

The Michigan Update

[Print This Issue](#)

In This Issue

[Medicaid Managed Care Enrollment Activity](#)

[MIChild](#)

[Adult Benefits Waiver](#)

[Duals in Medicaid HMOs](#)

[Integrated Care for Dual Eligibles](#)

[CSHCS Children in Medicaid HMOs](#)

[Medicaid Expansion in Michigan](#)

[Navigator Rules Finalized](#)

[Connecting Kids to Coverage](#)

[Medicaid Beneficiaries are Satisfied with Health Care Coverage](#)

[Patient-Centered Medical Homes](#)

Medicaid Managed Care Enrollment Activity

As of July 1, 2013, there were **1,251,332 Medicaid beneficiaries enrolled** in 13 Medicaid Health Plans (HMOs), **an increase of 6,731** since June 1, 2013. This enrollment increase is largely because the Department of Community Health (DCH) finalized a significant number of pending enrollments in June. The number of Medicaid beneficiaries eligible for managed care enrollment decreased in July - there were 1,295,538 eligible beneficiaries, down from 1,298,368 in June.

The number of Medicaid beneficiaries dually eligible for Medicare (duals) enrolled in Medicaid HMOs to receive their Medicaid benefits continues to grow - there were 39,515 duals enrolled in July, up from 38,257 in June, an increase of 1,258. The number of Medicaid children dually eligible for the Children's Special Health Care Services (CSHCS) program enrolled in Medicaid HMOs changed slightly - there were **17,789 CSHCS/Medicaid children enrolled** in July, an increase of 89 since June.

As the enrollment reports ([.pdf](#)) ([.xls](#)) reflect, every county in the state is served by at least one Medicaid Health Plan. Auto-assignment of beneficiaries into the HMOs is now in place in every county of the state and there are at least two HMOs serving every county in the Lower Peninsula. Beneficiaries in all 15 counties in the Upper Peninsula are auto-assigned through federal "Rural Exception" authority to the one HMO serving the counties, Upper Peninsula Health Plan.

For more information, contact [Esther Reagan](#), Senior Consultant, at (517) 482-9236.

[Pioneer ACO Model -
First Year Results](#)

[America's Best
Hospitals](#)

[CMS Imposes Provider
Enrollment Moratorium](#)

[Fitton Named to
Medicaid Institute](#)

[Medicaid Policies](#)

Quick Links

[About Us](#)

[Expertise](#)

[Services](#)

Contact Us

Phone:
1-800-678-2299

[Email](#)

[Locations:](#)

Atlanta, Georgia
Austin, Texas
Bay Area, California
Boston, Massachusetts
Chicago, Illinois
Denver, Colorado
Harrisburg, Pennsylvania
Indianapolis, Indiana
Lansing, Michigan
New York, New York
Olympia, Washington
Sacramento, California
Southern California
Tallahassee, Florida
Washington, DC

[Join Our Mailing List!](#)

MIChild

According to MAXIMUS, the DCH contractor for MIChild enrollment, there were **37,759 children enrolled** in the MIChild program as of July 1, 2013. This is a decrease of 78 since June 1, 2013.

As the enrollment report ([.pdf](#)) ([.xls](#)) for July shows, enrollment is dispersed between 10 plans, with almost 75 percent of the children enrolled with Blue Cross Blue Shield of Michigan (BCBSM). MIChild-enrolled children receive their dental care through contracted dental plans. Of the three available plans, more than 95 percent of the children are enrolled with either BCBSM (48.4 percent) or Delta Dental Plan (46.7 percent).

In last month's edition of *The Michigan Update* we reported on DCH's plan to transition MIChild enrollees from Blue Cross Blue Shield of Michigan to other MIChild Health Plans. DCH has now issued an L-letter (see the Medicaid Policies article in this newsletter for a link to the letter) with additional detail.

For more information, contact [Esther Reagan](#), Senior Consultant, at (517) 482-9236.

Adult Benefits Waiver (ABW)

As of the middle of July 2013, DCH reports there were **77,696 ABW beneficiaries enrolled** in the program, a **decrease of 1,819** since the middle of June. The decrease makes it clear that the enrollment applications received during the open enrollment period in April have now all been processed. There are 28 County Health Plans (CHPs) serving ABW beneficiaries in 73 of Michigan's 83 counties. As of July 1, 2013, the combined ABW **enrollment in the 28 CHPs was 70,136, an increase of 8,375** since June.

For more information, contact [Eileen Ellis](#), Managing Principal, at (517) 482-9236.

Duals in Medicaid HMOs

As of July 1, 2013, there were **39,515 Medicaid beneficiaries dually eligible for Medicare (duals) enrolled in Medicaid HMOs** to receive their Medicaid services. The number of duals enrolled through auto-assignment as of July 1, 2013 was 17,310, and the number of duals enrolled on a voluntary basis was 22,205. All Medicaid HMOs have duals enrolled, although the numbers

vary dramatically across plans.

A Medicaid HMO member who gains Medicare coverage and remains in the HMO is categorized as auto-assigned or voluntarily enrolled based on the means through which the member was initially enrolled in the HMO. Duals enrolled in a Medicare Special Needs Plan (SNP) for their Medicare benefits but receiving Medicaid on a fee-for-service basis are auto-assigned to the related Medicaid HMO if applicable. Any dual is able to "opt out" of the HMO and receive Medicaid benefits on a fee-for-service basis.

As the table below reflects, Molina Healthcare of Michigan has the most duals receiving their Medicaid services from an HMO, 27.9 percent of the total; UnitedHealthcare Community Plan has 23.3 percent of the total; Meridian Health Plan of Michigan has 15.9 percent of the total (but the most voluntary enrollees); and the other 10 plans share the remaining 32.9 percent.

July 2013 Medicaid Dual Eligible Enrollment			
Medicaid Health Plan	Voluntary Enrollees	Auto-Assigned Enrollees	Total Enrollees
Blue Cross Complete of MI	607	358	965
CoventryCares of MI	617	152	769
HealthPlus Partners	1,113	274	1,387
McLaren Health Plan	2,276	838	3,114
Meridian Health Plan of MI	5,107	1,192	6,299
Midwest Health Plan	1,333	799	2,132
Molina Healthcare of MI	3,411	7,611	11,022
PHP Mid-MI Family Care	291	50	341
Priority Health Govt. Programs	1,203	861	2,064
Pro Care Health Plan	25	37	62
Total Health Care	981	294	1,275
UnitedHealthcare Comm. Plan	4,610	4,584	9,194
Upper Peninsula Health Plan	631	260	891
Total	22,205	17,310	39,515

Eight of the 13 Medicaid HMOs in Michigan (or their parent organizations) are also federally contracted as Medicare Advantage Special Needs Plans (SNPs) to provide Medicare benefits for duals in Michigan: HealthPlus Partners, McLaren Health Plan, Meridian Health Plan of Michigan, Midwest Health Plan, Molina Healthcare of Michigan, Total Health Care, UnitedHealthcare Community Plan and Upper Peninsula Health Plan. As of July 1, 2013 these eightDual-SNPs have a combined enrollment of 17,081 duals for

whom they provide Medicare services (an increase of 1,089 since June 1, 2013); 56.4 percent of the duals that are enrolled in a Dual-SNP are enrolled in the Molina plan, 30.7 percent are enrolled in the UnitedHealthcare plan and the remaining 12.9 percent are spread across the other six plans. Not all of the duals enrolled in these Dual-SNPs are eligible to receive full Medicaid benefits. Some only receive assistance from the Medicaid program with Medicare coinsurance and deductible payments and/or monthly Medicare premiums.

For more information, contact [Esther Reagan](#), Senior Consultant, at (517) 482-9236.

Integrated Care for Dual Eligibles

In previous editions of The Michigan Update we have written about Michigan's plan to implement an integrated delivery system of health care for persons dually eligible for Medicare and Medicaid (duals). The state, with the Centers for Medicare & Medicaid Services (CMS) will enter into three-party contracts with Integrated Care Organizations (ICOs). The state will separately contract with Prepaid Inpatient Health Plans (PIHPs) to deliver behavioral health and developmental disabilities services to the demonstration population. A three-year demonstration is planned in four regions of the state. On July 26, 2013, the long-awaited [Request for Proposals](#) (RFP) to procure ICOs was released by the State.

Michigan is targeting roughly 90,000 duals out of more than 198,000 statewide in four regions. Excluded from the demonstration are:

- Individuals under age 21;
- Those with commercial HMO coverage or Medicare Advantage through an employer;
- The Medicaid MCO "special disenrollment" population;
- Individuals in a state psychiatric facility; and
- Duals who are currently incarcerated.

Dual eligibles enrolled in the state's MI CHOICE 1915(c) waiver or in a Program of All-Inclusive Care for the Elderly (PACE) plan may participate in the demonstration, but must first disenroll from their currently program.

Region	Counties	No. of Plans to be Awarded	No. of Duals	Duals in MCOs	% in MCOs
Region 1	Alger, Baraga, Chippewa, Delta, Dickinson, Gogebic, Houghton, Iron, Keweenaw, Luce, Mackinac, Marquette, Menominee, Ontonagon, Schoolcraft	1*	8,786	891	10.1%
Region 4	Barry, Berrien, Branch, Calhoun, Cass, Kalamazoo, St. Joseph, Van Buren	2	18,183	3,014	16.6%
Region 7	Wayne	3-4	50,235	13,191	26.3%
Region 8	Macomb	2-3	12,270	3,137	25.6%
Demonstration Total			89,474	20,233	22.6%

Proposals are due August 26, 2013. Readiness reviews of approved ICOs are scheduled to occur between October 2013 and May 2014 in order to meet the anticipated contract start date of July 1, 2014. Among many other requirements, organizations bidding on this procurement must be currently providing Medicaid and/or Medicare managed care services and have a Certificate of Authority (C of A) to operate as a Health Maintenance Organization in Michigan with the scope of the C of A allowing the bidder to offer the type of product required by the RFP. Bidders must be accredited by either the National Committee for Quality Assurance (NCQA) or URAC. In addition bidders must have passed the Medicare Model of Care evaluation with a score of at least 70 percent. The contracted ICOs will be required to cover virtually all physical health services covered by the Medicare and Medicaid programs and coordinate behavioral health services with PIHPs serving members in their respective regions. The state has established risk corridors for Year One of the contract. For Years Two and Three the ICOs will be at full risk. The state also intends to withhold an as yet undetermined amount of capitation for performance bonuses that will be awarded based on measures across quality of care, enrollee access and satisfaction, and administrative functions.

For more information, contact [Eileen Ellis](#), Managing Principal, at (517) 482-9236.

CSHCS Children in Medicaid HMOs

In previous editions of *The Michigan Update* we reported on the Department of Community Health's (DCH) plan to enroll children (and a few adults) receiving services from both the Children's Special Health Care Services (CSHCS) program and the Medicaid program in Medicaid Health Plans (HMOs). Enrollment began in October 2012, was phased in gradually over a few months and is now complete. As of July 1, 2013, there were **17,789 joint CSHCS/Medicaid beneficiaries enrolled in the Medicaid HMOs**. Of this total, 4,645 children were auto-assigned to an HMO and 13,144 - the vast majority - voluntarily enrolled. All Medicaid HMOs except Pro Care Health Plan have CSHCS/Medicaid

enrollees although the numbers vary across plans.

As the table below reflects, Meridian Health Plan of Michigan, which has the largest Medicaid enrollment of any Medicaid HMO, also has the most CSHCS/Medicaid enrollees receiving their services from an HMO, 26.6 percent of the total. Molina Healthcare of Michigan has 16.7 percent; United Healthcare Community Plan has 15.3 percent of the total; McLaren Health Plan has 10.2 percent; and the other eight plans share the remaining 31.2 percent.

July 2013 CSHCS/Medicaid Enrollment			
Medicaid Health Plan	Voluntary Enrollees	Auto- Assigned Enrollees	Total Enrollees
Blue Cross Complete of MI	403	60	463
CoventryCares of MI	190	200	390
HealthPlus Partners	837	106	943
McLaren Health Plan	1,318	493	1,811
Meridian Health Plan of MI	3,291	1,433	4,724
Midwest Health Plan	869	314	1,183
Molina Healthcare of MI	2,261	716	2,977
PHP Mid-MI Family Care	183	50	233
Priority Health Govt. Programs	1,161	187	1,348
Pro Care Health Plan	0	0	0
Total Health Care	351	206	557
UnitedHealthcare Comm. Plan	2,059	663	2,722
Upper Peninsula Health Plan	221	217	438
Total	13,144	4,645	17,789

For more information, contact [Esther Reagan](#), Senior Consultant, at (517) 482-9236.

Medicaid Expansion in Michigan

As reported in previous issues of *The Michigan Update*, the Michigan legislature has been debating legislation authorizing expansion of Medicaid eligibility to individuals with income below 138 percent of the federal poverty level (FPL) but has yet to approve a bill. The House of Representatives passed House Bill 4714 in mid-June and referred it to the Senate. The Senate then adjourned for its summer recess without acting on the bill but established a Healthy Michigan work group to discuss substitute language including Medicaid program reforms that could hopefully achieve passage by the Senate when the chamber resumes sessions in late August. In late July, Senate Appropriations

Chair Roger Kahn, the chair of the work group, released proposed language for a Senate bill authorizing the Medicaid expansion.

The language is largely consistent with that included in the House bill. Major elements of the bill are as follows.

- The bill includes language that requires hospitals accepting Medicaid to not charge uninsured individuals with income less than 500 percent of the FPL more than 115 percent of Medicare reimbursement.
- Changes would be made to financial incentives for contracted Medicaid managed care plans. This includes incentives to meet population-wide health improvement goals, changes to the performance incentive pool to address inappropriate use of the emergency department, ambulatory care, hospital readmission rates and utilization of generic drugs. The current health plan payment withhold would change from .19 percent to .75 percent to increase the performance incentive bonus pool, and a new incentive pool equivalent to .25 percent of payments would be created to incent member compliance with new cost sharing requirements.
- Changes would be made in cost sharing requirements for health plan members, including adjustments in pharmacy cost sharing to increase use of lower cost prescriptions and the creation of mandatory cost sharing established at 5.0 percent of annual income for affected enrollees with income between 100 and 133 percent of the FPL. Cost sharing could be reduced for health plan members complying with healthy behavior incentives.
- Consistent with the House bill, affected enrollees in Medicaid longer than 48 months, with income between 100 and 133 percent of the FPL, would be required to either pay increased cost sharing (up from 5.0 percent of income to 7.0 percent) or enroll in an Exchange health plan.

The legislation was reviewed by the Senate Government Operations Committee during a scheduled meeting on July 30. On July 31st the Committee also considered two additional proposals to expand coverage to the low-income uninsured in Michigan. One proposal, Senate Bill 422 sponsored by Senator Caswell, would create the Michigan Low-Income Health Plan Act. Under this proposal the state would fund a new coverage program for those with incomes below 100 percent of the FPL without use of any federal funds. Participating individuals and households would pay

premiums of between five dollars and twenty dollars per month, based on income.

Senate Bills 459 and 460, sponsored by Senator Colbeck, create the Patient-Centered Care Act. These bills do not address the issue of Medicaid expansion, but rather create a new coverage model. SB 459 creates new private exchange(s) in Michigan and new qualified health plans offered through the private exchange(s) that provide coverage through direct primary care combined with a high deductible insurance policy. (Direct primary care, while not defined in the bills, means a relationship in which an individual pays a flat monthly fee for access to and services from a primary care physician.) Beginning January 1, 2015, SB 460 would replace the existing Medicaid program with individual Health Savings Accounts that could be used purchase a Qualified Health Plan that is composed of Direct Primary Care services and a high-deductible insurance plan.

The Government Operations Committee heard testimony on all three proposals and sent all of the bills to the full Senate. HB 4714 was reported out with 4 yes votes and one "pass". SB 422 and the SB 459/460 package were both reported out with 3 yes and 2 no votes.

For more information, contact [Eileen Ellis](#), Managing Principal, at (517) 482-9236.

Navigator Rules Finalized

On July 17, 2013, [final rules](#) issued by the US Department of Health and Human Services for the "navigator" who will assist consumers in picking appropriate health plans in the newly formed health marketplaces / exchanges across the country were published in the Federal Register. Navigators, certified application counselors, and in-person assisters must be credible sources of objective information about qualified plans, eligibility for tax credits, and other relevant criteria and considerations. Federal navigators and assistance staff serving federal exchange states (such as Michigan) must have 30 hours of training and pass tests demonstrating proficiency. States running their own exchanges may establish more rigorous training criteria. In addition, each state must establish training programs for "certified application counselors," who may assist applicants in enrolling for health coverage, but are not on federal or state payrolls.

For more information, contact [Eileen Ellis](#), Managing Principal, at (517) 482-9236.

Connecting Kids to Coverage

On July 2, 2013, Health and Human Services (HHS) Secretary Kathleen Sebelius announced nearly \$32 million in grants for efforts to identify and enroll children eligible for Medicaid and the Children's Health Insurance Program (CHIP). The *Connecting Kids to Coverage Outreach and Enrollment* grants were awarded to 41 state agencies, community health centers, school-based organizations and non-profit groups in 22 states. One of the awardees was Washtenaw County Public Health; the agency received almost \$600,000. Information about the program and each of the grantee's planned activities, including the Washtenaw County program, is available on HHS' [InsureKidsNow website](#).

For more information, contact [Esther Reagan](#), Senior Consultant, at (517) 482-9236.

Medicaid Beneficiaries are Satisfied with Health Care Coverage

On July 8, 2013, the Center for Healthcare Research & Transformation (CHRT) issued a report with results of a survey of Michigan adults who were asked to rate their satisfaction and experience with health insurance. The report is called [Satisfaction with Health Care Coverage](#), and provides the results of the survey of more than 1,000 individuals with varying types of health care coverage, including Medicaid, Medicare, employer-sponsored or individually purchased coverage. The results indicated that Medicaid beneficiaries were the most satisfied with their health care coverage and those with individual coverage were the least satisfied. CHRT is a non-profit partnership between the University of Michigan and Blue Cross Blue Shield of Michigan designed to promote evidence-based care delivery, improve population health and expand access to care.

For more information, contact [Esther Reagan](#), Senior Consultant, at (517) 482-9236.

Patient-Centered Medical Homes

A recent [article](#) in *Health Services Research*, an official journal of AcademyHealth, reported the results of a study of patient-centered medical home (PCMH) data for a diverse statewide population of 2,432 primary care practices in Michigan. The article, entitled "Partial and Incremental PCMH Practice Transformation: Implications for

Quality and Costs," concluded that a PCMH model of care improves quality of care while reducing costs. The primary care practices are part of a multi-payer initiative begun in 2009 that collectively serve about two million Michigan residents, about half of whom are Blue Cross Blue Shield of Michigan (BCBSM) members. BCBSM estimates \$155 million in savings over the first three years of the program. The savings are attributed to expanded primary care office hours, 24-hour telephone access to a care team, and an emphasis on preventive care and proactive management of chronic disease. As one example, researchers found that PCMH practices average about 20 percent lower rates in inpatient admissions for patients with ambulatory care sensitive conditions such as asthma, high blood pressure or diabetes.

For more information, contact [Esther Reagan](#), Senior Consultant, at (517) 482-9236.

Pioneer ACO Model - First Year Results

In the December 2011 edition of *The Michigan Update*, we reported that US Health and Human Services (HHS) Secretary Kathleen Sebelius announced the names of 32 health care organizations from across the country to participate in a new Pioneer Accountable Care Organization (ACO) initiative made possible by the Affordable Care Act. Three of those organizations are in Michigan. On July 16, 2013, HHS announced some of the results from the initiative's first year, including the fact that some of the ACOs would not be continuing in the program. One of the ACOs dropping out of the program is operated by the University of Michigan Health System (U-M).

The U-M ACO is a partnership between U-M and IHA Health Services Corporation, an Ann Arbor-based healthcare provider group, and includes U-M's Faculty Group Practice. The other two Pioneer ACOs in the state, which will both continue in the program, are Genesys PHO (Physician Hospital Organization), a collaboration between Genesys Health System and several hundred primary care and specialty physicians, and Michigan Pioneer ACO, a partnership of the Detroit Medical Center (DMC) and its physicians, which is managed by the DMC PHO.

HHS stated that all 32 Pioneer ACOs delivered good results on quality measures and earned incentive payments during their first year. The ACOs were successful in lowering readmission rates and in improving both blood pressure control and cholesterol control for Medicare participants with diabetes. The costs for the more than 669,000

Medicare beneficiaries aligned to Pioneer ACOs grew by only 0.3 percent in 2012 while costs for similar Medicare beneficiaries grew by 0.8 percent in the same period. Thirteen of the 32 Pioneer ACOs produced shared savings with HHS, generating a gross savings of \$87.6 million in 2012 and \$33 million in savings to the Medicare program. Seven of the ACOs did not achieve the required savings and will be shifting to the Medicare Shared Savings Program model, including the U-M ACO. The Shared Savings Program is also an ACO model but with less financial risk for providers. Two other health care organizations will leave the program entirely.

According to the U-M, its Pioneer ACO, which covers 23,000 Medicare beneficiaries, realized a 0.3 percent savings in 2012. The U-M ACO's medical director, Dr. Tim Peterson, said the decision to withdraw from the Pioneer program was not a financial one but based on a desire to simplify the ACO's administrative structure, and he said patients served by U-M will not see any change in services as the organization transitions to a more standard type of ACO. Genesys PHO reported that the program essentially broke even in 2012 but expects savings in 2013, and DMC released a statement saying its Michigan Pioneer ACO reduced costs of treating Medicare beneficiaries in its program by 4.5 percent in 2012.

For more information, contact [Esther Reagan](#), Senior Consultant, at (517) 482-9236.

America's Best Hospitals

For the last 24 years, U.S. News & World Report has published annual rankings of the nation's best hospitals. The rankings span 16 medical specialties and cover almost 5,000 medical centers across the country. The [latest rankings](#) have just been released and the best hospitals in America identified. Hospitals scoring high in at least six specialties earn a spot on the Honor Role. Only 18 hospitals made this year's list. The highest ranking hospital was Johns Hopkins in Baltimore, followed by Massachusetts General in Boston, Mayo Clinic, Cleveland Clinic and UCLA Medical Center in Los Angeles.

For more information, contact [Esther Reagan](#), Senior Consultant, at (517) 482-9236.

CMS Imposes Provider Enrollment Moratorium

Using authority in the federal Affordable Care Act, on July 26, 2013, Centers for Medicare & Medicaid Services (CMS) Administrator Marilyn Tavenner [announced](#) temporary provider enrollment moratoria impacting the Medicare, Medicaid, and the Children's Health Insurance Program (CHIP) in three states. The enrollment moratoria prohibits home health agencies in the Miami and Chicago metropolitan areas and ambulance providers in the Houston metropolitan area from newly enrolling in these programs for approximately the next six months. Ms. Tavenner noted that these three areas are health care fraud "hot spots" and the action is being taken to continue strong anti-fraud efforts underway across the country.

For more information, contact [Esther Reagan](#), Senior Consultant, at (517) 482-9236.

Fitton Named to Medicaid Institute

On July 8, 2013, DCH Director James K. Haveman [announced](#) that Michigan's Medicaid Director, Steve Fitton, has been named to participate in the 2014 class of the Medicaid Leadership Institute, the fifth group of Medicaid directors chosen since 2009 for this prestigious executive training program. The institute is operated by the Center for Health Care Strategies through a grant from the Robert Wood Johnson Foundation. He is one of seven state Medicaid directors competitively chosen for the program, which is designed to enhance the strategic thinking, substantive knowledge, individual leadership and technical skills that directors need to effectively lead and foster innovation in their state Medicaid programs.

For more information, contact [Esther Reagan](#), Senior Consultant, at (517) 482-9236.

Medicaid Policies

DCH has issued four final policies and 12 proposed policies that merit mention. The policies are available for review on [DCH's website](#).

- **MSA 13-21** clarifies for **Dentists and Dental Clinics** program policy related to **endodontic retreatment codes and pre-diagnostic service codes**.
- **MSA 13-22** reminds **Nursing Facilities** that **rules**

on working capital borrowings found in the Medicare Principles of Reimbursement **are applicable to interest expenses** under Medicaid. The bulletin also references **a recent and related order** issued by the DCH director.

- **MSA 13-23** advises **Practitioners, Clinics, Hospitals, Health Plans** and others of Healthcare Common Procedure Coding System (**HCPCS**) **updates**.
- **MSA 13-24** clarifies for **Practitioners, Clinics, Health Plans** and others program policy related to the **Medicaid Autism Services** benefit.
- A proposed policy (**1322-SBS**) has been issued that would introduce a new informational **modifier for use by school based services providers**. Comments are due to DCH by August 3, 2013.
- A proposed policy (**1321-MAGI**) has been issued that would implement the **beneficiary eligibility process changes** beginning October 1, 2013 to comply with the federal Affordable Care Act's requirements related to use of the **Modified Adjusted Gross Income (MAGI) methodology**. Comments are due to DCH by August 9, 2013.
- A proposed policy (**1326-Vision**) has been issued that would allow **occupational and physical therapists to perform orthoptic and pleoptic training** in an optometrist's office. The proposed policy would also establish parameters around coverage of such services. Comments are due to DCH by August 9, 2013.
- A proposed policy (**1325-Hospital**) has been issued that would **clarify the hospital credit balance refund process** to ensure compliance with federal requirements. Comments are due to DCH by August 13, 2013.
- A proposed policy (**1327-Dental**) has been issued that would **expand the Healthy Kids Dental program**, and the contract with Delta Dental Plan of Michigan, into **Ingham, Ottawa, and Washtenaw Counties**. Comments are due to DCH by August 13, 2013.
- A proposed policy (**1331-ICD**) has been issued that would provide information to assist **All Providers** in their preparation of business and systems changes necessary to implement the new International Classification of Diseases, 10th Edition, Clinical Modification and Procedure Coding System (**ICD-10-CM/ICD-10-PCS**) code sets on October 1, 2014. Comments are due to DCH by August 16, 2013.
- A proposed policy (**1330-NF**) has been issued that would **expand the definition of legal fees**

applicable to **Nursing Facilities** to include related costs for other types of representation of the provider in legal matters. Regulatory actions, audits, and appeals. The policy would also clarify the requirements and process for reporting legal fees and related costs associated with facility acquisition, mortgage, or financial transactions on the cost report. Comments are due to DCH by August 22, 2013.

- A proposed policy (**1328-EPSDT**) has been issued that would establish a **new chapter in the Medicaid Provider Manual** dedicated to the requirements associated with the **Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program**. The new chapter will consolidate information on this subject for easier access by providers. Comments are due to DCH by August 23, 2013.
- A proposed policy (**1317-Bulletins**) has been issued that would, pending approval from the federal government, reduce costs to DCH by **discontinuing the distribution of Medicaid policy bulletins and L letters through the US Mail** and instead release such information through email addresses on file at DCH. Comments are due to DCH by August 26, 2013.
- A proposed policy (**1323-Eligibility**) has been issued that would clarify policy regarding **individuals that are exempt from proving possession of or application for a Social Security Card**. Comments are due to DCH by August 26, 2013.
- A proposed policy (**1324-Telemedicine**) has been issued that would **update and clarify policy** regarding **telemedicine** coverage. Comments are due to DCH by August 26, 2013.
- A proposed policy (**1334-PDN**) has been issued that would require **Private Duty Nursing** services provided for children to be billed with a **different procedure code** that will permit use of modifiers for further clarification of services provided. Comments are due to DCH by August 29, 2013.

DCH has also released two L-letters of potential interest, which are available for review on the same web site.

L 13-36 was issued in early July to provide additional information, including a set of Frequently Asked Questions, related to the plan to **transition MIChild enrollees** currently in Blue Cross Blue Shield of Michigan (BCBSM) to **other MIChild Health Plans** for their physical health

services. The June edition of *The Michigan Update* also provided an article on this subject.

L 13-37 was issued in mid-July to advise that **MIChild** enrollees currently receiving their **dental care** through BCBSM's Blue Dental plan will **transition to Delta Dental** effective October 1, 2013. New enrollees in selected counties identified in the letter will have a choice between receiving dental care through Delta Dental or **Golden Dental Plan**.

For more information, contact [Esther Reagan](#), Senior Consultant, at (517) 482-9236.

[Health Management Associates](#) is an independent national research and consulting firm specializing in complex health care program and policy issues. Founded in 1985, in Lansing, Michigan, Health Management Associates provides leadership, experience, and technical expertise to local, state, and federal governmental agencies, regional and national foundations, investors, multi-state health system organizations and single site health care providers, as well as employers and other purchasers in the public and private sectors.