



Medical Care Advisory Council

Minutes

Date: Tuesday August 19, 2014

Time: 1:00 pm – 4:00 pm

Where: Michigan Health and Hospital Association Headquarters
2112 University Park Drive
Okemos, MI

Attendees: **Council Members:** Jan Hudson, Jackie Doig, Kim Singh, Dave Herbel, Kim Sibilsky, Diane Haas, Amy Hundley, Vicki Kunz for Marilyn Litka-Klein, Marion Owen, Cindy Schnetzler, Mike Vizona, Cheryl Bupp, April Stopczynski, Elmer Cerano

Staff: Steve Fitton, Dick Miles, Jackie Prokop, Brian Barrie, Pam Diebolt, Marie LaPres, Kathy Stiffler, Monica Kwasnik, Michelle Best

Attendees: Jamie Galbraith

Welcome and Introductions

Jan Hudson opened the meeting and introductions were made.

Healthy Michigan Plan

As of August 18, 2014, there are 364,929 beneficiaries enrolled in the Healthy Michigan Plan.

Enrollment Update, Including Catch-Up Processing

There are still many pending applications that are being processed. No significant problems with processing were reported. Approximately 30 percent of all applicants who apply through MIBridges are able to complete the application process without needing to contact a caseworker, which is noted as a significant process benefit for submitting electronic applications. A request was made for information about the specific number of pending Healthy Michigan Plan applications to be sent to the Medical Care Advisory Council (MCAC). Jan Hudson will send those numbers to the council.

The Michigan Department of Community Health (MDCH) has begun processing Healthy Michigan Plan Applications that were received through the Federally Facilitated Marketplace (FFM). The applications that are being processed are going through the system at a much higher rate than was expected, though some pending applications are still anticipated for applicants who need to provide additional information. Though the FFM initially reported receiving 110,000 applications for the Healthy Michigan Plan, to date there have been 85,000 applications received by MDCH from the FFM. Many of those applicants were found to have already been enrolled in the Healthy Michigan Plan or other Medicaid programs.

What's Working Well

- The Healthy Michigan Plan applications that have been submitted through MIBridges are mostly going through the system without any problems.

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- A meeting attendee asked if those applicants who apply for insurance in the FFM would be notified if they are eligible for the Healthy Michigan Plan. In response, it was noted that the FFM is able to assess potential eligibility for Michigan Medicaid programs, including the Healthy Michigan Plan, using the Modified Adjusted Gross Income (MAGI) methodology, but only Michigan Medicaid can make a final eligibility determination. Once an application is received by MDCH from the FFM, MDCH will send a notice to the applicant if they are found to be eligible for a Medicaid program. The two-way communication process between Michigan Medicaid and the FFM is still in development, but the Department is hoping to have it completed in time for the next Marketplace open enrollment period in November.
- The Federally Qualified Health Centers (FQHCs) have begun using Health Risk Assessments (HRAs), and they have been communicating well with the Department.
- The Medicaid Health Plans (MHPs) have reported that more people are getting dental coverage as a result of the Healthy Michigan Plan.
- Michigan Enrolls has added staff to the call center reduce wait times for beneficiaries applying for health care coverage by phone.

What's Not Working Well

- The MHPs have been experiencing problems with communication between the MIBridges system and Community Health Automated Medicaid Processing System (CHAMPS), resulting in retroactive enrollments into the Health Plans. Such enrollments should always be prospective. This problem has since been resolved.
- The Department of Human Services (DHS) has been experiencing computer problems that affect the department's ability to retroactively enroll beneficiaries into Medicaid programs prior to the first of the month in which they apply, regardless of determined eligibility prior to that date.
- Community Mental Health (CMH) Provider Organizations are facilitating enrollment into health plans for people from the community who come in with behavioral health illnesses, including substance use disorder. These beneficiaries require up to two months until their health plan selection is complete. The provider organizations are not being allowed to enroll with CHAMPS, since they are being told they are not a specialty provider. Medicaid does not currently enroll licensed psychologists and social workers into CHAMPS, but this is proposed as a future possibility. In many cases it was found that many Behavioral Health claims were being denied due to being improperly billed.
- A request was made for primary care physicians to be reimbursed using Mental Health assessment codes for initial behavioral health evaluations, in order to better serve the expanded Healthy Michigan Plan-eligible population. In response, MDCH indicated that this issue has been brought up before and will be revisited in future meetings.
- Some individuals are being denied Healthy Michigan Plan coverage if they have children who are already covered by Medicaid and therefore do not check the box on the MAGI application indicating that they want to apply for coverage for their children at the time they submit their own application. It was also reported that those applying for coverage through the FFM have not had any problems.
- Beginning August 2, 2014, applicants who apply for Medicaid and self-attest to legal residency or citizenship are being given full Medicaid benefits but will still go through a 90 day verification process. Previously, beneficiaries who self-attested to legal residency or citizenship were

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given Emergency Services Only (ESO) Medicaid until their status could be verified. If the individual doesn't answer the residency question or attest citizenship, MDCH is having DHS caseworkers verify that ESO should be given instead of full Medicaid coverage. Council members indicated that issues continue.

- There was discussion regarding whether current communication about Medicaid benefits is sufficient in the case where clients apply for Medicaid Health Care Coverage and are only eligible for a deductible plan or ESO.
- There have been implementation problems identified with Presumptive Eligibility (PE) that have forced its delay. The federal regulations have also changed to restrict coverage, including restrictions on hospitalization for pregnant women. The Department has been encouraging patients to fill out the entire MAGI application to avoid potential problems with PE.
- Income and the 5 percent disregard may not be appropriately determined in some instances. MDCH responded that the 5 percent disregard is being applied correctly, and goes to applicants whose income exceeds 133 percent of the Federal Poverty Level (FPL).
- There have been reports of some DHS offices not knowing how to handle certain issues regarding applicants' income.

Protocols – Healthy Behaviors and MIHealth Account

A public notice has been issued for the Healthy Behaviors and MIHealth Account protocols, and the Department is anticipating approval from the Centers for Medicare and Medicaid Services (CMS) by the end of August. There were several changes made as a result of comments on the draft protocols. For more information, a consultation summary containing comments and MDCH responses on the protocols has been posted to the Healthy Michigan Plan website at: www.michigan.gov/healthymichiganplan >> Healthy Michigan Plan Waiver Protocols. In addition, MIHealth account statements will be shared with focus groups to obtain feedback.

Expedited Enrollment Waiver for the Supplemental Nutritional Assistance Program (SNAP) and Parents

Approval from CMS has been granted for the Expedited Enrollment Waiver for SNAP. No timeline for implementation is yet known.

Fiscal Year (FY) 2015 Budget

Dick Miles gave an overview of the MDCH budget for FY 2015, including the expansion of the Healthy Kids Dental program to Kalamazoo and Macomb counties, the addition of \$26 million to the MI Choice program, and the expansion of the Program of All-Inclusive Care for the Elderly (PACE). An appropriation for the continued Primary Care Rate increase (at about 50% of the original increase) was included, as well as for the Disproportionate Share Hospital (DSH) Pool to support OB/GYNs, and the rural hospital pool, expanded Medicaid coverage for Breast Pumps and additional money for Home Help program providers. The state law regarding the primary care rate increase restricts the increase to Pediatrics, Family Practice and Internal Medicine. An attendee asked why OB/GYNs were not included in the rate increase, and staff noted that they are still being reimbursed up to 95 percent of the Medicare rate.

Staff voiced concern about the potential impact that the recent Michigan Supreme Court ruling in *International Business Machines (IBM) v. Department of Treasury* could have on the Medicaid program, noting that the decision in favor of IBM could cost the State of Michigan more than \$1 billion in tax revenue.

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Steve Fitton summarized the general fund appropriation for CMH, noting that it was not spread equally throughout the State of Michigan. He also expressed concern about dual eligibles, those on spend-down, and the differences among communities. Lynda Zeller added that the Behavioral Health and Developmental Disabilities Administration (BHDDA) is working with MSA to cover beneficiaries who need mild to moderate behavioral health services immediately before they are able to enroll in a health plan. Steve noted that FY 2015 funding is potentially an issue.

Long-Term Care

MI Choice

The MI Choice Program transitioned from a FFS payment model to a capitated payment model in October 2013. As a result of this transition, the payment structure to MI Choice waiver agencies was modified to pay agencies at the highest end of the trend rate in order to accommodate individuals with significant support needs who were not transitioning out of nursing homes. Additional funding has also been allocated to ease the transition for those with significant financial needs. MI Choice waiver agencies are now classified as Prepaid Ambulatory Health Plans (PAHPs) under the new capitated payment model, which requires the waiver agencies to submit to more federal regulations.

Currently, each long-term care program has its own Level of Care Determination (LOCD), and the state is working to implement a system (part of the waiver terms and conditions) in which the LOCD is completed in a conflict-free setting. This would allow the three long-term care programs (nursing facilities, MI Choice and PACE) to use the same LOCD. Financial eligibility is different for all three programs.

Integrated Care for Dually Eligible Beneficiaries

MDCH is working to have three-way contracts in place for integrated care among CMS, Integrated Care Organizations (ICOs) and the State of Michigan by early October, in order to implement the first two pilot regions of the state by January 1, 2015. Discussion continues between the ICOs and PIHPs concerning roles and responsibilities. Staff reiterated the complexity of this project.

Home Help Audit

An audit of the Home Help program at the end of June revealed 13 findings and two material issues. The potential liability for state repayment to the federal government is about \$1.5 million. It was also discovered that some Home Help providers had criminal backgrounds, though it was noted that beneficiaries are free to choose their own providers.

Two policies are currently in process to provide for criminal background checks for home help personal care service providers. A policy outlining mandatory exclusions for home help personal care service providers (e.g., Medicare fraud, elder abuse, etc.) has been issued as a final policy for implementation on September 1, 2014. A separate policy discussing permissive exclusions is to be implemented in October. This policy would allow providers convicted of certain crimes to serve as a home help aide if a beneficiary signs a consent form acknowledging awareness of the provider's criminal past.

A policy that would limit Home Help agency providers to hiring employees rather than using contract workers, and restrict family members of beneficiaries to working as individual providers rather than agency employees, is currently out for public comment. The intent of the policy changes is to protect the beneficiary but not limit access.

Managed Care Rebid – Issues to Address to Improve Contracts

There is a planned re-procurement for the Health Maintenance Organizations (HMOs) that contract with Medicaid. The Department is seeking input on what should be included in the bid and in the contracts to improve the quality of the program. Some suggestions were to include dental coverage in Managed Care Plans and improve Non-Emergency Medical Transportation (NEMT) coverage, and to standardize data collection, formularies, quality measures and reporting across all Managed Care Plans. The current contracts expire on September 30, 2015. An announcement was made about a stakeholder meeting to discuss the rebid prior to the November MCAC meeting. This procurement will be the largest in state history (\$40 billion for 5 years). Awards are not expected until the end of July 2015. The Department is exploring folding the MICHild program into this bid.

Policy Updates

A policy update handout was given to each attendee.

1427-HMP – This policy discusses updates to Healthy Michigan Plan Provider policy, and is posted for public comment until August 27.

Children's Health Insurance Program (CHIP) Reauthorization

Steve Fitton voiced support for a reauthorization of CHIP. He also solicited input on budget priorities for FY 2016.

Next Meeting: November 19, 2014