HEALTH MANAGEMENT ASSOCIATES

May 2015

The Michigan Update

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Medicaid Managed Care Enrollment Activity

As of May 1, 2015, there were **1,645,820 Medicaid beneficiaries, including Healthy Michigan Plan (HMP) beneficiaries, enrolled** in 13 Medicaid Health Plans (HMOs); this is an **increase of 36,308** since April. The enrollment total reflects an increase of 17,421 HMP enrollees since April and an increase of 18,887 non-HMP Medicaid enrollees.

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 available in every county, 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.

Healthy Michigan Plan

Healthy Michigan Plan (HMP) enrollment remains high, far exceeding original expectations. HMP enrollees are required to report any changes in their economic or health care coverage circumstance as those changes occur. They are also subject to an annual redetermination of eligibility; those that entered the program in April and May 2014 were recently subject to redetermination of eligibility. This requirement resulted in a caseload decrease of about 30,500 in early April and about 17,800 in early May, but the caseload rebounded throughout each month and stood

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at 599,178 as of May 26, 2015.

The Michigan Department of Health and Human Services (MDHHS) updates HMP enrollment statistics on its website weekly and includes a breakdown of enrollment by county. Not surprisingly, more than half of the newly approved HMP beneficiaries reside in the state's five largest counties:

May 26, 2015 Healthy Michigan Plan Enrollment	
Wayne	161,132
Macomb	48,064
Oakland	47,979
Genesee	35,074
Kent	31,583
Five-County Total	**323,832**
Statewide Total	**599,178**

The vast majority of these enrollees (nearly 500,000) have income below poverty and more than 51 percent of the enrollees are women. About 47 percent of the enrollees are between the ages of 19 and 34; more than 39 percent are between the ages of 35 and 54; and almost 14 percent are between the ages of 55 and 64.

Most of these enrollees are already or soon will be enrolled in the state's Medicaid managed care organizations for their health care services. As of May 1, 2015, there were a total of **464,825 HMP beneficiaries enrolled in the HMOs.** HMP enrollment totals by health plan are expected to increase again in June as newly eligible individuals continue to enroll in the program and choose an HMO or are assigned to an HMO if they do not select a plan.

Meridian Health Plan of Michigan, which has the largest Medicaid enrollment of any Medicaid HMO, also has the most HMP enrollees, 27.2 percent of the total. UnitedHealthcare Community Plan has 13.0 percent; McLaren Health Plan has 11.5 percent; Molina Healthcare of Michigan has 11.4 percent of the total; and the other nine plans share the remaining 36.9 percent.

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

Duals in Medicaid HMOs

There were **53,736** Medicaid beneficiaries dually eligible for Medicare (duals) enrolled in Medicaid HMOs to receive their Medicaid benefits in May 2015, a **decrease of 2,848** since April. This reduction may in part be due to implementation of Michigan's dual eligibles pilot program. Some individuals have transitioned to enrollment in one of the state's Integrated Care Organizations (ICO). Others that are eligible for enrollment in an ICO have opted out of the demonstration and thereafter receive their Medicaid services on a fee for service basis. (See the Integrated Care for Dual Eligibles article in this newsletter for more information.) 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 Advantage Special Needs Plan (SNP, or D-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.

Molina Healthcare of Michigan has the most duals receiving Medicaid services from an HMO, 25.2 percent of the total; Meridian Health Plan of Michigan has 18.9 percent of the total (but the most voluntary enrollees); UnitedHealthcare Community Plan has 17.9 percent of the total; and the other 10 plans share the remaining 38.0 percent.

Six of the 13 Medicaid HMOs in Michigan (or their parent organizations) are also federally contracted as D-SNPs to provide *Medicare* benefits for duals in Michigan: HAP Midwest Health Plan, HealthPlus Partners, Meridian Health Plan of Michigan, Molina Healthcare of Michigan, Total Health Care, and Upper Peninsula Health Plan. As of May 1, 2015 these six D-SNPs had a combined enrollment of 18,010 duals for whom they provide Medicare services; 71.4 percent of the duals enrolled in a D-SNP are enrolled in the Molina plan, 11.4 percent are enrolled in the Meridian plan (although some of the members may reside in northern Ohio) and the remaining 17.2 percent are spread across the other four plans. Not all of the duals enrolled in these D-SNPs are eligible to receive full Medicaid benefits. Some only receive assistance from the Medicaid program with Medicare coinsurance and deductible payments and/or monthly Medicare premiums.

There is one additional D-SNP in Michigan, Fidelis SecureCare of Michigan, Inc., which does not hold a Medicaid HMO contract but has been approved by the state as an Integrated Care Organization in the state's duals demonstration. As of May 1, 2015, Fidelis had 1,150 enrollees in its D-SNP. It is also an approved Medicare Advantage Institutional SNP (I-SNP) with 232 enrollees.

Two of the Medicaid HMOs - McLaren Health Plan and UnitedHealthcare Community Plan - discontinued their D-SNP products as of December 31, 2014.

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CSHCS Children in Medicaid HMOs

The Michigan Department of Health and Human Services (MDHHS) requires children (and a few adults) receiving services from both the Children's Special Health Care Services (CSHCS) program and the Medicaid program to enroll in Medicaid HMOs. As of May 1, 2015, there were **17,996 joint CSHCS/Medicaid beneficiaries enrolled in the Medicaid HMOs** - an increase of 373 since April. All Medicaid HMOs except Harbor Health Plan, Inc. have CSHCS/Medicaid enrollees, although the numbers vary across plans.

Meridian Health Plan of Michigan, which has the largest Medicaid enrollment of any Medicaid HMO, also has the most CSHCS/Medicaid enrollees receiving their services from an HMO, 25.0 percent of the total. Molina Healthcare of Michigan has 17.5 percent of the total; UnitedHealthcare Community Plan has 16.6 percent; and the other nine plans share the remaining 40.9 percent.

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

MIChild

According to MAXIMUS, the Michigan Department of Health and Human Services (MDHHS) contractor for MIChild enrollment, there were **44,508 children enrolled in the MIChild program as of May 1, 2015**. The May enrollment total reflects an **increase of 647** from the 43,861 children enrolled as of April 1, 2015. Of the total number of children enrolled, 892 enrollees are dually eligible for Children's Special Health Care Services

(CSHCS) and MIChild.

As the enrollment reports for May (pdf) (xls) show, enrollment is dispersed between 13 plans. The plans with the highest enrollment are Priority Health (with 16.2 percent of the total enrollees), Molina Healthcare of Michigan (with 15.1 percent), HealthPlus of Michigan (with 14.1 percent), and McLaren Health Plan (with 13.9 percent). Blue Cross Blue Shield of Michigan (BCBSM) had 6.9 percent of the enrollees as of May 1, 2015. The BCBSM market share has gradually dropped from about 75 percent in late 2013 when the insurer advised that it wished to terminate its MIChild contract. Children residing in counties where there are at least two health plans available are given the choice to enroll with one of those plans. Children in counties where BCBSM has been the only available health plan will remain enrolled with that plan until other plans expand their service areas to these counties. There are now only seven counties where BCBSM is the only available plan.

MIChild-enrolled children receive their dental care through contracted dental plans. Of the two available plans, 87 percent of the children were enrolled with Delta Dental Plan as of May 1, 2015. Delta Dental has a statewide service area. The remaining 13 percent of children were enrolled with Golden Dental Plan in a service area that includes eight counties. BCBSM was a statewide dental health plan as well through September 2013 when BCBSM terminated in full its participation in the MIChild dental program.

For more information, contact Esther Reagan, Senior Consultant, 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 adults dually eligible for Medicare and Medicaid (duals). The demonstration will last for three years and in four regions of the state. The entire Upper Peninsula is one region; eight counties in the southwest corner of the state are another region; and Wayne and Macomb Counties are two single-county regions.

Enrollment in the demonstration began in the Upper Peninsula and southwest regions in February with first enrollments effective on March 1, 2015. There is one

Integrated Care Organization (ICO) serving the Upper Peninsula, the Upper Peninsula Health Plan, and two ICOs serving the eight southwest counties: Aetna Better Health (CoventryCares) of Michigan and Meridian Health Plan of Michigan. **As of April 1, 2015, the most recent data available, there was a combined total of 134 enrollees in these plans.** The Upper Peninsula Health Plan had 32 enrollees; Aetna Better Health had 21 enrollees; and Meridian Health Plan had 81 enrollees.

Enrollment in the other two regions - Wayne and Macomb Counties - began in early April with first enrollments effective on May 1, 2015. There are five ICO choices in these two regions: Aetna Better Health of Michigan, AmeriHealth Michigan (partnered with Blue Cross Blue Shield of Michigan), Fidelis SecureCare of Michigan, HAP Midwest Health Plan, and Molina Healthcare of Michigan.

Both phases began with voluntary enrollments and will be followed by a passive enrollment process; duals passively enrolled will be able to opt out of the demonstration if they wish. The number of duals voluntarily enrolling in the demonstration thus far is low but the Michigan Department of Health and Human Services (MDHHS) expects that the passive enrollment process will raise total participation significantly.

MDHHS has received approval from the Centers for Medicare and Medicaid Services to reclassify duals residing in these regions as "excluded" rather than "voluntary", which means they will be disenrolled from Medicaid HMOs *not* serving as ICOs in the demonstration and will be given the option to enroll in an ICO or receive their Medicaid benefits on a fee-for-service basis.

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

State Budget

While the Michigan Department of Human Services and Michigan Department of Community Health were combined in April into the new Michigan Department of Health and Human Services, legislative action on the Fiscal Year (FY) 2015-2016 budgets occurred separately for the two former departments. The House/Senate Conference Committee on the Community Health budget finished its work on May 28th. On February 12, 2015 HMA published a Special Edition of *The Michigan Update* with information on Governor Rick Snyder's budget proposal for FY 2016. In

this issue we focus on major changes for FY 2016 that are retained in the legislative proposal and those that were modified.

In total the appropriation for Community Health programs represents an increase of more than $1.5 billion from the amount appropriated for the current fiscal year. State general funds are increased by $111.9 million. Much of the total funding increase relates to full year implementation of the Healthy Michigan Plan (HMP) and was included in the Governor's budget. The legislative proposal also represents a significant increase from the Governor's recommendation: an increase of $590.8 million in total, of which $227.3 million is state general fund revenues. Higher revenues estimates from the May revenue estimating conference were critical to development of a budget without any major programmatic cuts.

Health Insurance Claims Tax

The Governor's budget included an Issue Brief in support of his proposal to increase the Health Insurance Claims Assessment (HICA) from 0.75% to 1.3% and elimination of a statutory cap which would have increased HICA collections by $180 million. The Conference Committee did not agree to the Governor's proposal to increase the HICA from 0.75% to 1.30%. The Conference Committee further estimated that HICA collections will be $27.1 million less than the baseline budget. As a result there was a decrease in special revenues of $207.2 million and a corresponding increase in state general fund costs from the levels in the Governor's budget.

Dental Access

The Governor's budget also included an Issue Brief on dental access. Two policies were proposed. One was expansion of access to dental care for children by extending the Healthy Kids Dental program to Kent, Oakland and Wayne Counties for children through age eight. The second proposal was to move the adult dental benefit to a dental managed care provider with higher reimbursement rates. Each of the Governor's dental access proposals was scheduled for implementation partway through the fiscal year and would require additional funding for full year implementation in FY 2017.

The Conference Committee expanded on the Governor's proposal for Healthy Kids Dental by increasing the coverage to all children ages 0 to 12 in Kent, Oakland and Wayne Counties (the only counties not fully covered by Healthy Kids Dental in 2015). However the implementation was delayed until June 1, 2016 to reduce the FY 2106 cost. The cost of the legislative proposal is $37 million, which is

more than the $21.8 million the Governor had proposed. Since this initiative is only in effect for the last four months of FY 2016, an estimated $74 million will be required for full year funding in FY 2017.

While both chambers considered options to increase dental access for adults, at the end of the process the Conference Committee did not agree to the proposal to increase funding of adult dental services and to move adult dental to a managed care contract.

Hospital Reimbursement

The Governor's budget and the final conference committee recommendation contain significant changes in Medicaid hospital reimbursement. The largest single item is additional funding for **Medicaid Access to Care Initiative** (MACI) payments to the HMP. MACI payments only apply to fee-for-service Medicaid. The original assumption had been that almost all HMP services would be delivered through Medicaid managed care. However more than a year after implementation of HMP, there are on average about 120,000 HMP enrollees receiving care on a fee-for-service basis each month. Since HMP reimbursement should parallel "traditional" Medicaid reimbursement, the state is proposing a modification to the HMP reimbursement that would add MACI payments for hospitals that serve HMP enrollees. The proposed amount for the FY 2016 budget is $318.2 million. (Note: if the reimbursement modification is approved it would be effective with the start of HMP in April 2014. As a result, there is the potential that hospitals could receive up to $784 million in additional MACI payments between now and the end of FY 2016.)

The Governor's budget had restored several cuts to hospital reimbursement made as part of a FY 2015 executive order, but proposed that the non-federal share of these hospital payments be changed from state funds to hospital assessment funding (Quality Assurance Assessment Program, or QAAP). The Conference Committee recommendations are as follows:

- **Obstetrical Services in Rural Areas:** The Governor's budget eliminated $11 million in payments for obstetrical and newborn care at hospitals that qualify for the special rural hospital payments. The Conference Committee did not concur and retained funding for these payments aimed at supporting continued access to obstetrical services in rural areas of Michigan.

- **Graduate Medical Education (GME):** The Governor's budget restored a previous $14.5 million cut to GME payments, but changed the non-federal share of financing from state general funds to hospital assessment funding. The Conference Committee also restored the funding but disagreed with the use of QAAP as the non-federal share of the payments. Instead the Conference Committee retained use of state general funds as the non-federal revenue source.
- **Special Rural Hospital Payments:** The Governor's budget restored a $5.8 million cut in special payments for rural hospitals. However the Governor's budget proposed that all state funding be removed from the entire $34.8 million pool (replaced with $13.6 million in QAAP funding). The Conference Committee concurred with restoration of the cut, but did not concur with use of QAAP to fund this program.

Hospital Taxes

While the Conference Committee did not agree with some of the Governor's proposals to increase hospital taxes to fund specific reimbursement policies, the Conference Committee made an across-the-board increase of $92.9 million in the amount of hospital quality assurance assessments. At the same time the Conference Committee increased funding for Hospital Rate Adjustment (HRA) payments for the HMP population by $92.9 million. (The Conference Committee noted that for FY 2016 these HMP payments are still 100% funded by the federal government.)

Hospital Capital Cost Reimbursement

The Governor and Conference Committee both propose a modification to the calculation of hospital capital costs which is projected to reduce hospital payments by $34.8 million.

Managed Care Savings

The budget assumes that Medicaid managed care will generate the following savings:

- **Pharmacy:** While the Conference Committee rejected the Governor's proposal to carve the pharmacy benefit out of Medicaid managed care plans, the budget assumes a savings of $54.6 million from movement to a uniform formulary and pharmacy management by the HMOs. This is a higher level of savings than what the Governor's budget included.

- **Laboratory Reimbursement:** Executive Order 2015-5 assumes laboratory reimbursement savings effective August 1, 2015 by changing the benchmark from Medicare rates to Medicaid fee-for-service rates. Total savings are $31.8 million.
- **Managed Care Integration Savings:** The Governor and Conference Committee assume that Medicaid HMO rates can be reduced by $15.4 million to reflect savings from managed care coordination.

Other Medicaid Changes

- **Program Integrity:** The budget adds 10 positions for the Medicaid Inspector General and additional third party liability (TPL) activities and assumes that these initiatives and other TPL initiatives will reduce Medicaid expenditures by $37.5 million.
- **Primary Care Rates:** The budget includes additional funding to continue paying primary care providers at rates that are halfway between historical Medicaid rates and Medicare rates. The policy cost $72.5 million in FY 2015 and the annualization to a full year results in an additional cost of $24.2 million.
- **Ambulance Rates and Fees:** The Conference Committee increases Medicaid ambulance rates by $8.6 million to be funded a new quality assurance assessment program for ambulance providers. There is a net savings to the state of $1 million because the state retains a portion of all QAAP revenue.
- **Use Tax Actuarial Soundness:** The Conference Committee also included $16.8 million to cover the cost of the use tax paid by Medicaid HMOs.

Quick action is expected in the full House and Senate, with the budget presented to the Governor in early June.

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

Molina to Buy HealthPlus Partners

In an announcement on May 15, 2015, HealthPlus of Michigan, Inc. announced that it plans to sell its Medicaid and MIChild business - HealthPlus Partners - to Molina Healthcare of Michigan in attempt to salvage the rest of the company. The Michigan Department of Financial and Insurance Services (DIFS) sanctioned the company earlier

this year because it lacked sufficient cash in reserves to meet state requirements. Due to imposition of the Order of Supervision by DIFS, the federal government simultaneously suspended HealthPlus from enrolling Medicare Advantage members. HealthPlus Partners currently has over 90,000 Medicaid members in six counties and almost 6,300 MIChild members in 14 counties.

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

CMS Releases Sweeping Managed Care Rules

On May 26, 2015, the federal Centers for Medicare and Medicaid Services (CMS) released a proposed managed care rule intended to update and strengthen the Medicaid and Children's Health Insurance Program (CHIP) regulations last updated in 2003. "This proposed rule would modernize the Medicaid managed care regulations to reflect changes in the usage of managed care delivery systems. The proposed rule would align the rules governing Medicaid managed care with those of other major sources of coverage, including coverage through Qualified Health Plans and Medicare Advantage plans; implement statutory provisions; strengthen actuarial soundness payment provisions to promote the accountability of Medicaid managed care program rates; and promote the quality of care and strengthen efforts to reform delivery systems that serve Medicaid and CHIP beneficiaries. It would also ensure appropriate beneficiary protections and enhance policies related to program integrity. This proposed rule would also require states to establish comprehensive quality strategies for their Medicaid and CHIP programs regardless of how services are provided to beneficiaries. This proposed rule would also implement provisions of the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) and addresses third party liability for trauma codes."

CMS also published several two or three-page briefs describing key features or goals of the proposed rules, including "Improving the Beneficiary Experience", "Quality Improvement", "Program and Fiscal Integrity Improvement and Alignment", "Strengthening the Delivery of Managed Long Term Services and Supports", "Alignment with Medicare Advantage and Private Coverage Plans", and "Strengthening States' Delivery System Reform Efforts". These documents are available on the CMS website.

Comments on the proposed rule are due by 5:00 pm Eastern Daylight Time on July 27, 2015.

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

Medicaid Policies

The Michigan Department of Health and Human Services (MDHHS) has issued six final and four proposed policies that merit mention. They are available for review on DCH's website.

- **MSA 15-06** informs **Home Help Agency and Individual Providers** that the **change in policy announced in MSA 14-58, then delayed, will now be implemented effective June 1, 2015**. This policy modifies requirements for **provider enrollment and verification of provided services**. The initial release is attached to the latest policy bulletin.
- **MSA 15-07** clarifies for **School Based Services Providers and Billing Agents** department **audit and recoupment policies.**
- **MSA 15-08** advises **Pharmacy Providers and Federally Qualified Health Centers** that selected **pharmacies may administer certain vaccines** to adults and to children age 11 and older. Implementation of this policy is contingent upon federal State Plan Amendment approval.
- **MSA 15-10** notifies **Bridges Eligibility Manual Holders** of changes in certain **asset requirements** associated with Supplemental Security Income **(SSI)-Related Medicaid eligibility**.
- **MSA 15-13** advises **Home Help Agency Providers, Prepaid Inpatient Health Plans and Community Mental Health Services Programs** of changes in **Home Help Agency Provider Standards**.
- **MSA 15-17** informs **Hospitals and Medicaid Health Plans** that a **new Short Hospital Stay reimbursement rate** for certain outpatient and inpatient hospitals stays will be **effective July 1, 2015.** The bulletin includes the criteria to determine stays to which the new rate will apply.
- A proposed policy (**1522-DME**) has been issued that would establish **used equipment payment rates for 35 Durable Medical Equipment codes** and set **standards for the provision of used**

equipment to beneficiaries. Comments are due to MDHHS by June 24, 2015.

- A proposed policy (**1523-Supplies**) has been issued that would change the policy published in MSA 14-44 on **Coverage of Blood Glucose Testing Supplies** because it was too restrictive. Comments are due to MDHHS by June 24, 2015.
- A proposed policy (**1526-DSH**) has been issued that would implement an **increase in the Outpatient Uncompensated Care DSH Pool and eliminate the Indigent Care Agreement DSH Pool**. Comments are due to MDHHS by June 24, 2015.
- A proposed policy (**1527-Hospital**) has been issued that would **change the reimbursement methodology for State Psychiatric Hospitals** from the current cost-settled structure to a cost-based prospective per diem structure. Comments are due to MDHHS by June 26, 2015.

MDHHS has also released five L-letters of potential interest, which are available for review on the same website.

- **L 15-31** was released on May 26, 2015 to individual **Home Help** providers to inform them of a **change from paper logs** to identify tasks provided to a requirement for **recording service time through an Electronic Service Verification system** in the Community Health Automated Medicaid Processing System (CHAMPS).
- **L 15-32** was released in late May to remind **Nursing Facilities** that **changes in Medicaid-certified beds** (increase, decrease or relocation) **require State Medicaid Agency approval.**
- **L 15-33** was released on May 27, 2015 as a notice of the department's intent to submit a **waiver amendment for the MI Choice program** to the federal Centers for Medicare and Medicaid Services (CMS) in order to implement a **conflict-free (independent) nursing facility level of care determination process** by contracting, through a competitive procurement, with an entity to conduct the determinations. Currently the MI Choice waiver agencies conduct them. The amendment also updates MI Choice performance measures.

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