



# Medical Care Advisory Council

## Minutes

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**Date:** Thursday, February 15, 2012

**Time:** 1:00 – 4:30 p.m.

**Where:** Michigan Primary Care Association  
7215 Westshire Drive  
Lansing, Michigan

**Attendees:** **Council Members:** Jan Hudson, Peter Schonfeld, Warren White, William Mayer, Jackie Doig, Bev Crider, Dianne Haas, Jocelyn Vanda, Renee Canady, Tom Kochheiser, Dave LaLumia, Marion Owen, Barry Cargill, Kim Sibilsky, Mike Vizena, Cindy Schnetzler  
**MDCH Staff:** Steve Fitton, Dick Miles, Jackie Prokop, Pam Diebolt, Amy Allen, Cindy Linn

**Welcome and Introductions ..... Jan Hudson**

Jan Hudson opened the meeting; introductions were made.

**FY 2013 Executive Budget Recommendations ..... Steve Fitton**

Chuck Overbey from the State Budget Office was not present to discuss the budget. Steve explained the MDCH FY12 base as a whole was \$14.56 billion, with approximately \$2.9 billion in General Funds. The recommendation for FY13 is \$15.45 billion, with slightly over \$2.8 billion in General Funds. The FY13 General Funds are approximately \$100 million less than FY12, which is related to how the revenue is characterized from a Use Tax to a Claims Tax. Currently, there is a lawsuit against the Claims Tax.

Portions of the FY13 budget were adjusted to the FY12 base as some of the anticipated savings will not be realized in 2012. They include Estate Recovery (which was recently implemented), Mental Health Drugs on the Preferred Drug List (PDL), Integrated Care for Dual Eligibles, Home Help Activities for Daily Living (ADL), and enrollment of the Children's Special Health Care Services (CSHCS)/Medicaid eligible beneficiaries into the Health Plans. The CHAMPS system is funded at \$5.5 million for ongoing maintenance. The Electronic Health Records (EHR) initiative is funded at \$25 million.

Steve explained that if the administrative budget looks like it tripled, it didn't; it has been restructured.

On the revenue side, Steve explained the Claims Tax was implemented on January 1, 2012 and the Use Tax will end March 31, 2012.

Medicaid caseload is assumed to grow in FY13 over FY12 by 2.4% and by 2.8% for FY14. FY12 was adjusted down because caseload did not grow as it was estimated.

For hospitals, there were two significant one-time funding amounts in the budget for FY12: \$17 million that cushioned the big cut to Graduate Medical Education (GME), and a pool of approximately \$30 million designated to Rural Hospitals. Those one-time appropriations were not continued in the FY13 Executive Budget.

The FY13 budget includes a number of cost saving initiatives including waste, fraud and abuse, Third Party Liability (TPL), and overpayment detection efforts. There are also pharmacy savings for changing reimbursement for physician-administered and injectable drugs where physicians are incentivized to use less costly generic drugs. The initiatives are part of the Magellan contract.

The Executive Budget recommended several program expansions:

- *Healthy Kids Dental* expansion into primarily urban areas, with recommended funding of \$25 million gross, \$8.3 million General Funds (GF).
- \$34 million is designated for autism coverage and services.

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- As part of the Affordable Care Act (ACA) Primary Care Enhancement, primary care services will be paid at 100% of Medicare rates. Support is through \$281 million in designated federal funds. Jackie Prokop added that only those visits performed by primary care physicians will get the rate increase, and visits performed by Registered Nurses (RNs), Nurse Practitioners, or Physician Assistants will not receive the rate increase.
  - \$11 million is designated for MIChoice, funded in part by savings from nursing home transitions to the community and new GF to reduce the number of beneficiaries currently on the waiting list.
  - Non-emergency medical transportation rates are recommended to be increased for the first time in many years.
  - Chiropractic services for adults are recommended for restoration and funded at \$900,000.
  - \$2 million is recommended for coverage of wheelchairs at Medicare rates.

An attendee asked if the lawsuit on the Claims Tax could affect the proposed budget. Steve answered that he did not know what the impact could be on the budget or on the time frame.

Concern was also expressed that the primary care rate increase will not alleviate issues with access to specialty care. Development of a strategic plan for implementing the primary care rate increase was recommended.

## **Affordable Care Act (ACA) Implementation ..... Steve Fitton/Staff**

### **a. Dual Eligibles Integration Project**

Dick Miles stated the plan for integrated care is 90-95% complete, and it is being routed through the management review process. The plan will be released to the public on March 5, 2012. Estimated spending for the dual eligibles is about \$8 billion, which includes, the elderly, disabled beneficiaries and beneficiaries needing long term care (LTC). The final plan will be submitted to the Centers for Medicare and Medicaid Services (CMS) by April 26, 2012.

Additional questions can be submitted to the Integrated Care Mailbox at [Integratedcare@michigan.gov](mailto:Integratedcare@michigan.gov).

### **b. Exchange Planning Process and Legislation**

Chris Priest has been detailed to the Department of Licensing and Regulatory Affairs (LARA) for development of the Health Care Exchange. Chris was not available for today's meeting. Jan Hudson explained that Exchange Legislation has not passed the state House of Representatives. The State of Michigan was awarded \$10 million in federal funds for Exchange planning, but the House has not yet appropriated the funds.

### **c. Basic Health Program**

Eileen Ellis from Health Management Associates explained that the ACA establishes an option to create a basic health program for those people with incomes between 138% and 200% of the federal poverty level (FPL). The basic health program will be run by the states. If a state chooses to implement a basic health program, the insurance options offered on the Exchange for that population will be directed under the basic health plan framework. The federal government will give the states 95% of the cost of the lowest priced silver plan on the Exchange to subsidize those people enrolling in the program. This could impact up to 200,000 beneficiaries. Eileen indicated that if Michigan implements this program, it must be offered as part of the Exchange. The State must determine if it would be cost effective to provide this program as an alternative to purchasing coverage on the Exchange for this population. The financing of the project carries risks for the state. If costs are less than the federal subsidy, then the State must reinvest the funds back into the program. If costs are greater than expected, then the State must appropriate additional funding. The state does have the ability to adopt policies that can keep the program fiscally viable and, in the worst case, can end the program and revert to the federal subsidies generally available on the Exchange.

There was concern expressed about paying providers less than commercial rates, but that may be a key mechanism for managing costs. There is also concern about removing this large of a population from purchasing coverage on the Exchange. The positive potential of the basic health program is that it can procure insurance products that are more consistent across low income eligibility categories so that families have a more seamless experience in navigating provider networks and the different rules for beneficiaries. This also is an issue for individuals whose income changes, causing them to move from one eligibility category to another, but the expert commentary of this latter issue (labeled churn) is mixed.

Significant research is needed to determine the viability for Michigan of the basic health program.

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As an alternative, the County Health Plans are forming a co-op to provide this health care service under the rules of the ACA. (see below).

### d. Essential Benefits Development

The definition of Essential Benefits Development is a huge issue for both the private market and Medicaid. Jan Hudson explained there are 10 categories of benefits that must be provided by qualified health plans in the Exchange. The benefits must also be provided to the Medicaid expansion population. The ACA called for the HHS Secretary to establish a definition of what benefits/services would be included in the 10 categories known as the essential health benefits. In December 2011, the Secretary issued a letter providing flexibility to the states in defining these benefits. Comments were made to the Secretary at the end of January by some organizations stating they did not agree that individual states should identify the content of the essential benefits package. If the state chooses to not act on its own, the default is based on the largest small group plan in the state. If the state chooses the default plan, there could be a very low floor of benefits, rather than the robust coverage envisioned by the ACA. There is language in the Secretary's letter that gave insurance companies say in discussions to determine which benefits to cover. Concern arose as to whether insurance companies would try to "trade off" more expensive services for less expensive services.

### e. Michigan Co-Op Application

Bruce Miller explained that the federal government has put several billion dollars aside through the ACA for state-wide cooperative start-up loans. When looking at other states that formed co-ops, Michigan decided it would be beneficial to complete an application. A number of county health plans worked together to complete the application process. The goal of the co-op is to focus on individuals with income above 139% of the federal poverty level, making premiums affordable, providing good benefits to its members, and providing quality care through the Exchange. The State's application was submitted in December 2011, and it was deemed complete by the federal reviewer. Interviews have been set for early March 2012.

An attendee asked whether beneficiaries with county-based health plans would need to get health care within the county they live. Bruce responded that beneficiaries would not be limited to obtaining care in the county where they live.

### Medicaid Expansion and Eligibility Simplification/MI Bridges Expansion Experience .....Steve Fitton

At the last MCAC meeting, attendees were updated on the crosswalk and the focus groups that were formed. Amy Allen informed the group that MDCH is working on an eligibility crosswalk that will show how current eligibility groups will crosswalk to the Modified Adjusted Gross Income (MAGI) calculations with the new eligibility groups in 2014. Amy explained that the crosswalk will be helpful to MDCH in the future as it will help determine MAGI eligibility and how Federal Medical Assistance Percentage (FMAP) is calculated. Currently, it is unknown what the specifics of the program will be as far as income limits, reporting changes in income, thresholds with working requirements, etc. An attendee asked whether the crosswalk is complete. Amy and Steve responded that work needs to be done before it is complete. Steve made a note that Jan Hudson will provide all information on the crosswalk when it is complete.

The Robert Wood Johnson Foundation funded a contract to conduct two focus groups in southeastern Michigan and two groups in western Michigan. One of the groups was very low income and had experience with Medicaid. The other group qualified for the Medicaid expansion group and was uninsured but did not have any Medicaid experience. Both groups were presented with several questions about Medicaid. The first group, who had experience with Medicaid, tended to have no problem with the program and did not think any changes were necessary. The group that had no experience thought that Medicaid should be named something else and indicated they heard Medicaid provided substandard care, though they also indicated they would sign up for Medicaid. Questions were also asked about how the focus group participants would like to sign up for the program and what types of assistance should be available. The focus groups will provide information for a much broader survey that will be conducted in the next few months. After that data is compiled and analyzed, a final report will be forthcoming once the research analysis has been completed.

Steve stated there are an estimated three million people who will have to move through the Medicaid eligibility process. In order to be eligible for a subsidy, an individual must first qualify for Medicaid eligibility. This means that a Medicaid eligibility screening has to be done for anyone entering the Exchange, including those individuals who do not qualify for a subsidy. MDCH currently has 1.9 million people on Medicaid; 1.5 million of them will be moved to the simplification process. At least another 450,000 individuals will become Medicaid eligible as part of the newly-eligible groups. The Exchange will add an estimated 500,000 individuals to Medicaid. There is much work to be done to determine how people can get through the system to obtain insurance as seamlessly as possible.

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An attendee asked what "simplification" is. He feels the process is becoming more difficult, not getting easier, as he looks towards 2014. There are always problems with using the eligibility system and worries about the future. The attendee also referenced problems with newborns and getting hospitalizations covered.

Steve stated there are distinct differences between the eligibility system now and the future. Right now DHS has an integrated eligibility system which collects information needed to determine eligibility across their full range of assistance programs. This has the advantage of qualifying an individual for all of the services they are eligible to receive. But it does require that a large amount of information be collected and takes quite a bit of time.

The expectation for the future is an easier, more streamlined process that is focused on collecting a limited set of information for Medicaid and the Exchange subsidies. Questions about assets will be prohibited under the federal rule. There should be electronic matches against the Internal Revenue Service (IRS) information for wages, Social Security Administration for citizenship, etc. before someone receives a determination. DHS implemented an electronic online portal that allows people to apply for most assistance programs, including Medicaid, without going into a DHS office. The portal has been operational since December 17, 2011. Steve suggested it may be necessary to form a work group to address issues regarding the eligibility system.

**The meeting was adjourned at 4:30 p.m.**

**Next Meeting: Tuesday, May 15, 2012**

**Time: 1:00 pm to 4:30 pm**

**Location: MPHI Learning Center  
2436 Woodlake Circle  
Okemos, Michigan**