Medical Services Administration

# Medical Care Advisory Council

## Minutes

**Date:** May 17, 2005 (Wednesday)

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

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

**Attendees:** Jan Hudson, Roger Anderson, Kathy Whited, Ed Kemp, Sue Moran, Nick Lyon, Bill Mayer, Neil Oppenheimer, Larry Wagenknecht, Andy Farmer, Alison Hirschel, Jocelyn Vanda, Vernice Davis Anthony,Jaeson Gournier (for Walt Stilner), Paul Shaheen, Anita Liberman-Lampear, Priscilla Cheever, Sandi Kilde, Nick Lyon, Paul Reinhart, Steve Fitton, Dave LaLumia. Brad Geller, Karen Rothfuss

**Absent:** Herman Gray, Ed Canfield, Dan Briskie, Dianne Haas, Kathy Kendall, Kathleen Kirschenheiter, Jackie McLean, Bruce Bragg, Christine Chesney, Dan Wilhelm, William White, Gary Ley

### General Comments

The meeting began with an overview of the agenda, and the meeting materials. Jan Hudson brought copies of the DVD shown at the previous meeting, "The Face and Value of Medicaid in Michigan" for those whom had not already received one. Jan asked the members to share their testimony if they participated in the House or Senate Appropriations Subcommittee Hearings. Jan brought a copy of the letter that the Michigan League for Human Services sent to the House, and indicated it would also be sent to the Senate.

### Budget Highlights

Mr. Reinhart introduced Nick Lyon, Administrative Officer of Operations for the Department of Community Health, who discussed the status of the budget. The 2006 budget process started with the Executive Recommendation. The House is utilizing the "Price of Government" in their budget process. They are now working with the Senate Subcommittee. Mr. Lyon thanked the members who testified about what the budget cuts mean to them. He felt it was important for the Senators to hear. Workgroups have begun on the House budget. It appears that the Governor's recommended physician provider tax will be rejected, so that leaves an immediate $40 million deficit. As has been demonstrated in the past, optional populations such as caretaker relatives and Group 2 19 and 20 year olds have been primary targets for legislative cuts. Other areas they may target are the Medicaid DSH (Disproportionate Share Hospital) payments and Healthy Michigan prevention projects. They are looking into whether there is a way to restore Graduate Medical Education. A House bill is expected to come out soon, so their budget concerns should be clear at that time. Representative Bruce Caswell from Hillsdale has been open to meeting with associations and private citizens about their budgetary concerns. Mr. Lyon does not feel there will be a large increase in revenues for 2006 and feels there will be an adjustment downward from the Executive recommendation.

There probably won't be an increase in revenues for 2005, so they are trying to latch on to any additional revenues from colleges and universities. The Medicaid caseloads are higher than what the budget was originally based on. A dollar amount will need to be determined and MDCH will need to work with the State Budget Office and the Legislators to come up with a solution for the current fiscal year. The 2006 caseload estimate is probably too low as well. At the present time, the caseload is approximately 11,000 above the original estimate, but is staying fairly steady at that rate. Mr. Fitton mentioned that eliminating the caretaker relative category would have a huge impact on hospitals. Any serious budget reductions are definitely going to hurt people.

A question and answer period followed. It was suggested that the MCAC could be utilized to assist the Department as the budget is evaluated. There was also a discussion about the need for policy changes and new revenue sources, and the need for individual Council members to take this message out into the community.

Mr. Reinhart gave a brief overview of the Third Share concept. It is a program for the uninsured, employed, low wage individual, wherein the employee provides 1/3, the employer provides 1/3 and the government provides 1/3 of the cost of insurance coverage. There are approximately 10,000 enrolled statewide at the present time. The manner in which the government 1/3 has been provided is through the hospital disproportionate share (DSH) financing. The Governor's budget for next year sets aside $10 million in the DSH allocation to help support this program. The state treasurer has drafted tax credit legislation that would give employers a tax credit for their share. One concern of the employers is the long-term viability of third share programs.

Mr. Reinhart met with Representative Alma Smith, some dentists, and some dental community lobbyists to convince them that they need a provider tax to help restore lost benefits. Unfortunately, it wasn't well received. On a positive note, Great Lakes Health Plan has decided to provide a preventive dental benefit for adults. This is a pilot project in limited service areas of Wayne, Oakland, and Macomb counties and will begin July 1, 2005. When oral health deteriorates, medical problems can often result. There are some opportunities available from a federal funding standpoint, which has been previously utilized with publicly affiliated physician groups. This has resulted in substantial subsidies for Wayne State, U of M, Hurley and MSU. A similar approach is going to be attempted with dentists in public clinics.

**Federal Reform**

Every two years the National Governors' Association revisits Medicaid policies. Governor Granholm is the vice-chair of the NGA's health committee and she and eight other governors are involved in Medicaid reform. The group is close to finalizing a paper and some of their suggestions are listed below:

- More transparent pricing on prescription drugs
- Allow managed care to participate in pharmacy rebates
- More flexibility in cost sharing
- More flexibility in benefit packages
- Ease administration of the Medicaid program, such as states being able to automatically import waivers that have been approved in other states
- Tax credits, or other incentives to encourage businesses to begin and/or maintain health care coverage to prevent increased Medicaid caseloads
- Slow long term care growth and improve access to community based care

The President's proposal was to cut spending by 60 billion over 10 years, but the budget resolution from Congress was to cut ten billion over 5 years, with the cuts not beginning until fiscal year 2007.

Ms. Hudson mentioned that there had been interest expressed in the long-term viability of the Medicaid program, and this was an issue that would be explored further in a future meeting.

**Provider Tax Update**

Representative Alma Smith has agreed to sponsor the bill and a draft has gone to the service bureau, but she would like to engage in more discussions with other legislators and physicians. Nursing homes, hospitals, and health plans currently have provider taxes. Most states presently utilize provider taxes since it is one of the few mechanisms remaining for states to obtain additional federal funding. These taxes aren't like regular taxes. The group being taxed actually ends up with more money, not less. Medicaid payment rates are clearly inadequate, and some studies from a few years ago ranked Michigan forty-fifth in physician payment rates. The physician provider tax would:

- Tax 2.3% of practice revenue
- Generate $230 million in tax revenue
- Use $188 million for a $246 million federal funding match
- Increase physician payments by $434 million which should line up with Medicare payments
- Utilize $40 million in tax revenue as a match to earn $52 million to finance physician base rates

The result is $206 million in new revenue to the system, which is a net gain of 32%. Practices with 3.5% or more in Medicaid will benefit from this tax.

The group discussed the budget problems and how it was important to get the information out to the counties, community groups, faith-based organizations and other entities with a vested interest in the outcome. The Council also decided to send a letter from the Medical Care Advisory Council to Mr. Reinhart about their concerns about the budget and the need for new sources of revenue. A copy of the letter would also be sent to the Governor, the Director of the Department of Community Health, and some legislators. Ms. Hudson volunteered to draft the letter.

**1115 Waiver**

A public meeting was held on May 4, 2005 to discuss the 1115 Demonstration Waiver Proposal draft. Three ways to save are to cut eligibility, benefits, and/or rates. All of these create more uncompensated care and more pressure on the system.

- Major Mandatory Services include: inpatient and outpatient hospital, physician, lab, x-ray, nurse midwife, certified nurse practitioner, Federally Qualified Health Centers, family planning, EPSDT, and nursing facility.

- Major Optional Services include: prescription drugs, mental health, physical and occupational therapy, optometrists, eyeglasses, dental, private duty nursing, home help, and home based long term care.

One area that always seems to garner attention is optional services. We presently cover some optional groups. If the Caretaker Relative category were cut, it would be interesting to see what type of impact that would have on county health plans who cover indigent adults in their local communities. One would speculate that a great deal of pressure would be put on those service systems in an effort to absorb additional indigents. We are spending $1.4 billion on mental health, $555 million on pharmacy (fee for service only), and much smaller amounts on home based long-term care, medical supplies, hospice and other optional services. The Governor has made significant efforts to protect Medicaid, and the Tobacco Tax was a huge step toward sustaining the program into 2005. It is difficult to imagine mental health and pharmacy being eliminated from the program. The increased caseload projection extends into fiscal year 2006. Although the 2006 Medicaid spending recommendation is for a total increase of 5.2%, spending per Medicaid beneficiary is an increase of only .5%.

The items in Modernizing Michigan Medicaid that need a waiver are:

- Maintain health plan rates at their current level and avoid regulation imposed rate increases
- Eligibility changes
- Benefit reductions

Sustainability initiatives are also included, and are listed below:

- Rate Reductions - $43.1 million
- Physician Assessment - $40 million
- Estate Recovery of - $4.3 million
- Closing Asset Loopholes - $8 million

A family planning waiver is also part of the sustainability initiatives, with a projected savings of $7.8 million.

The 1115 Waiver Proposal would include the following:

**Eligibility and Enrollment:**

- Freeze enrollment for 19 and 20 year olds
- Waive retroactive enrollment requirement

**Benefit Limitations to 19 and 20 year olds and Caretaker Relatives:**

- Limit inpatient benefits to 20 days per year
- Limit prescription drug coverage to 4 prescriptions per month
- $10 co-payment for emergency room visits
- Eliminate speech, hearing, vision, occupational and physical therapy

A waiver of federal regulations in terms of managed care rate setting is requested so rate increases will not have to be implemented. The main issues discussed at the public meeting were the elimination of the retroactive eligibility and the limit of 4 prescriptions per month. There did not appear to be much support for the waiver. The interface with the CSHCS program, as well as access to prenatal care under the waiver will be explored further. In addition, Council members expressed concern about access to therapy, the impact of the retroactive eligibility elimination on nursing facility residents and the Medicaid application process itself.

**Part D Update**

Handouts included the letter that the Centers for Medicare and Medicaid Services (CMS) sent out with the schedule for Medicare Part D training sessions in Michigan, the Medicare Prescription Assistance Coverage Benefit Activities as of May 16, 2005, and the MDCH Update on Part D. The CMS letter listed training sessions that will be available to provide an overview to various stakeholders in the outreach and eligibility initiative. The Medicare Prescription Assistance Coverage Benefit Activities list illustrates the statewide effort to train a variety of entities. Sue Moran asked MCAC members to e-mail her if they know of any groups who would benefit from the Michigan Medicare/Medicaid Assistance Program (MMAPS) training. Ms. Moran indicated that future announcements and publications from (CMS) would be shared with the MCAC members as they become available. A CMS checklist for state legislators was included in the Part D Update with questions and answers on the State Pharmacy Assistance Programs, (SPAPs), Low-Income Subsidy (LIS), Full-Benefit Dual Eligible Beneficiaries, and the Phased-Down State Contribution.

CMS is scheduled to begin mailing the low-income subsidy applications at the end of May 2005. These mailings will be staggered throughout May, June and July. The last digits of the beneficiaries' Social Security number will be used. MDCH will be sending out a letter around June 1st to our Medicaid/Medicare dually eligible beneficiaries and the EPIC beneficiaries advising them that their coverage will end January 1, 2006.

**Governor's LTC Taskforce Update**

In 2001, funding cuts to the MI Choice Home and Community Based Waiver program caused the program to be closed to new enrollments, and participation steadily declined.

In March 2002, seven individuals and five organizations sued the State of Michigan for alleged violations of the Medical Assistance Act, the Americans with Disabilities Act, and Section 504 of the Rehabilitation Act of 1973. The suit also included claims based on the 1999 Supreme Court *Olmstead* decision that held that unjustified isolation of persons with disabilities in institutions is discriminatory.

The plaintiffs ranged in age from 29 to 100, were African American and white, resided in nursing homes as well as the community, and lived in both urban and rural settings throughout the state. A settlement agreement was signed in February 2004, which included provisions to reopen the MI Choice program and change various aspects of that program. Under terms of the settlement, the Governor was required to establish a 21 person task force to assist the State in developing options for expansion of community based services and improvement of long term care services as a whole.

The Governor's Medicaid Long Term Care Task Force was established by Executive Order in 2004 and appointed 7 consumers/advocates, 7 providers and 7 legislators/state officials. The Task Force met monthly from the summer of 2004 through May 2005. In addition, seven workgroups were formed to discuss topics in more detail. The final report and recommendations were unanimously approved by the Task Force and will be released shortly. The highlights of the recommendations are listed below:

- Single Points of Entry (SPE) for long term care consumers to provide information and referral services
- Person Centered Planning which takes into account the choices of the individual
- Money Follows the Person which allows for flexible financing based on the individual's preferred setting

- Offer a wide array of services (the Task Force developed a list of more than 50 services that should be available)
- Maximize resources, promote consumer incentives and decrease fraud
- Create a 25 member Long Term Care Commission to oversee long term care reform
- Establish a quality management system and a Long Term Care Administration
- Build and sustain a competent long term care work force to provide high quality services
- Promote healthy aging through incentives, and develop caregiver support initiatives

The final report and recommendations will be available at http://www.ihcs.msu.edu/LTC/default.htm
A Kick Off Rally will be held at the Capitol on June 9, 2005.

**Policy Updates**

A Policy Bulletin Update and a Policy Project Update were included in the members' packets. All of the MCAC members receive copies of draft policies, and Mr. Ed Kemp, Director of the Program Policy Division reminded them that it allows them the opportunity to send comments to policy staff members related to the drafts. A discussion ensued in regard to incorporating the rationale for the policy changes into bulletins.

**Future Meetings, Topic Suggestions and Other Concerns**

Mr. Reinhart indicated that earlier meetings were more informational in nature and he would like to see the MCAC become more involved in projects as they evolve. Suggestions by members included forming workgroups, becoming an advocacy council, and conducting focus group. Members were asked to think about how they can be helpful to the organization.