



STATE OF MICHIGAN
EXECUTIVE OFFICE
LANSING

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September 10, 2018

The Honorable Alex Azar II
Secretary
U.S. Department of Health & Human Services
200 Independence Ave, SW
Washington, D.C. 20201

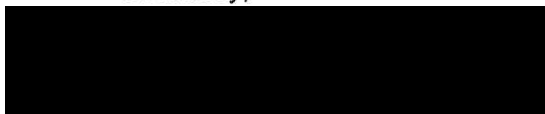
Dear Secretary Azar:

On behalf of the State of Michigan, I am pleased to submit the State's Healthy Michigan Plan (HMP) §1115 Demonstration Extension Application Amendment (Project No. 11-W-00245/5), in accordance with Michigan Public Act 208 of 2018. HMP was implemented in April 2014 to provide healthcare access to low-income, uninsured and underinsured Michigan residents. This demonstration project introduced cost-sharing initiatives and a Healthy Behavior Incentive Program that promotes beneficiary engagement in healthy behaviors and conscientious utilization of healthcare services. The State of Michigan is requesting approval for a 5-year extension of the demonstration waiver.

Through HMP, the Michigan Department of Health and Human Services has extended healthcare coverage to over 1,000,000 eligible low-income Michigan residents, with a current enrollment of approximately 655,000. The HMP program has made a significant impact on the health and well-being of Michigan residents and the proposed waiver extension amendment will enable the State to continue those efforts. Michigan seeks approval to empower individuals in our HMP program to improve their health by actively engaging in their communities and working to gain the skills necessary for independence and long-term success. The attached demonstration extension application amendment is designed to promote accountability, self-sufficiency, and independence from public assistance.

The State looks forward to its ongoing work with federal partners at the Centers for Medicare & Medicaid Services to ensure that HMP enrollees continue to have access to a quality healthcare benefit program that improves health outcomes.

Sincerely,



Rick Snyder
Governor

cc: Jennifer Kostasich, Project Manager, CMS
Ruth Hughes, Regional Administrator, CMS
Andrea Casart, Director, Division of Medicaid Expansion Demonstrations, CMS

Section 1115 Demonstration Extension Application

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

Submission Date: December 6, 2017
AMENDED: September 10, 2018

State of Michigan
Rick Snyder, Governor

Nick Lyon, Director
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Section I – Executive Summary

The Michigan Department of Health and Human Services (MDHHS) respectfully requests approval to extend its highly successful Healthy Michigan Plan demonstration waiver. Michigan has a proven record of efficiently managing health care costs and improving the State’s Medicaid program. As part of these efforts, MDHHS implemented the Michigan Medicaid expansion program, known as the Healthy Michigan Plan (HMP) administered under the §1115 Demonstration Waiver authority (Project No. 11-W-00245/5) on April 1, 2014. Through HMP, MDHHS has extended health care coverage to over 1,000,000 low-income Michigan residents who were previously either uninsured or underinsured. The current HMP enrollment is approximately 655,000. HMP is built upon systemic innovations that improve quality and stabilize health care costs. Other key program elements include: (a) the advancement of health information technology, (b) structural incentives for healthy behaviors and personal responsibility, (c) encouraging use of high value services, and (d) promoting the overall health and well-being of Michigan residents.

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

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

On December 17, 2015, the Centers for Medicare & Medicaid Services (CMS) approved an amendment to the HMP Demonstration Waiver which was referred to as the “Marketplace Option.” Beneficiaries who were impacted by that amendment were those:

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

On June 22, 2018, Gov. Rick Snyder signed Public Act (PA) 208 of 2018, included as Attachment A. As a result, MDHHS seeks to amend certain elements of the HMP through this demonstration extension amendment to comply with State law. Specifically, MDHHS seeks approval to amend the HMP waiver eligibility for health care coverage and cost-sharing

requirements applicable to individuals between 100% and 133% of the FPL who have had 48 months of cumulative eligibility for health care coverage through HMP. MDHHS also seeks provisions to address exemptions related to cost-sharing, medically frail individuals, and beneficiary hardship. Additionally, MDHHS seeks to add workforce engagement requirements as a condition of HMP eligibility for able-bodied adults ages 19 to 62. Finally, MDHHS seeks to end the Marketplace Option benefit.

In furtherance of Medicaid program objectives, Michigan seeks to promote work and community engagement and provide incentives to beneficiaries to increase their sense of purpose, build a healthy lifestyle, and further the positive physical and mental health benefits associated with work. MDHHS workforce engagement requirements are designed to assist, encourage, and prepare an able-bodied adult for a life of self-sufficiency and independence from governmental interference. Studies provide evidence of the correlation between income and health; as income increases overall health status improves. Risk factors such as smoking, obesity and poor nutrition are disproportionately evident in lower income groups. Chronic disease, depression, addiction and premature death rise as incomes drop. Income is also a driving force behind health disparities.^{1,2,3} These new HMP requirements are expected to help beneficiaries realize the mental and physical health benefits associated with gainful employment by incentivizing engagement in the workforce and providing future opportunities to obtain health care coverage through their employer or the federal marketplace. In addition, studies indicate that employment and community engagement are beneficial for health, particularly depression, general mental health, life satisfaction, and wellbeing.^{4,5}

Approval of this demonstration extension application request would allow the State of Michigan to continue to provide comprehensive health care coverage while incorporating new innovative approaches and structural incentives to increase beneficiary engagement in healthy behaviors and to promote personal responsibility in maintaining health care coverage. Furthermore, approval of an extension of the HMP waiver, which is currently set to expire on December 31, 2018, will continue to build on already achieved success. Michigan is requesting approval for a 5-year extension of the demonstration waiver.

¹ National Center for Health Statistics. (2012). *Health, United States, 2011: With Special Feature on Socioeconomic Status and Health*. Hyattsville, MD: US Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Health Statistics. Retrieved from: [http://www.cdc.gov/nchs/data/11.pdf](http://www.cdc.gov/nchs/data/hus/11.pdf).

² Braveman, Paula A., Catherine Cubbin, Susan Egerter, David R. Williams, and Elsie Pamuk. (2010). "Socioeconomic Disparities in Health in the United States: What the Patterns Tell Us." *American Journal of Public Health* 100 (S1): S186–S196. Retrieved from: <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2837459/>.

³ Pollack, C. E., C. Cubbin, A. Sania, M. Hayward, D. Vallone, B. Flaherty, and P. A. Braveman. (2013). "Do Wealth Disparities Contribute to Health Disparities within Racial/Ethnic Groups?" *Journal of Epidemiology and Community Health* 67 (5): 439–45. Retrieved from: <http://www.ncbi.nlm.nih.gov/pubmed/23427209>.

⁴ Van der Noordt, M., Jzelenberg, H., Droomers, M., and Proper, K. (2014) Health effects of employment: a systemic review of prospective studies. *Occupational and Environmental Medicine*, 71(10), 730-736.

⁵ Jenkinson, C., Dickens, A., Jones, K., Thompson-Coon, J., Taylor, R., Rogers, M., ... Richards, S. (2013). Is volunteering a public health intervention? A systematic review and meta-analysis of the health and survival of volunteers. *BMC Public Health*, 13(773), 1-10.

Approval for this extension amendment request is being sought effective January 1, 2019 with up to 6 months to implement the 48 months of cumulative coverage change in cost-sharing and healthy behaviors, and up to 12 months to implement the workforce engagement provisions.

Section II – Program History and Overview

A. HMP Program History

In January 2004, the State of Michigan’s Adult Benefits Waiver (ABW) was approved by CMS as a §1115 Demonstration Waiver. The ABW program provided a limited ambulatory benefit package to low-income, childless adults between the ages of 19-64, with incomes at or below 35% FPL and who were not otherwise eligible for Medicaid. The programmatic goals for the ABW demonstration were to improve the access and quality of appropriate healthcare services. The Michigan legislature passed Public Act 107 of 2013, which permitted MDHHS to augment its ABW program by expanding the eligibility criteria for this adult population overall, from 35% to 133% of the FPL, utilizing the Modified Adjusted Gross Income (MAGI) methodology. Concurrently, program benefits were expanded to include all federally mandated Essential Health Benefits (EHBs) under an Alternative Benefit Plan (ABP) State Plan Amendment. In December 2013, CMS approved the State’s request to amend the ABW waiver, which was subsequently renamed HMP. HMP was implemented on April 1, 2014.

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

The Marketplace Option amendment provided that beneficiaries with incomes greater than 100% of the FPL who had been enrolled in an HMP health plan for 12 consecutive months could be required to receive their health benefits through the Marketplace Option if they had not completed a healthy behavior.

PA 208 of 2018 amended HMP provisions that effectively eliminated the implementation of the Marketplace Option. It also directed MDHHS to seek new innovative approaches in administering the HMP with the goal of removing health related obstacles inhibiting or prohibiting enrollees from achieving their highest level of personal productivity. Through these new activities, MDHHS believes that these changes will more effectively encourage beneficiaries to engage in healthy behaviors and increase awareness of personal responsibility.

B. HMP Goals & Objectives

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

MDHHS' initial and continued goals for HMP include:

- Improving access to healthcare for uninsured or underinsured low-income Michigan residents;
- Improving the quality of healthcare services delivered;
- Reducing uncompensated care;
- Strengthening beneficiary engagement and personal responsibility;
- Encouraging individuals to seek preventive care, adopt healthy behaviors, and make responsible decisions about their healthcare;
- Supporting coordinated strategies to address social determinants of health in order to promote positive health outcomes, greater independence, and improved quality of life;
- Helping uninsured or underinsured individuals manage their health care issues;
- Encouraging quality, continuity, and appropriate medical care; and

This demonstration will incorporate an evaluation aimed at studying the effects infusing market-driven principles into a public healthcare insurance program by examining:

- The extent to which the increased availability of health insurance reduces the costs of uncompensated care borne by hospitals;
- The extent to which availability of affordable health insurance results in a reduction in the number of uninsured/underinsured individuals who reside in Michigan;
- Whether the availability of affordable health insurance, which provides coverage for preventive and health and wellness activities, will increase healthy behaviors and improve health outcomes;
- The extent to which beneficiaries feel that HMP has a positive impact on personal health outcomes and financial well-being;
- Whether a possible loss of HMP eligibility-encourages beneficiaries to engage in a healthy behavior and comply with the cost-sharing requirements; and
- The extent to which workforce engagement requirements impact individuals who transition from Medicaid obtain employer sponsored or other health insurance coverage, and how such transitions affect health and well-being.

C. HMP Program Overview

1. Eligibility

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

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

As part of this extension application for HMP, MDHHS seeks approval to continue certain demonstration provisions for individuals with income at or below 100% of the FPL. In addition, the State seeks to amend the HMP waiver eligibility and cost-sharing requirements for individuals with income between 100% and 133% of the FPL as described below:

a) Beneficiaries with income at or below 100% of the FPL

HMP beneficiaries who are at or below 100% of the FPL will continue to have eligibility for health care coverage and cost-sharing responsibilities consistent with the process outlined in the Healthy Michigan Healthy Behaviors Incentives Protocol and the Operational Protocol for the MI Health Accounts, included as Attachments B and C respectively.

b) Beneficiaries with income between 100% and 133% of the FPL

(1) After 48 months of HMP Eligibility

In order to maintain eligibility for HMP, individuals enrolled in Medicaid health plans with income between 100% and 133% of the FPL, who have had 48 months of cumulative HMP eligibility must:

- Complete or actively engage in an annual healthy behavior with effort given to making the healthy behaviors in subsequent years incrementally more challenging; and
- Pay a premium of 5% of their income (no co-pays required), not to exceed limits defined in 42 CFR 447.56(f).

After 48 months of cumulative HMP eligibility, beneficiaries will not be eligible for any cost sharing reductions and their MI Health Account will no longer be utilized for cost sharing liabilities.

(2) Loss of Eligibility for Health Care Coverage

Beneficiaries who have not met the program's healthy behavior or cost-sharing requirements will be notified 60 days before the end of their 48th month that their coverage under the HMP program will be ending. They will become eligible for HMP coverage again once they have come into compliance with the healthy behavior and cost-sharing requirements, at which point they will be re-enrolled the first day of the next available month.

MDHHS is working to identify supports and services that will assist individuals with meeting the cost sharing and healthy behavior requirements. MDHHS is exploring alternative payment methods and ways to provide additional assistance and expand the options for completing a health risk assessment and healthy behavior.

(3) Medically Frail Exemption

Individuals described in 42 CFR 440.315 will be exempt from the 48 months cumulative enrollment loss of coverage and from the 5% premium provision. Individuals will be given the option to self-report his/her medically frail status. The Medically Frail Identification Process is included as Attachment D.

(4) Cost-Sharing Exempt Status

Individuals who are exempt from premiums and cost-sharing pursuant to 42 CFR 447.56 will be exempt from the 5% premium requirement of the 48 months cumulative enrollment provision. This includes, but is not limited to, pregnant women, Native Americans, and children under 21 years of age. However, all beneficiaries exempt from paying premiums will still be required to complete or actively engage in an annual healthy behavior in order to remain on HMP. In the event an individual's cost-sharing exemption status changes (e.g. they turn 21 years old), he or she will be required to maintain compliance with HMP healthy behaviors and cost-sharing requirements, assuming other eligibility criteria are met.

(5) Hardship Exemption

MDHHS will consider hardship exemptions for the following:

- Cost-sharing responsibilities
- Loss of coverage

Examples of hardship exemptions may include, but are not limited to, the birth or death of a family member living with the beneficiary, a family emergency or other life changing event (divorce, domestic violence, etc.), or a temporary illness or injury.

2. Benefits

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

3. Cost-Sharing

All HMP beneficiaries are required to adhere to the cost-sharing requirements outlined in the MIHA protocol. The HMP has a unique MIHA vehicle where beneficiary cost-sharing requirements are satisfied, monitored and communicated to the beneficiary. Moreover, HMP incorporates the Healthy Behaviors Incentives Program which was created to reward beneficiaries for their conscientious use of health care services. Incentives, which are defined in the waiver protocol, include both reductions in cost-sharing responsibilities and select financial rewards. Participating HMP beneficiaries who are enrolled in an MHP may earn incentives on the basis of their active, appropriate participation in the health care delivery system. After 48 months of cumulative HMP eligibility, beneficiaries with incomes between 100% and 133% of the FPL will not be eligible for any cost-sharing reductions related to healthy behavior completion incentives, nor will they be eligible for any refunds.

Beneficiaries who are exempt from cost-sharing requirements by law, regulation or program policy will be exempt from cost-sharing obligations via the MI Health Account (e.g. individuals receiving hospice care, pregnant women receiving pregnancy-related services, individuals eligible for Children's Special Health Care Services, Native Americans in compliance with 42 CFR 447.56, etc.). Similarly, services that are exempt from cost sharing by law, regulation or program policy (e.g. preventive and family planning services), or as defined by the State's Healthy Behaviors Incentives Operational Protocol, will also be exempt for HMP beneficiaries.

Beneficiaries who are at or below 100% of the FPL will continue to pay cost-sharing consistent with the process outlined in the Operational Protocol for the MI Health Accounts. The HMP program has undergone some positive changes based on stakeholder and evaluator input over the course of MDHHS' experience with HMP. Some changes, such as revisions to the MIHA statement, have been implemented to improve beneficiary understanding of cost-sharing responsibilities. Other changes, such as revisions to the program's HRA tool and submission process, seek to increase the promotion of beneficiary engagement in the Healthy Behaviors Incentives Program. The program has also expanded the scope of services and medications associated with chronic medical conditions which are deemed exempt from cost-sharing as a way to reduce any potential financial barriers to important primary care.

4. Delivery Systems

Services for HMP beneficiaries are provided through a managed care delivery system.

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

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

- Comprehensive Health Plans: The State's contracted MHPs provide acute care, physical health services and most pharmacy benefits.
- Behavioral Health Plans: Prepaid Inpatient Health Plans (PIHPs) provide inpatient and outpatient mental health, substance use disorder, and developmental disability services statewide to all enrollees in the demonstration.

5. Workforce Engagement Requirements

Beginning January 1, 2020, MDHHS seeks to implement work requirements for able-bodied adults as a condition of eligibility for HMP consistent with PA 208 of 2018. Once implemented, beneficiaries 19 to 62 years of age must work or engage in specified educational, job training, or community service activities for at least 80 hours per month to remain covered through the HMP unless they qualify for an exemption. HMP beneficiaries who are subject to workforce engagement requirements will be required to demonstrate that they are meeting the requirements through monthly verification. Beneficiaries who fail to meet the requirements will lose HMP coverage until they comply.

Workforce engagement requirements include the following:

- Participation of an average of 80 hours per month of qualifying activities or a combination of any qualifying activities; and
- Self-attest to compliance with, or exemption from, workforce engagement requirements to MDHHS on a monthly basis.

MDHHS will offer internet reporting for self-attestation using technology already in place with increasing rates of utilization. MDHHS intends to offer telephone reporting options for beneficiaries with limited or no internet access.

The following is the list of qualifying activities:

- Employment, self-employment, or having income consistent with being employed or self-employed (makes at least minimum wage for an average of 80 hours per month);
- Education directly related to employment (i.e., high school equivalency test preparation, postsecondary education);
- Job training directly related to employment;
- Vocational training directly related to employment;
- Unpaid workforce engagement directly related to employment (i.e., internship);

- Tribal employment programs;
- Participation in a substance use disorder treatment (court ordered, prescribed by a licensed medical professional, or Medicaid-funded Substance Use Disorder (SUD) treatment);
- Community service completed with a non-profit 501(c)(3) or 501(c)(4) organization (can only be used as a qualifying activity for up to 3 months in a 12-month period); and
- Job search directly related to job training.

A beneficiary is allowed 3 months of noncompliance within a 12-month reporting period. After 3 months of noncompliance, a beneficiary who remains noncompliant will not receive health care coverage for at least one month and will be required to come into compliance before coverage is reinstated.

The following individuals are exempt from workforce engagement requirements:

- A caretaker of a family member under 6 years of age (only one parent at a time can claim this exemption);
- Beneficiaries currently receiving temporary or permanent long-term disability benefits from a private insurer or from the government;
- Full-time student who is not a dependent or whose parent/guardian qualifies for Medicaid
- Pregnant women;
- A caretaker of a dependent with a disability who needs full-time care based on a licensed medical professional's order (this exemption is allowed one time per household);
- A caretaker of an incapacitated individual even if the incapacitated individual is not a dependent of the caretaker;
- Beneficiaries who have proven they meet a good cause temporary exemption (as defined in PA 208 of 2018);
- Beneficiaries designated as medically frail;
- Beneficiaries with a medical condition resulting in a work limitation according to a licensed medical professional order;
- Beneficiaries who have been incarcerated within the last 6 months;
- Beneficiaries currently receiving unemployment benefits from the State of Michigan; and
- Beneficiaries under 21 years of age who had previously been in foster care placement in this state.

Additionally, beneficiaries in compliance with or exempt from the work requirements of the Supplemental Nutrition Assistance Program or Temporary Assistance for Needy Families Program are deemed compliant with or exempt from the workforce engagement requirements outlined above. Additional reporting will not be required.

MDHHS shall enforce the provisions of this section by conducting the compliance review process on medical assistance recipients under HMP who are required to meet the workforce engagement requirements of this section. If an individual is found, through the compliance review process, to have misrepresented his or her compliance with the workforce engagement

requirements in this section, he or she shall not be allowed to participate in the HMP for a one-year period. However, if an individual is locked out of the HMP program and subsequently becomes eligible for another Medicaid program, they may begin receiving services under the other Medicaid program once their eligibility for the other program is determined.

MDHHS is working to identify supports and services that will assist individuals with meeting the workforce engagement requirements and plans to leverage existing partnerships with community stakeholders whenever possible. For example, MDHHS is exploring Michigan Works Agency programs available to Medicaid beneficiaries and ways to assist with transportation and child care needs. In addition, MDHHS is in discussions to develop a new work partnership program that will connect beneficiaries in need of work to health-related jobs that have labor shortages (e.g. home health aides, home help providers, certified nurse assistants and non-emergency medical transportation providers). Additionally, MDHHS is committed to providing early and robust communication, beneficiary education and advocacy involvement to help assure that HMP members do not lose coverage because of lack of understanding the systems or process. MDHHS plans to utilize lessons learned during the implementation of the original HMP waiver, including the use of focus group testing, to assure that communications are clear, understandable and actionable.

Section III – Waivers and Expenditure Authorities

A. Waiver Authorities

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

- *Premiums, § 1092(a)(14), insofar as it incorporates § 1916 and 1916A* - To the extent necessary to enable the State to require monthly premiums for individuals eligible in the adult population described in section 1902(a)(10)(A)(i)(VIII) of the Act, who have income between 100 and 133 percent of the FPL.
- *State-wideness § 1902(a)(1)* - To the extent necessary to enable the State to require enrollment in managed care plans only in certain geographical areas for those eligible in the adult population described in section 1902(a)(10)(A)(i)(VIII) of the Act.
- *Freedom of Choice § 1902(a)(23)(A)* - To the extent necessary to enable the State to restrict freedom of choice of provider for those eligible in the adult population described in section 1902(a)(10)(A)(i)(VIII) of the Act. No waiver of freedom of choice is authorized for family planning providers.
- *Proper and Efficient Administration § 1902(a)(4)* - To enable the State to limit beneficiaries to enrollment in a single prepaid inpatient health plan or prepaid ambulatory health plan in a region or region(s) and restrict disenrollment from them.

- *Comparability § 1902(a)(17)* - To the extent necessary to enable the State to vary the premiums, cost-sharing and healthy behavior reduction options as described in the Special Terms and Conditions.
- *Provision of Medical Assistance §1902(a)(8) and § 1902(a)(10)* - To the extent necessary to enable the state to not make medical assistance available to beneficiaries who fail to comply with healthy behavior incentive program or workforce engagement requirements unless the beneficiary is exempted.
- *Eligibility §1902(a)(10) or § 1902(a)(52)* - To the extent necessary to enable the State to bar re-enrollment, until qualifications are met, for beneficiaries with income above 100 percent of the FPL who have lost coverage due to failure to complete or actively engage in a healthy behavior, fail to pay cost-sharing requirements, and fail to meet workforce engagement requirements subject to the exemptions and qualifying events described herein.
- *Reasonable Promptness §1902(a)(3) and § 1902(a)(8)* - To the extent necessary to enable the State to prohibit participation in HMP for a one-year period for beneficiaries who have misrepresented their compliance with workforce engagement requirements.

B. Expenditure Authorities

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

Section IV – Reporting

MDHHS has routinely documented the progress of HMP since its inception in 2014 and submits quarterly and annual reports to CMS. These reports can be found at [www.medicaid.gov](http://www.michigan.gov/mdhhs/0,5885,7-339-71547_4860---,00.html).

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

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

MDHHS developed HMP Performance Monitoring Specifications beginning with the initiation of the program in 2014. Many of the measures for fiscal year (FY) 2015 were informational as MDHHS refined its data collection and analysis process. Performance standards were set for

these measures in FY 2016 and will continue in FY 2017 and beyond. Performance areas include Adult Access to Ambulatory Health Services, Outreach and Engagement to Facilitate Entry to Primary Care, Adults' Generic Drug Utilization, Plan All-Cause Acute 30-Day Readmissions, and Timely Completion of Initial Health Risk Assessment. Please see Attachment E for the full PMR and EQRO reports.

Section V – Program Financing

Historical HMP demonstration expenditures for all eligible groups are included in the budget neutrality monitoring table below as reported in the CMS Medicaid and Children's Health Insurance Program Budget and Expenditure System. Total expenditures include those that both occurred and were paid in the same quarter in addition to adjustments to expenditures paid in quarters after the quarter of service. HMP demonstration expenditures have historically remained under per-member-per-month (PMPM) budget neutrality limits as defined by the demonstration special terms and conditions. The following table includes expenditures and member months by demonstration year (DY) starting April 1, 2014 through June 30, 2018.

Table 2: Healthy Michigan Plan Budget Neutrality Monitoring					
	DY 5 - PMPM	DY 6 - PMPM	DY 7 - PMPM	DY 8 - PMPM	DY 9 - PMPM
Approved HMP PMPM	\$ 667.36	\$ 602.21	\$ 569.80	\$ 598.86	\$ 629.40
Actual HMP PMPM (YTD)	\$ 478.00	\$ 478.47	\$ 499.28	\$ 468.75	\$ 407.64
Total Expenditures (YTD)	\$1,785,379,000.00	\$3,477,577,652.00	\$3,874,699,771.00	\$3,905,254,785.00	\$1,727,739,555.00
Total Member Months (YTD)	3,735,115	7,268,118	7,760,576	8,331,177	4,238,422

Healthy Michigan demonstration expenditure and enrollment projections developed by Milliman, Inc., an MDHHS actuarial contractor, are detailed in the following table, which has been updated to reflect the per member per month increases related to the passage of P.A. 175 of 2018, the Insurance Provider Assessment, as well as additional revenues for directed payments to physicians and hospitals.

Table 3: Healthy Michigan Demonstration Budget Neutrality Projections

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

* The Healthy Michigan Plan currently provides monthly coverage to approximately 655,000 individuals. MDHHS has determined that approximately 400,000 of the enrolled beneficiaries could be impacted by the waiver amendment changes, such as now having to pay increased cost-sharing to remain enrolled, complete healthy behaviors to remain enrolled, and/or obtain work or engage in other qualifying activities, report these activities monthly and timely, and maintain records to document these activities should supporting documentation be requested by MDHHS as part of the workforce engagement compliance review process. As the State implements the newly approved requirements, it will undertake active outreach to beneficiaries and partner with community stakeholders to ensure that beneficiaries understand program requirements and do not lose coverage as a result of noncompliance. MDHHS will actively monitor enrollment over the course of the demonstration.

Table 4
State of Michigan - Department of Health and Human Services
Healthy Michigan Expansion
Section 1115 Demonstration PMPM Development

	Managed Care Population						
	Projected Enrollment	Medical Services Base	GME, SNAF, HRA	Applicable Taxes	Administrative	Health Insurer Fee	FFS-Rx
CY 2018	551,854	\$309.91	\$107.33	\$16.53	\$41.19	\$11.87	\$59.16
CY 2019	554,614	312.62	118.04	22.54	41.55	12.37	63.89
CY 2020	557,387	323.57	119.22	22.54	43.00	12.71	69.00
CY 2021	560,173	334.90	120.41	22.54	44.51	13.06	74.52
CY 2022	562,974	346.62	121.61	22.54	46.06	13.42	80.48

	Fee-For-Service Population			Behavioral Health	Total Rate
	Projected Enrollment	Base Cost	MACI Payments		
CY 2018	125,249	\$266.53	\$205.37	\$41.19	\$573.47
CY 2019	124,623	277.90	207.43	43.54	598.83
CY 2020	124,000	289.76	209.50	45.06	618.58
CY 2021	123,380	302.12	211.60	46.64	639.21
CY 2022	122,763	315.00	213.71	48.27	660.74

Section VI – Evaluation Report

Demonstration Evaluation Activities

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

MDHHS will ensure that its evaluation design for the current Section 1115 demonstration is updated to reflect the changes described herein. Specifically, the Department will evaluate how increased cost-sharing impacts utilization as well as the choice of coverage for the subset of beneficiaries affected by the above changes. MDHHS will examine the waiver's impact on the beneficiaries through the §1115 Demonstration Monitoring and Evaluation Process. The Healthy Michigan Evaluation Domain IV currently assesses the beneficiaries' views on the impact of HMP through a beneficiary survey data. The Healthy Michigan Voices No Longer Enrolled Report will assess the impact on those beneficiaries whose health coverage ended and then compare those results to those who remain enrolled in the program. Currently, the No Longer Enrolled Report has focuses on the two following aims: (1) consumer behavior and health insurance literacy and (2) decisions about when, where, and how to seek coverage. Updates and additions will also be incorporated into the State's quality strategy as appropriate, and timely and accurate reporting on the implementation process will occur through the State's existing Section 1115 waiver reporting process, consistent with directives from the CMS.

A. Overview

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

1. The extent to which the increased availability of health insurance reduces the costs of uncompensated care borne by hospitals;
2. The extent to which availability of affordable health insurance results in a reduction in the number of uninsured/underinsured individuals who reside in Michigan;
3. Whether the availability of affordable health insurance, which provides coverage for preventive and health and wellness activities, will increase healthy behaviors and improve health outcomes;
4. The extent to which beneficiaries believe that HMP has a positive impact on personal health outcomes and financial well-being;
5. Whether requiring beneficiaries to make contributions toward the cost of their health care has an impact on the continuity of their coverage, and whether collecting an average co-pay from beneficiaries in lieu of co-payments at the point of service, and increasing

communication to beneficiaries about their required contributions (through quarterly statements) affects beneficiaries' propensity to use services;

6. Whether providing an MIHA into which beneficiaries' contributions are deposited, that provides quarterly statements that include explanation of benefits (EOB) information and details utilization and contributions, and allows for reductions in future contribution requirements, deters beneficiaries from receiving needed health services or encourages beneficiaries to be more cost-conscious;
7. Whether a possible loss of HMP eligibility for health care coverage encourages beneficiaries to engage in a healthy behavior and comply with the cost-sharing requirements; and
8. The extent to which workforce engagement requirements impact beneficiaries who transition from Medicaid obtain employer sponsored or other health insurance coverage, and how such transitions affect health and well-being.

B. Overview of Evaluation Methods

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

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

Methods

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

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

Key Findings

Key findings from the Interim Report on Primary Care Practitioners' Views of the Impact of the Healthy Michigan Plan (Attachment G.1) are highlighted below.

Providers expressed varying degrees of familiarity with features of HMP.

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

Most providers reported accepting new Medicaid/HMP patients.

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

Most providers reported completing Health Risk Assessments.

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

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

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

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

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

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

- PCPs noted HMP has allowed patients to get much needed care, improved financial stability, provided a sense of dignity, improved mental health, increased accessibility to

care and compliance (especially medications), and helped people engage in healthy behaviors such as quitting smoking.

Limitations

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

Conclusions

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

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

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

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

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

D. 2016 Healthy Michigan Voices Enrollee Survey

Methods

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

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

Key Findings

Key findings from the Interim Report of the 2016 Healthy Michigan Voices Enrollee Survey (Attachment G.2) are highlighted below.

Many enrollees did not have insurance prior to HMP.

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

Enrollees reported improvements in their health status with HMP.

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

Many enrollees have chronic health conditions.

- 69.2% reported they had a chronic health condition, with 60.8% reporting at least one physical health condition and 32.1% reporting at least one mental health condition.
- 30.1% reported they had a chronic health condition that was newly diagnosed since enrolling in HMP.

Enrollees expressed their perspectives on HRAs.

- 45.9% of those who said they completed an HRA did so because a PCP suggested it; 33.0% did so because they received a mailed form; 12.6% completed it by phone at enrollment.

- Most of those who reported completing the HRA felt it was valuable for improving their health (83.7%) and was helpful for their PCP to understand their health needs (89.7%). 80.7% of those who said they completed an HRA chose to work on a health behavior.

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

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

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

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

Enrollees reported a reduction in foregone care.

- 33.0% of enrollees reported not getting care they needed in the year before enrollment in HMP; 77.5% attributed this to cost concerns. Since enrolling in HMP, 5.6% reported foregone care; 25.4% attributed this to cost concerns.
- 83.3% strongly agree or agreed that without HMP they would not be able to go to a doctor.

Enrollees reported on their experiences using the ER for care.

- 28.0% of those who visited the ER in the past year said they called their usual provider's office first. 64.0% said they were more likely to contact their usual doctor's office before going to the ER than before they had HMP.
- Enrollees who were younger, female, and resided in regions with a higher proportion of uninsured were more likely to self-report any ER visits in the past 12 months. Other factors that were significantly associated with any self-reported ER use were a greater number of outpatient visits, 2 or more chronic conditions, a mental health or substance use disorder condition, fair or poor health, or perceived discrimination related to their insurance or ability to pay.

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

- 48.8% reported they were employed/self-employed, 27.6% were out of work, 11.3% were unable to work, and 2.5% were retired.
- HMP enrollees were more likely to be employed if their health status was excellent, very good, or good vs. fair or poor (56.1% vs. 32.3%) or if they had no chronic conditions (59.8% vs. 44.1%).

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

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

- The majority of respondents knew that HMP covers routine dental visits (77.2%), eyeglasses (60.4%), and counseling for mental or emotional problems (56.0%). Only one-fifth (21.2%) knew that HMP covers brand-name as well as generic medications.

Few enrollees reported challenges using their HMP coverage.

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

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

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

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

- 87.6% strongly agreed or agreed that the amount they pay overall for HMP seems fair.
- 88.8% strongly agreed or agreed that the amount they pay for HMP is affordable.
- 68.2% said they received a MIHA statement. 88.3% strongly agreed or agreed they carefully review each statement to see how much they owe. 88.4% strongly agreed or agreed the statements help them be more aware of the cost of health care.
- 75.6% of respondents knew some visits, tests, and medicines have no co-pays. Only 14.4% were aware they could not be disenrolled from HMP for not paying their bill. Only 28.1% were aware they could reduce the amount they owed by completing an HRA.

Limitations

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

Conclusions

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

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

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

E. Domain V/VI Report

The focus of Domains V and VI is to evaluate the role of cost-sharing in the program with a focus on:

- 1) whether the cost-sharing structure, specifically the assessment of co-payments for certain medical services and monthly contributions, affects how much enrollees spend (Hypothesis 1);
- 2) whether the cost-sharing structure affects the services enrollees use (Hypothesis 2);
- 3) whether the cost-sharing structure affects enrollees' likelihood of disenrolling from the program (Hypothesis 3); and
- 4) whether healthy behavior rewards are associated with more use of preventive care (Hypothesis 4).

Methods

Data

To find out how cost-sharing affected behavior, the evaluation team focused on those enrollees who had experience with the cost-sharing features of the Healthy Michigan Plan (HMP). Cost-sharing begins after six months of continuous enrollment in an HMP managed care plan. Enrollment data from the MDHHS Data Warehouse was used to determine the study population and included enrollees who met the following criteria:

- First month of HMP managed care (MC) between April 2014 and March 2015 (1st year of HMP):
- HMP MC enrollment for at least 18 consecutive months:
- Between 22 and 62 years old in 2014; and
- Not enrolled in a special program (e.g. nursing home care, hospice care).

The evaluation team analyzed data from a 30-month period (April 2014-September 2016). Enrollees in other Medicaid programs for a portion of this 30 months were included if they met the criteria above. For some analyses, survey data was used as described in the body of the report. A copy of the report is included as Attachment G.3.

Analysis

For all hypotheses, the evaluation team completed statistical analyses of multivariate relationships between outcomes (e.g. total spending, service use, disenrollment) and key explanatory variables of interest, cost-sharing and income as a percent of the federal poverty level (FPL). The team utilized linear and non-linear regression techniques that have been validated to provide accurate associations between variables and tested the results with alternative models. For hypotheses 1 and 2, the team compared spending and use of preventive care and other services for three different income groups: 0-35% FPL, 36-99% FPL, 100+% FPL. Since many in the 0-35% group had no reported income, they were effectively exempt from cost-sharing. Those in the 36-99% category faced co-payments for services used but not monthly contributions, and those in the 100+% category faced both co-payments and monthly contributions. For hypothesis 3, the team compared disenrollment for those who had cost-sharing against those who did not, and especially focused on those close to 100% FPL. For hypothesis 4, the team examined whether enrollees with a completed health risk assessment were more likely to use a preventive service.

Results

Demographic Characteristics

The population of 158,369 enrollees who met the selection criteria were:

- 55% female;
- 64% white;
- Likely to live in the Detroit Metro area (42%); and
- Likely to have an income at 0-35% FPL (58%).

Cost-Sharing Characteristics

- Slightly more than half of the population (51%) had a cost-sharing obligation (either a co-pay or contribution that generated a non-zero statement).
- The average quarterly statement for those with an obligation was \$16.85 (\$11.11 for those below 100% FPL and \$30.93 for those at or above 100% FPL).
- Overall, about one quarter (23%) of all enrollees who owed anything paid in full, about half (48%) of those who owed money made no payments.
- People above 100% of FPL were more likely to pay some or all of their statement than people below despite their higher average obligations.

- After the first potential 6-month period of cost-sharing (months 7-12 of enrollment), rates of payment dropped. For those who paid at least once, an estimated 65% paid in full for months 7-12 and 56% paid in full for months 13-18.

1. Medical and Pharmaceutical Spending (Hypothesis 1)

Spending here is defined not just as the cost-sharing amount the enrollee is obligated to pay for the service, but as the total amount spent by both the health plan and the enrollee.

- Average monthly amount spent (April 2014-Sept 2016): \$360.
- Median monthly spending: \$136.
- Those with incomes 0-35% FPL spent more per month (\$391) than those with incomes 36-99% FPL (\$313) or 100+% FPL (\$327).
- Pharmaceutical spending increased for the entire HMP population with 18 months of continuous enrollment. That result is consistent with, and probably driven by, the initiation and maintenance of medications for chronic disease.
- Medical spending remained flat or declined for those with higher levels of cost-sharing, either from co-payments or monthly contributions. Though IHPI cannot definitively attribute this change to cost-sharing attributes of HMP, these general patterns may indicate that those with monthly contributions may have become more efficient users of the healthcare system over time.

2. Service Use (Hypothesis 2)

- The evaluation team used services exempt from co-payments (vs. services where co-payments are likely) as an indicator of which services the state deems high (vs. low) value. During the study period, 81% of enrollees received a co-pay exempt preventive service (exemption often based on care for a chronic condition per program rules). 56% received a service likely to have a co-payment and incurred a co-payment for it (vision exam, chiropractic treatment, new patient visit, office consultation). All income groups had similar rates of co-pay exempt and co-pay likely service use.
- Co-pay exempt preventive service use and co-pay likely service use declined over time.
- Use of the emergency department declined over time.

3. Disenrollment (Hypothesis 3)

- People with co-pay exempt chronic conditions are less likely to disenroll than those without. Among those with co-payments, those with the highest co-payments are less likely to disenroll.
- Enrollees just above 100% FPL have a higher rate of disenrollment than those just below it, which may be caused by monthly contributions. However, those with evidence of higher medical needs do not have higher disenrollment above 100% FPL, suggesting the plan retains clinically vulnerable populations regardless of cost sharing obligations.
- Among previously enrolled individuals, those with cost-sharing obligations and those who pay their obligations are more likely than those without obligations to gain insurance after disenrolling from HMP, underscoring that disenrollment does not always lead to uninsurance.

- In a survey of those no longer enrolled in Healthy Michigan, most enrollees said the amount they had to pay was fair and affordable. Among those with any cost obligations, 89% said they felt the amount they had to pay was fair and 95% said the amount they had to pay was affordable.

4. Healthy Behaviors (Hypothesis 4)

- People who have a recorded attestation for a completed Health Risk Assessment are much more likely than those who do not have an attestation to have a preventive visit (84% vs. 50%), have a preventive screening (93% vs. 71%), and use a co-pay exempt medication to control a chronic disease (66% vs. 48%).

5. Conclusion

Overall, IHPI found that cost-sharing requirements may reduce the amount spent by plans and enrollees on medical services, though IHPI could not rule out other causes of the decline. Cost-sharing does not appear to affect the mix of high- and low-value services used in this population. Monthly contribution amounts may cause increased disenrollment from the plan among those with low medical spending and no chronic conditions but not among those with higher medical needs. While people who complete Health Risk Assessments are more likely to also complete healthy preventive behaviors, IHPI could not determine if the health risk assessments themselves increased these behaviors or if they were both the result of a physician visit.

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

Methods

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

Key Findings

The amount of uncompensated care provided by Michigan hospitals fell substantially after the implementation of HMP. Comparing 2013 and 2015 for a consistent set of hospitals, uncompensated care costs decreased by almost 50%. For the average hospital, annual uncompensated care expenses fell from \$7.21 million to \$3.77 million. As a percentage of total hospital expenses, uncompensated care decreased from 5.2% to 2.9%. Over 90% of hospitals saw a decline in uncompensated care between FY 2013 and FY 2015 (Attachment G.4).

Limitations

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

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

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

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

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

H. Future Evaluation Reports

Domain I: Uncompensated Care

This report will be available in the fall of 2018.

Domain II: Insurance Coverage

Preliminary results from analyses completed thus far:

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

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

Domain III: Utilization

Interim results were available in the fall of 2017.

Domain IV: Provider and Enrollee Perspectives

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

Domain V/VI: Consumer Behavior

This report will be available in the spring of 2018.

I. Evaluation Plan for Extension Period

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

Section VII - Public Notice Process

A. Public Notice, Comment and Hearings Process

For Demonstration Extension Submitted December 6, 2017

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

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

For Demonstration Extension Amendment Submitted September 10, 2018

MDHHS began its discussions on the proposed demonstration extension application amendments at the MCAC meeting which took place on June 18, 2018. MDHHS expanded its public engagement on July 9, 2018 by posting the proposed demonstration expansion application amendment request on the MDHHS dedicated HMP webpage available at www.michigan.gov/healthymichiganplan. On this webpage, the public was informed about the demonstration waiver amendment process, which included public notice and hearing information and provided opportunities for and instructions on how to submit comments. This is in addition

to publishing a public notice in selected newspapers throughout the state on July 9, 2018, which included, among other information, details regarding the proposed demonstration waiver amendment, as well as the website, hearing and public comment information. A copy of the notice is included as Attachment J.

A public hearing regarding the proposed demonstration extension application amendment was held on July 31, 2018, from 2:00 p.m. – 3:00 p.m. at the Michigan Library and Historical Center located at 702 W Kalamazoo St, Lansing, MI 48915. A second public hearing was held August 1, 2018 from 2:00 p.m. – 3:00 p.m. at the Cadillac Place located at 3044 West Grand Boulevard Detroit, Michigan. In addition to the notice procedures described above, MDHHS sent email notifications of this event to providers, stakeholders and the media. The public hearing in Lansing had webinar capability and both public hearings had telephone and in-person capability (with sign interpretation available for those present). Comments were accepted until August 12, 2018. As required by the existing Special Terms and Conditions, a summary of the comments received with notes of any changes to the proposal are included as Attachment K. The attachment also includes copies of all the written comments received.

The webinar and all materials were promptly posted to the HMP website for interested parties to review to assist them in their comments if they had been unable to attend in person or by telephone.

B. Tribal Consultation

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

As part of the demonstration extension application amendment process, MDHHS also issued a letter on July 9, 2018 notifying Tribal Chairs and Health Directors of the proposed waiver changes and amended application. A copy of the notice is included as Attachment M.

Additional Tribal Consultation has occurred on the following dates.

- *July 12, 2017 - In person meeting -MI Tribal Health Director's Association Meeting*
- *August 28, 2017 - Quarterly Tribal Health Directors conference call*
- *September 15, 2017 – Pokagon Band of Potawatomi Director of Health Services*
- *October 11, 2017 – Tribal Health Directors Meeting*
- *October 18, 2017 – Tribal Health Directors Conference Call*

Additional Tribal Consultation for Extension Application Amendment

- *July 11, 2018 – In person meeting – Quarterly Tribal Health Director's Association Meeting*
- *August 6, 2018 – Tribal Consultation Conference Call*
- *August 27, 2018 – In person meeting – Tribal Consultation Meeting*

Tribal Consultation Summary

A consultation conference call and two in-person meetings were held with the tribes to discuss the waiver extension amendment. A summary of the tribal comments is included as Attachment N. The attachment also includes copies of all the written comments received.

C. Post-Award Forums

In accordance with the HMP Waiver Special Terms and Conditions, MDHHS provides continuous updates to the program's MCAC at regularly scheduled meetings. These meetings provide an opportunity for attendees to provide program comments or suggestions. A copy of the meeting minutes for the 2016, 2017, and 2018 meetings are included as Attachment O.

D. Additional Stakeholder Engagement

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

- Michigan Association of Local Public Health Administrative Forum, on June 10, 2017, in Lansing, MI
- MDHHS/MHPs Operations Annual Conference, on July 19, 2017, in Acme, MI
- 2017 Michigan Primary Care Association Annual Conference, on July 24, 2017, in Acme, MI
- Michigan Association of Health Plans Meetings, on June 23, 2017 and August 4, 2017, in Lansing, MI
- Durable Medical Equipment Liaison Meeting, on September 11, 2017, in Lansing, MI
- Michigan State Medical Society/Medicaid Quarterly Meeting, September 12, 2017, in Lansing, MI
- Pharmacy Liaison Meeting on September 21, 2017 in Lansing, MI
- Michigan Association of Health Plans on September 29, 2017 in Lansing, MI
- Orthotics and Prosthetics Medicaid Provider Liaison Meeting on October 25, 2017 in Lansing, MI
- MI Marketplace Option Provider Training Webinar on November 7, 2017.

E. Additional Stakeholder Engagement for Extension Application Amendment

- Durable Medical Equipment Liaison Meeting on June 25, 2018, in Lansing, MI
- Pharmacy Liaison Meeting on June 8, 2018, in Lansing, MI
- Medicaid Health Plan and MDHHS Operation Meeting on July 10, 2018, in Okemos, MI
- Michigan Association for Local Public Health -Administrator's Forum on July 12, 2018, in Okemos, MI
- Michigan Association of Health Plans on July 13, 2018, in Lansing, MI
- Michigan State Medical Society/Medicaid Quarterly Meeting on July 16, 2018, in Lansing, MI

- Michigan Primary Care Association Meeting on July 16, 2018, in Lansing, MI
- Conference Call with MDHHS and Governor’s Office on July 17, 2018 that included the following Associations:
 - American Cancer Society Cancer Action Network
 - American Diabetes Association
 - American Heart Association
 - American Lung Association
 - Chronic Disease Coalition
 - Epilepsy Foundation in Michigan
 - Hemophilia Federation of America
 - Hemophilia Foundation of Michigan
 - Leukemia and Lymphoma Society
 - Lutheran Services in America
 - National Multiple Sclerosis Society
 - National Organization for Rare Disorders
 - March of Dimes
- Cystic Fibrosis Association – Conference Call with MDHHS, July 27, 2018.
- Medical Care Advisory Council Meeting on August 8, 2018, in Okemos, MI
- The Olmstead Group Meeting on August 9, 2018, in Lansing, MI

Section VII – List of Attachments

Attachment A: Public Act 208 of 2018

Attachment B: Revised Healthy Behaviors Incentive Protocol

Attachment C: Revised MI Health Account Operational Protocol

Attachment D: Medically Frail Identification Process

Attachment E: Monitoring Reports

Attachment F: Healthy Michigan Plan Evaluation Plan

Attachment G: Healthy Michigan Plan Evaluation Reports

1. Primary Care Practitioners' Views of the Impact of the Healthy Michigan Plan
2. 2016 Healthy Michigan Voices Enrollee Survey
3. Domain V/VI Report
4. Public Act 107 of 2013 §105d(8) 2015 Report on Uncompensated Care

Attachment H: Public Notice

Attachment I: Public Comment Summary

Attachment J: Public Notice – Demonstration Extension Application Amendment

Attachment K: Public Comment Summary and Written Comments Submitted

Attachment L: Tribal Notice

Attachment M: Tribal Notice – Demonstration Extension Application Amendment

Attachment N: Tribal Comment Summary and Written Comments Submitted

Attachment O: Medical Care Advisory Council Meeting Minutes