Section 1115 Demonstration Extension Application

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

Submission Date:
TBD
No later than 12/31/2022

State of Michigan
Gretchen Whitmer, Governor

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Section I – Executive Summary

The Michigan Department of Health and Human Services (MDHHS) 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, 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 1,000,000 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.

Through HMP, Michigan established a 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 implemented 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.

In December 2017, MDHHS submitted an application to extend the HMP demonstration, which included the Marketplace Option. Under the Marketplace Option, beneficiaries with income greater than 100% of the FPL and enrolled in an HMP health plan for 12 consecutive months would be required to receive their health benefits through a Marketplace health plan if they have not completed a healthy behavior.

In September 2018, an additional application was submitted to amend certain elements of the HMP demonstration, including the Marketplace Option, in order to comply with new state law provisions (Michigan Compiled Laws 400.105d and 400.107a,b). The Healthy Michigan Plan waiver approved in December 2018 provided demonstration authority for the state to require, beginning no sooner than January 1, 2020:

(1) Beneficiaries, ages 19 to 62, to complete and timely report 80 hours per month of community engagement activities, such as employment, education directly related to employment, job training, job search activities, participation in substance use disorder

treatment (SUD), and community service, as a condition of continued Medicaid eligibility;
(2) Beneficiaries who have been enrolled in the demonstration more than 48 months to pay a monthly premium of five percent of income for continued eligibility; and
(3) Beneficiaries who have been enrolled in the demonstration more than 48 months to complete a health risk assessment (HRA) at redetermination or complete a healthy behavior in the previous 12 months, as a condition of eligibility.

In April 2021, MDHHS was notified that CMS had determined that, "on balance, the authorities that permit Michigan to require community engagement as a condition of eligibility are not likely to promote the objectives of the Medicaid statute". As a result, the authorities described in (1) above were withdrawn. The authorities described in (2) and (3) above have not been implemented to date, as a result of the COVID-19 Public Health Emergency and the Maintenance of Effort requirements established pursuant to the Families First Coronavirus Response Act (FFCRA) enacted on March 18, 2020.

Through this waiver renewal application process, MDHHS seeks to extend approval of the Healthy Michigan Plan waiver program as currently approved. Approval of this renewal application request would allow the State of Michigan to continue to provide comprehensive health care coverage while incorporating new innovative approaches and structural incentives to increase beneficiary engagement in healthy behaviors and to promote personal responsibility in maintaining health care coverage.

Approval for this request is being sought effective January 1, 2024.

Section II – Program History and Overview

A. Healthy Michigan Plan 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 access to appropriate and quality healthcare services.

In September 2013 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.

In December 2017, MDHHS submitted an application to extend the HMP demonstration; however, after the enactment of Public Act 208 of 2018, which directed MDHHS to seek approval of new workforce engagement, healthy behaviors, and cost sharing requirements, MDHHS submitted an additional application to amend certain elements of the HMP demonstration, including ending the Marketplace Option benefit.

The HMP waiver application approved in December 2018 extended the demonstration through December 2023 and permitted the state to, no sooner than January 1, 2020, require workforce engagement as a condition of continued Medicaid eligibility, as well as put in place new requirements for individuals above 100% FPL who have been enrolled in HMP for 48 or more cumulative months. Pursuant to Public Act 208 of 2018, individuals with incomes between 100% and 133% of the FPL who have been enrolled in HMP for 48+ cumulative months may lose or be denied eligibility for failure to pay MIHA fees or copayment liabilities and/or for non-completion of an annual Health Risk Assessment or healthy behavior.

The approval of the workforce engagement requirements was withdrawn by CMS in April 2021, and Michigan was unable to implement the new requirements for individuals with incomes between 100% and 133% of the FPL who have been enrolled in HMP for 48+ cumulative months due to the COVID-19 Public Health Emergency (PHE) and the Maintenance of Effort requirements established pursuant to the Families First Coronavirus Response Act (FFCRA) enacted on March 18, 2020.

The COVID-19 PHE has significantly impacted the HMP demonstration. As noted above, several waiver authorities that were approved during the last program extension have yet to be implemented. Additionally, program enrollment has grown exponentially during the PHE with average annual enrollment increasing from approximately 660,000 in 2019 to nearly 1,000,000 individuals in 2022. This program growth only reinforces the importance of the HMP demonstration as MDHHS now seeks to extend the demonstration period.

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)

As part of this renewal application for HMP, MDHHS seeks approval to continue all existing waiver provisions.

Pursuant to Public Act 208 of 2018, this includes the requirement that, in order to maintain eligibility for HMP, individuals with incomes between 100% and 133% of the FPL who have had 48 months of cumulative eligibility coverage must:

- Complete or commit to an annual healthy behavior; and
- Pay a monthly MI Health Account Fee of five percent of income.

MDHHS also seeks to continue the exemptions approved previously:

- American Indian/Alaska Natives and children under 21 years of age are exempt from paying premiums pursuant to 42 CFR 447.56(a), but will still be required to complete an HRA or complete an annual healthy behavior in order to remain on HMP.
- Pregnant women are exempt from paying premiums pursuant to 42 CFR 447.56(a), and while they are encouraged to participate in the Healthy Behavior Incentives Program, they will not be subject to loss of eligibility for failure to comply with the HRA or annual healthy behavior requirement.
- Beneficiaries who are identified or self-report as medically frail, as described in 42 CFR 440.315, will be exempt from paying premiums and from the requirement to complete an HRA or complete an annual healthy behavior.
- Beneficiaries who are not enrolled in a MHP are exempt from the premiums and from the requirement to complete an HRA or complete an annual healthy behavior.
- Beneficiaries who are enrolled in the Flint Michigan section 1115 demonstration are exempt from the premiums and from the requirement to complete an HRA or complete an annual healthy behavior.

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.

3. Cost-Sharing

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 service with reductions in cost-sharing responsibilities. After 48 months of cumulative HMP eligibility coverage, beneficiaries will not be eligible for any cost-sharing reductions related to healthy behavior completion incentives.

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.

4. Delivery Systems

Services for HMP are provided through a managed care delivery system. HMP eligible beneficiaries are initially mandatorily enrolled into a MHP, with the exception of those 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.

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.

- *Provision of Medical Assistance §1902(a)(8) and § 1902(a)(10)* - To the extent necessary to enable the state to suspend eligibility for, and not make medical assistance available to, beneficiaries with income above 100 percent of the FPL who have been enrolled in the demonstration more than 48 months who fail to comply with healthy behavior incentive program requirements and/or fail to comply with cost-sharing requirements, unless the beneficiary is exempted.

- *Eligibility §1902(a)(10) or § 1902(a)(52)* - To the extent necessary to enable the State to prohibit re-enrollment, and deny eligibility, for beneficiaries with income above 100 percent of the FPL who have been enrolled in the demonstration more than 48 months who are disenrolled for failure to complete a healthy behavior and/or failure comply with cost-sharing requirements, subject to the exceptions and qualifying events described herein.

B. Expenditure Authorities

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- Expenditures for Healthy Behaviors Program incentives that offset beneficiary cost sharing liability.

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: MDHHS dental measures, hospital readmission measures, a subset of CMS Child and Adult Core Set measures, as well as a subset of HEDIS measures. Additionally, financial reports, encounter data, network adequacy (provider-to-member ratio reports) and grievance and appeals

data are captured via other reporting mechanisms. Please see Attachment XX for the full PMR and EQRO reports.

Section V – Program Financing

Historical Healthy Michigan 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. Healthy Michigan Plan 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—including pharmaceutical rebates—and enrollment by demonstration year (DY) January 1, 2017 through June 30, 2022. Expenditures for DY 13 are currently limited to two quarters as this demonstration year is in progress. Total expenditures for DY 13 are expected to increase in alignment with previous years.

Healthy Michigan Demonstration Budget Neutrality Monitoring				
Demonstration Year	Projected HMP PMPM	Actual HMP PMPM (YTD)	Total Expenditures (YTD)	Total Member Months (YTD)
DY 8 – 2017	$598.86	$484.97	$4,040,415,709	8,331,249
DY 9 – 2018	$550.55	$491.82	$4,158,671,229	8,455,653
DY 10 – 2019	$569.30	$511.81	$4,262,864,050	8,328,989
DY 11 – 2020	$588.87	$476.80	$4,430,332,139	9,291,835
DY 12 – 2021	$609.30	$492.91	$5,535,644,259	11,230,622
DY 13 – 2022	$630.64	$390.65	$2,349,193,721	6,013,542

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

Healthy Michigan Demonstration Budget Neutrality Projections				
Demonstration Year	Approved HMP PMPM	Projected HMP PMPM	Projected Expenditures	Projected Enrollment
DY 14 – 2023	-	$666.42	$7,266,939,177	10,904,436
DY 15 – 2024	-	$693.15	$7,257,595,312	10,470,528
DY 16 – 2025	-	$716.65	$7,481,671,364	10,439,736
DY 17 – 2026	-	$741.53	$7,766,706,931	10,473,879
DY 18 – 2027	-	$767.53	$8,065,369,686	10,508,280

Section VI – Evaluation Report

A. Summary of Evaluation

The 2022 Healthy Michigan Plan Interim Evaluation Report focuses on the current/ongoing HMP policies which are the Healthy Behaviors Incentives Program and beneficiary cost-sharing, and the four broad goals of the overall demonstration: reduce uninsurance and uncompensated care, promote primary care/responsible use of services, support financial well-being, and support coordinated strategies that address social determinants of health (SDOH). The following sources of data are used in the evaluation:

- Administrative data from the State of Michigan's Enterprise Data Warehouse
- Beneficiary survey (Healthy Michigan Voices)
- Interviews with beneficiaries
- Interviews with providers
- Interviews with key informants
- Credit report data from Experian
- Behavioral Risk Factor Surveillance System (BRFSS) from the National Center for Health Statistics
- American Community Survey (ACS) from the U.S. Census Bureau
- HCUP Fast Stats inpatient discharge data from the Agency for Healthcare Research and Quality
- Medicare cost reports from the Centers for Medicare and Medicaid Services (CMS)

The evaluation builds on key findings from the Healthy Michigan Plan Final Summative Evaluation Report[1] for the first five years of HMP (2014-2018) and related articles published in academic research journals.[2]

B. Results and Interpretations

a. Healthy Behaviors Incentives Program

Some beneficiaries and primary care providers (PCPs) described the HRA as an opportunity to identify and set goals for health behavior change. This may be particularly true for beneficiaries who have been without a primary care medical home for an extended period, or for patients new to a primary care practice. However, HRA completion is uneven, which may reflect inconsistency in how it is introduced to beneficiaries. Some beneficiaries recall receiving an HRA from their Medicaid health plan. Some primary care settings (often FQHCs) monitor which patients are due for an HRA and are proactive about encouraging completion. In other primary care settings, beneficiaries are responsible for initiating the process of completing an HRA.

[1] Healthy Michigan Plan Evaluation Final Summative Report, March 2020
[2] IHPI Member Publications on Medicaid Expansion in Michigan

In addition, PCPs emphasized that behavior change requires sustained engagement and support, which is not readily achieved through annual HRA completion. Moreover, in most primary care practices, the HRA form is not integrated into the EMR, so it does not enable PCPs to track progress over time or to recall behavior change goals chosen by the beneficiary in the prior year.

The HMV survey found beneficiary reports of HRA completion were associated with higher rates of preventive service use, consistent with our previous evaluation of the first demonstration period. Our analysis of administrative data confirmed this pattern, but the effect size was small compared to the strength of association between continuity of primary care visits and preventive services. This raises the issue of whether the motivating factor is the completion of the HRA form or the conversation with PCPs about health behaviors and preventive services. In addition, we cannot differentiate whether completion of the HRA provided a catalyst for beneficiaries to schedule and obtain preventive services or whether beneficiaries who were more motivated to seek preventive services were also more likely to complete an HRA.

An important feature of the Healthy Behaviors Incentive Program is its financial incentive. Our HMV survey found that less than one-third of beneficiaries knew they could get a reduction in the amount they had to pay by completing an HRA or healthy behavior. PCPs were similarly unaware of the financial incentives. Interviews with beneficiaries confirmed that the Healthy Behaviors Incentives Program was not the primary motivator of their engagement in healthy behaviors. While many recalled completing at least one HRA, most were unaware of financial incentives; among the few who knew about the possibility of a financial reward, it was not their reason for adopting a healthy behavior goal. Instead, most reported self-motivation or encouragement from their providers supported their adoption of healthy behaviors. Changes in the financial incentives over time (e.g., the discontinuation of program-wide gift cards in FY19[3]) and differences in the incentive based on income may contribute to beneficiaries' lack of awareness about the financial incentives. For example, beneficiaries who are under 100% FPL and do not reach the threshold of paying 2% of their income in copays would not receive a financial incentive.

b. Cost-Sharing

HMP cost-sharing is intended to support the HMP objectives of strengthening beneficiary engagement and personal responsibility, and encouraging individuals to make responsible decisions about their healthcare. Findings from this evaluation suggest that the HMP demonstration has been partially effective in achieving these objectives.

The MI Health Account statement is the primary method of communicating with beneficiaries about HMP cost-sharing. Our HMV survey found that nearly three-quarters of beneficiaries recalled getting a MI Health Account statement in the past year. In interviews, beneficiaries said they did not have questions about the statement, but most beneficiaries did not understand how the amount owed is calculated; most simply checked to see what they owed.

[3] MDHHS Medical Care Advisory Council June 18, 2018 Meeting Minutes

c. Reduce uninsurance

The HMP demonstration has been effective in achieving the objective of improving access to healthcare for uninsured or underinsured low-income Michigan residents. The changes in insurance coverage we observed in the first few years after HMP implementation were sustained through 2020. In particular, Michigan adults ages 19 through 64 experienced significant gains in Medicaid coverage and reductions in the proportion of uninsured individuals compared with states that did not expand Medicaid. These effects were concentrated among low-income adults.

d. Promote primary care/responsible use of services

The HMP demonstration has been effective in encouraging individuals to seek primary care and preventive services and make responsible decisions about their healthcare. The HMV survey found that nearly all beneficiaries reported having a known primary care provider. Despite the COVID-19 PHE which affected availability and access to primary care, three quarters of beneficiaries reported a primary care visit, and three quarters reported no barriers to primary care. Analysis of administrative claims showed that among beneficiaries with multi-year HMP enrollment, over half had at least one primary care visit each year.

Many PCPs described practice-based strategies to support HMP beneficiaries in responsible use of primary care services. Some practices have adjusted their scheduling practices to offer more same-day appointments and after-hours appointments. Many practices have protocols in place to contact patients after an ED visit, using this opportunity to educate patients about using the primary care practice as the first-choice option in the future. Many primary care practices have care managers and community health workers conducting regular outreach to high-need beneficiaries to support their self-management of health conditions, identify problems with social determinants of health, and avoid unnecessary ED visits.

Despite this overall success, some beneficiaries still experience barriers to primary care. Both beneficiaries and PCPs reported challenges with transportation to medical appointments. Some beneficiaries also reported difficulty scheduling primary care appointments, which was exacerbated by COVID-19 constraints on the health care system. Minimizing these types of barriers is essential for reducing non-urgent ED visits.

e. Support financial well-being

Interim findings from this evaluation provide qualitative evidence that the HMP demonstration has been effective in supporting financial well-being. Beneficiary and key informant interviews highlighted many examples of HMP having a positive impact on beneficiaries' financial well-being, including the role of coverage in minimizing health care costs and worries and freeing up financial resources for other life needs such as food, transportation, and housing. There is also evidence of positive effects on employment as the HMV survey found that most beneficiaries are employed, and some interviewees stated that they gained access to medical treatments that allowed them to begin or continue working.

f. Sustain the safety net and support coordinated strategies to address social determinants of health

The HMP demonstration has been effective in reducing uncompensated care and supporting coordinated strategies to address social determinants of health.

Changes in insurance coverage at the population level were reflected in changes in the payer mix for inpatient hospitalizations, whereby increases in Medicaid as a source of payment were associated with a significant decline in the fraction of discharges coded as self-pay. Hospital uncompensated care in Michigan was reduced by half following HMP implementation, a stark contrast to the experience of states that did not expand Medicaid, which experienced no decline in uncompensated care. The changes in hospital payer mix and hospital uncompensated care in the first few years after HMP implementation were sustained through 2020.

Key informant interviews highlighted numerous examples of HMP's key role in fostering collaboration and coordination of health and human services organizations across sectors, including safety-net providers, health plans, healthcare systems, and social service organizations. This role has been particularly important for sustaining safety-net providers, enabling them to implement and maintain innovative programs focused on SDOH by addressing both health care and social needs of beneficiaries.

HMP coverage for large numbers of adults, including new populations not previously covered by Medicaid, increased access to reimbursable care, contributed to interagency partnerships and coalitions and innovations in programs and service delivery, including those that address SDOH, that could be sustained over time. This expanded coverage contributed to the financial stability of safety-net provider organizations and the ability to expand critical services to meet growing needs, including those for substance use disorders and COVID-19. HMP increased access to care and was associated with improved health and other outcomes for beneficiaries, many of whom were previously uninsured or unconnected to services addressing SDOH. During the COVID-19 pandemic, HMP maintained access to coverage and care for beneficiaries and offered coverage for new beneficiaries affected by unemployment and coverage losses. Partnerships among diverse organizations enhanced outreach and communications about initiating and maintaining enrollment and meeting HMP requirements.

Trends in the state's costs for HMP support its sustainability. Capitation rates for both administrative and medical claims costs have remained relatively stable for the HMP population since 2016, and cost trends over time compare favorably to other Medicaid benefit programs.

C. Recommendations

Regarding the four specified goals of the overall demonstration, we learned that HMP was highly effective in:

- Reducing uninsurance
- Promoting primary care
- Supporting financial well-being

- Sustaining the safety net and supporting strategies to address social determinants of health

Based on the success in achieving these main goals of the overall demonstration, we recommend that Medicaid expansion through the Healthy Michigan Plan continue with strong support beyond the current demonstration period.

Our evaluation findings also provide insights for any state Medicaid program considering features incorporated into HMP. Across several components of our evaluation, we learned that the current structure of HRAs and healthy behaviors incentives are not well understood by many HMP beneficiaries and are not viewed as well-functioning by primary care providers. MDHHS has implemented several changes[4] to the Healthy Behaviors Incentives Program in response to both our previous evaluation findings and feedback from HMP beneficiaries, providers, and health plans. Some changes facilitated the completion of HRA forms, including implementing streamlined secure statewide HRA submission processes for providers and deletion of the lab results portion of the HRA form. Other changes facilitated beneficiary participation in the Healthy Behaviors Incentives Program such as additional mechanisms to document healthy behaviors through claims/encounter data. To improve understanding of the program, MDHHS has updated beneficiary guidance and worked with an external partner to educate providers. While MDHHS discontinued program-wide gift cards as an incentive for HRA completion, some of the Medicaid health plans use gift cards to incentivize engagement in health behavior change activities.

Given the challenges with informing beneficiaries and with facilitating usefulness to providers, we offer the following recommendations to states considering incorporating HRAs and healthy behaviors incentives into a Medicaid expansion program:

- Expand the focus from completing the HRA form to supporting beneficiary engagement in behavior change over time.
- Give careful consideration to allowing variable processes and structures for health plans – dealing with multiple processes places a burden on providers.
- Facilitate mechanisms for providers to integrate program tools into EMRs and other practice systems.
- Plan for ongoing communication about program goals, processes, and incentives to beneficiaries and providers.

Michigan should continue to focus on these areas too, given that beneficiary and provider understanding of the program remains limited.

We also learned that beneficiary understanding of HMP cost-sharing policies is uneven and generally incomplete, even with the simplified MI Health Account statement implemented by MDHHS in 2017 as well as later changes. Thus, if incorporating cost-sharing into a Medicaid expansion program: Implement a simplified approach with (a) income-based fees and/or a method of charging equal quarterly amounts so that beneficiaries know more generally what costs to expect, and (b) co-payments for a small number of high-priority services (e.g., ED visits)

[4] MSA Bulletin 19-35

so that beneficiaries can better understand the link between service utilization and cost-share obligations.

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 August 24, 2022. MDHHS extended its public engagement on September 19, 2022 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 August 19, 2022, 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 XX.

A virtual public hearing regarding the proposed demonstration waiver extension will be held on October 7, 2022, from 9 a.m. to 11 a.m. In addition to the notice procedures described above, MDHHS sent email notifications of this event to providers and stakeholders. This public hearing has telephone and webinar capability (with sign interpretation available). Comments were accepted until October 31, 2022. 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 XX.

B. Tribal Consultation

Consistent with the State Plan, MDHHS issued a letter on August 8, 2022 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 XX.

C. Additional Tribal Consultation

Additional Tribal Consultation has occurred on the following date:

- *September 21 2022, 2022, 11:00am – 12:00pm – Virtual meeting with Interested Tribal Members*

D. 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 2022 meetings are included as Attachment XX.

Attachments

Attachment #1 PMR & EQRO Reports

Attachment #2 Public Notice

Attachment #3 Summary of Public Comments Received

Forthcoming

Attachment #4 Tribal Notice

STATE OF MICHIGAN
DEPARTMENT OF HEALTH AND HUMAN SERVICES
LANSING

GRETCHEN WHITMER
GOVERNOR

ELIZABETH HERTEL
DIRECTOR

Date

NAME
TITLE
ADDRESS
CITY STATE ZIP

Dear Tribal Chair and Health Director:

RE: Healthy Michigan Plan §1115 Demonstration Waiver Renewal

This letter, in compliance with Section 1902(a)(73) and Section 2107(e)(1)(C) of the Social Security Act, serves as notice to all Tribal Chairs and Health Directors of the intent by the Michigan Department of Health and Human Services (MDHHS) to submit a renewal to the Healthy Michigan Plan (HMP) §1115 Demonstration Waiver request to the Centers for Medicare & Medicaid Services (CMS).

The primary goal of the Healthy Michigan Plan is to improve access to health care services for low-income Michigan residents who are uninsured or underinsured, while implementing a comprehensive benefit package with the intent to improve health outcomes. The expected effective date of this waiver extension is January 1, 2024. MDHHS expects that the waiver extension will have a positive impact on Native American populations located in the state, as they will be able to continue to receive services through the Healthy Michigan Plan and will be able to voluntarily enroll in the managed care delivery system.

The first public hearing for this waiver renewal will Wednesday August 24, 2022, as part of the Medical Care Advisory Council meeting. Input regarding this Healthy Michigan Plan Waiver Renewal is highly encouraged, and comments regarding this notice of intent may be submitted to Lorna Elliott-Egan, MDHHS Liaison to the Michigan tribes. Lorna can be reached at 517-512-4146, or via email at Elliott-EganL@michigan.gov. **Please provide all input by** September 30, 2022**.**

In addition, MDHHS is offering to set up group or individual consultation meetings to discuss the Healthy Michigan Plan Waiver Renewal, according to the tribes' preference. Consultation meetings allow tribes the opportunity to address any concerns and voice any suggestions, revisions, or objections to be relayed to the author of the proposal. If you would like additional information or wish to schedule a consultation meeting, please contact Lorna Elliott-Egan at the telephone number or email address provided above.

MDHHS appreciates the continued opportunity to work collaboratively with you to care for the residents of our state.

An electronic copy of this letter is available at www.michigan.gov/medicaidproviders >> Policy, Letters & Forms.

Sincerely,

Farah Hanley
Chief Deputy for Health

CC: Keri Toback, CMS
Nancy Grano, CMS
Chasity Dial, CEO, American Indian Health and Family Services of Southeastern Michigan
Daniel Frye, Director, Indian Health Service - Bemidji Area Office
Lorna Elliott-Egan, MDHHS

Attachment #5 Medical Care Advisory Council Meeting Minutes 2022

Forthcoming