HEALTH MANAGEMENT ASSOCIATES

December 2017

The Michigan Update

In This Issue

Happy Holidays from HMA

Medicaid Managed Care Enrollment Activity

As of December 1, 2017, there were **1,778,889 Medicaid beneficiaries, including 536,963 Healthy Michigan Plan (HMP) beneficiaries,** enrolled in the 11 Medicaid Health Plans (HMOs). This is an overall increase of 2,434 since November. The number of HMP beneficiaries enrolled in HMOs increased by 397, and the number of non-HMP enrollees increased by 2,037.

As the enrollment reports (pdf) (xls) for December 2017 reflect, every county in the state is served by at least one Medicaid HMO. Auto-assignment of beneficiaries into the HMOs is available in every county, and in addition to the HMOs with smaller service areas, there are three HMOs – McLaren Health Plan, Meridian Health Plan of Michigan and Molina Healthcare of Michigan – authorized to serve all counties in the Lower Peninsula and a fourth – UnitedHealthcare Community Plan – authorized to serve all but three of the Lower Peninsula counties. Beneficiaries in all 15 counties in the Upper Peninsula are auto-assigned, through federal "Rural Exception" authority, to the one HMO serving the counties, Upper Peninsula Health Plan.

The plans with the highest total enrollment as of December 1, 2017 were Meridian Health Plan of Michigan with 28.0 percent of the total, Molina Healthcare of Michigan with 20.0 percent, and UnitedHealthcare Community Plan with 14.3 percent of the total.

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The Michigan Department of Health and Human Services requires children (and a few adults) receiving services from both the Children's Special Health Care Services (CSHCS) program and the Medicaid program to enroll in Medicaid HMOs. As of December 1, 2017, there were **20,060 joint CSHCS/Medicaid beneficiaries enrolled in the Medicaid HMOs**, an **increase of 277** enrollees since November. All Medicaid HMOs have CSHCS/Medicaid enrollees, although the numbers vary across plans. As of December 1st, Meridian Health Plan of Michigan had the most CSHCS/Medicaid beneficiaries enrolled (27.3 percent of the total); Molina Healthcare of Michigan had 24.4 percent; and UnitedHealthcare Community Plan had 14.3 percent of the total.

Aside from Michigan's Medicare/Medicaid financial alignment demonstration, MI Health Link, there were an additional **39,125 Medicaid beneficiaries dually eligible for Medicare (duals) enrolled in Medicaid HMOs** for their acute care Medicaid benefits in December 2017, an **increase of 273** since November. All Medicaid HMOs have duals enrolled, although the numbers vary significantly across plans. As of December 1st, Meridian Health Plan of Michigan had the most duals enrolled (27.2 percent); Molina Healthcare of Michigan had 26.2 percent; and McLaren Health Plan followed with 15.1 percent of the total enrollees.

There were **35,416 MIChild beneficiaries enrolled in Medicaid HMOs** in December 2017, a **decrease of 112** since November. All Medicaid HMOs have MIChild beneficiaries enrolled, although the numbers vary dramatically across plans. As of December 1st, Meridian Health Plan of Michigan had the most MIChild enrollees (28.0 percent of the total); Molina Healthcare of Michigan had 17.4 percent; UnitedHealthcare Community Plan had 12.9 percent; and Priority Health Choice had 12.2 percent of the total enrollees.

For additional information, contact Eileen Ellis, Senior Fellow, or Esther Reagan, Senior Consultant, at (517) 482-9236.

Healthy Michigan Plan Enrollment

The number of Healthy Michigan Plan (HMP) enrollees increased each month from September 2016 through August 2017. According to the Michigan Department of Health and Human Services (MDHHS) website, HMP enrollment stood at **673,711 as of December 18, 2017.** (Early release of *The Michigan Update* this month due to the holidays precluded reporting the enrollment count for the last Monday of the

month as is generally the value used for comparison. The last Monday count for December will be reported in the January 2018 edition of the newsletter.) Although the HMP caseload drops at the beginning of each month because of an annual eligibility redetermination requirement, it generally rebounds by the last Monday of the month.

For additional information, contact Eileen Ellis, Senior Fellow, at (517) 482-9236.

MI Health Link

In previous editions of *The Michigan Update* we have written about Michigan's implementation of an integrated health care delivery system for adults dually eligible for Medicare and Medicaid (duals). The demonstration, called MI Health Link, is approved to last for five years (through 2019) and operates in four regions of the state. The entire Upper Peninsula is one region; eight counties in the southwest corner of the state form another region (Barry, Berrien, Branch, Calhoun, Cass, Kalamazoo, St. Joseph, and Van Buren); and Macomb and Wayne Counties are two single-county regions. Medicaid and Medicare physical health care services (including long-term services and supports) are provided by HMOs that have contracts as Integrated Care Organizations (ICOs) to serve the duals.

Over the last year, the number of MI Health Link enrollees has fluctuated, with increases in some months and decreases in others. The Michigan Department of Health and Human Services (MDHHS) reports that **as of December 1, 2017, the MI Health Link enrollment was 38,509, a decrease of 71 enrollees since November.**

There are seven ICOs serving one or more of the demonstration regions. The table below provides enrollment information by region for each ICO as of December 1, 2017.

MI Health Link Enrollment	Upper Pen. Region	SW MI Region	Macomb Region	Wayne Region	Total
Aetna Better Health of MI		3,457	827	3,044	7,328
AmeriHealth Michigan			705	2,531	3,236
MI Complete Health / Fidelis			482	1,963	2,445

HAP Midwest Health Plan			997	3,787	4,784
Meridian Health Plan of MI		5,581			5,581
Molina Healthcare of MI			1,869	8,945	10,814
Upper Peninsula Health Plan	4,321				4,321
Total	**4,321**	**9,038**	**4,880**	**20,270**	**38,509**

As of December 1, 2017, Molina Healthcare of Michigan had the most enrollees, both voluntarily and passively enrolled (28.1 percent of the combined total); Aetna Better Health of Michigan had 19.0 percent; Meridian Health Plan of Michigan had 14.5 percent; and HAP Midwest Health Plan had 12.4 percent of the total.

At this point, about 94.7 percent of the MI Health Link enrollees are living in a community setting, and about 5.3 percent of the enrollees live in a nursing facility. Only 2.3 percent of the total enrollees living in a community setting are receiving home and community-based long-term services and supports through the MI Health Link program waiver; however, a significant number of these enrollees are receiving in-home services and supports from the ICOs through the State Plan personal care benefit.

While all the plans have enrollees receiving care in nursing facilities, the Upper Peninsula Health Plan had the largest share as of December 1st (23.6 percent of the total enrollees residing in nursing facilities). Aetna Better Health of Michigan had 17.9 percent; and Molina Healthcare of Michigan had 17.2 percent of the total.

Although the majority of MI Health Link enrollees are passively enrolled, 21.7 percent voluntarily joined the demonstration. The voluntary enrollment percentage has more than tripled in the last two years.

MDHHS also reports that as of December 1, 2017, more than 51,000 duals eligible for participation in the demonstration have chosen to opt out; this number has remained quite stable for several months. These individuals receive their Medicaid benefits on a fee-for-service basis but retain the option to voluntarily enroll in the demonstration at any time.

On a statewide basis, more than half of the MI Health Link enrollees are individuals under the age of 65. These younger

individuals qualified for Medicare and Medicaid based on a disability.

For additional information, contact Esther Reagan, Senior Consultant, at (517) 482-9236.

Michigan D-SNPs

Three of the 11 Medicaid HMOs in Michigan (or their parent organizations) are also federally contracted as D-SNPs (Medicare Advantage Special Needs Plans for persons dually eligible for Medicare and Medicaid [duals]) to provide Medicare benefits: HAP Midwest Health Plan, Meridian Health Plan of Michigan, and Molina Healthcare of Michigan. As of December 1, 2017, these **three D-SNPs had a combined enrollment of 15,515 duals** for whom they provide Medicare services.

More than 70 percent of the duals enrolled in a Michigan D-SNP (10,913 individuals) are enrolled with Molina; 4,171 duals are enrolled with Meridian but, according to federal enrollment reports, some reside in northern Ohio; and 431 duals are enrolled with HAP. None of these duals are participating in the MI Health Link demonstration.

Not all duals enrolled in these D-SNPs are eligible to receive full Medicaid benefits. Some only receive assistance from the Medicaid program with their Medicare coinsurance and deductible payments and/or monthly Medicare premiums.

For more information, contact Esther Reagan, Senior Consultant, at (517) 482-9236.

Providers Must Enroll in Michigan's Medicaid Program

On December 18, 2017, the Michigan Department of Health and Human Services (MDHHS) issued a press release to reinforce a new requirement, effective January 1, 2018, that all professional health care providers serving Michigan Medicaid beneficiaries, including those participating through one of the state's contracted Medicaid Health Plans (HMOs), must be screened and enrolled in the Medicaid program. This requirement was explained in more detail in a policy bulletin (MSA 17-48) issued in November.

The policy will bring MDHHS into compliance with federal provider enrollment requirements in the 21st Century Cures Act and initially will apply only to "typical" providers, such as physicians, certified nurse practitioners, dentists and chiropractors. Effective March 1, 2018, the HMOs will no

longer be able to make payments to these providers or for any services ordered or referred by them. Effective May 1, 2018, the HMOs will no longer be able to pay for prescription drug claims written by a non-enrolled prescriber.

The MDHHS plans to apply the policy to "atypical" providers, who provide support services to Medicaid beneficiaries and who generally do not have professional licensure requirements later in 2018.

For more information, contact Esther Reagan, Senior Consultant, at (517) 482-9236.

RFI Released for Section 298 Initiative Pilot Sites

On December 20, 2017, the Michigan Department of Health and Human Services (MDHHS) issued a press release to announce that a Request for Information (RFI) had been posted to the state's procurement site. The press release also included a link to the RFI. The purpose of the RFI is to select up to three pilot sites for the Section 298 Initiative, as required by the Michigan Legislature in Section 298 of Public Act 107 of 2017.

Only Community Mental Health Service Programs (CMHSPs) are eligible to respond to the RFI, and the applicant CMHSP must submit a signed memorandum of support from at least 50 percent of the Medicaid Health Plans within the proposed pilot region. Further, the applicant CMHSP must have a plan demonstrating full financial integration. Responses to the RFI are due to the state by February 13, 2018, and pilot decisions are anticipated by February 28, 2018

For more information, contact Esther Reagan, Senior Consultant, at (517) 482-9236.

Medicaid Expansion and the Opioid Crisis

On November 28, 2017, the Center for Healthcare Research & Transformation (CHRT) at the University of Michigan released an Issue Brief, dated August 9, 2017, with the results of a study examining the impact of Medicaid expansion on public behavioral health care in three demographically-similar midwestern states: Michigan and Indiana, both expansion states, and Wisconsin, a non-expansion state.

Titled *The Impact of the ACA on Community Mental Health and Substance Abuse Services: Experience in 3 Great Lakes States*, the report suggests that Medicaid expansion – the Healthy Michigan Plan in Michigan – has had an overall

beneficial effect for the enrolled population with a substance use disorder, including those with an opioid addiction, through increased access to care. The brief notes that in Michigan, 14 percent more people received substance use disorder services in 2016, after the Medicaid expansion in 2014, than in 2012 and wait times for services were reduced.

For more information, contact Esther Reagan, Senior Consultant, at (517) 482-9236.

Half of Michigan's HMP Enrollees Work

The University of Michigan Institute for Healthcare Policy and Innovation (IHPI) was selected by the Michigan Department of Health and Human Services (MDHHS) to conduct a formal evaluation of the Healthy Michigan Plan (HMP). Such an evaluation is a requirement when a state is given federal demonstration approval under authority granted in Section 1115 of the Social Security Act. The IHPI has recently released a report, as part of this evaluation, on the findings from a survey of HMP enrollees that asked about their health and employment status.

The IHPI report, *Employment Status and Health Characteristics of Adults with Expanded Medicaid Coverage in Michigan*, states that 48.8 percent of the approximately 4,000 HMP survey respondents indicated they were employed or self-employed on either a full or part-time basis but with income below the maximum for program participation (133 percent of the federal poverty level). The report notes that 27.6 percent of the respondents indicated they were out of work, with the majority saying they had health issues impacting their ability to work. Another 11.3 percent of the respondents said they were unable to work, largely due to their health. The remaining 12.2 percent of respondents said they were retired (2.5 percent), students (5.2 percent), or homemakers (4.5 percent).

Authors of the report said that findings from this study suggest "states considering work requirements should evaluate their potential impact on individuals, and the potential return on expenditures required for enforcement."

For more information, contact Esther Reagan, Senior Consultant, at (517) 482-9236.

Food Assistance Work Requirements

On November 28, 2017, the Michigan Department of Health and Human Services (MDHHS) issued a news release to

advise that able-bodied adults ages 18 to 49 without dependents in 10 Michigan counties – Allegan, Barry, Berrien, Clinton, Eaton, Grand Traverse, Ingham, Ionia, Kalamazoo, and Livingston – will be required to meet a federal work requirement to continue receiving food assistance benefits through the Supplemental Nutrition Assistance Program (SNAP). About 16,000 people are potentially affected by the change, which is effective January 1, 2018. MDHHS has indicated it will work with those impacted to help them meet the requirement.

The federal time limit for receiving SNAP benefits without meeting the work requirement is three months. Michigan received a waiver of the work requirement in 2002 due to high unemployment at that time. The reduction in the state's jobless rate over the last few years means the state is no longer eligible for a waiver. This policy is being phased in, with initial implementation in counties with the lowest unemployment rates. The work requirement was reinstated in January 2017 for able-bodied adults in Kent, Oakland, Ottawa, and Washtenaw Counties. MDHSS expects the work requirement to be in place statewide by October 2018.

For more information, contact Esther Reagan, Senior Consultant, at (517) 482-9236.

Citizens Research Council Report on Medicaid Expansion

On December 5, 2017, the Citizens Research Council of Michigan (CRC) released a report titled: *Medicaid Expansion: Prescription For A Healthier Michigan.* The report was accompanied by a webinar held on December 11th. A recording of the webinar and the presentation slides are also available on the CRC website (www.crcmich.org).

The CRC report examines the history of Michigan's Medicaid expansion through the Healthy Michigan Plan (HMP) in the context of the history of Medicaid and of the Affordable Care Act. HMP now covers more than 650,000 Michigan residents, which has resulted in a reduction in the number of uninsured Michigan residents by more than 50 percent. Among the topics addressed by the CRC report are the implications of Michigan Medicaid expansion on: access to care for those now covered by HMP, uncompensated care costs for Michigan hospitals, impact on the Michigan economy, and health outcomes for HMP enrollees.

The CRC report states that Medicaid expansion has kept Michigan health insurance premium costs lower than would have otherwise occurred. In addition, Michigan can be

innovative in partnering with HMP enrollees to improve their health status through healthy behaviors such as exercising and quitting smoking.

A primary conclusion of the report is that the "sunset" mechanism in the HMP legislation is defective. State law indicates that HMP must end when the state budget cost of the program is less than the direct savings realized by the state (primarily through reduced health care costs for programs such as mental health and corrections health care). Since the state share of HMP is gradually increasing, the House Fiscal Agency has concluded that the counted "net savings" may be close to zero by 2021. The CRC report points out that this trigger doesn't count the broader impact of Medicaid expansion, such as improvement of the state's economy and the well-being of Michigan residents. CRC states that "making continuation of the program contingent upon attributable program savings exceeding the program's cost is not only abnormal in terms of policy analysis, but also abdicates the legislature's core oversight duties".

For additional information, contact Eileen Ellis, Senior Fellow, at (517) 482-9236.

Housing as a Social Determinant of Health in Michigan

Since 2013, the National Governors Association (NGA) Center for Best Practices Health Division has worked with 10 state Medicaid programs and one territory on strategies for complex care populations. The NGA center provided technical assistance for development of state-level solutions, seeking to improve health outcomes while reducing costs for populations with complex care needs.

In October 2017, the NGA released a report on this initiative, *Building Complex Care Programs: A Road Map for States*. Nationally, high-need, high-cost consumers represent only about 5 percent of Medicaid enrollment but account for about 50 percent of Medicaid spending. The NGA report provides information about lessons learned in creating complex care programs and a tool (road map) to guide states through the stages of implementation of new initiatives.

Michigan was one of the 10 states that participated in this initiative. The Michigan initiative cited in the report targeted individuals with high use of hospital emergency departments (ED). Claims data identified 2,700 Medicaid enrollees with 20 or more ED visits in a 12-month period. More than half of the target population were potential clients

for Federally Qualified Health Center (FQHC) Health Homes for individuals with chronic medical conditions, available in 21 Michigan counties. However, additional analysis indicated that 83 percent of those potential FQHC Health Home clients had a psychiatric admission, a residential substance use disorder admission, or a serious mental illness diagnosis. The state determined it was likely that the medical conditions covered by the FQHC Health Homes were in many cases secondary to the primary behavioral health care needs.

Michigan also sought to match Medicaid data with the Homeless Management Information System (HMIS) and was able to successfully link claims data with HMIS for 60 percent of the 2,700 enrollees. Based on this match, the state found that at least 16 percent of the identified individuals with complex care needs were homeless. The initiative moved to identifying supports for the housing needs of this population, including assistance through the Michigan State Housing Development Authority or tenancy support available through the Community Mental Health system.

For additional information, contact Eileen Ellis, Senior Fellow, at (517) 482-9236.

340B Program

In last month's edition of The Michigan Update, we reported that the federal Centers for Medicare & Medicaid Services (CMS) had released a final rule related to the *Medicare* Hospital Outpatient Prospective Payment System. Included in the rule was language reducing the level of reimbursement to hospitals purchasing drugs through the 340B program. The rule has been challenged by the American Hospital Association and other associations representing hospitals. The changes to the 340B program for Medicare are scheduled to take effect January 1, 2018. To provide guidance to hospitals related to billing for drugs purchased through the 340B program on and after January 1st, CMS released a Frequently Asked Questions document on December 13, 2017.

For more information, contact Esther Reagan, Senior Consultant, at (517) 482-9236.

Medicaid Policies

The Michigan Department of Health and Human Services (MDHHS) has issued nine final policies and three proposed

policies that merit mention. They are available for review on the department's website.

- **MSA 17-34** notifies **Practitioners, Local Health Departments, Clinics, Medicaid Health Plans, and Others** of updates to the Early and Periodic Screening, Diagnosis, and Treatment (**EPSDT**) Chapter of the Medicaid Provider Manual due to issuance of **new preventive pediatric health care guidelines and a new periodicity schedule** by the American Academy of Pediatrics.
- **MSA 17-36** provides updated information to **All Providers** about the **MDHHS-File Transfer process**.
- **MSA 17-37** advises **Practitioners, Medicaid Health Plans, and Clinics** of a **rate update for neonatal and pediatric critical care and intensive care services**. Implementation is **contingent upon approval of a State Plan Amendment**.
- **MSA 17-38** informs **Bridges Eligibility Manual Holders** that the department will implement an **asset verification program to electronically detect unreported assets** belonging to applicants and recipients of **AFDC medically needy and SSI-related Medicaid categories** that require a resource test.
- **MSA 17-40** notifies **All Providers** of additional details regarding changes related to the department's implementation of the **Modernizing Continuum of Care** project. One change relates to **managed care entities** moving from multiple provider IDs to a **single ID per contract**. Another change relates to implementation of **Program Enrollment Types**, which will **replace Level of Care codes**. And another change relates to **where Patient Pay Amounts will appear on the eligibility response**.
- **MSA 17-41** advises **Maternal Infant Health Program (MIHP) Providers and Medicaid Health Plans** that on and after January 1st, **MIHP consultants will be responsible for reviewing and facilitating written authorization for program exceptions**.
- **MSA 17-44** informs **All Providers** of **Quarterly Updates to the Medicaid Provider Manual.**
- **MSA 17-45** notifies **Prepaid Inpatient Health Plans and Community Mental Health Services Programs** of a **new policy** that formalizes **standards for training, certification and practices** for **Peer Recovery Coaches.**
- **MSA 17-46** advises **Nursing Facilities, Hospice Providers, Hospitals, and Others** of new policies and procedures related to the department's implementation of the **Modernizing Continuum of Care** project. Some of the changes relate to implementation of **Program**

Enrollment Types, which will **replace Level of Care codes** and to **how admission / discharge or enrollment / disenrollment information will be added to and viewed in** the Community Health Automated Medicaid Processing System (**CHAMPS**).

- A proposed policy (**1730-DMEPOS**) has been issued that would **clarify age limitations** for **durable medical equipment, prosthetics, orthotics and supplies.** Comments are due to MDHHS by January 5, 2018.
- A proposed policy (**1725-Injectables**) has been issued that would provide an update regarding the **coverage of outpatient physician-administered drug and biological products** and describe the **reimbursement process for specific drugs not covered by the Medicaid Health Plans**. Comments are due to MDHHS by January 19, 2018.
- A proposed policy (**1727-HH**) has been issued that would describe changes to the **Home Help Agency provider standards** to clarify MDHHS expectations. Comments are due to MDHHS by March 1, 2018.

MDHHS has also released two L-letters of potential interest, which are available for review on the same website.

- **L 17-54** was released on December 7, 2017 as a notice to Tribal Chairs and Health Directors of the department's **intent to submit a State Plan Amendment** to **waive the requirements for the Recovery Audit Contractor (RAC)** under Section 1902(a)(42)(B)(i) of the Social Security Act **and be granted an exception to utilize** its agreement with the Centers for Medicare & Medicaid Services (CMS) **Unified Program Integrity Contractor** to conduct audits of the providers that the Michigan RAC previously conducted.
- **L 17-56** was released on December 7, 2017 as a notice to Tribal Chairs and Health Directors of the department's **intent to submit a State Plan Amendment** to make a **technical change**, required by CMS, to the Children's Health Insurance Program (**CHIP**) **State Plan** to document **compliance with the Mental Health Parity and Addiction Equity Act of 2008.**

For additional information, contact Esther Reagan, Senior Consultant, at (517) 482-9236.

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