

HEALTH MANAGEMENT ASSOCIATES

Special Edition: Michigan Medicaid Budget and More | June 2016

The Michigan Update

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Medicaid Managed Care Enrollment Activity

The Michigan Department of Health and Human Services (MDHHS) has advised that technical problems have delayed release of managed care enrollment numbers for Medicaid, Healthy Michigan Plan, dually eligible Medicare-Medicaid, Children's Special Health Care Services, and MICHild enrollees. Enrollment numbers were not received in May and have not yet been received for June. When information is available, it will be reported in *The Michigan Update*.

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

Healthy Michigan Plan

The Healthy Michigan Plan (HMP) enrollment level, according to the Michigan Department of Health and Human Services (MDHHS) [website](#), stood at **620,090 as of May 31, 2016 and at 595,593 as of June 6, 2016**. As these two enrollment numbers show, the HMP caseload drops by about 25,000 at the beginning of each month as a result of an annual eligibility redetermination requirement; it generally rebounds by the end of the month.

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

Flint Medicaid Wavier

On May 9, 2016, the Michigan Department of Health and Human Services [announced](#) that children and pregnant women served by the city of Flint's water system since April 2014 could begin enrolling in Medicaid, MICHild, or the Healthy Michigan Plan. An estimated 15,000 children and pregnant women in families with

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incomes below 400 percent of the federal poverty level are eligible through the special "Flint Water Group" category under the provisions of the waiver recently approved by the federal government. These individuals qualify for retroactive Medicaid coverage for services received on or after March 1, 2016.

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

MI Health Link

In previous editions of *The Michigan Update* we have written about Michigan's implementation of an integrated health care delivery system for adults dually eligible for Medicare and Medicaid (duals). The demonstration, called MI Health Link, will last for five years (through 2019) and operate in four regions of the state. The entire Upper Peninsula is one region; eight counties in the southwest corner of the state form another region (Barry, Berrien, Branch, Calhoun, Cass, Kalamazoo, St. Joseph, and Van Buren); and Wayne and Macomb Counties are two single-county regions.

As of May 1, 2016, the Michigan Department of Health and Human Services (MDHHS) reports there were **30,813 enrollees** in these health plans, down from 31,766 in April, and down from 42,727 in September 2015 when the demonstration was fully implemented. Enrollment figures for June have not yet been received from MDHHS.

About 16 percent of the enrollees voluntarily joined the MI Health Link demonstration (this percentage has more than doubled in the last six months). Most participants were passively enrolled (assigned to a health plan but with the ability to change to a different plan or opt out of the demonstration). Also as of May 1st, more than 48,000 duals eligible for participation in the demonstration have chosen to opt out (not participate). These individuals will receive their Medicaid benefits on a fee-for-service basis but retain the option to voluntarily enroll in the demonstration at a later time.

There are seven ICOs serving one or more of the demonstration regions. The table below provides enrollment information by region for each ICO.

MI Health Link Enrollment May 1, 2016	Upper Pen. Region	SW MI Region	Macomb Region	Wayne Region	Total
Aetna Better Health		2,810	516	1,958	5,284

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AmeriHealth Michigan			569	2,021	2,590
MI Complete Health / Fidelis			381	1,888	2,269
HAP Midwest Health Plan			853	3,651	4,504
Meridian Health Plan of MI		4,475			4,475
Molina Healthcare of MI			1,295	6,889	8,184
Upper Peninsula Health Plan	3,507				3,507
Total	3,507	7,285	3,614	16,407	30,813

Molina Healthcare of Michigan has the most enrollees, both voluntarily and passively enrolled (26.6 percent of the combined total); Aetna Better Health of Michigan has 17.1 percent of the total; HAP Midwest Health Plan has 14.6 percent; and Meridian Health Plan of Michigan has 14.5 percent. At this point, more than 94 percent of the MI Health Link enrollees are living at home, but less than one percent of them are receiving home and community-based long-term services and supports (although many are receiving personal care in the home). About 5.6 percent of the MI Health Link enrollees live in a nursing facility. Although all of the plans have enrollees receiving care in nursing facilities, Molina Healthcare of Michigan has the largest share, more than 26 percent of the total.

As noted above, the MI Health Link enrollment total has dropped a little each month since September 2015 when there were 42,727 enrollees in the demonstration. Part of this decrease in enrollment may be attributable to temporary disruptions in Medicaid eligibility. In many instances when Medicaid eligibility is reinstated, the department is not permitted to passively enroll the dual a second time; if the dual wants to participate in MI Health Link, they need to voluntarily re-enroll in the demonstration.

MDHHS has recently announced that, within allowable parameters, it will begin passively enrolling certain duals into the ICOs on a monthly basis, including duals newly eligible for MI Health Link enrollment since the last passive assignment process in 2015, duals who recently moved into one of the demonstration areas, certain duals eligible for passive enrollment but who temporarily lost their Medicaid eligibility in 2015, and qualified individuals newly eligible for Medicare for whom the Centers for Medicare & Medicaid Services has not already assigned a plan. The first

passive enrollment group is expected to include about 15,000 individuals: at least 900 in the Upper Peninsula region, more than 2,750 in each of the Southwest and Macomb County regions, and more than 9,000 in the Wayne County region. These passive enrollments were scheduled to be effective June 1, 2016. The results of this enrollment process will be reported when information is available from MDHHS.

The MDHHS has established an [enrollment dashboard](#) on the MI Health Link page on its website. According to the MI Health Link website, for May 2016, more than half of the MI Health Link enrollees are individuals under the age of 65. These younger individuals qualified for Medicare and Medicaid based on a disability.

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

Michigan D-SNPs

Four of the 11 Medicaid HMOs in Michigan (or their parent organizations) are also federally contracted as D-SNPs (Medicare Advantage Special Needs Plans for persons dually eligible for Medicare and Medicaid [duals]) to provide *Medicare* benefits for duals in Michigan: HAP Midwest Health Plan, Meridian Health Plan of Michigan, Molina Healthcare of Michigan, and Upper Peninsula Health Plan. As of May 1, 2016 these four D-SNPs had a combined enrollment of 12,990 duals for whom they provide Medicare services. Almost 80 percent of the duals enrolled in a D-SNP are enrolled in the Molina plan. None of these duals are participating in the MI Health Link demonstration.

Not all of the duals enrolled in these D-SNPs are eligible to receive full Medicaid benefits. Some only receive assistance from the Medicaid program with their Medicare coinsurance and deductible payments and/or monthly Medicare premiums.

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

2016-2017 Michigan Department of Health and Human Services (MDHHS) Budget

Michigan's Revenue Estimating Conference, held on May 17, 2016, resulted in a reduction of \$460 million in estimated revenues for the 2016-2017 fiscal year (FY), which will begin October 1, 2016. Based on the revised revenue estimates, new targets were established for the budgets for state agencies and programs. The state general fund target for MDHHS was reduced by \$33 million from Governor Rick Snyder's original Executive Budget

Recommendation.

All other conference committees completed their work by June 1st and reported their recommendations to the full legislature. The conference committee on the MDHHS budget was scheduled to meet on June 1st, but was recessed due to inability to reach consensus on language related to quality reporting requirements for hospitals receiving Medicaid Graduate Medical Education (GME) payments. The committee met briefly on June 7th and adopted an agreement on the MDHHS budget. Highlights of the Medicaid and mental health provisions of the budget are noted below.

Funding for Specialty Drugs

With respect to specialty medications, Michigan's Pharmacy and Therapeutics Committee recently recommended coverage of additional drugs to treat Cystic Fibrosis and Hepatitis C. These drugs were added to the Medicaid formulary in April 2016. The conference committee budget for FY 2016-2017 includes \$238.2 million to cover the full year costs of Hepatitis C drugs for Medicaid beneficiaries (\$66.5 million in state general funds). Coverage of Orkambi for Cystic Fibrosis for approximately 320 children enrolled in Medicaid and/or Children's Special Health Care Services is budgeted at \$66.3 million Gross (\$43.7 million in state general funds). The Executive budget had projected that 7,000 Medicaid beneficiaries would receive Hepatitis C treatments. The conference committee estimates slightly more than 5,000 individuals will receive this service.

The Executive Budget proposal to create a pharmacy reserve fund was not adopted.

Integration of Mental Health Services with Physical Health Services

As noted in previous editions of *The Michigan Update*, the Governor's budget for FY 2016-2017 included provisions related to the integration of behavioral health services and physical health services within the Medicaid program. Section 298 of the MDHHS portion of the Executive Budget Bill went beyond initiating a study of integration and proposed that by September 30, 2017 the funding for Medicaid behavioral health services would be transferred from the Prepaid Inpatient Health Plans (PIHPs) to the Health Plan Services (HMO) budget.

This became the most contentious issue in the FY 2016-2017 budget. Both the House of Representatives and the Senate replaced the Governor's recommendation with language that created a workgroup and a report requirement related to integrated behavioral and physical health services. The conference committee language was based on the House language with additional goals for the workgroup to consider. As summarized in

the conference committee decision document, the new Section 298 includes the following provisions:

1. Requires MDHHS to work with a workgroup to recommend the most effective financing model and policies for behavioral and physical health coordination. Language includes required workgroup participants.
2. Workgroup goals must include: (a) core principles of person-centered planning, (b) avoiding the return to a medical and institutional model, (c) coordination of physical and behavioral health services at the point of service, (d) ensure full access to community-based services and supports, (e) ensure full access to integrated behavioral and physical health services, (f) reinvest efficiencies gained back into services, and (g) ensure transparency.
3. Workgroup recommendations must include a plan for transition to any new financing model or recommended policies, including a plan to ensure continuity of care, and consideration of one or more pilot programs.
4. Requires the workgroup to recommend annual benchmarks to measure progress in implementation of any new financing model or policy recommendations over a three year period.
5. Requires a status update after each workgroup meeting and a final report by January 15, 2017.
6. Prohibits the transfer of responsibility for behavioral health services from the PIHPs to any other entity without legislative authorization, except for pilot programs as described in (3).

Hospital Quality Data Reporting

As noted above, the final issue that delayed agreement on the conference report was language on quality reporting by hospitals. The final version of Section 1805 requires that hospitals receiving Medicaid GME payments must submit quality data to a non-profit organization that meets certain standards. Consumers must be able to "compare safe practices by hospital campus, including, but not limited to, perinatal care, hospital-acquired infection, and serious reportable events".

The Conference Report on the MDHHS budget included the following policy and/or funding changes relative to current year policy:

Healthy Kids Dental: The legislature agreed with the Executive Recommendation to expand the Healthy Kids Dental program to cover all eligible children in all Michigan counties at a cost of \$25.6 million (state share of \$8.9 million). The final expansion group is children between the ages of 13 and 20 in Kent, Oakland and Wayne Counties.

Adult Dental Services: The Senate had proposed increased rates

for adult dental services effective July 1, 2017 to rates that would allow for a managed care contract for adult dental services. The cost of the Senate proposal was \$23.0 million. The conference committee only included funding to increase reimbursement and expand access to dental services for pregnant women enrolled in Medicaid, at a cost of \$2,726,000 (\$950,000 state general fund).

Medicaid Health Plan Efficiencies: The conference committee reduced funding for Medicaid HMOs by \$37.9 million (\$10.2 million state general fund) based on assumed efficiencies related to Emergency Department utilization, reductions in hospital readmissions, and other utilization efficiencies.

Private Duty Nursing: The Senate proposed to increase rates by 20 percent at a cost of \$6.6 million. The House provided \$3.3 million for a 10 percent rate increase. The conference committee settled on a rate increase of 15 percent at a cost of \$4.95 million (state share of \$1.725 million). Private duty nursing reimbursement rates were last increased more than a decade ago.

Ambulance Rates: The budget for FY 2016-2017 expands the Quality Assurance Assessment Program (QAAP) for ambulance providers to provide rate increases in managed care and Healthy Michigan Plan payments for ambulance services. Funding for this rate increase is \$35.5 million. With federal funds and QAAP assessments paid by ambulance providers, there is a net state general fund savings of \$2.9 million.

PACE: The FY 2016-2017 budget expands funding for the Program of All-inclusive Care for the Elderly (PACE) from \$66 million to \$92.5 million. This proposed expansion allows for additional slots at current Michigan PACE sites and new sites in Jackson and Traverse City. There is no net budgetary impact as funding for other long-term care services was reduced by the same amount.

Community Mental Health Non-Medicaid funding: The funding for non-Medicaid services from Community Mental Health was increased by \$3.0 million.

Primary Care: The Senate increased rates for primary care services by 6 percent. This increase was not included in the conference recommendation. The conference report includes language (Section 1701) directing MDHHS to consider implementing a Direct Primary Care Pilot for Medicaid beneficiaries. The direct primary care provider must be under contract with at least one Medicaid Health Plan. If a pilot program is initiated, the legislature has specified a minimum set of performance measures, including an assessment of the direct primary care costs and the savings generated from direct primary care. The budget does not include any new funding for this potential initiative.

Dental Clinics: The conference committee doubled the funding for the University of Detroit Dental Clinic from the current \$1 million to a total of \$2 million for FY 2016-2017. The funding is 100 percent from the state general fund. The conference committee also included \$1.55 million of general fund money for possible support of rural dental clinics.

State Innovation Model (SIM): The Senate reduced SIM funding from \$25 million to \$100 to create an opportunity to discuss the *Blueprint for Health Innovation* in the conference committee. The conference committee agreed to reduce the funding by \$15 million, leaving \$10 million for FY 2016-2017. (These are 100 percent federal funds.)

Other Medicaid and Medical Services Administration Changes

The total budget for physical health care for Medicaid beneficiaries is \$14.46 billion, of which the state general fund share is \$2.07 billion. The FY 2016-2017 budget includes a few notable changes for the Medical Services Administration. In addition, there are many technical adjustments in the Medicaid budget.

- **Integrated Service Delivery:** The FY 2016-2017 budget includes 15 new positions and \$43.2 million to update and streamline the electronic application and enrollment process for services through MDHHS. (The non-federal share is 10 percent, or \$4.32 million.)
- **Healthy Michigan Plan (HMP) Administration:** The FY 2016-2017 budget reduces funding for the HMP call center by \$8.1 million and also reduces funding for HMP marketing and advertising by \$1 million.
- **Fewer individuals dually enrolled in Medicaid and Medicare** are choosing the Integrated Care Organizations (ICO) as part of the "duals demonstration" than was anticipated by the FY 2015-2016 budget. As a result, \$239.8 million is removed from the ICO budget line and the long-term care services line is similarly increased.
- **The federal requirement to eliminate the Use Tax on Medicaid HMOs and the PIHPs as of January 1, 2017** has a negative revenue implication for the state which is not specific to the Medicaid budget. Since the cost of this tax is an allowable cost for the Medicaid Health Plans and the PIHPs and therefore reimbursed by Medicaid, elimination of the tax reduces Medicaid and Healthy Michigan Plan HMO and PIHP costs by about \$479.5 million (state general fund share of \$165.0 million) for the nine months from January to September of 2017.
- **Actuarially Sound Rates:** The budget includes funding for a 2 percent rate increase for HMOs for the Healthy Michigan

Plan and a 1.5 percent rate increase for the PIHPs and HMOs for traditional Medicaid.

Both a summary Conference Report and a detailed Conference Report are available online from the [Senate Fiscal Agency](#). The actual bill is also available on the [legislature's website](#).

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

Health Insurance Claims Assessment (HICA) and Use Tax

On May 24, 2016, a set of four bills was introduced in the Michigan Senate to continue the Use Tax on Medicaid Health Plans (HMOs) and Prepaid Inpatient Health Plans (PIHPs) under a revised structure as of January 1, 2017 and would eliminate the HICA tax as of that same date (which is otherwise scheduled to increase from 0.75 percent to 1.0 percent on January 1, 2017).

The four bills would do the following:

- Create a new version of the Medicaid managed care Use Tax as of January 1, 2017 (SB 989)
- Designate that the funds collected by that tax be deposited in a new "Health Services Fund" and be used for five specified non-Medicaid purposes (SB 988)
- Allocate State Income Tax revenues to fund the non-federal share of the cost of reimbursing Medicaid HMOs and PIHPs for their incurred taxes (SB 990)
- Modify the HICA to end on December 31, 2018, and to be reduced to 0.0 percent on January 1, 2017 if the federal government agrees to match the cost to the Medicaid managed care entities of the new Use Tax.

The five programs that would be supported by the Health Services Fund are:

- Safe Drinking Waiver Revolving Fund (\$2.0 million)
- Community Mental Health non-Medicaid services (\$100 million)
- Local public health department non-Medicaid services (\$30.0 million)
- Federal Medicare Pharmaceutical Program (\$150 million in FY 2016-2017 and \$204 million in each subsequent fiscal year)
- Clinical and mental health services in the Department of Corrections (balance of funds collected).

The bills were sent to the Senate Committee on Michigan Competitiveness which reported them out to the full Senate with a favorable recommendation and without amendment. The full Senate approved the bills on June 8th. The House has received the bills and referred them to the House Committee on Insurance.

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

State Innovation Model: Patient-Centered Medical Homes

The Michigan Department of Health and Human Services (MDHSS) recently announced the first phase of Accountable Systems of Care within the *Blueprint for Health Innovation* initiative, Michigan's State Innovation Model (SIM). The first phase of this multi-payer initiative will focus on Patient-Centered Medical Homes (PCMH). The PCMH initiative is scheduled to begin on January 1, 2017, to coincide with the December 31, 2016 end of the Michigan Primary Care Transformation (MiPCT) initiative. Physician practices interested in the SIM PCMH initiative must submit an "Intent to Participate" (ITP) by June 30, 2016.

Michigan was one of eight states that received funding in 2012 for the Multi-Payer Advanced Primary Care Practice Demonstration. MiPCT, which brought together Medicare, Medicaid, and several private insurers, reached over 1.2 million patients served by 1,900 providers in 350 primary care practices. Participating practices received funding for practice transformation, care coordination, and performance incentives.

The SIM PCMH initiative is open to any current MiPCT practice in any region of the state, and to other physician practices located in the 2017 SIM pilot regions. These five regions are:

- Genesee County
- Jackson County
- Muskegon County
- Washtenaw and Livingston Counties
- Northern Michigan (Antrim, Benzie, Charlevoix, Emmet, Grand Traverse, Kalkaska, Manistee, Missaukee, and Wexford Counties)

It should be noted that the Northern Michigan Community Health Innovation Region includes additional counties, but only these nine counties are included in the 2017 SIM PCMH initiative.

Information about the intent to participate process is available on the [MDHSS website](#). As noted above, the ITP must be completed by June 30, 2016. The ITP is non-binding. Practices that complete the ITP will subsequently receive a full application and

participation agreement. According to a MDHHS webinar held May 11, 2016, physician practices must be able to demonstrate that by January 1, 2017 they will have certain capabilities including:

- Accreditation as a PCMH from one of several recognized bodies
- Implementation of an Electronic Health Record
- Enrollment as a Medicaid provider
- Embedded care management / coordination staff meeting standards set by the Initiative

The PowerPoint slides from the May 11th webinar are also available at the website link noted above.

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

Medicaid Benefits and Zika Virus

On June 1, 2016, the federal Department of Health and Human Services released an [Informational Bulletin](#) to inform State Medicaid agencies and other interested stakeholders about how Medicaid services and authorities can help states and territories prevent, detect, and respond to the Zika virus. The letter identified and encouraged states to use federal funding flexibilities available.

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

Child Lead Poisoning Elimination Board

Governor Rick Snyder issued [Executive Order 2016-9](#) on May 20, 2016 has created a new Child Lead Poisoning Elimination Board that will be chaired by Lieutenant Governor Brian Calley and include 11 additional members. The board is created as a temporary commission and is charged with making "recommendations to the Governor concerning testing of children for elevated blood lead, follow-up monitoring and services, including case management; environmental lead investigations; remediation and abatement; and dashboards and reporting." A written report is due to the Governor by November 4, 2016. Directors, or their designees, from the departments of Environmental Quality, Health and Human Services, Licensing and Regulatory Affairs and the Michigan State Housing Development Authority will be part of the board, along with [seven additional appointees](#): Riley Alley, Dr. Mona Hanna-Attisha, Mayor Rosalyn Bliss, Paul Haan, Rebecca Meuninck, Dr. Abdul El-Sayed, and Lyke Thompson.

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

Oral Health Coalition Unveils Plan to Improve Dental Access

On May 17, 2016, the Oral Health Coalition in collaboration with the Michigan Department of Health and Human Services released the [2020 Michigan State Oral Health Plan](#) and a companion Progress Report. The Plan is focused on improving three key goals around dental health: enhancing professional integration between providers across the lifespan; increasing knowledge and awareness of the importance of oral health to overall health; and increasing access to oral health care among underserved and/or hard to reach populations.

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

MDHHS Chief Deputy Director

On May 31, 2016, Michigan Department of Health and Human Services Director Nick Lyon announced that his Chief Deputy Director, Tim Becker, will be leaving the department on July 8, 2016 to join Hope Network as executive vice president. His successor has not yet been named.

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

Medicaid Policies

Since our last newsletter, the Michigan Department of Health and Human Services (MDHHS) has issued ten final policies and five proposed policies, two of which were issued simultaneously with final policies, that merit mention. They are available for review on the department's [website](#).

- **MSA 16-10** notifies **All Providers** that **Targeted Case Management Services** are covered for **pregnant women and children served by the Flint water system**. This policy was simultaneously released for public comment (**1612-TCM-Flint**), with comments due to MDHHS by June 8, 2016. The policy notes that it is contingent upon legislative funding appropriation (which has occurred) and State Plan approval from the federal government.
- **MSA 16-11** notifies **All Providers and Bridges Eligibility Manual Holders** of a **new Medicaid eligibility category - Flint Water Group (FWG)** - for pregnant women and

children served by the Flint water system. This policy was simultaneously released for public comment (**1614-FWG**), with comments due to MDHHS by June 8, 2016.

- **MSA 16-12** advises **Local Health Departments, Hospitals, Physicians, Clinics and Pharmacies** that the Children's Special Health Care Services (**CSHCS**) program may cover the **out-of-pocket pharmacy costs** related to covered diagnoses for beneficiaries enrolled with a **Medicare Part D** Pharmacy Drug Plan.
- **MSA 16-13** notifies **Federally Qualified Health Centers, Hospitals, Local Health Departments, Medicaid Health Plans** and Others that MDHHS is **implementing MI Care Team** (a Primary Care Health Home Benefit) effective July 1, 2016.
- **MSA 16-14** advises **Practitioners, Hospitals, Clinics, Prepaid Inpatient Health Plans, Medicaid Health Plans** and Others that fully-licensed **Marriage and Family Therapists may enroll** as Medicaid providers and **bill for services directly**. They will no longer be required to file claims under a delegating/supervising physician's identifier.
- **MSA 16-15** informs **Medicaid Health Plans, Practitioners** and Others of a **new form for prior authorization of Practitioner services**. A facsimile of the form is attached.
- **MSA 16-16** clarifies for **Ambulance Providers, Hospitals and Medicaid Health Plans** Medicaid policy pertaining to **prior authorization of ambulance services**.
- **MSA 16-17** advises **Bridges Eligibility Manual Holders** of an update to **resource eligibility policy** for Supplemental Security Income related Medicaid programs.
- **MSA 16-18** notifies **Medicaid Private Duty Nursing Providers** of **updates to the Private Duty Nursing Chapter** of the Medicaid Provider Manual.
- **MSA 16-20** notifies **All Providers of Quarterly Updates to the Medicaid Provider Manual**.
- A proposed policy (**1616-EPSDT**) has been issued that would clarify program policy regarding coverage of **behavioral health treatment services for children with Autism Spectrum Disorders**. Comments are due to MDHHS by June 16, 2016.
- A proposed policy (**1606-LHD**) has been issued that would revise **Medicaid outreach requirements for Local Health Departments** and clarify federal Medicaid matching fund claiming requirements. Comments are due to MDHHS by June 17, 2016.
- A proposed policy (**1617-LHD**) has been issued that would align Medicaid policy with an approved State Plan Amendment allowing **on-site environmental investigations related to blood lead poisoning** of a

beneficiary's home or primary residence. Comments are due to MDHHS by July 15, 2016.

MDHHS has also released ten L-letters of potential interest, which are available for review on the same website.

- **L 16-22** was released on May 2, 2016 to remind **Nursing Facilities** about Medicaid financial eligibility policy related to the purchase of **private insurance policies for coverage of ancillary services** and of the program's policies related to **offsetting patient pay amounts**.
- **L 16-28** was released on May 2, 2016 as a notice of the department's intent to submit a waiver **amendment for the Section 1915(b) MI Choice waiver**. The purpose of the amendment is to **add non-emergency medical transportation as a covered service** under the waiver and to **implement the coverage in a geographically phased manner**. The first phase counties are identified in the letter. **L 16-32** was released on May 31, 2016 as **additional information**. **L 16-33** was also released on May 31, 2016 **to Interested Parties, including MI Choice Waiver Agencies** with information about the waiver amendment.
- **L 16-21** was released on May 9, 2016 to **MI Choice Waiver Directors** to clarify current expectations regarding the **Nursing Facility Level of Care Determination** process.
- **L 16-30** was released on May 17, 2016 as a notice of the department's intent to submit a State Plan Amendment to update Plan language referencing the **fee schedules and effective dates listed under Individual Practitioner Services**.
- **L 16-24** was released on May 17, 2016 to clarify **how days should be counted for correct billing of Hospice services**.
- **L 16-31** was released on May 18, 2016 to **School Based Services** providers to provide amended **contract bill back information for the State Fiscal Year 2016**.
- **L 16-08** was released on May 19, 2016 as a notice of the department's intent to submit a State Plan Amendment related to **Diabetes Self-Management Education and Training programs**.
- **L 16-19** was released on May 26, 2016 to notify Medicaid **providers that received at least \$5 million in payments during calendar year 2015 of reporting requirements** associated with the Deficit Reduction Act of 2005.

For additional 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.