DY 10 – Q4		The state has passed legislation that will offer members an opportunity to cure previous months of non-compliance. This will allow beneficiaries to attest to an exemption or the completion of qualifying activities within a 60-day calendar reporting period.
3.2.3 From the design details outlined in the implementation plan, describe any changes or challenges with the state's procedures for CE entities, such as employers, volunteer supervisors, schools, and other institutions, to report community engagement activities, if applicable.	DY 10 – Q4		The State is working to educate community partners so they can assist beneficiaries with reporting (e.g., use of community partner resources [computers]). Michigan does not plan to develop the capacity for other entities to directly report individual beneficiary compliance at this time but will continue to explore options to decrease barriers to reporting.
3.2.4 Compared to the demonstration design details outlined in the implementation plan, describe any changes or challenges with the state's process for beneficiaries to file for an exemption.	DY 10 – Q4		Exemptions will be reported through the MI Bridges (online electronic portal) and via telephone Interactive Voice Response (IVR). There will be an option to speak to a Customer Service Representative (CSR) to report compliance. Additionally, the state has developed a paper form to report exemptions through January 31, 2020. The state does not expect changes to the state's process for beneficiaries to file for an exemption.

Prompts	Demonstration year (DY) and quarter first reported	Metric(s) (if any)	Summary
3.2.5 Compared to the demonstration design details outlined in the implementation plan, describe any changes or challenges with how the state will verify beneficiaries' compliance with CE requirements.	DY 10 – Q4		In Michigan, compliance reviews will be completed by the centrally located Special Processing Office (SPO). The department will sample 10% of beneficiaries who report compliance or are deemed in a compliance activity. Compliance reviews will include a review of case records and use other sources available to determine compliance. Instances where information is not obtained or does not support the compliance activity will be subject to additional review that may include a referral to the Office of Inspector General (OIG) and/or removal of the compliance month that will be replaced with a countable non-compliant month. Michigan is working with CMS to define this process.
3.2.6 Describe the actions taken by the state to use additional data sources or leverage other entities to verify compliance with or identify potential exemptions from CE requirements.	DY 10 – Q4		Michigan will utilize Bridges to identify TANF and SNAP recipients and exempt this population from community engagement reporting requirements. MDHHS SPO staff will utilize system data sources, external data sources such as Equifax, or a Verification Check List to request verification directly from a beneficiary to verify compliance or identify potential exemptions.
☒ The state has no implementation updates to report for this reporting topic.			

Prompts	Demonstration year (DY) and quarter first reported	Metric(s) (if any)	Summary
CE.Mod_4. Operationalize strategies for noncompliance			
CE.Mod_4.1 Metric trends			
4.1.1 Discuss any data trends related to the number of beneficiaries who have experienced: a) new suspensions b) new disenrollments Describe and explain changes (+ or -) greater than two percent.	DY 10 – Q4	CE_33-34	
4.1.2 Discuss any data trends related to the number of beneficiaries who have experienced reinstatement of benefits after suspension. Describe and explain changes (+ or -) greater than two percent.	DY 10 – Q4	CE_35-40	
4.1.3 Discuss any data trends related to the number of beneficiaries who have experienced re-entry after disenrollment. Describe and explain changes (+ or -) greater than two percent.	DY 10 – Q4	CE_41-46	
☒ The state has no metrics related to this reporting topic.			

Prompts	Demonstration year (DY) and quarter first reported	Metric(s) (if any)	Summary
CE.Mod_4.2 Implementation update			
4.2.1 Compared to the demonstration design details outlined in the implementation plan, describe any changes or expected changes to policies around identifying beneficiaries at risk of noncompliance and strategies to assist beneficiaries at risk of noncompliance in meeting the requirements.	DY 10 – Q4		The State is developing system functionality to identify and track "failed" months. Michigan will send a letter to each beneficiary after every "failed" non-compliance month (a month in which the beneficiary had a reporting requirement and failed to report qualifying activity compliance, failed to report an exemption, or attested to not meeting community engagement requirements).
4.2.2 Compared to the demonstration design details outlined in the implementation plan, describe any changes or expected changes to the process for compliance actions or benefit reactivation (from suspension) and/or reenrollment (from termination) once community engagement requirements are met.	DY 10 – Q4		Once a beneficiary who is not exempt has reached the third "failed" month, they will receive a closure notice more than 10 days before a negative action takes place. This notice will include instructions on opportunity to cure per state legislation. Once the beneficiary's HMP case closes for non-compliance with community engagement requirements, they must serve a one-month penalty period. After that time, they may reapply and attest to completing the requisite qualifying activities to gain eligibility. Michigan will develop a new functionality to track those beneficiaries who lose coverage for non-compliance.

Prompts	Demonstration year (DY) and quarter first reported	Metric(s) (if any)	Summary
4.2.3 Compared to the demonstration design details outlined in the implementation plan, describe any changes or expected changes to how a beneficiary who is about to be suspended or disenrolled will be screened for other Medicaid eligibility groups.	DY 10 – Q4		Michigan will utilize current functionality in Bridges to cascade through the Medicaid categories as well as utilization of the established ex-parte review process before certification of Healthy Michigan Plan closure.
4.2.4 Compared to the demonstration design details outlined in the implementation plan, describe any changes or expected changes from the current renewal process, including changes for beneficiaries in suspension status due to noncompliance with CE requirements.	DY 10 – Q4		The state is making changes to its redetermination packet to allow beneficiary exemption self-attestation.
4.2.5 Compared to the demonstration design details outlined in the implementation plan, describe any changes or expected changes to the process by which beneficiaries may reenroll after disenrollment or suspension for failure to comply with CE requirements.	DY 10 – Q4		Michigan will add questions to the Health Care Coverage applications (paper and electronic) to collect beneficiary attestation of compliance with community engagement requirements in any of the previous 12 months (including the application month) for which the month has not already been reported, as well as add questions to collect attestation to an exemption. Beneficiaries attesting to an exemption will be approved without having to serve the penalty month. Beneficiaries attesting to completion of qualifying activities will be approved for the first eligible month following the penalty month.

Prompts	Demonstration year (DY) and quarter first reported	Metric(s) (if any)	Summary
4.2.6 Report any modifications to the appeals processes for beneficiaries enrolled in the 1115 CE demonstration.	DY 10 – Q4		Michigan will utilize the current appeals process for beneficiaries enrolled in the community engagement demonstration, including appeals for disenrollment for noncompliance and denials of exemption requests.
☒ The state has no implementation updates to report for this reporting topic.			

Prompts	Demonstration year (DY) and quarter first reported	Metric(s) (if any)	Summary
CE.Mod_5. Develop comprehensive communications strategy			
CE.Mod_5.1 Metric trends - ***No metric trend analysis is required for this reporting topic***			
CE.Mod_5.2 Implementation update			
5.2.1 Compared to the demonstration design details outlined in the implementation plan, describe any change or expected changes to the state's strategy to communicate with beneficiaries about: a) General CE policies b) Exempt populations and good cause circumstances c) Suspension or disenrollment for noncompliance d) Reactivation following suspension or reentry after disenrollment for noncompliance	DY 10 – Q4		Michigan will utilize its Health Care Coverage Determination Notice to communicate disenrollment for noncompliance and the actions needed to attest to an exemption or attest to compliance with community engagement requirements. Michigan will communicate to beneficiaries regarding benefits after disenrollment for noncompliance in its Health Care Coverage Determination Notice. Members can view the disenrollment notice in MI Bridges, can contact the Beneficiary Help Line, use the MI Health Button to check healthy behavior information, and review the program informational booklet.

Prompts	Demonstration year (DY) and quarter first reported	Metric(s) (if any)	Summary
5.2.2 Describe any outreach or education activities that were conducted with CE partners, such as qualified health plans, managed care organizations, providers, or community organizations, during this reporting period.	DY 10 – Q4		MDHHS regularly meets with the staff of Medicaid Health Plans to address operational issues, programmatic issues, and policy updates and clarifications. MDHHS continues to work closely with provider groups through meetings, Medicaid provider policy bulletins, and various interactions with community partners and provider trade associations. Progress reports are provided by MDHHS to the Medical Care Advisory Council (MCAC) at regularly scheduled quarterly meetings.
5.2.3 Compared to the demonstration design details outlined in the implementation plan, describe any changes or challenges with how materials or communications were accessible to beneficiaries with limited English proficiency, low literacy, in rural areas, and other diverse groups.	DY 10 – Q4		Michigan's Implementation Plan includes components to support communication with beneficiaries with limited English proficiency, low literacy, in rural areas, and other diverse groups. Changes are not expected at this time.
5.2.4 Compared to the demonstration design details outlined in the implementation plan, describe any changes or challenges with the state's plan to communicate modifications of community engagement requirements to beneficiaries with disabilities.	DY 10 – Q4		Michigan does not have modifications to the requirements based on disability; however, beneficiaries with a disability can be exempted from community engagement requirements under several categories, such as medically frail or good cause.

Prompts	Demonstration year (DY) and quarter first reported	Metric(s) (if any)	Summary
5.2.5 Describe any communication or outreach conducted to CE partner organizations during this reporting period.	DY 10 – Q4		The state continually communicates in regular meetings with the MCAC, Medicaid Health Plans, provider groups, and community organizations regarding upcoming changes to the Healthy Michigan Plan. This quarter, MDHHS conducted regional forums throughout the State of Michigan to explain the new workforce engagement requirements for non-exempt HMP beneficiaries. Additionally, several webinars for providers and other stakeholder groups were held this quarter. MDHHS continued to coordinate with community partners to assist beneficiaries with reporting qualifying activities and exemptions.
5.2.6 Describe any internal staff training conducted during this reporting period.	DY 10 – Q4		This quarter, the state offered in-person and webinar informational presentations for department staff.
☐ The state has no implementation updates to report for this reporting topic.			

Prompts	Demonstration year (DY) and quarter first reported	Metric(s) (if any)	Summary
CE.Mod_6. Establish continuous monitoring			
CE.Mod_6.1 Metric trends - ***No metric trend analysis is required for this reporting topic***			
CE.Mod_6.2 Implementation update			
6.2.1 Describe any analyses that the state has conducted to inform its monitoring beyond the required monitoring reports. Describe if these analyses have suggested the need to make changes in any CE policies.	DY 10 – Q4		No additional changes have been made to the demonstration design. Additionally, the state cannot submit its Monitoring Protocol prior to Implementation Plan approval. The state has not conducted any analyses to inform its monitoring beyond the required monitoring reports.
6.2.2 Describe if the state has assessed the availability of transportation. If the state identified any gaps in supports, describe what steps have been taken to address those gaps.	DY 10 – Q4		Michigan continues to explore other support opportunities and will provide updated information when available. The state will continue to connect members to existing resources (ex. 211 and local organizations) for the purpose of serving the Healthy Michigan Plan Community Engagement population.
6.2.3 Describe if the state has assessed the availability of childcare supports. If the state identified any gaps in supports, describe what steps have been taken to address those gaps.	DY 10 – Q4		Michigan continues to explore other support opportunities and will provide updated information when available. The state will continue to connect members to 211 for existing resources and pursue discussions with the Michigan Department of Education to determine if Healthy Michigan Plan Community Engagement activities could qualify members for Child Development and Care (CDC) program eligibility.

Prompts	Demonstration year (DY) and quarter first reported	Metric(s) (if any)	Summary
6.2.4 Describe if the state has assessed the availability of language supports. If the state has identified any gaps in supports, describe what steps have been taken to address those gaps.	DY 10 – Q4		Michigan continues to explore other support opportunities and will provide updated information when available. The Medicaid beneficiary help line will be used to identify language access services.
6.2.5 Describe if the state has assessed the availability of placement assistance supports. If the state has identified any gaps in supports, describe what steps have been taken to address those gaps.	DY 10 – Q4		Michigan continues to explore other support opportunities and will provide updated information when available.
6.2.6 Describe if the state has assessed the availability of other supports, including assistance from other agencies and entities complementing Medicaid efforts. If the state has identified any gaps in supports, describe what steps have been taken to address those gaps.	DY 10 – Q4		Michigan continues to explore other support opportunities and will provide updated information when available.

Prompts	Demonstration year (DY) and quarter first reported	Metric(s) (if any)	Summary
6.2.7 Describe the state's assessment of whether qualifying community engagement activities are available during a range of times, through a variety of means, and throughout the year.	DY 10 – Q4		MDHHS continues to explore other support opportunities and will provide updated information when available.
6.2.8 Describe if the state has conducted an assessment for areas with high unemployment, limited economic opportunities, and/or limited educational activities. If the state has identified any, has the state adjusted CE requirements in those areas?	DY 10 – Q4		Michigan will examine a variety of sources to identify geographic areas with high unemployment and limited economic and/or education opportunities. The state plans to utilize data for county-specific unemployment rates and possible Bridges logic previously used to for the Time-Limited Food Assistance (TLFA) requirement by county when unemployment was high. The state is exploring means to identify areas with high unemployment and subsequent actions to adjust community engagement requirements. Additional information will be provided as available.
6.2.9 Describe if the state has assessed that reasonable modifications and supports are available for beneficiaries with disabilities by region. Describe how the state will address gaps in supports. Note the frequency with which the state will assess reasonable modifications and the availability of supports.	DY 10 – Q4		Beneficiaries with a reported disability can be exempt from community engagement requirements under several categories, such as medically frail or good cause.

Prompts	Demonstration year (DY) and quarter first reported	Metric(s) (if any)	Summary
☒ The state has no implementation updates to report for this reporting topic.			

Prompts	Demonstration year (DY) and quarter first reported	Metric(s) (if any)	Summary
CE.Mod_7. Develop, modify, and maintain systems			
CE.Mod_7.1 Metric trends - ***No metric trend analysis is required for this reporting topic***			
CE.Mod_7.2 Implementation update			
7.2.1 Describe if the state has developed or enhanced its systems capabilities as described in the implementation plan for: a) Eligibility and enrollment system b) CE reporting for beneficiaries c) CE reporting for other CE entities d) Integration of data from other public programs, such as SNAP and TANF e) Suspension of benefits and payments and/or termination of eligibility f) Benefit reactivation and/or reenrollment once community engagement requirements are met g) Other significant systems changes and modifications	DY 10 – Q4		Michigan is in the process of enhancing its eligibility and enrollments system to allow for eligibility determinations to be made on beneficiaries who are subject to Community Engagement requirements. Additionally, the state is enhancing its systems for beneficiaries to report compliance with Community Engagement requirements. Michigan is currently not planning to enhance or develop systems which allow employers, volunteers, schools, etc. to report community engagement activities completed by beneficiaries. Michigan will utilize known information within its integrated eligibility system, Bridges, to allow data from programs such as SNAP and TANF to be utilized in determining eligibility for beneficiaries who are subject to community engagement requirements. Systems will be modified to terminate eligibility for beneficiaries who do not comply with the community engagement and/or 48-month requirement criteria or do not have an exemption from that criteria. Bridges has existing functionality that allows for the reactivation of benefits once eligibility criteria is met. Additional functionality will be added to allow MDHHS staff to enter reported compliance information after the closure and reactivate eligibility.

Prompts	Demonstration year (DY) and quarter first reported	Metric(s) (if any)	Summary
7.2.2 Describe any additional systems modifications that the state is planning to implement.	DY 10 – Q4		The state does not have additional changes to note at this time.
☒ The state has no implementation updates to report for this reporting topic.			

4. Narrative information on implementation for any eligibility and coverage demonstration

Prompts	Demonstration year (DY) and quarter first reported	Metric(s) (if any)	Summary
AD.Mod_1. Metrics and operations for demonstrations with any eligibility and coverage policies (report for all beneficiaries in the demonstration)			
AD.Mod_8.1 Metric trends			
8.1.1 Discuss any data trends related to overall enrollment in the demonstration. Describe and explain changes (+ or -) greater than two percent.	DY 10 – Q4	AD_1-5	Overall enrollment in the Healthy Michigan Plan demonstration this quarter was consistent with typical program enrollment. No significant changes to enrollment were reported.
8.1.2 Discuss any data trends related to mid-year loss of demonstration eligibility. At a minimum, changes (+ or -) greater than two percent should be described.	DY 10 – Q4	AD_6-11	Metrics related to mid-year loss of demonstration eligibility are currently in development. During this quarter, the state discussed the data sources and staff resources needed to collect this information. The state intends to report the required metrics in future quarterly reports.
8.1.3 Discuss any data trends related to enrollment duration at time of disenrollment. Describe and explain changes (+ or -) greater than two percent.	DY 10 – Q4	AD_12-14	The state has reviewed the recommended metrics provided by CMS. The state plans to satisfy and refine CMS required metrics prior to completing recommended metrics. The state will review its ability to provide CMS recommended metrics for future quarterly reports.

Prompts	Demonstration year (DY) and quarter first reported	Metric(s) (if any)	Summary
8.1.4 Discuss any data trends related to renewals. Describe and explain changes (+ or -) greater than two percent.	DY 10 – Q4	AD_15-22	Metrics related to demonstration renewals are currently in development. The state was able to collect metric AD 15 this quarter reporting beneficiaries due for renewal. During this quarter, the state discussed the data sources and staff resources needed to collect this information. The state intends to report the required metrics in future quarterly reports.
8.1.5 Discuss any data trends related to cost sharing limits. Describe and explain changes (+ or -) greater than two percent.	DY 10 – Q4	AD_23	The state generated these metrics on a retrospective basis as opposed to point-in-time due to the timing of the metric's release. As a result, the data lag makes it difficult to determine data trends. The state is working toward providing this metric on a point-in-time basis as defined by CMS for future quarterly reports.
8.1.6 Discuss any data trends related to appeals and grievances. Describe and explain changes (+ or -) greater than two percent.	DY 10 – Q4	AD_24-28	The state has reviewed the recommended metrics provided by CMS. The state plans to satisfy and refine CMS required metrics prior to completing recommended metrics. The state will review its ability to provide CMS recommended metrics for future quarterly reports.
8.1.7 Discuss any data trends related to access to care. Describe and explain changes (+ or -) greater than two percent.	DY 10 – Q4	AD_29-37	The state reported required access to care metrics similar to those reported last quarter and will continue to monitor this metric for changes. The state has reviewed the recommended metrics provided by CMS. The state plans to satisfy and refine CMS required metrics prior to completing recommended metrics. The state will review its ability to provide CMS recommended metrics for future quarterly reports.
8.1.8 Discuss any data trends related to quality of care and health outcomes. Describe and explain changes (+ or -) greater than two percent.	DY 10 – Q4	AD_38-44	Metrics related to quality of care are currently in development. The state will continue providing existing quality reports as attachments while metrics are in development. During this quarter, the state engaged in discussions on data sources and staff resources needed to collect this information. Additional discussions on meeting this reporting requirement are expected to continue. The state intends to report the required metrics in future quarterly reports.

Prompts	Demonstration year (DY) and quarter first reported	Metric(s) (if any)	Summary
8.1.9 Discuss any data trends related to administrative costs. Describe and explain changes (+ or -) greater than two percent.	DY 10 – Q4	AD_45	Total computable demonstration administrative costs for this quarter amounted to $1,616,939 as reported on the CMS 64.10 WAIV form.
☐ The state has no metrics trends to report for this reporting topic.			
AD.Mod_8.2 Implementation update			
8.2.1 Highlight significant demonstration operations or policy considerations that could positively or negatively impact beneficiary enrollment, compliance with requirements, access to services, timely provision of services, budget neutrality, or any other provision that has potential for beneficiary impacts. Also note any activity that may accelerate or create delays or impediments in achieving the demonstration's approved goals or objectives, if not already reported elsewhere in this document. See report template instructions for more detail.	DY 10 – Q4		This quarter, the state continued to prepare for the implementation of upcoming Community Engagement and Healthy Behavior demonstration requirements. Michigan also engaged in communication planning activities including letters to beneficiaries, drafting program specific policies, updating the website and preparing for public presentations. Additionally, MDHHS issued a policy bulletin to all providers regarding policy and operational updates to the HMP program. This bulletin details qualifying activities, exemptions, penalties, and healthy behavior and cost sharing requirements. This quarter, a lawsuit was filed challenging Healthy Michigan work requirements. MDHHS continued with implementation activities this quarter pursuant to state law.
☐ The state has no implementation updates to report for this reporting topic.			

5. Narrative information on other reporting topics

Prompts	Demonstration year (DY) and quarter first reported	Metric(s) (if any)	Summary
1. Financial/budget neutrality			
1.1 Current status and analysis			
1.1.1 Discuss the current status of financial/budget neutrality and provide an analysis of the budget neutrality to date. If the CE component is part of a comprehensive demonstration, the state should provide an analysis of the CE-related budget neutrality and an analysis of budget neutrality as a whole.	DY 10 – Q4		
☒ The state has no metrics trends to report for this reporting topic.			
1.2 Implementation update			
1.2.1 Describe any anticipated program changes that may impact financial/budget neutrality.	DY 10 – Q4		The state does not expect program changes with financial or budget neutrality impact.
☒ The state has no implementation updates to report for this reporting topic.			

Prompts	Demonstration year (DY) and quarter first reported	Metric(s) (if any)	Summary
2. Demonstration evaluation update			
2.1 Narrative information			
2.1.1 Provide updates on CE evaluation work and timeline. The appropriate content will depend on when this report is due to CMS and the timing for the demonstration. See report template instructions for more details.	DY 10 – Q4		The state's independent evaluator, University of Michigan's Institute for Healthcare Policy & Innovation (IHPI), worked this quarter with the state to finalize the new demonstration evaluation design.
2.1.2 Provide status updates on deliverables related to the demonstration evaluation and indicate whether the expected timelines are being met and/or if there are any real or anticipated barriers in achieving the goals and timeframes agreed to in the STCs.	DY 10 – Q4		Objective I: Assess beneficiary views on the impact of the Healthy Michigan Plan through the 2018 Healthy Michigan Voices (HMV) surveys. IHPI completed analyses of 2018 HMV survey data and longitudinal analyses of 2016, 2017, and 2018 HMV survey data. The evaluation team's activity plan included developing 2018 HMV survey reports, submission to MDHHS for review, and making any final edits to the reports. IHPI completed analyses for the 2018 HMV Second Follow-Up Survey and submitted the report to MDHHS in November 2019; received feedback from MDHHS on the report and submitted a revised version in December 2019. Analyses of the 2018 HMV Follow-Up Survey of Individuals No Longer Enrolled in HMP are nearly complete and a report highlighting the key findings will be submitted to MDHHS in early 2020. The 2018 Cohort II report was approved by MDHHS in October 2019.

			Objective II: Continue planning with IHPI evaluation team and MDHHS for the second phase post-renewal evaluation activities and finalize new evaluation design for the demonstration period ending December 31, 2023. Members of the IHPI evaluation team worked with MDHHS to finalize the design for the second phase of the evaluation for the next five-year period (2019-2023). IHPI participated in monthly calls with MDHHS regarding implementation of the new HMP waiver features of work requirements and changes to eligibility requirements as well as plans for the new evaluation design. IHPI submitted a revised draft of the new evaluation design to MDHHS in November 2019 and it was shared with CMS in December 2019. In preparation for the randomized control trial component of the evaluation, IHPI conducted the randomization of non-exempt enrollees to the "Research Group." IHPI developed drafts of a letter and an FAQ document for enrollees assigned to this group. IHPI also continued planning for the 2020 baseline beneficiary survey and submitted a draft baseline survey instrument to MDHHS for review.
2.1.3 List anticipated evaluation-related deliverables related to this demonstration and their due dates.	DY 10 – Q4		The state will continue working with IHPI and CMS to complete a comprehensive demonstration evaluation design.
☐ The state has no CE demonstration evaluation update to report for this reporting topic.			

Prompts	Demonstration year (DY) and quarter first reported	Metric(s) (if any)	Summary
3. Other demonstration reporting			
3.1 General reporting requirements			
3.1.1 Does the state foresee the need to make future changes to the STCs, implementation plan, or monitoring protocol, based on expected or upcoming implementation changes?	DY 10 – Q4		The state expects future changes may be needed to demonstration STCs based on technical corrections and state legislation.
3.1.2 Compared to the details outlined in the STCs and the monitoring protocol, has the state formally requested any changes or does the state expect to formally request any changes to: a) The schedule for completing and submitting monitoring reports? b) The content or completeness of submitted reports? Future reports?	DY 10 – Q4		The state expects to request a change to the monitoring report schedule. Michigan has historically experienced issues with a 60-day timeline to complete quarterly monitoring reports due to data lag. The state believes it can meet reporting requirements within 90 days of a quarter's end.

Prompts	Demonstration year (DY) and quarter first reported	Metric(s) (if any)	Summary
3.1.3 Has the state identified any real or anticipated issues submitting timely post approval demonstration deliverables, including a plan for remediation?	DY 10 – Q4		Yes, as described in section 3.1.2 above the state experiences challenges in submitting complete quarterly reports 60 days after the quarter ends. Michigan believes that it can complete quarterly reports within 90 days of a quarter's end.
☐ The state has no updates on general reporting requirements to report for this reporting topic.			
3.2 Post-award public forum			
3.2.1 If applicable within the timing of the demonstration, provide a summary of the annual post-award public forum held indicating any resulting action items or issues. A summary of the post-award public forum should be included here for the period during which the forum was held and in the annual report.	DY 10 – Q4		Yes, the state's Medical Care Advisory Council met on November 14, 2019. The meeting minutes have been included as an attachment to this report.
☐ There was not a post-award public forum held during this reporting period and this is not an annual report, so the state has no post award public forum update to report for this reporting topic.			

Prompts	Demonstration year (DY) and quarter first reported	Metric(s) (if any)	Summary
4. Notable state achievements and/or innovations			
4.1 Narrative information			
4.1.1 Provide any relevant summary of achievements and/or innovations in demonstration enrollment, benefits, operations, and policies (1) pursuant to the CE hypotheses (or if broader demonstration, then CE related) or (2) that served to provide better care for individuals, better health for populations, and/or reduce per capita cost. Achievements should focus on significant impacts to beneficiary outcomes. Whenever possible, the summary should describe the achievement or innovation in quantifiable terms, e.g., number of impacted beneficiaries.	DY 10 – Q4		The department is learning from experiences of other states and is dedicated to best practices preventing unintentional loss of coverage among program participants. This quarter, MDHHS made numerous efforts to provide education on the HMP changes including 14 regional forums to date, in addition to several webinars for providers and other stakeholder groups. Additionally, the MDHHS Special Processing Office accomplished the manual processing of almost 12,000 cumulative exemption forms by the end of the quarter.
☐ The state has no notable achievements or innovations to report for this reporting topic.			

Medicaid Section 1115 Eligibility and Coverage Demonstration Monitoring Protocol - Planned metrics (AD)
State Michigan
Demonstration Name Healthy Michigan Plan Section 1115 Demonstration
Submitted on 4/24/2020

State will report (Y/N)	Reporting topic[a]	Reporting priority	#	Metric name	Sta
Y	1.1.1 Enrollment	Required	AD_1	Total enrollment in the demonstration	
Y	1.1.1 Enrollment	Required	AD_2	Beneficiaries in suspension status for noncompliance	
Y	1.1.1 Enrollment	Required	AD_3	Beneficiaries in a non-eligibility period who are prevented from re-enrolling for a defined period of time	
Y	1.1.1 Enrollment	Required	AD_4	New enrollees	
Y	1.1.1 Enrollment	Required for states with a defined re-enrollment or re-instatement pathway	AD_5	Re-enrollments or re-instatements using defined pathways after disenrollment or suspension of benefits for noncompliance with demonstration policies	
Y	1.1.1 Enrollment	Required	AD_6	Re-enrollments or re-instatements for beneficiaries not using defined pathways after disenrollment or suspension of benefits for noncompliance	
Y	1.1.2 Mid-year loss of demonstration eligibility	Required	AD_7	Beneficiaries determined ineligible for Medicaid, any reason, other than at renewal	
Y	1.1.2 Mid-year loss of demonstration eligibility	Required	AD_8	Beneficiaries no longer eligible for Medicaid, failure to provide timely change in circumstance information	
Y	1.1.2 Mid-year loss of demonstration eligibility	Required	AD_9	Beneficiaries determined ineligible for Medicaid after state processes a change in circumstance reported by a beneficiary	
Y	1.1.2 Mid-year loss of demonstration eligibility	Required	AD_10	Beneficiaries no longer eligible for the demonstration due to transfer to another Medicaid eligibility group	
N	1.1.2 Mid-year loss of demonstration eligibility	Recommended	AD_11	Beneficiaries no longer eligible for the demonstration due to transfer to CHIP	
N	1.1.3 Enrollment duration at time of disenrollment	Recommended	AD_12	Enrollment duration, 0-3 months	

N	1.1.3 Enrollment duration at time of disenrollment	Recommended	AD_13	Enrollment duration, 4-6 months
N	1.1.3 Enrollment duration at time of disenrollment	Recommended	AD_14	Enrollment duration 6-12 months
Y	1.1.4 Renewal	Required	AD_15	Beneficiaries due for renewal
Y	1.1.4 Renewal	Required	AD_16	Beneficiaries determined ineligible for the demonstration at renewal, disenrolled from Medicaid
Y	1.1.4 Renewal	Required	AD_17	Beneficiaries determined ineligible for the demonstration at renewal, transfer to another Medicaid eligibility category
Y	1.1.4 Renewal	Required	AD_18	Beneficiaries determined ineligible for the demonstration at renewal, transferred to CHIP
Y	1.1.4 Renewal	Required	AD_19	Beneficiaries who did not complete renewal, disenrolled from Medicaid
Y	1.1.4 Renewal	Required	AD_20	Beneficiaries who had pending/uncompleted renewals and were still enrolled
Y	1.1.4 Renewal	Required	AD_21	Beneficiaries who retained eligibility for the demonstration after completing renewal forms
N	1.1.4 Renewal	Recommended	AD_22	Beneficiaries who renewed ex parte
Y	1.1.5 Cost sharing limit	Required	AD_23	Beneficiaries who reached 5% limit
N	1.1.6 Appeals and grievances	Recommended	AD_24	Appeals, eligibility
N	1.1.6 Appeals and grievances	Recommended	AD_25	Appeals, denial of benefits
N	1.1.6 Appeals and grievances	Recommended	AD_26	Grievances, care quality
N	1.1.6 Appeals and grievances	Recommended	AD_27	Grievances, provider or managed care entities
N	1.1.6 Appeals and grievances	Recommended	AD_28	Grievances, other
Y	1.1.7 Access to care	Required	AD_29	Primary care provider availability
Y	1.1.7 Access to care	Required	AD_30	Primary care provider active participation
Y	1.1.7 Access to care	Required	AD_31	Specialist provider availability

	1.1.7 Access to care	Required	AD_32	Specialist provider active participation	
Y					
	1.1.7 Access to care	Recommended	AD_33	Preventive care and office visit utilization	
N					
	1.1.7 Access to care	Recommended	AD_34	Prescription drug use	
N					
	1.1.7 Access to care	Recommended	AD_35	Emergency department utilization, total	
N					
	1.1.7 Access to care	Recommended. Required for states with copayments for non-emergency use.	AD_36	Emergency department utilization, non-emergency	
Y					
	1.1.7 Access to care	Recommended	AD_37	Inpatient admissions	
N					
	1.1.8 Quality of care and health outcomes	Required (AD_38A or AD_38B-1 - 3. States do not have to report both.)	AD_38A	Medical Assistance with Smoking and Tobacco Use Cessation (MSC-AD) [NCQA; NQF #0027; Medicaid Adult Core Set; Adjusted HEDIS measure]	
	1.1.8 Quality of care and health outcomes	Required (AD_38A or AD_38B. States do not have to report both.)	AD_38B	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention (rate 1) [PCPI Foundation; NQF #0028]	
	1.1.8 Quality of care and health outcomes	Required	AD_39-1	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA-AD) [NCQA; NQF # 2605; Medicaid adult Core Set; Adjusted HEDIS measure]	
Y					

	1.1.8 Quality of care and health outcomes	Required	AD_39-2	Follow-Up After Emergency Department Visit for Mental Illness (FUM-AD) [NCQA; NQF # 2605; Medicaid adult Core Set; Adjusted HEDIS measure]	
Y					
	1.1.8 Quality of care and health outcomes	Required	AD_40	Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET-AD) [NCQA; NQF #0004; Medicaid Adult Core Set; Adjusted HEDIS measure]	
Y					
Y	1.1.8 Quality of care and health outcomes	Required	AD_41	PQI 01: Diabetes Short-Term Complications Admission Rate (PQI01-AD) [AHRQ; NQF #0272; Medicaid Adult Core Set]	
Y	1.1.8 Quality of care and health outcomes	Required	AD_42	PQI 05: Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate (PQI05-AD) [AHRQ; NQF #0275; Medicaid Adult Core Set]	
Y	1.1.8 Quality of care and health outcomes	Required	AD_43	PQI 08: Heart Failure Admission Rate (PQI08-AD) [AHRQ; NQF #0277; Medicaid Adult Core Set]	
Y	1.1.8 Quality of care and health outcomes	Required	AD_44	PQI 15: Asthma in Younger Adults Admission Rate (PQI15-AD) [AHRQ; NQF #0283; Medicaid Adult Core Set]	
	1.1.9 Administrative cost	Recommended	AD_45	Administrative cost of demonstration operation	
N					
Add rows for any additional state-identified metrics					

[a] The reporting topics correspond to the prompts for reporting topic AD.Mod_1 in the monitoring report template.

End of workbook

ndard information on CMS-provided metrics

Metric description	Data source	Calculation lag	Measurement period
The unduplicated number of beneficiaries enrolled in the demonstration at any time during the measurement period. This indicator is a count of total program enrollment. It includes those newly enrolled during the measurement period and those whose enrollment continues from a prior period. This indicator is not a point-in-time count. It captures beneficiaries who were enrolled for at least one day during the measurement period.	Administrative records	30 days	Month
The number of demonstration beneficiaries in suspension status for noncompliance with demonstration policies as of the last day of the measurement period	Administrative records	30 days	Month
The number of prior demonstration beneficiaries who are in a non-eligibility period, meaning they are prevented from re-enrolling for some defined period of time, because they were disenrolled for noncompliance with demonstration policies. The count should include those prevented from re-enrolling until their redetermination date.	Administrative records	30 days	Month
Number of beneficiaries in the demonstration who began a new enrollment spell during the measurement period, have not had Medicaid coverage within the prior 3 months and are not using a state-specific pathway for re-enrollment after being disenrolled for noncompliance	Administrative records	30 days	Month
Number of beneficiaries in the demonstration who began a new enrollment spell (or had benefits re-instated) in the current measurement period by using a state-defined pathway for re-enrollment (or re-instatement of benefits), i.e., meeting certain requirements, after being disenrolled (or having benefits suspended) for noncompliance with premium requirements, community engagement requirements, or other demonstration-specific requirements.	Administrative records	30 days	Month
Number of beneficiaries in the demonstration who began a new enrollment spell (or had benefits re-instated) in the current measurement period, have had Medicaid coverage within the prior 3 months and are not using a state-specific pathway for re-enrollment after being disenrolled for noncompliance (or re-instatement of benefits after being suspended for noncompliance)	Administrative records	30 days	Month
Total number of beneficiaries in the demonstration determined ineligible for Medicaid and disenrolled during the measurement period (separate reasons reported in other indicators), other than at renewal	Administrative records	30 days	Month
Number of beneficiaries enrolled in the demonstration and who lost eligibility for Medicaid during the measurement period due to failure to provide timely change in circumstance information	Administrative records	30 days	Month
Number of beneficiaries who were enrolled in the demonstration and lost eligibility for Medicaid during the measurement period because they are determined ineligible after the state processes a change in circumstance	Administrative records	30 days	Month
Number of beneficiaries who were enrolled in the demonstration and transferred from the demonstration to a Medicaid eligibility group not included in the demonstration during the measurement period	Administrative records	30 days	Month
Number of beneficiaries who were enrolled in the demonstration and transferred from the demonstration to CHIP during the measurement period	Administrative records	30 days	Month
Number of demonstration beneficiaries who lost eligibility for Medicaid during the measurement period and whose enrollment spell had lasted 3 or fewer months at the time of disenrollment	Administrative records	30 days	Month

Number of demonstration beneficiaries who lose eligibility for Medicaid during the measurement period whose enrollment spell had lasted between 4 and 6 months at the time of disenrollment	Administrative records	30 days	Month
Number of demonstration beneficiaries who lost eligibility for Medicaid during the measurement period whose enrollment spell had lasted 6 or more months (up to 12 months) at the time of disenrollment	Administrative records	30 days	Month
Total number of beneficiaries enrolled in the demonstration who were due for renewal during the measurement period	Administrative records	30 days	Month
Number of beneficiaries enrolled in the demonstration and due for renewal during the measurement period who complete the renewal process and are determined ineligible for Medicaid	Administrative records	30 days	Month
Number of beneficiaries enrolled in the demonstration and due for renewal during the measurement period who complete the renewal process and move from the demonstration to a Medicaid eligibility group not included in the demonstration	Administrative records	30 days	Month
Number of beneficiaries enrolled in the demonstration and due for renewal during the measurement period who complete the renewal process, but move from the demonstration to CHIP	Administrative records	30 days	Month
Number of beneficiaries enrolled in the demonstration and due for renewal during the measurement period who are disenrolled from Medicaid for failure to complete the renewal process	Administrative records	30 days	Month
Number of beneficiaries enrolled in the demonstration and due for renewal during the measurement period for whom the state had not completed renewal determination by the end of the measurement period and were still enrolled	Administrative records	30 days	Month
Number of beneficiaries enrolled in the demonstration and due for renewal during the measurement period who remained enrolled in the demonstration after responding to renewal notices	Administrative records	30 days	Month
Number of beneficiaries enrolled in the demonstration and due for renewal during the measurement period who remained enrolled as determined by third-party data sources or available information, rather than beneficiary response to renewal notices	Administrative records	30 days	Month
Number of beneficiaries enrolled in the demonstration who reached the 5% of income limit on cost sharing and premiums during the month	Administrative records	30 days	Month
Number of appeals filed by beneficiaries enrolled in the demonstration during the measurement period regarding Medicaid eligibility	Administrative records	None	Quarter
Number of appeals filed by beneficiaries enrolled in the demonstration during the measurement period regarding denial of benefits	Administrative records	None	Quarter
Number of grievances filed by beneficiaries enrolled in the demonstration during the measurement period regarding the quality of care or services provided	Administrative records	None	Quarter
Number of grievances filed by beneficiaries enrolled in the demonstration during the measurement period regarding a provider or managed care entity. Managed care entities include Managed Care Organizations (MCO), Prepaid Inpatient Health Plans (PIHP), and Prepaid Ambulatory Health Plans (PAHP).	Administrative records	None	Quarter
Number of grievances filed by beneficiaries enrolled in the demonstration during the measurement period regarding other matters that are not subject to appeal	Administrative records	None	Quarter
Number of primary care providers enrolled to deliver Medicaid services at the end of the measurement period	Provider enrollment databases	90 days	Quarter
Number of primary care providers enrolled to deliver Medicaid services with service claims for 3 or more demonstration beneficiaries during the measurement period	Provider enrollment databases and claims and encounters	90 days	Quarter
Number of specialists enrolled to deliver Medicaid services at the end of the measurement period	Provider enrollment databases	90 days	Quarter

Number of specialists enrolled to deliver Medicaid services with service claims for 3 or more demonstration beneficiaries during the measurement period	Provider enrollment databases and claims and encounters	90 days	Quarter
Total utilization of preventive care and office visits per 1,000 demonstration beneficiary months during the measurement period	Claims and encounters and other administrative records	90 days	Quarter
Total utilization of 30-day prescription fills per 1,000 demonstration beneficiary months in the measurement period	Claims and encounters; other administrative records	90 days	Quarter
Total number of emergency department (ED) visits per 1,000 demonstration beneficiary months during the measurement period	Claims and encounters; other administrative records	90 days	Quarter
Total number of ED visits for non-emergency conditions per 1,000 demonstration beneficiary months during the measurement period. If the state differentiates emergent/non-emergent visit copayments, then non-emergency visits should be identified for monitoring purposes using the same criteria used to assess the differential copayment. If the state does not differentiate emergent/non-emergent copayments, then non-emergency visits should be defined as all visits not categorized as emergent using the method below.	Claims and encounters; other administrative records	90 days	Quarter
Total number of inpatient admissions per 1,000 demonstration beneficiary months during the measurement period	Claims and encounters; other administrative records	90 days	Quarter
This metric consists of the following components; each assesses different facets of providing medical assistance with smoking and tobacco use cessation: • Advising smokers and tobacco users to quit • Discussing cessation medications • Discussing cessation strategies	Consumer Assessment of Healthcare Providers and Systems (CAHPS) Health Plan survey, Adult Version	90 days	Calendar year
This metric consists of the following components: 1. Percentage of beneficiaries aged 18 years and older who were screened for tobacco use one or more times within 24 months 2. Percentage of beneficiaries aged 18 years and older who were screened for tobacco use and identified as a tobacco user who received tobacco cessation intervention 3. Percentage of beneficiaries aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received cessation intervention if identified as a tobacco user	Claims and encounters	90 days	Calendar year
Percentage of ED visits for beneficiaries age 18 and older who have a principal diagnosis of alcohol or other drug (AOD) abuse or dependence, and who had a follow-up visit with a corresponding principal diagnosis for AOD. Two rates are reported: 1. Percentage of ED visits for AOD abuse or dependence for which the beneficiary received follow-up within 30 days of the ED visit (31 total days). 2. Percentage of ED visits for AOD abuse or dependence for which the beneficiary received follow-up within 7 days of the ED visit (8 total days).	Claims and encounters	90 days	Calendar year

Percentage of ED visits for beneficiaries age 18 and older who have a principal diagnosis of mental illness or intentional self-harm, and who had a follow-up visit with a corresponding principal diagnosis for mental illness. Two rates are reported: 1. Percentage of ED visits for mental illness or intentional self-harm for which the beneficiary received follow-up within 30 days of the ED visit (31 total days). 2. Percentage of ED visits for mental illness or intentional self-harm for which the beneficiary received follow-up within 7 days of the ED visit (8 total days).	Claims and encounters	90 days	Calendar year
Percentage of beneficiaries age 18 and older with a new episode of AOD abuse or dependence who received the following: 1. Initiation of AOD Treatment. Percentage of beneficiaries who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization, telehealth, or medication assisted treatment (MAT) within 14 days of the diagnosis 2. Engagement of AOD Treatment. Percentage of beneficiaries who initiate treatment and who had two or more additional AOD services or MAT within 34 days of the initiation visit The following diagnosis cohorts are reported for each rate: (1) Alcohol abuse or dependence, (2) Opioid abuse or dependence, (3) Other drug abuse or dependence, and (4) Total AOD abuse or dependence. A total of 8 separate rates are reported for this measure.	Claims and encounters or EHR	90 days	Calendar year
Number of inpatient hospital admissions for diabetes short-term complications (ketoacidosis, hyperosmolarity, or coma) per 100,000 beneficiary months for beneficiaries age 18 and older	Claims and encounters	90 days	Calendar year
Number of inpatient hospital admissions for chronic obstructive pulmonary disease (COPD) or asthma per 100,000 beneficiary months for beneficiaries age 40 and older	Claims and encounters	90 days	Calendar year
Number of inpatient hospital admissions for heart failure per 100,000 beneficiary months for beneficiaries age 18 and older	Claims and encounters	90 days	Calendar year
Number of inpatient hospital admissions for asthma per 100,000 beneficiary months for beneficiaries aged 18 to 39	Claims and encounters	90 days	Calendar year
Cost of contracts or contract amendments and staff time equivalents required to administer demonstration policies, including premium collection, health behavior incentives, premium assistance, community engagement requirements and/or retroactive eligibility waivers	Administrative records	None	Demonstration year

	Baseline, annual goals, and demonstration target			Alig
Reporting frequency	Baseline reporting period (MM/DD/YYYY--MM/DD/YYYY)	Annual goal	Overall demonstration target	Attest that planned reporting matches the CMS-provided specification (Y/N)
Quarterly	01/01/2020-03/31/2020	TBD	TBD	Y
Quarterly	N/A	N/A	N/A	N/A
Quarterly	01/01/2020-03/31/2020	TBD	TBD	Y
Quarterly	01/01/2020-03/31/2020	TBD	TBD	Y
Quarterly	04/01/2020-06/30/2020	TBD	TBD	Y
Quarterly	04/01/2020-06/30/2020	TBD	TBD	Y
Quarterly	01/01/2020-03/31/2020	TBD	TBD	Y
Quarterly	01/01/2020-03/31/2020	TBD	TBD	Y
Quarterly	01/01/2020-03/31/2020	TBD	TBD	Y
Quarterly	01/01/2020-03/31/2020	TBD	TBD	Y
Quarterly	N/A	N/A	N/A	N
Quarterly	N/A	N/A	N/A	N

Quarterly	N/A	N/A	N/A	N
Quarterly	N/A	N/A	N/A	N
Quarterly	01/01/2020-03/31/2020	TBD	TBD	Y
Quarterly	01/01/2020-03/31/2020	TBD	TBD	Y
Quarterly	01/01/2020-03/31/2020	TBD	TBD	Y
Quarterly	01/01/2020-03/31/2020	TBD	TBD	Y
Quarterly	01/01/2020-03/31/2020	TBD	TBD	Y
Quarterly	01/01/2020-03/31/2020	TBD	TBD	Y
Quarterly	01/01/2020-03/31/2020	TBD	TBD	Y
Quarterly	N/A	N/A	N/A	N
Quarterly	01/01/2020-03/31/2020	TBD	TBD	Y
Quarterly	N/A	N/A	N/A	N
Quarterly	N/A	N/A	N/A	N
Quarterly	N/A	N/A	N/A	N
Quarterly	N/A	N/A	N/A	N
Quarterly	N/A	N/A	N/A	N
Quarterly	01/01/2020-03/31/2020	TBD	TBD	Y
Quarterly	01/01/2020-03/31/2020	TBD	TBD	Y
Quarterly	01/01/2020-03/31/2020	TBD	TBD	Y

Quarterly	01/01/2020-03/31/2020	TBD	TBD	Y
Quarterly	N/A	N/A	N/A	N
Quarterly	N/A	N/A	N/A	N
Quarterly	N/A	N/A	N/A	N
Quarterly	01/01/2020-03/31/2020	TBD	TBD	N
Quarterly	N/A	N/A	N/A	N
Annually	TBD	TBD	TBD	TBD
Annually	TBD	TBD	TBD	TBD
Annually	01/01/2020-12/31/2020	TBD	TBD	TBD

Annually				
	01/01/2020-12/31/2020	TBD	TBD	TBD
Annually				
	01/01/2020-12/31/2020	TBD	TBD	TBD
Annually				
	01/01/2020-12/31/2020	TBD	TBD	TBD
Annually				
	01/01/2020-12/31/2020	TBD	TBD	TBD
Annually				
	01/01/2020-12/31/2020	TBD	TBD	TBD
Annually				
	01/01/2020-12/31/2020	TBD	TBD	TBD
Annually				
	N/A	N/A	N/A	N

gnment with CMS-provided technical specifications			Initi
Explanation of any deviations from the CMS-provided specifications. Could include different data sources or state-specific definitions, policies, codes, target populations, etc.	**Dates covered by first measurement period for metric (MM/DD/YYYY - MM/DD/YYYY)**	**Report name of first report in which the metric will be submitted (Format: DY1 Q3 quarterly report)**	**Submission date of first report in which the metric will be reported (MM/DD/YYYY)**
N/A	04/01/2019 - 06/30/2019	DY10 Q2	9/30/2019
N/A	N/A	N/A	N/A
N/A	01/01/2020-03/31/2020	DY11 Q1	5/31/2020
N/A	04/01/2019 - 06/30/2019	DY10 Q2	9/30/2019
N/A	04/01/2020-06/30/2020	DY11 Q1	8/31/2020
N/A	04/01/2020-06/30/2020	DY11 Q1	8/31/2020
N/A	01/01/2020-03/31/2020	DY11 Q1	5/31/2020
N/A	01/01/2020-03/31/2020	DY11 Q1	5/31/2020
N/A	01/01/2020-03/31/2020	DY11 Q1	5/31/2020
N/A	01/01/2020-03/31/2020	DY11 Q1	5/31/2020
N/A	N/A	N/A	N/A
N/A	N/A	N/A	N/A

N/A	N/A	N/A	N/A	
N/A	N/A	N/A	N/A	
N/A	01/01/2020-03/31/2020	DY11 Q1		5/31/2020
N/A	01/01/2020-03/31/2020	DY11 Q1		5/31/2020
N/A	01/01/2020-03/31/2020	DY11 Q1		5/31/2020
N/A	01/01/2020-03/31/2020	DY11 Q1		5/31/2020
N/A	01/01/2020-03/31/2020	DY11 Q1		5/31/2020
N/A	01/01/2020-03/31/2020	DY11 Q1		5/31/2020
N/A	01/01/2020-03/31/2020	DY11 Q1		5/31/2020
N/A	N/A	N/A	N/A	
N/A	01/01/2020-03/31/2020	DY11 Q1		5/31/2020
N/A	N/A	N/A	N/A	
N/A	N/A	N/A	N/A	
N/A	N/A	N/A	N/A	
N/A	N/A	N/A	N/A	
N/A	N/A	N/A	N/A	
N/A	01/01/2020-03/31/2020	DY11 Q1		5/31/2020
N/A	01/01/2020-03/31/2020	DY11 Q1		5/31/2020
N/A	01/01/2020-03/31/2020	DY11 Q1		5/31/2020

N/A	01/01/2020-03/31/2020	DY11 Q1		5/31/2020
N/A	N/A	N/A	N/A	
N/A	N/A	N/A	N/A	
N/A	N/A	N/A	N/A	
TBD	01/01/2020-03/31/2020	DY11 Q1		5/31/2020
N/A	N/A	N/A	N/A	
TBD	TBD	TBD	TBD	
TBD	TBD	TBD	TBD	
TBD	01/01/2020-12/31/2020	DY11 Annual Report		3/31/2021

TBD	01/01/2020-12/31/2020	DY11 Annual Report		3/31/2021
TBD	01/01/2020-12/31/2020	DY11 Annual Report		3/31/2021
TBD	01/01/2020-12/31/2020	DY11 Annual Report		3/31/2021
TBD	01/01/2020-12/31/2020	DY11 Annual Report		3/31/2021
TBD	01/01/2020-12/31/2020	DY11 Annual Report		3/31/2021
TBD	01/01/2020-12/31/2020	DY11 Annual Report		3/31/2021
N/A	N/A	N/A	N/A	

al reporting date

State plans to phase in reporting (Y/N)	Explanation of any plans to phase in reporting over time
N	N/A
N	The state does not have a suspension policy.
N	N/A
N	N/A
N	N/A
N	N/A
N	N/A
N	N/A
N	N/A
N	N/A
N	Michigan will prioritize required metrics and will evaluate the feasibility of incorporating recommended metrics when demonstration waiver reporting becomes established.
N	Michigan will prioritize required metrics and will evaluate the feasibility of incorporating recommended metrics when demonstration waiver reporting becomes established.

N	Michigan will prioritize required metrics and will evaluate the feasibility of incorporating recommended metrics when demonstration waiver reporting becomes established.
N	Michigan will prioritize required metrics and will evaluate the feasibility of incorporating recommended metrics when demonstration waiver reporting becomes established.
N	N/A
N	N/A
N	N/A
N	N/A
N	N/A
N	N/A
N	N/A
N	Michigan will prioritize required metrics and will evaluate the feasibility of incorporating recommended metrics when demonstration waiver reporting becomes established.
N	N/A
N	Michigan will prioritize required metrics and will evaluate the feasibility of incorporating recommended metrics when demonstration waiver reporting becomes established.
N	Michigan will prioritize required metrics and will evaluate the feasibility of incorporating recommended metrics when demonstration waiver reporting
N	Michigan will prioritize required metrics and will evaluate the feasibility of incorporating recommended metrics when demonstration waiver reporting becomes established.
N	Michigan will prioritize required metrics and will evaluate the feasibility of incorporating recommended metrics when demonstration waiver reporting becomes established.
N	Michigan will prioritize required metrics and will evaluate the feasibility of incorporating recommended metrics when demonstration waiver reporting
N	N/A
N	N/A
N	N/A

N	N/A
N	Michigan will prioritize required metrics and will evaluate the feasibility of incorporating recommended metrics when demonstration waiver reporting becomes established.
N	Michigan will prioritize required metrics and will evaluate the feasibility of incorporating recommended metrics when demonstration waiver reporting becomes established.
N	Michigan will prioritize required metrics and will evaluate the feasibility of incorporating recommended metrics when demonstration waiver reporting becomes established.
N	N/A
N	Michigan will prioritize required metrics and will evaluate the feasibility of incorporating recommended metrics when demonstration waiver reporting becomes established.
TBD	TBD
TBD	TBD
N	N/A

N	N/A
N	N/A
N	N/A
N	N/A
N	N/A
N	N/A
N	Michigan will prioritize required metrics and will evaluate the feasibility of incorporating recommended metrics when demonstration waiver reporting becomes established.

Medicaid Section 1115 Eligibility and Coverage Demonstration Monitoring Protoco

State	Michigan
Demonstration Name	Healthy Michigan Plan Section 1115 Demonstration
Submitted on	4/24/2020

State will report (Y/N)	Reporting Topic[a]	Reporting priority	#
Y	CE.Mod_1: Specify community engagement policies	Required	CE_1
Y	CE.Mod_1: Specify community engagement policies	Required	CE_2
Y	CE.Mod_1: Specify community engagement policies	Required	CE_3
N	CE.Mod_1: Specify community engagement policies	Required	CE_4
Y	CE.Mod_1: Specify community engagement policies	Required	CE_5
Y	CE.Mod_1: Specify community engagement policies	Required	CE_6
Y	CE.Mod_1: Specify community engagement policies	Required	CE_7

Y	CE.Mod_1: Specify community engagement policies	Required	CE_8
Y	CE.Mod_1: Specify community engagement policies	Required	CE_9
Y	CE.Mod_1: Specify community engagement policies	Required	CE_10
Y	CE.Mod_1: Specify community engagement policies	Required	CE_11
Y	CE.Mod_1: Specify community engagement policies	Required	CE_12
Y	CE.Mod_1: Specify community engagement policies	Required	CE_13
Y	CE.Mod_1: Specify community engagement policies	Required	CE_14
Y	CE.Mod_1: Specify community engagement policies	Required	CE_15
Y	CE.Mod_1: Specify community engagement policies	Required	CE_16

Y	CE.Mod_1: Specify community engagement policies	Required	CE_17
Y	CE.Mod_1: Specify community engagement policies	Required	CE_18
Y	CE.Mod_1: Specify community engagement policies	Required	CE_19
Y	CE.Mod_1: Specify community engagement policies	Required	CE_20
Y	CE.Mod_1: Specify community engagement policies	Required	CE_21
Y	CE.Mod_1: Specify community engagement policies	Required	CE_22
Y	CE.Mod_1: Specify community engagement policies	Required	CE_23
Y	CE.Mod_1: Specify community engagement policies	Required	CE_24
N	CE.Mod_2: Establish beneficiary supports and modifications	Required	CE_25
N	CE.Mod_2: Establish beneficiary supports and modifications	Recommended	CE_26
N	CE.Mod_2: Establish beneficiary supports and modifications	Recommended	CE_27
N	CE.Mod_2: Establish beneficiary supports and modifications	Recommended	CE_28

N	CE.Mod_2: Establish beneficiary supports and modifications	Recommended	CE_29
N	CE.Mod_2: Establish beneficiary supports and modifications	Recommended	CE_30
N	CE.Mod_2: Establish beneficiary supports and modifications	Recommended	CE_31
N	CE.Mod_2: Establish beneficiary supports and modifications	Recommended	CE_32
N	CE.Mod_4: Operationalize strategies for noncompliance	Required	CE_33
Y	CE.Mod_4: Operationalize strategies for noncompliance	Required	CE_34
N	CE.Mod_4: Operationalize strategies for noncompliance	Required if state has a suspension policy	CE_35
N	CE.Mod_4: Operationalize strategies for noncompliance	Recommended	CE_36
N	CE.Mod_4: Operationalize strategies for noncompliance	Recommended	CE_37
N	CE.Mod_4: Operationalize strategies for noncompliance	Recommended	CE_38
N	CE.Mod_4: Operationalize strategies for noncompliance	Recommended	CE_39

N	CE.Mod_4: Operationalize strategies for noncompliance	Recommended	CE_40
Y	CE.Mod_4: Operationalize strategies for noncompliance	Required	CE_41
N	CE.Mod_4: Operationalize strategies for noncompliance	Recommended	CE_42
N	CE.Mod_4: Operationalize strategies for noncompliance	Recommended	CE_43
N	CE.Mod_4: Operationalize strategies for noncompliance	Recommended	CE_44
N	CE.Mod_4: Operationalize strategies for noncompliance	Recommended	CE_45
N	CE.Mod_4: Operationalize strategies for noncompliance	Recommended	CE_46

I - Planned metrics (CE)

Metric name	Stand
Total beneficiaries subject to the community engagement requirement, not exempt	
Total beneficiaries who were exempt from the community engagement requirement in the month	
Beneficiaries with approved good cause circumstances	
Beneficiaries subject to the community engagement requirement and in suspension status due to failure to meet requirement	
Beneficiaries subject to the community engagement requirement and receiving benefits who met the requirement for qualifying activities	
Beneficiaries subject to the community engagement requirement and receiving benefits, but in a grace period or allowable month of noncompliance	
Beneficiaries who successfully completed make-up hours or other activities to retain active benefit status after failing to meet the community engagement requirement in a previous month	

Beneficiaries in a non-eligibility period who were disenrolled for noncompliance with the community engagement requirement and are prevented from re-enrolling for a defined period of time

Beneficiaries who met the community engagement requirement by satisfying requirements of other programs

Beneficiaries who met the community engagement requirement through employment for the majority of their required hours

Beneficiaries who met the community engagement requirement through job training or job search for the majority of their required hours

Beneficiaries who met the community engagement requirement through educational activity for the majority of their required hours

Beneficiaries who met the community engagement requirement who were engaged in other qualifying activity for the majority of their required hours

Beneficiaries who met the community engagement requirement by combining two or more activities

Beneficiaries exempt from Medicaid community engagement requirements because they were exempt from requirements of SNAP and/or TANF

Beneficiaries exempt from Medicaid community engagement requirements on the basis of pregnancy

Beneficiaries exempt from Medicaid community engagement requirements due to former foster youth status

Beneficiaries exempt from Medicaid community engagement requirements due to medical frailty

Beneficiaries exempt from Medicaid community engagement requirements on the basis of caretaker status

Beneficiaries exempt from Medicaid community engagement requirements on the basis of unemployment insurance compensation

Beneficiaries exempt from Medicaid community engagement requirements due to substance abuse treatment status

Beneficiaries exempt from Medicaid community engagement requirements due to student status

Beneficiaries exempt from Medicaid community engagement requirements because they were excused by a medical professional

Beneficiaries exempt from Medicaid community engagement requirements, other

Total beneficiaries receiving supports to participate and placement assistance

Beneficiaries provided with transportation assistance

Beneficiaries provided with childcare assistance

Beneficiaries provided with language supports

Beneficiaries assisted with placement in community engagement activities

Beneficiaries provided with other non-Medicaid assistance

Beneficiaries who requested reasonable modifications to community engagement processes or requirements due to disability

Beneficiaries who were granted reasonable modifications to community engagement processes or requirements due to disability

Beneficiaries newly suspended for failure to complete community engagement requirements

Beneficiaries newly disenrolled for failure to complete community engagement requirements

Total beneficiaries whose benefits were reinstated after being in suspended status for noncompliance

Beneficiaries whose benefits were reinstated because their time-limited suspension period ended

Beneficiaries whose benefits were reinstated because they completed required community engagement activities

Beneficiaries whose benefits were reinstated because they completed “on-ramp” activities other than qualifying community engagement activities

Beneficiaries whose benefits were reinstated because they newly meet community engagement exemption criteria or had a good cause circumstance

Beneficiaries whose benefits were reinstated after successful appeal of suspension for noncompliance

Total beneficiaries re-enrolling after disenrollment for noncompliance

Beneficiaries re-enrolling after completing required community engagement activities

Beneficiaries re-enrolling after completing “on-ramp” activities other than qualifying community engagement activities

Beneficiaries re-enrolling after re-applying, subsequent to being disenrolled for noncompliance with community engagement requirements

Beneficiaries re-enrolling because they newly met community engagement exemption criteria or had a good cause circumstance

Beneficiaries re-enrolling after successful appeal of disenrollment for noncompliance

lard information on CMS-provided metrics

Metric description	Data source
The number of beneficiaries enrolled in the demonstration whose income and eligibility group were subject to the community engagement requirement and who did not have an individual exemption from the requirement or an approved good cause circumstance	Administrative records
The number of beneficiaries enrolled in income and eligibility groups that were subject to the community engagement requirement, but had an individual exemption from the policy. This excludes circumstances that give rise to good cause.	Administrative records
The number of beneficiaries enrolled in the demonstration who met the state criteria for good cause circumstances, such as serious illness, birth or death of a family member, severe weather, family emergencies, or life-changing event	Administrative records
The number of demonstration beneficiaries in suspension status due to failure to meet the community engagement requirement, including those newly suspended for noncompliance during the measurement period	Administrative records
The number of beneficiaries enrolled in the demonstration who were subject to the community engagement requirement and met the requirement by engaging in qualifying activities	Administrative records
The number of beneficiaries enrolled in the demonstration who were subject to the community engagement requirement, but did not meet the requirement. This includes beneficiaries who have not yet begun qualifying activities and those who logged some hours, but failed to meet total required hours.	Administrative records
The number of beneficiaries enrolled in the demonstration who were subject to the community engagement requirement and met additional requirements to retain active benefit status after previously failing to meet the requirement. This captures beneficiaries who successfully satisfy the “opportunity to cure” requirement and therefore are not suspended (if state has this policy).	Administrative records

The number of prior demonstration beneficiaries who were disenrolled from Medicaid for noncompliance with the community engagement requirement and are in a non-eligibility period, meaning they are prevented from re-enrolling for some defined period of time. The count should include those prevented from re-enrolling until their redetermination date.	Administrative records
The number of beneficiaries enrolled in the demonstration who were subject to the community engagement requirement and met the requirement by satisfying requirements in other programs such as SNAP or TANF, regardless of whether they are "deemed" by the state to be in compliance with Medicaid requirements or must take reporting action	Administrative records
The number of beneficiaries enrolled in the demonstration who were subject to and met the community engagement requirement, who were self-employed or employed in subsidized and/or unsubsidized settings. Includes both those "deemed" by the state to be in compliance with Medicaid requirements because they are working more than the number of required hours and those who must report their hours.	Administrative records
The number of beneficiaries enrolled in the demonstration who were subject to and met the community engagement requirement by engaging in on-the-job training, job skills training, vocational education and training, job search activities, job search training, a state-sponsored workforce program, or similar activity	Administrative records
The number of beneficiaries enrolled in the demonstration who were subject to and met the community engagement requirement by engaging in education related to employment, general education, accredited English-as-a-second-language education, accredited homeschooling, or a state-designated class	Administrative records
The number of beneficiaries enrolled in the demonstration who were subject to the community engagement requirement and met the requirement through a state-specified activity not captured by other reporting categories, including community work experience, community service/public service, volunteer work, caregiving for a dependent, participation in substance use disorder treatment, enrollment in Medicaid employer-sponsored insurance premium assistance, or other activity	Administrative records
The number of beneficiaries enrolled in the demonstration who were subject to the community engagement requirement and met the requirement by engaging in a combination of activities defined in metrics CE_10 through CE_13, such as a combination of employment and education	Administrative records
The number of beneficiaries enrolled in the demonstration who were exempt from the community engagement requirement because they were exempt from the SNAP and/or TANF work requirements. This does not include beneficiaries who are meeting SNAP and/or TANF work requirements.	Administrative records
The number of beneficiaries enrolled in the demonstration who were exempt from the community engagement requirement because they are pregnant	Administrative records

The number of beneficiaries enrolled in the demonstration who were exempt from the community engagement requirement because they were formerly part of the foster care system	Administrative records
The number of beneficiaries enrolled in the demonstration who were exempt from the community engagement requirement because they are identified as medically frail	Administrative records
The number of beneficiaries enrolled in the demonstration who were exempt from the community engagement requirement because they are primary caregiver of a dependent child or incapacitated/disabled household member	Administrative records
The number of beneficiaries enrolled in the demonstration who were exempt from the community engagement requirement because they are receiving unemployment insurance compensation	Administrative records
The number of beneficiaries enrolled in the demonstration who were exempt the community engagement requirement because they are participating in a drug or alcohol treatment and rehabilitation program	Administrative records
The number of beneficiaries enrolled in the demonstration who were exempt from the community engagement requirement because they are a student enrolled a number of hours/week, defined by state	Administrative records
The number of beneficiaries enrolled in the demonstration who were exempt from the community engagement requirement because a medical professional determined the beneficiary had an acute medical condition separate from disability or frailty	Administrative records
The number of beneficiaries enrolled in the demonstration who were exempt from the community engagement requirement because they are exempt for another reason not captured by other reporting categories, including age above the upper limit defined by the state and enrollment in employer-sponsored insurance through premium assistance	Administrative records
The number of beneficiaries enrolled in the demonstration who were given supports to enable them to participate, including supports due to disability and assistance from other agencies and entities complementing Medicaid efforts	Administrative records
The number of beneficiaries enrolled in the demonstration who were given transportation assistance to enable participation in community engagement activities	Administrative records
The number of beneficiaries enrolled in the demonstration who were given childcare assistance to enable participation in community engagement activities	Administrative records
The number of beneficiaries enrolled in the demonstration who were given language supports to enable participation in community engagement activities	Administrative records

The number of beneficiaries enrolled in the demonstration who were given placement assistance, including through state department of labor support centers	Administrative records
The number of beneficiaries enrolled in the demonstration who were given other assistance, including assistance from other agencies and entities complementing Medicaid efforts, to participate in community engagement activities	Administrative records
The number of beneficiaries enrolled in the demonstration who requested a reasonable modification of community engagement processes (such as assistance with exemption requests or appeals) or requirements (such as the number of hours) due to disability	Administrative records
The number of beneficiaries enrolled in the demonstration who were granted a modification of community engagement processes (such as assistance with exemption requests or appeals) or requirements (such as the number of hours) due to disability	Administrative records
The number of demonstration beneficiaries newly suspended for noncompliance during the measurement period (if state has a suspension policy)	Administrative records
The number of demonstration beneficiaries newly disenrolled for noncompliance with community engagement requirements during the measurement period	Administrative records
The number of demonstration beneficiaries whose benefits were reinstated during the measurement period after suspension in a prior month triggered by noncompliance with community engagement requirements, including those reinstated due to compliance, determination of exemption, and successful appeal or good cause circumstances	Administrative records
The number of demonstration beneficiaries whose benefits were reinstated during the measurement period after suspension in a prior month triggered by noncompliance with community engagement requirements (if state has a suspension policy), because a defined suspension period ended	Administrative records
The number of demonstration beneficiaries whose benefits were reinstated during the measurement period after suspension in a prior month triggered by noncompliance with community engagement requirements (if state has a suspension policy), because they completed qualifying activities	Administrative records
The number of demonstration beneficiaries whose benefits were reinstated during the measurement period after suspension in a prior month triggered by noncompliance with community engagement requirements (if state has a suspension policy) because they used a special pathway for re-enrollment such as a state-approved educational course	Administrative records
The number of demonstration beneficiaries whose benefits were reinstated during the measurement period after suspension in a prior month triggered by noncompliance with community engagement requirements (if state has a suspension policy) because they were newly determined exempt or had a good cause circumstance	Administrative records

The number of demonstration beneficiaries whose benefits were reinstated during the measurement period after suspension in a prior month triggered by noncompliance with community engagement requirements (if state has a suspension policy) because they successfully appealed	Administrative records
Total number of beneficiaries re-enrolled in the demonstration during the measurement period after disenrollment in the last 12 months for noncompliance or because they were in suspended status on their redetermination date (depending on state policy), including those re-enrolling after being determined exempt or after successful appeal	Administrative records
Total number of beneficiaries re-enrolled in the demonstration during the measurement period because they completed qualifying activities, subsequent to disenrollment in the last 12 months for noncompliance or because they were in suspended status on their redetermination date (depending on state policy)	Administrative records
Total number of demonstration beneficiaries re-enrolled during the measurement period because they used a special pathway for re-enrollment such as a state-approved educational course, subsequent to disenrollment in the last 12 months for noncompliance or because they were in suspended status on their redetermination date (depending on state policy)	Administrative records
The number of beneficiaries re-enrolled in the demonstration during the measurement period because they re-applied, subsequent to disenrollment in the last 12 months for noncompliance (or because they were in suspended status on their redetermination date). This includes those who re-applied immediately after disenrollment and those who did so after a disenrollment (non-eligibility) period.	Administrative records
The number of beneficiaries re-enrolled in the demonstration during the measurement period because they were newly determined exempt, subsequent to disenrollment in the last 12 months for noncompliance (or because they were in suspended status on their redetermination date)	Administrative records
The number of beneficiaries re-enrolled in the demonstration during the measurement period after successful appeal (including retroactive determination of a good cause circumstance by the state), subsequent to disenrollment in the last 12 months for noncompliance (or because they were in suspended status on their redetermination date)	Administrative records

			Baseline, an
Calculation lag	Measurement period	Reporting frequency	Baseline reporting period (MM/DD/YYYY--MM/DD/YYYY)
30 days	Month	Quarterly	01/01/2020-03/31/2020
30 days	Month	Quarterly	01/01/2020-03/31/2020
30 days	Month	Quarterly	01/01/2020-03/31/2020
30 days	Month	Quarterly	N/A
30 days	Month	Quarterly	01/01/2020-03/31/2020
30 days	Month	Quarterly	01/01/2020-03/31/2020
30 days	Month	Quarterly	01/01/2020-03/31/2020

30 days	Month	Quarterly	01/01/2020-03/31/2020
30 days	Month	Quarterly	01/01/2020-03/31/2020
30 days	Month	Quarterly	01/01/2020-03/31/2020
30 days	Month	Quarterly	01/01/2020-03/31/2020
30 days	Month	Quarterly	01/01/2020-03/31/2020
30 days	Month	Quarterly	01/01/2020-03/31/2020
30 days	Month	Quarterly	01/01/2020-03/31/2020
30 days	Month	Quarterly	01/01/2020-03/31/2020
30 days	Month	Quarterly	01/01/2020-03/31/2020

30 days	Month	Quarterly	01/01/2020-03/31/2020
30 days	Month	Quarterly	01/01/2020-03/31/2020
30 days	Month	Quarterly	01/01/2020-03/31/2020
30 days	Month	Quarterly	01/01/2020-03/31/2020
30 days	Month	Quarterly	01/01/2020-03/31/2020
30 days	Month	Quarterly	01/01/2020-03/31/2020
30 days	Month	Quarterly	01/01/2020-03/31/2020
30 days	Month	Quarterly	01/01/2020-03/31/2020
30 days	Month	Quarterly	N/A
30 days	Month	Quarterly	N/A
30 days	Month	Quarterly	N/A
30 days	Month	Quarterly	N/A

30 days	Month	Quarterly	N/A
30 days	Month	Quarterly	N/A
30 days	Month	Quarterly	N/A
30 days	Month	Quarterly	N/A
30 days	Month	Quarterly	N/A
30 days	Month	Quarterly	01/01/2020-03/31/2020
30 days	Month	Quarterly	N/A
30 days	Month	Quarterly	N/A
30 days	Month	Quarterly	N/A
30 days	Month	Quarterly	N/A
30 days	Month	Quarterly	N/A

30 days	Month	Quarterly	N/A
			01/01/2020-03/31/2020
30 days	Month	Quarterly	
30 days	Month	Quarterly	N/A
30 days	Month	Quarterly	N/A
30 days	Month	Quarterly	N/A
30 days	Month	Quarterly	N/A
30 days	Month	Quarterly	N/A

nual goals, and demonstration target		Alig
Annual goal	**Overall demonstration target**	**Attest that planned reporting matches the CMS-provided specification (Y/N)**
TBD	TBD	Y
TBD	TBD	Y
TBD	TBD	Y
N/A	N/A	N
TBD	TBD	Y
TBD	TBD	Y
TBD	TBD	Y

TBD	TBD	Y
TBD	TBD	Y
TBD	TBD	N
TBD	TBD	N
TBD	TBD	N
TBD	TBD	N
TBD	TBD	N
TBD	TBD	Y
TBD	TBD	Y

TBD	TBD	Y
TBD	TBD	Y
TBD	TBD	Y
TBD	TBD	Y
TBD	TBD	Y
TBD	TBD	Y
TBD	TBD	Y
TBD	TBD	Y
TBD	TBD	Y
N/A	N/A	N
N/A	N/A	N
N/A	N/A	N
N/A	N/A	N

N/A	N/A	N
N/A	N/A	N
N/A	N/A	N
N/A	N/A	N
N/A	N/A	N
TBD	TBD	Y
N/A	N/A	N
N/A	N/A	N
N/A	N/A	N
N/A	N/A	N
N/A	N/A	N

N/A	N/A	
		N
TBD	TBD	Y
N/A	N/A	
		N
N/A	N/A	
		N
N/A	N/A	
		N
N/A	N/A	
		N
N/A	N/A	
		N

gnment with CMS-provided technical specifications	
Explanation of any deviations from the CMS-provided specifications. Could include different data sources or state-specific definitions, policies, codes, target populations, etc.	**Dates covered by first measurement period for metric (MM/DD/YYYY - MM/DD/YYYY)**
N/A	01/01/2020-03/31/2020
N/A	01/01/2020-03/31/2020
N/A	01/01/2020-03/31/2020
N/A	N/A
N/A	01/01/2020-03/31/2020
N/A	01/01/2020-03/31/2020
N/A	01/01/2020-03/31/2020

N/A	01/01/2020-03/31/2020
N/A	01/01/2020-03/31/2020
Michigan does not plan to collect hours associated with qualifying activies. Michigan will be able to report on qualifying activites by category but not with an hourly breakout.	01/01/2020-03/31/2020
Michigan does not plan to collect hours associated with qualifying activies. Michigan will be able to report on qualifying activites by category but not with an hourly breakout.	01/01/2020-03/31/2020
Michigan does not plan to collect hours associated with qualifying activies. Michigan will be able to report on qualifying activites by category but not with an hourly breakout.	01/01/2020-03/31/2020
Michigan does not plan to collect hours associated with qualifying activies. Michigan will be able to report on qualifying activites by category but not with an hourly breakout.	01/01/2020-03/31/2020
Michigan does not plan to collect hours associated with qualifying activies. Michigan will be able to report on qualifying activites by category but not with an hourly breakout.	01/01/2020-03/31/2020
N/A	01/01/2020-03/31/2020
N/A	01/01/2020-03/31/2020

N/A	01/01/2020-03/31/2020
N/A	01/01/2020-03/31/2020
N/A	01/01/2020-03/31/2020
N/A	01/01/2020-03/31/2020
N/A	01/01/2020-03/31/2020
N/A	01/01/2020-03/31/2020
N/A	01/01/2020-03/31/2020
N/A	01/01/2020-03/31/2020
N/A	01/01/2020-03/31/2020
N/A	N/A
N/A	N/A
N/A	N/A
N/A	N/A

N/A	N/A
N/A	N/A
N/A	N/A
N/A	N/A
N/A	N/A
N/A	01/01/2020-03/31/2020
N/A	N/A
N/A	N/A
N/A	N/A
N/A	N/A
N/A	N/A

N/A	N/A
N/A	01/01/2020-03/31/2020
N/A	N/A
N/A	N/A
N/A	N/A
N/A	N/A
N/A	N/A

		Initial reporting date
Report name of first report in which the metric will be submitted (Format: DY1 Q3 quarterly report)	**Submission date of first report in which the metric will be reported (MM/DD/YYYY)**	**State plans to phase in reporting (Y/N)**
DY11 Q1	5/31/2020	N
DY11 Q1	5/31/2020	N
DY11 Q2	8/31/2020	N
N/A	N/A	N
DY11 Q1	5/31/2020	N
DY11 Q2	8/31/2020	N
DY11 Q2	8/31/2020	N

DY11 Q2	8/31/2020	N
DY11 Q1	5/31/2020	N
DY11 Q1	5/31/2020	N
DY11 Q1	5/31/2020	N
DY11 Q1	5/31/2020	N
DY11 Q1	5/31/2020	N
DY11 Q1	5/31/2020	N
DY11 Q1	5/31/2020	N
DY11 Q1	5/31/2020	N
DY11 Q1	5/31/2020	N

DY11 Q1		5/31/2020	N
DY11 Q1		5/31/2020	N
DY11 Q1		5/31/2020	N
DY11 Q1		5/31/2020	N
DY11 Q1		5/31/2020	N
DY11 Q1		5/31/2020	N
DY11 Q1		5/31/2020	N
DY11 Q1		5/31/2020	N
N/A	N/A		N
N/A	N/A		N
N/A	N/A		N
N/A	N/A		N

N/A	N/A		N
N/A	N/A		N
N/A	N/A		N
N/A	N/A		N
N/A			N
	N/A		
DY11 Q2		8/31/2020	N
N/A	N/A		N
N/A	N/A		N
N/A	N/A		N
N/A	N/A		N
N/A	N/A		N

N/A	N/A		N
DY11 Q2		8/31/2020	N
N/A	N/A		N
N/A	N/A		N
N/A	N/A		N
N/A	N/A		N
N/A	N/A		N

Explanation of any plans to phase in reporting over time

N/A

N/A

Michigan requires at least one quarter lag to report this metric.

Michigan does not have a suspension policy.

N/A

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N/A

Michigan is assessing its ability to collect data on beneficiary supports.

Michigan will prioritize required metrics and will evaluate the feasibility of incorporating recommended metrics when demonstration waiver reporting becomes established.
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Medicaid Section 1115 Eligibility and Coverage Demonstration Report - Metrics reporting (AD)

State	Michigan
Demonstration Name	Healthy Michigan Plan
Demonstration Year (DY)	DY 10
Calendar Dates for DY	01/01/2019 - 12/31/2019
Reporting Period	Q4
Calendar Dates for Reporting Period	10/01/2019 - 12/31/2019
Submitted on	4/24/2020

Eligibility and Coverage Demonstration Metrics (AD)[a]

Metric name	#	Metric	Metric description	Data source	Date of monitoring data	Demonstration	< 50% FPL	50-100% FPL	>100% FPL	Age 19-26	Age 27-35	Age 36-45	Age 46-55	Age 56-64	Male	Female	White	Black or African American	Asian	American Indian or Alaskan Native	Other race	Unknown race	Hispanic ethnicity	Non-Hispanic ethnicity	Unknown ethnicity	Exempt groups	Specific eligibility groups New Adult Group
1.1.1 Enrollment	AD_1	Total enrollment in the demonstration	The unduplicated number of beneficiaries enrolled in the demonstration at any time during the measurement period. This indicator is a count of total program enrollment. It includes those newly enrolled during the measurement period and those whose enrollment continues from a prior period. This indicator is not a point-in-time count. It captures beneficiaries who were enrolled for at least one day during the measurement period.	Administrative records	30 days	680,305 682,922 688,748	400,974 396,851 396,027	149,378 152,678 155,908	129,953 133,393 136,813	163,247 163,792 165,109	163,415 164,049 165,450	131,574 132,138 133,304	126,447 126,772 127,504	95,622 96,171 97,381	346,096 347,552 350,900	334,209 335,370 337,848	389,769 391,728 395,627	160,252 159,872 160,547	4,807 4,908 5,045	[illegible] 7,978 8,041	35,745 35,802 35,752	81,768 82,634 83,736	34,971 35,021 34,971	645,152 647,739 653,634	182 162 143	- - -	629,308 634,017 640,150
1.1.1 Enrollment	AD_2	Beneficiaries in suspension status for noncompliance	The number of demonstration beneficiaries in suspension status for noncompliance with demonstration policies as of the last day of the measurement period	Administrative records	30 days	N/A N/A N/A	N/A N/A N/A	N/A N/A N/A	N/A N/A N/A	N/A N/A N/A	N/A N/A N/A	N/A N/A N/A	N/A N/A N/A	N/A N/A N/A	N/A N/A N/A	N/A N/A N/A	N/A N/A N/A	N/A N/A N/A	N/A N/A N/A	N/A N/A N/A	N/A N/A N/A	N/A N/A N/A	N/A N/A N/A	N/A N/A N/A	N/A N/A N/A	N/A N/A N/A	N/A N/A N/A
1.1.1 Enrollment	AD_3	Beneficiaries in a non-eligibility period who are prevented from re-enrolling for a defined period of time	The number of prior demonstration beneficiaries who are in a non-eligibility period, meaning they are prevented from re-enrolling for some defined period of time, because they were disenrolled for noncompliance with demonstration policies. The count should include those prevented from re-enrolling until their redetermination date.	Administrative records	30 days	0 0 0	0 0 0	0 0 0	0 0 0	- - -	- - -	- - -	- - -	- - -	0 0 0	0 0 0	0 0 0	0 0 0	0 0 0	0 0 0	0 0 0	0 0 0	0 0 0	0 0 0	0 0 0	0 0 0	0 0 0
1.1.1 Enrollment	AD_4	New enrollees	Number of beneficiaries in the demonstration who began a new enrollment spell during the measurement period, have not had Medicaid coverage within the prior 3 months and are not using a state-specific pathway for re-enrollment after being disenrolled for noncompliance	Administrative records	30 days	28,776 30,934 30,995	17,457 17,713 17,800	5,968 6,781 6,735	5,351 6,440 6,460	8,926 9,548 9,577	7,148 7,612 7,629	5,436 5,457 5,414	4,269 4,486 4,561	2,997 3,831 3,814	13,785 14,427 15,052	14,991 16,507 15,943	15,163 17,315 17,526	7,642 7,057 6,996	134 298 292	372 357 373	1,780 1,776 1,670	3,685 4,131 4,138	1,830 1,844 1,745	26,946 29,090 29,250	0 0 0	0 0 0	24,316 26,527 26,759
1.1.1 Enrollment	AD_5	Re-enrollments or re-instatements using defined pathways after disenrollment or suspension of benefits for noncompliance with demonstration policies	Number of beneficiaries in the demonstration who began a new enrollment spell (or had benefits re-instated) in the current measurement period by using a state-defined pathway for re-enrollment (or re-instatement of benefits), i.e., meeting certain requirements, after being disenrolled (or having benefits suspended) for noncompliance with premium requirements, community engagement requirements, or other demonstration-specific requirements.	Administrative records	30 days	0 0 0	0 0 0	0 0 0	0 0 0	0 0 0	0 0 0	0 0 0	0 0 0	0 0 0	0 0 0	0 0 0	0 0 0	0 0 0	0 0 0	0 0 0	0 0 0	0 0 0	0 0 0	0 0 0	0 0 0	0 0 0	0 0 0
1.1.1 Enrollment	AD_6	Re-enrollments or re-instatements for beneficiaries not using defined pathways after disenrollment or suspension of benefits for noncompliance	Number of beneficiaries in the demonstration who began a new enrollment spell (or had benefits re-instated) in the current measurement period who have had Medicaid coverage within the prior 3 months and are not using a state-specific pathway for re-enrollment after being disenrolled for noncompliance (or re-instatement of benefits after being suspended for noncompliance).	Administrative records	30 days	0 0 0	0 0 0	0 0 0	0 0 0	0 0 0	0 0 0	0 0 0	0 0 0	0 0 0	0 0 0	0 0 0	0 0 0	0 0 0	0 0 0	0 0 0	0 0 0	0 0 0	0 0 0	0 0 0	0 0 0	0 0 0	0 0 0
1.1.2 Mid-year loss of demonstration eligibility	AD_7	Monthly count of beneficiaries determined ineligible for Medicaid, any reason, other than at renewal	Beneficiaries determined ineligible for Medicaid, any reason, other than at renewal	Administrative records	30 days	TBD TBD TBD	TBD TBD TBD	TBD TBD TBD	TBD TBD TBD	TBD TBD TBD	TBD TBD TBD	TBD TBD TBD	TBD TBD TBD	TBD TBD TBD	TBD TBD TBD	TBD TBD TBD	TBD TBD TBD	TBD TBD TBD	TBD TBD TBD	TBD TBD TBD	TBD TBD TBD	TBD TBD TBD	TBD TBD TBD	TBD TBD TBD	TBD TBD TBD	TBD TBD TBD	TBD TBD TBD
1.1.2 Mid-year loss of demonstration eligibility	AD_8	Monthly count of beneficiaries determined ineligible for Medicaid after state processes a change in circumstance reported by a beneficiary	Beneficiaries no longer eligible for Medicaid, failure to provide timely change in circumstance information	Administrative records	30 days	TBD TBD TBD	TBD TBD TBD	TBD TBD TBD	TBD TBD TBD	TBD TBD TBD	TBD TBD TBD	TBD TBD TBD	TBD TBD TBD	TBD TBD TBD	TBD TBD TBD	TBD TBD TBD	TBD TBD TBD	TBD TBD TBD	TBD TBD TBD	TBD TBD TBD	TBD TBD TBD	TBD TBD TBD	TBD TBD TBD	TBD TBD TBD	TBD TBD TBD	TBD TBD TBD	TBD TBD TBD
1.1.2 Mid-year loss of demonstration eligibility	AD_9	Monthly count of beneficiaries determined ineligible for Medicaid after state processes a change in circumstance reported by a beneficiary	Beneficiaries determined ineligible for Medicaid after state processes a change in circumstance reported by a beneficiary	Administrative records	30 days	TBD TBD TBD	TBD TBD TBD	TBD TBD TBD	TBD TBD TBD	TBD TBD TBD	TBD TBD TBD	TBD TBD TBD	TBD TBD TBD	TBD TBD TBD	TBD TBD TBD	TBD TBD TBD	TBD TBD TBD	TBD TBD TBD	TBD TBD TBD	TBD TBD TBD	TBD TBD TBD	TBD TBD TBD	TBD TBD TBD	TBD TBD TBD	TBD TBD TBD	TBD TBD TBD	TBD TBD TBD
1.1.2 Mid-year loss of demonstration eligibility	AD_10	Monthly count of beneficiaries no longer eligible for the demonstration due to transfer to another Medicaid eligibility group	Beneficiaries no longer eligible for the demonstration due to transfer to another Medicaid eligibility group	Administrative records	30 days	TBD TBD TBD	TBD TBD TBD	TBD TBD TBD	TBD TBD TBD	TBD TBD TBD	TBD TBD TBD	TBD TBD TBD	TBD TBD TBD	TBD TBD TBD	TBD TBD TBD	TBD TBD TBD	TBD TBD TBD	TBD TBD TBD	TBD TBD TBD	TBD TBD TBD	TBD TBD TBD	TBD TBD TBD	TBD TBD TBD	TBD TBD TBD	TBD TBD TBD	TBD TBD TBD	TBD TBD TBD
1.1.2 Mid-year loss of demonstration eligibility	AD_11	Monthly count of beneficiaries no longer eligible for the demonstration due to transfer to CHIP	Beneficiaries no longer eligible for the demonstration due to transfer to CHIP	Administrative records	30 days	N/A N/A N/A	N/A N/A N/A	N/A N/A N/A	N/A N/A N/A	N/A N/A N/A	N/A N/A N/A	N/A N/A N/A	N/A N/A N/A	N/A N/A N/A	N/A N/A N/A	N/A N/A N/A	N/A N/A N/A	N/A N/A N/A	N/A N/A N/A	N/A N/A N/A	N/A N/A N/A	N/A N/A N/A	N/A N/A N/A	N/A N/A N/A	N/A N/A N/A	N/A N/A N/A	N/A N/A N/A
1.1.3 Enrollment duration at time of disenrollment	AD_12	Enrollment duration 0-3 months	Number of demonstration beneficiaries who lost eligibility for Medicaid during the measurement period and whose enrollment spell had lasted 3 or fewer months at the time of disenrollment	Administrative records	30 days	N/A N/A N/A	N/A N/A N/A	N/A N/A N/A	N/A N/A N/A	N/A N/A N/A	N/A N/A N/A	N/A N/A N/A	N/A N/A N/A	N/A N/A N/A	N/A N/A N/A	N/A N/A N/A	N/A N/A N/A	N/A N/A N/A	N/A N/A N/A	N/A N/A N/A	N/A N/A N/A	N/A N/A N/A	N/A N/A N/A	N/A N/A N/A	N/A N/A N/A	N/A N/A N/A	N/A N/A N/A
1.1.3 Enrollment duration at time of disenrollment	AD_13	Enrollment duration 4-6 months	Number of demonstration beneficiaries who lose eligibility for Medicaid during the measurement period whose enrollment spell had lasted between 4 and 6 months at the time of disenrollment	Administrative records	30 days	N/A N/A N/A	N/A N/A N/A	N/A N/A N/A	N/A N/A N/A	N/A N/A N/A	N/A N/A N/A	N/A N/A N/A	N/A N/A N/A	N/A N/A N/A	N/A N/A N/A	N/A N/A N/A	N/A N/A N/A	N/A N/A N/A	N/A N/A N/A	N/A N/A N/A	N/A N/A N/A	N/A N/A N/A	N/A N/A N/A	N/A N/A N/A	N/A N/A N/A	N/A N/A N/A	N/A N/A N/A
1.1.3 Enrollment duration at time of disenrollment	AD_14	Enrollment duration 6-12 months	Number of demonstration beneficiaries who lost eligibility for Medicaid during the measurement period whose enrollment spell had lasted 6 or more months (up to 12 months) at the time of disenrollment	Administrative records	30 days	N/A N/A N/A	N/A N/A N/A	N/A N/A N/A	N/A N/A N/A	N/A N/A N/A	N/A N/A N/A	N/A N/A N/A	N/A N/A N/A	N/A N/A N/A	N/A N/A N/A	N/A N/A N/A	N/A N/A N/A	N/A N/A N/A	N/A N/A N/A	N/A N/A N/A	N/A N/A N/A	N/A N/A N/A	N/A N/A N/A	N/A N/A N/A	N/A N/A N/A	N/A N/A N/A	N/A N/A N/A
1.1.4 Renewal	AD_15	Beneficiaries due for renewal	Total number of beneficiaries enrolled in the demonstration who were due for renewal during the measurement period	Administrative records	30 days	62,440 60,415 59,960	39,143 37,991 39,076	15,039 13,745 13,521	8,258 8,679 7,363	13,941 13,660 14,127	15,466 15,781 15,123	12,124 11,177 11,626	11,319 10,671 10,799	9,590 9,126 8,285	31,103 31,149 31,553	31,337 29,266 28,407	36,630 35,640 34,466	13,960 12,585 13,731	567 559 434	715 675 679	3,092 2,858 3,162	7,476 8,098 7,488	3,017 2,782 3,104	59,401 57,604 56,844	22 29 12	N/A N/A N/A	58,275 56,869 56,152
1.1.4 Renewal	AD_16	Beneficiaries determined ineligible for the demonstration at renewal, disenrolled from Medicaid	Number of beneficiaries enrolled in the demonstration and due for renewal during the measurement period who complete the renewal process and are determined ineligible for Medicaid	Administrative records	30 days	TBD TBD TBD	TBD TBD TBD	TBD TBD TBD	TBD TBD TBD	TBD TBD TBD	TBD TBD TBD	TBD TBD TBD	TBD TBD TBD	TBD TBD TBD	TBD TBD TBD	TBD TBD TBD	TBD TBD TBD	TBD TBD TBD	TBD TBD TBD	TBD TBD TBD	TBD TBD TBD	TBD TBD TBD	TBD TBD TBD	TBD TBD TBD	TBD TBD TBD	TBD TBD TBD	TBD TBD TBD
1.1.4 Renewal	AD_17	Beneficiaries determined ineligible for the demonstration at renewal, transfer to another Medicaid eligibility category	Number of beneficiaries enrolled in the demonstration and due for renewal during the measurement period who complete the renewal process and move from the demonstration to a Medicaid eligibility group not included in the demonstration	Administrative records	30 days	TBD TBD TBD	TBD TBD TBD	TBD TBD TBD	TBD TBD TBD	TBD TBD TBD	TBD TBD TBD	TBD TBD TBD	TBD TBD TBD	TBD TBD TBD	TBD TBD TBD	TBD TBD TBD	TBD TBD TBD	TBD TBD TBD	TBD TBD TBD	TBD TBD TBD	TBD TBD TBD	TBD TBD TBD	TBD TBD TBD	TBD TBD TBD	TBD TBD TBD	TBD TBD TBD	TBD TBD TBD
1.1.4 Renewal	AD_18	Beneficiaries determined ineligible for the demonstration at renewal, transferred to CHIP	Number of beneficiaries enrolled in the demonstration and due for renewal during the measurement period who complete the renewal process but move from the demonstration to CHIP	Administrative records	30 days	TBD TBD TBD	TBD TBD TBD	TBD TBD TBD	TBD TBD TBD	TBD TBD TBD	TBD TBD TBD	TBD TBD TBD	TBD TBD TBD	TBD TBD TBD	TBD TBD TBD	TBD TBD TBD	TBD TBD TBD	TBD TBD TBD	TBD TBD TBD	TBD TBD TBD	TBD TBD TBD	TBD TBD TBD	TBD TBD TBD	TBD TBD TBD	TBD TBD TBD	TBD TBD TBD	TBD TBD TBD
1.1.4 Renewal	AD_19	Beneficiaries who did not complete renewal, disenrolled from Medicaid	Number of beneficiaries enrolled in the demonstration and due for renewal during the measurement period who are disenrolled from Medicaid for failure to complete the renewal process	Administrative records	30 days	TBD TBD TBD	TBD TBD TBD	TBD TBD TBD	TBD TBD TBD	TBD TBD TBD	TBD TBD TBD	TBD TBD TBD	TBD TBD TBD	TBD TBD TBD	TBD TBD TBD	TBD TBD TBD	TBD TBD TBD	TBD TBD TBD	TBD TBD TBD	TBD TBD TBD	TBD TBD TBD	TBD TBD TBD	TBD TBD TBD	TBD TBD TBD	TBD TBD TBD	TBD TBD TBD	TBD TBD TBD
1.1.4 Renewal	AD_20	Beneficiaries who had pending/uncompleted renewals and were still enrolled	Number of beneficiaries enrolled in the demonstration and due for renewal during the measurement period for whom the state had not completed renewal determination by the end of the measurement period and were still enrolled	Administrative records	30 days	TBD TBD TBD	TBD TBD TBD	TBD TBD TBD	TBD TBD TBD	TBD TBD TBD	TBD TBD TBD	TBD TBD TBD	TBD TBD TBD	TBD TBD TBD	TBD TBD TBD	TBD TBD TBD	TBD TBD TBD	TBD TBD TBD	TBD TBD TBD	TBD TBD TBD	TBD TBD TBD	TBD TBD TBD	TBD TBD TBD	TBD TBD TBD	TBD TBD TBD	TBD TBD TBD	TBD TBD TBD
1.1.4 Renewal	AD_21	Beneficiaries who retained eligibility for the demonstration after completing renewal forms	Number of beneficiaries enrolled in the demonstration and due for renewal during the measurement period who remained enrolled in the demonstration after responding to renewal notices	Administrative records	30 days	TBD TBD TBD	TBD TBD TBD	TBD TBD TBD	TBD TBD TBD	TBD TBD TBD	TBD TBD TBD	TBD TBD TBD	TBD TBD TBD	TBD TBD TBD	TBD TBD TBD	TBD TBD TBD	TBD TBD TBD	TBD TBD TBD	TBD TBD TBD	TBD TBD TBD	TBD TBD TBD	TBD TBD TBD	TBD TBD TBD	TBD TBD TBD	TBD TBD TBD	TBD TBD TBD	TBD TBD TBD
1.1.4 Renewal	AD_22	Beneficiaries who renewed ex parte	Number of beneficiaries enrolled in the demonstration and due for renewal during the measurement period who remained enrolled as determined by third-party data sources or available information, rather than beneficiary response to renewal notices	Administrative records	30 days	N/A N/A N/A	N/A N/A N/A	N/A N/A N/A	N/A N/A N/A	N/A N/A N/A	N/A N/A N/A	N/A N/A N/A	N/A N/A N/A	N/A N/A N/A	N/A N/A N/A	N/A N/A N/A	N/A N/A N/A	N/A N/A N/A	N/A N/A N/A	N/A N/A N/A	N/A N/A N/A	N/A N/A N/A	N/A N/A N/A	N/A N/A N/A	N/A N/A N/A	N/A N/A N/A	N/A N/A N/A
1.1.5 Cost sharing limit	AD_23	Monthly count of beneficiaries who reached 5% limit	Beneficiaries who reached 5% limit	Administrative records	30 days	100,684 40,536 35,889	78,841 27,752 24,645	20,779 6,247 5,374	11,067 6,537 5,870	23,857 11,226 10,057	25,650 10,900 9,584	17,008 6,717 5,884	19,504 6,457 5,727	14,823 5,251 4,677	50,254 19,992 17,996	50,430 20,544 17,893	59,554 24,019 21,565	23,498 8,640 7,586	531 282 202	1,132 453 418	4,088 1,852 1,626	11,957 3,006 4,591					
1.1.6 Appeals and grievances	AD_24	Appeals, eligibility	Number of appeals filed by beneficiaries enrolled in the demonstration during the measurement period regarding Medicaid eligibility	Administrative records	None	N/A																					
1.1.6 Appeals and grievances	AD_25	Appeals, denial of benefits	Number of appeals filed by beneficiaries enrolled in the demonstration during the measurement period regarding denial of benefits	Administrative records	None	N/A																					
1.1.6 Appeals and grievances	AD_26	Grievances, care quality	Number of grievances filed by beneficiaries enrolled in the demonstration during the measurement period regarding the quality of care or services provided	Administrative records	None	N/A																					
1.1.6 Appeals and grievances	AD_27	Grievances, provider or managed care entities	Number of grievances filed by beneficiaries enrolled in the demonstration during the measurement period regarding a provider or managed care entity. Managed care entities include Managed Care Organizations (MCO), Prepaid Inpatient Health Plans (PIHP), and Prepaid Ambulatory Health Plans (PAHP)	Administrative records	None	N/A																					
1.1.6 Appeals and grievances	AD_28	Grievances, other	Number of grievances filed by beneficiaries enrolled in the demonstration during the measurement period regarding other matters that are not subject to appeal	Administrative records	None	N/A																					
1.1.7 Access to care	AD_29	Primary care provider availability	Number of primary care providers enrolled to deliver Medicaid services at the end of the measurement period	Provider enrollment databases	90 days	43,403																					
1.1.7 Access to care	AD_30	Primary care provider active participation	Number of primary care providers enrolled to deliver Medicaid services with service claims for 3 or more demonstration beneficiaries during the measurement period	Provider enrollment databases and claims and encounters	90 days	17,728																					
1.1.7 Access to care	AD_31	Specialist provider availability	Number of specialists enrolled to deliver Medicaid services at the end of the measurement period	Provider enrollment databases	90 days	68,325																					
1.1.7 Access to care	AD_32	Specialist provider active participation	Number of specialists enrolled to deliver Medicaid services with service claims for 3 or more demonstration beneficiaries during the measurement period	Provider enrollment databases and claims and encounters	90 days	41,975																					
1.1.7 Access to care	AD_33	Preventive care and office visit utilization	Total utilization of preventive care and office visits per 1,000 demonstration beneficiary months during the measurement period	Claims and encounters and other administrative records	90 days	N/A N/A N/A	N/A N/A N/A	N/A N/A N/A	N/A N/A N/A	N/A N/A N/A	N/A N/A N/A	N/A N/A N/A	N/A N/A N/A	N/A N/A N/A	N/A N/A N/A	N/A N/A N/A	N/A N/A N/A	N/A N/A N/A	N/A N/A N/A	N/A N/A N/A	N/A N/A N/A	N/A N/A N/A	N/A N/A N/A	N/A N/A N/A	N/A N/A N/A	N/A N/A N/A	N/A N/A N/A
1.1.7 Access to care	AD_34	Prescription drug use	Total utilization of 30-day prescription fills per 1,000 demonstration beneficiary months in the measurement period.	Claims and encounters; other administrative records	90 days	N/A N/A N/A	N/A N/A N/A	N/A N/A N/A	N/A N/A N/A	N/A N/A N/A	N/A N/A N/A	N/A N/A N/A	N/A N/A N/A	N/A N/A N/A	N/A N/A N/A	N/A N/A N/A	N/A N/A N/A	N/A N/A N/A	N/A N/A N/A	N/A N/A N/A	N/A N/A N/A	N/A N/A N/A	N/A N/A N/A	N/A N/A N/A	N/A N/A N/A	N/A N/A N/A	N/A N/A N/A
1.1.7 Access to care	AD_35	Emergency department utilization, total	Total number of emergency department (ED) visits per 1,000 demonstration beneficiary months during the measurement period	Claims and encounters; other administrative records	90 days	TBD TBD TBD	TBD TBD TBD	TBD TBD TBD	TBD TBD TBD	TBD TBD TBD	TBD TBD TBD	TBD TBD TBD	TBD TBD TBD	TBD TBD TBD	TBD TBD TBD	TBD TBD TBD	TBD TBD TBD	TBD TBD TBD	TBD TBD TBD	TBD TBD TBD	TBD TBD TBD	TBD TBD TBD	TBD TBD TBD	TBD TBD TBD	TBD TBD TBD	TBD TBD TBD	TBD TBD TBD
1.1.7 Access to care	AD_36	Emergency department utilization, non-emergency	Total number of ED visits for non-emergency conditions per 1,000 demonstration beneficiary months during the measurement period. If the state differentiates emergent/non-emergent visit copayments, then non-emergency visits should be identified for monitoring purposes using the same criteria used to assess the differential copayment. If the state does not differentiate emergent/non-emergent copayments, then non-emergency visits should be defined as all visits not categorized as emergent using the method below.	Claims and encounters; other administrative records	90 days	N/A N/A N/A	N/A N/A N/A	N/A N/A N/A	N/A N/A N/A	N/A N/A N/A	N/A N/A N/A	N/A N/A N/A	N/A N/A N/A	N/A N/A N/A	N/A N/A N/A	N/A N/A N/A	N/A N/A N/A	N/A N/A N/A	N/A N/A N/A	N/A N/A N/A	N/A N/A N/A	N/A N/A N/A	N/A N/A N/A	N/A N/A N/A	N/A N/A N/A	N/A N/A N/A	N/A N/A N/A
1.1.7 Access to care	AD_37	Inpatient admissions	Total number of inpatient admissions per 1,000 demonstration beneficiary months during the measurement period	Claims and encounters; other administrative records	90 days	N/A N/A N/A	N/A N/A N/A	N/A N/A N/A	N/A N/A N/A	N/A N/A N/A	N/A N/A N/A	N/A N/A N/A	N/A N/A N/A	N/A N/A N/A	N/A N/A N/A	N/A N/A N/A	N/A N/A N/A	N/A N/A N/A	N/A N/A N/A	N/A N/A N/A	N/A N/A N/A	N/A N/A N/A	N/A N/A N/A	N/A N/A N/A	N/A N/A N/A	N/A N/A N/A	N/A N/A N/A
1.1.8 Quality of care and health outcomes	AD_38A	Medical Assistance with Smoking and Tobacco Use Cessation (MSC-AD) [NCQA; NQF #0027; Medicaid Adult Core Set; Adjusted HEDIS measure][f]	This metric consists of the following components; each assesses different facets of providing medical assistance with smoking and tobacco use cessation: • Advising smokers and tobacco users to quit • Discussing cessation medications • Discussing cessation strategies	Consumer Assessment of Healthcare Providers and Systems (CAHPS) Health Plan survey, Adult	90 days	TBD TBD TBD	TBD TBD TBD	TBD TBD TBD	TBD TBD TBD																		TBD TBD TBD
1.1.8 Quality of care and health outcomes	AD_38B	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention [PCPI Foundation; NQF #0028]	This metric consists of the following components: 1. Percentage of beneficiaries aged 18 years and older who were screened for tobacco use one or more times within 24 months 2. Percentage of beneficiaries aged 18 years and older who were screened for tobacco use and identified as a tobacco user who received tobacco cessation intervention 3. Percentage of beneficiaries aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received cessation intervention if identified as a tobacco user	--	--																						
			1. Percentage of beneficiaries aged 18 years and older who were screened for tobacco use one or more times within 24 months	Claims and encounters or EHR	90 days	TBD TBD TBD	TBD TBD TBD	TBD TBD TBD	TBD TBD TBD																		TBD TBD TBD
			2. Percentage of beneficiaries aged 18 years and older who were screened for tobacco use and identified as a tobacco user who received tobacco cessation intervention	Claims and encounters or EHR	90 days	TBD TBD TBD	TBD TBD TBD	TBD TBD TBD	TBD TBD TBD																		TBD TBD TBD
			3. Percentage of beneficiaries aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received cessation intervention if identified as a tobacco user	Claims and encounters or EHR	90 days	TBD TBD TBD	TBD TBD TBD	TBD TBD TBD	TBD TBD TBD																		TBD TBD TBD
1.1.8 Quality of care and health outcomes	AD_39-1	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA-AD) [NCQA; NQF # 2605; Medicaid adult Core Set; Adjusted HEDIS measure][f]	Percentage of ED visits for beneficiaries age 18 and older who have a principal diagnosis of alcohol or other drug (AOD) abuse or dependence, and who had a follow-up visit with a corresponding principal diagnosis for AOD. Two rates are reported:	--	--																						
			1. Percentage of ED visits for AOD abuse or dependence for which the beneficiary received follow-up within 30 days of the ED visit (31 total days)	Claims and encounters	90 days	TBD TBD TBD	TBD TBD TBD	TBD TBD TBD	TBD TBD TBD																		TBD TBD TBD
			2. Percentage of ED visits for AOD abuse or dependence for which the beneficiary received follow-up within 7 days of the ED visit (8 total days)	Claims and encounters	90 days	TBD TBD TBD	TBD TBD TBD	TBD TBD TBD	TBD TBD TBD																		TBD TBD TBD
1.1.8 Quality of care and health outcomes	AD_39-2	Follow-Up After Emergency Department Visit for Mental Illness (FUM-AD) [NCQA; NQF # 2605; Medicaid adult Core Set; Adjusted HEDIS measure][f]	Percentage of ED visits for beneficiaries age 18 and older who have a principal diagnosis of mental illness or intentional self-harm, and who had a follow-up visit with a corresponding principal diagnosis for mental illness. Two rates are reported:	--	--																						
			1. Percentage of ED visits for mental illness or intentional self-harm for which the beneficiary received follow-up within 30 days of the ED visit (31 total days)	Claims and encounters	90 days	TBD TBD TBD	TBD TBD TBD	TBD TBD TBD	TBD TBD TBD																		TBD TBD TBD
			2. Percentage of ED visits for mental illness or intentional self-harm for which the beneficiary received follow-up within 7 days of the ED visit (8 total days)	Claims and encounters	90 days	TBD TBD TBD	TBD TBD TBD	TBD TBD TBD	TBD TBD TBD																		TBD TBD TBD
1.1.8 Quality of care and health outcomes	AD_40	Initiation of Alcohol and Other Drug Abuse or Dependence Treatment (IET-AD) [NCQA; NQF #0004; Medicaid Adult Core Set; Adjusted HEDIS measure][f]	Percentage of beneficiaries age 18 and older with a new episode of AOD abuse or dependence who received the following: 1. Initiation of AOD Treatment. Percentage of beneficiaries who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization, telehealth, or medication assisted treatment (MAT) within 14 days of the diagnosis 2. Engagement of AOD Treatment. Percentage of beneficiaries who initiate treatment and who had two or more additional AOD services or MAT within 34 days of the initiation visit The following diagnosis cohorts are reported for each rate: (1) Alcohol abuse or dependence, (2) Opioid abuse or dependence, (3) Other drug abuse or dependence, and (4) Total AOD abuse or dependence. A total of 8 separate rates are reported for this measure.	--	--																						
			1. Initiation of AOD Treatment - Alcohol abuse or dependence (rate 1, cohort 1)	Claims and encounters or EHR	90 days	TBD TBD TBD	TBD TBD TBD	TBD TBD TBD	TBD TBD TBD																		TBD TBD TBD
			2. Initiation of AOD Treatment - Opioid abuse or dependence (rate 1, cohort 2)	Claims and encounters or EHR	90 days	TBD TBD TBD	TBD TBD TBD	TBD TBD TBD	TBD TBD TBD																		TBD TBD TBD
			3. Initiation of AOD Treatment - Other drug abuse or dependence (rate 1, cohort 3)	Claims and encounters or EHR	90 days	TBD TBD TBD	TBD TBD TBD	TBD TBD TBD	TBD TBD TBD																		TBD TBD TBD
			4. Initiation of AOD Treatment - Total AOD abuse or dependence (rate 1, cohort 4)	Claims and encounters or EHR	90 days	TBD TBD TBD	TBD TBD TBD	TBD TBD TBD	TBD TBD TBD																		TBD TBD TBD
			5. Engagement of AOD Treatment - Alcohol drug abuse or dependence (rate 2 cohort 1)	Claims and encounters or EHR	90 days	TBD TBD TBD	TBD TBD TBD	TBD TBD TBD	TBD TBD TBD																		TBD TBD TBD
			6. Engagement of AOD Treatment - Opioid drug abuse or dependence (rate 2, cohort 2)	Claims and encounters or EHR	90 days	TBD TBD TBD	TBD TBD TBD	TBD TBD TBD	TBD TBD TBD																		TBD TBD TBD
			7. Engagement of AOD Treatment - Other AOD abuse or dependence (rate 2, cohort 3)	Claims and encounters or EHR	90 days	TBD TBD TBD	TBD TBD TBD	TBD TBD TBD	TBD TBD TBD																		TBD TBD TBD
			8. Engagement of AOD Treatment - Total AOD abuse or dependence (rate 2, cohort 4)	Claims and encounters or EHR	90 days	TBD TBD TBD	TBD TBD TBD	TBD TBD TBD	TBD TBD TBD																		TBD TBD TBD
1.1.8 Quality of care and health outcomes	AD_41	PQI 01: Diabetes Short-Term Complications Admission Rate (PQI01-AD) [AHRQ; NQF #0272; Medicaid Adult Core Set]	Number of inpatient hospital admissions for diabetes short-term complications (ketoacidosis, hyperosmolarity, or coma) per 100,000 beneficiary months for beneficiaries age 18 and older	Claims and encounters	90 days	TBD TBD TBD	TBD TBD TBD	TBD TBD TBD	TBD TBD TBD																		TBD TBD TBD
1.1.8 Quality of care and health outcomes	AD_42	PQI 05: Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate (PQI05-AD) [AHRQ; NQF #0275; Medicaid Adult Core Set]	Number of inpatient hospital admissions for chronic obstructive pulmonary disease (COPD) or asthma per 100,000 beneficiary months for beneficiaries age 40 and older.	Claims and encounters	90 days	TBD TBD TBD	TBD TBD TBD	TBD TBD TBD	TBD TBD TBD																		TBD TBD TBD
1.1.8 Quality of care and health outcomes	AD_43	PQI 08: Heart Failure Admission Rate (PQI08-AD) [AHRQ; NQF #0277; Medicaid Adult Core Set]	Number of inpatient hospital admissions for heart failure per 100,000 beneficiary months for beneficiaries age 18 and older	Claims and encounters	90 days	TBD TBD TBD	TBD TBD TBD	TBD TBD TBD	TBD TBD TBD																		TBD TBD TBD
1.1.8 Quality of care and health outcomes	AD_44	PQI 15: Asthma in Younger Adults Admission Rate (PQI15-AD) [AHRQ; NQF #0283; Medicaid Adult Core Set]	Number of inpatient hospital admissions for asthma per 100,000 beneficiary months for beneficiaries aged 18 to 39.	Claims and encounters	90 days	TBD TBD TBD	TBD TBD TBD	TBD TBD TBD	TBD TBD TBD																		TBD TBD TBD
1.1.9 Administrative cost	AD_45	Administrative cost of demonstration operation	Cost of contracts or contract amendments and staff time equivalents required to administer demonstration policies, including premium collection, health behavior incentives, premium assistance, community engagement requirements and/or retroactive eligibility waivers	Administrative records	None	$1,616,939																					

Note: States must prominently display the following notice on any display of Measure rates:

The MSC-AD, FUA-AD, FUM-AD, and IET_AD measures (metrics AD_38A, AD_39, and AD_40) are Healthcare Effectiveness Data and Information Set ("HEDIS®") measures that are owned and copyrighted by the National Committee for Quality Assurance ("NCQA"). NCQA makes no representations, warranties, or endorsement about the quality of any organization or physician that uses or reports performance measures and NCQA has no liability to anyone who relies on such measures or specifications.

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Certain non-NCQA measures in the CMS 1115 eligibility and coverage demonstration contain HEDIS Value Sets (VS) developed by and included with the permission of the NCQA. Proprietary coding is contained in the VS. Users of the proprietary code sets should obtain all necessary licenses from the owners of these code sets. NCQA disclaims all liability for use or accuracy of the VS with the non-NCQA measures and any coding contained in the VS.

AD_8, AD_9, AD_11, AD_12, AD_13, AD_14 should each be less than or equal to AD_7

Medicaid Section 1115 Eligibility and Coverage Demons	
State	Michigan
Demonstration Name	Healthy Michigar
Demonstration Year (DY)	DY 10
Calendar Dates for DY	01/01/2019 - 12/
Reporting Period	Q4
Calendar Dates for Reporting Period	10/01/2019 - 12/
Submitted on	4/24/2020

Eligibility and Coverage Demonstratic

Reporting Topic[b]	#
CE.Mod_1: Specify community engagement policies	CE_1
CE.Mod_1: Specify community engagement policies	CE_2
CE.Mod_1: Specify community engagement policies	CE_3
CE.Mod_1: Specify community engagement policies	CE_4
CE.Mod_1: Specify community engagement policies	CE_5
CE.Mod_1: Specify community engagement policies	CE_6
CE.Mod_1: Specify community engagement policies	CE_7
CE.Mod_1: Specify community engagement policies	CE_8

CE.Mod_1: Specify community engagement policies	CE_9
CE.Mod_1: Specify community engagement policies	CE_10
CE.Mod_1: Specify community engagement policies	CE_11
CE.Mod_1: Specify community engagement policies	AD_12
CE.Mod_1: Specify community engagement policies	CE_13
CE.Mod_1: Specify community engagement policies	CE_14
CE.Mod_1: Specify community engagement policies	CE_15
CE.Mod_1: Specify community engagement policies	CE_16
CE.Mod_1: Specify community engagement policies	CE_17
CE.Mod_1: Specify community engagement policies	CE_18
CE.Mod_1: Specify community	

CE.Mod_1: Specify community engagement policies	CE_19
CE.Mod_1: Specify community engagement policies	CE_20
CE.Mod_1: Specify community engagement policies	CE_21
CE.Mod_1: Specify community engagement policies	CE_22
CE.Mod_1: Specify community engagement policies	CE_23
CE.Mod_1: Specify community engagement policies	CE_24
CE.Mod_2: Establish beneficiary supports and modifications	CE_25
CE.Mod_2: Establish beneficiary supports and modifications	CE_26
CE.Mod_2: Establish beneficiary supports and modifications	CE_27
CE.Mod_2: Establish beneficiary supports and modifications	CE_28
CE.Mod_2: Establish beneficiary supports and modifications	CE_29
CE.Mod_2: Establish beneficiary supports and modifications	CE_30
CE.Mod_2: Establish beneficiary supports and modifications	CE_31
CE.Mod_2: Establish beneficiary supports and modifications	CE_32

CE.Mod_4: Operationalize strategies for noncompliance	CE_33
CE.Mod_4: Operationalize strategies for noncompliance	CE_34
CE.Mod_4: Operationalize strategies for noncompliance	CE_35
CE.Mod_4: Operationalize strategies for noncompliance	CE_36
CE.Mod_4: Operationalize strategies for noncompliance	CE_37
CE.Mod_4: Operationalize strategies for noncompliance	CE_38
CE.Mod_4: Operationalize strategies for noncompliance	CE_39
CE.Mod_4: Operationalize strategies for noncompliance	CE_40
CE.Mod_4: Operationalize strategies for noncompliance	CE_41

CE.Mod_4: Operationalize strategies for noncompliance	CE_42
CE.Mod_4: Operationalize strategies for noncompliance	CE_43
CE.Mod_4: Operationalize strategies for noncompliance	CE_44
CE.Mod_4: Operationalize strategies for noncompliance	CE_45
CE.Mod_4: Operationalize strategies for noncompliance	CE_46

Add rows for any additional state-identified metrics

[a] States should create a new metrics report for each re

[b] The reporting topics correspond to the reporting topi

[c] The reporting topics correspond to the reporting topic

[d] Report count metrics in the numerator column.

[e] If applicable. See CMS-provided technical specificatior

[f] Add columns as necessary to report additional income

[g] Add columns as necessary to report exempt groups.

[h] Add columns as necessary to report specific eligibility

[i] Add columns as necessary to report phase-in cohorts, i

Checks:

CE_1 should be l

CE_1 should be e

CE_4 should be l

CE_8 should be l

CE_2 should be e
CE_35 should be
CE_41 should be

stration Report - Metrics reporting (CE)

n Plan

/31/2019

/31/2019

on Metrics (CE)[a]

Metric name
Total beneficiaries subject to the community engagement requirement, not exempt
Total beneficiaries who were exempt from the community engagement requirement in the month
Beneficiaries with approved good cause circumstances
Beneficiaries subject to the community engagement requirement and in suspension status due to failure to meet requirement
Beneficiaries subject to the community engagement requirement and receiving benefits who met the requirement for qualifying activities
Beneficiaries subject to the community engagement requirement and receiving benefits but in a grace period or allowable month of noncompliance
Beneficiaries who successfully completed make-up hours or other activities to retain active benefit status after failing to meet the community engagement requirement in a previous month
Beneficiaries in a non-eligibility period who were disenrolled for noncompliance with community engagement requirement and are prevented from re-enrolling for a defined period of time

Beneficiaries who met the community engagement requirement by satisfying requirements of other programs

Beneficiaries who met the community engagement requirement through employment for the majority of their required hours

Beneficiaries who met the community engagement requirement through job training or job search for the majority of their required hours

Beneficiaries who met the community engagement requirement through educational activity for the majority of their required hours

Beneficiaries who met the community engagement requirement who were engaged in other qualifying activity for the majority of their required hours

Beneficiaries who met the community engagement requirement by combining two or more activities

Beneficiaries exempt from Medicaid community engagement requirements because they were exempt from requirements of SNAP and/or TANF

Beneficiaries exempt from Medicaid community engagement requirements on the basis of pregnancy

Beneficiaries exempt from Medicaid community engagement requirements due to former foster youth status

Beneficiaries exempt from Medicaid community engagement requirements due to medical frailty

Beneficiaries exempt from Medicaid community

Beneficiaries exempt from Medicaid community engagement requirements on the basis of caretaker status

Beneficiaries exempt from Medicaid community engagement requirements on the basis of unemployment insurance compensation

Beneficiaries exempt from Medicaid community engagement requirements due to substance abuse treatment status

Beneficiaries exempt from Medicaid community engagement requirements due to student status

Beneficiaries exempt from Medicaid community engagement requirements because they were excused by a medical professional

Beneficiaries exempt from Medicaid community engagement requirements, other

Total beneficiaries receiving supports to participate and placement assistance

Beneficiaries provided with transportation assistance

Beneficiaries provided with childcare assistance

Beneficiaries provided with language supports

Beneficiaries assisted with placement in community engagement activities

Beneficiaries provided with other non-Medicaid assistance

Beneficiaries who requested reasonable modifications to community engagement processes or requirements due to disability

Beneficiaries who were granted reasonable modifications to community engagement processes or requirements due to disability

Beneficiaries newly suspended for failure to complete community engagement requirements

Beneficiaries newly disenrolled for failure to complete community engagement requirements

Total beneficiaries whose benefits were reinstated after being in suspended status for noncompliance

Beneficiaries whose benefits were reinstated because their time-limited suspension period ended

Beneficiaries whose benefits were reinstated because they completed required community engagement activities

Beneficiaries whose benefits were reinstated because they completed “on-ramp” activities other than qualifying community engagement activities

Beneficiaries whose benefits were reinstated because they newly meet community engagement exemption criteria or had a good cause circumstance

Beneficiaries whose benefits were reinstated after successful appeal of suspension for noncompliance

Total beneficiaries re-enrolling after disenrollment for noncompliance

Beneficiaries re-enrolling after completing required community engagement activities

Beneficiaries re-enrolling after completing “on-ramp” activities other than qualifying community engagement activities

Beneficiaries re-enrolling after re-applying, subsequent to being disenrolled for noncompliance with community engagement requirements

Beneficiaries re-enrolling because they newly met community engagement exemption criteria or had a good cause circumstance

Beneficiaries re-enrolling after successful appeal of disenrollment for noncompliance

porting quarter.
cs in the CE.Mod_1 section of the monitoring report templat
:s in section CE.Mod_1 of the monitoring report template.

ıs.
groups.

groups.
if applicable.

ess than or equal to AD_1
equal to the sum of metrics CE_5 and CE_6
ess than or equal to AD_2
ess than or equal to AD_3

Metric description
The number of beneficiaries enrolled in the demonstration whose income and eligibility group were subject to the community engagement requirement and who did not have an individual exemption from the requirement.
The number of beneficiaries enrolled in income and eligibility groups that were subject to the community engagement requirement, but had an individual exemption from the policy. This excludes circumstances that give rise to good cause.
The number of beneficiaries enrolled in the demonstration who met the state criteria for good cause circumstances, such as serious illness, birth or death of a family member, severe weather, family emergencies, or life-changing event
The number of demonstration beneficiaries in suspension status due to failure to meet the community engagement requirement, including those newly suspended for noncompliance during the measurement period
The number of beneficiaries enrolled in the demonstration who were subject to the community engagement requirement and met the requirement by engaging in qualifying activities
The number of beneficiaries enrolled in the demonstration who were subject to the community engagement requirement but did not meet the requirement. This includes beneficiaries who have not yet begun qualifying activities and those who logged some hours, but failed to meet total required hours.
The number of beneficiaries enrolled in the demonstration who were subject to the community engagement requirement and met additional requirements to retain active benefit status after previously failing to meet the requirement. This captures beneficiaries who successfully satisfy the “opportunity to cure” requirement and therefore are not suspended (if state has this policy).
The number of prior demonstration beneficiaries who were disenrolled from Medicaid for noncompliance with the community engagement requirement and are in a non-eligibility period, meaning they are prevented from re-enrolling for some defined period of time. The count should include those prevented from re-enrolling until their redetermination date.

The number of beneficiaries enrolled in the demonstration who were subject to the community engagement requirement and met the requirement by satisfying requirements in other programs such as SNAP or TANF, regardless of whether they are "deemed" by the state to be in compliance with Medicaid requirements or must take reporting action

The number of beneficiaries enrolled in the demonstration who were subject to and met the community engagement requirement, who were self-employed or employed in subsidized and/or unsubsidized settings. Includes both those "deemed" by the state to be in compliance with Medicaid requirements because they are working more than the number of required hours and those who must report their hours.

The number of beneficiaries enrolled in the demonstration who were subject to and met the community engagement requirement by engaging in on-the-job training, job skills training, vocational education and training, job search activities, job search training, a state-sponsored workforce program, or similar activity

The number of beneficiaries enrolled in the demonstration who were subject to and met the community engagement requirement by engaging in education related to employment, general education, accredited English-as-a-second-language education, accredited homeschooling, or a state-designated class

The number of beneficiaries enrolled in the demonstration who were subject to the community engagement requirement and met the requirement through a state-specified activity not captured by other reporting categories, including community work experience, community service/public service, volunteer work, caregiving for a dependent, participation in substance use disorder treatment, enrollment in Medicaid employer-sponsored insurance premium assistance, or other activity.

The number of beneficiaries enrolled in the demonstration who were subject to the community engagement requirement and met the requirement by engaging in a combination of activities defined in metrics CE_35 through CE_38, such as a combination of employment and education

The number of beneficiaries enrolled in the demonstration who were exempt from the community engagement requirement because they were exempt from the Supplemental Nutrition Assistance Program (SNAP) and/or Temporary Assistance to Needy Families (TANF) work requirements. This does not include beneficiaries who are meeting SNAP and/or TANF work requirements

The number of beneficiaries enrolled in the demonstration who were exempt from the community engagement requirement because they are pregnant

The number of beneficiaries enrolled in the demonstration who were exempt from the community engagement requirement because they were formerly part of the foster care system

The number of beneficiaries enrolled in the demonstration who were exempt from the community engagement requirement because they are identified as medically frail

The number of beneficiaries enrolled in the demonstration who were exempt from the

community engagement requirement because they are primary caregiver of a dependent child or incapacitated/disabled household member

The number of beneficiaries enrolled in the demonstration who were exempt from the community engagement requirement because they are receiving unemployment insurance compensation.

The number of beneficiaries enrolled in the demonstration who were exempt the community engagement requirement because they are participating in a drug or alcohol treatment and rehabilitation program.

The number of beneficiaries enrolled in the demonstration who were exempt from the community engagement requirement because they are a student enrolled a number of hours/week, defined by state

The number of beneficiaries enrolled in the demonstration who were exempt from the community engagement requirement because a medical professional determined the beneficiary had an acute medical condition separate from disability or frailty

The number of beneficiaries enrolled in the demonstration who were exempt from the community engagement requirement because they are exempt for another reason not captured by other reporting categories, including age above the upper limit defined by the state and enrollment in employer-sponsored insurance through premium assistance.

The number of beneficiaries enrolled in the demonstration who were given supports to enable them to participate, including non-Medicaid supports and supports due to disability

The number of beneficiaries enrolled in the demonstration who were given transportation assistance to enable participation in community engagement activities

The number of beneficiaries enrolled in the demonstration who were given childcare assistance to enable participation in community engagement activities.

The number of beneficiaries enrolled in the demonstration who were given language supports to enable participation in community engagement activities

The number of beneficiaries enrolled in the demonstration who were given placement assistance, including through Department of Labor support centers.

The number of beneficiaries enrolled in the demonstration who were given other non-Medicaid assistance to participate in community engagement activities

The number of beneficiaries enrolled in the demonstration who requested a reasonable modification of community engagement processes (such as assistance with exemption requests or appeals) or requirements (such as the number of hours) due to disability

The number of beneficiaries enrolled in the demonstration who were granted a modification of community engagement processes (such as assistance with exemption requests or appeals) or requirements (such as the number of hours) due to disability

The number of demonstration beneficiaries newly suspended for noncompliance during the measurement period (if state has a suspension policy)

The number of demonstration beneficiaries newly disenrolled for noncompliance with community engagement requirements during the measurement period

The number of demonstration beneficiaries whose benefits were reinstated during the measurement period after suspension in a prior month triggered by noncompliance with community engagement requirements, including those reinstated due to compliance, determination of exemption, and successful appeal or good cause circumstances

The number of demonstration beneficiaries whose benefits were reinstated during the measurement period after suspension in a prior month triggered by noncompliance with community engagement requirements (if state has a suspension policy), because a defined suspension period ended.

The number of demonstration beneficiaries whose benefits were reinstated during the measurement period after suspension in a prior month triggered by noncompliance with community engagement requirements (if state has a suspension policy), because they completed qualifying activities

The number of demonstration beneficiaries whose benefits were reinstated during the measurement period after suspension in a prior month triggered by noncompliance with community engagement requirements (if state has a suspension policy), because they used a special pathway for re-enrollment such as a state-approved educational course

The number of demonstration beneficiaries whose benefits were reinstated during the measurement period after suspension in a prior month triggered by noncompliance with community engagement requirements (if state has a suspension policy) because they were newly determined exempt or had a good cause circumstance

The number of demonstration beneficiaries whose benefits were reinstated during the measurement period after suspension in a prior month triggered by noncompliance with community engagement requirements (if state has a suspension policy) because they successfully appealed

Total number of beneficiaries re-enrolled in the demonstration during the measurement period after disenrollment in the last 12 months for noncompliance or because they were in suspended status on their redetermination date (depending on state policy), including those re-enrolling after being determined exempt or after successful appeal.

Total number of beneficiaries re-enrolled in the demonstration during the measurement period because they completed qualifying activities, subsequent to disenrollment in the last 12 months for noncompliance or because they were in suspended status on their redetermination date (depending on state policy).

Total number of demonstration beneficiaries re-enrolled during the measurement period because they used a special pathway for re-enrollment such as a state-approved educational course, subsequent to disenrollment in the last 12 months for noncompliance or because they were in suspended status on their redetermination date (depending on state policy).

The number of beneficiaries re-enrolled in the demonstration during the measurement period because they re-applied, subsequent to disenrollment in the last 12 months for noncompliance (or because they were in suspended status on their redetermination date). This includes those who re-applied immediately after disenrollment and those who did so after a disenrollment (non-eligibility) period.

The number of beneficiaries re-enrolled in the demonstration during the measurement period because they were newly determined exempt, subsequent to disenrollment in the last 12 months for noncompliance (or because they were in suspended status on their redetermination date).

The number of beneficiaries re-enrolled in the demonstration during the measurement period after successful appeal (including retroactive determination of a good cause exemption by the state), subsequent to disenrollment in the last 12 months for noncompliance (or because they were in suspended status on their redetermination date)

te.

Data source	Calculation lag	Attest that reporting matches CMS-provided specification (Y/N)
Administrative records	30 days	
Administrative records	30 days	
Administrative records	30 days	
Administrative records	30 days	
Administrative records	30 days	
Administrative records	30 days	
Administrative records	30 days	
Administrative records	30 days	

Administrative records	30 days
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Administrative records	30 days
Administrative records	30 days
Administrative records	30 days

Administrative records 30 days

Administrative records 30 days

Administrative records 30 days

Administrative records 30 days

Administrative records 30 days

Describe any deviations from CMS-provided measure specifications	Reporting issue (Y/N) (further describe in the data and reporting issues tab [CE])

Measurement period (month, quarter, year[c])	Dates covered by measurement period (MM/DD/YYYY-MM/DD/YYYY)	Demonstration Denominator	Demonstration Numerator[d]
Month 1			
Month 2			
Month 3			
Month 1			
Month 2			
Month 3			
Month 1			
Month 2			
Month 3			
Month 1			
Month 2			
Month 3			
Month 1			
Month 2			
Month 3			
Month 1			
Month 2			
Month 3			
Month 1			
Month 2			
Month 3			
Month 1			
Month 2			
Month 3			

Month 1

Month 2

Month 3

Month 1

Month 2

Month 3

Month 1

Month 2

Month 3

Month 1

Month 2

Month 3

Month 1

Month 2

Month 3

Month 1

Month 2

Month 3

Month 1

Month 2

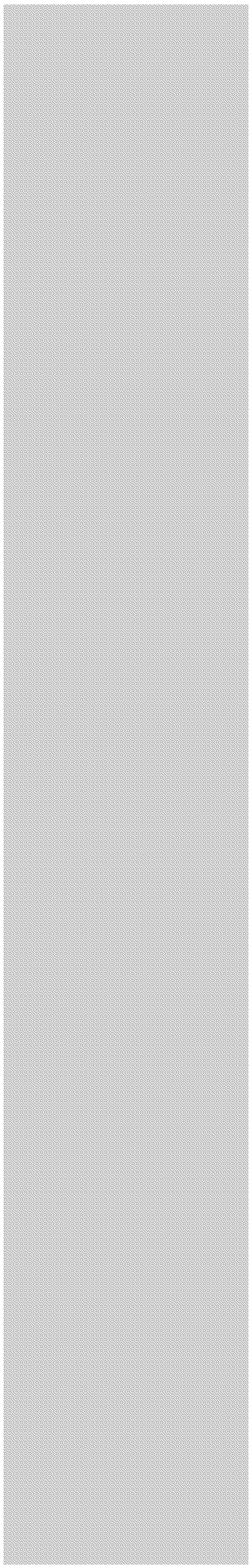
Month 3

Month 1

Month 2

Month 3

Month 1
Month 2
Month 3
Month 1
Month 2
Month 3
Month 1
Month 2
Month 3
Month 1



Month 2
Month 3
Month 1
Month 2
Month 3
Month 1
Month 2
Month 3
Month 1
Month 2
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Month 2
Month 3
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Month 2
Month 3
Month 1
Month 2
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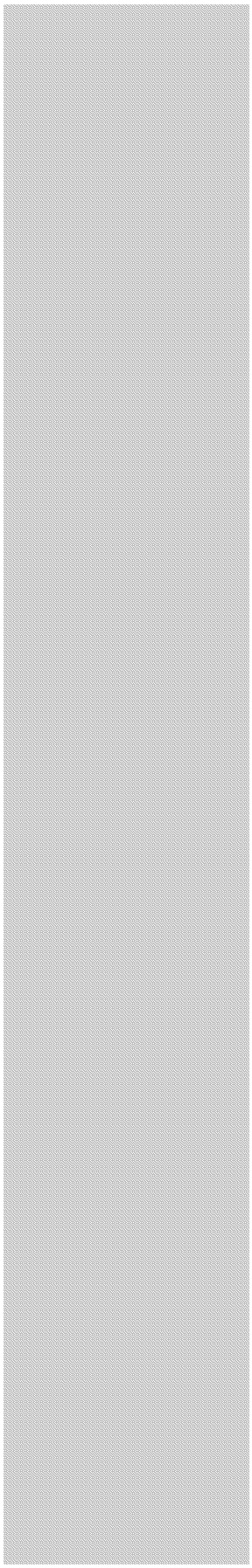
Month 2
Month 3



Month 1
Month 2
Month 3
Month 1
Month 2
Month 3
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Month 2
Month 3
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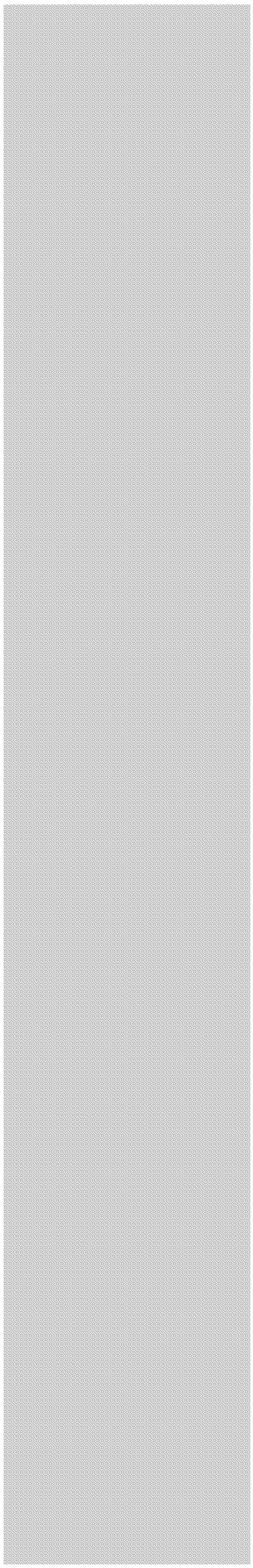
Month 3
Month 1
Month 2
Month 3



Month 1

Month 2

Month 3

Month 1

Month 2

Month 3

Month 1

Month 2

Month 3

Month 1

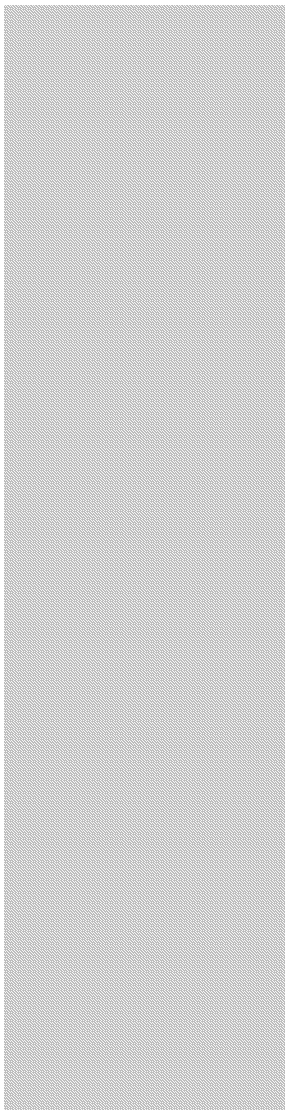
Month 2

Month 3

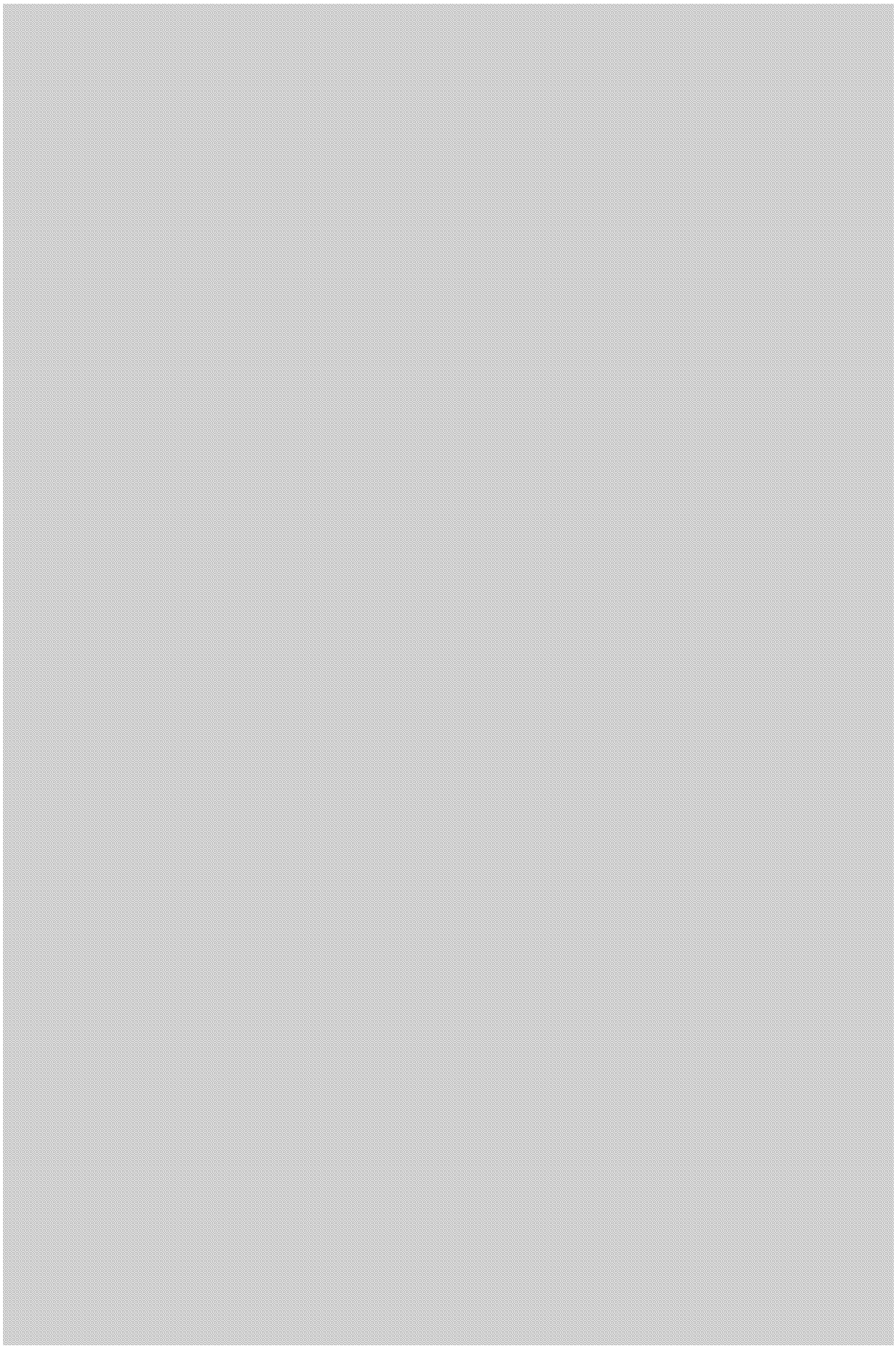
Month 1

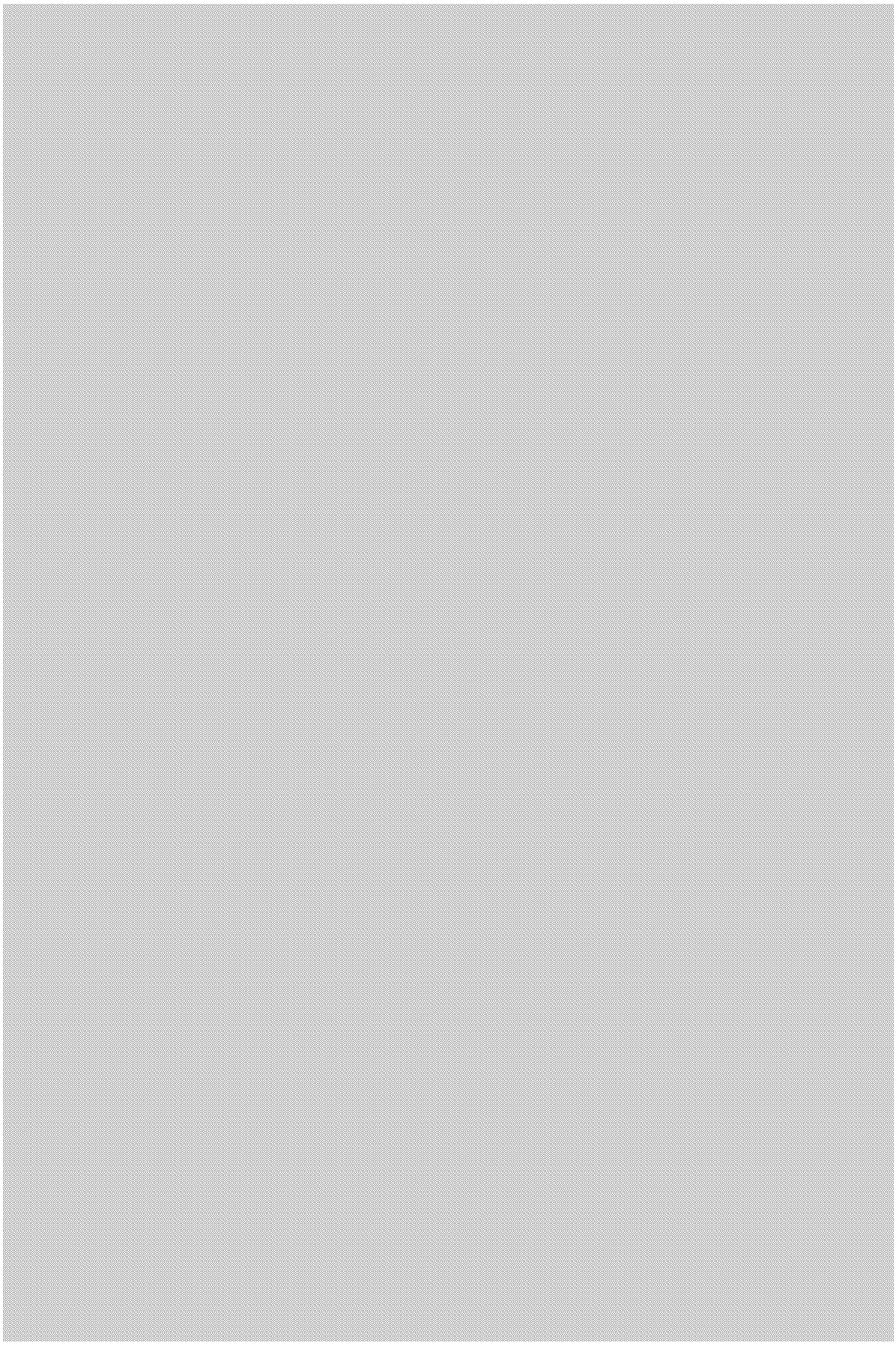
Month 2

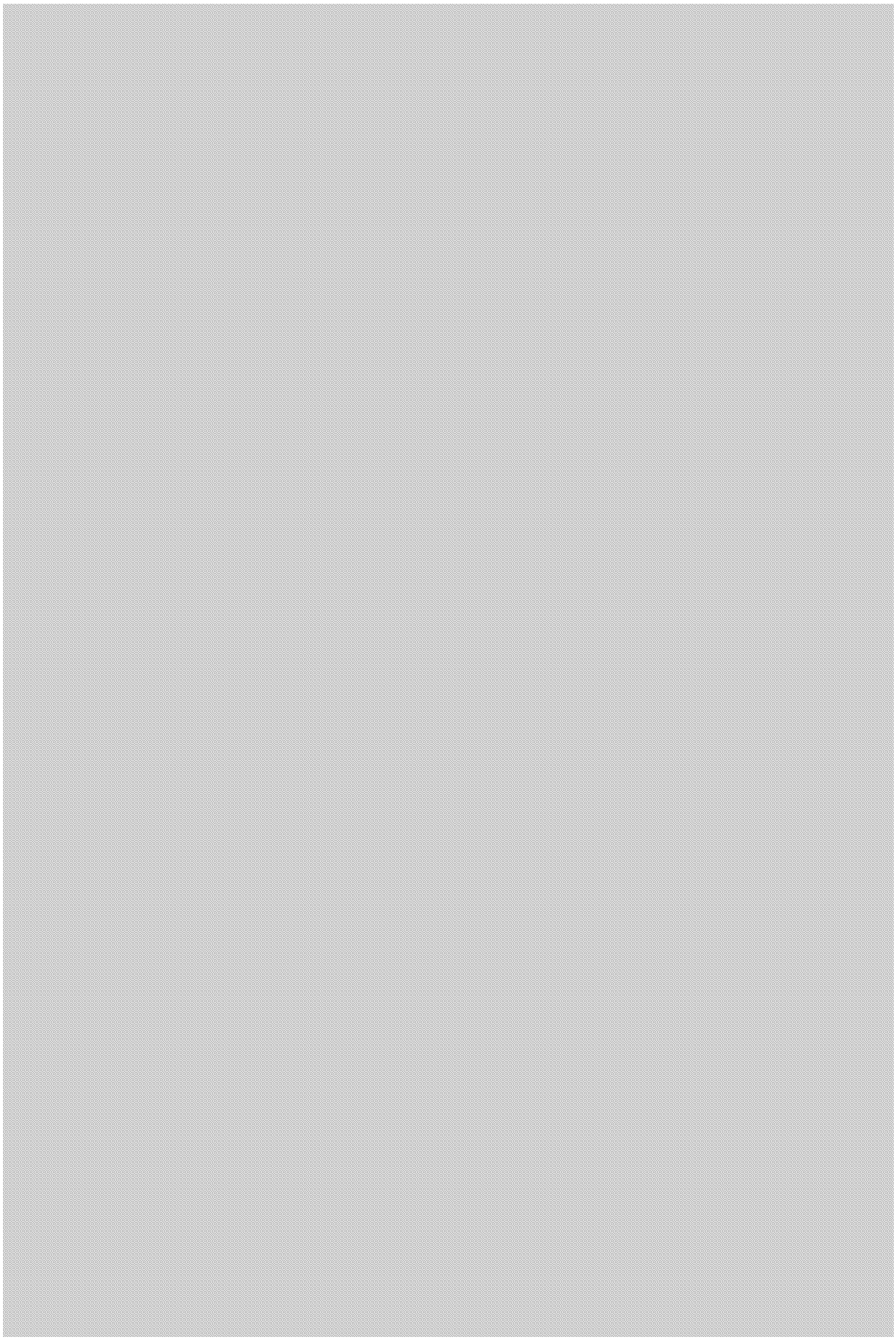
Month 3



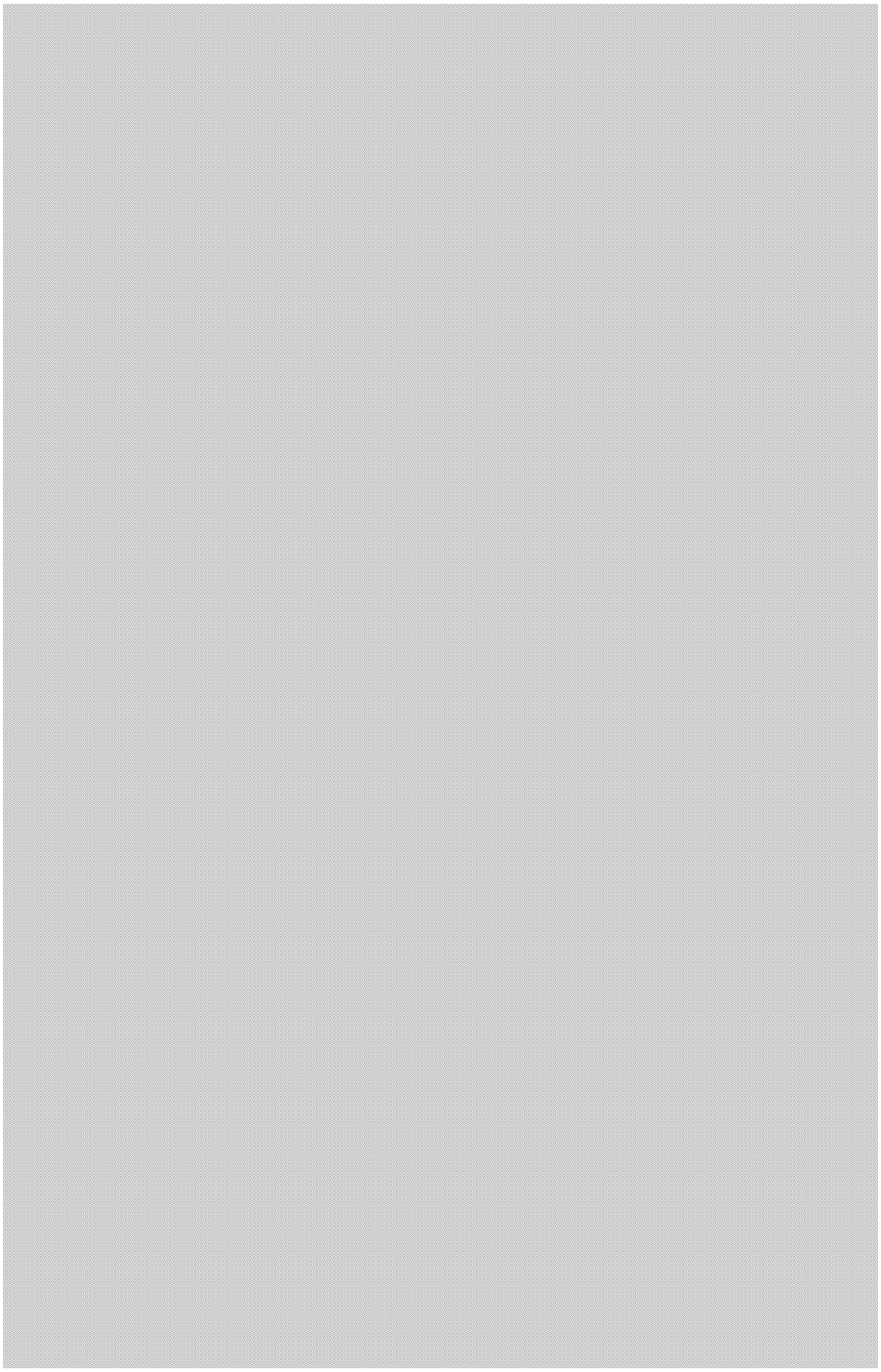
Rate/Percentage[e]	< 50% FPL[f]		
	Denominator	Numerator[d]	Rate/Percentage[e]

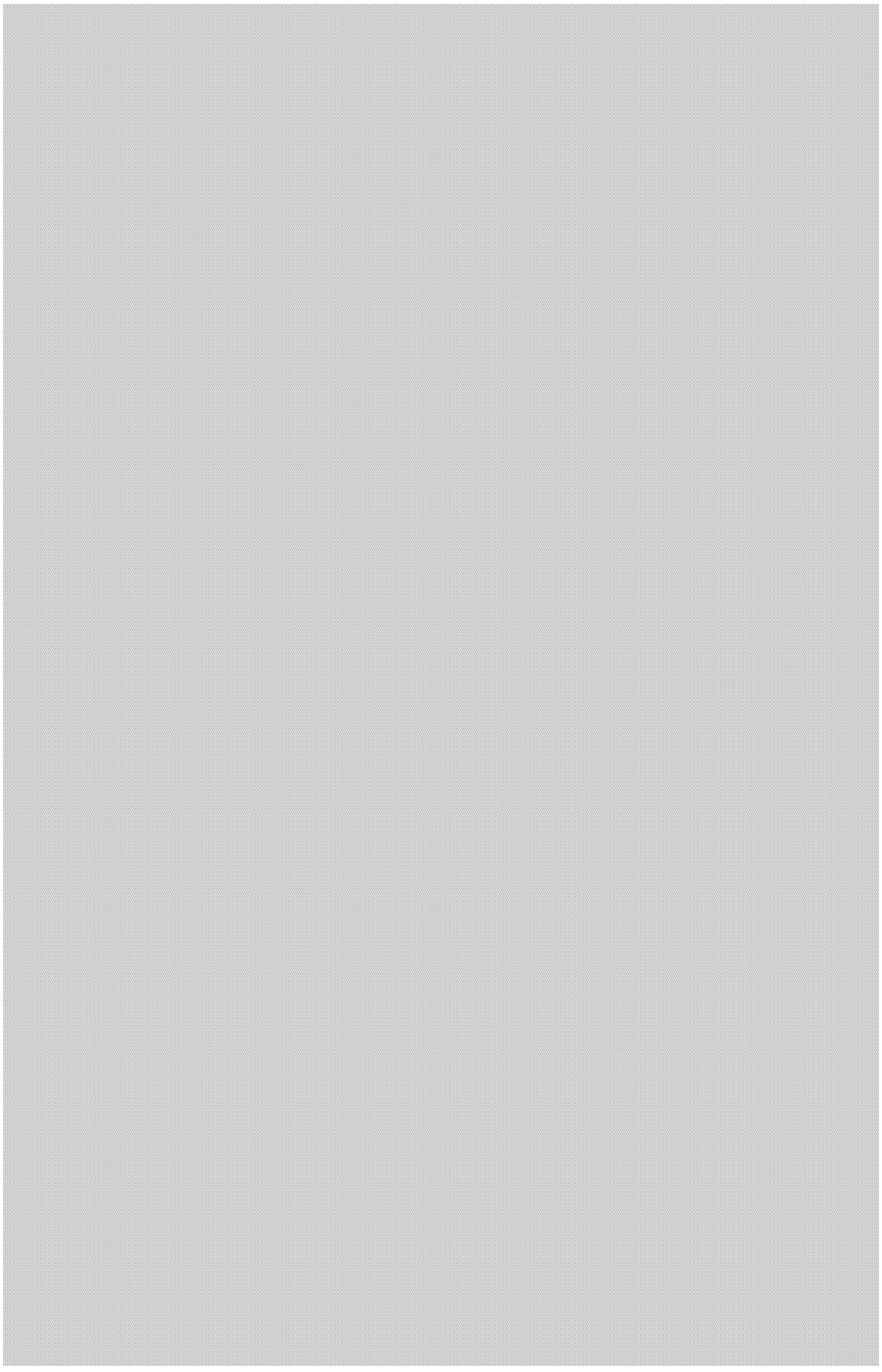


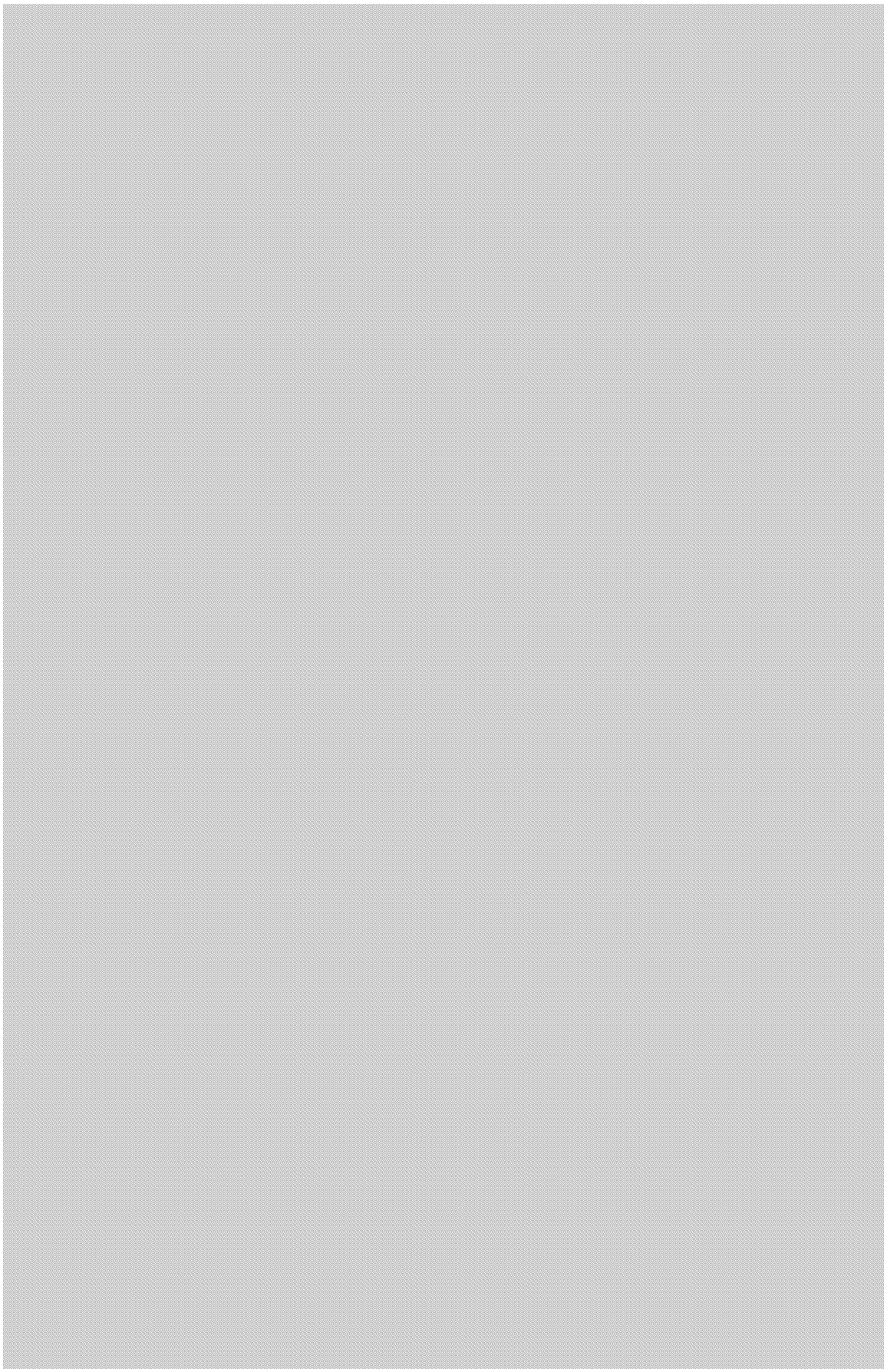




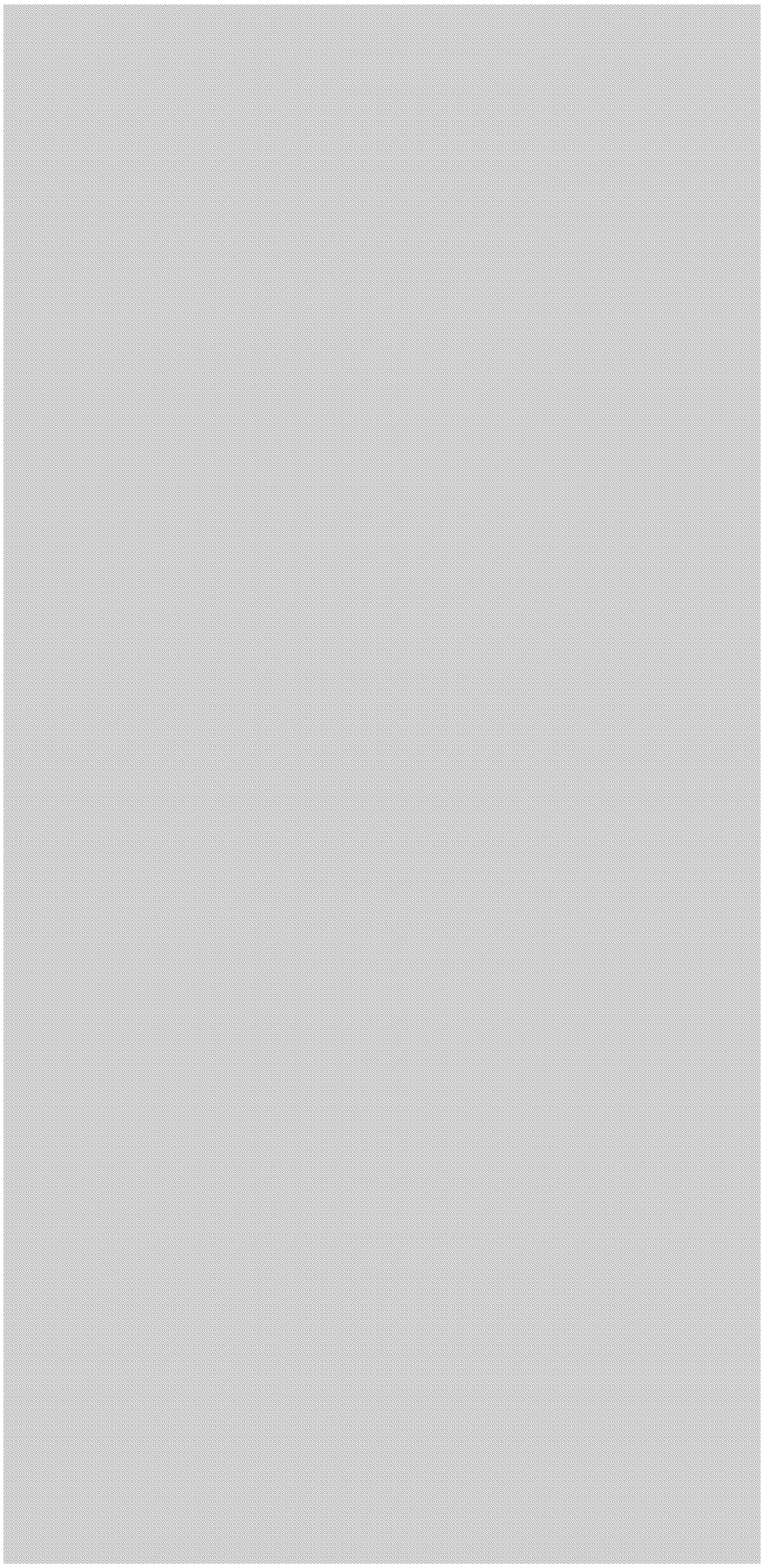
50-100% FPL[f]			
Denominator	Numerator[d]	Rate/Percentage[e]	Denominator

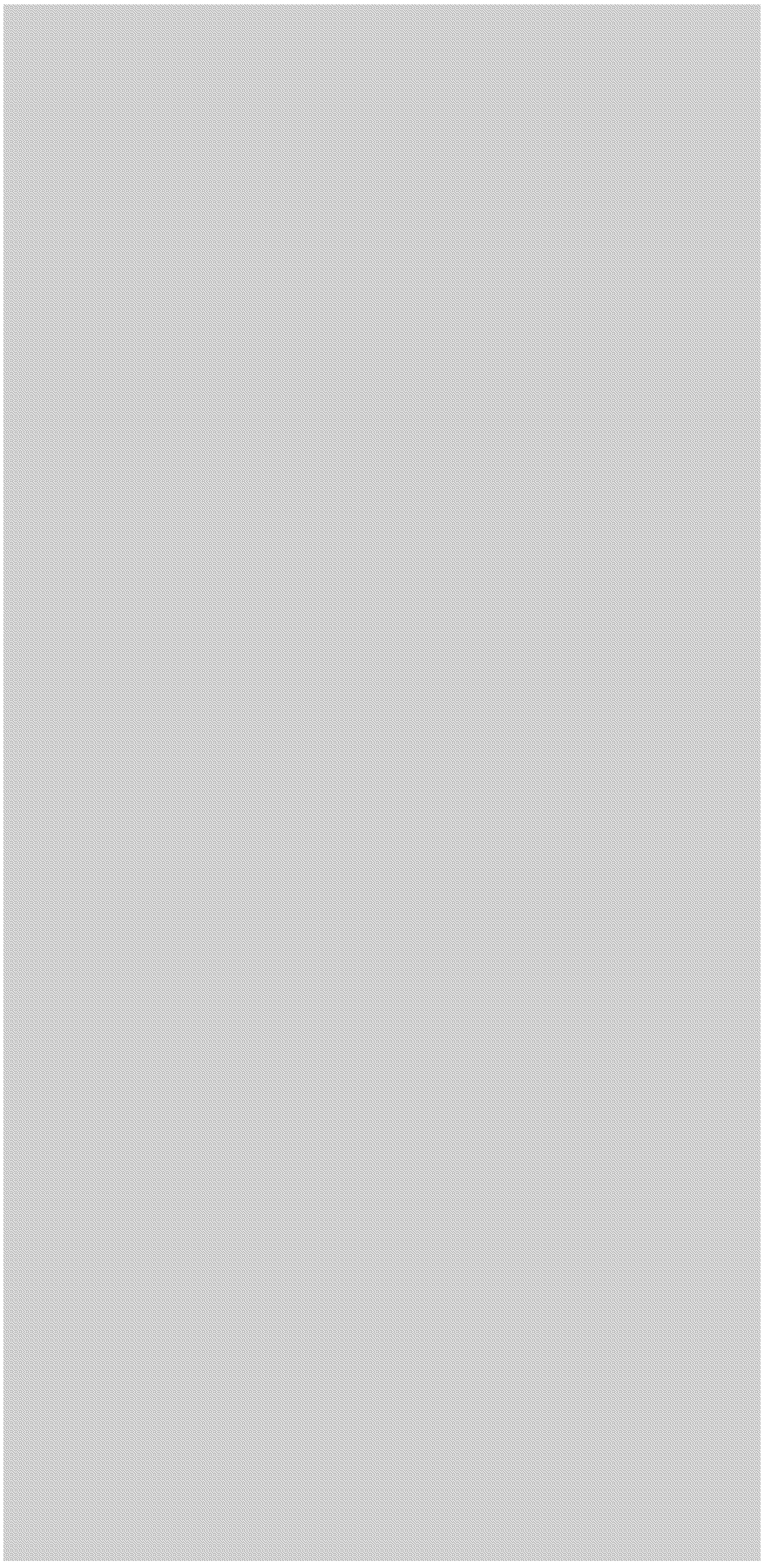


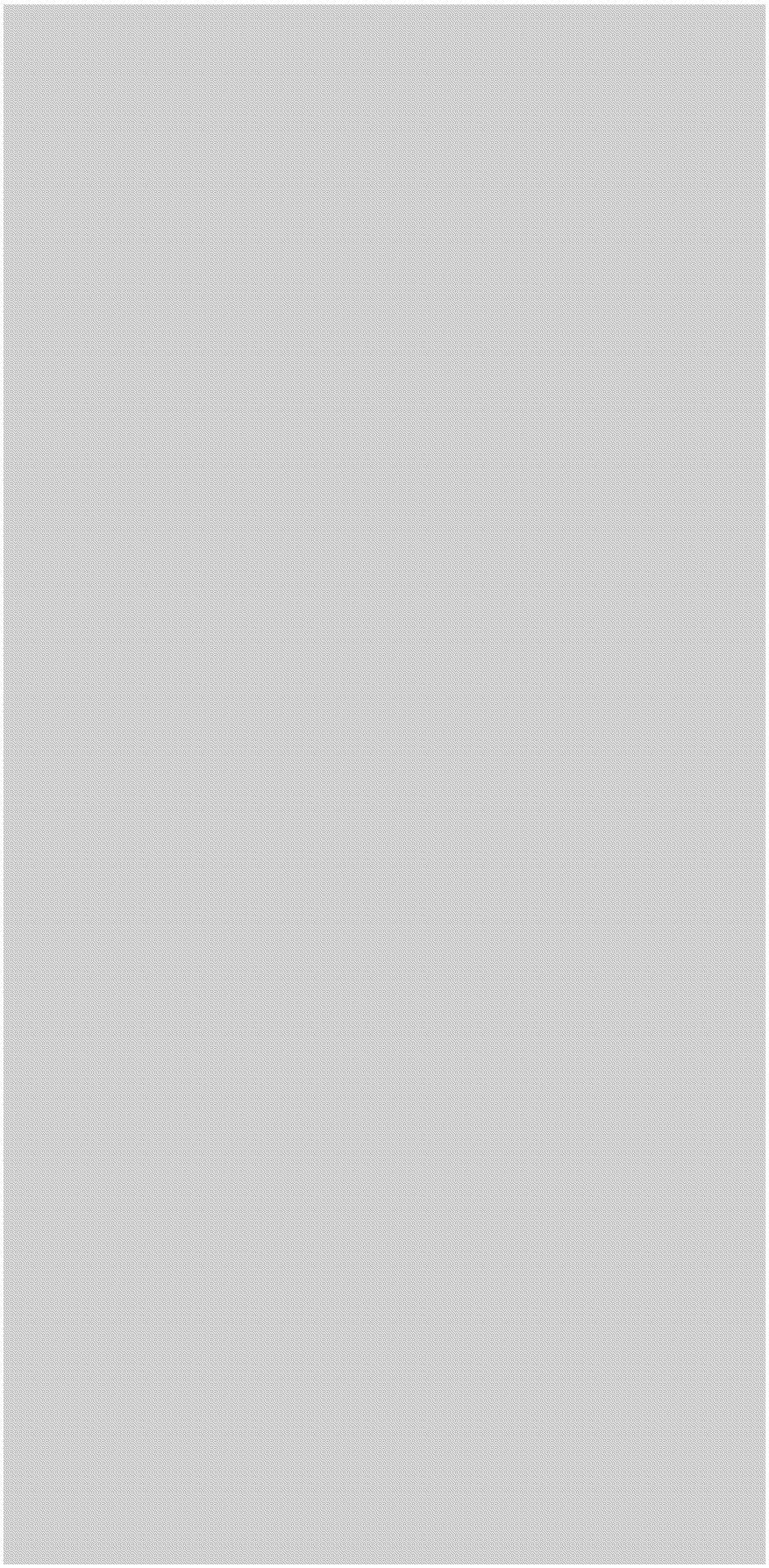


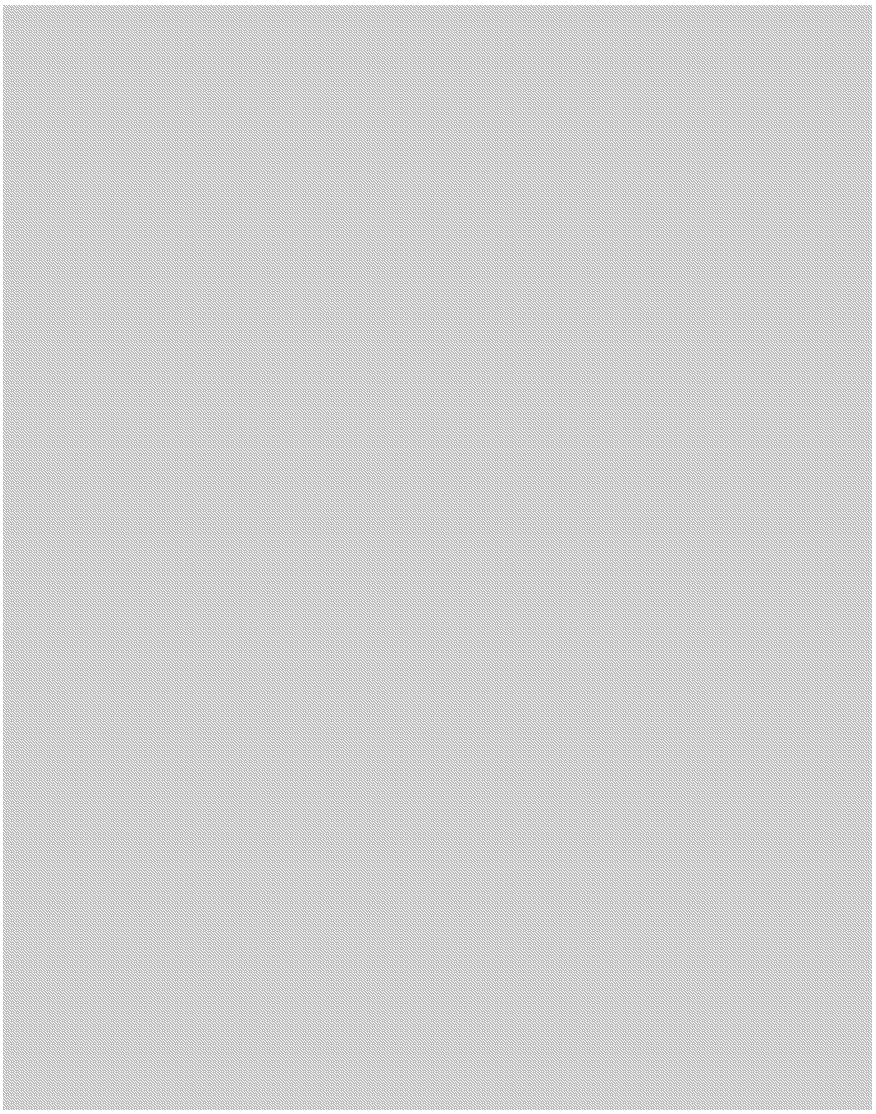


>100% FPL[f]			Age 19-26
Numerator[d]	Rate/Percentage[e]	Denominator	Numerator[d]

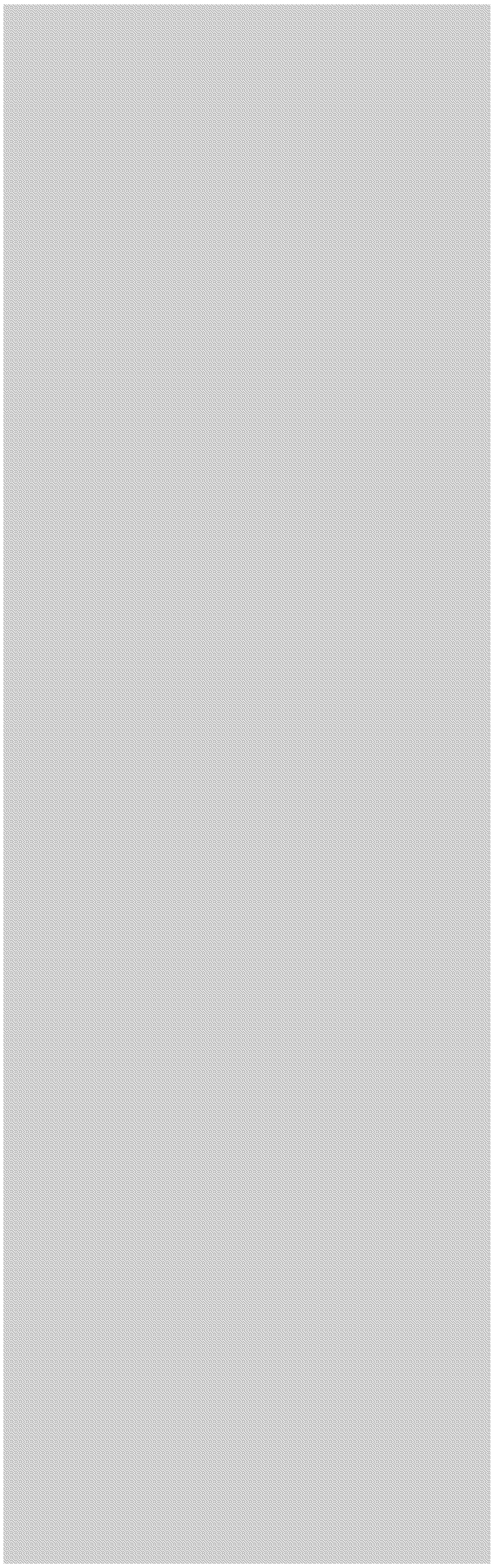


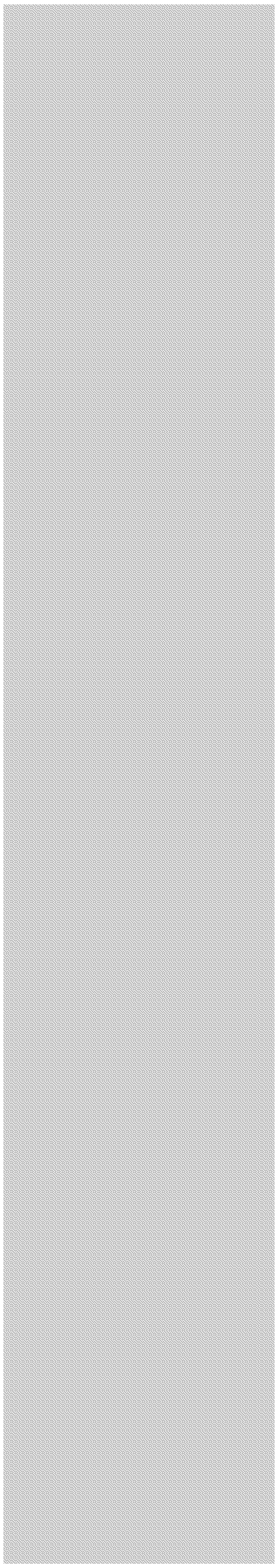


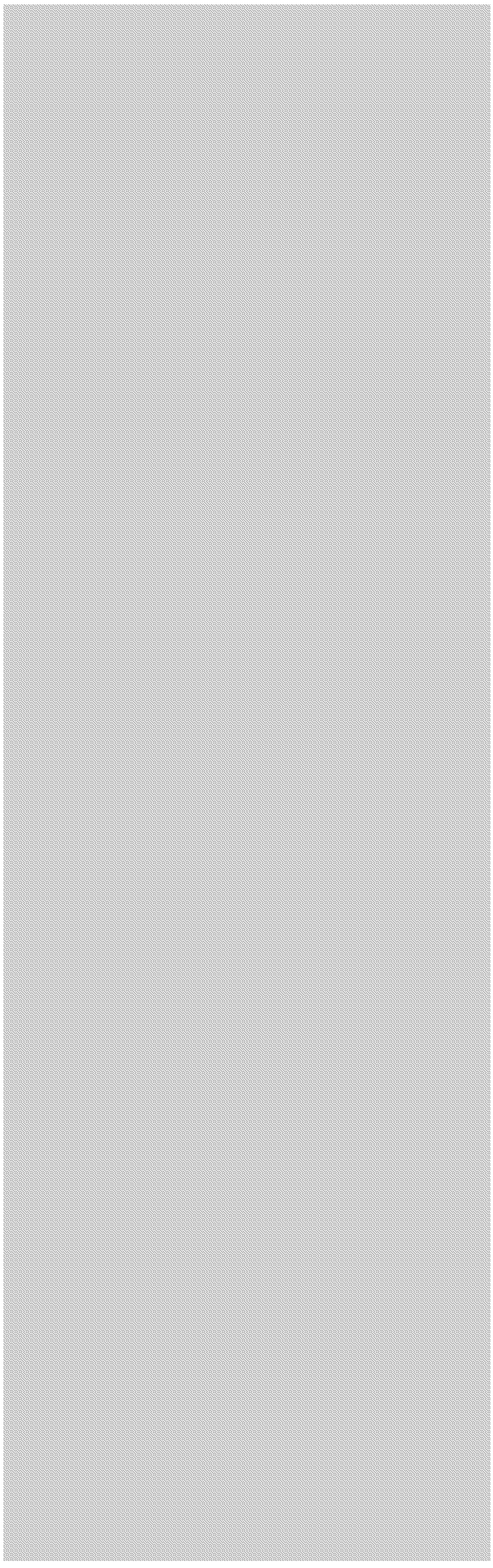


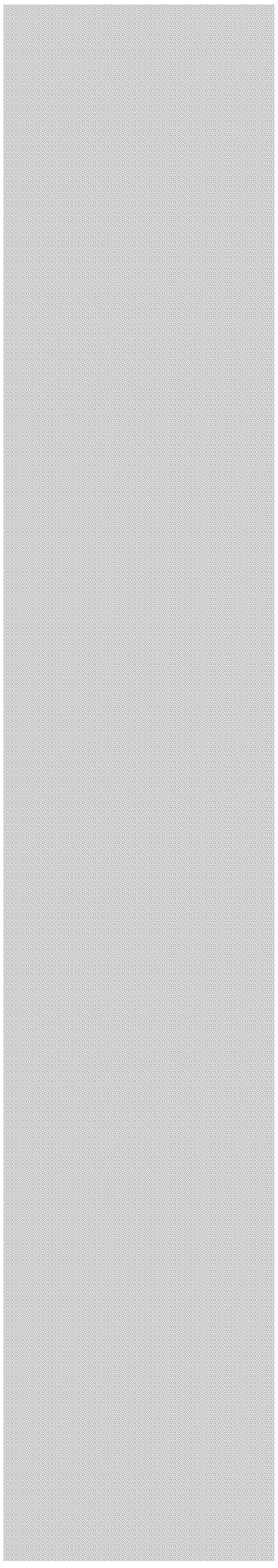


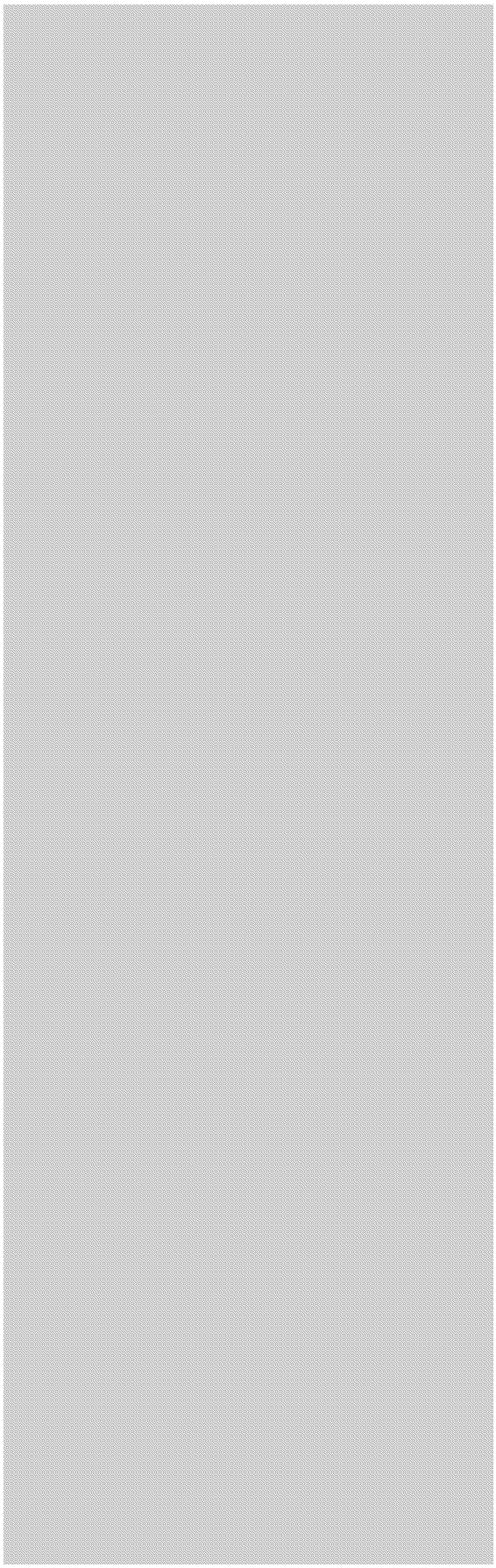
	Age 27-35		
Rate/Percentage[e]	Denominator	Numerator[d]	Rate/Percentage[e]

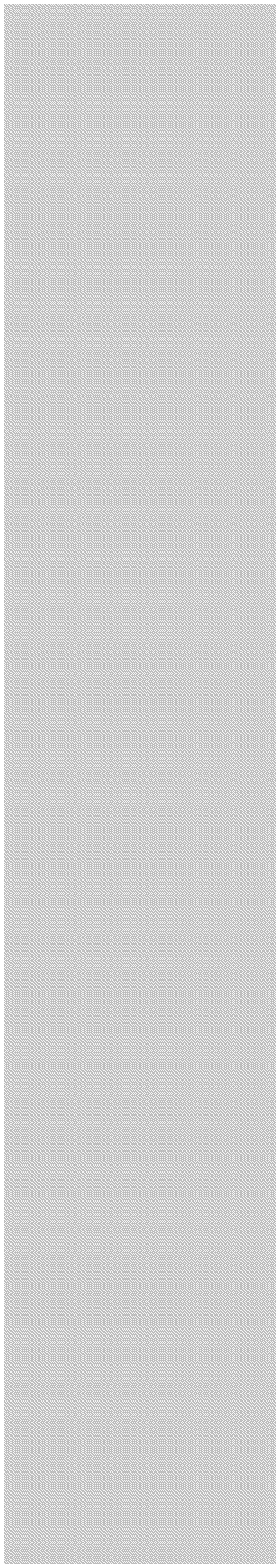


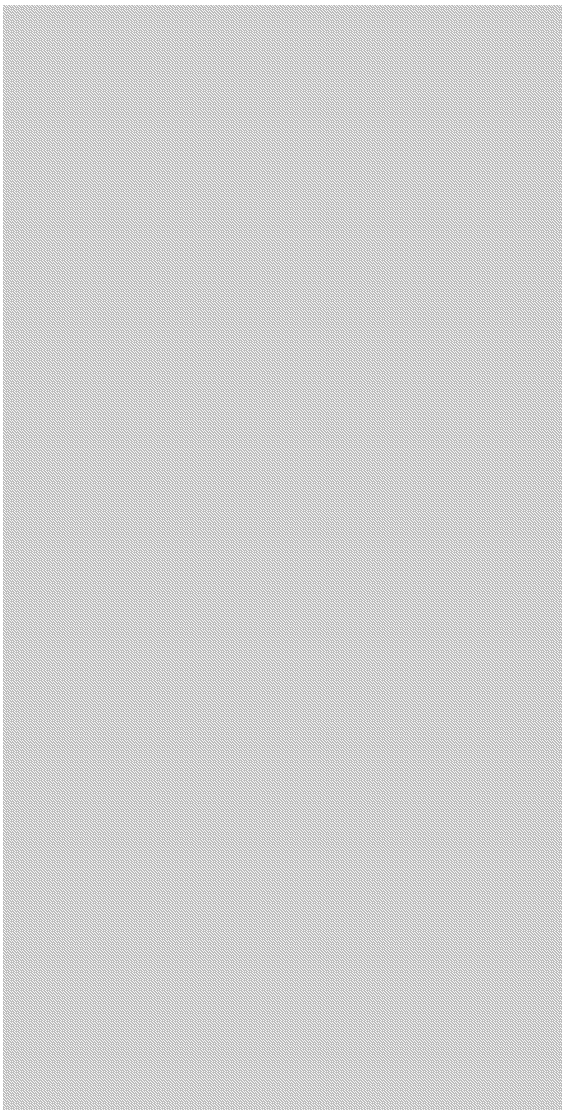


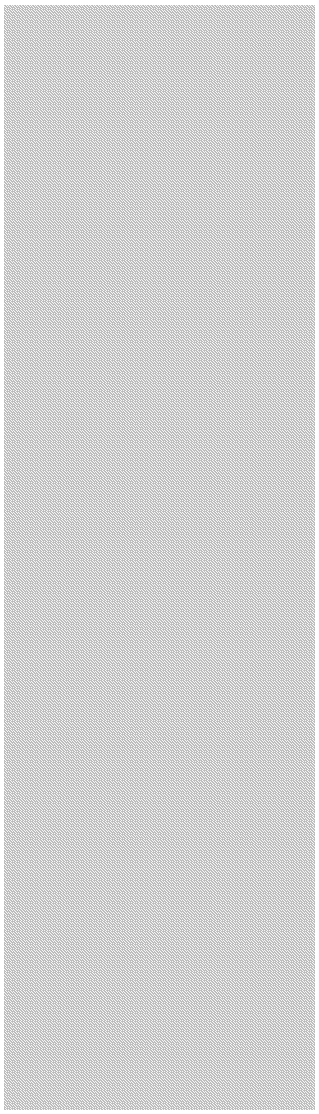




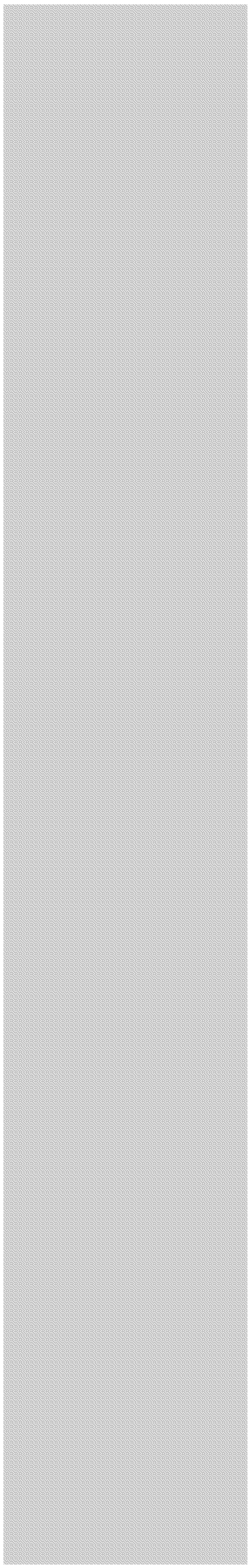


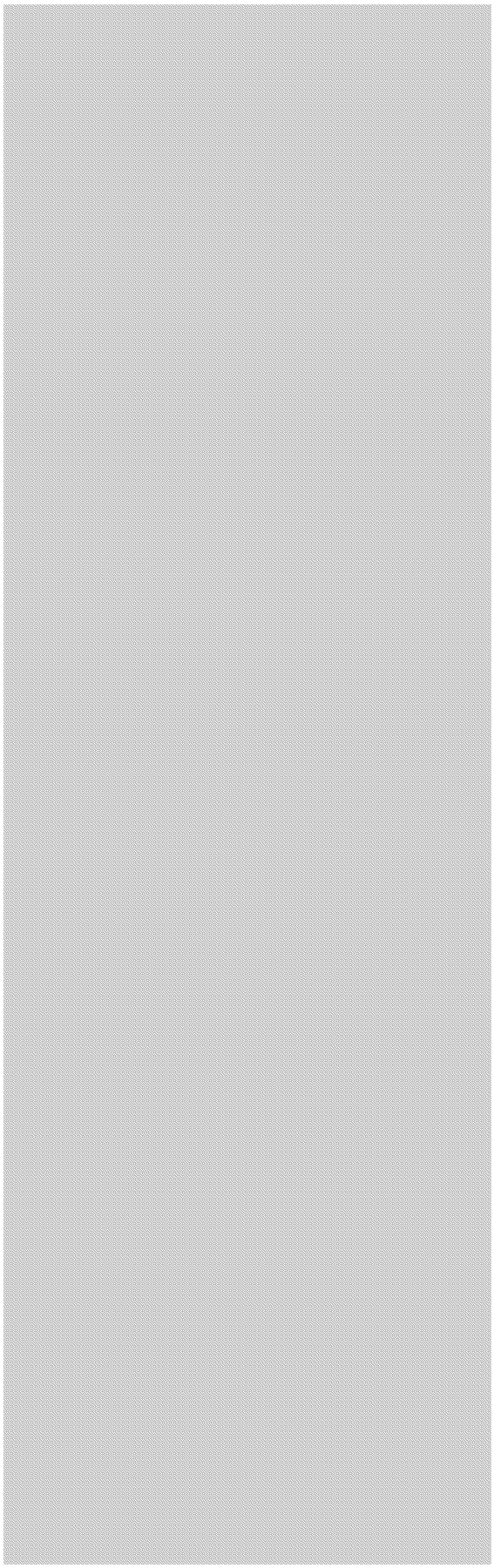


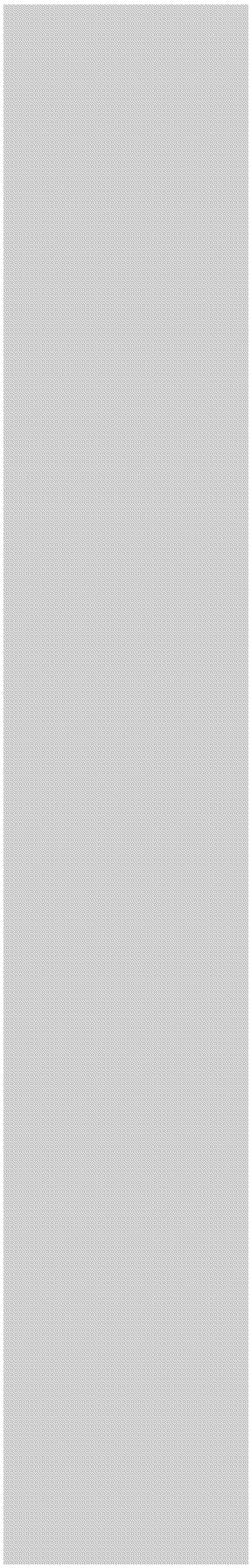


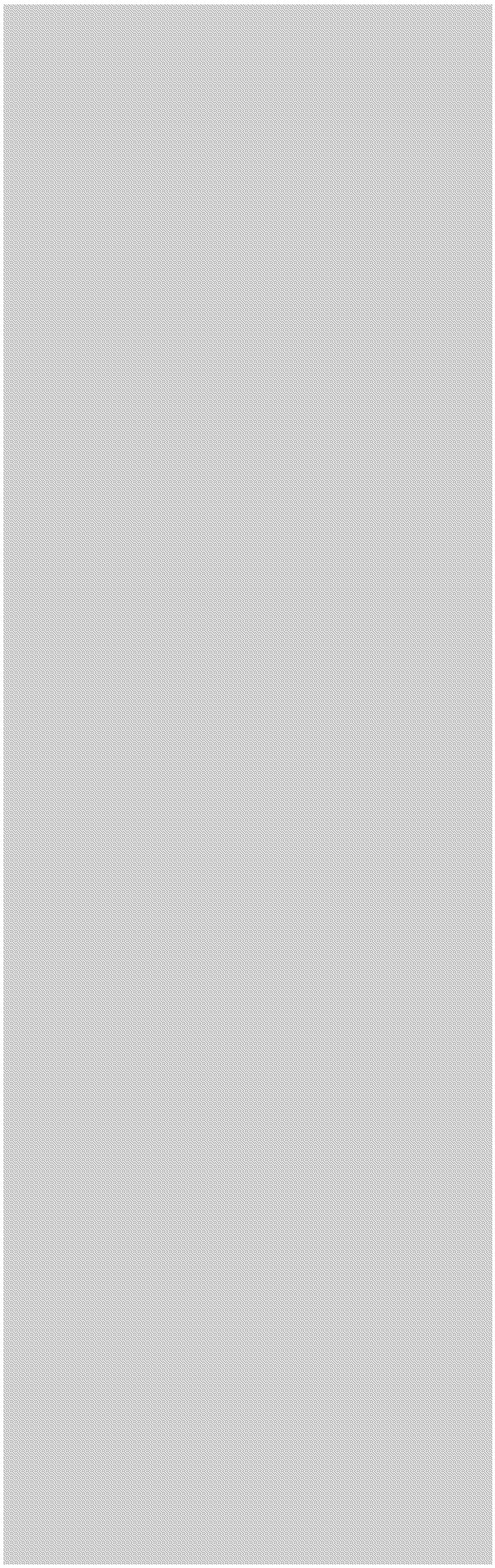


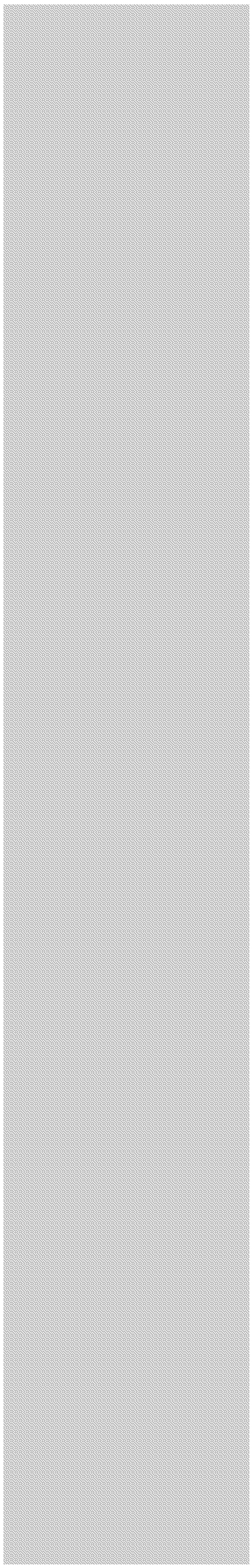
Age 36-45			
Denominator	Numerator[d]	Rate/Percentage[e]	Denominator

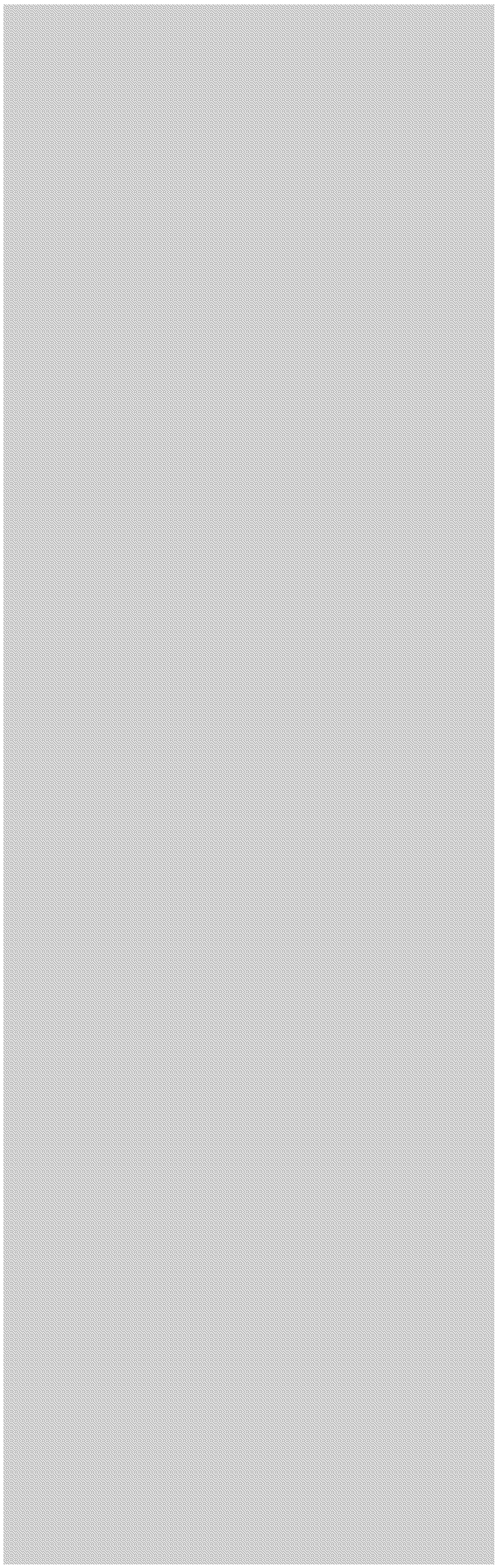


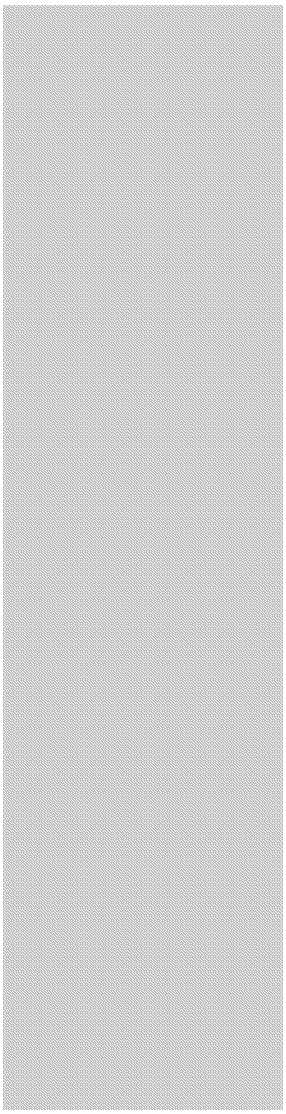


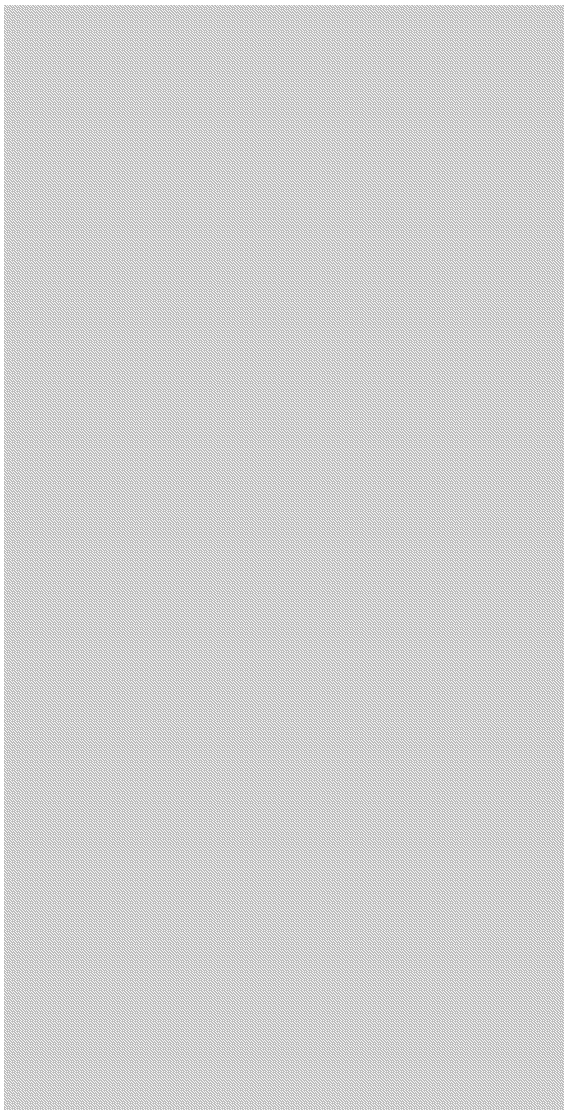




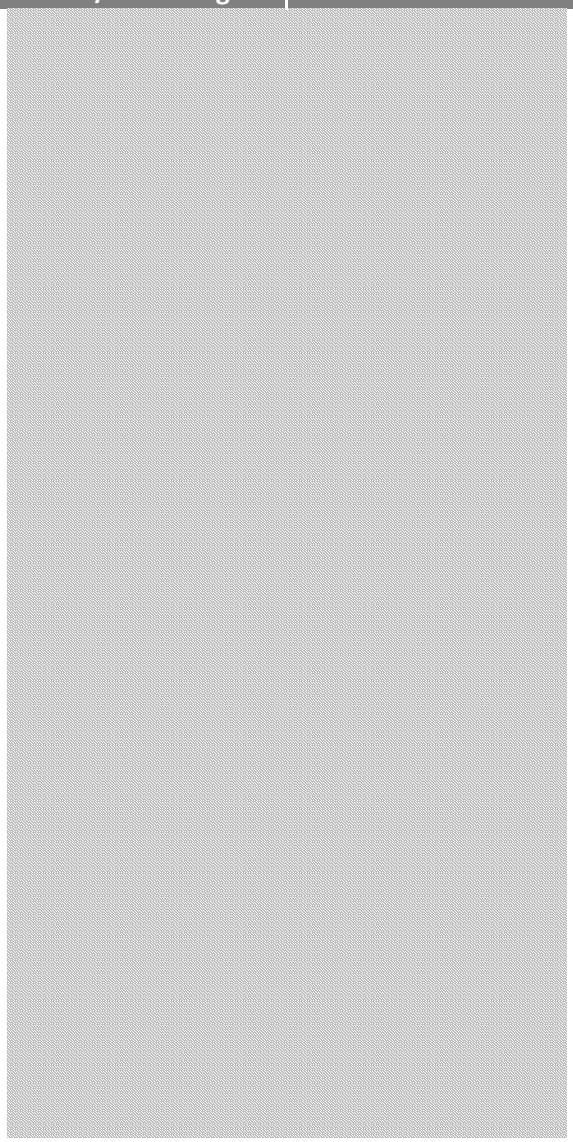


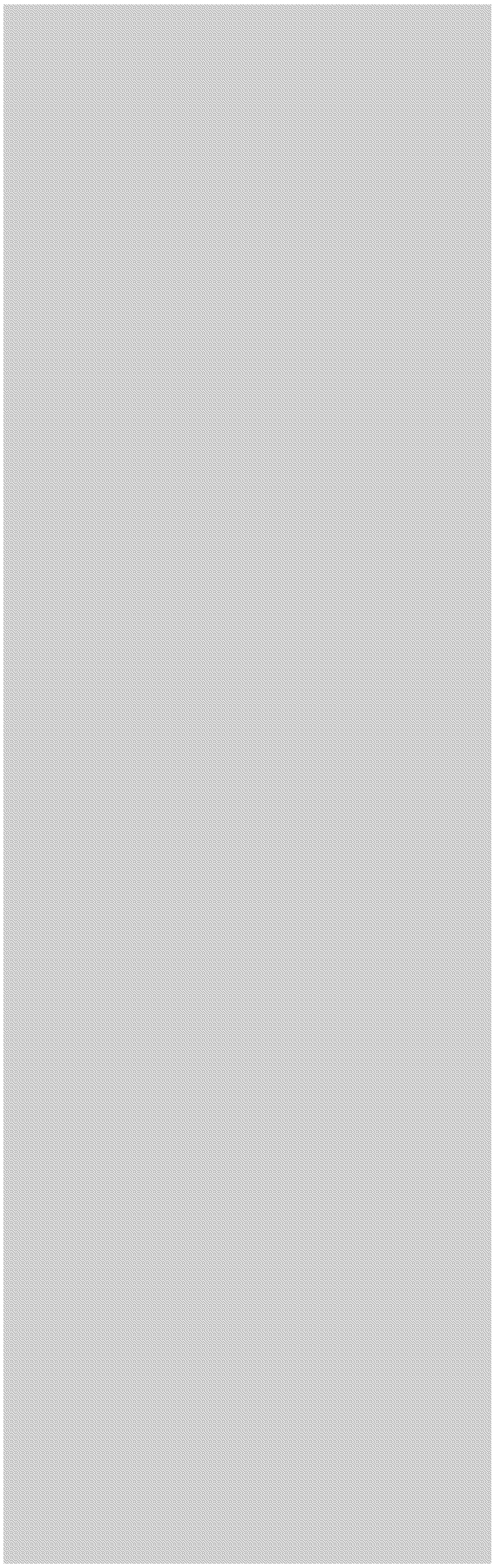


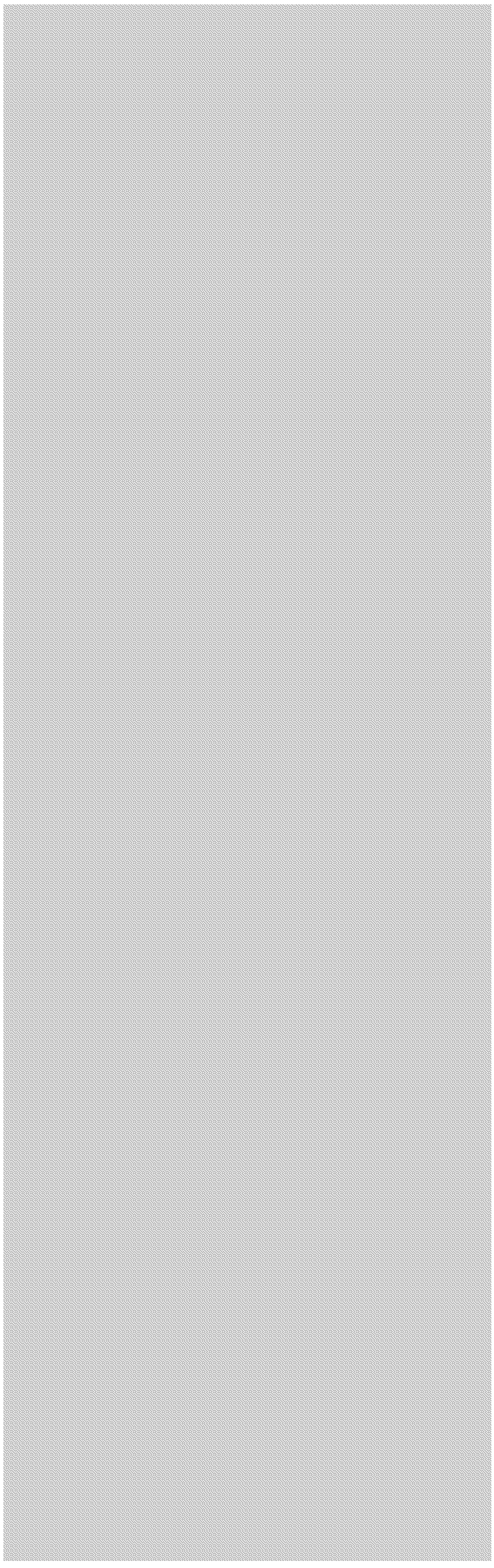


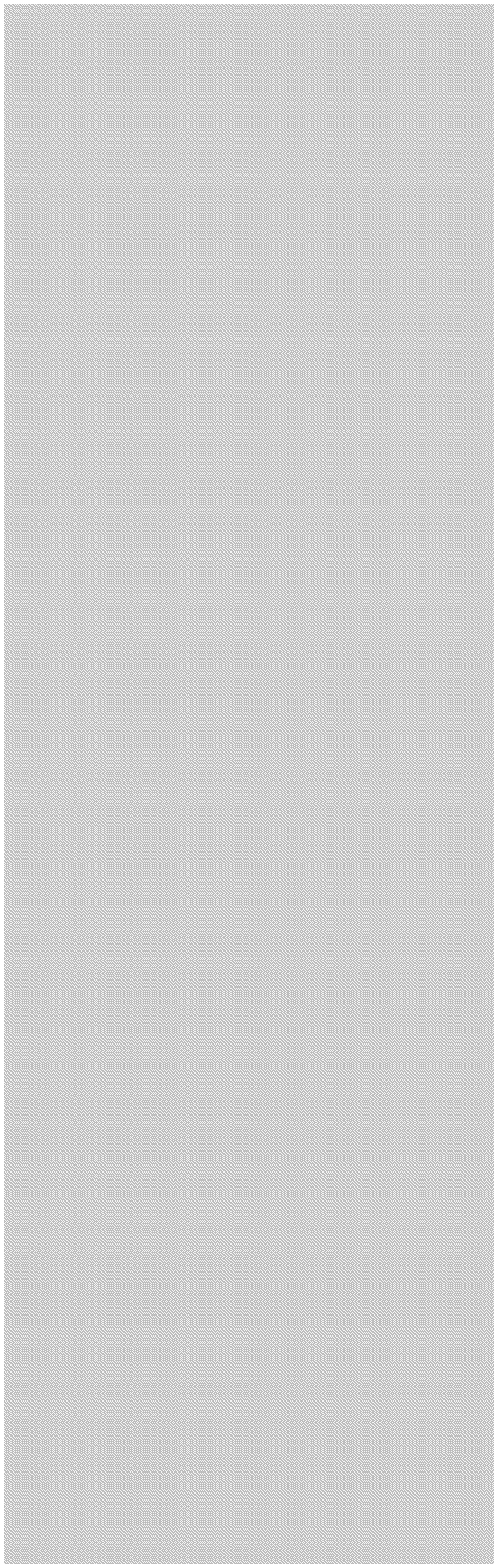


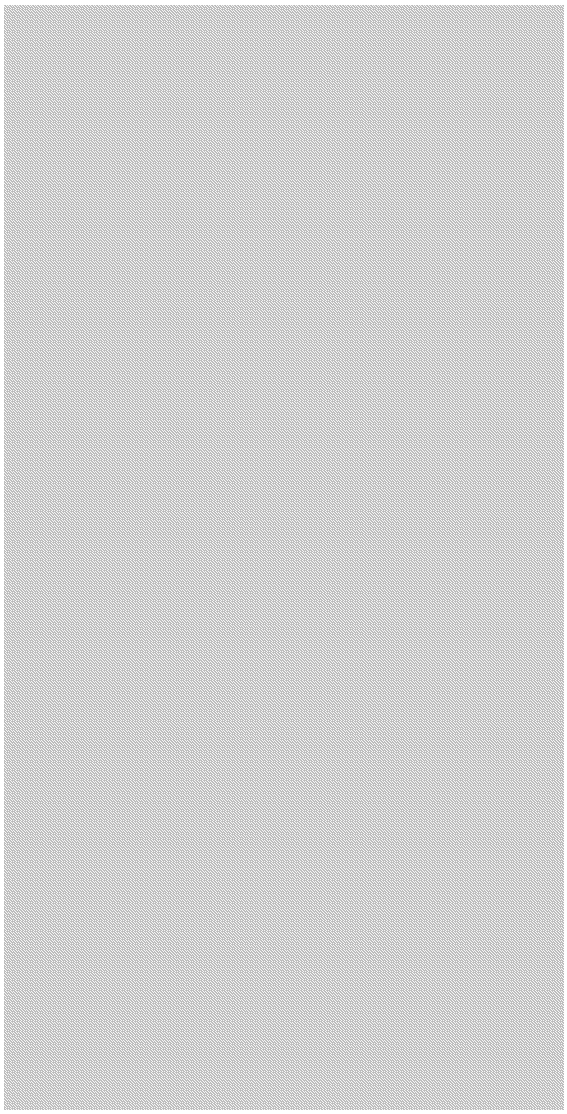
Age 46-55			Age 56-64
Numerator[d]	Rate/Percentage[e]	Denominator	Numerator[d]



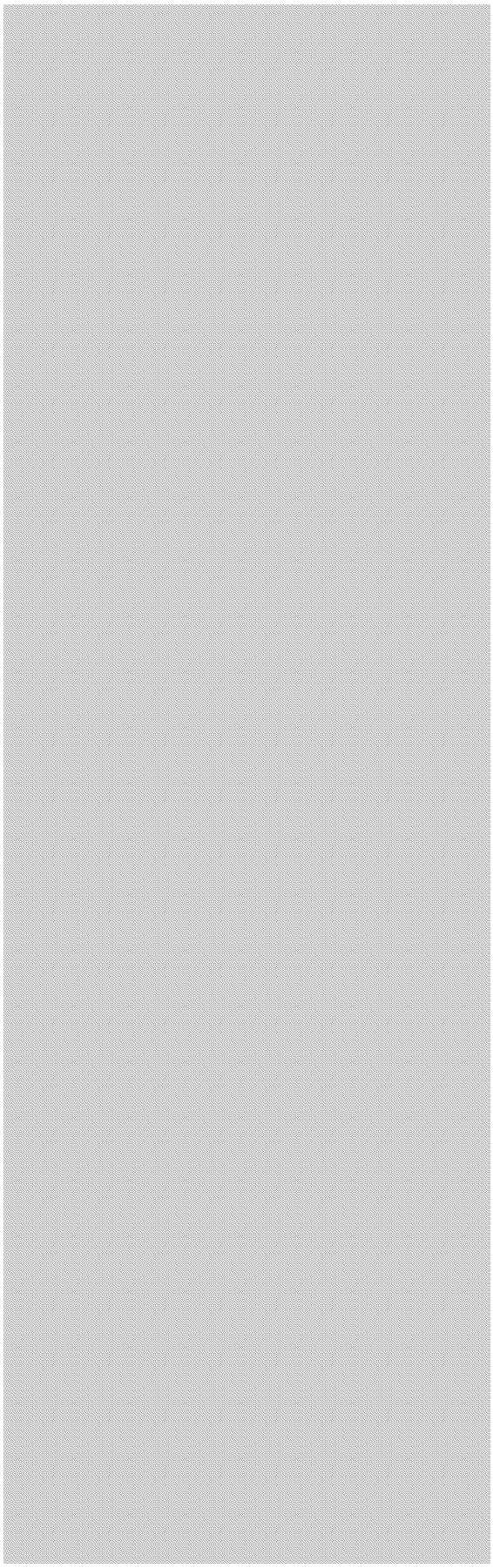


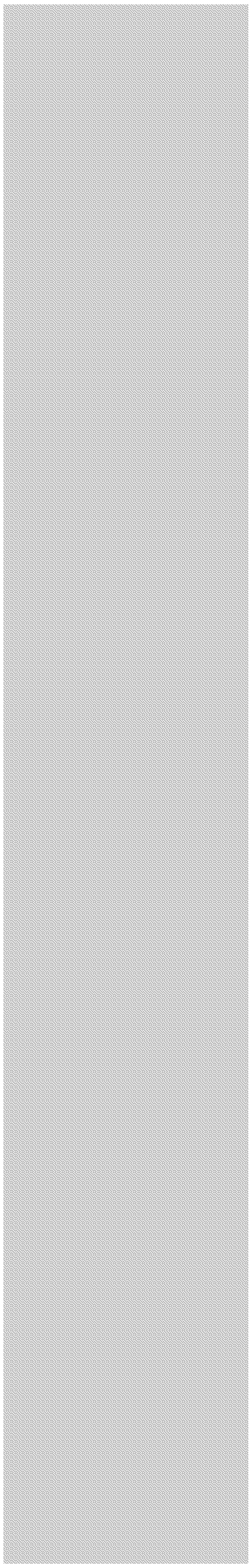


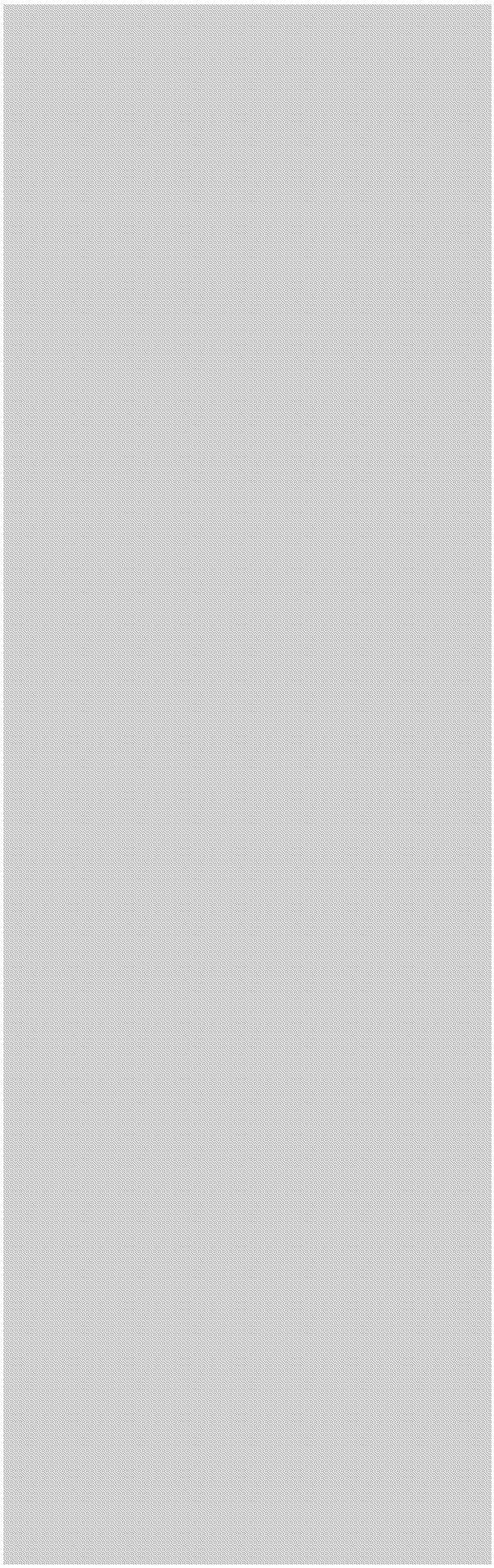


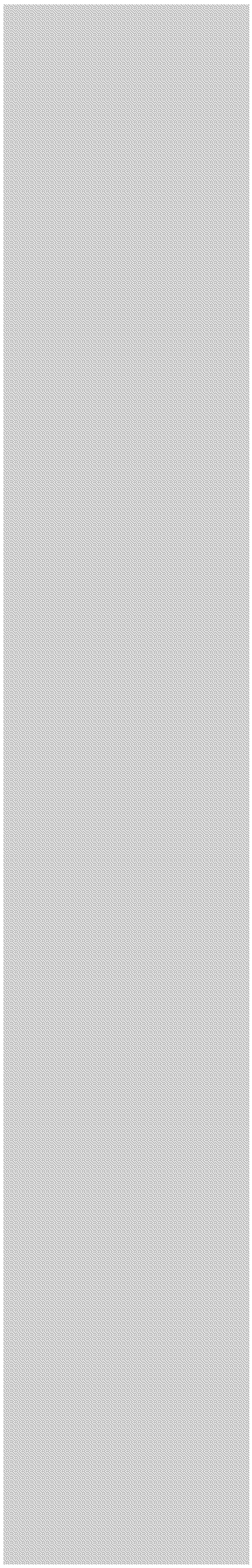


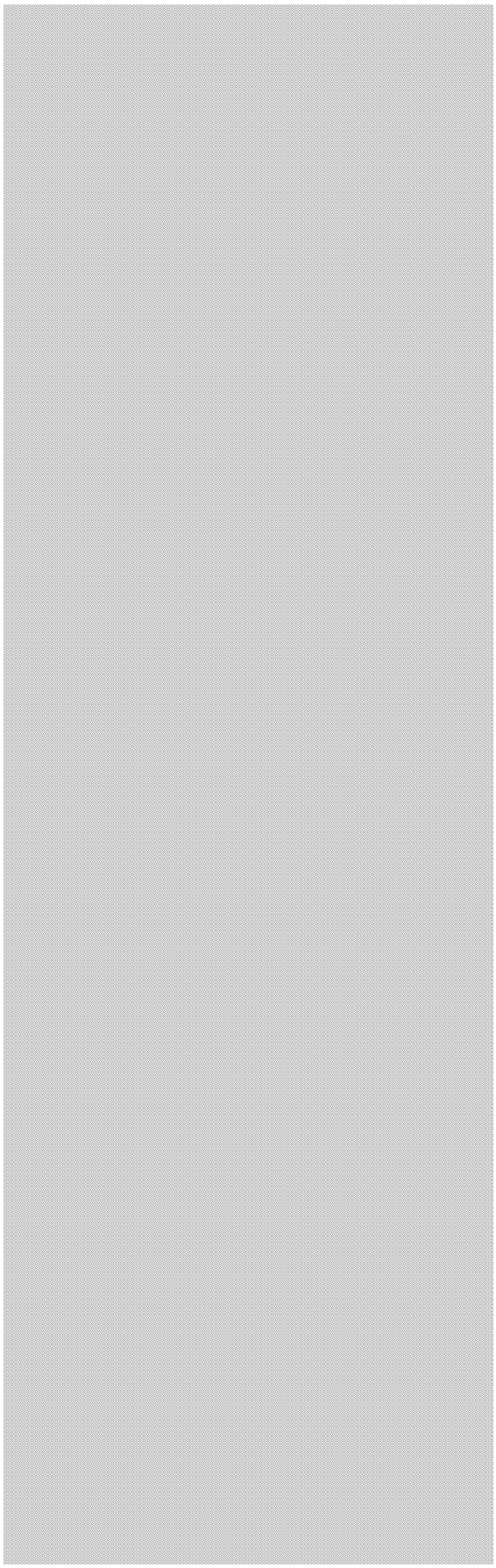
	Male		
Rate/Percentage[e]	Denominator	Numerator[c]	Rate/Percentage[d]

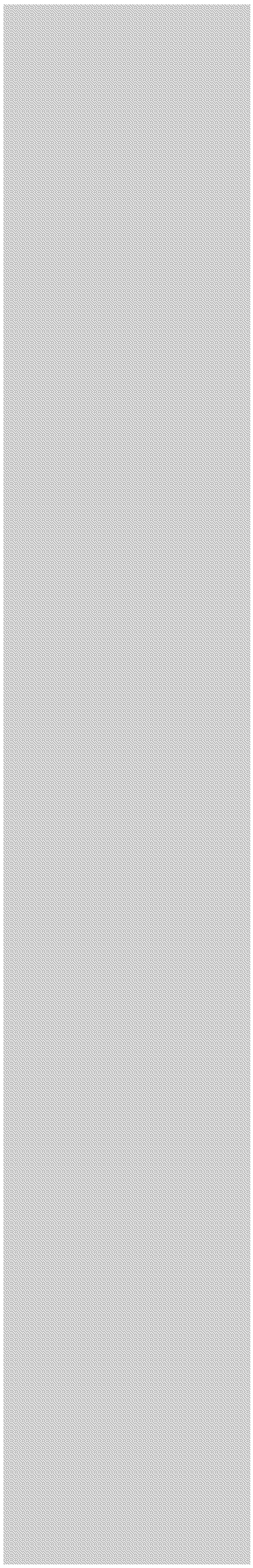


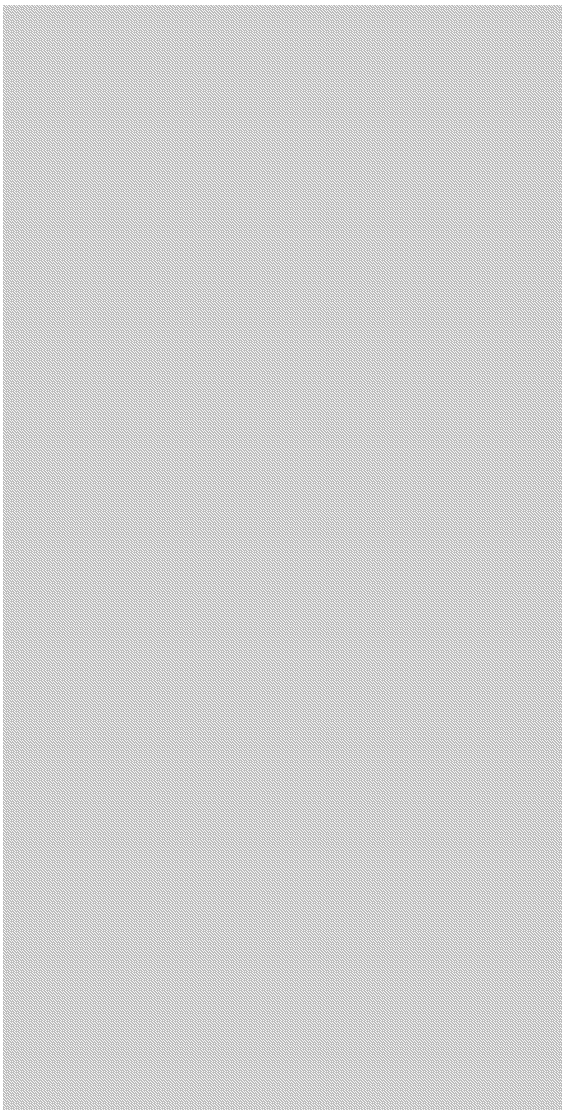


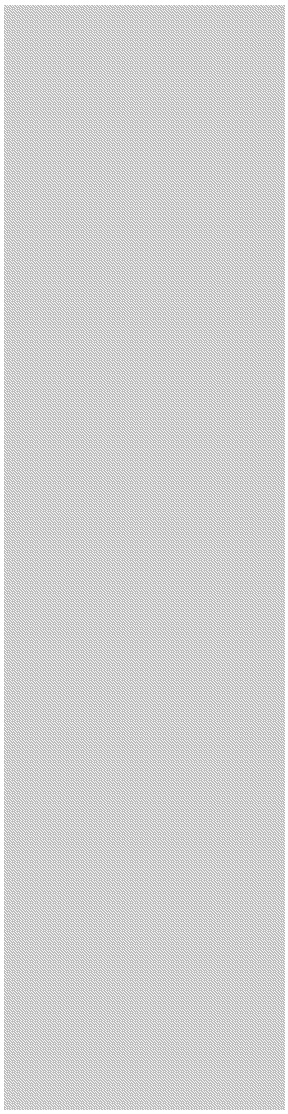




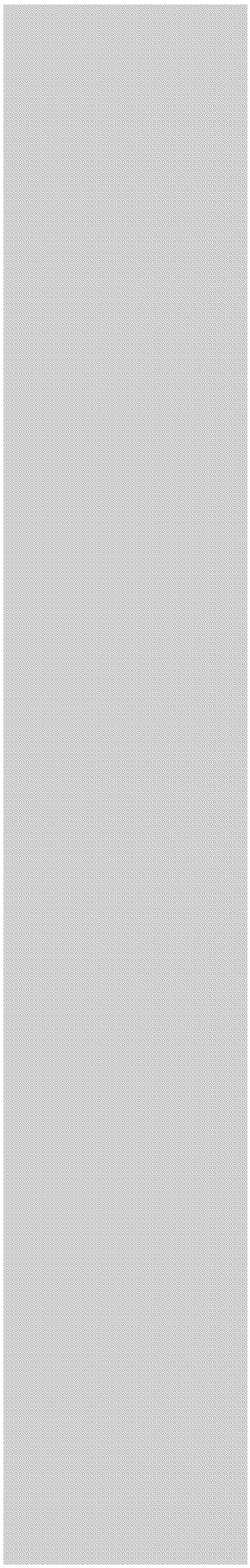


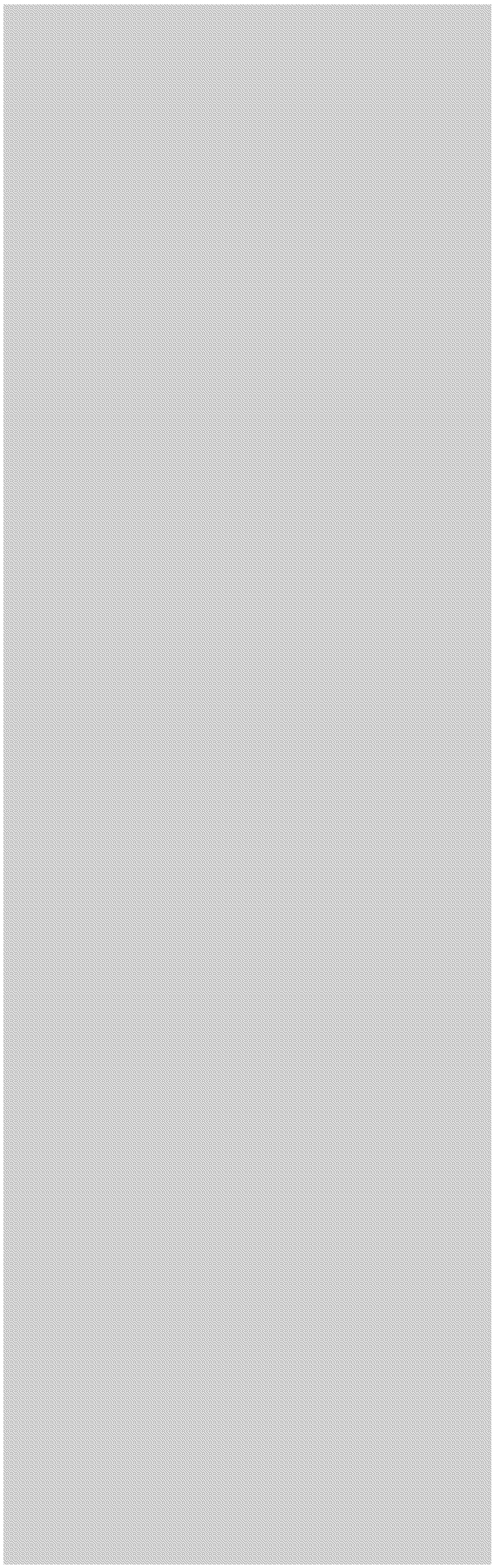


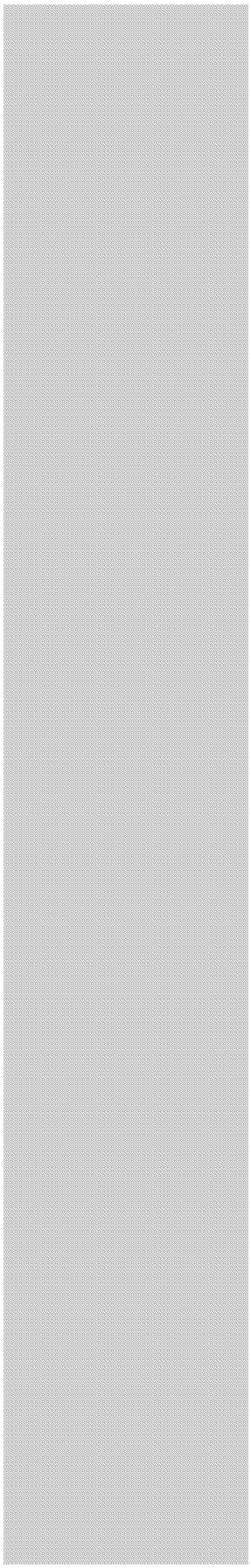


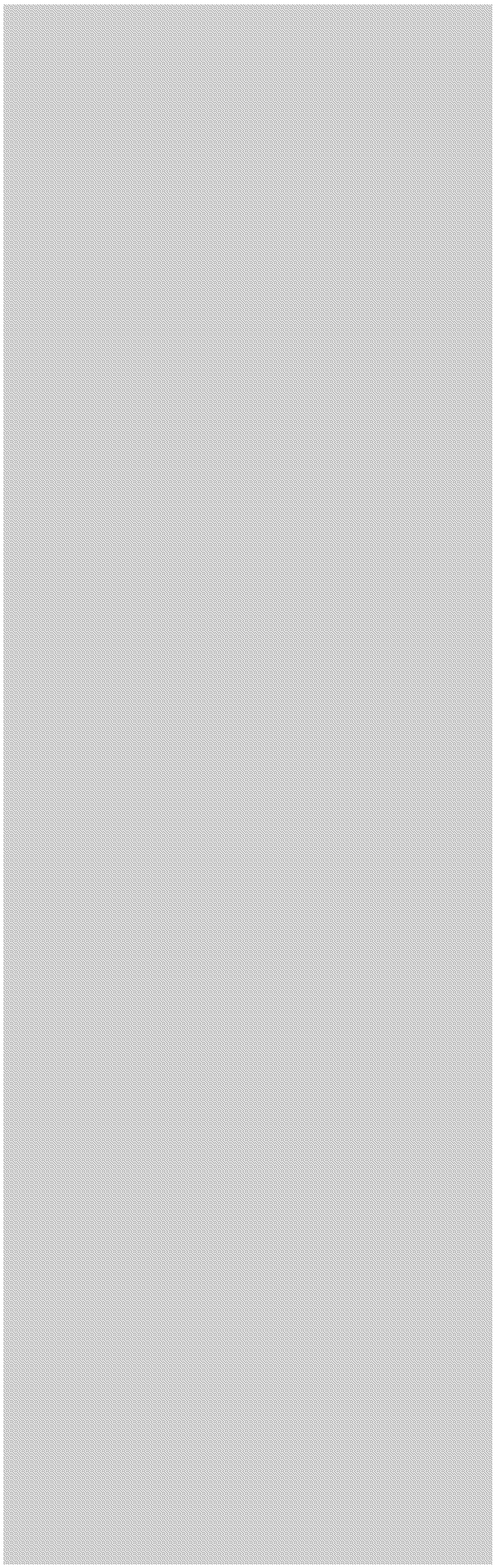


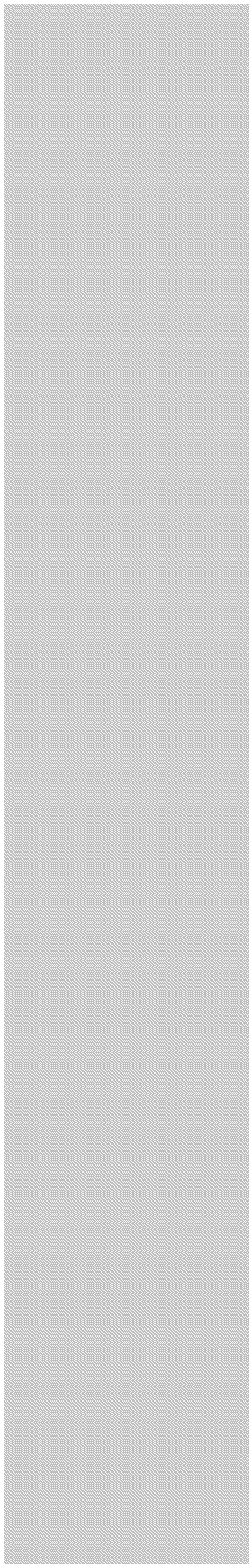
Female			
Denominator	Numerator[c]	Rate/Percentage[d]	Denominator

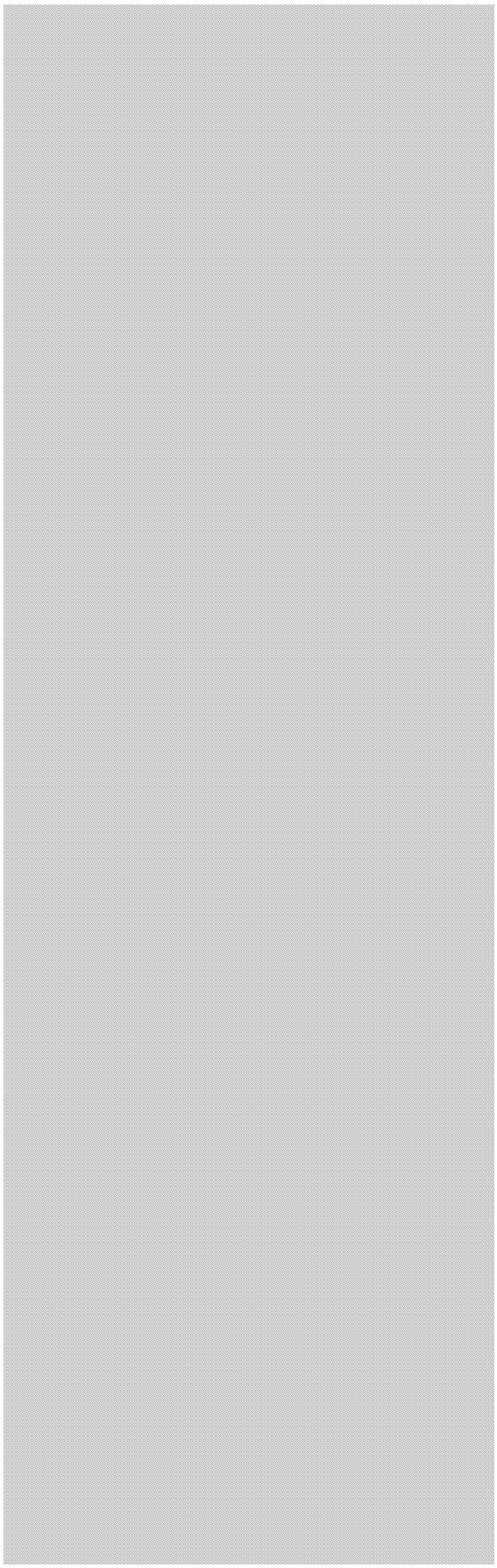


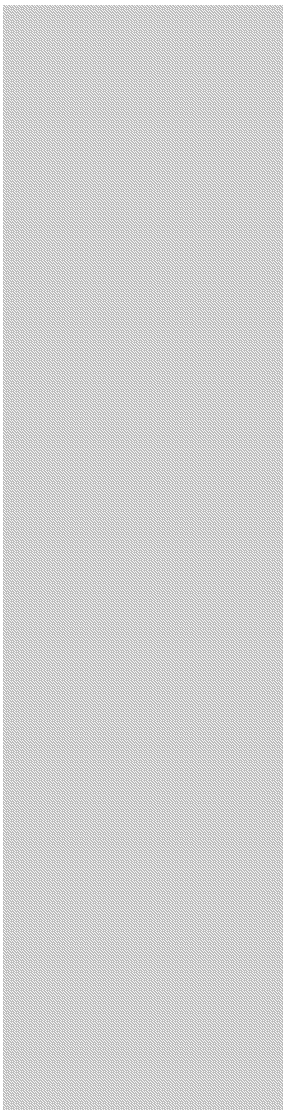


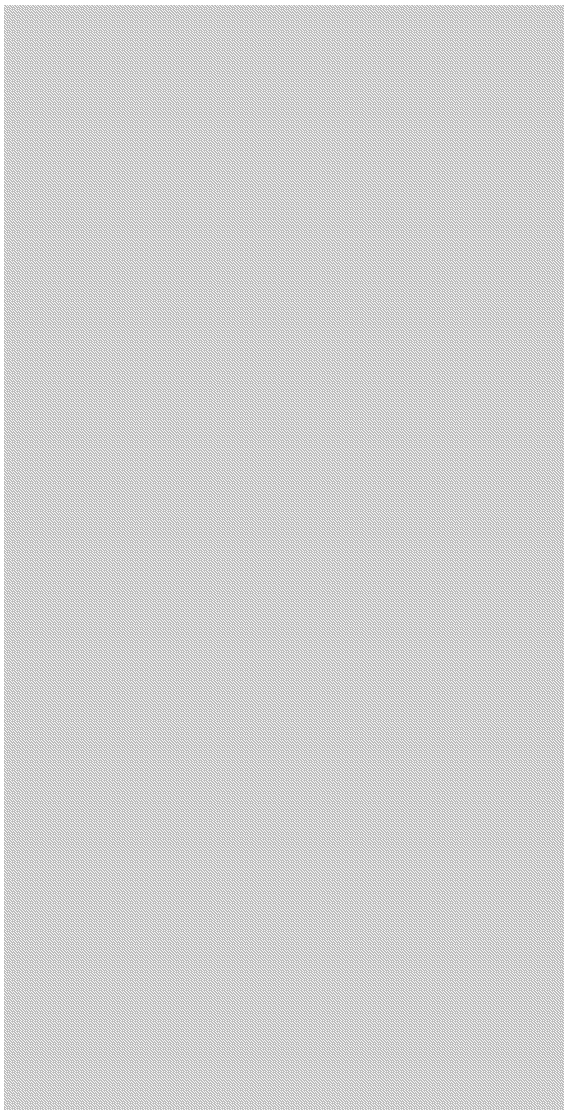




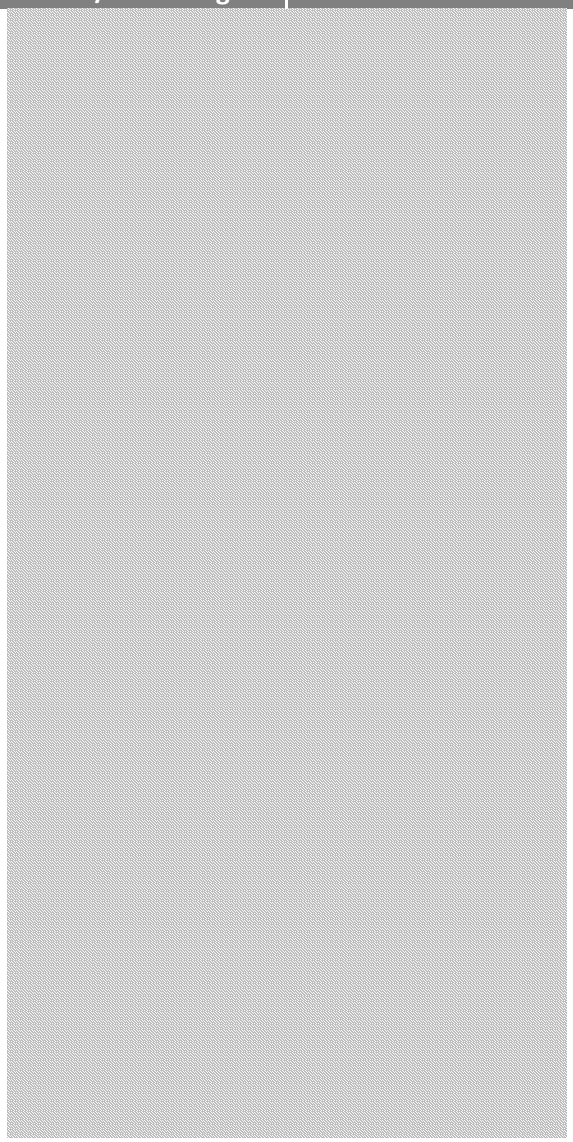


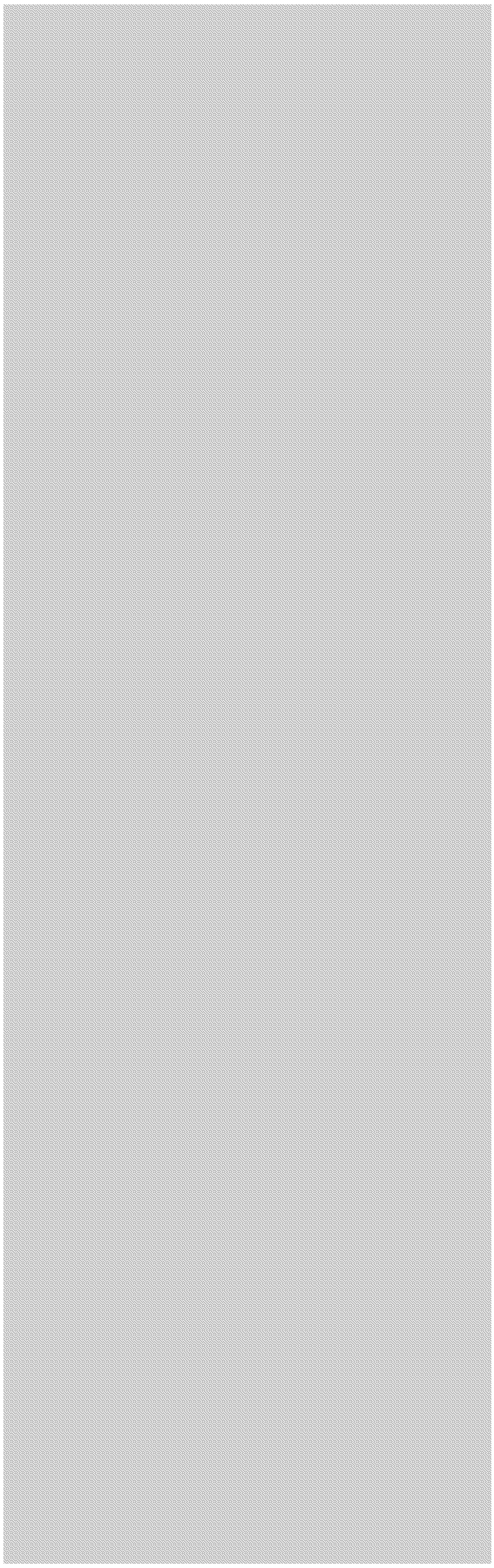


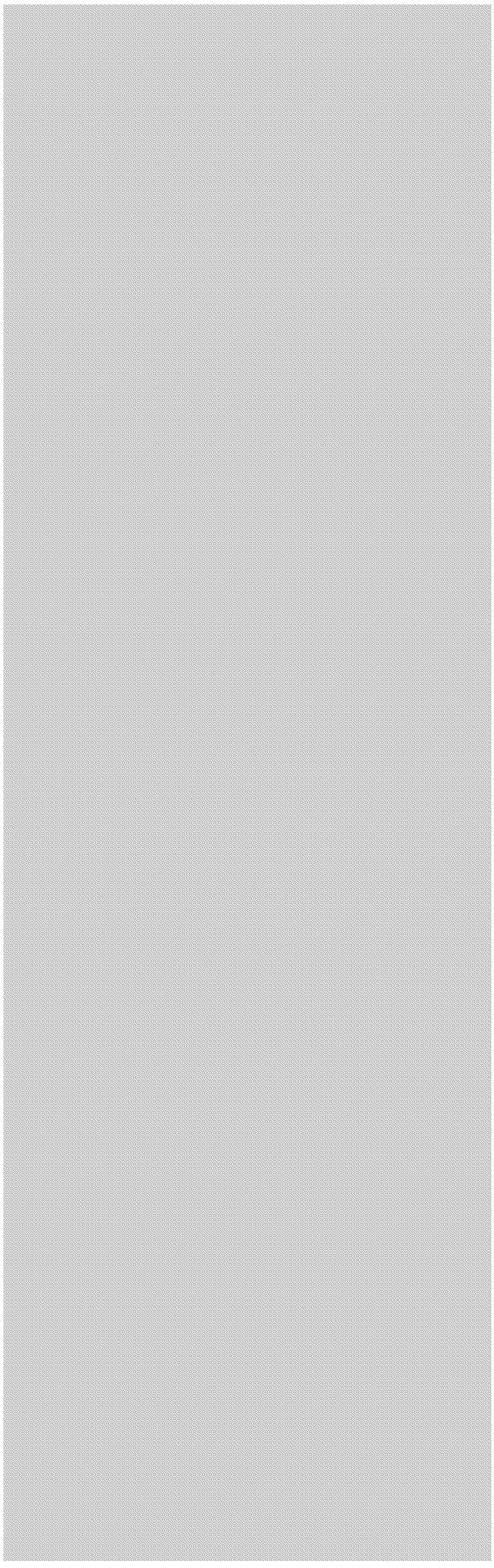


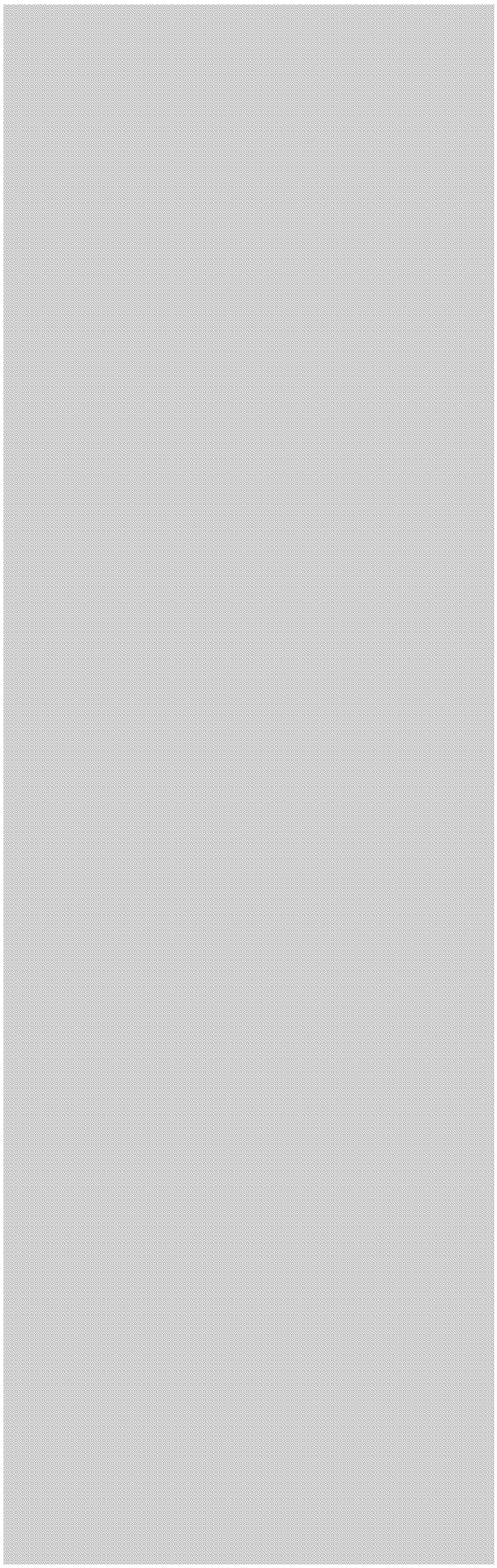


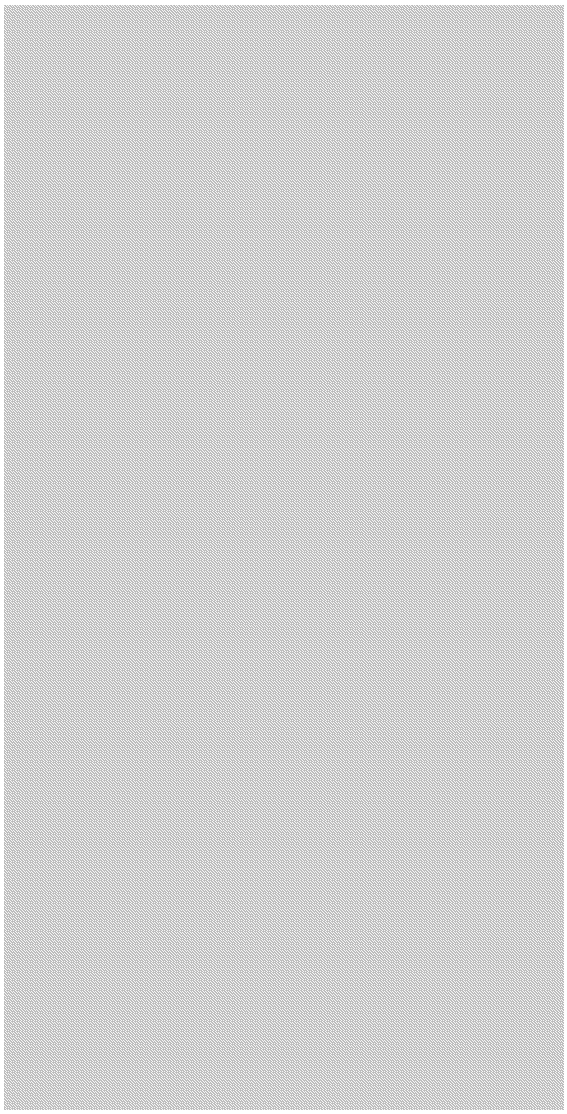
White			Black or African America	
Numerator[d]	Rate/Percentage[e]	Denominator	Numerator[d]	



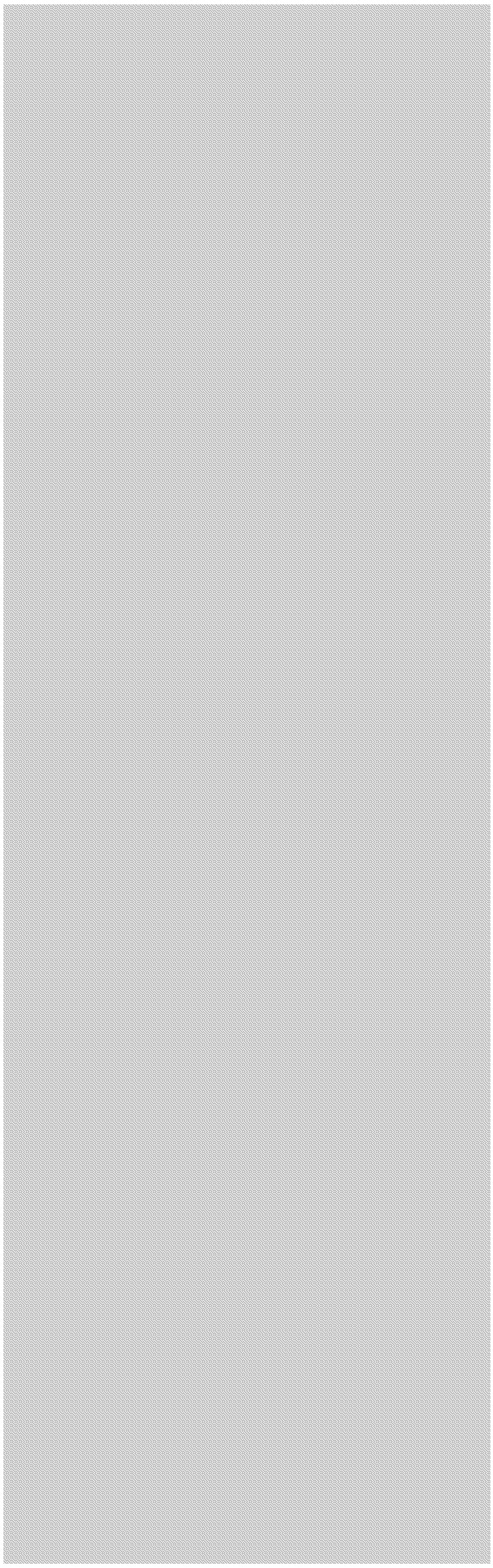


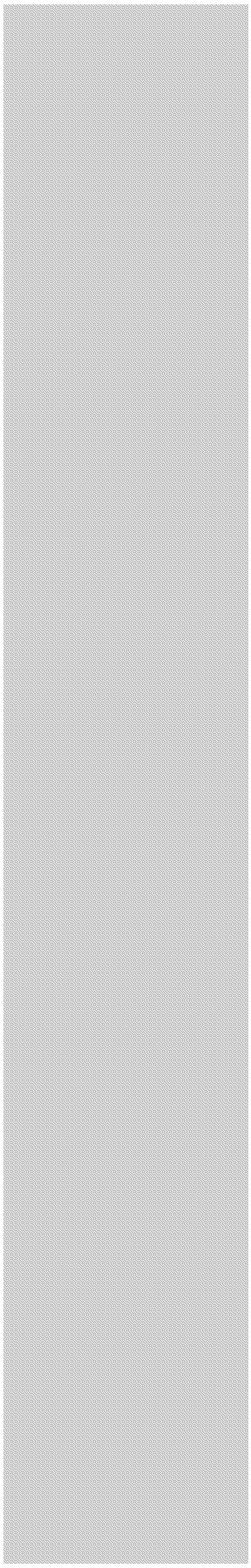


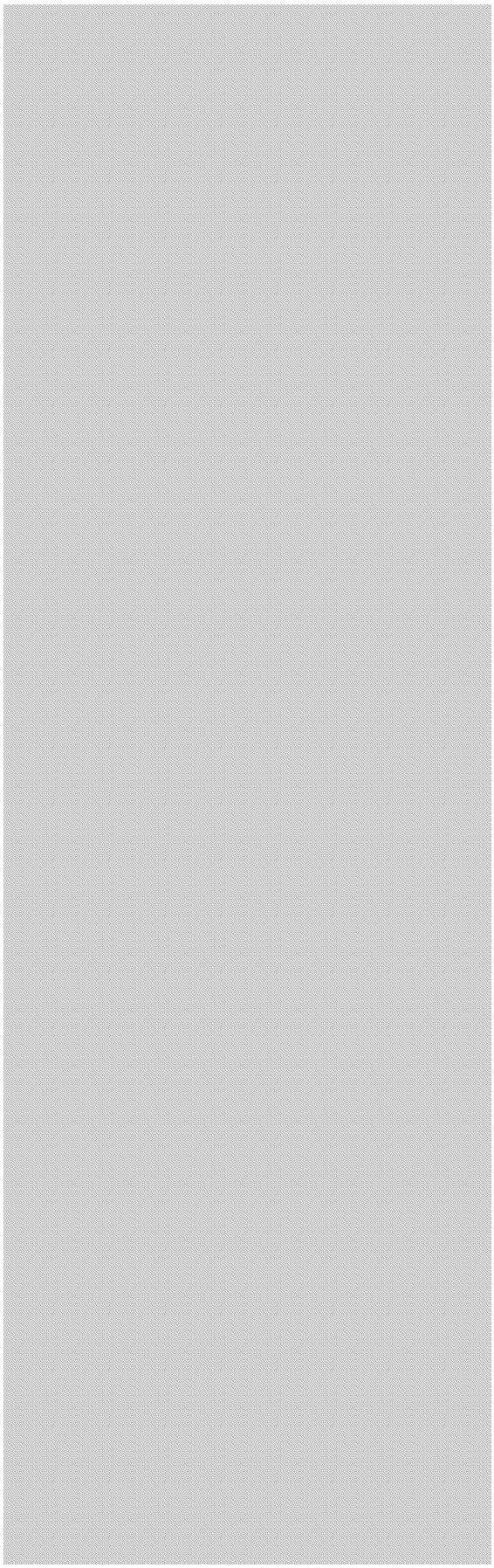


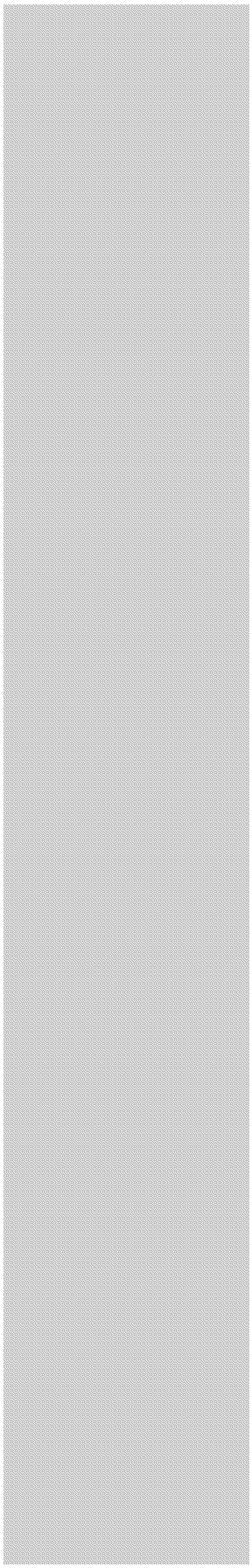


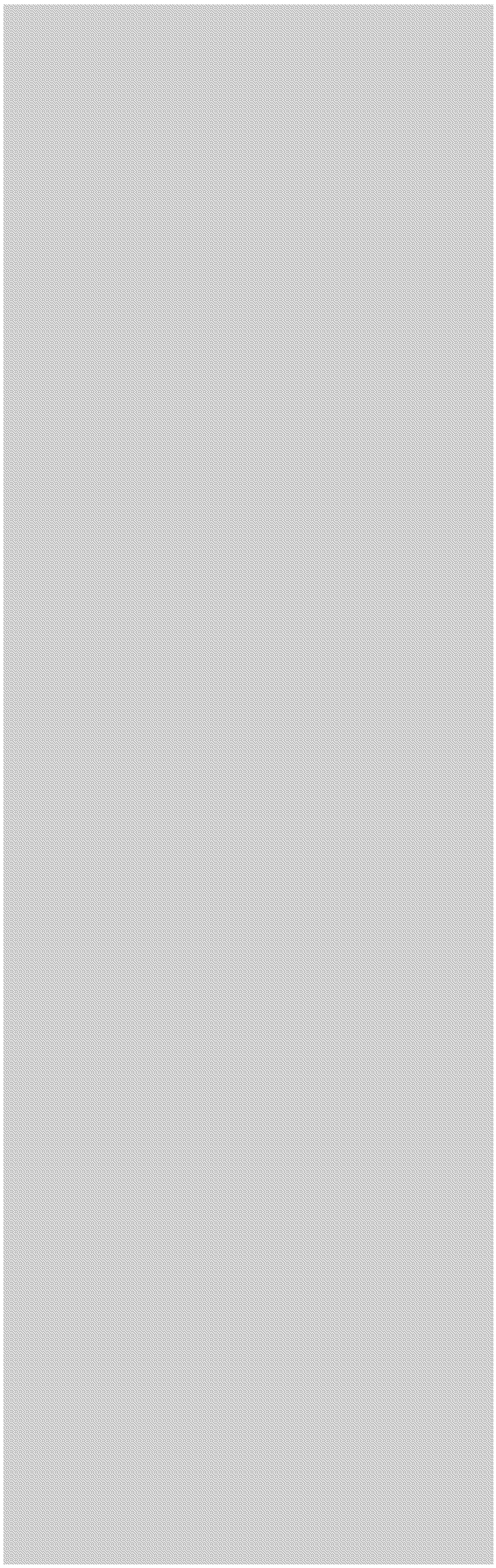
n	Asian		
Rate/Percentage[e]	Denominator	Numerator[d]	Rate/Percentage[e]

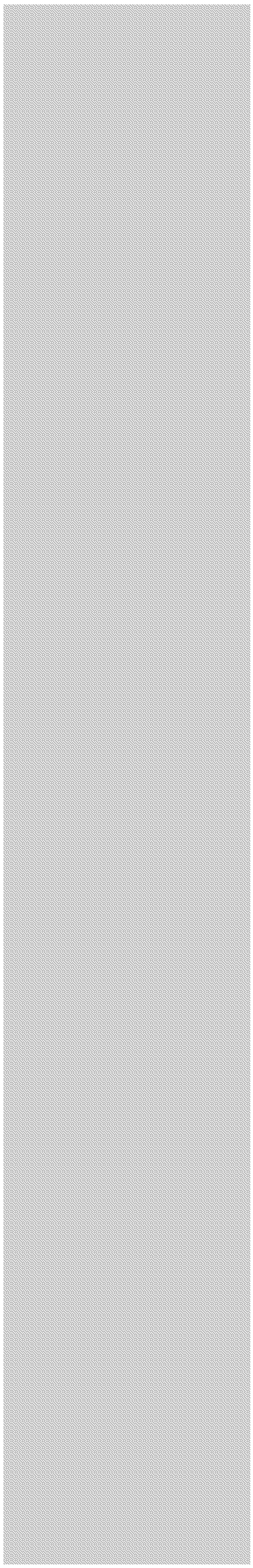


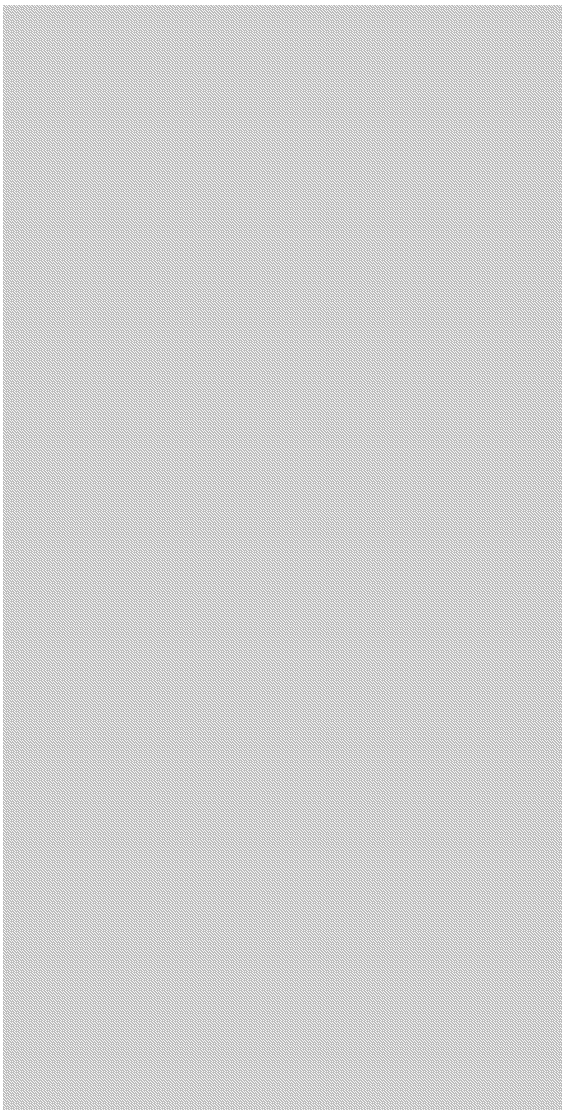


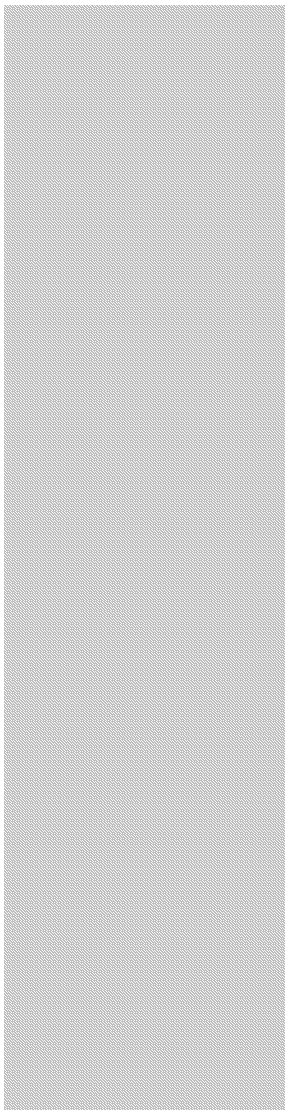




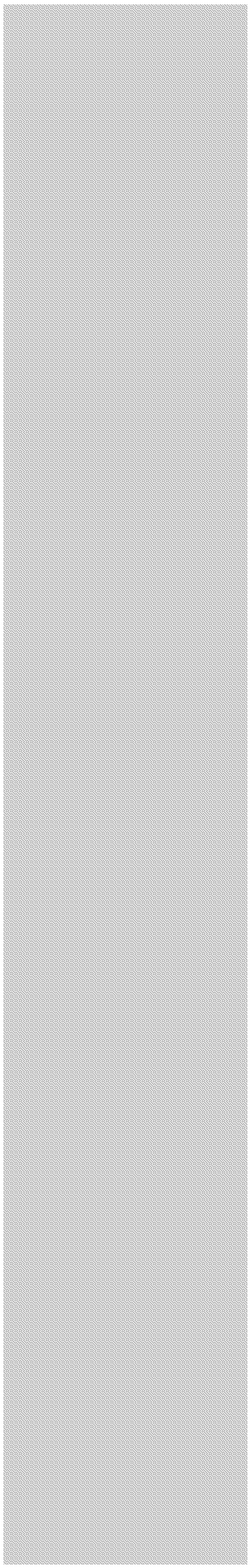


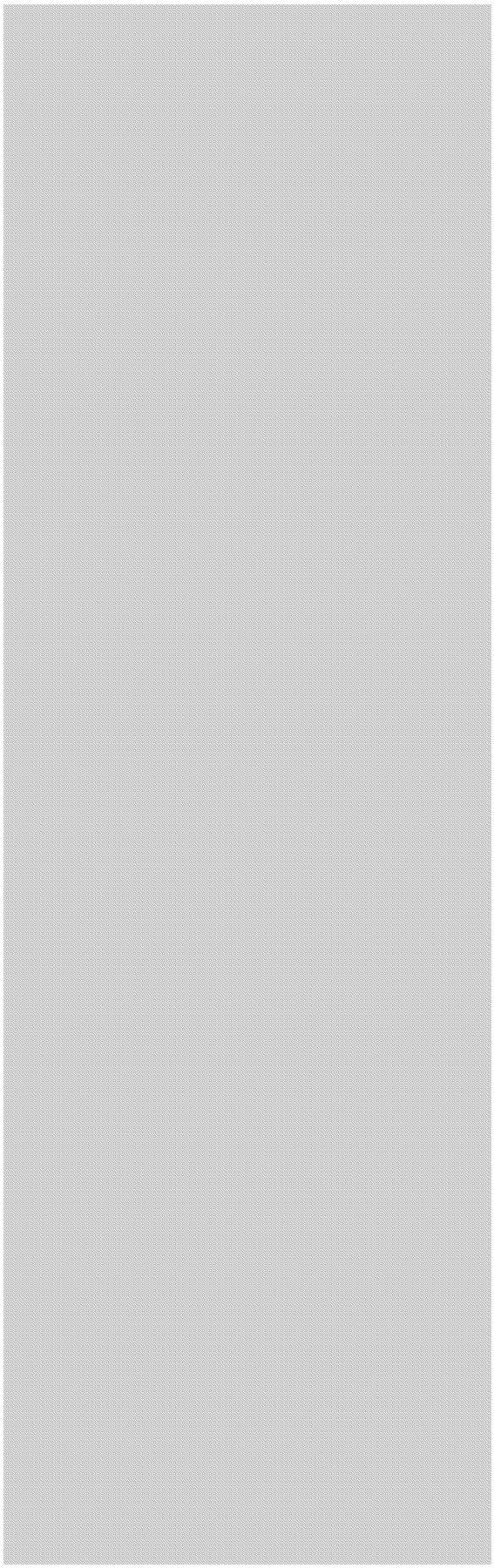


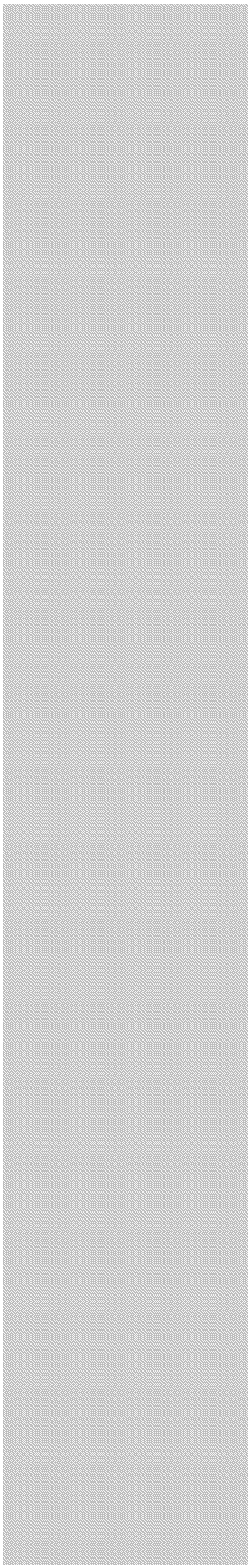


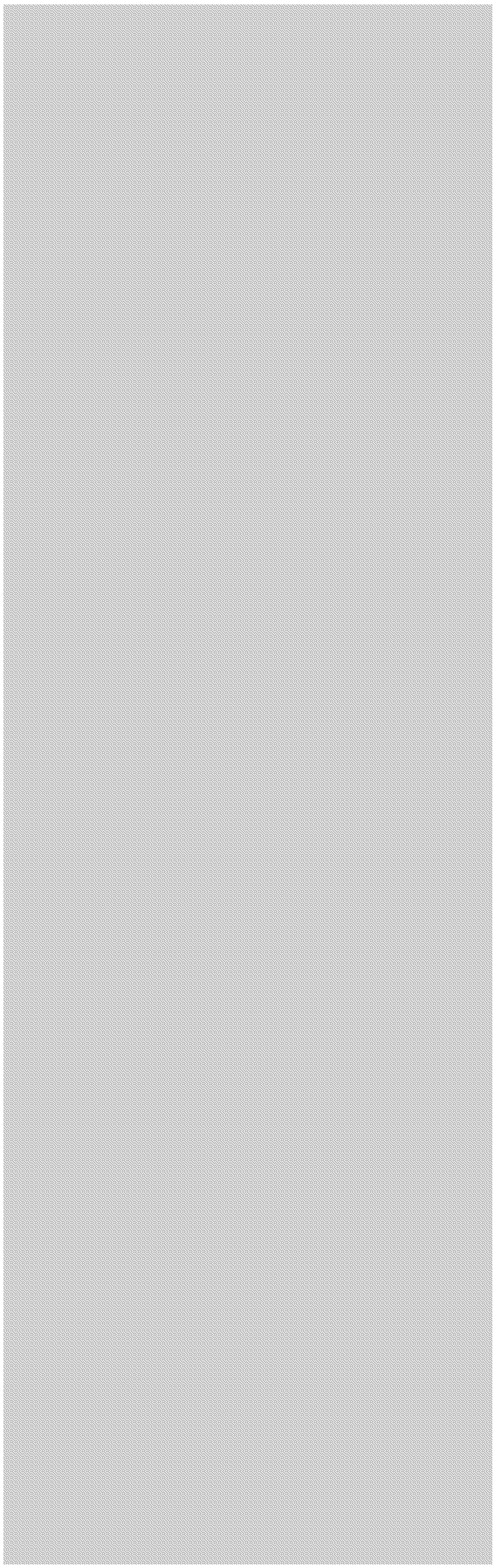


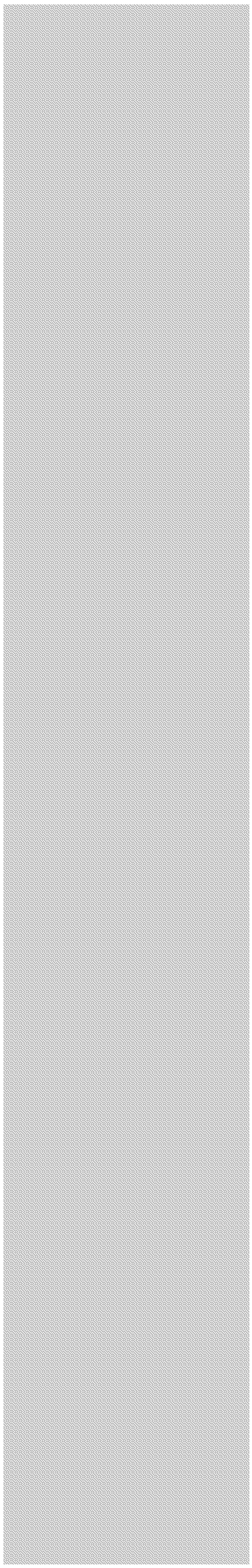
American Indian or Alaskan Native			
Denominator	Numerator[d]	Rate/Percentage[e]	Denominator

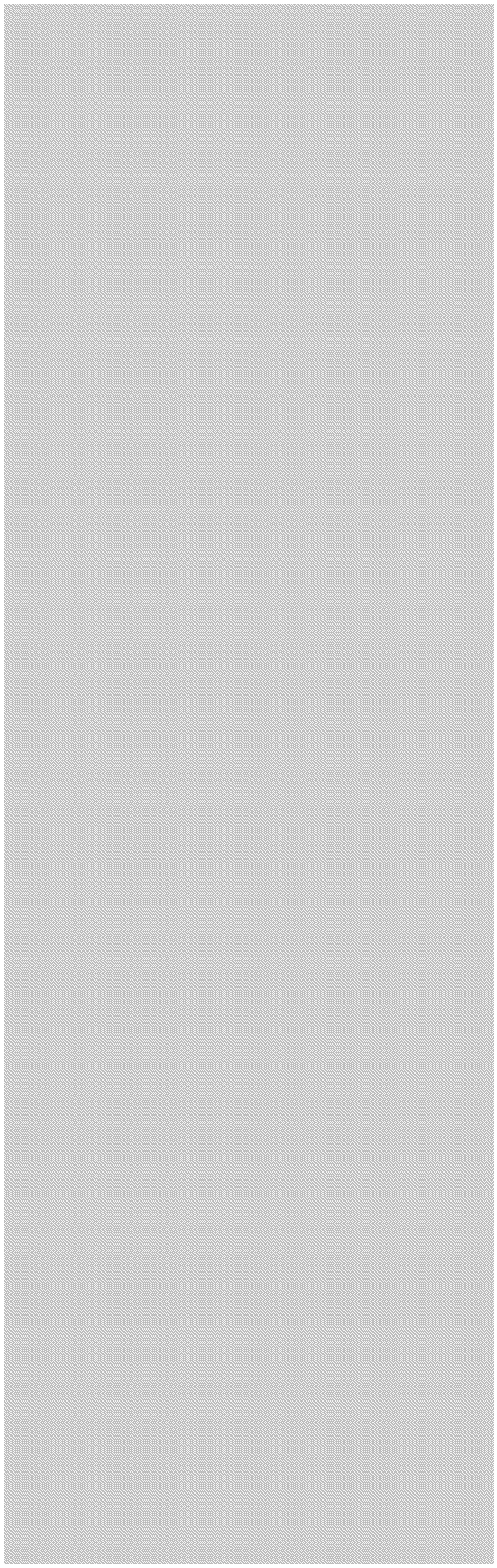


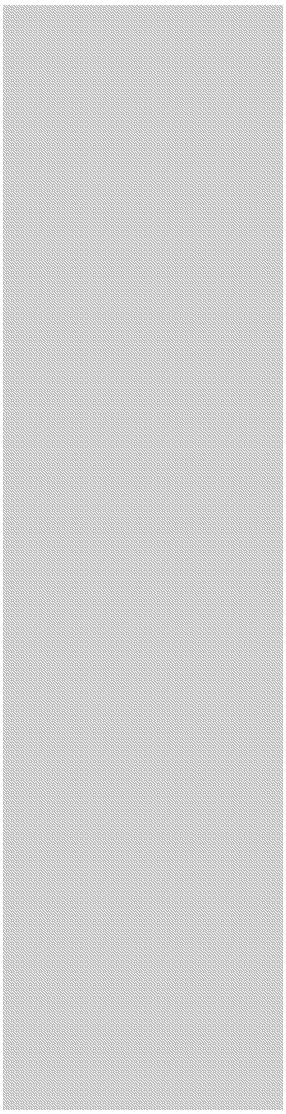


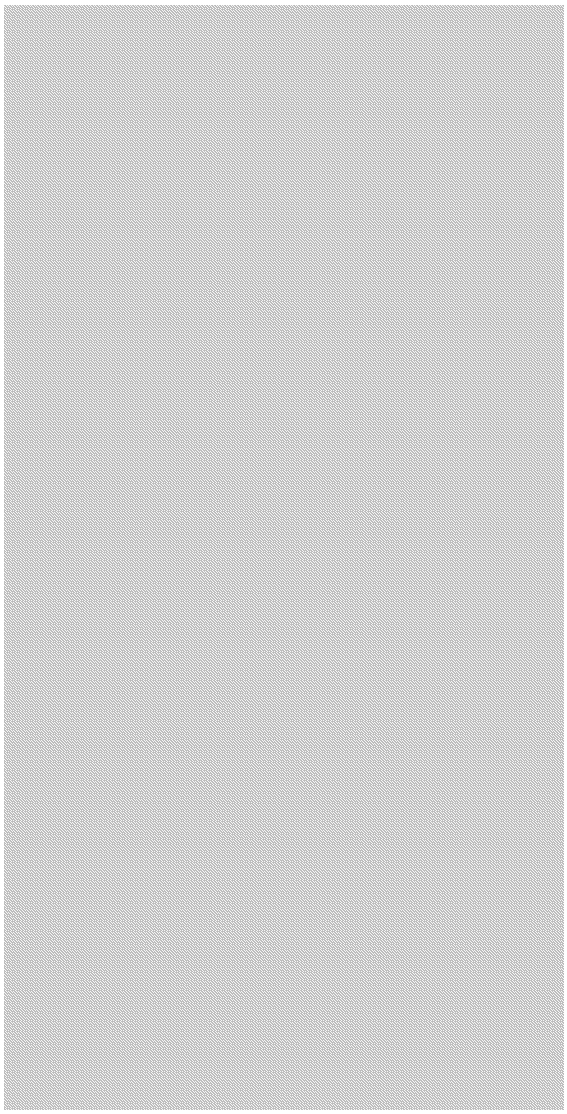




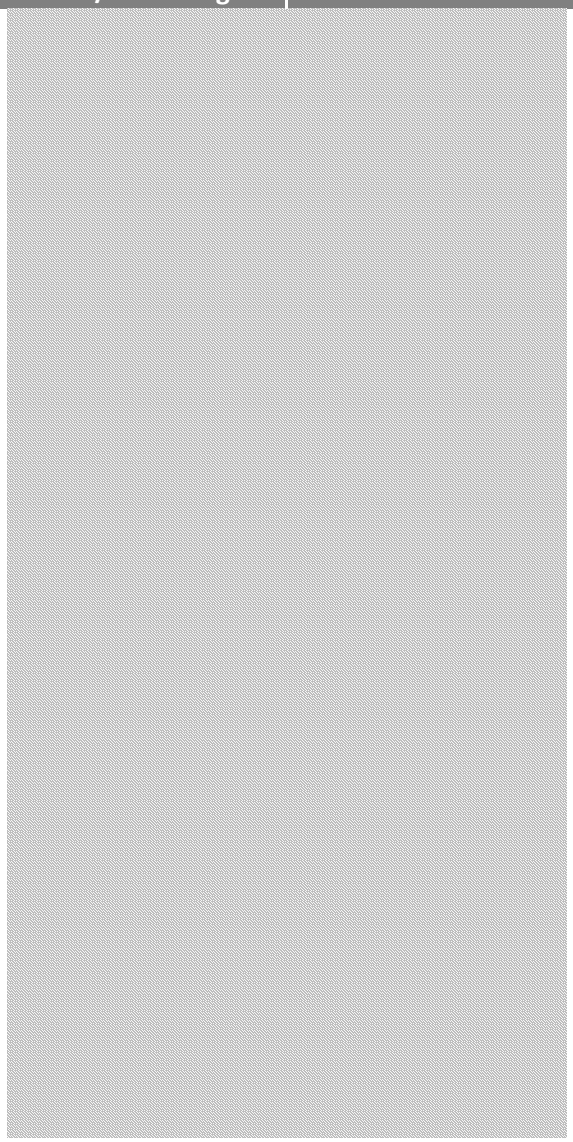


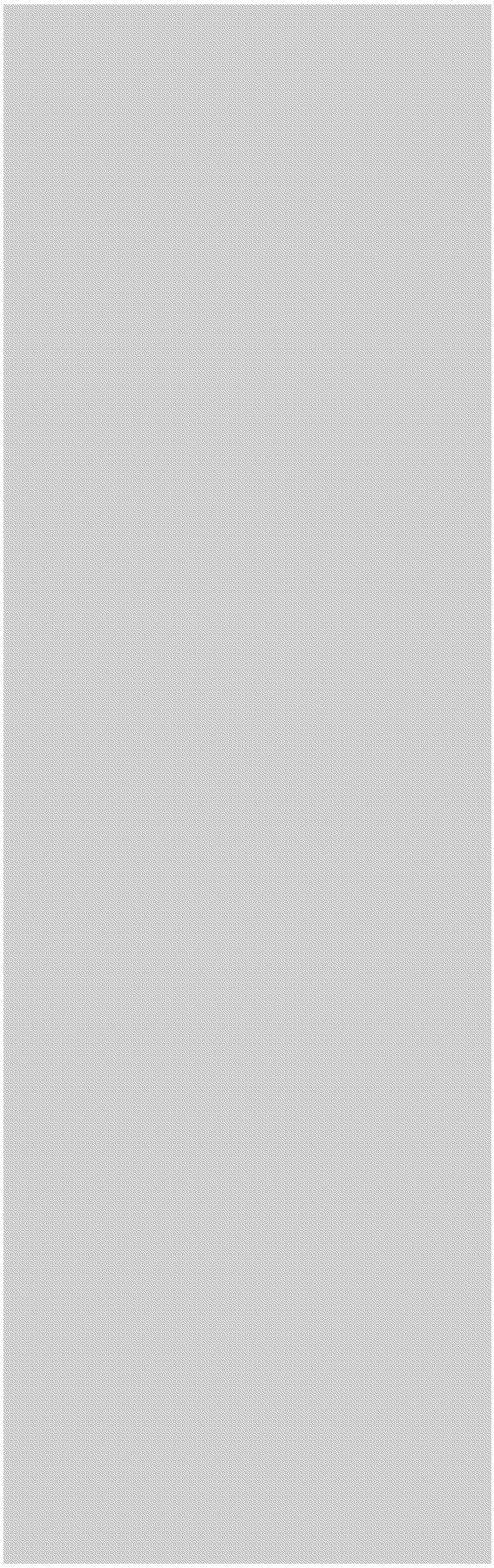


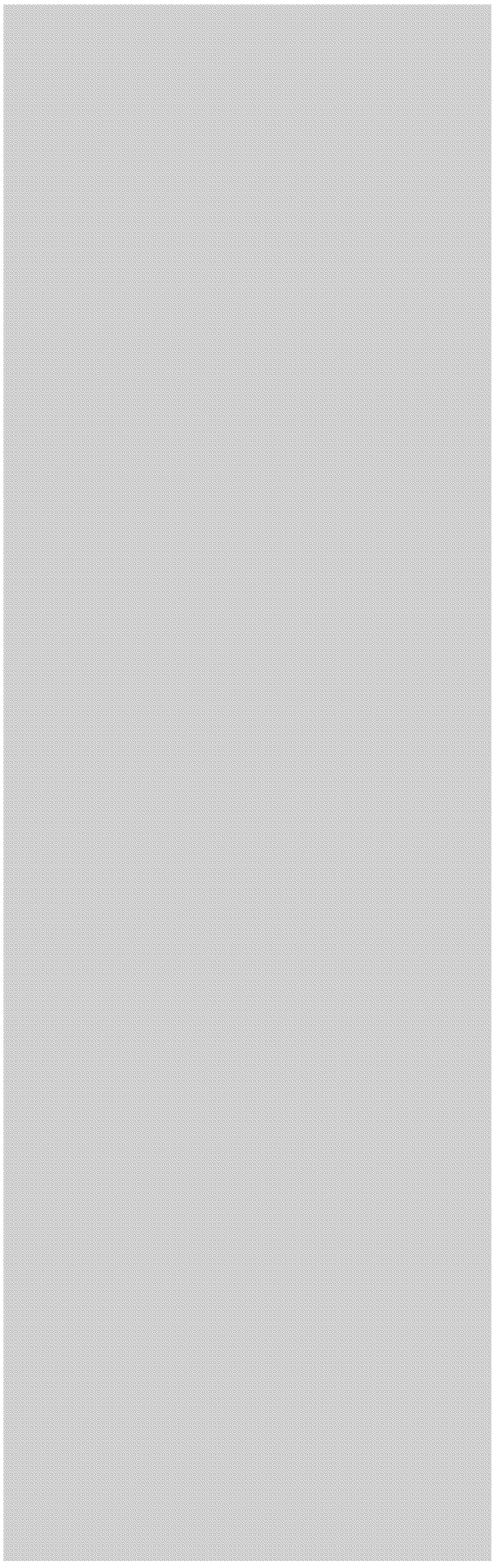


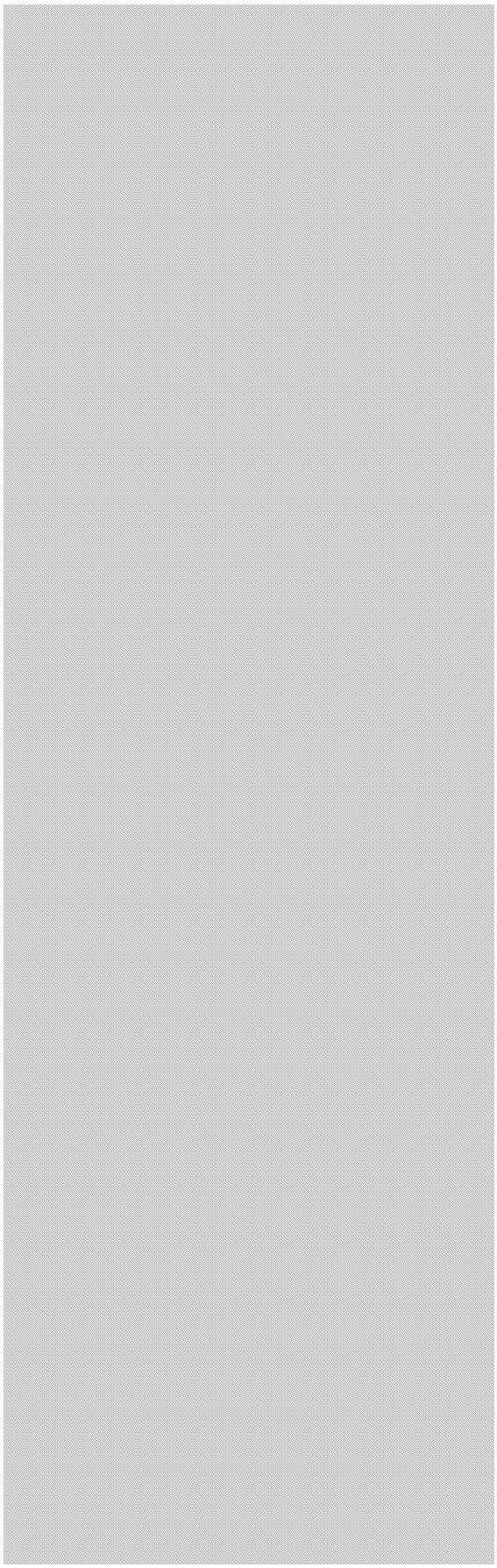


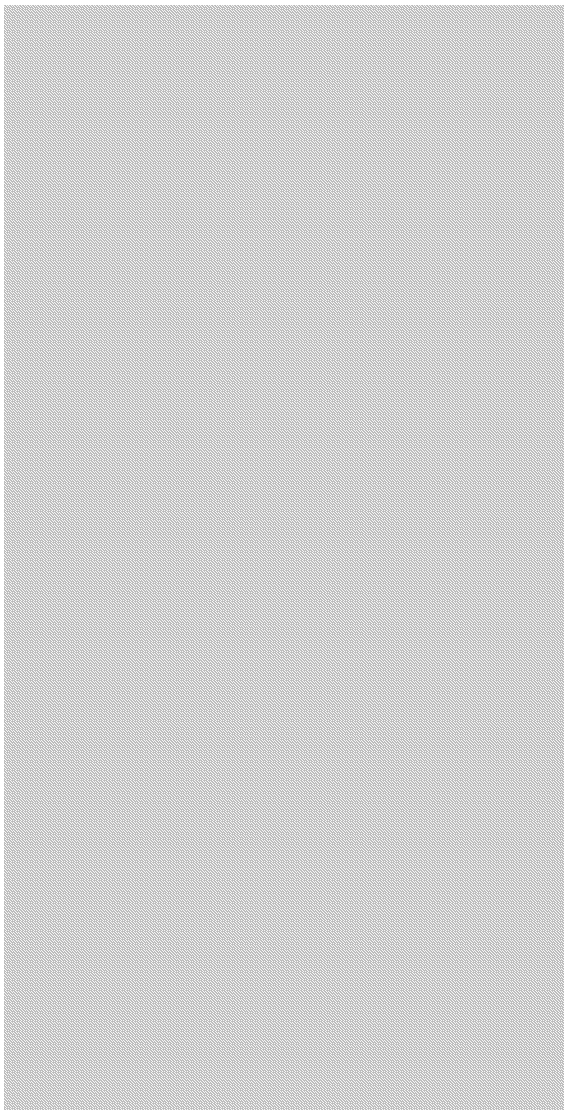
Other race			Unknown race
Numerator[d]	Rate/Percentage[e]	Denominator	Numerator[d]



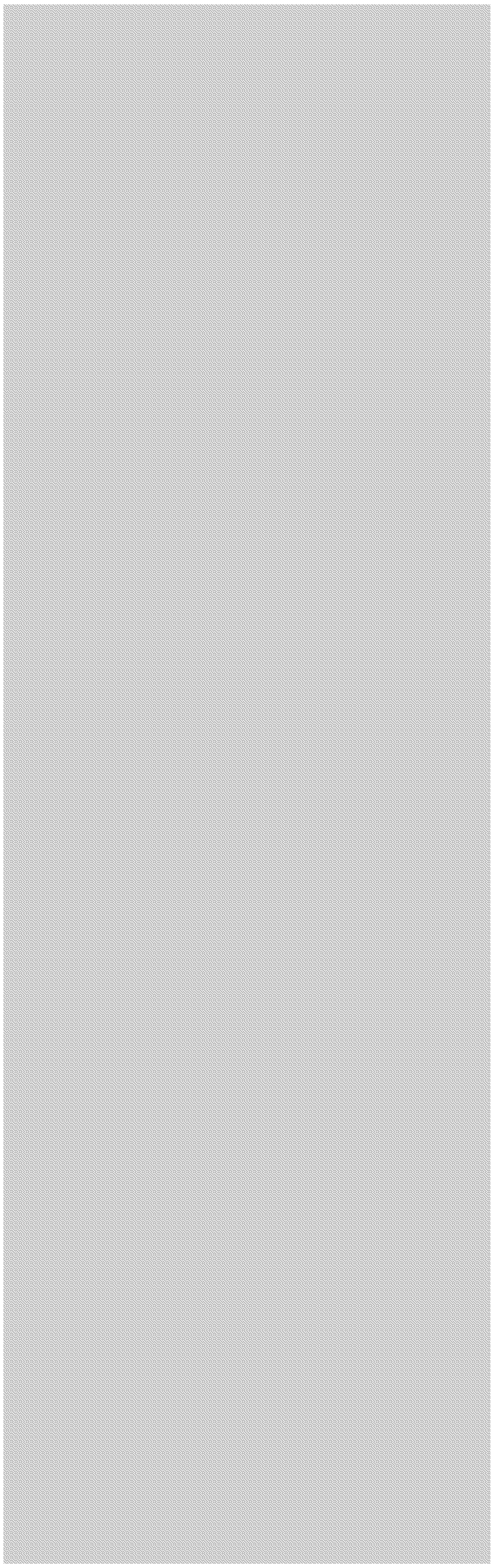


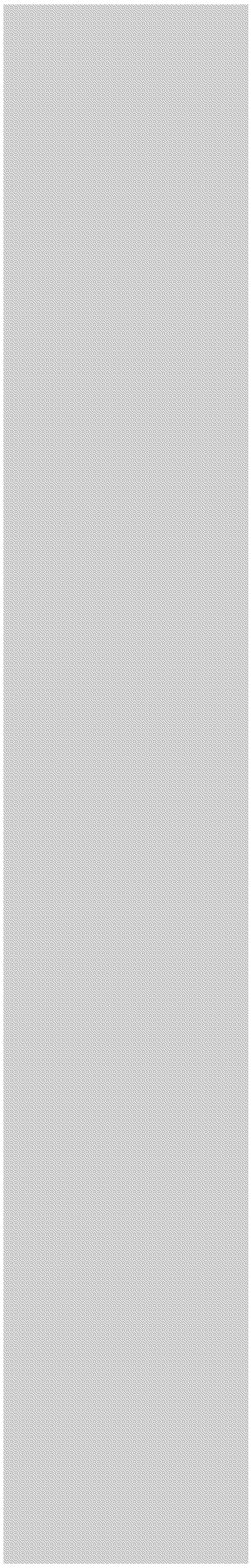


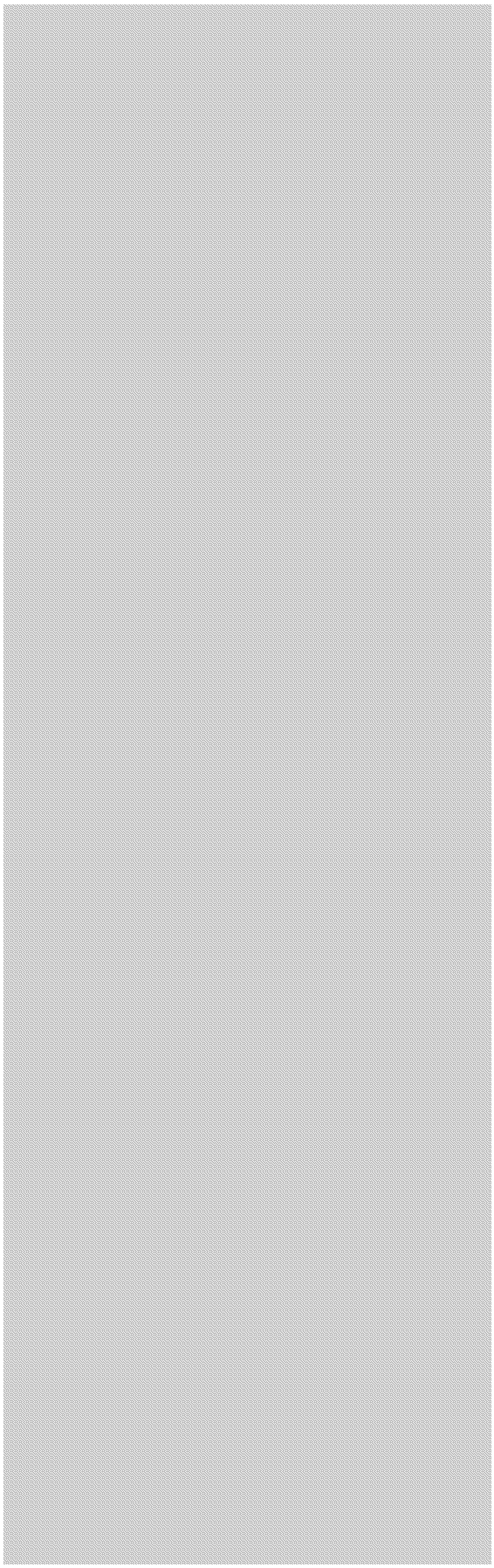


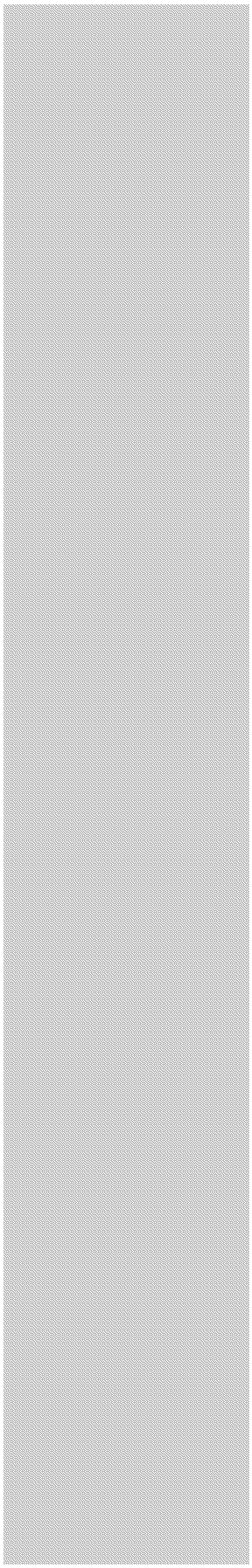


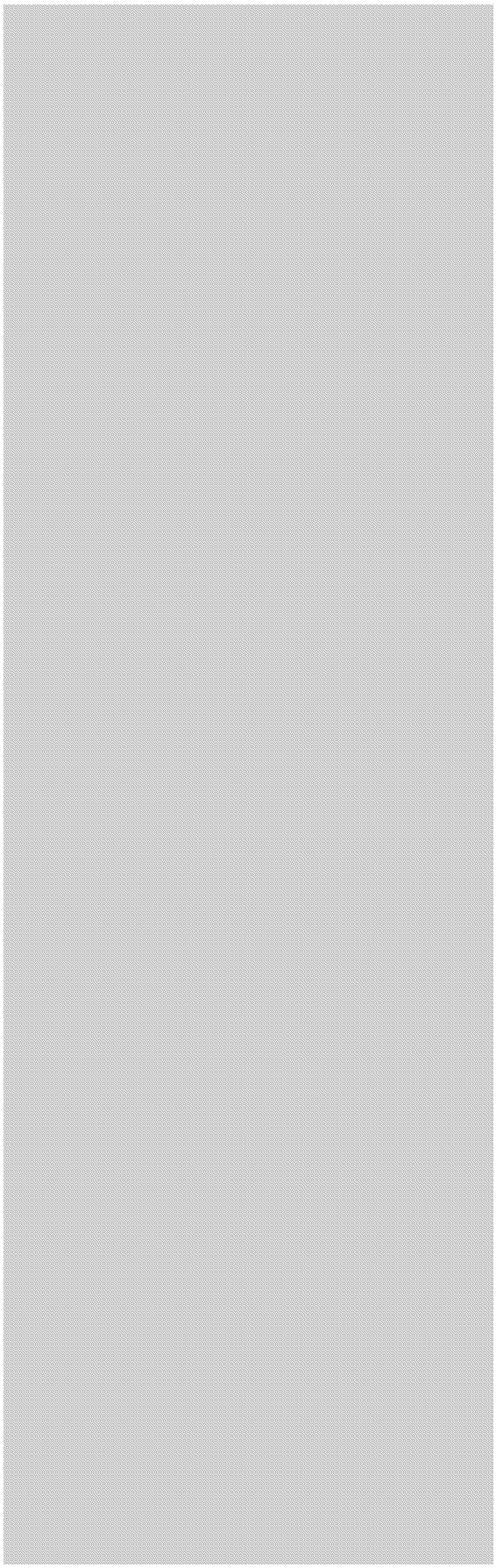
	Hispanic ethnicity		
Rate/Percentage[e]	Denominator	Numerator[d]	Rate/Percentage[e]

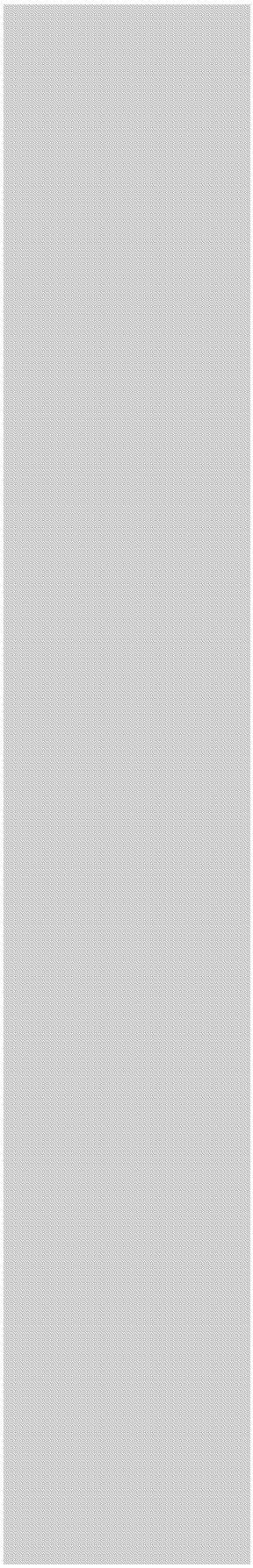


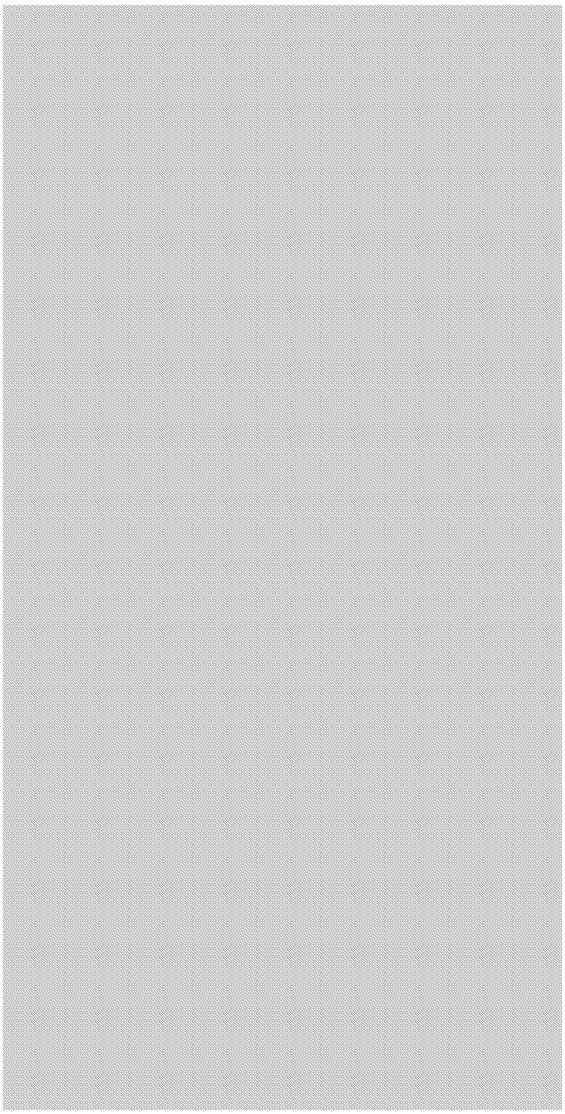


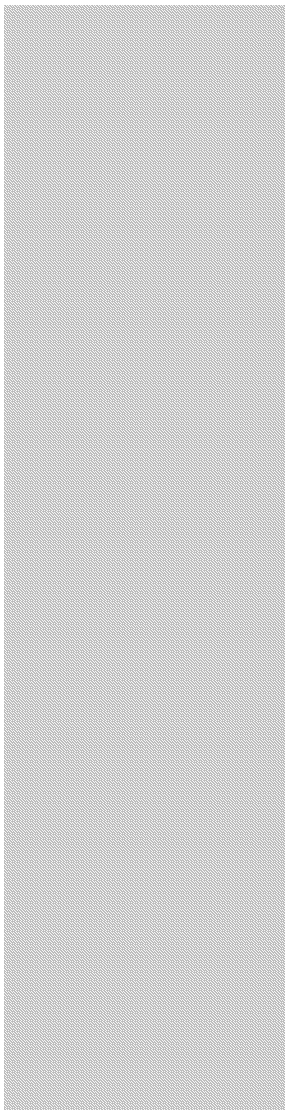




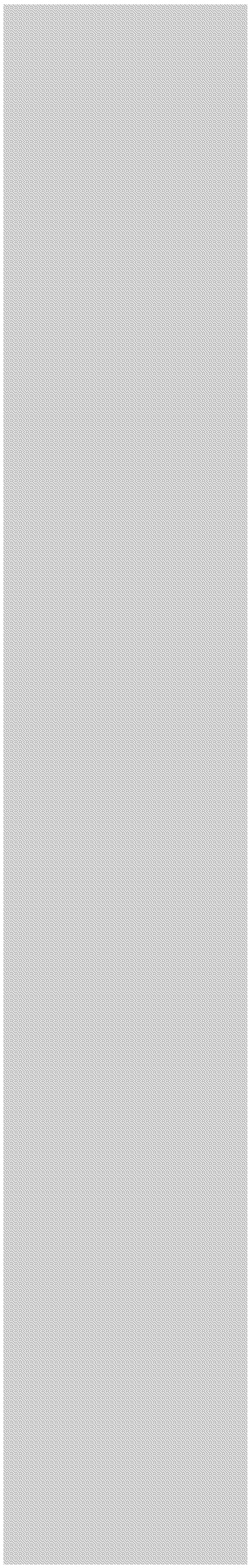


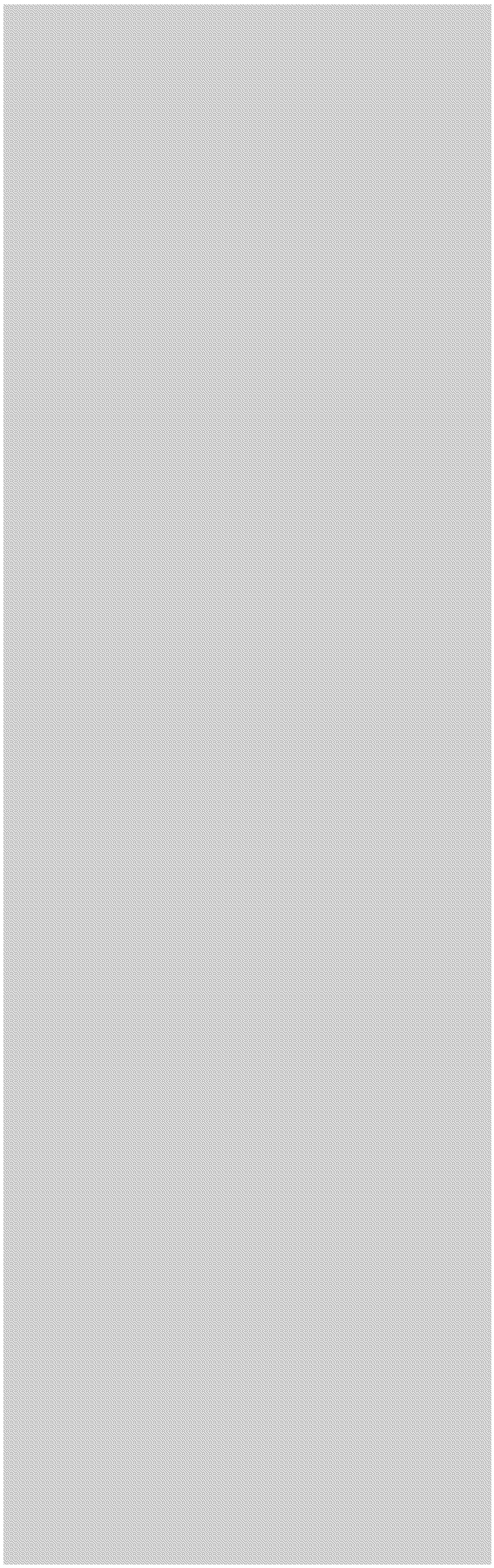


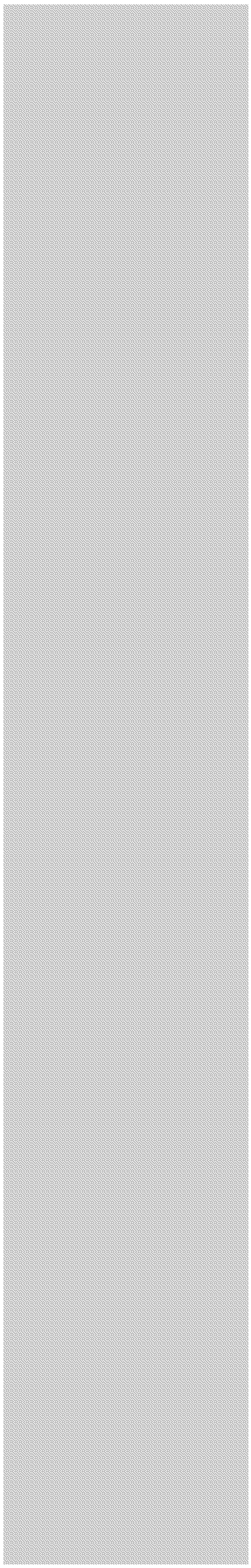


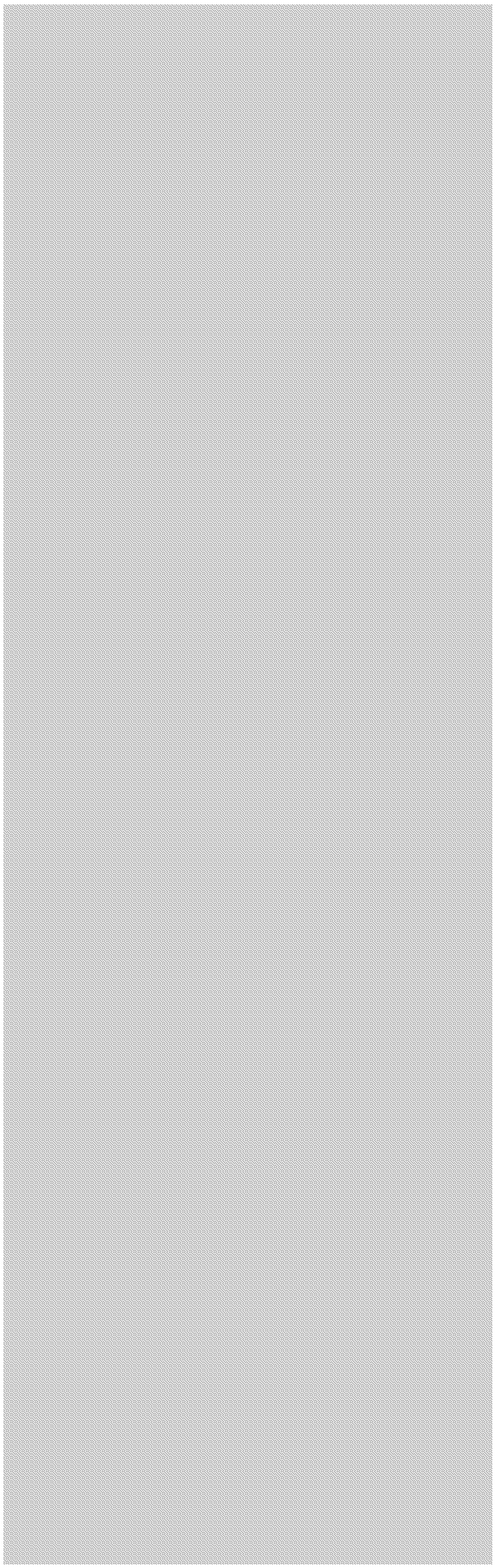


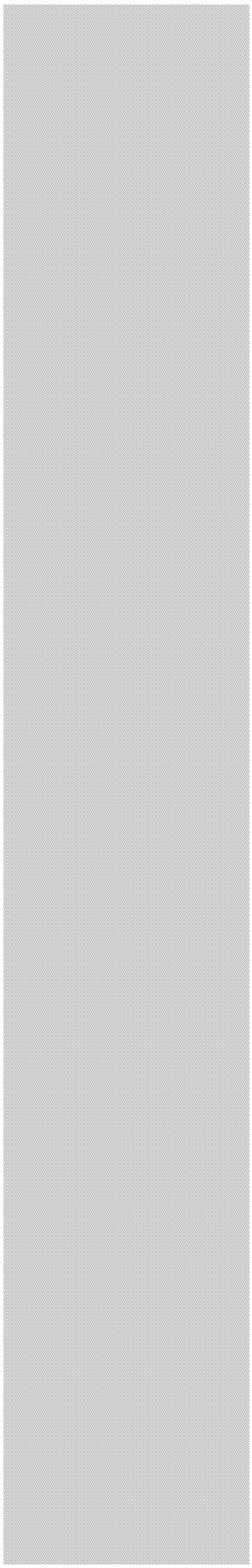
Non-Hispanic ethnicity			
Denominator	Numerator[d]	Rate/Percentage[e]	Denominator

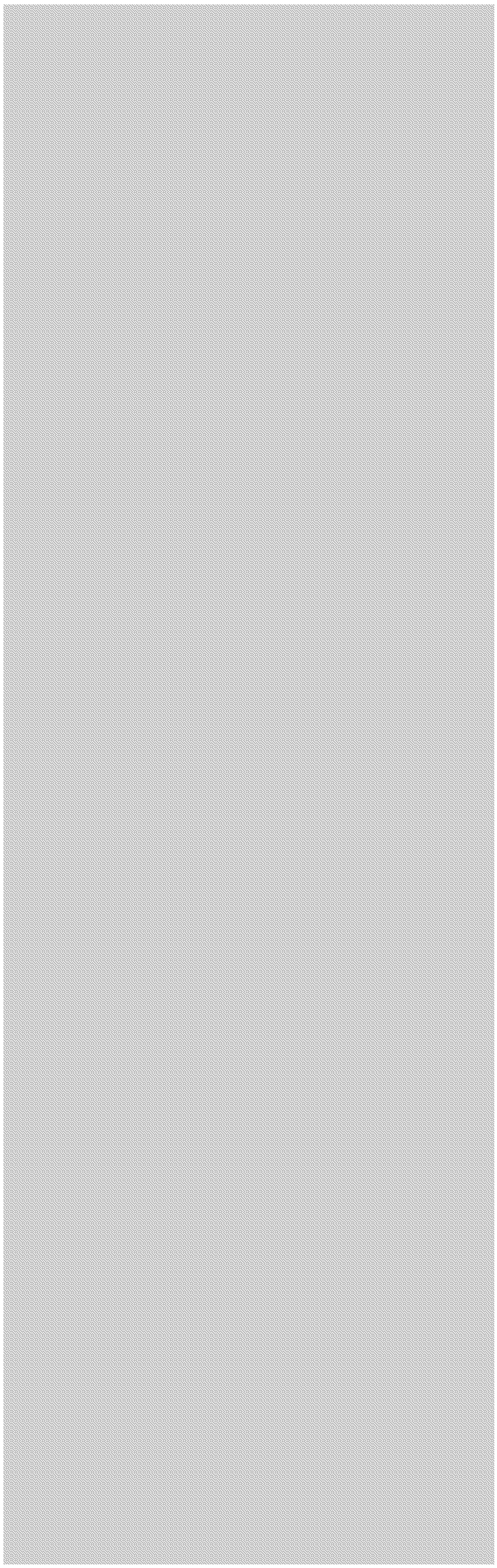


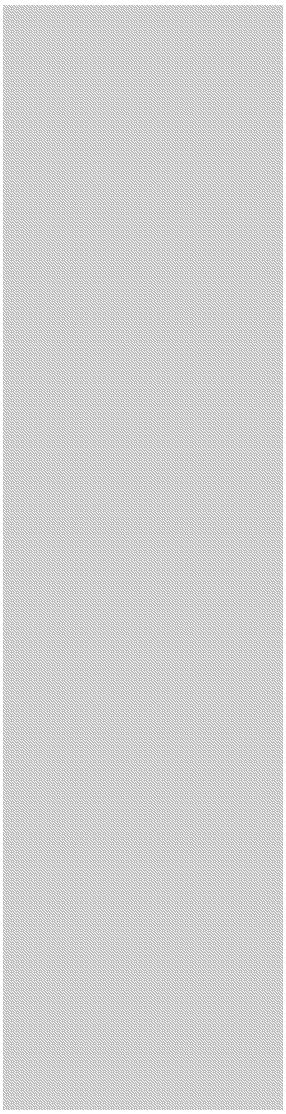


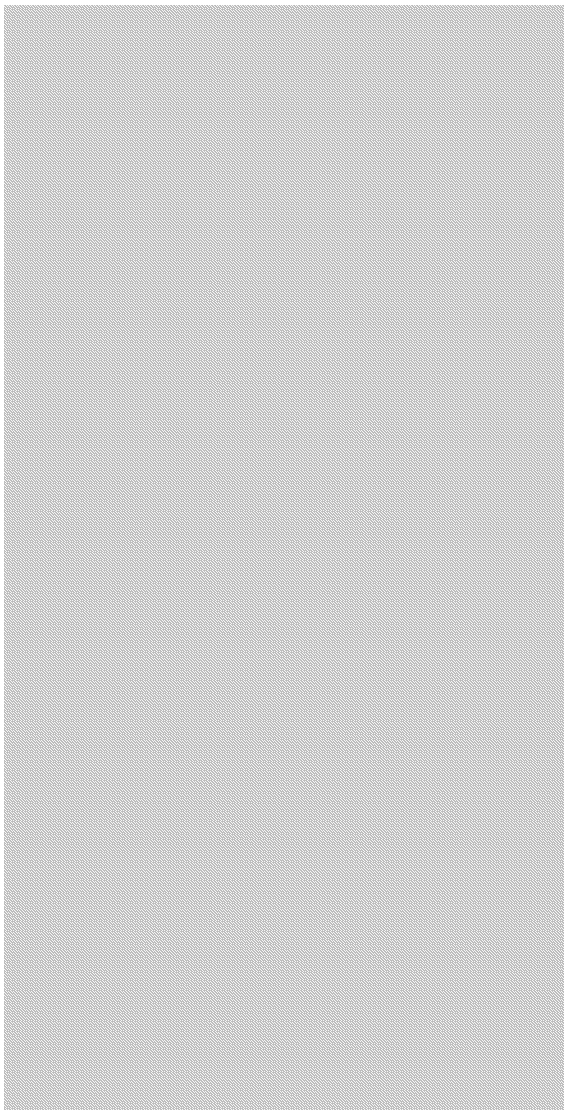












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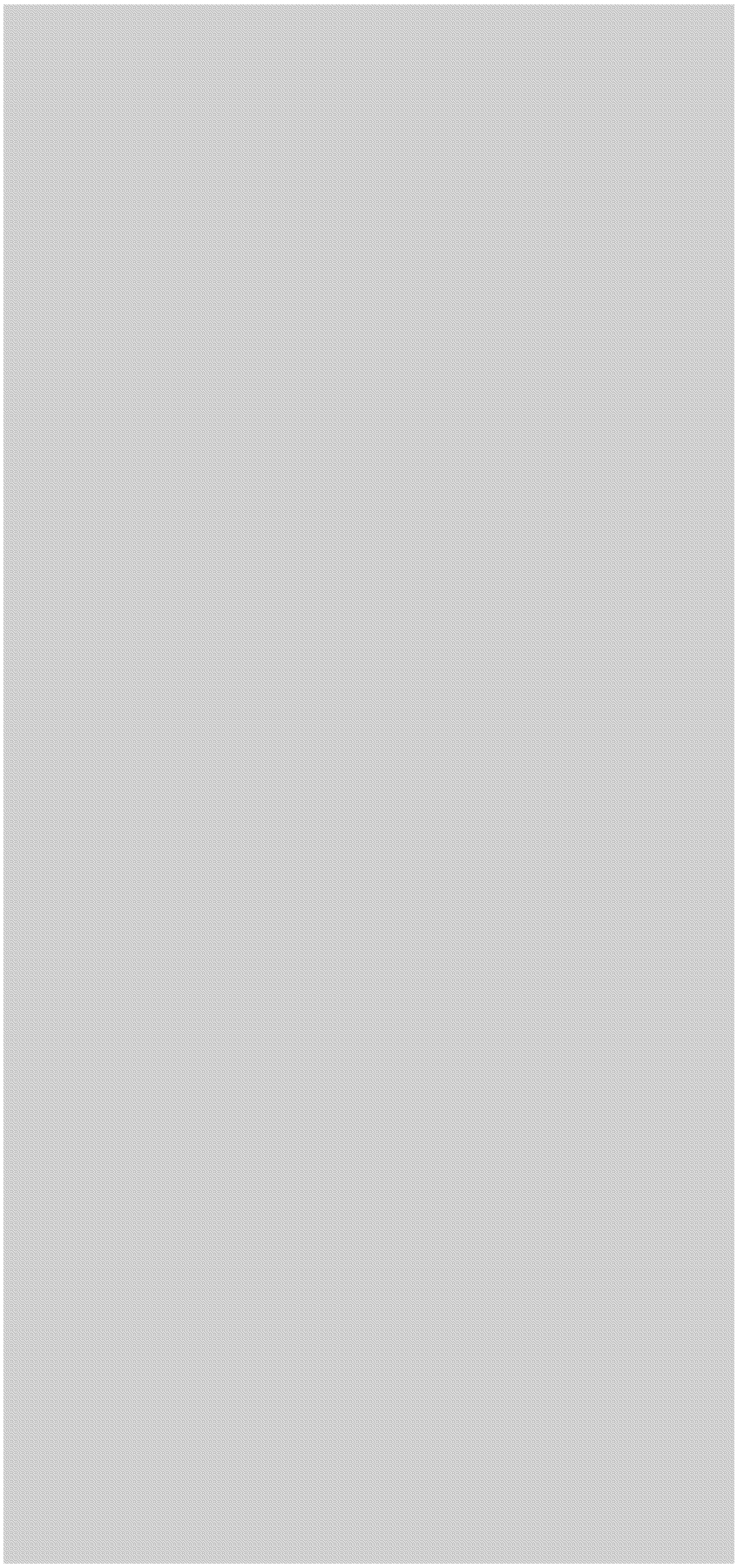
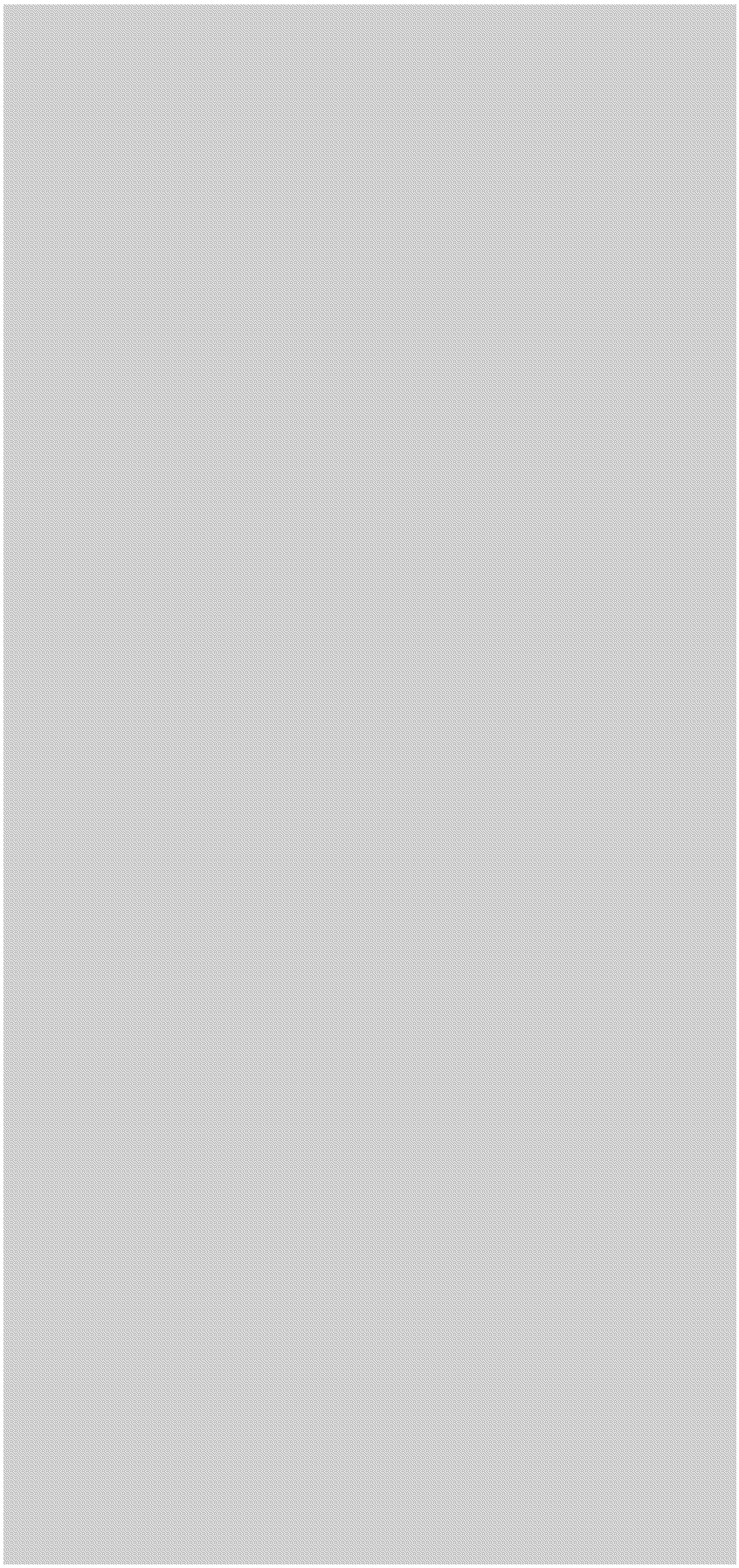
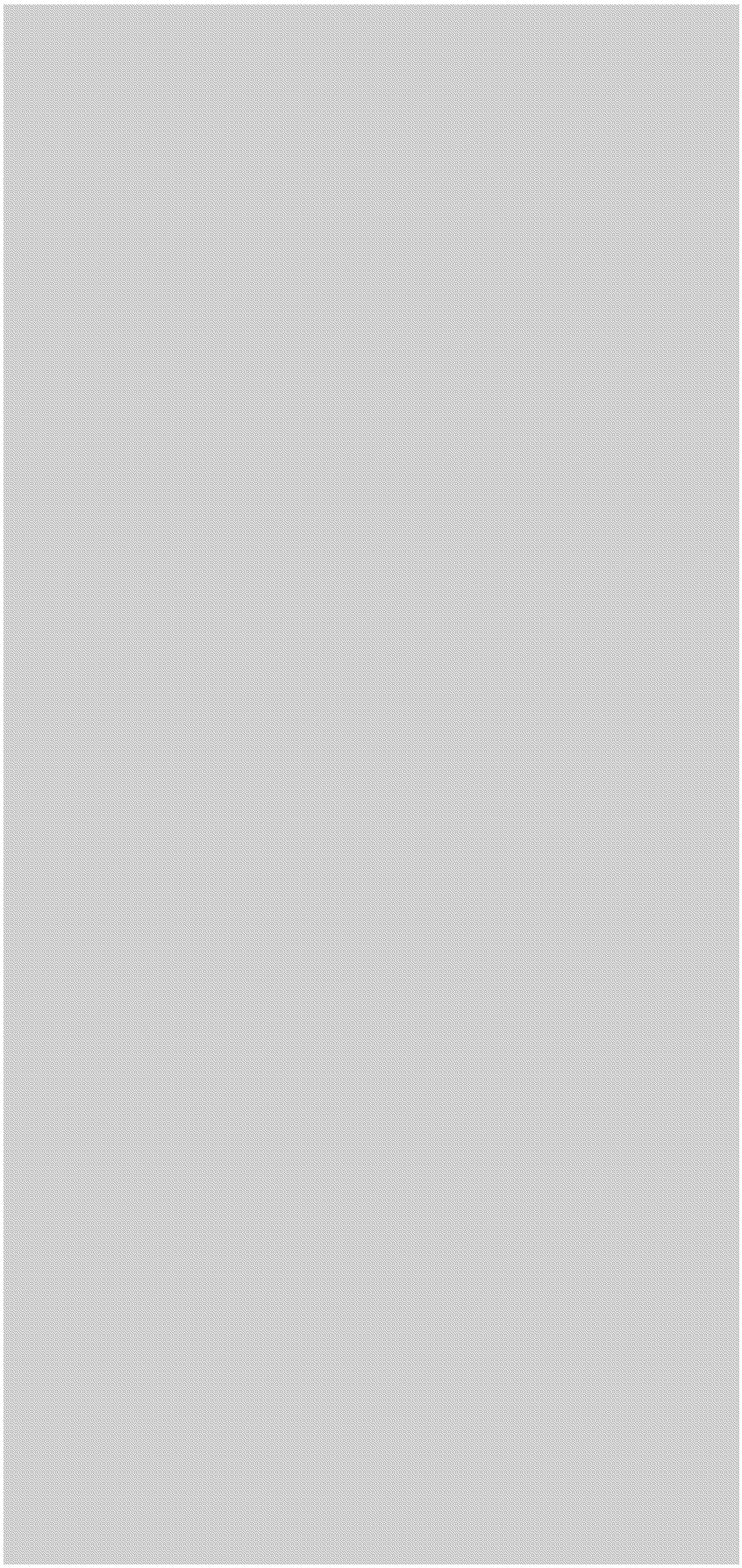
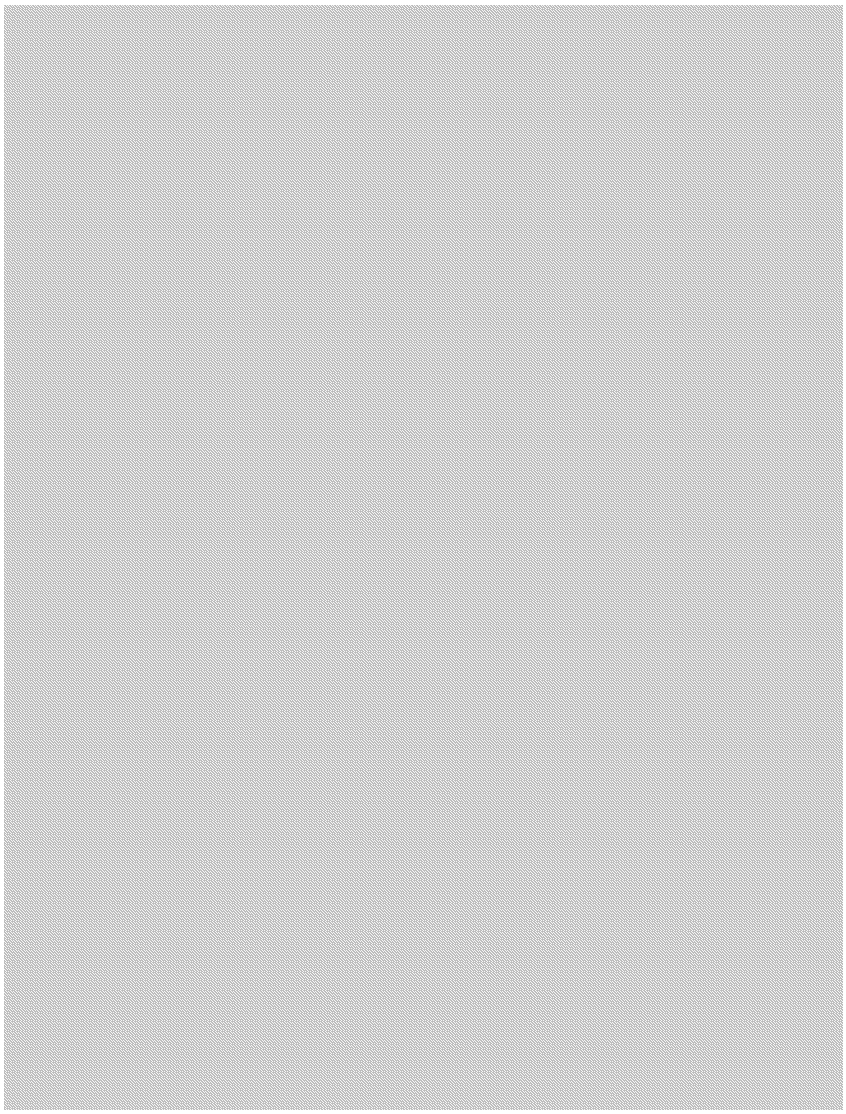
Numerator[d]	Rate/Percentage[e]	Denominator	Numerator[d]

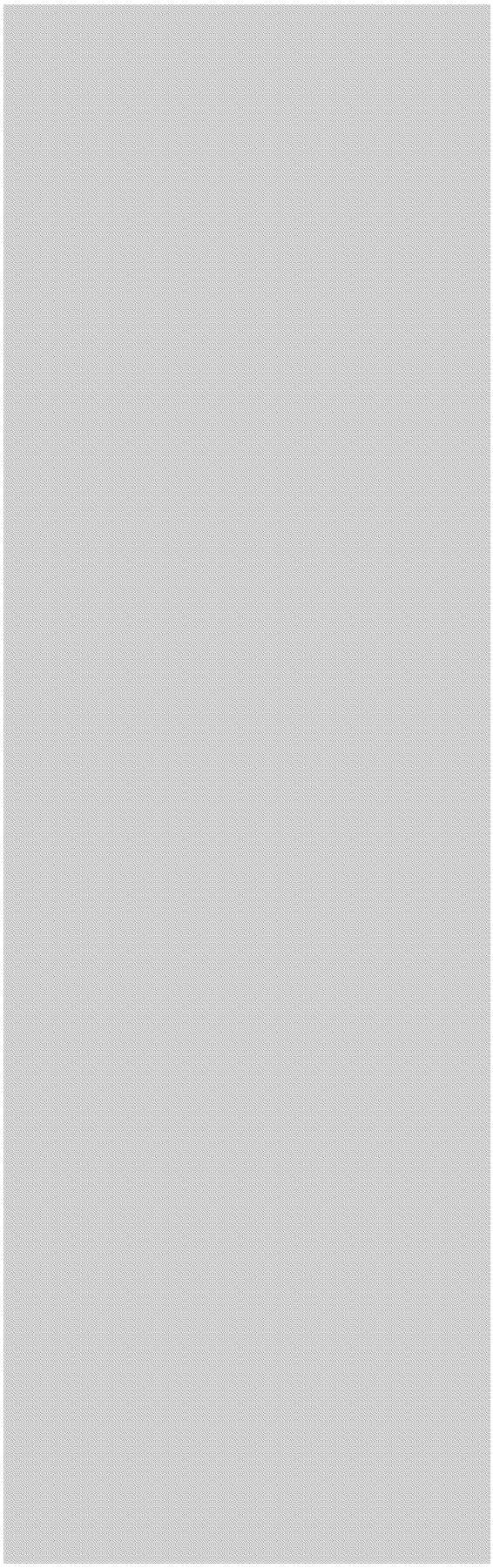


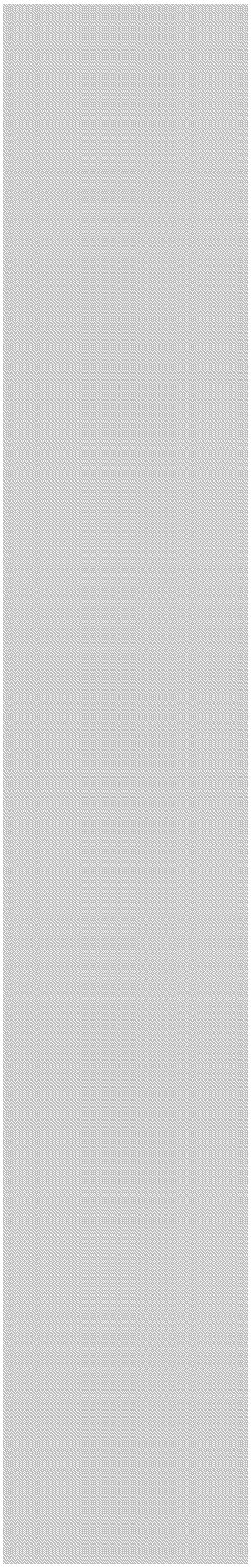


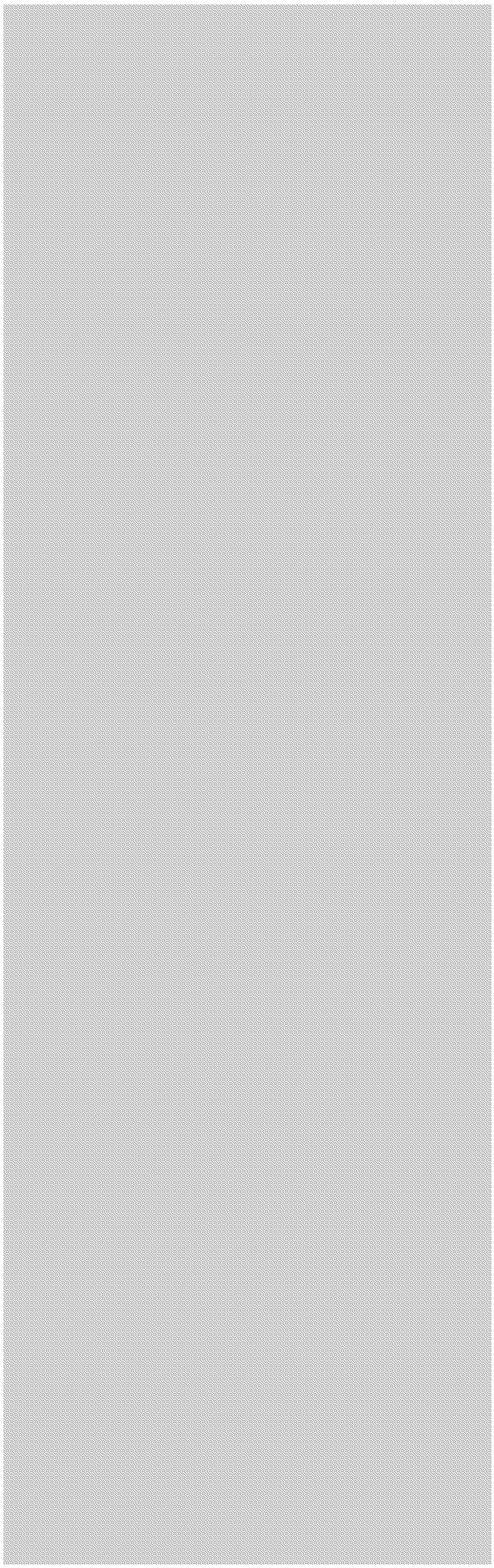


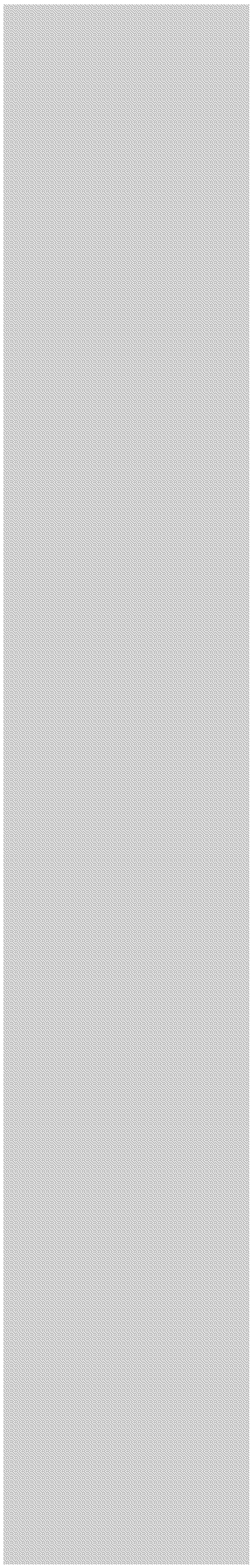


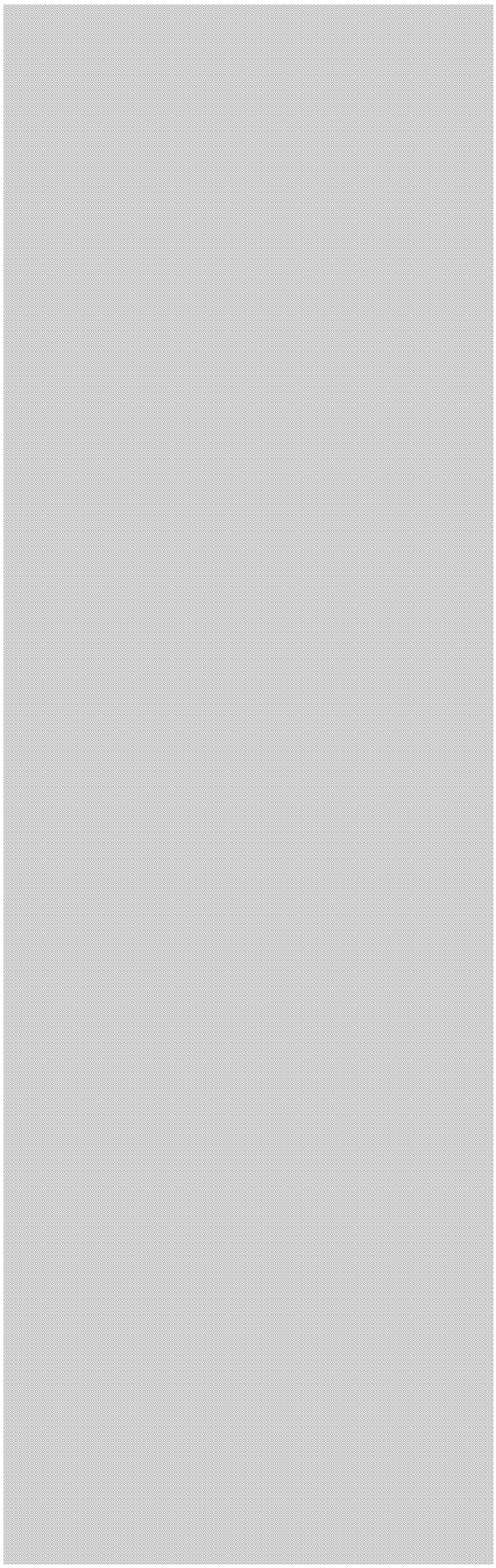
Rate/Percentage[e]	Specific eligibility groups[h]		
	Denominator	Numerator[d]	Rate/Percentage[e]

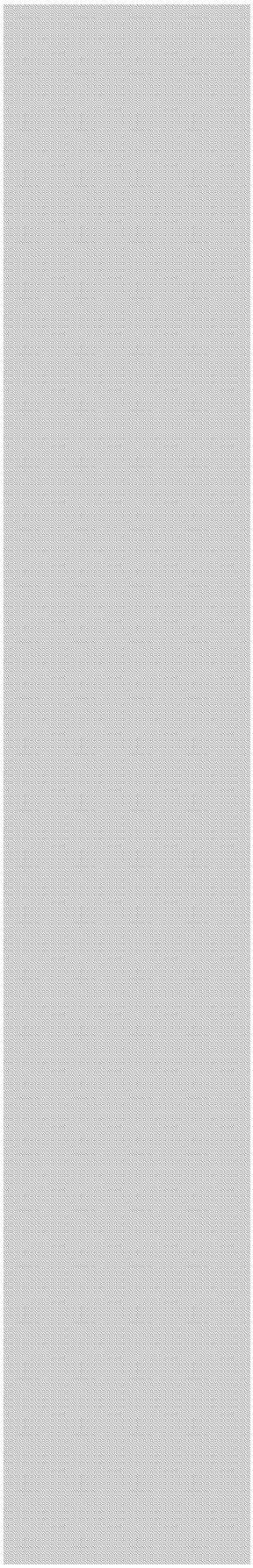


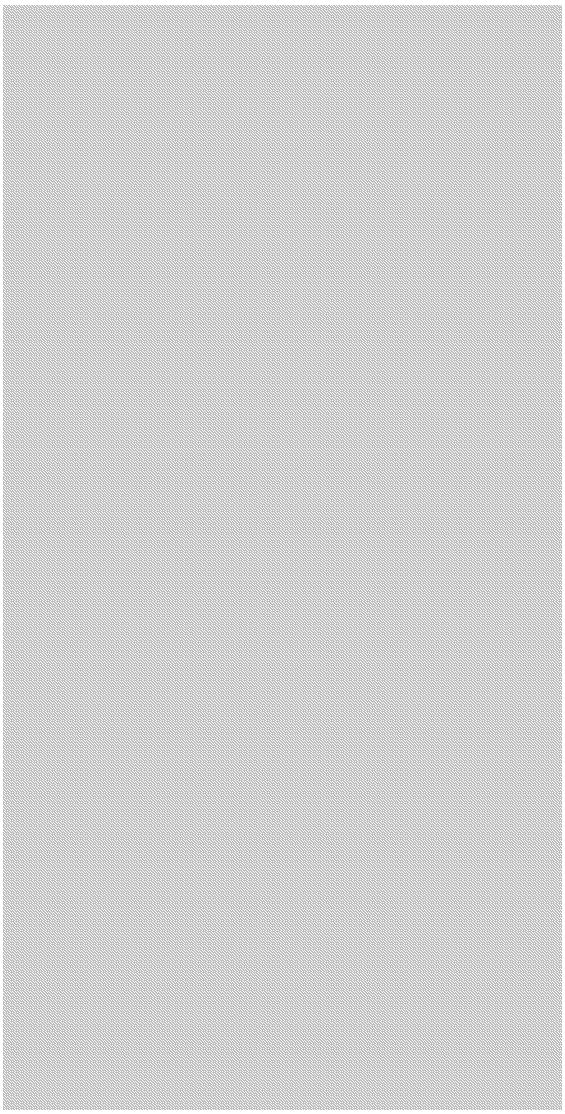


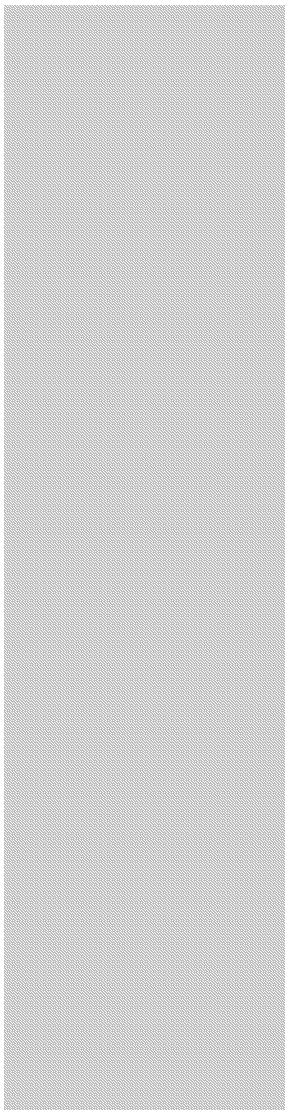












Medicaid Section 1115 Eligibility and Coverage Demonstration Report - Data and reporting issues (AD)

State	Michigan
Demonstration Name	Healthy Michigan Plan
Demonstration Year (DY)	DY 10
Calendar Dates for DY	01/01/2019 - 12/31/2019
Reporting Period	Q4
Calendar Dates for Reporting Period	10/01/2019 - 12/31/2019
Submitted on	4/24/2020

Data Reporting Issues (AD)

Category	Metric(s) impacted
EXAMPLE: Appeals and grievances (Delete row before submitting)	*EXAMPLE: AD_23 Grievance, other*
Enrollment	*AD_7 - AD_10*
☐ The state does not have any data and reporting issues related to this section. All associated metrics are reported as outlined in monitorin	
Mid-year loss of demonstration eligibility	*[Add rows as needed]*
☐ The state does not have any data and reporting issues related to this section. All associated metrics are reported as outlined in monitorin	
Enrollment duration at time of disenrollment	*[Add rows as needed]*
☐ The state does not have any data and reporting issues related to this section. All associated metrics are reported as outlined in monitorin	
Renewal	*AD_15 - AD_21*
☐ The state does not have any data and reporting issues related to this section. All associated metrics are reported as outlined in monitorin	
Cost sharing limit	*[Add rows as needed]*
☑ The state does not have any data and reporting issues related to this section. All associated metrics are reported as outlined in monitori	
Appeals and grievances	*[Add rows as needed]*
☑ The state does not have any data and reporting issues related to this section. All associated metrics are reported as outlined in monitori	
Access to care	*AD_35*
☐ The state does not have any data and reporting issues related to this section. All associated metrics are reported as outlined in monitori	
Quality of care and health outcomes	*AD_36 - AD_44*
☐ The state does not have any data and reporting issues related to this section. All associated metrics are reported as outlined in monitori	
Administrative cost	*[Add rows as needed]*
☑ The state does not have any data and reporting issues related to this section. All associated metrics are reported as outlined in monitori	

Note: States must prominently display the following notice on any display of Measure rates:

The MSC-AD, FUA-AD, FUM-AD, and IET_AD measures (metrics AD_38A, AD_39, and AD_40) are Healthcare Effe
copyrighted by the National Committee for Quality Assurance ("NCQA"). NCQA makes no representations, warra
reports performance measures and NCQA has no liability to anyone who relies on such measures or specificatior

The measure specification methodology used by CMS is different from NCQA's methodology. NCQA has not valic
Calculated measure results, based on the adjusted HEDIS specifications, may be called only "Uncertified, Unaudit

Certain non-NCQA measures in the CMS 1115 eligibility and coverage demonstration contain HEDIS Value Sets (\
contained in the VS. Users of the proprietary code sets should obtain all necessary licenses from the owners of tl
NCQA measures and any coding contained in the VS.

[a] The state should also use this column to provide updates on any data or reporting issues described in previous

End of workbook

Summary of issue	Date and report in which issue was first reported
EXAMPLE: *Difficulty collecting data for metric AD_23.*	*EXAMPLE:* *8/1/18; DY 1 Qtr. 1*
Difficulty collecting data	*DATE; DY10 Q2*
ıg protocol.	
ıg protocol.	
ıg protocol.	
Difficulty collecting data	*DATE; DY10 Q2*
ıg protocol.	
ing protocol.	
ing protocol.	
Difficulty collecting data	*DATE; DY10 Q2*
ing protocol.	
Difficulty collecting data	*DATE; DY10 Q2*
ing protocol.	
ing protocol.	

ctiveness Data and Information Set ("HEDIS®") measures that are owned and
ıanties, or endorsement about the quality of any organization or physician that uses or
ıs.

ɹated the adjusted measure specifications but has granted CMS permission to adjust.
ted HEDIS rates."

/S) developed by and included with the permission of the NCQA. Proprietary coding is
hese code sets. NCQA disclaims all liability for use or accuracy of the VS with the non-

reports. When applicable, the state should note when issues are resolved. If an issue was noted as resolved in the pre

Estimated number of impacted beneficiaries	Known or suspected cause(s) of issue (if applicable)
EXAMPLE: *24*	*EXAMPLE:* *Grievances are submitted via hardcopy through the mail to regional field offices. Often the field offices are slow to report the number of grievances they have received to the central office.*
Unknown	*The state is transitioning to the new waiver reporting format*
Unknown	*The state is transitioning to the new waiver reporting format*
Unknown	*The state is transitioning to the new waiver reporting format*
Unknown	*The state is transitioning to the new waiver reporting format*

Remediation plan and timeline for resolution (if applicable)/Status update if issue previously reported
EXAMPLE: *Central office is working on an electronic grievance filing system. That system will be completed by the end of the calendar year, and we will be able to quickly generate monthly, quarterly and yearly reports regarding grievances.*
The state will acquire the needed data and receive training on new data sources
The state will acquire the needed data and receive training on new data sources
The state will acquire the needed data and receive training on new data sources
The state will acquire the needed data and receive training on new data sources

Medicaid Section 1115 Eligibility and Coverage Demonstration Report - Data and reporting issues (CE)

State	Michigan
Demonstration Name	Healthy Michigan Plan
Demonstration Year (DY)	DY 10
Calendar Dates for DY	01/01/2019 - 12/31/2019
Reporting Period	Q4
Calendar Dates for Reporting Period	10/01/2019 - 12/31/2019
Submitted on	4/24/2020

Data Reporting Issues (CE)

Reporting Topic	Metric(s) impacted
EXAMPLE: CE.Mod_2: Establish beneficiary supports and modifications (Delete before submitting)	*EXAMPLE: CE_32 Beneficiaries exempt from Medicaid community engagement requirements for good cause*
CE.Mod_1: Specify community engagement policies	*All*
☐ The state does not have any data and reporting issues related to this section. All associated metrics are reported as outlined in monitorir	
CE.Mod_2: Establish beneficiary supports and modifications	*All*
☐ The state does not have any data and reporting issues related to this section. All associated metrics are reported as outlined in monitorir	
CE.Mod_4: Operationalize strategies for noncompliance	*All*
☐ The state does not have any data and reporting issues related to this section. All associated metrics are reported as outlined in monitorir	

End of workbook

Summary of issue	Date and report in which issue was first reported
EXAMPLE: *Awaiting additional data for metric CE_32 for September 2018.*	*EXAMPLE:* *8/1/18; DY 1 Qtr. 1*
Michigan's Community Engagement requirements due not begin until 01/01/2020 ıg protocol.	
Michigan's Community Engagement requirements due not begin until 01/01/2020 ıg protocol.	
Michigan's Community Engagement requirements due not begin until 01/01/2020 ıg protocol.	

Estimated number of impacted beneficiaries	Known or suspected cause(s) of issue (if applicable)
EXAMPLE: *100*	*EXAMPLE:* *Good cause exemption requests filed for the September 2018 are still being processed.*

Remediation plan and timeline for resolution (if applicable)/Status update if issue previously reported
EXAMPLE: *Good cause exemption processing for September 2018 will be completed in November and at that time we will be able to report this metric accurately. An additional case worker is being assigned to these requests for more timely processing in the future.*

Version 1.0.
End of workbook

Medical Services Administration
Bureau of Medicaid Care Management and Customer Service

PERFORMANCE MONITORING REPORT

Healthy Michigan Plan Measures

Composite – All Plans

January 2020

Produced by:
Quality Improvement and Program Development – Managed Care Plan Division

Table of Contents

Healthy Michigan Plan

Appendixes

Figures

Table

Executive Summary

This Performance Monitoring Report (PMR) is produced by the Quality Improvement and Program Development (QIPD) Section of the Managed Care Plan Division (MCPD) to track quality, access, and utilization in the Michigan Medicaid program to better support high quality care for beneficiaries.

The Michigan Department of Health and Human Services (MDHHS) monitors the performance of the State's Medicaid Health Plans (MHPs) through 33 key performance measures aimed at improving the quality and efficiency of health care services provided to the Michigan residents enrolled in a Medicaid program. These measures include MDHHS Administrative Measures; Healthy Michigan Plan (HMP) Measures; MDHHS Dental Measures; CMS Core Set Measures; Health Equity HEDIS Measures; HEDIS Measures and Managed Care Quality Measures. **This report focuses only on the following HMP Measures:**

Healthy Michigan Plan (HMP) Measures				
Adults' Generic Drug Utilization	*Completion of Annual HRA*	*Outreach & Engagement to Facilitate Entry to PCP*	*Transition into Consistently Fail to Pay (CFP) Status*	*Transition out of Consistently Fail to Pay (CFP) Status*

Data for these measures are represented on a quarterly basis. The body of the report contains a cross-plan analysis of the most current data available for each of these measures. Measurement Periods may vary and are based on the specifications for that individual measure. Appendix A contains specific three letter codes identifying each of the MHPs. Appendix B contains the one-year plan specific analysis for each measure.

MHPs are contractually obligated to achieve specified standards for most measures. The following table displays the number of MHPs meeting or exceeding the standards for the performance measure versus total MHPs, as reported in the Performance Monitoring Report, during the listed quarter for fiscal year 2020 unless otherwise noted.

Table 1: Fiscal Year 2020

Quarterly Reported Measures	**Reported in 1st Quarter**		**Reported in 2nd Quarter**		**Reported in 3rd Quarter**		**Reported in 4th Quarter**	
Adults' Generic Drug Utilization	11/11							
Completion of Annual HRA	2/11							
Outreach & Engagement to Facilitate Entry to PCP	7/11							
	> 100% FPL	≤100% FPL	> 100% FPL	≤100% FPL	> 100% FPL	≤100% FPL	> 100% FPL	≤100% FPL
Transition into CFP Status – Cohort 1	11/11	10/11						
Transition into CFP Status – Cohort 2	11/11	10/11						
Transition into CFP Status – Cohort 3	11/11	10/11						
Transition out of CFP Status – Cohort 1	10/11	11/11						
Transition out of CFP Status – Cohort 2	7/11	8/11						
Transition out of CFP Status – Cohort 3	9/11	10/11						

Healthy Michigan Plan Enrollment

Michigan Medicaid Managed Care (HMP-MC) enrollment has remained steady over the past year. In December 2019, enrollment was 528,766, up 2,270 enrollees (0.4%) from January 2019. An increase of 3,936 enrollees (0.7%) was realized between November 2019 and December 2019.

Figure 1: HMP-MC Enrollment, January 2019 – December 2019

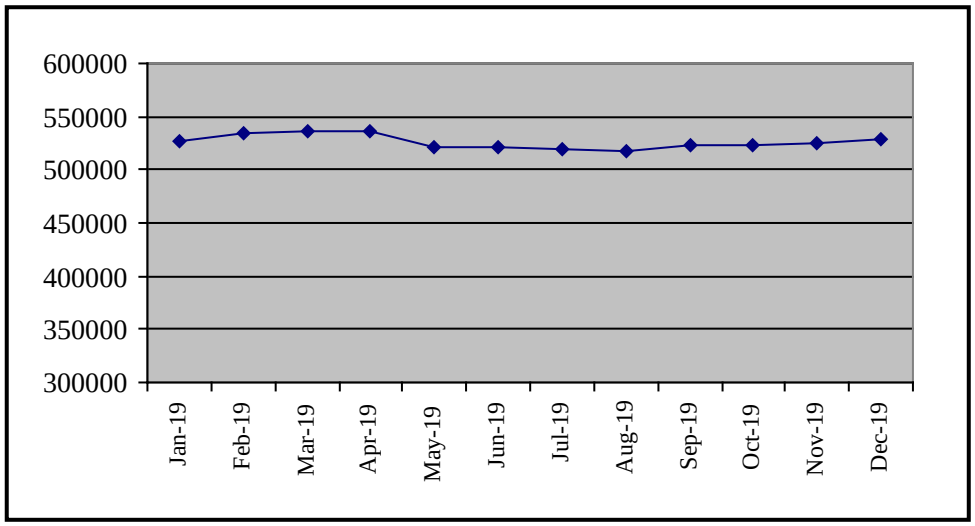
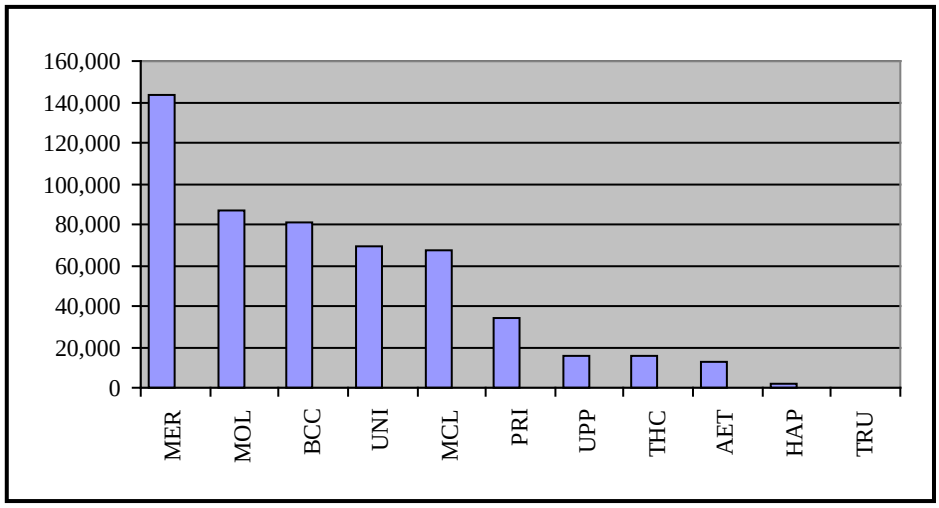


Figure 2: HMP-MC Enrollment by Medicaid Health Plan, December 2019



Medicaid Health Plan News

The Performance Monitoring Report contains data for all Michigan Medicaid Health Plans, where data is available. Ten Medicaid Health Plans are contracted with the State of Michigan to provide comprehensive health care services.

As of January 1, 2020, Trusted Health Plan Michigan (TRU) is no longer an active Medicaid Health Plan. However, their information will continue to appear in the quarterly PMRs until such data is no longer available.

Cross-Plan Performance Monitoring Analyses

The following section includes a cross-plan analysis for each performance measure. An analysis of the most current data available for each performance measure is included. For detailed questions regarding measurement periods or standards, see the Performance Monitoring Specifications.

Adults' Generic Drug Utilization

Measure
The percentage of generic prescriptions filled for adult members of health plans during the measurement period.

Standard
At or above 80% (as shown on bar graph below)

Measurement Period
April 2019 – June 2019

Data Source
MDHHS Data Warehouse

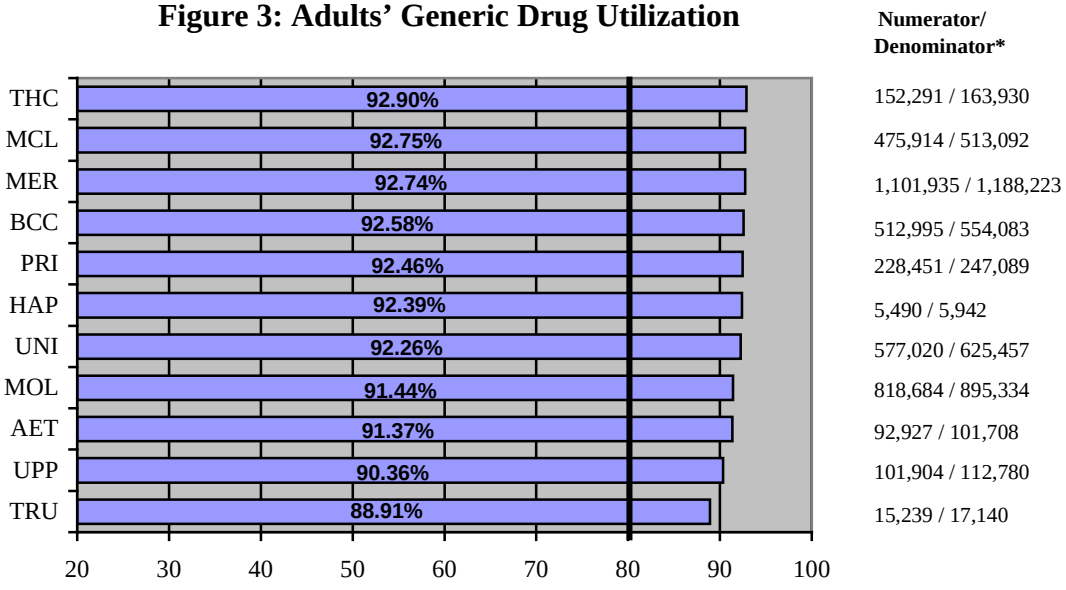
Measurement Frequency
Quarterly

Summary: All of the plans met or exceeded the standard. Results ranged from 88.91% to 92.90%.

Table 2: Comparison across Medicaid Programs

Medicaid Program	Numerator	Denominator	Percentage
Michigan Medicaid All	4,136,526	4,483,093	92.27%
Fee For Service (FFS) only	9,116	9,983	91.32%
Managed Care only	4,097,360	4,440,694	92.27%
MA-MC	2,034,761	2,211,211	92.02%
HMP-MC	2,013,964	2,177,161	92.50%

Figure 3: Adults' Generic Drug Utilization



Adult's Generic Drug Utilization Percentages

*Numerator depicts the number of eligible beneficiaries who had generic prescriptions filled. Denominator depicts the total number of eligible beneficiaries.

Completion of Annual Health Risk Assessment (HRA)

Measure
The percentage of Healthy Michigan Plan members enrolled in a health plan who had a Health Risk Assessment (HRA) completed during the measurement period.

Standard
At or above 12% (as shown on bar graph below)

Measurement Period
July 2018 – June 2019

Data Source
MDHHS Data Warehouse

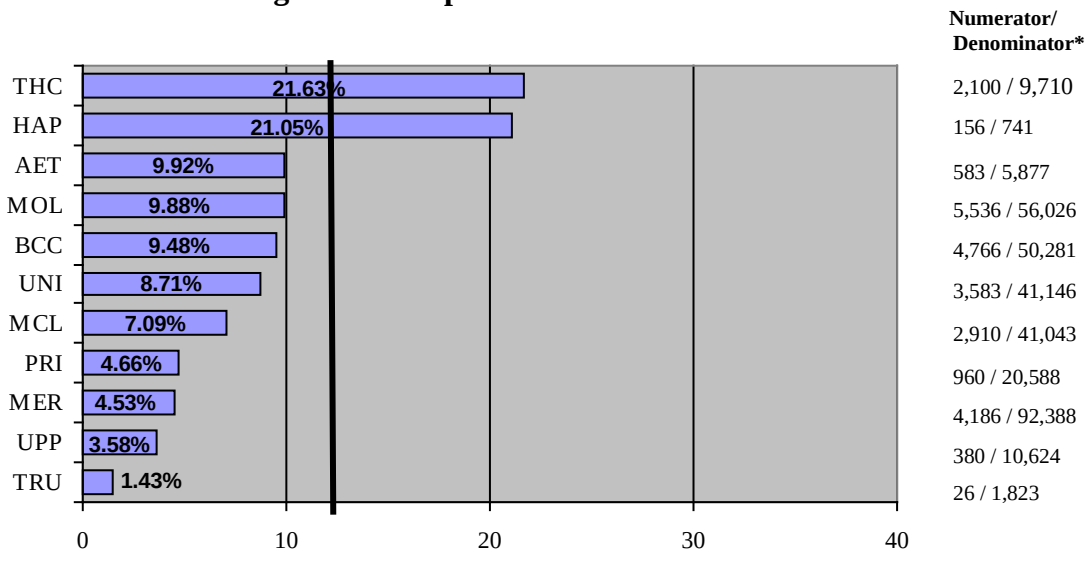
Measurement Frequency
Quarterly

Summary: Two plans (**HAP and THC**) met or exceeded the standard, while nine plans (AET, BCC, MCL, MER, MOL, PRI, TRU, UNI, and UPP) did not. Results ranged from 1.43% to 21.63%.

Table 3: Program Total

Medicaid Program	Numerator	Denominator	Percentage
HMP-MC	29,466	388,280	7.59%

Figure 4: Completion of Annual HRA



Completion of Annual HRA Percentages

*Numerator depicts the number of eligible beneficiaries who completed a second HRA within one year (defined as 11-15 months) of their first HRA. Denominator depicts the total number of eligible beneficiaries.

Outreach and Engagement to Facilitate Entry to Primary Care

Measure
The percentage of Healthy Michigan Plan members who have an ambulatory or preventive care visit within 150 days of enrollment into a health plan who had not previously had an ambulatory or preventive care visit since enrollment in Healthy Michigan Plan.

Standard
At or above 50% (as shown on bar graph below)

Enrollment Dates
January 2019 – March 2019

Data Source
MDHHS Data Warehouse

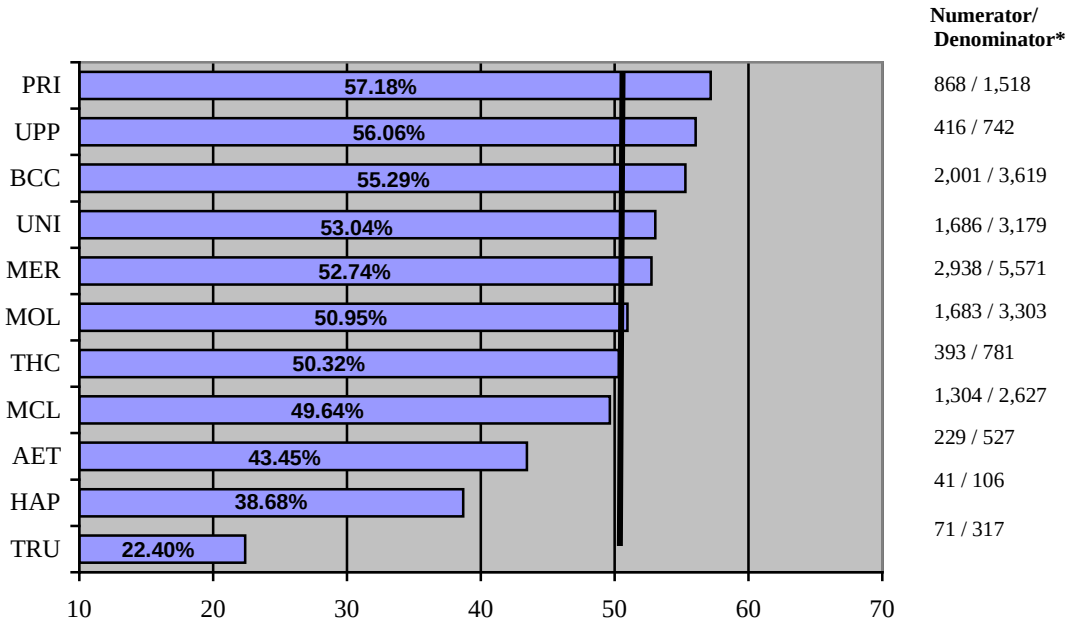
Measurement Frequency
Quarterly

Summary: Seven plans (**BCC, MER, MOL, PRI, THC, UNI, and UPP**) met or exceeded the standard, while four plans (AET, HAP, MCL, and TRU) did not. Results ranged from 22.40% to 57.18%.

Table 4: Program Total[1]

Medicaid Program	Numerator	Denominator	Percentage
HMP-MC	15,563	26,223	59.35%

Figure 5: Outreach & Engagement to Facilitate Entry to Primary Care



Outreach & Engagement to Facilitate Entry to Primary Care Percentages

*Numerator depicts the number of eligible beneficiaries who had an ambulatory or preventive care visit within 150 days of enrollment in a health plan. Denominator depicts the total number of eligible beneficiaries.

[1] This includes visits during the HMP FFS period prior to enrollment in a Medicaid health plan.

Transition into Consistently Fail to Pay (CFP) Status

Measure
The percentage of Healthy Michigan Plan members who transitioned from non-CFP status into CFP status during the last quarter of the measurement period.

Standard
Income level over 100% FPL - At or **below** 30%
Income level up to 100% FPL – At or **below** 7%

Measurement Period
November 2018 – December 2019

Data Source
MDHHS Data Warehouse

Measurement Frequency
Quarterly

*****This is a reverse measure. A lower rate indicates better performance.***

Summary:
In ***Cohort 1***, for income levels over 100% FPL, all of the plans met or exceeded the standard. Results ranged from 4.65% to 20.00%. For income levels up to 100% FPL, 10 plans (**AET, BCC, HAP, MCL, MER, MOL, PRI, THC, UNI, and UPP**) met or exceeded the standard, while one plan (TRU) did not. Results ranged from 3.23% to 8.24%.

In ***Cohort 2***, for income levels over 100% FPL, all of the plans met or exceeded the standard. Results ranged from 0.00% to 25.00%. For income levels up to 100% FPL, 10 plans (**AET, BCC, MCL, MER, MOL, PRI, THC, TRU, UNI, and UPP**) met or exceeded the standard, while one plan (HAP) did not. Results ranged from 1.92% to 8.11%.

In ***Cohort 3***, for income levels over 100% FPL, all of the plans met or exceeded the standard. Results ranged from 0.00% to 16.67%. For income levels up to 100% FPL, 10 plans (**AET, BCC, MCL, MER, MOL, PRI, THC, TRU, UNI, and UPP**) met or exceeded the standard, while one plan (HAP) did not. Results ranged from 1.96% to 8.70%.

Table 5: Transition into CFP Status - Cohort 1

MHP	FPL over 100% (N)	FPL over 100% (D)	Rate	Standard Achieved	FPL up to 100% (N)	FPL up to 100% (D)	Rate	Standard Achieved
AET	2	43	4.65%	Yes	17	302	5.63%	Yes
BCC	67	786	8.52%	Yes	166	3416	4.86%	Yes
HAP	2	10	20.00%	Yes	1	31	3.23%	Yes
MCL	62	777	7.98%	Yes	109	2757	3.95%	Yes
MER	158	1713	9.22%	Yes	361	6216	5.81%	Yes
MOL	66	727	9.08%	Yes	187	1097	5.52%	Yes
PRI	34	522	6.51%	Yes	61	1439	4.24%	Yes
THC	12	133	9.02%	Yes	24	613	3.92%	Yes
TRU	1	5	20.00%	Yes	7	85	**8.24%**	**No**
UNI	55	707	7.78%	Yes	152	2695	5.64%	Yes
UPP	15	295	5.08%	Yes	29	763	3.80%	Yes

Table 6: Transition into CFP Status - Cohort 2

MHP	FPL over 100% (N)	FPL over 100% (D)	Rate	Standard Achieved	FPL up to 100% (N)	FPL up to 100% (D)	Rate	Standard Achieved
AET	1	59	1.69%	Yes	13	315	4.13%	Yes
BCC	67	740	9.05%	Yes	145	3364	4.31%	Yes
HAP	0	3	0.00%	Yes	3	37	**8.11%**	**No**
MCL	66	841	7.85%	Yes	132	2930	4.51%	Yes
MER	161	1612	9.99%	Yes	315	6392	4.93%	Yes
MOL	73	840	8.69%	Yes	150	3671	4.09%	Yes
PRI	33	490	6.73%	Yes	51	1523	3.35%	Yes
THC	7	109	6.42%	Yes	24	631	3.80%	Yes
TRU	1	4	25.00%	Yes	1	52	1.92%	Yes
UNI	52	708	7.34%	Yes	118	2718	4.34%	Yes
UPP	20	296	6.76%	Yes	40	785	5.10%	Yes

Table 7: Transition into CFP Status - Cohort 3

MHP	FPL over 100% (N)	FPL over 100% (D)	Rate	Standard Achieved	FPL up to 100% (N)	FPL up to 100% (D)	Rate	Standard Achieved
AET	4	64	6.25%	Yes	13	453	2.87%	Yes
BCC	85	887	9.58%	Yes	174	4213	4.13%	Yes
HAP	1	6	16.67%	Yes	4	46	**8.70%**	**No**
MCL	83	958	8.66%	Yes	144	3500	4.11%	Yes
MER	197	1905	10.34%	Yes	411	8041	5.11%	Yes
MOL	70	918	7.63%	Yes	193	4723	4.09%	Yes
PRI	47	557	8.44%	Yes	94	1841	5.11%	Yes
THC	15	130	11.54%	Yes	33	810	4.07%	Yes
TRU	0	9	0.00%	Yes	3	153	1.96%	Yes
UNI	62	877	7.07%	Yes	158	3183	4.96%	Yes
UPP	19	352	5.40%	Yes	44	959	4.59%	Yes

Transition out of Consistently Fail to Pay (CFP) Status

Measure
The percentage of Healthy Michigan Plan members who transitioned from CFP status to non-CFP status during the last quarter of the measurement period.

Standard
Income level over 100% FPL - At or above 2%
Income level up to 100% FPL – At or above 2%

Measurement Period
November 2018 – December 2019

Data Source
MDHHS Data Warehouse

Measurement Frequency
Quarterly

Summary:
In ***Cohort 1***, for income levels over 100% FPL, 10 plans (**AET, BCC, MCL, MER, MOL, PRI, THC, TRU, UNI, and UPP**) met or exceeded the standard, while one plan (HAP) did not. Results ranged from 0.00% to 5.56%. For income levels up to 100% FPL, all of the plans met or exceeded the standard. Results ranged from 2.17% to 5.58%.

In ***Cohort 2***, for income levels over 100% FPL, seven plans (**BCC, HAP, MCL, MER, MOL, PRI, and UNI**) met or exceeded the standard, while four plans (AET, THC, TRU, and UPP). Results ranged from 0.00% to 22.22%. For income levels up to 100% FPL, eight plans (**BCC, MCL, MER, MOL, PRI, THC, UNI, and UPP**) met or exceeded the standard, while three plans (AET, HAP, and TRU) did not. Results ranged from 0.00% to 5.41%.

In ***Cohort 3***, for income levels over 100% FPL, nine plans (**BCC, MCL, MER, MOL, PRI, THC, TRU, UNI, and UPP**) met or exceeded the standard, while two plans (AET and HAP) did not. Results ranged from 0.00% to 5.14%. For income levels up to 100% FPL, 10 plans (**AET, BCC, HAP, MCL, MER, MOL, PRI, THC, UNI, and UPP**) met or exceeded the standard, while one plan (TRU). Results ranged from 1.35% to 13.33%.

Table 8: Transition out of CFP Status - Cohort 1

MHP	FPL over 100% (N)	FPL over 100% (D)	Rate	Standard Achieved	FPL up to 100% (N)	FPL up to 100% (D)	Rate	Standard Achieved
AET	3	102	2.94%	Yes	4	184	2.17%	Yes
BCC	26	840	3.10%	Yes	94	1733	5.42%	Yes
HAP	0	18	**0.00%**	**No**	1	20	5.00%	Yes
MCL	37	900	4.11%	Yes	73	1524	4.79%	Yes
MER	86	2125	4.05%	Yes	173	3633	4.76%	Yes
MOL	36	1097	3.28%	Yes	99	2283	4.34%	Yes
PRI	18	429	4.20%	Yes	25	681	3.67%	Yes
THC	3	123	2.44%	Yes	15	353	4.25%	Yes
TRU	1	18	5.56%	Yes	1	33	3.03%	Yes
UNI	31	818	3.79%	Yes	84	1505	5.58%	Yes
UPP	6	257	2.33%	Yes	14	395	3.54%	Yes

Table 9: Transition out of CFP Status – Cohort 2

MHP	FPL over 100% (N)	FPL over 100% (D)	Rate	Standard Achieved	FPL up to 100% (N)	FPL up to 100% (D)	Rate	Standard Achieved
AET	0	76	**0.00%**	**No**	1	187	**0.53%**	**No**
BCC	21	775	2.71%	Yes	63	1626	3.87%	Yes
HAP	2	9	22.22%	Yes	0	19	**0.00%**	**No**
MCL	31	893	3.47%	Yes	66	1533	4.31%	Yes
MER	52	1888	2.75%	Yes	186	3441	5.41%	Yes
MOL	36	1059	3.40%	Yes	90	2194	4.10%	Yes
PRI	13	455	2.86%	Yes	21	676	3.11%	Yes
THC	2	134	**1.49%**	**No**	7	329	2.13%	Yes
TRU	0	12	**0.00%**	**No**	0	33	**0.00%**	**No**
UNI	32	745	4.30%	Yes	75	1459	5.14%	Yes
UPP	5	270	**1.85%**	**No**	22	414	5.31%	Yes

Table 10: Transition out of CFP Status - Cohort 3

MHP	FPL over 100% (N)	FPL over 100% (D)	Rate	Standard Achieved	FPL up to 100% (N)	FPL up to 100% (D)	Rate	Standard Achieved
AET	2	122	**1.64%**	**No**	8	232	3.45%	Yes
BCC	26	1040	2.50%	Yes	83	2093	3.97%	Yes
HAP	0	16	**0.00%**	**No**	2	15	13.33%	Yes
MCL	23	1084	2.12%	Yes	78	1843	4.23%	Yes
MER	75	2468	3.04%	Yes	185	4495	4.12%	Yes
MOL	36	1344	2.68%	Yes	114	2940	3.88%	Yes
PRI	20	554	3.61%	Yes	34	804	4.23%	Yes
THC	6	160	3.75%	Yes	9	429	2.10%	Yes
TRU	1	27	3.70%	Yes	1	74	**1.35%**	**No**
UNI	30	995	3.02%	Yes	78	1733	4.50%	Yes
UPP	16	311	5.14%	Yes	31	451	6.87%	Yes

Appendix A: Three Letter Medicaid Health Plan Codes

Below is a list of three letter codes established by MDHHS identifying each Medicaid Health Plan.

AET	Aetna Better Health of Michigan
BCC	Blue Cross Complete of Michigan
HAP	HAP Empowered
MCL	McLaren Health Plan
MER	Meridian Health Plan of Michigan
MOL	Molina Healthcare of Michigan
PRI	Priority Health Choice
THC	Total Health Care
TRU	Trusted Health Plan Michigan, Inc.
UNI	UnitedHealthcare Community Plan
UPP	Upper Peninsula Health Plan

Appendix B: One Year Plan-Specific Analysis

Aetna Better Health of Michigan – AET

HEALTHY MICHIGAN PLAN:

Performance Measure	Measurement Period	Standard	Plan Result	Standard Achieved
Adults' Generic Drug Utilization	**Apr 19 – Jun 19**	**80%**	**91.37%**	**Yes**
Completion of Annual HRA	**Jul 18 – Jun 19**	**12%**	**9.92%**	**No**
Outreach/Engagement to Facilitate Entry to Primary Care	**Jan 19 – Mar 19**	**50%**	**43.45%**	**No**

Transition into CFP Status: [Nov 18 – Dec 19]						
Standard >100% FPL	**Cohort 1 Result**	**Standard Achieved**	**Cohort 2 Result**	**Standard Achieved**	**Cohort 3 Result**	**Standard Achieved**
30%	**4.65%**	**Yes**	**1.69%**	**Yes**	**6.25%**	**Yes**
Standard ≤100% FPL	**Cohort 1 Result**	**Standard Achieved**	**Cohort 2 Result**	**Standard Achieved**	**Cohort 3 Result**	**Standard Achieved**
7%	**5.63%**	**Yes**	**4.13%**	**Yes**	**2.87%**	**Yes**

This is a reverse measure. A lower rate indicates better performance.

Transition out of CFP Status: [Nov 18 – Dec 19]						
Standard >100% FPL	**Cohort 1 Result**	**Standard Achieved**	**Cohort 2 Result**	**Standard Achieved**	**Cohort 3 Result**	**Standard Achieved**
2%	**2.94%**	**Yes**	**0.00%**	**No**	**1.64%**	**No**
Standard ≤100% FPL	**Cohort 1 Result**	**Standard Achieved**	**Cohort 2 Result**	**Standard Achieved**	**Cohort 3 Result**	**Standard Achieved**
2%	**2.17%**	**Yes**	**0.53%**	**No**	**3.45%**	**Yes**

- Shaded areas represent data that are newly reported this month.
- For questions regarding measurement periods or standards, see the Performance Monitoring Specifications

Appendix B: One Year Plan-Specific Analysis

Blue Cross Complete of Michigan – BCC

HEALTHY MICHIGAN PLAN:

Performance Measure	Measurement Period	Standard	Plan Result	Standard Achieved
Adults' Generic Drug Utilization	**Apr 19 – Jun 19**	**80%**	**92.58%**	**Yes**
Completion of Annual HRA	**Jul 18 – Jun 19**	**12%**	**9.48%**	**No**
Outreach/Engagement to Facilitate Entry to Primary Care	**Jan 19 – Mar 19**	**50%**	**55.29%**	**Yes**

***Transition into CFP Status: [Nov 18 – Dec 19]**						
Standard >100% FPL	**Cohort 1 Result**	**Standard Achieved**	**Cohort 2 Result**	**Standard Achieved**	**Cohort 3 Result**	**Standard Achieved**
30%	**8.52%**	**Yes**	**9.05%**	**Yes**	**9.58%**	**Yes**
Standard ≤100% FPL	**Cohort 1 Result**	**Standard Achieved**	**Cohort 2 Result**	**Standard Achieved**	**Cohort 3 Result**	**Standard Achieved**
7%	**4.86%**	**Yes**	**4.31%**	**Yes**	**4.13%**	**Yes**

****This is a reverse measure. A lower rate indicates better performance.***

Transition out of CFP Status: [Nov 18 – Dec 19]						
Standard >100% FPL	**Cohort 1 Result**	**Standard Achieved**	**Cohort 2 Result**	**Standard Achieved**	**Cohort 3 Result**	**Standard Achieved**
2%	**3.10%**	**Yes**	**2.71%**	**Yes**	**2.50%**	**Yes**
Standard ≤100% FPL	**Cohort 1 Result**	**Standard Achieved**	**Cohort 2 Result**	**Standard Achieved**	**Cohort 3 Result**	**Standard Achieved**
2%	**5.42%**	**Yes**	**3.87%**	**Yes**	**3.97%**	**Yes**

- Shaded areas represent data that are newly reported this month.
- For questions regarding measurement periods or standards, see the Performance Monitoring Specifications

Appendix B: One Year Plan-Specific Analysis

HAP Empowered – HAP

HEALTHY MICHIGAN PLAN:

Performance Measure	Measurement Period	Standard	Plan Result	Standard Achieved
Adults' Generic Drug Utilization	**Apr 19 – Jun 19**	**80%**	**92.39%**	**Yes**
Completion of Annual HRA	**Jul 18 – Jun 19**	**12%**	**21.05%**	**Yes**
Outreach/Engagement to Facilitate Entry to Primary Care	**Jan 19 – Mar 19**	**50%**	**38.68%**	**No**

*Transition into CFP Status: [Nov 18 – Dec 19]						
Standard >100% FPL	**Cohort 1 Result**	**Standard Achieved**	**Cohort 2 Result**	**Standard Achieved**	**Cohort 3 Result**	**Standard Achieved**
30%	**20.00%**	**Yes**	**0.00%**	**Yes**	**16.67%**	**Yes**
Standard ≤100% FPL	**Cohort 1 Result**	**Standard Achieved**	**Cohort 2 Result**	**Standard Achieved**	**Cohort 3 Result**	**Standard Achieved**
7%	**3.23%**	**Yes**	**8.11%**	**No**	**8.70%**	**No**

This is a reverse measure. A lower rate indicates better performance.

Transition out of CFP Status: [Nov 18 – Dec 19]						
Standard >100% FPL	**Cohort 1 Result**	**Standard Achieved**	**Cohort 2 Result**	**Standard Achieved**	**Cohort 3 Result**	**Standard Achieved**
2%	**0.00%**	**No**	**22.22%**	**Yes**	**0.00%**	**No**
Standard ≤100% FPL	**Cohort 1 Result**	**Standard Achieved**	**Cohort 2 Result**	**Standard Achieved**	**Cohort 3 Result**	**Standard Achieved**
2%	**5.00%**	**Yes**	**0.00%**	**No**	**13.33%**	**Yes**

- Shaded areas represent data that are newly reported this month.
- For questions regarding measurement periods or standards, see the Performance Monitoring Specifications

Appendix B: One Year Plan-Specific Analysis

McLaren Health Plan – MCL

HEALTHY MICHIGAN PLAN:

Performance Measure	Measurement Period	Standard	Plan Result	Standard Achieved
Adults' Generic Drug Utilization	**Apr 19 – Jun 19**	**80%**	**92.75%**	**Yes**
Completion of Annual HRA	**Jul 18 – Jun 19**	**12%**	**7.09%**	**No**
Outreach/Engagement to Facilitate Entry to Primary Care	**Jan 19 – Mar 19**	**50%**	**49.64%**	**No**

***Transition into CFP Status: [Nov 18 – Dec 19]**						
Standard >100% FPL	**Cohort 1 Result**	**Standard Achieved**	**Cohort 2 Result**	**Standard Achieved**	**Cohort 3 Result**	**Standard Achieved**
30%	**7.98%**	**Yes**	**7.85%**	**Yes**	**8.66%**	**Yes**
Standard ≤100% FPL	**Cohort 1 Result**	**Standard Achieved**	**Cohort 2 Result**	**Standard Achieved**	**Cohort 3 Result**	**Standard Achieved**
7%	**3.95%**	**Yes**	**4.51%**	**Yes**	**4.11%**	**Yes**

****This is a reverse measure. A lower rate indicates better performance.***

Transition out of CFP Status: [Nov 18 – Dec 19]						
Standard >100% FPL	**Cohort 1 Result**	**Standard Achieved**	**Cohort 2 Result**	**Standard Achieved**	**Cohort 3 Result**	**Standard Achieved**
2%	**4.11%**	**Yes**	**3.47%**	**Yes**	**2.12%**	**Yes**
Standard ≤100% FPL	**Cohort 1 Result**	**Standard Achieved**	**Cohort 2 Result**	**Standard Achieved**	**Cohort 3 Result**	**Standard Achieved**
2%	**4.79%**	**Yes**	**4.31%**	**Yes**	**4.23%**	**Yes**

- Shaded areas represent data that are newly reported this month.
- For questions regarding measurement periods or standards, see the Performance Monitoring Specifications

Appendix B: One Year Plan-Specific Analysis

Meridian Health Plan of Michigan – MER

HEALTHY MICHIGAN PLAN:

Performance Measure	Measurement Period	Standard	Plan Result	Standard Achieved
Adults' Generic Drug Utilization	**Apr 19 – Jun 19**	**80%**	**92.74%**	**Yes**
Completion of Annual HRA	**Jul 18 – Jun 19**	**12%**	**4.53%**	**No**
Outreach/Engagement to Facilitate Entry to Primary Care	**Jan 19 – Mar 19**	**50%**	**52.74%**	**Yes**

***Transition into CFP Status: [Nov 18 – Dec 19]**						
Standard >100% FPL	**Cohort 1 Result**	**Standard Achieved**	**Cohort 2 Result**	**Standard Achieved**	**Cohort 3 Result**	**Standard Achieved**
30%	**9.22%**	**Yes**	**9.99%**	**Yes**	**10.34%**	**Yes**
Standard ≤100% FPL	**Cohort 1 Result**	**Standard Achieved**	**Cohort 2 Result**	**Standard Achieved**	**Cohort 3 Result**	**Standard Achieved**
7%	**5.81%**	**Yes**	**4.93%**	**Yes**	**5.11%**	**Yes**

****This is a reverse measure. A lower rate indicates better performance.***

Transition out of CFP Status: [Nov 18 – Dec 19]						
Standard >100% FPL	**Cohort 1 Result**	**Standard Achieved**	**Cohort 2 Result**	**Standard Achieved**	**Cohort 3 Result**	**Standard Achieved**
2%	**4.05%**	**Yes**	**2.75%**	**Yes**	**3.04%**	**Yes**
Standard ≤100% FPL	**Cohort 1 Result**	**Standard Achieved**	**Cohort 2 Result**	**Standard Achieved**	**Cohort 3 Result**	**Standard Achieved**
2%	**4.76%**	**Yes**	**5.41%**	**Yes**	**4.12%**	**Yes**

- Shaded areas represent data that are newly reported this month.
- For questions regarding measurement periods or standards, see the Performance Monitoring Specifications

Appendix B: One Year Plan-Specific Analysis

Molina Healthcare of Michigan – MOL

HEALTHY MICHIGAN PLAN:

Performance Measure	Measurement Period	Standard	Plan Result	Standard Achieved
Adults' Generic Drug Utilization	**Apr 19 – Jun 19**	**80%**	**91.44%**	**Yes**
Completion of Annual HRA	**Jul 18 – Jun 19**	**12%**	**9.88%**	**No**
Outreach/Engagement to Facilitate Entry to Primary Care	**Jan 19 – Mar 19**	**50%**	**50.95%**	**Yes**

*Transition into CFP Status: [Nov 18 – Dec 19]						
Standard >100% FPL	**Cohort 1 Result**	**Standard Achieved**	**Cohort 2 Result**	**Standard Achieved**	**Cohort 3 Result**	**Standard Achieved**
30%	**9.08%**	**Yes**	**8.69%**	**Yes**	**7.63%**	**Yes**
Standard ≤100% FPL	**Cohort 1 Result**	**Standard Achieved**	**Cohort 2 Result**	**Standard Achieved**	**Cohort 3 Result**	**Standard Achieved**
7%	**5.52%**	**Yes**	**4.09%**	**Yes**	**4.09%**	**Yes**

This is a reverse measure. A lower rate indicates better performance.

Transition out of CFP Status: [Nov 18 – Dec 19]						
Standard >100% FPL	**Cohort 1 Result**	**Standard Achieved**	**Cohort 2 Result**	**Standard Achieved**	**Cohort 3 Result**	**Standard Achieved**
2%	**3.28%**	**Yes**	**3.40%**	**Yes**	**2.68%**	**Yes**
Standard ≤100% FPL	**Cohort 1 Result**	**Standard Achieved**	**Cohort 2 Result**	**Standard Achieved**	**Cohort 3 Result**	**Standard Achieved**
2%	**4.34%**	**Yes**	**4.10%**	**Yes**	**3.88%**	**Yes**

- Shaded areas represent data that are newly reported this month.
- For questions regarding measurement periods or standards, see the Performance Monitoring Specifications

Appendix B: One Year Plan-Specific Analysis

Priority Health Choice – PRI

HEALTHY MICHIGAN PLAN:

Performance Measure	Measurement Period	Standard	Plan Result	Standard Achieved
Adults' Generic Drug Utilization	**Apr 19 – Jun 19**	**80%**	**92.46%**	**Yes**
Completion of Annual HRA	**Jul 18 – Jun 19**	**12%**	**4.66%**	**No**
Outreach/Engagement to Facilitate Entry to Primary Care	**Jan 19 – Mar 19**	**50%**	**57.18%**	**Yes**

***Transition into CFP Status: [Nov 18 – Dec 19]**						
Standard >100% FPL	**Cohort 1 Result**	**Standard Achieved**	**Cohort 2 Result**	**Standard Achieved**	**Cohort 3 Result**	**Standard Achieved**
30%	**6.51%**	**Yes**	**6.73%**	**Yes**	**8.44%**	**Yes**
Standard ≤100% FPL	**Cohort 1 Result**	**Standard Achieved**	**Cohort 2 Result**	**Standard Achieved**	**Cohort 3 Result**	**Standard Achieved**
7%	**4.24%**	**Yes**	**3.35%**	**Yes**	**5.11%**	**Yes**

****This is a reverse measure. A lower rate indicates better performance.***

Transition out of CFP Status: [Nov 18 – Dec 19]						
Standard >100% FPL	**Cohort 1 Result**	**Standard Achieved**	**Cohort 2 Result**	**Standard Achieved**	**Cohort 3 Result**	**Standard Achieved**
2%	**4.20%**	**Yes**	**2.86%**	**Yes**	**3.61%**	**Yes**
Standard ≤100% FPL	**Cohort 1 Result**	**Standard Achieved**	**Cohort 2 Result**	**Standard Achieved**	**Cohort 3 Result**	**Standard Achieved**
2%	**3.67%**	**Yes**	**3.11%**	**Yes**	**4.23%**	**Yes**

- Shaded areas represent data that are newly reported this month.
- For questions regarding measurement periods or standards, see the Performance Monitoring Specifications

Appendix B: One Year Plan-Specific Analysis

Total Health Care – THC

HEALTHY MICHIGAN PLAN:

Performance Measure	Measurement Period	Standard	Plan Result	Standard Achieved
Adults' Generic Drug Utilization	**Apr 19 – Jun 19**	**80%**	**92.90%**	**Yes**
Completion of Annual HRA	**Jul 18 – Jun 19**	**12%**	**21.63%**	**Yes**
Outreach/Engagement to Facilitate Entry to Primary Care	**Jan 19 – Mar 19**	**50%**	**50.32%**	**Yes**

*Transition into CFP Status: [Nov 18 – Dec 19]						
Standard >100% FPL	**Cohort 1 Result**	**Standard Achieved**	**Cohort 2 Result**	**Standard Achieved**	**Cohort 3 Result**	**Standard Achieved**
30%	**9.02%**	**Yes**	**6.42%**	**Yes**	**11.54%**	**Yes**
Standard ≤100% FPL	**Cohort 1 Result**	**Standard Achieved**	**Cohort 2 Result**	**Standard Achieved**	**Cohort 3 Result**	**Standard Achieved**
7%	**3.92%**	**Yes**	**3.80%**	**Yes**	**4.07%**	**Yes**

This is a reverse measure. A lower rate indicates better performance.

Transition out of CFP Status: [Nov 18 – Dec 19]						
Standard >100% FPL	**Cohort 1 Result**	**Standard Achieved**	**Cohort 2 Result**	**Standard Achieved**	**Cohort 3 Result**	**Standard Achieved**
2%	**2.44%**	**Yes**	**1.49%**	**No**	**3.75%**	**Yes**
Standard ≤100% FPL	**Cohort 1 Result**	**Standard Achieved**	**Cohort 2 Result**	**Standard Achieved**	**Cohort 3 Result**	**Standard Achieved**
2%	**4.25%**	**Yes**	**2.13%**	**Yes**	**2.10%**	**Yes**

- Shaded areas represent data that are newly reported this month.
- For questions regarding measurement periods or standards, see the Performance Monitoring Specifications

Appendix B: One Year Plan-Specific Analysis

UnitedHealthcare Community Plan – UNI

HEALTHY MICHIGAN PLAN:

Performance Measure	Measurement Period	Standard	Plan Result	Standard Achieved
Adults' Generic Drug Utilization	**Apr 19 – Jun 19**	**80%**	**92.26%**	**Yes**
Completion of Annual HRA	**Jul 18 – Jun 19**	**12%**	**8.71%**	**No**
Outreach/Engagement to Facilitate Entry to Primary Care	**Jan 19 – Mar 19**	**50%**	**53.04%**	**Yes**

***Transition into CFP Status: [Nov 18 – Dec 19]**						
Standard >100% FPL	**Cohort 1 Result**	**Standard Achieved**	**Cohort 2 Result**	**Standard Achieved**	**Cohort 3 Result**	**Standard Achieved**
30%	**7.78%**	**Yes**	**7.34%**	**Yes**	**7.07%**	**Yes**
Standard ≤100% FPL	**Cohort 1 Result**	**Standard Achieved**	**Cohort 2 Result**	**Standard Achieved**	**Cohort 3 Result**	**Standard Achieved**
7%	**5.64%**	**Yes**	**4.34%**	**Yes**	**4.96%**	**Yes**

****This is a reverse measure. A lower rate indicates better performance.***

Transition out of CFP Status: [Nov 18 – Dec 19]						
Standard >100% FPL	**Cohort 1 Result**	**Standard Achieved**	**Cohort 2 Result**	**Standard Achieved**	**Cohort 3 Result**	**Standard Achieved**
2%	**3.79%**	**Yes**	**4.30%**	**Yes**	**3.02%**	**Yes**
Standard ≤100% FPL	**Cohort 1 Result**	**Standard Achieved**	**Cohort 2 Result**	**Standard Achieved**	**Cohort 3 Result**	**Standard Achieved**
2%	**5.58%**	**Yes**	**5.14%**	**Yes**	**4.50%**	**Yes**

- Shaded areas represent data that are newly reported this month.
- For questions regarding measurement periods or standards, see the Performance Monitoring Specifications

Appendix B: One Year Plan-Specific Analysis

Upper Peninsula Health Plan – UPP

HEALTHY MICHIGAN PLAN:

Performance Measure	Measurement Period	Standard	Plan Result	Standard Achieved
Adults' Generic Drug Utilization	**Apr 19 – Jun 19**	**80%**	**90.36%**	**Yes**
Completion of Annual HRA	**Jul 18 – Jun 19**	**12%**	**3.58%**	**No**
Outreach/Engagement to Facilitate Entry to Primary Care	**Jan 19 – Mar 19**	**50%**	**56.06%**	**Yes**

***Transition into CFP Status: [Nov 18 – Dec 19]**						
Standard >100% FPL	**Cohort 1 Result**	**Standard Achieved**	**Cohort 2 Result**	**Standard Achieved**	**Cohort 3 Result**	**Standard Achieved**
30%	**5.08%**	**Yes**	**6.76%**	**Yes**	**5.40%**	**Yes**
Standard ≤100% FPL	**Cohort 1 Result**	**Standard Achieved**	**Cohort 2 Result**	**Standard Achieved**	**Cohort 3 Result**	**Standard Achieved**
7%	**3.80%**	**Yes**	**5.10%**	**Yes**	**4.59%**	**Yes**

This is a reverse measure. A lower rate indicates better performance.

Transition out of CFP Status: [Nov 18 – Dec 19]						
Standard >100% FPL	**Cohort 1 Result**	**Standard Achieved**	**Cohort 2 Result**	**Standard Achieved**	**Cohort 3 Result**	**Standard Achieved**
2%	**2.33%**	**Yes**	**1.85%**	**No**	**5.14%**	**Yes**
Standard ≤100% FPL	**Cohort 1 Result**	**Standard Achieved**	**Cohort 2 Result**	**Standard Achieved**	**Cohort 3 Result**	**Standard Achieved**
2%	**3.54%**	**Yes**	**5.31%**	**Yes**	**6.87%**	**Yes**

- Shaded areas represent data that are newly reported this month.
- For questions regarding measurement periods or standards, see the Performance Monitoring Specifications

Medical Services Administration
Bureau of Medicaid Care Management and Customer Service

PERFORMANCE MONITORING REPORT

MDHHS Dental Measures

Composite – All Plans

January 2020

Produced by:
Quality Improvement and Program Development – Managed Care Plan Division

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MDHHS Dental Measures

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Executive Summary

This Dental Performance Monitoring Report (PMR) is produced by the Quality Improvement and Program Development (QIPD) Section of the Managed Care Plan Division (MCPD) to track quality, access, and utilization in the Michigan Medicaid program to better support high quality care for beneficiaries.

The Michigan Department of Health and Human Services (MDHHS) monitors the performance of the State's Medicaid Health Plans (MHPs) through 33 key performance measures aimed at improving the quality and efficiency of health care services provided to the Michigan residents enrolled in a Medicaid program. These measures include MDHHS Administrative Measures; Healthy Michigan Plan (HMP) Measures; MDHHS Dental Measures; CMS Core Set Measures; Health Equity HEDIS Measures; HEDIS Measures and Managed Care Quality Measures. **This report focuses only on the following MDHHS Dental Measures**:

MDHHS Dental Measures		
Diagnostic Dental Services	*Preventive Dental Services*	*Restorative (Dental Filings) Dental Services*
Comprehensive Diabetes Care: Diagnostic Dental Exam	*Comprehensive Diabetes Care: Preventive Dental Visit*	*Comprehensive Diabetes Care: Restorative Dental Visit*
Diagnostic Dental Visits in Pregnant Women	*Preventive Dental Visits in Pregnant Women*	*Restorative Dental Visits in Pregnant Women*
Adults: Any Dental		

Data for these measures will be represented on a quarterly basis. The body of the report contains a cross-plan analysis of the most current data available for each of these measures. Measurement Periods may vary and are based on the specifications for that individual measure. Appendix A contains specific three letter codes identifying each of the MHPs. Appendix B contains the one-year plan specific analysis for each measure.

The following table displays the number of MHPs meeting or exceeding the standards for the performance measure versus total MHPs, as reported in the Performance Monitoring Report, during the listed quarter for fiscal year 2020 unless otherwise noted.

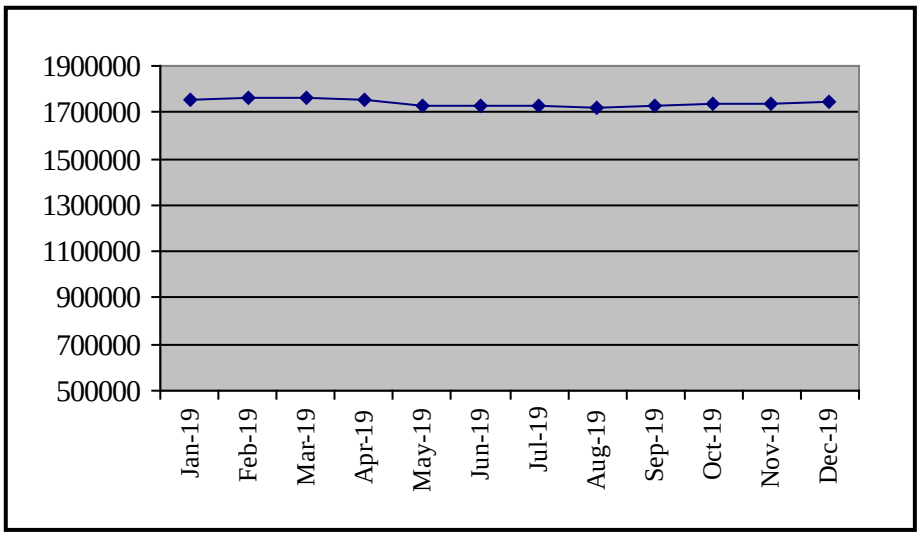
Table 1: Fiscal Year 2020[1]

Quarterly Reported Measures	Reported in 1st Quarter	Reported in 2nd Quarter	Reported in 3rd Quarter	Reported in 4th Quarter
Diagnostic Dental Services	1/11			
Preventive Dental Services	5/11			
Restorative (Dental Fillings) Dental Services	1/11			
Comprehensive Diabetes Care: Diagnostic Dental Exam	N/A			
Comprehensive Diabetes Care: Preventive Dental Visit	N/A			
Comprehensive Diabetes Care: Restorative Dental Visit	N/A			
Diagnostic Dental Visits in Pregnant Women	N/A			
Preventive Dental Visits in Pregnant Women	N/A			
Restorative Dental Visits in Pregnant Women	N/A			
Adults: Any Dental Visit	N/A			

Managed Care Enrollment

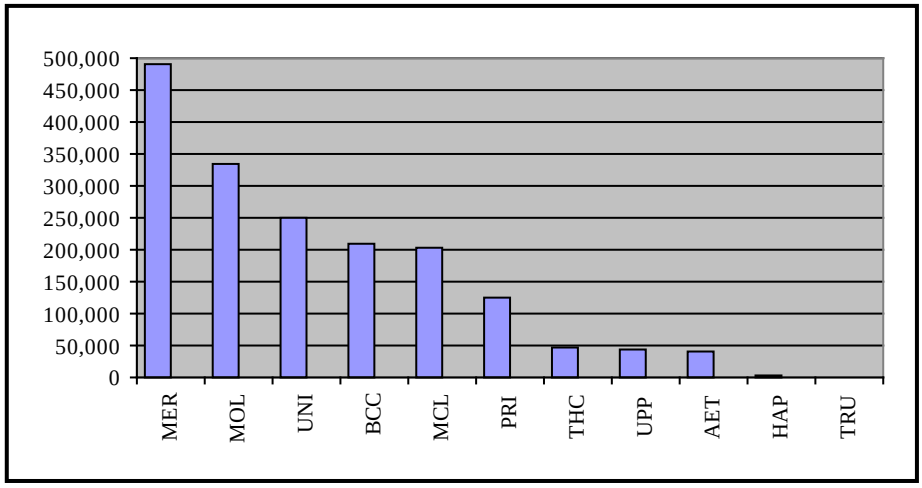
Michigan Medicaid Managed Care (MA-MC) enrollment has remained steady over the past year. In December 2019, enrollment was 1,744,193, down 7,587 enrollees (0.4%) from December 2019. An increase of 7,338 enrollees (0.4%) was realized between November 2019 and December 2019.

Figure 1: Medicaid Managed Care Enrollment, January 2019 – December 2019



[1] N/A will be shown for measures where the standard is Informational Only.

Figure 2: Medicaid Managed Care Enrollment by Health Plan, December 2019



Medicaid Health Plan News

The Performance Monitoring Report contains data for all Michigan Medicaid Health Plans, where data is available. Ten Medicaid Health Plans are contracted with the State of Michigan to provide comprehensive health care services.

As of January 1, 2020, Trusted Health Plan Michigan (TRU) is no longer an active Medicaid Health Plan. However, their information will continue to appear in the quarterly PMRs until such data is no longer available.

Cross-Plan Performance Monitoring Analyses

The following section includes a cross-plan analysis for each performance measure. An analysis of the most current data available for each performance measure is included. For detailed questions regarding measurement periods or standards, see the Performance Monitoring Specifications.

Diagnostic Dental Services

Measure
The percentage of Healthy Michigan Plan members between the ages of 19 and 64 who received at least one diagnostic dental service within the measurement period.

Standard
At or above 30% (as shown on bar graph below)

Measurement Period
July 2018 – June 2019

Data Source
MDHHS Data Warehouse

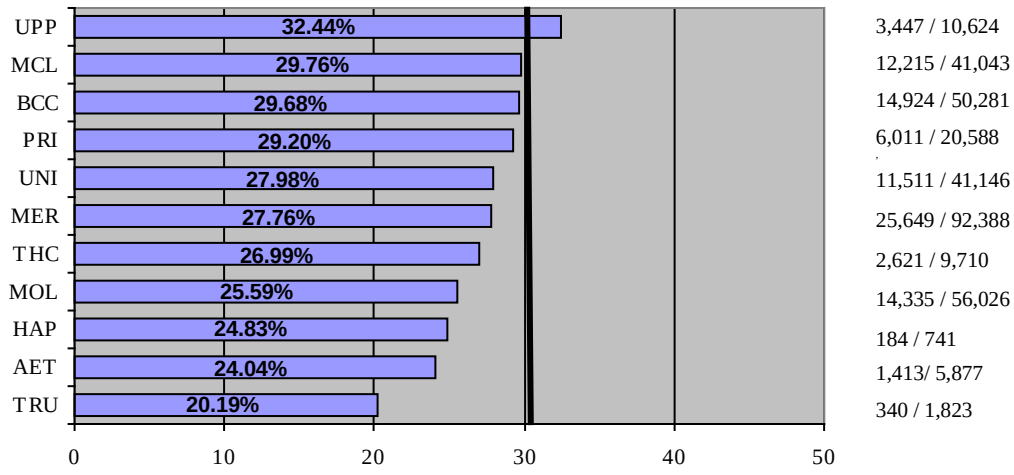
Measurement Frequency
Quarterly

Summary: One of the plans (**UPP**) met or exceeded the standard, while 10 plans (AET, BCC, HAP, MCL, MER, MOL, PRI, THC, TRU, and UNI) did not. Results ranged from 20.19% to 32.44%.

Table 2: Comparison across Medicaid Programs

Medicaid Program	Numerator	Denominator	Percentage
HMP Fee For Service (FFS) Only	1,135	6,266	18.11%
HMP Managed Care (MC) Only	94,844	336,177	28.21%

Figure 3: Diagnostic Dental Services



Diagnostic Dental Services Percentages

*Numerator depicts the number of eligible beneficiaries between the ages of 19 and 64 who had at least one diagnostic dental service. Denominator depicts the total number of eligible beneficiaries.

Preventive Dental Services

Measure
The percentage of Healthy Michigan Plan members between the ages of 19 and 64 who received at least one preventive dental service within the measurement period.

Standard
At or above 17% (as shown on bar graph below)

Measurement Period
July 2018 – June 2019

Data Source
MDHHS Data Warehouse

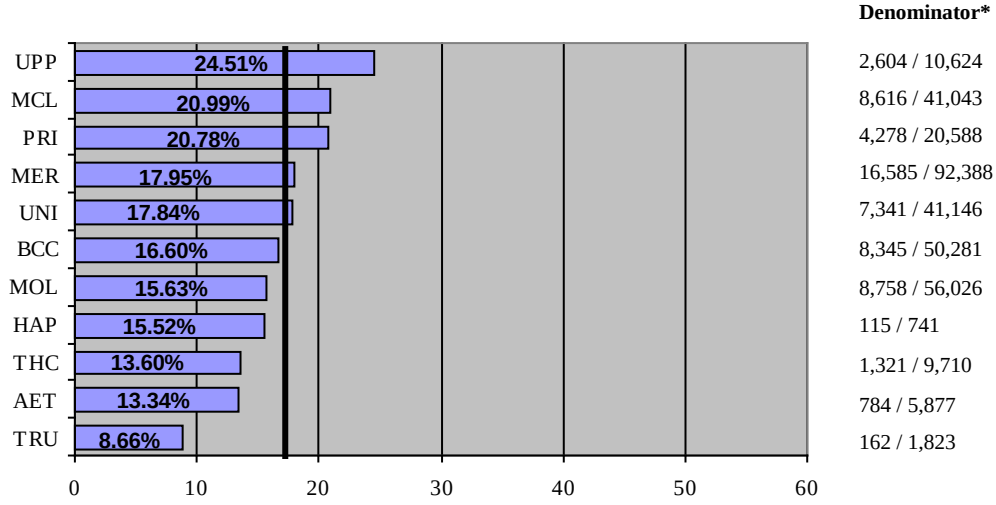
Measurement Frequency
Quarterly

Summary: Five of the plans (**MCL, MER, PRI, UNI and UPP**) met or exceeded the standard, while six plans (AET, BCC, HAP, MOL, THC, and TRU) did not. Results ranged from 8.89% to 24.51%.

Table 3: Comparison across Medicaid Programs

Medicaid Program	Numerator	Denominator	Percentage
HMP Fee For Service (FFS) Only	612	6,266	9.77%
HMP Managed Care (MC) Only	60,203	336,177	17.91%

Figure 4: Preventive Dental Services



*Numerator depicts the number of eligible beneficiaries between the ages of 19 and 64 who had at least one preventive dental service. Denominator depicts the total number of eligible beneficiaries.

Restorative (Dental Fillings) Services

Measure
The percentage of total eligible Healthy Michigan Plan members between the ages of 19 and 64 who received at least one restorative (dental fillings) dental service within the measurement period.

Standard
At or above 14% (as shown on bar graph below)

Measurement Period
July 2018 – June 2019

Data Source
MDHHS Data Warehouse

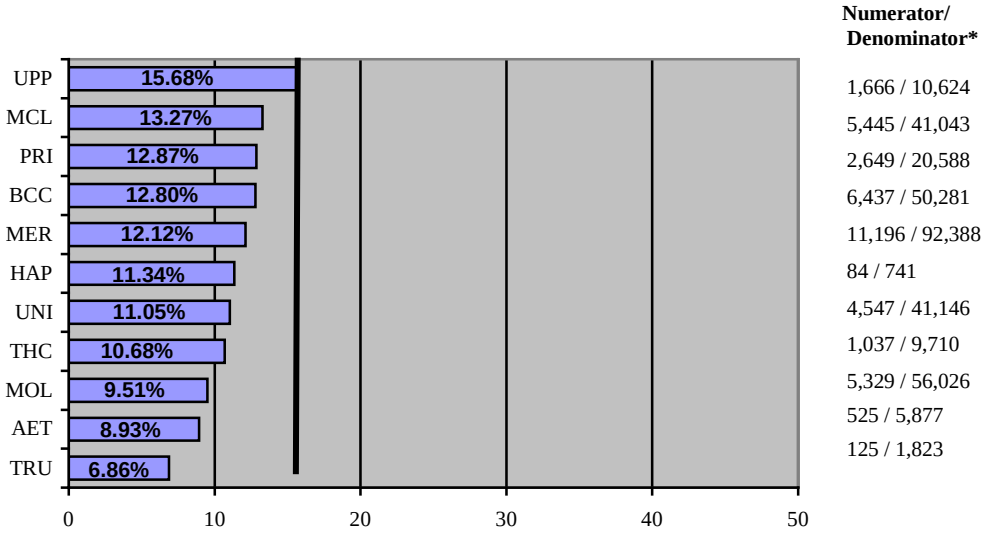
Measurement Frequency
Quarterly

Summary: One of the plans (**UPP**) met or exceeded the standard, while 10 plans (AET, BCC, HAP, MCL, MER, MOL, PRI, THC, TRU, and UNI) did not. Results ranged from 6.86% to 15.68%.

Table 4: Comparison across Medicaid Programs

Medicaid Program	Numerator	Denominator	Percentage
HMP Fee For Service (FFS) Only	414	6,266	6.61%
HMP Managed Care (MC) Only	40,021	336,177	11.90%

Figure 5: Restorative (Dental Fillings) Dental Services



Restorative (Dental Fillings) Dental Services Percentages

*Numerator depicts the number of eligible beneficiaries between the ages of 19 and 64 who had at least one restorative dental service. Denominator depicts the total number of eligible beneficiaries.

Comprehensive Diabetes Care: Diagnostic Dental Exam

Measure
The percentage of Healthy Michigan Plan members between the ages of 19 and 64 with Type 1 or Type 2 Diabetes who received at least one diagnostic dental service within the measurement period.

Standard
N/A – Informational Only

Measurement Period
July 2018 – June 2019

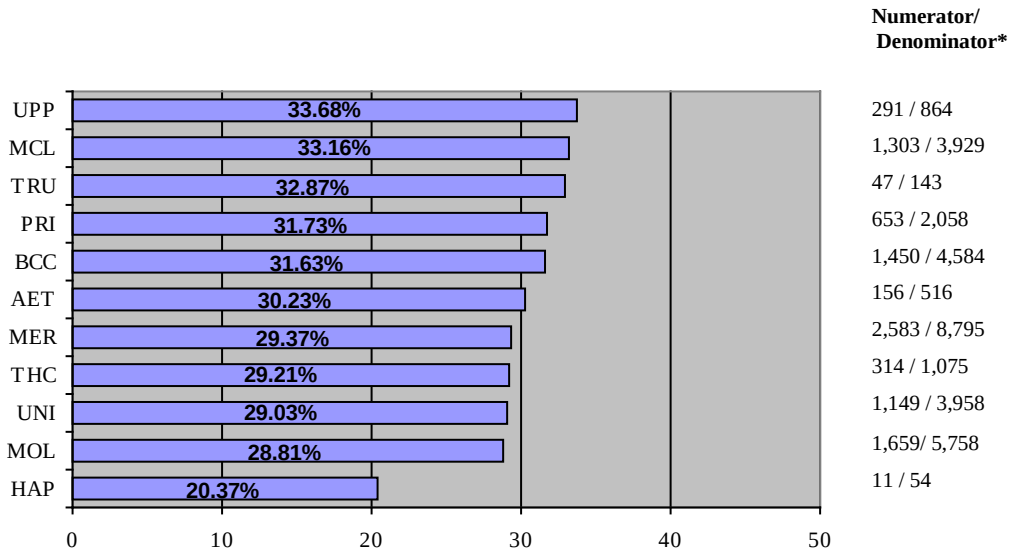
Data Source
MDHHS Data Warehouse

Measurement Frequency
Quarterly

Table 5: Comparison across Medicaid Programs

Medicaid Program	Numerator	Denominator	Percentage
HMP Fee For Service (FFS) Only	183	564	32.45%
HMP Managed Care (MC) Only	9,872	32,437	30.43%

Figure 6: Comprehensive Diabetes Care: Diagnostic Dental Exam



Comprehensive Diabetes Care: Diagnostic Dental Exam Percentages

*Numerator depicts the unduplicated number of all eligible members with diabetes who received at least one diagnostic dental service. Denominator depicts the unduplicated number of all eligible members with diabetes.

Comprehensive Diabetes Care: Preventive Dental Visit

Measure
The percentage of Healthy Michigan Plan members between the ages of 19 and 64 with Type 1 or Type 2 Diabetes who received at least one preventive dental service within the measurement period.

Standard
N/A – Informational Only

Measurement Period
July 2018 – June 2019

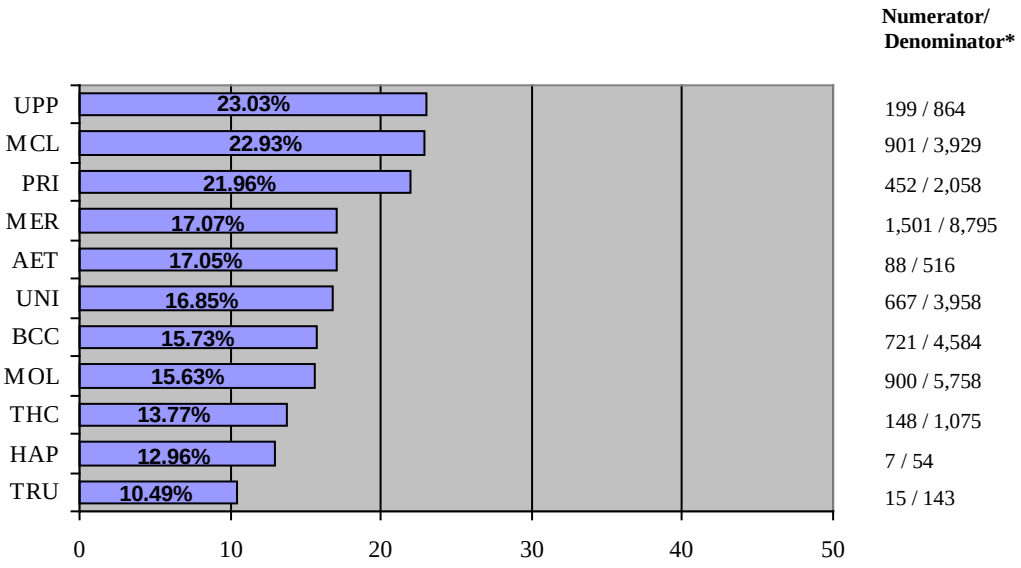
Data Source
MDHHS Data Warehouse

Measurement Frequency
Quarterly

Table 6: Comparison across Medicaid Programs

Medicaid Program	Numerator	Denominator	Percentage
HMP Fee For Service (FFS) Only	82	564	14.54%
HMP Managed Care (MC) Only	5,727	32,437	17.66%

Figure 7: Comprehensive Diabetes Care: Preventive Dental Visit



Comprehensive Diabetes Care: Preventive Dental Visit Percentages

*Numerator depicts the unduplicated number of all eligible members with diabetes who received at least one preventive dental service. Denominator depicts the unduplicated number of all eligible members with diabetes.

Comprehensive Diabetes Care: Restorative Dental Visit

Measure
The percentage of Healthy Michigan Plan members between the ages of 19 and 64 with Type 1 or Type 2 Diabetes who received at least one restorative dental service within the measurement period.

Standard
N/A – Informational Only

Measurement Period
July 2018 – June 2019

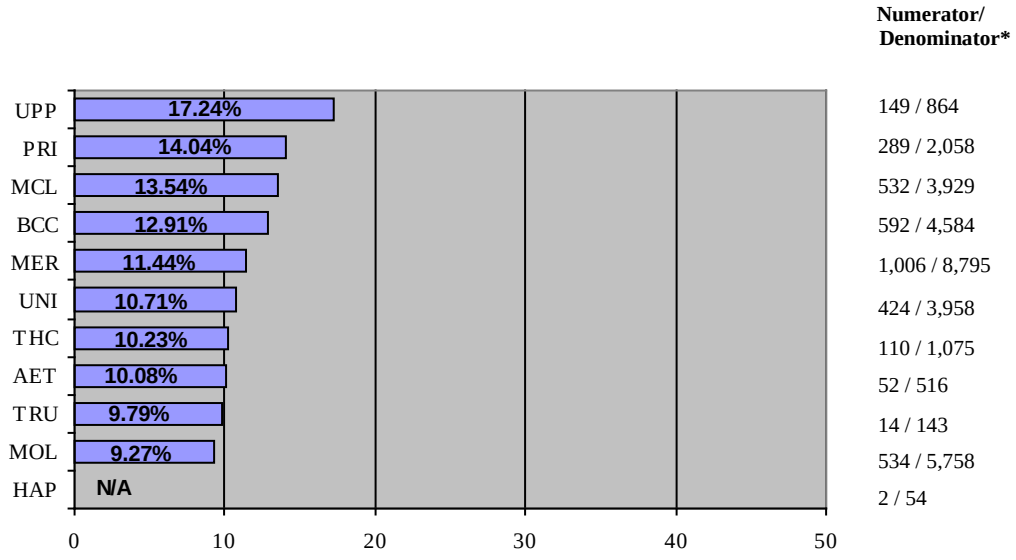
Data Source
MDHHS Data Warehouse

Measurement Frequency
Quarterly

Table 7: Comparison across Medicaid Programs

Medicaid Program	Numerator	Denominator	Percentage
HMP Fee For Service (FFS) Only	44	564	7.80%
HMP Managed Care (MC) Only	3,804	32,437	11.73%

Figure 8: Comprehensive Diabetes Care: Restorative Dental Visit[2]



Comprehensive Diabetes Care: Restorative Dental Visit Percentages

*Numerator depicts the unduplicated number of all eligible members with diabetes who received at least one restorative dental service. Denominator depicts the unduplicated number of all eligible members with diabetes.

[2] Results showing N/A are for plans with a numerator less than 5 and a denominator less than 30.

Diagnostic Dental Visits in Pregnant Women

Measure
The percentage of pregnant women who received at least one diagnostic dental service either during their pregnancy or 90 days postpartum.

Standard
N/A – Informational Only

Measurement Period
July 2018 – June 2019

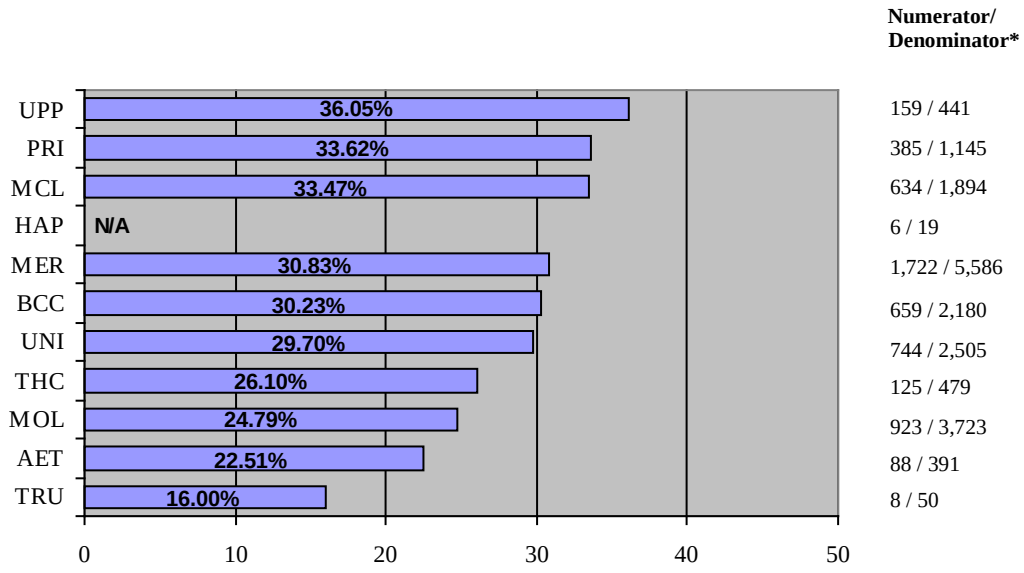
Data Source
MDHHS Data Warehouse

Measurement Frequency
Quarterly

Table 8: Comparison across Medicaid Programs

Medicaid Program	Numerator	Denominator	Percentage
Michigan Medicaid All	8,464	33,021	25.63%
Fee For Service (FFS) only	88	457	19.26%
Managed Care only	5,747	19,332	29.73%
MA-MC	3,450	11,862	29.08%

Figure 9: Diagnostic Dental Visits in Pregnant Women[3]



Diagnostic Dental Visits in Pregnant Women

*Numerator depicts the unduplicated number of all eligible pregnant members who received at least one diagnostic dental service. Denominator depicts the unduplicated number of all eligible pregnant members.

[3] Results showing N/A are for plans with a numerator less than 5 and a denominator less than 30.

Preventive Dental Visits in Pregnant Women

Measure
The percentage of pregnant women who received at least one preventive dental service either during their pregnancy or 90 days postpartum.

Standard
N/A – Informational Only

Measurement Period
July 2018 – June 2019

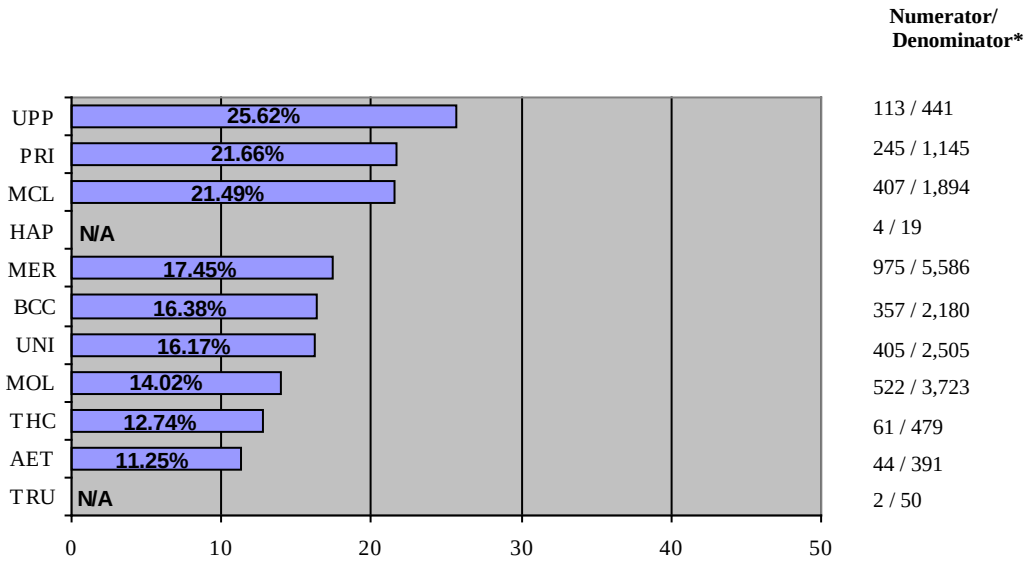
Data Source
MDHHS Data Warehouse

Measurement Frequency
Quarterly

Table 9: Comparison across Medicaid Programs

Medicaid Program	Numerator	Denominator	Percentage
Michigan Medicaid All	4,837	33,021	14.65%
Fee For Service (FFS) only	48	457	10.50%
Managed Care only	3,298	19,332	17.06%
MA-MC	1,839	11,862	15.50%

Figure 10: Preventive Dental Visits in Pregnant Women[4]



Preventive Dental Visits in Pregnant Women

*Numerator depicts the unduplicated number of all eligible pregnant members who received at least one preventive dental service. Denominator depicts the unduplicated number of all eligible pregnant members.

[4] Results showing N/A are for plans with a numerator less than 5 and a denominator less than 30.

Restorative Dental Visits in Pregnant Women

Measure
The percentage of pregnant women who received at least one restorative dental service either during their pregnancy or 90 days postpartum.

Standard
N/A – Informational Only

Measurement Period
July 2018 – June 2019

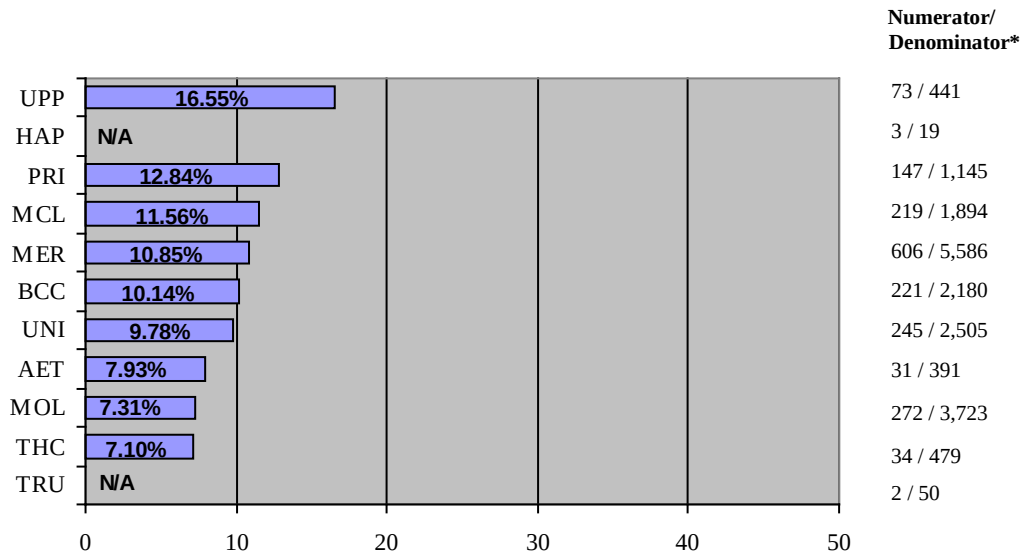
Data Source
MDHHS Data Warehouse

Measurement Frequency
Quarterly

Table 10: Comparison across Medicaid Programs

Medicaid Program	Numerator	Denominator	Percentage
Michigan Medicaid All	2,847	33,021	8.62%
Fee For Service (FFS) only	34	457	7.44%
Managed Care only	1,943	19,332	10.05%
MA-MC	1,092	11,862	9.21%

Figure 11: Restorative Dental Visits in Pregnant Women[5]



Restorative Dental Visits in Pregnant Women

*Numerator depicts the unduplicated number of all eligible pregnant members who received at least one restorative dental service. Denominator depicts the unduplicated number of all eligible pregnant members.

[5] Results showing N/A are for plans with a numerator less than 5 and a denominator less than 30.

Adults: Any Dental Visit

Measure
The percentage of Healthy Michigan Plan members between the ages of 19 and 64 who received at least one dental service within the measurement period.

Standard
N/A – Informational Only

Measurement Period
July 2018 – June 2019

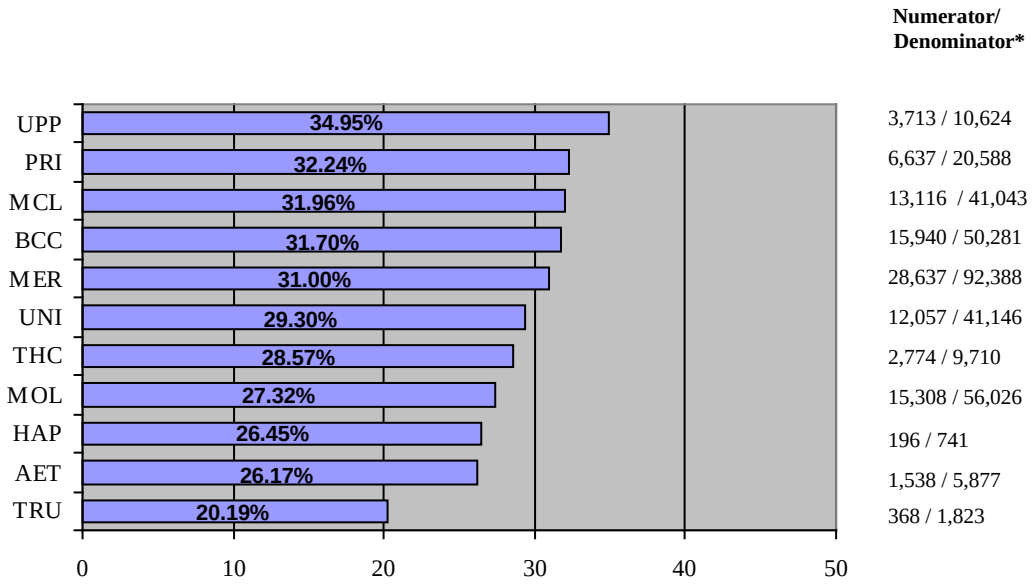
Data Source
MDHHS Data Warehouse

Measurement Frequency
Quarterly

Table 11: Comparison across Medicaid Programs

Medicaid Program	Numerator	Denominator	Percentage
HMP Fee For Service (FFS) Only	1,235	6,266	19.71%
HMP Managed Care (MC) Only	102,621	336,177	30.53%

Figure 12: Adults: Any Dental Visit



Adults: Any Dental Visit

*Numerator depicts the unduplicated number of all eligible pregnant members who received at least one dental service. Denominator depicts the unduplicated number of all eligible members.

Appendix A: Three Letter Medicaid Health Plan Codes

Below is a list of three letter codes established by MDHHS identifying each Medicaid Health Plan.

AET	Aetna Better Health of Michigan
BCC	Blue Cross Complete of Michigan
HAP	HAP Empowered
MCL	McLaren Health Plan
MER	Meridian Health Plan of Michigan
MOL	Molina Healthcare of Michigan
PRI	Priority Health Choice
THC	Total Health Care
TRU	Trusted Health Plan Michigan, Inc.
UNI	UnitedHealthcare Community Plan
UPP	Upper Peninsula Health Plan

Appendix B: One Year Plan-Specific Analysis

Aetna Better Health of Michigan – AET

MDHHS DENTAL MEASURES:

Performance Measure	Measurement Period	Standard	Plan Result	Standard Achieved
Diagnostic Dental Services	**Jul 18 – Jun 19**	**30%**	**24.04%**	**No**
Preventive Dental Services	**Jul 18 – Jun 19**	**17%**	**13.34%**	**No**
Restorative (Dental Fillings) Dental Services	**Jul 18 – Jun 19**	**14%**	**8.93%**	**No**
Comprehensive Diabetes Care: Diagnostic Dental Exam	**Jul 18 – Jun 19**	**Informational Only**	**30.23%**	**N/A**
Comprehensive Diabetes Care: Preventive Dental Visit	**Jul 18 – Jun 19**	**Informational Only**	**17.05%**	**N/A**
Comprehensive Diabetes Care: Restorative Dental Visit	**Jul 18 – Jun 19**	**Informational Only**	**10.08%**	**N/A**
Diagnostic Dental Visits in Pregnant Women	**Jul 18 – Jun 19**	**Informational Only**	**22.51%**	**N/A**
Preventive Dental Visits in Pregnant Women	**Jul 18 – Jun 19**	**Informational Only**	**11.25%**	**N/A**
Restorative Dental Visits in Pregnant Women	**Jul 18 – Jun 19**	**Informational Only**	**7.93%**	**N/A**
Adults: Any Dental Visit	**Jul 18 – Jun 19**	**Informational Only**	**26.17%**	**N/A**

- Shaded areas represent data that are newly reported this month.
- For questions regarding measurement periods or standards, see the Performance Monitoring Specifications

Appendix B: One Year Plan-Specific Analysis

Blue Cross Complete – BCC

MDHHS DENTAL MEASURES:

Performance Measure	Measurement Period	Standard	Plan Result	Standard Achieved
Diagnostic Dental Services	**Jul 18 – Jun 19**	**30%**	**29.68%**	**No**
Preventive Dental Services	**Jul 18 – Jun 19**	**17%**	**16.60%**	**No**
Restorative (Dental Fillings) Dental Services	**Jul 18 – Jun 19**	**14%**	**12.80%**	**No**
Comprehensive Diabetes Care: Diagnostic Dental Exam	**Jul 18 – Jun 19**	**Informational Only**	**31.63%**	**N/A**
Comprehensive Diabetes Care: Preventive Dental Visit	**Jul 18 – Jun 19**	**Informational Only**	**15.73%**	**N/A**
Comprehensive Diabetes Care: Restorative Dental Visit	**Jul 18 – Jun 19**	**Informational Only**	**12.91%**	**N/A**
Diagnostic Dental Visits in Pregnant Women	**Jul 18 – Jun 19**	**Informational Only**	**30.23%**	**N/A**
Preventive Dental Visits in Pregnant Women	**Jul 18 – Jun 19**	**Informational Only**	**16.38%**	**N/A**
Restorative Dental Visits in Pregnant Women	**Jul 18 – Jun 19**	**Informational Only**	**10.14%**	**N/A**
Adults: Any Dental Visit	**Jul 18 – Jun 19**	**Informational Only**	**31.70%**	**N/A**

- Shaded areas represent data that are newly reported this month.
- For questions regarding measurement periods or standards, see the Performance Monitoring Specifications

Appendix B: One Year Plan-Specific Analysis

HAP Empowered – HAP

MDHHS DENTAL MEASURES:

Performance Measure	Measurement Period	Standard	Plan Result	Standard Achieved
Diagnostic Dental Services	**Jul 18 – Jun 19**	**30%**	**24.83%**	**No**
Preventive Dental Services	**Jul 18 – Jun 19**	**17%**	**15.52%**	**No**
Restorative (Dental Fillings) Dental Services	**Jul 18 – Jun 19**	**14%**	**11.34%**	**No**
Comprehensive Diabetes Care: Diagnostic Dental Exam	**Jul 18 – Jun 19**	**Informational Only**	**20.37%**	**N/A**
Comprehensive Diabetes Care: Preventive Dental Visit	**Jul 18 – Jun 19**	**Informational Only**	**12.96%**	**N/A**
Comprehensive Diabetes Care: Restorative Dental Visit	**Jul 18 – Jun 19**	**Informational Only**	**N/A**	**N/A**

Plan Results with a numerator less than 5 and/or a denominator less than 30 will be represented with N/A.

Diagnostic Dental Visits in Pregnant Women	**Jul 18 – Jun 19**	**Informational Only**	**N/A**	**N/A**

Plan Results with a numerator less than 5 and/or a denominator less than 30 will be represented with N/A.

Preventive Dental Visits in Pregnant Women	**Jul 18 – Jun 19**	**Informational Only**	**N/A**	**N/A**

Plan Results with a numerator less than 5 and/or a denominator less than 30 will be represented with N/A.

Restorative Dental Visits in Pregnant Women	**Jul 18 – Jun 19**	**Informational Only**	**N/A**	**N/A**

Plan Results with a numerator less than 5 and/or a denominator less than 30 will be represented with N/A.

Adults: Any Dental Visit	**Jul 18 – Jun 19**	**Informational Only**	**26.45%**	**N/A**

- Shaded areas represent data that are newly reported this month.
- For questions regarding measurement periods or standards, see the Performance Monitoring Specifications

Appendix B: One Year Plan-Specific Analysis

McLaren Health Plan – MCL

MDHHS DENTAL MEASURES:

Performance Measure	Measurement Period	Standard	Plan Result	Standard Achieved
Diagnostic Dental Services	**Jul 18 – Jun 19**	**30%**	**29.76%**	**N/A**
Preventive Dental Services	**Jul 18 – Jun 19**	**17%**	**20.99%**	**Yes**
Restorative (Dental Fillings) Dental Services	**Jul 18 – Jun 19**	**14%**	**13.27%**	**No**
Comprehensive Diabetes Care: Diagnostic Dental Exam	**Jul 18 – Jun 19**	**Informational Only**	**33.16%**	**N/A**
Comprehensive Diabetes Care: Preventive Dental Visit	**Jul 18 – Jun 19**	**Informational Only**	**22.93%**	**N/A**
Comprehensive Diabetes Care: Restorative Dental Visit	**Jul 18 – Jun 19**	**Informational Only**	**13.54%**	**N/A**
Diagnostic Dental Visits in Pregnant Women	**Jul 18 – Jun 19**	**Informational Only**	**33.47%**	**N/A**
Preventive Dental Visits in Pregnant Women	**Jul 18 – Jun 19**	**Informational Only**	**21.49%**	**N/A**
Restorative Dental Visits in Pregnant Women	**Jul 18 – Jun 19**	**Informational Only**	**11.56%**	**N/A**
Adults: Any Dental Visit	**Jul 18 – Jun 19**	**Informational Only**	**31.96%**	**N/A**

- Shaded areas represent data that are newly reported this month.
- For questions regarding measurement periods or standards, see the Performance Monitoring Specifications

Appendix B: One Year Plan-Specific Analysis

Meridian Health Plan of Michigan – MER

MDHHS DENTAL MEASURES:

Performance Measure	Measurement Period	Standard	Plan Result	Standard Achieved
Diagnostic Dental Services	**Jul 18 – Jun 19**	**30%**	**27.76%**	**No**
Preventive Dental Services	**Jul 18 – Jun 19**	**17%**	**17.95%**	**Yes**
Restorative (Dental Fillings) Dental Services	**Jul 18 – Jun 19**	**14%**	**12.12%**	**No**
Comprehensive Diabetes Care: Diagnostic Dental Exam	**Jul 18 – Jun 19**	**Informational Only**	**29.37%**	**N/A**
Comprehensive Diabetes Care: Preventive Dental Visit	**Jul 18 – Jun 19**	**Informational Only**	**17.07%**	**N/A**
Comprehensive Diabetes Care: Restorative Dental Visit	**Jul 18 – Jun 19**	**Informational Only**	**11.44%**	**N/A**
Diagnostic Dental Visits in Pregnant Women	**Jul 18 – Jun 19**	**Informational Only**	**30.83%**	**N/A**
Preventive Dental Visits in Pregnant Women	**Jul 18 – Jun 19**	**Informational Only**	**17.45%**	**N/A**
Restorative Dental Visits in Pregnant Women	**Jul 18 – Jun 19**	**Informational Only**	**10.85%**	**N/A**
Adults: Any Dental Visit	**Jul 18 – Jun 19**	**Informational Only**	**31.00%**	**N/A**

- Shaded areas represent data that are newly reported this month.
- For questions regarding measurement periods or standards, see the Performance Monitoring Specifications

Appendix B: One Year Plan-Specific Analysis

Molina Healthcare of Michigan – MOL

MDHHS DENTAL MEASURES:

Performance Measure	Measurement Period	Standard	Plan Result	Standard Achieved
Diagnostic Dental Services	**Jul 18 – Jun 19**	**30%**	**25.59%**	**No**
Preventive Dental Services	**Jul 18 – Jun 19**	**17%**	**15.63%**	**No**
Restorative (Dental Fillings) Dental Services	**Jul 18 – Jun 19**	**14%**	**9.51%**	**No**
Comprehensive Diabetes Care: Diagnostic Dental Exam	**Jul 18 – Jun 19**	**Informational Only**	**28.81%**	**N/A**
Comprehensive Diabetes Care: Preventive Dental Visit	**Jul 18 – Jun 19**	**Informational Only**	**15.63%**	**N/A**
Comprehensive Diabetes Care: Restorative Dental Visit	**Jul 18 – Jun 19**	**Informational Only**	**9.27%**	**N/A**
Diagnostic Dental Visits in Pregnant Women	**Jul 18 – Jun 19**	**Informational Only**	**24.79%**	**N/A**
Preventive Dental Visits in Pregnant Women	**Jul 18 – Jun 19**	**Informational Only**	**14.02%**	**N/A**
Restorative Dental Visits in Pregnant Women	**Jul 18 – Jun 19**	**Informational Only**	**7.31%**	**N/A**
Adults: Any Dental Visit	**Jul 18 – Jun 19**	**Informational Only**	**27.32%**	**N/A**

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- For questions regarding measurement periods or standards, see the Performance Monitoring Specifications

Appendix B: One Year Plan-Specific Analysis

Priority Health Choice – PRI

MDHHS DENTAL MEASURES:

Performance Measure	Measurement Period	Standard	Plan Result	Standard Achieved
Diagnostic Dental Services	**Jul 18 – Jun 19**	**30%**	**29.20%**	**No**
Preventive Dental Services	**Jul 18 – Jun 19**	**17%**	**20.78%**	**Yes**
Restorative (Dental Fillings) Dental Services	**Jul 18 – Jun 19**	**14%**	**12.87%**	**No**
Comprehensive Diabetes Care: Diagnostic Dental Exam	**Jul 18 – Jun 19**	**Informational Only**	**31.73%**	**N/A**
Comprehensive Diabetes Care: Preventive Dental Visit	**Jul 18 – Jun 19**	**Informational Only**	**21.96%**	**N/A**
Comprehensive Diabetes Care: Restorative Dental Visit	**Jul 18 – Jun 19**	**Informational Only**	**14.04%**	**N/A**
Diagnostic Dental Visits in Pregnant Women	**Jul 18 – Jun 19**	**Informational Only**	**33.62%**	**N/A**
Preventive Dental Visits in Pregnant Women	**Jul 18 – Jun 19**	**Informational Only**	**21.66%**	**N/A**
Restorative Dental Visits in Pregnant Women	**Jul 18 – Jun 19**	**Informational Only**	**12.84%**	**N/A**
Adults: Any Dental Visit	**Jul 18 – Jun 19**	**Informational Only**	**32.24%**	**N/A**

- Shaded areas represent data that are newly reported this month.
- For questions regarding measurement periods or standards, see the Performance Monitoring Specifications

Appendix B: One Year Plan-Specific Analysis

Total Health Care – THC

MDHHS DENTAL MEASURES:

Performance Measure	Measurement Period	Standard	Plan Result	Standard Achieved
Diagnostic Dental Services	**Jul 18 – Jun 19**	**30%**	**26.99%**	**No**
Preventive Dental Services	**Jul 18 – Jun 19**	**17%**	**13.60%**	**No**
Restorative (Dental Fillings) Dental Services	**Jul 18 – Jun 19**	**14%**	**10.68%**	**No**
Comprehensive Diabetes Care: Diagnostic Dental Exam	**Jul 18 – Jun 19**	**Informational Only**	**29.21%**	**N/A**
Comprehensive Diabetes Care: Preventive Dental Visit	**Jul 18 – Jun 19**	**Informational Only**	**13.77%**	**N/A**
Comprehensive Diabetes Care: Restorative Dental Visit	**Jul 18 – Jun 19**	**Informational Only**	**10.23%**	**N/A**
Diagnostic Dental Visits in Pregnant Women	**Jul 18 – Jun 19**	**Informational Only**	**26.10%**	**N/A**
Preventive Dental Visits in Pregnant Women	**Jul 18 – Jun 19**	**Informational Only**	**12.74%**	**N/A**
Restorative Dental Visits in Pregnant Women	**Jul 18 – Jun 19**	**Informational Only**	**7.10%**	**N/A**
Adults: Any Dental Visit	**Jul 18 – Jun 19**	**Informational Only**	**28.57%**	**N/A**

- Shaded areas represent data that are newly reported this month.
- For questions regarding measurement periods or standards, see the Performance Monitoring Specifications

Appendix B: One Year Plan-Specific Analysis

UnitedHealthcare Community Plan – UNI

MDHHS DENTAL MEASURES:

Performance Measure	Measurement Period	Standard	Plan Result	Standard Achieved
Diagnostic Dental Services	**Jul 18 – Jun 19**	**30%**	**27.98%**	**No**
Preventive Dental Services	**Jul 18 – Jun 19**	**17%**	**17.84%**	**Yes**
Restorative (Dental Fillings) Dental Services	**Jul 18 – Jun 19**	**14%**	**11.05%**	**No**
Comprehensive Diabetes Care: Diagnostic Dental Exam	**Jul 18 – Jun 19**	**Informational Only**	**29.03%**	**N/A**
Comprehensive Diabetes Care: Preventive Dental Visit	**Jul 18 – Jun 19**	**Informational Only**	**16.85%**	**N/A**
Comprehensive Diabetes Care: Restorative Dental Visit	**Jul 18 – Jun 19**	**Informational Only**	**10.71%**	**N/A**
Diagnostic Dental Visits in Pregnant Women	**Jul 18 – Jun 19**	**Informational Only**	**29.70%**	**N/A**
Preventive Dental Visits in Pregnant Women	**Jul 18 – Jun 19**	**Informational Only**	**16.17%**	**N/A**
Restorative Dental Visits in Pregnant Women	**Jul 18 – Jun 19**	**Informational Only**	**9.78%**	**N/A**
Adults: Any Dental Visit	**Jul 18 – Jun 19**	**Informational Only**	**29.30%**	**N/A**

- Shaded areas represent data that are newly reported this month.
- For questions regarding measurement periods or standards, see the Performance Monitoring Specifications

Appendix B: One Year Plan-Specific Analysis

Upper Peninsula Health Plan – UPP

MDHHS DENTAL MEASURES:

Performance Measure	Measurement Period	Standard	Plan Result	Standard Achieved
Diagnostic Dental Services	**Jul 18 – Jun 19**	**30%**	**32.44%**	**Yes**
Preventive Dental Services	**Jul 18 – Jun 19**	**17%**	**24.51%**	**Yes**
Restorative (Dental Fillings) Dental Services	**Jul 18 – Jun 19**	**14%**	**15.68%**	**Yes**
Comprehensive Diabetes Care: Diagnostic Dental Exam	**Jul 18 – Jun 19**	**Informational Only**	**33.68%**	**N/A**
Comprehensive Diabetes Care: Preventive Dental Visit	**Jul 18 – Jun 19**	**Informational Only**	**23.03%**	**N/A**
Comprehensive Diabetes Care: Restorative Dental Visit	**Jul 18 – Jun 19**	**Informational Only**	**17.24%**	**N/A**
Diagnostic Dental Visits in Pregnant Women	**Jul 18 – Jun 19**	**Informational Only**	**36.05%**	**N/A**
Preventive Dental Visits in Pregnant Women	**Jul 18 – Jun 19**	**Informational Only**	**25.62%**	**N/A**
Restorative Dental Visits in Pregnant Women	**Jul 18 – Jun 19**	**Informational Only**	**16.55%**	**N/A**
Adults: Any Dental Visit	**Jul 18 – Jun 19**	**Informational Only**	**34.95%**	**N/A**

- Shaded areas represent data that are newly reported this month.
- For questions regarding measurement periods or standards, see the Performance Monitoring Specifications

Michigan Department of Health and Human Services
Medical Services Administration

Medical Care Advisory Council

Meeting Minutes

Date: Thursday, November 14, 2019
Time: 1:00 p.m. – 4:30 p.m.
Where: Michigan Public Health Institute
2436 Woodlake Circle, Suite 380
Okemos, MI 48864

Attendees: **Council Members:** Alison Hirschel, David LaLumia (for Marion Owen), Chris George (for Amy Hundley), Amy Zaagman, Amber Bellazaire, Melissa Samuel, Linda Vail, Warren White, Dawne Velianoff, Farah Jalloul, April Stopczynski, Tiffany Stone (for Dominick Pallone), Kim Singh, Lisa Dedden Cooper, Kristin Reese

Staff: Kate Massey, Kathy Stiffler, Erin Emerson, Brian Keisling, Brian Barrie, Jackie Prokop, Marie LaPres, Phil Kurdunowicz, Susan Kengas, Cindy Linn, Jennifer Schuette, Dawn Sweeney, Steven Prichard

Other Attendees: Randy Walainis, Chelena Bell

Welcome, Introductions, Announcements

Alison Hirschel opened the meeting and introductions were made.

Public Health Administration – Statewide Needs Assessment

In June 2019, the Michigan Department of Health and Human Services (MDHHS) Public Health Administration began the process of conducting a state health assessment with a goal of determining the following:

- How healthy are Michigan residents?
- What health conditions are causing Michigan residents the greatest challenges, what are the root causes of those conditions, what factors contribute to these causes?
- What resources currently exist to help address common health conditions among Michigan residents?

To conduct the state health assessment, the Public Health Administration will use the Mobilizing for Action through Planning and Partnerships (MAPP) framework as a guide. The MAPP framework consists of six phases: the state health assessment, which comprises phases one through four, and the state health improvement plan, which comprises phases five and six. MDHHS is working through the state health assessment portion of the MAPP framework, which includes planning and conducting a "visioning" meeting with various stakeholders. The department is currently in the process of conducting four assessments,

which include: the state health status assessment, themes & strengths assessment, public health systems assessment, and forces of change assessment. Handouts were provided to meeting attendees to provide additional details about the MAPP framework, and information about this process will also be made available on the MDHHS website in the future.

Budget Update

Budget Process

Susan Kangas, from the MDHHS Financial Operations Administration, provided an update on the FY 2021 budget development process. A budget development timeline handout was distributed to meeting attendees, and the document was discussed.

Healthy Michigan Plan (HMP)

Regional Forums and Webinars

In October 2019, MDHHS began conducting regional forums throughout the State of Michigan to explain the new workforce engagement requirements for non-exempt HMP beneficiaries that will take effect on January 1, 2020. MDHHS has completed 14 regional forums to date, in addition to several webinars for providers and other stakeholder groups. MDHHS staff discussed the feedback that was received at the forums and during the webinars and reported that many of the comments were from individuals seeking clarification on the medically frail criteria and how to report an exemption, as well as the compliance review process. In addition, many providers sought clarification on how to bill and provide services on behalf of beneficiaries who may be noncompliant with the work requirements.

MDHHS staff also shared samples of printed materials that were developed for beneficiaries and community navigators to provide information on the work requirements and exemption criteria. Copies of the printed materials are available on the MDHHS website at www.michigan.gov/healthymichiganplan >> Changes Coming in 2020. MDHHS staff and meeting attendees continued to discuss the regional forums and supplemental printed materials at length, and the following issues were raised:

- In response to an inquiry, MDHHS staff confirmed that any time a beneficiary spends in training or continuing education to meet occupational licensing requirements counts toward compliance with workforce engagement requirements.
- MDHHS is partnering with community navigators and outreach coordinators to assist beneficiaries with reporting compliance with workforce engagement requirements or reporting an exemption. Meeting attendees shared that some community navigators and community outreach coordinators have expressed concern about their ability to handle the volume of beneficiaries who will seek assistance in this process.
  In response, MDHHS staff asked the Medical Care Advisory Council (MCAC) to submit ideas for which partnering organizations may be able to help find other willing individuals to enroll as community navigators.

September and December Beneficiary Letters and Mailing

In September 2019, MDHHS mailed letters to approximately 270,000 HMP beneficiaries who were identified as being subject to the workforce engagement requirements to provide information on how to report work or other activity, as well as the process for reporting an exemption if applicable. MDHHS also mailed letters to beneficiaries who had an exemption identified in the system. They received information on the work requirements but were informed that they were excused from having to report.

Following the September mailing, Governor Whitmer signed into law PA 50 of 2019, which allows an exemption from the reporting requirement if MDHHS is able to verify a beneficiary's compliance through other data available to the department. MDHHS staff expect that this change will result in approximately 60,000 HMP beneficiaries being excused from having to report work or other activities. In addition, the following groups of beneficiaries will be exempt from having to report:

- Approximately 20,000 beneficiaries who are currently incarcerated;
- Over 10,000 beneficiaries who returned an exemption attestation form following the September mailing; and
- Approximately 18,000 beneficiaries who will be chosen at random as part of a control group for participation in a study on the implementation of workforce engagement requirements that will compare the experiences of beneficiaries who are required to report 80 hours per month of work or other activities to those who are exempt from reporting.

MDHHS is working to send a follow-up letter in December to HMP beneficiaries who do not currently meet an exception based on MDHHS records with information on the work requirements and the process for reporting compliance or an exemption, as applicable.

48-Month Cumulative Enrollment Changes – Delayed until October 1, 2020

Beginning October 1, 2020, beneficiaries who have been enrolled in HMP for 48 cumulative months and have incomes above 100 percent of the federal poverty level (FPL) will be required to engage in a healthy behavior and contribute 5 percent of their income toward cost-sharing as a condition of continued enrollment.

HMP Operations and Process Questions

MDHHS staff and meeting attendees continued to discuss the process for outreach to HMP beneficiaries. One meeting attendee suggested that the department work with local public libraries to distribute materials related to HMP work requirements to beneficiaries who use library resources to report compliance. MDHHS staff also offered to make informational materials available to other partnering organizations for individual printing and distribution.

Flint Waiver Renewal

MDHHS is continuing work to submit an application to extend the Waiver for Individuals Impacted by Flint Water to the Centers for Medicare & Medicaid Services (CMS). The waiver expanded Medicaid eligibility to include children up to the age of 21 and pregnant women who lived, received childcare, or education at an address served by the Flint water system with incomes up to 400 percent FPL. The current waiver expires in February 2021, and the renewal application must be submitted to CMS by February 2020 for the program to continue. As an update to the discussion at the previous MCAC meeting in August 2019, Erin Emerson indicated that the department is continuing to consider changes to the targeted case management benefit for individuals impacted by Flint water to allow for a limited telemedicine component. MDHHS is also planning to conduct a regional forum in Flint in January 2020 to discuss the waiver extension application. The department will continue to seek renewal of the waiver until such a time as no individual meets the eligibility requirements.

MI Health Link

Currently, the MI Health Link demonstration for individuals who are dually eligible for Medicare and Medicaid is set to expire on December 31, 2020. MDHHS has submitted a letter of intent to seek a five-year extension of the demonstration to CMS and is now working to incorporate stakeholder feedback for program enhancements into the extension application that will be submitted at a later date.

Long-Term Care Updates

Brian Barrie provided updates on the following projects administered by the Bureau of Long-Term Care Services & Support:

- MDHHS is working with the MI Choice waiver agencies to fill an additional 1,000 openings in the MI Choice waiver program, as well as administering a five percent rate increase to providers of MI Choice waiver services. In response to an inquiry, Mr. Barrie indicated that the department works with an independent accounting firm annually to ensure actuarial soundness of provider reimbursement rates prior to submission to CMS. **NOTE:** Following the meeting, a decision was made by MDHHS leadership not to pursue these changes to the MI Choice Waiver program at this time.

- The Auditor General's office is working with department staff to conduct a performance audit of the Home Help program.

- MDHHS is in the early stages of planning for implementation of a managed long-term services and supports (LTSS) program, beginning with identifying opportunities for process improvement in the current service delivery system, and exploring the establishment of independent options counseling. The department also conducted a stakeholder meeting on September 5, 2019 and began an LTSS feasibility study on October 1, 2019, as required by the legislature. Another stakeholder meeting to discuss the implementation of managed LTSS will take place on December 4, 2019,

with an additional meeting to be held in February 2020.

- MDHHS submitted a Request for Information (RFI) for the implementation of an Electronic Visit Verification (EVV) system for personal care services providers and received responses from several potential vendors nationwide. The department is reviewing the responses and has submitted a request to extend the deadline for compliance with the 21st Century Cures act to January 1, 2021 in order to allow for additional time to establish an EVV system.

- The department is working in conjunction with several caregiver programs with funding from the Michigan Health Endowment Fund to develop "caregiving maps" for individuals receiving personal care services. The project, known as We All Care, seeks to map out the full network of individuals who assist in providing direct care services to a beneficiary, including friends and relatives who provide unpaid services. The goal of this mapping project is to identify individuals who are part of a beneficiary's "informal" network of caregivers who can be contacted to assist the beneficiary if the regular caregiver is unavailable.

Asset Test Change

MDHHS staff from the Economic Stability Administration shared that the asset limit for individuals to receive food and cash assistance will be increased to $15,000 effective December 1, 2019. The department announced an increase in the asset limit with the goal of allowing beneficiaries to save money for other needs such as house repairs without losing eligibility for benefits. In addition, the department will no longer be required to verify that beneficiaries receiving food assistance own only one vehicle and will accept beneficiary self-attestation regarding compliance with asset limits. There are no changes to the income limit for benefits eligibility, which will continue to require verification.

Policy Updates

A policy bulletin handout was distributed, and the following items were discussed:

- Bulletin MSA 19-26 – Caring 4 Students (C4S) Program
- Proposed Policy 1926-HMP – Healthy Michigan Plan Updates
- Proposed Policy 1931-Eligiblity – Medicaid Lock-Out
- Proposed Policy 1936-Pharmacy – Medicaid Health Plan Pharmacy Drug Coverage Transition

Future Agenda Items

Alison Hirschel invited meeting attendees to share ideas for future agenda items.

The meeting was adjourned at 3:00 p.m.

MDHHS Michigan Department of Health & Human Services

Medical Services Administration

BULLETIN MSA

Bulletin Number: MSA 19-35

Distribution: All Providers, Bridges Eligibility Manual (BEM) and Bridges Administrative Manual (BAM) Holders

Issued: December 2, 2019

Subject: Healthy Michigan Plan Updates

Effective: January 1, 2020

Programs Affected: Healthy Michigan Plan

The Michigan Department of Health and Human Services (MDHHS) will implement new work requirements beginning on January 1, 2020 for Medicaid beneficiaries who have Healthy Michigan Plan (HMP) health care coverage. The purpose of this bulletin is to provide information regarding changes to the HMP program. MDHHS is implementing these requirements in compliance with Public Act 208 of 2018 and the Special Terms and Conditions of the Section 1115 Demonstration Waiver Amendment that was approved by the Centers for Medicare & Medicaid Services (CMS) on December 21, 2018. HMP beneficiaries who are at least 19 but younger than 62 and do not meet exemption criteria will be subject to the new work requirements as a condition of eligibility.

The bulletin also provides updated information on the policy and operational processes for the administration of key elements of the HMP program:

- The Healthy Behaviors Incentives Program and administration of related healthy behavior requirements
- MI Health Account co-pays and fees for HMP beneficiaries
- Identification process for HMP beneficiaries who are medically frail

I. HMP Work Requirements

Beginning on January 1, 2020, HMP beneficiaries who are at least 19 but younger than 62 will be required to complete and report 80 hours of work or other qualifying activities per month as a condition of eligibility unless they meet exemption criteria.

Beneficiaries who are enrolled on or after January 1, 2020 will be required to complete work or other qualifying activities for their second full month of having HMP health care coverage after they become eligible. In accordance with Public Act 50 of 2019, beneficiaries must report work or other qualifying activities for the previous month by the end of each current month.

A. Work and Other Qualifying Activities

Beneficiaries are required to complete and report 80 hours each month of any combination of work or other qualifying activities listed in the table below. Beneficiaries will be able to report work or other qualifying activities either (1) in-person at kiosks in MDHHS field offices, (2) online via the MI Bridges Portal, or (3) by phone via the Healthy Michigan Plan Work Requirement and Exemption Reporting Line.

Work or Other Qualifying Activities for HMP Eligibility	
Type of Work or Qualifying Activity	**Description**
Employment	Individuals who work for another individual or organization in exchange for money are considered to be employed.
Self-Employment	Self-employment includes: • Working in exchange for money. • Working in exchange for goods or services (in-kind). Work-In-Kind does not include the exchange of money.
Income Consistent with Being Employed or Self-Employed	This activity is defined as making money equal to earning the state-mandated minimum wage for 80 hours per month. Examples include earnings from a pension or retirement plan, rental income, or other types of income.
Education Directly Related to Employment	This activity includes participating in an educational program directly related to employment. The beneficiary can participate in person or online, and the beneficiary may also report study hours. Examples of educational programs include (1) preparing for and taking a High School Equivalency test such as the General Equivalency Diploma (GED) exam, (2) attending a basic skills program (e.g. English as a Second Language, computer skills, reading and writing skills), or (3) taking classes with the goal of getting a degree or certificate. The beneficiary can take classes at a university, college, community college, or other post-secondary school.
Job Training	This activity includes receiving training for the beneficiary's job from the beneficiary's employer. Job training can also include participating in job skills training, job training through a workforce program, training to become self-employed, or a job-training program at a community college.
Tribal Employment Program	If the beneficiary is a member of a federally recognized Tribe, the beneficiary can report hours spent in an employment program that has been authorized by the Tribe.
Vocational Training	This activity includes training for a specific type of job or trade. Examples include participating in an apprenticeship program; vocational training shorter than six months; or a full-time practicum, clinicals, or similar program. Vocational training can also include time spent in a classroom, laboratory, studying, or other related activity.

Work or Other Qualifying Activities for HMP Eligibility	
Type of Work or Qualifying Activity	**Description**
Unpaid Workforce Engagement	This activity includes working for a company or organization who is not the beneficiary's employer and developing experience or skills for a future job.
Participation in Substance Use Disorder (SUD) Treatment	This activity includes SUD treatment that is mandated by a court or prescribed by a licensed medical professional. Examples of related activities include participating in counseling, support group meetings or other recovery support programs, residential or inpatient treatment programs, intensive outpatient programs, or medication assisted treatment programs.
Community Service	This activity includes volunteering or providing community service. A beneficiary must volunteer or serve with a non-profit 501(c)(3) or 501(c)(4) organization. Examples include volunteering with a faith-based organization, homeless shelter, soup kitchen, animal shelter, or food bank. A beneficiary can only report this activity for three months per calendar year.
Job Search Related to Employment	This activity is related to looking and applying for jobs. Searching for a job includes searching for a job through a workforce program, completing a job skills assessment or job readiness workshop, preparing or submitting resumes or e-mail applications to apply for job openings, interviewing for jobs, or traveling to job interviews or job fairs.

In accordance with Public Act 50 of 2019, MDHHS will use administrative data when possible to deem that beneficiaries are currently complying with work or other qualifying activities. MDHHS will notify beneficiaries if they are currently deemed to be compliant with work requirements. Beneficiaries who have not received notification related to deeming of compliance should continue to report applicable work or other qualifying activities.

B. Exemptions from Work Requirements

Beneficiaries who meet one or more of the following exemption categories are not required to complete or report work or other qualifying activities. MDHHS will use administrative data to assign an exemption status to beneficiaries when available. Beneficiaries will also be able to report exemptions either (1) in-person at kiosks in MDHHS field offices, (2) online via the MI Bridges Portal, or (3) by phone via the Healthy Michigan Plan Work Requirement and Exemption Reporting Line. Exemptions will last for 12 months from the reported date or until the next health care coverage re-determination, whichever comes first. Based upon the results of the health care coverage re-determination, the beneficiary's exemption may either be extended or ended.

- Beneficiaries who are medically frail
- Beneficiaries who are a caretaker of a family member under 6 years of age. Only one parent at a time can claim this exemption per household.
- Beneficiaries who are receiving temporary or permanent long-term disability benefits from a private insurer or from the government
- Full-time students who are not a dependent of a parent or guardian or whose parent or guardian qualifies for Medicaid
- Beneficiaries who are pregnant or were pregnant within the last two months
- Beneficiaries who are a caretaker of a dependent with a disability who needs full-time care based on a licensed medical professional's order. Only one enrolled HMP beneficiary may claim this exemption per household.
- Beneficiaries who are a caretaker of an incapacitated individual even if the incapacitated individual is not a dependent of the caretaker
- Beneficiaries who have attested to meeting the good cause temporary exemption as defined under state law (MCL 400.107(a)(2)(d))
- Beneficiaries with a medical condition resulting in a work limitation according to a licensed medical professional's order
- Beneficiaries who have been incarcerated within the last six months
- Beneficiaries receiving unemployment benefits from the State of Michigan
- Beneficiaries under 21 years of age who had previously been in foster care placement in Michigan
- Beneficiaries who are receiving food assistance (i.e. Supplemental Nutrition Assistance Program (SNAP)) or cash assistance (e.g. Temporary Assistance for Needy Families (TANF) program) from MDHHS
- Beneficiaries who have been assigned by the department to the control group for the evaluation of the Section 1115 Demonstration Waiver

C. Penalties for Non-Compliance with Work Requirements

Beneficiaries who are non-compliant for three months in a single calendar year may be disenrolled and will be subject to a one-month penalty of non-coverage. Beneficiaries will not be disenrolled if the beneficiary can demonstrate good cause for non-compliance, demonstrate that he or she qualifies for an exemption, or satisfy the work requirement by reporting completion of 80 hours for a previous non-compliant month.

In accordance with Public Act 50 of 2019, beneficiaries will have the opportunity to "cure" previous months of non-compliance by reporting completion of the required number of hours of work or other qualifying activities for the specific month of non-compliance. Beneficiaries may cure previous months of non-compliance up to 60 days (two months) after the required reporting date.

Individuals who were disenrolled for non-compliance with HMP work requirements may re-apply for health care coverage. If the individual re-applies for health care coverage, the individual can be approved for re-enrollment in HMP, but the individual must attest that he or she has completed 80 hours of work or other qualifying activities in at least one previously unreported month in the past 12 months before an individual's re-

enrollment into HMP is approved. The individual may also report an exemption as part of the application process. If the individual reports an exemption during the one-month penalty of non-coverage, the individual can be approved for re-enrollment in HMP without serving the one-month penalty.

II. HMP Healthy Behavior Requirements

A. Current Healthy Behavior Requirements

MDHHS developed a Healthy Behaviors Incentives Program for HMP beneficiaries who are enrolled in a Medicaid Health Plan (MHP). The purpose of the Healthy Behaviors Incentives Program is to encourage beneficiaries to maintain and implement healthy behaviors as identified in collaboration with their health care provider primarily via a standardized Health Risk Assessment (HRA). MDHHS encourages HMP beneficiaries to complete an HMP HRA on an annual basis, and beneficiaries are offered the opportunity to receive a reduction in cost sharing based on submission of a completed HRA. In addition to the HMP HRA, beneficiaries may also complete a healthy behavior and potentially qualify for incentives by:

- Completing an approved wellness program through an MHP. These programs can take many forms, such as evidence-based tobacco cessation support or health coaching services.
- Completing an appointment for one of the following preventive health services: (1) annual medical check-up, (2) dental check-up or cleaning, (3) recommended cancer screening, (4) recommended vaccination(s), and (5) other preventive care services.

B. Additional Information

Comprehensive information on the Healthy Behaviors Incentives Program and the administration of healthy behavior requirements can be found in the “Policy and Operational Process Document: Healthy Behavior Requirements” included with this bulletin.

III. Cost Sharing Requirements

MDHHS currently requires HMP beneficiaries who are enrolled in an MHP to satisfy cost sharing requirements through a MI Health Account. Cost sharing requirements, which include co-pays and fees, are administered through the MI Health Account. Fees, which were formerly known as contributions, are based on a beneficiary's income level.

Beginning January 1, 2020, medically frail HMP beneficiaries with a MI Health Account will be exempt from co-pays for Medicaid Health Plan covered services and MI Health Account fees. Beginning April 1, 2020, medically frail HMP beneficiaries will not be required to pay co-pays for any Fee-for-Service covered benefits. Additional information on the administration of MI Health Account co-pays and fees can be found in the “Policy and

Operational Process Document: MI Health Account Co-Pays and Fees for HMP Beneficiaries" included with this bulletin.

IV. Process for Identification of Medically Frail HMP Beneficiaries

HMP beneficiaries who are considered medically frail in accordance with 42 CFR 440.315(f) are exempt from the work requirements. MDHHS will identify medically frail beneficiaries by (1) self-attestation by the beneficiary and (2) retrospective claims analysis. Additional information on the identification process can be found in the "Policy and Operational Process Document: Identification of Medically Frail Beneficiaries" included with this bulletin.

Manual Maintenance

Retain this bulletin until the information is incorporated into the Michigan Medicaid Provider Manual, Bridges Eligibility Manual (http://www.mfia.state.mi.us/olmweb/ex/html/) and the Bridges Administration Manual (http://www.mfia.state.mi.us/olmweb/ex/html/).

Questions

Any questions regarding this bulletin should be directed to Provider Inquiry, Department of Health and Human Services, P.O. Box 30731, Lansing, Michigan 48909-8231, or e-mailed to ProviderSupport@michigan.gov. When you submit an e-mail, be sure to include your name, affiliation, NPI number, and phone number so you may be contacted if necessary. Providers may phone toll-free 1-800-292-2550.

Approved

Kate Massey, Director
Medical Services Administration

Attachments

Policy and Operational Process Document: Healthy Behavior Requirements

I. INTRODUCTION

The Michigan Department of Health and Human Services (MDHHS) developed a Healthy Behaviors Incentives Program specific to the Healthy Michigan Plan (HMP) managed care population. The purpose of the Healthy Behaviors Incentives Program is to encourage beneficiaries to maintain and implement healthy behaviors as identified in collaboration with their health care provider primarily via a standardized Health Risk Assessment (HRA).

Following evaluation and additional feedback from stakeholders, MDHHS is updating the Healthy Behaviors Incentives Program to promote greater beneficiary engagement and reward progress towards healthy behaviors over time. These changes are meant to strengthen the program's capacity to encourage behavior change for both new and existing enrollees. MDHHS modified the HMP HRA and the overall incentive framework in support of these goals, expanding the scope of services and medications deemed exempt from cost sharing as a way to reduce barriers to needed care, and detailing the impact of certain healthy activities on delivery system options as described below.

II. HEALTH RISK ASSESSMENT

HMP beneficiaries are expected to remain actively engaged with the Healthy Behaviors Incentives Program each year that they are in HMP. MDHHS has developed an HRA that assesses a broad range of health issues and behaviors including, but not limited to, the following:

- Physical activity
- Nutrition
- Alcohol, tobacco, and substance use
- Mental health
- Influenza vaccination

The HRA is available for completion by all HMP managed care enrollees. New beneficiaries will continue to be informed about the program when they first enroll by the enrollment broker and in the welcome packets they receive from their MHP. In order to remain relevant and appropriate for members who have completed multiple annual HRAs, the form accounts for consideration of progress on the previous year's goals for existing members, as attested by the primary care provider. Additional healthy behaviors have been added to the HRA, such as recommended cancer screenings and preventive dental care, to ensure the selection of targeted healthy behaviors is sufficiently diverse for members who have already achieved multiple healthy behavior goals. As some healthy behavior goals may require significant annual effort to maintain (i.e., not regressing into prior tobacco use), an additional goal of maintaining a previously achieved healthy behavior goal(s) has also been added. The revised HRA is posted on the department's website at www.michigan.gov/healthymichiganplan.

Assistance with completion of the HRA is available to new and existing beneficiaries. To start the HRA, members can answer the first self-report portion on their own, with the assistance of the enrollment broker or with assistance from their selected MHP. Another

option is that members can answer the first portion of the HRA online through a secure statewide beneficiary portal called the MyHealthButton. The HRA has also been translated into Spanish and Arabic. The self-report sections include assessment of engagement in healthy behaviors and questions that indicate how much assistance beneficiaries may need to achieve health in regard to particular issues. The final portion of the HRA will be done in the primary care provider's office and includes attestations by the provider that the beneficiary has acknowledged changes in behavior that may need to be made, and the member's willingness/ability to address those behaviors.

Successful entry into any health care system includes an initial visit to a primary care provider, especially for beneficiaries who may have unmet health needs. For HMP managed care enrollees, this initial appointment can include a conversation about the healthy behaviors identified in the HRA, member concerns about their own health needs, member readiness to change, and provider attestations of the member's willingness/ability to address health needs. HMP beneficiaries are expected to contact their primary care provider within 60 days of enrollment to schedule a well care appointment and complete the HRA, though there is no penalty for beneficiaries who choose not to do so.

An annual preventive visit is a benefit of the HMP and existing members are encouraged to complete an annual HRA with their primary care provider. As the program matures, HMP members will increasingly be at different stages of behavior change. The revisions to the HRA are designed to keep the program meaningful for both newly enrolled members and those who have begun to make significant lifestyle changes.

III. ADDITIONAL MECHANISMS TO DOCUMENT HEALTHY BEHAVIOR ACTIVITIES

To improve the ability of individuals to participate in the Healthy Behaviors Incentives Program, additional mechanisms to document healthy behaviors have been added for individuals who may have completed healthy behavior activities but do not have a submitted HRA for documentation. The documentation includes claims/encounters data and documented participation in wellness and population health management programs, including those submitted by an MHP.

MDHHS will use claims and encounter data to document healthy behaviors for managed care enrollees who utilize preventive and wellness services that meet the following criteria.

Make and keep an appointment for any of the following:

- Annual preventive visit
- Preventive dental services
- Appropriate cancer screening
- Advisory Committee on Immunization Practices (ACIP) recommended vaccination(s)
- Other preventive screenings

The associated codes for the health services listed above will be posted on the department's website at www.michigan.gov/healthymichiganplan. This mechanism to document healthy behaviors will primarily involve the review of historical claims information (from the preceding 12 months) for the presence of the selected codes.

All MHPs must ensure their members have access to evidence based/best practices wellness programs to reduce the impact of common risk factors such as obesity or hypertension. These programs can take many forms, such as evidence-based tobacco cessation support, health coaching services and free or reduced-cost gym memberships. The MHPs are also required to provide population health management programs which address social determinants of health such as food security or health literacy. These kinds of programs play an important role in helping members achieve their healthy behavior goal(s) and provide important skills and resources so that individuals can self-manage their health. To encourage participation in these valuable programs, members with documented participation in approved MHP wellness and population health management programs will also be eligible for Healthy Behaviors Incentives.

IV. HEALTHY BEHAVIORS INCENTIVES

HMP managed care enrollees will be rewarded for addressing behaviors necessary for improving health. MDHHS believes that this approach serves as an innovative model that rewards members for appropriate use of their health care benefits. Managed care enrollees who complete an HRA with a primary care provider attestation and agree to address or maintain healthy behaviors will receive an incentive. Existing members must also review their progress on their previous year's goal(s) with their primary care provider, who must attest on the HRA that the individual achieved or made significant progress towards their selected healthy behavior goal(s) over the last year to be eligible for an incentive. All individuals receiving an incentive are eligible for a 50 percent reduction in co-pays for the rest of the year once the enrollee has paid 2 percent of their income in co-pays. Individuals who pay a MI Health Account fee (those above 100 percent of the FPL) will also be eligible for a reduction in their monthly MI Health Account fee to 1 percent of income. To encourage consistent multi-year participation in the Healthy Behaviors Incentives Program, individuals who pay a MI Health Account fee (those above 100 percent of the FPL) will have their monthly MI Health Account fee waived in its entirety if they complete an annual HRA on time each year over two or more years. Members who complete an assessment and acknowledge that changes are necessary but who have significant physical, mental or social barriers to addressing them at this time (as attested by the primary care provider) are also eligible for the incentives.

MHP enrollees who complete the HRA but decline to engage in healthy behaviors are not eligible for incentives.

Members may complete more than one HRA during a year, but may only receive an incentive once per year. Members who initially decline to address behavior change may become eligible if they return to the provider, complete the assessment, and agree to address one or more behavior changes, as attested to by their primary care provider. Members do NOT have to complete the initial appointment or assessment during a specific window of time to be eligible for the incentive. The clock on the annual incentive begins when the member completes the initial appointment and assessment.

Individuals who do not complete a HRA but are identified as completing a healthy behaviors activity (as documented through specific claims/encounters data or documented participation in wellness and population health management programs) will earn the same MI Health Account co-pays and fee reductions as individuals who complete the HRA and agree to address or maintain a healthy behavior.

Any earned reductions in cost sharing will be applied through the MI Health Account, as detailed in the "Policy and Operational Process Document: MI Health Account co-pays and fee for HMP Beneficiaries." Consistent with state law, a member who has earned a reduction in cost sharing but is subsequently found to be in 'consistently failed to pay' status will lose all or a portion of that reduction for the remainder of the year in which it was earned. All individuals will lose the 50 percent reduction in co-pays. Those individuals who pay a MI Health Account fee (those above 100 percent of the FPL) will no longer qualify for the reduction in their monthly MI Health Account fee, but their monthly MI Health Account fee will not exceed 2 percent of income.

A member has consistently failed to pay when either of the following has occurred:

- No payments have been received for three consecutive invoiced months; or
- Less than 50 percent of total cost sharing requirements have been met over a 12-month payment period and the beneficiary owes at least $3.00

V. STRUCTURED INTERVENTIONS TO ASSIST WITH IDENTIFIED HEALTHY BEHAVIORS

Beneficiaries will have access to structured ongoing support in their efforts to improve healthy behaviors as identified through the Healthy Behaviors Incentives Program. All MHPs are required to have policies in place indicating how they use the HRA data to identify members who have identified healthy behaviors goal(s) and their process for outreach and education to these members. They are also required to report annually on the members reached and provide documentation of the support services, education or other interventions provided by the MHP. Examples of these interventions include patient education, health coaching and linkages to community programs. In addition, all MHPs have robust care management programs to assist their members in obtaining health goals. For example, all MHPs have a diabetes case management program which includes information on nutrition and physical activity. The information gleaned from the HRA can be used by the MHPs to determine suitability for member enrollment into this type of care management program, or for referral for other covered services that will assist the member in changing unhealthy behaviors or maintaining current healthy activities.

Once a member has been identified as in need of any covered services, MHPs coordinate care with necessary providers to ensure that timely, appropriate services are rendered. The MHPs are contractually obligated to cover smoking cessation counseling and treatment in accordance with the Treating Tobacco Use and Dependence: 2008 Update, issued by the U.S. Department of Health and Human Services. It includes counseling, telephonic quit line support, over-the-counter and prescription medications, and combination therapy. Annual preventive visits, Advisory Committee on Immunization Practices (ACIP) recommended vaccinations and treatments for alcohol use, SUD and mental health issues are covered services under HMP. MHPs also cover maternity care and dental services for

HMP enrollees. MDHHS expects MHPs to adhere to recognized clinical practice guidelines for the treatment of HMP members.

VI. REDUCING ACCESS BARRIERS

Access to care for Medicaid members is critical. MDHHS has and will continue to measure access to necessary providers, especially primary care providers upon whom HMP managed care enrollees rely to earn their incentives. With passage of the HMP legislation, network adequacy reports were developed for each county in the state based on the potential enrollment of new members into HMP.

In addition, HMP members may receive services, including the initial appointment and completion of the HRA, through Fee-For-Service (FFS) before they are enrolled in an MHP. Given the short time period (usually one month) that new enrollees are in FFS before enrollment in an MHP, MDHHS expects there to be relatively few instances of an FFS provider completing the initial appointment and the HRA. When it does occur, the MHPs are responsible for either working directly with the FFS provider to obtain the HRA or assisting the member in getting the necessary HRA information from the provider. Providers have also been instructed to give each beneficiary a copy of their completed assessment at the initial appointment so the beneficiary can forward a copy of their completed HRA to their MHP after enrollment. Beneficiaries who complete the HRA during the FFS period are eligible for the incentives upon enrollment into an MHP.

VII. EDUCATION AND OUTREACH STRATEGY

MDHHS has developed a four-pronged education strategy that will ensure members hear the same message across different entities and will maximize the potential for member engagement in healthy behaviors and achievement of incentives. At all potential points of contact in the enrollment process (the enrollment broker, MDHHS, MHPs, and providers), members will receive information about the Healthy Behaviors Incentives Program, including eligibility requirements. To ensure consistency, member engagement scripts with Healthy Behaviors Incentives Program information will be developed and shared with the enrollment broker and the MHPs.

Language has been included in the HMP handbook, brochures and other member communications to inform beneficiaries about potential reductions in their cost sharing based on their engagement in healthy behaviors.

The department's enrollment broker can facilitate member questions on the HRA, inform beneficiaries about the Healthy Behaviors Incentives, assist them with choosing a primary care provider, and encourage them to schedule and complete their initial appointment. When MHPs make welcome calls to new HMP members, their scripts include information about the Healthy Behaviors Incentives Program. During these calls, MHPs will assist members in scheduling an initial appointment and can arrange for transportation if necessary. MHPs can also assist the member to complete the HRA telephonically with a registered nurse, Certified Health Education Specialist (CHES), or other appropriately credentialed personnel as directed and approved by MDHHS. MHPs send welcome packets to new members within 10 days of enrollment into the plan. These packets will include written information on the Healthy Behaviors Incentives Program at no higher than

a 6.9 grade level. MHPs will also include Healthy Behaviors Incentives Program information on their website and in their member newsletters.

Information about the Healthy Behaviors Incentives Program and how to participate is also included in the mobile application for beneficiaries, the MyHealthButton. It includes an online option for starting the HRA, a repository where beneficiaries can see their completed HRA results submitted by their primary care provider, and tools and resources to assist them with achieving their selected healthy behavior goal(s).

VIII. PROVIDER STRATEGY

MDHHS developed a voluntary, web-based training for providers which covered the HMP HRA, Healthy Behaviors Incentives, and associated processes in 2014. The training was available for completion online and had continuing medical education (CME) units associated with it. Given the many updates to the Healthy Behaviors Incentives Program, MDHHS is now developing new multi-media materials for providers to educate them about the upcoming changes to the program.

MHP provide current information about the Healthy Behaviors Incentives Program to the providers in their networks through provider newsletters and provider portals. MHPs are also required to pay an incentive to providers who complete the HRA with their HMP members. Details of the provider incentive and payment mechanism are plan-specific and are made available to providers by the MHPs with which they participate. Providers who work with patients to complete the HRA during the FFS period are eligible for the MHP provider incentive once the member has enrolled in the MHP.

Currently, the HRA submission process for providers is different for each MHP. MDHHS implemented two secure statewide submission processes to streamline the process for providers. These new processes allow providers to submit completed HRAs via a central MDHHS fax line or through a direct data entry option within CHAMPS via a new HRA Provider Profile. When a provider completes an HRA for a managed care enrollee utilizing either the central MDHHS fax or through direct data entry into CHAMPS, the completed HRA is securely routed to the appropriate MHP for application of incentives.

IX. DATA SYSTEMS AND MONITORING PROCESSES

HRA and Wellness program data is put into electronic file formats and securely transferred from the enrollment broker and MHPs to the department's data warehouse where it is then stored. It is possible to query all aspects of this Healthy Behaviors Incentives Program data, and queries and performance measures are utilized for tracking and monitoring at the beneficiary, provider and plan level.

Policy and Operational Process Document: MI Health Account Co-Pays and Fees for HMP Beneficiaries

I. INTRODUCTION

This document outlines the policy and operational process for Healthy Michigan Plan (HMP) co-pays and fees. These requirements apply to the Michigan Department of Health and Human Services (MDHHS), the department's contracted MHPs, and the department's selected payment vendor[1] as further described herein.

The department's payment vendor will establish a MI Health Account for all beneficiaries who are enrolled in HMP through the MHPs. The MI Health Account is a unique health care savings vehicle through which various cost sharing requirements, which include co-pays and additional fees for beneficiaries with higher incomes, will be satisfied, monitored and communicated to the beneficiary. Fees, which were formerly known as contributions, are based on a beneficiary's income level.

II. MI HEALTH ACCOUNT POLICY AND OPERATIONAL PROCESS

Cost sharing, as described further below, includes both MI Health Account co-pays and fees based on income. Once enrolled in an HMP MHP, most cost sharing obligations will be satisfied through the MI Health Account. However, point of service co-pays may be required for a limited number of services that are carved out of the MHPs, such as certain drugs.

Beneficiaries who are exempt from cost sharing requirements by law, regulation, or program policy will be exempt from cost sharing obligations via the MI Health Account (e.g. individuals who are medically frail, individuals receiving hospice care, pregnant women receiving pregnancy-related services, individuals eligible for Children's Special Health Care Services, American Indians and Alaska Natives in compliance with 42 CFR 447.56, etc.). Similarly, services that are exempt from cost sharing by law, regulation or program policy (e.g., preventive and family planning services), or as defined by the "Policy and Operational Process Document: Healthy Behavior Requirements", will also be exempt for HMP beneficiaries. Finally, beneficiaries cannot be charged more than 5 percent of their total income through any combination of MI Health Account co-pays and fees.

In addition, those services that are considered private and confidential under the department's Explanation of Benefits framework will be excluded from the Healthy Michigan Plan Statement and, therefore, will be exempt from cost sharing for these HMP enrollees. MDHHS, in cooperation with its Data Warehouse vendor, will ensure that claims information submitted to the payment vendor for use in preparing the Healthy Michigan Plan Statement excludes those confidential services and/or medications outlined in this

[1] There is a single vendor that all of the MHPs use for the billing and processing of payment function. This vendor is designated as a mandatory subcontractor for the MHPs, and each of the plans contract with the payment vendor to provide services related to the MI Health Account processing, consistent with document. MDHHS also holds a contract with the payment vendor which lays out the vendor's obligation to both MDHHS and the MHPs with respect to these functions.

framework. The department's Explanation of Benefits framework is updated by MDHHS at least annually. The Explanation of Benefits framework is also shared with the MHPs for use in preparing Explanation of Benefits documents for federal health care program beneficiaries. The framework is available to other providers upon request. Finally, unless otherwise specified by this document or the "Policy and Operational Process Document: Healthy Behavior Requirements", co-pay amounts will be consistent with Michigan's State Plan.

A. Required Co-Pays

HMP utilizes an innovative approach to co-pays that is intended to reduce barriers to valuable health care services and promotes consumer engagement. During an HMP beneficiary's first six months of enrollment in an MHP, there will be no co-pays collected at the point of service for MHP covered services. At the end of the six-month period, an average monthly co-pay experience for the beneficiary will be calculated. The initial look-back period will include encounters during the first three months of enrollment in the MHP in order to account for claim lag and allow for stabilization of the encounter data. Analysis of the beneficiary's co-pay experience will be recalculated on a quarterly basis going forward.

The average co-pay amount is re-calculated every three months to reflect the beneficiary's current utilization of health care services, consistent with available data. MDHHS will consider the dates of service and adjudication date for claims received to determine the beneficiary's experience and calculate the co-pay amount going forward. These co-pay amounts will be based on encounter data submitted by the MHPs to MDHHS and will be shared via interface with the payment vendor. The payment vendor is then responsible for communicating the co-pay amounts due to the beneficiary via a quarterly account statement as described in Section V. This account statement will include a summary of account activity and any future amounts due, as well as a detailed (encounter level) explanation of services received. As noted earlier, one important exception to the amount of encounter level detail provided is that confidential services will not be shown on the Healthy Michigan Plan Statement; therefore, the beneficiary will have no cost sharing associated with those services. The provision of this encounter level data to the beneficiary is key to engaging the beneficiary as a more active consumer of health care services and will also provide sufficient information for the beneficiary to recognize and pursue resolution of any discrepancies through the appeals process. MDHHS reserves the right to modify the statement at any time, in consultation with the Centers for Medicare & Medicaid Services (CMS).

The co-pay amounts collected from the beneficiary by the payment vendor will be disbursed to the MHPs and will not accumulate in the MI Health Account. In addition, there will be no distribution of funds from the MI Health Account to the beneficiary to pay co-pays. However, information regarding co-pays owed and paid will be included as an informational item on the quarterly Healthy Michigan Plan Statement, as further defined and described in Section V. Ensuring that beneficiaries are aware of the amounts owed or why payment was not required (i.e., a preventive service was provided) is a key component of HMP. The MHPs, in cooperation with MDHHS and the payment vendor, will be responsible for beneficiary education and engagement consistent with Section VII.

Reductions in co-pays will be implemented consistent with the “Policy and Operational Process Document: Healthy Behavior Requirements”. The payment vendor is responsible for determining when each beneficiary has reached the threshold that enables co-pay reductions to occur. The payment vendor will also communicate co-pay reductions to the beneficiary as part of the Healthy Michigan Plan Statement.

B. Required MI Health Account Fees

In addition to any relevant co-pays, a monthly MI Health Account fee is also required for beneficiaries who have an income greater than 100 percent of the FPL. Consistent with state law, MI Health Account fees are not required during the first six months the individual is enrolled in an MHP. However, the payment vendor will notify the beneficiary, a welcome letter and, when applicable, through scripts used by the vendor’s customer service representatives, that MI Health Account fees will be required on a monthly basis starting in month seven.

Consistent with the Special Terms and Conditions and the “Policy and Operational Process Document: Healthy Behavior Requirements”, the MI Health Account fee amount will not exceed 2 percent of the monthly gross income of the beneficiary's household, with reductions occurring for Healthy Behaviors as described therein.

In addition, MDHHS considers the fact that multiple HMP beneficiaries may reside in the same household when calculating MI Health Account fee amounts. This modification is intended to align the amounts contributed by the household more closely with that of the federal exchange as well as existing regulatory limits on household cost sharing.

The payment vendor calculates the required MI Health Account fee amount and communicate this to the beneficiary, along with instructions for payment, as part of the MI Health Account quarterly statement. More information about the process for calculating MI Health Account fees can be found on the department's website at www.healthymichiganplan.org >> click on "What are the costs" >> click on "MI Health Account"

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C. Impact of Health Care Services Received on the MI Health Account

Beneficiary remittances to the MI Health Account are not the first source of payment for health care services rendered. The MHPs are responsible for ‘first dollar’ coverage of any MHP covered services that the beneficiary receives up to a specified amount, but the amount will vary from person to person. For example:

- For individuals at or below 100 percent of the FPL, co-pays will accumulate in the account, and the MHPs will be responsible for payment of all MHP covered services.

- For individuals above 100 percent of the FPL (who pay additional monthly fees to the account), the MHPs may utilize beneficiary funds from the MI Health Account once the beneficiary has received a certain amount and type of health care services.

- This means that the amount that the MHPs must pay before tapping funds from beneficiary payments will vary from beneficiary to beneficiary based on his or her annual MI Health Account fee amount.

- The amount of MHP responsibility for these beneficiaries will be based on the following formula:

  $1000 – (amount of beneficiary's annual MI Health Account fee) = MHP "First Dollar" Coverage Amount

To further explain this calculation, if an individual has a required annual MI Health Account fee of $300 per year, the MHP will be responsible for the first $700 of services before using any funds from beneficiary payment. In addition, given the limitations on cost sharing and the importance of maintaining beneficiary confidentiality, the impact of various services on funds in the MI Health Account will vary.

In addition, as noted above, only services covered by the MHPs will impact the MI Health Account. As a result, any items or services that are carved out of the MHPs (e.g. psychotropic drugs, Prepaid Inpatient Health Plan [PIHP] services) will not impact the MI Health Account or be reflected on any account statement. MDHHS and the MHPs have identified the services that will be carved-out of the MHP's scope of coverage via the managed care contracts. These contracts are available via the department's website. The Healthy Michigan Plan Statement will also clarify for the beneficiary that the statement may not reflect all health care services that they received (i.e., because the service was confidential, the claim was not submitted, or the MHP does not cover the service).

Finally, any services considered confidential under the department's Explanation of Benefits framework or otherwise excluded from cost sharing based on law, regulation or program policy will not be subject to any cost sharing through the MI Health Account. This limitation includes the use of funds from beneficiary payments by the MHPs once the plan's first dollar responsibility is exceeded. While no confidential services may be reflected on the Healthy Michigan Plan Statement, services that do not require suppression but are exempt from cost sharing of any type must be reflected on the statement as a service for which no payment is required, such as preventive services.

D. MI Health Account Cost Sharing Reductions

Both types of cost sharing (co-pays and fees) may be reduced if certain requirements are met.

1) MI Health Account Reductions Related to Chronic Conditions

   The MHPs must waive co-pays if doing so promotes greater access to services that prevent the progression of and complications related to chronic disease consistent with the following. MDHHS has provided the MHPs with lists of conditions and services, which include both diagnosis codes and drug classes, for which co-pays must be waived for all HMP beneficiaries. These lists will be posted on the

department's website at www.michigan.gov/healthymichiganplan. The MHPs may suggest additions or revisions to these lists, and MDHHS will review these suggestions annually. However, any additions must be approved in advance by MDHHS and shared with the payment vendor and all other MHPs to ensure consistency and appropriate calculation and collection of amounts owed. MDHHS will continue to engage stakeholders on this issue and ensure transparency and access to information surrounding these lists, which will include both provider and beneficiary education and outreach, policy bulletins when appropriate, and online availability of the lists. Any reductions to the lists must be approved in advance by CMS.

2) MI Health Account Healthy Behavior Cost Sharing Reductions

a. Co-Pays

Co-pays may also be reduced if a beneficiary engages in certain healthy behaviors, as detailed in the "Policy and Operational Process Document: Healthy Behavior Requirements". Before co-pays may be reduced, a beneficiary's co-payments must reach a 2 percent threshold of their income. Beneficiaries are only eligible for reductions if they are compliant with cost-sharing obligations.

The evaluation period for determining whether a beneficiary has satisfied the threshold for co-pay reduction will be the beneficiary's enrollment year for the MHP. This means that the beneficiary will have one year to make progress toward the threshold of co-payments before that threshold resets. Once the threshold is reached, the reductions will be processed and reflected on the next available Healthy Michigan Plan Statement. Additional information on the criteria for earning these reductions is included in the "Policy and Operational Process Document: Healthy Behavior Requirements".

b. Fee Reductions

The payment vendor, with participation by and oversight from the MHPs and MDHHS, is responsible for ensuring that the calculation and collection of all cost sharing amounts is performed in accordance with the "Policy and Operational Process Document: Healthy Behavior Requirements" with respect to the waiver or reduction of any required cost sharing. This includes, but is not limited to, the existence of appropriate interfaces between MDHHS, the MHPs and the payment vendor to transmit account information, encounter data and any other beneficiary information necessary to provide an accurate accounting of amounts due, received and expended from the MI Health Account. Refer to the "Policy and Operational Process Document: Healthy Behavior Requirements" for further information.

III. ACCOUNT ADMINISTRATION

The MHPs, the payment vendor and MDHHS are jointly responsible for ensuring that procedures and system requirements are in place to ensure appropriate account functions consistent with the following:

- Interest on account balances is not required.

- Upon a beneficiary's death, the balance of any funds in the MI Health Account will be returned to MDHHS after a 120-day claims run-off period.

- State law limits the return of funds contributed by the beneficiary to the beneficiary only for the purchase of private insurance.

- When the beneficiary is no longer eligible for HMP health care coverage, the balance of any funds contributed by the beneficiary will be issued to the beneficiary after a 120-day claims run-off period from the encounter transaction date for the purchase of private health insurance coverage. The payment vendor will utilize information provided via the department's claims and eligibility systems, along with the vendor's own account expenditure information, to determine whether a beneficiary qualifies for a voucher.

- The payment vendor must modify the amount of required cost sharing if the beneficiary reports a change in income and communicate any changes in amounts owed to the beneficiary, the MHP and MDHHS, as appropriate. Beneficiaries are required to notify their MDHHS eligibility specialist of any changes and are made aware of this requirement in both the rights and responsibilities section of the beneficiary handbook, communications from MDHHS, and the Healthy Michigan Plan Statement. MDHHS is the system of record for these changes, and the payment vendor will make prospective adjustments as needed. Adjustments will be made based upon information received from the department's eligibility system. Adjustments will also be made based upon the reported date of the change in income.

- All amounts received from the beneficiary will be credited to any balance owed and will be reflected on the next available quarterly statement. Similarly, disbursement of funds by the payment vendor to the MHPs from the MI Health Account (when applicable) is required in a timely manner, following appropriate verification of claims for covered services.

- The payment vendor will be responsible for the transfer of funds and appropriate credit and debit information in the event a beneficiary changes his or her MHP.

- Beneficiaries lack a property interest in MI Health Account funds contributed by them. To that end, any amounts in the MI Health Account are not considered income to the beneficiary upon distribution and will not be counted as assets.

- No interest may be charged to the beneficiary on accrued co-pay or fee liabilities.

- Any amounts remaining in the account after the first year will not offset the beneficiary's MI Health Account fee requirement for the next year. In addition, the amount that must be covered by the MHP as 'first dollar' will decrease in each subsequent enrollment year when beneficiary funds from beneficiary payment remain in the account.

- The maximum amount of beneficiary funds that may accumulate in a MI Health Account is capped at $1000. If a beneficiary's MI Health Account balance reaches $1000, his or her fees will be suspended until the account balance falls below $1000. The MHP may utilize these funds for services rendered consistent with this document.

- The payment vendor must provide multiple options for the beneficiary to remit co-pays and fees due. These options must include, at a minimum, a check, money order, and electronic transfer (e.g. Automated Clearing House or ACH). Any such partner must be free or low cost and prior approved by MDHHS.

- Months 7-18 of enrollment in an MHP will constitute the first year for MI Health Account accounting purposes.

- The payment vendor has a process in place to accept third party contributions to the MI Health Account on behalf of the beneficiary. This includes ensuring that any amounts received are credited to the appropriate beneficiary and the remitter (or individual who made the payment) is tracked, and providing multiple options for individuals or entities to make contributions on behalf of a beneficiary (e.g. money order, check, online ACH, etc.). Because the amount of beneficiary funds that can accumulate in the MI Health Account is capped at $1000, third parties may not contribute amounts in excess of that limit. State law does not limit which individuals or entities may contribute to the MI Health Account on the beneficiary's behalf, and any third party's contribution will be applied directly to the beneficiary's fee requirement. Because the beneficiary lacks a property interest in any amounts in the MI Health Account, including his or her own payments, the contributions of any third party are not considered income, assets or resources of the beneficiary for any purpose.

- In the event contributions are received from a third party as part of a federal health initiative (such as the Ryan White Program) all excess funds must be returned to the appropriate remitter (i.e., the person or program who made the payment) if required by relevant law and regulation.

MDHHS will monitor both the MHPs and the payment vendor for compliance with the above requirements.

IV. BENEFICIARY AND PROVIDER ENGAGEMENT

A. Beneficiaries

1) Healthy Michigan Plan Statements and MI Health Account Costs

A primary method of increasing awareness of health care costs and promoting consumer engagement in this population will be through the use of a quarterly Healthy Michigan Plan Statement. These Healthy Michigan Plan Statements will be drafted at the appropriate grade reading level and will reflect the principles outlined in this document, as well as the "Policy and Operational Process Document: Healthy Behavior Requirements" when applicable.

The payment vendor must provide the beneficiary with at least the following information on a quarterly basis (along with year-to-date information when appropriate):

- MI Health Account balance
- Expenditures by the MHP for covered services over the past three months
- Co-pay amount due for next three months
- Co-pays collected in previous three months
- Past due amounts
- MI Health Account Fee amount due for the next three months
- MI Health Account Fees collected in previous three months
- Reduction to co-pays applied when calculating the amount due for the next three months due to beneficiary compliance with healthy behaviors (as applicable)
- Reduction to MI Health Account fees applied when calculating the amount owed due to beneficiary compliance with healthy behaviors (as applicable)
- An appropriate subset of encounter-level information regarding services received, including (but not limited to) the following:
  - A description of the procedure, drug or service received
  - Date of service
  - Co-payment amount assigned to that service
  - Provider information
  - Amount paid for the service

The Healthy Michigan Plan Statement must contain the above information and be in a form and format approved by MDHHS. Hard copies of these statements must be sent to beneficiaries through U.S. mail on a quarterly basis, though beneficiaries may elect to receive electronic statements as approved by MDHHS. In terms of expenditure information, the Healthy Michigan Plan Statement will reflect only those services provided by the MHPs and will only share utilization details consistent with privacy and confidentiality laws and regulations. The Healthy Michigan Plan Statement will also include information for beneficiaries on what to do if they have questions or concerns about the services or costs shown on the statement. Beneficiaries will also have the option to utilize the MHP's grievance process, as appropriate.

V. BENEFICIARY EDUCATION FOR MI HEALTH ACCOUNT

The MHPs and the payment vendor will be responsible for beneficiary education regarding the role of the MI Health Account and the beneficiary's cost sharing responsibilities. While the Healthy Michigan Plan Statements are designed to provide beneficiaries with

information on health care costs and related financial responsibilities, it is important that the beneficiary also receive information that helps them become a more informed health care consumer.

The department's contract with the MHPs requires the plans' member services staff to have general knowledge of the MI Health Account, appropriate contact information for the payment vendor for more specific questions, and the ability to address any complaints members have regarding the payment vendor. In addition, because the payment vendor is a subcontractor of the MHPs, the plans are required by contract to monitor the payment vendor's operations.

The payment vendor will be responsible for providing sufficient staffing and other administrative support to handle beneficiary questions regarding the MI Health Account and will be obligated to educate beneficiaries (via in person, telephone, or written communication) regarding these topics. This education must include information on how to use the statements and make required payments and address any questions or complaints regarding the beneficiary's use of the MI Health Account. The MHPs are responsible for providing members with handbooks that include information about HMP generally, including the MI Health Account and its cost sharing mechanism. Finally, MDHHS will work with the MHPs and the provider community to ensure that information on potential cost sharing amounts is provided to the beneficiary at the point of service.

A. Providers and MHPs

The MHPs, on behalf of MDHHS, will be responsible for education within their provider networks regarding the unique cost sharing framework of the MI Health Account as it applies to HMP. This may include in-person contact (on an individual or group basis), as well as information provided in newsletters, email messages and provider portals. This education must include, but is not limited to, the following topics:

- The co-payment mechanism and the impact on provider collection;
- The importance of providing services without collection of payment at the point of service for all MHP covered services;
- Options for reducing required fees to the MI Health Account (as more fully described in the "Policy and Operational Process Document: Healthy Behavior Requirements"), including provider responsibilities associated with those reductions; and
- The elimination of co-pays (through the MI Health Account mechanism) for certain chronic conditions (as more fully described in the "Policy and Operational Process Document: Healthy Behavior Requirements"), as well as the scope of coverage and cost sharing exemptions for preventive services.

MDHHS has partnered with various professional associations within the state, as well as its provider outreach division, to ensure that education regarding HMP and the MI Health Account occurs consistent with procedures already in place to address education needs in light of program changes.

B. Ongoing Strategy

MDHHS will receive regular reports from the payment vendor and the MHPs regarding the operation of the MI Health Account. For example, the payment vendor will provide regular reports to MDHHS and the MHPs regarding MI Health Account collections and disbursements and may provide additional information regarding beneficiary engagement and understanding as reflected through the payment vendor's call center operations upon the department's request. This information will allow MDHHS, the MHPs, and the payment vendor to identify opportunities for improvement, make any needed adjustments and evaluate the success of any changes.

Finally, the MHPs will be evaluated on the success of cost sharing collections as required by state law through the cost sharing bonus. This measure will be monitored by MDHHS annually, with the opportunity for program changes to address any identified deficiencies.

VI. CONSEQUENCES

State law requires that MDHHS develop a range of consequences for those beneficiaries who consistently fail to meet payment obligations under the HMP program. These consequences will impact those beneficiaries whose payment history meets the department's definition of non-compliance with respect to cost sharing. For the purposes of initiating the consequences described below, non-compliant means either: 1) That the beneficiary has not made any cost sharing payments (co-pays or fees) in more than 90 consecutive calendar days; or 2) that the beneficiary has met less than 50 percent of his or her cost sharing obligations as calculated over a one-year period.

In addition to the consequences described herein, MDHHS may limit potential reductions for those who fail to pay required cost sharing (as this consequence is required by state law). Information on the impact of these consequences on any cost sharing reductions is included in the "Policy and Operational Process Document: Healthy Behavior Requirements".

All beneficiaries who are non-compliant with cost sharing obligations will be subject to the following consequences. First, the payment vendor will prepare targeted messaging for the beneficiary regarding his or her delinquent payment history and the amounts owed. This may occur via the Healthy Michigan Plan Statement or other written or electronic forms of correspondence and may include telephone contact as appropriate.

In addition, state law requires MDHHS to work with the Michigan Department of Treasury to offset state tax returns, and access lottery winnings when applicable, for beneficiaries who consistently fail to meet payment obligations. MDHHS has a formal arrangement with the Department of Treasury to pursue a state tax return offset for individuals who fail to pay required cost sharing and have not responded to the messaging strategy outlined above. All beneficiaries will have access to due process prior to the initiation of any tax offset process, and these debts will not be reported to credit reporting agencies. The MHPs may receive recovered funds, but only to the extent that the plan would have been entitled had the beneficiary paid as required. All other funds recovered will revert to MDHHS. MDHHS also plans to allow the MHPs to pursue additional beneficiary consequences for non-

payment, consistent with the state law authorizing the creation of HMP, subject to formal approval prior to any implementation. However, loss of eligibility, denial of enrollment in an MHP, or denial of services is not permitted for failure to pay required co-pays or fees.

Finally, regardless of the consequences pursued by MDHHS or the MHPs, providers may not deny services for failure to pay required cost sharing amounts. The MHPs are responsible for communicating this to their contracted providers through the plan's provider education process, and for monitoring provider practices to ensure that access to services is not denied for non-payment of cost sharing.

VII. REPORTING REQUIREMENTS

The MHPs and the payment vendor are required to develop, generate and distribute reports to the MDHHS, and make information available to each other as necessary to support the functioning of the MI Health Account obligations, both as specified in this document and upon the department's request. The following information is available and shared as described herein:

- The MHPs, in cooperation with the payment vendor, must provide to MDHHS an accounting for review to verify that the MI Health Account function is operating in accordance with this document; and

- On a monthly basis, the payment vendor will provide MDHHS with information on co-pays and fees due, reductions applied, and collections by enrollee.

Policy and Operational Process Document: Identification of Medically Frail Beneficiaries

BACKGROUND

Healthy Michigan Plan (HMP) beneficiaries who are considered medically frail in accordance with 42 CFR 440.315(f) are exempt from work requirements. Beneficiaries who are medically frail may have any of the following:

- A physical, mental, or emotional health condition that limits a daily activity (like bathing, dressing, daily chores, etc.)
- A physical, intellectual, or developmental disability that impairs the ability to perform one or more activities of daily living
- A physical, mental, or emotional health condition that requires frequent monitoring
- A disability determination based on Social Security criteria (SSDI)
- A chronic substance use disorder
- A serious and complex medical conditions or special medical needs
- Is in a nursing home, hospice, or is receiving home help services
- Is homeless
- Is a survivor of domestic violence

Beneficiaries identified as medically frail will remain exempt for 12 months from the reported date or until their next health care coverage redetermination date, whichever comes first. Based upon the results of the redetermination, the exemptions may either be extended or will end. Medically frail beneficiaries will be identified by the following methods:

Self-Identification

Individuals may report and self-attest to their medically frail status through any of the medical assistance program applications: Application for Health Coverage & Help Paying Costs (DCH-1426), the all programs Assistance Application (MDHHS-1171), and the online MI Bridges Application. A telephone option for application is also available.

Application processes include questions that allow individuals to report and attest that they have physical, mental, or emotional health conditions that limit their daily activities, such as bathing, dressing, or daily chores; or limit their ability to work, attend school, or take care of daily needs. Additionally, questions will allow the individual to report they reside in a medical or nursing facility. Applications will also include an appendix allowing individuals to report and attest to any of the exemptions for work requirements as applicable.

If beneficiaries become medically frail during a period of eligibility, they may update their application information. In addition to the paper and online applications, there will be an HMP Work Requirement and Exemption Reporting Line (telephone option) that will allow beneficiaries to report and attest to exemptions at any time.

Retrospective Claims Analysis

When available, MDHHS will review health care claims data available within the Community Health Automated Medicaid Processing System (CHAMPS) from the preceding 12 months for the presence of select diagnosis codes to identify beneficiaries considered medically frail. The list of codes is included as Appendix A. MDHHS may pursue updates to this list on an annual basis. The claims data to be reviewed include the following:

a. ICD-10 diagnosis codes (over 350 codes selected) that identify:
    - Individuals with disabling mental disorders;
    - Individuals with serious and complex medical conditions; and
    - Individuals with a physical, intellectual or developmental disability that significantly impairs their ability to perform one or more activities of daily living.
b. Whether a beneficiary is in a nursing home or hospice or is receiving services through the Adult Home Help program or Children's Special Health Care Services program.
c. Whether a beneficiary is homeless.
d. Whether a beneficiary is a survivor of domestic violence.

Appendix A: Medically Frail Diagnosis Codes

CODE	DESCRIPTION
A170	TUBERCULOUS MENINGITIS
A171	MENINGEAL TUBERCULOMA
A1781	TUBERCULOMA OF BRAIN AND SPINAL CORD
A1782	TUBERCULOUS MENINGOENCEPHALITIS
A1783	TUBERCULOUS NEURITIS
A1789	OTHER TUBERCULOSIS OF NERVOUS SYSTEM
A179	TUBERCULOSIS OF NERVOUS SYSTEM UNSPECIFIED
A1801	TUBERCULOSIS OF SPINE
A1802	TUBERCULOUS ARTHRITIS OF OTHER JOINTS
A1803	TUBERCULOSIS OF OTHER BONES
A1809	OTHER MUSCULOSKELETAL TUBERCULOSIS
A1810	TUBERCULOSIS OF GENITOURINARY SYSTEM UNSPECIFIED
A1811	TUBERCULOSIS OF KIDNEY AND URETER
A1812	TUBERCULOSIS OF BLADDER
A1813	TUBERCULOSIS OF OTHER URINARY ORGANS
A1814	TUBERCULOSIS OF PROSTATE
A1815	TUBERCULOSIS OF OTHER MALE GENITAL ORGANS
A1816	TUBERCULOSIS OF CERVIX
A1817	TUBERCULOUS FEMALE PELVIC INFLAMMATORY DISEASE
A1818	TUBERCULOSIS OF OTHER FEMALE GENITAL ORGANS
A182	TUBERCULOUS PERIPHERAL LYMPHADENOPATHY
A1831	TUBERCULOUS PERITONITIS
A1832	TUBERCULOUS ENTERITIS
A1839	RETROPERITONEAL TUBERCULOSIS
A184	TUBERCULOSIS OF SKIN AND SUBCUTANEOUS TISSUE
A1850	TUBERCULOSIS OF EYE UNSPECIFIED

CODE	DESCRIPTION
A1851	TUBERCULOUS EPISCLERITIS
A1852	TUBERCULOUS KERATITIS
A1853	TUBERCULOUS CHORIORETINITIS
A1854	TUBERCULOUS IRIDOCYCLITIS
A1859	OTHER TUBERCULOSIS OF EYE
A186	TUBERCULOSIS OF INNER MIDDLE EAR
A187	TUBERCULOSIS OF ADRENAL GLANDS
A1881	TUBERCULOSIS OF THYROID GLAND
A1882	TUBERCULOSIS OF OTHER ENDOCRINE GLANDS
A1883	TUBERCULOSIS OF DIGESTIVE TRACT ORGANS NEC
A1884	TUBERCULOSIS OF HEART
A1885	TUBERCULOSIS OF SPLEEN
A1889	TUBERCULOSIS OF OTHER SITES
B20	HUMAN IMMUNODEFICIENCY VIRUS HIV DISEASE
B900	SEQUELAE OF CENTRAL NERVOUS SYSTEM TUBERCULOSIS
B901	SEQUELAE OF GENITOURINARY TUBERCULOSIS
B902	SEQUELAE OF TUBERCULOSIS OF BONES AND JOINTS
B908	SEQUELAE OF TUBERCULOSIS OF OTHER ORGANS
D5700	HB-SS DISEASE WITH CRISIS, UNSPECIFIED
D5701	HB-SS DISEASE WITH ACUTE CHEST SYNDROME
D5702	HB-SS DISEASE WITH SPLENIC SEQUESTRATION
D571	SICKLE-CELL DISEASE WITHOUT CRISIS
D5720	SICKLE-CELL/HB-C DISEASE WITHOUT CRISIS
D57211	SICKLE-CELL/HB-C DISEASE WITH ACUTE CHEST SYNDROME
D57212	SICKLE-CELL/HB-C DISEASE WITH SPLENIC SEQUESTRATION
D57219	SICKLE-CELL/HB-C DISEASE WITH CRISIS, UNSPECIFIED
D5740	SICKLE-CELL THALASSEMIA WITHOUT CRISIS
D57411	SICKLE-CELL THALASSEMIA WITH ACUTE CHEST SYNDROME
D57412	SICKLE-CELL THALASSEMIA WITH SPLENIC SEQUESTRATION
D57419	SICKLE-CELL THALASSEMIA WITH CRISIS, UNSPECIFIED
D5780	OTHER SICKLE-CELL DISORDERS WITHOUT CRISIS
D57811	OTHER SICKLE-CELL DISORDERS WITH ACUTE CHEST SYNDROME
D57812	OTHER SICKLE-CELL DISORDERS WITH SPLENIC SEQUESTRATION
D57819	OTHER SICKLE-CELL DISORDERS WITH CRISIS, UNSPECIFIED
D808	OTHER IMMUNODEF W/PREDOMINANTLY ANTIBODY DEFECTS
D809	IMMUNODEF W/PREDOMINANTLY ANTIBODY DEFECTS UNS
D810	SEVERE COMBINED IMMUNODEF W/RETICULAR DYSGENESIS
D811	SEVERE COMBINED IMMUNODEF LOW T & B-CELL NUMBERS
D812	SEVERE COMBINED IMMUNODEF W/NORMAL B-CELL NUMBRS
D8130	ADENOSINE DEAMINASE DEFICIENCY, UNSPECIFIED
D8131	SEVERE COMBINED IMMUNODEF DUE TO ADENOSINE DEAMINASE DEFIC
D8132	ADENOSINE DEAMINASE 2 DEFICIENCY
D8139	OTHER ADENOSINE DEAMINASE DEFICIENCY
D814	NEZELOFS SYNDROME

CODE	DESCRIPTION
D815	PURINE NUCLEOSIDE PHOSPHORYLASE DEFICIENCY
D816	MAJ HISTOCOMPATIBILITY COMPLX CLASS I DEFICIENCY
D817	MAJ HISTOCOMPATIBILTY COMPLX CLASS II DEFICIENCY
D81810	BIOTINIDASE DEFICIENCY
D81818	OTHER BIOTIN-DEPENDENT CARBOXYLASE DEFICIENCY
D81819	BIOTIN-DEPENDENT CARBOXYLASE DEFICIENCY UNS
D8189	OTHER COMBINED IMMUNODEFICIENCIES
D819	COMBINED IMMUNODEFICIENCY UNSPECIFIED
D820	WISKOTT-ALDRICH SYNDROME
D821	DI GEORGES SYNDROME
D823	IMMUNODEFIC FLW HEREDITARY DEFECT RESPONS TO EBV
D828	IMMUNODEFIC ASSOCIATED W/OTH SPEC MAJOR DEFECT
D829	IMMUNODEFICIENCY ASSOCIATED W/MAJOR DEFECTS UNS
D830	CVI W/PREDOMINANT ABN OF B-CELL NUMBERS & FUNCT
D831	CVI W/PREDOMINANT IMMUNOREGULATORY T-CELL D/O
D832	CVI WITH AUTOANTIBODIES TO B- OR T-CELLS
E701	OTHER HYPERPHENYLALANINEMIAS
E7502	TAY-SACHS DISEASE
E7521	FABRY-ANDERSON DISEASE
E7522	GAUCHER DISEASE
E7523	KRABBE DISEASE
E75240	NIEMANN-PICK DISEASE TYPE A
E75241	NIEMANN-PICK DISEASE TYPE B
E75242	NIEMANN-PICK DISEASE TYPE C
E75243	NIEMANN-PICK DISEASE TYPE D
E75248	OTHER NIEMANN-PICK DISEASE
E75249	NIEMANN-PICK DISEASE UNSPECIFIED
E7525	METACHROMATIC LEUKODYSTROPHY
E7529	OTHER SPHINGOLIPIDOSIS
E840	CYSTIC FIBROSIS WITH PULMONARY MANIFESTATIONS
E8419	CYSTIC FIBROSIS W/OTH INTESTINAL MANIFESTATIONS
E848	CYSTIC FIBROSIS WITH OTHER MANIFESTATIONS
E849	CYSTIC FIBROSIS UNSPECIFIED
E8840	MITOCHONDRIAL METABOLISM DISORDER UNSPECIFIED
F0150	VASCULAR DEMENTIA WITHOUT BEHAVIORAL DISTURBANCE
F0151	VASCULAR DEMENTIA WITH BEHAVIORAL DISTURBANCE
F0280	DEMENTIA OTH DZ CLASS ELSW W/O BEHAVRL DISTURB
F0281	DEMENTIA OTH DISEAS CLASS W/BEHAVIORAL DISTURB
F0390	UNSPEC DEMENTIA WITHOUT BEHAVIORAL DISTURBANCE
F0391	UNSPECIFIED DEMENTIA WITH BEHAVIORAL DISTURBANCE
F04	AMNESTIC DISORDER DUE KNOWN PHYSIOLOGICAL COND
F060	PSYCHOTIC DISORDER W HALLUCIN DUE TO KNOWN PHYSIOL CONDITION
F061	CATATONIC DISORDER DUE TO KNOWN PHYSIOLOGICAL CONDITION
F062	PSYCHOTIC DISORDER W DELUSIONS DUE TO KNOWN PHYSIOL COND

CODE	DESCRIPTION
F0631	MOOD DISORDER DUE TO KNOWN PHYSIOL COND W DEPRESSV FEATURES
F0632	MOOD DISORD D/T PHYSIOL COND W MAJOR DEPRESSIVE-LIKE EPSD
F0633	MOOD DISORDER DUE TO KNOWN PHYSIOL COND W MANIC FEATURES
F0634	MOOD DISORDER DUE TO KNOWN PHYSIOL COND W MIXED FEATURES
F064	ANXIETY DISORDER DUE TO KNOWN PHYSIOLOGICAL CONDITION
F200	PARANOID SCHIZOPHRENIA
F201	DISORGANIZED SCHIZOPHRENIA
F202	CATATONIC SCHIZOPHRENIA
F203	UNDIFFERENTIATED SCHIZOPHRENIA
F205	RESIDUAL SCHIZOPHRENIA
F2081	SCHIZOPHRENIFORM DISORDER
F2089	OTHER SCHIZOPHRENIA
F209	SCHIZOPHRENIA UNSPECIFIED
F21	SCHIZOTYPAL DISORDER
F22	DELUSIONAL DISORDERS
F23	BRIEF PSYCHOTIC DISORDER
F24	SHARED PSYCHOTIC DISORDER
F250	SCHIZOAFFECTIVE DISORDER BIPOLAR TYPE
F251	SCHIZOAFFECTIVE DISORDER DEPRESSIVE TYPE
F258	OTHER SCHIZOAFFECTIVE DISORDERS
F259	SCHIZOAFFECTIVE DISORDER UNSPECIFIED
F28	OTH PSYCHOT D/O NOT DUE SUBSTANCE/PHYSIOLOG COND
F29	UNS PSYCHOSIS NOT DUE SUBSTANCE/PHYSIOLOG COND
F3012	MANIC EPISODE WITHOUT PSYCHOTIC SYMPTOMS, MODERATE
F3013	MANIC EPISODE, SEVERE, WITHOUT PSYCHOTIC SYMPTOMS
F302	MANIC EPISODE, SEVERE WITH PSYCHOTIC SYMPTOMS
F3112	BIPOLAR DISORD, CRNT EPISODE MANIC W/O PSYCH FEATURES, MOD
F3113	BIPOLAR DISORD, CRNT EPSD MANIC W/O PSYCH FEATURES, SEVERE
F312	BIPOLAR DISORD, CRNT EPISODE MANIC SEVERE W PSYCH FEATURES
F3132	BIPOLAR DISORDER, CURRENT EPISODE DEPRESSED, MODERATE
F314	BIPOLAR DISORD, CRNT EPSD DEPRESS, SEV, W/O PSYCH FEATURES
F315	BIPOLAR DISORD, CRNT EPSD DEPRESS, SEVERE, W PSYCH FEATURES
F3162	BIPOLAR DISORDER, CURRENT EPISODE MIXED, MODERATE
F3163	BIPOLAR DISORD, CRNT EPSD MIXED, SEVERE, W/O PSYCH FEATURES
F3164	BIPOLAR DISORD, CRNT EPISODE MIXED, SEVERE, W PSYCH FEATURES
F321	MAJOR DEPRESSIVE DISORDER, SINGLE EPISODE, MODERATE
F322	MAJOR DEPRESSV DISORD, SINGLE EPSD, SEV W/O PSYCH FEATURES
F323	MAJOR DEPRESSV DISORD, SINGLE EPSD, SEVERE W PSYCH FEATURES
F331	MAJOR DEPRESSIVE DISORDER, RECURRENT, MODERATE
F332	MAJOR DEPRESSV DISORDER, RECURRENT SEVERE W/O PSYCH FEATURES
F333	MAJOR DEPRESSV DISORDER, RECURRENT, SEVERE W PSYCH SYMPTOMS
F4001	AGORAPHOBIA WITH PANIC DISORDER
F410	PANIC DISORDER [EPISODIC PAROXYSMAL ANXIETY]
F4311	POST-TRAUMATIC STRESS DISORDER, ACUTE

CODE	DESCRIPTION
F4312	POST-TRAUMATIC STRESS DISORDER, CHRONIC
F440	DISSOCIATIVE AMNESIA
F441	DISSOCIATIVE FUGUE
F444	CONVERSION DISORDER WITH MOTOR SYMPTOM OR DEFICIT
F445	CONVERSION DISORDER WITH SEIZURES OR CONVULSIONS
F446	CONVERSION DISORDER WITH SENSORY SYMPTOM OR DEFICIT
F447	CONVERSION DISORDER WITH MIXED SYMPTOM PRESENTATION
F4481	DISSOCIATIVE IDENTITY DISORDER
F4522	BODY DYSMORPHIC DISORDER
F481	DEPERSONALIZATION-DEREALIZATION SYNDROME
F600	PARANOID PERSONALITY DISORDER
F601	SCHIZOID PERSONALITY DISORDER
F71	MODERATE INTELLECTUAL DISABILITIES
F72	SEVERE INTELLECTUAL DISABILITIES
F73	PROFOUND INTELLECTUAL DISABILITIES
F801	EXPRESSIVE LANGUAGE DISORDER
F840	AUTISTIC DISORDER
F845	ASPERGERS SYNDROME
F848	OTHER PERVASIVE DEVELOPMENTAL DISORDERS
F849	PERVASIVE DEVELOPMENTAL DISORDER UNSPECIFIED
F952	TOURETTES DISORDER
G041	TROPICAL SPASTIC PARAPLEGIA
G114	HEREDITARY SPASTIC PARAPLEGIA
G1221	AMYOTROPHIC LATERAL SCLEROSIS
G130	PARANEOPLASTIC NEUROMYOPATHY AND NEUROPATHY
G131	OTH SYSTEM ATROPHY PRIM AFFECT CNS NEOPLASTIC DZ
G231	PROGRESSIVE SUPRANUCLEAR OPHTHALMOPLEGIA
G300	ALZHEIMERS DISEASE WITH EARLY ONSET
G301	ALZHEIMERS DISEASE WITH LATE ONSET
G308	OTHER ALZHEIMERS DISEASE
G309	ALZHEIMERS DISEASE UNSPECIFIED
G3109	OTHER FRONTOTEMPORAL DEMENTIA
G3183	DEMENTIA WITH LEWY BODIES
G35	MULTIPLE SCLEROSIS
G450	VERTEBRO-BASILAR ARTERY SYNDROME
G451	CAROTID ARTERY SYNDROME HEMISPHERIC
G452	MULTIPLE & BILATERAL PRECEREBRAL ARTERY SYND
G453	AMAUROSIS FUGAX
G454	TRANSIENT GLOBAL AMNESIA
G458	OTH TRANSIENT CERBRL ISCHEMIC ATTACKS & REL SYND
G459	TRANSIENT CEREBRAL ISCHEMIC ATTACK UNSPECIFIED
G460	MIDDLE CEREBRAL ARTERY SYNDROME
G461	ANTERIOR CEREBRAL ARTERY SYNDROME
G462	POSTERIOR CEREBRAL ARTERY SYNDROME

CODE	DESCRIPTION
G7100	MUSCULAR DYSTROPHY, UNSPECIFIED
G7101	DUCHENNE OR BECKER MUSCULAR DYSTROPHY
G7102	FACIOSCAPULOHUMERAL MUSCULAR DYSTROPHY
G7109	OTHER SPECIFIED MUSCULAR DYSTROPHIES
G731	LAMBERT-EATON SYNDROME IN NEOPLASTIC DISEASE
G800	SPASTIC QUADRIPLEGIC CEREBRAL PALSY
G801	SPASTIC DIPLEGIC CEREBRAL PALSY
G802	SPASTIC HEMIPLEGIC CEREBRAL PALSY
G803	ATHETOID CEREBRAL PALSY
G804	ATAXIC CEREBRAL PALSY
G808	OTHER CEREBRAL PALSY
G809	CEREBRAL PALSY UNSPECIFIED
G8100	FLACCID HEMIPLEGIA AFFECTING UNSPECIFIED SIDE
G8101	FLACCID HEMIPLEGIA AFFECTING RIGHT DOMINANT SIDE
G8102	FLACCID HEMIPLEGIA AFFECTING LEFT DOMINANT SIDE
G8103	FLACCID HEMIPLEGIA AFFECTING RT NONDOMINANT SIDE
G8104	FLACCID HEMIPLEGIA AFFECTING LT NONDOMINANT SIDE
G8110	SPASTIC HEMIPLEGIA AFFECTING UNSPECIFIED SIDE
G8111	SPASTIC HEMIPLEGIA AFFECTING RIGHT DOMINANT SIDE
G8112	SPASTIC HEMIPLEGIA AFFECTING LEFT DOMINANT SIDE
G8113	SPASTIC HEMIPLEGIA AFFECTING RT NONDOMINANT SIDE
G8114	SPASTIC HEMIPLEGIA AFFECTING LT NONDOMINANT SIDE
G8190	HEMIPLEGIA UNS AFFECTING UNSPECIFIED SIDE
G8191	HEMIPLEGIA UNS AFFECTING RIGHT DOMINANT SIDE
G8192	HEMIPLEGIA UNS AFFECTING LEFT DOMINANT SIDE
G8193	HEMIPLEGIA UNS AFFECTING RIGHT NONDOMINANT SIDE
G8194	HEMIPLEGIA UNS AFFECTING LEFT NONDOMINANT SIDE
G8220	PARAPLEGIA UNSPECIFIED
G8221	PARAPLEGIA COMPLETE
G8222	PARAPLEGIA INCOMPLETE
G8250	QUADRIPLEGIA UNSPECIFIED
G8251	QUADRIPLEGIA C1-C4 COMPLETE
G8252	QUADRIPLEGIA C1-C4 INCOMPLETE
G8253	QUADRIPLEGIA C5-C7 COMPLETE
G8254	QUADRIPLEGIA C5-C7 INCOMPLETE
G830	DIPLEGIA OF UPPER LIMBS
G8310	MONOPLEGIA LOWER LIMB AFFECTING UNSPECIFIED SIDE
G8311	MONOPLEGIA LOWER LIMB RIGHT DOMINANT SIDE
G8312	MONOPLEGIA LOWER LIMB LEFT DOMINANT SIDE
G8313	MONOPLEGIA LOWER LIMB RIGHT NONDOMINANT SIDE
G8314	MONOPLEGIA LOWER LIMB LEFT NONDOMINANT SIDE
G8320	MONOPLEGIA UPPER LIMB AFFECTING UNSPECIFIED SIDE
G8321	MONOPLEGIA UPPER LIMB RIGHT DOMINANT SIDE
G8322	MONOPLEGIA UPPER LIMB LEFT DOMINANT SIDE

CODE	DESCRIPTION
G8323	MONOPLEGIA UPPER LIMB RIGHT NONDOMINANT SIDE
G8324	MONOPLEGIA UPPER LIMB LEFT NONDOMINANT SIDE
G8330	MONOPLEGIA UNS AFFECTING UNSPECIFIED SIDE
G8331	MONOPLEGIA UNS AFFECTING RIGHT DOMINANT SIDE
G8332	MONOPLEGIA UNS AFFECTING LEFT DOMINANT SIDE
G8333	MONOPLEGIA UNS AFFECTING RIGHT NONDOMINANT SIDE
G8334	MONOPLEGIA UNS AFFECTING LEFT NONDOMINANT SIDE
H4930	TOTAL EXTERNAL OPHTHALMOPLEGIA UNSPECIFIED EYE
H4931	TOTAL EXTERNAL OPHTHALMOPLEGIA RIGHT EYE
H4932	TOTAL EXTERNAL OPHTHALMOPLEGIA LEFT EYE
H4933	TOTAL EXTERNAL OPHTHALMOPLEGIA BILATERAL
H4940	PROGRESSIVE EXTERNAL OPHTHALMOPLEGIA UNS EYE
H4941	PROGRESSIVE EXTERNAL OPHTHALMOPLEGIA RIGHT EYE
H4942	PROGRESSIVE EXTERNAL OPHTHALMOPLEGIA LEFT EYE
H4943	PROGRESSIVE EXTERNAL OPHTHALMOPLEGIA BILATERAL
H5120	INTERNUCLEAR OPHTHALMOPLEGIA UNSPECIFIED EYE
H5121	INTERNUCLEAR OPHTHALMOPLEGIA RIGHT EYE
H5122	INTERNUCLEAR OPHTHALMOPLEGIA LEFT EYE
H5123	INTERNUCLEAR OPHTHALMOPLEGIA BILATERAL
H52511	INTERNAL OPHTHALMOPLEGIA COMPLETE TOTAL RT EYE
H52512	INTERNAL OPHTHALMOPLEGIA COMPLETE TOTAL LT EYE
H52513	INTERNAL OPHTHALMOPLEGIA COMPLETE TOTAL BILAT
H52519	INTERNAL OPHTHALMOPLEGIA COMPLETE TOTAL UNS EYE
I120	HYPERTENSIVE CKD W/STAGE 5 CKD OR ESRD
I1311	HTN HEART & CKD W/O HF W/STAGE 5 CKD OR ESRD
I132	HTN HEART & CKD W/HF W/STAGE 5 CKD OR ESRD
I69351	HEMIPLEGIA FLW CEREBRAL INFARCT AFF RT DOM SIDE
I69352	HEMIPLEGIA FLW CEREBRAL INFARCT AFF LT DOM SIDE
I69353	HEMIPLEGIA FLW CEREBRAL INFARCT AFF RT NON-DOM
I69354	HEMIPLEGIA FLW CEREBRAL INFARCT AFF LT NON-DOM
I69359	HEMIPLEGIA FLW CEREBRAL INFARCT AFFCT UNS SIDE
M623	IMMOBILITY SYNDROME PARAPLEGIC
N184	CHRONIC KIDNEY DISEASE STAGE 4 SEVERE
N185	CHRONIC KIDNEY DISEASE STAGE 5
N186	END STAGE RENAL DISEASE
Q050	CERVICAL SPINA BIFIDA WITH HYDROCEPHALUS
Q051	THORACIC SPINA BIFIDA WITH HYDROCEPHALUS
Q052	LUMBAR SPINA BIFIDA WITH HYDROCEPHALUS
Q053	SACRAL SPINA BIFIDA WITH HYDROCEPHALUS
Q054	UNSPECIFIED SPINA BIFIDA WITH HYDROCEPHALUS
Q055	CERVICAL SPINA BIFIDA WITHOUT HYDROCEPHALUS
Q056	THORACIC SPINA BIFIDA WITHOUT HYDROCEPHALUS
Q057	LUMBAR SPINA BIFIDA WITHOUT HYDROCEPHALUS
Q058	SACRAL SPINA BIFIDA WITHOUT HYDROCEPHALUS

CODE	DESCRIPTION
Q059	SPINA BIFIDA UNSPECIFIED
Q900	TRISOMY 21, NONMOSAICISM (MEIOTIC NONDISJUNCTION)
Q901	TRISOMY 21, MOSAICISM (MITOTIC NONDISJUNCTION)
Q902	TRISOMY 21, TRANSLOCATION
Q909	DOWN SYNDROME, UNSPECIFIED
Q910	TRISOMY 18, NONMOSAICISM (MEIOTIC NONDISJUNCTION)
Q911	TRISOMY 18, MOSAICISM (MITOTIC NONDISJUNCTION)
Q912	TRISOMY 18, TRANSLOCATION
Q913	TRISOMY 18, UNSPECIFIED
Q914	TRISOMY 13, NONMOSAICISM (MEIOTIC NONDISJUNCTION)
Q915	TRISOMY 13, MOSAICISM (MITOTIC NONDISJUNCTION)
Q916	TRISOMY 13, TRANSLOCATION
Q917	TRISOMY 13, UNSPECIFIED
Q920	WHOLE CHROMOSOME TRISOMY, NONMOSAICISM (MEIOTIC NONDISJUNCTION)
Q921	WHOLE CHROMOSOME TRISOMY, MOSAICISM (MITOTIC NONDISJUNCTION)
Q922	PARTIAL TRISOMY
Q925	DUPLICATIONS WITH OTHER COMPLEX REARRANGEMENTS
Q9261	MARKER CHROMOSOMES IN NORMAL INDIVIDUAL
Q9262	MARKER CHROMOSOMES IN ABNORMAL INDIVIDUAL
Q927	TRIPLOIDY AND POLYPLOIDY
Q928	OTHER SPECIFIED TRISOMIES AND PARTIAL TRISOMIES OF AUTOSOMES
Q929	TRISOMY AND PARTIAL TRISOMY OF AUTOSOMES, UNSPECIFIED
Q930	WHOLE CHROMOSOME MONOSOMY, NONMOSAICISM (MEIOTIC NONDISJUNCTION)
Q931	WHOLE CHROMOSOME MONOSOMY, MOSAICISM (MITOTIC NONDISJUNCTION)
Q932	CHROMOSOME REPLACED WITH RING, DICENTRIC OR ISOCHROMOSOME
Q937	DELETIONS WITH OTHER COMPLEX REARRANGEMENTS
Q9381	VELO-CARDIO-FACIAL SYNDROME
Q9388	OTHER MICRODELETIONS
Q9389	OTHER DELETIONS FROM THE AUTOSOMES
Q939	DELETION FROM AUTOSOMES, UNSPECIFIED
Q952	BALANCED AUTOSOMAL REARRANGEMENT IN ABNORMAL INDIVIDUAL
Q953	BALANCED SEX/AUTOSOMAL REARRANGEMENT IN ABNORMAL INDIVIDUAL
Q992	FRAGILE X CHROMOSOME
R4181	AGE-RELATED COGNITIVE DECLINE
R532	FUNCTIONAL QUADRIPLEGIA
R54	AGE-RELATED PHYSICAL DEBILITY
T7411XA	ADULT PHYSICAL ABUSE, CONFIRMED, INITIAL ENCOUNTER
T7411XD	ADULT PHYSICAL ABUSE, CONFIRMED, SUBSEQUENT ENCOUNTER
T7411XS	ADULT PHYSICAL ABUSE, CONFIRMED, SEQUELA
T7421XA	ADULT SEXUAL ABUSE, CONFIRMED, INITIAL ENCOUNTER
T7421XD	ADULT SEXUAL ABUSE, CONFIRMED, SUBSEQUENT ENCOUNTER
T7421XS	ADULT SEXUAL ABUSE, CONFIRMED, SEQUELA

CODE	DESCRIPTION
T7431XA	ADULT PSYCHOLOGICAL ABUSE, CONFIRMED, INITIAL ENCOUNTER
T7431XD	ADULT PSYCHOLOGICAL ABUSE, CONFIRMED, SUBSEQUENT ENCOUNTER
T7431XS	ADULT PSYCHOLOGICAL ABUSE, CONFIRMED, SEQUELA
T7451XA	ADULT FORCED SEXUAL EXPLOITATION, CONFIRMED, INIT
T7451XD	ADULT FORCED SEXUAL EXPLOITATION, CONFIRMED, SUBS
T7451XS	ADULT FORCED SEXUAL EXPLOITATION, CONFIRMED, SEQUELA
T7611XA	ADULT PHYSICAL ABUSE, SUSPECTED, INITIAL ENCOUNTER
T7611XD	ADULT PHYSICAL ABUSE, SUSPECTED, SUBSEQUENT ENCOUNTER
T7611XS	ADULT PHYSICAL ABUSE, SUSPECTED, SEQUELA
T7621XA	ADULT SEXUAL ABUSE, SUSPECTED, INITIAL ENCOUNTER
T7621XD	ADULT SEXUAL ABUSE, SUSPECTED, SUBSEQUENT ENCOUNTER
T7621XS	ADULT SEXUAL ABUSE, SUSPECTED, SEQUELA
T7631XA	ADULT PSYCHOLOGICAL ABUSE, SUSPECTED, INITIAL ENCOUNTER
T7631XD	ADULT PSYCHOLOGICAL ABUSE, SUSPECTED, SUBSEQUENT ENCOUNTER
T7631XS	ADULT PSYCHOLOGICAL ABUSE, SUSPECTED, SEQUELA
T7651XA	ADULT FORCED SEXUAL EXPLOITATION, SUSPECTED, INIT
T7651XD	ADULT FORCED SEXUAL EXPLOITATION, SUSPECTED, SUBS
T7651XS	ADULT FORCED SEXUAL EXPLOITATION, SUSPECTED, SEQUELA
Z510	ENCOUNTER FOR ANTINEOPLASTIC RADIATION THERAPY
Z5111	ENCOUNTER FOR ANTINEOPLASTIC CHEMOTHERAPY
Z5112	ENCOUNTER FOR ANTINEOPLASTIC IMMUNOTHERAPY
Z590	HOMELESSNESS
Z6911	ENCNTR FOR MNTL HLTH SERV FOR VICTIM OF SPOUS OR PRTNR ABUSE
Z6981	ENCOUNTER FOR MENTAL HEALTH SERVICES FOR VICTIM OF OTH ABUSE
Z7682	AWAITING ORGAN TRANSPLANT STATUS