

The Michigan Update

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*Happy Holidays from
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Medicaid Managed Care Enrollment Activity

As of December 1, 2012, there were **1,245,470 Medicaid beneficiaries enrolled** in 13 Medicaid Health Plans (HMOs), an **increase of 17,722** since November 1, 2012. The number of Medicaid beneficiaries eligible for managed care enrollment also increased in December - there were 1,311,176 eligible beneficiaries, up from 1,296,034 in November. The number of Medicaid beneficiaries dually eligible for Medicare (duals) enrolled in Medicaid HMOs to receive their Medicaid benefits continues to grow - there were **31,142 duals enrolled in December**, up from 29,617 in November, an increase of 1,525. The number of Medicaid children dually eligible for the Children's Special Health Care Services (CSHCS) program enrolled in Medicaid HMOs also continues to grow - there were **5,671 Medicaid/CSHCS children enrolled in December**, up from 1,487 (an increase of almost 400 percent) in November.

As the enrollment reports ([.pdf](#)) ([.xls](#)) reflect, 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.

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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 the plan of the Department of Community Health (DCH) to enroll children (and a few adults) receiving services from the Children's Special Health Care Services (CSHCS) program and the Medicaid program in Medicaid Health Plans (HMOs). Enrollment began in October 2012 and is expected to be completed by February 2013. As of December 1, 2012, there were **5,671 CSHCS/Medicaid beneficiaries enrolled in the Medicaid HMOs** to receive their Medicaid benefits. Of this total, 410 children were auto-assigned to an HMO and 5,261 - the vast majority - voluntarily enrolled. All Medicaid HMOs except Pro Care Health Plan have CSHCS/Medicaid enrollees although the numbers vary across plans.

As the table below reflects, Meridian Health Plan of Michigan has the most CSHCS/Medicaid enrollees receiving their Medicaid services from an HMO, more than 26 percent of the total. United Healthcare Community Plan has 14 percent of the total; Molina Healthcare of Michigan has almost 13 percent; McLaren Health Plan has almost 12 percent; and the other eight plans share the remaining 35 percent. Since the CSHCS/Medicaid enrollment into HMOs is being phased on a geographic basis, the distribution among plans is largely reflective of the service areas of those plans. Southeast Michigan is scheduled to be last.

December 2012 CSHCS/Medicaid Enrollment			
Medicaid Health Plan	Voluntary Enrollees	Auto-Assigned Enrollees	Total Enrollees
Blue Cross Complete of MI	196	5	201
CoventryCares of MI	62	0	62
HealthPlus Partners	295	1	296
McLaren Health Plan	656	17	673
Meridian Health Plan of MI	1,441	42	1,483
Midwest Health Plan	332	15	347
Molina Healthcare of MI	700	23	723
PHP Mid-MI Family Care	61	6	67
Priority Health Govt. Programs	562	9	571
Pro Care Health Plan	0	0	0
Total Health Care	169	8	177
UnitedHealthcare Comm. Plan	768	27	795
Upper Peninsula Health Plan	19	257	276
Total	5,261	410	5,671

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Duals in Medicaid HMOs

As of December 1, 2012, there were **31,142 Medicaid beneficiaries dually eligible for Medicare (duals) enrolled in Medicaid HMOs** to receive their Medicaid services, an increase of 1,525 since November. The number of duals enrolled through auto-assignment as of December 1, 2012 was 15,331, and the number of duals enrolled on a voluntary basis was 15,811. 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 31 percent of the total; UnitedHealthcare Community Plan has almost 24 percent of the total; Meridian Health Plan of Michigan has almost 15 percent of the total (but the most voluntary enrollees); and the other 10 plans share the remaining 31 percent.

December 2012 Medicaid Dual Eligible Enrollment			
Medicaid Health Plan	Voluntary Enrollees	Auto-Assigned Enrollees	Total Enrollees
Blue Cross Complete of MI	347	296	643
CoventryCares of MI	459	101	560
HealthPlus Partners	767	181	948
McLaren Health Plan	1,624	704	2,328
Meridian Health Plan of MI	3,715	871	4,586
Midwest Health Plan	985	686	1,671
Molina Healthcare of MI	2,442	7,256	9,698
PHP Mid-MI Family Care	203	37	240
Priority Health Govt. Programs	877	687	1,564

Pro Care Health Plan	20	21	41
Total Health Care	689	199	888
UnitedHealthcare Comm. Plan	3,247	4,060	7,307
Upper Peninsula Health Plan	436	232	668
Total	15,811	15,331	31,142

Six of the 13 Medicaid HMOs in Michigan are also federally contracted as Medicare Advantage Special Needs Plans (SNPs) to provide *Medicare* benefits for duals: McLaren Health Plan, Meridian Health Plan of Michigan, Midwest Health Plan, Molina Healthcare of Michigan, UnitedHealthcare Community Plan and Upper Peninsula Health Plan. As of December 1, 2012 these six SNPs have a combined enrollment of 14,980 duals for whom they provide Medicare services; 57.7 percent of the duals enrolled in SNPs for Medicare services are enrolled in the Molina plan, 30.1 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 **37,901 children enrolled** in the MIChild program as of December 1, 2012. This is a decrease of 191 since November 1, 2012.

As the enrollment report ([.pdf](#)) ([.xls](#)) for December shows, enrollment is dispersed between 10 plans, with more than 75 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 (48.1 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 December 2012, DCH reports there were **28,979 ABW beneficiaries enrolled** in the program, **a decrease of 699** since the middle of

November and the lowest enrollment since the beginning of the program in January 2004. There are 28 County Health Plans (CHPs) serving ABW beneficiaries in 73 of Michigan's 83 counties. As of December 1, 2012, the combined ABW **enrollment in the 28 CHPs was 26,370**, a **decrease of 174** since November.

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

Michigan Receives CHIPRA Bonus

The Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) established performance bonuses, giving states an incentive to support enrollment and retention of eligible children in Medicaid and CHIP and helping to defray the costs associated with increasing enrollment of the lowest income children. On December 19, 2012, the US Department of Human Services announced that fiscal year 2012 bonuses totaling \$306 million would be awarded to 23 states. Michigan qualified for and received a bonus of \$3,296,270.

To qualify for a performance bonus states must implement at least five out of eight specific program features aimed at streamlining their enrollment procedures to improve children's health coverage programs and must increase children's enrollment in Medicaid above a baseline level for the fiscal year. The eight program features include (Michigan's bonus was based on the first six features):

- 12-month continuous eligibility regardless of income or other changes
- Elimination or reduced verification of asset requirements
- No requirement for an in-person interview
- Common application and renewal forms for Medicaid and CHIP
- Automatic/administrative renewals using pre-populated forms or electronic verifications
- Presumptive eligibility allowing access to needed benefits during eligibility determination
- Express Lane Eligibility, which uses eligibility findings from other public benefit programs for Medicaid and CHIP determinations
- Premium assistance

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Freedom to Work

One of the bills signed by Governor Rick Snyder in late December (Senate Bill 564 - Public Act 356 of 2012) revises eligibility criteria and premium payment requirements for Michigan's Freedom to Work (FTW) Medicaid program. The FTW program allows full Medicaid benefits for persons meeting federal disability criteria who have returned to the work force. These individuals are determined eligible for Medicaid although their earned and unearned income is higher than would otherwise qualify them for benefits. Monthly premiums are required, based on income, to offset the cost of health care benefits. The revision in law modifies income eligibility criteria and eliminates the requirement that the individual be covered by Medicaid before qualifying for the program. The number of persons who may newly qualify for this program is estimated to be about 3,300, and the net increase in state general fund costs (after revenue adjustments for federal Medicaid matching funds, premiums and income and sales tax) is projected to be about \$1.6 million per year.

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Medicaid Expansion

One of the provisions of the Affordable Care Act permits states to expand Medicaid eligibility to 133 percent of the federal poverty level (with an additional five percent income disregard) beginning January 2014. The individuals who would gain Medicaid coverage through this provision are adults between the ages of 21 and 65 who are not eligible for Medicare. This group is estimated at approximately 400,000 in Michigan, a large portion of which will be individuals that are not parents. Under the act, the federal government would pay 100 percent of the increased cost of health care for this newly eligible population through 2016; then the federal match rate would be gradually reduced and would be 90 percent in 2020 and beyond. In late December the federal government issued guidelines relative to the expansion. The guidance specifically noted that states cannot expand Medicaid eligibility to less than 133 percent of the poverty level and receive 100 percent federal funding. Governor Rick Snyder has not yet decided whether Michigan should expand eligibility, saying his decision will depend largely on whether the state's medical practices have the capacity to accept an influx of new patients.

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Melanie Brim to Succeed Retiring Jean Chabut at DCH

Jean Chabut, Director of DCH's Public Health Administration for many years will be retiring in a few months. Melanie Brim, Deputy Director of DCH's Policy and Planning Administration since April 2011, has been appointed by DCH Director James Haveman to succeed Ms. Chabut beginning in January 2013. There will be a brief transition period. Prior to her appointment as a deputy director, Ms. Brim was Director of the Bureau of Health Professions for almost a decade, responsible for licensing and regulation of Michigan's health professionals.

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

Patrick Barrie

Patrick C. Barrie, Executive Director of the Washtenaw Community Health Organization, died suddenly on December 3, 2012. Mr. Barrie served as Deputy Director of the Mental Health Substance Abuse Administration in DCH from 1995 through 2008 and was instrumental in the department's shift to managed care for behavioral health services.

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

Medicaid Policies

DCH has issued ten final policies and four proposed policies that merit mention. The policies are available for review on [DCH's web site](#).

- **MSA 12-57** informs **Nursing Facilities and other Long-Term Care Providers** of Medicaid requirements for **borderland** providers, specifically that facilities must have a current license as well as a standard Health Survey and Life Safety Code Survey.
- **MSA 12-58** advises **Practitioners, Clinics and Independent Laboratories** that maximum **daily dollar limits for laboratory services** will be eliminated effective for dates of service on and after January 1, 2013.

- **MSA 12-59** provides guidance to **Hospitals, Physicians and Clinics** regarding **elective, non-medically indicated deliveries** prior to 39 weeks gestation.
- **MSA 12-60** notifies **Nursing Facilities** of **cost reporting options** when terminating Medicaid program participation or closing.
- **MSA 12-61** informs **Hospitals and Medicaid Health Plans** of new **inpatient hospital reimbursement rates** effective for admissions on and after January 1, 2013. DCH is also converting from **date of admission to date of discharge** for reimbursement.
- **MSA 12-62** notifies **Hospitals, Ambulatory Surgical Centers (ASCs)** and others of an update to the Outpatient Prospective Payment System (**OPPS**) and **ASC** statewide budget neutrality **reduction factor** effective January 1, 2013 - from 55.3 percent to 54.3 percent.
- **MSA 12-63** advises **All Providers** that DCH will no longer issue policy bulletins with updates to the **Sanctioned Provider List**. Instead, the list will be maintained on the DCH web site.
- **MSA 12-65** informs **All Providers** that beginning January 1, 2013 DCH will implement a new **predictive modeling process** for fee-for-service claims. Claims flagged during the process will undergo a **detailed analysis**, which could include a review of medical records or previously paid claims.
- **MSA 12-66** notifies **Practitioners, Hospitals and Medicaid Health Plans** of a **physician primary care rate increase** effective for dates of service on and after January 1, 2013 and through December 31, 2014. The increase will be applied to a **specific set of services and procedures** rendered by physicians with a **specialty designation** of family medicine, general internal medicine or pediatric medicine.
- **MSA 12-67** advises **All Providers** of the quarterly **Updates to the Medicaid Provider Manual** and also includes an **ICD-10 implementation update**.
- A proposed policy (**1253-NEMT**) has been issued that would permit **documentation of medical necessity for non-emergency ambulance transports** to be **signed by physician assistants, nurses or discharge planners** employed by the attending physician or facility to which the individual is admitted. Comments are due to DCH by December 29, 2012.
- A proposed policy (**1256-PPR**) has been issued that would notify providers of changes related to

DCH's **post-payment review hospital contract**. Comments are due to DCH by December 29, 2012.

- A proposed policy (**1241-MHP**) has been issued that would clarify **responsibilities of non-contracted hospitals and Medicaid Health Plans** concerning patient **post-stabilization authorization determinations**. Comments are due to DCH by January 8, 2013.
- A proposed policy (**1255-RA**) has been issued that would establish a **Fiscal Year 2013 Rural Access Pool** for small rural hospitals and sole community hospitals. Comments are due to DCH by January 18, 2013.

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***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.*