Medical Services Administration

Medical Care Advisory Council

Minutes

Date: March 23, 2005 (Wednesday)

Time: 1:00 P.M. to 4:30 P.M.

Where: Michigan Public Health Institute
Interactive Learning Center
2436 Woodlake Circle, Suite 380
Okemos MI 48864

Attendees: Neil Oppenheimer, Sandy Kramer, Jocelyn Vanda, Dave LaLumia, William Mayer, Roger Anderson, Sue Moran, Kathy Whited, Ed Kemp, Paul Reinhart, Jan Hudson, Kathy Kendall, Steve Fitton, Dave McLaury, Anita Liberman-Lampear, Andrew Farmer, Paul Shaheen, Walt Stillner, Kathleen Kirschenheiter, Priscilla Cheever, Edward Canfield, Larry Wagenknecht, Alison Hirschel, Christine Chesney, Warren White, Reg Carter, Karen Rothfuss

Absent: Herman Gray, Vernice Davis-Anthony, Diane Haas, John Barnas, Dan Briskie, Jackie McLean, Sandra Kilde, Carol Olthoff, Daniel Wilhelm, Gary Ley, Bruce Bragg

General Comments

The meeting started with the introduction of new member, Dr. William Mayer. He is a physician-epidemiologist and is the Chief Medical Officer of the Family Health Center in Battle Creek, MI. The Family Health Center is a Federally Qualified Health Center with over 20,000 patients and 80,000 patient visits per year. More than half of those are Medicaid patient visits. He is also a consultant to the Stryker Center at Kalamazoo College.

Each Council member present was given a binder to hold meeting materials. All the handouts from this meeting were included in the binder, and are listed below:

- March 23, 2005 Meeting Agenda
- Minutes from 1-6-05 MCAC meeting
- Information on the physician provider tax
- Key Recommendations of Fiscal Year 2006 MDCH Executive Budget
- Modernizing Michigan Medicaid
- New York Times Editorial, “Medicaid in the Cross Hairs”
- Effects of Changes in Medicaid on Incomes and Jobs in Michigan
- Letter From Governor Granholm to the Congressional Delegation protesting cuts to the Medicaid program
- Medicare Part D PowerPoint Presentation
- Update on MMIS System re-bid
- State Plan Amendments Monthly Status Report
- Policy Draft and Bulletin Lists
- Policy Bulletins Issued since last meeting
- LTC Task Force Update

A DVD produced by The Partnership for Michigan's Health titled "The Face and Value of Medicaid in Michigan" was shown. The Partnership consists of the Michigan Health and Hospital Association, The Michigan State Medical Society, and the Michigan Osteopathic Association. The DVD is being used as an educational tool with state legislators and others to help them understand the impact of cutting Medicaid services. Major points of the film were:

- 1.4 million Michigan residents receive health care coverage from Medicaid, which is 1 in every 7 Michigan residents.
- Most are children and families, the elderly, pregnant women and the disabled.
- It is the primary safety net for the poor and uninsured and the caseload is growing.
- Even though Medicaid beneficiaries are primarily children and their parents, a large portion of funding is utilized for long-term care services.
- There are access issues when it comes to services for children and that impacts the entire family.
- Many primary care doctors are dropping out of Medicaid, so those who accept Medicaid are seeing larger and larger percentages of Medicaid patients. Cuts to Medicaid will have a huge impact on them.
- A reduction in benefits is not a reduction in cost. The cost is still there and it will be passed on to someone else. In many cases, it will be the employers in Michigan, who still cover the majority of group health insurance costs.
- Medicaid extends beyond the human benefits of saving lives. It generates thousands of good jobs and is a value to taxpayers, especially compared to the cost of private insurance.

Jan Hudson mentioned that the Kaiser Family Foundation recently released a report with a section on optional eligibility groups and optional services. It is available at www.kff.org.

Budget Highlights

One of the goals in putting together a large and diverse advisory council is to solicit advice. Paul Reinhart shared some of the information he will be presenting to the House Appropriations Subcommittee on April 13, 2005. For Fiscal 2005, Medicaid reductions are consistent with what the Governor recommended. The only difference is that they will be in an Executive Order instead of a negative supplemental. These include a 4% rate reduction for most providers, and a $6 million graduate medical education reduction.

The Fiscal 2006 presentation will include the background of Medicaid, the price of government and the Governor's recommendations. Mr. Reinhart will include a copy of the Medicaid organizational chart which shows it is a very lean organization. Medicaid presently has 310 staff administering a $7.5 to $8 billion health insurance program. The Medicaid caseload went up another 5,000 cases in March and now stands at 1,443,900. The distribution of the caseload and expenditures is:

- Under 21 – 55% of caseload, 19% of expenditures
- Childless adults – 5% of caseload, 1% of expenditures
- Parents/Adults – 16% of caseload, 13% of expenditures
- Elderly – 5 % of caseload, 28% of expenditures
- Disabled – 19% of caseload, 40% of expenditures

The Governor's recommendation for funding for 2006 is almost $8 billion. Funding needs are increasing due to the unemployment rate, which correlates to the Medicaid caseload. The House went through the "Price of Government" process and one key factor is for government to be effective,

efficient and accountable. Mr. Reinhart would argue that the Michigan Medicaid program is clearly efficient. It provides comprehensive health care at a cost well below what commercial insurers and other state Medicaid programs spend. Medicaid spending in fiscal year 2004 only increased 1.5% per beneficiary, while during that same period, Blue Cross spending increased 10.5%. If projections for fiscal year 2005 prove correct, Medicaid spending will only increase by 2.5% per beneficiary, while Blue Cross spending will increase from 7% to 9%. Of the seven Great Lakes States, Michigan ranked 6th lowest in spending per beneficiary. One of the main reasons why spending has been held down is the effective management of the pharmacy program. In fiscal year 2004, pharmacy spending per beneficiary actually went down.

From an accountability standpoint, Mr. Reinhart pointed out that performance measurements are utilized in managed care and a report is produced yearly. Health plans were selected this year based on performance rather than on a low bid basis. Michigan has been recognized in national publications as a trailblazer in the managed care area.

In regard to the economic goal of sustaining jobs in Michigan, the Michigan Medicaid program supports 200,000 workers in the state.

Other goals are to make Michigan's people healthier and improve access to care and the quality of care. All beneficiaries in managed care have primary care physicians located within 30 minutes or 30 miles of their homes. The National Committee for Quality Assurance ranked three of the Michigan Medicaid health plans in the top ten.

The Governor's fiscal year 2006 Medical Services Administration Recommendations are as follows:

- An honest assessment of the expected caseload and appropriate funding
- Per beneficiary spending increase of only .5%
- Replace the Medicaid Management Information System (MMIS) which is 30 years old. Michigan is the last state in the country still using its original computer system.
- Michigan Modernization Program – eligibility changes, benefit constraints, and sustainability initiatives. These are listed on page 8 of the Modernizing Michigan Medicaid handout.

MDCH is in the process of seeking a research and demonstration 1115 Waiver. This would reduce eligibility and benefits for two groups. The three month retroactive eligibility would be eliminated for all applicants and enrollment would be frozen for 19 and 20 year olds. Benefit constraints would apply to the 19 and 20 year old group and the Caretaker Relative group. Council members expressed concern in regard to the retroactive eligibility elimination, particularly as it pertains to pregnant women, nursing facility residents, and those needing therapies. The benefit constraints would only apply to non-disabled and non-pregnant beneficiaries, which make up only about 45,000 of the 1.4 million Medicaid beneficiaries. Concern was also expressed regarding how the Children's Special Health Care Services would be affected by Medicaid cuts.

Physician Provider Tax

Steve Fitton discussed the physician provider tax. He indicated that there have been several meetings with the provider community and this proposal has not been met with enthusiasm. Part of the motivation behind the tax is to fill a hole in the budget, but mainly it is because the status quo isn't working. Medicaid rates have continued to erode against practice costs and Medicare rates. Current Medicaid rates are approximately 60% of Medicare rates. There are access problems with certain specialties and sub-specialties, and in certain geographic pockets of the state. Access is becoming

more difficult as a growing number of physicians no longer treat Medicaid patients. This increases the burden on those physicians that are willing to treat Medicaid patients. Mr. Fitton mentioned that there would probably be a 4% rate reduction for the remainder of 2005, effective May 1, 2005. If the physician provider tax were adopted, the 4% would be restored prior to the adoption of the provider tax.

In reviewing the physician provider tax handouts, Mr. Fitton indicated that the major benefits would be:

- Substantial additional federal revenue would be brought to the state.
- It makes it possible for Medicaid to reimburse at Medicare levels.
- The gross payment to physicians in the aggregate would be approximately double the amount of the tax.
- Improved access for Medicaid beneficiaries in general and particularly in the areas with acute access problems.
- With possible federal Medicaid reform and block grants or other non-matching funding, Michigan's base federal funding would be increased.
- It should be of economic benefit to the state.

If the physician provider tax is not adopted, the 4% rate reduction to physicians will likely be carried into 2006.

In the discussion that followed, Council members indicated that there is a great deal of concern in the provider community. One opinion expressed was that physicians were being singled out. Mr. Fitton replied that hospitals, nursing home providers, and health maintenance organizations are already assessed a tax and that has helped sustain the Medicaid program. Tort reform was suggested, as was the idea for the government to give physicians a tax benefit for the difference between the Medicaid and Medicare reimbursement rates. One member proposed giving the physicians a tax break in exchange for seeing Medicaid beneficiaries for free. For physicians that see a high percentage of Medicaid this probably would not be a workable solution. Another suggestion was to tailor the tax to reward physicians for seeing more Medicaid beneficiaries, and penalize those who don't see their fair share. There was concern that if a practice takes on more Medicaid beneficiaries, new employees would need to be hired because they often require more assistance than other patients do. Mention was made that a practice of 45 physicians in southwest Michigan with approximately 25% Medicaid beneficiaries wrote off $4 million in Medicaid charges last year. Another concern was that they would only receive the tax and not receive a rate increase. A general distrust of government was expressed. It was pointed out that other laws have a sunset provision if the Federal government decides to prohibit Michigan Medicaid from using specific funds to receive a federal match. Mr. Reinhart indicated that similar provisions could be included in the law. Members were encouraged to submit other ideas for generating revenue.

Medicare Part D

Although the meeting focus was on low-income and dually eligible, (those with both Medicare and Medicaid,) Medicare Part D will affect everyone. Dave McLaury indicated that this program would dramatically change prescription drug coverage in this country. In the future, employers may remove prescription drug coverage as a benefit and will instead turn it over to the Federal government. Mr. McLaury and Ms. Sue Moran chair a MDCH workgroup that meets monthly with other partners in this transition. MMAP (Michigan Medicare/Medicaid Assistance Program) pamphlets were provided as an example of a resource for seniors, and MDCH is working closely with them to service our population.

Sandy Kramer from Health Management Associates (formerly a pharmacy policy analyst and budget analyst with the State of Michigan) presented a PowerPoint on Medicare Part D. Congress passed a new Medicare Prescription drug program in December 2003, effective January 1, 2006. It was named the "MMA", or Medicare Prescription Drug, Improvement, and Modernization Act. MMA is more than drug coverage. Rates and Health Savings Accounts have changed and there is a new pricing index for pharmacies. MMA mandates that Medicaid coverage for Part D drugs to the dually eligible ends on January 1, 2006. Other highlights included:

- Prescription Drug Plans (PDPs) and Medicare Advantage Prescription Drug Plans (MA-PDs) will administer the plans and they will be risk-bearing entities.
- Beneficiaries will have at least 2 plans to choose from and enrollment is voluntary. However, those who do not initially enroll will be assessed a late enrollment penalty. Mailings will be going out to advise beneficiaries of this program.
- Each plan will determine which drugs will be covered, although 2 drugs from each class must be included.
- Covered drugs will include Medicaid required drugs, Insulin and its supplies, and prescription smoking cessation drugs. Medicaid optional drugs, and Medicare Part A and Part B drugs will be excluded.
- Those dually enrolled in Medicare and Medicaid will be automatically enrolled in Part D. There is a provision included that allows them to change the pharmacy plan they were automatically enrolled in.
- The enrollment period begins November 15 2005 and ends May 15, 2006.
- Part D will be helpful to low-income beneficiaries because premiums, deductibles and coinsurance will be at a discounted rate, or will be of no cost to them.
- The phase down state contribution is a per capita payment to CMS based on 2003 state per capita Medicaid pharmacy costs trended up by a national growth factor to 2006. The increased cost is not funded in the 2006 Medicaid budget.
- The PDP formularies may not be as comprehensive as Medicaid's.
- Michigan Medicaid has a number of issues related to this program, including the transition period, coverage, increased costs, higher Medicaid enrollment, and the state's role in the process.

Medicaid Management Information System (MMIS)

Dave McLaury discussed the need for a new MMIS. The current system is over 30 years old and is difficult to modify and maintain. Michigan is one of only twelve states that operate their own system. This is a joint venture between MDCH and DIT (the Department of Information Technology). The Advanced Planning Document filed by MDCH was approved by CMS (Centers for Medicare and Medicaid Services.) They have committed to approximately $56 million in enhanced Federal matching funds on a 90/10 match basis over a three year period. A Request for Proposal will be issued in the next few weeks to solicit a vendor. The Federal government must certify any new MMIS system. Michigan Medicaid wants to transfer an existing system from another state and have the vendor customize it to meet Michigan's business rules. Implementation will take approximately two years. The new system will have a web portal, and improved security and protection of data. Customer service will improve with the ability for providers to submit claims online, and real time processing will replace batch processing. Administrative capabilities will improve as well. MDCH and DIT are working closely with the Department of Human Services (formerly known as FIA) as they pursue a replacement for their current eligibility system.

Policy Highlights

Ed Kemp discussed the list of policy bulletins that had been issued since January 1, 2005. The Council members will be receiving the draft bulletins electronically, and the final bulletins by mail. Some Council members felt it would be helpful to incorporate the rationale for the policy change in the bulletins. Mr. Kemp spoke about the annuity policy draft. MDCH hopes to tighten up loopholes regarding annuities and trusts since people are sheltering assets in order to become Medicaid eligible.

Kathy Whited advised that the 2005 version of the Provider Manuals CD is available and she brought a supply with her. The web will be updated on April 1, 2005 with all of the changes.

Future Meetings

The Council was interested in adding a May meeting. Suggested topics for the next meeting or a future meeting were:

- National Governors' Association Task Force
- The LTC Task Force
- Budget update
- Medicare Part D update
- Managed care progress on ESPDT services
- The long term future of the Medicaid program beyond 2006
- Third Share Plans
- Federal Medicaid reform

The consensus of the members was to limit future meetings to three hours.