Michigan Department of Community Health

Rick Snyder, Governor
James K. Haveman, Director

Medical Services Administration

Medical Care Advisory Council (MCAC)

Minutes

Date: Thursday, August 22, 2013

Time: 1:00 p.m.

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

Attendees: **Council Members:** Jan Hudson, Priscilla Cheever, Barry Cargill, Tom Kochheiser, Warren White, Cheryl Bupp, Robin Reynolds, Alison Hirschel, Elmer Cerano, Jackie Doig, Kim Sibilsky, Tawana Nettles-Robinson, Dave Lalumia, Mark Swan, Bev Crider, Mike Vizena, Kim Singh, Pam Lupo, Larry Wagenknecht, Vickie Kunz, Jane Goetschy, Cindy Schnetzler, Renee Canady

Staff: Dick Miles, Jackie Prokop, Debbie Eggleston, Brian Barrie, Cindy Linn, Pam Diebolt

Additional Attendees: Steve McRae, Eric Roath, Elizabeth Reese, Sarah Mahoney

Welcome and Introductions

Jan Hudson opened the meeting and introductions were made. Jan announced that Steve Fitton is not in attendance today and that Dick Miles and Jackie Prokop will provide information in his absence.

Affordable Care Act Implementation

Medicaid Expansion/Reform

Update on HB 4714 and Senate Substitutes-Dick Miles and Jackie Prokop

House Bill 4714 has changed significantly since the last meeting. Dick Miles indicated that the Senate Operations Committee discharged an amended version of HB 4714, as well as two substitute bills, to the Senate floor. A possible vote is expected on Tuesday. The best case scenario is that HB 4714 is passed during the first week of September. The Department of Community Health (MDCH) will then work towards implementation, which includes waiver requests, state plan amendments, system changes and beneficiary notifications. Some systems change work has already begun.

Under the bill, Medicaid expansion will be called the Healthy Michigan Plan. House Bill 4714 includes language regarding a Healthy Michigan Account for patient cost sharing. Medicaid Health Plans will be responsible for setting up the Healthy Michigan Accounts. Beneficiaries will be required to pay co-pays and if they are between 100% and 133% of the FPL, they will also have to pay a 2% contribution to their Healthy Michigan Account. The amounts that are required to be paid in may be reduced based on healthy behaviors. Contributions will be tracked by MDCH or can be delegated to the health plans and quarterly reports must be sent to the beneficiaries.

There will be three Medicaid groups if the bill is passed: currently eligible, newly eligible up to 100% of FPL and newly eligible from 100-133% of the FPL. Many of the newly eligible are childless adults. Those newly eligible will likely be fee for service initially, and then move into managed care plans thru Maximus. The capitation payments for this population will be the similar to regular Medicaid. The Centers for Medicare and Medicaid Services (CMS) is supportive of Michigan's participation in Medicaid expansion and has provided input regarding the waivers. Two new waivers are needed for the expansion. One is needed for the Healthy Michigan Account and the other is required for the 100-133% FPL population who has a choice after 48 months to purchase health insurance on the Federally Facilitated Marketplace (FFM) or increase their contribution to up to 7% of income. The Department is focused on the first waiver now and will submit the second waiver later. It is not clear how long the waiver approval will take. MDCH has asked CMS whether applications that would qualify for expansion that are submitted between October 1, 2013 and January 1, 2014 must reapply, or whether the information can simply be reprocessed through the eligibility system after January 1, 2014.

The members discussed whether the MCAC could be part of the stakeholder process via a special meeting. The Department will be in touch with the group if a stakeholder meeting is held. Members also expressed interest in reviewing the waiver before it is sent to CMS. No public comment is required for a waiver amendment.

MAGI Rules Conversion-Jackie Prokop

The Affordable Care Act requires that states implement the modified adjusted gross income (MAGI) methodology for reporting income and determining Medicaid eligibility no later than January 1, 2014. States have the option of early implementation on October 1 to coincide with implementation of the Exchange. From October 1, 2013 to December 31, 2013, there will be two tracks for determining Medicaid eligibility. When an applicant completes the standard streamlined application, the MAGI eligibility methodology will be used. Applicants found to be eligible for Medicaid using this methodology would not be eligible for services until January 1, 2014. The existing Department of Human Services (DHS) eligibility system will also be in place until December 31, 2013. Applicants found to be eligible for existing programs using this methodology can begin receiving benefits immediately. People applying for Medicaid expansion will use the streamlined application.

After January 1, 2014, the state will only use MAGI determinations for determining Medicaid eligibility, except that MAGI will not be applied to the aged, blind and disabled population. The MAGI methodology does not use an asset test. If someone applies at DHS and is found ineligible for Medicaid, he/she will be directed to the FFM to apply for health care insurance using the streamlined application.

The MAGI manual is currently out for promulgation for both MDCH and DHS. The policy is going out for second public comment period concurrent with the final distribution to incorporate information in latest release of a clarification of the rules. The MAGI conversion will proceed even if Medicaid expansion is not passed.

Medicaid Coordination with Exchange-Jackie Prokop

The Governor's Office is developing a Healthy Michigan Website that will include FFM information. The Department will develop a new 1-800 line for both businesses and applicants that will be available after October 1, 2013. Maximus will help staff the line.

Outreach and Enrollment Plans-Jackie Prokop

Michigan is working with the Federal Government on outreach and enrollment efforts. The Department will issue FAQs and develop a webpage to access the streamlined application. A correspondence workgroup has been developed. The Department is hoping to have a separate communication system from Bridges.

Dual Eligibles Integration Project Update-Dick Miles

The Department is three years into the integrated care demonstration project planning and implementation efforts. Susan Yontz is the project manager. A request for proposals (RFP) was released on August 6, 2013 for entities interested in becoming integrated care organizations. Questions about the RFP were due by August 12, 2013 and 285 questions were received. The questions have been answered but not yet posted. Phased implementation of the project is planned for July 2014. The Department is working with CMS to develop a Memorandum of Understanding (MOU) that lays out the structure of program. Release of the MOU is planned for September 2013. Once the MOU is signed and the RFP bid process concludes, the project will enter the readiness review phase to make sure the selected plans are able to meet the requirements and provide the services stated in their bids. The readiness review will be conducted by a CMS contractor.

Two new waivers are required for implementation of the project; a C-waiver is required for provisions of home and community-based service and a B-waiver will allow MDCH to make enrollment mandatory similar to the existing MIChoice Waiver with a choice component. A phased enrollment process is planned to begin in July 2014, which begins with opt-in enrollment followed by passive enrollment.

Staff is working on securing a date for the next quarterly forum in the Upper Peninsula in mid- or late-October.

MIChild Conversion-Dr. Debbie Eggleston/Dick Miles

Effective October 1, 2013, Blue Cross/Blue Shield of Michigan (BCBSM) will begin transitioning out of the MIChild program. Currently, approximately 80% of MIChild participants are enrolled in a BCBSM preferred provider organization (PPO). The Department is working with the Medicaid Health Plans, plus the Grand Valley Health Plan, to establish adequate MIChild coverage throughout the state to replace BCBSM. The health plans must apply to and receive approval from the Department of Insurance and Financial Services as MIChild plans in the counties they wish to serve. Adequate coverage will not be available in all counties on October 1st, so BCBSM will continue to provide services in those counties for an additional 3-6 months. For those counties with adequate coverage, beneficiaries are being transitioned to their new MIChild health plans. Dental benefits covered by BCBSM will be covered by Delta Dental.

BCBSM pays rates to its providers that are higher than Medicaid rates. Staff are working on rate structure for the new MIChild health plans that falls between current Medicaid rates and the current BCBSM PPO rates.

Kathy Stiffler is leading this project. Staff are working with the Michigan Health Plan Association, with BCBSM and with CMS regarding the MIChild state plan changes.

CSHCS Transition to Managed Care-Member Feedback

Members reported that health plan staff are not trained or educated on prosthetics/orthotics benefits and activity level, so providers spend a lot of time educating and communicating to plans. The Managed Care Division and Program Review Division group will be conducting case studies to address this issue. A meeting has been scheduled for next Monday.

Members reported problems with durable medical equipment, denial of occupational therapy or physician therapy that is deemed as educational rather than medical, denial of pharmacy anti-rejection drugs and issues about formularies and authorization of medications.

Members reported that there are inconsistencies between plans for coverage of transportation, lodging and reimbursement and that the health plans are not clear on benefits.

Adult Benefits Waiver Open Enrollment Update-Dick Miles

The Adult Benefits Waiver caseload peaked at around 79,000 in July 2013 and now going back down. The waiver expires in October 2014.

Hospital Reimbursement Redesign-Dick Miles

The state pays out $3.6 billion annually to hospitals, but collects $720 million in provider taxes, which creates a net annual payment of $2.9 billion. The current financing mechanisms for hospitals are very complex. It is difficult to manage hospital reimbursement activities and pools. Mandatory enrollment of pregnant women into health plans and mandatory enrollment of CSHCS beneficiaries into health plans further affected hospital financing and disbursements. Hospitals would like their reimbursement to be predictable.

The Department has hosted seven technical workgroup meetings. The technical workgroup is made up of a variety of hospitals located throughout the state. They are charged with making recommendations to the steering committee, comprised of MSA bureau directors and the Medicaid director. No recommendations have yet been made to steering committee. The group has not reached consensus, but they do have ideas on the table to take to the steering committee. So far, the process has been a learning experience for the hospitals and other members of the group.

MI Choice Waiver Renewal-Brian Barrie

A renewal application was submitted to CMS at the beginning of July 2013. The Department has answered two rounds of CMS questions. Coordination and preparation with CMS was done before the application was submitted, which makes the process run more smoothly. The Department is looking at a 10/1/2013 start date for waiver. The new rate structure will use a capitation system. The preliminary rates are age based because no acuity level data has been collected yet. The Department is working with MI Choice agencies to review the preliminary rates to assure the rates are workable and reflect costs of high cost users. A full acuity-based reimbursement system should be implemented in subsequent years.

MI Choice is not a capped program, but funding is limited, which causes a waiting list. The new payment methodology may help address the waiting list. The intent is to have the rate structures in place to minimize problems with high cost clients and contract language might need to address what waiver agencies can and cannot do. The Dual Eligibles Integration Project does not affect the MI Choice waiver in those regions. People eligible for both Medicaid and Medicare will have choice between the demonstration and MI Choice.

Policy Updates-Jackie Prokop

MSA 13-17 -This bulletin announces that ordering/referring provider edits are currently informational edits, but will turn to hard edits that deny claims on October 1, 2013.

Proposed Policy 1327-The Healthy Kids Dental contract will expand to Ingham, Ottawa and Washtenaw counties. CMS must approve the waiver amendment before the contract can be expanded.

Proposed Policy 1324-This policy removes the 50-mile restriction for telemedicine.

Proposed Policy 1321-This policy promulgates the MAGI eligibility policy for both MDCH and DHS. This policy will be released for final before October 1, 2013.

A member asked how payments are going for the primary care rate increase. The state plan amendment was approved and fee for service payments started in January 2013. The health plan payment methodology is approved by CMS and payments are to be made some time in September 2013, retroactive to January 1, 2013. The primary care rate increase will be paid for calendar years 2013 and 2014 only. Michigan was first state to get their state plan amendment submitted and approved.

The meeting was adjourned at 4:15 p.m.