HEALTH MANAGEMENT ASSOCIATES

THE MICHIGAN UPDATE 2019

OCTOBER

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MEDICAID MANAGED CARE ENROLLMENT ACTIVITY

As of October 1, 2019, there were **1,734,266 Medicaid beneficiaries, including 523,823 Healthy Michigan Plan (HMP) beneficiaries,** enrolled in the 11 Michigan Medicaid Health Plans (HMOs). As the table below shows, this is an overall **increase of 2,672** since September 1, 2019. Although the number of HMP beneficiaries enrolled in HMOs decreased by 26, the number of non-HMP enrollees increased by 2,698. As the table also shows, the October 2019 enrollment total is more than 55,000 below the total for September 2018.

	Sept. 2018	Nov. 2018	Jan. 2019	March 2019	May 2019	July 2019	Sept. 2019	Oct. 2019
All Medicaid Beneficiaries Enrolled	**1,789,450**	**1,755,709**	**1,751,429**	**1,761,472**	**1,724,124**	**1,725,780**	**1,731,594**	**1,734,266**
• Total HMP Enrollees	550,742	540,098	526,431	536,784	521,784	519,784	523,849	523,823
• Total CSHCS/ Medicaid Enrollees	21,416	19,040	22,020	21,026	22,310	22,953	23,616	23,947
• Total Medicare/ Medicaid Enrollees (Duals)	39,563	38,965	39,261	38,756	38,301	39,034	39,012	39,092
• Total MIChild Enrollees	34,873	34,847	36,448	35,860	35,364	36,866	38,608	38,744

The number of beneficiaries identified as mandatory managed care enrollees but not yet enrolled in a Medicaid HMO has varied dramatically during the past 15 months, from a low of 45,305 in July 2018 to a high of 111,082 in January 2019. In October 2019, the number of mandatory but not yet enrolled beneficiaries was 83,831. This is an increase of 1,406 since September but still well below the 86,563 count of mandatory but not yet enrolled beneficiaries in August 2019.

As the enrollment reports for October (pdf, xls) 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. 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 these counties, Upper Peninsula Health Plan.

The plans with the highest total enrollment in October were Meridian Health Plan of Michigan with more than 28 percent of the total, Molina Healthcare of Michigan with 19 percent, and UnitedHealthcare Community Plan with more than 14 percent of the total number of enrollees.

Healthy Michigan Plan (HMP)

There were 523,823 HMP beneficiaries enrolled as of October 1, 2019 in the Medicaid HMOs. This is a **decrease of 26 since September 1, 2019**. As the table above shows, while there have been some increases and decreases over the last several months, the October count of enrollees is almost 27,000 below the count for September 2018. We note that total HMP enrollment (both in managed care and fee-for-service) has also decreased over this time period by a similar number. In addition, enrollment of HMP beneficiaries in the Medicaid HMOs has been affected by a large fluctuation in the number of HMP beneficiaries mandated to enroll in a Medicaid HMO but not yet assigned to a plan. In December 2018, the number of mandatory but unenrolled beneficiaries was 27,979. The number jumped to 57,771 in January 2019, dropped to 29,045 by May, and as of October 1, 2019, there were 35,721 mandatory but unenrolled beneficiaries, an increase of 1,532 since September.

All Medicaid HMOs have HMP beneficiaries enrolled, although the numbers vary across plans. The plans with the highest enrollment in October were Meridian Health Plan of Michigan with more than 27 percent of the total, Molina Healthcare of Michigan with more than 16 percent, and Blue Cross Complete with more than 15 percent of the total enrollees.

CSHCS/Medicaid

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. There were **23,947 joint CSHCS/Medicaid beneficiaries enrolled as of October 1, 2019** in the Medicaid HMOs, **an increase of 331 since September 1, 2019.**

All Medicaid HMOs have CSHCS/Medicaid enrollees, although the numbers vary across plans. The plans with the highest enrollment in October were Meridian Health Plan of Michigan with 22.5 percent of the total, Molina Healthcare of Michigan with 22.2 percent, and Blue Cross Complete with almost 14 percent of the total enrollees.

MIChild

There were **38,744 MIChild beneficiaries enrolled as of October 1, 2019** in Medicaid HMOs. As the table above reflects, the number of enrolled MIChild beneficiaries **increased by 136 between September 1, 2019 and October 1, 2019.**

All Medicaid HMOs have MIChild beneficiaries enrolled, although the numbers vary dramatically across plans. The plans with the highest enrollment in October were Meridian Health Plan of Michigan with almost 29 percent of the total, Molina Healthcare of Michigan with almost 17 percent, and UnitedHealthcare Community Plan with more than 13 percent of the total enrollees.

Medicare/Medicaid

Aside from Michigan's Medicare/Medicaid financial alignment demonstration, MI Health Link, there were an additional **39,092 Medicaid beneficiaries dually eligible for Medicare (duals) enrolled as of October 1, 2019** in Medicaid HMOs for their acute care Medicaid benefits. As the table above reflects, the number of enrolled duals **increased by 80 between September 1, 2019 and October 1, 2019.**

All Medicaid HMOs have duals enrolled, although the numbers vary significantly across plans. The plans with the highest enrollment in October were Meridian Health Plan of Michigan with more than 30 percent of the total, Molina Healthcare of Michigan with 19 percent, and McLaren Health Plan with almost 15 percent of the total enrollees.

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

NCQA'S HEALTH INSURANCE PLAN RANKINGS

The National Committee for Quality Assurance (NCQA) released its latest annual Health Insurance Plan Rankings for 2019 in mid-September. The rankings, separately for Private (Commercial), Medicare and Medicaid health insurance plans, are based on the plans' combined HEDIS®, CAHPS®, and NCQA Accreditation standards scores related to consumer satisfaction, prevention, and treatment, and are limited to managed care organizations, including both health maintenance organizations (HMOs) and preferred provider organizations (PPOs). NCQA studied nearly 1,400 health plans across the country and rated 1,021, including 438 Private/Commercial plans, 412 Medicare plans, and 171 Medicaid plans.

Blue Care Network of Michigan (HMO) and Blue Cross Blue Shield of Michigan (PPO) scored highest among the Commercial plans in Michigan and ranked 8th and 9th, respectively, in the country, up from 51st and 54th, respectively, in last year's rankings.

Of the 412 Medicare plans rated across the country, the HMO/POS plan offered by Priority Health was the highest-ranking Michigan plan, in the 22nd slot nationally, the same position the plan occupied in last year's rankings. Aetna Life Insurance (PPO) ranked second in Michigan and was in 45th place nationally.

The highest-ranking Medicaid plan in Michigan was the Upper Peninsula Health Plan (HMO), at 14th place nationally (one position lower than in last year's rankings). Meridian Health Plan of Michigan (HMO) ranked second in Michigan and came in at 27th place nationally (down two positions from last year); and Priority Health (HMO) was in 30th place nationally (down from 10th place in 2018).

Ratings for all plans are available on the NCQA website.

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

MI HEALTH LINK

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

The number of MI Health Link enrollees continues to fluctuate, with increases in some months and decreases in others. The Michigan Department of Health and Human Services (MDHHS) reports that **as of October 1, 2019, the MI Health Link enrollment total was 37,018, a decrease of 277 enrollees since September 1, 2019.**

The tables below illustrate MI Health Link enrollment fluctuation by month during 2018 and to date in 2019. Note that the enrollment total for December 2018 was the lowest for the calendar year, more than 4,000 below the total for May, which was the highest monthly total for the year. The enrollment totals for January through May 2019 were all below totals for any month in 2018; the enrollment total for September 2019 was the highest this calendar year; and the total for October was slightly below the September count but still higher than any other month in 2019. This fluctuation could be tied to the months during which MDHHS processes passive enrollments.

Jan. 2018	Feb. 2018	March 2018	April 2018	May 2018	June 2018
38,045	38,571	38,562	37,798	39,021	38,327
July 2018	**August 2018**	**Sept. 2018**	**Oct. 2018**	**Nov. 2018**	**Dec. 2018**
37,518	37,103	36,394	35,651	34,827	34,655

Jan. 2019	Feb. 2019	March 2019	April 2019	May 2019	June 2019
34,367	34,444	33,672	33,145	33,095	35,612
July 2019	**August 2019**	**Sept. 2019**	**Oct. 2019**		
34,771	36,621	37,295	37,018		

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 **October 1, 2019**.

MI Health Link Enrollment	Upper Pen. Region	SW MI Region	Macomb Region	Wayne Region	Total
Aetna Better Health of MI		3,285	866	3,186	7,337
AmeriHealth Michigan			643	2,220	2,863
HAP Empowered, Inc.			971	3,562	4,533
Meridian Health Plan of MI		4,956			4,956
MI Complete Health			506	1,935	2,441
Molina Healthcare of MI			1,866	9,015	10,881
Upper Peninsula Health Plan	4,007				4,007
Total	**4,007**	**8,241**	**4,852**	**19,918**	**37,018**

As of October 1, 2019, Molina Healthcare of Michigan had the most enrollees, both voluntarily and passively enrolled (more than 29 percent of the combined total); Aetna Better Health of Michigan came in second with almost 20 percent; and Meridian Health Plan of Michigan had more than 13 percent of the total enrollees.

At present, about 95 percent of the MI Health Link enrollees are living in a community setting, and the remaining 5 percent of the enrollees live in a nursing facility. About 5 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 the other enrollees living in a community setting receive in-home services and supports from the ICOs through the Medicaid State Plan personal care benefit called Home Help.

While all plans have enrollees receiving care in nursing facilities, Aetna Better Health of Michigan had the largest share during October 2019; over 21 percent of the total enrollees residing in nursing facilities were part of Aetna. Molina Healthcare of Michigan had the second highest share of enrollees at almost 19 percent; and Upper Peninsula Health Plan came in third, with almost 18 percent of total enrollees residing in nursing facilities.

Although the majority of MI Health Link enrollees are passively enrolled and can opt out of the demonstration at any time, the percentage that voluntarily joined the demonstration has grown over time. As of October 1, 2019, the voluntary enrollment percentage was 24.9, a slight reduction from the previous few months.

MDHHS also reports that just over 60,000 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, or re-enroll, in the demonstration at any time.

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.

MI HEALTH LINK A SUCCESS

On October 23, 2019, the Michigan Department of Health and Human Services (MDHHS) announced that two new reports highlight the success of and enrollee satisfaction with the MI Health Link program, Michigan's integrated healthcare delivery system demonstration for adults dually eligible for Medicare and Medicaid (duals). *(See the MI Health Link article in this newsletter for additional information.)*

The federal Centers for Medicare & Medicaid Services (CMS) contracted with Alan Newman Research to conduct a series of focus groups to better understand the experience of beneficiaries enrolled in the program. Overall, a summary of the focus group findings shows participants reported very high satisfaction with health plan experiences. CMS also contracted with RTI International to monitor and evaluate the MI Health Link program's impact on beneficiary experience, quality of care, service utilization and cost. The report shows reductions in both the probability of inpatient admissions as well as preventable emergency visits.

A link to the reports is included in the announcement.

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

MICHIGAN D-SNPS

Three of the 11 Medicaid HMOs in Michigan 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: Meridian Health Plan of Michigan, Molina Healthcare of Michigan, and UnitedHealthcare Community Plan. **As of October 1, 2019, these three D-SNPs had a combined enrollment of 24,326 duals** for whom they provide Medicare services.

More than 51 percent of the duals enrolled in a Michigan D-SNP (12,497 individuals) in October 2019 were enrolled with Molina; over 38 percent (9,303 duals) were enrolled with Meridian; and 2,526 duals (more than 10 percent of the total) were enrolled with UnitedHealthcare. None of these duals are participating in the MI Health Link demonstration. In addition to these three health plans, beginning January 1, 2019, two additional health plans were approved as D-SNPs serving Michigan – Humana Medical Plan and Health Alliance Plan of Michigan (HAP). Humana had 1,628 enrollees as of October 1, 2019 and HAP had 50 enrollees. HAP is the parent organization for HAP Midwest Health Plan, one of the Medicaid HMOs, and HAP Empowered, one of the ICOs participating in MI Health Link.

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

HEALTHY MICHIGAN PLAN ENROLLMENT

The Michigan Department of Health and Human Services reports enrollment counts for the Healthy Michigan Plan (HMP), its Medicaid expansion program for low-income non-elderly adults who do not meet eligibility criteria for traditional program coverage, at the beginning of each week on its website. Enrollment stood at **661,563 as of October 28, 2019**, the last counting day of the month. This is a **decrease of 435 since September 30, 2019**, the last counting day in September.

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MICHIGAN BUDGETS FOR FISCAL YEAR (FY) 2019-2020

A partial shutdown of Michigan state government on October 1 was avoided when Governor Gretchen Whitmer, a Democrat, signed into law all state budgets on September 30. The Governor, stating her dissatisfaction with many of the provisions in the budget bills, made a possibly unprecedented number of vetoes –147 items across all budgets – including 48 vetoes in the budget for the Michigan Department of Health and Human Services (MDHHS), the agency responsible for all public assistance and healthcare programs, including Medicaid and behavioral health. In total, the vetoes cut almost a billion dollars from the budgets and impacted several critical services and funding streams.

On October 1, the State Administrative Board held a special meeting at the Governor's request and approved transfer of more than $600 million between line items in the various department budgets. This approach to budget modifications by the executive branch of government had not been used for almost three decades and, along with the many vetoes, was not well received by the Republican-controlled Legislature.

It soon became clear that part of the objective behind the vetoes, which also included items the Governor supported, was to get legislative leaders back to the table to craft a budget more in line with her vision, including a long-term commitment to addressing infrastructure issues such as the state's roads and bridges. Although legislative leaders have expressed their reluctance to revisit the budgets, saying the "budget is done," meetings have happened and several supplemental budget bills have been introduced from both sides of the aisle and within both chambers of the Legislature. Some of the bills are line-item specific and they have all been assigned to the various appropriations subcommittees. How quickly they will be addressed and how the entire budget situation will be resolved is unclear at this point. One issue of controversy relates to the Governor's use of the State Administrative Board; legislative leaders have expressed concern about working on a supplemental budget only to have it modified again by the Board. As of the release of this newsletter, no supplemental appropriation bills have been sent to the Governor for signature.

Although many line items in the MDHHS budget were vetoed, several important provisions in the appropriation survived. Changes from current funding and policy include the following.

Actuarially Sound Rates: The budget includes $211.5 million to support a 2 percent rate increase for the Healthy Kids Dental Plans and for the Medicaid Health Plans (HMOs) for both traditional Medicaid and the Healthy Michigan Plan (HMP), as well as a 2.75 percent increase in rates for behavioral healthcare provided by the Prepaid Inpatient Health Plans (PIHPs), and a 5.75 percent increase for PIHP autism services.

Support for HMP Workforce and Community Engagement Requirement Implementation: The Governor's Executive Budget Recommendation included $10 million for employment and training-related services and supports to help HMP beneficiaries meet the new HMP work requirement which is effective January 1, 2020. The Legislature did not include this funding in the budget that was sent to the Governor. On October 1st, the State Administrative Board transferred nearly $6.1 million in state general funds to the HMP administration line item for this purpose; these funds were from other line items in the MDHHS budget.

Medicaid Adult Home Help Minimum Wage Increase: Funding for Adult Home Help, Michigan's Medicaid State Plan personal care benefit, is increased by $31.2 million to fund an increase in the Michigan minimum wage from $9.25 to $9.65 per hour on January 1, 2020, plus an additional $0.25 per hour above the minimum wage as of April 1, 2020.

Office of Inspector General Medicaid Managed Care Audit: The budget (Section 1507) expands the roll of the MDHHS Inspector General (IG) to include Medicaid managed care payments. The IG staff is increased by 30 positions. Estimated savings (net of $3.4 million for the cost of the additional staff) are $17.1 million, of which $6.9 million is the estimated state general fund share of the savings.

Managed Care Pharmacy Administration: There are two aspects of the budget with respect to pharmacy administration by Medicaid HMOs.

- The budget reduces the pharmacy administration component of HMO rates for a savings of $19.9 million (of which the state general fund share is $5 million). The budget notes that prescription drug administration rates have been based on a percentage of pharmacy costs, such that use of more expensive drugs has led to a proportionate increase in payments to HMOs for their administrative costs.
- The Legislature included $7.6 million (of which the state share is $1.9 million) to require that beginning February 1, 2020 Medicaid HMOs must only contract with pharmacy benefit managers that reimburse pharmacies based on dispensing fees and ingredient costs comparable to Medicaid fee-for-service rates. The Governor vetoed this funding and Section 1625 which authorized this action.

Additionally, MDHHS has released a proposed policy that would remove administration of the pharmacy benefit from Medicaid HMOs and as of December 1, 2019 would transfer the function to the pharmacy benefit manager for fee-for-service Medicaid, which is Magellan Rx. The policy bulletin indicates that this action is tied to the FY 2019-2020 budget. While there is no fiscal action or language in the budget anticipating this policy change, the Governor's veto letter for the MDHHS budget states "I am directing the department to implement policy changes that will achieve additional efficiencies." Recent media reports indicate that the Whitmer administration is expecting to save $50 million as a result of this action.

Rural Hospital Payments: The conference report submitted to the Governor made numerous changes that would enhance Medicaid payments to rural hospitals. The Governor vetoed a total of $154.1 million in rural hospital pools and hospital outpatient rate increases (state general fund savings of $41.3 million).

Graduate Medical Education: The prior year (FY 2018-2019) appropriation included $5 million in state general funds, plus $5 million in private funding and the associated federal match, for a total of $28.1 million for the MiDocs consortium. These funds were to support increased physician residency training programs in both rural and urban underserved communities. Because of a significant amount of unspent funds available to carry forward (as a "work project"), the legislature reduced FY 2019-2020 funding for MiDocs by $10.6 million. The Governor vetoed the FY 2019-2020 funding for the MiDocs program and the language in Section 1870 of the bill related to that initiative. The unspent funds from FY 2018-2019 are still available for use during FY 2019-2020 since they were carried forward as a "work project."

Psychiatric Residency Program: The budget eliminates funding of $8.4 million (state general fund share $3 million) for a psychiatric residency training program through Beaumont Health.

Special Hospital Payments: In the aggregate, Special Hospital Payments are increased by $274.7 million, with a net savings to the state general fund of $9.7 million and an increase to the hospital Quality Assurance Assessment Program of $90.4 million. Included in this item are changes to the Hospital Rate Adjustment program, outpatient Disproportionate Share Hospital funding, and the Medicaid Access to Care Initiative payments to hospitals.

Nursing Facility Reimbursement – Capital Costs: The Governor's Executive Budget recommendation for FY 2019-2020 included a change in methodology to determine the limit on allowable nursing facility capital costs based on a 15-year rolling average of new construction costs. The cost of this change was estimated at $4.9 million. The Legislature concurred with this Executive recommendation. However, the Governor's vetoes deleted Section 1645 and the related funding.

Nursing Facility Reimbursement – Variable Costs: The Executive Budget proposed decreasing the limit on variable costs (costs other than capital costs) from the 80th percentile to the 70th percentile. The final legislative budget did not make this change and there was no veto. However, MDHHS recently issued a proposed policy (1938-NF) that would reduce the variable cost limit from the 80th percentile to the 65th percentile of variable costs for all classes of nursing facilities. The policy is proposed to be effective November 1, 2019, contingent upon federal approval of a Medicaid State Plan amendment. The policy bulletin indicates that this action is tied to the FY 2019-2020 budget. While there is no fiscal action or language in the budget anticipating this policy change, as previously noted, the Governor's veto letter for the MDHHS budget states "I am directing the department to implement policy changes that will achieve additional efficiencies."

MI Choice Waiver: The MI Choice waiver provides long-term services and supports outside of a nursing facility setting. (MI Choice does not include the Adult Home Help program.) The Legislature added $40.5 million ($14.6 million state general funds) to this program and increased the number of slots by 1,000. The increase in costs for the MI Choice waiver is offset by a reduction in Medicaid days in nursing facilities.

Other vetoed rate increases related to Medicaid services for children and youth include:

- Private Duty Nursing rates: The Legislature included $3.9 million (state share of $1.4 million) to fund a 15 percent rate increase as of January 1, 2020 for private duty nursing services for beneficiaries under the age of 21. The Governor vetoed Section 1702 and the related funding.
- Pediatric Psychiatric rates: The Legislature included $10.7 million (state share of $3.9 million) to increase payments to pediatric psychiatrists by 15 percent. The Governor vetoed Section 1790 and the related funding.
- Neonatology rates: The Legislature included $5.2 million (state general fund share of $1.9 million) to increase rates for neonatal care to 80 percent of Medicare rates. (Last fiscal year the neonatology rates were increased from 64 percent of Medicare rates to 75 percent of Medicare rates). The Governor vetoed Section 1791 and the related funding.

Non-Emergency Medical Transportation Pilot: The budget eliminates $1.4 million that had been appropriated for a pilot designed to increase use of public transportation when Medicaid beneficiaries need transportation to doctor appointments and other non-emergency services.

Behavioral Health Integration Implementation: The Governor vetoed Section 298 which authorized three pilot projects and a demonstration model for integration of physical and behavioral healthcare. She also vetoed $3.1 million for administrative support, including a project facilitator, project evaluators, actuarial rate setting, contractual services, and staffing (3 positions). On October 21st, MDHHS announced that work on the three pilot programs was ending.

In addition to the changes noted above, there were other less significant changes to funding and policy for Medicaid and behavioral healthcare services. In her letter that accompanied the signing of the budget for MDHSS, the Governor noted that as well as the 48 vetoes, she deemed 26 sections of the bill (language or boilerplate) to in whole or in part violate various provisions of the Michigan Constitution and to therefore be unenforceable.

Traditional Medicaid Cost Adjustments: The May caseload consensus estimates (between the State Budget Office, the Senate Fiscal Agency, and the House Fiscal Agency) resulted in estimates of higher trends in traditional Medicaid enrollment and costs than had previously been forecast. Because of these revised estimates, the total budget for traditional Medicaid, including behavioral healthcare services, was increased by $260.8 million. Due to an improving Michigan economy, the federal Medicaid matching rate for Michigan decreased from 64.45 percent to 64.06 percent on October 1, 2019, thus requiring a larger state and local share. The net change in state and local costs from decreased federal funding and increased program costs is an increase of $150.4 million from FY 2018-2019.

Healthy Michigan Plan (HMP) Cost Adjustments*:* The May caseload consensus estimates resulted in a lower trend in HMP enrollment and costs than had previously been forecast. The budget also assumes some HMP beneficiaries will be disenrolled from the program due to the new workforce and community engagement requirements. Because of these estimates, the total budget for HMP for medical and behavioral healthcare costs was reduced by $94.5 million, of which $50 million is the estimated impact of the work requirement. Since the federal share of HMP costs decreases by an additional three percentage points (from 93 percent to 90 percent) on January 1, 2020, the net cost from state and local sources will increase by $81.9 million. It should be noted that the federal share of HMP costs is scheduled to remain at 90 percent in the future.

More detail on the budget for FY 2019-2020 for the MDHHS (as of October 1, 2019) is available from the House Fiscal Agency at this link.

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

WORKFORCE AND COMMUNITY ENGAGEMENT REQUIREMENTS

In previous editions of *The Michigan Update*, most recently last month, we have reported on Michigan's workforce and community engagement requirements, which are scheduled for implementation on January 1, 2020. The requirements – 80 hours of work, job search or community engagement activities each month – will impact many adults age 19-62 with Healthy Michigan Plan (HMP – Medicaid expansion program) coverage that are not exempted (excused). The requirements will not apply to beneficiaries in this age group with "traditional" Medicaid program eligibility.

The Michigan Department of Health and Human Services (MDHHS) continues to develop and disseminate information for impacted beneficiaries as well as community organizations and providers that will hopefully assist the beneficiaries in both understanding the requirements and complying with the necessary reporting to ensure they do not lose healthcare benefits. MDHHS has established a page on its website dedicated primarily to these requirements.

Letters have been sent to beneficiaries that, based on information known to MDHHS, will not be subject to the requirements. This information could relate to a beneficiary's medical condition, based on services for which Medicaid payments have been made, which places the beneficiary in a "medically frail" category. A beneficiary may also be identified as exempt based on information available to MDHHS related to their receipt of food or cash assistance, state unemployment benefits, or disability payments. An exemption will last for 12 months or until the beneficiary's next eligibility renewal date, whichever is first.

Letters have also been sent to beneficiaries that MDHHS believes may be subject to the requirements; these letters explain the circumstances that could exempt a beneficiary from the requirements and include a form that can be completed and submitted if the beneficiary believes they meet exemption criteria.

All correspondence is being sent with brightly-colored packaging and easy to understand language. Examples of the letters are available on the department's website. MDHHS has developed a booklet that provides detailed information about the requirements in easy to understand language. The booklet identifies other reasons that may qualify a beneficiary for an exemption.

MDHHS staff are conducting forums across the state to share information with beneficiaries, providers, Medicaid HMO staff, and representatives of community organizations. Dates and places where the forums are being held are also identified on the referenced department website. Feedback from the forums will be used to further refine messaging and administrative processes. It was clear from hearing the presentation and questions at one of the forums that there will be situations requiring special consideration. For example, while full-time students are identified as eligible for an exemption, one forum attendee asked if a student attending classes on a part-time basis at two colleges simultaneously could be considered a full-time student; MDHHS staff responded that the beneficiary should consider whether the sum of classes at both colleges would equate to a full-time load if the classes were all at one college. If this is the case, a request for exemption could be appropriate.

Compliance with the workforce requirements will be through self-reporting, and MDHHS will do sample reviews to ensure program integrity. Beneficiaries are being strongly encouraged to keep necessary documentation to support their reports of compliance. The documentation requirement is especially important for beneficiaries that are self-employed. In some cases, work requirements may be satisfied through hours worked or through income received if that amount equates to what 80 hours at minimum wage would provide.

MDHHS has established multiple means for beneficiaries to report their compliance with the workforce or community engagement requirements or to request an exemption after January 2020. Beneficiaries may use a MI Bridges account to communicate online or they may use a dedicated telephone line (1-833-895-4355 / TTY 1-866-501-5656). Beneficiaries may also visit their local MDHHS office and speak in person to one of the staff.

Beneficiaries must report compliance by the end of the month following the month to which the requirements applied; for example, for the month of January 2020, compliance must be reported by February 29, 2020. Failure to respond after three months could result in loss of healthcare benefits. Beneficiaries will have the ability to “cure” a reporting failure.

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

298 PILOTS

On October 21, 2019, the Michigan Department of Health and Human Services (MDHHS) announced the end of discussions around the "Section 298" pilots. The Section 298 Initiative was a statewide effort intended to improve the integration of physical health services and specialty behavioral healthcare in Michigan. Discussions were ongoing for three years but pilot participants were unable to reach an agreement on a path forward. In light of this and Governor Whitmer's veto of language related to the pilots in Public Act 67 of 2019, the MDHHS budget for fiscal year 2019-2020, MDHHS Director Robert Gordon announced that all movement in this direction has stopped. Director Robert Gordon also indicated in the announcement that he would be "sharing the department's vision for a stronger behavioral health system" in the coming weeks.

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

MDHHS RECEIVES $3.4 MILLION GRANT

On October 22, 2019, the Michigan Department of Health and Human Services announced receipt of a $3.4 million grant from the federal Centers for Medicare & Medicaid Services that will allow the department to conduct a needs assessment of substance use disorder (SUD) treatment and recovery provider capacity for the state's Medicaid program. The needs assessment will help determine current use of and need for SUD services, where additional SUD services are needed in the state, how many additional providers are required to address the need, and strategies to increase the number of patients current providers can serve. Michigan was one of 15 states to receive the grant funding. MDHHS is partnering with the University of Michigan's Institute for Healthcare Policy & Innovation to conduct the needs assessment.

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

19TH ANNUAL MEDICAID BUDGET SURVEY

On October 18, 2019, the Kaiser Family Foundation (KFF) released two reports on state Medicaid budgets and policies: *A View from the States: Key Medicaid Policy Changes – Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2019 and 2020* and *Medicaid Enrollment & Spending Growth: FY 2019 & 2020***.** The reports were the result of a survey of Medicaid directors across the country, conducted by Health Management Associates (HMA) and KFF staff in collaboration with the National Association of Medicaid Directors.

The reports address trends in Medicaid spending, enrollment, and policy initiatives for fiscal years (FY) 2019 and 2020 and highlight changes implemented in FY 2019 and planned for FY 2020. Key findings include:

- Multiple states reported expansions or enhancements to provider rates and benefits.
- Several states implemented, adopted, or continued to debate the ACA Medicaid expansion.
- A growing number of states continued to pursue work requirements and other policies promoted by the Trump administration that could restrict eligibility.
- States are implementing Medicaid initiatives to address social determinants of health, control prescription drug spending, improve birth outcomes and reduce infant mortality, and address the opioid epidemic.

HMA has included an "In Focus" article in the October 23, 2019 edition of the *HMA Weekly Roundup*, which elaborates on the key findings above.

The reports were authored by Kathleen Gifford, Aimee Lashbrook, Eileen Ellis, and Mike Nardone from HMA, and by Elizabeth Hinton, Robin Rudowitz, Maria Diaz, and Marina Tian from the Kaiser Family Foundation.

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

ASSET TEST LIMITS INCREASED FOR PUBLIC ASSISTANCE

On October 17, 2019, Governor Gretchen Whitmer announced a policy change related to state eligibility for food and cash assistance. As a result of the policy change, additional people will be able to receive assistance through the Supplemental Nutrition Assistance Program (SNAP) and the Family Independence Program (FIP), as well as the State Emergency Relief (SER) Program. The new policy allows people to have up to $15,000 in assets and still be eligible. The former policy limited assets to $5,000 for SNAP, $3,000 for FIP, and $500 for SER. The policy change also removes vehicles from the asset calculation.

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

MEDICAID POLICIES

The Michigan Department of Health and Human Services (MDHHS) has released four final and eight proposed policies that merit mention. Two of the final policies were released simultaneously for public comment. They are available for review on the department's website.

- **MSA 19-26** advises **School Based Services (SBS) Providers** of an **expansion of the existing SBS program** to include coverage and reimbursement policies associated with nursing and behavioral healthcare **services for general education students, referred to as Caring 4 Students**. The policy is simultaneously being issued as a proposed policy (**1917-SBS**) with comments due to MDHHS by November 4, 2019.
- **MSA 19-28** notifies **Nursing Facilities, County Medical Care Facilities, Hospital Long-Term Care Units, State Veterans' Homes, and Ventilator-Dependent Care Units** of **changes to the Nursing Facility Cost Reporting & Reimbursement Appendix** of the Medicaid Provider Manual. Implementation of this policy is **contingent upon approval of a State Plan Amendment** by the Centers for Medicare & Medicaid Services (CMS).
- **MSA 19-31** informs **Bridges Eligibility and Administrative Manual Holders and the Medicaid Non-Emergency Medical Transportation (NEMT) Contractor** of changes in fee-for-service NEMT policies related to **meal and lodging reimbursement and timely filing of the Medical Transportation Statement**.
- **MSA 19-32** notifies **Hospitals** that, as **required by language in Public Act 67 of 2019**, the MDHHS budget for fiscal year 2019-2020, and **contingent upon approval of a State Plan Amendment** by CMS, the **Rural Access Pool for small rural hospitals and sole community hospitals will be discontinued**. This policy is simultaneously being issued as a proposed policy (**1937-RAP**) with comments due to MDHHS by November 4, 2019.
- A proposed policy (**1936-Pharmacy**) has been issued that would **discontinue coverage of outpatient prescription drugs by the Medicaid HMOs** and instead cover drugs on a fee-for-service basis for managed care enrollees. Comments are due to MDHHS by November 4, 2019.
- A proposed policy (**1938-NF**) has been issued that would **change the percentile of the Indexed Variable Costs per resident day for all classes of nursing facilities** from 80 percent to 65 percent. Comments are due to MDHHS by November 4, 2019.
- A proposed policy (**1926-HMP**) has been issued that would **implement workforce and community engagement requirements** for Medicaid beneficiaries with Healthy Michigan Plan coverage beginning in January 2020. This policy is required by language in Public Act 208 of 2018. Comments are due to MDHHS by November 6, 2019.

- A proposed policy (**1931-Eligibility**) has been issued that would **limit, restrict or suspend Medicaid eligibility and coverage for up to one year for individuals convicted of Medicaid fraud** in federal court due to their own misrepresentations. Comments are due to MDHHS by November 12, 2019.
- A proposed policy (**1929-Enrollment**) has been issued that would provide updates to **enrollment requirements and billing instructions associated with Limited License Psychologists**. Comments are due to MDHHS by November 18, 2019.
- A proposed policy (**1930-DMEPOS**) has been issued that would **expand provider enrollment criteria for providers of durable medical equipment, prosthetics, orthotics and supplies** to align more closely with other payers and to clarify physical location requirements. Comments are due to MDHHS by November 25, 2019.

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

- **L 19-36** was released October 1, 2019 as a notice to Tribal Chairs and Health Directors of the department's **intent to submit State Plan Amendments and a Waiver Amendment** to CMS related to **elimination of Rural Access Pool** payments to hospitals, **reduction of the nursing facility Variable Cost Limits** from the 80th to the 65th percentile, and **conversion of prescription drug coverage from administration by Medicaid HMOs to fee-for-service** coverage.
- **L 19-37** was released October 15, 2019 as a notice to **Home Help Agency providers** that a **rate increase** has been authorized for services rendered on and after October 1, 2019, as authorized by language in Public Act 67 of 2019, the MDHHS budget for fiscal year 2019-2020. **A statewide rate is established at $16.08 per hour**.
- **L 19-39** was released October 28, 2019 as a notice to Tribal Chairs and Health Directors of the department's **intent to submit a State Plan Amendment** to CMS to **update the reimbursement methodology and increase the reimbursement rate for hearing aid devices**.

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