Michigan Department of Community Health
MDCH
Rick Snyder, Governor
Olga Dazzo, Director

Medical Services Administration

Medical Care Advisory Council

Minutes

Date: Thursday, May 15, 2012

Time: 1:00 – 4:30 p.m.

Where: Michigan Public Health Institute
2436 Woodlake Circle
Okemos, MI

Attendees: **Council Members:** Peter Schonfeld, Alison Hirschel, Marion Owen, Thomas Kochheiser, Dave Herbel, Jocelyn Vanda, Kim Sibilsky, Cindy Schnetzler, Pam Lupo, Anita Liberman-Lampear, Deb Brinson, Michael Vizena, Warren White, Patricia McFarland,
Staff: Steve Fitton, Dick Miles, Charles Overbey, Jackie Prokop, Pam Diebolt, Sue Moran, Amy Allen, Linda Zeller, Karen Parker,
Additional Attendees: Tawana Robinson, Shaun Bennett

Welcome and Introductions

Jan Hudson opened the meeting; introductions were made. Jan announced there is a policy symposium being co-sponsored on May 22, 2012 by the Michigan Consumers for Health Care, the Michigan Health Policy Forum and the Michigan State University Institute for Health Care Studies. On June 19, 2012 there is a policy forum hosted by the Michigan League for Human Services discussing state policies recently implemented by the Department of Human Services, including their impacts on families and communities.

FY13 Budget Update and Conference Committee Process

The Revenue Estimating Conference is tomorrow and based on revenues that are agreed to, the final budgets will be written. Chuck Overbey added that funding targets are supposed to be agreed upon by this coming weekend between the House and the Senate. The plan is to have the FY 2013 budget completed by the end of May 2012. The targets will identify the amount of money that the conference committees will have available to finalize the departments' budgets. There are many significant $100 placeholders in the Michigan Department of Community Health (MDCH) budget, which are viewed as good because it keeps those items alive to be discussed at conference committee. Many of those items are important to the administration and the department as a whole. Chuck is very optimistic about the MDCH budget. Medicaid caseload consensus was reached last week and caseloads will be adequately funded. Medicaid caseloads have flattened out recently. Steve would like to know if this is because the economy is getting better and less people need Medicaid; if so, that's a great indicator. If people are having a hard time gaining access to Medicaid, then that is a problem. Chuck added that they think that there might be an issue with underemployment that could be contributing to the flattening of caseloads. That is, individuals are working a part time job or at low wages that put them above eligibility requirements.

Chuck believes that revenues will come in higher than projected. There are significant expansions in the budget including Healthy Kids Dental, autism treatment, and restoration of chiropractic services.

Council Members requested a letter of support to Conference Committee members for full funding for key items still under discussion. Jan agreed to draft a letter and send it as soon as possible.

Affordable Care Act Implementation

Dual Eligibles Integration Project [CMS comment period until May 30, 2012]

This plan applies to dual eligible beneficiaries (persons with Medicare and Medicaid coverage). There was a little less than $1 million dollars given to develop a plan for implementation for this project. The final proposal submitted to the federal government contained no major changes from the proposal that the Department shared for stakeholder comments. There were over 30 letters of support for the dual eligible project received from a variety of organizations, including many consumer advocacy groups. Jan Hudson added that MCAC sent a letter of support for the structure of the dual eligibles project. Steve complimented staff on the stakeholder process.

There are concerns from provider groups and advocates with the dual eligible proposal in regards to rates; dual, rather than single contract; the definition of the Care Bridge; eligibility issues (particularly for spend down clients), and that the proposal was high level and lacking in details.

Dick Miles added the proposal that was submitted to the Centers for Medicare/Medicaid Services (CMS) is located on the MDCH website for anyone that is interested.

Steve requested additional letters of support from Council members.

The FY 13 budget includes savings of $30 million for this initiative.

Physician Rate Increase Effective January 1, 2013

The Affordable Care Act (ACA) requires primary care physician (PCP) rates to be increased to Medicare rates effective January 1, 2013 in preparation for the Medicaid expansion on January 1, 2014. MDCH will get 100% federal match initially. The rate increase applies to internal medicine physicians, family practice physicians, or pediatricians.

Jackie Prokop explained a few highlights. There are 3 provider types that will be included in the Physician Rate Increase; Family Medicine, General, and Pediatric Medicine. CMS provided guidance stating that if a Physician is board certified he/she can be flagged in the system so they receive the increased rates. It can get confusing if the Physician is board certified in 2 or more different areas such as internal medicine or endocrinology. There are still many questions in regards to payment. If the Physician is one of the three included in the increase and is not board certified CMS says they can look back at claims in the last year and if 60 percent of claims were primary care, they would receive the increased rate.

CMS has issued their range of evaluation and management codes.

Jackie clarified that if a Nurse Practitioner or PA completes a visit that they do receive the increased rate. The rule is unclear if they receive the Physician rate at 100% or the increased Medicare rate at 85%; Jackie believes it is 85%.

Vaccination code rates increase with this law and should be implemented January 1, 2013.

Obstetricians are not included in the increase. Pediatrician's visits in hospitals would be included in the increase.

Jan Hudson added that the rate increase is based on what the states were paying as of July 1, 2009. So, if states had reduced their rates after July 1, 2009 they would have to restore the level of those decreases at the regular Medicaid matching rate.

Medicaid Essential Benefits Development (Full Medicaid or Other)

MDCH received federal guidance in January 2012 but is still awaiting full details and regulations. Medicaid must select a benchmark plan. MDCH can use the current Medicaid plan as its benchmark but can also choose from the largest non-Medicaid HMO plan, largest federal employee plan, or any State employee plan. MDCH is currently consulting to get a comparison of the current fee-for-service (FFS) program and managed care program compared to the services within the 10 benefit categories that will be required to be provided. The Office of Financial and Insurance Regulation (OFIR) has prepared a document which includes services that are anticipated to fall into the 10 benefit categories. Nothing has been formally decided, but MDCH is using this as a guide. The analysis should be received by the end of the week and should show any potential coverage gaps in care or coverage. MDCH will then decide what Medicaid Essential Benefits package will be provided to those newly eligible. Steve indicated that a comprehensive benefit package is certainly affordable since the federal government will be paying 100% of the cost for the new eligibles for the first 3 years.

Eligibility Simplification Crosswalk

Documents, shared with meeting attendees, showing current medically needy Medicaid groups and where those groups will be in 2014 were discussed. At the last meeting it was explained there was work going on for a crosswalk for current eligibility groups to the new method in 2014. The handout shows current eligibility categories in comparison to 2014 eligibility categories. Amy Allen added that in 2014 income determinations will be based on Modified Adjusted Gross Income (MAGI). For some eligibility categories MDCH has the ability to apply a MAGI equivalent to qualify individuals that might not be eligible otherwise. It is important for MDCH to know who is currently in the Medicaid population and who will be in the new eligibility group because the increased federal match will only apply to the newly eligible. Jan would like to have attendees review the handout and give MDCH opinions on what the right options would be for the state have to make a decision. Jan added that she will be

resending the email with the handout for individuals to print and look over. If there are any questions on this topic please email Amy Allen at AllenA7@michigan.gov.

MI Bridges Expansion Update

DHS implemented kiosks in some local offices in December 2011. Jane Goestchy explained that the third and final wave of MI Bridges has been released. Jane passed out handouts for the attendees providing highlights. On April 28, 2012 MI Bridges 3 was released. It is now possible to check benefits and submit redetermination information online. Initially there was a problem with the MI Bridges program that resets passwords. DHS has implemented a password reset to fix the problem. Jane reported that there were a few glitches initially, but everything is working well currently. There is also Arabic translation.

Jane indicated that some clients are intimidated by using the computer. For this reason, there are navigators in each office that can help people through the entire application process. Paper applications will still be available for individuals not wanting to fill out an online application.

How are the standards of promptness (SOP) since adding the kiosks? Jane says that the SOP is good, at 94% for all programs. The processing centers lead all the offices in SOP since they solely work on applications and don't have interruptions. Long Term Care (LTC) specialists are being mandated to attend the most recent policy MI Bridges training by the end of July.

Jane added that there should be a kiosk in every DHS office and a navigator by the end of summer 2012. Applicants will be able to upload necessary documentation so they will not have to follow-up by mailing documents.

If there are questions please email Jane at goetschyj@michigan.gov or call her at 517-373-0038.

Policy Updates

Children's Special Health Care Services Managed Care Update

Sue Moran reported there are around 20,000 children eligible for CSHCS with the full Medicaid benefit. Currently, if a beneficiary is CSHCS only or CSHCS/Medicaid they are excluded from enrollment into a Medicaid health plan, but enrollment will become mandatory for beneficiaries with CSHCS and Medicaid coverage. Beneficiaries with CSCHS only continue to be exempt from the health plan enrollment. MDCH is currently working with the health plans with a target date of October 1, 2012. This may not be a solid date.

Primary care physicians are not covered within the CSHCS program so with the new enrollment, important PCP visits will not be missed. MDCH would like to create consistency with coverage of primary care services among that population.

There is an internal workgroup including individuals from MDCH, Office of Medical Affairs, and staff from CSHCS. They meet on a regular basis to work through operational details. There is also an operational workgroup. Medicaid Health Plans are engaged in the planning process. There is also outreach to external stakeholders to obtain their input.

There will be a family focused approach to this process. Language in the new Medicaid Health Plan Contract that pertains to this population will be included. Families will have to select a health plan with the new process; there is no auto selection. There will be outreach procedures to work with families on making a choice of health plan if no choice is made. This is based on array of providers used, child's needs, and geographic location.

Sue explained there will be carvouts in this program. For example, an individual who requires private duty nursing (PDN) will stay in FFS. Psychotropic drugs and dental will remain carved out and added to the list are clotting factors.

CSHCS families can receive care planning, which is a reimburseable service. This is a carve out program. Rates are being developed for this population.

Medicaid Autism Coverage

Steve Fitton expects the FY 2013 budget to cover Applied Behavior Analysis (ABA) therapy for Autism for Medicaid and MIChild recipients. The Conference Committee will determine the level of funding. The Senate included only a $100 dollar placeholder for this service. It will require a State Plan Amendment or waiver under the Medicaid program. The best case scenario would be a January 1, 2013 implementation date. Once the budget is finalized and the funding for Autism coverage is known, MDCH will begin working with CMS on the coverage.

Chiropractic Service Restoration

Jackie Prokop noted that Chiropractic services for adults are restored effective June 1, 2012. If funding is not continued in the FY 13 budget, 600,000 letters will have to be mailed to Medicaid recipients providing notice of the termination of the benefit.

ICD 10 Delayed

Jackie Prokop explained CMS has announced that ICD-10 will be delayed 1 year, now to be implemented October 1, 2014. There will be updates in the quarterly update bulletins. Due to the magnitude of the project, MDCH is moving forward as if there is no delay. The entire coding structure is being changed with the change from ICD-9 to ICD-10. ICD-9 has around 24,000 codes, whereas ICD-10 has around 160,000 diagnosis codes. This project is funded with 90% federal match.

MIPCT

Sue passed out handouts to attendees. There were originally up to 150,000 Medicare beneficiaries to be included and CMS would fund no more than $10 dollars per Medicare beneficiary per month. Multi payer demonstration is a common payment methodology and must be budget neutral to Medicare over 3 years. It is not a grant or money that CMS is handing to MDCH; it is Medicare joining other payers in paying for the model.

Michigan is the largest participating state in the demonstration. There are 477 practices eligible and 410 practices currently have signed agreements with the state. They are affiliated with 36 physician organizations and represent over 1700 providers. There is a lot of work going on around this project as it is statewide. Participating payers include Managed Care only Medicaid, Medicare, Blue Care Network, Blue Cross Blue Shield PPO. A feature of the Michigan model is that all payer data will come together and it can be evaluated at the PO level. Each quarter practices must report where they are in regards to their level and they will have to report the revenue they took in under MIPCT as well as any expenses.

Both the PO and practice must sign the agreement, which tells the practice what they need to work on. They fall into 4 categories: Secure Management, Self-Management Support, Care Coordination, and linking persons to community services.

As far as funding, $.26 cents per member per month for administrative expenses provided through U of M Health System is assessed. $3 per member per month is assessed for Care Management support, $1.50 for practice transformation, and $3 for incentive pool for a total payment of $7.76. Medicare is paying an additional $2 to cover the prevalence of chronic conditions among Medicare recipients. Practice transformation payments go directly to the facility. Incentive payments are paid out twice a year to the PO. Blue Cross Blue Shield is paying based on claim, rather than a monthly capitation.

Practice transformation payments are to help build the infrastructure. For year one, there are 2 expectations of practices. Practices must expand their hours of access by 8 hours in first 6 months and 12 hours by the end of the year.

If you would like any more information on this topic please contact Sue Moran at morans@michigan.gov.

Claims Tax Lawsuit Update

Jan Judson reported that the oral argument regarding the Claims Tax lawsuit has been set for June 12, 2012.

The next meeting is set for Thursday August 23, 2012.