HEALTH MANAGEMENT ASSOCIATES

June 2017

The Michigan Update

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Medicaid Managed Care Enrollment Activity

As of June 1, 2017, there were **1,805,574 Medicaid beneficiaries, including 545,785 HMP beneficiaries,** enrolled in the 11 Medicaid Health Plans (HMOs). This is an overall **decrease of 3,087** since May. The number of HMP enrollees decreased by 1,084 and the number of non-HMP enrollees decreased by 2,003.

As the enrollment reports (pdf) (xls) for June 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 June 1, 2017 were Meridian Health Plan of Michigan with 28.0 percent of the total, Molina Healthcare of Michigan with 20.3 percent, UnitedHealthcare Community Plan with 14.4 percent, and McLaren Health Plan with 10.8 percent of the total. Meridian also had the most HMP enrollees in June, with 28.6 percent of the total. Molina placed second, with 17.2 percent; and Blue Cross Complete came in third, with 14.5 percent.

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

1-800-678-2299

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HMOs. As of June 1, 2017, there were **19,061 joint CSHCS/Medicaid beneficiaries enrolled in the Medicaid HMOs**, an increase of 37 since May. All Medicaid HMOs have CSHCS/Medicaid enrollees, although the numbers vary across plans. Meridian Health Plan of Michigan has the most CSHCS/Medicaid beneficiaries enrolled (27.2 percent of the total); Molina Healthcare of Michigan has 25.3 percent of the total; and UnitedHealthcare Community Plan has 14.8 percent.

Aside from Michigan's Medicare/Medicaid financial alignment demonstration, MI Health Link, there were an additional **36,873 Medicaid beneficiaries dually eligible for Medicare (duals) enrolled in Medicaid HMOs** for their acute care Medicaid benefits in June 2017, an increase of 208 since May. All Medicaid HMOs have duals enrolled, although the numbers vary significantly across plans. As of June 1st, Molina Healthcare of Michigan had the most duals receiving Medicaid services from an HMO (27.3 percent of the total); Meridian Health Plan of Michigan had 25.9 percent of the total (but the most voluntary enrollees); and McLaren Health Plan had 15.0 percent of the total enrollees.

There were **34,641 MIChild beneficiaries enrolled in Medicaid HMOs** in June 2017, an increase of 322 since May but a decrease of almost 3,000 since November of last year. We believe that some of the children formerly enrolled in MIChild coverage have more recently qualified for other Medicaid eligibility categories for children due to changes in family income. (While MIChild enrollment has recently declined, total enrollment of children in Medicaid, including MIChild, increased by almost 11,000 between November 2016 and March 2017.) All Medicaid HMOs have MIChild beneficiaries enrolled, although the numbers vary dramatically across plans. As of June 1st, Meridian Health Plan of Michigan had the most MIChild enrollees (26.3 percent of the total); Molina Healthcare of Michigan had 18.3 percent of the total; UnitedHealthcare Community Plan had 13.1 percent; and McLaren Health Plan had 12.6 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 remained relatively steady for the 20 months ending on August 31, 2016, but increased each month since, until this month. According to the Michigan Department of Health and Human Services (MDHHS) website, HMP enrollment stood at

678,098 as of June 26, 2017. After seven months of record setting end-of-month enrollment figures, this is the first month where the enrollment total has dipped slightly (down 1,794 from May but still higher than April). Perhaps the lower number is because there were only four Mondays (the day when new enrollment totals are posted by MDHHS) in June, while there were five Mondays in May. It will be interesting to see what the end-of-month number is in July when there are again five Mondays. Although the HMP caseload drops at the beginning of each month because of an annual eligibility redetermination requirement, it generally rebounds by the end of the month. Since August 2016, the declines at the start of each month have been much smaller than in the past. With growth during each month like prior trends, the result is a current month-end enrollment total more than 64,000 higher than at the end of August 2016.

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 and operate 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.

Due to a passive enrollment process implemented June 1, 2016 by the Michigan Department of Health and Human Services (MDHHS), there were **38,767 enrollees that month** in the ICOs. This was an increase of almost 8,000 enrollees from the May 2016 enrollment level of 30,813, but still below the 42,757 enrollees in September 2015 when the demonstration was initially implemented. Since June 2016, the number of MI Health Link members has fluctuated, with increases in some months and decreases in others. **As of June 1, 2017, the MI Health Link enrollment was 37,985, an increase of 85 enrollees since May.**

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 June 1, 2017.

MI Health Link Enrollment	Upper Pen. Region	SW MI Region	Macomb Region	Wayne Region	Total
Aetna Better Health of MI		3,436	856	3,024	7,316
AmeriHealth Michigan			708	2,488	3,196
MI Complete Health / Fidelis			431	1,794	2,225
HAP Midwest Health Plan			1,003	3,938	4,941
Meridian Health Plan of MI		5,539			5,539
Molina Healthcare of MI			1,806	8,697	10,503
Upper Peninsula Health Plan	4,265				4,265
Total	**4.265**	**8,975**	**4,804**	**19,941**	**37,985**

As of June 1, 2017, Molina Healthcare of Michigan had the most enrollees, both voluntarily and passively enrolled (27.7 percent of the combined total); Aetna Better Health of Michigan had 19.3 percent of the total; Meridian Health Plan of Michigan had 14.6 percent; and HAP Midwest Health Plan had 13.0 percent. At this point, about 94.6 percent of the MI Health Link enrollees are living in a community setting, and about 5.4 percent of the enrollees live in a nursing facility. Only 1.7 percent of the total enrollees are receiving home and community-based long-term services and supports through the MI Health Link program waiver; however, a significant number of 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 June 1st (23.5 percent of the total enrollees residing in nursing facilities). Molina Healthcare of Michigan placed second, with 17.4 percent; and Aetna Better Health of Michigan came in third, with 16.9 percent.

While the majority of MI Health Link enrollees are passively enrolled, 19.6 percent voluntarily joined the demonstration. The voluntary enrollment percentage has more than tripled

since September 2015. MDHHS also reports that as of June 1, 2017, almost 51,000 duals eligible for participation in the demonstration have chosen to opt out. These individuals receive their Medicaid benefits on a fee-for-service basis but retain the option to voluntarily enroll in the demonstration at a later time.

The MDHHS has established an enrollment dashboard on the MI Health Link page on its website. According to the MI Health Link website, 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 June 1, 2017, these **three D-SNPs had a combined enrollment of 14,011 duals** for whom they provide Medicare services. More than 76 percent of the duals enrolled in a D-SNP are enrolled with Molina Healthcare of Michigan. 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.

Michigan Medicaid Budget for FY 2018

The final agreement on the MDHHS budget for the state fiscal year (FY) that begins October 1, 2017 includes an increase of $562.7 million in total funding for the Michigan Department of Health and Human Services (MDHHS) from current year appropriations, which is an increase of nearly $90 million from the first conference agreement. This total reflects restoration of many of the Governor's funding

priorities that had not been included in the first conference agreement.

Changes to Medicaid and Behavioral Health Funding

The budget sent to the Governor includes several changes to the agreement that had been reached by the House/Senate Conference committee. Among those changes are the following:

- Direct Care Wage Increase: The final agreement increases the wages of direct care workers by $0.50 per hour effective October 1, 2017. Cost is $45 million ($14.2 million General Fund/General Purpose – GF/GP).
- Autism Services: The final budget restores the $5 million cut that had been proposed as part of the conference agreement ($1.8 million GF/GP).
- Behavioral Health Integration Pilot: The final budget adds $3.1 million ($1 million GF.GP) and 3 positions to support the costs of an independent facilitator, evaluation, and state agency support of the integration pilots created by Section 298.
- State Psychiatric Hospital Staffing Enhancement: The first conference agreement had cut the increase in staffing for state hospitals from 72 positions to 36 positions. The final bill restores the Executive recommendation.

Notable Agreements Retained from the First Conference Committee

- Special Hospital Payments: The Executive had proposed a $217.6 million reduction in Quality Assurance Assessment Program (QAAP) funded payments to hospitals (Medicaid Access to Care Initiative or MACI, and Hospital Rate Adjustment or HRA). The House and Senate agreed with the Executive recommendation. However, the numbers were revised to reflect the May caseload consensus. The conference agreement decreases these payments by $168.1 million, of which $20.0 million is state general funds.
- Medicaid Non-Emergency Medical Transportation (NEMT) Expansion: The Governor had proposed a $12.0 million increase to expand the NEMT broker program into additional counties. The conference agreement does not concur with this expansion and instead provides an increase of $1.4 million gross ($0.5 million GF/GP) to expand the use of local public transportation.
- Ambulance QAAP: The Executive budget included $10.3 million gross ($0.0 million GF/GP) to add QAAP-funded supplemental Healthy Michigan Plan ambulance payments. The legislature agreed with the Executive. (Section 1790 of the bill provides additional instructions.)

- New Nursing Facility Quality Pool: The budget for FY 2018 establishes a new Nursing Facility Quality Pool of $73.0 million, funded with $47.3 in federal funds and nearly $34.0 million in revenues from increased nursing facility assessments, resulting in a net savings of more than $8.2 million to the General Fund. The payments from this pool are to be based on CMS star quality ratings, licensed beds, and Medicaid utilization.
- Program of All-inclusive Care for the Elderly (PACE) Expansion: The Executive added $20.0 million to support a 2.5% rate increase, increased enrollment at existing PACE sites and to fund two new PACE sites in Newaygo County and in central Michigan. (There is no net cost to the state for PACE expansions since long-term care funding is reduced by the same amount.) The legislature reduced the funding by $1.6 million to support a per member per month increase of 1.0% rather than 2.5%.
- Medicaid Direct Primary Care Pilot: The legislature added $5.7 million ($2.0 million GF/GP) on a one-time basis to support a Medicaid direct primary care pilot. (Boilerplate in Section 1913 provides significant detail on this initiative.)
- Other Medical Services Program Reductions: The Executive proposed $10.4 million in reductions by eliminating Graduate Medical Education (GME) payments for Authority Health (formerly the Detroit Wayne County Health Authority), eliminating the dental rate increase for pregnant Medicaid beneficiaries, eliminating funding for the University of Detroit dental clinic and the Medicaid Health Plan immunization grant, and by reducing funding for the Wayne State Psychiatric residency program. The conference agreement only eliminates GME payments for Authority Health ($2.8 million gross, $1.3 million GF/GP).

Boilerplate Changes

There were several changes in boilerplate language from the first conference agreement to the final bill. Most were not material.

Section 298 Behavioral Health Integration: Many changes were made to the language of this section of the bill. Many were minor, but several were significant. Language was eliminated that would have required a reduction in the number of Prepaid Inpatient Health Plans (PIHPs) for Medicaid behavioral health services. There were also several changes related to initiatives to integrate physical and behavioral health care services, including the following:

- The pilots or demonstration projects outside of Kent County are now required to “to achieve fully financially integrated Medicaid behavioral health and physical health benefit and financial integration demonstration models”.

The Kent County pilot is only described as fully integrated “services”.

- Language was deleted that would have required Medicaid Health Plans participating in the Kent County pilot to “use the CMHSP in Kent County as the provider of behavioral health specialty supports and services.” We would note that the language for the pilots in other geographic areas still requires a model that “allows the CMHSP in the geographic area of the pilot project to be a provider of behavioral health supports and services.”
- A new subsection provides nearly $3.1 million in funding to support the implementation of the pilot projects and demonstration models, including three additional state staff, hiring an independent project facilitator, and the cost of evaluating the initiative.

Section 1764 – Actuarial Soundness Certification of Medicaid Health Plan Rates: The original conference agreement followed the Senate language which required MDHHS to ensure that any new or revised state policy bulletins are not promulgated to negatively impact certified health plan rates. The conference agreement revises the requirement so that MDHHS must ensure that policies are not promulgated that materially impact certified rates in a negative manner.

Section 1806 – Common Formulary for Medicaid Health Plans: The Executive budget had deleted this section. The conference bill requires MDHHS to monitor progress on implementation of the common formulary and report to the legislature. The description of the public input process is less prescriptive in the final bill than it was in the initial conference agreement.

Section 1857: Managed Long-Term Services and Supports: This section was added by the Senate and retained in the final budget. It requires MDHHS to explore the implementation of a “managed long-term support service” by July 1, 2018. However, there is no requirement that the department submit a report on its findings.

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

Michigan Medicaid Releases RFP for Children’s Dental Care

On May 12, 2017, the State of Michigan released a Request for Proposals (RFP) associated with the Michigan Department of Health and Human Services (MDHHS) Healthy Kids Dental (HKD) program for the almost one million children enrolled

in Medicaid and the Children's Health Insurance Program (CHIP).

The MDHHS is seeking to award risk-based contracts to two qualified statewide vendors. In addition, MDHHS may consider awarding a third risk-based contract to a bidder serving Region 10, which consists of Wayne, Oakland, and Macomb counties. Proposals are due July 31, 2017. Following a readiness review / transition period, the new contracts will be implemented April 1, 2018.

The HKD program has been in place for several years to help ensure that children have access to dental care. The program was initially implemented in a few counties, gradually expanded geographically, and gained statewide coverage as of October 1, 2016. The current vendor is Delta Dental of Michigan.

As stated in the RFP, the HKD program is a key component of Michigan's comprehensive oral health plan. "Specific goals include:

1. Leveraging the HKD model to promote good oral health practices among the HKD population that result in:
    - increased utilization of preventive Dental Services
    - increased oral health education that emphasizes the importance of good oral health and practices
    - decreased dental anxiety
2. Promoting a patient-centered approach that recognizes the importance of dental care in overall health care and promoting professional integration and coordination of care across provider types.
3. Increasing the number of dental providers participating in the HKD program.
4. Increasing access to oral health care.
5. Designing and implementing best practices for Dental Service delivery in dental care health shortage areas with limited dental providers.
6. Collaborating with community organizations and stakeholders resulting in partnerships that leverage existing dental programs (i.e. school based, dental clinics etc.).
7. Increasing education and Dental Service usage among Enrollees who are pregnant and Children with Special Needs."

Successful vendors will need to maintain a dentist to enrollee ratio of at least one full-time unique general dentist per 650 members with a minimum of 20 hours per week per practice location, with a few exceptions identified in the RFP.

The vendors will be required to adhere to all applicable federal and state managed care rules and requirements.

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

Better Care Reconciliation Act of 2017

On June 22, 2017, Senate leadership in Washington, DC released a discussion draft of the Better Care Reconciliation Act of 2017 (BCRA). At present, the Senate is targeting a vote after the July 4th holiday. HMA has developed a summary of the BCRA, which appeared in the June 28, 2017 edition of the *HMA Weekly Roundup*.

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

Single Audit Report

On June 28, 2017, the Michigan Auditor General released a Single Audit Report covering the state fiscal year ending September 30, 2016. The audit and the resulting 243-page report focused heavily on state computer systems, including those operated by and for programs administered by the Michigan Department of Health and Human Services. The audit found that the state could face federal fines because some departments did not have sufficient management controls to ensure that only authorized persons had access to program eligibility files, and that there may have been instances when people receiving services were not qualified, or that documentation was not always verified and available to support their eligibility.

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

2017 Kids Count Data Book®

The *2017 Kids Count Data Book*, published by the Annie E. Casey Foundation, was released on June 13, 2017. The annual publication provides information and rankings for all states on key indicators of child well-being. The 2017 report ranked Michigan 32nd in the nation in overall child well-being, down from 31st in 2016 and still behind the other Great Lakes states. The Michigan League for Public Policy, an advocacy group for low-income children and families works with the Foundation to provide additional Michigan-specific

statistics, which are available on the League's website and highlighted below.

Health indicators for Michigan dropped slightly from the 2016 report, moving the state down to 17th nationally from 14th in 2016. Health indicators include the percentage of low birth weight babies, children without health insurance, child and teen deaths, and teens abusing alcohol or drugs. The percentage of children with health insurance is a bright spot for Michigan; just 3 percent of Michigan children are uninsured, which is better than the national average of 5 percent.

Economic well-being indicators for Michigan put the state at 31st among all states. These indicators include the percentage of children living in poverty, children whose parents lack secure employment, children living in households with a high housing cost burden, and teens not in school and not working. Seven percent of Michigan's 16- to 19-year olds are not attending school or working.

Family and Community indicators for Michigan did not change the state's national ranking; Michigan remained at 29th in 2017. These indicators include the percentage of children in single-parent families, children in families where the household head lacks a high school diploma, children living in high-poverty areas, and teen births per 1,000. Since 2009, the percentage of children living in high poverty areas has remained unchanged at 17 percent.

Michigan has dropped to 41st in the country for children's education (down from 40th in 2016 and 37th in 2015). The report notes that 71 percent of fourth-graders are not proficient in reading and 71 percent of eighth-graders are not proficient in math.

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

- **MSA 17-13** notifies **All Providers** of new Medicaid program **coverage parameters for preventive care services for adult Medicaid beneficiaries**.
- **MSA 17-16** informs **All Providers** that, contingent upon federal State Plan amend approval, the **Graduate Medical Education Innovations**

Program is being **expanded** to include **sponsoring institutions**.

- **MSA 17-17** advises **Bridges Eligibility and Administrative Manual Holders, Medicaid Health Plans, the Medicaid Non-Emergency Medical Transportation (NEMT) Contractor and Maternal and Infant Health Program Providers** of NEMT **rate changes** applicable to transportation for beneficiaries receiving care on a **fee-for-service** basis.
- **MSA 17-18** informs **Durable Medical Equipment Providers, Therapists, Practitioners and Medicaid Health Plans** of changes to Medicaid's **Speech Generating Device** policy for beneficiaries receiving care on a **fee-for-service** basis
- **MSA 17-19** informs **All Providers** of **Quarterly Updates to the Medicaid Provider Manual.**

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

- **L 17-22** was released on June 1, 2017 as a notice to Tribal Chairs and Health Directors of the department's **intent to submit a State Plan Amendment** to make a **reduction to the Quality Assurance Supplement (QAS) percentage to nursing facilities** for the months of August and September 2017. The reduction is a result of lower than expected revenue for nursing facility QAS payments.
- **L 17-21** was released on June 22, 2017 as a notice to Tribal Chairs and Health Directors of the department's **intent to submit a State Plan Amendment to allow an exception to the Current Asset Value determination process for Class I nursing facilities** that lack building acquisition data from the original building owner.
- **L 17-23** was released on June 22, 2017 as a notice to Tribal Chairs and Health Directors of the department's **intent to submit a State Plan Amendment** to establish **coverage parameters for pediatric outpatient intensive feeding program services** for beneficiaries with significant feeding and swallowing difficulties.

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

leadership, experience, and technical expertise to local, state, and federal governmental agencies, regional and national foundations, investors, multi-state health system organizations and single site health care providers, as well as employers and other purchasers in the public and private sectors.