

FLINT MICHIGAN 1115 DEMONSTRATION: SECOND EXTENSION PERIOD REQUEST

PROJECT NUMBER 11-W-00302/5

State of Michigan
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9/22/2025

Executive Summary

The Michigan Department of Health and Human Services (MDHHS) requests a five-year extension of the Flint Section 1115 Demonstration (Project Number 11-W-00302/5) through September 30, 2031. This extension will maintain uninterrupted coverage and services for children up to age 21 and pregnant women affected by lead exposure from the Flint water system, ensuring that vulnerable populations continue to receive critical Medicaid benefits and targeted supports.

Since its initial approval in 2016, the demonstration has:

- **Expanded eligibility** to children and pregnant women up to 400% of the federal poverty level who would not otherwise qualify for Medicaid.
- **Delivered comprehensive benefits**, including the full Medicaid state plan, Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) for children, and exemption from premiums and cost-sharing.
- **Provided targeted supports**, such as Targeted Case Management (referred to as Family Supports Coordination Services in Michigan and referenced as TCM throughout this document) and home lead investigation services, addressing health risks associated with lead exposure.
- **Maintained compliance** with all Special Terms and Conditions (STCs¹), reporting requirements, and budget neutrality parameters.

As of September 2025, more than 54,000 distinct children and pregnant women have enrolled in the program. Beneficiaries have accessed over 944,000 primary care visits, and more than 1,300 enrollees are currently engaged in TCM services. Quality monitoring and external reviews show improved well-child visits, prenatal care access, and blood lead screening rates.

The interim evaluation conducted by Michigan State University confirms the demonstration's effectiveness in expanding coverage, eliminating financial barriers to care, and improving health outcomes. Community partners report satisfaction with the program while highlighting opportunities for continued improvement in service awareness and administrative processes.

For the second extension period (Demonstration Years 11–15), MDHHS requests continuation of the existing waiver and expenditure authorities with no programmatic changes. The state remains committed to:

- Preserving eligibility for the Flint demonstration population, consistent with the August 29, 2025, policy bulletin.²
- Continuing provision of TCM and home lead investigations.
- Monitoring outcomes and maintaining strong quality oversight.
- Sustaining budget neutrality and meeting all federal reporting obligations.

¹[Flint Waiver 1115 Demonstration Approval: Special Terms and Conditions](#)

²[MDHHS Policy Bulletin MMP 25-33](#)

The demonstration remains a critical tool in protecting the health of Flint residents impacted by the water crisis. Without this extension, thousands of children and pregnant women would lose access to essential coverage and services. Approval of this request will allow Michigan to continue its progress, safeguard long-term health outcomes, and uphold Medicaid's objectives for some of the state's most vulnerable populations.

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History of the Demonstration

Initial Approval (2016–2021)

In 2016, the Centers for Medicare & Medicaid Services (CMS) approved Michigan’s application to establish the Flint Section 1115 Demonstration (Project Number 11-W-00302/5) in response to the public health emergency of lead exposure from the Flint water system. Implementation of the waiver expanded Medicaid eligibility to low-income children up to age 21 and pregnant women served by the Flint water system during a state-specified time-period and who would otherwise not qualify for Medicaid. This population included children in households with incomes from 212 up to and including 400 percent of the federal poverty level (FPL), and pregnant women in households with incomes from 195 up to and including 400 percent of the FPL.

Under the demonstration, individuals received the full Medicaid state plan benefit package, with children also entitled to Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services. Enrollees were exempt from premiums and cost-sharing. Additional services included Targeted Case Management (TCM) and home lead investigations for eligible children and pregnant women. Coverage was primarily delivered through Medicaid managed care plans.

The initial approval period extended from March 1, 2016, through February 28, 2021. Michigan successfully implemented the demonstration, expanded coverage to the target population, and provided critical services and supports. The state complied with all Special Terms and Conditions (STCs), submitted required monitoring reports, and remained within budget neutrality limits.

First Extension (2021–2026)

In 2021, CMS approved Michigan’s request for a five-year extension through September 30, 2026. During Demonstration Years 6 through 9 (September 15, 2021–September 30, 2025), Michigan continued to provide uninterrupted coverage and services to the Flint population. Enrollment remained stable, targeted case management and lead investigation services continued, and the state met all federal reporting requirements. Michigan demonstrated ongoing compliance with STCs, including STCs 17 and 17a, which require the state to determine the end date of the special eligibility period and conduct adequate noticing.

Following the U.S. Environmental Protection Agency’s May 2025 announcement lifting the emergency order on Flint’s drinking water, declaring the city in compliance with Safe Drinking Water Act standards, the Michigan Department of Health and Human Services (MDHHS) issued Medicaid Policy Bulletin MMP 25-33. This policy formally codified eligibility criteria and service delivery expectations for the Flint Waiver population, in alignment with STC 17 and 17a. The promulgation of MMP 25-33 marked a critical milestone in the state’s transition from immediate crisis management to a responsive, policy-based framework aligned with ongoing community need, ensuring continued access to care for populations still at risk of the long-term impacts of lead exposure. The policy was developed through MDHHS’s formal policy promulgation process, including public comment and tribal consultation, reinforcing transparency and stakeholder

engagement. Michigan also maintained budget neutrality, further reinforcing the waiver’s value.

Second Extension Request (2026–2031)

As the state concludes Demonstration Year 9 (October 1, 2024 – September 30, 2025), Michigan is seeking a second five-year extension, from October 1, 2026, through September 30, 2031. The request is for continuation of the same program design and authorities previously approved under the initial demonstration and first extension.

In July 2025, MDHHS issued public notice and engaged in tribal consultation related to the proposed conclusion of the Special Eligibility Period (SEP). Within these forums, MDHHS also signaled its intent to pursue a second extension. While not serving as the formal vehicle for the demonstration extension notice, the alignment of this communication was intentional. The inclusion of the intent to pursue a second extension served to reinforcing the state’s commitment to continued coverage and pre-emptively address potential concerns that the end of the SEP might be misinterpreted as the end of the demonstration itself.

Subsequent tribal and public notices, including announcements of public hearing opportunities and additional tribal consultation, have been established to support formal engagement with the public and interested stakeholders specific to the demonstration extension request. Maintaining Michigan’s commitment to ensuring access to comprehensive Medicaid coverage and lead-related supports for affected children and pregnant women in Flint, while upholding all federal STC, monitoring, and budget neutrality requirements.

Purpose

The Flint Michigan Section 1115 Demonstration exists to ensure that children and pregnant women affected by lead exposure from the Flint water system have access to comprehensive Medicaid coverage and related services, regardless of standard Medicaid eligibility.

The demonstration achieves this by:

- Expanding Medicaid eligibility to the affected population within specified income ranges.
- Providing all state plan benefits, including Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) for children.
- Offering targeted supports such as Targeted Case Management (TCM) and home lead investigation services to address lead-related health risks.

The requested second five-year extension (Demonstration Years 11–15; October 1, 2026 – September 30, 2031) will maintain uninterrupted access to these benefits and services. While the initial public health emergency has concluded, ongoing monitoring, case management, and health services remain critical to addressing the long-term impacts of lead exposure from the

Flint water system. This extension will allow Michigan to continue serving the Flint population effectively by maintaining access to critical services, support ongoing case management, and monitor long-term health outcomes.

Waiver and Expenditure Authorities Requested

Michigan is requesting continuation of the same authorities approved under the current Flint Michigan Section 1115 Demonstration for the second five-year extension period (Demonstration Years 11–15; October 1, 2026 – September 30, 2031). No changes to waivers or expenditure authorities are requested. All authorities will continue to be subject to the Special Terms and Conditions (STCs) established for the demonstration.

Specifically, MDHHS seeks continuation of the following waivers of state plan requirements under §1902 of the Social Security Act:

³ [MDHHS Policy Bulletin MMP 25-33](#)

- **Provision of Medical Assistance (§1902(a)(8); §1902(a)(10))** – To permit the state to limit medical assistance (and treatment as eligible) to children up to age 21 and pregnant women who were served by the Flint water system from April 1, 2014, through September 30, 2025. This includes any child born to a pregnant woman served by the Flint water system during that time. An individual is considered served by the Flint water system if, for more than one day, they:
 1. Resided in a dwelling connected to the system;
 2. Were employed at a location served by the system; or
 3. Received childcare or education at a location connected to the system.
- **Comparability (§1902(a)(17) or §1902(a)(10)(B))** – To enable the state to waive premiums for individuals who resided in the Flint water system area from April 1, 2014, through September 30, 2025 and to provide home lead exposure evaluations only for individuals meeting these non-financial criteria.
- **Freedom of Choice (§1902(a)(23))** – To allow the state to restrict provider choice for children and pregnant women with respect to targeted case management and home lead exposure evaluation. This includes limiting choice to providers within Managed Care Entity (MCE) and Prepaid Inpatient Health Plan (PIHP) networks. No waiver of freedom of choice is authorized for family planning providers.

Additionally, MDHHS seeks continuation of the CMS-approved expenditure authority that enables:

- Expenditures for evaluation of potential lead exposure in the homes of eligible children under 21 and eligible pregnant women residing in the Flint water system area from April 1, 2014 through September 30, 2025, regardless of whether an elevated blood lead level has been documented.

Goals and Objectives

Since the demonstration’s initial approval in 2016, the Flint Michigan Section 1115 Demonstration has successfully promoted the objectives of Medicaid and achieved the state’s goals by expanding access to services, improving health outcomes, and providing critical supports for children and pregnant women affected by lead exposure.

Key accomplishments include:

- **Expanded Medicaid Eligibility:**
 - MDHHS has maintained eligibility for children up to age 21 and pregnant women in households up to 400 percent of the Federal Poverty Level (FPL) served by the Flint water system during the state-specified period.
 - As of September 2025, a total of 54,553 pregnant women and children have been enrolled in the demonstration.

- In support of the second extension period, MDHHS issued a policy bulletin⁴ on August 29, 2025 (effective October 1, 2025) clarifying eligibility rules, ensuring uninterrupted access for the target population.
- **Comprehensive Services:**
 - Beneficiaries receive the full Medicaid state plan benefit package, including EPSDT for children.
 - Individuals are exempt from premiums and cost-sharing.
 - Targeted Case Management (TCM) services continue for all eligible children and pregnant women up to 12 months post-delivery, including:
 - Face-to-face comprehensive assessment and individualized care planning
 - Coordination with primary care providers, other providers, and Medicaid Health Plans as appropriate
 - Planning, linking, follow-up, and ongoing monitoring
- **Utilization of Services:**
 - As of September 2025:
 - 944,404 cumulative primary care provider visits among enrolled beneficiaries
 - 1,319 beneficiaries actively receiving ongoing TCM services
- **Improved Access and Health Outcomes:**
 - Increased screening and blood lead testing for children
 - Increased prenatal care access for pregnant women
 - Beneficiaries report easier access to care and services needed for themselves or their children

Objectives for the Second Extension Period (Demonstration Years 11–15):

1. Maintain access to comprehensive Medicaid coverage for eligible children and pregnant women affected by the Flint water system.
2. Ensure continuity of eligibility in accordance with the August 2025 policy bulletin⁴, effective October 1, 2025.
3. Continue provision of lead-related supports, including TCM and home lead investigation services.
4. Monitor and evaluate health outcomes to ensure continued improvement in care access and quality.
5. Ensure program compliance with STCs, monitoring, and budget neutrality requirements throughout the extension period.

Enrollment

Enrollment into the Flint Medicaid waiver program began on May 9, 2016. The Michigan Department of Health and Human Services (MDHHS) uses an electronic administrative renewal

⁴ [MDHHS Policy Bulletin MMP 25-33](#)

process to redetermine eligibility based on verification of income and residency, facilitating enrollment and retention annually.

Demonstration enrollment activity is detailed in this section. Enrollment data were derived from the MDHHS Data Warehouse.

- For reporting purposes, the Children enrollment group includes demonstration enrollees under the age of 21.
- Pregnant women are identified using pregnancy indicators in the MDHHS Data Warehouse. To avoid duplication, pregnant women are excluded from the Children enrollment group.
- Demonstration years in the following tables align with the definitions in the Special Terms and Conditions.

The following tables present unduplicated counts of beneficiaries affected by the demonstration for each year of the current approval period:

1. Medicaid / CHIP Enrollment by Demonstration Year

Medicaid/CHIP Enrollment by Demonstration Year			
Demonstration Year	Enrollment Group		Total Medicaid/CHIP Enrollment
	Children	Pregnant Women	
1	1,265,574	117,935	2,898,870
2	1,255,784	113,813	2,912,025
3	1,246,670	108,516	2,893,218
4	1,267,781	110,625	2,993,234
5	1,244,158	102,831	2,976,832
6	1,277,606	114,269	3,232,759
7	1,311,969	111,312	3,414,390
8	1,300,644	113,727	3,462,575
9*	1,140,904	109,014	3,016,321
Cumulative Enrollment*	2,166,374	356,330	5,066,186

*Year to date

2. Flint Demonstration Enrollment by Demonstration Year

- The Cumulative Enrollment row shows the total distinct number of Flint waiver enrollees over the demonstration period.

Flint Demonstration Enrollment by Demonstration Year			
Demonstration Year	Enrollment Group		Total Flint Demonstration Enrollment
	Children	Pregnant Women	
1	29,985	1,813	31,798
2	32,990	1,735	34,725

3	31,047	1,254	32,301
4	30,075	1,318	31,393
5	28,019	1,120	29,139
6	28,233	988	29,221
7	28,283	888	29,171
8	28,611	1,094	29,705
9*	26,004	1,074	27,078
Cumulative Enrollment*	48,296	6,257	54,553

*Year to date

3. Flint Demonstration Disenrollment by Demonstration Year

- The Cumulative Disenrollment row shows the distinct number of individuals who disenrolled from the Flint waiver over the course of the demonstration period.

Demonstration Year	Enrollment Group		Total Flint Demonstration Disenrollment
	Children	Pregnant Women	
1	6,223	1,103	7,326
2	8,310	3,629	11,939
3	7,168	927	8,095
4	8,678	981	9,659
5	3,655	815	4,470
6	3,181	685	3,866
7	3,759	567	4,326
8	8,723	732	9,455
9*	5,946	803	6,749
Cumulative Disenrollment*	43,402	6,145	49,547

*Year to date

Note: Data were retrieved in September 2025, reflecting cumulative enrollment and disenrollment through current Demonstration Year 9.

The Children and Pregnant Women enrollment groups are subsets of the total Medicaid/CHIP population; therefore, adding these two groups together will not equal the total Medicaid/CHIP population.

Implementation/Operational Details

Targeted Case Management Services

TCM is provided to all eligible children and pregnant women to support navigation of medical, developmental, and behavioral health services. Services include comprehensive assessments,

individualized care planning, linkage to providers and community resources, and coordination with primary care and specialty providers. MDHHS ensures ongoing monitoring of TCM service delivery and utilization to maintain continuity of care. TCM services are available to eligible beneficiaries up to age 21 and pregnant women up to 12 months post-delivery.

EPSDT and Managed Care Delivery

Children receive full EPSDT services as part of the Medicaid state plan benefit package. Medicaid services are primarily delivered through the state's contracted Medicaid Health Plans (MHPs) which provide coordinated access to primary and specialty care. MHPs work closely with MDHHS to ensure provider network adequacy, timely access, and adherence to program requirements.

Home Lead Investigation Services

Eligible households receive home lead investigations to assess potential exposure and mitigate risk. MDHHS coordinates with local public health departments to schedule and perform investigations, ensuring alignment with broader public health efforts in Flint.

Monitoring and Evaluation

MDHHS conducts internal program monitoring, reviewing enrollment, service utilization, and outcomes. Annual monitoring reports are submitted to CMS using the updated structured template and cadence effective June 25, 2025.⁵ Operational data are used to identify risks, inform course corrections, and evaluate the effectiveness of service delivery.

STC Compliance

The program maintains full compliance with the demonstration Special Terms and Conditions (STCs).⁶ All eligibility, enrollment, service delivery, and reporting processes are consistent with the approved terms and conditions.

Reporting Requirements

MDHHS submits required reporting to CMS, including annual monitoring reports, quarterly monitoring calls, and ad hoc reports as needed. Reporting includes program activity, enrollment data, TCM and EPSDT utilization, and home lead investigation outcomes.

⁵ [CMS Monitoring Redesign Overlay Letter](#)

⁶ [Flint Waiver 1115 Demonstration Approval: Special Terms and Conditions](#)

Outcome Measures

MDHHS tracks key outcome metrics, such as utilization of primary care services, developmental and behavioral screenings, and enrollment retention. Outcomes inform program management, quality improvement initiatives, and support the demonstration's ongoing evaluation activities.

Quality Monitoring, Quality Assessment, and EQRO Activities

Quality Assessment Process

Michigan evaluates the quality, accessibility, and efficiency of services provided under the Flint Waiver from both a broad and targeted perspective. MDHHS conducts an annual statewide assessment of its managed care delivery systems in collaboration with the state's nine contracted MHPs. This process includes reporting on Healthcare Effectiveness Data and Information Set (HEDIS) measures, including:

- Child and adolescent care, aligning with the waiver's pediatric eligibility group
- Pregnancy care, aligning with the waiver's pregnant women eligibility group

Additional measures of access and utilization support evaluation of overall Medicaid service delivery in Michigan.

Internal Quality Assessment

MDHHS performs monthly evaluations, quarterly reports, and annual reviews covering:

- Enrollment and changes in enrollment status
- Service utilization
- Access to care

These internal quality assessments complement the formal EQRO reviews and help ensure continuous oversight of service delivery and beneficiary outcomes.

Quality Assessment Summary (2025 Data)

Internal reviews and interim assessments conducted in collaboration with Michigan State University indicate continued success in program reach and service delivery:

- As of September 2025, 54,553 cumulative pregnant women and children have been enrolled in the program.⁷
- TCM services continue as part of the comprehensive benefits, including:

⁷ For reporting purposes, children are defined as individuals under the age of 21, and pregnant women are identified using indicators in the Michigan Department of Health and Human Services' Data Warehouse. To avoid duplication, pregnant women are excluded from the children enrollment group.

- Face-to-face assessments, history-taking, reassessment, and individualized care planning
- Planning, linking, coordination, follow-up, and monitoring to assist beneficiaries in accessing needed services
- Coordination with primary care providers, other providers, and MHPs as applicable
- Service utilization outcomes: 90 percent of cumulative enrollees had used a primary care provider, totaling 944,404 primary care visits, and 1,319 enrollees were actively receiving ongoing TCM services since program inception.

Changes to Quality Assessment

The state intends to maintain its current quality assurance monitoring program for the Flint Waiver. No significant modifications to internal QA processes, TCM monitoring, or service delivery oversight are planned during the requested extension period.

External Quality Review (EQRO) Summary

External quality reviews of the state’s Medicaid Health Plans (MHPs) show improvements to quality of and access to care. In 2023, MHP performance levels on well-visits for children within the first 15 months of life and 18 to 21-year-old adolescents ranked above national averages, with steady improvements year over year for all other age groups. The rate of children who had at least one lead screening by age 2 continues to improve after a decrease during the COVID-19 pandemic. To support continuous improvement in lead screenings and allow more timely identification of elevated blood lead levels, all MHPs initiated formal Performance Improvement Projects aimed at improving screening rates at age 1 and at age 2. Similarly, the percentage of pregnant persons who received a prenatal care visit during the first trimester showed a 5.36-point increase in 2023 compared to the prior year.

Full EQRO reports for the Flint Waiver population are included in the Appendices.

Evaluation of the Demonstration

Evaluation Activities and Findings to Date

The Flint Medicaid Expansion (FME) waiver evaluation assesses the program’s effectiveness in increasing access to healthcare services, expanding Medicaid eligibility, and improving health outcomes for children and pregnant women exposed to lead. The interim evaluation report, submitted by Michigan State University (MSU) on July 31, 2025, covers the period from September 15, 2021, through December 31, 2024, and is included in Appendix E. Additional evaluation reports, including the Summative Evaluation Report, will continue through September 2026.

Key findings from the interim evaluation include:

- Waiver enrollment remained steady, with 48,016 unique beneficiaries enrolled from May 2016 through September 2023, and 15,533 (32 percent) enrolled for the entire period. Children enrollment stabilized at approximately 25,000 per month, while pregnant women enrollment peaked in October 2016 and decreased over time.
- The waiver successfully eliminated financial barriers to care by expanding Medicaid eligibility above 212 percent of the federal poverty level (FPL), with the high-income group (above 212 percent FPL) increasing to a peak of 6 percent in 2022 before slightly decreasing to 5 percent in 2023.
- Enrollees reported increased access to services, including well-child visits, age-appropriate developmental screenings, and prenatal lead testing, compared to non-enrollees with similar characteristics.
- Low utilization of targeted case management (TCM) services limited the ability to statistically evaluate the impact of TCM; however, survey data indicate that those who used TCM reported satisfaction with services and improved access to resources.
- Improved health outcomes were observed in age-appropriate childhood immunization rates, confidence in managing chronic conditions, and access to referral services to mitigate educational or behavioral challenges.
- Community partner feedback indicated general awareness of the waiver and satisfaction with enrollment processes, with opportunities noted for enhanced administrative processes and community education.
- Preliminary interpretations suggest the waiver achieved moderate success in meeting its overarching goals while highlighting areas for continued improvement, particularly in lead testing awareness and TCM service utilization.

Planned Evaluation Activities During Extension Period

A copy of the interim evaluation report and plans for evaluating the waiver extension are included in Appendix E. MDHHS will continue partnering with Michigan State University to extend the evaluation through September 2026, using the research questions and hypotheses previously outlined in the interim report. Tracking longer-term trends and previously identified targets remains important, and additional data sources and methodologies may be developed through data use agreements with other agencies or departments. Challenges from earlier evaluation periods—such as compiling data sources and conducting community outreach—have largely been addressed, allowing evaluation to continue without major impediments. The interim evaluation also highlighted actionable areas for improvement, including increasing awareness and use of Targeted Case Management services, supporting ongoing lead screening for children and pregnant enrollees, and enhancing community education and administrative processes. These findings underscore the continued need for the waiver to improve access, service utilization, and health outcomes.

During the extension period, planned evaluation activities include:

- Ongoing administrative and survey data collection to assess access to services, health outcomes, and TCM utilization.

- Continued engagement with community partners to identify barriers, opportunities, and best practices for outreach and enrollment.
- Regular interim reporting to CMS, aligned with updated demonstration monitoring guidance.
- Summative evaluation culminating in a final report expected by March 31, 2027, assessing the demonstration’s cumulative impact and informing future program improvements.
- Integration of additional data sources, as available, to refine utilization estimates and participant-reported outcomes.

Available data to date indicate the waiver has been successful in meeting selected goals, with opportunities for enhanced performance remaining. The interim and future summative evaluations provide a foundation for continuous quality improvement and evidence-based program refinement.

Budget Neutrality and Financial Data

To report on past enrollment and expenditures and to make projections, the population is separated into two groups: “Full Coverage” beneficiaries and “TCM-Only” beneficiaries. “Full Coverage” beneficiaries include all individuals under 21 years of age and pregnant women (of any age) under 400 percent of the federal poverty level (FPL) but higher than the FPL for their enrollment category (between 212 and 400 percent FPL for children under 20, between 133 and 400 percent FPL for age 20, and between 195 and 400 percent FPL for pregnant women). “TCM-Only” beneficiaries are individuals who were Medicaid-eligible prior to the waiver but receive additional targeted case management (TCM) services as a result of the demonstration.

Historical and Projected Expenditures

The Demonstration years in the following tables are aligned with the definitions in the special terms and conditions. Since the data were retrieved in September 2025, enrollment for demonstration year 9 is not complete.

	Total Member Months		Total Utilization			
DY 2016*	220,723	TCM-Only Benes	215,606	TCM-Only Benes	\$832,457	
		Full Coverage Benes	5,117	Full Coverage Benes	\$597,133	
DY 2017	341,155	TCM-Only Benes	331,770	\$3,035,871	TCM-Only Benes	\$2,033,836
		Full Coverage Benes	9,385		Full Coverage Benes	\$1,002,035
DY 2018	325,791	TCM-Only Benes	315,091	\$3,584,764	TCM-Only Benes	\$2,283,043
		Full Coverage Benes	10,700		Full Coverage Benes	\$1,301,721
DY 2019	312,299	TCM-Only Benes	301,224	\$3,664,937	TCM-Only Benes	\$2,388,925
		Full Coverage Benes	11,075		Full Coverage Benes	\$1,276,012
DY 2020	310,786	TCM-Only Benes	298,284	\$4,805,817	TCM-Only Benes	\$3,712,154
		Full Coverage Benes	12,502		Full Coverage Benes	\$1,093,663
DY 2021	312,066	TCM-Only Benes	299,304	\$4,075,970	TCM-Only Benes	\$2,304,079
		Full Coverage Benes	12,762		Full Coverage Benes	\$1,771,891
DY 2022	298,361	TCM-Only Benes	291,918	\$5,188,036	TCM-Only Benes	\$3,007,260

		Full Coverage Benes	6,443		Full Coverage Benes	\$2,180,776
DY 2023	283,635	TCM-Only Benes	276,234	\$5,479,096	TCM-Only Benes	\$3,207,786
		Full Coverage Benes	7,401		Full Coverage Benes	\$2,271,310
DY 2024	281,634	TCM-Only Benes	273,255	\$5,963,530	TCM-Only Benes	\$3,257,382
		Full Coverage Benes	8,379		Full Coverage Benes	\$2,706,148
DY 2025 (Projected)	281,935	TCM-Only Benes	257,938	\$6,914,678	TCM-Only Benes	\$3,939,279
		Full Coverage Benes	8,825		Full Coverage Benes	\$2,975,399

*Program enrollment began in May 2016, this row reflects on 9 months of data

Enrollment and Expenditure Projections

Projecting the next five years of costs associated with the waiver involves population projection followed by utilization. Historic enrollment and costs were analyzed for the two enrollment groups. A “per member per month” (PMPM) cost was calculated for each group, with trends applied to estimate future costs. The PMPM was multiplied by the member months expected each year for both groups to project total waiver utilization.

	Total Member Months		Total Utilization			
DY 2026 (Projected)	268,685	TCM-Only Benes	259,425	\$7,055,742	TCM-Only Benes	\$3,921,682
		Full Coverage Benes	9,260		Full Coverage Benes	\$3,134,060
DY 2027 (Projected)	262,644	TCM-Only Benes	252,773	\$7,507,012	TCM-Only Benes	\$4,122,500.48
		Full Coverage Benes	9,871		Full Coverage Benes	\$3,384,511.86
DY 2028 (Projected)	256,603	TCM-Only Benes	246,121	\$7,958,283	TCM-Only Benes	\$4,323,319.05
		Full Coverage Benes	10,482		Full Coverage Benes	\$3,634,963.53
DY 2029 (Projected)	250,561	TCM-Only Benes	239,469	\$8,409,553	TCM-Only Benes	\$4,524,137.62
		Full Coverage Benes	11,903		Full Coverage Benes	\$3,885,415.20
DY 2030 (Projected)	244,520	TCM-Only Benes	232,816	\$8,860,823	TCM-Only Benes	\$4,724,956.19
		Full Coverage Benes	11,704		Full Coverage Benes	\$4,135,866.87

These projections reflect an average number of distinct beneficiaries per year based on the overall member months. The state is not requesting any changes to the program. Based on current projections, a large number of individuals in both categories would lose coverage if the waiver were discontinued.

Funding Sources

The state’s intended source for financing the non-federal share of expenditures under the demonstration is the state general fund.

Public Notice and Comment Process

Documentation of Public Notice

The following methods were used by the state to provide notice to the public and solicit input from interested parties:

- Notice (L 25-56) sent to Tribal Chairs and Health Directors on (9/19/25)
- Full public notice posted on department website (9/19/25)

- Abbreviated public notice sent to state newspapers (9/19/25)
- Public meeting & open comment held by Medicaid Advisory Council (9/23/25)
- Public meeting & open comment held in Flint, MI (10/20/25)

Summary of Public Comments and State Response

A full summary of written, oral, and electronic comments, along with responses from MDHHS, will be included in the final version following the closure of the public comment period.

Appendices

Appendix A: Glossary of Terms

Term / Acronym	Definition / Explanation
DY	Demonstration Year – the year associated with the Medicaid demonstration period.
EQRO	External Quality Review Organization – independent entity contracted to review Medicaid managed care performance.
TCM	Targeted Case Management – Medicaid service providing care coordination for eligible individuals.
TCM-Only Beneficiaries	Members receiving only TCM services, not full Medicaid coverage.
Full Coverage Beneficiaries	Medicaid members receiving the full range of covered services.
Total Member Months	Sum of all months of enrollment for all members during a given year.
Total Utilization	Total expenditures for services provided to members during a given year.
PMPM	Per-Member-Per-Month – average monthly cost per enrolled member, calculated as Total Utilization ÷ Total Member Months.
MDHHS	Michigan Department of Health and Human Services – state agency administering Medicaid in Michigan.
MHP	Medicaid Health Plans
CMS	Centers for Medicare & Medicaid Services – federal agency overseeing Medicaid and Medicare programs.
Public Notice	Official announcement informing the public about program changes, eligibility, or opportunities to comment.
Abbreviated Public Notice	Shortened version of the public notice for broader distribution.
Tribal Notice	Notification specifically for federally recognized tribes regarding program updates or consultation opportunities.
Press Release	Public-facing announcement issued to media outlets.
Erratum Notice	Correction or clarification issued after the original publication of a report or document.

Term / Acronym	Definition / Explanation
SPA	State Plan Amendment – formal change to a state’s Medicaid plan requiring CMS approval.
VPP	Voluntary Provider Program – optional program or benefit available under a demonstration (if applicable).
Projected Values	Estimates of member counts, utilization, and costs for future demonstration years, used for planning and budgeting.
Actual Values	Observed data for member counts, utilization, and costs during completed demonstration years.

Appendix B: References/Supporting Documents

B.1 MDHHS Policy Bulletin – Flint Medicaid Demonstration Eligibility Updates

- **Title:** “Eligibility for Flint Medicaid Demonstration Population”
- **Bulletin Number:** MMP 25-33
- **Date Issued:** August 29, 2025
- **Effective Date:** October 1, 2025
- **Description:** Clarifies eligibility parameters for children and pregnant women served by the Flint water system, ensuring continued access to Medicaid coverage and lead-related supports for the second extension period (Demonstration Years 11–15).
- **Link / Attachment:** [Final-Bulletin-MMP-25-33-Eligibility.pdf](#)

B.2 Previous Extension Application

- **Title:** *Flint Medicaid Expansion Waiver Extension Application*
- **Date Submitted:** 2020
- **Description:** Prior extension application approved by CMS for Demonstration Years 6–9 (March 2020 – September 2025). Serves as a reference for historical program design, budget neutrality methodology, and evaluation framework.
- **Link / Attachment:** <https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/mi-health-impacts-potential-lead-exposure-pa.pdf>

B.3 MDHHS Policy Bulletin – Flint Medicaid Waiver Implementation

- **Title:** *Implementation of Flint Medicaid Waiver*
- **Bulletin Number:** MSA 16-10
- **Date Issued:** March 3, 2016
- **Effective Date:** March 1, 2016
- **Description:** Announces implementation of the Flint Waiver, outlining eligibility groups, benefits, and covered services available to children and pregnant women impacted by the Flint water crisis.

- **Link / Attachment:** https://www.michigan.gov/mdhhs/-/media/Project/Websites/mdhhs/Folder1/Folder98/MSA_16-10.pdf?rev=022b1af6bf834cbc89756d6704c1d6f2&hash=E7096EA82CEF9EB47FADCA7E8993B0F4B.5 MDHHS Policy Bulletin – Flint Waiver Service Guidance
- **Title:** *Flint Waiver Coverage and Services*
- **Bulletin Number:** MSA 16-11
- **Date Issued:** March 3, 2016
- **Effective Date:** March 1, 2016
- **Description:** Provides detailed operational guidance on enrollment processes, service delivery, and provider responsibilities under the Flint Waiver.
- **Link / Attachment:** https://www.michigan.gov/mdhhs/-/media/Project/Websites/mdhhs/Folder1/Folder46/MSA_16-11.pdf?rev=32646acf48c243179a709e3c390a2ba6&hash=C2FA7321D3C569A46C486BB794B1EEBF

B.4 MDHHS Policy Bulletin – Flint Waiver Administrative Updates

- **Title:** *Administrative Updates for Flint Medicaid Waiver*
- **Bulletin Number:** HASA 22-08
- **Date Issued:** September 9, 2022
- **Effective Date:** October 1, 2022
- **Description:** Updates program administration processes, reporting requirements, and coordination across state systems to support waiver operations.
- **Link / Attachment:** https://www.michigan.gov/-/media/Project/Websites/mdhhs/Folder1/Folder2/Folder1/HASA_22-08.pdf?rev=347bf717e2b04ae7aaf6ae3178c36e6f

B.5 Presentations

- **Title:** *Community and Stakeholder Presentations on Flint Medicaid Waiver*
- **Date Range:** TBD
- **Description:** Includes MDHHS-led presentations to CMS, community stakeholders, and advisory groups that summarize program design, implementation, evaluation progress, and lessons learned.
- **Link / Attachment:** *to be linked/attached upon completion of presentations*

Appendix C: EQRO Reports

C.1 2023–2024 External Quality Review Technical Report for Medicaid Health Plans

- **Title:** 2023–2024 External Quality Review Technical Report for Medicaid Health Plans
- **Link to Report:** https://www.michigan.gov/mdhhs/-/media/Project/Websites/mdhhs/Assistance-Programs/Medicaid-BPHASA/Other-Prov-Specific-Page-Docs/MI2024_MHP_EQR-TR_Report_F1_071825.pdf?rev=74abc45790234c3abe9f8d60c92c8a7b&hash=860A91D9E74F87AB76245EF1A0F86306
- **Description:** Technical review of Medicaid Health Plans covering DY2023–2024, including performance measures, compliance evaluation, and quality improvement recommendations. The erratum corrects minor errors identified after initial publication.

C.2 2022–2023 External Quality Review Technical Report for Medicaid Health Plans

- **Title:** 2022–2023 External Quality Review Technical Report for Medicaid Health Plans
- **Link to Report:** https://www.michigan.gov/mdhhs/-/media/Project/Websites/mdhhs/Assistance-Programs/Medicaid-BPHASA/Other-Prov-Specific-Page-Docs/MI2023_MHP_EQR-TR_Report_F1.pdf?rev=db214fc4e2224df29343a81cc9b08bd2&hash=798B30EB1D1E1AB597AD62AAE5C83396
- **Description:** Evaluation of Medicaid Health Plan performance and quality metrics for DY2022–2023, providing key findings and recommendations for improvement.

C.3 2021–2022 External Quality Review Technical Report for Medicaid Health Plans

- **Title:** 2021–2022 External Quality Review Technical Report for Medicaid Health Plans
- **Link to Report:** https://www.michigan.gov/mdhhs/-/media/Project/Websites/mdhhs/Assistance-Programs/Medicaid-BPHASA/Other-Prov-Specific-Page-Docs/MI2022_MHP_EQR-TR_Report_F1.pdf?rev=1e1861a955b244cea0f28a852733264e&hash=892B992E34BDC980CA3C11F49F542AB1
- **Description:** Technical review and analysis of Medicaid Health Plan performance, including compliance, service delivery, and quality improvement opportunities for DY2021–2022.

C.4 2020–2021 External Quality Review Technical Report for Medicaid Health Plans

- **Title:** 2020–2021 External Quality Review Technical Report for Medicaid Health Plans
- **Link to Report:** https://www.michigan.gov/mdhhs/-/media/Project/Websites/mdhhs/Assistance-Programs/Medicaid-BPHASA/MI2021_MHP_EQR-TR_Report_F1.pdf?rev=677c4dfa7a314ba59347688ae62c9557&hash=BC3F9E7A0B0E9919507EE2422C15495B
- **Description:** Comprehensive assessment of Medicaid Health Plan performance for DY2020–2021, identifying strengths, gaps, and recommendations for quality improvement.

C.5 2019–2020 External Quality Review Technical Report for Medicaid Health Plans

- **Title:** 2019–2020 External Quality Review Technical Report for Medicaid Health Plans
- **Link to Report:** https://www.michigan.gov/mdhhs/-/media/Project/Websites/mdhhs/Folder2/Folder49/Folder149/MI2019-20_MHP_EQR-TR_Report_F1.pdf?rev=6e970bd145cd49b4a1c88504d37b527a&hash=E7CF79232EAA3DE08CA90965F0BED29B
- **Description:** Review and evaluation of Medicaid Health Plan operations and quality measures for DY2019–2020, with detailed findings and recommendations.

Appendix D: Public Notice Materials

D.1 Full Public Notice

- **Title:** Flint, Michigan Section 1115 Demonstration Waiver Extension Application
- **Link:** [https://www.michigan.gov/mdhhs/-/media/Project/Websites/mdhhs/Assistance-Programs/Medicaid-BPHASA/Other-Prov-Specific-Page-Docs/Revised-Flint-Waiver-Renewal---Short-and-Long-Public-Notice_091725-\(2\).pdf?rev=a3d85fba752a4ad7847838fba40282f7&hash=97CBE40C4C59F4DB4926E2D1736FBFAE](https://www.michigan.gov/mdhhs/-/media/Project/Websites/mdhhs/Assistance-Programs/Medicaid-BPHASA/Other-Prov-Specific-Page-Docs/Revised-Flint-Waiver-Renewal---Short-and-Long-Public-Notice_091725-(2).pdf?rev=a3d85fba752a4ad7847838fba40282f7&hash=97CBE40C4C59F4DB4926E2D1736FBFAE)
- **Date Issued:** 9/19/2025
- **Description:** In compliance with federal and state notice requirements, it provides: a comprehensive description of the demonstration extension; locations and internet addresses where copies of the application are available for public review; timeframe and postal and email addresses for public comments; and the location, date, and time of two public hearings.

D.2 Abbreviated Public Notice

- **Title:** Flint, Michigan Section 1115 Demonstration Waiver Extension Application
- **Link:** [https://www.michigan.gov/mdhhs/-/media/Project/Websites/mdhhs/Assistance-Programs/Medicaid-BPHASA/Other-Prov-Specific-Page-Docs/Revised-Flint-Waiver-Renewal---Short-and-Long-Public-Notice_091725-\(2\).pdf?rev=a3d85fba752a4ad7847838fba40282f7&hash=97CBE40C4C59F4DB4926E2D1736FBFAE](https://www.michigan.gov/mdhhs/-/media/Project/Websites/mdhhs/Assistance-Programs/Medicaid-BPHASA/Other-Prov-Specific-Page-Docs/Revised-Flint-Waiver-Renewal---Short-and-Long-Public-Notice_091725-(2).pdf?rev=a3d85fba752a4ad7847838fba40282f7&hash=97CBE40C4C59F4DB4926E2D1736FBFAE)
- **Date Issued:** 9/19/2025
- **Description:** An abbreviated version of the Public Notice, it provides: a description of the demonstration extension; locations and internet addresses where copies of the application are available for public review; timeframe and postal and email addresses for public comments; and the location, date, and time of two public hearings.

D.3 Tribal Notice

- **Title:** Section 1115 Waiver Extension Request to Assist in Addressing Health Impacts from Potential Lead Exposure in Flint, Michigan
- **Link:** <https://www.michigan.gov/mdhhs/-/media/Project/Websites/mdhhs/Assistance-Programs/Medicaid-BPHASA/2025-L-Letters/Numbered-Letter-L-25-56.pdf?rev=0ff163b86daa45e9a5bd7285e5b7f0ea&hash=24869038E7BAC5C3CC6A94F385E9BFE4>
- **Document Number / Identifier:** Provider Letter Number L 25-56
- **Date Issued:** 9/19/2025
- **Description:** Provides notification and consultation materials specifically for federally recognized tribes. Ensures that tribal governments are informed of the demonstration extension and invited to submit feedback or request meetings.

D.4 Public Comments

- **Title:** “Summary of Public Comments on Flint Michigan Section 1115 Demonstration”
- **Date Issued / Compiled:** *TBD*
- **Description:** Consolidated summary of all public comments received in response to the public notice. Includes comments from individuals, advocacy groups, and other stakeholders, along with MDHHS responses where applicable.

D.5 Website Notice

- **Title:** Section 1115 Waiver - Medicaid Eligibility for Flint Residents
- **URL:** <https://www.michigan.gov/mdhhs/assistance-programs/section-1115-waiver-medicaid-eligibility-for-flint-residents>
- **Description:** Central online location where the full public notice, abbreviated notice, Tribal notice, and related materials are posted for public access.

Appendix E: Flint Michigan Section 1115 Demonstration Interim Evaluation Report

- **Title:** *Flint Michigan Section 1115 Demonstration Interim Evaluation Report*
- **Author:** Michigan State University Institute for Health Policy
- **Date Submitted to MDHHS:** July 31, 2025
- **Coverage Period:** September 15, 2021 – December 31, 2024
- **Description:** Provides an interim evaluation (pre-CMS review) of waiver operations, enrollment, service utilization, and outcomes, including preliminary findings and recommendations to inform the waiver extension.
- **Link / Attachment:** MSU-Interim-Evaluation-2025.pdf



Flint, Michigan Section 1115 Demonstration

Project Number 11-W-00302/5

September 15, 2021 – December 31, 2024

Interim Evaluation Report

Submitted: July 31, 2025



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Executive Summary

In April 2014, the City of Flint switched the municipal water supply from Lake Huron and the Detroit River to the Flint River. A lack of adequate corrosion control of the new water source by the local water treatment facility resulted in pipes leaching lead and other contaminants (Masten, et. al., 2016). The presence of lead and other contaminants in the city's water source created a public health crisis.

Health providers discovered that Flint children's blood lead levels (BLL) increased significantly from 2.4% to 4.9% after the water source change (Hanna-Attisha, 2016). Neighborhoods with aging lead pipes and infrastructure experienced a 6% increase in lead levels in the drinking water (Raymond & Brown, 2017). State and federal emergency declarations were announced in 2016 to leverage resources intended to mitigate potential health effects of the lead exposure and improve ongoing health outcomes.

Lead is a neurotoxin and high BLLs can affect the developing brain and neural systems. Lead exposure in utero and in young children has the potential to cause serious physical and developmental delays. Most notably, neurodevelopmental effects can impact cognitive development, behavior, and a healthy life trajectory. Likewise, in unborn children, lead crosses the placenta as a toxin and can cause miscarriage, low-birth weight, and affect major organs. These effects are difficult to ameliorate and often sustained into adulthood.

The Michigan Department of Health and Human Services (MDHHS) successfully applied to the Center for Medicare and Medicaid Services (CMS) for an 1115 Demonstration Waiver known as the Flint Medicaid Expansion (FME). The FME was approved March 3, 2016, and enrollment commenced on May 9, 2016, approximately two years after the water switch date of April 25, 2014. The waiver increased the Medicaid eligibility maximum income level from 212% federal poverty level (FPL) to 400% FPL. The waiver authorization also provided targeted case management (TCM) as a supplemental benefit to ensure broader access to needed health supports. Benefits were limited to pregnant women and children 21 years of age and younger who were exposed to contaminated water.

A condition of waiver approval was the requirement for a third-party evaluation. Michigan State University College of Human Medicine's Institute for Health Policy was contracted to perform the evaluation. The First Demonstration period of the evaluation covered a five-year period from March 2016 to September 2021 (Demonstration Years 1-5). The Renewal Demonstration period evaluation covered an additional five-year period from September 15, 2021, to September 30, 2026, described as Demonstration Years 6-10 (Table 1). Evaluation activities thus far have been conducted based on calendar years.

Table 1: CMS Demonstration Year (DY) Definition

Demonstration Years (DY)		
DY 6	September 15, 2021 – September 30, 2022	12 months
DY 7	October 1, 2022 – September 30, 2023	12 months
DY 8	October 1, 2023 – September 30, 2024	12 months
DY 9	October 1, 2024 – September 30, 2025	12 months
DY 10	October 1, 2025 – September 30, 2026	12 months

In this cumulative interim report, completed evaluation activities from 9/15/2021 to 12/31/2024 are described. The specific evaluation activities included Medicaid administrative data analyses for dates of service 9/15/2021–9/30/2023, enrollee surveys conducted in calendar years 2023 and 2024, and community partner surveys conducted in the 2024 calendar year. Administrative data cycles were delayed due to the need to allow at least 90 days for claims processing. Thus, the administrative data obtained for this report is restricted to Demonstration Years 6 (9/15/2021–9/30/2022) and 7 (10/1/2022–9/30/2023).

Preliminary findings from administrative claims data along with enrollee survey responses suggest the waiver had moderate success in meeting the overarching goals to improve access to services, expand Medicaid eligibility, and improve health outcomes. Currently available data suggests positive impacts for the three domains. Below is a summary of key findings.

Domain 1, Access to Services, were evaluated through two sub-hypotheses. Both sub-hypotheses were supported by information collected through administrative claims and enrollee survey data.

Domain 1 Hypothesis 1.1 stated, *“FME Demonstration enrollees will access services to identify and address physical or behavioral health issues associated with lead exposure at a rate higher than non-enrollees with similar individual and neighborhood characteristics over the duration of the demonstration.”* Analyses documented statistical differences between FME and comparison groups in several measures. Preliminary analyses of 9/15/2021–9/30/2023 Medicaid claims suggest FME enrollees under age twelve accessed well-child visits and pregnant FME enrollees received recommended lead testing during pregnancy at higher rates than the comparison group during this timeframe. These differences may indicate improved access to services and heightened awareness of the importance of lead testing during pregnancy. Unfortunately, FME enrollees experienced declines in lead testing and follow-up after detecting EBLL in children before age two as well as access to timely prenatal care according to administrative data. However, FME enrollee survey respondents reported the waiver increased their access to health care services and felt their provider was working in their best interest.

Domain 1 Hypothesis 1.2 stated *“Enrollees who participate with TCM service will access medical, social, educational, and other services at a rate higher than enrollees with similar individual and neighborhood characteristics who do not participate with TCM services over the duration of the FME Demonstration.”* Due to low TCM uptake and participation, limited impact was documented. The rate of TCM utilization has continued to remain low. However, survey



participants who reported using TCM expressed greater positive sentiments about the waiver's impact on access to resources and services compared to survey participants who did not use TCM. The 2023 and 2024 child surveys revealed that children using TCM services had moderately higher rates of developmental screening in the first three years. Despite the low number of FME enrollees using TCM services, those involved reported high levels of trust and engagement in services and, in most cases, improved health status.

Domain 2, Expanded Medicaid Eligibility, stated *"the proportion of new enrollees between 212-400% FPL will increase over the duration of the FME Demonstration representing an increase in the proportion of individuals having health care coverage."* The waiver increased income eligibility from 212% to 400% FPL providing coverage to a population that normally would not be eligible for Medicaid. In general, enrollment relied on individuals having knowledge of the expanded income eligibility. Community providers and partners confirmed there was low community awareness regarding the requirements of the waiver. This observation emphasized the importance of improving client and community education, to increase accessibility and enrollment. Overall, a small percentage of total FME enrollees were in the 212-400% FPL category; in part, because of the low average income within this community Enrollees at the higher income level were more likely to report having another form of health insurance prior to FME enrollment compared to the lower FPL enrollees. Additionally, a greater percentage of the higher FPL category survey participants reported enrolling in the waiver to cover the cost of health care than their low FPL counterparts.

Domain 3, Improved Health Outcomes, stated *"Enrollees will have improved health outcomes compared to non-enrollees with similar individual and neighborhood characteristics over the duration of the FME Demonstration."* Preliminary analyses showed that enrollees may experience positive health outcomes as a result of waiver participation. Childhood immunization rates for both the FME and comparison group have been noted to decrease from 9/15/2021 through 9/30/2023, which aligns with the decrease in national vaccination rates. However, the rate of decline of immunization services among FME children two years of age was found to be less than that of non-enrollees. The percentage of survey participants with a chronic condition(s) who reported having access to services as a result of the waiver increased between the 2023 and 2024 surveys. Participants also reported improved confidence in managing their health condition(s) as a result of the waiver.

The results described in this report are provisional. As the evaluation continues to obtain additional data points, the patterns identified may change. Preliminary findings from administrative health data and enrollee survey responses suggest the waiver had moderate success in meeting the overarching goal to improve access to services, expand Medicaid eligibility, and improve health outcomes.

Notably, greater utilization of well-child visits and developmental screening for waiver enrollees compared to the comparison group was observed. Enrollee and comparison groups experienced a decline in accessing prenatal care for this reporting period. This observation may be associated with an overall downward trending in birth rates. It may also be an artifact of timing associated with the COVID-19 pandemic. During the COVID-19 pandemic, the rate of accessing health services decreased and it may not have rebounded in DY 6-7. Access to lead



testing for children and pregnant residents of Flint was lower than in previous reports. It could also be a result of providers being less aware of the requirement to complete blood lead level testing as the urgency and publicity of the water crisis has lessened over time.

TCM participation continued to be low, but those who utilized these services benefitted. Thirty percent of enrollees reported having a chronic condition(s) and indicated that the waiver allowed them greater access to services for these health conditions. This is a testament to the benefit and usefulness of FME. Survey respondents and community partners expressed satisfaction and acknowledged benefits of TCM.

The FME waiver was intrinsically different than typical Medicaid demonstration waivers. This waiver was enacted in response to an environmental emergency rather than testing options to improve existing services or innovate payment structures.

Reinforcing existing benefits associated with the waiver are needed. Namely, increasing and strengthening messaging around the importance of child health services and developmental screening post lead exposure. Pregnant women would also benefit from heightened awareness of the impact of lead on a developing fetus and mitigation strategies. Preliminary findings suggest a need to increase communication to enrollees, providers, and the greater community about waiver eligibility and associated TCM service. Thus, it is recommended that, for future Medicaid expansion efforts, there be regular and consistent communication and education efforts to the community about access to services and conditions of waiver eligibility.

The full impact of the approved Renewal Demonstration period cannot yet be assessed until the completion of the waiver evaluation period. Early results suggest the waiver has provided moderate success in achieving the state's overarching goals for the waiver with remaining opportunities to improve.

Data sources targeted for the 2025 evaluation year activity include administrative claims data (10/1/2023-9/30/2024) and the 2025 enrollee surveys. Evaluation activities in process as of this submission date (June 2025) will be available in a forthcoming 2025 Annual Report with an anticipated submission date of March 03, 2026.

General Background Information

The Flint Medicaid Expansion (FME) waiver, funded by the Centers for Medicare & Medicaid Services (CMS) and administered by the Michigan Department of Health & Human Services (MDHHS), was designed to address the public health emergency that resulted from the Flint Water Crisis. In April 2014, the water source for the City of Flint was switched from Lake Huron and the Detroit River to the Flint River to decrease costs. The change in the water’s chemical composition, without appropriate treatment, caused lead pipes to leach toxins into the Flint municipal water supply exposing individuals in their homes and workplaces.

The main consequence of the water switch was heightened lead levels in the city water that resulted in elevated blood lead levels (EBLL) for Flint residents (National Center for Environmental Health, 2024). Lead is a neurotoxin and, although no level is considered safe, acceptable limits are defined and assessed through screening programs. Children with EBLL have an increased risk of potential future health issues (Lanphear, et al., 2024). Likewise, fetuses of pregnant women having EBLL face similar risks for cognitive disorders and behavioral difficulties.

The onset of EBLL symptoms becomes particularly distinct as adolescents enter school-age (Hanna-Attisha, 2016; Roja & Trujillo, 2019). In 2014, it was estimated that over 100,000 residents were affected by the water change; of which approximately 25,000 were infants and children (United States Census Bureau, 2014). Individuals residing outside of affected sections of the city, but working, attending school, admitted to hospital, residential health care settings, or incarcerated in Flint were also at risk for exposure.

In January 2016, the event was declared a state and federal emergency. This declaration leveraged federal aid to support state and local response efforts. The initial FME waiver was approved in March 2016 with implementation and enrollment commencing in May 2016. The First Demonstration period covered a 5-year period from March 2016 through September 2021, Demonstration Years 1-5. The Renewal Demonstration period covers the 5-year period from September 2021 through September 30, 2026, Demonstration Years 6-10, as defined in Table 1.

Table 1: CMS Demonstration Year (DY) Definition

Demonstration Years (DY)		
Demonstration Year 6	September 15, 2021 – September 30, 2022	12 months
DY 7	October 1, 2022 – September 30, 2023	12 months
DY 8	October 1, 2023 – September 30, 2024	12 months
DY 9	October 1, 2024 – September 30, 2025	12 months
DY 10	October 1, 2025 – September 30, 2026	12 months

The intent of the waiver was to expand access to health care services and to mitigate the potential impacts of lead exposure for children up to age 21 and those born to exposed pregnant women during the exposure period. Specific eligibility modifications included:



- Increased the income threshold for children from 212% federal poverty level (FPL) and pregnant women from 195% FPL to 400% FPL.
- Provided children and pregnant women above 400% FPL with the option to buy into the Medicaid benefit.
- Added Targeted Case Management (TCM) benefits to assist enrollees in accessing needed medical, behavioral, educational, and other services.

The expansion covers individuals meeting eligibility criteria, from the date the water source was originally switched to the Flint River (4/25/2014) through a date on which the water is officially deemed safe. Lead levels in the water have met state and federal standards. Further, on May 19, 2025, the United States Environmental Protection Agency (EPA) announced the City of Flint had officially completed requirements established in the 2016 Safe Drinking Water Act. Specifically, the city had replaced over 97% of lead pipes to homes (United States Environmental Protection Agency, 2025). With pipe replacement coming to a close, waiver eligibility is expected to change. New enrollment may be terminated. However, the waiver remains necessary to ensure ongoing access to services for previously enrolled beneficiaries to mitigate effects of previous lead exposure. As of the submission of this report (June 2025), FME waiver enrollment remains open.

A condition for waiver approval was the requirement for an independent evaluation. MDHHS engaged Michigan State University College of Human Medicine's Institute for Health Policy (IHP) to carry out the evaluation goals and activities described in the Centers for Medicare and Medicaid Services (CMS) approved evaluation proposal. The evaluation team included faculty and staff from IHP as well as faculty from other departments of the Colleges of Human Medicine (CHM) and Social Science (CSS). The CHM Departments of Epidemiology and Biostatistics, Public Health, and Family Medicine along with the College of Social Science's Office for Survey Research collaborated on the evaluation.

The Renewal Demonstration period evaluation team included:

- Karen Clark, BA, Office for Survey Research, CSS, MSU
- Sabrina Ford, PhD, Institute for Health Policy, CHM, MSU
- Nicole Jones, PhD, C.S. Mott Department of Public Health, CHM, MSU
- Joan Ilardo, PhD, LMSW; Office of Medical Education Research and Development & Department of Family Medicine, CHM, MSU
- Zhehui Luo, PhD; Department of Epidemiology and Biostatistics, CHM, MSU
- Kathleen Oberst, RN, PhD; Institute for Health Policy, CHM, MSU
- Elizabeth Richardson, MPP, Institute for Health Policy, CHM, MSU
- Richard Sadler, PhD; C.S. Mott Department of Public Health, CHM, MSU
- Liang Wang, PhD, Department of Epidemiology and Biostatistics, CHM, MSU
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The FME Waiver renewal application for the second 5-year period (DYs 6-10) was submitted with no major program changes. Lessons learned from the first evaluation period (DY 1-5) provided opportunities to enhance the second evaluation proposal (DY 6-10). This included an increased focus on administrative and operational aspects of the waiver that were intended to enhance participation. The renewal evaluation proposal was approved by CMS on 1/30/2023.

The evaluation findings contained in this report are preliminary and reflect the completed activities conducted by the evaluation team from 9/15/2021 to 12/31/2024. Activities completed thus far consist of analyzing data collected through Medicaid administrative data, FME enrollee surveys, and community partner surveys. Data sources targeted for the 2025 evaluation year activity include administrative claims data and enrollee surveys. Evaluation activities in process as of this submission date (June 2025) will be available in the forthcoming 2025 Annual Report with an anticipated submission date of March 03, 2026.

Evaluation Questions and Hypotheses

The approved Evaluation Design for the Renewal Demonstration addressed the following domains set forth in the approved FME Waiver application:

- Domain 1. Access to Services
- Domain 2. Expanded Medicaid Eligibility
- Domain 3. Improved Health Outcomes

A summary of all measures by domain are presented in the Methodology “Evaluation Measures” section of this report. A copy of the approved Renewal Demonstration Evaluation Plan is provided in Appendix 1 and contains detailed specifications of each measure included under each domain.

The following provides a description of how FME demonstration goals were translated into measurable targets.

Domain 1. Access to Services

The approved FME Waiver Renewal Demonstration expanded Medicaid eligibility and access to health care services for at risk populations (children and pregnant women) exposed to lead contaminated water. FME enrollees were also provided targeted case management (TCM) services to navigate health related services. Additionally, coverage for evaluation of potential lead exposures in homes of eligible FME enrollees was offered without the requirement that elevated blood lead levels were documented in advance of the environmental assessment.

The ability to pay out of pocket for services or the availability of health insurance to cover associated costs is one factor in accessing health care. Another influence is the degree of health literacy and understanding on the importance for screening and preventive health services. Thus, the TCM benefit was included with the expectation that it would assist enrollees in overcoming barriers to access health care services as well as provide education on the importance of utilizing these services. Hypotheses related to enrollee adherence to



recommended age-appropriate services were designed to inform whether the goal to improve access to care was met. Due to barriers related to obtaining pipe replacement data, enrollee surveys included questions about home lead pipe replacement and testing.

For the Renewal evaluation, Domain 1 consisted of two hypotheses: 1.1) waiver enrollees will access services at a rate higher than non-enrollees; and 1.2) waiver enrollees who use TCM will access services at a rate higher than enrollees who do not use TCM. Most health-related Domain 1 sub-hypotheses reflect utilization of preventive services endorsed by the U.S. Preventive Services Task Force to promote overall health. The following describes how Domain 1 evaluation hypotheses align with the state's demonstration goals.

Hypothesis 1.1

*Hypothesis 1.1 – “FME Demonstration enrollees will access services to identify and address physical or behavioral health issues associated with lead exposure at a rate higher than **non-enrollees with similar individual and neighborhood characteristics** over the duration of the demonstration.”*

The waiver is expected to provide Medicaid coverage and health care access. Evaluation questions for Hypothesis 1.1 measured the state's target of improving waiver enrollee's access to health care services through the expansion of eligibility criteria. Domain 1, Hypothesis 1.1 consisted of nine sub-hypotheses focusing on the uptake of specific preventive services recommended for children up to 21 years of age and pregnant women. Enrollee health care utilization rates were compared to non-enrollees with similar individual and neighborhood characteristics to assess whether the waiver increased access.

Child/Pediatric Measures:

- H1.1.1. FME Demonstration enrollees will access age-appropriate well-child exams at a rate higher than non-enrollees with similar individual and neighborhood characteristics over the duration of the demonstration.
- H1.1.2. FME Demonstration enrollees will access age-appropriate developmental screening at a rate higher than non-enrollees with similar individual and neighborhood characteristics over the duration of the demonstration.
- H1.1.3. FME Demonstration enrollees will access age-appropriate lead testing and follow-up/retesting as indicated at a rate higher than non-enrollees with similar individual and neighborhood characteristics over the duration of the demonstration.

Pregnancy Measures:

- H1.1.4. Pregnant FME Demonstration enrollees will access timely prenatal and postpartum care at a rate higher than non-enrollees with similar individual and neighborhood characteristics over the duration of the demonstration.
- H1.1.5. Pregnant FME Demonstration enrollees will access recommended lead testing at a rate higher than non-enrollees with similar individual and neighborhood characteristics over the duration of the demonstration.



H1.1.6. Pregnant FME Demonstration enrollees will participate in the state's Maternal Infant Health Program (MIHP) at a rate higher than non-enrollees with similar individual and neighborhood characteristics over the duration of the demonstration.

Improved Care & Satisfaction Measures:

H1.1.7. FME Demonstration enrollees will attest to improved health care access as a result of waiver participation.

H1.1.8. FME Demonstration enrollees will attest to satisfaction with their ability to access health care services as a result of waiver participation.

Lead Hazard Investigation:

H1.1.9. FME Demonstration enrollees will attest to having evaluation of potential lead exposure in their home if their pipes have not been replaced.

Hypothesis 1.2

*Hypothesis 1.2 – “FME Demonstration enrollees who participate with TCM services will access medical, social, educational, and other services at a rate higher than FME **demonstration enrollees with similar individual and neighborhood characteristics who do not participate with TCM** services over the duration of the demonstration.”*

The waiver included TCM benefits to assist enrollees in overcoming barriers to accessing needed medical, social, educational, and other services. Preventive health care service utilization rates for TCM and non-TCM users were analyzed to determine if the provision of TCM benefits achieved the state's goal of increasing access to services. The same preventive health care services in Hypothesis 1.1 were assessed. The rationale was that TCM participants would have additional assistance in understanding the importance of and accessing needed services versus enrollees who did not use the TCM benefit. FME enrollees who did not take advantage of the TCM benefit would navigate the health system more independently and might be unaware of available supports or services associated with mitigating lead exposure. Domain 1 Hypothesis 1.2 included nine sub-hypotheses.

Child/Pediatric Measures:

H1.2.1. FME Demonstration enrollees who participate with TCM will access age-appropriate well-child exams at a rate higher than enrollees who do not participate with TCM over the duration of the demonstration.

H1.2.2. FME Demonstration enrollees who participate with TCM will access age-appropriate developmental screening at a rate higher than enrollees who do not participate with TCM over the duration of the demonstration.

H1.2.3. FME Demonstration enrollees who participate with TCM will access age-appropriate lead testing and follow-up/retesting as indicated at a rate higher than enrollees who do not participate with TCM over the duration of the demonstration.



Pregnancy Measures:

H1.2.4. Pregnant FME Demonstration enrollees who participate with TCM will access timely prenatal and postpartum care at a rate higher than pregnant enrollees who do not participate with TCM over the duration of the demonstration.

H1.2.5. Pregnant FME Demonstration enrollees who participate with TCM will access recommended lead testing at a rate higher than pregnant enrollees who do not participate with TCM over the duration of the demonstration.

H1.2.6. Pregnant FME Demonstration enrollees who participate with TCM will participate in the state's Maternal Infant Health Program (MIHP) at a rate higher than pregnant enrollees who do not participate with TCM over the duration of the demonstration.

Improved Care & Satisfaction Measures:

H1.2.7. FME Demonstration enrollees who participate with TCM will attest to improved health care access as a result of waiver participation at a rate higher than enrollees who do not participate with TCM.

H1.2.8. FME Demonstration enrollees who participate with TCM will attest to satisfaction with their ability to access health care services as a result of TCM participation.

Lead Hazard Investigation:

H1.2.9. FME Demonstration enrollees who participate with TCM will attest to having evaluation of potential lead exposure in their home if their pipes have not been replaced as a result of TCM participation.

Domain 2. Expanded Medicaid Eligibility

Hypothesis 2 – *“The proportion of new enrollees between 212-400% FPL will increase over the duration of the FME Demonstration representing an increase in the proportion of individuals having health care coverage.”*

Domain 2 aligned evaluation efforts with the State's goal to expand financial eligibility. Medicaid eligibility was expanded to allow individuals at higher income levels to enroll. The intention was to eliminate financial barriers to health care so exposed individuals could receive services they might otherwise be unable to access. Individuals above 212% FPL are typically not eligible for Michigan Medicaid. Therefore, community outreach efforts were necessary to inform individuals at higher income levels that they may qualify for Medicaid under the FME waiver.

Domain 2 evaluates how enrollees in the expanded income eligibility group obtained information about the waiver and the degree to which the waiver provided them with an opportunity to replace existing health insurance coverage. Additionally, community partners supporting Medicaid enrollment needed to know the eligibility criteria expansion. Domain 2 consisted of four sub-hypotheses.



- H2.1. FME Demonstration enrollees between 212-400% FPL will attest to having information regarding expanded Medicaid eligibility resulting in waiver participation.
- H2.2. Community partners involved with Medicaid enrollment will attest to awareness of FME Demonstration eligibility and enrollment processes.
- H2.3. Community partners involved with Medicaid enrollment will attest to satisfaction with FME Demonstration enrollment processes.
- H2.4. FME Demonstration enrollees between 212-400% FPL will attest that the demonstration authorized expanded Medicaid eligibility offered a new opportunity to obtain health care coverage versus serving as a replacement for existing health care coverage.

Domain 3. Improved Health Outcomes

Hypothesis 3 – *“Enrollees will have improved health outcomes compared to non-enrollees with similar individual and neighborhood characteristics over the duration of the FME Demonstration.”*

The goal of the waiver was to improve health outcomes for children at or under 21 years of age and pregnant women who were exposed to the contaminated water. Domain 3 was established to determine if enrollees experienced better health outcomes, than similar individuals who were not enrolled, based on the theory that the FME waiver increased access to care as described in the driver diagram (Table 2). Domain 3 consisted of five sub-hypotheses.

- H3.1. FME Demonstration enrollees will have improved age-appropriate completed immunization status compared to non-enrollees with similar individual and neighborhood characteristics over the duration of the demonstration.
- H3.2. Pregnant Demonstration enrollees will have higher birth weights compared to non-enrollees with similar individual and neighborhood characteristics over the duration of the demonstration.
- H3.3. FME Demonstration enrollees will report improved health status as a result of the waiver participation.
- H3.4. FME Demonstration enrollees will report improved confidence in chronic condition self-management as a result of the waiver participation.
- H3.5. FME Demonstration enrollees will have an increased rate of referrals to specialized programs intended to mitigate potential educational and/or behavioral disabilities during childhood (ages 0-21) as a result of waiver participation.



Table 2. Domains as the drivers of the FME demonstration, including primary and secondary drivers of the domain.

Aim (Goal or Objective of the Work)	Primary Drivers (Key Drivers: System components or factors contributing directly to achieving aim)	Secondary Drivers (Actions, interventions, or lower-level components necessary to achieve the primary driver)
FME Demonstration enrollees will have increased access to selected health care services compared to non-enrollees having similar individual and neighborhood characteristics by 9/30/2026.	Individual having health care insurance.	History of lead exposure from contaminated water.
	Individual level of cost-sharing for health care services.	Household income level (FPL %).
	Ability to navigate health care systems.	Eligible population knowledgeable about demonstration eligibility and benefits.
		TCM and community service organization staff knowledge about FME demonstration eligibility and benefits.
Health literacy.	Enrollees seek care in primary care settings rather than urgent or emergent care settings.	
	Enrollees knowledgeable about recommended preventive care services.	
The number and proportion of FME demonstration enrollees at 212-400% FPL will increase by 9/30/2026 representing an increase in the proportion of individuals having health care coverage.	Eligible population knowledgeable about demonstration eligibility and benefits.	FME Demonstration communications and dissemination to potentially affected community members.
		Community partner(s) knowledgeable about demonstration eligibility and benefits.
Eligible population willing to choose Medicaid.	Efficient FME demonstration enrollment processes.	
FME Demonstration enrollees will have improved selected health outcomes compared to non-enrollees having similar individual and neighborhood characteristics by 9/30/2026.	Receipt of age-appropriate recommended preventive care services.	Enrollee participation with TCM services.
	Receipt of care coordination.	Enrollee is more confident in managing chronic conditions.
	Healthy living environments.	Enrollee awareness of the state’s redesigned Elevated Blood Lead-Nurse Care Management (EBL-NCM) program and the Lead Safe Home Program (LSHP).

Methodology

Evaluation Design

The approved evaluation plan, located in Appendix 1, proposed a pre-post, two-group comparison design, similar to a difference-in-differences (DiD) analytic strategy, when the parallel trend assumption was likely satisfied (Callaway & Sant’Anna, 2021; Goodman-Bacon, 2021; Wooldridge, 2023). Enrollee and community partner surveys provided complementary

information not available in the MDHHS Health Services Data Warehouse. A summary of the evaluation timeframe is presented in the Methodology “Evaluation Period” section of this report.

The evaluation project was reviewed and determined not “research,” as defined by the Common Rule in the U.S. Department of Health and Human Services (DHHS) regulations for protection of human research subjects, by the Michigan State University Institutional Review Board (IRB).

Target and Comparison Populations

The overall evaluation target population consisted of beneficiaries who enrolled in the FME waiver. The comparison groups varied depending on the specific hypothesis being tested. Administrative outcome measures were based on the Health Plan Employer Data Information Set (HEDIS) reporting. The comparison group was selected from records for Medicaid beneficiaries residing in other counties that were not eligible to enroll in the FME waiver and had similar characteristics to the FME-enrolled population.

The comparison populations for hypotheses about targeted enrollees were selected using a two-step procedure. First, three counties with a policy and health environment similar to that of Genesee County were identified using the K-means clustering method based on county-level socioeconomic, demographic, and health characteristics. Then, Medicaid beneficiaries in those counties with similar individual characteristics to the FME enrollees were selected. For different evaluation hypotheses, we considered different potential covariates. As stated above, the comparison group for the hypotheses regarding TCM utilization included the FME-enrolled beneficiaries who did not utilize TCM. Analyses based on administrative health data focused on those with continuous eligibility according to the corresponding HEDIS specifications. The approved Renewal Demonstration Evaluation Plan, located in Appendix 1, provides more in-depth detail into how target and comparison populations were selected.

Hypotheses regarding TCM utilization defined the target population as those FME-enrolled beneficiaries with documented TCM service utilization at least once during each analytic period (12 to 18-month period depending on the analytic sample). The comparison group for these measures included FME enrollees who did not use any TCM services during the analytic period. Evaluation measures derived from survey data did not include a comparison group.

Evaluation Period

The Renewal Demonstration period was approved for an additional five-year period from September 15, 2021, to September 30, 2026, described as Demonstration Years 6-10. The renewal evaluation proposal was approved by CMS on January 30, 2023. Formal evaluation activities began in February 2023.

Four timeframes were identified for this interim report coinciding with timeframes before, during, and after the water switch. The post-water switch timeframe was further subdivided by

activities during DY1-5 and activities occurring during DY6-10. These timeframes are described in Table 3.

The first period (T1) represents the baseline year before the water switch from May 1, 2013, to April 30, 2014. The second period (T2) represents the during/post-water-switch but prior to the FME implementation from May 1, 2014, to April 30, 2016. The third period (T3) refers to the First Demonstration period beginning in May 2016, (DYs 1-5). The last period (T4) refers to the period to date from the beginning of the Renewal Demonstration (DYs 6-10). The post-period was separated into T3 and T4 because the Renewal Demonstration evaluation aims to assess the performance of FME’s continued impact from the conclusion of the first Demonstration period (DY1-5) through the end of the renewal demonstration (DYs 6-10). Throughout the “Findings” section of this report, periods T1 and T2 are occasionally referred to as “pre-waiver” and T3-T4 as “post-waiver” periods.

Table 3. Evaluation Timeframe

Timeframe Code	Timeframe Description
T1	Baseline year prior to the water switch (May 1, 2013 – April 30, 2014).
T2	During/post water switch, FME not implemented (May 1, 2014 – April 30, 2016).
T3	Post water switch, FME demonstration 1 (May 1, 2016 – September 14, 2021). DY 1-5
T4	Post water switch, FME demonstration 2 (September 15, 2021 – September 30, 2026). DY 6-10

Evaluation Measures

Renewal Demonstration period evaluation measures are assembled representing the three domains identified as over-arching goals in the approved MDHHS Waiver Application: 1) Access to Services, 2) Expanded Medicaid Eligibility, and 3) Improved Health Outcomes. The following provides a summary of how evaluation goals were operationalized into measurable outcomes.

Domain 1. Access to Services

Hypothesis 1.1

*“FME Demonstration enrollees will access services to identify and address physical or behavioral health issues associated with lead exposure at a rate higher than **non-enrollees with similar individual and neighborhood characteristics** over the duration of the demonstration.”*

Hypothesis 1.1 assessed enrollee and comparison group rates of accessing and receiving services to identify physical or behavioral health issues associated with lead exposure. Specific evaluation measures associated with Hypothesis 1.1 included the HEDIS measures, Michigan Medicaid pregnancy related program participation, Vital Records data, and enrollee surveys. Table 4 provides a summary of H1.1 sub-hypotheses, evaluation measures, measure steward, and evaluation methods.



Table 4. Hypothesis 1.1 Evaluation Measures and Methods

Sub-Hypothesis	Evaluation Measure	Measure Steward	Evaluation Method
H1.1.1 – H1.1.3 A greater proportion of child enrollees will obtain age-appropriate exams and screenings.	H1.1.1 Age-appropriate well-child exams. H1.1.1.1 Well-child visits in the first 15 Months – Six or more well-child visits. H1.1.1.2 Well-child visits for ages 15 months to 30 months – Two or more well-child visits. H1.1.1.3 Child and adolescent well-care visits, stratified: a) Ages 3 to 11 years b) Ages 12 to 17 years c) Ages 18 to 21 years	National Committee for Quality Assurance	Difference-in-differences analysis compared the FME enrollees and the comparison group in the post- vs. pre-periods. The period definition varied depending on the evaluation measures and data availability.
	H1.1.2 Age-appropriate developmental screenings.	Oregon Health & Science University	
	H1.1.3 Age-appropriate lead testing and follow-up/retesting. H1.1.3.1 “The percentage of children 2 years old or less who had 1 or more capillary or venous lead blood test for lead poisoning by their second birthday.” H1.1.3.2 “Re-testing after the detection of elevated blood lead levels following CDC guidelines for the recommended time frame for re-testing on the blood lead level in the first test” (CDC, 2018).	H1.1.3.1 – National Committee for Quality Assurance H1.1.3.2 – Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)	
H1.1.4 – H1.1.6 A greater proportion of pregnant enrollees will participate in appropriate care and testing.	H1.1.4 Timely prenatal and postpartum care. H1.1.4.1 The percentage of deliveries that received a prenatal care visit in the first trimester, on the enrollment start date or within 42 days of enrollment. H1.1.4.2 The percentage of deliveries that had a postpartum visit on or between 21 and 56 days after delivery.	National Committee for Quality Assurance	
	H1.1.5 Utilization of recommended lead testing.	American Congress of Obstetricians and Gynecologists	
	H1.1.6 Participation in the State of Michigan’s Maternal Infant Health Program (MIHP).	N/A	
H.1.1.7 – H.1.1.9 Enrollees will attest to improved care and satisfaction with the waiver.	H1.1.7 Enrollee attestation to improved health care services.	Agency for Healthcare Research and Quality – Consumer Assessment of Healthcare	Enrollee survey summarized distribution of evaluation measures.
	H1.1.8 Enrollee attestation to satisfaction with their ability to access health care services.		



Sub-Hypothesis	Evaluation Measure	Measure Steward	Evaluation Method
		Providers and Systems (AHQR-CAHPS) Question Modification	
	H1.1.9 Enrollee attestation to home pipe replacement or evaluation.	N/A	

Hypothesis 1.2

*“FME Demonstration enrollees who participate with TCM services will access medical, social, educational, and other services at a rate higher than FME **demonstration enrollees with similar individual and neighborhood characteristics who do not participate with TCM services over the duration of the demonstration.**”*

Hypothesis 1.2 compared rates of accessing medical, social, and educational services between **FME enrollees who participated in TCM services** and **FME enrollees who did not**. Sub-hypotheses and evaluation methods for H1.2 were the same as those listed for H1.1 in Table 4. Specific evaluation measures associated with Hypothesis 1.2 were the same as H1.1, except the focus was on TCM participants compared to TCM non-participants among all the FME enrollees.

Domain 2. Expanded Medicaid Eligibility

“The proportion of new FME Demonstration enrollees between 212-400% FPL will increase over the duration of the demonstration, representing an increase in the proportion of individuals having health care coverage.”

Domain 2 was designed to assess the impact of the income limit expansion. Participation and utilization across different FPLs, as supported by enrollment numbers, was reported. Specific evaluation methods included enrollee and community partner survey data. Table 5 provides a summary of H2 sub-hypotheses, evaluation measures, measure steward, and evaluation methods.

Table 5. Domain 2 Evaluation Measures and Methods

Sub-Hypothesis	Evaluation Measure	Measure Steward	Evaluation Method
H2.1 & H2.4 Enrollees, between 212-400% FPL, will attest to awareness of and access to the waiver.	H2.1 Enrollee attestation to waiver awareness.	AHQR-CAHPS Question Modification	Enrollee survey summarized distribution of evaluation measures.
	H2.4 Enrollee attestation that the waiver provided a new opportunity to obtain health care.		
H2.2 – H2.3 Community partners will attest to awareness of and satisfaction with the waiver.	H2.2 Community partner attestation to awareness of waiver eligibility and enrollment processes.	N/A	Community partner survey summarized distribution of evaluation measures.
	H2.3 Community partner attestation of satisfaction with waiver enrollment processes.	N/A	



Domain 3. Improved Health Outcomes

*“Enrollees will have **improved health outcomes** compared to non-enrollees with similar individual and neighborhood characteristics over the duration of the FME Demonstration.”*

The expansion of benefits provides enrollees with opportunities to optimize access to care and supports to improve overall health status. Health outcomes of interest included completed immunization rates, birth weights, and self-reported health status. Additionally, due to EBLL potentially increasing the risk of children having developmental delays, a measure assessing the rate of referrals to educational and behavioral programs was defined. Since the Family Educational Rights Act (FERPA) protects student education records, individual level data from educational institutions was not available. Therefore, child survey data was used to assess the rate of referrals to educational and behavioral programs. Table 6 provides a summary of H3 sub-hypotheses, evaluation measures, measure steward, and evaluation methods.

Table 6. Domain 3 Evaluation Measures and Methods

Sub-Hypothesis	Evaluation Measure	Measure Steward	Evaluation Method
H3.1 A greater proportion of enrollees will have improved access to preventative services.	H3.1.1 Child immunization status of children 2 years of age.	National Committee for Quality Assurance	Difference-in-differences analysis compared the FME enrollees and the comparison group in the post- vs. pre-periods. The period definition varied depending on the evaluation measures and data availability.
	H3.1.2 Immunization for adolescents.		
H3.2 A greater proportion of pregnant enrollees will have higher birth weights.	H3.2 Low birth weights.	Agency for Healthcare Research & Quality	
H3.3 – H3.4 Enrollees will attest to improved health status and confidence managing chronic health conditions.	H3.3 Enrollee attestation of higher self-reported health status.	AHRQ-CAHPS/BRFSS Question Modification	Enrollee survey summarized distribution of evaluation measures.
	H3.4 Enrollee attestation improved confidence self-managing chronic health conditions.	N/A	
H3.5 Enrollees will have an increased rate of referrals to educational and behavioral programs.	H3.5 Enrollee attestation to receiving referrals for specialized programs aimed to mitigate potential educational and/or behavioral disabilities.	State of Michigan Department of Education	

Data Sources

Data sources used to support evaluation activities thus far included:

- MDHHS Health Services Data Warehouse (DYS 6-7: September 2021 – September 2023)
- Enrollee 2023 and 2024 Surveys,
- Community Partner 2024 Survey, and
- Publicly available data.

MDHHS Health Services Data Warehouse

The MDHHS data warehouse served as the primary data source for most Domain 1 sub-hypotheses; this source also supported elements of Domains 2 and 3. The data warehouse contains Medicaid enrollment files, administrative paid claims (fee-for-service) and accepted encounters (managed care), Vital Records, and Michigan Care Improvement Registry (MCIR) with individual-level immunization history. Medicaid enrollment files include eligibility months and indicators for different benefit plans, address (geocoded at the census tract level), income level (%FPL), and key demographic characteristics (age, gender, race/ethnicity). Claims and encounters data include ICD-9 (before October 2015) and ICD-10 diagnosis codes, procedure codes, billing modifier and billing/rendering providers for inpatient and outpatient services. State Vital Records are used to source birth certificate information to obtain birthweight data. MCIR data include vaccine products and dates of administration. Administrative claims require a run-out period between the date of service and the full adjudication of the service for reimbursement. The minimum of 90 days was allowed for claims processing. The interim report includes administrative health data May 1, 2013, through DY 7 (10/1/2022-9/30/2023).

MSU IHP employs staff with the necessary permissions and expertise to acquire data from the warehouse to support evaluation analyses as honest brokers. The evaluation team does not validate data extracted from the warehouse with primary sources such as medical record reviews. Conversations between MSU IHP staff responsible for pulling data and MDHHS program staff occur regularly, to ensure relevant fields are captured and coded variables are correctly interpreted. Data review continues throughout the evaluation. Independent review and validation of codes used to process data and conduct statistical analyses is performed by evaluation team statisticians.

Enrollee Survey

Enrollee survey data is a valuable data source to inform the evaluation. Key measures such as satisfaction with care, home pipe replacement or evaluation, and improved health and education outcomes required input from FME waiver enrollees. To expand survey accessibility, the 2024 survey process included Spanish and Arabic options upon request. Enrollee surveys were conducted in 2023 and 2024. Copies of the 2023 and 2024 survey tools are available in Appendix 2. At the time of submitting this report, the 2025 survey iteration is being prepared for dissemination.

Enrollees were randomly selected and invited to participate in the survey through a mailed letter sent to the postal address on record in the warehouse data. Survey participation methods



included paper, web-based survey platform Qualtrics, or telephone interview. Participants were offered a \$20 gift card redeemable at Rewards Genius. Rewards Genius is a service that allows card holders to choose from over 200 gift card options. Individuals who did not respond within three weeks of the initial mailing were sent a postcard reminder. Non-responders to this additional outreach received the paper survey through the mail with a postage paid return envelope. Data collection remained open 30 days beyond the survey mailing date.

Double-blind data entry methods were utilized to compile paper and telephone survey responses. Surveys completed by telephone were subjected to monitoring by supervisory staff. Web-based responses to the survey were directly entered by the respondent and captured by the software. In addition to using an authentication process for a selected respondent to access the online survey, the web survey restricted each unique credential to one response. This prevented participants from completing more than one survey. The online survey was further protected from non-FME enrollee participants by restrictions imposed on the ability of internet search engines to locate the survey.

Enrollee Survey Sampling

For the Renewal Demonstration period, a cross-sectional design was utilized to survey a new cohort of randomly selected current FME enrollees each fiscal year. Enrollees were stratified into four groups at the time of sampling, based on age and FPL: 1) children with family income at or below 212% FPL, 2) pregnant women with income at or below 195% FPL, 3) children with family income above 212% FPL, and 4) pregnant with income above 195% FPL.

The sampling fraction for the 2023 survey was driven by budget constraints and the aim to estimate the TCM utilization rate in higher-income children (stratum 3) within a 3% margin of error (Lohr, 1999). In the 2024 survey, a simple random sample was selected from stratum 1 to detect a 13% TCM utilization rate (based on historic data) with a 3% margin of error, and 100% sampling was used for strata 2 to 4 due to small population sizes in these strata.

A high percentage of undeliverable mailed survey instruments was observed during 2023. Due to the amount of time between the sample selection and the mailing process, it is possible that addresses in the data source were no longer valid. The elapsed time was several months, and Medicaid beneficiaries may have frequent address changes. In light of this experience, the survey implementation process from survey selection to mailing was expedited for the 2024 survey to occur within one month. Further details regarding the rate of undeliverable mail rate are reported in the 2023 enrollee survey under the “Methodological Limitations” sub-section.

Community Partner Survey

An additional data source was required to support the testing of Domain 2 sub-hypotheses related to community partner awareness of and satisfaction with waiver enrollment processes. An online community partner survey collected data from representatives at Genesee Health System (GHS), Greater Flint Health Coalition (GFHC), and the Flint Registry in 2024. Community partners were identified based on their roles with Medicaid and FME waiver enrollment and/or provision of TCM services.



GHS is the designated provider for the TCM benefit. Greater Flint Health Coalition (GFHC) may also provide TCM services through a sub-contract to GHS and also enroll individuals into Medicaid. Both organizations continue to provide TCM services to enrollees. The Flint Registry was included because they are a trusted community resource and actively screen community members for waiver eligibility and provide referrals to eligible individuals for FME enrollment.

These community partners identified staff members responsible for FME screening, enrollment processing, or providing TCM services to participate with the survey. Five staff members representing the three organizations participated. Evaluation team members followed up with participants regarding their reported experiences with and perceptions of FME enrollment processes. Refer to Appendix 3 for the approved community partner survey documentation.

Publicly Available Data

Publicly available data were utilized to refine data analyses. Recent literature on social determinants of health (SDOH) suggests that social and built environments are important predictors of health outcomes (Braverman & Gottlieb, 2014; Siddika et al., 2023). The Centers for Disease Control and Prevention's (CDC) 2020 Social Vulnerability Index (SVI) ranks census tracts on 15 social factors and grouped them into four related themes:

- Socioeconomic (income, poverty, employment, education),
- Household composition and disability (age, single parenting, disability),
- Minority status and language (race, ethnicity, English-language proficiency), and
- Housing and transportation (housing structure, crowding, vehicle access).

Each census tract was assigned a ranking for each SVI theme and an overall ranking within the state. Geocoded addresses at the census tract level, for Medicaid enrollees in the target and comparison populations, used proxy variables for neighborhood socioeconomic data for each enrollee.

The County Health Rankings & Roadmaps (CHR&R) data, created by the University of Wisconsin Population Health Institute, was used to identify comparison counties through the K-means methods. The CHR&R “provides data, evidence, guidance, and examples to build awareness of the multiple factors that influence health and support community leaders working to improve health and increase health equity” (University of Wisconsin Population Health Institute, 2018). The rankings were unique in their ability to measure the health of nearly every county in all 50 states, and are complemented by guidance, tools, and resources designed to “accelerate community learning and action.”

Analytic Methods

Sample mean, standard deviation, frequency, and percentage were used to describe demographic characteristics (age, sex, income level, race/ethnicity, residence) and health outcomes (domain measures based on administrative health data). For the outcome measures evaluated using the DiD methods (with either repeated cross-sections or panel data), we employed the augmented inverse propensity-score weighting (AIPW) or the two-way fixed effects (TWFE) linear regression models when the parallel trend assumption was likely satisfied



(Callaway & Sant’Anna, 2021; Goodman-Bacon, 2021; Wooldridge, 2023). The cluster-robust standard errors (at the census tract level using cross-sectional data or the individual level using panel data) were used to generate 95% confidence intervals (CIs).

We used weighted logistic or multinomial logistic regression models with non-response adjusted sampling weights to calculate the 95% CIs to analyze the outcome measures evaluated using enrollee surveys. Only child survey results are presented at this time due to the small sample size and response rate for adult surveys.

Qualitative narratives are presented for community partner surveys due to small target sampling frames.

Methodological Limitations

Violations of the DiD Assumptions

The key identification assumptions for DiD estimation are parallel trend (PT) and no anticipation (NA). These assumptions are not testable using observed data since unobserved counterfactual data are required but not available. The PT assumption says that, had there been no waiver, the enrollees and comparison groups would have had the same changes in outcomes over time. The NA assumption says that the individuals do not change their behaviors in anticipation of the waiver; this assumption is likely to hold because, even if an affected individual expected to be eligible for the waiver, they were unlikely to afford private care management services. We used a pre-trend test to examine if the average change in the outcome depended on the waiver in the pre-waiver period. However, this test has low power with two pre-waiver periods. Therefore, all analyses using the DiD estimation should be interpreted with caution even when the pre-trend test passed.

2023 Enrollee Survey – Response and Undeliverable Rates

It is important to note that a low response rate does not indicate that the data does not represent the population. Survey research analyzes data using system demographic variables to see whether non-response bias exists in the presence of nationwide declining response rates. In other words, it can be said that the data is representative of the population if those who respond are not different than those who do not respond.

For the 2023 survey, there was an expected response rate of 30%. However, the response rate for the 2023 survey was approximately 16%. This response rate is partially attributed to the national decline in survey participation. An additional factor believed to depress survey participation is “survey fatigue” due to the increased prevalence of survey research and data collection efforts targeting members of the Flint community since the water crisis (Shiyab, 2023).

In addition to a low response rate, for the 2023 enrollee survey, a high undeliverable mail rate at approximately 13% was observed. To assess whether there were patterns within the undeliverable and non-response rates, evaluators conducted hot spot analyses in the Environmental Systems Research Institute’s (ESRI) ArcMap 10.8. All respondents were



geocoded to the most accurate available address (either at the home, ZIP code, or municipality level). Getis-Ord G_i^* Hot Spot Analysis was run to determine whether significant geographic clustering existed anywhere in the study area. In both instances (i.e., with undeliverable and with no response cases), virtually zero spatial clustering existed.

While the overall undeliverable rate was fairly high, this was evenly/randomly distributed across the study area; Flint residents were not more or less likely to be in this undeliverable group. This included 10% of respondents who lived in the City of Flint and 14% of respondents who lived outside the city. For the no response group, this included approximately 76% of respondents who lived in the City of Flint and 73% of respondents who lived outside the city. There was no evidence of patterns in the undeliverable and no response rates. The impact of the COVID-19 public health emergency and interruption of usual Medicaid redetermination processes until May 2023 was felt to be a significant contributor to the amount of inaccurate/outdated contact information.

To decrease the undeliverable rate, the 2024 enrollee survey preparation process was adjusted to decrease the length of time between enrollee identification and survey mailing. For the 2024 enrollee survey, the undeliverable rate reached approximately 11%.

After adjusting the survey preparation process to decrease the undeliverable rate, the response rate increased to 22% for the 2024 enrollee survey. The increased response rate for the 2024 enrollee survey may also be due to the lower undeliverable rate. Response rate patterns throughout the rest of the Renewal Demonstration period will be monitored.

Another opportunity to disseminate survey participation information may be through email communications. The 2023 survey sample provided contained email addresses for more than half of the identified enrollees. Medicaid enrollment processing does collect email information from individuals with the proviso that it will not be shared. Official government business contacts do not use email addresses. All communications are through postal addresses lending reliance on an assumption that enrollees maintain up to date postal mailing information. There may be opportunities to leverage available email addresses in collaboration with MDHHS to disseminate survey links to eligible participants in future years. Another option under consideration for future survey dissemination would be to use text messaging. Federal law permits texting to individuals without prior permission if two conditions are met: 1) human interaction is involved in the actual sending of the message, and 2) the message is not being used to sell the individual a product or service. In a recent study using text messaging, Michigan State University's Office for Survey Research was able to increase the response rate by 4%.

TCM Utilization

Genesee Health System (GHS) is the designated provider organization (DPO) for TCM services. We used a combination of the DPO's billing NPI (National Provider Identifier) and TCM-related CPT (Current Procedural Terminology) codes specified by the waiver benefit plan to identify enrollee TCM utilization. Using DPO's NPI and CPT codes together, 263 beneficiaries were identified during the DY1-5 evaluation period and two beneficiaries were identified in DY6-7.



Thus, we transitioned analyses to focus only on the allowable CPT codes in outpatient claims data to identify TCM services. This decision potentially leads to an overestimate of enrollees who utilized the services. When comparing self-reported TCM users from enrollee surveys to the claim-based TCM users, there was a considerable mismatch between the proportion of survey participants identified as using TCM through administrative data and who self-reported using TCM services. Notably, there were more participants who self-reported using TCM than there were with TCM service claims.

The pattern of low to nearly zero TCM claims identified when requiring a specific NPI coincided with contracting information obtained from the DPO and MDHHS. Interviews with community partners documented they continued to provide TCM services but had ceased billing under the TCM CPT codes. This explanation for the lack of administrative data available for the evaluation was communicated to MDHHS. The state partners confirmed contracting and billing interruptions and efforts are underway to address these.

Preliminary Findings

Results presented as part of this interim report include data collected through completed evaluation activities occurring between 9/15/2021 and 12/31/2024. Due to the time needed to allow claims processing to occur, the most recent administrative claims data available for this report ends 9/30/2023. Below are preliminary findings presented by evaluation domain and hypotheses. Results described should not be interpreted as final because additional data from future activities may influence observed trends and patterns.

FME Waiver Enrollment

Figure 1 depicts the monthly number of enrolled children and pregnant women, from May 2016 to September 2023, identified using a combination of Modified Adjusted Gross Income (MAGI) and Medicaid benefit plan codes in the MDHHS Health Services Data Warehouse. Pregnant enrollees younger than 22 years of age were excluded from the enrolled children cohort to avoid double counting. These numbers are broadly consistent with the MDHHS quarterly and annual reports to the CMS. The total number of enrolled children stabilized at approximately 25,000 each month since September 2019. The number of enrolled pregnant women peaked in October 2016 and has steadily declined (Figure 1).



From May 2016 to September 2023, a total of 48,016 unique beneficiaries enrolled in the waiver for at least one month and 15,533 (32.3%) enrolled in the whole eight-year period. Most enrollees had low income and were already enrolled in Medicaid. Figure 2 shows the percentages of FME enrollees with incomes greater than 212% of the FPL increased steadily over time and peaked at 5.6% in 2022.



Enrollee Survey Participant Characteristics

Similar to DY1-5 findings, web-based survey completion continued to be the most frequently used modality compared to telephone or paper survey response rates (79% in the 2023 survey and 85% in the 2024 survey). Stepwise logistic regression was used to estimate the response probability using sampling strata, enrollee age, gender, race/ethnicity, Flint residency, enrollment category, other benefits, other insurance, and opting for the Buy-in program or not. The inverse of the predicted probability was used as a non-response adjustment weight. The sampling weight and the non-response adjustment weight were multiplied to estimate the recalibrated sampling weights. The target population was the sampling frame of each survey and was used to assess the recalibrated sampling weights.

Table 7 shows the weighted characteristics were close to the corresponding target population (all enrollees) in each survey. The response rate for the 2023 survey was 16% and increased to 22% in the 2024 survey. Low response rates for 2023 and 2024 adult survey participants (n=24 (15%) and n=112 (17%), respectively) precluded accurate estimation and hypothesis testing. Henceforth, all survey-based results refer to child survey participants.



Table 7. Unweighted and Weighted Distributions of Demographic Characteristics of the 2023 and 2024 Enrollee Survey Data

	2023 Survey (N=764)			2024 Survey (N=1,253)		
	Unweighted	Weighted	Target (N=26,634)	Unweighted	Weighted	Target (N=23,116)
Age						
0-21	733 (95.9)	97.4	25952 (97.4)	1141 (91.1)	97.3	22460 (97.2)
>21	31 (4.1)	2.6	682 (2.6)	112 (8.9)	2.7	656 (2.8)
Sex						
Female	373 (48.8)	48.0	13201 (49.6)	670 (53.5)	48.1	11515 (49.8)
Race						
non-Hispanic white	278 (36.4)	35.7	8906 (33.4)	501 (40.0)	33.1	7749 (33.5)
non-Hispanic black	405 (53.0)	54.9	15545 (58.4)	636 (50.8)	57.7	13367 (57.8)
Hispanic/Other	46 (6.0)	5.4	1215 (4.6)	74 (5.9)	4.9	1071 (4.6)
Unknown	35 (4.6)	4.0	968 (3.6)	42 (3.4)	4.3	929 (4.0)
Did the beneficiary have the following?						
Flint Zip codes	574 (75.1)	76.1	20149 (75.7)	831 (66.3)	70.0	16302 (70.5)
CSHCS/MiChild	49 (6.4)	6.5	1453 (5.5)	72 (5.7)	7.4	1489 (6.4)
Other insurance	*	0.5	79 (0.3)	*	0.1	49 (0.2)
Buy-in	105 (13.7)	3.2	862 (3.2)	293 (23.4)	4.4	939 (4.1)
Pregnancy indicator	31 (4.1)	3.3	640 (2.4)	80 (6.4)	2.1	541 (2.3)
Poverty level based on the maximum income						
FPL 0	380 (49.7)	55.8	15035 (56.5)	503 (40.1)	50.5	11809 (51.1)
FPL 1~138%	210 (27.5)	30.6	8533 (32.0)	331 (26.4)	34.4	7969 (34.5)
FPL 139~195%	52 (6.8)	7.1	1620 (6.1)	111 (8.9)	8.6	1882 (8.1)
FPL 196~212%	17 (2.2)	2.0	274 (1.0)	33 (2.6)	1.1	283 (1.2)
FPL > 212.01%	105 (13.7)	4.4	1172 (4.4)	275 (21.9)	5.5	1172 (5.1)

* Cell numbers smaller than 10 are suppressed. CSHCS = Children’s Special Health Care Services. MiChild is the Michigan Medicaid program for children under age 19 who meet the income requirements.



Domain 1. Access to Care

The waiver aims to increase access to health care services by expanding FPL eligibility, offering TCM services, and eliminating existing cost-sharing requirements. Additionally, enrollees were provided coverage for the evaluation of potential lead exposures in the homes of eligible enrollees in the absence of documented elevated blood lead levels.

Hypothesis H1.1

Hypothesis 1.1 – ***“FME Demonstration enrollees will access services to identify and address physical or behavioral health issues associated with lead exposure at a rate higher than non-enrollees with similar individual and neighborhood characteristics throughout the demonstration.”***

Rates of selected services between enrollees and selected comparison groups were analyzed. Within Hypothesis 1.1, there were nine (9) distinct sub-hypotheses (Table 4). Administrative claims (T1 through 9/30/2023) and survey (2023 and 2024) data were utilized to assess these sub-hypotheses.

Hypothesis 1.1.1

- H1.1.1 – ***“FME Demonstration enrollees will access age-appropriate well-child exams at a rate higher than non-enrollees with similar individual and neighborhood characteristics over the duration of the demonstration.”***

Table 8 displays the difference-in-differences (DiD) estimates for the H1.1.1.1 – H1.1.1.3 HEDIS measures described in Table 4. A DiD estimate is the difference in the mean outcome between the waiver-impacted group and the comparison group before and after waiver implementation. It can be interpreted as the impact of the waiver among enrollees, had there been no waiver, under certain identification assumptions; the chief of which is the parallel trend assumption. The heterogeneous DiD estimators allow the two FME Demonstration periods to have different effects.

The DiD estimation relies on parallel trends and no anticipation assumptions in all pre-periods. Therefore, the effect of a policy before it is enacted in the pre-period should be zero (Goodman-Bacon, 2021). If the target and comparison groups’ outcomes change at a similar rate in the pre-period, this assumption is more likely satisfied. When one rejects the null hypothesis that the effect is zero (P-value < 0.05), the DiD estimates are in question. This is referred to as the pre-trend test. Among the two DiD estimates (augmented inverse propensity-score weighting (AIPW) or the two-way fixed effects (TWFE) linear regression), if both passed the pre-trend test, we reported the double-robust AIPW estimate; if both failed the pre-trend test, the one with a larger P-value for the pre-trend test was presented in Table 8.

For H1.1.1.1 and H1.1.1.2, the pre-period was 5/2014–4/2016 (T2) due to the required 15-month or 30-month claims data not being available for the 2013 cohort, and the post-periods were T3 and T4, separately (defined in Table 3). For H1.1.1.3, the pre-period was 5/2013–4/2016 (T1 and T2 combined), and the post-periods were T3 and T4, separately.



H1.1.1.1: FME enrollees had higher rates of well-child visits in the first 15 months of life than the comparison group. These rates decreased for both groups in 2020 which was attributed to a change in the HEDIS technical specification. The percentages of well-child visits for enrollees increased from 58% to 62% in the DY1-5 period and 63% in the DY 6-7 period whereas the comparison group's rates decreased from 65% to 59% in the DY1-5 period and 61% in the DY6-7 period. This led to statistically significant DiD estimates of 12% (95% CI 5%, 18%) and 10% (95% CI 8%, 12%), respectively, for the two post-periods. The pre-trend test P-value = 0.052, indicating some potential violation of the parallel-trend assumption. One caveat was that, to perform the pre-trend test, the two years in T2 were used as two periods.

H1.1.1.2: Both FME enrollees and the comparison group experienced a decline in well-child visits for ages 15 to 30 months of life, with the comparison's decline at a faster rate. In addition, the pre-trend test P-value was <0.01. Thus, although DiD estimates were statistically significant, the result should be interpreted with caution.

H1.1.1.3: For well-child visits for ages 3 to 21 years, both FME enrollees and the comparison group experienced an increase in the DY1-5 period and a decline in the DY6-7 period to date. The DiD estimate for the DY1-5 period was not significant (1%, 95% CI: -4%, 7%). Although the DiD estimate for the DY6-7 period was statistically significant (2%, 95% CI: 1%, 4%), it was driven by the larger decline in the comparison group.

H1.1.1.3.a: The results for well-child visits among children aged 3 to 11 years were similar to the above, with a statistically insignificant effect in the DY1-5 period. Although the DiD estimate for the DY6-7 period was statistically significant (4%, 95% CI: 1%, 8%) and passed the pre-trend test (P-value 0.214), it was driven by the larger decline in the comparison group.

H1.1.1.3.b: The rate of accessing well-child visits among children aged 12 to 17 years increased in the DY1-5 period from 46% to 50% in both FME and comparison groups. The rate declined in the DY6-7 period to 43% for FME enrollees and 41% in the comparison group. There was no statistically significant effect in either Demonstration period.

H1.1.1.3.c: The well-child visit rate among children aged 18 to 21 years increased in the DY1-5 period from 27% to 30% in both FME and comparison groups. This declined in the DY6-7 period to approximately 22% in both groups. There was no statistically significant effect in either Demonstration period.

Table 8. Difference-in-differences (DiD) estimates of the proportions of children with age-appropriate well-child exams

Measure	Group	Pre-FME (A)	First FME Demonstration (DY 1-5) (B)	Renewal FME Demonstration (DY 6-7) (C)	DiD (B vs. A)	DiD (C. vs. A)
H1.1.1.1* Well-child visits in first 15 months	FME	0.58 (0.57, 0.60)	0.62 (0.61, 0.64)	0.63 (0.60, 0.65)	0.11 (0.05, 0.18)	0.10 (0.08, 0.12)
	Comparison	0.65 (0.63, 0.66)	0.59 (0.58, 0.60)	0.61 (0.60, 0.62)		
	Difference	-0.065	0.030	0.018	P-value (pre-trend) = 0.059	
H1.1.1.2 Well-child visits 15-30 months	FME	0.62 (0.61, 0.63)	0.62 (0.61, 0.63)	0.59 (0.56, 0.62)	0.08 (0.002, 0.16)	0.07 (0.02, 0.12)
	Comparison	0.67 (0.65, 0.68)	0.61 (0.60, 0.61)	0.56 (0.55, 0.58)		
	Difference	-0.047	0.013	0.026	P-value < 0.01	
H1.1.1.3 Well-child visits 3-21 years	FME	0.48 (0.48, 0.48)	0.52 (0.52, 0.52)	0.44 (0.43, 0.44)	0.01 (-0.04, 0.06)	0.02 (0.01, 0.04)
	Comparison	0.47 (0.47, 0.47)	0.50 (0.49, 0.50)	0.42 (0.42, 0.42)		
	Difference	0.010	0.024	0.020	P-value = 0.563	
H1.1.1.3.a Well-child visits 3-11 years	FME	0.56 (0.56, 0.56)	0.60 (0.59, 0.60)	0.53 (0.53, 0.54)	0.02 (-0.07, 0.11)	0.04 (0.01, 0.08)
	Comparison	0.54 (0.54, 0.55)	0.57 (0.56, 0.57)	0.50 (0.50, 0.51)		
	Difference	0.016	0.028	0.031	P-value = 0.214	
H1.1.1.3.b* Well-child visits 12-17 years	FME	0.46 (0.45, 0.46)	0.50 (0.50, 0.51)	0.43 (0.42, 0.44)	0.01 (-0.05, 0.07)	0.01 (-0.07, 0.09)
	Comparison	0.46 (0.45, 0.46)	0.50 (0.49, 0.50)	0.41 (0.41, 0.42)		
	Difference	-0.000	0.007	0.014	P-value = 0.090	
H1.1.1.3.c Well-child visits 18-21 years	FME	0.27 (0.26, 0.27)	0.30 (0.29, 0.31)	0.22 (0.21, 0.23)	0.002 (-0.01, 0.01)	-0.01 (-0.03, 0.002)
	Comparison	0.26 (0.25, 0.27)	0.29 (0.28, 0.29)	0.23 (0.22, 0.23)		
	Difference	0.008	0.012	-0.005	P-value = 0.317	

*Estimate for H1.1.1.3.b was based on TWFE, and all other estimates were based on AIPW, all controlling for age, race, ethnicity, FPL, CSHCS, buy-in or other insurance, and the overall SVI ranking at the census tract level.

Hypothesis 1.1.2

- *H1.1.2 – “FME Demonstration enrollees will access age-appropriate developmental screening at a rate higher than non-enrollees with similar individual and neighborhood characteristics over the duration of the demonstration.”*

The screening for risk of developmental, behavioral, and social delays in the first 3 years of life was identified using the procedure code 96110 in Medicaid claims data. The percentage of FME enrollees with at least one age-appropriate screening increased from approximately 25% in the



pre-period to 41% in the two post-periods. In contrast, the rates for the comparison group increased continuously from 33% to 46%. The DiD estimates were not statistically significant in either period (Table 9).

Table 9. The percentage of children screened for risk of developmental, behavioral, and social delays using a standardized screening tool in the first three years of life.

Measure	Group	Pre-FME (A)	First FME Demonstration (DY 1-5) (B)	Renewal FME Demonstration (DY 6-7) (C)	DiD (B vs. A)	DiD (C. vs. A)
H1.1.2 Age- appropriate developmental screenings	FME	0.25 (0.24, 0.25)	0.41 (0.40, 0.41)	0.41 (0.39, 0.43)	0.08 (-0.12, 0.27)	0.04 (-0.16, 0.23)
	Comparison	0.33 (0.32, 0.33)	0.41 (0.41, 0.42)	0.46 (0.46, 0.47)		
	Difference	-0.081	-0.006	-0.053	P-value (pre-trend) = 0.032	

* Based on the two-way fixed effect estimator, controlling for age, black, FPL, and the overall SVI ranking at the census tract level

Hypothesis 1.1.3

- *H1.1.3 – “FME Demonstration enrollees will access age-appropriate lead testing and follow-up/retesting as indicated at a rate higher than non-enrollees with similar individual and neighborhood characteristics over the duration of the demonstration.”*

H1.1.3.1: Both FME enrollee and comparison groups experienced a steady decline in lead testing for children up to age two from the pre-period to the two post-periods (Table 10). The DiD estimates were not statistically significant in either post-period.

H1.1.3.2: The follow-up test after EBLL detection in children 21 years of age and under increased from 16% to 32% in the DY1-5 period but dropped to 24% in the DY6-7 period to date among the FME enrollees. The rates for the comparison group increased continuously, albeit at a slower rate initially. The DiD estimate for the DY1-5 period was statistically significant (8%, 95% CI: 4%, 13%). The effect became negative but not statistically significant for the DY6-7 to date (Table 10).



Table 10. Lead test for children by age two and follow-up test of an elevated blood lead level for children up to 21 years of age

Measure	Group	Pre-FME (A)	First FME Demonstration (DY 1-5) (B)	Renewal FME Demonstration (DY 6-7) (C)	DiD (B vs. A)	DiD (C. vs. A)
H1.1.3.1* Blood lead level testing under 2 years	FME	0.79 (0.78, 0.80)	0.77 (0.76, 0.78)	0.51 (0.48, 0.54)	0.01 (-0.06, 0.13)	-0.12 (-0.27, 0.03)
	Comparison	0.76 (0.75, 0.77)	0.75 (0.74, 0.75)	0.60 (0.59, 0.61)		
	Difference	0.026	0.026	-0.093	P-value (pre-trend) = 0.347	
H1.1.3.2** Blood lead level re-testing	FME	0.18 (0.15, 0.21)	0.32 (0.29, 0.36)	0.24 (0.12, 0.40)	0.08 (0.04, 0.13)	-0.04 (-0.16, 0.08)
	Comparison	0.17 (0.15, 0.19)	0.24 (0.23, 0.26)	0.32 (0.28, 0.36)		
	Difference	0.013	0.078	-0.086	P-value = 0.206	

* Based on the AIPW estimates, controlling for age, race, ethnicity, FPL, CSHCS, buy-in or other insurance, and the overall SVI ranking at the census tract level.

** Based on the TWFE estimates, controlling for age, race, ethnicity, FPL, CSHCS, buy-in or other insurance, and the overall SVI ranking at the census tract level.

Hypothesis 1.1.4

- *H1.1.4 – “Pregnant FME Demonstration enrollees will access timely prenatal and postpartum care at a rate higher than non-enrollees with similar individual and neighborhood characteristics over the duration of the demonstration.”*

H1.1.4.1: In the DY1-5 period, the rate of timely prenatal care for the FME enrollees increased slightly whereas the comparison group experienced a slight decline. This led to a statistically significant DiD estimate of 4% (95% CI: 0.2%, 8%). In the DY6-7 period, both groups had a significant decline. Although the comparison group had a lower rate for timely prenatal care than the enrollees, the DiD estimate was not statistically significant in this period. Because the pre-trend test P-value was slightly smaller than 0.05, the estimates should be interpreted with caution (Table 11).

H1.1.4.2: In both the pre-period and the two post-periods, the comparison group had higher rates in post-partum care than FME enrollees. The differences between the two groups remained relatively constant around 7%. Therefore, the DiD estimates were not statistically significant (Table 11).

Table 11. The proportion of pregnant enrollees with timely prenatal and postpartum care*

Measure	Group	Pre-FME (A)	First FME Demonstration (DY 1-5) (B)	Renewal FME Demonstration (DY 6-7) (C)	DiD (B vs. A)	DiD (C. vs. A)
H1.1.4.1** Timely prenatal care	FME	0.76 (0.75, 0.77)	0.77 (0.75, 0.78)	0.62 (0.58, 0.65)	0.04 (0.002, 0.08)	0.01 (-0.13, 0.15)
	Comparison	0.76 (0.74, 0.77)	0.74 (0.73, 0.74)	0.59 (0.57, 0.60)		
	Difference	0.007	0.028	0.032	P-value (pre-trend) = 0.046	
H1.1.4.2 Timely postpartum care	FME	0.48 (0.47, 0.50)	0.44 (0.42, 0.46)	0.61 (0.57, 0.64)	0.02 (-0.003, 0.04)	0.01 (-0.01, 0.03)
	Comparison	0.56 (0.55, 0.57)	0.51 (0.50, 0.52)	0.68 (0.66, 0.69)		
	Difference	-0.079	-0.069	-0.072	P-value = 0.389	

* Continuous eligibility: Pregnant women with live birth based on the HEDIS specification and continuously enrolled 43 days before delivery through 60 days after delivery.

** Based on the two-way fixed effect estimator, controlling for age, black, FPL, and the overall SVI ranking at the census tract level

Hypothesis 1.1.5

- H1.1.5 – *“Pregnant FME Demonstration enrollees will access recommended lead testing at a rate higher than non-enrollees with similar individual and neighborhood characteristics over the duration of the demonstration.”*

During the DY1-5 period, FME-enrolled pregnant women experienced a significant increase in lead testing, primarily in the first year of the DY1-5 period; this may be attributed to heightened awareness. In the following years, the rates decreased steadily, with an average rate of 67% in the DY1-5 period and 18% in the DY6-7 period. In the comparison group, the rate remained constant across all three periods at approximately 7%. Given these differences in trends, the pre-trend test failed (Table 12).

Table 12. Having recommended lead testing during pregnancy

Measure	Group	Pre-FME (A)	First FME Demonstration (B)	Renewal FME Demonstration (C)	DiD (B vs. A)	DiD (C. vs. A)
H1.1.5 Lead level testing during pregnancy	FME	0.06 (0.05, 0.07)	0.67 (0.65, 0.68)	0.18 (0.16, 0.21)	0.57 (0.57, 0.58)	0.08 (0.07, 0.10)
	Comparison	0.07 (0.06, 0.08)	0.07 (0.07, 0.08)	0.08 (0.07, 0.09)		
	Difference	-0.009	0.596	0.103	P-value (pre-trend) < 0.01	

* Based on the AIPW estimates, controlling for age, race, ethnicity, FPL, CSHCS, buy-in or other insurance, and the overall SVI ranking at the census tract level.

Hypothesis 1.1.6

- H1.1.6 – *“Pregnant FME Demonstration enrollees will participate in the state’s Maternal Infant Health Program (MIHP) at a rate higher than non-enrollees with similar individual and neighborhood characteristics over the duration of the demonstration.”*

The MIHP participation rate remained constant for FME enrollees across the three periods. For the comparison group, the rate declined from 40% in the pre-period to 33% in the DY6-7 period (Table 13). Although the gaps between enrollees and the comparison group narrowed over time, the DiD estimates were not statistically significant.

Table 13. Participation in MIHP

Measure	Group	Pre-FME (A)	First FME Demonstration (DY 1-5) (B)	Renewal FME Demonstration (DY 6-7) (C)	DiD (B vs. A)	DiD (C. vs. A)
H1.1.6 MIHP Participation	FME	0.28 (0.27, 0.30)	0.29 (0.28, 0.31)	0.27 (0.24, 0.30)	0.03 (-0.01, 0.06)	0.02 (-0.06, 0.11)
	Comparison	0.40 (0.38, 0.41)	0.35 (0.34, 0.36)	0.33 (0.32, 0.34)		
	Difference	-0.111	-0.062	-0.059	P-value (pre-trend) = 0.614	

* Based on the AIPW estimates, controlling for age, race, ethnicity, FPL, CSHCS, buy-in or other insurance, and the overall SVI ranking at the census tract level.

Hypothesis 1.1.7

- H1.1.7 – “FME Demonstration enrollees will attest to improved health care access as a result of waiver participation.”

In the 2024 enrollee survey, participants were asked to what extent they agreed with the statement, “Being enrolled in the waiver allowed [MY CHILD] to get the medical care, tests, and/or treatment needed last year.” Response categories ranged from “Strongly Agree” to “Strongly Disagree.” Over 75% of responders agreed or strongly agreed (Table 14). Data from the 2023 enrollee survey is not reported here. This is because the 2023 survey question was reworded to possibly capture a broader stratification of responses. However, after analyses, we found limited the ability to compare 2023 and 2024; an acknowledged hazard of changing a survey question mid-term. Reported here are 2024 outcomes which are similar previously (DY1-5) reported outcomes for the survey. This will be investigated more fully as a design consideration in future reporting.

Table 14. Accessing medical care, tests, and/or treatment needed last year

	Children Unweighted N (Weighted %)
<i>Being enrolled in the waiver allowed [CHILD] to get the medical care, tests, and/or treatment needed last year.</i>	(N=1131)
Strongly Agree	495 (42.2)
Agree	355 (32.8)
Neutral	236 (21.0)
Disagree	29 (2.3)
Strongly disagree	18 (1.7)

* Cell with missing value was suppressed.

Hypothesis 1.1.8

- H1.1.8 – “FME Demonstration enrollees will attest to satisfaction with their ability to access health care services as a result of waiver participation.”



To assess enrollee satisfaction with health care services, participants were asked to what extent they agree with the statements “*The waiver helps me get the health care services [CHILD] needs*” and “*I feel that the healthcare providers are working in [CHILD]’s best interest.*” The majority of survey participants in 2023 and 2024 agreed or strongly agreed with the two statements (Table 15). There was a statistically significant increase in the proportions of enrollees who strongly agreed with both statements from 2023 to 2024.

Table 15. Satisfaction with access to health care services

	Children Unweighted N (Weighted %)	
	2023 Survey (N=733)	2024 Survey (N=1137)
<i>The waiver helps me get the health care services [CHILD] needs.</i>		
Strongly agree**	160 (19.7)	353 (28.6)
Agree	280 (38.3)	403 (37.1)
Neutral	232 (33.4)	323 (29.9)
Disagree	46 (6.5)	40 (2.8)
Strongly disagree	15 (2.1)	18 (1.6)
<i>I feel that the healthcare providers are working in [CHILD]’s best interest.</i>		
Strongly agree**	210 (27.1)	439 (36.9)
Agree	341 (46.4)	494 (45.0)
Neutral	153 (22.1)	181 (16.5)
Disagree	26 (3.8)	14 (1.2)
Strongly disagree	*	*

* Cells with missing values and counts less than or equal to 5 are suppressed.

** The proportions increased significantly with p-values less than 0.01 based on the weighted logistic regressions.

Approximately 32% of 2023 child survey participants and 31% of 2024 child survey participants identified as having a chronic condition(s). These participants were asked to what extent they agreed to the statement “*Since enrolling in the waiver, I have access to more resources that help manage [CHILD]’s chronic health condition(s).*” Of those with a chronic condition(s), 37% of 2023 participants and 53% 2024 participants agreed or strongly agreed that, since enrolling in the waiver, they have access to more resources to help manage chronic health condition(s) (Table 16).

Table 16. Satisfaction with access to chronic health care services

	Children with Chronic Conditions* Unweighted N (Weighted %)	
	2023 Survey (N=241)	2024 Survey (N=351)
<i>Since enrolling in the waiver, I have access to more resources that help manage [CHILD]’s chronic health condition(s).</i>		
Strongly agree	29 (9.2)	105 (27.9)
Agree	66 (27.5)	89 (25.3)
Neutral	100 (43.3)	116 (33.6)
Disagree	31 (13.4)	29 (9.2)
Strongly disagree	15 (6.7)	12 (4.1)

*p<0.01.



Hypothesis 1.1.9

- H1.1.9 – “FME Demonstration enrollees will attest to having an evaluation of potential lead exposure in their home if their pipes have not been replaced.”

Participants were asked, “Do you know if the lead pipes to your home have been replaced since the onset of the Flint Water Crisis in 2014/2015?” Nearly 50% of 2023 child survey participants and 60% of 2024 survey participants indicated they did not know if their pipes had been replaced (Table 17). There was a significant decrease in the proportion of enrollees who answered Yes to this question in 2024 compared with 2023.

The pipe replacement question included programmed skip patterning to ask about pipe lead testing. In the event a respondent reported they did not know if the pipes had been replaced or knew the pipes had not been replaced, they were asked whether the pipes were tested for lead. In the 2024 enrollee survey, if they did not confirm that their pipes had been replaced, i.e., if they answered “No” or “Don’t know,” they were asked the follow-up question, “Have the pipes in your house been tested for lead?” This question was not asked in the 2023 survey. Among 2024 child survey participants who were unsure or claimed their pipes had not been replaced, 22% believed their pipes had been tested for lead and 51% were unsure if their pipes had been tested.

Table 17. Lead pipe replacement and testing

	Children Unweighted N (Weighted %)	
	2023 Survey (N=732)	2024 Survey (N=1121)
<i>Do you know if the lead pipes to your home have been replaced since the onset of the Flint Water Crisis in 2014/2015?</i>		
Yes	191 (25.5)	244 (19.9)
No	179 (24.4)	225 (22.0)
Don’t Know	362 (50.1)	654 (58.2)
<i>If not Yes, Have the pipes in your house been tested for lead?</i>		2024 Survey (N=835)*
Yes	N/A	191 (22.3)
No		229 (26.8)
Don’t Know		415 (50.9)

* Cell with missing value was suppressed.

Hypothesis H1.2

Hypothesis 1.2 – “FME Demonstration enrollees who participate with TCM services will access medical, social, educational, and other services at a rate higher than FME Demonstration enrollees, with similar individual and neighborhood characteristics, who do not participate with TCM services throughout the demonstration.”

The TCM benefit was included with the intention of facilitating enrollee access to services and navigating barriers to care. Therefore, it was anticipated that enrollees who used TCM would have greater access to care compared to enrollees who did not have these supports. Hypothesis 1.2 was aimed at comparing rates of selected services among enrollees who utilized TCM services to rates of enrollees who did not.



Using the combination of approved CPT codes (T1017 and T2024) and authorized provider NPI, we identified only a small number of enrollees who could be classified as TCM users. After eliminating the NPI qualifier from TCM identification and using the CPT codes and FME benefit flag combination, the percentage of FME enrollees with at least one TCM service claim ranged from 3.2% in 2016 to 5.3% in 2023 (Table 18). However, in the 2024 enrollee survey, 14% self-reported as current or previous TCM users, which confirmed the underbilling of the TCM services.

Table 18. FME enrollees age ≤21 who had at least one TCM service utilization in each of the measurement periods

	First Demonstration Period (DY 1-5)					Renewal Demonstration Period (DY 6-7)	
	5/1/16— 4/30/17	5/1/17— 4/30/18	5/1/18— 4/30/19	5/1/19— 4/30/20	5/1/20— 8/31/21	9/1/21— 9/30/22	10/1/22— 9/30/23
FME Enrollees	N=32147	N=32793	N=30969	N=30107	N=28839	N=27671	N=27443
TCM Participants, N (%)	1044 (3.2)	1241 (3.8)	1334 (4.3)	1255 (4.2)	1316 (4.6)	1407 (5.0)	1482 (5.3)

Self-reported TCM service utilization in enrollee surveys remains low. Approximately 87% of 2023 child survey participants and 86% of 2024 child survey participants reported never using TCM services. To assess reasons for TCM under-utilization, participants were asked to identify the reason(s) they may not have used TCM or stopped using TCM. Overall, 62% of 2023 and 2024 child survey participants reported not having heard of TCM (Table 19).

Table 19. Reasons for not using TCM services (2023 and 2024 Surveys)

<i>What are some reasons you have not used or stopped using Family Supports Coordination/Targeted Care Management (TCM)? Please check all that apply.</i>	Children Unweighted N (Weighted %)	
	2023 Survey (N=645)	2024 Survey (N=1045)
[CHILD]'s needs were met before I enrolled in the waiver/TCM	157 (23.1)	242 (22.6)
[CHILD]'s needs were met somewhere else	60 (8.8)	101 (8.5)
TCM did not have the services [CHILD] needed	11 (1.7)	32 (3.3)
I have never heard of TCM	391 (62.1)	621 (62.1)
No need	9 (1.5)	26 (1.1)
Too busy	*	*
Ineligible	*	*
Other	33 (5.7)	35 (3.9)

*Cell numbers less than or equal to 5 are suppressed.



Hypothesis 1.2.1

- H1.2.1 – *“FME Demonstration enrollees who participate with TCM will access age-appropriate well-child exams at a rate higher than enrollees who do not participate with TCM over the duration of the demonstration.”*

In the DY6-7 period, three enrollees in the first 15 months of life and 26 enrollees within 15-30 months utilized TCM services. Due to the low number of enrollees using TCM, analyses for Hypothesis 1.2.1 could not be tested at this time.

Hypothesis 1.2.2

- H1.2.2 – *“FME Demonstration enrollees who participate with TCM will access age-appropriate developmental screening at a rate higher than enrollees who do not participate with TCM over the duration of the demonstration.”*

In the DY6-7 period to date, TCM participants accessed age-appropriate developmental screenings within the first three years of life at higher rates than non-participants (Table 20). Due to a small sample size, the difference was not statistically significant.

Table 20. Developmental Screening in the first three years of life with continuous eligibility *

	Renewal Demonstration Period (DY 6-7)	
	Claim-based TCM participants	Claim-based TCM non-participants
FME enrollees, N	95	3251
Screening, N (%)	52 (54.7)	1316 (40.5)

* Continuous eligibility: No more than one gap in enrollment of up to 45 days.

Hypothesis 1.2.3

- H1.2.3 – *“FME Demonstration enrollees who participate with TCM will access age-appropriate lead testing and follow-up/retesting at a rate higher than enrollees who do not participate with TCM over the duration of the demonstration.”*

In the DY6-7 period, due to the low number of enrollees using TCM service (n=21), analyses for Hypothesis 1.2.3 could not be tested at this time.

Hypothesis 1.2.4 – 1.2.6

- H1.2.4 – *“Pregnant FME Demonstration enrollees who participate with TCM will access timely prenatal and postpartum care at a rate higher than pregnant enrollees who do not participate with TCM over the duration of the demonstration.”*
- H1.2.5 – *“Pregnant FME Demonstration enrollees who participate with TCM will access recommended lead testing at a rate higher than pregnant enrollees who do not participate with TCM over the duration of the demonstration.”*
- H1.2.6 – *“Pregnant FME Demonstration enrollees who participate with TCM will participate with MIHP at a rate higher than pregnant enrollees who do not participate with TCM over the duration of the demonstration.”*

In the current evaluation period, the number of pregnant women utilizing TCM services was too small (n=14) to generate meaningful estimates for these hypotheses. No summary statistics were reported.

Hypothesis 1.2.7

- H1.2.7. – *“FME Demonstration enrollees who participate with TCM will attest to improved health care access as a result of waiver participation at a rate higher than enrollees who do not participate with TCM.”*

To assess if TCM users’ level of access to care differed from non-users, 2024 child survey responses to the statement *“Being enrolled in the waiver allowed [CHILD] to get the medical care, tests, and/or treatment needed last year”* were compared. Both self-reported TCM participants (78%) and non-participants (74%) expressed a positive sentiment toward waiver enrollment (Table 21).

Similar to H1.1.7 findings, only the 2024 survey findings are reported because the 2023 enrollee survey question did not effectively address the hypothesis and collected confounding that differed from DY1-5 and 2024 enrollee survey findings.

Table 21. Getting the medical care, tests, and/or treatment needed last year (2024) between self-reported TCM participants and non-participants

	2024 Survey (Child)	
	Unweighted N (Weighted %)	
<i>Being enrolled in the waiver allowed [CHILD] to get the medical care, tests, and/or treatment needed last year.</i>	Self-reported TCM Participants (N=142)	Self-reported TCM Non-participants (N=989)
Strongly Agree	82 (54.5)	413 (40.5)
Agree	33 (25.1)	320 (34.0)
Neutral	23 (17.9)	213 (21.4)
Disagree	*	28 (2.5)
Strongly disagree	*	15 (1.6)

*Cells with missing values and counts less than or equal to 5 were suppressed.

Hypothesis 1.2.8

- H1.2.8. – *“FME Demonstration enrollees who participate with TCM will attest to satisfaction with their ability to access services as a result of TCM participation.”*

Direct comparison of satisfaction levels between 2023 and 2024 surveys is limited. The question relating to satisfaction was changed from 2023 to 2024 to better link the impact of the waiver specifically. The 2023 enrollees who reported their children ever using the TCM services were asked to rate their satisfaction in the last 6 months. The 2024 enrollees who reported their children currently (in the past year) using the TCM services were asked how satisfied they were over the last year. Over 80% of current self-reported TCM users in both surveys expressed positive sentiment towards the services received (Table 22). No comparison across survey waves was made, due the difference in survey questions.



Table 22. Self-reported TCM participants' satisfaction rate

	Self-reported Child TCM Participants Unweighted N (Weighted %)
<i>Over the last 6 months, how satisfied are you with the services your child's Supports Coordinator provides?</i>	2023 Survey (N=91)
Very satisfied	38 (40.4)
Somewhat satisfied	35 (40.0)
Somewhat dissatisfied	14 (14.9)
Very dissatisfied	*
<i>Last year (2023), how satisfied were you with the services [CHILD]'s Supports Coordinator provided?</i>	2024 Survey (N=88)
Very satisfied	51 (59.2)
Somewhat satisfied	24 (27.0)
Somewhat dissatisfied	10 (12.8)
Very dissatisfied	*

*Cells with missing values and counts less than or equal to 5 were suppressed.

Hypothesis 1.2.9

- H1.2.9 – *“FME Demonstration enrollees who participate with TCM will attest to having an evaluation of potential lead exposure in their home if their pipes have not been replaced as a result of TCM participation.”*

In the 2023 survey, approximately 28% of self-reported TCM users and 25% of non-users reported the pipes in their home have been replaced. In the 2024 survey, 25% of self-reported TCM users and 19% of non-users reported their pipes were replaced. The difference was not statistically significant, based on a design-based F-test (p=0.593 and 0.241, respectively) (Rao and Thomas, 1989). Half of TCM users and non-users indicated they did not know if the pipes in their homes had been replaced (Table 23).

In the 2024 survey, if participants answered “No” or “Don’t Know,” they were asked, *“Have the pipes in your house been tested for lead?”* Nearly 20% of self-reported TCM users and 21% non-users responded positively. However, close to half of both groups indicated they did not know if the pipes in their homes had been tested.



Table 23. Lead pipe replacement and testing between TCM participants and non-participants

<i>Do you know if the lead pipes to your home have been replaced since the onset of the Flint Water Crisis in 2014/2015?</i>	Self-reported TCM Participants Unweighted N (Weighted %)	Self-reported TCM Non-Participants Unweighted N (Weighted %)
	2023 Survey (Child)	
	N=91	N=638
Yes	25 (27.6)	164 (25.0)
No	24 (27.3)	155 (24.1)
Don't know	42 (45.1)	319 (50.9)
	2024 Survey (Child)	
	N=137	N=984
Yes	40 (25.3)	204 (19.1)
No	25 (19.4)	200 (22.4)
Don't know	72 (55.4)	580 (58.6)

Domain 2. Expand Medicaid Eligibility

Hypothesis 2 – *“The proportion of new FME Demonstration enrollees between 212-400% FPL will increase over the duration of the demonstration representing an increase in the proportion of individuals having health care coverage.*

The waiver aimed to increase access to health care services by expanding eligibility for those who might be uninsured due to their income being above the standard Medicaid FPL and lacking employer sponsored healthcare coverage. With these revised qualifications, it was important that newly eligible individuals and parties involved in the enrollment process were aware of the revised qualifications.

In addition to standardized quantitative metrics, such as proportions of enrollees with incomes between 212-400% FPL (Figure 2), qualitative inputs from enrollee surveys and community organizations provided data to assess knowledge of and satisfaction with the waiver. These data informed the evaluation about the processes required to participate with the waiver as well as the degree to which the expanded eligibility provided a new opportunity to obtain health insurance or was used as replacement coverage for other existing forms of health insurance.

Sub-hypotheses were addressed using administrative data, enrollee, and community partner survey data.

Hypothesis 2.1

- H2.1 – *“FME Demonstration enrollees between 212-400% FPL will attest to having information regarding expanded Medicaid eligibility resulting in waiver participation.”*

Survey participants were identified as being in the high FPL (>212%) and low FPL (≤212%) income groups through Medicaid enrollment data. Table 24 compares how enrollees in the two



FPL groups obtained information about the waiver as reported through the child surveys in 2023 and 2024. In the 2023 survey, no statistically significant differences were detected between the high- and low-income groups using the design-based F-test. Over 30% of enrollees learned about the waiver from the local health department, including the high-income enrollees (36%). However, these percentages decreased to about 20% in the 2024 survey.

In the 2024 survey, both FPL groups (approximately 50%) indicated that letters and mailed materials were the predominant source of information about the waiver. This result was not comparable to the 2023 survey because of the change in response choice categories. In the 2024 survey, this was one of six options, whereas in the 2023 survey, this was extracted from the free text responses in the “Other” category.

Compared with the low FPL group, the high FPL group was more likely to obtain information from media outlets (i.e., TV, radio, online, flyers, etc.) in the 2024 survey, 12% vs. 6%, respectively. These percentages were higher in the 2023 survey (20% high income group and 15% low-income group), although they were not statistically significantly different due to the smaller sample size in 2023.

Table 24. Source of information regarding the waiver program (check all that apply)

How did you find out about the waiver? Please check all that apply.	2023 Survey (Child)		2024 Survey (Child)	
	≤ 212% FPL (N=626)	> 212% FPL (N=114)	≤ 212% FPL (N=867)	> 212% FPL (N=274)
Local Health Department	189 (30.1)	37 (35.7)	171 (20.1)	57 (18.2)
My doctor or another health care provider	84 (13.7)	9 (9.0)	101 (12.6)	15 (8.5)
My Medicaid/Medicare case worker	152 (24.3)	23 (25.9)	142 (15.9)	46 (20.1)
Family and/or friend	75 (12.0)	23 (15.2)	66 (7.1)	22 (5.6)
Media § (TV/Radio/Online/Flyers/Posters)	93 (14.7)	29 (19.5)	56 (6.1)	29 (11.7)
Letter/Mailed Materials**	77 (12.5)	*	424 (49.3)	127 (46.0)

§ Statistically different between high- and low-income groups in 2024 survey.

* Cell counts less than or equal to 5 were suppressed.

** The higher percentages in 2024 for this category were due to a change in the response categories to this question.

Hypothesis 2.2 and 2.3

- H2.2 – “Community partners involved with Medicaid enrollment will attest to awareness of FME Demonstration eligibility and enrollment processes.”
- H2.3 – “Community partners involved with Medicaid enrollment will attest to satisfaction with FME Demonstration enrollment processes.”

For the community partner survey, three community-based agencies (GHS, GFHC, and the Flint Registry) were identified for their key roles with FME waiver enrollment and/or provision of TCM services in the Flint community. Staff members from these agencies involved in either: 1) enrolling individuals in Medicaid and the FME Waiver, and/ or 2) delivering FME TCM services were asked to participate in the community partner survey. Five completed the survey: two from GHS, two from GFHC, and one from the Flint Registry.

A total of two GHS staff members completed the initial survey. One staff member worked as a family supports services supervisor dedicated to providing TCM services to waiver enrollees. The other staff member was a clinical coordinator. This staff member assisted individuals with waiver enrollment and provided TCM. The staff members from GFHC were social workers who interacted with FME enrollees by providing TCM services. The participant from the Flint Registry was a referral process manager that connected FME eligible residents to “organizations that will help mitigate the effects of lead” and functioned as “a bridge to connect those in the program to services they quality [for].” While this work was important to the Flint community, they did not work directly with the Medicaid waiver enrollment process.

A follow-up questionnaire was sent to the GHS participant who identified as directly enrolling eligible individuals into the waiver along with the request to invite other colleagues involved in waiver enrollment to complete the questionnaire as well. Two GHS staff members participated in the follow-up questionnaire: the clinical coordinator who participated in the initial survey and a supports coordination technician who did not participate in the initial survey. The supports coordination technician assisted in waiver enrollment and provided TCM services to beneficiaries.

Hypothesis 2.2

- H2.2 – “Community partners involved with Medicaid enrollment will attest to awareness of FME Demonstration eligibility and enrollment processes.”

Community partner survey participants expressed awareness of the waiver and provided feedback regarding their satisfaction. Their responses highlighted opportunities to enhance administrative processes and community education/awareness.

All survey participants indicated they were aware the waiver was still available to Flint residents and that enrollment was ongoing. However, only the two follow-up questionnaire participants attested to awareness of the enrollment process. Both follow-up questionnaire participants described the process as working with MDHHS staff or the MI Bridges website to assist their clients in the waiver application and to determine eligibility (Table 25). Based on conversations with MDHHS staff, this description of the process was accurate.

Table 25. Waiver enrollment process

	GHS Clinical Coordinator	GHS Supports Coordination Technician
<i>In a few sentences, please summarize the process of enrolling clients into the FME waiver.</i>	“MDHHS was contacted on behalf of the consumer. Family Navigators worked closely with the DHS Caseworker to have the FME waiver added. We also assisted the families with completing a MIBridges application and answering the questions appropriately in the questionnaire section pertaining to the flint water exposure.”	“For families or individuals not enrolled in FME, assistance was provided to contact Michigan Department of Health and Human Services (MDHHS) or navigate MI Bridges to address questions related to exposure to Flint Water and determinate eligibility.”

Hypothesis 2.3

- H2.3 – *“Community partners involved with Medicaid enrollment will attest to satisfaction with FME Demonstration enrollment processes.”*

To assess community partner satisfaction with the enrollment process, participants were asked to describe challenges and recommendations to enhance enrollment efficiency (Table 26). The primary challenge reported by participants working with the enrollment process was low community awareness and education regarding the waiver. Additional issues included challenges related to client accessibility of services and coordination with other agencies.

Table 26. Challenges and recommendations to improve enrollment process efficiency

	GHS Clinical Coordinator	GHS Supports Coordination Technician
<i>What are challenges clients have encountered when getting on the waiver?</i>	“MDHHS staff not being knowledgeable about the waiver accessibility and difficulty with agencies coordinating care.”	“Challenges included accessibility, difficulty with care coordination between agencies, and lack of consumer education regarding available services.”
<i>What changes do you recommend making to processes to improve FME waiver enrollment efficiency?</i>	“Improving community partner education about services, agency collaboration, Program Administration being more open to recognizing and utilizing staff ideas that are directly working with consumers.”	“Educating community partnerships is needed to improve the efficiency of the FME enrollment process.”

Three participants not involved with enrollment but in providing TCM offered recommendations to improve waiver administrative/referral processes through the community partner survey. Two participants from GFHC mentioned that they would like their organization to “have the ability to authorize their own clients into FSC Services” to improve timeliness of connections for clients.

Hypothesis 2.4

- H2.4 – *“FME Demonstration enrollees between 212-400% FPL will attest that the demonstration authorized expanded Medicaid eligibility offered a new opportunity to obtain health care coverage versus serving as a replacement for existing health care coverage.”*

The 2023 and 2024 enrollee surveys were used to assess whether enrollees between 212-400% FPL sought out the waiver to replace coverage or if it provided a new form of coverage altogether. Participants were asked *“Prior to enrolling in the waiver, did you have health care coverage?”* In 2023, approximately 34% of enrollees in the high-income limit (>212% FPL) had prior coverage through the health insurance exchange market, their parents, or employers. In comparison, only 8% in the lower-income group had prior coverage through these means (Table 27). In 2024, approximately 29% of enrollees in the high-income limit (>212% FPL) had prior



coverage through the health insurance exchange market, their parents, or employers. In comparison, only 9% in the lower-income group had prior coverage through these means. In both survey years, the differences in prior coverage between higher- and lower-income groups were statistically significant (P-values <0.01 using the Rao-Thomas test).

Table 27. Source of health insurance coverage prior to enrolling in the waiver (check all that apply)

	2023 Survey (Child)		2024 Survey (Child)	
	≤ 212% FPL (N=626)	> 212% FPL (N=114)	≤ 212% FPL (N=867)	> 212% FPL (N=274)
<i>Prior to enrolling in the waiver, did [CHILD] have health care coverage? Please check all that apply.</i>				
Insurance you (or your parents, your spouse, your employer) purchased	54 (8.2)	51 (33.8)	95 (9.2)	85 (28.5)
I didn't have a health care coverage plan	*	*	*	*

*Cell numbers suppressed

To identify why enrollees switched to the waiver, and to determine if enrollees with higher income joined the waiver to lower the cost of health care, participants were asked “*What were reasons for enrolling in the waiver?*” The question response choice instruction was to select “all that apply.”

Enrollees in the >212% FPL group were more likely to enroll in the waiver to lower the cost of health care compared with those with lower income (25% vs. 8% in 2023, and 20% vs. 8% in 2024). Furthermore, enrollees in the low-income group (78%) were more likely to have already been enrolled in Medicaid prior to the waiver than enrollees in the high-income group (68%) (Table 28).

Table 28. Reason for enrolling in the Waiver

	2023 Survey (Child)		2024 Survey (Child)	
	≤ 212% FPL (N=626)	> 212% FPL (N=114)	≤ 212% FPL (N=867)	> 212% FPL (N=274)
<i>What were the reasons for enrolling in the waiver? Please check all that apply.</i>				
To lower the amount of money I pay for health care	54 (8.2)	34 (24.8)	79 (8.2)	66 (19.6)
Already enrolled in Medicaid	486 (78.2)	65 (65.6)	678 (78.1)	174 (68.8)
To get doctor visits, dental visits, vision care, nutrition counseling, etc.	95 (15.2)	32 (22.1)	140 (16.0)	64 (18.9)
To get the extra Family Supports Coordination/Targeted Case Management services, from Genesee Health System or Genesee CHAP, not usually paid for by Medicaid	86 (14.1)	18 (16.1)	99 (11.5)	25 (15.1)
To get someone to help with behavioral or emotional services	78 (12.4)	13 (9.0)	85 (9.8)	25 (8.4)
Change in family and/or job status	37 (5.9)	6 (3.2)	50 (5.4)	9 (2.5)
Other reasons	17 (2.8)	*	38 (4.6)	6 (1.6)

*Cell counts less than or equal to 5 were suppressed.



Domain 3. Improved Health Outcomes

Hypothesis 3 – *“FME Demonstration enrollees will have improved health outcomes compared to non-enrollees with similar individual and neighborhood characteristics over the duration of the demonstration.”*

The approved demonstration provided opportunities to increase access to healthcare and additional support, to improve overall health status and health outcomes. Measures such as childhood immunization and birth weight served as proxies for overall health outcomes. Individualized feedback was sought through qualitative processes for self-reported health status measures.

Hypothesis 3.1

- H3.1 – *“FME Demonstration enrollees will have improved age-appropriate completed immunization status compared to non-enrollees with similar individual and neighborhood characteristics over the duration of the demonstration.”*

H3.1.1: Age-appropriate childhood immunization rates among children 2 years of age continuously declined for both the FME enrollee and the comparison groups. Enrollee rates decreased from 36% in the pre-period to 31% in the DY6-7 period while the comparison group’s rates decreased from 48% to 37% (Table 29). One caveat was that, to incorporate two years of claims data for each individual, the pre-period included only children who turned two years old in 5/2015-4/2016. Thus, no pre-trend test could be performed. The DiD estimates were positive in both post-periods, but the results were driven by the larger decline in the comparison group.

H3.1.2: Age-appropriate immunization rates for adolescents 13 years of age increased in the DY1-5 period for both the enrollee and the comparison groups with the enrollees having a larger increase (from 47% to 64%). In the DY6-7 period, rates declined for both groups but were still higher than their pre-period rates (Table 29). The DiD estimates were positive for both post-periods, but neither was statistically significant.



Table 29. Childhood Immunization Status

Measure	Group	Pre-FME (A)	First FME Demonstration (DY 1-5) (B)	Renewal FME Demonstration (DY 6-7) (C)	DiD (B vs. A)	DiD (C. vs. A)
H3.1.1 Immunization under 2 years	FME	0.36 (0.34, 0.38)	0.35 (0.33, 0.36)	0.31 (0.28, 0.34)	0.06 (0.03, 0.10)	0.08 (0.03, 0.12)
	Comparison	0.48 (0.46, 0.50)	0.41 (0.40, 0.41)	0.37 (0.36, 0.38)		
	Difference	-0.117	-0.060	-0.062	P-value (pre-trend) = N/A	
H3.1.2* Immunization for adolescents	FME	0.47 (0.46, 0.49)	0.64 (0.63, 0.65)	0.62 (0.60, 0.63)	0.03 (-0.08, 0.15)	0.04 (-0.14, 0.21)
	Comparison	0.50 (0.49, 0.52)	0.62 (0.61, 0.63)	0.58 (0.57, 0.59)		
	Difference	-0.029	0.021	0.039	P-value = 0.047	

* Based on the two-way fixed effect estimator, controlling for age, black, FPL, and the overall SVI ranking at the census tract level

Hypothesis 3.2

- H3.2 – *“Pregnant FME Demonstration enrollees will have higher birth weights compared to non-enrollees with similar individual and neighborhood characteristics over the duration of the demonstration.”*

We used the percentage of infants born under the weight of 2500 grams (LBW) as the outcome for this hypothesis (Table 30). There was a statistically significant DiD estimate in the DY1-5 period in which the prevalence of LBW infants in the enrollee group was lower than the population’s baseline (13.5% vs. 14.2%). The comparison group’s prevalence of LBW remained at 10.7%. In the DY6-7 period to date, however, the waiver group experienced a slightly larger increase in the outcome prevalence than the comparison group and DiD estimate in this period was not statistically significant. The result should be interpreted with caution because the pre-trend test failed in both the TWFE and AIPW estimation.

Table 30. Infants with low birthweight

Measure	Group	Pre-FME (A)	First FME Demonstration (DY 1-5) (B)	Renewal FME Demonstration (DY 6-7) (C)	DiD (B vs. A)	DiD (C. vs. A)
H3.1.1 Low birth weights	FME	0.142 (0.13, 0.15)	0.135 (0.12, 0.15)	0.149 (0.13, 0.17)	-0.01 (-0.02, -0.003)	-0.01 (-0.04, 0.01)
	Comparison	0.107 (0.10, 0.12)	0.107 (0.10, 0.11)	0.115 (0.11, 0.12)		
	Difference	0.035	0.029	0.035	P-value (pre-trend) = 0.019	

* Based on the two-way fixed effect estimator, controlling for infant gender, race/ethnicity, FPL, Buy-in option, and the overall SVI ranking at the census tract level.

Hypothesis 3.3

- H3.3 – *“FME Demonstration enrollees will have higher self-reported health status as a result of the waiver participation.”*

In the 2023 enrollee survey, participants were asked how they would rate their child’s overall health in 2022. This survey did not provide a direct comparison of enrollees’ experiences before and after waiver participation. Therefore, the wording was adjusted for the 2024 survey to better address Hypothesis 3.3.

In the 2024 enrollee survey, participants were asked to rate their own or their child’s overall health last year (in 2023) and if they would have rated their overall health the same if they had not been in the waiver. This question was added to the 2024 survey to have a direct comparison of enrollees’ experiences before and after waiver participation for overall, physical, and behavioral health status. Approximately 64% of children answered, “Yes” whereas 27% answered, “Don’t know.” Only 9% of children chose “No” (Table 31).

Table 31. Self-reported health status

	Children Unweighted N (Weighted %)
<i>Had [CHILD or YOU] not been enrolled in the waiver, would you still have rated your overall health as [ANSWER TO PREVIOUS QUESTION] last year (in 2023)?</i>	2024 Survey (N=1134)
Yes	717 (64.4)
No	111 (8.8)
Don’t Know	306 (26.9)

There were similar follow-up questions asking participants to rate their and their child’s physical and behavioral/emotional health in 2023 and whether their physical and behavioral/emotional health would have been the same in 2023 had they not been enrolled in the waiver. These responses were similar to the overall health status question.

Hypothesis 3.4

- H3.4 – *“FME Demonstration enrollees will have higher self-reported confidence in chronic condition self-management as a result of the waiver participation.”*

Approximately 32% of 2023 child survey participants and 31% of 2024 child survey participants identified as having a chronic condition(s). To assess H3.4, participants were asked to what extent they agreed with the statement, *“Since enrolling in the waiver, I am more confident that I can manage my child’s chronic health condition(s).”* Of those with a chronic condition, 43% of 2023 participants and 63% of 2024 participants agreed or strongly agreed that they were more confident in their ability to manage their chronic health conditions (Table 32). The increase in reporting was statistically significant ($p < 0.01$) documenting more individuals reporting having access to resources to help them manage their conditions.



Table 32. Chronic condition management confidence

	Children	
	Unweighted N (Weighted %)	
<i>Since enrolling in the waiver, I am more confident that I can manage my child's chronic health condition(s).</i>	2023 Survey (N=239)	2024 Survey (N=351)
Strongly agree	40 (14.6)	107 (28.3)
Agree	73 (29.9)	117 (34.5)
Neutral	102 (44.4)	103 (29.6)
Disagree	19 (8.6)	13 (3.7)
Strongly disagree	*	11 (4.0)

* Cell with missing values or counts less than or equal to five were suppressed.

Hypothesis 3.5

- H3.5 – *“FME Demonstration enrollees will have an increased rate of referrals to specialized programs intended to mitigate potential educational and/or behavioral disabilities during childhood (ages 0-21).”*

The evaluation team could not obtain data from the Michigan Department of Education regarding individual referrals to specialized programs because of the Federal Education Rights Privacy Act (FERPA). Therefore, the enrollee survey was used to collect information on educational issues for enrolled children. Participants in the child survey were asked if they had been informed their child should be tested for learning problems. The percentage of surveys answering “Yes” to this question decreased from 29% in 2023 to 27% in 2024.

Survey participants were also asked if their child had an Individualized Education Plan (IEP). If they answered “Yes,” they were asked the follow-up question *“What types of services does your child receive through their IEP?”* Typical services were listed, and respondents could select all that applied. Among school-aged children identified for inclusion in the survey, approximately 25% of 2023 and 2024 were identified as having an IEP (Table 33). Within both survey cohorts that indicated having an IEP, the most common service received was special education programming.



Table 33. Referrals to specialized education programs.

	Children	
	Unweighted N (Weighted %)	
<i>Does your child have an Individualized Education Plan (IEP)?</i>	2023 Survey (N=737)	2024 Survey (N=1135)
Yes	164 (22.5)	284 (26.6)
<i>What types of services does your child receive through their IEP? Please select all that apply.</i>	2023 Survey (N=164)	2024 Survey (N=284)
Special education programs	107 (65.2)	173 (64.2)
Supplementary aides	40 (24.4)	83 (30.9)
Alternate assessment (test) participation	56 (33.6)	90 (30.1)
Transition planning	33 (20.1)	56 (20.7)
Personal curriculum (course/graduation requirements)	36 (21.9)	65 (22.0)
IEP Services – Speech/Physical/Occupational/Behavioral Therapy	18 (9.9)	33 (10.0)
Other	13 (9.1)	21 (7.5)

Conclusions

Since 2016, the Flint Medicaid Expansion waiver has increased access for enrollees to healthcare services intended to mitigate impact of potential lead hazard exposures resulting from the Flint Water Crisis. This report details the evaluation of waiver activity occurring throughout the Renewal Demonstration Period, DY 6-7 (September 15, 2021, to December 31, 2024).

Throughout the DY6-7 period, waiver enrollment remained steady. From May 2016 through September 2023, a total of 48,016 unique beneficiaries were enrolled in the FME waiver for at least one month and 15,533 (32%) were enrolled for the entire period. These statistics were consistent with MDHHS quarterly and annual reports submitted to CMS. The total number of children enrolled in the waiver stabilized in September 2019 and has remained at approximately 25,000 child beneficiaries each month. The number of pregnant women enrolled in the waiver peaked in October 2016 and has steadily decreased over time.

The waiver eliminated financial barriers to health care by expanding Medicaid eligibility to cover individuals at income levels above 212% FPL. Since the introduction of the waiver in 2016, the percentage of enrollees with incomes greater than 212% of the FPL increased over time and peaked at 6% in 2022 before slightly dropping to 5% in 2023.

FME enrollees are benefiting from the waiver based on preliminary findings collected through administrative health data and enrollee surveys. Thus far, there have been continuing trends of enrollees utilizing services such as well-child visits and prenatal lead testing at higher rates than the comparison group. Additionally, enrollees continue to report satisfaction with the benefits received and increased confidence in managing chronic conditions.

Several measures in *Domain 1: Access to Care* Hypothesis 1.1 demonstrated increased service utilization among FME enrollees. Enrollee survey responses indicated satisfaction with



improved access to care. The TCM utilization rate remained too low to carry out statistical tests comparing TCM users and non-users to test Hypothesis 1.2. Despite the lack of administrative data, enrollee survey responses indicated satisfaction among enrollees who utilized TCM benefits. Statistical comparisons to evaluate *Domain 2: Expand Medicaid Eligibility* identified that a low percentage of enrollees fell within the high FPL income group. This group was more likely to have health insurance coverage prior to being on the waiver and a higher percentage reported enrolling in the waiver to decrease the cost of health care. This may represent a shift in coverage rather than an opportunity for new coverage. The available survey questions did not provide the necessary data to discriminate between these options. Community partners involved in the enrollment process indicated they were aware of the ongoing process and were satisfied. Several noted challenges and opportunities for improvement regarding administrative/referral processes and increased community education efforts were identified. Sub-hypotheses for *Domain 3: Improved Health Outcomes* highlighted that the FME group experienced improved age-appropriate child immunization and low birth rates over time. Child survey responses identified an increase in enrollees with a chronic condition(s) reporting they had more access to resources and were more confident in their ability to manage their chronic condition(s) as a result of waiver enrollment.

Reported below are Renewal Demonstration period evaluation findings thus far.

Domain 1. Access to Services

The FME waiver expanded Medicaid eligibility, access to health care services, TCM service benefits, and home lead exposure evaluations for at risk populations exposed to the lead contaminated water. Domain 1, Access to Services, was measured with administrative health and enrollee survey data. Within Domain 1, there were two sub-hypotheses: 1.1) waiver enrollees will access services at a rate higher than non-enrollees, and 1.2) waiver enrollees who use TCM will access services at a rate higher than enrollees who do not use TCM. Below is a summary of evaluation measures and findings for Domain 1 hypotheses.

Hypothesis 1.1

Hypothesis 1.1. *“FME Demonstration enrollees will access services to identify and address physical or behavioral health issues associated with lead exposure at a rate higher than **non-enrollees with similar individual and neighborhood characteristics** over the duration of the demonstration.”*

Evaluation questions for Hypothesis 1.1 investigated the state’s target of improving waiver enrollee’s access to health care services through the expansion of eligibility criteria. Domain 1 Hypothesis 1.1 was measured using administrative health data for enrollees and non-enrollees with similar individual and neighborhood characteristics as well as survey data from enrolled individuals.

Enrollees experienced higher rates of well-child visits in all age groups, except for ages 18-21, than the comparison group; a continuing trend from the FDY1-5 period. Based on data from the DY1-5 and DY6-7 periods, the percentage of enrollees with at least one age-appropriate developmental screening increased from 25% in the year before the DY1-5 to 41% in the DY6-7



period, which was a higher increase than the comparison group. The increase in developmental screening may indicate improved access to developmental screening services.

Lead testing for pregnant enrollees significantly increased in the DY1-5 period, peaking one year after waiver implementation, to an average rate of 67% and decreased in the DY6-7 period to an average rate of 18% while the rate for the comparison group remained constant at approximately 7%. The majority of 2023 and 2024 enrollee survey participants were unsure if the pipes in their home had been replaced. Among 2024 survey participants who were unsure, or indicated their pipes had not been replaced, a small proportion answered that their pipes had been tested for lead.

H1.1.1. *FME Demonstration enrollees will access age-appropriate well-child exams at a rate higher than non-enrollees with similar individual and neighborhood characteristics over the duration of the demonstration.* These exams were analyzed for three specific age groups: up to 15 months, 15-30 months, 3-11 years, and 12-21 years. FME enrollees experienced higher rates of accessing well-child visits in the first 15 months of life than the comparison group. For this age group, between the pre-period and DY1-5 period, the rate of accessing well-child visits increased for FME enrollees and decreased for the comparison group. For the 15- to 30-month age group, while both the FME and comparison groups experienced a decline in accessing well-child visits between the pre-period and DY6-7 period, the comparison group experienced a steeper decline. For the 3- to 11-year age group, both groups experienced an increase in well-child visits in the DY1-5 period and a decrease in the DY6-7 period. There was no significant difference for well-child visits in the 12-17 and 18-21 age groups for both the DY1-5 and DY6-7 periods.

H1.1.2. *FME Demonstration enrollees will access age-appropriate developmental screening at a rate higher than non-enrollees with similar individual and neighborhood characteristics over the duration of the demonstration.* Rates for accessing age-appropriate developmental screenings increased for both the FME and comparison groups between the pre-period and two post-periods.

H1.1.3. *FME Demonstration enrollees will access age-appropriate lead testing and follow-up/retesting as indicated at a rate higher than non-enrollees with similar individual and neighborhood characteristics over the duration of the demonstration.* The FME and comparison groups both experienced a steady decline in lead testing for children up to 2 years of age from the pre-period to the two post-periods. Follow-up/retesting after detecting EBLI in children 21 years of age and under experienced a significant increase in the DY1-5 period and a decrease in the DY6-7 period. In the DY6-7 period, although the rate decreased, the change was not statistically significant.

H1.1.4. *Pregnant FME Demonstration enrollees will access timely prenatal and postpartum care at a rate higher than non-enrollees with similar individual and neighborhood characteristics over the duration of the demonstration.* In the DY1-5 period, the rate of timely prenatal care increased for the FME group and decreased for the comparison group. Both groups experienced a decline in accessing prenatal care in the DY6-7 period with no statistically significant difference. For access to post-partum care, the



comparison group had higher rates than the FME group; differences were constant across the three periods.

H1.1.5. *Pregnant FME Demonstration enrollees will access recommended lead testing at a rate higher than non-enrollees with similar individual and neighborhood characteristics over the duration of the demonstration.* Lead testing for pregnant enrollees significantly increased in the DY1-5 period and decreased in the DY6-7 period while the comparison group's rate remained constant between the pre- and two post-periods. Across all three periods, enrollees accessed lead testing at a higher rate than the comparison group.

H1.1.6. *Pregnant FME Demonstration enrollees will participate in the state's Maternal Infant Health Program (MIHP) at a rate higher than non-enrollees with similar individual and neighborhood characteristics over the duration of the demonstration.* MIHP participation rates remained constant from the pre-period to the DY6-7 period for the FME group while the rate for the comparison group decreased over time.

H1.1.7. *FME Demonstration enrollees will attest to improved health care access as a result of waiver participation.* The majority of 2024 child enrollee survey participants reported the waiver improved access to health care services such as medical care, tests, and/or treatment. With the 2023 enrollee survey not effectively addressing H1.1.7, statistical testing over time was unavailable.

H1.1.8. *FME Demonstration enrollees will attest to satisfaction with their ability to access health care services as a result of waiver participation.* The majority of 2023 and 2024 child enrollee survey participants agreed or strongly agreed that the waiver helps them get the health care services their child needs, and their providers are working in their child's best interest. Between the 2023 and 2024 surveys, the percent of participants agreeing or strongly agreeing slightly increased over time but was not statistically significant.

H1.1.9. *FME Demonstration enrollees will attest to having evaluation of potential lead exposure in their home if their pipes have not been replaced.* In the 2023 and 2024 enrollee surveys, participants were asked if the pipes to their home had been replaced since the onset of the Flint Water Crisis. One-half of 2023 and 2024 child survey participants indicated that they did not know if their pipes had been replaced. In the 2024 enrollee survey, of those that were unsure or claimed their pipes had not been replaced, the majority of participants were unsure if their pipes had been tested for lead.

Hypothesis 1.2

Hypothesis 1.2. *"FME Demonstration enrollees who participate with TCM services will access medical, social, educational, and other services at a rate higher than FME **demonstration enrollees with similar individual and neighborhood characteristics who do not participate with TCM services over the duration of the demonstration.**"*

The TCM benefit was included to assist enrollees in overcoming barriers to access health care services as well as provide education on the importance of utilizing these services. Domain 1 Hypothesis 1.2 was measured using administrative health and survey data for self-reported TCM users and non-users.



The percentage of enrollees with at least one TCM claim increased from 3% in 2016-2017 to 6% in 2022-2023. However, the TCM utilization rate remained too low to carry out statistical tests comparing TCM users and non-users. In both the 2023 and 2024 enrollee surveys, the majority of participants who reported not using TCM indicated it was because they were unaware of the benefit.

Enrollees who reported using TCM services had higher rates of developmental screening within the first three years of life and lead screenings before age two than the non-TCM users. Furthermore, enrollees that utilized TCM services were satisfied with the services received and had a stronger belief that the waiver helped them access resources compared to non-users. To improve TCM service utilization, it is recommended to increase TCM service awareness and educational opportunities within the community.

H1.2.1. *FME Demonstration enrollees who participate with TCM will access age-appropriate well-child exams at a rate higher than enrollees who do not participate with TCM over the duration of the demonstration.* Analyses could not be completed due to the low number of enrollees who used TCM services.

H1.2.2. *FME Demonstration enrollees who participate with TCM will access age-appropriate developmental screening at a rate higher than enrollees who do not participate with TCM over the duration of the demonstration.* In the DY6-7 period to date (09/01/2021 – 09/30/2023), TCM participants accessed age-appropriate developmental screenings within the first three years of life at higher rates than non-participants. Due to a small sample size, the difference was not statistically significant.

H1.2.3. *FME Demonstration enrollees who participate with TCM will access age-appropriate lead testing and follow-up/retesting as indicated at a rate higher than enrollees who do not participate with TCM over the duration of the demonstration.* Analyses could not be completed due to the low number of enrollees who used TCM services.

H1.2.4. *Pregnant FME Demonstration enrollees who participate with TCM will access timely prenatal and postpartum care at a rate higher than pregnant enrollees who do not participate with TCM over the duration of the demonstration.* Analyses could not be completed due to the low number of pregnant enrollees who used TCM services.

H1.2.5. *Pregnant FME Demonstration enrollees who participate with TCM will access recommended lead testing at a rate higher than pregnant enrollees who do not participate with TCM over the duration of the demonstration.* Analyses could not be completed due to the low number of pregnant enrollees who used TCM services.

H1.2.6. *Pregnant FME Demonstration enrollees who participate with TCM will participate in the state's Maternal Infant Health Program (MIHP) at a rate higher than pregnant enrollees who do not participate with TCM over the duration of the demonstration.* Analyses could not be completed due to the low number of pregnant enrollees who used TCM services.

H1.2.7. *FME Demonstration enrollees who participate with TCM will attest to improved health care access as a result of waiver participation at a rate higher than enrollees who do not*



participate with TCM. In the 2024 survey, both self-reported TCM participants and non-participants expressed a positive sentiment towards the waiver improving access to care; there was no statistically significant difference.

H1.2.8. *FME Demonstration enrollees who participate with TCM will attest to satisfaction with their ability to access health care services as a result of TCM participation.* The majority of 2023 and 2024 child survey respondents using TCM services indicated being very or somewhat satisfied with their ability to access services.

H1.2.9. *FME Demonstration enrollees who participate with TCM will attest to having evaluation of potential lead exposure in their home if their pipes have not been replaced as a result of TCM participation.* In the 2023 enrollee survey, approximately half of both TCM users and non-users indicated they did not know if the pipes in their home had been replaced. No statistically significant change was observed between the 2023 and 2024 surveys.

Domain 2. Expand Medicaid Eligibility

Hypothesis 2 – *“The proportion of new enrollees between 212-400% FPL will increase over the duration of the FME Demonstration representing an increase in the proportion of individuals having health care coverage.”*

To eliminate financial barriers to health care, Medicaid eligibility was expanded to cover individuals at income levels above 212%. Domain 2, Expand Medicaid Eligibility, assessed how enrollees in the above 212% income group obtained information about the waiver and the degree to which the waiver provided them with an opportunity to obtain health insurance coverage as well as community partner awareness and satisfaction with the waiver. This domain was measured using enrollee and community partner surveys.

When considering income based on FPL, approximately 15% of 2023 survey participants and 24% of survey participants (unweighted) were in the high FPL (>212%) income category. Based on survey results, these individuals, in comparison to the lower income group, were more likely to receive information about the waiver through social media outlets (i.e., TV, radio, online, flyers). In the 2023 survey, over 30% of both FPL groups learned about the waiver through mailed materials. In the 2024 survey, nearly half of individuals in both FPL survey groups indicated mailed materials and letters were the primary source of information; this was not an answer option available in the 2023 survey. Additionally, across both surveys, a significantly higher proportion of the high FPL group reported having health insurance coverage prior to being on the waiver whereas the low FPL group had a significantly higher percentage reporting being enrolled in Medicaid prior to being on the waiver. In comparison to the low FPL group, a higher percentage of the high FPL participants reported enrolling in the waiver to decrease the cost of health care.

Overall, community partners, particularly those directly involved in the enrollment process were aware of the continued waiver process. Community partners that participated in the enrollment process were satisfied with current processes but noted challenges and room for improvement regarding community education and administrative/referral processes.



The primary challenge noted by community partners who work with the enrollment process was low community awareness and education regarding the waiver. They also reported issues related to client accessibility and coordination with other agencies. Thus, enhancing communication with the Flint community regarding the waiver is key; especially at a time when some school-age children may be experiencing developmental challenges as a result of the water crisis.

H2.1. FME Demonstration enrollees between 212-400% FPL will attest to having information regarding expanded Medicaid eligibility resulting in waiver participation. In the 2023 survey, most participants in both FPL groups reported learning about the waiver through their local health department. This rate slightly decreased in the 2024 survey. In the 2024 survey, the majority of both FPL groups learned about the waiver through letters and mailed materials; this was not an answer choice in the 2023 survey. Compared with the low FPL group, the high FPL group was more likely to obtain information via media outlets (i.e., TV, radio, online, flyers) in the 2024 survey.

H2.2. Community partners involved with Medicaid enrollment will attest to awareness of FME Demonstration eligibility and enrollment processes. Community partners involved with Medicaid enrollment expressed awareness of the waiver and were able to provide a detailed account of the enrollment process. Partners in this position worked closely with MDHHS caseworkers and eligible individuals to determine eligibility and help them navigate the enrollment application.

H2.3. Community partners involved with Medicaid enrollment will attest to satisfaction with FME Demonstration enrollment processes. Community partners provided feedback regarding their satisfaction with the enrollment process. The primary challenges working with the enrollment process were low community awareness of the waiver, program accessibility, and coordination with other agencies. Suggested areas of improvement included enhancing administrative processes and community education/awareness opportunities.

H2.4. FME Demonstration enrollees between 212-400% FPL will attest that the demonstration authorized expanded Medicaid eligibility offered a new opportunity to obtain health care coverage versus serving as a replacement for existing health care coverage. Across the 2023 and 2024 child surveys, when compared to the low FPL group, a greater percentage of participants in the high FPL group reported having health insurance coverage prior to being on the waiver. Enrollees in the high FPL group were also more likely to enroll in the waiver to lower the cost of health care whereas participants in the low-income group were more likely to have already been enrolled in Medicaid prior to enrolling in the waiver.

Domain 3. Improved Health Outcomes

Hypothesis 3 – *“Enrollees will have improved health outcomes compared to non-enrollees with similar individual and neighborhood characteristics over the duration of the FME Demonstration.”*



The waiver's goal was to improve health outcomes for children at or under 21 and pregnant women who were exposed to the contaminated water. Domain 3, Improved Health Outcomes, was measured using administrative health and enrollee survey data.

Enrollees experienced positive health impacts from waiver participation. Age-appropriate childhood immunization rates for children 13 years of age increased for both the FME enrollee and comparison groups between the pre- and DY1-5 periods with the FME experiencing a higher increase. In the DY6-7 period, utilization rates decreased for both groups but were still higher than pre-period rates. However, enrollees had less decline in immunization rates compared to the comparison group.

Approximately 30% of 2023 and 2024 child survey participants identified as having a chronic condition(s). Between the 2023 and 2024 child surveys, there was an increase in the percentage of participants who reported that, since being on the waiver, they have more access to resources and are more confident in their ability to manage their chronic condition(s). Additionally, the percentage of participants reporting they had been informed that their child should be tested for learning problems decreased from 37% in 2023 to 27% in 2024. Approximately 25% of 2023 and 2024 child survey participants had an IEP with the majority receiving special education programming.

H3.1. FME Demonstration enrollees will have improved age-appropriate completed immunization status compared to non-enrollees with similar individual and neighborhood characteristics over the duration of the demonstration. Age-appropriate childhood immunization rates for children 2 years of age decreased for both the FME and comparison groups between the pre-period to the FY6-7 period. Age-appropriate immunization for children 13 years of age increased for both groups in the DY1-5 period with the FME group having a larger increase. In the DY6-7 period, the rate for both groups decreased but was still higher than pre-period rates.

H3.2. Pregnant Demonstration enrollees will have higher birth weights compared to non-enrollees with similar individual and neighborhood characteristics over the duration of the demonstration. In the DY1-5 period, the low birth weight (LBW) rate for the enrollee group was lower than the population baseline and was statistically significant. The comparison group was not statistically different than the population baseline at that time. In the DY6-7 period, the enrollee group experienced a slightly higher increase in LBW rates than the comparison group but was not statistically significant.

H3.3. FME Demonstration enrollees will report improved health status as a result of the waiver participation. In the 2024 enrollee survey, participants were asked to rate their child's overall health status and if they would have rated their overall health the same if they had not been in the waiver. The majority of participants reported they would have rated their overall health the same had they not been enrolled in the waiver.

H3.4. FME Demonstration enrollees will report improved confidence in chronic condition self-management as a result of the waiver participation. Over a quarter of 2023 and 2024 survey participants reported their child having a chronic condition(s). Of the 2023 and



2024 enrollee survey participants who reported having a chronic condition(s), 37% of 2023 participants and over half of 2024 participants indicated that the waiver helped them access more resources to manage the condition(s). Additionally, the proportion of participants who agreed or strongly agreed that being enrolled in the waiver improved their confidence in managing their child's chronic health condition(s) increased between the 2023 and 2024 surveys.

H3.5. FME Demonstration enrollees will have an increased rate of referrals to specialized programs intended to mitigate potential educational and/or behavioral disabilities during childhood (ages 0-21) as a result of waiver participation. The proportion of survey participants reporting they had been informed their child should be tested for learning problems decreased between the 2023 and 2024 surveys. Approximately one quarter of 2023 and 2024 child enrollee survey participants had an individualized education plan (IEP) with the most common service utilized being special education programming.

Interpretations, Policy Implications, and Interactions with Other State Initiatives

Preliminary findings suggest the waiver had moderate success in meeting the overarching goal to increase access to services, expand Medicaid eligibility, and improve health outcomes for those that utilize TCM. The following is a summary of key evaluation findings obtained through December 2024 and recommendations for how waiver efforts could evolve to better achieve stated objectives.

A main goal of the waiver was to increase access to needed health care in response to the water crisis. Enrollees under twelve years of age experienced higher rates of well-child visits than non-enrollees during DYs 6-7. Across the country, utilization of well-child visits is highest for infants, toddlers, and young children and decreases as children age (Michigan Medicine Child Health Evaluation and Research Center, 2023). Increased public health communications in the Flint community could encourage continued well-child visits; especially in school-age children who may exhibit increased health issues (e.g., asthma, behavioral, learning difficulties, etc.). Flint Community Schools may be an appropriate venue for disseminating information about the importance of prevention and screening health services, particularly to enhance recommendations for children potentially exposed to lead.

Increased access to developmental screenings was also observed. This may be a result of referral processes integrating additional screening standards based on symptoms of lead exposure or heightened awareness among the pediatric community for children having possible lead exposures. Also, in 2022, GHS established the Center for Children's Integrated Services which housed programs such as the Neurological Center for Excellence (Genesee Health System Center for Children's Integrated Services, n.d.). As the designated provider for TCM services, this new program likely contributed to increased awareness of symptoms and access to timely and appropriate screening.



Both enrollee and comparison groups experienced a decline in accessing timely prenatal care thus far in the DY6-7 period. This observation may be associated with the downward trend in birth rates; the national birth rate has decreased 2% annually since 2014 and the City of Flint has followed similar trends (Division for Vital Records & Health Statistics., n.d.; National Center for Health Statistics, 2024). It may also be an artifact of timing associated with the COVID-19 pandemic winding down. Decreases in health utilization overall may not have rebounded during this period.

Access to lead testing for pregnant and child enrollees was lower than in previous reports. It is understandable that these rates would decline over this period because the immediate, crisis-based need for lead testing has diminished. However, lead is a serious health threat particularly for child health and behavioral outcomes. It is recommended that local health plans encourage providers to educate clients on the importance of lead testing by 2 years of age as well as follow-up testing if EBLLs are detected. For pregnant enrollees, a decline in the utilization of lead screening services indicates a need for increased communication with providers to emphasize the importance of specialized services to reduce potential neonatal health risks.

Opportunity for community education is supported by the observation that a majority of survey participants reported they did not know if the pipes to their homes have been replaced. Individuals were also unsure if their water had been tested in the absence of pipe replacement. This is concerning given only that 97% of pipes leading to homes in the affected areas had been replaced as of December 2024 and the EPA has declared the City of Flint had officially completed pipe replacement requirements. Lead is a pervasive problem in older, urban communities requiring ongoing, consistent lead surveillance. Individual education regarding opportunities to evaluate household risk factors may be warranted.

Low utilization of TCM services hindered analyses to fully evaluate the impact of these services. In 2023 and 2024 surveys, many participants who did not use TCM services indicated the reason to be they were unaware of the TCM benefit. It is possible they had utilized TCM services but were unclear what it was called or what was covered as part of that service. This points to a need for clear communication to providers and enrollees about the waiver's availability and benefits to lead-exposed individuals. Communication is critical now, particularly since the crisis has waned.

[Policy Recommendations and Implications](#)

Many of the recommendations below are already in place as part of FME. However, given the waiver is in its ninth year, existing policies should be strengthened and recomunicated to the Flint community and those with a history of exposure to the contaminated water.

[Strengthen Child Health and Developmental Screening](#)

Although not directly part of waiver services, enhanced outreach and reminders for well-child visits should be implemented, particularly targeting adolescents and young adults, to address declining rates. This may include promoting the importance of developmental screening benchmarks through TCM programming to enhance early detection of health risks and timely referrals. As children age, and depending on the level of lead exposure, screening should be



closely monitored during adolescence when lead exposure developmental and behavioral effects are manifested. An additional strategy for reaching families with school-age children would be to collaborate with local educators. They can provide educational resources such as information on how to identify symptoms of lead exposure and provide referrals for children experiencing behavioral or learning symptomology potentially related to lead exposure.

Expand and Improve Prenatal and Maternal Health Awareness and Access

To improve early and sustained prenatal care, it is essential to increase maternal care program referrals to pregnant women. It is recommended that TCM managers be encouraged to refer pregnant women to both specialized (MIHP) and general prenatal services. While the immediate crisis of lead exposure through tap water has been greatly reduced, other sources of lead exposure in the community remain (e.g., lead paint, soil, factory work, etc.).

Increase Community Education Efforts

Clarity about waiver services is still confusing to some in the community. Thus, public awareness campaigns and community education is needed to increase knowledge of waiver availability, eligibility, and services covered. A benefit of increasing community education efforts is that it would reach a larger audience within the City of Flint. Not every child and pregnant woman exposed to the contaminated water enrolled in the waiver. However, these children are still at risk of developing health issues as a result of the water and should be aware of lead exposure symptoms.

Lessons Learned and Recommendations

Findings detailed in this report are preliminary. While a full description of recommendations are limited at this time, current findings provide insight that can improve not only the present FME waiver but future Medicaid Expansion waivers for similar environmental and public health crises.

Enrollment in this waiver has been lower than expected in the DY 6-7 period and engagement of those over 212% FPL has remained low. Reasons for low enrollment are not fully understood since there was no direct data source to identify individuals in the community who were eligible for the waiver but did not enroll.

It is important to note that the City of Flint population has substantially declined since the beginning of the waiver by approximately 20%; the population was 100,000 in 2014 and dropped to less than 80,000 in 2024 (United States Census Bureau, 2024). Many families with higher resources have left the city since the onset of the water crisis. Those who were unable to leave the city, because of fewer resources (e.g., transportation, nutrition, literacy, etc.), tended to have higher rates of developmental difficulties (Sadler et al., 2021). Low uptake of the waiver and available services may be connected with population having fewer resources needed to access these benefits.

This evaluation utilized a mixed-methods model of analyses through the use of administrative health, community partner, and enrollee survey data. It is noted that, although the survey response rates are acceptable, bias may be introduced because those who respond to the



survey may be more amenable to waiver utilization and acceptability. Survey participants and enrollee group characteristics were fairly similar. In this report, all survey data analyses were weighted and accounted for during sampling design.

It is recommended that, for future Medicaid Expansion efforts, there be consistent and ongoing communication and education efforts to the target community. Greater communication from MDHHS to the community and providers is important to sustain enrollment and education regarding benefits covered by the waiver.

Additionally, it is essential to increase awareness regarding sustained lead exposure and the importance of lead testing as well as providing developmental screening assessments. Evidence suggests the effects of lead exposure manifest during late childhood and early adolescence (Lanphear et al., 2024; Lieberman-Cribbin et al., 2024). Lead exposure is a known childhood risk and there are policies and mechanisms in place to promote appropriate testing by providers. Consistent education of lead exposure and long-term risks of EBLL to the community are key to improving the health of those that are still at risk. It is recommended that providers be encouraged to educate their clients on the importance of lead testing by age 2 and follow-up lead testing after detecting EBLLs.

An extremely low pattern of TCM claims was identified in administrative health data for DY6-7 and state partners confirmed they were experiencing contracting and billing interruptions. In an effort to circumvent this in future waivers, it is recommended DPOs be provided with administrative supports to assist them in providing waiver services to enrollees. Additionally, based on conversations with GFHC (the DPO sub-contractor) it is recommended the DPO list be expanded so multiple organizations can facilitate needed services.

The TCM benefit was utilized less than anticipated, despite reports of satisfaction from enrollees using TCM services. There may be several reasons for this observation including low awareness of the benefit and minimal reporting of TCM claims. According to 2023 and 2024 enrollee survey results, the majority of enrollees who did not use TCM services indicated they did not know about the benefit. In the First Demonstration period, during provider key informant interviews, we discovered that providers were not billing provided TCM services through FME due to administrative barriers established during the COVID-19 pandemic (i.e., telehealth TCM not being covered). Furthermore, the percent of 2023 and 2024 survey participants who self-identified as using TCM services was higher than the number identified as having a TCM claim between 10/01/2021–9/30/2023. The difference in the number of enrollees who identified as using services compared to the number identified through administrative data may be a result of enrollees not understanding what TCM included. It could also be that they received TCM, but the services were billed under a different program that had less administrative burden. It is recommended that an assessment can be undertaken to assess the characteristics of those who use TCM.

Providers should continue to closely monitor developmental issues, particularly in adolescence, where symptoms of potential lead poisoning may reveal cognitive affects. Adolescents who had high or sustained lead exposure have been studied for decades. Evidence indicates the



potential impact of lead exposure typically manifest during late childhood and early adolescence (Lanphear et al., 2024).

A full description of recommendations is limited at this time. In this cumulative interim report, completed evaluation activities and progress from 9/15/2021 to 12/31/2024 are described. The evaluation is expected to continue through September 2026 with the Summative Evaluation Report due March 31, 2027. As additional data is collected, utilization estimates, and enrollee ratings may change from the provisional data reported here. However, currently available data suggest that the waiver has been successful in meeting selected goals and objectives with opportunities for enhanced performance remaining.



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Appendix

Appendix 1. Approved Renewal Application



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demo-appvd-eval-des



Appendix 2. Enrollee Survey Tools



CHILD-LETTER-2023.
pdf



ADULT-LETTER-2023.
pdf



FLINT-2023-CHILD.p
df



FLINT-2023-ADULT.p
df



FLINT2023-SPANISH.
pdf



CHILD-LETTER-2024.
pdf



ADULT-LETTER-2024.
pdf



CHILD-2024-ENGLIS
H.pdf



CHILD-2024-SPANIS
H.pdf



CHILD-2024-ARABIC.
pdf



ADULT-2024-ENGLIS
H.pdf



ADULT-2024-SPANIS
H.pdf



ADULT-2024-ARABIC
.pdf



Appendix 3. 2024 Community Partner Survey



Targeted Case
Management Survey_