HEALTH MANAGEMENT ASSOCIATES

March 2015

The Michigan Update

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Medicaid Managed Care Enrollment Activity

As of March 1, 2015, there were **1,606,323 Medicaid beneficiaries, including Healthy Michigan Plan (HMP) beneficiaries, enrolled** in 13 Medicaid Health Plans (HMOs); this is an **increase of 19,994** since February. The enrollment total reflects an increase of 19,720 HMP enrollees since February and an increase of 274 non-HMP Medicaid enrollees. Even with this increase, the total number of non-HMP Medicaid managed care enrollees in March - 1,163,003 - is still well below the June 2014 enrollment figure of 1,330,638.

While Medicaid managed care enrollment has increased for both HMP and non-HMP Medicaid enrollees, the managed care enrollment increase has not kept pace with the increase in total Medicaid enrollment. For example, HMP managed care enrollment increased by less than 20,000 in March while total HMP enrollment has been increasing by more than 30,000 individuals per month. (See additional articles in this newsletter for more information regarding Medicaid and Healthy Michigan Plan enrollment trends.)

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 available in every county, 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.

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Healthy Michigan Plan

At the one year anniversary of implementing the Healthy Michigan Plan (HMP), enrollment continues to grow, far exceeding original expectations. The Michigan Department of Community Health (MDCH) reports that since launching

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the program on April 1, 2014, enrollment has grown to 603,681 as of March 30, 2015.

HMP enrollees are required to report any changes in their economic or health care coverage circumstance as those changes occur. They are also subject to an annual redetermination of eligibility; those that entered the program in the early months will soon be subject to redetermination of eligibility. As a result there may be some decline in the number of HMP enrollees or at least a decline in the rate of increase of HMP enrollment in the near future.

The MDCH updates HMP enrollment statistics on its website weekly and includes a breakdown of enrollment by county. Not surprisingly, more than half of the newly approved HMP beneficiaries reside in the state's five largest counties:

March 30, 2015 Healthy Michigan Plan Enrollment	
Wayne	161,586
Macomb	47,874
Oakland	47,771
Genesee	35,992
Kent	31,704
Five-County Total	**324,927**
Statewide Total	**603,681**

The vast majority of these enrollees (nearly 500,000) have income below poverty and more than 51 percent of the enrollees are women. About 47 percent of the enrollees are between the ages of 19 and 34; more than 39 percent are between the ages of 35 and 54; and almost 14 percent are between the ages of 55 and 64.

Virtually all of these enrollees are already or soon will be enrolled in the state's Medicaid managed care organizations for their health care services. As of March 1, 2015, there were a total of **443,319 HMP beneficiaries enrolled in the HMOs.** HMP enrollment totals by health plan are expected to increase again in April as newly eligible individuals continue to enroll in the program and choose an HMO or are assigned to an HMO if they do not select a plan. However the rate increase in HMP managed care enrollees continues to lag the rate of increase in total HMP enrollment.

Meridian Health Plan of Michigan, which has the largest Medicaid enrollment of any Medicaid HMO, also has the most HMP enrollees, 26.4 percent of the total. UnitedHealthcare Community Plan has 12.9 percent; McLaren Health Plan and Molina Healthcare of Michigan each have 11.7 percent of the total; and the other nine plans share the remaining 37.3 percent.

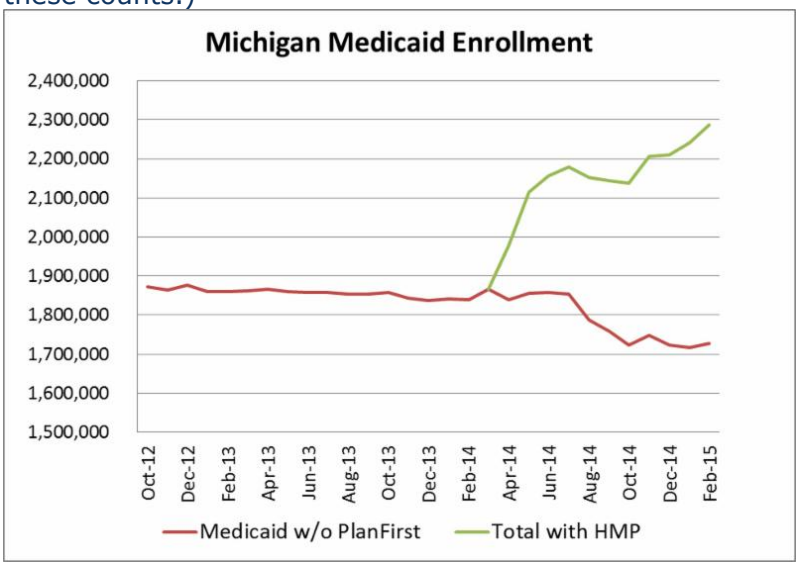
The long-term future of the HMP is not assured. The legislation that authorized creation of HMP also included some future requirements for the program. MDCH is required to seek an additional federal waiver which would affect individuals who have been enrolled in HMP for 48 cumulative months and have income at or above 100 percent of the Federal Poverty Level. These individuals would be given a choice of moving to the health benefits exchange or remaining in Medicaid with increased cost-sharing requirements of up to seven percent of income. The HMP statute specifies that absent federal waiver approval by December 31, 2015, MDCH must notify HMP enrollees by January 31, 2015 that the HMP program will be terminated on April 30, 2016.

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

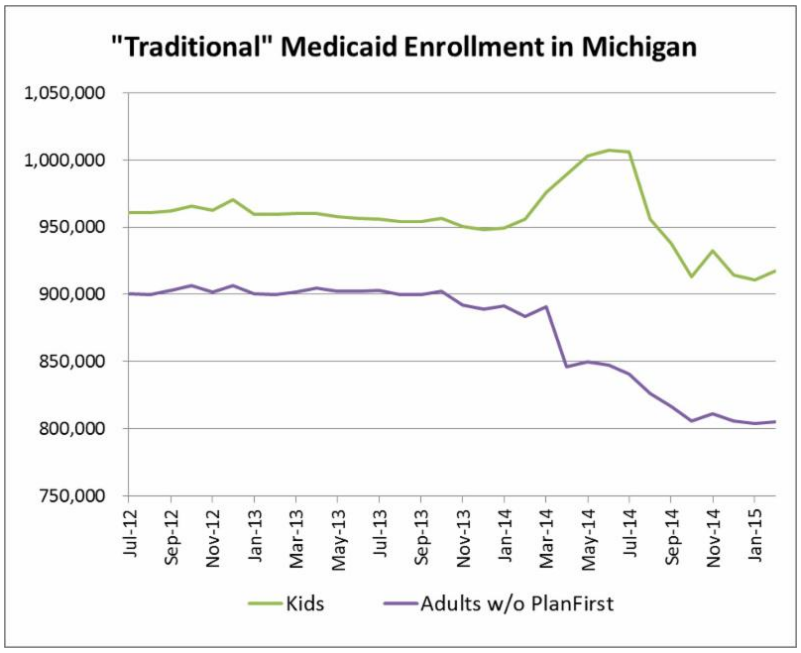
Trends in Medicaid Enrollment

As noted in the Healthy Michigan Plan article, enrollment in the Healthy Michigan Plan (HMP) continues to climb through March 2015. However enrollment in non-HMP Medicaid (or "traditional" Medicaid) has been declining for nearly a year.

When HMP and "traditional" Medicaid numbers are combined, Michigan Medicaid enrollment reflects an increase from below 1.85 million at the beginning of 2014 to more than 2.3 million currently, as shown in the following graph. (Note: *PlanFirst!* is Michigan's single benefit Family Planning waiver which only covers contraceptive services and is therefore excluded from these counts.)



The decline in "traditional" Medicaid enrollment was very small from late 2012 through the beginning of 2014. The dramatic changes in 2014 were different for children than for adults, as shown in the following graph.



The changes in Medicaid eligibility rules and processes that began in January 2014 (including a change of income counting rules, increases in the income limits for children's Medicaid, elimination of the asset test for parents, and suspension of redeterminations of eligibility) appear to have resulted in a significant increase in the enrollment of children but no positive impact on the number of adults enrolled in Medicaid. Implementation of the HMP in April 2014 coincides with a further reduction in the number of adults with "traditional" Medicaid. The resumption of Medicaid eligibility redeterminations in July 2014 appears to have led to a decline in enrollment for both adults and children.

At the same time Michigan's unemployment rate was dropping which may have resulted in fewer persons meeting the "traditional" Medicaid income thresholds.

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

Duals in Medicaid HMOs

There were **56,486** Medicaid beneficiaries dually eligible for Medicare (duals) enrolled in Medicaid HMOs to receive their Medicaid benefits in March 2015, an **increase of 709** since February. 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 Advantage Special Needs Plan (SNP, or D-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.

Molina Healthcare of Michigan has the most duals receiving Medicaid services from an HMO, 24.2 percent of the total; Meridian Health Plan of Michigan has 19.4 percent of the total (but the most voluntary enrollees); UnitedHealthcare Community Plan has 19.2 percent of the total; and the other 10 plans share the remaining 37.2 percent.

Six of the 13 Medicaid HMOs in Michigan (or their parent organizations) are also federally contracted as D-SNPs to provide *Medicare* benefits for duals in Michigan: HAP Midwest Health Plan, HealthPlus Partners, Meridian Health Plan of Michigan, Molina Healthcare of Michigan, Total Health Care, and Upper Peninsula Health Plan. As of March 1, 2015 these six D-SNPs had a combined enrollment of 17,706 duals for whom they provide Medicare services; 70.1 percent of the duals enrolled in a D-SNP are enrolled in the Molina plan, 12.2 percent are enrolled in the Meridian plan and the remaining 17.7 percent are spread across the other four plans. 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 Medicare coinsurance and deductible payments and/or monthly Medicare premiums.

There is one additional D-SNP in Michigan, Fidelis SecureCare of Michigan, Inc., which does not hold a Medicaid HMO contract but has been approved by the state as an Integrated Care Organization in the state's duals demonstration. As of March 1, 2015, Fidelis had 1,232 enrollees in its D-SNP. It is also an approved Medicare Advantage Institutional SNP (I-SNP) with 242 enrollees.

Two of the Medicaid HMOs - McLaren Health Plan and UnitedHealthcare Community Plan - no longer appear on the federal list of approved D-SNPs as of December 31, 2014.

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CSHCS Children in Medicaid HMOs

The Michigan Department of Community Health (MDCH) requires children (and a few adults) receiving services from both the Children's Special Health Care Services (CSHCS) program and the Medicaid program to enroll in Medicaid HMOs. As of March 1, 2015, there were **17,615 joint CSHCS/Medicaid beneficiaries enrolled in the Medicaid HMOs** - an decrease of 25 since February. All Medicaid HMOs except Harbor Health Plan, Inc. have CSHCS/Medicaid enrollees, although the numbers vary across plans.

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, 25.1 percent of the total. Molina Healthcare of Michigan has 17.7 percent of the total; UnitedHealthcare Community Plan has 16.7 percent; and the other nine plans share the remaining 40.5 percent.

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MIChild

According to MAXIMUS, the Michigan Department of Community Health (DCH) contractor for MIChild enrollment, there were **42,490 children enrolled in the MIChild program as of March 1, 2015**. The March enrollment total reflects an **increase of 1,644** from the 38,196 40,846 children enrolled as of February 1, 2015. Of the total number of children enrolled, 872 enrollees are dually eligible for Children's Special Health Care Services (CSHCS) and MIChild.

As the enrollment reports for March (pdf) (xls) show, enrollment is dispersed between 13 plans. The plans with the highest enrollment are Priority Health (with 16 percent of the total enrollees), Molina Healthcare of Michigan (with 15.4 percent), HealthPlus of Michigan (with 14.1 percent), and McLaren Health Plan (with 13.8 percent). Blue Cross Blue Shield of Michigan (BCBSM) had 6.7 percent of the enrollees as of March 1, 2015. The BCBSM market share has gradually dropped from about 75 percent in late 2013 when the insurer advised that it wished to terminate its MIChild contract. Children residing in counties where there are at least two health plans available are given the choice to enroll with one of those plans. Children in counties where BCBSM has been the only available health plan will remain enrolled with that plan until other plans expand their service areas to these counties. There are now only seven counties where BCBSM is the only available plan.

MIChild-enrolled children receive their dental care through contracted dental plans. Of the two available plans, 86.9 percent of the children were enrolled with Delta Dental Plan as of March 1, 2015. Delta Dental has a statewide service area. The remaining 13.1 percent of children were enrolled with Golden Dental Plan in a service area that includes eight counties. BCBSM was a statewide dental health plan as well through September 2013 when BCBSM terminated in full its participation in the MIChild dental program.

MIChild is part of the Michigan implementation of CHIP (the Children's Health Insurance Program), which provides a higher level of federal funding for children in families with incomes above Medicaid eligibility levels. While the

Affordable Care Act created enhanced federal funding rates for CHIP through 2019 and requires states to maintain current income eligibility levels through that same period, federal funding for CHIP is only appropriated through September 2015.

On March 26th the US House of Representatives passed the Medicare Access and CHIP Reauthorization Act (MACRA) which extends CHIP funding through September 2017. The bill also deals with an imminent threat of cuts of twenty-one percent in physician rates under the Medicare program. Rather than a one-year "Doc Fix" as has occurred in the past, the bill establishes rate increases of 0.5 percent per year for five years. Senate action is still required on this bill.

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Medicaid Budget for Fiscal Year 2016

The last full week of March saw a flurry of activity on the Michigan budgets for fiscal year (FY) 2016, including action by Appropriations Committees in both the House and Senate on the budget for the Michigan Department of Community Health (MDCH). Both chambers of the legislature proposed significant changes to the Governor's recommendations for the Medicaid program.

The largest fiscal point of difference relates to the **Health Insurance Claims Assessment (HICA)**. The Governor's budget assumes an increase of $180.1 million in HICA revenues by increasing the taxation rate from 0.75 percent to 1.30 percent and by removing a cap on the HICA tax. Both the House and the Senate rejected this change, which results in the need to find other revenues or cut programs.

- The House bill moves $37.5 million from the Merit Award Fund to Medicaid.
- The Senate bill moves $40 million in additional Tobacco Settlement Revenues to Medicaid.
- The Senate bill also assumes Medicaid savings from increased Third Party Liability collections of nearly $19.8 million and increased recoveries by the Medicaid Inspector General of $16.9 million.

Both chambers indicate that part of the shortfall will be made up with cuts in other areas of the budget. The amount of state general fund dollars for the entire MDCH budget is $2.993 billion in the Governor's recommendation, $3.121 billion in the House bill and $3.128 billion in the Senate proposal, a significant difference.

Two of the major Medicaid policy changes in the Governor's budget for FY 2016 relate to dental services.

- The Governor and House extend **Healthy Kids Dental** to Kent, Oakland, and Wayne Counties as of October 2015, but only for children under age nine. The Senate expands the program to all children in these three remaining counties, but delays the implementation to July 1, 2016.
- The Governor's budget increases the funding for **Adult Dental Services**, with an anticipated implementation of managed adult dental services as of July 1, 2016. The Senate reduces the cost of this item by delaying implementation to September 1, 2016. The House did not concur with increases funding for adult dental services, but includes a $100 placeholder to enable continued discussion of this item.

Both the House and the Senate rejected the Governor's proposal to carve pharmacy services out of the Medicaid HMOs. The Senate assumes that through establishment of a single formulary and shared rebate savings the same $48.8 million in savings can be achieved. The House concurs with the Senate but assumes that $54.6 million can be saved.

The most significant changes relate to reimbursement of **hospitals**.

- While all versions of the budget restore current year cuts to **Graduate Medical Education (GME)**, the Governor and House increase hospital taxes (Quality Assurance Assessment Program or QAAP) to pay for GME whereas the Senate restores state funding.
- The Governor proposed elimination of $11 million in enhanced funding for **Obstetrical Services** in rural hospitals. Both the House and Senate restore these funds.
- The Governor, House and Senate treat the current **Small/Rural Hospital Pool** very differently. Both the Governor and the Senate restore the FY 2015 cut ($5.8 million). However the Governor proposes use of hospital taxes as the non-federal share of the $34.9 million pool, while the Senate retains state general funds. The House does not restore the cut, but does not require a hospital tax to pay for the smaller $29.1 million pool.
- The Governor and the House assume $34.8 million in savings from a change in the formula for **Hospital Capital Payments**. The Senate rejects this change.
- The Senate creates a **"Value DSH Pool"** of $2.9 million designed to reward hospitals that provide low-cost high-quality care.
- While the Senate rejects increased hospital taxes to fund GME, the Senate proposes an even larger

increase in hospital taxes ($85.2 million) to fund hospital payments in general.

The Senate also establishes a **QAAP for ambulance providers** to generate $17.2 million in QAAP fees. The initiative would fund a $40 million increase in Medicaid payments for ambulance services and save the state nearly $3.5 million.

The House and Senate bills each include many other adjustments to the Medicaid program. These actions are preliminary since there will be a revenue estimating conference on May 5th. After the new consensus revenue estimates for FY 2016 are developed, legislative and executive leadership will develop new targets for the amount of state general fund spending in each budget. The ultimate goal is to finish all budgets by June 15th.

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Michigan's Blueprint for Health Innovation

As previously reported in *The Michigan Update*, Michigan received a $70 million award from the federal government under the State Innovation Model (SIM) initiative. The Michigan Department of Community Health, as the awardee, is being assisted by a team led by the Michigan Public Health Institute (MPHI), which is managing implementation of the *Blueprint for Health Innovation (Blueprint)*. As stated in recent MPHI documents, the purpose of this award is to "test strategies to achieve better health and better care at lower costs through service delivery innovations, payment reforms, and population health improvement investments".

One of the foundational elements of the *Blueprint* is development of Accountable Systems of Care (ASCs). On March 27th, MPHI released the SIM Accountable System of Care Capacity Assessment for entities interested in becoming an ASC. The assessment must be completed by May 1st, a delay from the original target date of April 13th. A wide range of types of entities might lead an ASC. In a discussion of the types of organizations that should respond to the ASC Capacity Assessment, the SIM team indicates the following:

> "Entities that are eligible to lead Accountable Systems of Care will likely include large group practices, physician organizations, physician-hospital organizations, independent practice associations, health systems, critical access hospitals, and health center controlled networks. Federally Qualified Health Centers and Rural Health Clinics, Community Mental Health Services Providers, and Health Plans are eligible to lead Accountable Systems of Care if they meet the organizational and functional requirements

specified."

A similar tool is expected to be released in April to assess the capacity of entities/groups interested in participating as Community Health Innovation Regions (CHIRs). The goal of the SIM initiative is to select regions that have a backbone agency for the CHIR and have one or more ASCs to begin implementation of the *Blueprint* at the beginning of 2016.

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

Department of Health and Human Services

In last month's edition of *The Michigan Update*, we reported that Governor Rick Snyder had released an Executive Order to combine the Departments of Community Health and Human Services into a single department to be called the Michigan Department of Health and Human Services. Although a few members of the Legislature expressed concern about the merger, no action was taken to stop it before the Legislature's spring recess so the order will take effect on April 10, 2015.

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Khouri Named New State Treasurer

On March 17, 2015, Governor Rick Snyder named Nick Khouri, a vice president at DTE Energy and a former chief deputy in the Treasury Department as Michigan's new State Treasurer. Mr. Khouri will assume his duties on April 20, 2015, succeeding Kevin Clinton who will step down to rejoin the private sector.

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Drug Settlement

Global pharmaceutical company Daiichi Sankyo Inc., with its US headquarters in New Jersey, has agreed to pay the federal government and 49 state Medicaid programs a total of $39 million to resolve allegations that it violated the False Claims Act by paying kickbacks to induce physicians to prescribe several of the company's drug products, including Azor, Benicar, Tribenzor and Welchol. The case stemmed from a complaint filed by a former sales representative under whistleblower provisions of the Act. The company will also enter into a corporate integrity agreement with the federal government, which obligates it to undertake substantial internal compliance reforms for

the next five years.

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Michigan Receives HUD Grant

Michigan Department of Community Health (MDCH) Director Nick Lyon announced on March 20, 2015 that as the result of a collaborative application effort between MDCH and the Michigan State Housing Development Authority (MSHDA), more than $5.5 million has been awarded to the state by the US Department of Housing and Urban Development (HUD). The funding, through the Section 811 Project Rental Assistance grant program, will provide affordable rental housing and supportive services to extremely low-income persons with disabilities. MSHDA will administer the program intended to help prevent unnecessary institutionalization and homelessness. Michigan was one of 25 states selected to receive funding.

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

ACA Impact in Michigan

The Center for Healthcare Research and Transformation (CHRT) at the University of Michigan has released two issue briefs related to the impact of the Affordable Care Act (ACA) on Michigan.

The first brief explores consumer experiences with insurance coverage and access to care in Michigan between mid-2012 and late 2014. *Cover Michigan Survey: Coverage and Health Care Access* is the result of data analysis from two CHRT surveys, the latest of which was fielded beginning in September 2014. The brief provides evidence of a dramatic change in Michigan's health care landscape as a result of the first year of the Affordable Care Act's (ACA) coverage expansions. According to the brief, the number of residents reporting that they were uninsured, struggling to pay medical bills and/or delaying medical care has dropped significantly compared to CHRT's survey findings from before the launch of the ACA coverage expansions. The brief also notes that while access to primary care has not been a problem in 2014, access to specialty care has become more of a challenge.

The second brief provides an overview of ACA initiatives and their effect on both health care consumers and insurers in Michigan. *The Impact of the Affordable Care Act in Michigan* also reviews some of the major changes providers have faced over the five years of the ACA's existence, addressing both the Healthy Michigan Plan and the Health Insurance Marketplace.

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Medicaid Policies

The Michigan Department of Community Health (DCH) has issued two final policies and nine proposed policies that merits mention. It is available for review on DCH's website.

- **MSA 15-04** informs **Dentists** and others of policies specific to **mobile dental facilities**.
- **MSA 15-05** notifies **All Providers** of **Quarterly Updates to the Medicaid Provider Manual**, shares an **ICD-10 Project Update** and makes other clarifications and announcements.
- A proposed policy (**1506-Pharmacy**) has been issued that would **permit participating pharmacies to administer all vaccines** recommended by the Advisory Committee for Immunization Practices to adults age 19 and older. The policy would also allow certain pharmacies to participate in the **Vaccines for Children** program and administer recommended vaccines to adolescent beneficiaries 11 through 18 years of age. Comments are due to MDCH by April 6, 2015.
- A proposed policy (**1460-Pharmacy**) has been issued that **would allow pharmacy providers to be reimbursed for injectable drugs** administered in the outpatient hospital, clinic or physician office setting using a rate based on the National Drug Code. Comments are due to MDCH by April 9, 2015.
- A proposed policy (**1509-SBS**) has been issued that would establish procedures for **recovery of funds resulting from adverse School Based Services audit findings** by MDCH auditors. Comments are due to MDCH by April 15, 2015.
- A proposed policy (**1511-Hospital**) has been issued that would establish **new reimbursement logic** for certain claims that qualify as **short hospitalization stays**. Comments are due to MDCH by April 15, 2015.
- A proposed policy (**1512-Home Help**) has been issued that would provide **standards for Home Help agency providers** to qualify for **reimbursement at the agency rate**. Comments are due to MDCH by April 17, 2015.
- A proposed policy (**1505-Eligibility**) has been issued that would describe changes to **income and asset limits** and the **premium calculation methodology** for the **Freedom to Work** program. Comments are due to MDCH by April 28, 2015.
- A proposed policy (**1508-Pharmacy**) has been issued that would clarify **documentation requirements** for participating **Pharmacies** related to **inventory and purchase histories**. Comments are due to MDCH by April 28, 2015.

- A proposed policy (**1517-Eligibility**) has been issued that would add language to the **Bridges Eligibility Manual** clarifying Medicaid asset eligibility policy related to **purchase of an annuity solely for the benefit of a community spouse** (of a Medicaid beneficiary residing in a nursing facility). Comments are due to MDCH by April 29, 2015.
- A proposed policy (**1520-Eligibility**) has been issued that would add language to the **Bridges Eligibility and Administrative Manuals** to **disregard resources from estate recovery** equal to the amount of a Long-Term Care (LTC) insurance policy under the LTC partnership, paid to or on behalf of a Medicaid beneficiary. Comments are due to MDCH by April 30, 2015.

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

- **L 15-16** was released on March 4, 2015 to remind **Nursing Facilities** in regions included in the **MI Health Link** demonstration program that their **residents dually eligible for Medicare and Medicaid benefits** may have recently received a letter informing them of their **eligibility for, benefits of and right to program participation**. The letter explains the MI Health Link program and provides contact information should there be any questions.
- **L 15-15** was released on March 16, 2015 to remind **Hospice Providers** that **hospice is not a benefit offered by MI Health Link** - a demonstration program in certain regions of the state for Medicaid beneficiaries dually eligible for Medicare. The letter advises Hospice providers of **steps that should be taken to ensure that MI Health Link participants who elect hospice benefits begin receiving them without delay**.
- **L 15-21** was released on March 16, 2015 to remind **Home Health Agencies that HCPCS code G0154** (Direct Skilled Nursing Services of a Licensed Nurse in the Home Health Setting) **cannot be billed when a Medicaid beneficiary is receiving Private Duty Nursing Services** (HCPCS code T1000).
- **L 15-22** was released on March 16, 2015 to inform **Adult Home Help Services Providers** about the new program called **MI Health Link** and how it impacts them as providers of personal care services. The letter also provides contact information should there be any questions.
- **L 15-19** was released on March 18, 2015 to give notice of MDCH's intent to submit a State Plan Amendment to implement a **primary care health homes pilot** project in Michigan's Federally Qualified Health Centers in accordance with Section

2703 of the Affordable Care Act. The pilot project will be focused on **beneficiaries with at least one behavioral health condition and either the presence or risk of another chronic health condition**.

- **L 15-24** was released to selected Medicaid providers to inform them of a requirement in federal law applicable to any entity receiving at least **$5 million in Medicaid payments** during calendar year 2014. Such providers must **complete and submit to DCH** a form - **Certification of Compliance with Section 6032 of the Deficit Reduction Act (DRA) of 2005**. This provision in federal law relates to **employee education about false claims recovery**.

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