I. Purpose

This document describes the background, along with the requirements for development, implementation and operation of the MI Health Account. These requirements apply to the Michigan Department of Health and Human Services ("Department"), the Department's contracted health plans, and the Department's selected MI Health Account vendor[1] as further described below.

II. Background

All individuals enrolled in the Healthy Michigan Plan through the Department's contracted Medicaid health plans will have access to a MI Health Account. The MI Health Account is a unique health care savings vehicle through which various cost-sharing requirements, which include co-pays and additional contributions for beneficiaries with higher incomes, will be satisfied, monitored and communicated to the beneficiary. The Department has established uniform standards and expectations for the MI Health Account's operation through this Operational Protocol and by contract as appropriate.

III. Cost-Sharing

Cost-sharing, as described further below, includes both co-pays and, when applicable to the beneficiary, contributions based on income. Once enrolled in a Medicaid health plan, 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 health plans, 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 receiving hospice care, pregnant women receiving pregnancy-related services, individuals eligible for Children's Special Health Care Services, Native Americans 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 State's Healthy Behaviors Incentives Operational Protocol, will also be exempt for Healthy Michigan Plan beneficiaries.

In addition, those services that are considered private and confidential under the Department's Explanation of Benefits framework will be excluded from the MI Health Account statement and, therefore, will be exempt from cost sharing for these Healthy Michigan Plan enrollees. The Department, in cooperation with its Data Warehouse vendor, will ensure that the claims information submitted to the MI Health Account vendor for use in preparing the MI Health Account statement excludes those confidential services and/or

[1] There is a single vendor that all of the Department's contracted Medicaid health plans use for the MI Health Account function. This vendor is designated as a mandatory subcontractor for the health plans, and each of the plans contract with the MI Health Account vendor to provide services related to the MI Health Account, consistent with this protocol. The Department also holds a contract with the MI Health Account vendor which lays out the vendor's obligation to both the Department and the health plans with respect to the MI Health Account function.

medications outlined in this framework. The Department's Explanation of Benefits framework is updated by the Department at least annually, is shared with the contracted health plans for use in preparing Explanation of Benefits documents for federal health care program beneficiaries, and is available to other providers upon request. Finally, unless otherwise specified by this Operational Protocol or the Healthy Behaviors Incentives Operational Protocol, co-pay amounts will be consistent with Michigan's State Plan.

A. Co-pays

The Healthy Michigan Plan utilizes an innovative approach to co-pays that is intended to reduce barriers to valuable health care services and promote consumer engagement. During a Healthy Michigan Plan beneficiary's first six months of enrollment in a health plan, there will be no co-pays collected at the point of service for health plan 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 a health plan 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 following examples, along with the attached **Appendix 1** (which is a more general, visual representation of a beneficiary enrolling with a health plan in May) provide further clarification.

During her first three months in a Healthy Michigan Plan health plan, a beneficiary has the following services: In April 2014, she visits her physician for a sinus infection ($2 co-pay). In May (2014), she visits the dentist for a filling ($3 co-pay), and fills one preferred prescription for antibiotics at the pharmacy ($1). The beneficiary will receive notice of these potential co-pay amounts at the time the services are rendered. All of the above claims are paid by the health plan in June 2014. The MI Health Account vendor receives claim information on this beneficiary from the Department's Data Warehouse vendor in early October 2014, which includes claims paid during April, May and June of 2014 for services that occurred on or after April 1, 2014. This claim information includes the above services with the related co-pay amounts.

The MI Health Account vendor calculates the average monthly co-pay experience for that beneficiary to be $2.00 ($6 in expenditures divided over a 3 month period equals an average of $2 per month). Therefore, this beneficiary will be required to remit $2 per month into the MI Health Account for the next three months. The beneficiary will receive her first quarterly MI Health Account statement on or about October 15, 2014 with her first payment of $2.00 due November 15, 2014; her second payment due December 15, 2014 and her third payment due January 15, 2015. The beneficiary (and all other Healthy Michigan Plan beneficiaries) will also have the option to pay the entire amount due all at once. The MI Health Account vendor will recalculate the average monthly co-pay experience for the beneficiary in January 2015, which will be based on the beneficiary's copayments from July, August, and September of 2014. The beneficiary will then be notified of her new monthly copayment obligation in January 2015, which will be in effect during February, March, and April of 2015.

During another beneficiary's first three months in a Healthy Michigan Plan health plan, a beneficiary has the following services: A visit to her doctor for a preventive visit ($0) in April of 2014; a visit to an endocrinologist to assess and control her diabetes in May of 2014($0); and finally, she fills a diabetes related prescription ($0) in June of 2014. All of the above claims are paid by the health plan in June 2014. The MI Health Account vendor receives claim information on this beneficiary from the Department's Data Warehouse vendor in early October 2014, which includes claims paid during April, May and June of 2014 for services that occurred on or after April 1, 2014. This claim information includes the above services with the related co-pay amounts.

The MI Health Account vendor calculates the average monthly co-pay experience for this beneficiary to be $0 because none of these services have co-pays associated with them. This beneficiary will not be required to remit any funds to the MI Health Account for co-pays over the next 3 months, but will receive a quarterly MI Health Account statement detailing her services for educational purposes.

The average co-pay amount is re-calculated every three months to reflect the beneficiary's current utilization of healthcare services, consistent with available data. The Department 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 health plans to the Department, and will be shared via interface with the MI Health Account vendor. The MI Health Account vendor is then responsible for communicating the co-pay amounts due to the beneficiary via a quarterly account statement as described in Section VII.A.1. 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 MI Health Account 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 process described in Section X. The Department reserves the right to modify the account statement at any time, in consultation with CMS.

The co-pay amounts collected from the beneficiary by the MI Health Account vendor will be disbursed to the health plans 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 MI Health Account quarterly statement, as further defined and described in Section VII.A.1. 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 the Healthy Michigan Plan.

The health plans, in cooperation with the State and MI Health Account vendor, will be responsible for beneficiary education and engagement consistent with Section VII.

Reductions in co-pays will be implemented consistent with the State's Healthy Behaviors Incentives Operational Protocol. The MI Health Account vendor is responsible for determining when each beneficiary has reached the threshold that enables co-pay reductions to occur. The MI Health Account vendor will also communicate co-pay reductions to the beneficiary as part of the MI Health Account statement (see Section V for further discussion).

B. Required Contributions

In addition to any relevant co-pays, a monthly contribution is also required for beneficiaries whose income places them above 100% of the Federal Poverty Level. Consistent with state law, contributions are not required during the first six months the individual is enrolled in a health plan. However, the MI Health Account vendor will notify the beneficiary, via the MI Health Account statement, a welcome letter and, when applicable, through scripts used by the vendor's customer service representatives, that contributions will be required on a monthly basis starting in month seven.

After April 1, 2018, consistent with the revisions to the Special Terms and Conditions and the Healthy Behaviors Incentives Operational Protocol, the contribution amount will not exceed two percent of the amount that represents the beneficiary's percentage of the Federal Poverty Level, with reductions occurring for Healthy Behaviors as described therein. However, in practice, the Department plans to consider family composition when calculating contribution amounts. For example, when a beneficiary with several dependents qualifies for the Healthy Michigan Plan, the Department will consider that fact when assessing their contribution amount. For example:

A beneficiary with three dependents has an annual income of around $28,000. A beneficiary with no children has an annual income of around $14,000. Both apply for the Healthy Michigan Plan. Due to difference in their family size, both beneficiaries would be eligible for the Healthy Michigan Plan at 120 percent of the Federal Poverty Level. The contribution for both will not exceed $23 per month because some income from the beneficiary with three dependents will be recognized as support for these dependents.

In addition, the Department intends to consider the fact that multiple Healthy Michigan Plan covered individuals reside in the same household when calculating contribution amounts. For example, if both individuals in a married couple qualify for the Healthy Michigan Plan at 101 percent of the Federal Poverty Level, each would be required to pay no more than $13 per month for their individual coverage (or $26 per month for the household). 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 MI Health Account vendor will calculate the required contribution amount and communicate this to the beneficiary, along with instructions for payment, as part of the MI Health Account quarterly statement.

IV. Impact of Healthcare Services Received on the MI Health Account

Beneficiary contributions to the MI Health Account are not the first source of payment for health care services rendered. The health plans are responsible for 'first dollar' coverage of any health plan covered services the beneficiary receives up to a specified amount, though that amount will vary from person to person. For example:

- For individuals at or below 100 percent of the Federal Poverty Level, because co-pays will not accumulate in the account, the health plans will be responsible for payment of all health plan covered services.

- For individuals above 100 percent of the Federal Poverty Level (who make additional monthly contributions to the account), the health plan 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 the health plans must pay before tapping beneficiary contributions will vary from beneficiary to beneficiary based on his or her annual contribution amount.
    - The amount of health plan responsibility for these beneficiaries will be based on the following formula:

$1000 – (amount of beneficiary's annual contribution) =

Health Plan "First Dollar" Coverage Amount

To further explain this calculation, if an individual has a required annual contribution of $300 per year, the health plan will be responsible for the first $700 of services before using any beneficiary contributions. 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. The following are examples of how the MI Health Account vendor will determine the amount of MI Health Account funds, if any, that may be used to offset the cost of certain services covered by the health plan.

A beneficiary has a monthly contribution requirement of $25, which he remits as required. The beneficiary receives no services for the first 9 months he is in the health plan. Therefore, the beneficiary has contributed $75 (no contributions for the first 6 months, followed by 3 months of contributions) into the MI Health Account and none of those funds have been utilized by the health plan. The beneficiary's total annual contribution is expected to be $300.

In month 10, the beneficiary contracts strep throat and visits his primary care provider for evaluation and treatment. Per the above formula, the health plan will be responsible for payment of the first $700 in services. The cost of the office visit, strep test and antibiotic are less than $700, therefore, the health plan is responsible for the cost of all of those services and may not receive funds from the MI Health Account.

A beneficiary has a monthly contribution requirement of $20, which she remits as required. The beneficiary does not receive any services in the first 9 months she is in the health plan. Therefore, the beneficiary has contributed $60 (no contributions for the first 6 months plus 3 months of contributions) and none of those funds have been utilized by the health plan. The beneficiary's total annual contribution is expected to be $240.

In month 10, the beneficiary develops appendicitis and requires surgery. Per the above formula, the health plan will be responsible for the first $760 in services. The fees for the surgery are more than $760. After the health plan pays for the first $760 of services, it may receive funds from the MI Health Account (in this case, $60). The beneficiary will continue to owe $20 per month until her remaining obligation ($180) is satisfied. In the interim, the health plan will pay the providers involved the remaining fees for the services provided, and may receive the next $180 remitted by the beneficiary.

In addition, as noted above, only services covered by the health plans will impact the MI Health Account. As a result, any items or services that are carved out of the health plans (e.g. psychotropic drugs, PIHP services) will not impact the MI Health Account or be reflected on any account statement. The Department and the contracted health plans identify the services that will be carved-out of the health plan's scope of coverage via the managed care contracts. These contracts are available via the State's website. The MI Health Account 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 health plan does not cover the service).

The following scenario illustrates a beneficiary requiring a carved-out service and the cost-sharing impact:

A beneficiary has a monthly contribution of $20, and he pays timely for 3 months (for a total of $60). The beneficiary fills a prescription for a psychotropic drug at his local pharmacy. The beneficiary will be responsible for paying any applicable co-payment for that drug at the pharmacy (point of service). The health plan will not be responsible for payment for the psychotropic drug as this is a service that is carved out from the health plans, and there will be no impact on the MI Health Account as a result. In addition, no funds from the MI Health Account will be distributed to the beneficiary to pay any required co-pay at the point of 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 beneficiary contributions by the health plans once the plan's first dollar responsibility is exceeded. While no confidential services may be reflected on the MI Health Account 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 which are described in the following example.

A beneficiary has a monthly contribution of $20, and she pays timely for 3 months (for a total of $60). The following month, the beneficiary has colonoscopy and mammogram screenings that result in fees in excess of $1000. The health plan must pay for these preventive services and may not seek funds from the MI Health Account for those services. The MI Health Account statement will reflect that preventive services are exempt from any cost sharing on the part of the beneficiary.

V. Cost-Sharing Reductions

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

A. Reductions Related to Chronic Conditions

The health plans 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. The Department has provided the plans with lists of conditions and services, which include both diagnosis codes and drug classes, for which co-pays must be waived for all Healthy Michigan Plan beneficiaries. These lists are included as **Appendix 2**. The health plans may suggest additions or revisions to these lists, and the Department will review these suggestions annually. However, any additions must be approved in advance by the Department and shared with the MI Health Account vendor and all other contracted health plans to ensure consistency and appropriate calculation and collection of amounts owed. The Department 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.

B. Healthy Behavior Cost-Sharing Reductions

1. Co-Pays

Co-pays may also be reduced if a beneficiary engages in certain healthy behaviors, as detailed in the Healthy Behaviors Incentives Operational Protocol. Before co-pays may be reduced, a beneficiary's co-payments must reach a threshold percentage of the beneficiary's income. Beginning on April 1, 2018, co-pay reductions may occur when the following thresholds are reached:

- For beneficiaries whose income is between 100% and 133% of the Federal Poverty Level: When annual accumulated co-pays reach three percent (3%) of income;

- For beneficiaries whose income is at or below 100% of the Federal Poverty Level: When annual accumulated co-pays reach two percent (2%) of income.

The evaluation period for determining whether a beneficiary has satisfied the threshold for co-pay reduction will be the beneficiary's enrollment year. 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 MI Health Account statement. Additional information on the criteria for earning these reductions is included in the Healthy Behaviors Incentives Operational Protocol.

2. Contribution Reductions

Healthy Michigan Plan beneficiaries may be required to receive services through a Qualified Health Plan (QHP) participating on the federal marketplace or a health plan meeting the criteria for QHP certification, if they do not satisfy the Department's Healthy Behavior Incentives Requirements. These individuals will have a full 12 months of enrollment in a Medicaid health plan to complete the healthy behavior requirements detailed in the Healthy Behaviors Incentives Operational Protocol. During this grace period, contribution amounts will not exceed 2% of income. Contribution reductions for beneficiaries outside of the grace period will occur consistent with the Healthy Behaviors Incentives Operational Protocol.

The MI Health Account vendor, with participation by and oversight from the health plans and the Department, is responsible for ensuring that the calculation and collection of all cost-sharing amounts is performed in accordance with the Healthy Behaviors Incentives Operational Protocol 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 the Department, the health plans and the MI Health Account 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. See the Healthy Behaviors Incentives Operational Protocol for further information.

VI. Account Administration

The health plans, the MI Health Account vendor and the Department 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 the State 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 the Healthy Michigan Plan, the balance of any funds contributed by the beneficiary will be issued to the beneficiary, after a 120-day claims run-off period, for the purchase of private health insurance coverage. The vendor will utilize information provided via the Department's claims and eligibility systems, along with its own account expenditure information, to determine whether or not a beneficiary qualifies for a voucher.

- The MI Health Account 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 health plan and the Department, as appropriate. Beneficiaries are required to notify their Department of Health and Human Services specialist of any changes, and are made aware of this requirement in both the rights and responsibilities section of the beneficiary handbook, communications from the Department and the MI Health Account statement. The Department is the system of record for these changes, and the MI Health Account vendor will make adjustments as needed via information received from the Department's eligibility system.

- 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 MI Health Account vendor to the health plans from the MI Health Account (when applicable) is required in a timely manner, following appropriate verification of claims for covered services.

- The MI Health Account vendor will be responsible for the transfer of funds and appropriate credit and debit information in the event a beneficiary changes plans.

- 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 copay or contribution liabilities. Beneficiary consequences for failure to pay are described in this Operational Protocol and may not include loss of eligibility, enrollment or access to services.

- Any amounts remaining in the account after the first year will not offset the beneficiary's contribution requirement for the next year. In addition, the amount that must be covered by the health plan as 'first dollar' will decrease in each subsequent enrollment year when beneficiary contributions remain in the account. For example, if a beneficiary contributes $250 in the first year and this amount rolls over to the next year, in year 2, the beneficiary will contribute $250 and the health plan will be responsible for the first *$500* in services (consistent with the framework described herein).

- 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 contributions will be suspended until the account balance falls below $1000. The health plans may utilize these funds for services rendered consistent with this Operational Protocol.

- The MI Health Account vendor must provide multiple options for the beneficiary to remit co-pays and contributions due. These options must include, at a minimum check, money order, electronic transfer (e.g. Automated Clearing House or ACH), and may include other payments through a designated partner such as Western Union, Walmart or Meijer. Any such partner must be free or low cost and prior approved by the Department.

- Months 7-18 of enrollment in a health plan will constitute the first year for MI Health Account accounting purposes.

- The MI Health Account 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 contribution requirement. Because the beneficiary lacks a property interest in any amounts in the MI Health Account, including his or her own contributions, 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 a 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.

The Department will monitor both the health plans and the MI Health Account vendor for compliance with the above requirements.

VII. Beneficiary and Provider Engagement

A. Beneficiaries

1. MI Health Account Statements

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 MI Health Account Statement. These MI Health Account statements will be easy to understand and drafted at the appropriate grade reading level and will reflect the principles outlined in this Operational Protocol, as well as the Healthy Behaviors Incentives Operational Protocol when applicable.

The MI Health Account 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 health plan 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
- Contribution amount due for the next three months
- Contributions 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 contributions 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 MI Health Account statement must contain the above information, and be in a form and format approved by the Department, in consultation with CMS. 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 the Department. In terms of expenditure information, the MI Health Account statement will reflect only those services provided by the health plans and will only share utilization details consistent with privacy and confidentiality laws and regulations. The MI Health Account 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 health plan's grievance process, as appropriate. Additional detail regarding beneficiary rights in this regard is contained in Section X.

2. Beneficiary Education

Both the health plans and the MI Health Account vendor will be responsible for beneficiary education regarding the role of the MI Health Account and the beneficiary's cost-sharing responsibilities. While the MI Health Account 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 health plans requires the plans' member services staff to have general knowledge of the MI Health Account, appropriate contact information for the MI Health Account vendor for more specific questions, and the ability to address any complaints members have regarding the MI Health Account vendor. In addition, because the MI Health Account vendor is a subcontractor of the health plans, the plans are required by contract to monitor the MI Health Account vendor's operations.

The MI Health Account 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, written or electronic communication) regarding these topics. This education must include information on how to use the statements and make required contributions and co-pays, and address any questions or complaints regarding the beneficiary's use of the MI Health Account. The health plans are responsible for providing members with handbooks that include information about the Healthy Michigan Plan generally, including the MI Health Account and its cost-sharing mechanism. Finally, the Department will work with the health plans and the provider community to ensure that information on potential cost-sharing amounts is provided to the beneficiary at the point of service.

B. Providers

The health plans, on behalf of the state, will be responsible for education within their provider networks regarding the unique cost-sharing framework of the MI Health Account as it applies to the Healthy Michigan Plan. 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 health plan covered services;
- Options for reducing required contributions to the MI Health Account (as more fully described in the Healthy Behaviors Incentives Operational Protocol), 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 Healthy Behaviors Incentives Operational Protocol), as well as the scope of coverage and cost-sharing exemptions for preventive services.

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

C. Ongoing Strategy

The Department will receive regular reports from the MI Health Account vendor and the health plans regarding the operation of the MI Health Account. For example, the MI Health Account vendor will provide regular reports to the Department and the health plans regarding MI Health Account collections and disbursements, and may provide additional information regarding beneficiary engagement and understanding as reflected through the vendor's call center operations upon the Department's request.

This information will allow the Department, the health plans and the MI Health Account vendor to identify opportunities for improvement, make any needed adjustments and evaluate the success of any changes.

The Department will also continue to elicit feedback from the health plans, providers, beneficiaries and other stakeholders about the MI Health Account. Account operations information will be shared and/or discussed, as appropriate, with various stakeholders, including the Medical Care Advisory Council, the Michigan Association of Health Plans, the Michigan State Medical Society and the health plans themselves. The Department meets with the Medical Care Advisory Council and the Michigan State Medical Society quarterly, and the health plans and their trade association generally on a monthly basis. Stakeholder input will be considered for any program changes, and feedback will be accepted on an ongoing basis via the Department's dedicated Healthy Michigan Plan email address.

Finally, the health plans 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 the Department annually, with the opportunity for program changes to address any identified deficiencies.

VIII. Consequences

State law requires that the Department develop a range of consequences for those beneficiaries who consistently fail to meet payment obligations under the Healthy Michigan Plan. 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 contributions) 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, the Department 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 Healthy Behaviors Incentives Operational Protocol.

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

In addition, State law requires the Department to work with the State's Department of Treasury to offset state tax returns, and access lottery winnings when applicable, for beneficiaries who consistently fail to meet payment obligations. The Department 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**.** The Department is also considering additional methods for pursuing these funds, including through its internal collection and program support process. 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 health plans 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 the State. The Department also plans to allow the health plans to pursue additional beneficiary consequences for non-payment, consistent with the State law authorizing the creation of the Healthy Michigan Plan, subject to formal approval prior to any implementation. However, loss of eligibility, denial of enrollment in a health plan, or denial of services is not permitted.

Finally, regardless of the consequences pursued by the Department or the health plans, providers may not deny services for failure to pay required cost-sharing amounts. The health plans 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.

IX. Reporting Requirements

Both the health plans and the MI Health Account vendor are required to develop, generate and distribute reports to the Department, and make information available to each other as necessary to support the functioning of the MI Health Account, both as specified in this Operational Protocol, and upon the Department's request. The following information is available and shared as described herein:

- The health plans, in cooperation with the MI Health Account vendor, must provide to the Department an accounting for review to verify that the MI Health Account function is operating in accordance with this Operational Protocol; and

- On a monthly basis, the MI Health Account vendor will provide the Department with information on co-pays and contributions due, reductions applied, and collections by enrollee.

X. Grievances and Appeals

Healthy Michigan Plan beneficiaries will have the opportunity to contest various facets of the MI Health Account function through the relevant processes operated by the health plans, and the Department when appropriate, consistent with federal law and regulation and this operational protocol. Any dispute regarding the receipt of services (as shown on the MI Health Account statement) must be pursued through the relevant health plan and will be treated as a grievance, while any action taken by the health plans that serves to limit access to covered services would be considered an adverse action and entitle the beneficiary to the full complement of appeal rights permitted by law and/or contract.

Disputes regarding increases in cost-sharing amounts (outside of the variances in the average monthly co-pay experience described herein) will be investigated by the Department, in cooperation with the MI Health Account vendor, with right to a Medicaid Fair Hearing. Other concerns or complaints associated with the operation of the MI Health Account will be addressed by the Department, with the assistance of the MI Health Account vendor. The Department will provide beneficiaries with information on the appeals process for cost-sharing changes associated with the MI Health Account, as well as general information on how to address complaints or other concerns.

The health plans are required by contract to inform beneficiaries of the grievance and appeals process at the time of enrollment, any time an enrollee files a grievance, and any time the plan takes an action that would entitle the beneficiary to appeal rights. Health plan member handbooks also contain instructions on how to file a grievance.

I. Background

The Michigan Department of Health and Human Services ("Department"), in consultation with stakeholders, developed a Healthy Behaviors Incentives Program specific to the Healthy Michigan Plan 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. Uniform standards were developed to ensure that all Healthy Michigan Plan managed care members have the opportunity to earn incentives and that those incentives are applied consistently by the managed care plans or their vendor.

Following evaluation and additional feedback from stakeholders, the Department is now updating the Healthy Behaviors Incentives Program to promote greater beneficiary engagement and reward progress towards healthy behaviors over time. These proposed changes are meant to strengthen the program's capacity to encourage behavior change for both new and existing enrollees. The Department is modifying the Healthy Michigan Plan Health Risk Assessment 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

Healthy Michigan Plan beneficiaries are expected to remain actively engaged with the Healthy Behaviors Incentives Program each year that they are in the Healthy Michigan Plan. The Department has developed a Health Risk Assessment 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 Health Risk Assessment is available for completion by all Healthy Michigan Plan managed care members. New beneficiaries continue to be informed about the program when they first enroll by the enrollment broker and in the welcome packets they receive from their managed care plan. In order to remain relevant and appropriate for members who have completed multiple annual Health Risk Assessments, the form will now account for consideration of progress on the previous year's goals for existing members, as attested by the primary care provider. Additional healthy behaviors will be added to the Health Risk Assessment, 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 (ex. not regressing into prior tobacco use), an

additional goal of maintaining previously achieved healthy behaviors goal(s) will also be added. The revised Health Risk Assessment can be found in Appendix 3.

Assistance with completion of the Health Risk Assessment is available to new and existing beneficiaries. To start the Health Risk Assessment, members can answer the first self-report portion on their own, with the assistance of the enrollment broker or with assistance from their selected managed care plan. A new option which is available is that members can now answer the first portion of the Health Risk Assessment online through a secure statewide beneficiary portal called the MyHealthButton. The Health Risk Assessment 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 regards to particular issues. The final portion of the Health Risk Assessment will be done in the primary care provider office and includes attestations by the provider that the beneficiary has acknowledged changes in behavior that may need to be made, and the members' willingness/ability to address those behaviors.

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

An annual preventive visit is a benefit of the Healthy Michigan Plan and existing members are encouraged to complete an annual Health Risk Assessment with their primary care provider. As the program matures, Healthy Michigan Plan members will increasingly be at different stages of behavior change. The revisions to the Health Risk Assessment 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

Beginning on April 1, 2018, beneficiaries in the demonstration above 100 percent of the Federal Poverty Level (FPL) who have been in the program for at least one year, who are not medically frail or exempt from cost-sharing (because they are pregnant, children, etc.), and who have chosen not to participate in the Healthy Behaviors Incentives Program will be required to enroll in a Qualified Health Plan (QHP) participating on the Marketplace or a health plan meeting the criteria for QHP certification (herein both types of health plans are referred to as a QHP). To improve the ability of individuals to participate in the Healthy Behaviors Incentives Program, additional mechanisms to document healthy behaviors are being added for individuals who may have completed healthy behavior activities but do not have a submitted Health Risk Assessment for documentation. The new documentation will include claims/encounters data and documented participation in wellness and population health management programs, including those submitted by a Medicaid health plan.

The Department will use claims and encounter data to document healthy behaviors for managed care plan members 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
- Tobacco cessation
- Advisory Committee on Immunization Practices (ACIP) recommended vaccination(s)
- Other preventive screening

The associated codes for the health services listed above can be found in Appendix 4. 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.

In addition, with the introduction of the new managed care contract in January 2016, all managed care plans must ensure its 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 managed care plans 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 managed care plan wellness and population health management programs will also be eligible for Healthy Behaviors Incentives.

IV. Healthy Behaviors Incentives

Healthy Michigan Plan managed care members will be rewarded for addressing behaviors necessary for improving health. The Department believes that this approach serves as an innovative model that rewards members for appropriate use of their health care benefits. Appendix 5 graphically describes the eligibility criteria for Healthy Behaviors Incentives: managed care members who complete a Health Risk Assessment with a primary care provider attestation and agree to address or maintain healthy behaviors will receive an incentive. All individuals receiving an incentive are eligible for a 50 percent reduction in copays once the appropriate threshold is met. The threshold is 2 percent of income for those at or below 100 percent of the Federal Poverty Level and 3 percent for those with incomes greater than 100 percent of the Federal Poverty Level. Those individuals at or below 100 percent of the Federal Poverty Level will also be eligible to receive a $50 gift card. Individuals who pay a contribution (those above 100 percent of the Federal Poverty Level) will also be eligible for a reduction in their monthly contribution to 1 percent of income. To encourage consistent multi-year participation in the Healthy Behaviors Incentives Program, individuals who pay a contribution (those above 100 percent of the Federal Poverty Level) will have their monthly contribution waived in its entirety if they complete an annual Health Risk Assessment on time each year over 2 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.

Managed care plan members who complete the Health Risk Assessment but decline to engage in healthy behaviors are not eligible for incentives. Additionally, members in the demonstration above 100 percent of the Federal Poverty Level (FPL) who complete the Health Risk Assessment but decline to engage in healthy behaviors may be required to enroll in a QHP.

Members may complete more than one Health Risk Assessment during a year, but may only receive an incentive once per year (one gift card or one annual contribution reduction). 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 Health Risk Assessment but are identified as completing a healthy behaviors activity as documented through specific claims/encounter data or documented participation in wellness and population health management programs will earn the same contribution and copay reductions as individuals who complete the Health Risk Assessment and agree to address or maintain a healthy behavior. This means individuals at or below 100 percent of the Federal Poverty Level will earn only the copay reductions for participating in a healthy behavior activity. However, these individuals can become eligible

for the gift card incentive at any time if they complete a Health Risk Assessment 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 MI Health Account Operational Protocol. Consistent with State law, a member who has earned a reduction in cost-sharing, but is subsequently found to be in 'consistently fail 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 copays and individuals at or below 100 percent of the Federal Poverty Level will also lose eligibility to receive a $50 gift card. Those individuals who pay a contribution (those above 100 percent of the Federal Poverty Level) will lose eligibility for the reduction in their monthly contribution to 1 percent of income, but their monthly contribution 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 90 consecutive calendar days, or less than 50 percent of total cost-sharing requirements have been met by the end of the year.

V. Marketplace Option

Communication and support for participation in the Healthy Behaviors Incentives Program begins at enrollment and enrollees can join at any time. To further emphasize the importance of initiating and maintaining participation, Healthy Michigan Plan managed care members earning above 100 percent of the Federal Poverty Level who have been enrolled in a managed care plan for at least 12 months, are not medically frail or have other exclusions, and who choose not to participate in the Healthy Behaviors Incentives Program will be required to receive health services through a QHP. Detailed information about enrollment requirements and health services provided by QHPs can be found in the Healthy Michigan Plan Marketplace Option Operational Protocol.

Once enrolled in the Healthy Michigan Plan Marketplace Option, QHP enrollees will be eligible for the Healthy Behaviors Incentives Program if they subsequently complete the Healthy Michigan Plan Health Risk Assessment. As QHPs do not have operational mechanisms in place to coordinate and process Health Risk Assessments and Healthy Behaviors Incentives, the Department is working with a vendor to create a telephonic option for Health Risk Assessment completion for Healthy Michigan Plan Marketplace Option enrollees. This Health Unit will enable QHP enrollees to complete the entire Health Risk Assessment telephonically with a health educator or registered nurse.

Enrollees who complete the Health Risk Assessment through this Health Unit will earn a 50 percent QHP premium reduction for the remainder of the QHP enrollment period. In addition, at the end of their QHP enrollment period, enrollees who completed a Health Risk Assessment may return to the Healthy Michigan Plan. The member's new managed care plan will receive their completed Health Risk Assessment information securely transmitted from the Department and will be responsible for providing the beneficiary with structured ongoing support in their efforts to improve healthy behaviors. The managed care plan will also be responsible for ensuring a secure mechanism to transmit the Health Risk Assessment information to the members' primary care provider in a timely manner so that the

information can be reviewed between the primary care provider and the member at their next appointment.

VI. 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 managed care plans are required to have policies in place indicating how they use the Health Risk Assessment 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 managed care plan. Examples of these interventions include patient education, health coaching and linkages to community programs. In addition, all managed care plans have robust care management programs to assist their members in obtaining health goals. For example, all managed care plans have a diabetes case management program which includes information on nutrition and physical activity. The information gleaned from the Health Risk Assessment can be used by the managed care plans 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, managed care plans coordinate care with necessary providers to ensure that timely, appropriate services are rendered. The managed care plans are contractually obligated to cover smoking cessation counseling and treatment in accordance with Treating Tobacco Use and Dependence: 2008 Update, issued by the US Department of Health and Human Services. This 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, substance use disorder and mental health issues are covered services under the Healthy Michigan Plan. Managed care plans also cover maternity care and dental services for Healthy Michigan Plan enrollees. The Department expects managed care plans to adhere to recognized clinical practice guidelines for the treatment of Healthy Michigan Plan members.

VII. Reducing Financial Barriers

Financial barriers to appropriate care can influence the health-seeking behaviors of low-income populations. For this reason, preventive services are exempt from co-pay requirements as outlined in the MI Health Account Operational Protocol. In addition, per the Healthy Michigan Plan legislation (Public Act 107 of 2013), and in an effort to remove barriers to necessary care for Healthy Michigan Plan members, the Department has eliminated copays ‘to promote greater access to services that prevent the progression of and complications related to chronic diseases’. The Department believes that by eliminating copays for services related to chronic disease and the associated pharmaceuticals, members will be better able to achieve their health goals. An expanded list of these chronic disease and associated codes is attached (Appendix 2).

VIII. Reducing Access Barriers

Access to care for Medicaid members is critical. The Department has and will continue to measure access to necessary providers, especially primary care providers upon whom Healthy Michigan Plan managed care members rely to earn their incentives. With passage of the Healthy Michigan Plan legislation, network adequacy reports were developed for each county in the state based on the potential enrollment of new members into the Healthy Michigan Plan. Departmental estimates of potential enrollment indicated no counties that required an increased network to fall within the Department's required primary care provider to member ratio of 1:750. Further, on January 1, 2016, Michigan Medicaid implemented a new managed care contract which requires a primary care provider to member ratio of 1:500 to further strengthen network adequacy.

In addition, Healthy Michigan Plan members may receive services, including the initial appointment and completion of the Health Risk Assessment, through Fee-For-Service (FFS) before they are enrolled in a managed care plan. Given the short time period (usually one month) that new enrollees are in FFS before enrollment in a managed care plan, the Department expects there to be relatively few instances of a FFS provider completing the initial appointment and the Health Risk Assessment. When it does occur, the managed care plans are responsible for either working directly with the FFS provider to obtain the Health Risk Assessment or assisting the member in getting the necessary Health Risk Assessment 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 Health Risk Assessment to their health plan after enrollment. Beneficiaries who complete the Health Risk Assessment during the FFS period are eligible for the incentives upon enrollment into a managed care plan.

IX. Education and Outreach Strategy

The Department 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, the Department, managed care plans, 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 managed care plans.

Language has been included in the Healthy Michigan Plan handbook, brochures and other member communications to inform beneficiaries about potential reductions in their cost-sharing based on their engagement in healthy behaviors. This language will be expanded to inform members about the new opportunities to be eligible for incentives through the Healthy Behaviors Incentives Program. It will also include information about the requirement to join a QHP if enrollees choose not to participate in the Healthy Behaviors Incentives Program

during the one year grace period and have no other exclusions. The Department will ensure that updated language is provided at all potential points of contact.

The Department's enrollment broker can facilitate member questions on the Health Risk Assessment, 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 managed care plans make welcome calls to new Healthy Michigan Plan members, their scripts include information about the Healthy Behaviors Incentives Program. During these calls, managed care plans will assist members in scheduling an initial appointment and can arrange for transportation if necessary. All managed care plans 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. Managed care plans will also include Healthy Behaviors Incentives Program information on their website and in their member newsletters.

The MI Health Account quarterly statement received by each Healthy Michigan Plan member is intended to be an educational tool that will present information regarding any reductions earned via the Healthy Behaviors Incentives Program. It also includes reminders for members about potential cost-sharing reductions and incentives that may be available for them. The detailed contents of the MI Health Account statement are discussed in the MI Health Account Operational Protocol.

Information about the Healthy Behaviors Incentives Program and how to participate is also included in the mobile application for beneficiaries, the MyHealthButton, which was developed by the Department for beneficiaries in 2015. It includes an online option for starting the Health Risk Assessment, a repository where beneficiaries can see their completed Health Risk Assessment results submitted by their primary care provider, and tools and resources to assist them with achieving their selected healthy behavior goal(s). There has been statewide outreach to inform beneficiaries of this new online option. The Department will continue to develop new education and outreach initiatives on the Healthy Behaviors Incentives Program for the duration of the demonstration.

X. Provider Strategy

Primary care provider participation plays a key role in healthy behavior change, and collaborative effort between beneficiaries and their health care providers is essential for the success of the Healthy Behaviors Incentives Program. For this reason, the Department developed an outreach strategy for providers which was carried out in 2014 and involved collaboration with the Michigan State Medical Society, the Michigan Osteopathic Association, Michigan Academy of Family Physicians and the Michigan Primary Care Association. The Department also sent a letter to all practitioners, Federally Qualified Health Centers, Tribal Health Centers, Rural Health Centers, and managed care plans on June 13, 2014 and a policy bulletin (14-39) was distributed to all providers on August 28, 2014. Not only did this ensure that providers were adequately informed about the Healthy Behaviors Incentives Program, but they were able to share a consistent message with patients. These same mechanisms will be used to inform providers about updates to the program. The

Department has been in discussion with provider organizations regarding these changes, and will distribute bulletins on these changes to providers in the summer of 2017.

The Department developed a voluntary, web-based training for providers which covered the Healthy Michigan Plan Health Risk Assessment, Healthy Behaviors Incentives, and associated processes. The training is available for completion online and has continuing medical education (CME) units associated with it. The Department regularly updates the course content as necessary and annually evaluates whether the course remains relevant for providers.

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

Currently, the Health Risk Assessment submission process for providers is different for each managed care plan. Based on feedback from providers about the complexity of keeping track of multiple plan-specific methods for secure submission of completed Health Risk Assessments, the Department is developing a secure state-wide submission portal (with print and electronic options) to streamline the submission process for providers. The Department began working with a vendor to develop this process in February 2017. The Department will partner with multiple provider groups to educate providers about the submission portal. When a provider completes a Health Risk Assessment for a managed care member, the completed Health Risk Assessment will be securely routed to the appropriate managed care plan for application of incentives.

XI. Data Systems and Monitoring Processes

Health Risk Assessment data is put into electronic file formats and securely transferred from the enrollment broker and managed care plans to the State's data warehouse, where it is then stored. The files include member name and ID number, the member's managed care plan, and the name and National Provider Identifier of the primary care provider who completed the Health Risk Assessment so that Health Risk Assessment data can be tracked and monitored at the beneficiary, provider and plan level. Health Risk Assessment data can be cross referenced with care provided to beneficiaries through encounter data. Health Risk Assessment data is monitored monthly and the Department developed a measure of Health Risk Assessment completion which is reported quarterly. This measure was also included in the performance bonus for managed care plans starting in SFY2016.

The healthy behaviors file will now be expanded to include the new Healthy Behaviors Incentives Program data. Managed care plans will generate a list of members who are eligible for incentives because the member participated in approved wellness programs. This

information will be submitted to the Department through modification of the healthy behaviors file. The Department will identify the members who are eligible for incentives because the member utilized identified wellness health services documented through claims/encounters. The healthy behavior incentive information completed telephonically for QHP members will be submitted utilizing current data transfer systems developed with the vendor for Health Risk Assessment data, which will be revised and tested with this new data set. Development of these modifications began in spring 2017 and extensive testing will occur prior to implementation in the fall of 2017. This data will then be stored in the State's data warehouse. Just like the Health Risk Assessment data, it will be possible to query all aspects of the program data and new queries and performance measures will be developed for tracking and monitoring at the beneficiary, provider and plan level.

Cross-referencing with encounter data also assists with monitoring provider accountability. Managed care plans are required to set standards for accountability for their provider networks. In addition, the Department developed an Access to Care measure specific to the Healthy Michigan Plan managed care population to determine how many new members completed an initial appointment within 150 days of enrollment into the managed care plan. This measure is based on encounter data extracted from the State's data warehouse and is tracked by region, managed care plan, and as a state overall. In SFY2016, this measure was included in the Performance Bonus for the managed care plans as well.

The Department receives the amount of cost-sharing expected and received by each Healthy Michigan Plan member from the MI Health Account vendor. On a quarterly basis, the Department cross references a sample of beneficiaries with records in the State's data warehouse indicating they had earned a reduction with beneficiaries who had reductions processed. A sample of each managed care plan's population is pulled. Results are processed and reported to confirm accurate application of cost-sharing reductions. Plans found to be in non-compliance with processes and procedures related to application of cost-sharing reductions are subject to established remedies and sanctions, per the Medicaid Health Plan contract. The MI Health Account vendor responsible for the QHP premium reduction will be subject to similar monitoring processes to confirm accurate application of cost-sharing reductions.

All Healthy Michigan Plan beneficiaries will have the opportunity to contest various facets of the Healthy Behaviors Incentives Program through the Medicaid health plans and the Department, as appropriate. Any dispute arising between the beneficiary and the primary care provider and/or Medicaid health plan regarding information reported on the Health Risk Assessment, additional healthy behaviors documentation, or appropriate application of incentives earned through the Medicaid health plans will be treated as a grievance. Disputes regarding the application of Healthy Behavior cost-sharing reductions (from beneficiaries enrolled in a Medicaid health plan or Marketplace health plan) or the options for Healthy Michigan Plan enrollment will be handled by the Department in accordance with applicable laws and regulations and the operational protocols associated with this demonstration.

The Medicaid health plans are contractually obligated to inform their members of the grievance process at the time of enrollment. Instructions on how to file a grievance are

detailed in the Member Handbook for each managed care plan. The beneficiary helpline telephone number will also be included on correspondence from the Department, and from the Department's vendor administering the MI Health Account and Marketplace Option premium collection.

Beneficiary helpline staff can direct members to resources for addressing complaints or other concerns associated with the Healthy Behaviors Incentives Program.

XII. Ongoing Engagement of Stakeholders and the Public

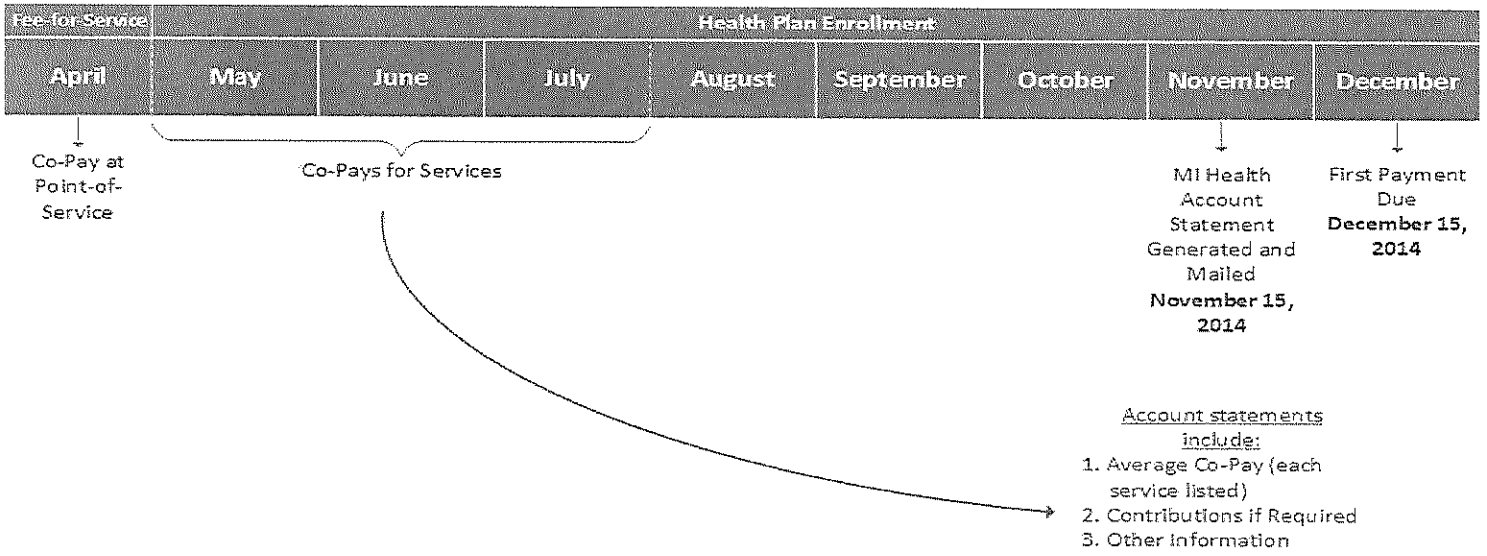
The Department began planning the Healthy Behaviors Incentives Program in December 2013. During that planning period, the Department held regular meetings with the managed care plans, provider organizations and the Medical Care Advisory Council, which is made up of staff from the Department, managed care plans, local health departments, medical, oral, and mental health providers, various advocacy groups, and Medicaid beneficiaries. Informational presentations were made to stakeholder and advocacy groups, as well as Tribal partners. The Department has continued to elicit feedback from managed care plans, providers and other stakeholders throughout the duration of the Healthy Behaviors Incentives Program. Results from data analysis are discussed annually during both the Clinical Advisory Committee and Medical Care Advisory Council meetings and stakeholder input was considered for these program changes. The Department monitors feedback on the program from the beneficiary helpline, provider helpline, and all advocacy and stakeholder groups. Results from interim reports of surveys and other investigations carried out by the University of Michigan as part of the program evaluation have also been taken into consideration.

The Department will continue to elicit feedback from providers, beneficiaries, managed care plans and other stakeholders about the Healthy Behaviors Incentives Program. Stakeholder input will be considered for any program changes, and feedback will be accepted on an ongoing basis. The Department will continue to monitor the managed care plans' implementation of the incentives program to ensure that adequate outreach and education efforts are maintained throughout the demonstration. The Department will report on the Healthy Behaviors Incentives Program each year to stakeholder and advocacy groups. Through the formal evaluation, the department will publish reports on access to care, self-reported health status, and other relevant measures of success and engagement.

ATTACHMENT D
Healthy Behaviors Incentives Program Protocol
Appendix 1: MI Health Account Operation Timeline

Appendix 1

MI Health Account Operation Timeline



HEALTHY MICHIGAN PLAN

DRAFT

Treatment Category	Drug Class	Description	Chronic Condition(s) Treated
Alzheimer's Disease	H1A	ALZHEIMER'S THERAPY, NMDA RECEPTOR ANTAGONISTS	Alzheimer's Disease and Related Disorders or Senile Dementia
	H1C	ALZHEIMER'S THX,NMDA RECEPTOR ANTAG-CHOLINES INHIB	Alzheimer's Disease and Related Disorders or Senile Dementia
	J1B	CHOLINESTERASE INHIBITORS	Alzheimer's Disease and Related Disorders or Senile Dementia
Anemia	C3B	IRON REPLACEMENT	Anemia (Includes Sickle Cell Disease)
	C6E	VITAMIN E PREPARATIONS	Anemia (Includes Sickle Cell Disease)
	C6F	PRENATAL VITAMIN PREPARATIONS	Anemia (Includes Sickle Cell Disease)
	C6L	VITAMIN B12 PREPARATIONS	Anemia (Includes Sickle Cell Disease)
	C6M	FOLIC ACID PREPARATIONS	Anemia (Includes Sickle Cell Disease)
	C6Q	VITAMIN B6 PREPARATIONS	Anemia (Includes Sickle Cell Disease)
	N1B	ERYTHROPOIESIS-STIMULATING AGENTS	Anemia (Includes Sickle Cell Disease)
	N1F	THROMBOPOIETIN RECEPTOR AGONISTS	Anemia (Includes Sickle Cell Disease)
	N1H	SICKLE CELL ANEMIA AGENTS	Anemia (Includes Sickle Cell Disease)
	P1M	LHRH (GNRH) AGONIST ANALOG PITUITARY SUPPRESSANTS	Anemia (Includes Sickle Cell Disease)
	P1P	LHRH(GNRH)AGNST PIT.SUP-CENTRAL PRECOCIOUS PUBERTY	Anemia (Includes Sickle Cell Disease)
	P5A	GLUCOCORTICOIDS	Anemia (Includes Sickle Cell Disease)
	V1I	CHEMOTHERAPY RESCUE/ANTIDOTE AGENTS	Anemia (Includes Sickle Cell Disease)
	V1O	ANTINEOPLASTIC LHRH(GNRH) AGONIST,PITUITARY SUPPR.	Anemia (Includes Sickle Cell Disease)
	W7K	ANTISERA	Anemia (Includes Sickle Cell Disease)
Arthritis	C7A	HYPERURICEMIA TX - XANTHINE OXIDASE INHIBITORS	RA/OA (Rheumatoid Arthritis/Osteoarthritis)
	D6A	DRUGS TO TX CHRONIC INFLAMMATORY DISEASE OF COLON	RA/OA (Rheumatoid Arthritis/Osteoarthritis)
	D6A	DRUGS TO TX CHRONIC INFLAMMATORY DISEASE OF COLON	RA/OA (Rheumatoid Arthritis/Osteoarthritis)
	D6F	DRUG TX-CHRONIC INFLAM. COLON DX,5-AMINOSALICYLAT	RA/OA (Rheumatoid Arthritis/Osteoarthritis)
	H3D	ANALGESIC/ANTIPYRETICS, SALICYLATES	RA/OA (Rheumatoid Arthritis/Osteoarthritis)
	P1E	ADRENOCORTICOTROPHIC HORMONES	RA/OA (Rheumatoid Arthritis/Osteoarthritis)
	P5A	GLUCOCORTICOIDS	RA/OA (Rheumatoid Arthritis/Osteoarthritis)
	Q5E	TOPICAL ANTI-INFLAMMATORY, NSAIDS	RA/OA (Rheumatoid Arthritis/Osteoarthritis)
	R1R	URICOSURIC AGENTS	RA/OA (Rheumatoid Arthritis/Osteoarthritis)
	S2B	NSAIDS, CYCLOOXYGENASE INHIBITOR - TYPE ANALGESICS	RA/OA (Rheumatoid Arthritis/Osteoarthritis)
	S2C	GOLD SALTS	RA/OA (Rheumatoid Arthritis/Osteoarthritis)
	S2I	ANTI-INFLAMMATORY, PYRIMIDINE SYNTHESIS INHIBITOR	RA/OA (Rheumatoid Arthritis/Osteoarthritis)
	S2J	ANTI-INFLAMMATORY TUMOR NECROSIS FACTOR INHIBITOR	RA/OA (Rheumatoid Arthritis/Osteoarthritis)
	S2J	ANTI-INFLAMMATORY TUMOR NECROSIS FACTOR INHIBITOR	RA/OA (Rheumatoid Arthritis/Osteoarthritis)
	S2K	ANTI-ARTHRITIC AND CHELATING AGENTS	RA/OA (Rheumatoid Arthritis/Osteoarthritis)
	S2L	NSAIDS,CYCLOOXYGENASE-2(COX-2) SELECTIVE INHIBITOR	RA/OA (Rheumatoid Arthritis/Osteoarthritis)
	S2M	ANTI-INFLAM. INTERLEUKIN-1 RECEPTOR ANTAGONIST	RA/OA (Rheumatoid Arthritis/Osteoarthritis)
	S2N	ANTI-ARTHRITIC, FOLATE ANTAGONIST AGENTS	RA/OA (Rheumatoid Arthritis/Osteoarthritis)
	S2N	ANTI-ARTHRITIC, FOLATE ANTAGONIST AGENTS	RA/OA (Rheumatoid Arthritis/Osteoarthritis)
	S2P	NSAID,COX INHIBITOR-TYPE AND PROTON PUMP INHIBITOR	RA/OA (Rheumatoid Arthritis/Osteoarthritis)
	S2Q	ANTINFLAMMATORY, SEL.COSTIM.MOD.,T-CELL INHIBITOR	RA/OA (Rheumatoid Arthritis/Osteoarthritis)
	S2T	NSAIDS(COX NON-SPEC.INHIB)AND PROSTAGLANDIN ANALOG	RA/OA (Rheumatoid Arthritis/Osteoarthritis)
	S2V	ANTI-INFLAMMATORY, INTERLEUKIN-1 BETA BLOCKERS	RA/OA (Rheumatoid Arthritis/Osteoarthritis)
	S2X	NSAID AND HISTAMINE H2 RECEPTOR ANTAGONIST COMB.	RA/OA (Rheumatoid Arthritis/Osteoarthritis)

Treatment Category	Drug Class	Description	Chronic Condition(s) Treated
Arthritis Con't.	S2Z	ANTI-INFLAMMATORY,PHOSPHODIESTERASE-4(PDE4) INHIB.	RA/OA (Rheumatoid Arthritis/Osteoarthritis)
	V1B	ANTINEOPLASTIC - ANTIMETABOLITES	RA/OA (Rheumatoid Arthritis/Osteoarthritis)
	Z2E	IMMUNOSUPPRESSIVES	RA/OA (Rheumatoid Arthritis/Osteoarthritis)
	Z2U	MONOCLONAL ANTIBODY-HUMAN INTERLEUKIN 12/23 INHIB	RA/OA (Rheumatoid Arthritis/Osteoarthritis)
	Z2V	INTERLEUKIN-6 (IL-6) RECEPTOR INHIBITORS	RA/OA (Rheumatoid Arthritis/Osteoarthritis)
	Z2W	ANTI-CD20 (B LYMPHOCYTE) MONOCLONAL ANTIBODY	RA/OA (Rheumatoid Arthritis/Osteoarthritis)
	Z2Z	JANUS KINASE (JAK) INHIBITORS	RA/OA (Rheumatoid Arthritis/Osteoarthritis)
Behavioral Health/Substance Abuse	C0D	Anti Alcoholic Preparations	Alcohol Dependence
	H3T	NARCOTIC ANTAGONISTS	Alcohol Dependence
	H2E	SEDATIVE-HYPNOTICS,NON-BARBITURATE	Alcohol Dependence and Depression
	H2F	ANTI-ANXIETY DRUGS	Alcohol Dependence and Depression
	H2D	BARBITURATES	Anxiety
	H2E	SEDATIVE-HYPNOTICS,NON-BARBITURATE	Bipolar Disorder
	H2F	ANTI-ANXIETY DRUGS	Bipolar Disorder
	H2G	ANTIPSYCHOTICS,PHENOTHIAZINES	Bipolar Disorder
	H2M	BIPOLAR DISORDER DRUGS	Bipolar Disorder
	H2S	SELECTIVE SEROTONIN REUPTAKE INHIBITOR (SSRIS)	Bipolar Disorder
	H2U	TRICYCLIC ANTIDEPRESSANTS,REL.NON-SEL.REUPT-INHIB	Bipolar Disorder
	H4B	ANTICONVULSANTS	Bipolar Disorder
	H7D	NOREPINEPHRINE AND DOPAMINE REUPTAKE INHIB (NDRIS)	Bipolar Disorder
	H7E	SEROTONIN-2 ANTAGONIST/REUPTAKE INHIBITORS (SARIS)	Bipolar Disorder
	H7T	ANTIPSYCHOTIC,ATYPICAL,DOPAMINE,SEROTONIN ANTAGNST	Bipolar Disorder
	H7X	ANTIPSYCHOTICS, ATYP, D2 PARTIAL AGONIST/5HT MIXED	Bipolar Disorder
	H7Z	SSRI-ANTIPSYCH, ATYPICAL,DOPAMINE,SEROTONIN ANTAG	Bipolar Disorder
	H8W	ANTIPSYCHOTIC-ATYPICAL,D3/D2 PARTIAL AG-5HT MIXED	Bipolar Disorder
	H2H	MONOAMINE OXIDASE(MAO) INHIBITORS	Depression
	H2M	BIPOLAR DISORDER DRUGS	Depression
	H2S	SELECTIVE SEROTONIN REUPTAKE INHIBITOR (SSRIS)	Depression
	H2U	TRICYCLIC ANTIDEPRESSANTS & REL. NON-SEL. RU-INHIB	Depression
	H2W	TRICYCLIC ANTIDEPRESSANT/PHENOTHIAZINE COMBINATNS	Depression
	H2X	TRICYCLIC ANTIDEPRESSANT/BENZODIAZEPINE COMBINATNS	Depression
	H4B	ANTICONVULSANTS	Depression
	H7B	ALPHA-2 RECEPTOR ANTAGONIST ANTIDEPRESSANTS	Depression
	H7C	SEROTONIN-NOREPINEPHRINE REUPTAKE-INHIB (SNRIS)	Depression
	H7D	NOREPINEPHRINE AND DOPAMINE REUPTAKE INHIB (NDRIS)	Depression
	H7E	SEROTONIN-2 ANTAGONIST/REUPTAKE INHIBITORS (SARIS)	Depression
	H7J	MAOIS - NON-SELECTIVE & IRREVERSIBLE	Depression
	H7Z	SSRI & ANTIPSYCH,ATYP,DOPAMINE&SEROTONIN ANTAG CMB	Depression
	H8P	SSRI & 5HT1A PARTIAL AGONIST ANTIDEPRESSANT	Depression
	H8T	SSRI & SEROTONIN RECEPTOR MODULATOR ANTIDEPRESSANT	Depression
	H2G	ANTI-PSYCHOTICS,PHENOTHIAZINES	Schizophrenia
	H7O	ANTIPSYCHOTICS,DOPAMINE ANTAGONISTS,BUTYROPHENONES	Schizophrenia
	H7P	ANTIPSYCHOTICS,DOPAMINE ANTAGONISTS, THIOXANTHENES	Schizophrenia
	H7S	ANTIPSYCHOTICS,DOPAMINE ANTAGONST,DIHYDROINDOLONES	Schizophrenia

Treatment Category	Drug Class	Description	Chronic Condition(s) Treated
Behavioral Health/Substance Abuse Con't.	H7U	ANTIPSYCHOTICS, DOPAMINE & SEROTONIN ANTAGONISTS	Schizophrenia
	H7T	ANTIPSYCHOTICS,ATYPICAL,DOPAMINE,& SEROTONIN ANTAG	Schizophrenia and Depression
	H7X	ANTIPSYCHOTICS, ATYP, D2 PARTIAL AGONIST/5HT MIXED S	Schizophrenia and Depression
	H2G	ANTIPSYCHOTICS,PHENOTHIAZINES	Schizophrenia, Schizotypal, Delusional, and Other Non-Mood Psychotic Disorders
	H6J	ANTIEMETIC/ANTIVERTIGO AGENTS	Schizophrenia, Schizotypal, Delusional, and Other Non-Mood Psychotic Disorders
	H7O	ANTIPSYCHOTICS,DOPAMINE ANTAGONISTS,BUTYROPHENONES	Schizophrenia, Schizotypal, Delusional, and Other Non-Mood Psychotic Disorders
	H7P	ANTIPSYCHOTICS,DOPAMINE ANTAGONISTS, THIOXANTHENES	Schizophrenia, Schizotypal, Delusional, and Other Non-Mood Psychotic Disorders
	H7S	ANTIPSYCHOTICS,DOPAMINE ANTAGONST,DIHYDROINDOLONES	Schizophrenia, Schizotypal, Delusional, and Other Non-Mood Psychotic Disorders
	H7T	ANTIPSYCHOTIC,ATYPICAL,DOPAMINE,SEROTONIN ANTAGNST	Schizophrenia, Schizotypal, Delusional, and Other Non-Mood Psychotic Disorders
	H7U	ANTIPSYCHOTICS, DOPAMINE AND SEROTONIN ANTAGONISTS	Schizophrenia, Schizotypal, Delusional, and Other Non-Mood Psychotic Disorders
	H7X	ANTIPSYCHOTICS, ATYP, D2 PARTIAL AGONIST/5HT MIXED	Schizophrenia, Schizotypal, Delusional, and Other Non-Mood Psychotic Disorders
	H8W	ANTIPSYCHOTIC-ATYPICAL,D3/D2 PARTIAL AG-5HT MIXED	Schizophrenia, Schizotypal, Delusional, and Other Non-Mood Psychotic Disorders
	C0D	ANTI-ALCOHOLIC PREPARATIONS	Substance Use Disorder
	H3W	NARCOTIC WITHDRAWAL THERAPY AGENTS	Substance Use Disorder
Cancer	C6M	FOLIC ACID PREPARATIONS	Cancer - All Inclusive
	C7F	APPETITE STIM. FOR ANOREXIA,CACHEXIA,WASTING SYND.	Cancer - All Inclusive
	F1A	ANDROGENIC AGENTS	Cancer - All Inclusive
	H2E	SEDATIVE-HYPNOTICS,NON-BARBITURATE	Cancer - All Inclusive
	H2F	ANTI-ANXIETY DRUGS	Cancer - All Inclusive
	H3A	ANALGESICS, NARCOTICS	Cancer - All Inclusive
	H6J	ANTIEMETIC/ANTIVERTIGO AGENTS	Cancer - All Inclusive
	H7O	ANTIPSYCHOTICS,DOPAMINE ANTAGONISTS,BUTYROPHENONES	Cancer - All Inclusive
	H7T	ANTIPSYCHOTIC,ATYPICAL,DOPAMINE,SEROTONIN ANTAGNST	Cancer - All Inclusive
	J9A	INTESTINAL MOTILITY STIMULANTS	Cancer - All Inclusive
	N1C	LEUKOCYTE (WBC) STIMULANTS	Cancer - All Inclusive
	N1E	PLATELET PROLIFERATION STIMULANTS	Cancer - All Inclusive
	P1M	LHRH (GNRH) AGONIST ANALOG PITUITARY SUPPRESSANTS	Cancer - All Inclusive
	P4L	BONE RESORPTION INHIBITORS	Cancer - All Inclusive
	P5A	GLUCOCORTICOIDS	Cancer - All Inclusive
	R2A	FLUORESCENCE CYSTOSCOPY/OPTICAL IMAGING AGENTS	Cancer - All Inclusive
	S2N	ANTI-ARTHRITIC, FOLATE ANTAGONIST AGENTS	Cancer - All Inclusive
	V1A	ANTINEOPLASTIC - ALKYLATING AGENTS	Cancer - All Inclusive
	V1B	ANTINEOPLASTIC - ANTIMETABOLITES	Cancer - All Inclusive
	V1C	ANTINEOPLASTIC - VINCA ALKALOIDS	Cancer - All Inclusive
	V1D	ANTIBIOTIC ANTINEOPLASTICS	Cancer - All Inclusive
	V1E	STEROID ANTINEOPLASTICS	Cancer - All Inclusive

Treatment Category	Drug Class	Description	Chronic Condition(s) Treated
Cancer Con't.	V1F	ANTINEOPLASTICS,MISCELLANEOUS	Cancer - All Inclusive
	V1G	RADIOACTIVE THERAPEUTIC AGENTS	Cancer - All Inclusive
	V1I	CHEMOTHERAPY RESCUE/ANTIDOTE AGENTS	Cancer - All Inclusive
	V1J	ANTINEOPLASTIC - ANTIANDROGENIC AGENTS	Cancer - All Inclusive
	V1O	ANTINEOPLASTIC LHRH(GNRH) AGONIST,PITUITARY SUPPR.	Cancer - All Inclusive
	V1Q	ANTINEOPLASTIC SYSTEMIC ENZYME INHIBITORS	Cancer - All Inclusive
	V1R	PHOTOACTIVATED, ANTINEOPLASTIC AGENTS (SYSTEMIC)	Cancer - All Inclusive
	V1T	SELECTIVE ESTROGEN RECEPTOR MODULATORS (SERMS)	Cancer - All Inclusive
	V1W	ANTINEOPLASTIC EGF RECEPTOR BLOCKER MCLON ANTIBODY	Cancer - All Inclusive
	V1X	ANTINEOPLAST HUM VEGF INHIBITOR RECOMB MC ANTIBODY	Cancer - All Inclusive
	V2A	NEOPLASM MONOCLONAL DIAGNOSTIC AGENTS	Cancer - All Inclusive
	V3C	ANTINEOPLASTIC - MTOR KINASE INHIBITORS	Cancer - All Inclusive
	V3E	ANTINEOPLASTIC - TOPOISOMERASE I INHIBITORS	Cancer - All Inclusive
	V3F	ANTINEOPLASTIC - AROMATASE INHIBITORS	Cancer - All Inclusive
	V3N	ANTINEOPLASTIC - VEGF-A,B AND PLGF INHIBITORS	Cancer - All Inclusive
	V3P	ANTINEOPLASTIC - VEGFR ANTAGONIST	Cancer - All Inclusive
	V3R	ANTINEOPLASTIC,ANTI-PROGRAMMED DEATH-1 (PD-1) MAB	Cancer - All Inclusive
	V3Y	ANTI-PROGRAMMED CELL DEATH-LIGAND 1 (PD-L1) MAB	Cancer - All Inclusive
	W7B	VIRAL/TUMORIGENIC VACCINES	Cancer - All Inclusive
	Z2G	IMMUNOMODULATORS	Cancer - All Inclusive
	Z8B	PORPHYRINS AND PORPHYRIN DERIVATIVE AGENTS	Cancer - All Inclusive
Chronic Cardiovascular Disease	A1A	DIGITALIS GLYCOSIDES	Atrial Fibrillation
	A2A	ANTIARRHYTHMICS	Atrial Fibrillation
	A9A	CALCIUM CHANNEL BLOCKING AGENTS	Atrial Fibrillation
	J7A	ALPHA/BETA-ADRENERGIC BLOCKING AGENTS	Atrial Fibrillation
	J7C	BETA-ADRENERGIC BLOCKING AGENTS	Atrial Fibrillation
	M9L	ANTICOAGULANTS,COUMARIN TYPE	Atrial Fibrillation
	M9T	THROMBIN INHIBITORS, SELECTIVE, DIRECT, REVERSIBLE	Atrial Fibrillation
	M9V	DIRECT FACTOR XA INHIBITORS	Atrial Fibrillation
	M9V	DIRECT FACTOR XA INHIBITORS	DVT
	M9E	THROMBIN INHIBITORS,SEL.,DIRECT,&REV.-HIRUDIN TYPE	DVT and Ischemic Heart Disease
	M9K	HEPARIN AND RELATED PREPARATIONS	DVT and Ischemic Heart Disease
	M9L	ANTICOAGULANTS,COUMARIN TYPE	DVT and Ischemic Heart Disease
	M9T	THROMBIN INHIBITORS,SELECTIVE,DIRECT, & REVERSIBLE	DVT and Ischemic Heart Disease
	M9F	THROMBOLYTIC ENZYMES	DVT and Stroke/Transient Ischemic Attack
	A7B	VASODILATORS,CORONARY Ischemic	Heart Disease and Heart Failure
	A1A	DIGITALIS GLYCOSIDES	Heart Failure
	A1C	INOTROPIC DRUGS	Heart Failure
	A7J	VASODILATORS, COMBINATION	Heart Failure
	J7C	BETA-ADRENERGIC BLOCKING AGENTS	Heart Failure and Ischemic Heart Disease
	C6N	NIACIN PREPARATIONS	Hyperlipidemia
	D7L	BILE SALT SEQUESTRANTS	Hyperlipidemia
	M4D	ANTIHYPERLIPIDEMIC - HMG COA REDUCTASE INHIBITORS	Hyperlipidemia and Ischemic Heart Disease
	M4E	LIPOTROPICS	Hyperlipidemia and Ischemic Heart Disease

Treatment Category	Drug Class	Description	Chronic Condition(s) Treated
Chronic Cardiovascular Disease Con't.	M4L	ANTIHYPERLIPIDEMIC-HMG COA REDUCTASE INHIB.&NIACIN	Hyperlipidemia and Ischemic Heart Disease
	M4M	ANTIHYPERLIP.HMG COA REDUCT INHIB&CHOLEST.AB.INHIB	Hyperlipidemia and Ischemic Heart Disease
	M4I	ANTIHYPERLIP - HMG-COA&CALCIUM CHANNEL BLOCKER CB	Hyperlipidemia, Hypertension, Ischemic Heart Disease
	A4A	ANTIHYPERTENSIVES, VASODILATORS	Hypertension
	A4B	ANTIHYPERTENSIVES, SYMPATHOLYTIC	Hypertension
	A4C	ANTIHYPERTENSIVES, GANGLIONIC BLOCKERS	Hypertension
	A4K	ACE INHIBITOR/CALCIUM CHANNEL BLOCKER COMBINATION	Hypertension
	A4T	RENIN INHIBITOR, DIRECT	Hypertension
	A4U	RENIN INHIBITOR,DIRECT AND THIAZIDE DIURETIC COMB	Hypertension
	A4V	ANGIOTEN.RECEPTR ANTAG./CAL.CHANL BLKR/THIAZIDE CB	Hypertension
	A4W	RENIN INHIBITOR,DIRECT & ANGIOTENSIN RECEPT ANTAG.	Hypertension
	A4X	RENIN INHIBITOR, DIRECT & CALCIUM CHANNEL BLOCKER	Hypertension
	A4Y	ANTIHYPERTENSIVES, MISCELLANEOUS	Hypertension
	A4Z	RENIN INHIB, DIRECT& CALC.CHANNEL BLKR & THIAZIDE	Hypertension
	J7B	ALPHA-ADRENERGIC BLOCKING AGENTS	Hypertension
	J7B	ALPHA-ADRENERGIC BLOCKING AGENTS	Hypertension
	J7E	ALPHA-ADRENERGIC BLOCKING AGENT/THIAZIDE COMB	Hypertension
	J7H	BETA-ADRENERGIC BLOCKING AGENTS/THIAZIDE & RELATED	Hypertension
	A7H	VASOACTIVE NATRIURETIC PEPTIDES	Hypertension and Heart Failure
	J7A	ALPHA/BETA-ADRENERGIC BLOCKING AGENTS	Hypertension and Heart Failure
	R1E	CARBONIC ANHYDRASE INHIBITORS	Hypertension and Heart Failure
	R1F	THIAZIDE AND RELATED DIURETICS	Hypertension and Heart Failure
	R1H	POTASSIUM SPARING DIURETICS	Hypertension and Heart Failure
	R1L	POTASSIUM SPARING DIURETICS IN COMBINATION	Hypertension and Heart Failure
	R1M	LOOP DIURETICS	Hypertension and Heart Failure
	A4F	ANTIHYPERTENSIVES, ANGIOTENSIN RECEPTOR ANTAGONIST	Hypertension, Ischemic Heart Disease and Heart Failure
	A4H	ANGIOTENSIN RECEPTOR ANTGNST & CALC.CHANNEL BLOCKR	Hypertension, Ischemic Heart Disease and Heart Failure
	A4I	ANGIOTENSIN RECEPTOR ANTAG./THIAZIDE DIURETIC COMB	Hypertension, Ischemic Heart Disease and Heart Failure
	A4J	ACE INHIBITOR/THIAZIDE & THIAZIDE-LIKE DIURETIC	Hypertension, Ischemic Heart Disease and Heart Failure
	A9A	CALCIUM CHANNEL BLOCKING AGENTS	Hypertension, Ischemic Heart Disease and Heart Failure
	A2C	ANTIANGINAL & ANTI-ISCHEMIC AGENTS,NON-HEMODYNAMIC	Ischemic Heart Disease
	C4A	ANTIHYPERGLY.DPP-4 INHIBITORS &HMG COA RI(STATINS)	Ischemic Heart Disease
	M4E	LIPOTROPICS	Ischemic Heart Disease
	M9D	ANTIFIBRINOLYTIC AGENTS	Ischemic Heart Disease
	A4D	ANTIHYPERTENSIVES, ACE INHIBITORS Hypertension,	Ischemic Heart Disease and Heart Failure
	A7C	VASODILATORS,PERIPHERAL	Ischemic Heart Disease and Stroke/Transient Ischemic Attack
	M9P	PLATELET AGGREGATION INHIBITORS	Ischemic Heart Disease and Stroke/Transient Ischemic Attack
Chronic Kidney Disease	A4A	HYPOTENSIVES, VASODILATORS	Chronic Kidney Disease
	A4B	HYPOTENSIVES, SYMPATHOLYTIC	Chronic Kidney Disease
	A4C	HYPOTENSIVES, GANGLIONIC BLOCKERS	Chronic Kidney Disease
	A4D	HYPOTENSIVES, ACE BLOCKING TYPE	Chronic Kidney Disease
	A4F	HYPOTENSIVES-ANGIO RECEPTOR ANTAG	Chronic Kidney Disease
	A4H	ANGITNS RCPT ANTGST & CA.CHNL BLCKR	Chronic Kidney Disease
	A4I	ANG REC ANT/THZ & THZ-REL DIU COMBS	Chronic Kidney Disease

Treatment Category	Drug Class	Description	Chronic Condition(s) Treated
Chronic Kidney Disease Con't.	A4J	ACE INH/THZ & THZ-LIKE DIURET COMBS	Chronic Kidney Disease
	A4K	ACE INHIBITOR/CCB COMBINATION	Chronic Kidney Disease
	A4N	ARB-BB COMBINATION	Chronic Kidney Disease
	A4T	RENIN INHIBITOR, DIRECT	Chronic Kidney Disease
	A4U	RENIN INHB, DIRCT/THIAZD DIURET CMB	Chronic Kidney Disease
	A4V	ANGTN.RCPT ANT/CA.CHANL BLK/THZD CB	Chronic Kidney Disease
	A4W	RENIN INHBT,DRCT & ANGTN RCPT ANTAG	Chronic Kidney Disease
	A4X	RENIN INHBTR, DRCT & CA CHNNL BLCKR	Chronic Kidney Disease
	A4Y	HYPOTENSIVES, MISCELLANEOUS	Chronic Kidney Disease
	A4Z	RENIN INHB,DRCT/CA CHNL BLK/THZD CB	Chronic Kidney Disease
	A7J	VASODILATORS,COMBINATION	Chronic Kidney Disease
	C1A	ELECTROLYTE DEPLETERS	Chronic Kidney Disease
	C1F	CALCIUM REPLACEMENT	Chronic Kidney Disease
	C3B	IRON REPLACEMENT	Chronic Kidney Disease
	C4A	ANTIHYPERGLY DPP4 INHB & HMG COA RI	Chronic Kidney Disease
	C4B	ANTIHYPERGLY-Glucocort Recpt Bl	Chronic Kidney Disease
	C4C	ANTIHYPERGLY,DPP-4 INH&THIAZOL	Chronic Kidney Disease
	C4D	Antihyperglycemic SGLT2	Chronic Kidney Disease
	C4E	SGLT2 INHIB-BIGUANIDE CMB	Chronic Kidney Disease
	C4F	ANTIHYPERGLY,(DPP-4) INHI & BIG CMB	Chronic Kidney Disease
	C4G	INSULINS	Chronic Kidney Disease
	C4H	ANTIHYPERGLY,AMYLIN ANALOG TYPE	Chronic Kidney Disease
	C4I	ANTIHYPERGLY,INCRETIN MIMETIC	Chronic Kidney Disease
	C4J	ANTIHYPERGLYCEMIC, DPP-4 INHIBITORS	Chronic Kidney Disease
	C4K	ORAL HYPOGLYCEMICS, SULFONYLUREAS	Chronic Kidney Disease
	C4L	ORAL HYPOGLYC., NON-SULFONYLUREAS	Chronic Kidney Disease
	C4M	HYPOGLYCEMICS, ALPHA-GLUCOSIDASE	Chronic Kidney Disease
	C4N	HYPOGLYCEMICS, INSULIN-RESPONSE	Chronic Kidney Disease
	C4R	HYPOG,INSUL-RESPON & INSUL RELEA CB	Chronic Kidney Disease
	C4S	HYPOGLY,INSUL-REL STIM & BIGUAN CMB	Chronic Kidney Disease
	C4T	HYPOGLY,INSUL-RESP ENHAN & BIGU CMB	Chronic Kidney Disease
	C4V	ANTHYPERGLYCEMIC-DOPAM RCPTR AGONST	Chronic Kidney Disease
	C4W	SGLT-2/DPP-4 CMB	Chronic Kidney Disease
	C4X	INSULIN, LONG ACT-GLP1 REC.AG	Chronic Kidney Disease
	C6D	VITAMIN D PREPARATIONS	Chronic Kidney Disease
	D7L	BILE SALT SEQUESTRANTS	Chronic Kidney Disease
	J7B	ALPHA-ADRENERGIC BLOCKING AGENTS	Chronic Kidney Disease
	M4D	ANTIHYPERLIPD-HMG COA REDUCT INHB	Chronic Kidney Disease
	M4E	LIPOTROPICS	Chronic Kidney Disease
	M4J	ANTHYPRLIPD-HMG COA & PL AG INH CMB	Chronic Kidney Disease
	M4L	ANTIHYPERLIPD-HMG COA & NIACIN COMB	Chronic Kidney Disease
	M4M	ANTHYPRLPD-HMG COA & CHL AB INH CMB	Chronic Kidney Disease
	M9K	HEPARIN AND RELATED PREPARATIONS	Chronic Kidney Disease
	N1B	ERYTHROPOIESIS-STIMULATING AGENTS	Chronic Kidney Disease
	P4D	HYPERPARATHYROID TX AGENTS - VITAMIN D ANALOG-TYPE	Chronic Kidney Disease

Treatment Category	Drug Class	Description	Chronic Condition(s) Treated
Chronic Kidney Disease Con't.	P4M	CALCIMIMETIC,PARATHYROID CALCIUM ENHANCER	Chronic Kidney Disease
	R1M	LOOP DIURETICS	Chronic Kidney Disease
Chronic Pulmonary Disease	Z2F	MAST CELL STABILIZERS	Asthma
	Z4B	LEUKOTRIENE RECEPTOR ANTAGONISTS	Asthma
	A1B	XANTHINES	Asthma and COPD
	A1D	GENERAL BRONCHODILATOR AGENTS	Asthma and COPD
	B6M	GLUCOCORTICOIDS, ORALLY INHALED	Asthma and COPD
	J5A	ADRENERGIC AGENTS,CATECHOLAMINES	Asthma and COPD
	J5D	BETA-ADRENERGIC AGENTS	Asthma and COPD
	J5G	BETA-ADRENERGIC AND GLUCOCORTICOID COMBINATIONS	Asthma and COPD
	J5J	BETA-ADRENERGIC AND ANTICHOLINERGIC COMBINATIONS	COPD
	Z2X	PHOSPHODIESTERASE-4 (PDE4) INHIBITORS	COPD
	B0B	CYSTIC FIB-TRANSMEMB CONDUCT.REG.(CFTR)POTENTIATOR	Cystic Fibrosis
	B0F	CYSTIC FIBROSIS-CFTR POTENTIATOR-CORRECTOR COMBIN.	Cystic Fibrosis
	B3A	MUCOLYTICS	Cystic Fibrosis
	C6E	VITAMIN E PREPARATIONS	Cystic Fibrosis
	W1A	PENICILLINS	Cystic Fibrosis
	W1F	AMINOGLYCOSIDES	Cystic Fibrosis
	W1N	POLYMYXIN AND DERIVATIVES	Cystic Fibrosis
	W1P	BETALACTAMS	Cystic Fibrosis
	W1Q	QUINOLONES	Cystic Fibrosis
	W1S	CARBAPENEMS (THIENAMYCINS)	Cystic Fibrosis
	W1Y	CEPHALOSPORINS - 3RD GENERATION	Cystic Fibrosis
	W1Z	CEPHALOSPORINS - 4TH GENERATION	Cystic Fibrosis
Diabetes	C4B	ANTIHYPERGLYCEMIC-GLUCOCORTICOID RECEPTOR BLOCKER	Diabetes Mellitus
	C4C	ANTIHYPERGLY,DPP-4 ENZYME INHIB &THIAZOLIDINEDIONE	Diabetes Mellitus
	C4D	ANTIHYPERGLYCEMC-SOD/GLUC COTRANSPORT2(SGLT2)INHIB	Diabetes Mellitus
	C4F	ANTIHYPERGLYCEMIC,DPP-4 INHIBITOR & BIGUANIDE COMB	Diabetes Mellitus
	C4G	INSULINS	Diabetes Mellitus
	C4H	ANTIHYPERGLYCEMIC, AMYLIN ANALOG-TYPE	Diabetes Mellitus
	C4I	ANTIHYPERGLY,INCRETIN MIMETIC(GLP-1 RECEP.AGONIST)	Diabetes Mellitus
	C4J	ANTIHYPERGLYCEMIC, DPP-4 INHIBITORS	Diabetes Mellitus
	C4K	ANTIHYPERGLYCEMIC, INSULIN-RELEASE STIMULANT TYPE	Diabetes Mellitus
	C4L	ANTIHYPERGLYCEMIC, BIGUANIDE TYPE	Diabetes Mellitus
	C4M	ANTIHYPERGLYCEMIC, ALPHA-GLUCOSIDASE INHIBITORS	Diabetes Mellitus
	C4N	ANTIHYPERGLYCEMIC,THIAZOLIDINEDIONE(PPARG AGONIST)	Diabetes Mellitus
	C4R	ANTIHYPERGLYCEMIC,THIAZOLIDINEDIONE & SULFONYLUREA	Diabetes Mellitus
	C4S	ANTIHYPERGLYCEMIC,INSULIN-REL STIM.& BIGUANIDE CMB	Diabetes Mellitus
	C4T	ANTIHYPERGLYCEMIC,THIAZOLIDINEDIONE & BIGUANIDE	Diabetes Mellitus
	C4V	ANTIHYPERGLYCEMIC - DOPAMINE RECEPTOR AGONISTS	Diabetes Mellitus

Treatment Category	Drug Class	Description	Chronic Condition(s) Treated
Glaucoma	Q2G	OPHTHALMIC ANTIFIBROTIC AGENTS	Glaucoma
	Q6G	MIOTICS/OTHER INTRAOC. PRESSURE REDUCERS	Glaucoma
	Q6J	MYDRIATICS	Glaucoma
	R1B	OSMOTIC DIURETICS	Glaucoma
	R1E	CARBONIC ANHYDRASE INHIBITORS	Glaucoma
Hemophilia	M0E	ANTIHEMOPHILIC FACTORS	Hemophilia
	M0F	FACTOR IX PREPARATIONS	Hemophilia
	M0I	FACTOR IX COMPLEX (PCC) PREPARATIONS	Hemophilia
	M0K	FACTOR X PREPARATIONS	Hemophilia
	M9D	ANTIFIBRINOLYTIC AGENTS	Hemophilia
HIV	W5C	ANTIVIRALS, HIV-SPECIFIC, PROTEASE INHIBITORS	HIV
	W5I	ANTIVIRALS, HIV-SPECIFIC, NUCLEOTIDE ANALOG, RTI	HIV
	W5J	ANTIVIRALS, HIV-SPECIFIC, NUCLEOSIDE ANALOG, RTI	HIV
	W5K	ANTIVIRALS, HIV-SPECIFIC, NON-NUCLEOSIDE, RTI	HIV
	W5L	ANTIVIRALS, HIV-SPEC., NUCLEOSIDE ANALOG, RTI COMB	HIV
	W5M	ANTIVIRALS, HIV-SPECIFIC, PROTEASE INHIBITOR COMB	HIV
	W5N	ANTIVIRALS, HIV-SPECIFIC, FUSION INHIBITORS	HIV
	W5O	ANTIVIRALS, HIV-SPEC, NUCLEOSIDE-NUCLEOTIDE ANALOG	HIV
	W5P	ANTIVIRALS, HIV-SPEC, NON-PEPTIDIC PROTEASE INHIB	HIV
	W5Q	ARTV CMB NUCLEOSIDE,NUCLEOTIDE,&NON-NUCLEOSIDE RTI	HIV
	W5T	ANTIVIRALS, HIV-SPECIFIC, CCR5 CO-RECEPTOR ANTAG.	HIV
	W5U	ANTIVIRALS,HIV-1 INTEGRASE STRAND TRANSFER INHIBTR	HIV
	W5X	ARV CMB-NRTI,N(T)RTI, INTEGRASE INHIBITOR	HIV
Lead Exposure	C8A	METALLIC POISON,AGENTS TO TREAT	Lead Exposure
	C8C	LEAD POISONING, AGENTS TO TREAT (CHELATING-TYPE)	Lead Exposure
Liver Disease	D7A	BILE SALTS	Liver Disease, Cirrhosis and Other Liver Conditions (except Viral Hepatitis)
	D7E	FARNESOID X RECEPTOR (FXR) AGONIST, BILE AC ANALOG	Liver Disease, Cirrhosis and Other Liver Conditions (except Viral Hepatitis)
	D7U	BILIARY DIAGNOSTICS,RADIOPAQUE	Liver Disease, Cirrhosis and Other Liver Conditions (except Viral Hepatitis)
	D9A	AMMONIA INHIBITORS	Liver Disease, Cirrhosis and Other Liver Conditions (except Viral Hepatitis)
	M0B	PLASMA PROTEINS	Liver Disease, Cirrhosis and Other Liver Conditions (except Viral Hepatitis)
	M0G	ANTIPORPHYRIA FACTORS	Liver Disease, Cirrhosis and Other Liver Conditions (except Viral Hepatitis)
	M9U	THROMBOLYTIC - NUCLEOTIDE TYPE	Liver Disease, Cirrhosis and Other Liver Conditions (except Viral Hepatitis)
	P5A	GLUCOCORTICOIDS	Liver Disease, Cirrhosis and Other Liver Conditions (except Viral Hepatitis)
	R1H	POTASSIUM SPARING DIURETICS	Liver Disease, Cirrhosis and Other Liver Conditions (except Viral Hepatitis)
	R1L	POTASSIUM SPARING DIURETICS IN COMBINATION	Liver Disease, Cirrhosis and Other Liver Conditions (except Viral Hepatitis)

Treatment Category	Drug Class	Description	Chronic Condition(s) Treated
Liver Disease Con't.	R1M	LOOP DIURETICS	Liver Disease, Cirrhosis and Other Liver Conditions (except Viral Hepatitis)
	V1B	ANTINEOPLASTIC - ANTIMETABOLITES	Liver Disease, Cirrhosis and Other Liver Conditions (except Viral Hepatitis)
	V1D	ANTIBIOTIC ANTINEOPLASTICS	Liver Disease, Cirrhosis and Other Liver Conditions (except Viral Hepatitis)
	V1Q	ANTINEOPLASTIC SYSTEMIC ENZYME INHIBITORS	Liver Disease, Cirrhosis and Other Liver Conditions (except Viral Hepatitis)
	W1F	AMINOGLYCOSIDES	Liver Disease, Cirrhosis and Other Liver Conditions (except Viral Hepatitis)
	W4C	AMEBICIDES	Liver Disease, Cirrhosis and Other Liver Conditions (except Viral Hepatitis)
	W9C	RIFAMYCINS AND RELATED DERIVATIVE ANTIBIOTICS	Liver Disease, Cirrhosis and Other Liver Conditions (except Viral Hepatitis)
	N1F	THROMBOPOIETIN RECEPTOR AGONISTS	Viral Hepatitis
	P5A	GLUCOCORTICOIDS	Viral Hepatitis
	W0A	HEPATITIS C VIRUS - NS5A REPLICATION COMPLEX INHIB	Viral Hepatitis
	W0B	HEP C VIRUS-NS5B POLYMERASE AND NS5A INHIB. COMBO.	Viral Hepatitis
	W0D	HEPATITIS C VIRUS - NS5A, NS3/4A, NS5B INHIB CMB.	Viral Hepatitis
	W0E	HEPATITIS C VIRUS- NS5A AND NS3/4A INHIBITOR COMB	Viral Hepatitis
	W5A	ANTIVIRALS, GENERAL	Viral Hepatitis
	W5F	HEPATITIS B TREATMENT AGENTS	Viral Hepatitis
	W5G	HEPATITIS C TREATMENT AGENTS	Viral Hepatitis
	W5I	ANTIVIRALS, HIV-SPECIFIC, NUCLEOTIDE ANALOG, RTI	Viral Hepatitis
	W5V	HEPATITIS C VIRUS NS3/4A SERINE PROTEASE INHIB.	Viral Hepatitis
	W5Y	HEP C VIRUS,NUCLEOTIDE ANALOG NS5B POLYMERASE INH	Viral Hepatitis
	W7B	VIRAL/TUMORIGENIC VACCINES	Viral Hepatitis
	W7K	ANTISERA	Viral Hepatitis
	Z2E	IMMUNOSUPPRESSIVES	Viral Hepatitis
	Z2G	IMMUNOMODULATORS	Viral Hepatitis
Medical Supplies	X2A	NEEDLES/NEEDLELESS DEVICES	Medical Supplies
	X2B	SYRINGES AND ACCESSORIES	Medical Supplies
	X5B	BANDAGES AND RELATED SUPPLIES	Medical Supplies
	Y7A	RESPIRATORY AIDS,DEVICES,EQUIPMENT	Medical Supplies
	Y9A	DIABETIC SUPPLIES	Medical Supplies
Obesity	D5A	FAT ABSORPTION DECREASING AGENTS	Obesity
	J5B	ADRENERGICS, AROMATIC, NON-CATECHOLAMINE	Obesity
	J8A	ANTI-OBESITY - ANOREXIC AGENTS	Obesity
	J8C	ANTI-OBESITY SEROTONIN 2C RECEPTOR AGONISTS	Obesity
Osteoporosis	C1F	CALCIUM REPLACEMENT	Osteoporosis
	C6D	VITAMIN D PREPARATIONS	Osteoporosis
	F1A	ANDROGENIC AGENTS	Osteoporosis
	G1A	ESTROGENIC AGENTS	Osteoporosis
	G1D	ESTROGEN-PROGESTIN WITH ANTIMINERALOCORTICOID COMB	Osteoporosis
	G1G	ESTROGEN-SELECTIVE ESTROGEN RECEPTOR MOD(SERM)COMB	Osteoporosis

Treatment Category	Drug Class	Description	Chronic Condition(s) Treated
	P4B	BONE FORMATION STIM. AGENTS - PARATHYROID HORMONE	Osteoporosis
	P4L	BONE RESORPTION INHIBITORS	Osteoporosis
	P4N	BONE RESORPTION INHIBITOR AND VITAMIN D COMBS.	Osteoporosis
	P4O	BONE RESORPTION INHIBITOR AND CALCIUM COMBINATIONS	Osteoporosis
Smoking Cessation	J3A	SMOKING DETERRENT AGENTS (GANGLIONIC STIM,OTHERS)	Tobacco Use Disorder
	J3C	SMOKING DETERRENT-NICOTINIC RECEPT.PARTIAL AGONIST	Tobacco Use Disorder
Stroke	C4A	ANTIHYPERGLY. DPP-4 INHIBITORS-HMG COA RI(STATINS)	Stroke/Transient Ischemic Attack
	H3D	ANALGESIC/ANTIPYRETICS, SALICYLATES	Stroke/Transient Ischemic Attack
	M4D	ANTIHYPERLIPIDEMIC - HMG COA REDUCTASE INHIBITORS	Stroke/Transient Ischemic Attack
	M4L	ANTIHYPERLIPIDEMIC-HMG COA REDUCTASE INHIB.-NIACIN	Stroke/Transient Ischemic Attack
	M9K	HEPARIN AND RELATED PREPARATIONS	Stroke/Transient Ischemic Attack
	M9P	PLATELET AGGREGATION INHIBITORS	Stroke/Transient Ischemic Attack

Health Risk Assessment

INSTRUCTIONS

The Healthy Michigan Plan is very interested in helping you get healthy and stay healthy. We want to ask you a few questions about your current health. Your doctor and your health plan will use this information to better meet your health needs. The information you provide in this form is personal health information protected by federal and state law and will be kept confidential. It CANNOT be used to deny health care coverage.

We also encourage you to see your doctor for a check-up as soon as possible after you enroll with a health plan, and at least once a year after that. An annual check-up appointment is a covered benefit of the Healthy Michigan Plan. Contact your health plan if you need transportation assistance to get to and from this appointment.

If you need assistance with completing this form, contact your health plan. You can also call the Beneficiary Help Line at 1-800-642-3195 or TTY 1-866-501-5656 if you have questions.

You can also learn more at this website: www.healthymichiganplan.org.

Instructions for completing this Health Risk Assessment for Healthy Michigan Plan:

- Answer the questions in sections 1-3 as best you can. You are not required to answer all of the questions.
- Call your doctor's office to schedule an annual check-up appointment. Take this form with you to your appointment.
- Your doctor or other primary care provider will complete section 4. He or she will send your results to your health plan.
- There is a Healthy Behavior Reward for agreeing to address or maintain healthy behaviors on your health risk assessment. This reward can be a gift card or a reduction in monthly MI Health Account payments, depending on your income.
- Don't forget to complete a new health risk assessment each year.

After your appointment, keep a copy or printout of this form that has your doctor's signature on it. This is your record that you completed your annual Health Risk Assessment.

For questions and/or problems, or help to translate, call the Beneficiary Help Line at 1-800-642-3195 or TTY 1-866-501-5656.

Spanish: Si necesita ayuda para traducir o entender este texto, por favor llame al telefono, 1-800-642-3195 or TTY 1-866-501-5656

Arabic: TTY 1-866-501-5656

إذا كان لديكم أيّ سؤال، يرجى الإتصال بخط المساعدة على الرقم المجاني ٢١٩٥-٦٤٢-٨٠٠-١

HEALTHY MICHIGAN PLAN

Health Risk Assessment

First Name, Middle Name, Last Name, and Suffix				Date of Birth (mm/dd/yyyy)
Mailing Address		Apartment or Lot Number		**mihealth** Card Number
City	State	Zip Code	Phone Number	Other Phone Number

SECTION 1 - Initial assessment questions (check one for each question)

1. **In general, how would you rate your health?** ☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

2. **Has a doctor told you that you have hearing loss or are deaf?** ☐ Yes ☐ No

3. **(For women only) Are you currently pregnant?** ☐ Yes ☐ No ☐ Not applicable (men only)

4. **In the last 7 days, how often did you exercise for at least 20 minutes in a day?**
   ☐ Every day ☐ 3-6 days ☐ 1-2 days ☐ 0 days

   Exercise includes walking, housekeeping, jogging, weights, a sport or playing with your kids. It can be done on the job, around the house, just for fun or as a work-out.

5. **In the last 7 days, how often did you eat 3 or more servings of fruits or vegetables in a day?**
   ☐ Every day ☐ 3-6 days ☐ 1-2 days ☐ 0 days

   Each time you ate a fruit or vegetable counts as one serving. It can be fresh, frozen, canned, cooked or mixed with other foods.

6. **In the last 7 days, how often did you have (5 or more for men, 4 or more for women) alcoholic drinks at one time?** ☐ Never ☐ Once a week ☐ 2-3 times a week ☐ More than 3 times during the week

   1 drink is 1 beer, 1 glass of wine, or 1 shot.

7. **In the last 30 days have you smoked or used tobacco?** ☐ Yes ☐ No

   If YES, Do you want to quit smoking or using tobacco?
   ☐ Yes ☐ I am working on quitting or cutting back right now ☐ No

8. **How often is stress a problem for you in handling everyday things such as your health, money, work, or relationships with family and friends?**
   ☐ Almost every day ☐ Sometimes ☐ Rarely ☐ Never

First Name, Middle Name, Last Name, and Suffix	mihealth Card Number

9. Do you use drugs or medications (other than exactly as prescribed for you) which affect your mood or help you to relax? ☐ Almost every day ☐ Sometimes ☐ Rarely ☐ Never

This includes illegal or street drugs and medications from a doctor or drug store if you are taking them differently than exactly how your doctor told you to take them.

10. Have you had a flu shot in the last year? ☐ Yes ☐ No

11. How long has it been since you last visited a dentist or dental clinic for any reason?

☐ Never ☐ Within the last year ☐ Between 1-2 years ☐ Between 3-5 years ☐ More than 5 years

12. Do you have access to transportation for medical appointments?

☐ Yes ☐ No ☐ Sometimes, but it is not reliable

Transportation could be your own car, a friend who drives you, a bus pass, or taxi. Your health plan can help you with a ride to and from medical appointments.

13. Do you need help with food, clothing, utilities, or housing? ☐ Yes ☐ No

This could be trouble paying your heating bill, no working refrigerator, or no permanent place to live.

14. A checkup is a visit to a doctor's office that is NOT for a specific problem. How long has it been since your last checkup? ☐ Within the last year ☐ Between 1-3 years ☐ More than 3 years

SECTION 2 - Annual appointment

A routine checkup is an important part of taking care of your health. An annual check-up appointment is a covered benefit of the Healthy Michigan Plan and your health plan can help you with a ride to and from this appointment.

Date of appointment: _____
(mm/dd/yyyy)

At my appointment, I would most like to talk with my doctor about:

_____

An annual appointment gives you a chance to talk to your doctor and ask any questions you may have about your health including questions about medications or tests you might need.

Take this form to your check-up and complete the rest of the form with your doctor at this appointment.

First Name, Middle Name, Last Name, and Suffix	mihealth Card Number

Section 3 - Readiness to change

Your Healthy Behavior

Small everyday changes can have a big impact on your health. Think about the changes you would be most interested in making over the next year**.** It is also important to get any health screenings recommended by your doctor.

Now that you have thought about your healthy behavior, answer questions 1 - 3. For each question, use the scale provided and pick a number from 0 through 5.

1.	**Thinking about your healthy behavior, do you want to make some small lifestyle changes in this area to improve your health?**	☐ **0** I don't want to make changes now	☐ **1**	☐ **2** I want to learn more about changes I can make	☐ **3**	☐ **4** Yes, I know the changes I want to start making	☐ **5**
2.	**How much support do you think you would get from family or friends if they knew you were trying to make some changes?**	☐ **0** I don't think family or friends would help me	☐ **1**	☐ **2** I think I have some support	☐ **3**	☐ **4** Yes, I think family or friends would help me	☐ **5**
3.	**How much support would you like from your doctor or your health plan to make these changes?**	☐ **0** I do not want to be contacted	☐ **1**	☐ **2** I want to learn more about programs that can help me	☐ **3**	☐ **4** Yes, I am interested in signing up for programs that can help me	☐ **5**

Section 4 – To be completed by your primary care provider

Primary care providers should fill out this form for Healthy Michigan Plan beneficiaries enrolled in Managed Care Plans only. Fill in the "Healthy Behaviors Goals Progress" question and select a "Healthy Behavior Goals" statement in discussion with your patient. Sign the Primary Care Provider Attestation, including the date of the appointment. Both parts of Section 4 must be filled in for the attestation to be considered complete.

Healthy Behaviors Goals Progress

Did the patient maintain or achieve/make significant progress towards their selected health behavior goal(s) over the last year?

- ☐ Not applicable – this is the first known Healthy Michigan Plan Health Risk Assessment for this patient.
- ☐ Yes
- ☐ No
- ☐ Patient had a serious medical, behavioral, or social condition or conditions which precluded addressing unhealthy behaviors.

First Name, Middle Name, Last Name, and Suffix	mihealth Card Number

Healthy Behavior Goals

Choose one of the following for the next year:

☐ 1. Patient does not have health risk behaviors that need to be addressed at this time.

☐ 2. Patient has identified at least one behavior to address over the next year to improve their health (choose one or more below):

- ☐ *Increase physical activity, learn more about nutrition and improve diet, and/or weight loss*
- ☐ *Reduce/quit tobacco use*
- ☐ *Annual influenza vaccine*
- ☐ *Follow-up appointment for screening or management (if necessary) of hypertension, cholesterol and/or diabetes*
- ☐ *Follow-up appointment for recommended cancer or other preventative screening(s)*
- ☐ *Other: explain* _____
- ☐ *Reduce/quit alcohol consumption*
- ☐ *Treatment for substance use disorder*
- ☐ *Dental visit*
- ☐ *Follow-up appointment for maternity care/reproductive health*
- ☐ *Follow-up appointment for mental health/behavioral health*

☐ 3. Patient has a serious medical, behavioral or social condition(s) which precludes addressing unhealthy behaviors at this time.

☐ 4. Unhealthy behaviors have been identified, patient's readiness to change has been assessed, and patient is not ready to make changes at this time.

☐ 5. Patient has committed to maintain their previously achieved Healthy Behavior Goal(s).

Primary Care Provider Attestation

I certify that I have examined the patient named above and the information is complete and accurate to the best of my knowledge. I have provided a copy of this Health Risk Assessment to the member listed above.

Provider Last Name	Provider First Name	National Provider Identifier (NPI)
Provider Telephone Number		Date of Appointment
Signature		Date

Submission Instructions:

<submission instructions here>

AUTHORITY: MCL 400.105(d)(1)(e)

COMPLETION: Is voluntary, but required for participation in certain Healthy Michigan Plan programs.

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

ACIP VACCINES	
PROCEDURE CODE	**DIAGNOSIS CODE**
90620	NA
90621	NA
90630	NA
90632	NA
90636	NA
90649	NA
90650	NA
90651	NA
90654	NA
90656	NA
90658	NA
90661	NA
90670	NA
90673	NA
90674	NA
90686	NA
90688	NA
90707	NA
90714	NA
90715	NA
90716	NA
90732	NA
90733	NA
90734	NA
90736	NA
90740	NA
90744	NA
90746	NA
90747	NA
G0008	NA
G0009	NA
G0010	NA
Q2034	NA
Q2035	NA
Q2036	NA
Q2037	NA
Q2038	NA
Q2039	NA

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

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

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

CANCER SCREENING: COLORECTAL	
PROCEDURE CODE	**DIAGNOSIS CODE**
45330	Z1211, Z1212, Z1213, Z800, Z8371, Z86010
45331	Z1211, Z1212, Z1213, Z800, Z8371, Z86010
45333	Z1211, Z1212, Z1213, Z800, Z8371, Z86010
45338	Z1211, Z1212, Z1213, Z800, Z8371, Z86010
45346	Z1211, Z1212, Z1213, Z800, Z8371, Z86010
45378	Z1211, Z1212, Z1213, Z800, Z8371, Z86010
45380	Z1211, Z1212, Z1213, Z800, Z8371, Z86010
45384	Z1211, Z1212, Z1213, Z800, Z8371, Z86010
45385	Z1211, Z1212, Z1213, Z800, Z8371, Z86010
45388	Z1211, Z1212, Z1213, Z800, Z8371, Z86010
81528	NA
82270	NA
82274	Z1211, Z1212, Z1213, Z800, Z8371, Z86010
G0104	NA
G0105	NA
G0121	NA
G0328	NA

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

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

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

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

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

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

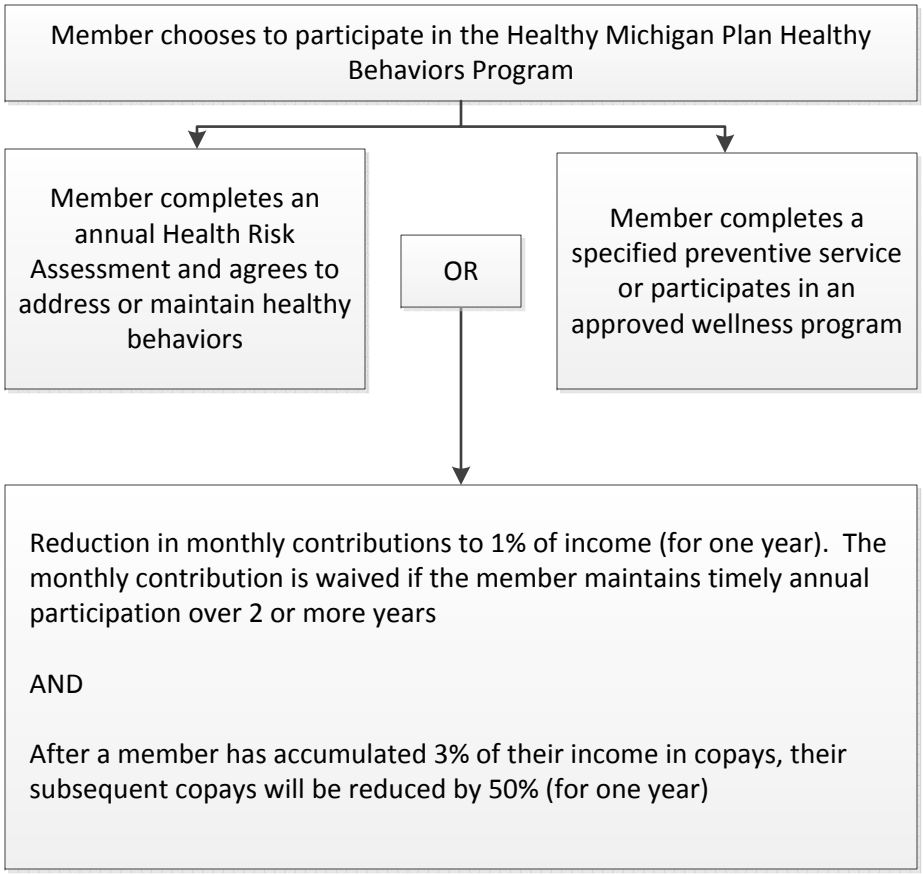
STI SCREENING: GONORRHEA	
PROCEDURE CODE	**DIAGNOSIS CODE**
87590	NA
87591	NA
87592	NA
87850	NA

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

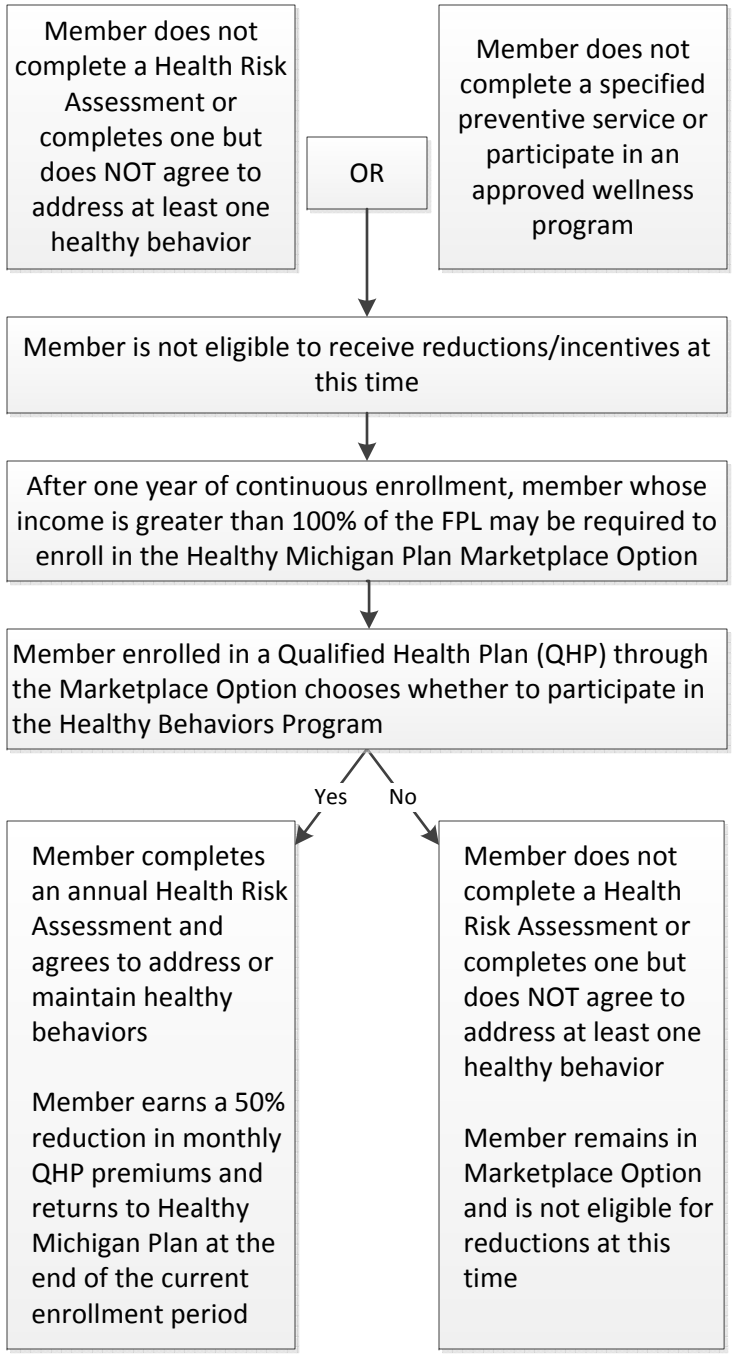
STI SCREENING: SYPHILIS (NONPREGNANT)	
PROCEDURE CODE	**DIAGNOSIS CODE**
86592	NA
86593	NA

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

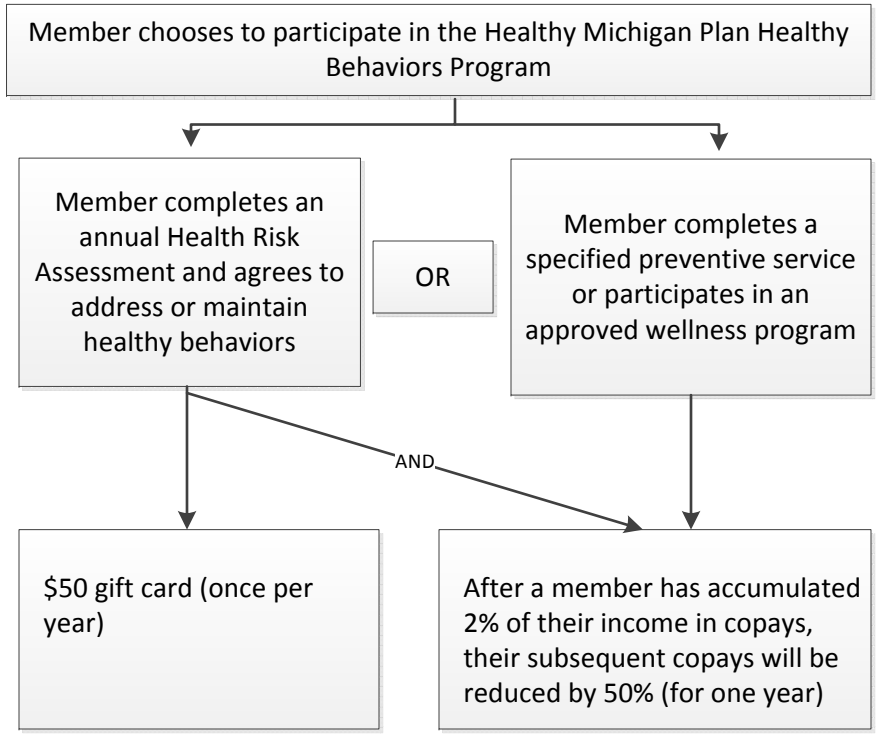
Healthy Michigan Plan Healthy Behaviors Incentives Eligibility and Distribution
Income > 100% FPL

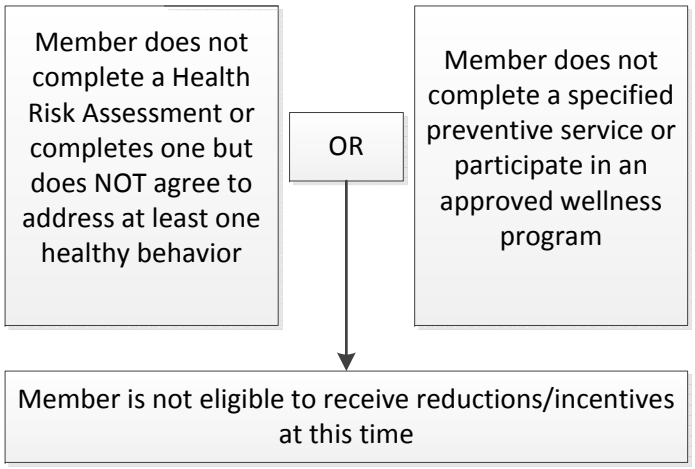


Note: Members may complete a Healthy Behavior at any time during the year to become eligible for the incentives program. Reductions in monthly contributions or copays are not effective until payments begin to be made, after 6 months of enrollment. Members who complete an HRA and acknowledge that changes 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.



Healthy Michigan Plan Healthy Behaviors Incentives Eligibility and Distribution
Income ≤ 100% FPL





Note: Members may complete a Healthy Behavior at any time during the year to become eligible for the incentives program.

Note: Reductions in monthly contributions or copays are not effective until payments begin to be made, after 6 months of enrollment.

Note: Members who complete an HRA 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.