OPEN MINDS

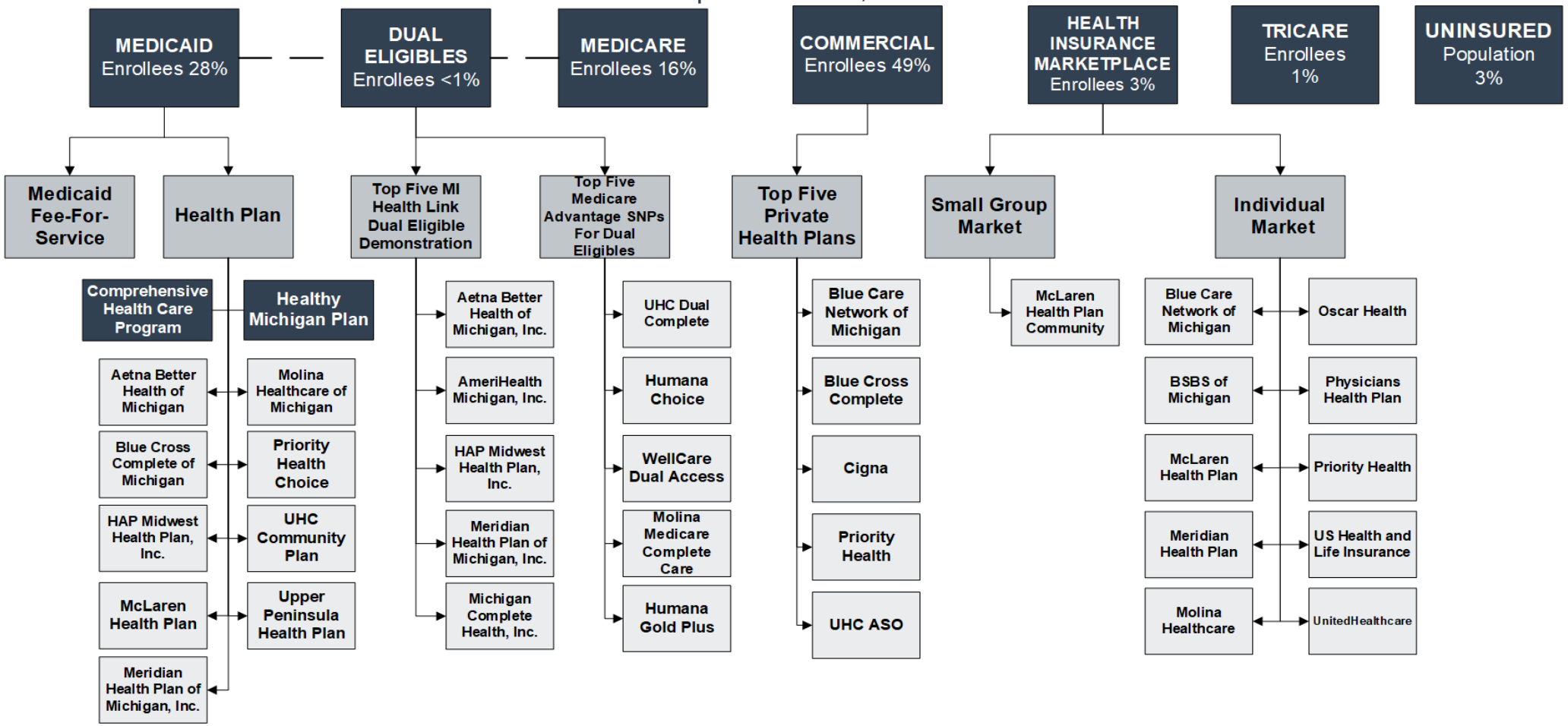
Michigan Health & Human Services Market System Profile

Health & Human Services System Market Profile Overview

A. Executive Summary

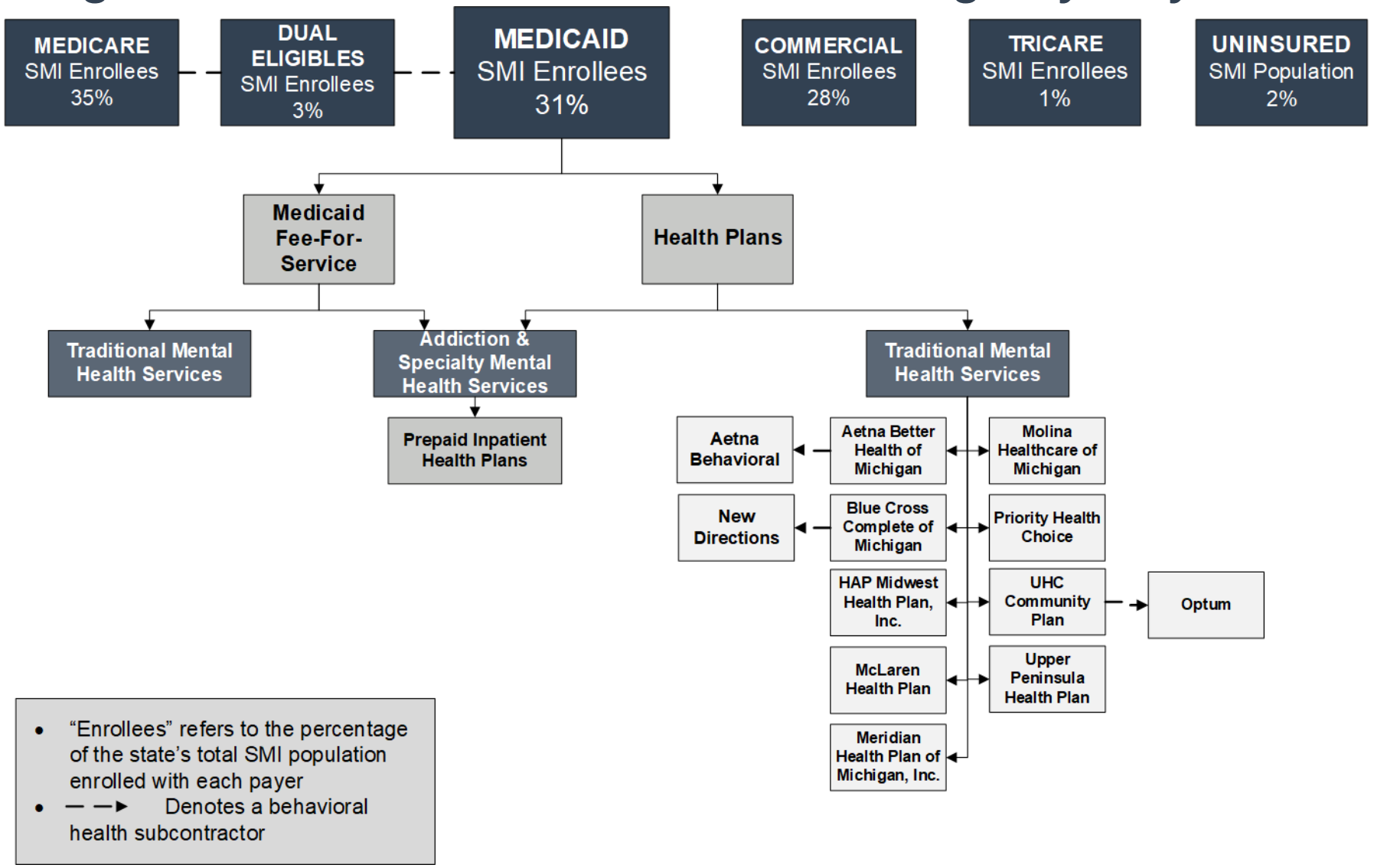
A.1. Michigan Physical Health Care Coverage by Payer

Total Michigan Population- 10,050,811
Estimated SMI Population- 697,853



"Enrollees" refers to the percentage of the state's total population enrolled with each payer.

A.1. Michigan Behavioral Health Care Coverage by Payer



- "Enrollees" refers to the percentage of the state's total SMI population enrolled with each payer
- — —► Denotes a behavioral health subcontractor

A.2. Health & Human Services Care Coordination Initiatives

Care Coordination Entities For Chronic Care Populations (Including SMI)		
Care Coordination Entity	**Active Program**	**Description**
Managed Care Health Plan	✓	Health plans are responsible for care coordination.
Primary Care Case Management (PCCM)		None
Accountable Care Organization (ACO) Program		None
Affordable Care Act (ACA) Model Health Home	✓	The state has three health home programs for individuals with SMI, individuals with opioid disorders, and individuals with chronic and behavioral health conditions.
Patient-Centered Medical Home (PCMH)		Michigan's PCMH program received funding through a State Innovation Model (SIM) grant. Funding ended for this in FY2020.
Dual Eligible Demonstration	✓	The state extended their dual eligible demonstration MI HealthLink through December 2024.
Managed Long-Term Services and Supports (MLTSS)	✓	Services provided through Michigan's Habilitation Supports and MI Choice waivers are managed by prepaid inpatient health plans.
Certified Community Behavioral Health Clinics (CCBHC) Grant	✓	Michigan currently has 13 CCBHCs participating in the demonstration program.
Other Care Coordination Initiative		None

A.3. Health Care Safety-Net Delivery System

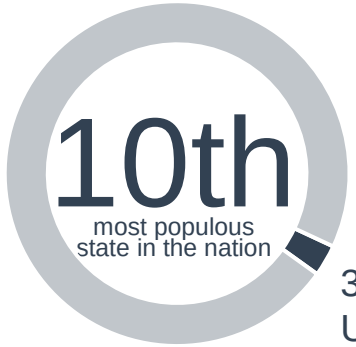
Physical Health Services

- The Department of Health and Human Services is responsible for safety-net services for the physical health population.

B. Michigan Health Financing System Overview

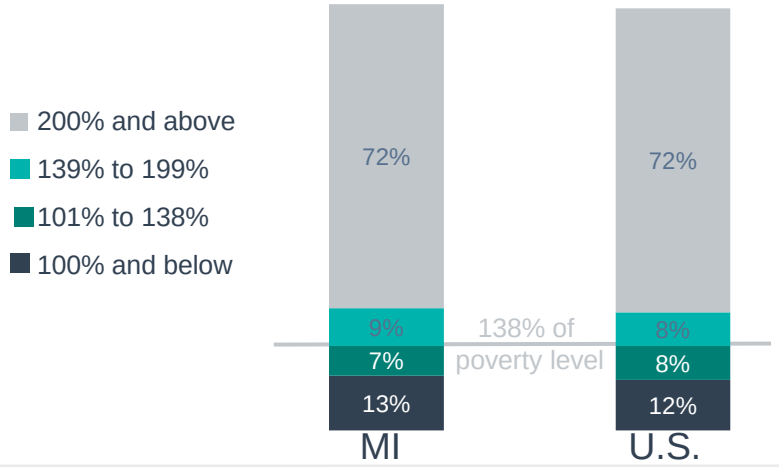
B.1. Population Demographics

Total Michigan Population- 10,050,811
Estimated SMI Population- 697,853



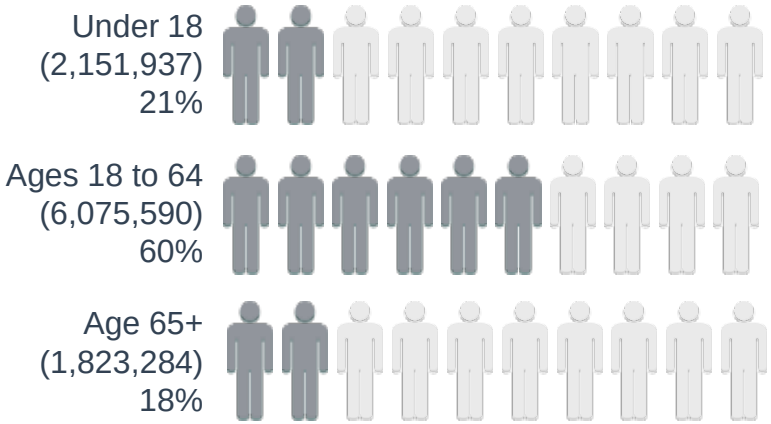
3% of the
U.S. population

Population Distribution By Income To Poverty Threshold Ratio

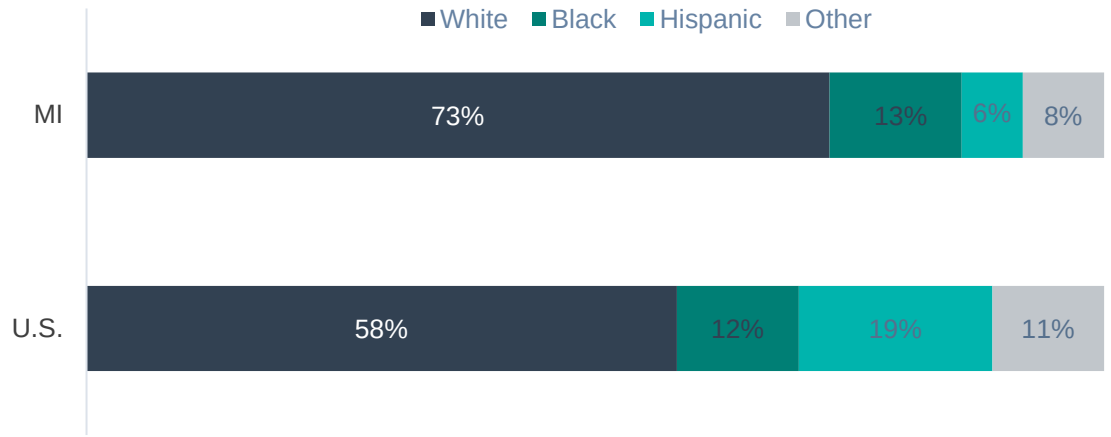


Median Household Income	
Michigan	$63,498
U.S.	$69,717

Population Distribution By Age

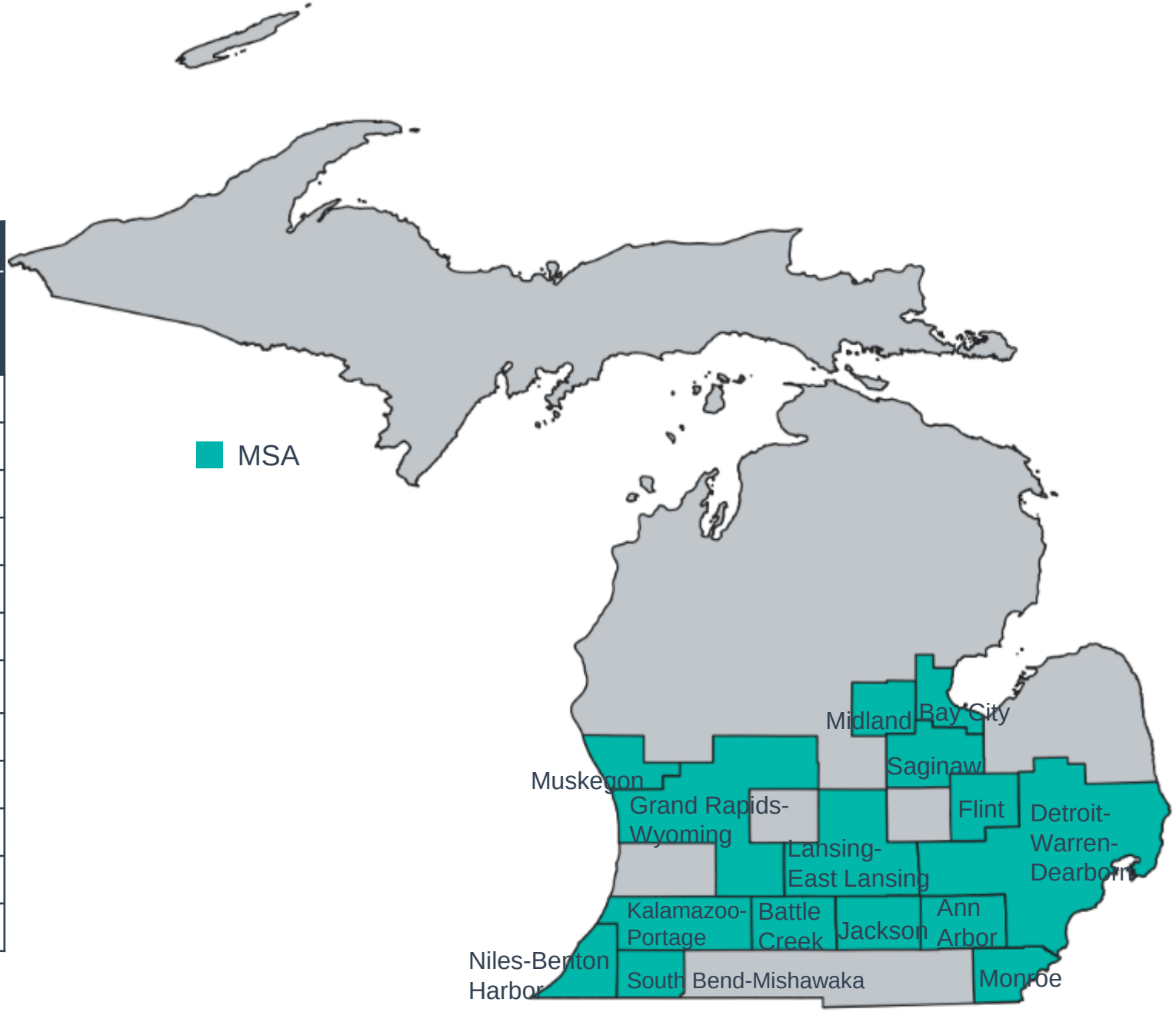


Michigan & U.S. Racial Composition

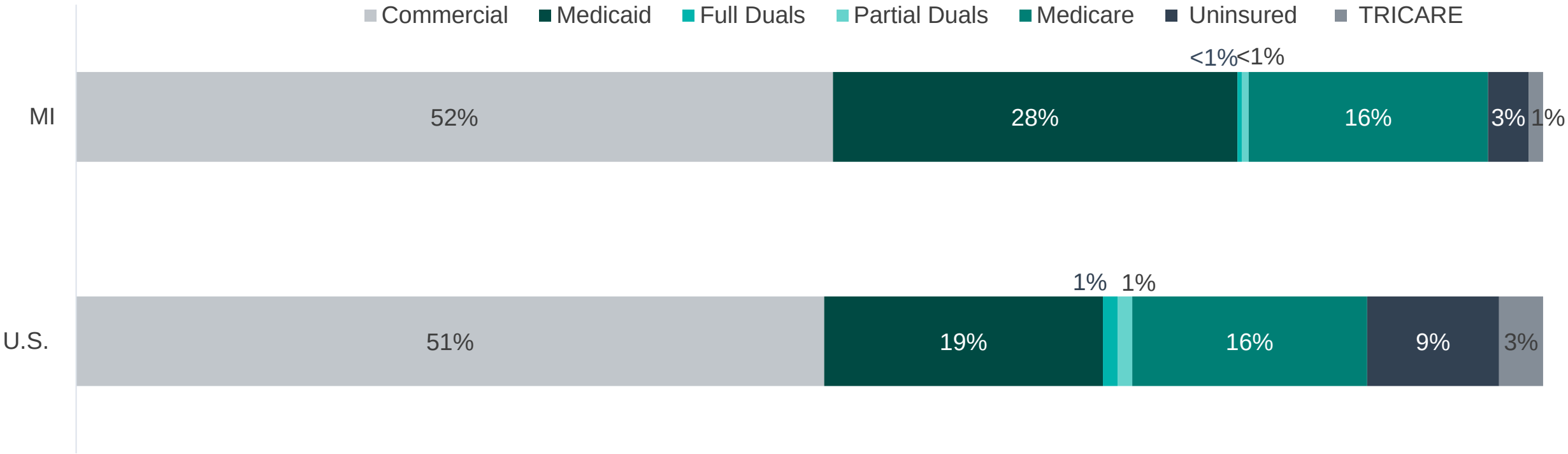


B.2. Population Centers

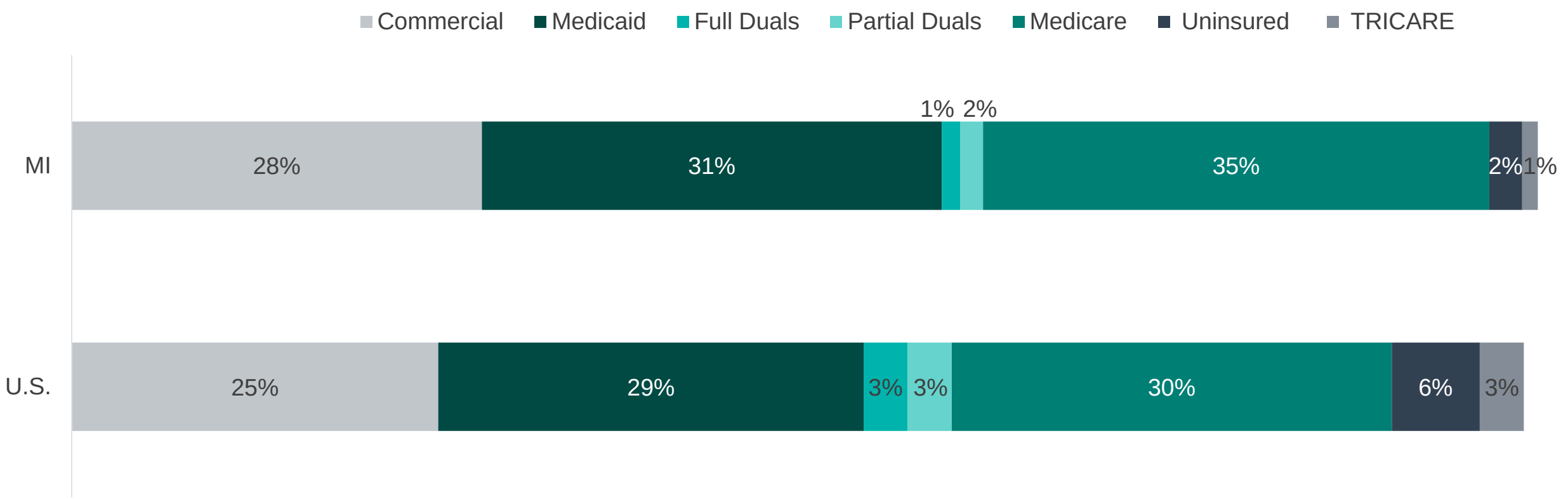
Metropolitan Statistical Areas (MSAs)		
MSA	**Michigan MSA Residents**	**Percent Of Population**
Total MSA Population	**8,463,877**	**84%**
Detroit-Warren-Dearborn, MI	4,365,205	43%
Grand Rapids-Kentwood, MI	1,091,620	11%
Lansing-East Lansing, MI	540,281	5%
Flint, MI	404,208	4%
Ann Arbor, MI	369,390	4%
South Bend-Mishawaka, IN-MI	323,695	3%
Kalamazoo-Portage, MI	261,108	3%
Saginaw, MI	189,591	2%
Muskegon, MI	176,511	2%
Jackson, MI	160,050	2%
Other MSAs	582,218	6%



B.3. Population Distribution By Payer: National vs. State



B.3. SMI Population Distribution By Payer: National vs. State



B.4. Largest Michigan Health Plans By Enrollment

Plan Name	Plan Type	Enrollment*
Blue Cross Complete	Commercial	3,664,161
Michigan Medicare Fee-For-Service (FFS)	Medicare	948,711
Priority Health Insurance Company	Commercial	571,584
Blue Care Network of Michigan HMO	Commercial	567,799
MeridianHealth	Medicaid managed care	556,971
Michigan Medicaid FFS	Medicaid	550,330
Priority Health	Commercial	448,576
Medicare Plus Blue	Medicare advantage	434,777
Molina Healthcare of Michigan	Medicaid managed care	386,260
Blue Cross Complete	Medicaid managed care	323,164

*Medicaid enrollment as of March 2023; TRICARE as of December 2022; Commercial as of March 2023; Medicare enrollment as of March 2023

B.4. Largest Michigan Health Plans By Estimated SMI Enrollment

Plan Name	Plan Type	Enrollment*	Estimated SMI Enrollment
Michigan Medicare Fee-For-Service (FFS)	Medicare	948,711	151,794
Blue Cross Complete	Commercial	3,664,161	150,231
Medicare Plus Blue	Medicare advantage	434,777	69,564
MeridianHealth	Medicaid managed care	556,971	47,900
Michigan Medicaid Fee-For-Service (FFS)	Medicaid	550, 330	47,328
Molina Healthcare of Michigan	Medicaid managed care	386,260	33,218
Blue Cross Complete	Medicaid managed care	323,164	27,792
UnitedHealthcare Community Plan	Medicaid managed care	297,013	25,543
Priority Health Insurance Company	Commercial	571,584	23,435
Blue Care Network of Michigan HMO	Commercial	567,799	23,280

*Medicaid enrollment as of March 2023; TRICARE as of December 2022; Commercial as of March 2023; Medicare enrollment as of March 2023

B.5. Health Insurance Marketplace

Health Insurance Marketplace	
Health Insurance Marketplace Percent	3%
Type Of Marketplace	Federal & State
Individual Enrollment Contact	https://www.healthcare.gov/
	1-800-318-2596
Small Business Enrollment Contact	https://www.healthcare.gov/small-businesses/
	1-800-706-7893

2023 Individual Market Health Plans
1. Blue Care Network 2. Blue Cross Blue Shield of Michigan 3. McLaren Health Plan 4. Meridian (Ambetter) 5. Molina Healthcare 6. Oscar Health 7. Physicians Health Plan 8. Priority Health 9. US Health and Life Insurance Company 10. UnitedHealthcare

2023 Small Group Market Health Plans
1. McLaren Health Plan Community

B.6. Accountable Care Organizations

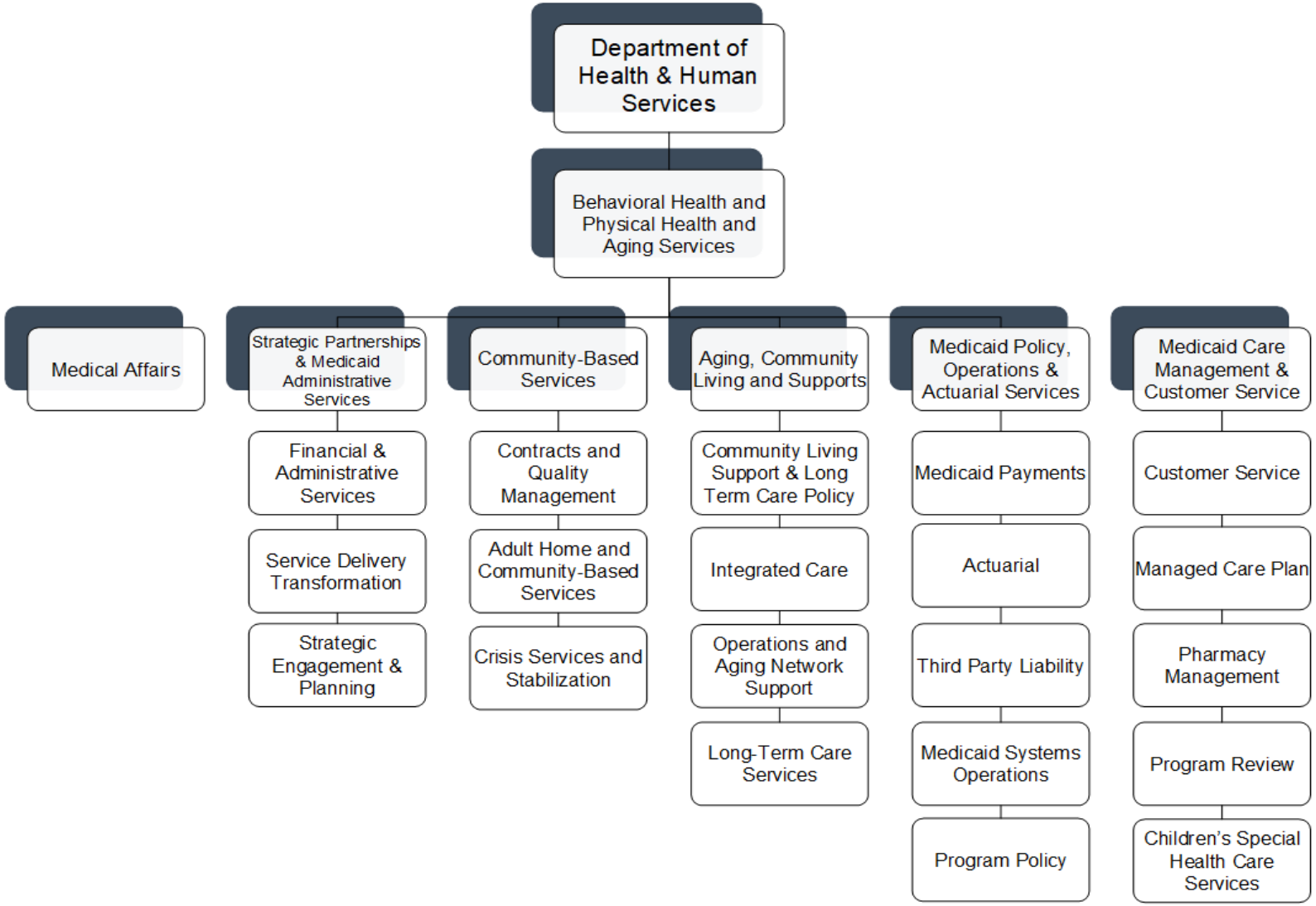
Medicare Shared Savings ACOs	
1. Accountable Care Organization of Aurora	14. Oakwood Accountable Care Organization, LLC
2. AdvantagePoint Health Alliance – Great Lakes	15. OSF Healthcare System
3. Aledade Accountable Care 16, LLC	16. Physician Organization Michigan ACO, LLC
4. Aledade Independent ACO, LLC	17. PMC ACO, LLC
5. CHA ACO, LLC	18. Prime Accountable Care, LLC
6. Federation ACO	19. ProMedica Health Network, Inc
7. Genesys PHO	20. The Accountable Care Organization, Ltd
8. Greater Genesee County ACO,	21. Trillium Health
9. Indiana Lakes ACO, LLC	22. UOP ACO, LLC
10. McAuley Health Partners ACO	23. USMM Accountable Care Partners
11. McLaren High Performance Network	24. West Michigan Accountable Care Organization, LLC
12. Mercy Health Select, LLC	
13. Northwest Ohio ACO, LLC	

End-Stage Renal Disease ACO
1. Fresenius Seamless Care of Michigan

Next Generation ACO
1. Bellin Health Partners
2. Henry Ford Accountable Care Organization
3. Reliance Next Generation ACO LLC

C. Medicaid Administration, Governance & Operations

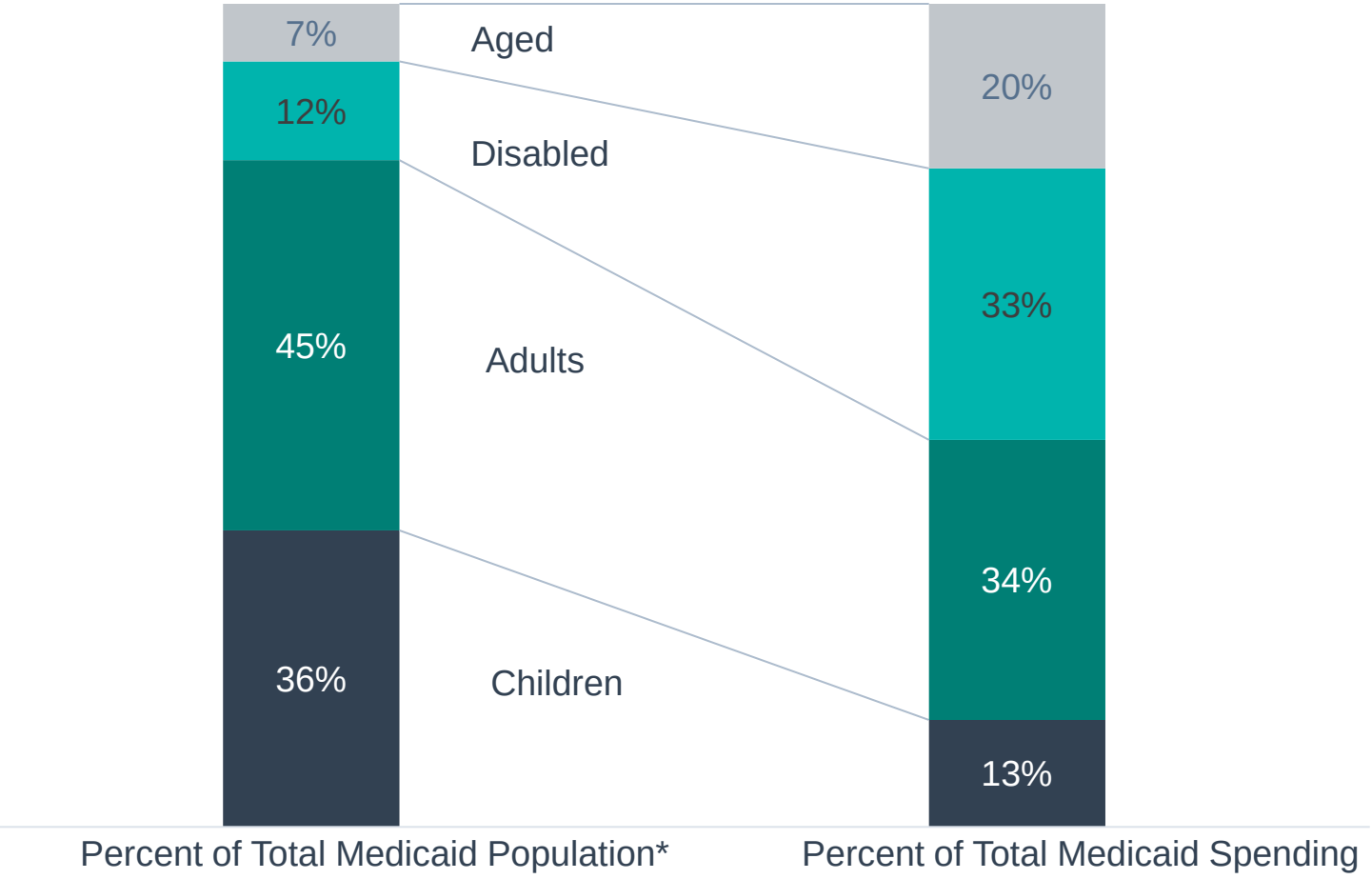
C.1. Medicaid Governance: Organization Chart



C.1. Medicaid Governance: Key Leadership

Name	Position	Department	Email
Elizabeth Hertel	Director	Michigan Department of Health and Human Services	hertele@michigan.gov
Katherine Massey	Senior Deputy Director	MDHHS, Bureau of Behavioral and Physical and Aging Services	masseyk@michigan.gov
Jean Ingersoll	Assistant Deputy Director of Critical Support	Michigan Department of Health and Human Services,	IngersollJ2@michigan.gov
Brian Keisling	State Bureau Administrator	MDHHS, Bureau of Medicaid Policy, Operations & Actuarial Services	keislingb@michigan.gov
Erin Emerson	Senior Policy Executive	MDHHS, Office of Strategic Partnerships & Medicaid Administrative Services	emersone@michigan.gov
Penny Rutledge	State Bureau Administrator	MDHHS, Bureau of Medicaid Care Management & Customer Service	rutledgep@michigan.gov

C.2. Medicaid Program Spending By Eligibility Group



Medicaid Spending Per Enrollee, FY 2020		
	U.S.	MI
All populations	$8,718	$7,563
Children	$3,495	$2,735
Adults	$5,461	$5,202
Expansion adults	$7,227	$6,111
Blind and disabled	$23,123	$18,580
Aged	$18,552	$22,014

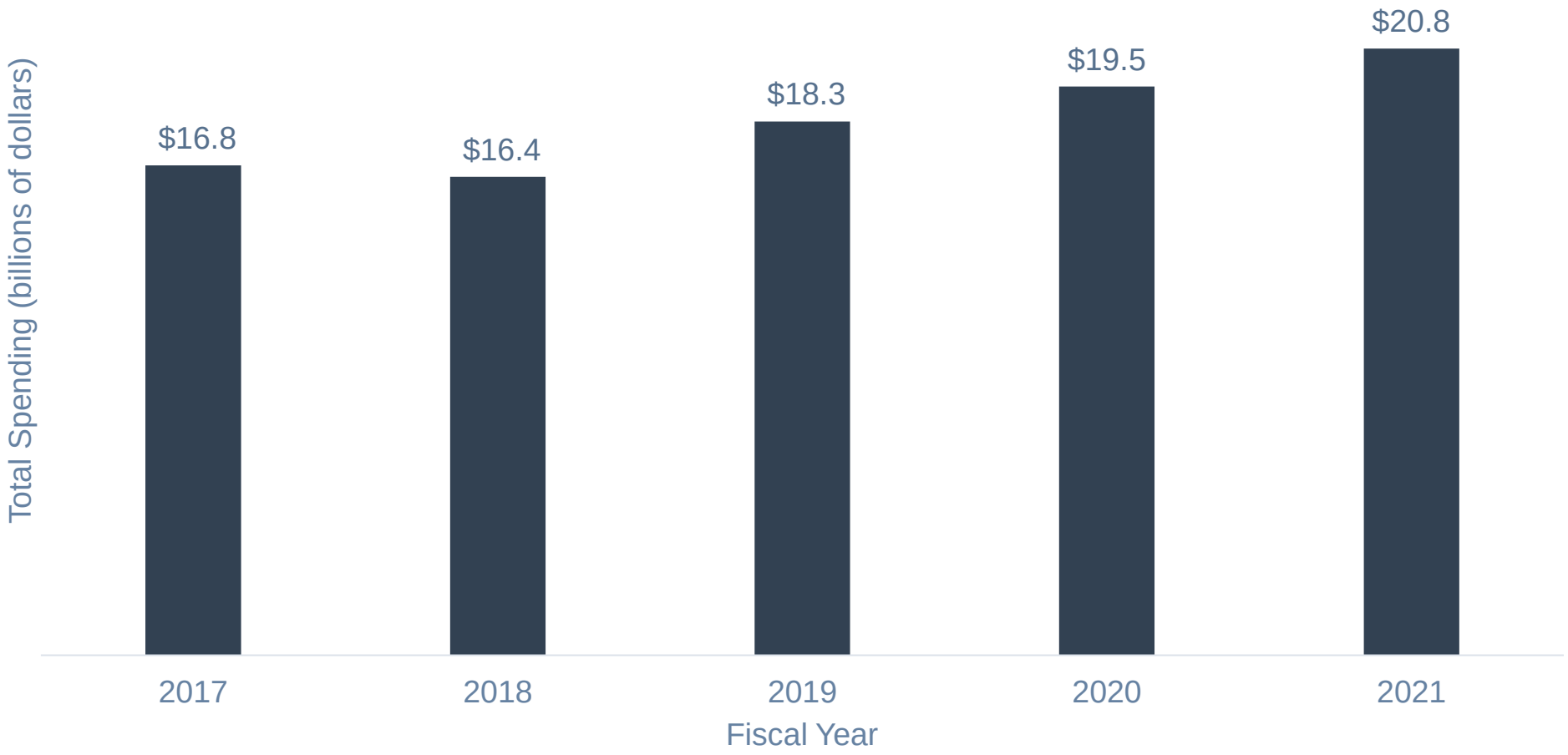
*Based on 2020 data.

C.2. Medicaid Program Spending: Budget

Budget Item	SFY21 Spending	Percent Of Budget
Managed care and premium assistance	$14,300,000,000	69%
Institutional LTSS	$1,940,000,000	9%
Hospital	$1,248,000,000	6%
Home- and community-based LTSS	$1,001,000,000	5%
Medicare premiums and coinsurance	$685,000,000	3%
Other acute services	$598,000,000	3%
Drugs	$553,000,000	3%
Physician services	$259,000,000	1%
Clinic and health center	$227,000,000	1%
Dental	$25,000,000	<1%
Other Practitioner	$16,000,000	<1%
Budget Total: $20,852,000,000		

Federal & County Financial Participation	
FY 2023 Federal Medical Assistance Percentage (FMAP)	71.7%
CY 2023 Newly Eligible FMAP (expansion population)	88%
Counties contribute to state Medicaid share	Yes

C.2. Medicaid Program Spending: Change Over Time



C.3. Medicaid Expansion Status

Medicaid Expansion	
Participating In Expansion	Yes
Date Of Expansion	April 2014
Medicaid Eligibility Income Limit For Able-Bodied Adults	133% of Federal Poverty Level (FPL); Parents at 54% of FPL Note: The Patient Protection and Affordable Care Act (PPACA) requires that 5% of income be disregarded when determining eligibility.
Legislation Used To Expand Medicaid	Public Act 107 of 2013
Number Of Individuals Enrolled In The Expansion Group (September 2022)	1,014,176
Number Of Enrollees Newly Eligible Due To Expansion	953,272
Benefits Plan For Expansion Population	The alternative benefit plan provides full state plan services and additional prescription drug, dental services, and vision benefits to all Healthy Michigan members in the expansion population.

C.4. Medicaid Program Benefits

Federally Mandated Services

1. Inpatient hospital services other than services in an institution for mental disease (IMD)
2. Outpatient hospital services
3. Rural Health Clinic services
4. Federally Qualified Health Center (FQHC) services
5. Laboratory and x-ray services
6. Nursing facilities for individuals 21 and over
7. Early and Periodic Screening and Diagnosis and Treatment (EPSDT)
8. Family planning services and supplies for individuals of child-bearing age
9. Physician services
10. Medical and surgical services of a dentist
11. Home health services
12. Nurse midwife services
13. Nurse practitioner services
14. Pregnancy services, including tobacco cessation programs
15. Free standing birth centers
16. Non-emergency transportation to medical care

Michigan's Optional Services

1. Optometry services
2. Chiropractic services
3. Podiatry services
4. Physical, occupational, or speech therapy
5. Clinic services
6. Dental services
7. Prescription drugs
8. Dentures, prosthetics, and orthotics
9. Eyeglasses
10. Diagnostic services
11. Rehabilitative services
12. Targeted case management
13. Durable medical equipment
14. Skilled nursing and inpatient hospital services for individuals over age 65 in IMD
15. Inpatient psychiatric facility services for individuals under 22 years old
16. Hospice care
17. Nursing facility services for patients under 21 years old

D. Medicaid Financing & Service Delivery System

D.1. Medicaid Financing & Service Delivery System

Medicaid System Characteristics		
Characteristics	**Medicaid Fee-For-Service (FFS)**	**Medicaid Managed Care**
Enrollment (March 2023)	550,330	2,300,648
SMI Enrollment	• Michigan does not specifically preclude individuals with SMI from enrolling in managed care based on a diagnosis of SMI. As a result, the majority of the SMI population is enrolled in managed care. • Estimated 81% of SMI population is enrolled in managed care, and 19% in FFS.	
Management	• Traditional physical and behavioral health services: MDHHS • Specialty behavioral health services: Prepaid Inpatient Health Plans (PIHPs)	• Traditional physical and behavioral health services: 10 health plans • Specialty behavioral health services: PIHPs
Payment Model	• Physical and behavioral health services: FFS • Specialty behavioral health services: Capitated rate	• Physical and behavioral health services: Capitated rate • Specialty behavioral health services: Capitated rate
Geographic Service Area	Statewide	Statewide; One health plan is responsible for the upper peninsula region, and the remaining ten health plans share coverage of the rest of the state

Total Medicaid: 2,850,978 | Total Medicaid With SMI: 245,184

D.1. Medicaid System Overview

Medicaid Financial Delivery System Enrollment	
Total Medicaid population distribution	As of March 2023: 19% in fee-for-service (FFS), 81% in managed care
SMI population inclusion in managed care	• Michigan does not specifically preclude individuals with SMI from enrolling in managed care; therefore, the majority of the SMI population is enrolled in managed care. • Estimated 19% of population in FFS, 81% in managed care
Dual eligible population inclusion in managed care	• Managed care is mandatory for dual eligibles in dual eligible demonstration counties and voluntary in other counties. • Estimated 25% of population in FFS, 75% in managed care

Medicaid Financing & Risk Arrangements: Behavioral Health		
Service Type	**FFS Population**	**Managed Care Population**
Traditional behavioral health	Covered FFS by the state	Included in the health plan's capitation rate
Specialty behavioral health	Covered by at-risk prepaid inpatient health plans (PIHP)	Excluded from the health plan's capitation rate; covered by at-risk PIHPs
Pharmaceuticals	Covered FFS by the state	Antipsychotics, psychotropics, and addiction disorder treatment drugs are provided FFS by the state. All other drugs are included in the health plan's capitation rate.
Long-term services and supports (LTSS)	Michigan's Habilitation Supports and MI Choice waivers are covered by at-risk PIHPs. All other LTSS services are covered FFS by the state.	Excluded from health plan's capitation rate, but services covered through Michigan's Habilitation Supports and MI Choice waivers are covered by at-risk PIHPs.

D.1. Medicaid Care Coordination Initiatives

Medicaid Care Coordination Entities For Chronic Care Populations (Including SMI)		
Care Coordination Entity	**Active Program**	**Description**
Managed Care Health Plan	✓	Health plans are responsible for care coordination.
Primary Care Case Management (PCCM)		None
Accountable Care Organization (ACO) Program		None
Affordable Care Act (ACA) Model Health Home	✓	The state has three health home programs for individuals with SMI, individuals with opioid disorders, and individuals with chronic and behavioral health conditions.
Patient-Centered Medical Home (PCMH)		Michigan's PCMH program received funding through a State Innovation Model (SIM) grant. Funding ended for this in FY2020.
Dual Eligible Demonstration	✓	The state extended their dual eligible demonstration MI HealthLink through December 2024.
Managed Long-Term Services and Supports (MLTSS)	✓	Services provided through Michigan's Habilitation Supports and MI Choice waivers are managed by prepaid inpatient health plans.
Certified Community Behavioral Health Clinics (CCBHC) Grant		Michigan was awarded a CCBHC planning grant, but was not selected to participate in the pilot phase of the program.
Other Care Coordination Initiative		None

D.1. Medicaid Service Delivery System Enrollment By Eligibility Group

Population	Mandatory FFS Enrollment	Option To Enroll In FFS Or Managed Care	Mandatory Managed Care Enrollment
Parents and caretakers			X
Children			X
Blind and disabled individuals			X
Aged individuals			X
Dual eligibles		X*	
Medicaid expansion			X
Individuals residing in nursing homes	X		
Individuals residing in ICF/IDD	X		
Individuals in foster care	X (Individuals in residential settings or incarcerated)		X
Other populations	• Individuals receiving home- and community-based services • Individuals receiving emergency services only • Medicare premium payments only • Individuals in traumatic brain injury residential rehabilitation program • Individuals with commercial managed care coverage • Hospice • Emergency and inpatient services for incarcerated individuals	• Native Americans • Persons with migrant status	Pregnant women

*Dual eligibles in dual demonstration counties have the option to enroll in the dual demonstration or FFS. Those who live outside the dual demonstration counties have the option to enroll in Medicaid managed care or FFS.

D.2. Medicaid FFS Program: Overview

- FFS enrollment as of March 2023 was 550,330.

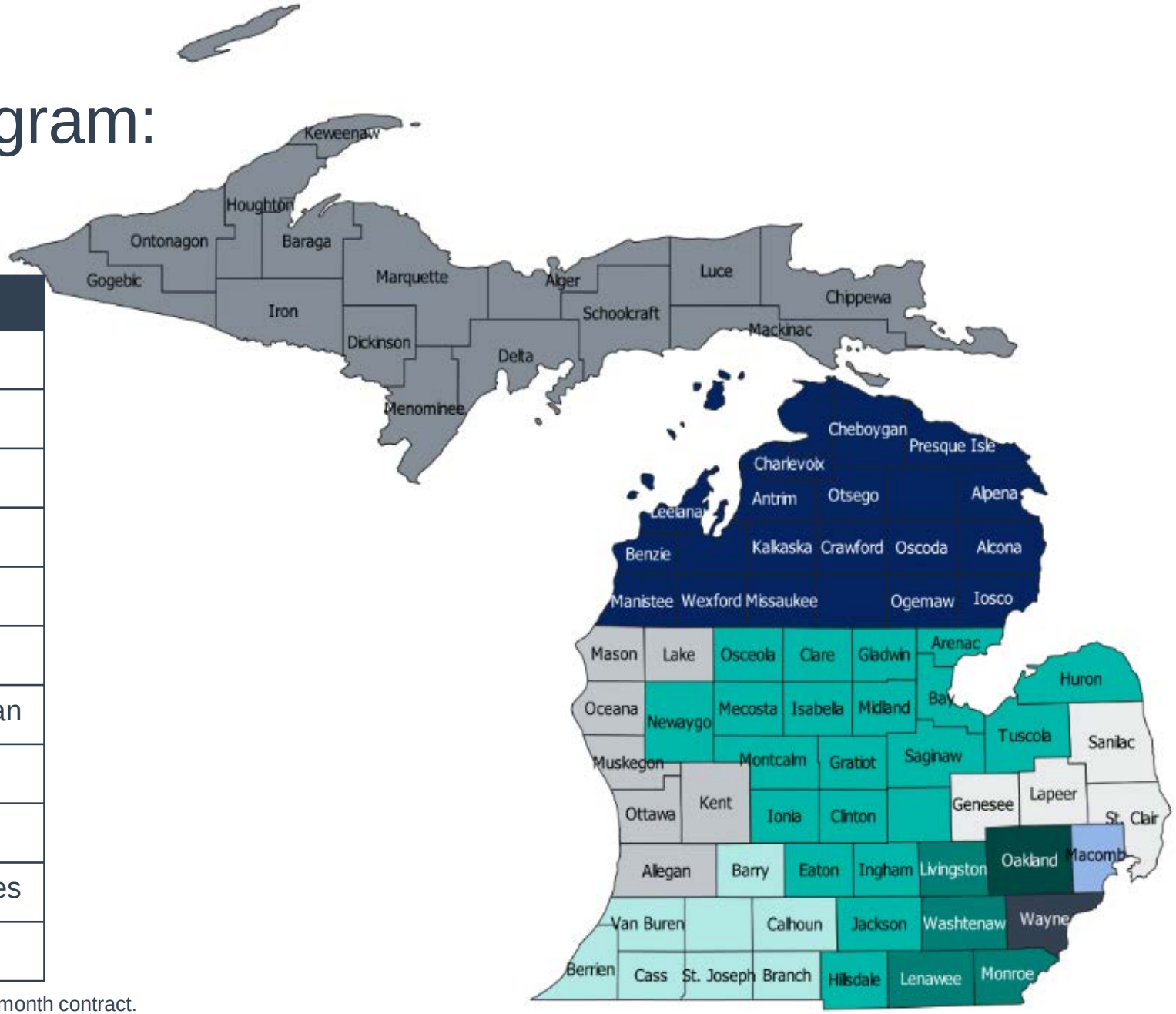
D.2. Medicaid FFS Program: Behavioral Health Benefits

- Michigan delivers addiction treatment and specialty mental health services to the FFS population through prepaid inpatient health plans (PIHPs).
- Community Mental Health Services Programs (CMHSPs), which are operated at the county or joint county level, are the building blocks of the Medicaid behavioral health service delivery system.
- Large CMHSPs—generally those serving more than 20,000 Medicaid enrollees—and regional affiliations of smaller CMHSPs operate as PIHPs and receive capitated payments for addiction treatment services and specialty mental health services.
  - A chart listing the PIHPs, their component CMHSPs, and their service areas can be found in section G.4.
- PIHPs contract with CMHSPs and other provider organizations to deliver addiction treatment services and specialty mental health services.
- Individuals receive mental health services through the FFS system if they demonstrate:
  - Mild to moderate psychiatric symptoms, or signs of sufficient intensity to cause subjective distress or mildly disordered behavior
  - Minor or temporary functional limitations or impairments
  - Minimal clinical instability
- If enrollees demonstrate more severe symptoms, they receive specialty behavioral health services through the local PIHP, and do not have a choice of plan.

D.2. Medicaid FFS Program: PIHP Regions

Prepaid Inpatient Health Plan Regions		
	Region	**PIHP**
	1	NorthCare Network
	2	Northern Michigan Regional Entity
	3	Lakeshore Regional Entity*
	4	Southwest Michigan Behavioral Health
	5	Mid-State Health Network
	6	CMH Partnership of Southeast Michigan
	7	Detroit Wayne Mental Health Authority
	8	Oakland Community Health Network
	9	Macomb County Mental Health Services
	10	Region 10

*Due to budgetary issues, Lakeshore Regional Entity is currently on a month-to-month contract.



D.2. Medicaid FFS Program: Behavioral Health Benefits

Benefits Provided Through The FFS System
1. Mental health outpatient visits 2. Psychotropic and addiction disorder treatment and drugs 3. Acute medical detoxification services 4. Behavioral Health Targeted Case Management 5. Community Support Services for individuals with SEM, SMI, or I/DD 6. Peer-Delivered or Peer-Operated Support Services 7. Psychiatric Diagnostic Evaluation services for beneficiaries under 21

State Plan Benefits Provided By The PIHP
1. Inpatient hospital psychiatric services 2. Outpatient partial hospitalization psychiatric care 3. Intensive outpatient counseling 4. Assertive community treatment 5. Clubhouse model programs 6. Crisis residential services 7. Intensive crisis stabilization services 8. Individual, group, and family therapy 9. Crisis intervention 10. Outpatient addiction treatment services 11. Pharmacological supports 12. Inpatient and residential addiction disorder treatment services* 13. Targeted case management

*Coverage of residential treatment in an institution of mental disease (IMD) is allowed via a 1115 demonstration.

1915 (b3) Waiver Services Provided By The PIHP**
1. Assistive technology 2. Community living services 3. Enhanced pharmacy 4. Environmental modifications 5. Family support and training 6. Housing assistance 7. Peer support services 8. Respite care services 9. Skill building assistance 10. Support and service coordination 11. Supported/integrated employment services 12. Fiscal intermediary services 13. Wrap-around services for children with SED 14. Treatment planning

**Additional services available through 1915 (b) waiver savings

D.2. Medicaid FFS Program: SMI Population

- Michigan does not specifically preclude individuals with SMI from enrolling in managed care based on a diagnosis of SMI. As a result, the majority of the SMI population is enrolled in managed care.
- As of March 2023, *OPEN MINDS* estimates that 19% of the SMI population was enrolled in FFS.
- Individuals with SMI are eligible to receive specialty mental health services through their regional PIHP.

D.2. Medicaid FFS Program: Pharmacy Benefit

Michigan FFS Program Pharmacy Benefit & Utilization Restrictions	
State Uses Pharmacy Benefit Manager	Magellan
Responsible For Financing General Pharmacy Benefit	Medicaid FFS
Responsible For Financing Mental Health Pharmacy Benefit	Medicaid FFS
State Uses A Preferred Drug List (PDL) For General Pharmacy	Yes, the Michigan Pharmaceutical Product List (MPPL). The state has moved to a merged PDL between FFS and Managed Care.
State Uses A PDL For Mental Health Drugs	Yes, anticonvulsants, antidepressants, antipsychotics, and antixylotics are included on the general pharmacy PDL
State Uses A PDL For Addiction Treatment Drugs	Yes, included on the general pharmacy PDL.
Coverage Of Antipsychotic Injectable Medications	Antipsychotic injectable medications are covered on the general pharmacy PDL.
Utilization Restrictions For Mental Health Or Addiction Treatment Drugs	• Although antipsychotics are included on the PDL all antipsychotics are preferred. • Quantity limits, safety, and clinical edits apply to other mental health drugs. • On May 1, 2019, the state began to allow an initial 14-day prescription for medication assisted treatment (MAT) without prior authorization. All MAT drugs require clinical prior authorization.
State Has A Pharmacy Lock-In Program Or Other Restriction Program	Yes, individuals are enrolled in the Beneficiary Monitoring Program (BMP) if they mis-utilize emergency room, pharmacy, or physician services. Under the program, beneficiaries may be restricted to one provider organization, clinical professional, or pharmacy. They may also be restricted from refilling medications until 95% of the medication is consumed in accordance with the prescribed instructions. Placement is for a minimum of 24 months.

D.3. Medicaid Managed Care Program: Overview

- Managed care enrollment as of February March 2023 was 2,300,648.
- **Comprehensive Health Care Program (CHCP):** Michigan's managed care program for children, parents/caretakers, and the aged, blind, and disabled population.
  - CHCP enrollment as of March 2023 was 1,223,694.
  - Ten health plans are fully at-risk for providing physical health benefits.
  - Individuals have the choice of the health plans available in their region.
- **Healthy Michigan Plan (HMP):** Michigan's alternative Medicaid expansion plan for adults between the ages of 19 and 64 who have income less than 138% of the FPL.
  - HMP enrollment as of March 2023 was 1,076,954.
  - Individuals are enrolled in the 10 health plans available in the CHCP.
  - Individuals have the choice of the health plans available in their region.
- The health plans are required to increase the number of value-based arrangements they have with provider organizations each year. The state has not set a threshold for the amount or number of payments that must be in these arrangements.

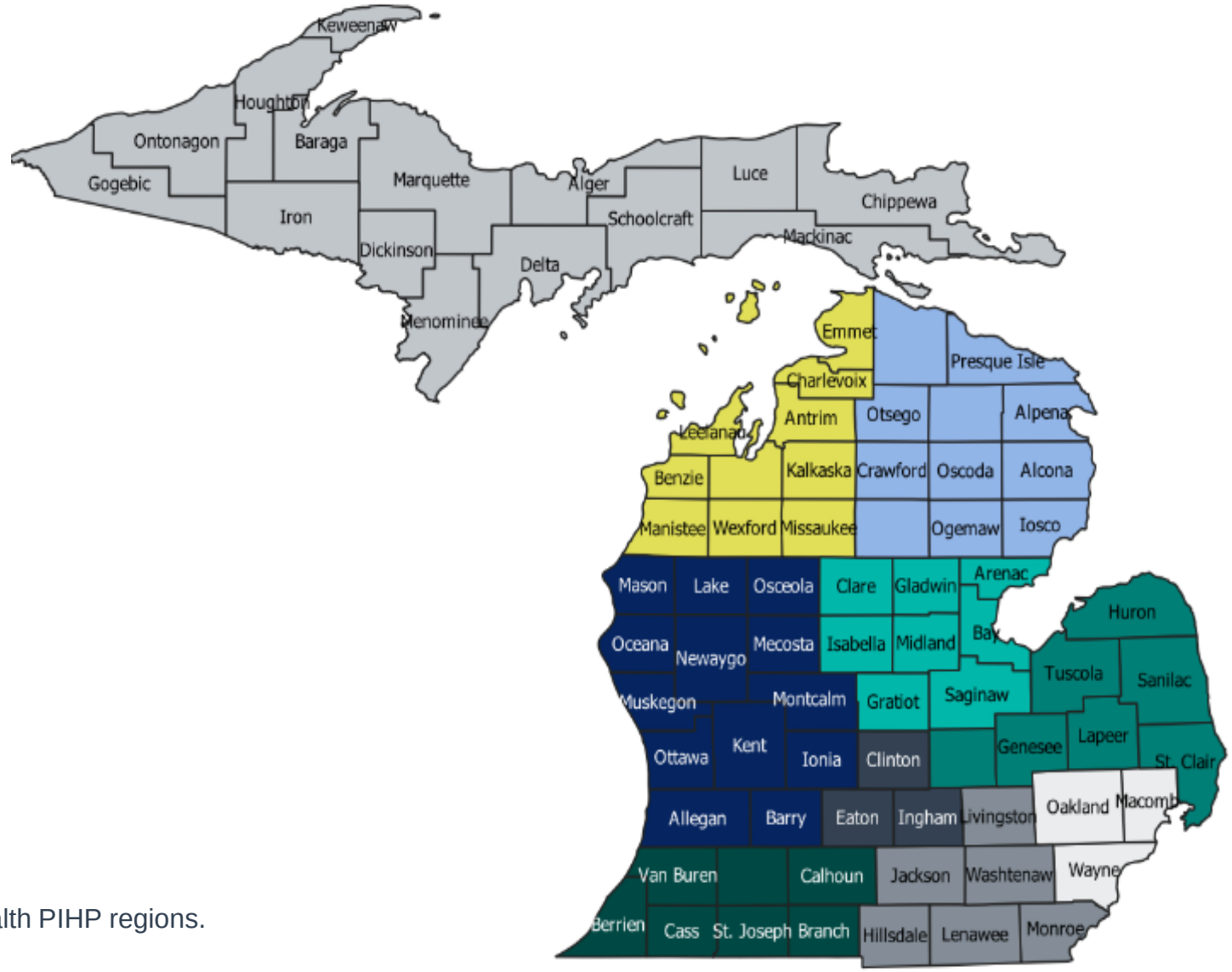
D.3. Medicaid Managed Care Program: Healthy Michigan Plan

- The Healthy Michigan Plan (HMP) is Michigan's alternative Medicaid expansion plan for adults between the ages of 19 and 64 who have an income less than 133% of the FPL.
- HMP is authorized through a section 1115 demonstration waiver, which was renewed for four years in December 2018. The renewal included amendments to add cost-sharing and adds work requirements. These amendments went into effect in January 2020.
  - In March 2020, the work requirements were ruled unlawful and are no longer enforced.
- All HMP enrollees must pay copayments that are not collected at the time of service, but rather are totaled by the state and billed quarterly based on the prior six months of utilization. Enrollees pay these totaled copayments over a three-month period. Contributions are not required during the first six months of enrollment.
  - Individuals with incomes over 100% of the FPL are required to make a monthly contribution—not to exceed 2% of their income—into a MI Health Account. After the health plans pay for a certain amount of services, varying by individual, the health plan can access money in the account to pay for services.
  - All HMP beneficiaries can reduce their copayments and contributions by completing healthy behaviors.
  - Coverage is not denied if individuals do not make payments.

D.3. Medicaid Managed Care Program: Health Plan Regions

Medicaid Managed Care Health Plan Regions

- Region 1
- Region 2
- Region 3
- Region 4
- Region 5
- Region 6
- Region 7
- Region 8
- Region 9
- Region 10



Note, the managed care regions do not align with behavioral health PIHP regions.

D.3. Medicaid Managed Care Program: Health Plans By Region

Region	Counties	Managed Care Organizations
1	Alger, Baraga, Chippewa, Delta, Dickinson, Gogebic, Houghton, Iron, Keweenaw, Luce, Mackinac, Marquette, Menominee, Ontonagon, Schoolcraft	Upper Peninsula Health Plan
2	Antrim, Benzie, Charlevoix, Emmet, Grand Traverse, Kalkaska, Leelanau, Manistee, Missaukee, Wexford	McLaren Health Plan, Meridian Health Plan of Michigan, Molina Healthcare of Michigan, UnitedHealthcare Community Plan
3	Alcona, Alpena, Cheboygan, Crawford, Iosco, Montmorency, Ogemaw, Oscoda, Otsego, Presque Isle, Roscommon	McLaren Health Plan, Meridian Health Plan of Michigan, Molina Healthcare of Michigan, UnitedHealthcare Community Plan
4	Allegan, Barry, Ionia, Kent, Lake, Mason, Mecosta, Montcalm, Muskegon, Newaygo, Oceana, Osceola, Ottawa	Blue Cross Complete of Michigan, McLaren Health Plan, Meridian Health Plan of Michigan, Molina Healthcare of Michigan, Priority Health Choice, UnitedHealthcare Community Plan
5	Arenac, Bay, Clare, Gladwin, Gratiot, Isabella, Midland, Saginaw	McLaren Health Plan, Meridian Health Plan of Michigan, Molina Healthcare of Michigan, UnitedHealthcare Community Plan
6	Genesee, Huron, Lapeer, Sanilac, Shiawassee, St. Clair, Tuscola	Blue Cross Complete of Michigan, HAP Empowered Health Plan, McLaren Health Plan, Meridian Health Plan of Michigan, Molina Healthcare of Michigan, UnitedHealthcare Community Plan
7	Clinton, Eaton, Ingham	Blue Cross Complete of Michigan, McLaren Health Plan, Meridian Health Plan of Michigan, Molina Healthcare of Michigan

D.3. Medicaid Managed Care Program: Health Plans By Region

Region	Counties	Managed Care Organizations
8	Berrien, Branch, Calhoun, Cass, Kalamazoo, St. Joseph, Van Buren	Aetna Better Health of Michigan, McLaren Health Plan, Meridian Health Plan of Michigan, Molina Healthcare of Michigan, Priority Health Choice, UnitedHealthcare Community Plan
9	Hillsdale, Jackson, Lenawee, Livingston, Monroe, Washtenaw	Aetna Better Health of Michigan, Blue Cross Complete of Michigan, McLaren Health Plan, Meridian Health Plan of Michigan, Molina Healthcare of Michigan, UnitedHealthcare Community Plan
10	Macomb, Oakland, Wayne	Aetna Better Health of Michigan, Blue Cross Complete of Michigan, HAP Empowered Health Plan, McLaren Health Plan, Meridian Health Plan of Michigan, Molina Healthcare of Michigan, Total Health Care, UnitedHealthcare Community Plan

D.3. Medicaid Managed Care Program: Health Plan Characteristics

Aetna Better Health

1. Profit status: For-profit
2. Parent company: Aetna/ CVS
3. Behavioral health subcontractor: Aetna Behavioral
4. Pharmacy benefits manager: CVS Caremark
5. Region: 8, 9, 10
6. Enrollment share: 3%

Blue Cross Complete of Michigan

1. Profit status: Non-profit
2. Parent company: None
3. Behavioral health subcontractor: New Directions
4. Pharmacy benefits manager: None
5. Region: 4, 6, 7, 9,10
6. Enrollment share: 14%

HAP Empowered Health Plan

1. Profit status: For-profit
2. Parent company: Health Alliance
3. Behavioral health subcontractor: None
4. Pharmacy benefits manager: Express Scripts
5. Region: 6,10
6. Enrollment share: 1%

McLaren Health Plan

1. Profit status: Non-profit
2. Parent company: None
3. Behavioral health subcontractor: None
4. Pharmacy benefits manager: MedImpact
5. Region: 2-10
6. Enrollment share: 12%

Meridian Health Plan of Michigan, Inc.

1. Profit status: For-profit
2. Parent company: Centene-WellCare Health Plans*
3. Behavioral health subcontractor: None
4. Pharmacy benefits manager: Meridian RX
5. Region: 2-10
6. Enrollment share: 25%

Molina Healthcare of Michigan

1. Profit status: For-profit
2. Parent company: Molina Healthcare
3. Behavioral health subcontractor: None
4. Pharmacy benefits manager: CVS Caremark
5. Region: 2-10
6. Enrollment share: 18%

D.3. Medicaid Managed Care Program: Health Plan Characteristics

Priority Health Choice

1. Profit status: Non-profit
2. Parent company: None
3. Behavioral health subcontractor: None
4. Pharmacy benefits manager: Express Scripts, Inc.
5. Region: 4, 8
6. Enrollment share: 13%

UnitedHealthcare Community Plan

1. Profit status: For-profit
2. Parent company: UnitedHealth
3. Behavioral health subcontractor: Optum
4. Pharmacy benefits manager: OptumRx
5. Region: 2-6, 8-10
6. Enrollment share: 13%

Upper Peninsula Health Plan

1. Profit status: For-profit
2. Parent company: None
3. Behavioral health subcontractor: None
4. Pharmacy benefits manager: Magellan RX
5. Region: 1
6. Enrollment share: 2%

D.3. Medicaid Managed Care Program: Behavioral Health Overview

- Health plans are responsible for providing outpatient mental health visits and psychiatric screening and stabilization in the emergency room for individuals not subsequently admitted.
- Acute medical detoxification services are provided FFS by the state.
- Prepaid inpatient health plans (PIHPs) provide all other addiction treatment and specialty mental health services.
- Health plans must coordinate with appropriate PIHPs to ensure specialty mental health services are provided.
- Psychotropic and addiction treatment drugs are provided FFS by the state. All other drugs are included in the health plan’s capitation rate.

D.3. Medicaid Managed Care Program: Behavioral Health Overview

- These guidelines are designed to assist health plans and PIHPs in determining who is responsible for benefits. Health plans and PIHPs are expected to make critical clinical decision-making processes based on the written local agreement, common sense, and the best treatment path for the beneficiary.

Health Plan's General Area Of Responsibility For Outpatient Mental Health Services
1. Beneficiaries experiencing or demonstrating mild or moderate psychiatric symptoms, or signs of sufficient intensity to cause subjective distress or mildly disordered behavior, with minor or temporary functional limitations and minimal clinical instability.
2. Beneficiaries whose functional disabilities related to a past serious mental illness have substantially subsided if there has been no serious exacerbation of the condition within the past 12 months.
3. Beneficiaries who retain signs and symptoms of previous serious mental illness, and currently need ongoing routine medication management without further specialized services and supports.

PIHP's General Area Of Responsibility For Outpatient Mental Health Services
1. Beneficiaries who currently have—or have had—a serious mental illness within the past 12 months.
2. Beneficiaries who had a serious mental illness longer than 12 months ago and who require specialized services to address clinically significant residual symptoms and impairments—or to prevent relapse.

D.3. Medicaid Managed Care Program: Behavioral Health Benefits

Benefits Provided By The Health Plans
1. Outpatient mental health visits
2. Psychiatric screening and stabilization in the emergency room for patients not subsequently admitted

Benefits Provided FFS By The State
1. Psychotropic and addiction treatment drugs
2. Acute medical detoxification services

State Plan Benefits Provided By The PIHPs
1. Inpatient hospital psychiatric services
2. Outpatient partial hospitalization psychiatric care
3. Intensive outpatient counseling
4. Assertive community treatment
5. Clubhouse model programs
6. Crisis residential services
7. Intensive crisis stabilization services
8. Individual, group, and family therapy
9. Crisis intervention
10. Outpatient addiction treatment services
11. Pharmacological supports
12. Addiction disorder treatment services*
13. Targeted case management
14. Sub-acute detoxification

*Coverage of residential treatment in an institution of mental disease (IMD) is allowed via a 1115 demonstration.

1915 (b3) Waiver Services Provided By The PIHPs**
1. Assistive technology
2. Community living supports
3. Non-prescription pharmacy
4. Environmental modifications
5. Family support and training
6. Housing assistance
7. Peer supports
8. Respite care services
9. Skill building assistance
10. Support and service coordination
11. Supported/Integrated employment
12. Fiscal intermediary services
13. Wraparound services for children and adolescents

**Additional services available through 1915 (b) waiver savings

D.3. Medicaid Managed Care Program: SMI Population

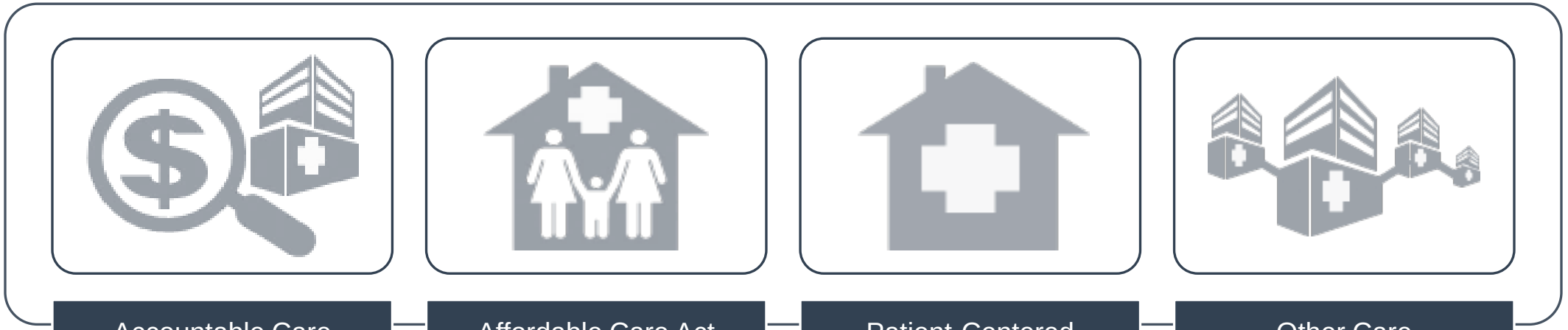
- Michigan does not specifically preclude individuals with SMI from enrolling in managed care based on a diagnosis of SMI. As a result, the majority of the SMI population is enrolled in managed care.
- As of March 2023, *OPEN MINDS* estimates that 81% of the SMI population was enrolled in managed care.
- Individuals with SMI are eligible to receive specialty mental health services through the PIHPs.
- Medicaid expansion population, if medically frail, must be offered the full array of state plan benefits. Medically frail individuals include adults with serious mental illness and chronic addiction disorders.

D.3. Medicaid Managed Care Program: Pharmacy Benefit

- The state has gone through with plans for a single, unified PDL for both managed care and FFS

Michigan Managed Care Program Pharmacy Benefit	
Responsible For Financing General Pharmacy Benefit	Included in the health plan's capitation rate.
Responsible For Financing Mental Health Pharmacy Benefit	Mental health drugs and most addiction treatment drugs are excluded from the health plan's capitation rate and covered FFS by the state.
Health Plan Uses A Preferred Drug List (PDL) For General Pharmacy	Managed care plans are required to use the new merged PDL.
Health Plan Uses A PDL For Mental Health Drugs	Yes, the state includes anticonvulsants, antidepressants, antipsychotics, and antixylotics are included on its FFS PDL, the Michigan Pharmaceutical Product List (MPPL).
Health Plan Uses A PDL For Addiction Treatment Drugs	Yes, included on the State FFS PDL, MPPL.
Health Plan Use Of Utilization Restrictions For Mental Health & Addiction Treatment Drugs	• Although antipsychotics are included on the PDL all antipsychotics are preferred. • Quantity limits, safety, and clinical edits apply to other mental health drugs. • On May 1, 2019, the state began to allow an initial 14-day prescription for medication assisted treatment (MAT) without prior authorization. All MAT drugs require clinical prior authorization.
Health Plan Allowed To Implement Pharmacy Lock-In Program	The health plan contract does not contain information related to the development of a pharmacy lock-in program.

D.4. Medicaid Program: Care Coordination Initiatives



Accountable Care Organization (ACO) Program	Affordable Care Act Health Home	Patient-Centered Medical Home	Other Care Coordination Initiative
None	Michigan has three health home programs for individuals with: 1. Chronic and behavioral health conditions – MI Care Team 2. Serious and persistent mental illness 3. Opioid use disorder	None	None

D.4. State Medicaid Health Home Characteristics

Chronic Care Management For Individuals With Serious & Persistent Mental Health Conditions Health Home Overview	
Target Population	Individuals with one or more serious and persistent mental health condition
Enrollment Model	Automatic assignment based on claims data with opt-out
Geographic Service Area	Thirty-Eight counties: Alcona, Alger, Alpena, Antrim, Baraga, Benzie, Charlevoix, Cheboygan, Chippewa, Crawford, Delta, Dickinson, Emmet, Gogebic, Grand Traverse, Houghton, Iosco, Iron, Kalkaska, Keweenaw, Leelanau, Luce, Mackinac, Manistee, Marquette, Menominee, Missaukee, Montmorency, Oakland, Ogemaw, Ontonagon, Oscoda, Ostego, Presque Isle, Roscommon, Schoolcraft, and Wexford.
Care Delivery Model	• Community Mental Health Service Programs (CMHSPs) serve as health homes • Delivery of six core health home services • Michigan's Integrated Care Analytics Program will allow access to claims and encounter data to support care coordination. • The PIHPs and health plans must establish coordination agreements to assure continuity of care for health homes enrollees.
Payment Model	• PIHPs contract with CMHSPs for delivery of health home services • Monthly case rate of $137.19 for at least one health home encounter paid by the state to the CMHSP
Practice Performance & Improvement	• Acute inpatient care and services rate • Skilled nursing facility admission rate, emergency department visit rate, and 30-day readmission rate • Care cost of enrolled cohort compared to non-enrolled cohort

D.4. State Medicaid Health Home Characteristics

MI Care Team Overview- Health Homes For Individuals With Chronic & Behavioral Health Conditions	
Target Population	• Individuals diagnosed with anxiety or depression and at least one of the following chronic conditions: asthma, diabetes, heart disease, anxiety, chronic obstructive pulmonary disease (COPD), depression, or hypertension.
Enrollment Model	Opt-in enrollment with potential enrollees identified through claims data or provider referral
Geographic Service Area	Thirty-Eight counties: Alcona, Alger, Alpena, Antrim, Baraga, Benzie, Charlevoix, Cheboygan, Chippewa, Crawford, Delta, Dickinson, Emmet, Gogebic, Grand Traverse, Houghton, Iosco, Iron, Kalkaska, Keweenaw, Leelanau, Luce, Mackinac, Manistee, Marquette, Menominee, Missaukee, Montmorency, Oakland, Ogemaw, Ontonagon, Oscoda, Ostego, Presque Isle, Roscommon, Schoolcraft, and Wexford.
Care Delivery Model	• Federally qualified health centers (FQHCs) and Tribal Health Centers (THCs) act as health homes and are responsible for the provision of all health home services. • Each enrollee will have an individual plan of care, and access to an interdisciplinary care team. • Each health home must have onsite at least a primary care provider, a behavioral health consultant, a nurse care manager, a community health worker, and a health homes coordinator. Additionally, the health home must have access to a psychologist or psychiatrist.
Payment Model	• Assessment and health action plan rate per member for the first month: $148.05 • Ongoing care coordination monthly rate thereafter for contacting the beneficiary, and providing at least one core health home service during the month: $59.50
Practice Performance & Improvement	• Health homes must receive patient-centered medical home (PCMH) recognition from a national accrediting body • Hospital, ER, and Skilled Nursing Facility (SNF) admission rate, 30-day readmission rate • Screening for clinical depression, follow-up after mental illness hospitalization, initiation and engagement of addiction disorder treatment, care transition record transmission, chronic conditions composite indicator, hypertension control, body mass index (BMI) assessment, initiation and engagement of alcohol and/or other drug dependency treatment

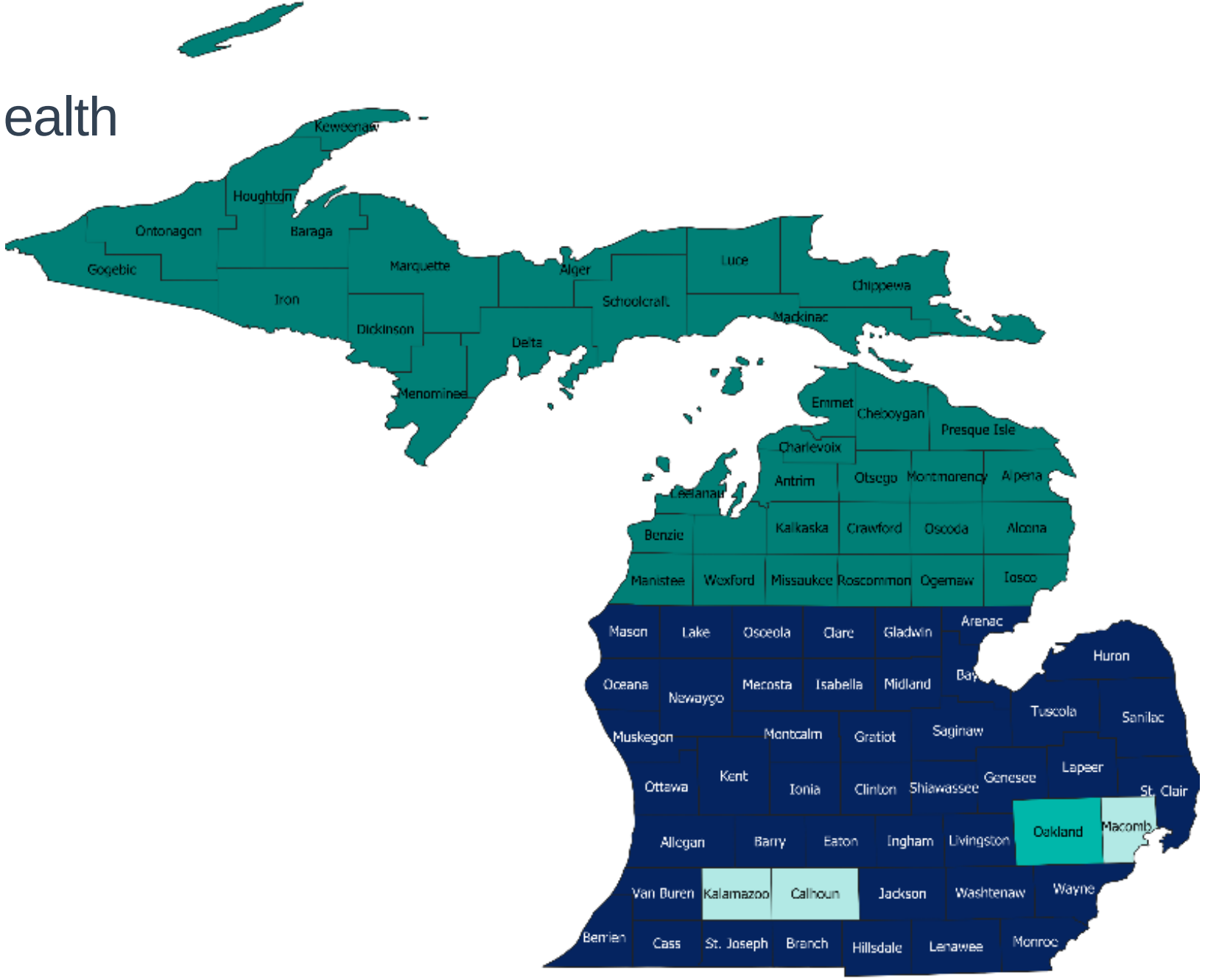
D.4. State Medicaid Health Home Characteristics

Opioid Health Home Overview	
Target Population	• Individuals with an opioid use disorder and have—or are at-risk of developing—another chronic condition
Enrollment Model	• Opt-out enrollment for individuals enrolled in medication assisted treatment (MAT); however, individual must consent to share health information and verify their diagnosis • Opt-in enrollment for individuals not enrolled in MAT
Geographic Service Area	Available in 40 counties: Alcona, Alger, Alpena, Antrim, Baraga, Benzie, Calhoun, Charlevoix, Cheboygan, Chippewa, Crawford, Delta, Dickinson, Emmet, Gogebic, Grand Traverse, Houghton, Iosco, Iron, Kalamazoo, Kalkaska, Keweenaw, Leelanau, Luce, Mackinac, Manistee, Marquette, Menominee, Missaukee, Montmorency, Ogemaw, Oscoda, Otsego, Presque Isle, Roscommon, Schoolfcraft, Wexford
Care Delivery Model	• PIHPs act as the lead entity, and are responsible for enrollment, high level care coordination, and paying the health home provider organizations • Office-based Opioid Treatment (OBOT) and opioid treatment programs (OTP) provide the health home services • Delivery of six health home core services
Payment Model	• PMPM: $364.48 • PMPM with P4P: $383.66
Practice Performance & Improvement	• Performance measures: Initiation and engagement of alcohol and other drug dependence treatment (50% of withhold), reduction in opioid-related hospitalizations per 100,000 (30% of withhold), and increase in peer recovery coach utilization (20% of withhold) • Analysis of health home costs and health home quality measures

D.4. State Medicaid Health Home Counties

Health Home Counties

- Opioid Health Home counties
- Behavioral Health Home counties
- Both Health Homes
- Counties not included in health homes programs



D.5. Medicaid Program: Demonstration & Care Management Waivers

Waiver Title	Waiver Description	Waiver Type	Effective Date	Expiration Date
Healthy Michigan	Authorizes alternative Medicaid expansion program that tests cost-sharing and work requirements for newly eligible adult population with incomes above 100% of the federal poverty level, including copayments, premiums, and healthy behavior incentives.	1115	01/01/2010	12/31/2023
Flint Michigan Section 1115 Demonstration	Authorizes Michigan to expand Medicaid to all pregnant women and children up to age 21 with incomes up to—and including—400% of the federal poverty level who are currently served by the Flint water system or were served by the Flint water system after April 2014.	1115	03/03/2016	09/30/2026
Michigan 1115 Behavioral Health Demonstration (formerly Pathways to Integration)	Authorizes Michigan to expand services available to consumers with SMI, SED, and addiction disorders.	1115	10/01/2019	09/30/2024
MI HealthLink (MI-19)	Coordinates supports and services for individuals who are dually eligible for both Medicare and Medicaid programs and reside in any one of the four demonstration regions.	1915 (b)	01/01/2023	12/31/2024
Michigan Comprehensive Health Care Program	Authorizes the state's managed care program for children, parents/ caretaker relatives, and the aged, blind, and disabled population.	1915 (b)	05/30/1997	12/31/2023
MI Choice	Authorizes the state's designated waiver agencies to provide managed long-term services and supports to individuals enrolled in the MI Choice Waiver.	1915 (b)	10/01/2018	09/30/2023
Healthy Kids Dental Waiver (MI-15)	Across the state of Michigan, Healthy Kids Dental is available to children who have Medicaid and are under the age of 21.	1915 (b)	01/01/2023	12/31/2024

D.5. Medicaid Program: Section 1915 (c) HCBS Waivers

Waiver Title	Target Population	2023 Enrollment Cap	Operating Unit	Concurrent Management Authority
MI Choice Waiver (0233.R05.00)	Individuals who are physically disabled ages 18 to 64, and individuals ages 65+	12,800	Michigan Department of Health and Human Services (MDHHS), Medical Services Administration	Yes, operates concurrently with the MI Choice 1915 (b) waiver
MI Habilitation Supports Waiver (0167.R05.00)	Individuals any age with developmental disabilities	8,268	MDHHS, Behavioral Health and Development Disabilities Administration and Medical Service Administration	Yes, operates concurrently with the 1915 (b) Managed Specialty Services and Supports Program waiver and Healthy Michigan 1115 demonstration waivers
MI Health Link HCBS Waiver (1126.R00.00)	Individuals who are physically disabled ages 21 to 64, and individuals ages 65+	5,388	MDHHS, Medical Services Administration	Yes, operates concurrently with the MI Health Link 1915 (b) waiver
MI Waiver for Children with Serious Emotional Disturbances (0438.R02.00)	Individuals with serious emotional disturbances ages 0 to 21	969	MDHHS, Medical Services Administration	Yes, operates concurrently with the Children with Serious Emotional Disturbances 1915 (b) waiver
MI Children's Waiver Program (4119.R05.00)	Individuals with autism ages 0 to 17, and individuals with I/DD ages 0 to 17	569	MDHHS, Behavioral Health and Development Disabilities Administration and Medical Service Administration	Yes, operates concurrently with the Children's Waiver Program 1915 (b) waiver

D.6. Medicaid Program New Initiatives: MLTSS

- Michigan currently operates a number of MLTSS programs.
  - Limited benefit capitated health plans currently provide managed HCBS to MI Choice and MI Habilitation Supports waiver participants.
  - The state's PACE plan and dual demonstration, Health Link, provide MLTSS through integrated at-risk health plans.
  - Approximately 17% of individuals enrolled in MLTSS receive these services through a capitated arrangement.
- In a review of the MI Health Link program, the Center for Health and Research Transformation recommends an overall timeline of five years as a starting point to guide MDHHS' next steps for global LTSS improvements and MLTSS planning with the recommendation for an extension.
  - The first stage, the MLTSS design/implement global opportunities for improvement, began January 2019 and ended April 2021. MDHHS are focusing on counseling planning, design, and implementation of comprehensive assessments and quality measurements.
  - The second stage, the MLTSS planning and design, starts June 2021 and extends to December 2022. During this time, MDHHS should focus on quality measurement strategies, person-centered planning, and integrated care management systems, standards, and processes.
  - The last stage, MLTSS readiness and program development, starts December 2022 and will end December 2023 with the new MLTSS program initiatives. MDHSS should continue to engage stakeholders, obtain budgetary and legislative approval, select contractors, inform provider organizations and consumers, phase-in operational resources, and conduct readiness reviews.

D.6. Medicaid Program New Initiatives: Prepaid Inpatient Health Plans

- Approximately 297,000 Medicaid beneficiaries received specialty behavioral health services through one of the Department's 10 contracted Prepaid Inpatient Health Plans (PIHPs) in FY22.
- The PIHPs are required to contract with the Community Mental Health Services Programs (CMHSPs) in their region.
  - Wayne, Oakland and Macomb County CMHSPs are both the PIHP and the CMHSP.
- The CMHSPs provide the Medicaid services and/or contract with other providers for the delivery of services.
- Contrary to the full-risk capitated managed care arrangement with the Medicaid Health Plans, the PIHPs have a shared-risk arrangement with the State.

D.6. Medicaid Program New Initiatives: Timeline

2021
- June: Second phase of MLTSS was planned to begin.

2022
- December: Third phase of MLTSS is planned to begin.

2024
- December: MI Health Link currently scheduled to expire.

Pending
- Implementation of the demonstration model for service level integration of behavioral health and physical health services

E. Dual Eligible Financing & Service Delivery System

E.1. Dual Eligible Medicaid Financing & Service Delivery System

Dual Eligible* Medicaid System Characteristics				
	Fee-For-Service (FFS)	**Managed Care**	**Dual Demonstration – MI Health Link**	**PACE**
Enrollment (March 2023)	246,975		42,501	4,578
SMI Enrollment	79,032		13,600	1,464
Management	• Traditional physical and behavioral health services: MDHHS • Specialty behavioral health services: PIHPs	• Traditional physical and behavioral health services: 11 health plans • Specialty behavioral health services: PIHPs	• Traditional physical and behavioral health services: Seven health plans • Specialty behavioral health services: PIHPs	18 non-profit organizations
Payment Model	• Physical and behavioral health services: FFS • Specialty behavioral health services: Capitated rate	• Physical and behavioral health services: Capitated • Specialty behavioral health services: Capitated rate	• Physical and behavioral health services: Blended capitated rate • Specialty behavioral health services: Capitated rate	Blended capitated rate
Geographic Service Area	Statewide	Statewide; one health plan is responsible for the upper peninsula region, and the remaining ten health plans share coverage of the rest of the state.	Four regions comprising 25 counties	Certain ZIP codes

Total Dual Eligible Enrollment: 294,054 | Total Dual Eligible Enrollment With SMI: 94,097

*Unless otherwise noted, the term *dual eligibles* in this section refers to Medicare enrollees with full Medicaid benefits.

E.2. Largest Dual Eligible Health Plans By Estimated SMI Enrollment

Health Plans	Parent Company	Plan Type	March 2023 Enrollment	Estimated SMI Enrollment
Molina Medicare Complete Care	Molina Healthcare, Inc	Medicare Advantage D-SNP	14,602	4,673
HumanaChoice	Humana, Inc	Medicare Advantage D-SNP	13,039	4,172
WellCare Dual Access	Meridian Health Plan of Michigan, Inc	Medicare Advantage D-SNP	12,245	3,918
PriorityMedicare	Priority Health Choice, Inc	Medicare Advantage D-SNP	7,704	2,465
UnitedHealthcare Dual Complete Choice	UnitedHealthcare, Inc	Medicare Advantage D-SNP	7,069	2,262
Humana Gold Plus	Humana, Inc	Medicare Advantage D-SNP	6,996	2,239
WellCare Dual Access Open	Meridian Health Plan of Michigan, Inc	Medicare Advantage D-SNP	3,266	1,045
UnitedHealthcare Dual Complete	UnitedHealthcare, Inc	Medicare Advantage D-SNP	3,094	990
PACE Southeast Michigan	PACE Southeast Michigan	PACE	1,461	468
UnitedHealthcare Dual Complete Select	UnitedHealthcare, Inc	Medicare Advantage D-SNP	700	224

E.3. Dual Eligible Medicaid Financing & Delivery System: Overview

- Dual eligible enrollment as of March 2023 was 294,054.
- Medicare covers most acute services (which may include psychiatric care), while Medicaid, the payer of last resort, covers LTSS and non-physician behavioral health services.
- D-SNP enrollment as of March 2023 is 40,500, SMI enrollment for D-SNP is 22,652.
- Michigan gives full benefit dual eligibles the option to enroll in Medicaid managed care or the FFS system. In counties where the dual demonstration operates, dual eligibles are enrolled in FFS if they opt-out of the demonstration.
  - All dual eligibles receive specialty behavioral health services through the Prepaid Inpatient Health Plan (PIHPs).

E.4. Dual Eligible Medicaid Financing & Delivery System: New Initiatives

- Michigan's dual demonstration program, MI Health Link, began enrollment in March 2015.
- As of March 2023, there were 42,501 enrollees in the program.
- MI Health Link was scheduled to end in December 2018, but the state submitted an amendment to extend this program and the HCBS waiver to CMS and has extended the dual demonstration through December 2024.
- However due to federal regulations the state must convert the MI Health Link program to an "integrated" Dual Eligible Special Needs Plan by 2026. MDHHS is currently working on this transition.
- Currently, for dual eligible beneficiaries, the entire state operates with Dual Eligible special Needs Plans (D-SNPs). However, by 2026, Michigan will either transition to a fully integrated dual eligible special needs plan (FIDE SNP) or a highly integrated dual eligible special needs plan (HIDE SNP).
  - FIDE SNPs includes coverage of primary, acute, and long-term services and supports benefits. FIDE SNPs must also cover behavioral health benefits unless the state carves behavioral health out of the capitation rate.
  - HIDE SNPs includes coverage of long-term services and supports benefits or behavioral health.

E.4. Dual Eligible Medicaid Financing & Delivery System: New Initiatives

MI Health Link Dual Eligible Demonstration Overview	
Target Population	Full benefit dual eligibles, aged 21 and over, in the selected regions. Excludes: • Individuals who reside in a state psychiatric hospital • Individuals without full Medicaid or Medicare coverage • Individuals who have a special disenrollment waiver from managed care
Geographic Service Area	Four regions consisting of 25 counties.
Enrollment Model	• Individuals are passively enrolled with the ability to opt-out • Individuals enrolled in PACE, MI Choice Waiver, or Money Follows the Person may disenroll from these programs and opt-in to MI Health Link.

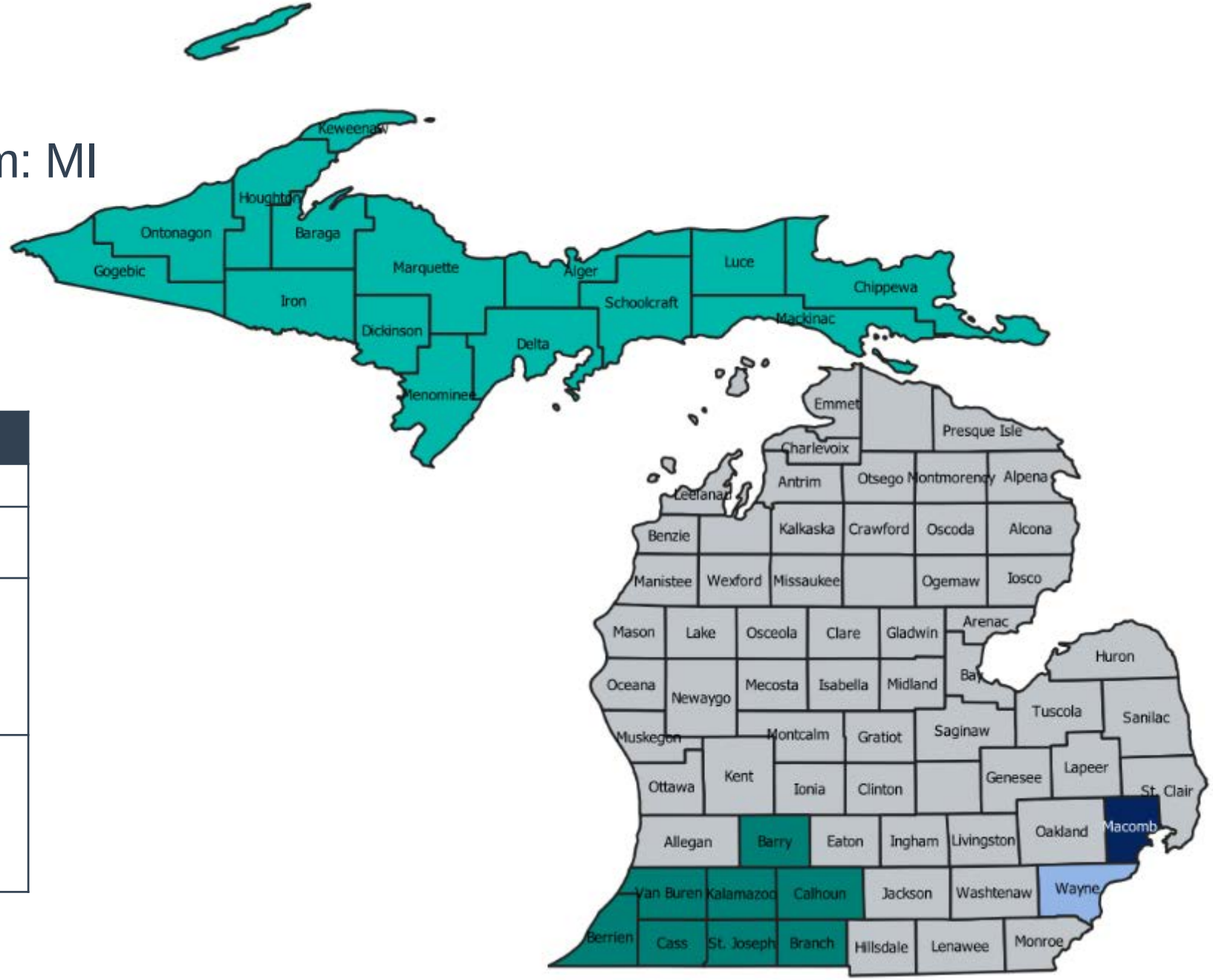
Care Delivery Model	• Care is delivered through Integrated Care Organizations (ICOs), which are similar to Medicaid health plans.
	• Prepaid inpatient health plans (PIHPs) deliver Medicaid specialty behavioral health services.
	• PIHPs are given the first opportunity to subcontract for Medicare behavioral health services and to provide care coordination to dual eligibles with intellectual/developmental disabilities (I/DD) or behavioral health issues.
	• Care Bridge: Care coordination framework for the demonstration.
	  • Person-centered care coordination team, led by an ICO care coordinator
	  • Facilitates access to services identified in the individual's integrated care and supports plan
	  • Establishes an integrated care bridge record, which shares consumer information across providers

E.4. Dual Eligible Medicaid Financing & Delivery System: New Initiatives

MI Health Link Dual Eligible Demonstration Overview	
Benefits	• Expanded long-term services and supports (LTSS) • All Medicare and Medicaid covered services
Payment Model	• Three capitated monthly payments per enrollee: Medicare Parts A/B and Part D by CMS and Medicaid by the state • The State contracts directly with PIHPs for delivery of Medicaid behavioral health services • ICOs must give the PIHPs the first opportunity to subcontract for Medicare behavioral health services • Quality withhold of 1% in year one (CY 2015-2016), 2% in year two (CY 2017), and 3% in the remaining years of the demonstration.
Practice Performance & Improvement	AHRQ, CMS, NCQA, HEDIS, CAHPS measures
Program Evaluation	CMS has released performance data on whether or not each health plan received the withhold amount in 2020. • Aetna, Amerihealth, HAP Empowered, Michigan Complete Health, Molina and Upper Peninsula Health Plan all reached 95% compliance. • Meridian reached 100% compliance.

E.4. Dual Eligible Medicaid Financing & Delivery System: MI Health Link Regions

Region		MI Health Link Plans
	Region 1	• Upper Peninsula Health Plan
	Region 4	• Aetna Better Health of Michigan • Meridian Health Plan
	Region 7	• Aetna Better Health of Michigan • Amerihealth • Michigan Complete Health • HAP Midwest Health Plan • Molina Healthcare
	Region 9	• Aetna Better Health of Michigan • Amerihealth • Michigan Complete Health • HAP Midwest Health Plan • Molina Healthcare



F. Long-Term Services & Supports Financing & Service Delivery System

F.1. LTSS Financing & Service Delivery System

LTSS* Medicaid System Characteristics	
Characteristics	**Medicaid Managed Care**
Enrollment (July 2022)	54,436
Estimated SMI Enrollment	17,419
Management	• Traditional physical and behavioral health services: Nine free standing programs with limited benefits. • Specialty behavioral health services: PIHPs
Payment Model	• Physical and behavioral health services: Blended capitated rate • Specialty behavioral health services: Capitated rate
Geographic Service Area	Four regions comprising 25 counties

* Long-Term Services & Supports

F.1. Medicaid LTSS Service Delivery System Enrollment By Eligibility Group

Population	Mandatory FFS Enrollment	Option To Enroll In FFS Or Managed Care	Mandatory Managed Care Enrollment*
Disabled adults			X
Disabled children			X
Blind individuals			X
Aged individuals			X
Dual eligibles		X*	
Individuals with I/DD			X
Individuals residing in nursing homes	X		
Individuals residing in ICF/IDD	X		
Other HCBS Recipients			X
Other populations	• Individuals receiving home- and community-based services • Individuals receiving emergency services only • Medicare premium payments only • Individuals in traumatic brain injury residential rehabilitation program • Individuals with commercial managed care coverage • Hospice • Emergency and inpatient services for incarcerated individuals	• Native Americans • Persons with migrant status	Pregnant women

*Dual eligibles in dual demonstration counties have the option to enroll in the dual demonstration or FFS. Those who live outside the dual demonstration counties have the option to enroll in Medicaid managed care or FFS.

F.2. LTSS Medicaid Financing & Delivery System: Overview

- Michigan provides long-term services and supports through the MI Choice/MI Habilitation Waiver and the Michigan Managed Specialty Support & Services Program (MSSP).
  - The MI Choice Waiver authorizes the state's designated waiver agencies to provide MLTSS for individuals ages 18 or older.
  - The MI Habilitation Supports waiver provides comprehensive long-term services and supports for individuals with developmental disabilities.
- In total, approximately 17% of the MLTSS population receive services through the MI Choice or Habilitation Supports waivers under limited benefit capitated health plans.
- As of July 2022, enrollment in MI Choice was 54,436
- Additionally, Michigan is currently exploring new initiatives to expand their MLTSS to cover more populations, focus on person-centered planning, and integrated care management systems. This is being completed over a three-stage process starting in January 2019 and ending by December 2023.

F.3. Medicaid LTSS Program: Health Plan Characteristics

Long-Term Services & Supports Health Plans
1. NorthCare Network
2. Northern Michigan Regional Entity
3. Beacon HealthOptions
4. Southwest Michigan Behavioral Health
5. Mid-State Health Network
6. CMH Partnership of Southeast Michigan
7. Detroit Wayne Mental Health Authority
8. Oakland Community Health Network
9. Malcomb County Mental Health Services

F.4. Medicaid LTSS Program: Health Benefits

Benefits Provided By The Health Plans
1. Outpatient mental health visits 2. Psychiatric screening and stabilization in the emergency room for patients not subsequently admitted

Benefits Provided FFS By The State
1. Psychotropic and addiction treatment drugs 2. Acute medical detoxification services

State Plan Benefits Provided By The PIHPs
1. Inpatient hospital psychiatric services 2. Outpatient partial hospitalization psychiatric care 3. Intensive outpatient counseling 4. Assertive community treatment 5. Clubhouse model programs 6. Crisis residential services 7. Intensive crisis stabilization services 8. Individual, group, and family therapy 9. Crisis intervention 10. Outpatient addiction treatment services 11. Pharmacological supports 12. Addiction disorder treatment services* 13. Targeted case management 14. Sub-acute detoxification

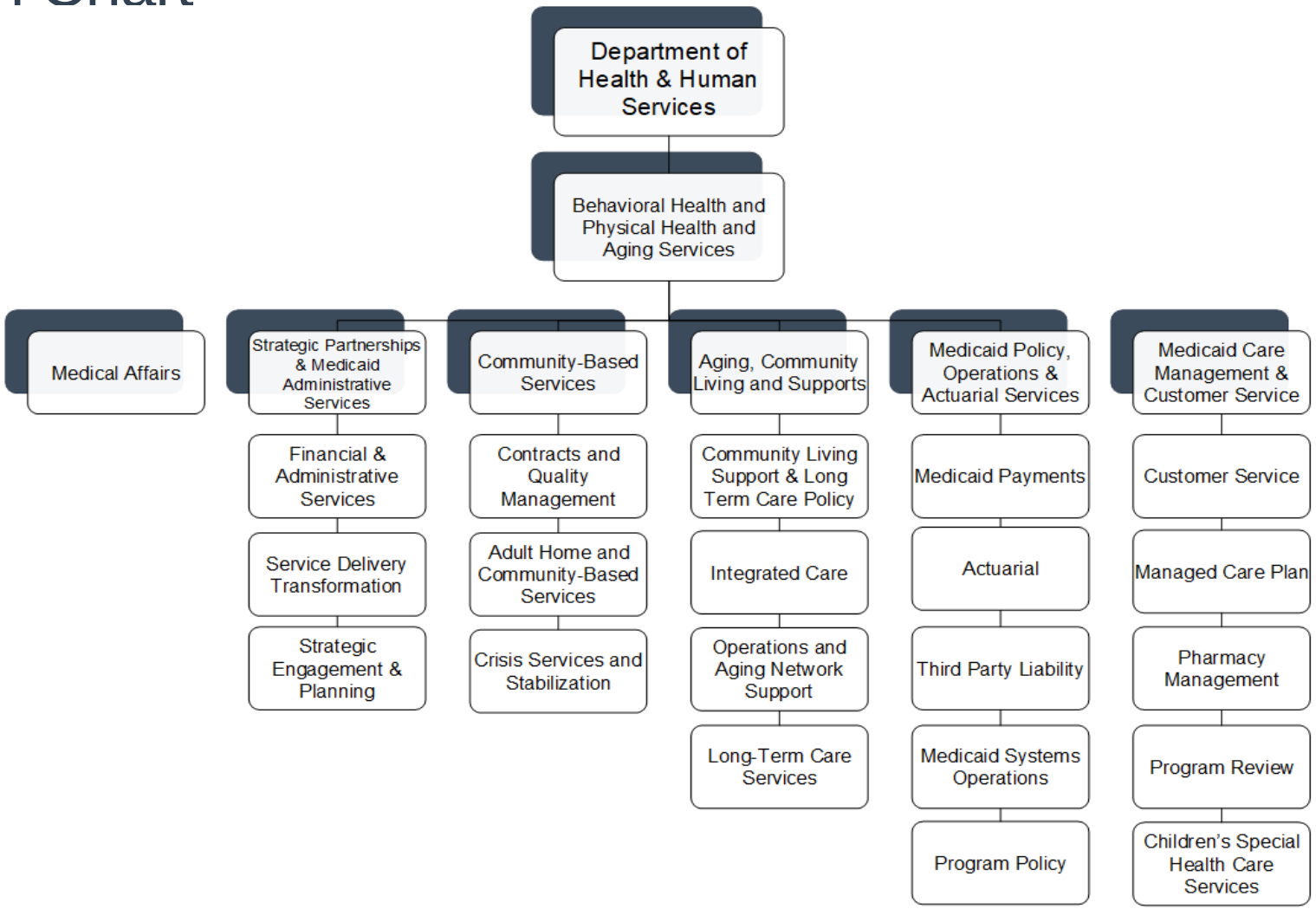
1915 (b3) Waiver Services Provided By The PIHPs**
1. Assistive technology 2. Community living supports 3. Non-prescription pharmacy 4. Environmental modifications 5. Family support and training 6. Housing assistance 7. Peer supports 8. Respite care services 9. Skill building assistance 10. Support and service coordination 11. Supported/Integrated employment 12. Fiscal intermediary services 13. Wraparound services for children and adolescents

F.5. LTSS Medicaid Financing & Delivery System: New Initiatives

- Michigan is currently exploring new initiatives to expand their MLTSS to cover more populations, focus on person-centered planning, and integrated care management systems. This is being completed over a three-stage process starting in January 2019 and ending by December 2023.
- In a review of the MI Health Link program, the Center for Health and Research Transformation recommends an overall timeline of five years as a starting point to guide MDHHS' next steps for global LTSS improvements and MLTSS planning with the recommendation for an extension.
  - The first stage, the MLTSS design/implement global opportunities for improvement, began January 2019 and continued until April 2021. MDHHS are focusing on counseling planning, design, and implementation of comprehensive assessments and quality measurements.
  - The second stage, the MLTSS planning and design, starts June 2021 and extends to December 2022. During this time, MDHHS should focus on quality measurement strategies, person-centered planning, and integrated care management systems, standards, and processes.
  - The last stage, MLTSS readiness and program development, starts December 2022 and will end December 2023 with the new MLTSS program initiatives. MDHSS should continue to engage stakeholders, obtain budgetary and legislative approval, select contractors, inform provider organizations and consumers, phase-in operational resources, and conduct readiness reviews.

G. State Behavioral Health Administration & Finance System

G.1. Department Of Behavioral Health & Developmental Disabilities: Organization Chart



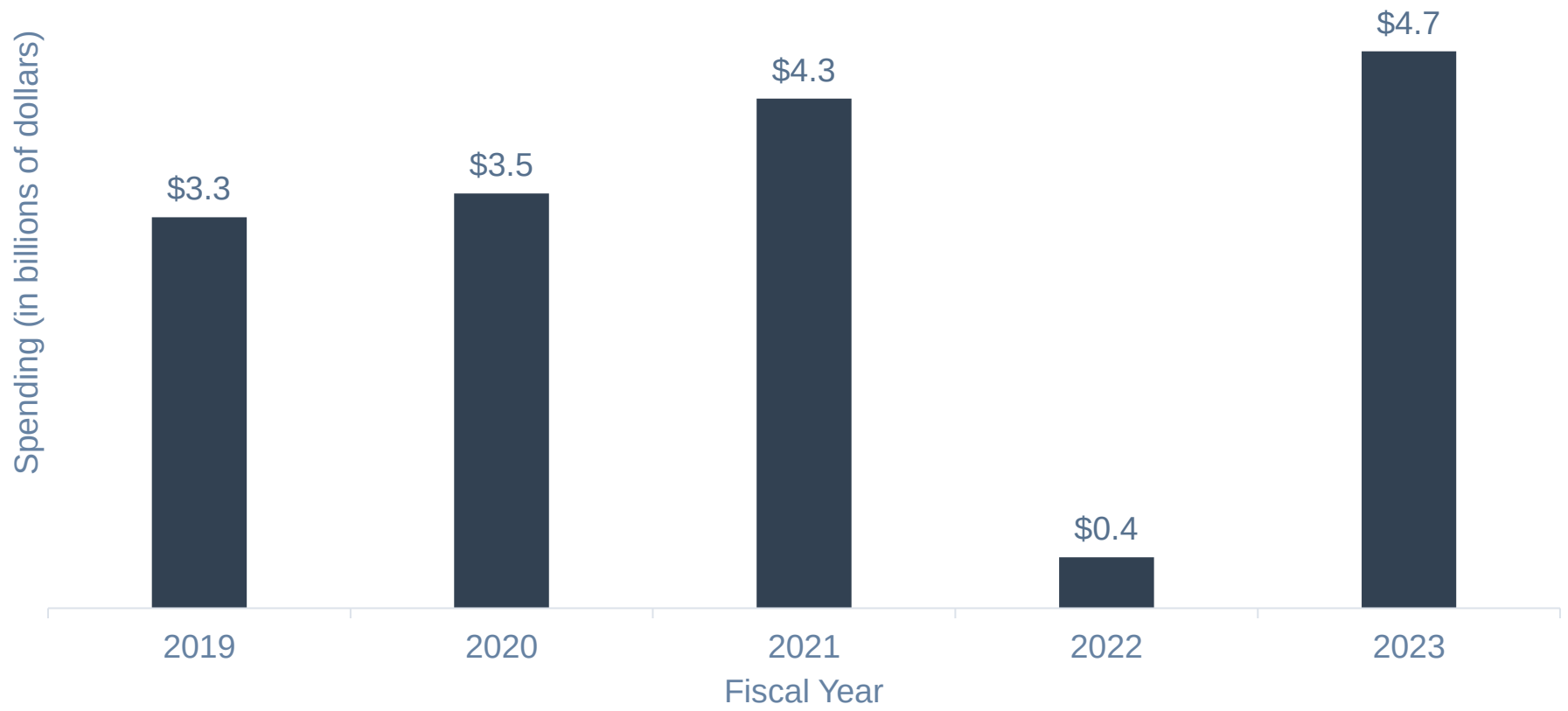
G.1. Behavioral and Physical Health and Aging Services Administration: Key Leadership

Name	Position	Department	Email
Elizabeth Hertel	Director	Michigan Department of Health and Human Services	hertele@michigan.gov
Katherine Massey	Senior Deputy Director	MDHHS, Behavioral and Physical Health and Aging Services Administration	masseyk@michigan.gov
George Mellos, M.D.	Senior Executive Psych Director	Michigan Department of Health and Human Services, State Hospital Administration	mellosg@michigan.gov
Jeffrey Wieferich	State Bureau Administrator	MDHHS, Behavioral and Physical Health and Aging Services Administration	wieferichj@michigan.gov

G.2. Behavioral and Physical Health and Aging Services Administration: Spending

Budget Item	SFY 2023 Requested Budget	Percent Of Budget
Medicaid mental health services	$3,088,701,000	65%
Healthy Michigan Plan – behavioral health	$590,959,600	12%
Autism services	$283,133,200	6%
State psychiatric hospitals	$248,124,900	5%
Community mental health non-Medicaid services	$125,578,200	3%
Certified Community Behavioral Health Clinic demonstration	$106,654,900	2%
Medicaid substance use disorder services	$93,445,100	2%
Community substance use disorder services	$80,199,700	2%
Behavioral health administration	$53,959,000	1%
Behavioral health community supports and services	$43,945,200	1%
Federal mental health block grant	$24,461,100	1%
State disability assistance program substance use disorder services	$2,018,800	<1%
Total Budget: $4,741,180,700		

G.2. Behavioral and Physical Health and Aging Services Administration: Spending Over Time



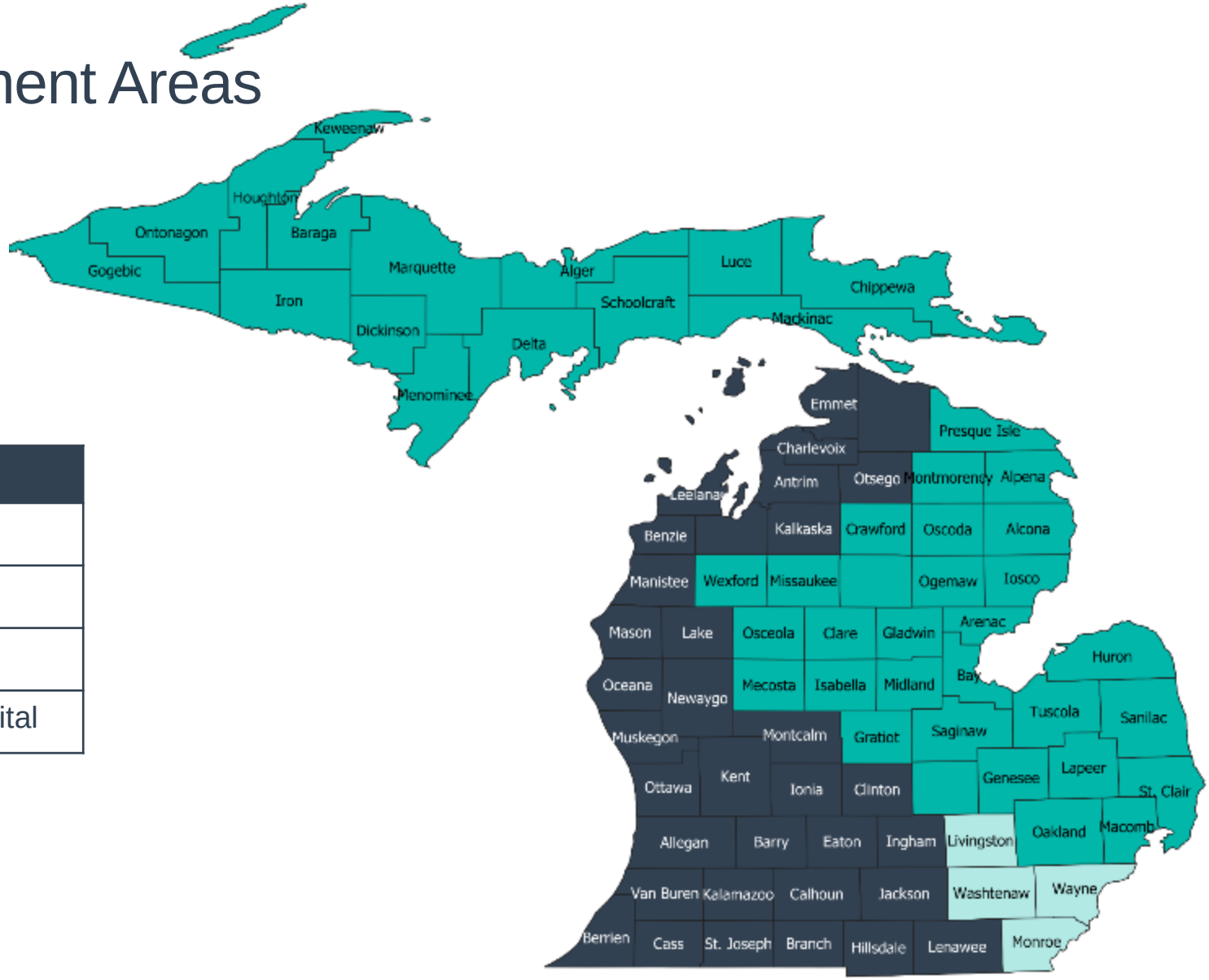
FY2019-21 actual spending; 2022-23 budget requested. In 2022 state allocated $237 million less than FY 2021.

G.3. State Psychiatric Institutions

State Psychiatric Institutions		
Institution	**Location**	**Beds**
Caro Center	Caro	150
Center for Forensic Psychiatry	Ann Arbor	210
Hawthorn Center (Pediatric)	Northville	55
Kalamazoo Psychiatric Hospital	Kalamazoo	150
Walter P. Reuther Psychiatric Hospital	Westland	180
Total		**745**

- The state is currently experiencing issues with inpatient psychiatric facility capacity. The state hospital waitlist averages 125 individuals at any time. As of May 2021, the state is still currently attempting to resolve these issues.
- In order to address this issue, the state is putting a number of initiatives in place:
  - Address workforce issues through hiring additional staff, offering loan repayment, and formalizing the use of telehealth.
  - Develop standardized operating procedures to enhance patient flow to, within, and from state hospitals to decrease waitlist.
  - Redevelop the methodology used to predict the number of beds that will be required.
  - Increase availability of pediatric beds.

G.3. State Psychiatric Catchment Areas

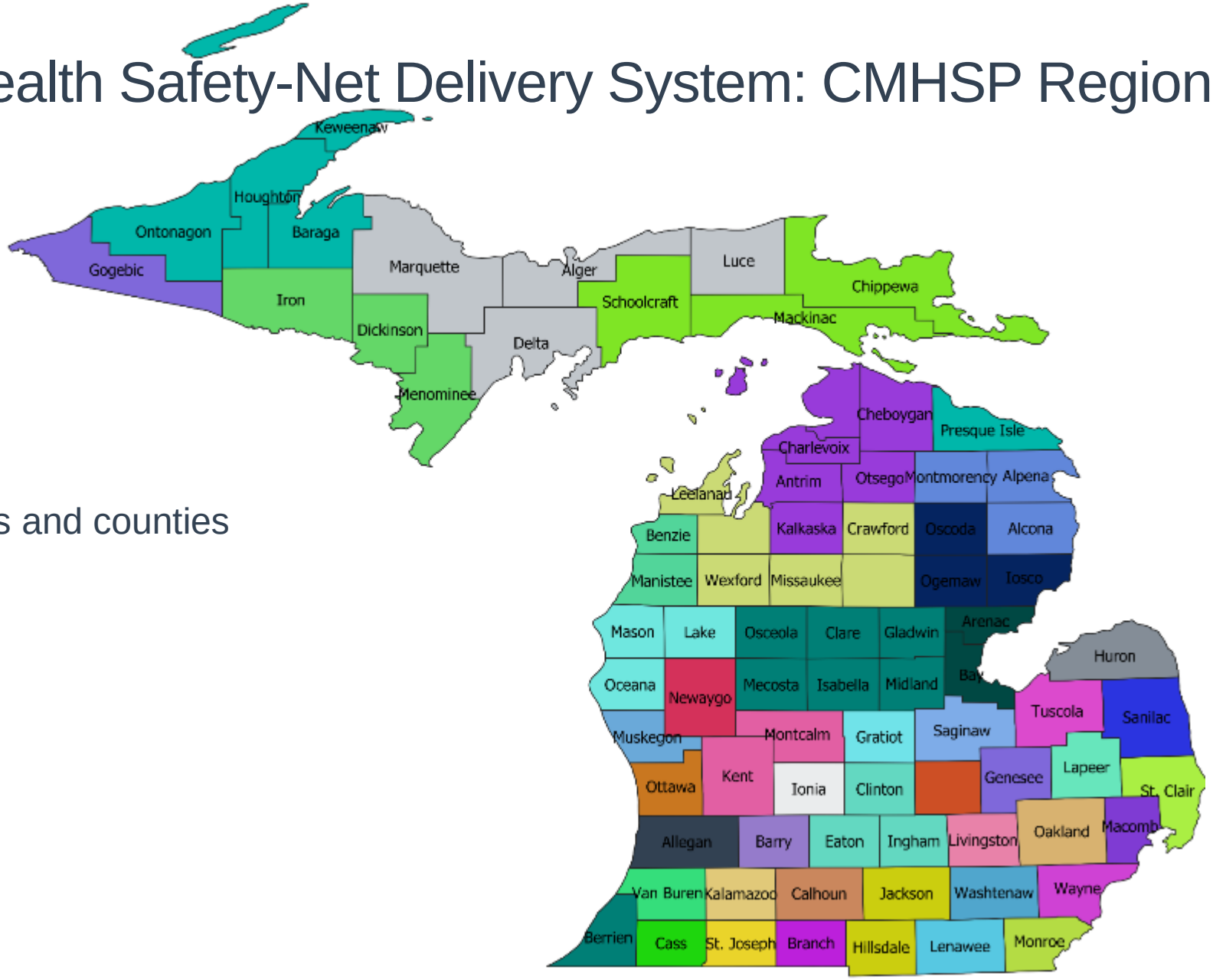


State Psychiatric Catchment Areas		
	Region	**State Hospital**
	1	Caro Center
	2	Kalamazoo Psychiatric Hospital
	3	Walter P. Reuther Psychiatric Hospital

G.4. Behavioral Health Safety-Net Delivery System

- The Michigan Department of Health and Human Services contracts with 46 Community Mental Health Services Programs (CMHSPs) to provide mental health services to safety-net population.
- As required by state law, the CMHSPs are created by individual counties or groups of counties, and are funded by a combination of federal, state, and county monies.
- At a minimum, CMHSPs are required to provide the following services to persons who do not qualify for Medicaid, to the extent permitted by allocated state general funds:
    - Crisis stabilization and response, including a 24-hour, 7-day per week crisis emergency service
    - Identification, assessment, and diagnosis to determine the specific needs of the individual and development of an individual plan of services
    - Planning, coordination, and monitoring to assist the individual in gaining access to services
    - Specialized mental health treatment, which includes therapeutic clinical interactions
    - Recipient rights services
    - Mental health advocacy
    - Prevention activities
    - Other services approved by the state
- CMHSPs also provide mental health services to the Medicaid population.
- Certain CMHSPs serving more than 20,000 Medicaid enrollees and regional affiliations of smaller CMHSPs operate as prepaid inpatient health plans (PIHPs). They receive capitated payments for Medicaid mental health and addiction disorder treatment covered services through a separate contract with the state.
- The PIHP contracts also require the PIHPs to provide safety-net addiction prevention and treatment services to uninsured persons using community grant funds on a fee-for-service (FFS) basis.

G.4. Behavioral Health Safety-Net Delivery System: CMHSP Regions*



*See next slide for regions and counties

G.4. Behavioral Health Safety-Net Delivery System: CMHSP Regions

Community Mental Health Services Programs		
	Region	**Counties**
	Allegan County CMH Services	Allegan
	AuSable Valley CMH Authority	Iosco, Ogemaw, Oscoda
	Barry County CMH Authority	Barry
	Bay-Arenac BHA	Arenac, Bay
	Berrien Mental Health Authority dba Riverwood Center	Berrien
	Centra Wellness Network	Benzie, Manistee
	CMH Authority of Clinton-Eaten-Ingham Counties	Clinton, Eaton, Ingham
	CMH for Central Michigan	Clare, Gladwin, Isabella, Mecosta, Midland, Osceola
	CMH of Ottawa County	Ottawa
	Community Mental Health & Substance Abuse Services of St. Joseph County	St.Joseph
	Copper Country CMH Services	Baraga, Houghton, Keweenaw, Ontonagon
	Detroit Wayne Integrated Health Network	Wayne
	Genesee Health System	Genesee
	Gogebic CMH Authority	Gogebic
	Gratiot Integrated Health Network	Gratiot

G.4. Behavioral Health Safety-Net Delivery System: CMHSP Regions

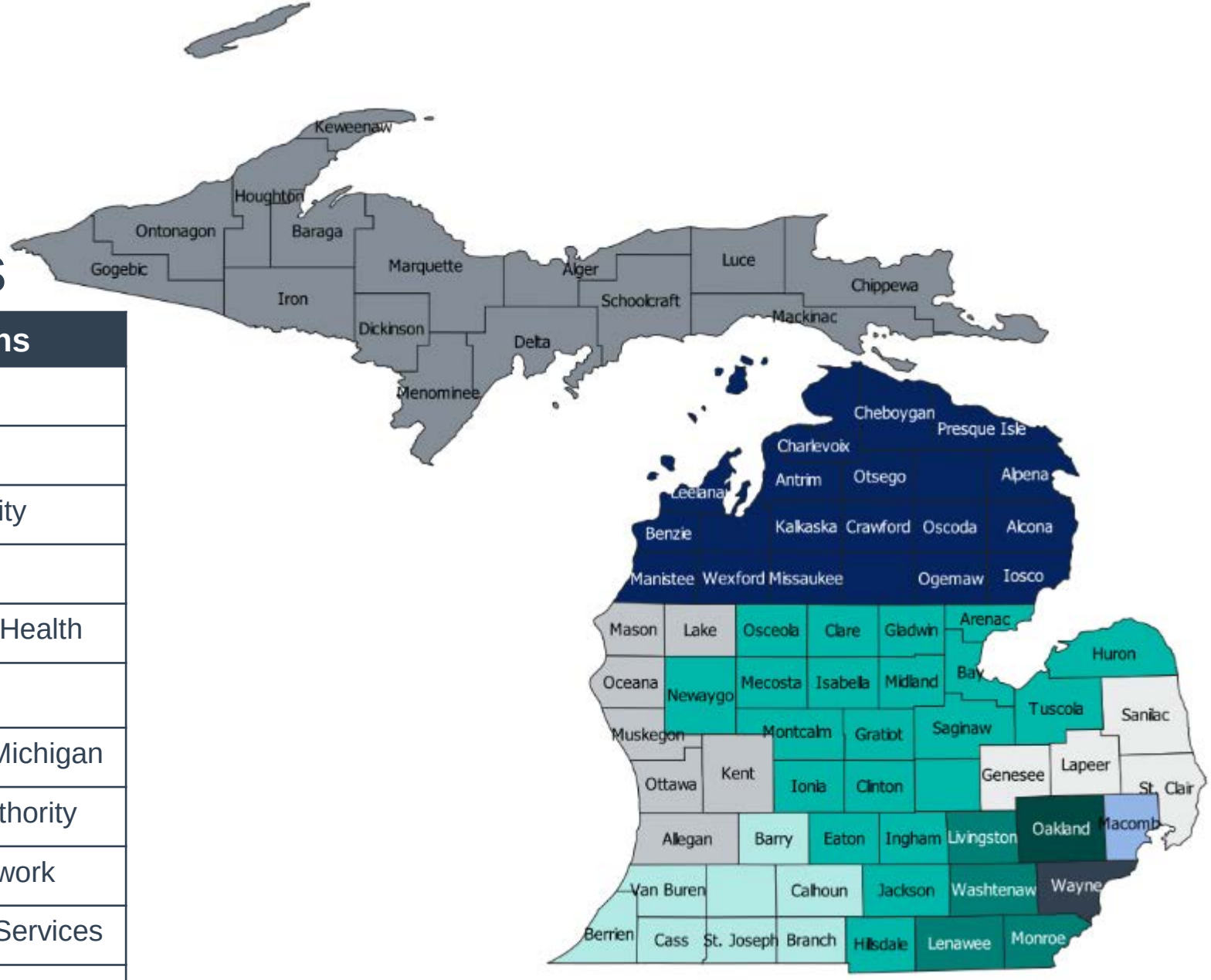
Community Mental Health Services Programs		
	Region	**Counties**
	HealthWest	Muskegon
	Hiawatha Behavioral Health	Chippewa, Mackinac, Schoolcraft
	Huron Behavioral Health	Huorn
	Integrated Services of Kalamazoo	Kalamazoo
	Lapeer County CMH Services	Lapeer
	Lenawee CMH Authority	Lenawee
	LifeWays CMH	Hillsdale, Jackson
	Livingston County CMH Authority	Livingston
	Macomb County CMH Services	Macomb
	Monroe CMH Authority	Monroe
	Montcalm Care Network	Montcalm
	Network180	Kent
	Newaygo County Mental Health Center	Newaygo
	North Country CMH Authority	Antrim, Charlevoix, Cheboyfan, Emmet, Kalkaska, Ostego
	Northeast Michigan CMH Authority	Alcona, Alpena, Montmorency, Presque Isle
	Northern Lakes CMH Authority	Crawford, Grand Traverse, Leelanau, Missaukee, Roscommon, Wexford

G.4. Behavioral Health Safety-Net Delivery System: CMHSP Regions

Community Mental Health Services Programs		
	Region	**Counties**
	Northpointe Behavioral Healthcare Systems	Dickinson, Iron, Menominee
	Oakland Community Health Network	Oakland
	Pathways Community Mental Health	Alger, Delta, Luce, Marquette
	Pines Behavioral Health Services	Branch
	Saginaw County AMH Authority	Saginaw
	Sanilac County CMH	Sanilac
	Shiawassee Health and Wellness	Shiawassee
	St. Clair County CMH Services	St. Clair
	Summit Pointe	Calhoun
	The Right Door for Hope, Recovery, and Wellness	Ionia
	Tuscola Behavioral Health Systems	Tuscola
	VanBuren Community Mental Health Authority	Van Buren
	Washtenaw County CMH	Wastenaw
	West Michigan CMH System	Lake, Mason, Oceana
	Woodlands Behavioral Healthcare Network	Cass

G.4. Behavioral Health Safety-Net Delivery System: PIHP Regions

Prepaid Inpatient Health Plan Regions		
	Region	**PIHP**
	1	NorthCare Network
	2	Northern Michigan Regional Entity
	3	Lakeshore Regional Entity
	4	Southwest Michigan Behavioral Health
	5	Mid-State Health Network
	6	CMH Partnership of Southeast Michigan
	7	Detroit Wayne Mental Health Authority
	8	Oakland Community Health Network
	9	Macomb County Mental Health Services
	10	Region 10



G.4. Behavioral Health Safety-Net Delivery System: PIHPs

Region	PIHP	Counties
1	NorthCare Network	Baraga, Houghton, Keweenaw, Ontonagon, Gogebic, Chippewa, Mackinac, Schoolcraft, Dickinson, Iron, Menominee, Alger, Delta, Luce, Marquette
2	Northern Michigan Regional Entity	Iosco, Ogemaw, Oscoda, Benzie, Manistee, Antrim, Charlevoix, Cheboygan, Emmet, Kalkaska, Otsego, Alcona, Alpena, Montmorency, Presque Isle, Crawford, Grand Traverse, Leelanau, Missaukee, Roscommon, Wexford
3	Lakeshore Regional Entity	Allegan, Muskegon, Ottawa, Kent, Lake, Mason, Oceana
4	Southwest Michigan Behavioral Health	Barry, Berrien, St. Joseph, Kalamazoo, Branch, Calhoun, Van Buren
5	Mid-State Network	Arenac, Bay, Clinton, Eaton, Ingham, Clare, Gladwin, Isabella, Mecosta, Midland, Osceola, Gratiot, Huron, Ionia, Hillsdale, Jackson, Montcalm, Newaygo, Saginaw, Shiawassee, Tuscola
6	CMH Partnership of Southeast Michigan	Lenawee, Livingston, Monroe, Washtenaw
7	Detroit Wayne Mental Health Authority	Wayne
8	Oakland County CMH Authority	Oakland
9	Macomb County Mental Health Services	Macomb
10	Region 10 prepaid inpatient health plan (PIHP)	Genesee, Lapeer, Sanilac, St. Clair

H. Appendices

H.1. *OPEN MINDS* Estimates For Share Of SMI Consumers Per Payer/Plan

Enrollment Category	Serious Mental Illness (SMI) Prevalence Estimate	Source
Commercial	4.1% of the commercially insured population over age 18	Substance Abuse and Mental Health Services Administration. (2022, January). Results from the 2020 National Survey on Drug Use and Health: Mental Health Detailed Tables. Retrieved December 2022 from https://www.samhsa.gov/data/sites/default/files/reports/rpt35323/NSDUHDetailedTabs2020v25/NSDUHDetailedTabs2020v25/2020NSDUHDetTabs01112022.zip
Medicaid	8.6% of individuals enrolled in traditional Medicaid	Substance Abuse and Mental Health Services Administration. (2022, January). Results from the 2020 National Survey on Drug Use and Health: Mental Health Detailed Tables. Retrieved December 2022 from https://www.samhsa.gov/data/sites/default/files/reports/rpt35323/NSDUHDetailedTabs2020v25/NSDUHDetailedTabs2020v25/2020NSDUHDetTabs01112022.zip
Medicare	16% of persons in the Medicare population, not dually eligible for Medicaid	Centers for Medicare and Medicaid Services. (2021). Medicare-Medicaid Coordination Office Report to Congress. Retrieved January 2023from https://www.cms.gov/files/document/mmco-report-congress.pdf

H.1. *OPEN MINDS* Estimates For Share Of SMI Consumers Per Payer/Plan

Enrollment Category	Serious Mental Illness (SMI) Prevalence Estimate	Source
Medicare-Medicaid Dual Eligibility	25% of persons in the Medicare population dually eligible for partial Medicaid benefits	Congressional Budget Office. (2013, June). Dual-Eligible Beneficiaries of Medicare and Medicaid: Characteristics, Health Care Spends, and Evolving Policies. Retrieved December 2022 from https://www.cbo.gov/sites/default/files/113th-congress-2013-2014/reports/44308_DualEligibles2.pdf
	32% of persons in the Medicare population dually eligible for full Medicaid benefits	U.S. Department of Health and Human Services. (2019, May 9). Analysis of Pathways to Dual Eligible Status: Final Report. Retrieved December 2022 from https://aspe.hhs.gov/basic-report/analysis-pathways-dual-eligible-status-final-report
Other Public	5.6% of persons served by the Veterans Administration health care system or the TRICARE military health system	Military Health Systems. (2020, August). Examination of Mental Health Accession Screening: Predictive Value of Current Measures and Report Processes. Retrieved December 2022 from https://www.health.mil/Reference-Center/Presentations/2019/11/04/Examination-of-Mental-Health-Accession-Screening-Update
No Health Care Insurance	6.2% of uninsured persons over age 18	Substance Abuse and Mental Health Services Administration. (2022, January). Results from the 2020 National Survey on Drug Use and Health: Mental Health Detailed Tables. Retrieved December 2022 from https://www.samhsa.gov/data/sites/default/files/reports/rpt35323/NSDUHDetailedTabs2020v25/NSDUHDetailedTabs2020v25/2020NSDUHDetTabs01112022.zip

H.2. Glossary Of Terms

Term	Abbreviation	Definition
Alternative Benefit Plan	ABP	State designed benefit package for the Medicaid expansion population (childless adults with income below 138% of the FPL). The benefit package must include the ten essential benefits as laid out in the PPACA. The Medicaid expansion population deemed medically frail (including those with SMI) are exempt from receiving benefits through the ABP.
Accountable Care Organizations	ACO	ACOs are groups of provider organizations—such as physicians and hospital systems—that form an agreement to coordinate care for a set group of individuals. If the ACO delivers high quality care—measured through performance metrics—and lowers the cost of providing care against a baseline, then the organization receives a portion of the savings generated. ACOs can exist alongside all payment structures (fee-for-service and managed care delivery systems) and payers (Medicare, Medicaid, commercial).
Administrative Services Organization	ASO	An arrangement in which an organization hires a third party to deliver administrative services to the organization, such as claims processing and billing. The ASO is not at-risk.
Capitation		A set amount of money paid per enrollee per month to a health care entity to cover the cost of health care services. Capitation can cover the cost of all health care services or subset of services, such as care coordination or home- and community-based services.
Carve-out		A carve-out is a Medicaid managed care financing model where some portion of Medicaid benefits—dental services, pharmacy services, behavioral health services, etc.—are separately managed and/or financed. Carve-out services can be financed on an at-risk basis by another organization or retained by the state Medicaid agency on a fee-for-service basis.
Certified Community Behavioral Health Clinic	CCBHC	Behavioral health clinics specially certified in a demonstration established by section 223 of the Protecting Access to Medicare Act of 2014. The clinics are designed to provide community-based mental health and addiction treatment services, to advance the integration of behavioral health with physical health care, and to provide care coordination across the full spectrum of health services.

H.2. Glossary Of Terms

Term	Abbreviation	Definition
Community Mental Health Center	CMHC	An organization that can demonstrate that it is actively providing all services in section 1913(c)(I) of the Public Health Services Act, including a.) Outpatient services, including specialized outpatient services for children, the elderly, individuals who are chronically mentally ill, and residents of the CMHC's mental health service area who have been discharged from inpatient treatment at a mental health facility; b.) 24 hour-a-day emergency care services; c.) Day treatment, or other partial hospitalization services, or psychosocial rehabilitation services; and d.) Screening for patients being considered for admission to state mental health facilities to determine the appropriateness of such admission. Additionally, the organization must meet the specifications for the state where it provides services.
Dual Eligible		An individual who is eligible for Medicare (Part A and B) and Medicaid. Medicare serves as the individual's primary insurance, and Medicaid acts as a supplement. Dual eligibles are sometimes referred to as Medicare-Medicaid enrollees (MMEs).
Federal Poverty Level	FPL	The U.S. Department of Health and Human Services sets a standard level of income that is used to determine eligibility for services and benefits, including Medicaid. In 2023, the FPL is $13,590 for an individual and $27,750 for a family of four.
Fee-For-Service	FFS	A system where the payer, in this case Medicaid, contracts directly with provider organizations and pays for providing care on a unit-by-unit basis. Health plans may also reimburse provider organizations on a FFS basis meaning they pay for each unit of care or test.
Health Home		A "whole person" care coordination model that specifically targets populations with chronic conditions including those with SMI. Health homes provide six essential functions: 1.) Comprehensive care management; 2.) Care coordination and health promotion; 3.) Comprehensive transitional care from inpatient to other settings, including appropriate follow-up; 4.) Individual and family support; 5.) Referral to community and social support services; 6.) Use of health information technology to link services. Health homes were originally developed as a Medicaid program, but have been adopted by other payers. For a state to have an official health home program they must have an approved state plan amendment.

H.2. Glossary Of Terms

Term	Abbreviation	Definition
Health Insurance Marketplace	HIM	Created by the PPACA, the health insurance marketplace is an online platform where individuals and small businesses can purchase health insurance. The federal government subsidizes coverage purchased on the marketplace through premium tax credits for individuals with income up to 400% of the FPL.
Home- & Community-Based Services	HCBS	Long-term services and supports provided in the home or community in order to avoid institutionalization. Traditionally provided through 1915(c) waivers, HCBS services are usually limited to specific populations and a specific number of people. HCBS services include skilled nursing care, personnel care services, assistance with activities of daily living, and custodial care.
Institutions For Mental Disease	IMD	A hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including addiction. Federal financial participation is available for Medicaid IMD services for individuals under the age of 21 and age 65 and over. In recent years, CMS has relaxed the rules prohibiting payments in IMDs for individuals ages 21-64. Medicaid health plans may provide up to 15 days of IMD services per month in lieu of state plan services if medically appropriate, cost effective, and consented to by the individual. Additionally, states may be granted a 1115 waiver authority to allow individuals to receive addiction and mental health treatment in IMDs.
Long-Term Services & Supports	LTSS	Services provided in the home, community, or institutional setting to those who have trouble living independently and completing activities of daily living as a result of cognitive disabilities, physical impairments, disabling chronic conditions, and/or age.
Managed Care		A health care delivery and financing system designed to manage cost, utilization, and quality. In Medicaid, states generally implement managed care through contracts with health plans, which provide a limited set of benefits to enrollees through a capitated or per person per month (PMPM) rate. The health plans generally assumes full-risk for the cost of treatment, and therefore contracts with a network of provider organizations to provide care at the most efficient rate possible while still maintaining member health.

H.2. Glossary Of Terms

Term	Abbreviation	Definition
Medicaid		Medicaid is a joint federal-state program that provides health coverage to economically disadvantaged populations, such as low-income adults, children, and aged, blind, and disabled (ABD) individuals. States establish their own eligibility standards, benefit packages, provider payment policies, and administrative structures under broad federal guidelines. Financing is a shared responsibility of the federal government and the states.
Medicaid Waiver		Granted by CMS, waivers allow states to make temporary changes to their Medicaid program in order to test out new ways to deliver health coverage.
Medicaid Waiver Section 1115	1115 waiver	Known as research and demonstration waivers, states can apply for program flexibility to test new or existing approaches to financing and delivering Medicaid and CHIP.
Medicaid Waiver Section 1915(b)	1915(b) waiver	States can apply for waivers to provide services through managed care delivery systems, or otherwise limit an individual's choice of health plan or provider organization.
Medicaid Waiver Section 1915(c)	1915(c) waiver	States can apply for waivers to provide long-term care services in home- and community-based settings, rather than institutional settings.
Medical Home		A medical home is not a physical place, but a model for care coordination. Medical homes provide primary care services, care coordination, enhanced access to care, and care that is culturally and linguistically appropriate. Medical homes exist across multiple payers.
Medicare		Federal health insurance for individuals over the age of 65, individuals with certain disabilities, and individuals with end stage renal disease. Medicare covers most acute care services (which may include psychiatric care), but does not cover LTSS or non-physician behavioral health services.
Medicare Advantage	MA	Medicare Part C - also known as Medicare Advantage - is a program which allows individuals who are eligible for Medicare Parts A and B to elect a private health plan to provide their Medicare coverage. The federal government pays the plan's premiums up to a set level, and individuals are responsible for the difference.

H.2. Glossary Of Terms

Term	Abbreviation	Definition
Medicare Advantage Special Needs Plan	SNP	A special type of Medicare Advantage plan that is designed to provide targeted coordinated care to individuals who are a) institutionalized; b) dual eligible; and/or c) meet the severe chronic disabled conditions set forth by CMS. Plans emphasize improved care primarily through continuity of care and care coordination.
Medicare Part A		Hospital Insurance: Covers hospital, skilled nursing care, hospice, and home health care for most eligible individuals at no cost. Financed through payroll tax and deductibles, copayments are only charged if a stay becomes long-term.
Medicare Part B		Supplementary Medical Insurance: Covers most outpatient services, and consumers pay a premium based on income level.
Medicare Part C		Medicare Part C - also known as Medicare Advantage - is a program which allows individuals who are eligible for Medicare Parts A and B to elect a private health plan to provide their Medicare coverage. The federal government pays the plan's premiums up to a set level, and individuals are responsible for the difference.
Medicare Part D		Outpatient Prescription Drug Benefit: Private plans contract with Medicare to provide coverage for prescription drugs. Most consumers pay premiums based on their income.
Metropolitan Statistical Area	MSA	An urbanized area with a population of at least 50,000 plus adjacent territory that has a high degree of social and economic integration as measured by commuting ties.
Patient-Centered Medical Home	PCMH	See Medical Home.
Patient Protection & Affordable Care Act	PPACA or ACA	U.S. health care reform signed into law in 2010. The legislation regulates certain aspects of private and public health insurance programs and authorizes an individual mandate to secure essential health coverage, premium tax credits for the purchase of private health insurance, and increased insurance coverage of preexisting conditions. In 2012 the Supreme Court ruled that state participation is optional for provisions of the law expanding Medicaid coverage to adults ages 18 to 64 with incomes under 138% of the FPL. In 2017, Congress repealed the tax penalties associated with the individual mandate essentially ending the mandate.

H.2. Glossary Of Terms

Term	Abbreviation	Definition
Primary Care Case Management	PCCM	A health care delivery system model with limited utilization and cost control. Under the PCCM model, Medicaid enrollees choose a primary care physician who acts as a gatekeeper for more intensive services. The primary care physician generally receives a per person per month (PMPM) fee for care coordination and is reimbursed fee-for-service for all medical services provided.
Program Of All Inclusive Care For The Elderly	PACE	PACE serves populations over the age of 55 who are eligible for skilled nursing home care by utilizing a comprehensive delivery system of social, medical, and long-term care services to keep enrollees in the community for as long as possible. PACE is an optional state Medicaid program, and may only be available in certain states, or regions within states.
Serious Mental Illness	SMI	A mental, behavioral, or emotional disorder that lasts for a sufficient duration of time and causes impairment of major life activities. Serious mental illnesses include major depression, schizophrenia, bipolar disorder, obsessive compulsive disorder (OCD), panic disorder, post traumatic stress disorder (PTSD), and borderline personality disorder.
Supported Employment		Provides services and supports to help individuals with disabilities become employed in an integrated or competitive work environment and retain that employment.
Supported Housing		Housing provided for as long as needed at little or no cost to individuals with mental illness, or other vulnerable populations who are homeless or at-risk for homelessness. Mental health and social services are offered to participants but are not a condition for participation in the program. The goal is to allow individuals to live as self-sufficient, independent lives as possible.
Value-Based Reimbursement	VBR	Reimbursement model in which payers financially reward or penalize health care provider organizations for performance on quality and cost of care. VBR payment mechanisms include P4P; capitation; shared savings models; shared risk models; and payments based on clinically-defined episodes, called episodes of care or bundled payments.

H.3. Sources

A. Executive Summary
1. Information compiled from sources provided throughout the profile.

B.1. Population Demographics
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