HEALTH MANAGEMENT ASSOCIATES

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The Michigan Update

Print This Issue

In This Issue

Medicaid Managed Care Enrollment Activity

As of March 1, 2012, there were **1,229,799 Medicaid beneficiaries enrolled** in 14 Medicaid Health Plans (HMOs), an **increase of 1,619** since February 1, 2012. The number of Medicaid beneficiaries eligible for managed care enrollment increased in March as well - there were 1,290,444 eligible beneficiaries, up from 1,289,495 in February. 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 **18,565 duals enrolled in March, up from 15,292 in February**, an increase of 3,273.Again this month, 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 March reflect, every county in the state is served by at least one Medicaid Health Plan.

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.

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

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Rolling Open Enrollment

Federal Medicaid law requires that beneficiaries mandatorily enrolled in contracted HMOs be given an opportunity annually to change health plans without cause. Historically Michigan has designated May as the annual open enrollment period. Beginning in May 2012 the state will move to a "rolling" open enrollment period. The last digit of a Medicaid case number will designate the open enrollment period for each beneficiary on that case. For example, if a case number ends in "7" the open enrollment period will be July. During November and December of each year, open enrollment letters will be mailed to cases including at least one beneficiary who otherwise did not receive a notice of opportunity to change health plans within the previous 12-month period.

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

Duals in Medicaid HMOs

The number of Medicaid beneficiaries dually eligible for Medicare ("duals") who were auto-assigned to Medicaid HMOs in March was 10,862; the number of duals voluntarily enrolling in the HMOs was 7,703. All Medicaid HMOs have duals enrolled although the numbers vary dramatically across plans.

Every HMO receives auto-assignment of duals. Those individuals enrolled in a Medicaid HMO who gain Medicare eligibility are auto-assigned to that HMO. Duals enrolled in a Medicare Special Needs Plan (SNP) for their Medicare benefits are auto-assigned to the related Medicaid HMO if applicable. Any auto-assigned dual enrollee 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 dual enrollees, about 37 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 (but the most voluntary enrollees); and the other 11 plans share the remaining 26 percent.

March 2012 Enrollment			
Medicaid Health Plan	**Voluntary Enrollees**	**Auto-Assigned Enrollees**	**Total Enrollees**
BlueCaid of MI	117	43	160
CareSource MI	211	327	538

HealthPlus Partners	364	96	460
McLaren Health Plan	604	86	690
Meridian Health Plan of MI	2,027	429	2,456
Midwest Health Plan	423	481	904
Molina Healthcare of MI	1,163	5,705	6,868
OmniCare Health Plan	234	55	289
PHP Mid-MI Family Care	107	23	130
Priority Health Govt. Programs	441	438	879
Pro Care Health Plan	10	12	22
Total Health Care	284	92	376
UnitedHealthcare Comm. Plan	1,496	2,907	4,403
Upper Peninsula Health Plan	222	168	390
Total	**7,703**	**10,862**	**18,565**

Six of the 14 Medicaid HMOs are federally contracted as Medicare Advantage SNPs to provide Medicare benefits for duals: CareSource, Meridian, Midwest, Molina, UnitedHealthcare and Upper Peninsula Health Plan. As of March 1, 2012 these six SNPs have a combined enrollment of 12,390 duals for whom they provide Medicare services; 60 percent of the duals enrolled in SNPs 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.

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

Integrated Care for Dual Eligibles

In previous editions of *The Michigan Update* (most recently in December 2011) we have reported on the Department of Community Health's (DCH) activities related to establishing an integrated system of care for individuals enrolled in both Medicare and Medicaid ("duals"). The next step in the process is submission of a proposed plan to the federal Centers for Medicare & Medicaid Services (CMS).

DCH has been gathering input from stakeholders and other interested parties through forums and interviews over the last several months and also released a Request for Input to solicit comments. Workgroups were established and meetings held to address specific issues, and a report of the recommendations of the four stakeholder workgroups was released in February. The results of these activities are available for review at

https://janus.pscinc.com/dualeligibles.

On March 5, 2012, DCH released for public comment its proposed plan for implementing an integrated system of care for the duals. State staff held public hearings on March 20th and 29th, at which Medicaid Director Steve Fitton emphasized that the plan is not yet finalized, must be approved by CMS and deviates in several ways from what the federal government expects in state proposals. For example, CMS anticipates the plan will utilize full-risk capitation as a reimbursement methodology, however DCH is proposing both a full-risk and a partial-risk program at the outset for flexibility. Mr. Fitton also said CMS expects implementation on January 1, 2013; however DCH prefers to pilot the system to ensure that it adequately meets the needs of beneficiaries. As proposed, the plan would be implemented in three quarterly intervals in three regions across the state. The first group enrolled in a region would include non-elderly individuals with disabilities, elderly individuals not using long-term care services and persons with serious mental illness or substance use disorders. The second group would include nursing facility residents and individuals participating in the MI Choice home and community-based services waiver program. The third group would include persons with intellectual/developmental disabilities. The PowerPoint presentation from the two March hearings is also available on the aforementioned web site.

Comments on the proposed plan are due to DCH on or before April 4, 2012 and will be considered prior to the plan's submission to CMS in late April. The proposed plan is available on the DCH web site at www.michigan.gov/mdch.

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

MIChild

According to MAXIMUS, the DCH contractor for MIChild enrollment, there were **37,411 children enrolled** in the MIChild program as of March 1, 2012. This is a **decrease of 46** since February 1, 2012.

As the enrollment report (.pdf) (.xls) for March 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.

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Adult Benefits Waiver (ABW)

As of the middle of March 2012, DCH reports there were **43,196 ABW beneficiaries enrolled** in the program, **a decrease of 1,675** since the middle of February. Enrollment in the program one year ago this month, just after the most recent open enrollment period ended, stood at 89,715.

There are 28 County Health Plans (CHPs) serving ABW beneficiaries in 73 of Michigan's 83 counties. As of March 1, 2012, the combined ABW **enrollment in the 28 CHPs was 39,256**, a **decrease of 1,526** since February. The enrollment level one year ago this month stood at 80,638.

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

Michigan Budget - Current Year

When the books for State Fiscal Year (FY) 2010-2011 were closed earlier this year a positive General Fund/General Purpose (GF/GP) balance was identified in an amount exceeding $565.0 million. In a letter dated February 9, 2012, the State Budget Office submitted a FY 2011-2012 supplemental request totaling $56.4 million in Gross appropriations ($23.8 million GF/GP). The request, which covered funding needs in multiple departments, is currently under consideration by the Legislature.

House Bill (HB) 4289, as passed by the House of Representatives, includes a number of supplemental funding items for DCH including:

- Increases in **Disproportionate Share Hospital** (DSH) funding ($9.6 million)
- Additional funding for **Graduate Medical Education** (GME) ($8.6 million)
- Reinstatement of DSH funding for **Wayne State University's** Psychiatric Residency program ($8.5 million)
- Increases in **Indigent Care Payments** to support additional indigent care agreement services to the low-income uninsured. ($7.2 million)

- Restoration of **Chiropractic benefits** coverage beginning April 1, 2012. ($450,000 annualized)

During House deliberations, an amendment was offered to authorize the Department of Licensing and Regulatory Affairs (LARA) to spend a $9.85 million federal award for continued development of MiHealth Marketplace, a Health Insurance Exchange in Michigan. The amendment was defeated, and the bill was approved by the House on March 20th and transferred to the Senate for consideration. In a subsequent interview with local media, Senate Appropriations Chair Roger Kahn stated that he felt there was little chance the House would act on anything related to Exchange planning until after the US Supreme Court rules on the constitutionality of the Affordable Care Act (ACA).

The Senate Appropriations Committee approved a substitute version of the bill on March 22nd, concurring with the House on most but not all provisions, however the full Senate has not yet taken up the bill.

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

Michigan Budget - Next Year

This past week the Senate and House Appropriations Subcommittees on DCH reported their recommended versions of HB 5378, a FY 2012-2013 DCH appropriation bill. Information follows detailing the major highlights of each subcommittee's recommendation as it compares to the Executive Recommendation of Governor Rick Snyder.

The House version of HB 5378 is fairly consistent with the Executive Recommendation. The bill funds several of the Governor's new initiatives including an expansion of available behavioral health services provided to Medicaid-eligible children with autism spectrum disorders (although language in the House bill restricts these services to children age five and younger), full recognition of an ACA-mandated increase in Medicaid reimbursement rates for primary care providers and full funding for the assumed Medicaid caseload and actuarially sound rates. A summary of the House decisions on major budget issues is provided in the table below.

The Senate version of HB 5378 could be best characterized as a continuation budget. The appropriation does not concur with any of the major program expansions recommended by the Governor and does not fund new

Senate spending initiatives. The Senate bill does provide placeholder funding for these Executive proposals and new Senate concepts such as restoration of Medicaid adult vision benefits, a Medicaid rate increase for ambulance services, a Medicaid rate increase for obstetricians, expansion of the essential health provider program, and a one-time pool of funds for rural and sole community hospitals. The Senate bill does accept most Executive proposals intended to reduce State expenditures, including recognition of savings resulting from implementation of the Integrated Care for Dual Eligibles program, but does not assume savings from the proposed inclusion of behavioral health medications in the Medicaid program's Preferred Drug List. A summary of Senate subcommittee decisions is also provided in the table below.

ITEM	GOV.	HOUSE	SENATE
Total (Gross) Spending	**$15.10 billion**	**$15.02 billion**	**$15.04 billion**
State (GF/GP) Spending	**$2.85 billion**	**$2.83 billion**	**$2.83 billion**
MEDICAID CHANGES			
Expansion of Medicaid therapies to children with autism under age 18	$34.1 million Gross / $10.1 million GF/GP	Same funding as Gov. but with expansion only to children up to age 5	Provides $300 placeholder
Expansion of Healthy Kids Dental to additional counties	$25.0 million Gross / $8.4 million GF/GP	$7.9 million Gross / $2.7 million GF/GP	Provides $100 placeholder
Expanded Medicaid Disproportionate Share Hospital (DSH) Funding	$25.4 million Gross / $0.0 GF/GP	Accepts Gov's funding and adds new $10.0 million DSH pool targeted to low DSH facilities	Same funding as Gov. and provides $100 placeholder for DSH expansion
Medicaid Graduate Medical Education (GME) Funding	Executive reduced GME funding $17.1 million Gross / $5.8 million	Restored GME reduction ($18.0 million Gross / $6.0 million GF/GP)	Provides $100 placeholder

	GF/GP		
Assumed savings from inclusion of behavioral health drugs on Preferred Drug List (PDL)	Assumed savings of $18.7 million Gross / $6.3 million GF/GP	Same assumed savings as Gov.	No assumed savings
Assumed savings from implementation of Integrated Care for Dual Eligibles initiative	Governor assumes savings of $29.8 million Gross / $10.0 million GF/GP	Assumes savings of $39.8 million Gross / $13.4 million GF/GP	Same assumed savings as Gov.
Home and Community-Based Services Waiver Expansion	$11.0 million Gross / $3.7 million GF/GP	Same funding as Gov.	Provides $100 placeholder
Restoration of Medicaid Chiropractic Coverage for Adults	$900,000 Gross / $302,500 GF/GP	Same funding as Gov.	Provides $100 placeholder
OTHER MAJOR CHANGES			
Healthy Michigan Fund	Governor increases funding $3.0 million	Not included	Provides $200 placeholder
Pregnancy Support Programs: New support program for low-income pregnant women and expansion of Nurse Family Partnership program	Not included	$3.0 million Gross / $0.0 GF/GP	Not included
New funding for improvements to Community Health Automated Medicaid Payment System (CHAMPS)	$54.4 million Gross /$10.9 million GF/GP	Not included	Did not fund improvements to data warehouse $53.4 million Gross / $9.9 million GF/GP

The recommendations from both the Senate and House Subcommittees will now be taken up by their respective

appropriations committees.

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Autism

One of the initiatives mentioned by Governor Snyder in his State of the State address was the need for legislation to require insurance companies in the state to cover treatment for autism spectrum disorders for children. Legislation was passed by both the House and Senate on March 29, 2012 (Senate Bills 414, 415 and 981) to require such coverage for children and to offer limited reimbursement from the State for the services - up to $50,000 per year per child, with the limit varied by age. Under the package, LARA will be charged with creating and implementing the incentive program through which carriers will seek reimbursement for paid claims. The Governor is expected to sign the bills, all of which were passed with immediate effect.

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

Health Insurance Claims Assessment Act

In previous editions of *The Michigan Update* - most recently in November 2011 - we have reported on the new Health Insurance Claims Assessment (HICA) Act, which required a new one percent assessment on most paid health insurance claims beginning on January 1, 2012. In December 2011, the Self-Insurance Institute of America (SIIA) filed a complaint in Federal Court challenging HICA as preempted by the Employee Retirement Income Security Act (ERISA) as it relates to self-insured group health plans that are subject to ERISA. SIIA also sought an injunction against the implementation and enforcement of HICA related to these groups. To date no injunction has been granted and the first quarterly payment of the HICA tax is due on April 30, 2012.

Organizations paying health insurance claims are encouraged to monitor the Department of Treasury's web site for updates regarding this requirement. A recent addition to the web site is an updated list of Frequently Asked Questions (FAQ). The web site is available at www.michigan.gov/taxes/0,4676,7-238-43519-264498--,00.html.

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Marquette General Health System

On March 6, 2012, the Board of Trustees at Marquette General Health System (MGHS) announced their signing of a memorandum of understanding (MOU) to join Duke LifePoint Healthcare, a joint venture of Duke University Health System, Inc. and LifePoint Hospitals. This non-binding MOU allows the parties to move forward over the next few months with due diligence and other necessary steps to pursue an acquisition of non-profit MGHS by for profit Duke LifePoint. The acquisition, which would be subject to various government approvals, including a thorough review process by the Michigan Attorney General, reportedly would result in significant financial commitments to MGHS, such as construction of a state-of-the-art outpatient surgery center, a comprehensive cancer center and new technology.

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Welfare Cuts Ruled Inappropriate

On March 27, 2012, a Genesee County Circuit Court Judge ruled that Department of Human Services (DHS) Director Maura Corrigan exceeded her authority by ending cash assistance - Temporary Assistance for Needy Families (TANF), known as the Family Independence Program (FIP) in Michigan - benefits for many Michigan families. DHS has stated that an appeal will be filed and a stay of the judge's order requested while the appeal process takes place.

In previous editions of *The Michigan Update* - most recently October 2011 - we reported on legislation signed into law (Public Acts 131 and 132 of 2011) to set a 48-month limit on receipt of cash assistance - TANF / FIP - unless the families meet specified exemption criteria. There is also a 60-month federal limit, which complicates the issue.

More than 11,000 families, representing about 40,000 people - largely children, were sent notices last fall that they would lose their FIP benefits unless they could provide documentation to demonstrate continuing eligibility under established exemption criteria. The action to take away these benefits was challenged at the outset by the Centers for Civil Justice, however the State

prevailed. A subsequent challenge was filed alleging that some of the families who lost benefits because they had reached the federal limit should remain eligible under the state limit due to a difference in applicable exception criteria. The recently issued ruling upheld the plaintiff's allegation.

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Central Intake System for Child and Elder Abuse Reports

The DHS has changed the way it receives reports of child and elder abuse to comply with a modified settlement agreement in a Children's Rights lawsuit. Rather than taking reports of abuse at local DHS offices across the state, which resulted in geographic differences in the way reported information was documented, reports are now initially handled by a central intake office. This centralization assures consistency of information gathering and an immediate decision on initiation of an investigation if warranted. The new system was piloted in Kent County for six months. The central intake call center is available 24 hours a day, seven days a week, and the toll-free telephone number is 1-855-444-3911.

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Medicaid Policies

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

- **MSA 12-05** advises **Hearing Centers, Hospitals and Practitioners** of changes in standards of coverage and prior authorization requirements for **cochlear implants and auditory osseointegrated implants**.
- **MSA 12-06** notifies **All Providers** of **updates to the Medicaid Provider Manual** effective April 1, 2012. The bulletin also advises providers of DCH's **progress in ICD-10 coding implementation**. The bulletin notes that although CMS has announced a delay in the compliance date for ICD-10 coding (see last month's edition of *The Michigan Update* for additional details), DCH will proceed as if there is no delay.

- **MSA 12-07** advises **All Providers** of a **new Medicaid Fraud Hotline telephone number** - 1-855-MI-FRAUD (643-7283).
- A proposed policy (**1206-Dental**) has been issued that would **revise dental radiograph policy to reflect digital radiographic imaging**. Comments are due to DCH by April 12, 2012.
- A proposed policy (**1208-Hospice**) has been issued that would clarify requirements for **covering hospice and curative services concurrently for children**. Comments are due to DCH by April 30, 2012.

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

- **L 12-08** was issued on February 29, 2012 as a notice of intent that DCH plans to submit to CMS a request for **amendment to the Section 1915(b)/(c) Managed Specialty Services and Supports Waiver**. The purpose of the amendment is to provide an **incentive payment** to PIHPs to increase access to Medicaid mental health specialty services and supports for children in foster care and certain children under the purview of DHS' Child Protective Services.
- **L 12-11** was issued on March 14, 2012 as a notice of intent that DCH plans to submit an amendment to its Medicaid State Plan in order to implement a Multi-Payer Advanced Primary Care Practice demonstration called the **Michigan Primary Care Transformation (MiPCT) Project**. Michigan is one of eight states selected by CMS in November 2010 to participate in this **patient-centered medical home** initiative. Other major payers in Michigan are participating in the MiPCT project along with Medicaid and its contracted HMOs, including Medicare, BCBSM and Blue Care Network. Additional information about MiPCT is available on the DCH web site at www.mipcc.org/what-were-doing/michigan-primary-care-transformation-demo-cms.
- **L 12-12** was issued on March 22, 2012 as a notice of intent that DCH plans to submit a request for **amendment to the Section 1915(b) Comprehensive Health Care Program Waiver**. The purpose of the amendment is to provide a **payment increase** to Medicaid HMOs for administrative and hospital reimbursement amounts in their capitation rates effective June 1.

2012.

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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.*