HEALTH MANAGEMENT ASSOCIATES

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The Michigan Update

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Medicaid Managed Care Enrollment Activity

As of October 1, 2011, there were **1,221,282 Medicaid beneficiaries enrolled** in 14 Medicaid Health Plans (HMOs), an **increase of 10,907** since September 1, 2011. The number of Medicaid beneficiaries eligible for managed care enrollment increased slightly in October - there were 1,280,306 eligible beneficiaries, up from 1,279,281 in September.

The large increase in HMO enrollment in the face of only a limited increase in the number of individuals eligible for managed care enrollment can be attributed to three factors:

1. The number of beneficiaries eligible but not yet enrolled in a contracted health plan, not counting exemptions, was 51,392, a decrease of almost 7,000 from the number in September.
2. There was also a decrease of almost 3,000 persons granted exceptions from managed care enrollment (from 10,553 to 7,632).
3. There was an increase of more than 1,000 Medicare enrollees also enrolled in Medicaid HMOs (from 389 in September to 1,448 in October).

As the enrollment reports (.pdf) (.xls) for October reflect, every county in the state is served by at least one Medicaid Health Plan. OmniCare Health Plan has recently been approved to serve Medicaid beneficiaries in Cass County, bringing the number of plans available in this county to four.

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.

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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.

Duals in Medicaid Health Plans

In the July edition of *The Michigan Update* we reported that DCH had issued a proposed policy that would allow most Medicaid beneficiaries dually eligible for Medicare ("duals") to voluntarily remain or enroll in Medicaid Health Plans as soon as October 1, 2011. A final policy was issued by DCH on October 1, 2011 (MSA 11-37 - see the Medicaid Policies article for a link to the bulletin) announcing the effective date as November 1, 2011, subject to approval of the policy by the federal Centers for Medicare and Medicaid Services (CMS). Details regarding CMS' concerns are unknown.

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

MIChild

According to MAXIMUS, the Department of Community Health (DCH) contractor for MIChild enrollment, there were **37,635 children enrolled** in the MIChild program as of October 1, 2011. This is an **increase of 61** since September 1, 2011. There are 7,668 children under age five enrolled in MIChild; 21,934 children are age 5-14; and 8,033 children are age 15-18.

As the enrollment report (.pdf) (.xls) for October shows, enrollment is dispersed between ten plans, with more than 78 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 (47.83 percent) or Delta Dental Plan (47.78 percent).

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

Adult Benefits Waiver (ABW)

As of the middle of October 2011, DCH reports there were **61,192 ABW beneficiaries enrolled** in the program, **a decrease of 9,600** since the middle of September. In part this large decline reflects the fact that individuals enrolled during the October 2010 open enrollment period are now having their eligibility reviewed as part of an annual "redetermination" process. Even with this month's decrease in caseload, there are still significantly more beneficiaries enrolled in the ABW program than one year ago this month when the caseload stood at 49,366, at the start of 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 October 1, 2011, the combined ABW **enrollment in the 28 CHPs was 54,868**, a **decrease of 9,152** since September. The October enrollment level is still well above the 36,664 enrollment count on October 1, 2010, prior to the open enrollment period last fall.

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

Integrated Care for Dual Eligibles

As reported most recently in the September 2011 edition of *The Michigan Update*, DCH submitted a successful proposal to CMS for funds to design a health care delivery model to integrate care for beneficiaries dually eligible for Medicare and Medicaid ("duals"). On October 7, 2011, DCH released an L-letter (L 11-36) soliciting individuals to participate in stakeholder work groups which will meet beginning in November. There are four work groups: Care Coordination and Assessment; Education, Outreach and Enrollee Protections; Performance Measurement and Quality Management and Service Array and Provider Network. The L-letter includes the charters and meeting dates for each work group.

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

Health Insurance Exchange

The Director of Michigan's Department of Licensing and Regulatory Affairs (LARA), Steven Hilfinger, announced on October 27, 2011 that the state has applied for $9.8 million in federal grant funds to continue development of the MIHealth Marketplace, a health insurance exchange for

Michigan. This second round of grant funds would be in addition to the $1 million previously received for exchange planning activities. The state should know in November whether the application was successful. Any federal funds awarded will need to be appropriated by the Legislature. Mr. Hilfinger also announced that another grant application for federal funds, for information technology support, will be submitted in December.

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

State Budget

The State of Michigan is expecting to finish Fiscal Year (FY) 2010-2011 with a surplus. How those funds will be allocated is expected to be an interesting debate. The House Fiscal Agency estimated revenues for the year will be about $285 million above the May Revenue Estimating Conference forecast ($140 million in the general fund and $145 million in the School Aid Fund). The Senate Fiscal Agency's estimates were higher; $431 million above the May forecast ($158.3 million in the general fund and $272.9 million in the School Aid Fund). Governor Rick Snyder is quoted as saying the state should "be thoughtful and cautious" about how the funds are used and, given the tenuous nature of the current national and international economy, perhaps wait until the January Revenue Estimating Conference before making any decisions.

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

Moving Ahead Amid Fiscal Challenges

On October 27, 2011, the Kaiser Commission on Medicaid and the Uninsured (KCMU) released a report on state Medicaid budgets and cost containment strategies. This report, *Moving Ahead Amid Fiscal Challenges: A Look at Medicaid Spending, Coverage and Policy Trends, Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2011 and 2012*, is another in a series of reports prepared over the last eleven years by HMA staff Vernon Smith, Kathleen Gifford and Eileen Ellis, with KCMU staff, following their survey of Medicaid officials.

Almost universally, states are in the midst of implementing cost reduction strategies to offset their loss on July 1, 2011 of the temporary increase to their Federal Medical Assistance Percentage (FMAP) provided under the

American Recovery and Reinvestment Act (ARRA). Although states projected total expenditure increases in their current fiscal year to be about 2.2 percent on average, they are faced with a need to boost their state share of funding by about 28.7 percent as a result of the lost federal funds if they are to maintain the status quo. With unemployment rates still high, caseloads remaining at record levels, maintenance of effort requirements in the federal health care reform legislation prohibiting new restrictions on Medicaid eligibility or enrollment processes and discussions at the federal level that could shift additional costs to the states, the status quo is not feasible.

Key findings in the report include:

- Restricting provider rates is a common strategy to reduce costs but a number of states have also implemented new provider taxes to generate additional federal matching funds and mitigate effects of the rate cuts.
- A number of states have eliminated, restricted or reduced Medicaid benefits for adults such as dental care, therapies, durable medical equipment and supplies and personal care services.
- Almost all states are making changes in their pharmacy programs, including the establishment of or revision to preferred drug lists, imposing additional prior authorization requirements and requiring supplemental drug rebates from manufacturers. States are also taking steps to control costs for high-cost specialty drugs.
- A number of states have already or are proposing to implement or increase cost sharing requirements on Medicaid beneficiaries. Prescription drugs and emergency room visits are commonly reported services for which copayments are now being required. Some states are also asking CMS for permission to impose copayments at higher levels and for Medicaid populations typically exempt from the requirement.
- States are enacting reforms to better deliver care and to prepare for the Medicaid expansion under health care reform in 2014 by expanding their managed care programs to new populations and service areas. They are expanding use of disease and care management programs and implementing patient-centered medical homes to help coordinate care for Medicaid beneficiaries dually eligible for Medicare as well as other Medicaid populations with chronic medical conditions. And states are

continuing their efforts to shift the delivery of long-term care services from institutions to community settings.

This report and related documents are available on the KCMU web site at www.kff.org/medicaid/8248.cfm.

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

Medicaid Is Doing Its Job

The Michigan League for Human Services recently released a new report - *Understanding Medicaid: Complex, Compassionate, Cost Effective* - that says the "Medicaid program is doing its job - providing health care benefits and services to those who qualify, and doing it efficiently."

The report notes that Michigan ranked first in the country in the number of people - about one million - who lost employer-sponsored health coverage between 2000 and 2009. During this same period, the Medicaid caseload in Michigan grew by more than 50 percent - from 1.1 million people to 1.7 million, and the caseload has continued to grow. Of the 1.9 million Medicaid beneficiaries on the roles in June 2011 (about 20 percent of the state's population) over one million people were under age 21 and more than 413,000 were eligible for program benefits due to age or disability, with about 60,000 beneficiaries over the age of 75.

The Medicaid program has become a primary financing option for low-income elderly and disabled persons in particular as the program pays for nearly 70 percent of all nursing home days in Michigan. On the other end of the age spectrum, Medicaid is critical to assuring prenatal care and healthy birth outcomes; in FY 2009-2010 the program paid for 51 percent of the births in the state by maintaining its eligibility policy covering pregnant women with income up to 185 percent of the Federal Poverty Level (about $33,900 for a family of three). With so many children covered by the program, it has played an integral role in assuring access to well child care and immunizations as well as dental care through the Healthy Kids Dental program.

The report goes on to stress the importance of supporting the Medicaid program at both the federal and state levels, to assure continued coverage of the health care needs of the current population and also to strengthen the program so that it will be able to address the needs of the more

than 500,000 additional individuals who will be eligible for Medicaid benefits when the health care reform law takes effect in 2014.

The complete report is available on the League's web site at www.milhs.org.

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

Welfare Cuts Briefly Delayed

In the August 2011 edition of *The Michigan Update* we reported on two bills passed by the Michigan legislature to set a four-year limit on cash assistance - Temporary Assistance for Needy Families (TANF), known as the Family Independence Program (FIP) in Michigan - for most recipients unless they meet specified exemption criteria. The bills were signed into law by Governor Rick Snyder on September 6, 2011 as Public Acts 131 and 132 of 2011 with effective dates of October 1, 2011. However, implementation was briefly delayed by order of US District Court Judge Paul Borman.

Passed into law as part of the state's budget balancing strategy for FY 2011-2012, more than 11,000 families, representing about 40,000 people - largely children, were sent notices in September that they would lose their FIP benefits as of October 1, 2011 unless they could provide documentation to demonstrate continuing eligibility under established exemption criteria. The 11,000 families represent about 13 percent of the families currently receiving FIP benefits.

A class action lawsuit was filed in US District Court on September 30, 2011 by the Center for Civil Justice alleging that the notices were deficient because the families' due process rights were not clearly stated, the policy under which the notices were issued was not publicly available and in some cases families still eligible for benefits were inappropriately included in the mailings. After a hearing on October 4, 2011, Judge Borman issued an order temporarily stopping the Department of Human Services (DHS) from implementing the law. He found the notices "do not provide sufficient information for a recipient to calculate his or her chances of succeeding at a challenge to the termination" and that "none of the notices mentions or refers to any statutory authority or policy directives, or even mentions that the terminations are a result of change in the law." He ordered DHS to mail another notice to the recipients that complies with federal rules.

DHS did re-issue notices to the affected FIP recipients on October 12, 2011. The very next day the Center for Civil Justice again filed suit, claiming the notices were still inadequate. The filing asked for an expedited hearing before Judge Borman. This time, the court ruled in the State's favor. Unless affected recipients successfully appeal and can show continuing eligibility, their FIP benefits will be discontinued.

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

CLASS Act Halted

One of the provisions in the 2010 federal health care reform legislation was the Community Living Assistance Service and Supports (CLASS) Act, a program envisioned as a bridge between long-term care coverage by private health plans and the Medicaid program. It was initially believed the program would save billions through the collection of premiums from individuals participating in the program. A condition of implementation, however, was that the program be certified as fiscally sound, self-financing and sustainable over a 75-year period. In an announcement October 14, 2011, US Department of Health and Human Services Secretary Kathleen Sebelius stated that after 19 months of work her department was unable to structure a voluntary program that would meet the fiscal requirements in the law. Accordingly, all work on the CLASS Act program has been terminated.

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

New MAC for Michigan

CMS has recently announced that Wisconsin Physicians Services (WPS) has been awarded the Medicare Administrative Contract (MAC) for Jurisdiction 8, which includes both Michigan and Indiana. WPS has been the Medicare Part B carrier for Michigan but will now assume responsibilities for Medicare Part A fiscal intermediary services as well, replacing the current Part A intermediary, National Government Services. In addition to fiscal intermediary services, as a MAC, WPS will also conduct enrollment, education and auditing functions related to the Medicare program.

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DSH Distribution

DCH is establishing a work group to study the methodology through which Disproportionate Share Hospital (DSH) funds are paid to hospitals serving Medicaid beneficiaries. Public Act 63 of 2011, the DCH appropriation measure for FY 2011-2012, requires a review of the distribution policy with a report to the legislature by March 1, 2012. The Michigan House of Representatives is considering the policy as well and several hospitals provided testimony at a recent subcommittee hearing, encouraging a change in the methodology to provide more DSH funds for their facilities.

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

Medicaid Fraud Conviction

On October 3, 2011, Michigan Attorney General Bill Schuette announced that an Ingham County jury had convicted Deborah D'Anna, the former CEO and office manager of Palmer Health Center, which operated clinics in Detroit and Romulus until 2005, of perpetrating a $3.3 million Medicaid fraud scheme. Ms. D'Anna was charged with using her access to medical records to bill the Medicaid program from 2006 to 2009 for services never rendered. According to the Attorney General's announcement, the payments were directed to her personal bank accounts in Florida. Her scheme was uncovered when a physician previously employed at one of the clinics reported Medicaid billings being submitted under his provider number for services he did not provide. She faces a maximum sentence of 20 years in prison.

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Medicaid Policies

DCH has issued three final policies and four proposed policies that merit mention. One of the proposed policies was released simultaneously with the final policy. 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 11-37** informs **All Providers** that **Medicaid beneficiaries dually eligible for Medicare**

benefits will transition from an excluded population to a voluntary population for **Medicaid Health Plan enrollment** effective November 1, 2011, subject to approval by CMS of the policy.

- **MSA 11-44** advises **Home Help Agency and Individual Providers** of changes in beneficiary **eligibility criteria for service** coverage. The bulletin also includes information pertinent to the **Independent Living Services** (ILS) program policy. This bulletin was **simultaneously issued for comment (1131-HHP)**. Comments are due to DCH by October 31, 2011.
- **MSA 11-45** informs **Hospice Providers** that Medicaid will follow **Medicare Conditions of Participation**, clarifies **policy regarding disenrollment from/revocation of hospice** and coverage for general inpatient care.
- A proposed policy (**1129-Hearing**) has been issued that would **update the Hearing Services Chapter** of the Medicaid Provider manual with current standards of coverage and prior authorization requirements for **cochlear implants and auditory osseointegrated implants**. Comments are due to DCH by November 3, 2011.
- A proposed policy (**1130-Therapy**) has been issued that would revise outpatient therapy policy to **allow 144 units of therapy to be provided in a one-year period without prior approval** and clarifies documentation requirements for **coordination of services for school-aged beneficiaries**. Comments are due to DCH by November 9, 2011.
- A proposed policy (**1132-Vision**) has been issued that would revise Medicaid coverage of **polycarbonate lenses for children** and clarify current coverage of **vision services for adults**. Comments are due to DCH by November 25, 2011.

DCH also released two L-letters that may be of interest. The first letter (**L 11-36**) was released on October 7, 2011 and relates to DCH activities associated with developing a plan to **integrate the financing and delivery of services for beneficiaries dually eligible for Medicare and Medicaid**. See more in the Integrated Care for Dual Eligibles article in this newsletter. The second letter (**L 11-37**) was issued on October 27, 2011 and announces the dates for **stakeholder meetings** related to DCH's renewal process for the **MI Choice waiver** under which **home and community-based services** are offered to Medicaid beneficiaries. Both letters are available at the same site as the policy bulletins.

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