HEALTH MANAGEMENT ASSOCIATES

April 2011

The Michigan Update

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Medicaid Managed Care Enrollment Activity

As of April 1, 2011, there were **1,237,623 Medicaid beneficiaries enrolled** in 14 Medicaid Health Plans (HMOs), an **increase of 10,147** since March 1, 2011. The number of Medicaid beneficiaries eligible for managed care enrollment also increased in April - there were 1,306,730 eligible beneficiaries, up from 1,289,327 in March. The number of beneficiaries eligible but not yet enrolled in a contracted health plan, not counting exemptions, was 57,702.

As the enrollment reports for April reflect, every county in the state is served by at least one Medicaid Health Plan.

Fee-for-service care is an option in four counties - Barry, Charlevoix, Cheboygan and Emmet - all of which have been designated as "Preferred Option" counties. (Note that the designation of Emmet County as a Preferred Option County is new in April.) Beneficiaries in these counties who do not specifically choose the fee-for-service option are auto-assigned to the 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.

MIChild

According to MAXIMUS, the Michigan Department of Community Health (DCH) contractor for MIChild enrollment, there were **34,826 children enrolled** in the MIChild program as of April 1, 2011. This is an **increase of 522** since March 2011.

As the enrollment report for April shows, enrollment is

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dispersed between nine plans, with almost 82 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, almost 97 percent of the children are enrolled with either BCBSM (47.44 percent) or Delta Dental Plan (49.10 percent).

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Adult Benefits Waiver (ABW)

As of the middle of April 2011, DCH reports there were **86,856 ABW beneficiaries enrolled** in the program, **a decrease of 2,859** since the middle of March. Even with this month's decrease in caseload, there are still more than twice as many beneficiaries enrolled in the ABW program than in September 2010 when the caseload stood at 41,405, before the open enrollment period that ran from October 1 through November 30, 2010.

There are 28 County Health Plans (CHPs) serving ABW beneficiaries in 73 of Michigan's 83 counties. As of April 1, 2011, the combined ABW **enrollment in the 28 CHPs was 78,475,** a **decrease of 2,163** since March but still more than twice the enrollment level prior to the open enrollment period last fall.

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Federal Budget

In recent weeks, greater public scrutiny and popular media coverage has been devoted to issues related to public finance. The Congress has undertaken steps meant to address needed authorization for continued federal spending and to address the long-term structure of the federal budget. This summary provides a brief overview.

Federal Fiscal Year (FY) 2010-2011 Appropriation Update

In April 2011 President Barack Obama and the Congress reached agreement on a FY 2010-2011 continuing budget resolution that would ensure federal spending authorization for the remainder of the fiscal year. Appropriators assumed the continuing resolution would reduce federal expenditures by nearly $40.0 billion. Major reductions related to health care spending include:

- Elimination of authorization for Free Choice vouchers, a mechanism created in the Patient Protection and Affordable Care Act (ACA - the federal health care reform law), that would permit individuals with access

to high-cost employer-based health coverage to obtain a subsidy provided through their employers for Health Insurance Exchange coverage beginning in 2014.
- Elimination of CHIPRA (Children's Health Insurance Program Reauthorization Act) performance bonuses paid to states that demonstrated process improvements in Medicaid and CHIP eligibility determination.
- A broad 0.2 percent reduction in all non-defense discretionary spending. This would impact a number of federal health care grant funds accessed by the State of Michigan.

Federal Budget Deficit Reduction Strategy

House of Representatives Proposal

There has also been a great deal of discussion about the structure of the federal budget for FY 2011-2012 and beyond. The House of Representatives passed a FY 2011-2012 appropriation bill that includes a number of sweeping changes in long-standing health coverage programs. Specifically the plan would:

- Modify the Medicare program from a health coverage entitlement to a "defined benefit" voucher program for some future Medicare beneficiaries (individuals less than 55 years of age today). Medicare beneficiaries would be provided a subsidy for the purchase of coverage on the private market.
- Cap federal Medicaid reimbursement to states. Federal funds for state Medicaid programs would be fixed at or near their current level and would be allowed to grow at a rate slower than the levels observed within state Medicaid programs (and all other health coverage efforts). The effect of this plan would be greater predictability and control over Medicaid cost at the federal level and likely greater need for state and local units of government to reduce Medicaid expenditures.
- Assumed repeal of the coverage expansions and insurance market changes in the ACA.

The House bill, which relies on a number of aggressive reductions in current Federal discretionary programs, is assumed by advocates to reduce the federal deficit by $5.8 trillion over the next decade. The House bill was rejected by the Senate.

Executive Proposal

Largely in response to the proposed House FY 2011-2012 appropriation bill, President Obama released a competing plan to reduce the federal deficit by an assumed $4.0 trillion over the next 12 years. The President's assumed expenditure reductions for health services would largely be achieved through reductions in reimbursement in the Medicare program and through savings associated with Medicaid and Medicare reform initiatives. Major proposals include:

- Expansion of the authority provided to the newly created Independent Payment Advisory Board to

reduce expenditures through the Medicare program (this would be largely achieved through reductions in Medicare reimbursement rates to providers).
- Creation of a cap on the rates states can use for Medicaid provider tax programs from 6.0 percent under current law to 3.5 percent in 2017 and beyond.
- Additional assumed savings linked with proposed efforts to reduce federal expenditures for beneficiaries dually eligible for the Medicaid and Medicare programs, to expand pharmaceutical rebates available through Medicaid programs and to limit fraud and abuse in public health coverage programs.

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DCH Budget

Both the Michigan Senate and the House of Representatives have revealed their FY 2011-2012 spending plans for DCH. These spending plans concur with or expand upon most of the major reductions included in Governor Rick Snyder's Executive Recommendation released in February. This summary provides a brief overview and the attached table provides additional detail.

Senate Bill 172: Assumes General Fund/General Purpose (GF/GP) expenditures for FY 2011-12 of $2.6 billion ($60.0 million GF/GP below the Executive Recommendation). The bill concurs with a number of Executive proposals and assumes further GF/GP savings through:

- Elimination of Medicaid Graduate Medical Education payments ($35.0 million GF/GP in savings).
- Elimination of all programs funded through the Healthy Michigan Fund ($9.9 million GF/GP in savings).
- Additional reductions to support for mental health and substance abuse efforts ($5.1 million and $2.0 million GF/GP in savings, respectively).
- Assumed Medicaid savings linked to administrative efficiencies and reform efforts ($8.6 million GF/GP in savings).

The bill was passed by the full Senate on April 26, 2011 on a party-line vote along with several other appropriation bills.

House Bill 4269: Assumes FY 2011-12 GF/GP expenditures of $2.7 billion ($25.5 million GF/GP below the Executive Recommendation). The bill concurs with a number of Executive savings proposals and assumes greater GF/GP savings associated with:

- Elimination of all but one program funded through the Healthy Michigan Fund ($9.1 million GF/GP in savings).
- Medicaid revenue maximization efforts ($3.6 million GF/GP in savings).
- Reductions to support for State Disability Assistance

(SDA) substance abuse services ($2.0 million GF/GP in savings) and Local Public Health ($1.7 million GF/GP in savings).
- The House proposal also modifies current law boilerplate to allocate $11.3 million in Medicaid Disproportionate Share Hospital (DSH) payments to facilities that previously received payments through what was commonly referred to as the "small hospital DSH pool".

The House bill has been reported out of the appropriations subcommittee and is waiting House Appropriations Committee action.

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New OFIR Commissioner

Ken Ross, the Commissioner of the Office of Financial and Insurance Regulation (OFIR) since February 2008, stepped down from the position on April 15, 2011. Shortly thereafter Governor Rick Snyder appointed his replacement, R. Kevin Clinton. Mr. Clinton, who has been working with OFIR as a special advisor, is an insurance actuary well known in the property and casualty insurance industry in Michigan. He served as President and CEO of American Physicians Capital, a physician's liability insurance firm, from 2004 until late 2010.

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HIP Michigan

Top officials with DCH, OFIR and health care associations in Michigan gathered in mid-April to urge residents of the state who may have been denied health insurance coverage because of pre-existing medical conditions to consider joining Michigan's new Health Insurance Program, HIP Michigan. Available since last fall, the program has not attracted as many applicants as federal funding will support.

One of the provisions of the Patient Protection and Affordable Care Act (ACA - the federal health care reform legislation) required implementation of a High Risk Pool Program to provide health insurance coverage for individuals unable to find insurance due to pre-existing medical conditions. The program is temporary and will expire when other provisions of the health care reform legislation take effect on January 1, 2014. When Michigan's Legislature did not take action to appropriate the federal money allocated for the program, the federal Department of Health and Human Services (HHS) assumed responsibility and is working with Physicians Health Plan of Mid-Michigan (PHP),

the health plan that received the competitively bid contract to administer the program. Enrollment in the program, which requires premiums based on age and the amount of deductible the individual will accept, has monthly premiums ranging from just over $100 to almost $700.

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Integrating Care for "Duals"

As originally reported in the February edition of The *Michigan Update*, in late 2010, the Centers for Medicare & Medicaid Services (CMS) issued a solicitation for proposals from states for funds to design health care delivery models to integrate care for beneficiaries dually eligible for Medicare and Medicaid ("duals"). The solicitation indicated that as many as 15 states with innovative proposals would each receive up to $1 million. Allowed under Section 3021 of ACA, the proposed models would need to fully integrate care for the duals, provide management of all funds (both Medicare and Medicaid) and test and evaluate systems of all-payer reform for medical care. Michigan submitted a successful proposal. CMS has indicated that states successfully completing the program design contract will be eligible to proceed to the implementation phase.

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CVS Pharmacy Settlement

CVS Pharmacy Inc. has agreed to pay the federal government $8 million and ten states a combined $9.5 million to resolve False Claims Act allegations. The settlement involved allegations that CVS submitted inflated prescription claims to Medicaid programs for beneficiaries also eligible for benefits under a primary third party insurance plan. Michigan is one of the ten states that will share the award.

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Payment for Provider-Preventable Conditions

The federal Centers for Medicare & Medicaid Services (CMS) has issued a proposed rule that would require state Medicaid agencies to implement a payment policy related to Provider-Preventable Conditions (PPCs), including Health Care-Acquired Conditions (HCACs).

The proposed policy, which would implement Section 2702

of Patient Protection and Affordable Care Act (ACA - the federal health care reform law), is very similar to the Medicare policy on Hospital-Acquired Conditions (HACs), and would take effect on July 1, 2011. Under the proposed rule, federal Medicaid funds would not be available to states for any amounts expended for providing medical assistance for HCACs. The rule would also authorize States to identify other PPCs for which Medicaid payment would be prohibited. The proposed rule is available at http://edocket.access.gpo.gov/2011/pdf/2011-3548.pdf.

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

Partnership for Patients: Better Care, Lower Costs

The *Partnership for Patients: Better Care, Lower Costs* program is a public-private partnership initiative of the federal government intended to help improve the quality, safety and affordability of health care for all Americans.

Announced in mid-April by HHS, the Partnership will bring together hospitals, employers, physicians, nurses and patient advocates, along with both federal and state government agencies to improve the quality, safety and affordability of health care in the country. A total of $1 billion in funding for the Partnership's activities was authorized by the Patient Protection and Affordable Care Act (ACA - the federal health care reform law), with about half of the funds coming from the Community-Based Transitions Program and the other half from the CMS Innovation Center.

The two goals of the Partnership are to:

- Keep patients from getting injured or sicker by decreasing preventable HACs - by the end of 2013 it is hoped that HACs will decrease by 40 percent compared to 2010.
- Help patients heal without complication - by the end of 2013 it is hoped that preventable complications during transitions between care settings will be decreased such that readmissions will be reduced by 20 percent compared to 2010.

HHS estimates that achieving these goals will save lives, prevent injuries to millions of people and potentially save as much as $35 billion annually across the health care system. For more information, contact Esther Reagan, Senior Consultant, at (517) 482-9236.

Medicaid Policies

DCH has issued one final policy and two proposed policies that merit mention. The policies are available for review on

DCH's web site at www.michigan.gov/mdch/0,1607,7-132-2945_5100-87513--,00.html.

- **MSA 11-16** advises **All Providers** that in compliance with Section 6505 of the Patient Protection and Affordable Care Act (ACA - the federal health care reform law) **payments for Medicaid items or services cannot be made to financial institutions or entities outside of the United States**.
- A proposed policy (**1112-DRG**) has been issued that would **replace the Inpatient Hospital DRG Policy** outlined in previous bulletins MSA 11-08 and MSA 11-13. The proposed policy is expected to address issues raised by hospitals relative to the earlier bulletins. Comments are due to DCH by May 26, 2011.
- A proposed policy (**1111-PPC**) has been issued that would require all Medicaid providers to **self-report any occurrence of a Provider Preventable Condition**. This policy change is required by Section 2702 of the Patient Protection and Affordable Care Act (ACA - the federal health care reform law). Comments are due to DCH by May 27, 2011.

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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.*