HEALTH MANAGEMENT ASSOCIATES

November 2012

The Michigan Update

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Medicaid Managed Care Enrollment Activity

As of November 1, 2012, there were **1,227,748 Medicaid beneficiaries enrolled** in 13 Medicaid Health Plans (HMOs), a **decrease of 4,651** since October 1, 2012. The number of Medicaid beneficiaries eligible for managed care enrollment also decreased in November - there were 1,296,034 eligible beneficiaries, down from 1,313,508 in October. The number of Medicaid beneficiaries dually eligible for Medicare (duals) enrolled in Medicaid HMOs to receive their Medicaid benefits continues to grow - there were **29,617 duals enrolled in November**, up from 28,291 in October, an increase of 1,326. The number of Medicaid children dually eligible for the Children's Special Health Care Services (CSHCS) program enrolled in Medicaid HMOs also continues to grow - there were **1,487 Medicaid/CSHCS children enrolled in November**, up from 645 in October.

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.

From November 2011 to November 2012 the number of non-Medicare, non-CSHCS enrollees in Medicaid HMOs has decreased by more than 18,500. While the total Medicaid enrollment in the month prior to each of these months is nearly identical (a 313 person increase from October 2011 to October 2012), there has been a decrease of more than 16,000 individuals enrolled in the family and child components of Medicaid in Michigan. The decline in this

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component of Medicaid may account for the drop in full benefit Medicaid HMO enrollment.

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

CSHCS Children in Medicaid HMOs

In previous editions of *The Michigan Update*, most recently in September 2012, we reported on the plan of the Department of Community Health (DCH) to enroll children (and a few adults) receiving services from the Children's Special Health Care Services (CSHCS) program and the Medicaid program in Medicaid Health Plans (HMOs). Enrollment has begun. As of November 1, 2012, there were **1,487 CSHCS/Medicaid beneficiaries enrolled in the Medicaid HMOs** to receive their Medicaid benefits. Of this total, 401 children were auto-assigned to an HMO and 1,086 voluntarily enrolled. All Medicaid HMOs except Pro Care Health Plan have CSHCS/Medicaid enrollees although the numbers vary across plans.

As the table below reflects, Meridian Health Plan of Michigan has the most CSHCS/Medicaid enrollees receiving their Medicaid services from an HMO, almost 21 percent of the total; Upper Peninsula Health Plan (UPHP) has 19 percent of the total; and the other 10 plans share the remaining 60 percent. The distribution is expected to change over the next few months as more CSHCS/Medicaid HMO enrollments occur. The current distribution is not surprising. Meridian Health Plan of Michigan is the largest Medicaid HMO with 23.5 percent of all Medicaid HMO enrollees. The high proportion for UPHP reflects the fact that this health plan is the only Medicaid HMO covering the Upper Peninsula. As a result, CSHCS/Medicaid enrollees could be immediately auto-assigned to UPHP.

November 2012 CSHCS/Medicaid Enrollment			
Medicaid Health Plan	**Voluntary Enrollees**	**Auto-Assigned Enrollees**	**Total Enrollees**
Blue Cross Complete of MI	24	5	29
CoventryCares of MI	30	0	30
HealthPlus Partners	29	1	30
McLaren Health Plan	79	14	93
Meridian Health Plan of MI	274	37	311
Midwest Health Plan	62	14	76
Molina Healthcare of MI	184	21	205
PHP Mid-MI Family Care	12	6	18
Priority Health Govt. Programs	201	9	210
Pro Care Health Plan	0	0	0

Total Health Care	24	8	32
UnitedHealthcare Comm. Plan	148	22	170
Upper Peninsula Health Plan	19	264	283
Total	**1,086**	**401**	**1,487**

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Duals in Medicaid HMOs

As of November 1, 2012, there were **29,617 Medicaid beneficiaries dually eligible for Medicare (duals) enrolled in Medicaid HMOs** to receive their Medicaid services. The number of duals enrolled through auto-assignment as of November 1, 2012 was 14,784, and the number of duals enrolled on a voluntary basis was 14,833. All Medicaid HMOs have duals enrolled although the numbers vary dramatically across plans. Read more

A Medicaid HMO member who gains Medicare coverage and remains in the HMO is categorized as auto-assigned or voluntarily enrolled based on the means through which the member was *initially* enrolled in the HMO. Duals enrolled in a Medicare Special Needs Plan (SNP) for their Medicare benefits but receiving Medicaid on a fee-for-service basis are auto-assigned to the related Medicaid HMO if applicable. Any dual is able to "opt out" of the HMO and receive Medicaid benefits on a fee-for-service basis.

As the table below reflects, Molina Healthcare of Michigan has the most duals receiving their Medicaid services from an HMO, almost 32 percent of the total; UnitedHealthcare Community Plan has almost 24 percent of the total; Meridian Health Plan of Michigan has more than 14 percent of the total (but the most voluntary enrollees); and the other 10 plans share the remaining 30 percent.

November 2012 Medicaid Dual Eligible Enrollment			
Medicaid Health Plan	**Voluntary Enrollees**	**Auto-Assigned Enrollees**	**Total Enrollees**
Blue Cross Complete of MI	301	284	585
CoventryCares of MI	438	90	528
HealthPlus Partners	712	159	871
McLaren Health Plan	1,536	656	2,192
Meridian Health Plan of MI	3,511	796	4,307
Midwest Health Plan	921	666	1,587
Molina Healthcare of MI	2,288	7,096	9,384
PHP Mid-MI Family	183	40	223

Care			
Priority Health Govt. Programs	835	652	1,487
Pro Care Health Plan	18	18	36
Total Health Care	638	189	827
UnitedHealthcare Comm. Plan	2,997	3,973	6,970
Upper Peninsula Health Plan	406	214	620
Total	**14,784**	**14,833**	**29,617**

Six of the 13 Medicaid HMOs in Michigan are also federally contracted as Medicare Advantage SNPs to provide *Medicare* benefits for duals: McLaren Health Plan, Meridian Health Plan of Michigan, Midwest Health Plan, Molina Healthcare of Michigan, UnitedHealthcare Community Plan and Upper Peninsula Health Plan. As of November 1, 2012 these six SNPs have a combined enrollment of 14,670 duals for whom they provide Medicare services; 57.8 percent of the duals enrolled in SNPs for Medicare services are enrolled in the Molina plan, 30.3 percent are enrolled in the UnitedHealthcare plan and the remaining 12 percent are spread across the other four plans.

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MIChild

According to MAXIMUS, the DCH contractor for MIChild enrollment, there were **38,092children enrolled** in the MIChild program as of November 1, 2012. This is a decrease of 445 since October 1, 2012.

As the enrollment report (.pdf) (.xls) for November shows, enrollment is dispersed between 10 plans, with more than 75 percent of the children enrolled with Blue Cross Blue Shield of Michigan (BCBSM). MIChild-enrolled children receive their dental care through contracted dental plans. Of the three available plans, more than 95 percent of the children are enrolled with either BCBSM (48.2 percent) or Delta Dental Plan (47.1 percent).

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Adult Benefits Waiver (ABW)

Enrollment in the ABW program has been closed since November 2010. As of the middle of November 2012, DCH

reports there were 29,678 ABW beneficiaries enrolled in the program,a decrease of 2,646 since the middle of October and the lowest enrollment since the beginning of the program in January 2004. There are 28 County Health Plans (CHPs) serving ABW beneficiaries in 73 of Michigan's 83 counties. As of November 1, 2012, the combined ABW enrollment in the 28 CHPs was 26,024, a decrease of 2,480 since October.

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

Lasher Moves Back to DCH

Geralyn Lasher, Governor Rick Snyder's Communications Director, is returning to DCH where she worked before the Governor assumed office and where she will lead a variety of initiatives for Director James K. Haveman. For example, if passed into law, Ms. Lasher will play a key role in setting up the independent non-profit entity that would receive $1.5 billion over 18 years from Blue Cross Blue Shield of Michigan through the BCBSM restructuring. Her replacement as the Governor's communication director has not yet been named.

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

Hilfinger Moves from LARA to MEDC

Steven Hilfinger, the Director of the Department of Licensing and Regulatory Affairs (LARA), is leaving that position to become the Chief Operating Officer for the Michigan Economic Development Corporation (MEDC) effective December 10, 2012. The MEDC is a quasi-public corporation that draws its funds from a variety of public and private sources. Governor Rick Snyder's office announced the change on November 29, 2012 and noted that Steve Arwood would take over as interim director of LARA until Governor Snyder names a new director.

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Health Insurance Exchange

One of the major provisions of the Affordable Care Act (ACA - the federal health care reform law) is the establishment of health insurance exchanges through

which individuals and small employers may find health insurance coverage beginning in 2014. Governor Rick Snyder has supported a Michigan-run exchange and received almost $10 million in federal grant funds to develop it; however the House of Representatives would not appropriate the funds because of several members' objections to the ACA. States were given until November 16, 2012 (a deadline later extended to December 14) to advise the US Department of Health and Human Services of their plans - to establish a state-run exchange, work with the federal government on a state/federal partnership exchange or let the federal government operate an exchange for state residents.

Governor Snyder submitted the required application, which indicated a request to collaborate on a state/federal partnership health insurance exchange, but noted in a press release that he would continue to work with the state legislature to explore establishment of a Michigan-run exchange if it is their will and there is time to do so.

On November 29, 2012, the House Health Policy Committee again took up Senate Bill 693, the legislation that would establish the MiHealth Marketplace, a state-run exchange for Michigan, but could not come to consensus. Although the Committee approved a motion to reconsider the bill on another day, Speaker of the House Jase Bolger announced shortly after the Committee meeting that the bill, and the issue of a state-run exchange, will very likely not be considered again.

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Health Insurance Claims Assessment Act

In previous editions of *The Michigan Update* - most recently in September 2012 - we have reported on the new Health Insurance Claims Assessment (HICA) Act, which required a one percent assessment on most paid health insurance claims beginning on January 1, 2012. The claims assessment replaced the six percent assessment on Medicaid Health Plans and the $1.2 billion it raised for the Medicaid program. In early September 2012, a spokesperson for the Michigan Department of Technology, Management and Budget (DTMB) announced that collections during the year have been lower than anticipated by about $130 million (that figure has now risen to $144 million). In mid-November, in an attempt to address the issue and noting that the deficit in collections for 2013 will likely be greater than in 2012, Senate

Appropriations Chair Roger Kahn introduced a new bill.

Senate Bill (SB) 1359 is essentially identical to SB 348 introduced in 2011, which became Public Act 142 of 2011 after amendments by the House of Representatives. Those amendments created an annual $10,000 cap on assessments collected per insured individual or covered life as well as a $400 million base collection amount per year and included a sunset date of January 1, 2014. SB 1359 would allow the State to adopt an adjustable rate in order to obtain the necessary revenue. Several business groups, including the Michigan Chamber of Commerce, the Michigan Manufacturers Association and the Small Business Association of Michigan have opposed the bill, citing concerns over the uncertainty of a variable tax.

On November 29, 2012, Senator Kahn told the media that he doesn't have the votes to move SB 1359 forward at this time and will re-work the bill for future consideration. He said the re-drafted bill will address issues raised during hearings.

When asked why the shortfall was so large, representatives from DCH and DTMB noted that claims are generally paid where policies are issued, not where services are rendered, and a number of insurers are out-of-state so not taxed. In addition, projections for claims in the medical sub-fund market were inaccurate as were the number of high-deductible plans, which have tripled recently. Efforts will be made to address these issues in the re-drafted bill as well.

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DCH Sets New PIHP Regions

On October 26, 2012, DCH issued a memorandum to Community Mental Health Services Program Directors and Substance Abuse Coordinating Agency Directors transmitting a new regional map that will be used in the upcoming Application for Participation for Managed Specialty Supports and Services process, which will likely occur in early 2013. The new map includes ten Prepaid Inpatient Health Plan (PIHP) service regions; there are currently 18 PIHPs. It is also likely that the new regional structure will be used for the Integrated Care for Dual Eligibles demonstration if Michigan receives approval from the Centers for Medicare and Medicaid Services to move forward. The new PIHP regions are not merely mergers of existing PIHP service areas. A new PIHP region may

include counties from as many as five current PIHP service areas. The new PIHP regions also vary significantly from the Medicaid Health Plan bidding regions and it appears at this time that the PIHP regions will not be used in the near term for Medicaid Health Plan contracting.

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

Wayne County Mental Health Authority

On November 29, 2012, the House of Representatives approved Senate Bills 1195 and 1196, which require the Detroit-Wayne Community Health Agency to become a mental health authority with all members of the newly-created authority appointed by the Wayne County Commission. The bills were passed by the Senate a few months ago. While the agency is currently staffed with county employees and most top officials are appointed by the Wayne County Executive, its board is comprised of six county appointees and six others appointed by the Detroit Mayor, resulting in frequent disagreements. As passed, the 12-member board will be appointed by the Commission, six from a list provided by the Wayne County Executive and six from a list provided by the Detroit Mayor. Supporters of the bills say this provision and others will ensure a greater focus on patient outcomes and allow for more transparency and accountability.

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

Healthy Babies are Worth the Wait

In mid-November, the Michigan Health and Hospitals Association, the March of Dimes and DCH announced the *Healthy Babies are Worth the Wait* campaign and their partnership in this educational effort. The objective of the campaign is to make expectant mothers and families, as well as physicians and hospitals, aware of the importance of waiting until at least 39 weeks to deliver a baby if the pregnancy is healthy. Michigan's pre-term birth rate - infants born at less than 37 weeks - is 12.4 percent, slightly higher than the national average of 12.2 percent. A press release from DCH provides links to additional information about this campaign.

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

Medicaid Policies

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

- **MSA 12-51** informs **All Providers** of Medicaid policy regarding **payment liability**, effective December 1, 2012. The stated policies address **both provider and beneficiary responsibilities** in instances where **a service would have been covered** and paid by Medicare or a commercial health insurance plan but some **requirement of the plan was not met.**
- **MSA 12-52** clarifies for **Federally Qualified Health Centers and Rural Health Clinics** the **prospective payment rate methodology**, effective December 1, 2012, used for **newly established clinics** and for clinics approved for **rebasing** when a **scope of service change** occurs.
- **MSA 12-53** advises **Medical Suppliers and Other Providers** of revised **mobility standards of coverage** for **seating systems and mobility devices**, such as wheelchairs. The policy is effective December 1, 2012.
- **MSA 12-54** notifies **Local Health Departments** that **full cost reimbursement will be made for Medicaid managed care encounters** retroactive to **January 2011**. Requirements to receive this reimbursement are specified.
- **MSA 12-55** informs **All Providers** of Medicaid **provider screening and enrollment requirements** to comply with **program integrity** provisions in the Affordable Care Act, the federal health care reform law. Unless specified otherwise in the bulletin, **all provisions are effective immediately.**
- A proposed policy (**1242-NF**) has been issued that would **align Medicaid and Medicare** policy pertaining to the **allowable length of a cost reporting period** for **nursing facilities terminating Medicaid program participation or closing**. Comments were due to DCH by November 30, 2012.
- A proposed policy (**1251-Sanction**) has been issued that would discontinue DCH issuance of **Medicaid sanctioned provider updates** through policy bulletins and instead **post the list on the DCH website**. Comments were due to DCH by November 30, 2012.

- A proposed policy (**1252-Modeling**) has been issued that would implement predictive modeling on all fee-for-service claim types, utilizing statistical analysis models to identify and flag claims in which there are billing irregularities. Comments were due to DCH by November 30, 2012.

On November 30, 2012, DCH also released an L-letter, which is available for review on the same web site.

L 12-46 announces the award of a **Medicaid Recovery Audit Contractor (RAC)** contract to **Health Management Systems, Inc.** (HMS) for a three-year period through mid-March of 2015. The letter provides general information about the audit approach.

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