HEALTH MANAGEMENT ASSOCIATES

June 2013

The Michigan Update

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Medicaid Managed Care Enrollment Activity

As of June 1, 2013, there were **1,244,601 Medicaid beneficiaries enrolled** in 13 Medicaid Health Plans (HMOs), **a decrease of 2,946** since May 1, 2013. This enrollment decrease is largely because the number of enrollments in process increased during May. The number of Medicaid beneficiaries eligible for managed care enrollment increased in June - there were 1,298,368 eligible beneficiaries, up from 1,294,213 in May.

The number of Medicaid beneficiaries dually eligible for Medicare (duals) enrolled in Medicaid HMOs to receive their Medicaid benefits continues to grow - there were **38,257 duals enrolled** in June, up from 36,916 in May, an increase of 1,341. The number of Medicaid children dually eligible for the Children's Special Health Care Services (CSHCS) program enrolled in Medicaid HMOs appears to have stabilized - there were **17,702 CSHCS/Medicaid children enrolled** in June, an increase of 47 since May.

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.

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

MIChild

Owner Vanguard Purchased

Medicaid Policies

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According to MAXIMUS, the DCH contractor for MIChild enrollment, there were **37,837 children enrolled** in the MIChild program as of June 1, 2013. This is a decrease of 42 since May 1, 2013.

As the enrollment report (.pdf) (.xls) for June shows, enrollment is dispersed between 10 plans, with almost 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 (48.4 percent) or Delta Dental Plan (46.7 percent).

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

BCBSM to Phase Out of MIChild

At a meeting of hospitals and Medicaid Health Plans held on June 17, 2013, DCH staff announced that Blue Cross Blue Shield of Michigan (BCBSM) will terminate its participation as a MIChild program statewide health plan.

This decision came after many discussions between the two parties about the applicability of certain federal requirements to the plan. BCBSM's departure from the program will be phased out over a period as yet uncertain because only seven counties currently have sufficient participation by other health plans to move forward. Thirty-eight counties are currently served by BCBSM and only one other plan and another 38 counties are currently served only by BCBSM. Health plans will need to develop new service areas and receive approval from the Department of Insurance and Financial Services before the transition can be completed. Because MIChild is considered a commercial product, plans will need to assure hospital contracts are in place before service area approval will be possible. The enrollment reports provided with this newsletter - see the "MIChild" article - indicate current service areas for other health plans.

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Adult Benefits Waiver (ABW)

As of the middle of June 2013, DCH reports there were **79,515 ABW beneficiaries enrolled** in the program, **an increase of 8,380** since the middle of May, and an increase of 53,500 since the middle of March. The increase is attributed to an **open enrollment period** during the

month of April, the first since October - November 2010. The highest ever enrollment in the ABW waiver program occurred in January 2011, shortly after the last open enrollment period; a total of 94,273 individuals were enrolled that month. There are 28 County Health Plans (CHPs) serving ABW beneficiaries in 73 of Michigan's 83 counties. As of June 1, 2013, the combined ABW **enrollment in the 28 CHPs was 61,761, an increase of 25,662** since May. Enrollment in the CHPs will continue to grow as additional individuals are assigned to a CHP.

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

Integrated Care for Dual Eligibles

In previous editions of *The Michigan Update* we have written about Michigan's plan to implement an integrated delivery system of health care for persons dually eligible for Medicare and Medicaid (duals) through contracts with Integrated Care Organizations (ICOs). The state proposes a three-year demonstration in four regions of the state - the entire Upper Peninsula, an eight-county region in southwest Michigan (Barry, Berrien, Branch, Calhoun, Cass, Kalamazoo, St. Joseph and Van Buren Counties), and the single county regions of Macomb and Wayne Counties, with implementation phased in beginning July 1, 2014.

On June 25, 2013, DCH held the first of what are to be quarterly forums around the state as part of an ongoing stakeholder engagement process. Some of the highlights from the presentation and discussion include:

- It is still the goal of DCH to release a Request for Proposals (RFP) during the summer and to finalize a Memorandum of Understanding with the Centers for Medicare & Medicaid Services (CMS) by September 2013.
- The procurement process will require applicants to successfully pass the Medicare criteria for designation as a Financial Alignment Demonstration participant; this includes passing the Model of Care requirements.
- Medicare payment rates are expected to be released in August 2013; Medicaid rates will be released later. The RFP may be issued prior to rate finalization.
- The two-contract approach remains in place for the demonstration. Medicaid funding for behavioral health services will flow directly to the Prepaid Inpatient Health Plans (PIHPs) as it does now and

Medicare funding for behavioral health services will flow through the ICOs to the PIHPs. The RFP is expected to include language regarding funding incentives for collaboration between the ICOs and PIHPs.

- While long-term care services are included in the demonstration, hospice services will be carved out of the demonstration and paid on a fee-for-service basis; this does not mean persons receiving hospice services are excluded from ICO enrollment.
- Medicaid beneficiaries with a deductible are excluded from the demonstration because they may not have coverage for an entire month.
- Enrollees in Medicare Advantage Special Needs Plans, as well as enrollees in a Program of All-Inclusive Care for the Elderly (PACE) or the MI Choice program will be able to continue this enrollment or enroll in an ICO.
- ICOs must offer care coordination services to all enrollees, with the level of intensity appropriate to each enrollee's needs; enrollees may choose not to receive the services.
- Extensive enrollee outreach and education will occur in preparation for the enrollment period. For a short time prior to the start of the enrollment process, perhaps 60 days, individuals will be able to opt in or opt out of the program. Thereafter, persons eligible for the program that do not make an active selection to enroll or decline enrollment in the program will be passively enrolled, but able to opt out.
- DCH will establish an Advisory Council comprised of no more than 30 individuals representing diverse communities, including enrollees and their families, advocates, and others. The application process for council membership will be posted on the DCH website in about six weeks.
- DCH will establish an independent Demonstration Ombudsman Program to assist beneficiaries in resolving issues related to the demonstration and to monitor beneficiary experience with the Integrated Care initiative.
- In addition, the Michigan Disability Rights Coalition has received a grant to fund the Michigan Voices for Better Health. The purpose of the grant is to support consumers and to work with providers and health plans to understand and resolve any systemic issues that arise.

The slides used by state staff during the forum will be posted on the DCH website.

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DCH Budget

As noted in the previous issue of *The Michigan Update*, the Michigan House of Representatives passed an omnibus appropriation (HB 4328) that included Fiscal Year 2013-2014 DCH funding. The DCH appropriation did not include funding to support the Medicaid expansion but funded several coverage expansions including the addition of three more counties (Ingham, Ottawa and Washtenaw) to the state's Healthy Kids Dental program. On June 4, 2013, the Michigan Senate passed HB 4328 without any changes and the bill was signed into law as Public Act 59 of 2013 by Governor Rick Snyder on June 18, 2013.

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Medicaid Expansion in Michigan

A reported in previous issues of *The Michigan Update*, the Michigan legislature has been debating legislation authorizing expansion of Medicaid eligibility to individuals with income below 138 percent of the federal poverty level (FPL) but has yet to approve a bill.

In May 2013, Representatives Al Pscholka and Matt Lori introduced HB 4714, legislation authorizing expansion of Michigan's Medicaid program. The legislation, as initially drafted, made expansion of the program contingent upon a number of factors, several of which could have been viewed unfavorably by the federal government. Potentially problematic elements of the initial bill included provisions that would require disenrollment of certain enrollees in the program after 48 months and a mandated link between Michigan's operation of a Medicaid expansion program and full federal funding to support Medicaid benefits for non-disabled adults.

The House Committee on Competitiveness created a substitute version of HB 4714, which addressed many of the concerns expressed about the structure of the Medicaid expansion and restructured the proposed program as follows:

- The substitute eliminated the requirement that DCH achieve a federal waiver allowing disenrollment of any individual enrolled in Medicaid for more than 48 months. This provision was replaced with new language to permit an increase in the maximum

out-of-pocket cost for those with income between 100 and 133 percent of the FPL enrolled in Medicaid for more than 48 months.
- The substitute struck language that would eliminate the Medicaid expansion when state financial participation would be required (in 2017) and replaced it with language to sunset the expansion program when state savings associated with the program are not sufficient to cover Michigan's matching funds requirement.
- The substitute would still require contracted health plans to create incentive programs to reduce enrollee cost sharing requirements.

The substitute version of HB 4714 was passed by the House on June 13 by a vote of 76-31.

Senate consideration of HB 4714 was scheduled for the week of June 18 to 20. DCH said the department needed time to write and negotiate a waiver including the plan's provisions with CMS; as such, a legislative decision by June 20, 2013 was necessary to ensure implementation in January 2014. The timeline also recognized that the legislature was scheduled to be out for a summer recess until August 27, returning only briefly on July 3rd and July 18th. Media reports suggest there was considerable internal debate within the majority Republican caucus about HB 4714 but the bill was never taken up for a vote. At this point it is not clear if there is sufficient support within the Senate for passage of the bill. More critically it is not clear if there is sufficient support within the majority Senate caucus to even permit a vote on the legislation.

Governor Rick Snyder has continued to advocate for his Healthy Michigan program, which includes Medicaid expansion. He has encouraged those that support Medicaid expansion to urge their Senators to convene a session during their summer recess and enact HB 4714. He has also scheduled public appearances around the state to increase public awareness of the legislation and its attributes. US Congressman Dan Kildee (D) has also launched a website, which includes a citizen petition, calling on the Governor and the state Senate to schedule a vote on the Medicaid reform and expansion bill.

On June 26, Senate Majority Leader Randy Richardville named a work group to examine the feasibility of Medicaid expansion. The group is to meet over the coming weeks, will be headed by Senate Appropriations Chair Roger Kahn (R-Saginaw) and will include Senator Bruce Caswell (R-Hillsdale), Senator John Pappageorge (R-Troy), Senator Dave Robertson (R-Grand Blanc), Senator Darwin Booher (R-Evart) and Senator Jim Marleau (R-Lake Orion). The group is tasked with identifying a feasible option for

expanding Medicaid in Michigan in 2014. Senator Kahn was quoted as saying on June 27 that the group has already had one discussion by telephone with more planned. He said the provisions of HB 4714 will be discussed along with those in SB 422 (see "Non-Medicaid Health Coverage Expansion" article) and that he hoped to make significant progress over the next few weeks.

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Non-Medicaid Health Coverage Expansion

Michigan Senator Bruce Caswell (R-Hillsdale) has introduced legislation that would provide a limited benefit health coverage plan to low-income uninsured in the state. Senate Bill (SB) 422 was introduced in June and referred to the Senate Committee on Appropriations. If enacted, SB 422 would create the Michigan Low Income Health Plan, a limited benefit health coverage product available to uninsured residents with income below 100 percent of the Federal poverty level. The plan would be structured as follows:

- Enrollees would pay a monthly premium to participate, ranging from $5 to $20 per month depending on family income.
- Coverage would be provided through Michigan's currently contracted Medicaid Health Plans.
- Enrollees would be entitled to the minimum essential health benefits defined in the federal health law, coverage for currently unspecified outpatient hospital procedures and an inpatient hospital benefit. Media reports suggest that the inpatient benefit would be subject to an annual dollar cap.

As introduced, the Low Income Health Plan would not utilize any federal Medicaid funding and has been described in media reports as a possible alternative to the proposed Medicaid expansion. The bill has not been addressed at the committee level.

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

Play or Pay Rule

A recent study conducted by the Ann Arbor-based Center for Healthcare Research and Transformation (CHRT) has found that most small businesses in Michigan will not be

affected by the "play or pay" rule on health insurance in the federal Affordable Care Act (ACA). The rule requires businesses with 50 or more employees to provide health insurance (play) or pay a penalty. The study found that 96 percent of all small businesses will not be affected because they have fewer than 50 workers - most have fewer than ten workers. Of the slightly larger businesses - those with between 50 and 99 employees - about 90 percent already offer health insurance coverage for their employees. The article did not assess whether current health insurance coverage offered by the small businesses meets the required Essential Health Benefits tests in ACA. It is possible that some employers may need to make minor adjustments to their policies.

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

Health Insurance Marketplace Plans in Michigan

On June 7, 2013, R. Kevin Clinton, Director of the Department of Insurance and Financial Services (DIFS), announced that 14 health insurance companies submitted plans to DIFS with requests for inclusion in the Michigan's Federally-Facilitated Health Insurance Marketplace (Exchange). The submitted plans will be reviewed to ensure that each applicant complies with state and federal requirements. The companies submitting plans include Alliance Health and Life Insurance Company, Blue Care Network of Michigan, Blue Cross Blue Shield of Michigan, Consumers Mutual Insurance of Michigan (a CO-OP), Health Alliance Plan, Humana Medical Plan of Michigan, Inc., McLaren Health Plan, Meridian Health Plan of Michigan, Inc., Molina Healthcare of Michigan, Physicians Health Plan, Priority Health, Priority Health Insurance Company, Total Health Care USA and UnitedHealthcare Life Insurance Company.

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2013 Kids Count Data Book

The 2013 Kids Count Data Book, published through the Annie E. Casey Foundation, was released on June 24, 2013. The annual publication provides information and rankings on all states on key indicators of child well-being. The 2013 report ranked Michigan 31st in the nation across all indicators of childhood wellbeing. Michigan ranked 36th in a composite measure of economic wellbeing, 32nd in

education metrics, 27th in measures related to family and community, and 23rd in measures of health. Consistent with previous years, the Data Book identified Michigan as one of the most effective states in providing access to health coverage for children, ranking Michigan 4th in the nation with 96 percent of Michigan children insured.

The Michigan League for Public Policy, an advocacy group for low-income children and families produced the Kids Count in Michigan data with funding from the Annie E. Casey Foundation. The Kids Count Data Book (and a data center) is available on the Foundation's website. National, state-specific and state comparison data are available.

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

Detroit Medical Center Owner Vanguard Purchased

Tenet Healthcare, a Dallas-based owner of for-profit hospitals and health systems throughout the United States, has purchased Vanguard Health Systems, owner of the Detroit Medical Center (DMC) hospital system. When Vanguard acquired the DMC in 2011, its purchase agreement detailed a number of requirements, including:

- A commitment that the owner would continue to adhere to the charity care mission of the DMC.
- Mandated capital investment into the DMC.
- A commitment to keep all of the DMC facilities open until 2021.

Tenet has made public statements confirming that each of the Vanguard purchase commitments will be honored under the new ownership agreement.

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

Medicaid Policies

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

- **MSA 13-15** advises **All Providers of updates to the Medicaid Provider Manual** effective July 1, 2013. The bulletin also advises providers of

changes in how the Supplemental Medicaid Bulletins list will be maintained, identifies selected injectable drugs that will be carved out of health plan contracts, explains changes in the Beneficiary Monitoring Program, and provides an ICD-10 project update.

- **MSA 13-16** notifies **Nursing Facilities and other Long-Term Care** providers that the three-year "look back" requirement associated with enrollment or certified bed requests will be reduced to two years.
- **MSA 13-17** informs **All Providers** of new Provider Enrollment **application fees** and **ordering/referring and attending provider enrollment and billing requirements**.
- **MSA 13-18** notifies **All Providers of new operating rules for HIPAA Transactions** of Eligibility (**270/271**) and Health Claim Status (**276/277**).
- **MSA 13-19** advises **Home Health Agencies, Physicians and other Practitioners** that a **physician certifying eligibility for home health services** must provide **documentation of a face-to-face encounter** with the beneficiary within 90 days prior to or 30 days after the start of care.
- **MSA 13-20** informs **Hospitals** that upon receipt of federal approval Medicaid Interim Payments (**MIPs**) and Capital Interim Payments (**CIPs**) will move **from a semi-monthly schedule to a monthly schedule**.
- A proposed policy (**1317-Bulletins**) has been issued that would allow DCH to **discontinue distribution of provider bulletins and L letters through the US Mail** and instead distribute the materials through email. Comments are due to DCH by July 6, 2013.
- A proposed policy (**1314-Eligibility**) has been issued that would more clearly describe in published policy the **prospective payment system methodology** applicable to **Federally Qualified Health Centers and Rural Health Clinics** receiving **payment from CHIP-funded programs**. Comments are due to DCH by July 13, 2013.
- A proposed policy (**1320-EHR**) has been issued that would **change the definition** of a **Medicaid encounter** for the **Medicaid Eligible Patient Volume** calculation in the **EHR incentive payment program** based on an update from the federal government. Comments are due to DCH by

July 13, 2013.

DCH has also released two L-letters of potential interest, which are available for review on the same web site.

L 13-19 was issued in late May to explain **how DCH will treat selected payment situations as a result of the two percent Medicare payment reduction** required by the federal "sequestration": crossover claims where Medicare is the primary payer and Medicaid is secondary; outpatient hospital and ambulatory surgery center claims where Medicaid is the primary payer; and the Affordable Care Act-related primary care rate increase.

L 13-32 cautions **Nursing Facilities** that **private insurance policies** offering coverage of ancillary services for Medicaid beneficiaries residing in the facilities, such as dental, vision and podiatry care, **may duplicate Medicaid covered services**. Should a resident choose to purchase such private coverage, facilities are encouraged to **advise the beneficiary to send the premium notice to the Department of Human Services** to allow an adjustment (reduction) to the beneficiary's patient pay amount. The letter also reminds facilities that **medically necessary care not covered by Medicaid may be an allowable offset** to a resident's patient pay amount; however facilities cannot use a resident's private insurance premium as an offset.

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