Legislative Analysis

MEDICAID EXPANSION REVISIONS

House Bill 4495 as introduced
Sponsor: Rep. Will Snyder
Committee: Health Policy
Revised 5-25-23

Phone: (517) 373-8080
http://www.house.mi.gov/hfa

Analysis available at
http://www.legislature.mi.gov

SUMMARY:

House Bill 4495 would amend the Social Welfare Act to remove or revise several requirements pertaining to health plans and enrollees in health plans under Michigan's expanded Medicaid program under the federal Affordable Care Act (ACA).

Under the Social Welfare Act, DHHS must seek a waiver from the U.S. Department of Health and Human Services to do certain things (without jeopardizing federal match dollars or otherwise incurring federal financial penalties and upon approval of the waiver). The bill would remove the term *waiver* from numerous provisions and replace it with the term *approval*. The bill also would remove provisions requiring DHHS to submit a written copy of approved waiver provisions from the U.S. Department of Health and Human Services to the legislature and requiring DHHS to pursue any or all necessary waivers to enroll persons eligible for both Medicaid and Medicare into the four integrated care demonstration regions.[1]

Currently, individuals eligible under the ACA who meet citizenship requirements and are otherwise eligible for the Medicaid program must be enrolled in a contracted health plan (i.e., managed care organization). The bill would retain this provision, but eliminate a requirement that the contracted health plan provide for an account into which money from any source can be deposited to pay for incurred health expenses, including co-pays.

The bill would also eliminate a provision that requires a contracted health plan to track all co-pays incurred for the first six months an individual is enrolled in the program and calculate the average monthly co-pay experience for the enrollee. Instead of requiring DHHS to implement a *co-pay structure that encourages* use of high-value services while discouraging low-value services, such as nonurgent use of emergency rooms, the bill would require the implementation of a *plan to encourage* the use of high-value services while discouraging low-value services.

DHHS is required to implement a pharmaceutical benefit *that utilizes co-pays at appropriate levels allowable by the Centers for Medicare and Medicaid Services* to encourage the use of high-value, low-cost prescriptions, such as generic prescriptions and 90-day prescription supplies, as appropriate. The bill would remove the italicized language, as well as language stating that this provision applies whether or not requested waivers are approved, the ACA is repealed, or the state terminates or opts out of the program established under the act.

Under the act, DHHS must require enrollees with annual incomes between 100% and 133% of federal poverty guidelines to contribute up to 5% of income for cost-sharing requirements. Cost-sharing includes co-pays and contributions made into the enrollee accounts. Required contributions to an account to pay for incurred health expenses are 2% of income. A required contribution may be reduced by the contracting health plan if healthy behaviors are being

[1] https://www.michigan.gov/mdhhs/doing-business/providers/integrated

addressed, as attested to by the health plan based on uniform standards developed by DHHS in consultation with the health plan. The bill would remove this provision and instead require DHHS to establish cost-sharing requirements for enrollees in the Healthy Michigan Plan (HMP)[2] as approved by the U.S. Department of Health and Human Services. The bill would also delete the requirement that DHHS develop a methodology to decrease the amount an enrollee's required contribution may be reduced based on certain factors.

The bill would retain a provision that a hospital participating in Medicaid must accept 115% of Medicare rates as payment in full from an uninsured individual with an annual income level of up to 250% of the federal poverty guidelines. However, it would remove language stating that the provision applies whether or not requested waivers are approved, the ACA is repealed, or the state terminates or opts out of the program being established in the act.

DHHS is currently required to work with providers, contracted health plans, and other departments to create processes that reduce the amount of uncollected cost-sharing and reduce the administrative cost of collecting cost-sharing. To this end, at least 0.25% of payments to contracted health plans must be withheld to establish a cost-sharing compliance bonus pool. The bill would delete these provisions.

Advance directives

Currently, DHHS must inform enrollees during the enrollment process about advance directives and require them to complete a department-approved advance directive on a form that includes an option to decline. This requirement would be deleted.

Integration into managed care

Currently, DHHS must make recommendations for a performance bonus incentive plan for long-term care managed care providers of up to 3% of their Medicaid capitation payments, consistent with other managed care performance bonus incentive plans. These payments have to comply with federal requirements and be based on measures that identify the appropriate use of long-term care services and focus on consumer satisfaction, consumer choice, and other appropriate quality measures applicable to community-based and nursing home services.

The bill would delete language requiring that, where appropriate, these quality measures must be consistent with quality measures used for similar services implemented by the integrated care for the dually eligible demonstration project.

Uncompensated care

The bill would remove a provision specifying that the Medicaid expansion program is being created in part to extend health coverage to Michigan's low-income citizens and to provide health insurance cost relief to individuals and the business community by reducing the cost shift related to uncompensated care. The bill also would remove a requirement that DHHS collect and examine relevant financial data for all hospitals in the state and evaluate the impact that providing medical coverage to the expanded population of enrollees has had on the actual cost of uncompensated care.

Impact on insurance rates

The Department of Insurance and Financial Services (DIFS) is currently required to examine the financial reports of health insurance companies and evaluate the impact that providing

[2] https://www.michigan.gov/mdhhs/assistance-programs/healthcare/healthymichigan

coverage to the expanded population has had on uncompensated care as it relates to insurance rates and rate filings, as well as its net effect on rates overall. DIFS must consider the evaluation in the annual approval of rates and must make an annual report regarding the evidence of the change in rates compared to the initial baseline report. The bill would delete this provision.

Financial incentives
DHHS is currently required to create, in collaboration with the contracted health plans and providers, financial incentives for contracted health plans that meet specified population improvement goals; providers who meet specified quality, cost, and utilization targets; and enrollees who demonstrate improved health outcomes or maintain healthy behaviors as identified in a risk assessment by their primary health care practitioner.

The bill would instead require DHHS, in collaboration with the contracted health plans, to create financial incentives for enrollees who demonstrate improved health outcomes, practice healthy behaviors, or complete screenings or procedures that improve health outcomes.

Administrative costs
The act currently requires DHHS to maintain administrative costs at a level of not more than 1% of the department's appropriation for the state Medicaid program. These costs are capped at the total administrative costs for the 2015-16 state fiscal year, except for inflation and project-related costs required to achieve medical assistance net general fund savings. The bill would delete this provision

Cost-sharing procedures and compliance metrics
DHHS is currently required to establish uniform procedures and compliance metrics for use by the health plans to ensure that cost-sharing requirements are being met. This includes ramifications for the plans' failure to comply with performance or compliance metrics. The bill would delete this provision.

Performance bonus incentive pool
Currently, DHHS is required to withhold at least 0.75% of payments to contracted health plans, except for specialty prepaid health plans, for the purpose of expanding the existing performance bonus incentive pool. The bill would revise the provision to instead *allow* DHHS to withhold up to 1% of payments to contracted health plans for the purpose of a performance bonus incentive pool. The bill also would also delete the requirement that the distribution of funds from the performance bonus incentive pool is contingent on the contracted health plan's completion of the required performance or compliance metrics.

Currently, the performance bonus incentive pool for contracted health plans that are not specialty prepaid health plans must include inappropriate utilization of emergency departments, ambulatory care, contracted health plan all-cause acute 30-day readmission rates, and generic drug utilization as a percentage of the total. These measurement tools must be considered and weighed within the six highest factors used in the formula.

The bill would delete this provision and instead require the performance bonus incentive pool for contracted health plans to include targets established for at least three and no more than five objectives established by DHHS in collaboration with the contracted health plans. Targets should focus on key current health priorities, improve health equity, utilize established measurements to set a baseline for performance improvement, and be determined at least six months before the measurement period to support planning and execution necessary for achievement of desired outcomes.

Performance bonus incentive pool (specialty prepaid health plans)
DHHS now must withhold, at a minimum, 0.75% of payments to specialty prepaid health plans for the purpose of establishing a performance bonus incentive pool. Distribution of funds is contingent on a plan's completion of required performance of compliance metrics, including at least partnering with other plans to reduce emergency department use for nonemergencies, increased participation in patient-centered medical homes, increased use of electronic health records and data sharing with other providers, and identification of enrollees who may be eligible for services through the Veterans Administration. The bill would delete this provision.

Substance abuse
DHHS is now *required* to measure contracted health plan or specialty prepaid health plan performance metrics on application of standards of care as they relate to appropriate treatment of substance abuse disorders and efforts to reduce such disorders. The bill would make this provision *permissive*. The bill would also delete the requirement that this provision applies whether or not requested waivers are approved, the ACA is repealed, or the state terminates or opts out of the program established under the act.

The second waiver
Where the first waiver was the Medicaid expansion request described above, the second waiver was sought to require individuals who had received medical assistance coverage for 48 months under the expanded program and who were between 100% and 133% of the federal poverty guidelines to choose to purchase private insurance coverage through an American health benefit exchange operated in the state by changing their Medicaid eligibility status so as to be considered eligible for federal advance premium tax credit and cost-sharing subsidies from the federal government; or remain in the Medicaid program but increase cost-sharing requirements up to 7% of income (from the maximum of 5% described earlier), and require minimum contributions of 3.5% (instead of 2%), with reductions again possible for certain healthy behaviors. DHHS must notify enrollees 60 days before the end of the enrollees' 48th month that coverage under the current program is no longer available to them and that they must choose one of those two items. The bill would eliminate these provisions.

In addition, the bill would delete several provisions regarding the implications to the expanded Medicaid program (which include the termination of medical coverage for enrollees) if subsequent renewal requests for waivers were not granted, or the waivers were canceled by the U.S. Department of Health and Human Services or invalidated, or if an approved waiver did not comply with provisions of the expanded Medicaid program.

The act provides that the provisions of the waivers do not apply to individuals cited under 42 CFR 440.315 of federal law. That section describes certain exempt individuals, e.g., pregnant women, the blind or disabled, individuals entitled to benefits under Medicare, the terminally ill in hospice care, parent or caretaker relatives, and the medically frail, among others

Termination of expansion if waiver approval not received
The bill would delete a provision specifying that if DHHS did not receive approval for both of the waivers or if federal matching funds for the Medicaid expansion program fall below 100% and the annual state savings and other nonfederal net savings of the program are insufficient to cover the reduced federal match, the Medicaid expansion program would be terminated.

Treasury and lottery intercepts
The bill would delete the requirement that DHHS coordinate with the Department of Treasury to create a procedure for offsetting the state tax refunds of an enrollee who owed a liability to the state of past due uncollected cost-sharing, as allowable by the federal government. The act also considers any nonpayment of required cost-sharing to be a current liability to the state under the Lottery Act and subjects it to the usual procedures for such liabilities. This provision would be deleted as well.

Defined terms
The bill would delete definitions for the terms *peace of mind registry*, *peace of mind registry organization*, and *state savings*. In addition, the term *medically indigent individual* currently includes an individual eligible under the HMP. The bill would delete language making this contingent on federal waivers or specified levels of funding.

Deletion or repeal of obsolete reporting provisions
The bill would delete provisions that required DHHS to do the following:

- Develop initiatives to improve the effectiveness of the Medicaid program and lower overall health care costs in Michigan and report on the results.
- Review and report on the feasibility of programs recommended by multiple national organizations to improve the cost-effectiveness of the medical assistance program.
- Convene a symposium to examine the issues of emergency department overutilization and improper use and issue a report with recommendations.
- Contract with an independent third-party vendor to review required reports on uncompensated care to develop a methodology for tracking costs and cost reductions and their effect on health insurance rates, with recommendations for annual review.

The bill also would repeal section 105c, which required the DHHS director to submit recommendations regarding Medicaid eligibility to legislative leaders and the State Budget Office, and section 105f, which required the directors of DHHS and DIFS to establish a Michigan Health Care Cost and Quality Advisory Committee and report its recommendations.

MCL 400.105d and 400.106 (amended) and MCL 400.105c and 400.105f (repealed)

FISCAL IMPACT:

House Bill 4495 would result in an indeterminate, but likely moderate, combination of state costs and state savings for the Department of Health and Human Services. The elimination of the requirements to establish a health expense account for each recipient could result in state administrative cost reductions and could result in a reduction on collected cost sharing and co-payments, which would increase state costs. Similarly, the elimination of the cost-sharing compliance bonus pool would result in both a decrease of contractual payment withholdings of 0.25% or more from managed care plans and the elimination of the incentive payments for co-pay collections.

Alternatively, allowing DHHS to establish objective-based performance payments with Medicaid managed care plans could result in cost savings derived from a reduction in health care costs resulting from decreases in unhealthy behavior as well as increased costs to support

the payments. The costs and savings would be determined by future contract negotiations and whether or not performance incentives are included.

Lastly, this bill would remove the provision on the Healthy Michigan Plan that eliminates the program if net costs become greater than net savings. The House Fiscal Agency estimates[3] that the Healthy Michigan Plan will incur net savings through at least FY 2030-31 under current policy, so this change would not have an immediate fiscal impact.

Any changes in Healthy Michigan Plan services costs would be shared 90% federal and 10% state, and any changes in Healthy Michigan Plan administrative costs would be shared, in most instances, 50% federal and 50% state.

Legislative Analyst: Susan Stutzky
Fiscal Analysts: Kevin Koorstra
Kent Dell

■ This analysis was prepared by nonpartisan House Fiscal Agency staff for use by House members in their deliberations and does not constitute an official statement of legislative intent.

[3] HFA Medicaid Overview, slide 32: https://house.mi.gov/hfa/PDF/Briefings/HHS_Medicaid_BudgetBriefing_fy22-23.pdf