DRAFT Proposal

Section 1115 Demonstration Extension Application

Healthy Michigan Plan
Project No. 11-W-00245/5

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Table of Contents

Section I – Executive Summary

The Michigan Department of Health and Human Services respectfully requests approval to extend its highly successful Healthy Michigan Plan demonstration waiver. Michigan has a proven record of efficiently managing health care costs and improving the State's Medicaid program. As part of these efforts, the Michigan Department of Health and Human Services (MDHHS) implemented the Michigan Medicaid expansion program, known as the Healthy Michigan Plan (HMP) administered under the §1115 Demonstration Waiver authority (Project No. 11-W-00245/5) on April 1, 2014. Through HMP, MDHHS has extended health care coverage to over 650,000 low-income Michigan residents who were previously either uninsured or underinsured. HMP is built upon systemic innovations that improve quality and stabilize health care costs. Other key program elements include: (a) the advancement of health information technology, (b) structural incentives for healthy behaviors and personal responsibility, (c) encouraging use of high value services, and (d) promoting the overall health and well-being of Michigan residents.

HMP is predicated on the establishment of the Healthy Behaviors Incentives Program and the MI Health Account (MIHA) which support beneficiary participation in healthy behaviors and awareness of personal health care utilization costs. The Healthy Behaviors Incentives Program encourages beneficiaries to achieve and maintain healthy behaviors in collaboration with their primary care providers, primarily through completion of a standardized Health Risk Assessment (HRA) and attesting to a healthy behavior. All HMP beneficiaries enrolled in Medicaid Health Plans (MHPs) have the opportunity to earn program incentives which are applied consistently across the participating plans.

HMP also implements innovative approaches to beneficiary cost-sharing and financial responsibility for health care expenses. For the subset of HMP beneficiaries with incomes above 100% of the federal poverty level (FPL), there is a requirement to pay monthly contributions toward the cost of their health care. The MIHA is a vehicle to collect cost sharing and also serves to increase beneficiaries' awareness of health care costs and promote engagement in their health service utilization.

On December 17, 2015, the Centers for Medicare & Medicaid Services (CMS) approved an amendment to the HMP Demonstration Waiver which is referred to as the "Marketplace Option." Beneficiaries who are impacted by this amendment are those:

- With incomes above 100% of the FPL,
- Enrolled in a Medicaid Health Plan (MHP) for twelve (12) consecutive months or more,
- Who did not complete a healthy behavior,
- Who are not medically frail in accordance with 42 CFR 440.315, and
- Who are not exempt from premiums and cost-sharing pursuant to 42 CFR 447.56

These beneficiaries will be transferred to the Marketplace Option beginning April 1, 2018. Marketplace Option enrolled beneficiaries will be receiving their health coverage through the Marketplace issuers.

At this time, MDHHS is not seeking any additional program changes with this demonstration renewal application request. With the approval of an extension of the HMP waiver, which is currently set to expire on December 31, 2018, MDHHS seeks to continue to build on program successes.

Section II – Program History and Overview

A. HMP Program History

In January 2004, the State of Michigan's Adult Benefits Waiver (ABW) was approved by CMS as a §1115 Demonstration Waiver. The ABW program provided a limited ambulatory benefit package to low-income, childless adults between the ages of 19-64, with incomes at or below 35% FPL and who were not otherwise eligible for Medicaid. The programmatic goals for the ABW demonstration were to improve the access and quality of appropriate healthcare services.

The Michigan legislature passed Public Act 107 of 2013, which permitted MDHHS to augment its ABW program by expanding the eligibility criteria for this adult population overall, from 35% to 133% of the FPL, utilizing the Modified Adjusted Gross Income Methodology. Concurrently, program benefits were expanded to include all federally mandated Essential Health Benefits (EHBs) under an Alternative Benefit Plan (ABP) State Plan Amendment. In December 2013, CMS approved the state's request to amend the ABW waiver, which was subsequently renamed HMP. HMP was implemented on April 1, 2014.

In September 2015, MDHHS sought CMS approval of a second HMP waiver amendment to implement additional directives contained in the state law (Public Act 107 of 2013). The request was made to continue the provision of affordable and accessible health care coverage for approximately 600,000 Michigan residents receiving HMP benefits at that time. CMS approved the second waiver amendment on December 17, 2015, which effectuates the Marketplace Option program updates.

The Marketplace Option amendment provides that beneficiaries with incomes greater than 100% of the FPL who have been enrolled in an HMP health plan for 12 consecutive months may be required to receive their health benefits through the Marketplace Option if they have not completed a healthy behavior. As required by state law, individuals who are determined medically frail in accordance with 42 CFR 440.315 are not eligible for the Marketplace Option. Details on MDHHS' three-pronged strategy for the identification of these individuals are detailed in the HMP Marketplace Option Protocol included in the HMP §1115 Demonstration Waiver Special Terms and Conditions. Additionally, individuals exempt from premiums and cost-sharing pursuant to 42 CFR 447.56 are exempt from the Marketplace Option.

The transition of the HMP beneficiaries who qualify for the Marketplace Option will begin on April 1, 2018. Beneficiaries enrolled in the Marketplace Option will receive the health benefits in accordance with the Marketplace Option ABP. Beneficiaries who do not qualify for the Marketplace Option will continue to receive their health benefits through HMP managed care.

B. HMP Goals & Objectives

The overarching goals of the HMP Demonstration are to increase access to quality health care, encourage the utilization of high-value services, promote beneficiary adoption of healthy behaviors, and implement evidence-based practice initiatives. Organized service delivery systems are utilized to improve coherence and overall program efficiency.

MDHHS' initial and continued goals for HMP include:

- Improving access to healthcare for uninsured or underinsured low-income Michigan residents;
- Improving the quality of healthcare services delivered;
- Reducing uncompensated care;
- Encouraging individuals to seek preventive care and encourage the adoption of healthy behaviors;
- Helping uninsured or underinsured individuals manage their health care issues;
- Encouraging quality, continuity, and appropriate medical care; and
- Studying the effects of a demonstration model that infuses market-driven principles into a public healthcare insurance program by examining:
    - The extent to which the increased availability of health insurance reduces the costs of uncompensated care borne by hospitals;
    - The extent to which availability of affordable health insurance results in a reduction in the number of uninsured/underinsured individuals who reside in Michigan;
    - Whether the availability of affordable health insurance, which provides coverage for preventive and health and wellness activities, will increase healthy behaviors and improve health outcomes; and
    - The extent to which beneficiaries feel that HMP has a positive impact on personal health outcomes and financial well-being.

C. HMP Program Overview

1. Eligibility

HMP targets individuals who are eligible in the new adult group under the State Plan.

Table 1: Eligibility				
Medicaid State Plan Group Description	**Federal Poverty Level and/or Other Qualifying Criteria**	**Funding Stream**	**Expenditure Group Reporting Name**	**Demonstration Specific Name**
Adults 19 through 64 described in §1902(a)(10((A)(i)(VIII), except as specifically excluded.	Income up to 133% FPL receiving ABP benefits, not disabled and not pregnant.	Title XIX	Healthy MI Adults	Healthy Michigan Plan (Project No. 11-W-00245/5)

2. Benefits

All beneficiaries covered by HMP are eligible for comprehensive services consistent with the ABP as described in the Medicaid State Plan. These benefits include the federally mandated 10 EHBs and many additional services which align with state plan services, such as dental, hearing aids, and vision services.

The Marketplace Option enrollees will also have access to the 10 EHBs in accordance with the Affordable Care Act and its implementing regulations. Enrollees will receive coverage of these EHBs from the defined Marketplace issuer provider network. All participating issuers must meet the network and service area requirements as required by the Michigan Department of Insurance and Financial Services (DIFS), including all essential community provider requirements specified by CMS.

3. Cost-Sharing

All HMP beneficiaries are required to adhere to the cost-sharing requirements outlined in the MIHA and HMP Marketplace Option Operational Protocols. The HMP has a unique MIHA vehicle where beneficiary cost-sharing requirements are satisfied, monitored and communicated to the beneficiary. Moreover, HMP incorporates the Healthy Behaviors Incentives Program which was created to reward beneficiaries for their conscientious use of health care services. Incentives, which are defined in the waiver protocol, include both reductions in cost-sharing responsibilities and select financial rewards. Participating HMP beneficiaries who are enrolled in a health plan may earn incentives on the basis of their active, appropriate participation in the health care delivery system.

The HMP program has undergone some positive changes based on stakeholder and evaluator input over the course of MDHHS' experience with HMP. Some changes, such as revisions to the MIHA statement, have been implemented to improve beneficiary understanding of cost-sharing responsibilities. Other changes, such as revisions to the program HRA tool and submission process, seek to increase the promotion of beneficiary engagement in the Healthy Behavior Incentive Program. The program has also expanded the scope of services and medications associated with chronic medical condition which are deemed exempt from cost-sharing as a way to reduce any potential financial barriers to important primary care.

4. Delivery Systems

Services for HMP are provided through a managed care delivery system. After April 1, 2018, when HMP has been operational for 48 months, beneficiaries with incomes above 100% of the FPL will receive services through either an HMP Medicaid Health Plan (MHP) or the Marketplace Option.

a. Healthy Michigan Plan

All HMP eligible beneficiaries are initially mandatorily enrolled into a MHP, with the exception of those few beneficiaries who meet the MHP enrollment exemption criteria or those beneficiaries who meet the voluntary enrollment criteria.

MDHHS utilizes two different types of managed care plans to provide the HMP ABP for the HMP demonstration population:

- Comprehensive Health Plans: The State's contracted MHPs provide acute care, physical health services and most pharmacy benefits.

- Behavioral Health Plans: Prepaid Inpatient Health Plans (PIHPs) provide inpatient and outpatient mental health, substance use disorder, and developmental disability services statewide to all enrollees in the demonstration.

Individuals who are enrolled in HMP on or after April 1, 2018, or who come into the higher income level (above 100% of the FPL) on or after April 1, 2018, will have one year of enrollment in HMP in order to allow time for completion of healthy behaviors before alternative contributions and cost sharing are applicable.

b. Marketplace Option

The Marketplace Option will be effective as of April 1, 2018, with monthly rolling enrollment thereafter. HMP beneficiaries who have incomes above 100% of the FPL and have not completed the healthy behavior requirements of the Healthy Behaviors Incentive Program must transition to the Marketplace Option, absent an applicable exception such as medical frailty, as outlined in the Marketplace protocol.

MDHHS will also provide or arrange for wrap-around benefits that are included in the Marketplace ABP but not covered by the Marketplace issuers. These benefits, covered as Fee-For-Service, are non-emergency medical transportation (NEMT); family planning services and supplies including access to out-of-network family planning providers; and access to Federally Qualified Health Center (FQHC) and Rural Health Center (RHC) services.

Section III – Waivers and Expenditure Authorities

A. Waiver Authorities

MDHHS requests the continuation of the following waivers of state plan requirements contained in §1902 of the Social Security Act, subject to the Special Terms & Conditions for the HMP §1115 Demonstration:

- *Premiums, § 1092(a)(14), insofar as it incorporates §§ 1916 and 1916A* - To the extent necessary to enable the state to require monthly premiums for individuals eligible in the adult population described in section 1902(a)(10)(A)(i)(VIII) of the Act, who have incomes between 100 and 133 percent of the federal poverty level (FPL).
- *State-wideness § 1902(a)(1)* - To the extent necessary to enable the state to require enrollment in managed care plans only in certain geographical areas for those eligible in the adult population described in section 1902(a)(10)(A)(i)(VIII) of the Act.
- *Freedom of Choice § 1902(a)(23)(A)* - To the extent necessary to enable the state to restrict freedom of choice of provider for those eligible in the adult population described in section 1902(a)(10)(A)(i)(VIII) of the Act. No waiver of freedom of choice is authorized for family planning providers.
- *Proper and Efficient Administration § 1902(a)(4)* - To enable the State to limit beneficiaries to enrollment in a single prepaid inpatient health plan or prepaid ambulatory health plan in a region or region(s) and restrict disenrollment from them.
- *Comparability § 1902(a)(17)* - To the extent necessary to enable the state to vary the premiums, cost-sharing and healthy behavior reduction options as described in these terms and conditions.
- *Payment of Providers §§ 1902(a)(13) and 1902 (a)(30)* - To the extent necessary to permit the state to limit payment to providers for individuals enrolled in the Marketplace Option to amounts equal to the market-based rates determined by the Qualified Health Plan providing primary coverage for services under the Marketplace Option.
- *Prior Authorization § 1902(a)(54), as it incorporates §1927(d)(5*) - To permit the state to require that requests for prior authorization for drugs in the Marketplace Option be addressed within 72 hours, rather than 24 hours. A 72-hour supply of the requested medication will be provided in the event of an emergency.

B. Expenditure Authorities

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- Expenditures for Healthy Behaviors Program incentives that offset beneficiary cost sharing liability.
- Expenditures for part or all of the cost of private insurance premiums, and for payments to reduce cost sharing, for individuals enrolled in a Marketplace issuer health plan through the Marketplace Option, to the extent that such expenditures do not meet cost effectiveness requirements or include amounts for benefits that are not otherwise covered under the approved state plan (but are incidental to coverage of state plan benefits).

- To the extent necessary to permit the state to offer premium assistance and cost sharing reduction payments that are determined to be cost effective using state developed tests of cost effectiveness that differ from otherwise permissible tests for cost effectiveness.

Section IV – Reporting

MDHHS has routinely documented the progress of HMP since its inception in 2014 and submits quarterly and annual reports to CMS. These reports can be found at www.medicaid.gov.

MDHHS also contracts with Health Services Advisory Group, Inc. (HSAG), an external quality review organization (EQRO), to aggregate and analyze MHP data and prepare annual technical reports on the quality and timeliness of, and access to, care furnished by the state's MHPs. The quality and performance reports can be found at: http://www.michigan.gov/mdhhs/0,5885,7-339-71547_4860---,00.html.

MDHHS completes Performance Monitoring Reports (PMR) for all MHPs that were licensed and approved to provide coverage to Michigan's Medicaid beneficiaries during reporting periods. These reports are based on data submitted by the health plans and include the following items: grievance and appeal reporting, a log of beneficiary contacts; financial reports, encounter data; pharmacy encounter data; provider rosters; primary care provider-to-member ratio reports; and access to care reports.

MDHHS developed HMP Performance Monitoring Specifications beginning with the initiation of the program in 2014. Many of the measures for fiscal year (FY) 2015 were informational as MDHHS refined its data collection and analysis process. Performance standards were set for these measures in FY 2016 and will continue in FY 2017 and beyond. Performance areas include Adult Access to Ambulatory Health Services, Outreach and Engagement to Facilitate Entry to Primary Care, Adults' Generic Drug Utilization, Plan All-Cause Acute 30-Day Readmissions, and Timely Completion of Initial Health Risk Assessment. Please see Attachment A for the full PMR and EQRO reports.

Section V – Program Financing

Historical HMP demonstration expenditures for all eligible groups are included in the budget neutrality monitoring table below as reported in the CMS Medicaid and Children's Health Insurance Program Budget and Expenditure System. Total expenditures include those that both occurred and were paid in the same quarter in addition to adjustments to expenditures paid in quarters after the quarter of service. HMP demonstration expenditures have historically remained under per-member-per-month (PMPM) budget neutrality limits as defined by the demonstration special terms and conditions. The following table includes expenditures and member months by demonstration year (DY) starting April 1, 2014 through June 30, 2017.

Table 2: Healthy Michigan Demonstration Budget Neutrality Monitoring				
	DY 5 - 2014	**DY 6 - 2015**	**DY 7 - 2016**	**DY 8 - 2017**
Approved HMP PMPM	$667.36	$602.21	$569.80	$598.86
Actual HMP PMPM (YTD)	$475.72	$480.41	$492.93	$446.22
Total Expenditures (YTD)	$1,776,995,398.00	$3,492,109,239.00	$3,824,569,481.00	$1,839,545,788.00
Total Member Months (YTD)	3,735,411	7,269,012	7,758,811	4,122,536

Healthy Michigan demonstration expenditure and enrollment projections developed by Milliman, Inc., an MDHHS actuarial contractor, are detailed in the following table:

Table 3: Healthy Michigan Demonstration Budget Neutrality Projections					
	DY 9 -2018	**DY 10 - 2019**	**DY 11 - 2020**	**DY 12 - 2021**	**DY 13 - 2022**
Approved HMP PMPM	$629.40	TBD	TBD	TBD	TBD
Projected HMP PMPM	$550.55	$569.30	$588.87	$609.30	$630.64
Projected Expenditures	$4,438,896,588.00	$4,604,748,464.56	$4,778,374,610.65	$4,960,115,373.92	$5,150,547,789.10
Projected Enrollment	8,062,644	8,088,468	8,114,496	8,140,716	8,167,140

Section VI – Evaluation Report

Demonstration Evaluation Activities

The HMP Demonstration Waiver is being independently evaluated by The Institute for Healthcare Policy & Innovation (IHPI) at the University of Michigan. This evaluation began in mid-2014 and will be completed in 2020. A final report will be available in mid-2020. For more information about evaluation activities, timelines, and deliverables, please see Attachment B for the §1115 Demonstration Waiver Amendment Evaluation Proposal. This interim evaluation summary provides an overview of the evaluation, presents highlights from work completed to date, and describes the timeline for upcoming reports.

A. Overview

The HMP Demonstration's program objectives and hypotheses, as identified in the waiver Special Terms and Conditions, are being assessed consistent with the CMS-approved evaluation plan. The evaluation examines multiple hypotheses associated with the following seven specific domains:

1. The extent to which the increased availability of health insurance reduces the costs of uncompensated care borne by hospitals;
2. The extent to which availability of affordable health insurance results in a reduction in the number of uninsured/underinsured individuals who reside in Michigan;
3. Whether the availability of affordable health insurance, which provides coverage for preventive and health and wellness activities, will increase healthy behaviors and improve health outcomes;

4. The extent to which beneficiaries believe that HMP has a positive impact on personal health outcomes and financial well-being;
5. Whether requiring beneficiaries to make contributions toward the cost of their health care has an impact on the continuity of their coverage, and whether collecting an average co-pay from beneficiaries in lieu of copayments at the point of service, and increasing communication to beneficiaries about their required contributions (through quarterly statements) affects beneficiaries' propensity to use services;
6. Whether providing an MIHA into which beneficiaries' contributions are deposited, that provides quarterly statements that include explanation of benefits (EOB) information and details utilization and contributions, and allows for reductions in future contribution requirements, deters beneficiaries from receiving needed health services or encourages beneficiaries to be more cost-conscious; and
7. Whether the preponderance of the evidence about the costs and effectiveness of the Marketplace Option when considered in its totality demonstrates cost effectiveness taking into account both initial and longer-term costs and other impacts such as improvements in service delivery and health outcomes.

B. Overview of Evaluation Methods

As described below, the evaluation uses a wide variety of data sources, including: hospital cost reports; Medicaid enrollment, utilization, and cost data from the Michigan Department of Health and Human Services Data Warehouse; provider survey data; enrollee survey data (the annual Healthy Michigan Voices survey); and interviews with enrollees and providers.

C. Primary Care Practitioners' Views of the Impact of the Healthy Michigan Plan

Methods

IHPI conducted 19 semi-structured telephone interviews with PCPs caring for HMP patients in five Michigan regions selected to provide racial/ethnic diversity and a mix of urban and rural communities. Interviews informed the development of survey items and guided the interpretation of survey findings. The evaluation team also surveyed all PCPs in Michigan with ≥12 HMP patients about practice changes and their experiences caring for patients with HMP. The final response rate was 56% with 2,104 respondents.

IHPI calculated descriptive statistics without survey weighting because the cohort included all PCPs with ≥12 HMP patients. Bivariate and multivariable logistic regression analyses assessed the association of personal, professional and practice characteristics with practice changes reported since Medicaid expansion. Multivariable models and chi-square goodness-of-fit tests calculated. Quotes from PCP interviews have been used to expand upon key survey findings.

Key Findings

Key findings from the Interim Report on Primary Care Practitioners' Views of the Impact of the Healthy Michigan Plan (Attachment C) are highlighted below.

Providers expressed varying degrees of familiarity with features of HMP.

- 71% were very/somewhat familiar with completing HRA.
- 25% reported being very/somewhat familiar with enrollee cost-sharing.
- 36% reported being very/somewhat familiar with healthy behavior incentives for patients.

Most providers reported accepting new Medicaid/HMP patients.

- 78% reported accepting new Medicaid/HMP patients. PCPs who are female, racial minorities, or non-physician PCPs, internal medicine specialists, have salaried income, report a Medicaid predominant payer mix, or previously provided care to the underserved were more likely to report accepting new Medicaid/HMP patients.
- 73% felt a responsibility to care for patients regardless of their ability to pay.
- 72% agreed all providers should care for Medicaid/HMP patients.
- 52% reported an increase in new patients to a great or to some extent.
- 57% reported an increase in new patients who had not seen a PCP in many years.
- 51% reported established patients who had been uninsured gained insurance.
- Most practices hired new clinicians (53%) and/or staff (58%) in the past year.
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Most providers reported completing Health Risk Assessments.

- 79% completed at least one HRA with a patient; most of those completed >10.
- 65% did not know if they or their practice has received a bonus for completing HRAs.
- 58% reported that financial incentives for patients and 55% reported financial incentives for practices had at least a little influence on completing HRAs.
- Most PCPs found HRAs useful for identifying and discussing health risks, persuading patients to address important health risks, and documenting behavior change goals.

Providers felt responsibility to decrease non-urgent ER use and identified facilitators and barriers to doing so.

- 30% felt that they could influence non-urgent emergency room (ER) use by their patients a great deal.
- 88% accepted major or some responsibility as a PCP to decrease non-urgent ER use.
- Many reported offering services to avoid non-urgent ER use, such as walk-in appointments, 24-hour telephone triage, weekend and evening appointments, and care coordinators or social work assistance for patients with complex issues.

Providers described positive benefits in terms of access though access challenges remain.

- PCPs with previously uninsured HMP patients reported some or great impact on health, health behavior, health care and function for those patients, particularly for control of chronic conditions, early detection of illness, and improved medication adherence.
- PCPs reported that HMP enrollees, compared to those with private insurance, more often had difficulty accessing specialists, medications, mental health care, dental care, and treatment for substance use and counseling for behavior change.

Providers expressed the many ways HMP had an impact on their patients.

- PCPs noted HMP has allowed patients to get much needed care, improved financial stability, provided a sense of dignity, improved mental health, increased accessibility to care and compliance (especially medications), and helped people engage in healthy behaviors such as quitting smoking.

Limitations

Survey responses were self-reported and may be prone to social desirability bias. The sample included only PCPs who cared for at least 12 HMP enrollees. Decision making regarding acceptance of new patients, practice changes, and experiences of the impact of HMP may differ for PCPs with fewer or no Medicaid patients or for specialists. IHPI developed a new set of survey items not used in previous studies to assess PCP attitudes toward various factors related to their Medicaid acceptance decision. These items were developed based on prior literature and the evaluation team's qualitative interviews with PCPs caring for HMP patients, and were cognitively tested with physician and non-physician PCPs serving HMP patients to ensure understanding and accuracy of responses. Performance of these items (e.g. whether they predict actual acceptance of HMP/Medicaid patients) should be validated in future studies. Finally, the qualitative interviews were limited to 19 PCPs in select regions of the state.

Conclusions

PCPs shared experiences from within the health system and thus provided valuable information about how Medicaid expansion is playing out for patients and providers. PCPs reported improved detection and management of chronic conditions such as diabetes and hypertension in patients who gained coverage due to Medicaid expansion, and better adherence to medical and medication regimens as well as improvements in health behaviors, better ability to work or attend school, and improved emotional well-being.

PCPs reported an increase in new patients, including some who had not sought primary care in many years. They reported hiring clinicians and staff; changing workflow for new patients; co-locating mental health services in primary care; and consulting with care coordinators, case managers, and community health workers.

Coverage for dental services, prescription drugs, and mental health services were specifically noted as previously unmet needs being addressed by HMP. Access to these services were described as "a lifesaver." Yet access to some services remains challenging for enrollees and lags behind access for those with private insurance.

PCPs varied substantially in their understanding of HMP features and, therefore, their ability to navigate or help patients obtain services. PCPs reported general familiarity with HRAs, but less familiarity with enrollee cost-sharing and rewards. Most surveyed PCPs felt they could, and should, influence ER utilization trends for their Medicaid patients.

IHPI survey results and interviews indicate that PCPs believe HMP has improved access to care; detection of serious health conditions; medication adherence; and management of chronic conditions and healthy behaviors – especially for previously uninsured patients.

E. 2016 Healthy Michigan Voices Enrollee Survey

Methods

Sampling for the Healthy Michigan Voices (HMV) enrollee survey was conducted 2016. At the time of sample selection, inclusion criteria for enrollees included: at least 12 months total HMP enrollment in fee-for-service or managed care including enrollment in 10 of past 12 months and managed care enrollment in 9 of the past 12 months, age 19-64, complete Michigan contact information and income level in the MDHHS Data Warehouse, and preferred language of English, Arabic, or Spanish. The sampling plan was based on four state regions (Upper Peninsula/North West/North East; West/East Central/East; South Central/South West/South East; Detroit) and three income categories (0-35%, 36-99%, ≥100% of the Federal Poverty Level). In total, 4,099 HMP enrollees participated in the 2016 HMV survey, and the weighted response rate was 53.7%.

Many survey items were drawn from large national surveys. Items specific to HMP (e.g. about HRAs, understanding of HMP) were developed by the evaluation team based on 67 semi-structured interviews with HMP enrollees. New items underwent cognitive testing and pre-testing before being included in the survey instrument. Responses were recorded in a computer-assisted telephone interviewing (CATI) system. Descriptive statistics with weights were calculated to adjust for selection and nonresponse bias. Bivariate and multivariate analyses were performed.

Key Findings

Key findings from the Interim Report of the 2016 Healthy Michigan Voices Enrollee Survey (Attachment C) are highlighted below.

Many enrollees did not have insurance prior to HMP.

- 57.9% did not have insurance at any time in the year before enrolling in HMP. About half of those who did have health insurance reported having Medicaid or other state insurance.

Enrollees reported improvements in their health status with HMP.

- 47.8% said their physical health had improved, 38.2% said their mental health had improved, and 39.5% said their dental health had improved since enrolling in HMP.

Many enrollees have chronic health conditions.

- 69.2% reported they had a chronic health condition, with 60.8% reporting at least one physical health condition and 32.1% reporting at least one mental health condition.
- 30.6% reported they had a chronic health condition that was newly diagnosed since enrolling in HMP.

Enrollees expressed their perspectives on HRAs.

- 45.9% of those who said they completed an HRA did so because a PCP suggested it; 33% did so because they received a mailed form; 12.6% completed it by phone at enrollment.
- Most of those who reported completing the HRA felt it was valuable for improving their health (83.7%) and was helpful for their PCP to understand their health needs (89.7%). 80.7% of those who said they completed an HRA chose to work on a health behavior.

Some enrollees reported working on cutting back or quitting tobacco use after HMP.

- 37.7% reported smoking or using tobacco in the last 30 days, and 75.2% of them said they wanted to quit. Of these, 90.7% were working on cutting back or quitting now.

Enrollees were more likely to report a regular source of care after HMP, and less likely to report the ER as their regular source of care.

- 20.6% had not had a primary care visit in five or more years before enrolling in HMP.
- 73.8% said that in the year before enrolling in HMP they had a place they usually went for health care. Of those, 16.8% used an urgent care center, 16.2% used an ER, and 65.1% used a doctor's office or clinic.
- 92.2% reported that in the year since enrolling in HMP they had a place they usually went for health care. Of those, 5.8% said that place was an urgent care center and 1.7% reported the emergency room, while 75.2% reported a doctor's office or clinic.
- 85.2% of those who reported having a PCP had a visit with their PCP in the last year.
- Those who reported seeing a PCP were more likely to note improved access to preventive care, completing an HRA, health behavior counseling and new diagnoses of a chronic condition since enrollment.

Enrollees reported a reduction in foregone care.

- 33% of enrollees reported not getting care they needed in the year before enrollment in HMP; 77.5% attributed this to cost concerns. Since enrolling in HMP, 5.6% reported foregone care; 25.4% attributed this to cost concerns.
- 83.3% strongly agreed/agreed that without HMP they would not be able to go to a doctor.

Enrollees reported on their experiences using the ER for care.

- 28.0% of those who visited the ER in the past year said they called their usual provider's office first. 64% said they were more likely to contact their usual doctor's office before going to the ER than before they had HMP.
- Respondents who used the ER were more likely than those who did not use the ER to report their health as fair/poor (40.1% vs. 23.2%) and to report chronic physical or mental health conditions (79.4% vs. 62.8%).

Enrollees reported on the impact of HMP on employment, education and ability to work.

- 48.9% reported they were employed/self-employed, 27.6% were out of work, 11.3% were unable to work, and 2.5% were retired.
- HMP enrollees were more likely to be employed if their health status was excellent, very good, or good vs. fair or poor (56.1% vs. 32.3%) or if they had no chronic conditions (59.8% vs. 44.1%).

- Among employed respondents, over two-thirds (69.4%) reported that HMP insurance helped them to do a better job at work.
- For the 27.6% of respondents who were out of work, 54.5% strongly agreed or agreed that HMP made them better able to look for a job.
- For the 12.8% of respondents who had changed jobs in the past 12 months, 36.9% strongly agreed or agreed that having HMP insurance helped them get a better job.

Some enrollees were knowledgeable about HMP program features but gaps in knowledge exist.

- The majority of respondents knew that HMP covers routine dental visits (77.2%), eyeglasses (60.4%), and counseling for mental or emotional problems (56%). Only one-fifth (21.2%) knew that HMP covers brand-name as well as generic medications.

Few enrollees reported challenges using their HMP coverage.

- Few (15.5%) survey respondents reported that they had questions or problems using their HMP coverage. Among those who did, about half (47.7%) reported getting help or advice, and most (74.2%) of those said that they got an answer or solution.

Many enrollees reported that problems paying medical bills improved with HMP.

- 44.7% said they had problems paying medical bills in the year before HMP.
- 85.9% said that since enrolling in HMP their problems paying medical bills got better.

Enrollees shared their perspectives on and knowledge about HMP cost-sharing requirements and the MIHA statement.

- 87.6% strongly agreed or agreed that the amount they pay overall for HMP seems fair.
- 88.8% strongly agreed or agreed that the amount they pay for HMP is affordable.
- 68.2% said they received a MIHA statement. 88.3% strongly agreed or agreed they carefully review each statement to see how much they owe. 88.4% strongly agreed or agreed the statements help them be more aware of the cost of health care.
- 75.6% of respondents knew some visits, tests, and medicines have no copays. Only14.4% were aware they could not be disenrolled from HMP for not paying their bill. Only 28.1% were aware they could reduce the amount they owed by completing an HRA.

Limitations

HMV survey responses may be prone to social desirability bias. While the survey was available in three languages, it was not available in all languages spoken by enrollees. While many measures were based on those used in large national surveys, some questions were developed specifically to assess enrollee perspectives on key features of the HMP program.

Conclusions

Three-fifths of respondents did not have insurance at any time in the year before enrolling in HMP and half of those who did were covered by Medicaid or another state program. HMP does not appear to have substantially replaced employer-sponsored insurance.

Most respondents said that without HMP they would not be able to see a doctor. Foregone care, usually due to cost, lessened considerably after enrollment. The percentage of enrollees who had a place they usually went for health care increased significantly with HMP whereas the percentage naming the ER as a regular source of care declined after enrolling in HMP (from 16.2% to 1.7%). There were some areas in which enrollee understanding of coverage (e.g., dental, vision and family planning) and cost-sharing requirements could be improved.

Many HMP enrollees reported improved functioning, ability to work, and job seeking after enrolling in HMP. Chronic health conditions were common among enrollees even though most enrollees were under 50 years old. Almost half of these conditions were newly diagnosed after enrolling in HMP. Overall, HMP enrollees expressed improved access to care, improved health behaviors, better management of chronic conditions, fewer financial barriers to care, and a sense that the amount they pay for HMP seems fair and affordable.

E. Public Act 107 of 2013 §105d(8) 2015 Report on Uncompensated Care

Methods

Each year, Michigan hospitals submit cost reports to the State Medicaid program. Based on data elements contained in these reports, the cost of uncompensated care provided by each hospital can be assessed. The cost reports for state FY 2015 include data on 142 hospitals.

Key Findings

The amount of uncompensated care provided by Michigan hospitals fell substantially after the implementation of HMP. Comparing 2013 and 2015 for a consistent set of hospitals, uncompensated care costs decreased by almost 50%. For the average hospital, annual uncompensated care expenses fell from $7.21 million to $3.77 million. As a percentage of total hospital expenses, uncompensated care decreased from 5.2% to 2.9%. Over 90% of hospitals saw a decline in uncompensated care between FY 2013 and FY 2015.

Limitations

FY 2015 is the first fiscal year that began after the HMP was in place. Thus, the impact of the HMP is more readily seen by focusing on the 88 hospitals that reported data for 2013 and 2015. In future years, changes in uncompensated care will be examined for all Michigan hospitals.

The full evaluation reports are available at www.michigan.gov/healthymichiganplan.

F. Lessons Learned from IHPI's Evaluation of HMP to Date

Lessons from conducting outreach to HMP enrollees through recruitment for the Healthy Michigan Voices survey:

- To meet the needs of enrollees who are more comfortable speaking Spanish or Arabic, sampling lists were reviewed for names that suggest Hispanic or Arabic ethnicity so that bilingual interviewers could place those calls. This helped put enrollees at ease about the project (e.g. "I only did the survey because you speak Arabic.")
- In the initial HMV survey, many enrollees offered descriptions and anecdotes not captured by fixed-choice or brief response items used with the computer-assisted telephone interview system. For subsequent waves, the evaluation team has asked enrollees if their interview could be recorded and nearly all have agreed, provided additional details about the enrollee experience.

G. Future Evaluation Reports

Domain I: Uncompensated Care
This report will be available in the fall of 2018.

Domain II: Insurance Coverage
Preliminary results from analyses completed thus far:

- The number of uninsured Michigan residents dropped sharply between 2013 and 2015.
- According to data from the U.S. Census Bureau's American Community Survey, the fraction of Michigan's total population that was uninsured was 11.3% in 2013 and 6.7% in 2015. The fraction with Medicaid increased from 19.9% to 23.1% over this period.
- Among non-elderly adults in Michigan (ages 19 through 64), the fraction uninsured dropped from 16.6% in 2013 to 9.0% in 2015, while the fraction with Medicaid increased from 13.9% to 19.2%.

The full report from this domain will be available in the fall of 2018.

Domain III: Utilization
Interim results will be available in the fall of 2017.

Domain IV: Provider and Enrollee Perspectives
Final interim reports for the 2016 Healthy Michigan Voices survey and Primary Care Provider survey will be available by the end of 2017. Reports based on subsequent annual Healthy Michigan Voices surveys will be available in 2018, 2019, and 2020. The report based on interviews with those who are eligible but unenrolled for HMP will be available at the end of 2017 and a second report will be completed at the end of 2018.

Domain V/VI: Consumer Behavior
This report will be available in the spring of 2018.

Domain VII: Marketplace Option
This report will be available in the spring of 2020.

Evaluation Plan for Extension Period

During the extension period, IHPI will continue to field and analyze the data from the Annual HMV Survey. Further, IHPI will conduct the Domain VII – Cost-Effectiveness Analysis of the Marketplace Option. For Domain III, IHPI will continue to examine the impact the Healthy Behavior Program's expansion on utilization. Finally, should IHPI continue to provide the Uncompensated Care Analysis as required in PA 107 of 2013, it will contribute to the future assessment of Domain I analysis.

Section VII - Public Notice Process

A. Public Notice, Comment and Hearings Process

MDHHS has been engaged in ongoing discussions with various stakeholders regarding HMP. MDHHS has provided regular updates on the progress of HMP to the Medical Care Advisory Council (MCAC) since the inception of the program. MDHHS began its discussions on the proposed demonstration waiver extension at the MCAC meetings which took place on June 26, 2017 and August 30, 2017. MDHHS extended its public engagement on September 26, 2017 by posting the proposed demonstration waiver extension request on the MDHHS dedicated HMP webpage available at www.michigan.gov/healthymichiganplan. On this webpage, the public was informed about the demonstration waiver renewal process, which included public notice and hearing information and provided opportunities for and instructions on how to submit comments. This is in addition to publishing a public notice in selected newspapers throughout the state on September 29, 2017, which included, among other information, details regarding the proposed demonstration waiver extension, as well as the website, hearing and public comment information. A copy of the notice is included as Attachment D.

A public hearing regarding the proposed demonstration waiver extension will be held on October 19, 2017, from 2:00 p.m. – 3:00 p.m. at the Michigan Public Health Institute located at 2436 Woodlake Circle, Suite 380, Okemos, MI 48864. In addition to the notice procedures described above, MDHHS sent email notifications of this event to providers, stakeholders and the media. This public hearing had telephone, webinar and in-person capability (with sign interpretation available for those present). Comments were accepted until October 30, 2017. As required by the existing Special Terms and Conditions, the MDHHS is including a summary of the comments received, with notes of any changes to the proposal, as a result, as Attachment E.

B. Tribal Consultation

Consistent with the State Plan, MDHHS issued a letter on August 16, 2017 notifying the Tribal Chairs and Health Directors of the plan to submit the proposed Demonstration Waiver extension. A copy of the notice is included as Attachment F.

Additional Tribal Consultation has occurred on the following dates.

- *July 12, 2017 - In person meeting -MI Tribal Health Director's Association Meeting*
- *August 28, 2017 - Quarterly Tribal Health Directors conference call*
- *September 15, 2017 – Pokagon Band of Potawatomi Director of Health Services*

C. Post-Award Forums

In accordance with the HMP Waiver Special Terms & Conditions, MDHHS provides continuous updates to the program's MCAC at regularly scheduled meetings. These meetings provide an opportunity for attendees to provide program comments or suggestions. A copy of the meeting minutes for the 2016 and 2017 meetings are included as Attachment G.

D. Additional Stakeholder Engagement

MDHHS has also discussed the proposed demonstration waiver extension in additional venues as part of its ongoing outreach and engagement with its stakeholders. The following is a listing of locations and events at which MDHHS addressed the proposed demonstration waiver extension:

- Michigan Association of Local Public Health Administrative Forum, on June 10, 2017, in Lansing, MI
- MDHHS/MHPs Operations Annual Conference, on July 19, 2017, in Acme, MI
- 2017 Michigan Primary Care Association Annual Conference, on July 24, 2017, in Acme, MI
- Michigan Association of Health Plans Meetings, on June 23, 2017 and August 4, 2017, in Lansing, MI
- Durable Medical Equipment Liaison Meeting, on September 11, 2017, in Lansing, MI
- Michigan State Medical Society/Medicaid Quarterly Meeting, September 12, 2017, in Lansing, MI
- Pharmacy Liaison Meeting on September 21, 2017 in Lansing, MI

Attachments: