Healthy Michigan Plan

Elizabeth Hertel
Michigan Department of Community Health
Director, Health Policy & Innovation
The Legislative Journey

- Included in the Fiscal Year 13-14 Executive Budget Recommendation
- Discussions parallel to appropriations process
- Addressing the lack of knowledge about Michigan Medicaid
- Development and passage of stand alone legislation in the House
- Further refinement through the Senate process
Healthy Michigan Overarching Goals

Coverage Expansion that Positively Impacts Uncompensated Care

Promote Healthy Behaviors

Greater Accountability for All

Alignment of Incentives and Accountability
Implementation Timeline

Public Act 107 of 2013, signed into law on September 16, 2013, did not have an immediate effect.

Cannot implement prior to 90 days after the end of legislative session.

Therefore, April 1, 2014 is roughly the implementation deadline.
Major Components of PA 107

- Expands Medicaid Eligibility
- Establishes Health Savings Accounts
- Promotes Healthy Behaviors Supported by Cost-Sharing Incentives
- Enrollment and Eligibility Changes
- Uncompensated Care Evaluation and Resulting DSH Reductions
- Medicaid Cost-Effectiveness and Performance Evaluation
- Expansion of Performance Bonus Incentive Pools
State law requires certain cost-sharing requirements. (co-pays and contributions)

Some of these requirements are not stated in federal regulation.

Need a waiver to implement what is in state law.
- Amending our current Adult Benefits waiver.

DCH is currently working with CMS to obtain waiver approval.
# Waivers Establishing Healthy Michigan Plan

## Waiver 1

| Authorize the expansion of the Medicaid program allowing the state to enroll eligible individuals (non-disabled adults) with incomes between 100-133% FPL | Establishes Health Savings Accounts into which money from any source can be deposited to pay for incurred health expenses, including, but not limited to co-pays |

## Waiver 2

By September 1, 2015, DCH shall seek an additional waiver from HHS that requires individuals with incomes between 100-133% FPL and who have had medical assistance coverage for 48 cumulative months beginning on the date of their enrollment in the new program choose one of the following options:

- Change MA eligibility status to be considered for federal advance premium tax credit and cost-sharing subsidies from the federal government to purchase private insurance through the American Benefit Exchange without financial penalty to the state
- Remain in the Medical Assistance Plan but increase cost sharing requirement up to 7% of income
Eligibility for Healthy Michigan Plan and Current Medicaid

Medicaid expansion fills the gap between current coverage and private health insurance coverage offered on the Exchange.
MI Health Account

- Account will provide information on health care services cost and utilization.
- Will show cost of services and amount of contribution in account.
- DCH will provide beneficiaries quarterly statements detailing this information.
- If enrollee becomes ineligible for MA, the remaining balance in the account shall be returned to that enrollee in the form a voucher for the sole purpose of purchasing and paying for private insurance.
MI Health Account: Cost Sharing Structure

DCH shall require enrollees with annual incomes between 100% and 133% of FPL:

- Contribute no more than 5% of income annually for cost-sharing requirements.
- Contributions do not apply the first 6 months of enrollment.
- Required contributions used to pay for incurred health expenses shall be 2% of income annually.

DCH shall require enrollees with incomes between 100% and 133% of FPL, who choose to stay in MAP following 48 months of enrollment:

- Contribute no more than 7% of income annually for cost-sharing requirements.
- Required contributions used to pay for incurred health expenses for covered benefits shall be 3.5% of income annually.
Service Delivery System

• Healthy Michigan beneficiaries will enroll into the one of the current Medicaid Health Plans.
• Current Medicaid populations that are exempt or voluntary from managed care will remain exempt or voluntary.
• Will use the current Prepaid Inpatient Health Plan (PIHP) system of care.
Coverage Expansion

Decrease in Uncompensated Care Utilization
Reduction in Uncompensated Care Utilization

<table>
<thead>
<tr>
<th>Hospitals</th>
<th>Overall Health System</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cost Savings</td>
<td>Cost Savings</td>
</tr>
<tr>
<td>Decrease in DSH Payments</td>
<td>Reduction in Overall Health Insurance Premiums</td>
</tr>
<tr>
<td>General Fund</td>
<td>Consumer Cost Savings</td>
</tr>
</tbody>
</table>
## Promoting Healthy Behavior

<table>
<thead>
<tr>
<th>Health Plan, Provider, and Enrollee Incentives for Cost Effectiveness and Efficiency:</th>
<th>Reductions in Contributions and Co-Pays</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Financial Incentives for Contracted Health Plans</strong></td>
<td><strong>Health Plans permitted to: Reduce required contributions to an individuals health savings account if “healthy behaviors are being addressed, as based on uniform standards developed by DCH in consultation with health plans.”</strong></td>
</tr>
<tr>
<td>Financial Incentives for Providers who meet specified quality, cost and utilization targets</td>
<td>Health Plans permitted to: Waive co-pays “to promote greater access to services that prevent the progression and complications related to chronic diseases.”</td>
</tr>
<tr>
<td>Financial Incentives for Enrollees who demonstrate improved health outcomes or maintain healthy behaviors as identified by health risk assessment and providers</td>
<td></td>
</tr>
</tbody>
</table>
Promoting Healthy Behavior

**Co-Pay Structure Design**

Department of Community Health to “design and implement a co-pay structure that encourages the use of high-value services, while discouraging low-value services such as non-urgent Emergency Department utilization.”

**Pharmaceutical Benefit Design**

DCH to implement a pharmaceutical benefit that utilizes co-pays at appropriate levels allowable by CMS to encourage the use of high-value, low-cost prescriptions.
Greater Accountability for All

Healthy Michigan requires greater accountability for:

**Beneficiaries**
- Manage Health Savings Accounts
- Cost Sharing
- Informed choices regarding treatment options
- Reporting fraud and abuse within the program

**Providers**
- Meet specified quality, cost and utilization targets
- Report fraud and abuse within the program

**Health Plans**
- Meet specified performance metrics
- Ensure enrollee cost-sharing compliance
Alignment of Incentives and Accountability: Cost Sharing Compliance

<table>
<thead>
<tr>
<th>Beneficiaries</th>
<th>Health Plans</th>
</tr>
</thead>
</table>
| DCH shall develop a methodology that decreases the amount an enrollee's required contribution may be reduced per section (1)(E), based on, but not limited to,  
- enrollee's failure to pay cost-sharing requirements and  
- inappropriate utilization of the ED | Beginning on October 1, 2015, a minimum of 0.25% of payments to contracted health plans shall be withheld for the purpose of establishing a cost-sharing compliance bonus pool |

DCH shall establish uniform procedures and compliance metrics for utilization by the contracted health plans to ensure cost-sharing requirements are being met. This includes ramifications for the contracted health plans failure to comply with performance or compliance metrics.
Alignment of Incentives and Accountability

**Fraud and Abuse**
Incentives for beneficiaries and providers tied to assisting the department in detecting and reporting fraud and abuse in the program

**Performance Bonus Incentive Pool**
Provide incentives for Health Plans meeting specified performance and compliance metrics
Impact on Base Operations

- Unique identification of population through systems
- Systems changes to reflect different service coverages, federal match rates, etc.
- Cost settlements complicated by different match rates
- Managed care reporting changed
2014 Reports, Recommendations, and Evaluations

- **DCH Enrollee Failure to Meet Cost-Sharing Requirement Report**: Plan of action for enrollees who consistently fail to meet cost-sharing requirements [105D(1)(B)].

- **DCH Baseline Uncompensated Care Report**: Evaluation of the impact of providing medical coverage to the expanded population has on uncompensated care costs. [105D(1)(8)].

- **DIFS Baseline Report: Effect of Uncompensated Care on Insurance Rates Report**: Evaluation of the impact that providing medical coverage to the expanded population has on the cost of uncompensated care as it relates to insurance rates and insurance rate filings as well as net effect on rates overall [105D(1)(9)].

- **DCH Emergency Department Utilization Report and Recommendations**: Identify the causes of overutilization and improper emergency service usage and include specific best practice recommendations for decreasing overutilization of EDs and improper Emergency Service usage [Sec.105D(1)(30)].
2014 Reports, Recommendations, and Evaluations (Cont.)

• Annual State Savings Calculations and Methodology Report: Calculations and methodology used to determine annual state savings and other nonfederal net savings submitted to the legislature [105D(1)(27)]

• DCH State Tax Refund Offset Report: By November 1 of each year, DCH shall submit all requests for the offset of state tax refunds claimed on returns filed or to be filed for that tax year. [105D(1)(28)]

• DCH Innovations and Initiatives Related to Cost Effectiveness and Performance of the Medical Assistance Program: Evaluation of the results of innovations and initiatives to improve the effectiveness and performance of the Medical Assistance Program and to lower overall health care costs to the state. [105D(1)(10)]

• Advisory Committee Report on Health Care Cost and Quality Database: Recommendations on the creation of a database on health care costs and health care quality in MI. [105F(3)]
2015 Reports, Recommendations, and Evaluations

• **DCH Effective Enrollment and Eligibility Recommendations:** DCH Director submit recommendation on how to most effectively determine Medicaid eligibility and enrollment for all applicants. [105C 3(18)]

• **DCH Uncompensated Care Report:** DCH shall make a report regarding the preceding FY evidence of the reduction in the amount of the actual cost of uncompensated care compared to the initial baseline report [105D(1)(8)].

• **Uncompensated Care Final Report:** By September 30, 2015 a final report and recommendations produced by an independent third party vendor to be submitted to the legislature [105D(1)(31)].

• **DCH LTC Managed Care Performance Bonus Incentive Plan Recommendations:** Recommendations for a Performance Bonus Incentive Plan for LTC managed care providers of up to 30% of their Medicaid capitation payments [105d(1)(4) 9(2)].
2015 Reports, Recommendations, and Evaluations (Cont.)

- **DCH Fraud and Abuse Detection and Savings Annual Report:** DCH shall develop incentives for enrollees and providers who assist the department in detecting fraud and abuse in the program, and then provide an annual report that includes the type of fraud detected, the amount saved, and the outcome of the investigation [105H]

- **DCH Review and Report of National Organization’s Recommendations on Cost-Effectiveness:** DCH shall review and report the feasibility of programs recommended by multiple national organizations (NCSL, ALEC, CSG, etc) on improving the cost-effectiveness of the MAP [105D(1)(11)]

- **DCH HCBS Report:** DCH shall provide to the legislature and governor an annual report showing the detail of its HCB case finding and placement activities [109(6) 37(27)]