HEALTH MANAGEMENT ASSOCIATES

October 2012

The Michigan Update

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Medicaid Managed Care Enrollment Activity

As of October 1, 2012, there were **1,232,399 Medicaid beneficiaries enrolled** in 13 Medicaid Health Plans (HMOs), **an increase of 236** since September 1, 2012. The number of Medicaid beneficiaries eligible for managed care enrollment also increased in October - there were 1,313,508 eligible beneficiaries, up from 1,288,139 in September. The number of enrollments "in process" statewide increased dramatically from 49,536 in September to 75,603 in October. These data imply that there will be a significant increase in Medicaid HMO enrollment in the next few months. The number of Medicaid beneficiaries dually eligible for Medicare (duals) enrolled in Medicaid HMOs to receive their Medicaid benefits continues to grow - there were **28,291 duals enrolled in October, up from 27,056 in September**, an increase of 1,235. There were **645 children** dually eligible for Medicaid and the Children's Health Care Services (**CSHCS**) program enrolled in the HMOs to receive their Medicaid benefits as of October 1, 2012.

As the enrollment reports (.pdf) (.xls) every county in the state is served by at least one Medicaid Health Plan. Auto-assignment of beneficiaries into the HMOs is now in place in every county of the state and there are at least two HMOs serving every county in the Lower Peninsula. Beneficiaries in all 15 counties in the Upper Peninsula are auto-assigned through federal "Rural Exception" authority to the one HMO serving the counties, Upper Peninsula Health Plan.

As a result of approved service area expansions, Priority Health Government Programs is now available to beneficiaries in Barry County and Meridian Health Plan of Michigan is now available in Cheboygan County. With these expansions, there are no longer any "Preferred

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Option" counties in Michigan.

For more information, contact Esther Reagan, Senior Consultant, at (517) 482-9236.

CSHCS Children in Medicaid HMOs

In previous editions of *The Michigan Update*, most recently in September 2012, we reported on DCH's plan to enroll children (and a few adults) receiving services from the Children's Special Health Care Services (CSHCS) program and the Medicaid program (CSHCS/MA beneficiaries) in Medicaid Health Plans (HMOs). Enrollment has begun. As of October 1, 2012, there were **645 CSHCS/MA beneficiaries enrolled in the Medicaid HMOs** to receive their Medicaid benefits. Of this total, 351 children were auto-assigned to an HMO and 294 voluntarily enrolled.

For more information, contact Esther Reagan, Senior Consultant, at (517) 482-9236.

Duals in Medicaid HMOs

As of October 1, 2012, there were **28,291 Medicaid beneficiaries dually eligible for Medicare (duals) enrolled in Medicaid HMOs** to receive their Medicaid services. The number of duals enrolled through auto-assignment as of October 1, 2012 was 14,536, and the number of duals enrolled on a voluntary basis was 13,755. All Medicaid HMOs have duals enrolled although the numbers vary dramatically across plans.

A Medicaid HMO member who gains Medicare coverage and remains in the HMO is categorized as auto-assigned or voluntarily enrolled based on the means through which the member was *initially* enrolled in the HMO. Duals enrolled in a Medicare Special Needs Plan (SNP) for their Medicare benefits but receiving Medicaid on a fee-for-service basis are auto-assigned to the related Medicaid HMO if applicable. Any dual is able to "opt out" of the HMO and receive Medicaid benefits on a fee-for-service basis.

As the table below reflects, Molina Healthcare of Michigan has the most duals receiving their Medicaid services from an HMO, more than 32 percent of the total; UnitedHealthcare Community Plan has almost 24 percent of the total; Meridian Health Plan of Michigan has more than 14 percent of the total (but the most voluntary enrollees); and the other 10 plans share the remaining 30 percent.

October 2012 Medicaid Dual Eligible Enrollment			
Medicaid Health Plan	**Voluntary Enrollees**	**Auto-Assigned Enrollees**	**Total Enrollees**
Blue Cross Complete of MI	273	283	556
CoventryCares of MI	401	89	490
HealthPlus Partners	671	150	821
McLaren Health Plan	1,451	586	2,037
Meridian Health Plan of MI	3,303	749	4,052
Midwest Health Plan	856	663	1,519
Molina Healthcare of MI	2,102	7,044	9,146
PHP Mid-MI Family Care	174	37	211
Priority Health Govt. Programs	769	605	1,374
Pro Care Health Plan	16	16	32
Total Health Care	585	168	753
UnitedHealthcare Comm. Plan	2,774	3,932	6,706
Upper Peninsula Health Plan	380	214	594
Total	**13,755**	**14,536**	**28,291**

Six of the 13 Medicaid HMOs in Michigan are also federally contracted as Medicare Advantage SNPs to provide *Medicare* benefits for duals: CareSource (now McLaren), Meridian, Midwest, Molina, UnitedHealthcare and Upper Peninsula Health Plan. As of October 1, 2012 these six SNPs have a combined enrollment of 14,557 duals for whom they provide Medicare services; 57.8 percent of the duals enrolled in SNPs for Medicare services are enrolled in the Molina plan, 30.2 percent are enrolled in the UnitedHealthcare plan and the remaining 12 percent are spread across the other four plans.

For more information, contact Esther Reagan, Senior Consultant, at (517) 482-9236.

MIChild

According to MAXIMUS, the DCH contractor for MIChild enrollment, there were **37,647 children enrolled** in the MIChild program as of October 1, 2012. This is a decrease of 397 since September 1, 2012.

As the enrollment report (.pdf) (.xls) for October shows, enrollment is dispersed between 10 plans, with 76 percent

of the children enrolled with Blue Cross Blue Shield of Michigan (BCBSM). MIChild-enrolled children receive their dental care through contracted dental plans. Of the three available plans, more than 95 percent of the children are enrolled with either BCBSM (48.2 percent) or Delta Dental Plan (47.1 percent).

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Adult Benefits Waiver (ABW)

Enrollment in the ABW program has been closed since November 2010. As of the middle of October 2012, DCH reports there were **32,324 ABW beneficiaries enrolled** in the program, **a decrease of 2,158** since the middle of September. There are 28 County Health Plans (CHPs) serving ABW beneficiaries in 73 of Michigan's 83 counties. As of October 1, 2012, the combined ABW **enrollment in the 28 CHPs was 29,024**, a **decrease of 2,365** since September.

For more information, contact Eileen Ellis, Managing Principal, at (517) 482-9236.

Pro Care Health Plan Purchased

With approval of the Michigan Office of Financial and Insurance Regulation, on October 22, 2012 the Detroit Medical Center and its Nashville-based parent, Vanguard Health Systems, Inc., finalized their purchase of Pro Care Health Plan, Inc., a Detroit-based HMO that covers Medicaid beneficiaries in Wayne County. Pro Care was licensed as an HMO in 2000 and has approximately 2,200 Medicaid members.

For more information, contact Esther Reagan, Senior Consultant, at (517) 482-9236.

America's Best Health Plans

The National Committee for Quality Assurance (NCQA) released its seventh annual Health Insurance Plan Rankings for 2012-2013 in late September. The rankings, separately for Private (Commercial), Medicare and Medicaid health insurance plans, are based on the plans' combined HEDIS®, CAHPS® and NCQA Accreditation standards scores and are limited to managed care organizations.

Michigan's Grand Valley Health Plan ranked 18th in the country among Private plans. Blue Cross Complete of Michigan ranked 4th in the country among Medicaid plans and five other Michigan Medicaid HMOs are also ranked in the top 20 Medicaid plans across the country:

- BlueCaid of Michigan (4)
- Priority Health (7)
- Midwest Health Plan (12)
- UnitedHealthcare Community Plan (15)
- HealthPlus (19)
- Total Health Plan (20)

Another four Michigan Medicaid HMOs ranked in the top 40 Medicaid plans nationally. The rankings are available on the NCQA web site.

For more information, contact Esther Reagan, Senior Consultant, at (517) 482-9236.

LARA Creates New Bureau

On October 18, 2012, Steven Hilfinger, Director of the Michigan Department of Licensing and Regulatory Affairs (LARA) announced creation of a new Bureau of Health Care Services, bringing together the bureaus previously known as Health Professions and Health Systems, responsible for licensing health care professionals and facilities. Mr. Hilfinger noted that the change is being made to simplify the health care regulatory structure and improve customer service. He said that a bureau director has not yet been selected and no reductions in workforce are anticipated.

For more information, contact Esther Reagan, Senior Consultant, at (517) 482-9236.

Autism Coverage Reimbursement

State law enacted earlier this year requires insurers to provide coverage for the diagnosis and treatment of autism spectrum disorders. The law also included a provision for insurers to obtain reimbursement for the cost of diagnosing and treating these disorders from the State. The Department of Licensing and Regulatory Affairs (LARA) is charged with implementing the billing and reimbursement process. On October 11, 2012, LARA launched a website for the program.

For more information, contact Eileen Ellis, Managing

Principal, at (517) 482-9236.

Blue Cross Blue Shield of Michigan Reform

In the September 2012 edition of *The Michigan Update* we reported on Governor Rick Snyder's proposal to dramatically reform how Blue Cross Blue Shield of Michigan (BCBSM) is structured and regulated in the state. We noted that two bills had been introduced mid-month - Senate Bill 1293 to amend the Insurance Code and Senate Bill 1294 to change Public Act 350 of 1980, the state law governing BCBSM. Hearings have occurred and a few amendments made and approved - notably a requirement that the Office of Financial and Insurance Regulation approve most-favored nation clauses in contracts between insurers and providers and inclusion of clarifying language related to the required $1.5 billion trust fund and the Michigan Health and Wellness Foundation that would oversee it. The bills were passed by the Senate on October 17, 2012. They have been referred to the House of Representatives where additional hearings are expected after the November general election.

For more information, contact Esther Reagan, Senior Consultant, at (517) 482-9236.

Henry Ford and Beaumont Pursuing Merger

At a press conference on October 31, 2012, the leaders of Henry Ford Health System and Beaumont Health System announced their plan to pursue a merger. These are two of the state's largest health systems, both with facilities in southeast Michigan.

Henry Ford has 23,000 employees and operates seven hospitals as well as 30 medical centers, and its Health Alliance Plan subsidiary is the second largest health care insurer in the state behind Blue Cross Blue Shield of Michigan. Beaumont has 18,000 employees and operates six hospitals and medical centers as well as four nursing care facilities. Beaumont has reportedly been seeking a partner for several months and talked with other hospital groups before agreeing to a deal with Henry Ford.

During the coming months, the two systems will conduct appropriate due diligence, including their relationships with medical schools - Henry Ford is linked with Wayne State University and Beaumont with Oakland University, and they must determine where services and service areas

overlap.

Due diligence will also be conducted by state regulators interested in, among other things, the impact of a merger on competition in the marketplace. Certificate of Need issues will be considered by DCH; and LARA, as the agency responsible for overseeing federal certification of hospitals must review and approve the merger as well.

For more information, contact Esther Reagan, Senior Consultant, at (517) 482-9236.

Medicaid Today; Preparing for Tomorrow

On October 25, 2012, the Kaiser Commission on Medicaid and the Uninsured (KCMU) released a report on state Medicaid budgets and cost containment strategies. This report, *Medicaid Today; Preparing for Tomorrow: A Look at State Medicaid Program Spending, Enrollment and Policy Trends - Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2012 and 2013*, is another in a series of reports prepared over the last twelve years by HMA staff Vernon Smith, Kathleen Gifford and Eileen Ellis, with KCMU staff, following their survey of Medicaid officials.

According to the report's Executive Summary:
After experiencing the impacts of the worst economic downturn since the Great Depression, state policy makers were finally beginning to see signs of economic recovery at the end of state fiscal year (FY) 2012 and heading into FY 2013. State revenue growth was positive and neither Medicaid spending nor enrollment was growing at the high rates seen only a few years before. Cost pressure and cost containment were still dominant themes, but states were also now able to consider positive program changes, payment and delivery system reforms and continue efforts to re-orient long-term care programs to community-based care models. Eligibility rules for Medicaid remained stable due to the maintenance of eligibility (MOE) protections that were part of health reform legislation, and a number of states adopted targeted eligibility expansions or simplified enrollment procedures.

The top 5 key findings from the survey are highlighted below:

1. Growth in Medicaid spending slowed in FY 2012 to a near-record low as the economy began to improve and enrollment growth slowed. Slow program growth is expected to continue for FY 2013.
2. Cost containment remained a strong focus for Medicaid, but with small improvements in the

economy, a number of states were able to make some targeted program improvements, including continued expansions of community-based long-term care options.

3. Medicaid eligibility levels remained stable in most states, as the Affordable Care Act (ACA) limited states from restricting Medicaid eligibility standards, methodologies or procedures. Despite tight budgets, a number of states reported targeted eligibility expansions or enrollment simplifications.
4. Medicaid programs are engaged in a range of delivery system changes, including managed care reforms and care coordination strategies. Some of the most significant of these are initiatives to better deliver care for those dually eligible for Medicare and Medicaid.
5. Looking ahead, states are preparing for the implementation of the ACA and are making decisions about the Medicaid expansion in the context of upcoming elections as well as potential Medicaid implications from an intense national debate about the federal budget deficit.

The complete report is available on HMA's website.

For more information, contact Eileen Ellis, Managing Principal, at (517) 482-9236.

The ACA's Medicaid Expansion

In an Issue Brief released on October 14, 2012, the Center for Healthcare Research and Transformation (CHRT) in Ann Arbor projected savings for Michigan of $1 billion over ten years if the state implemented the Medicaid expansion available under the Affordable Care Act (ACA - the federal health care reform law). The Brief, *The ACA's Medicaid Expansion: Michigan Impact - State Budgetary Estimates and Other Impacts*, notes that a combination of higher federal financial participation for the newly eligible Medicaid beneficiaries and expected health care cost reductions from having more Michigan residents insured could yield savings from 2014 through 2023. According to the news media, Governor Rick Snyder may be open to the expansion but acknowledges that Republicans in the House of Representatives have thus far balked at changes tied to the ACA. The Issue Brief is available on the CHRT website.

For more information, contact Esther Reagan, Senior Consultant, at (517) 482-9236.

4 X 4 Plan

In the June 2012 edition of *The Michigan Update*, we reported DCH's launch of a new healthy lifestyle program to combat obesity. The program encourages state residents to take four (4) actions and follow four (4) measures, hence the name "4 X 4 Plan". More recently DCH has issued approximately $900,000 in grant funding to six coalitions with plans to create environments that increase availability of healthy foods and access to physical activity opportunities in communities along with implementing multi-component community campaigns. The grantees include:

- Berrien County Health Department
- Capital Area Health Alliance
- District Health Department #10
- Greater Flint Health Coalition
- Inter-Tribal Council of Michigan
- Oakland County Health Division

For more information, contact Esther Reagan, Senior Consultant, at (517) 482-9236.

Abbott Laboratories Depakote Settlement

On October 2, 2012 a federal court in Virginia approved a settlement in which Abbott Laboratories agreed to pay more than $1.5 billion over allegations that it promoted the anti-seizure drug Depakote for uses not approved by the Food and Drug Administration, including treatment of schizophrenia, agitated dementia and autism. Michigan is one of the 45 states slated to receive a piece of the settlement.

For more information, contact Esther Reagan, Senior Consultant, at (517) 482-9236.

Primary Care Physician Rate Increase

DCH has released a proposed policy (*see the Medicaid Policies article in this newsletter*) to implement Section 1202 of the Affordable Care Act of 2010, the federal health care reform law. This law requires state Medicaid agencies to establish payment rates no lower than Medicare levels for specific primary care services rendered by physicians with specialties (or subspecialties) in family medicine, general internal medicine or pediatric medicine and to make payments at those levels for services rendered in

2013 and 2014. The enhanced payment rate is funded by the federal government.

The specific services for which the enhanced payment rates are available are Healthcare Common Procedure Coding System/Current Procedural Terminology (HCPCS/CPT) Evaluation and Management (E/M) codes 99201 through 99499 as well as vaccine administration codes 90460, 90461, 90471, 90472, 90473 and 90474. Payment rates will follow the Medicare fee schedule, be applicable to the site of service (facility or non-facility) and be adjusted for geographic location.

Physicians must meet the specified eligibility criteria to receive the enhanced payment and DCH is validating this information through the Community Health Automated Medicaid Processing System (CHAMPS) provider enrollment file. Board certification in an applicable specialty is acceptable documentation of eligibility. For physicians that have identified one of the designated specialties in their CHAMPS provider enrollment file but without board certification, DCH is reviewing the physicians' billing history to confirm that at least 60 percent of paid procedure codes are for the specified E/M or vaccination services. Physicians who believe they qualify for the enhanced payment rates are encouraged to check their CHAMPS provider enrollment record on the DCH website to verify that appropriate specialty information is on file.

The primary care services of non-physician providers working under physician supervision, such as physician assistants and nurse practitioners, will also be eligible for enhanced payment rates if the supervising physician qualifies for the enhanced rate as well. Physicians rendering care at Federally Qualified Health Centers, Rural Health Clinics or in Local Health Department Clinics are not eligible for enhanced payments.

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Medicaid Policies

DCH DCH has issued three final policies and nine proposed policies that merit mention. The policies are available for review on DCH's web site.

- **MSA 12-47** notifies **Optometrists, Rural Health Clinics and Federally Qualified Health Centers** that **Optometrists are eligible for Electronic**

Health record (EHR) Incentive Program payments.

- **MSA 12-48** informs **Ambulance Providers and Hospitals** of **prior authorization** requirements for both the base rate and mileage for **non-emergency air ambulance** transportation services by fixed wing aircraft.
- **MSA 12-49** advises **Hospitals** that the Disproportionate Share Hospital (**DSH**) payment **process is being modified**.
- A proposed policy (**1243-ACA**) has been issued that would implement **new Medicaid provider screening and enrollment requirements** and other measures related to Medicaid **fraud and abuse**. The requirements are consistent with provisions in the Affordable Care Act, the federal health care reform law. Comments were due to DCH on October 29, 2012.
- A proposed policy (**1239-TPL**) has been issued that would clarify existing policy regarding **Medicaid liability** in instances where a **service would have been covered** and paid by Medicare or a commercial health insurance plan **but some requirement of the plan was not met**. Comments are due to DCH by October 11, 2012.
- A proposed policy (**1237-NF**) has been issued that would require **out-of-state borderland nursing facilities** serving Michigan Medicaid beneficiaries to annually **provide survey and licensure information** to DCH. Comments are due to DCH by November 6, 2012.
- A proposed policy (**1246-DRG**) has been issued that would update the Medicare-Severity Diagnosis Related Group (**MS-DRG**) **Grouper from Version 29.0 to 30.0,** update hospital **DRG weights and rates** as well as **distinct part rehabilitation hospital per diem rates** and convert from date of admission-driven **coding and reimbursement to date of discharge**. Comments are due to DCH by November 6, 2012.
- A proposed policy (**1241-MHP**) has been issued that would clarify **responsibilities of non-contracted hospitals and Medicaid Health Plans** concerning **post-stabilization authorization determinations.** Comments are due to DCH by November 15, 2012.
- A proposed policy (**1245-ED**) has been issued that would require Medicaid-enrolled **birthing hospitals to use evidence-based guidelines for elective deliveries** in an effort to reduce elective delivery rates prior to 39 weeks completed gestation. Comments are due to DCH by November 20, 2012.

- A proposed policy (**1248-Lab**) has been issued that would **eliminate the $50 and $125 maximum daily limits for laboratory services** performed by practitioners, clinics and independent laboratories when rendered by the same provider, for the same beneficiary and on a single date of service. Comments are due to DCH by November 20, 2012.
- A proposed policy (**1249-RI**) has been issued that would implement Section 1202 of the Affordable Care Act (the federal health care reform law) and **increase physician primary care rates for designated services by qualified physicians to Medicare levels**. Comments are due to DCH by November 20, 2012.
- A proposed policy (**1140-MIHP**) has been issued that would clarify **transportation** services provided for **Maternal Infant Health Program beneficiaries enrolled in Medicaid Health Plans**. Comments are due to DCH by November 24, 2012.

For more information, contact Esther Reagan, Senior Consultant, at (517) 482-9236.

Health Management Associates is an independent national research and consulting firm specializing in complex health care program and policy issues. Founded in 1985, in Lansing, Michigan, Health Management Associates provides leadership, experience, and technical expertise to local, state, and federal governmental agencies, regional and national foundations, investors, multi-state health system organizations and single site health care providers, as well as employers and other purchasers in the public and private sectors.