HEALTH MANAGEMENT ASSOCIATES

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Medicaid Managed Care Enrollment Activity

As of February 1, 2012, there were **1,228,180 Medicaid beneficiaries enrolled** in 14 Medicaid Health Plans (HMOs), an **increase of 1,447** since January 1, 2012. The number of Medicaid beneficiaries eligible for managed care enrollment also increased in February - there were 1,289,495 eligible beneficiaries, up from 1,286,328 in January. There was also an increase in the number of Medicaid beneficiaries dually eligible for Medicare ("duals") enrolled in Medicaid HMOs to receive their Medicaid benefits - there were **15,292 duals enrolled in February, up from 13,650 in January**, an increase of 1,642. The increase in enrollment of duals was greater than the total HMO enrollment increase, implying a decline in the number of HMO enrollees receiving only Medicaid benefits.

As the enrollment reports (.pdf) (.xls) for February reflect, every county in the state is served by at least one Medicaid Health Plan. The reports also reflect that **UnitedHealthcare GLHP is now called UnitedHealthcare Community Plan** for consistency with plans owned by the same organization in other states across the country.

Auto-assignment of beneficiaries into Medicaid Health Plans is now in place in every county of the state. Fee-for-service care is an option in only one county - Barry - which is also the only remaining "Preferred Option" county. Beneficiaries in Barry County who do not specifically choose the fee-for-service option are auto-assigned to a contracted health plan but may return to fee-for-service at any time. Beneficiaries in all 15 counties in the Upper Peninsula are auto-assigned through federal "Rural Exception" authority to the one health plan serving the counties.

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Duals in Medicaid HMOs

The number of Medicaid beneficiaries dually eligible for Medicare auto-assigned to the Medicaid HMOs in February was 8,677; the number of duals voluntarily enrolling in the HMOs was 6,615. Every HMO has duals enrolled although the numbers vary dramatically across plans.

Molina Healthcare of Michigan has the most enrollees, about 41 percent of the total; UnitedHealthcare Community Plan has about 24 percent of the total; Meridian Health Plan of Michigan has about 13 percent of the total; and the other 11 plans share the remaining 22 percent.

Six of the 14 Medicaid HMOs are federally contracted as Medicare Advantage Special Needs Plans (SNPs) to provide Medicare benefits for duals: CareSource Michigan, Meridian, Midwest Health Plan, Molina, UnitedHealthcare and Upper Peninsula Health Plan. As of February 1, 2012 these six SNPs have a combined enrollment of 11,892 duals for whom they provide Medicare services; 60 percent of the duals are enrolled in the Molina plan, 29 percent are enrolled in the UnitedHealthcare plan and the remaining 11 percent are spread across the other four plans.

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CSHCS and Managed Care

The Department of Community Health (DCH) is meeting with stakeholders to develop a plan for enrolling children dually eligible for Medicaid and the Children's Special Health Care Services (CSHCS) program into Medicaid HMOs that meet core competency requirements being developed. Such enrollment is a requirement in current year DCH appropriation language. An October 1, 2012 implementation date is targeted. Several of the core competency requirements mirror current language in DCH's contract with the HMOs; however there are a number of other requirements proposed that would be specific to the special needs of the CSHCS population.

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MIChild

According to MAXIMUS, the DCH contractor for MIChild enrollment, there were **37,457 children enrolled** in the MIChild program as of February 1, 2012. This is a **decrease of 60** since January 1, 2012.

As the enrollment report (pdf) (.xls) for February shows, enrollment is dispersed between ten plans, with more than 77 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 or Delta Dental Plan, with each plan's enrollment level almost equal.

A Calendar Year 2011 MIChild Report was recently released and noted that 246,308 children have received health coverage through the MIChild program since its implementation in 1998. The report also shows that 20 percent of current enrollees are under age five; 22 percent are 5 to 14 years of age and 58 percent are age 15 to 18.

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Adult Benefits Waiver (ABW)

As of the middle of February 2012, DCH reports there were **44,871 ABW beneficiaries enrolled** in the program, **a decrease of 1,530** since the middle of January. Enrollment in the program one year ago this month, just after the most recent open enrollment period ended, stood at 92,978.

There are 28 County Health Plans (CHPs) serving ABW beneficiaries in 73 of Michigan's 83 counties. As of February 1, 2012, the combined ABW **enrollment in the 28 CHPs was 40,782**, a **decrease of 2,232** since January. The enrollment level one year ago this month stood at 82,725.

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

Federal Budget

On February 13, 2012, President Barack Obama's election year budget was unveiled. The Administration's Fiscal Year

(FY) 2013 proposed budget presents a $3.8 trillion spending plan, with a slight delay in deficit reduction. Medicare and Medicaid, and other health programs, are generally protected with proposed changes ("improvements") that will save $364 billion over the next ten years. In related news, President Obama recently approved legislation preventing the 27.4 percent reduction to Medicare physician payments, which was scheduled to take effect March 1, 2012.

The proposed budget embraces the preservation and implementation of the Patient Protection and Affordable Care Act (ACA - the federal healthcare reform law) and its guaranteed subsidies by providing resources to build state capacity and infrastructure. The proposed Department of Health and Human Services (HHS) budget ($76.4 billion) calls for more than $200 billion in Medicare cuts to hospitals, skilled nursing facilities, and other post-acute providers, as well as pharmaceutical companies. To help improve the financial stability of the Medicare program, higher income Medicare beneficiaries (defined as $85,000 for individuals) would pay higher Part B and Part D monthly premiums starting in 2017. New Medicare beneficiaries would be charged a copayment for certain home health services they receive (in 2017). To increase Medicare program integrity, the proposed budget invests $610 million to implement activities that reduce payment error rates, targeting high-risk services and supplies.

Medicaid proposals included in the budget are not new. The Medicaid provider tax threshold states have used would be reduced in 2015; a single blended matching rate for Medicaid and Children's Health Insurance Program (CHIP) spending is proposed to replace the myriad and complex array of matching formulas that confound states and the health sector (in 2017); and state Disproportionate Share Hospital (DSH) allotments would be rebased.

At this stage, the outlook for these federal budget proposals is uncertain. The proposals provide a framework for policy deliberations in a highly volatile year and, given election uncertainties, it could again be December before final decisions are made.

On February 22, 2012, President Obama signed into law legislation (H.R. 3630) delaying the 27.4 percent reduction in Medicare physician reimbursement rates scheduled to go into effect March 1, 2012. The legislation also extends the current cap on outpatient therapy services and a related exceptions process through December 2012. Language extending a Social Security payroll tax cut and

continuing unemployment benefits through December 2012 was included as well.

To fund the multi-billion "doc fix" provision, the measure calls for several healthcare-related budget offsets including but not limited to reductions in subsidies to hospitals for Medicare "bad debt" payments; reductions in a wellness and disease prevention fund authorized by ACA; and reductions in Medicaid DSH funding (but not until 2021). The new law also requires HHS and the Government Accountability Office (GAO) to conduct studies on new methodologies for Medicare payment, which physicians have repeatedly requested.

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Michigan Budget

On February 21, 2012, DCH Director Olga Dazzo testified before the House Appropriations Subcommittee on Community Health to provide an overview of Governor Rick Snyder's Executive Budget Recommendations for DCH, and on February 28th, Medicaid Director Steve Fitton also provided testimony. (See also the Special Edition of *The Michigan Update* released on February 10, 2012 that focused on the Governor's Recommendations.)

Ms. Dazzo's presentation referenced the need to assure that Medicaid HMO and Prepaid Inpatient Health Plan (PIHP) rates remain actuarially sound and noted that increases of 1.5 percent and 1.25 percent, respectively, would be required at a cost of $75.2 million Gross / $25.3 million General Fund/General Purpose (GF/GP). She also noted an increase in reimbursement rates paid for primary care services to parity with Medicare, an increase funded solely by federal Medicaid dollars ($281.8 million); and encouraged expanded coverage of treatment for autism spectrum disorders ($34.1 million Gross / $10.1 million GF/GP; continued expansion of the Healthy Kids Dental program beyond the current 65 counties ($25.0 million Gross / $8.4 million GF/GP) and an additional $115.3 million Gross / $45.8 million GF/GP to cover caseload adjustments for Medicaid, the CSHCS program and for mental health and substance abuse services. She encouraged restoration of adult chiropractic services, a modest increase in payment rates for non-emergency medical transportation and an expansion of the MI Choice home and community-based services program.

Ms. Dazzo also announced her hope to implement a new

multi-faceted program to reduce infant mortality and a program - called the "4 x 4 Plan" - focused on reducing obesity. She said she was hopeful that grant funding could be obtained from HHS for the obesity program.

Mr. Fitton's testimony stressed that although Michigan is among the lowest-cost states in the country for Medicaid, DCH constantly looks for ways to contain costs while assuring quality care. He reported that Medicaid caseload growth appears to be leveling off after the steep climb over the past few years, and while Medicaid provides coverage for about 40 percent of the state's children and pays for about half of all births, the most costly segment of the Medicaid population is the elderly and disabled. This group consumes about two-thirds of the total benefit cost of the program. He noted that treatment of autism spectrum disorders may increase program costs in the short term but lack of intervention could be more costly in the future. He also stated that establishing a new preferred drug list for psychotropic drugs is a multi-step process and any savings identified prior to completing the process are only estimates.

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Merging Mental Health and Substance Abuse

A tie-barred set of two House Bills (HB 4862 and HB 4863) are being considered in the Michigan House of Representatives that would move substance abuse services into community mental health agencies. Currently substance abuse coordinating agencies deliver substance abuse services and the community mental health agencies coordinate them. If approved by the legislature and signed into law by Governor Snyder, the consolidation would become effective January 1, 2013.

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A Mid-Year State Medicaid Budget Update

On February 13, 2012, the Kaiser Commission on Medicaid and the Uninsured (KCMU) released a mid-year update on state Medicaid budgets and cost containment strategies. This report - *A Mid-Year State Medicaid Budget Update for FY 2012 and A Look Forward to FY 2013* - updates

information in a report issued in October 2011. The earlier report - *Moving Ahead Amid Fiscal Challenges: A Look at Medicaid Spending, Coverage and Policy Trends, Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2011 and 2012* - is highlighted in the October 2011 edition of *The Michigan Update*. Both reports were prepared by HMA staff, led by Vernon Smith, with KCMU staff.

The mid-year update was based on structured discussions in November 2011 with the Executive Board of the National Association of Medicaid Directors (NAMD) and survey questions emailed to all 50 states and DC in December 2011 and January 2012. The report provides a mid-fiscal year 2012 update on state Medicaid issues, augmenting the findings from the comprehensive Medicaid budget survey report published in October 2011.

As states prepared their budgets for FY 2012, almost all continued to experience the ongoing effects of the "Great Recession" including high unemployment and depressed state revenue collections. At the same time, states were forced to dramatically increase FY 2012 state spending for Medicaid by an average of 28.7 percent largely to replace temporary Medicaid federal stimulus funds that expired in June 2011. However, compared to 2011, adopted budgets for FY 2012 assumed total Medicaid spending growth of only 2.2 percent (a near record low) as well as slower enrollment growth. Even within tight FY 2012 budgets, states continue to plan and implement a number of high priority initiatives, including the integration of care for Medicaid beneficiaries dually eligible for Medicare and activities related to health care reform.

Key points from the mid-year update include:

- For FY 2012, the majority of states are experiencing Medicaid spending and enrollment growth equal to or below original growth projections and 10 states reported mid-year Medicaid cuts. These mid-year cuts include additional benefit and provider rate restrictions. The Patient Protection and Affordable Care Act (ACA) "maintenance of eligibility" requirements generally prohibit states from restricting Medicaid eligibility or tightening enrollment procedures until 2014.
- Looking ahead, state interest in initiatives for duals remains high and states continue to move forward with the implementation of health reform.
- States are also continuing to grapple with the lingering effects of the Great Recession on state

revenues and Medicaid spending, although many states are beginning to see signs of economic improvement. While most have avoided the need for additional mid-year budget cuts, a few states have yet to close budget gaps for FY 2012. The outlook for 2013 and be-yond remains difficult with continued pressure to find Medicaid cuts, although few options for additional savings remain.
- Medicaid remains front and center in state budget discussions as governors release pro-posed budgets for FY 2013.

The mid-year update and the comprehensive report released in October 2011 are available on the KCMU web site at www.kff.org/medicaid/8248.cfm. The publications are also available on HMA's web site at www.healthmanagement.com.

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Kids Count Update on Poverty

In the August 2011 edition of *The Michigan Update* we reported that the Annie E. Casey Foundation had released the *2011 Kids Count Data Book* ranking all 50 states on ten key indicators of child well being. On February 23, 2012, the Foundation released a *Data Snapshot on High-Poverty Communities*, which ranked Michigan 44th among the states for concentration of poverty, defined as neighborhoods where 30 percent or more of the population lives in poverty. The report said there are 341,000 children living in high-poverty communities in Michigan, a 57 percent increase over the past ten years.

Among the 50 largest cities in the country, Detroit had the biggest share of children - two out of every three - living in concentrated poverty. The report also noted that poverty is not concentrated in urban areas in Michigan. In addition to Wayne, the counties with the largest share of children in neighborhoods with concentrated poverty are Alpena, Chippewa, Genesee, Ingham, Isabella, Roscommon and Saginaw.

The *Data Snapshot* is available on the Foundation's web site at: www.kidscount.org. Additional information is available on the Michigan League for Human Services' web site at www.milhs.org.

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

ICD-10 Implementation

US Health and Human Services Secretary Kathleen Sebelius announced on February 16, 2012 that the deadline for compliance with International Classification of Diseases 10th edition (ICD-10) coding, scheduled for October 1, 2013, will be delayed to a date as yet undetermined. DCH continues its progress toward implementation of the ICD-10 coding conversion and has thus far not announced a delay. For additional information about DCH's activities related to ICD-10, please check the Department's web site at www.michigan.gov/mdch/0,1607,7-132-2945_42542_42543_42546_42552_42696-256928--,00.html

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Medicaid Policies

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

- **MSA 12-02** advises **Hospitals, Outpatient Rehabilitation Facilities and Practitioners** of changes in **outpatient therapy service limitations**.
- **MSA 12-04** notifies **Eligibility Manual Holders, Family Planning Clinics, Practitioners and Others** that women with **Medicaid deductible eligibility** may qualify for **Plan First! family planning** services during periods prior to meeting deductible obligations.
- A proposed policy (**1201-Eligibility**) has been issued that would add terms to the **Beneficiary Eligibility Manual** related to **Medicaid eligibility and divestment** penalties. Comments are due to DCH by March 19, 2012.
- A proposed policy (**1203-Therapy**) has been issued to remind providers that **Speech-Language Pathologists must be licensed by the State of Michigan** in order to provide services for Medicaid beneficiaries. Comments are due to DCH by March 26, 2012.
- A proposed policy (**1204-Eligibility**) has been issued for the **Estate Recovery** program that would identify **criteria for recovering monies** from the estates of deceased Medicaid

beneficiaries. Comments are due to DCH by March 26, 2012.

- A proposed policy (**1144-MHSA**) has been issued that would revise the **Mental Health and Substance Abuse** chapter in the Medicaid Provider Manual related to **approved pharmacological supports**. Comments are due to DCH by March 26, 2012.

DCH has also issued three L-letters that merit mention. The letters are available for review on the same web site.

- **L 12-04** was issued in early February 2012 and directed to **Providers and Billing Agents**. It relates to **readiness** for Health Insurance Portability and Accountability Act (HIPAA) 5010 claim and encounter data submissions and notes that **DCH will no longer accept HIPAA 4010 claim and encounter submissions after March 2012.**
- **L 12-05** was issued in early February 2012 and directed to **Medicaid Health Plans** (HMOs). It advises that **prior authorization for hospital services is not permitted for members dually eligible for Medicare and receiving Medicare benefits on a fee-for-service basis.**
- **L 12-06** was issued on February 13, 2012 and directed to **Tribal Chairs and Health Directors**. It advises that DCH will be submitting a State Plan Amendment to allow qualifying **Optometrists** to participate in Michigan's Medicaid Electronic Health Record **(EHR) Incentive Program**.

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