

Health Plan Purchase a No Go

In the September 2009 edition of *The Michigan Update* we reported that Blue Care Network of Michigan, a subsidiary of Blue Cross Blue Shield of Michigan, had proposed to purchase Physicians Health Plan of Mid-Michigan (PHP), a Sparrow Health System subsidiary. That deal, which was intended to reduce costs for PHP and allow Sparrow to exit the payer business, met with challenges at both the state and federal levels over anti-trust concerns. Rather than enter what could possibly be a prolonged legal process with an uncertain outcome, the parties agreed to abandon the proposed acquisition.

Medicaid Policies

DCH has issued three final and five proposed policies that merit mention. (Two of the proposed policies were issued simultaneously with a final policy.) They are available on DCH's web site at: www.michigan.gov/mdch; click on Medicaid Policy Bulletins at the bottom of that page.

- **MSA 10-06** advises **All Providers** of **updates to the Medicaid Provider Manual** effective April 1, 2010. The bulletin also advises providers of **four procedure code changes**. The bulletin was **simultaneously issued for comment (M1003-Update)**. Comments are due to DCH by March 30, 2010.
- **MSA 10-07** advises **All Providers** that effective April 1, 2010 a **citizenship verification process** will be implemented for the **MiChild** program, as is currently required for Medicaid. The bulletin includes some specific **exemptions** to the requirement. The bulletin was **simultaneously issued for comment (1006-MiChild)**. Comments are due to DCH by March 30, 2010.
- **MSA 10-08** advises **Practitioners, Pharmacies,**

Medicaid Health Plans (MHPs) and others that effective April 1, 2010 certain Therapeutic Drug Classes (commonly known as the “**MHP 60/40 Carve-Outs**”) will **no longer be in the MHP benefit**.

- A proposed policy (**1010-ABW**) has been issued that would provide **cost-based reimbursement to Federally Qualified Health Centers** and Rural Health Clinics for services provided to the **ABW population**. Comments are due to DCH by April 22, 2010.
- A proposed policy (**1012-Dental**) has been issued that would **recognize and reimburse Registered Dental Hygienists** as a distinct provider type. **Supervision by a Dentist** would be required. Comments are due to DCH by April 22, 2010.
- A proposed policy (**1013-ASC**) has been issued that would **recognize and reimburse Ambulatory Surgical Centers** as a distinct provider type **consistent with Medicare's coverage and reimbursement policy** but with a **reduction factor** applied. Such recognition is required pursuant to Section 1642 in Public Act 131 of 2009, the DCH appropriation act for the current fiscal year. The policy would not be effective until January 2011. Comments are due to DCH by April 20, 2010.

DCH has also recently released three **L-letters** that may be of interest. **L 10-04** includes instructions to **Nursing Facilities and MHPs** related to **resident disenrollment from MHPs** following an erroneous enrollment. **L 10-07** and **L 10-08** emphasize the **rights of Nursing Facility residents** pursuant to **Olmstead** requirements to reside in the most integrated setting appropriate to their needs. The letters **encourage LTC providers to cooperate with MI Choice Waiver Agents and Centers for Independent Living** representatives as they discuss options with facility residents for **transitioning to a community setting**. The department's L-letters are available at the same site as program bulletins.

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The Michigan Update

A Monthly Publication of Health Management Associates

March 2010

Medicaid Managed Care Enrollment Activity

The Michigan Department of Community Health (DCH) has advised that due to problems resulting from implementation of its new Community Health Automated Medicaid Processing System (CHAMPS) and with the department's data warehouse, Medicaid managed care enrollment information for March is not available. DCH advises that these problems will hopefully be resolved within a few months but it is doubtful the enrollment detail for the missing months will ever be available. Information from DCH and the Department of Human Services (DHS) indicates that enrollment in Medicaid continues to increase by about 10,000 individuals every month. The recent resolution of issues with managed care auto-assignments also would imply that enrollment in the health plans continues to climb.

Adult Benefits Waiver

Also due to the department's CHAMPS and data warehouse problems, information regarding the Adult Benefits Waiver (ABW) caseload and enrollment levels in the County Health Plans (CHPs) is unavailable for March. Information from DHS indicates that enrollment is decreasing by about 2,500 individuals per month. Since ABW enrollment is currently closed, decreased enrollment is expected. An even greater decline may occur in the near future as the ABW cases that were opened during the open enrollment period of March through May 2009 are reviewed during the redetermination process. Failure to return required paperwork could result in loss of ABW benefits for some individuals.

In a previous issue of *The Michigan Update*, it was

reported that one of the provisions in the Children's Health Insurance Program Reauthorization Act (CHIPRA) of 2009 prohibited waivers under federal Title XXI (CHIP) authority from covering childless adults beyond December 2009. To assure continued health care for the population covered under Michigan's ABW program, DCH requested federal approval of a Section 1115 Medicaid demonstration waiver to cover uninsured non-pregnant childless adults age 19 through 64 with income at or below 35 percent of the federal poverty level, the same population covered under the former waiver. The new waiver offers the same package of services and uses the same delivery system as the earlier one and has been approved through September 2014.

MiChild

According to MAXIMUS, the DCH contractor for MiChild enrollment, there were **29,719 children enrolled** in the MiChild program as of **March 1, 2010**. This is a decrease of 585 since February 2010.

As the enclosed report for March shows, enrollment is dispersed between seven plans, with more than 88 percent of the children enrolled with Blue Cross Blue Shield of Michigan. MiChild is one of the largest components of the Children's Health Insurance Program (CHIP) in Michigan.

National Health Reform

A separate insert to this newsletter documents key features of the national health reform legislation enacted this week that affect Michigan and Medicaid. Several provisions of the budget described in the State Budget article are inconsistent with the provisions of the health reform legislation and must be modified for Michigan to comply with the new federal law.

The Michigan Update

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State Budget

On March 24, 2009 the Senate passed SB 1152, the DCH budget bill for FY 2010-2011 and referred it to the House of Representatives. In the aggregate the Senate reduced the total DCH budget by \$831 million and state general funds by \$96 million from the Governor's executive recommendation.

The most significant Senate changes from the Governor's budget were:

- Rejection of the proposed physician tax and related increase in physician rates to Medicare levels;
- A four percent cut in physician Medicaid rates for physician services other than pediatrics, well child visits, obstetrics, primary care and emergency services;
- An increase, from \$50 to \$100, in the beneficiary cost sharing requirement for the first day of an inpatient hospitalization;
- A 20 percent cut in state general funds for non-Medicaid community mental health (CMH);
- Restoration of adult dental and podiatry services and adult vision services (but not adult chiropractic services);
- Restoration of funding for several small DCH programs;
- Addition of a \$10 million hospital Disproportionate Share Hospital (DSH) pool (replacing the \$5 million pool that was previously eliminated, with similar rules for distribution);
- Elimination on July 1, 2011 (when the increased Federal Medical Assistance Percentage – FMAP – from the stimulus ends and states can cut Medicaid eligibility) of coverage for some “caretaker relatives” and some 19 to 20 year-old Medicaid beneficiaries;
- Assumption of additional savings from the Medicaid Inspector General office and the expanded Medicaid recovery staff; and
- An assumption that the three percent pay increase for unionized state employees is rescinded (valued at \$7.7 million in state general funds).

To balance its budget proposal, the Senate was able to take advantage of recent federal action related to the amount states must pay for the Medicare Part D premiums for low-income individuals (informally known as the “clawback”). The federal

Centers for Medicare & Medicaid Services (CMS) within the last few weeks agreed with the position of states that the state clawback payments should be calculated using the enhanced stimulus Medicaid matching rates – resulting in a lower state share of cost. For Michigan the value is estimated at \$101.3 million for the period from October 2008 through December 2010. The Senate agreed with the Governor's assumption that the enhanced stimulus Medicaid match rate would continue through June 2011. As a result, the total value of this revision to the clawback calculation would be \$123.8 million for Michigan. Since these dollars were not appropriated in FY 2010, all of them can be allocated to FY 2011 as an offset to state general fund costs. This enabled the Senate to reject the Governor's proposed physician tax with its assumed net gain in state general funds.

The Senate agreed with the Governor on many provisions of her budget including a three percent rate increase for Medicaid HMOs and the capitated mental health plans to maintain actuarial soundness. The deep cuts in funding for the Adult Benefits Waiver (both for physical health and mental health) were retained in the Senate budget.

The Senate bill moves the MICHild program exclusively to Medicaid HMOs as of October 1, 2010. Currently almost 90 percent of MICHild enrollees have chosen the Blue Cross Blue Shield MICHild program. Now that there are Medicaid HMOs in every county, the state is able to make this change, which will result in a savings to the state due to increased use taxes paid by HMOs.

Notable Senate boilerplate additions (beyond those implementing the actions described above) include the following:

- Section 1832 requires that the department continue work on standardization of billing forms and other documents and establish a workgroup on the potential expansion of e-billing for the Medicaid program.
- Section 1833 requires development of a payment methodology to reimburse non-emergency care in emergency departments at non-emergency rates.
- Section 1839 requires the department to work with relevant parties to explore the feasibility of seeking a modification of the Medicaid Adult Benefits Waiver to expand physician and mental health coverage to childless adults with mental illness.

No Wrong Door for Long-Term Care

In a letter recently distributed to Long-Term Care (LTC) stakeholders across the state, the Michigan Office of Services to the Aging (OSA) announced that the agency was recently awarded a grant from the federal Administration on Aging (AoA) for the development of Aging and Disability Resource Center (ADRC) partnerships. The grant funds will be used to build ADRC capacity in Michigan by utilizing existing LTC resources to develop a statewide “No Wrong Door” model for supports and services.

The letter notes that “ADRC partnerships are highly visible and trusted services in the community that empower persons of all ages and income levels to navigate the full range of LTC support options according to their cultures, values, and preferences. The core functions, as defined by the AoA, include: Information and Assistance (I&A); Streamlined Access; Options Counseling (OC); Person-Centered Hospital Discharge Planning; and Quality Assurance and Evaluation.” The letter also indicates the required members of any emerging ADRC partnership.”

Through the letter and its attachments, OSA is soliciting applications from developing ADRC partnerships seeking technical assistance, training, information technology infrastructure assistance and help in establishing and deploying a quality management plan. The letter and its attachments are available on the OSA web site at: www.miseniors.net/osaforms/content.aspx?sn=31&cn=Area+Agency+Meetings

Organizational Changes at MSA

The new Medicaid Director at DCH, Steve Fitton, announced another organizational change for the Medical Services Administration (MSA) that became effective March 21, 2010. Karen Parker has been appointed to the position of director for the Bureau of Medicaid Financial Management and Administrative Services. Ms. Parker is a long-time MSA employee with experience in several areas of the organization. As reported in the February edition of *The Michigan Update*, this bureau level position was vacated through a retirement in late 2009.

Detroit Medical Center Sale

Vanguard Health Systems, an investor-owned (for profit) corporation based in Tennessee, has offered to purchase the eight hospitals comprising the not for profit Detroit Medical Center (DMC). The sale is contingent upon approval by both corporate boards and Michigan Attorney General Mike Cox as well as designation of DMC's main campus as a renaissance zone allowing it to remain tax-free. Vanguard officials have said this purchase will not alter the DMC's charitable mission of serving the low-income residents of Detroit and surrounding areas and that they are prepared to invest more than \$800 million to renovate and strengthen DMC's facilities. A major heart treatment center is planned along with re-development of the Children's Hospital of Michigan, the largest pediatric center in the state. The purchase agreement also includes a provision that the eight hospitals will remain open for at least the next ten years.

Electronic Newsletter

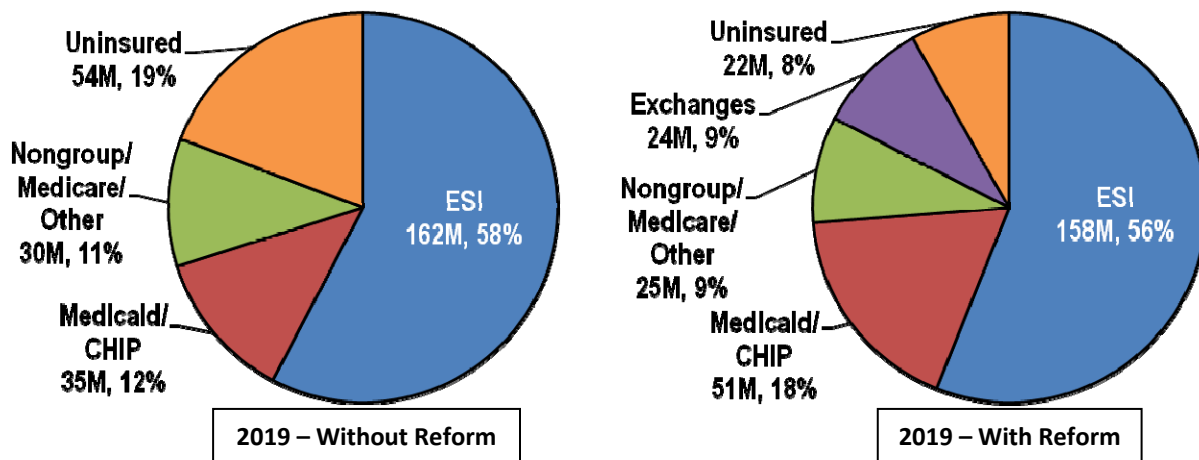
As announced in the November 2009 edition of *The Michigan Update*, Health Management Associates (HMA) will soon be issuing an electronic newsletter focused on national news and issues. It will be sent via email rather than in hard copy. **The first electronic newsletter is planned for release in April 2010 and *The Michigan Update* will be re-formatted and issued electronically beginning next month as well.**

To continue receiving HMA's newsletters it is essential that we have your contact information. If you have not yet submitted this information to HMA, enclosed is a form for your use in doing so. The form can be faxed to HMA or be sent via email; details are included on the form. **Please send the contact information by April 16, 2010.**

Thank you very much if you have already submitted a contact form. It is not necessary to submit another unless you wish to place additional names on our distribution list.

Passage of Reform Bill triggers new state responsibilities

On March 21, 2010, the House of Representatives passed the Senate bill (H.R. 3590 – The Patient Protection and Affordable Care Act w/ Manager’s Amendment) with the modifications made by the Reconciliation Bill (H.R. 4872). President Obama signed the Senate bill into law March 23. The Reconciliation Bill was passed by the full Congress on March 25 with only minor changes in sections not related to Health Reform. It will be signed into law separately. While there are a number of provisions that take effect immediately, the major coverage expansion does not take effect until 2014. The CBO estimates on enrollment below compare a 2019 snapshot of the **nonelderly** population with and without reform (ESI is employer-sponsored insurance):



Medicaid expansion and creation of health exchanges are the two key state responsibilities

- State-based health insurance exchanges will follow federal directives that implement insurance regulatory reform and facilitate enrollment of 24 million people.
- States without a high risk pool will need to create a temporary program in 90 days (by June 21st).
- A Medicaid expansion responsible for half of the reduction in the uninsured – 16 million of the 32 million newly-insured are projected to be covered by Medicaid.

Coverage reforms will expand Medicaid

- Medicaid enrollees today are largely low-income pregnant women and children, with many states opting to expand coverage to other low-income segments of the population.
- Combined Senate/Reconciliation Legislation expands Medicaid to all individuals under 133% FPL.
- CBO projects that the combined legislation will increase Medicaid/CHIP enrollment (currently 46.9 million) by an additional 16 million individuals by 2019 at a gross State and Federal cost of \$454 billion (\$434 billion federal cost and \$20 billion state cost) over the 2010 to 2019 period. (Some of the new enrollees are individuals already eligible for Medicaid/CHIP.)
- In 2014 (first year of the Medicaid expansion), additional federal Medicaid spending is \$29 billion. In 2019, additional federal Medicaid spending is \$98 billion. For states, the 2014-2016 medical coverage costs for newly eligible individuals will be entirely covered by the federal government (in subsequent years, the federal government covers more than 90% of costs).

Other Key Provisions Affecting States

- **Medicaid Rx rebate changes will impact base rebates and state supplemental rebates.** Base Medicaid rebates will increase from 15.1% of AMP to 23.1% of AMP, with the Federal government receiving the entire increment. Rebates that states receive will also apply to the Medicaid population covered by MCOs. States welcome the MCO component but are concerned that the base rebate increase will negatively affect their ability to negotiate supplemental rebates.
- **Physician Medicaid reimbursement rates increased for primary care services.** Required primary care rate increases to Medicare levels for 2013 and 2014 will help mitigate pressures on a program that struggles with access, rates and quality. **The cost of the rate increase is subject to 100% FMAP in these two years.** What will happen in 2015 is unclear: some cost may shift to the states.
- **Medicaid DSH impacts are significant, uncertain.** Medicaid DSH payments will be reduced by \$14.1 billion from 2012-2019 creating significant pressures on states and safety net hospitals.

Opportunities	Challenges
<ul style="list-style-type: none"> ▪ Manage unprecedented influx of federal revenues to providers and the state ▪ State-operated exchanges and more Medicaid enrollees puts states in position to lead in delivery system reform ▪ States can foster demonstrations of care models and related payment reforms (readmission policies, ambulatory care organizations, etc.) ▪ States can leverage their ability to make grants (such as HIT and wellness initiatives) and can influence the expansion of FQHCs and RHCs 	<ul style="list-style-type: none"> ▪ States are broke and ARRA FMAP expires in December 2010 or June 2011 – concern that new mandates (Medicaid expansion, etc.) are not fully funded ▪ Expansion on existing Medicaid – a program that struggles with access, rates and quality ▪ Infrastructure to manage multiple Medicaid eligibility models and interface with exchanges. ▪ Development of capitation rates and benefits for a population that is different from the traditional TANF/ABD model

Timeline of Reform Implementation

2010:	<ul style="list-style-type: none"> ▪ Medicaid maintenance of eligibility required until an exchange is operational ▪ Drug rebate provisions begin (15.1% to 23.1% and MCO parity) ▪ New state option to expand Medicaid up to 133% FPL without a waiver at regular FMAP until mandatory expansion takes place in 2014. No penalty in 2014 for “early adopters”.
2011:	<ul style="list-style-type: none"> ▪ Medicaid required to cover tobacco cessation services for pregnant women
2012:	<ul style="list-style-type: none"> ▪ State DSH allotment could be adjusted downward
2013:	<ul style="list-style-type: none"> ▪ Implementation of excise tax on “Cadillac plans” ▪ October 1 – states eligible for 23% point increase in regular CHIP match (capped at 100%) ▪ States evaluated for significant progress toward having exchange operational by 2014
2014:	<ul style="list-style-type: none"> ▪ Individual and employer mandates take effect – maintain minimum coverage or pay penalty ▪ States required to expand Medicaid coverage to non-pregnant, non-elderly below 133% FPL ▪ State Medicaid programs prohibited from excluding coverage for barbiturates, benzodiazepines, and tobacco cessation products
2015:	<ul style="list-style-type: none"> ▪ Federal funding for the CHIP program expires on September 20, 2015
2016:	<ul style="list-style-type: none"> ▪ Health care choice inter-state compacts may take effect, whereby states allow insurers to sell across state lines
2017:	<ul style="list-style-type: none"> ▪ States begin to pay a share of Medicaid expansion (new eligibles)

Michigan Medicaid Implications

- With expansion of Medicaid to cover all individuals with incomes up to 133% of FPL, by the end of 2014 Michigan Medicaid enrollment will have expanded by nearly 300,000 additional individuals. By the end of 2015 this total will have increased to nearly 450,000 individuals.
 - Nearly two-thirds of the new enrollees will be “childless adults”.
 - About 50,000 will be low-income parents or children that are currently eligible for Medicaid, but not enrolled in Medicaid.
- Under the maintenance of eligibility provisions, Michigan cannot reduce eligibility below the March 23, 2010 levels – both under the state plan and any waivers.
 - The Senate proposal to eliminate coverage for caretaker relatives and 19 to 20 year old Medicaid beneficiaries is not possible.
 - The Governor’s proposal to reduce Adult Benefits Waiver enrollment is also prohibited. (However ABW funding could still be reduced if benefits were cut.)
- As of January 1, 2014, the current Adult Benefits Waiver population will be subsumed within the expansion of full benefits Medicaid.
- Nationally Medicaid DSH federal funding will be reduced by \$14.1 billion. Michigan’s loss of DSH funding is expected to be about \$340 million in federal funds, or a reduction of more than \$500 million in DSH payments. (The reconciliation bill gives the Secretary of Health and Human Services discretion to develop the formula for achieving the DSH reduction, so the amount and timing is unknown.) Under the Senate formula, Michigan’s DSH payments would have reduced by about \$20 million per year for 2014 through 2016, then \$65 million in 2017, \$180 million in 2018 and \$200 million in 2019.

Other Michigan Implications

- Michigan will need to create a temporary high risk pool by June. This pool will cover individuals with pre-existing conditions that do not have access to employer-based coverage and have not been insured for at least six months. (Federal funds are available for this provision to cover administrative costs and some underwriting costs.)
- Michigan will be responsible for development of a state exchange where individuals can buy insurance.
- There will still be nearly 500,000 uninsured individuals in 2019 in Michigan.
 - Some will be undocumented immigrants.
 - Some will be low-income individuals that do not choose to enroll in Medicaid and are not subject to any penalty due to their income level.
 - Many will be low to moderate income individuals that cannot afford their share of premiums for employer-based insurance or those that do not have access to employer based insurance and cannot afford to purchase individual coverage through the exchange.
 - Some of the uninsured will be subject to a penalty and will choose to pay the penalty and “self insure”.