IN THE UNITED STATES DISTRICT COURT
FOR THE DISRICT OF COLUMBIA

ANDREA YOUNG, *et al.,*	
Plaintiffs,	
v.	Case No. 1:19-cv-03526
ALEX M. AZAR II., *et al.,*	
Defendants.	March 19, 2020

BRIEF OF AMICUS CURIAE MICHIGAN ASSOCIATION OF HEALTH PLANS IN SUPPORT OF INTERVENOR

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CORPORATE DISCLOSURE STATEMENT

Pursuant to the Local Rule 7(o)(5) of the United States District Court of the District of Columbia, incorporating Rule 29(a)(4) of the Federal Rules of Appellate Procedure, the undersigned counsel to Michigan Association of Health Plans certifies that the Michigan Association of Health Plans has no parent companies, subsidiaries, or affiliates that have issued shares to the public.

Date: March 19, 2020

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I. IDENTITY AND STATEMENT OF INTEREST OF AMICUS CURIAE MICHIGAN ASSOCIATION OF HEALTH PLANS

The Michigan Association of Health Plans (MAHP) is a nonprofit corporation established to promote the interests of member health plans. MAHP represents 10 health plans covering all of Michigan and more than 45 related business and affiliated organizations. Member health plans provide coverage through Medicaid, Medicare, and commercial products to more than 3 million Michigan citizens – nearly one in every three Michiganders. MAHP's mission is to provide leadership for the promotion and advocacy of high quality, accessible health care for the citizens of Michigan.

MAHP plans cover 450,000 of the 600,000 beneficiaries enrolled in the Healthy Michigan Plan (HMP) Medicaid demonstration program. Currently, 9 of MAHP's 10 member plans are contracted with the state of Michigan to cover HMP beneficiaries, and MAHP members represent 9 of the 10 plans currently contracted with the state to serve the HMP population. The total value of MAHP member plan contracts with the state of Michigan is $2.3 billion. Given the role that MAHP member plans play in the HMP demonstration, MAHP has a strong interest in the remedy ordered in this case. MAHP thus offers the court a unique perspective on the real-world impact to HMP beneficiaries were the court to vacate the entire HMP demonstration and eliminate the state's authority to implement managed care for HMP enrollees.

II. SUMMARY

The Plaintiffs are seeking to vacate the Centers for Medicare and Medicaid Services' (CMS') 2018 extension of Michigan's HMP demonstration, with specific challenges to three new conditions of eligibility: community engagement, payment of premium and cost-sharing

obligations, and healthy behavior participation. Though the Plaintiffs do not specifically challenge other components of the waiver, their complaint asks the court to permanently enjoin the implementation of the entire HMP demonstration. ECF No. 1 at 51. The HMP program currently covers 600,000 Michigan residents and relies on a robust managed care delivery system to provide services.[1] The state's authority to maintain this delivery system is derived from the HMP demonstration at issue in this case.

Managed care provides demonstrable benefits to HMP beneficiaries. Participating health plans provide essential services, some of which are not covered under a traditional FFS system. MCOs have also made substantial commitments and related investments in tools to improve quality of care and achieve better cost-efficiencies. These include care coordination and integration initiatives, expanded use of value-based payment models, population heath management, and an increased focus on addressing social determinants of health. Not only do HMP enrollees rely on the expanded services covered under the managed care contracts, they greatly benefit from many of the additional improvements and supports that a managed care model offers. Vacature of the entire HMP demonstration --eliminating the state's authority to run its HMP managed care program would result in significant disruption, uncertainty, and harm to beneficiaries, undermining the goals of maintaining access to care that are at the heart of this lawsuit. For these reasons, MAHP urges the court to sever any provisions it deems unlawfully approved and preserve the remainder of the HMP demonstration.

[1] Michigan Department of Health and Human Services, *Healthy Michigan Plan Information* (available at https://www.michigan.gov/mdhhs/0,5885,7-339-71547_2943_66797---,00.html).

III. BACKGROUND

A. The Role and Operation of Managed Care in Medicaid

Managed care is increasingly becoming the predominant delivery system in state Medicaid programs. Most states rely on managed care for providing services to their Medicaid beneficiaries and over two thirds of all Medicaid beneficiaries in the US are enrolled in a managed care plan.[2] Managed care is implemented through a contract between state Medicaid agencies and managed care organizations (MCOs), through which the MCOs receive a flat per member per month payment (a capitation payment) for covered services outlined in the contract.[3]

The services covered in an MCO contract include at least some and sometimes all of the services covered under fee-for-service (FFS). Some states deliver *all* Medicaid covered services through managed care, while many carve out some services and provide them on a FFS basis. Notably, however, managed care contracts may also include services that are *not* covered under FFS. States often require MCOs to offer services and supports not available in their FFS system. These may include requirements to invest in and leverage community health workers, incorporate systems to identify and address social determinants of health, institute a referral policy for community-based social services and/or partner with other local organizations to provide additional supports.

In a FFS system, the state enters into contracts with individual providers to deliver care to Medicaid beneficiaries, and is responsible for paying all claims for services provided. Under managed care, by contrast, the state contracts with MCOs to undertake these functions. The

[2] Kaiser Family Foundation, *Medicaid Managed Care Market Tracker* (available at https://www.kff.org/data-collection/medicaid-managed-care-market-tracker/).
[3] CMS, *Managed Care* (available at https://www.medicaid.gov/medicaid/managed-care/index.html).

MCOs subcontract with their own provider networks and are responsible for paying claims. Through these subcontracts, the MCOs can ensure that the providers are fully engaged in supporting the MCOs in fulfilling their contractual obligations to the state, thereby promoting the goals and objectives for the program set by the state.

The managed care model also frees plans to negotiate payment arrangements with providers that are different from the fee schedules set by the state under their FFS systems. Plans will use this flexibility to achieve savings where possible, increase payments as necessary to ensure access, and implement alternative payment arrangements that promote quality over quantity. Transitioning to such value-based payments is often an essential component for the state to fulfill its mission to improve quality outcomes and maximize cost-efficient care.

MCOs also provide the benefit of operating under a full risk model for the services covered in their contracts, which allow states to shift risk off their budgets and benefit from the added financial predictability of capitated payments. Plans are held to standards of quality, access, and cost-effectiveness with the expectation that they will appropriately manage the care furnished to their enrolled population within their allotted capitation payments. In all, MCOs offer significant value and financial stability to state Medicaid programs.

B. The Evolution of Managed Care in Michigan

Michigan first implemented Medicaid managed care in 1996 to address significantly increased Medicaid expenditures, a concern about provider accountability for utilization and a need for better tracking of access and quality.[4] Michigan created its initial Comprehensive Health

[4] Michigan Department of Health and Human Services, *Michigan Medicaid Quality Assessment and Improvement Strategy* 2015 (available at

Care Program (CHCP) through a waiver under Section 1915(b) of the Social Security Act, 42 U.S.C. §1396n, enabling the state to adopt mandatory managed care for the majority of its Medicaid beneficiaries.[5] After enactment of the Affordable Care Act, the state expanded its Medicaid program in 2014 to adults up to 133 percent of the federal poverty level, using federal demonstration authority under Section 1115 of the Social Security Act (42 U.S.C. §1315). Under the waiver, non-disabled adults from ages 19-64 with incomes at or below 133% of the federal poverty level receive coverage through the Healthy Michigan Plan. Michigan provides coverage to HMP enrollees through the MCOs used in the state's pre-existing managed care programs.[6]

The 2014 HMP demonstration term ran through December 30, 2018. In late 2018, Michigan received approval from CMS to extend the demonstration through December 2023 (the HMP Extension). As part of the HMP Extension, CMS also granted the state authority to condition eligibility for some beneficiaries on participation in a community engagement program, on payment of premiums and on fulfillment of healthy behavior requirements.[7]

Currently, managed care is the dominant delivery system in Michigan's managed care program; over 50% of Medicaid enrollees are covered through comprehensive managed care (full risk, capitated) and nearly 100% of enrollees are involved in some form of managed care.[8] HMP covers over 600,000 of these beneficiaries.

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https://www.michigan.gov/documents/mdhhs/Quality_Strategy_2015_FINAL_for_CMS_112515_657260_7.pdf).

[5] *Id.*

[6] CMS, *Managed Care in Michigan* (available at https://www.medicaid.gov/medicaid-chip-program-information/by-topics/delivery-systems/managed-care/downloads/michigan-mcp.pdf).

[7] CMS, *Healthy Michigan Section 1115 Demonstration*, 11-W-00245/5, ("HMP Demonstration"), Waiver List (Dec. 21, 2018) (available at https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/mi/mi-healthy-michigan-ca.pdf).

[8] CMS, *Medicaid Managed Care Enrollment and Program Characteristics*, 2017 (available at https://www.medicaid.gov/medicaid/managed-care/downloads/enrollment/2017-medicaid-managed-care-enrollment-report.pdf).

IV. ARGUMENT

A. The court should allow Michigan to continue to operate the managed care portions of the HMP demonstration program without disruption regardless of the outcome of the challenge to the community engagement and other portions of the 2018 HMP demonstration extension.

i. The conditions on eligibility approved in 2018 operate independently of the managed care program.

The plaintiffs have challenged the Secretary's approval of three specific aspects of the HMP waiver as being beyond his authority: the community engagement requirements, the premium and cost-sharing requirements, and the healthy behavior requirements. The complaint does not allege any legal or other deficiencies in the approval of the waivers necessary to implement the managed care program. Nonetheless, Count Two of the complaint also challenges the Secretary's approval of the HMP extension as a whole, (ECF No. 1 at ¶¶ 216-221) and asks the court to "preliminarily and permanently enjoin Defendants from implementing the practices purportedly authorized by … the approval of the Michigan HMP Amended Extension Application." *Id.* at 51.

The challenged provisions relate to individuals' eligibility for coverage through Michigan Medicaid. Any individual who does not complete the requisite community engagement, pay his or her premium or cost sharing obligations or fulfill the healthy behavior requirements is at risk of losing his or her eligibility for coverage. Eligibility determinations are a wholly separate process from providing and paying for care through managed care once a person is eligible. For HMP enrollees in Michigan, the state is solely responsible for determining eligibility. State of Michigan Comprehensive Health Care Program for the Michigan Department of Health and Human Services (available at https://www.michigan.gov/documents/contract_7696_7.pdf) (Sample MCO Contract) at 26. Once determined eligible, a beneficiary is enrolled into an MCO

by the state's enrollment contractor. *Id.* at 29. MCOs receive a file listing of individuals enrolled into their plan and are obligated to provide covered services to all those so enrolled. *Id.*

The operation of the managed care coverage provided by the MCOs is not impacted by changes in eligibility criteria. Such changes will only affect who and how many people are enrolled into the plans, not how the plans provide coverage. Swings in enrollment levels are common in Medicaid managed care as enrollment varies with, for example, changes in economic conditions (more people become Medicaid-eligible when the economy takes a downturn and vice-versa). Similarly, modifications in eligibility criteria, such as vacature of the community engagement requirement and the other contested provisions, will not require changes in how the managed care program operates.

Because the community engagement requirement is a condition of eligibility, operating independently of the managed care program, vacature of the entire HMP demonstration is inappropriate in this case. As the state suggests, the court should instead sever the approval of the community engagement requirement from the remaining portions of the HMP demonstration and allow the managed care program to proceed uninterrupted as the court continues to consider the remaining challenges brought by plaintiffs.

ii. CMS has historically and currently approved waivers to permit states to adopt managed care without also adopting the contested eligibility restrictions

The three specific waivers issued to Michigan that authorize it to implement a managed care delivery system for HMP enrollees are routine waivers that CMS has granted to states for many years. If, in determining severability, the court assesses the likelihood that CMS would have granted the managed care waivers without the community engagement requirements (and

potentially the other contested provisions of the waiver) (*see* ECF No. 23 at 11), it should take into account the routine nature of these waivers.

Three of the seven provisions waived by CMS in the HMP demonstration relate to the HMP managed care program: Statewideness (Section 1902(a)(1) (42 U.S.C. §1396a(a)(1))), Freedom of Choice (Section 1902(a)(23)(A) (42 U.S.C. §1396a(a)(23)(A))) and Proper and Efficient Administration (Section 1902(a)(4) (42 U.S.C. §1396a(a)(4))).[9] These waivers were also included in the original approval of the HMP demonstration in 2013.[10]

A review of CMS' 1115 waiver web site, which contains approval documents for each state's 1115 waivers dating back to 2010-2012,[11] illustrates just how common these waivers are and have been. At least 13 states have had waivers of the Statewideness requirement approved as part of their demonstration programs dating back to the earliest posted demonstration dates.[12] Of the 13 states, 10 have had their Statewideness waivers renewed during the Trump Administration.[13] Twenty states have waivers of Freedom of Choice that have been in place since the earliest waiver approvals listed on the CMS website,[14] all but four of which have

[9] HMP Demonstration, Waiver List (Dec. 21, 2018). The other four provisions waived relate to the required premiums, cost-sharing, healthy behavior and community engagement requirements.
[10] HMP Demonstration, Waiver List (Dec. 31, 2013) (available at https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/mi/Healthy-Michigan/mi-healthy-michigan-cms-amend-appvl-12302013.pdf).
[11] *See* Medicaid.gov, State Waivers List (available at https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/index.html) (CMS State Waivers List).
[12] *See* Waiver Lists for: California Bridge to Reform (Nov. 2010); Florida Medicaid Reform (Dec. 2011); Kentucky Health Care Partnership (Nov. 2008); Massachusetts MassHealth (Dec. 2011); New Jersey Comprehensive Waiver (Oct. 2012); New York Partnership Plan (April 2014); North Carolina Medicaid Reform (Dec. 2018); Oklahoma Sooner Care (Jan. 2010); Oregon Health Plan (Oct. 2002); Tennessee TennCare II (June 2012); Texas Health Care Transformation and Quality Improvement (Dec. 2011); Utah Primary Care Network (July 2010); and Vermont Global Commitment to Health (Jan. 2011).
[13] Kentucky, Oklahoma and Tennessee no longer have Statewideness waivers. *See* CMS State Waivers List.
[14] In addition to the 13 state waivers cited in note 12, *supra, see* Waiver Lists for: Arizona Health Care Cost Containment System (Oct. 2011); Delaware Diamond State Health Plan (Jan. 2011); Hawaii Quest

been reapproved during the Trump Administration.[15] And three states have received waivers of the Proper and Efficient Administration requirement in order to limit beneficiaries to enrollment in a single plan for certain services,[16] all three of which has been re-approved during the Trump Administration.[17] CMS has granted Tennessee all three of the managed care waivers granted to Michigan, dating at least back to 2012 (the most recent approval documents listed on the web site, although the waivers could date back to the earliest days of the waiver program in 1994[18]). All waivers cited as having been approved by the Trump Administration were approved at least once in this Administration without the adoption of a community engagement initiative.

Because the authority granted to Michigan to implement managed care for the HMP population is so routine, both historically and in the current Administration, it is highly likely that CMS would have granted these waivers in the absence of the contested provisions, and therefore the court should sever the approval of the community engagement requirements (or any contested approval it determines was improperly granted), and allow the managed care program to continue.

B. Michigan's Managed Care System Enhances Access and Quality of Care for HMP Beneficiaries

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Integration (Feb. 2008); Indiana Healthy Indiana Plan (Feb. 2015); Kansas KanCare (Jan. 2013); New Mexico Centennial Care (Nov. 2014); and Rhode Island Global Consumer Choice Compact Demonstration (Jan. 2009). CMS State Waivers List.

[15] The Freedom of Choice waiver in Indiana was reapproved with a community engagement requirement in 2018; the Kentucky Health Partnership has expired; the Oregon Health Plan has not been amended during the Trump Administration and Utah's Primary Care Network no longer includes a Freedom of Choice Waiver. *See* CMS State Waivers List.

[16] *See* Waiver Lists for: Arizona Health Care Cost Containment System (Oct. 2011); Rhode Island Global Consumer Choice Compact Demonstration (Jan. 2009); and Tennessee TennCare II (June 2012).

[17] *See* CMS State Waivers List.

[18] TennCare II, No. 11-W-00151/4, Special Terms and Conditions at 11 (available at https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/tn/tn-tenncare-ii-ca.pdf) ("Tenncare began as an 1115(a) demonstration project in January 1994").

Michigan has opted to operate its Medicaid program largely through managed care in a deliberate attempt to enhance access and quality for Medicaid beneficiaries, including those enrolled through the HMP waiver. It has entered into contracts with 10 MCOs; the contracts cover not just the HMP population but also certain eligible children, pregnant women, families, aged, blind and disabled individuals and others. Sample MCO Contract at 27. The intent is to "employ a population health management framework and contract with high performing health plans in order to build a Medicaid managed care delivery system that maximizes the health status of beneficiaries, improves Beneficiary experience and lowers cost." *Id.* at 23. The managed care system, which has continued to evolve since 1996, currently provides many tangible benefits to HMP enrollees, including enhanced access and improved quality of care.

i. Managed care provides enhanced access to care for HMP enrollees.

Michigan's managed care plans provide comprehensive coverage to HMP (and other) beneficiaries, with notable success in ensuring access to care. Data shows, for example, that access to preventive and ambulatory care for HMP adults between the ages of 30-44 is over 7% higher than FFS, and women covered under HMP are 18% more likely to obtain a breast cancer screening than the FFS population. Decl. of Dominick Pallone, ¶ 3 ("Pallone Decl.") (Exhibit A). Similarly, managed care has been shown to improve access to dental services as compared to FFS dental coverage. Both the adult and pregnant women HMP populations (who receive dental coverage through the MCOs) are over 10% more likely to obtain diagnostic dental services and approximately 7% more likely to seek preventative dental care than other beneficiaries for whom dental services are carved out of managed care. *Id.* at ¶ 3.

Moreover, managed care provides enrollees with access to additional services that are not covered under the traditional FFS system. For example, MCOs are required to cover habilitative

services and hearing aids for all HMP enrollees, which are not available in FFS. Sample MCO Contract at 49. And, as described below, MCOs must provide access to community health workers and peer support specialists who work closely with certain identified enrollees in assisting them to effectively access and interact with the health care system. *Id.* at 62, 67-68.

Overall, the MCOs are held to strict contractual standards for ensuring that their provider networks are adequate, that they provide access for individuals with limited English proficiency, who are deaf or hard of hearing, and who have physical or mental disabilities or special health care needs. *Id.* at 34. Services must be available 24 hours a day, seven days a week as medically necessary, and provided within specified travel distances and time requirements. *Id.* at 34-35. The contract specifies maximum primary care provider (PCP)-to-enrollee ratios, and requires all enrollees to have an assigned PCP. *Id.* at 36, 40.

Plaintiffs cite the threat to access to care as a primary concern driving their legal challenge to the HMP 1115 demonstration. ECF No. 1 at ¶ 9. But the portions of the demonstration authorizing managed care have actually enhanced access to care, and should therefore be preserved regardless of other remedies ordered.

ii. Managed care enhances the quality of care delivered to Medicaid beneficiaries

MCOs have been critical partners with the state of Michigan in enhancing the quality of care provided to HMP enrollees, though a variety of mechanisms.

a. Value-based payment

One significant tool driving quality improvement has been reforming provider reimbursement to reward quality over quantity. Michigan has committed to transitioning away

from traditional FFS fee schedule payments and toward value-based payment models, and the state's Medicaid managed care system is essential in this effort.

Under value-based payment arrangements, providers are at risk, to a greater or lesser degree, for the cost, quality and experience of care delivered to their patients. They stand to receive higher reimbursement for greater value and in some models, assume the downside risk of reduced funding if their performance does not meet benchmarks. The models incentivize providers to focus on quality and outcomes, with the intent of directly influencing the care received by beneficiaries.

The Michigan Medicaid MCO contract requires providers to shift an increasing percentage of their provider reimbursement to value-based models over the term of the contract. Sample MCO Contract at 28. They are required to report at least semiannually on their progress and comply with payment reform goals and threshold targets established by the state. *Id.* The increasing use of value-based payments stands in sharp contrast to Michigan's Medicaid FFS system, which relies largely on set fee schedules paying by the unit of care delivered.

b. Care coordination

Pursuant to their contracts with the state, MCOs have undertaken substantial efforts to promote care coordination not typically available in a FFS model. In addition to coordinating the services provided under the MCO contracts, Michigan requires plans to inform beneficiaries of services not directly covered under the contract and to coordinate that care. These include psychiatric services, restorative and rehabilitative services, substance use disorder treatment and counseling, therapies and transportation for individuals with intellectual and/or development disabilities and personal care services, among others. *Id.* at 61. Leveraging MCOs in this way

enables Michigan to better support HMP beneficiaries by linking them with additional relevant supports specifically targeted to their unique needs and circumstances.

c. Patient-centered medical homes

As part of this effort, Michigan has committed to expanding the role of patient-centered medical homes (PCMHs) in its delivery system and is increasingly reliant on MCOs to integrate these care models in their contracts. PCMHs are a model of care where a team of providers are accountable for providing and coordinating a patient's comprehensive health care needs in a patient-centered fashion. A growing body of evidence demonstrates the value of comprehensive integrated health models for prevention, chronic disease management, and reducing the need for high cost care, particularly for high need patients.[19] The MCO contracts currently require plans to expand their partnerships with PCMH-designated primary care practices and increase the number of beneficiaries served by these models of care. *Id.* at 28-29, 64.

d. Physical-behavioral health integration

MCOs have also been critical to the state's mission of better integrating physical and behavioral health care. Research increasingly shows that such integration—where physical and behavioral health care needs are provided by teams, typically in one setting—improves health and patient experience while reducing unnecessary costs.[20] Behavioral health integration is particularly important for Medicaid, as the program is the country's largest payer of behavioral health services, and covers a significant number of high-cost patients likely to suffer from co-

[19] Paul Cotton, *Patient-Centered Medical Home Evidences Increases with Time,* Health Affairs, (Sept. 10, 2018) (available at https://www.healthaffairs.org/do/10.1377/hblog20180905.807827/full/).

[20] Agency for Healthcare Research and Quality, *Literature Collection* (available at https://integrationacademy.ahrq.gov/node/3146) (a review of "growing evidence for the integration of behavioral health and primary care" last updated in September 2018).

morbidities and significant social barriers alongside their mental health needs.[21] Specifically, patients with behavioral health diagnoses endure higher rates of chronic physical conditions, unstable housing and employment, and ultimately lower life expectancies.[22]

MCOs are currently required to collaborate with the behavioral health plans (Prepaid Inpatient Health Plans or PIHPs), including maintaining coordinating agreements with the plans in their service area to maximize continuity of care and facilitate referrals. Sample MCO Contract at 64. They are also required to work with PIHPs to promote the placement of PCPs in behavioral health care settings, and behavioral health clinicians in primary care settings. *Id.* at 64. All this enables the program to better identify and target services to beneficiaries covered by both MCOs and PIHPs who suffer from behavioral as well as physical health conditions. *Id.* at 63.

e. Population health management

The level of coordination and integration described above is supported by significant investments by managed care plans in population health management, a tool increasingly relied upon for identifying and addressing the variety of social, economic, and environmental factors that influence health status, at a population (rather than patient-specific) level. Under their contracts, MCOs are required to institute population health management plans focused on identifying and targeting enhanced interventions to certain subpopulations in need, such as: those with greater social needs impacting health status (transportation, housing, food access, unemployment, education); those with poor health outcomes or high prevalence of chronic

[21] Center for Health Care Strategies, Inc., *Exploring the Impact of Integrated Medicaid Managed Care on Practice-Level Integration of Physical and Behavioral Health* (July 2019) (available at https://www.chcs.org/media/BH-Provider-Brief_070219.pdf).
[22] *Id.*

conditions; high risk enrollees who are high utilizers of services; and women with high risk pregnancies. *Id.* at 65. By leveraging managed care plans and their investments in population health management, Michigan is better equipped to support beneficiaries through targeted interventions to maximize health status.

f. Community health workers and social determinants of health

MCOs have further contributed significant capacity to these efforts through investments in networks of community health workers (CHWs) and other local peer support services that are not currently reimbursable under FFS. *Id.* at 62.[23] CHWs are critical partners for addressing social determinants of health. With deep ties to their communities, CHWs are well-positioned to support the most-at risk patients by screening them for adverse social determinants, linking them with necessary supports, and facilitating care coordination with MCOs. Understanding the health of the entire patient, rather than focusing solely on physical conditions, has been consistently shown to promote health and reduce health disparities.[24]

With their intensive focus on initiatives such as value-based payment care coordination, patient-centered medical homes, behavioral health integration, population health management, and the social determinants of health, MCOs have been key partners to the state in supporting its goals of improving quality, improving health status and reducing health disparities.[25]

C. Vacating the Entire HMP Waiver Would Unnecessarily Impose Significant Operational Challenges on the Managed Care Program and Inject Unnecessary Uncertainty into Michigan's Medicaid System

[23] "Outreach, engagement, education, and coordination services provided by CHWs or Peer Support Specialists to provide behavioral health integration."

[24] Kaiser Family Foundation, *Beyond Health Care: The Role of Social Determinants in Promoting Health and Health Equity* (May 10, 2018) (available at https://www.kff.org/disparities-policy/issue-brief/beyond-health-care-the-role-of-social-determinants-in-promoting-health-and-health-equity/).

[25] *See* Michigan Department of Health and Human Services, *Michigan Medicaid Quality Assessment and Improvement Strategy* at 9 (listing Michigan Medicaid managed care program goals).

Michigan's managed care system is providing demonstrable benefits to HMP beneficiaries that simply are not available under a FFS system, as described in Section II. If the authority to operate the HMP managed care program were vacated, the resulting disruption to MCO operations would have a far-reaching impact that would ultimately harm HMP beneficiaries, even if the state were subsequently able to regain separate authority to run the program.

MCO coverage of services not covered in FFS, such as dental care, hearing aids, rehabilitative services, and local support through CHWs, among others, would be eliminated, resulting in a loss of access for beneficiaries who depend on those services. Efforts to coordinate and integrate care, notably the increased reliance on PCMHs and the process of integrating physical and behavioral health, would be severely disrupted if not eliminated entirely given their reliance on the managed care infrastructure and support. Many providers participating in value-based payment models have heavily invested in the systems, staffing, and infrastructure necessary to succeed in these models, but those investments would not be compensated under the FFS fee schedule. A return to FFS, and its model of rewarding quantity over quality, will undermine critical delivery system reform initiatives and ultimately harm patient care. Disruption to systems developed by MCOs to coordinate care with providers of non-covered services and community-based organizations providing social services will impact the ability of beneficiaries—particularly those that are high-risk and suffer from co-morbidities—to access the targeted supports they need.

Michigan is particularly reliant on its contracted MCOs to arrange and provide cost-efficient, non-emergency medical transportation (NEMT), a mandatory benefit in Medicaid. Sample MCO Contract at 57-58. NEMT services are critical for ensuring patients, particularly

low-income Medicaid beneficiaries, do not miss appointments or delay care due to lack of transportation. Michigan MCOs offer NEMT services either by subcontracting with brokers to assemble networks of NEMT providers across the state or directly providing the service themselves. Currently, Michigan itself (as opposed to the MCOs) does not have the necessary direct contractual arrangements with brokers and other providers who are furnishing these services and it is unlikely that state would have capacity to absorb the HMP population into the limited NEMT arrangements it does have were the MCO contracts suspended.

The MCO contracts specify certain management information system capacities that MCOs must have to collect, analyze, integrate and report patient specific information, and require them to use Health Information Exchange and Health Information Technology to improve care management and coordination with other systems of care. *Id.* at 103-106. An abrupt termination of these data sharing and reporting requirements will create substantial operational burdens for the MCOs and impact the longer-term quality of the data collected and shared. If MCOs are no longer paying claims or collecting clinical data, even if only for a period of time, the state will have to capture that data directly and, ultimately, the value of the data sets will be compromised by the disruption. The data provided by MCOs is used to evaluate quality of care, access, population health, utilization, financial trends, and many other improvement metrics. Without this information, many of these efforts made by MCOs and providers will be undermined.

Population health management and other initiatives designed to address the social determinants of health required under HMP contracts will also be disrupted. As described above, MCOs must use their data sources to identify subpopulations in need of enhanced services and are required to stratify and restratify their enrollee population regularly to ensure that

beneficiaries are receiving needed population health services. Termination or suspension of the HMP portion of the MCO contracts would leave these vulnerable populations in the lurch, requiring those who had been targeted for enhanced services to again fend for themselves, and missing opportunities to bring newly identified individuals into these targeted systems of care.

As described above, both plans and providers have made commitments to various reforms and initiatives that require continuity and certainty for success. Substantial efforts by MCOs to expand care coordination, improve population management and enhance overall quality would be seriously undermined if the state's managed care authority is abruptly withdrawn. Even the injection of uncertainty into the future of the managed care program—for example, by remanding the waiver to CMS to reconsider whether it would approve the managed care program in the absence of the contested provisions—would entail serious repercussions by chilling the necessary ongoing investments of time, money and other resources into the care improvement initiatives launched through the program.

In short, the managed care systems that have developed in Michigan and are serving the HMP population are multi-faceted, complex, and ongoing. They have served HMP enrollees well, providing enhanced access and quality of care. Any disruption in these systems of care will have an immediate and significant impact on care for this population. Particularly at this time of unprecedented stress and demand on the health care system as the nation attempts to grapple with the crisis unleashed by the COVID-19 virus, now is not the time to further disrupt delivery systems that are working. The court should carefully weigh the potential harm to beneficiaries in crafting its remedy to its determination that the community engagement requirements are unlawful, and in any potential future ruling on the other contested waiver provisions.

V. CONCLUSION

The court should seriously consider the value that managed care delivery system brings to Medicaid beneficiaries and the state. The resulting disruptions and uncertainty from a decision to vacate the entire HMP 1115 demonstration will undermine the Plaintiffs' objectives in pursuing this challenge and eliminate significant gains and investments in quality, coordination, and tools for targeting and supporting the most at-risk patients in the state. The Michigan Association of Health Plans urges the Court to accept the recommendations of the Intervenor and sever the approval of the community engagement provision from the rest of the waiver.

Dated: March 19, 2020

Respectfully Submitted,

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EXHIBIT A

IN THE UNITED STATES DISTRICT COURT FOR THE
DISTRICT OF COLUMBIA

Andrea Young, et al.,	)	
	)	
Plaintiff,	)	
	)	
v.	)	No. 1:19-cv-03526-JEB
	)	
Alex M. Aza, et al.,	)	
	)	
Defendants.	)	

DECLARATION OF DOMINICK PALLONE

1. My name is Dominick Pallone. I am the Executive Director of the Michigan Association of Health Plans ("MAHP").

2. In my position, I regularly interact with the Michigan Department of Health and Human Services (MDHHS) on issues related to delivery of services to Michigan's Medicaid managed care programs, including quality reporting and evaluation. This interaction involves sharing of data.

3. MAHP received raw data on April 12, 2019 from Thomas Curtis, Manager, Quality Improvement and Program Development Section, Michigan Department of Health and Human Services, reflecting performance on quality metrics for patients enrolled in Michigan's managed care plans and patients covered by its fee for service (FFS) program. Based on this data, my staff calculated comparisons of performance between managed care and FFS on key metrics, and determined the following:

a. On the measure of Adult Access to Preventive/Ambulatory Care, 30-44 years old, performance for managed care beneficiaries was 7.38% higher than for FFS. This is a standardized measure from the Healthcare Effectiveness Data and Information Set (HEDIS) developed by the National Committee for Quality Assurance.

b. On the measure of Breast Care Screening, performance for managed care beneficiaries was 18.44% higher than FFS. This is a standardized HEDIS measure.

c. On the measure of Chronic Obstructive Pulmonary Disease or Asthma in Older Adults Admission Rate, where a lower rate indicates better performance, performance for managed care beneficiaries was 28.28% lower than for FFS. This measure is a standardized Prevention Quality Indicator (PQI 05) developed by the Agency for Health Care Quality of the U.S. Department of Health and Human Services.

I make this declaration under penalty of perjury.

Dominick Pallone
Executive Director, MAHP

March 19, 2020