HEALTH MANAGEMENT ASSOCIATES

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MEDICAID MANAGED CARE ENROLLMENT ACTIVITY

As of April 1, 2019, there were **1,755,243 Medicaid beneficiaries, including 535,535 Healthy Michigan Plan (HMP) beneficiaries,** enrolled in the 11 Michigan Medicaid Health Plans (HMOs). As the table below shows, this is an overall **decrease of 6,229** since March 1, 2019. The number of HMP beneficiaries enrolled in HMOs decreased by 1,249, and the number of non-HMP enrollees decreased by 4,980. As the table also shows, the April enrollment total is more than 34,000 below the total for September 2018, but similar to the total for November 2018.

	Sept. 2018	Oct. 2018	Nov. 2018	Dec. 2018	Jan. 2019	Feb. 2019	March 2019	April 2019
All Medicaid Beneficiaries Enrolled	**1,789,450**	**1,777,481**	**1,755,709**	**1,750,668**	**1,751,429**	**1,765,189**	**1,761,472**	**1,755,243**
• Total HMP Enrollees	550,742	543,570	540,098	534,457	526,431	535,310	536,784	535,535
• Total CSHCS/Medicaid Enrollees	21,416	19,683	19,040	18,498	22,020	21,712	21,026	22,547
• Total Medicare/Medicaid Enrollees (Duals)	39,563	39,445	38,965	39,472	39,261	39,236	38,756	38,645
• Total MIChild Enrollees	34,873	35,043	34,847	35,079	36,448	35,423	35,860	36,074

The number of individuals identified as mandatory managed care enrollees but not yet enrolled in a Medicaid HMO has increased since mid-2018, from a low of 45,305 in July 2018 to 66,552 as of December 1, 2018. The number of individuals not yet enrolled in a health plan dramatically increased as of January 1, 2019, to 111,082, dropped to 70,307 as of February 1, 2019, increased again to 84,807 as of March 1, 2019, and dropped slightly, to 83,608, as of April 1, 2019.

As the enrollment reports for April (pdf, xls) reflect, every county in the state is served by at least one Medicaid HMO. Auto-assignment of beneficiaries into the HMOs is available in every county. In addition to the HMOs with smaller service areas, there are three HMOs – McLaren Health Plan, Meridian Health Plan of Michigan and Molina Healthcare of Michigan – authorized to serve all counties in the Lower Peninsula and a fourth – UnitedHealthcare Community Plan – authorized to serve all but three of the Lower Peninsula counties. Beneficiaries in all 15 counties in the Upper Peninsula are auto-assigned, through federal "Rural Exception" authority, to the one HMO serving these counties, Upper Peninsula Health Plan.

The plans with the highest total enrollment in April were Meridian Health Plan of Michigan with more than 28 percent of the total, Molina Healthcare of Michigan with 19 percent, and UnitedHealthcare Community Plan with more than 14 percent of the total number of enrollees.

Healthy Michigan Plan (HMP)

There were 535,535 HMP beneficiaries enrolled as of April 1, 2019 in the Medicaid HMOs. This is **an increase of 1,249 since March 1, 2019**; however, as the table above shows, the April count of enrollees is more than 15,000 below the count for September 2018. All Medicaid HMOs have HMP beneficiaries enrolled, although the numbers vary across plans. The plans with the highest enrollment in April were Meridian Health Plan of Michigan with more than 24 percent of the total, Molina Healthcare of Michigan with more than 16 percent, and Blue Cross Complete with more than 15 percent of the total enrollees.

CSHCS/Medicaid

The Michigan Department of Health and Human Services (MDHHS) 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. There were **22,547 joint CSHCS/Medicaid beneficiaries enrolled as of April 1, 2019** in the Medicaid HMOs, an **increase of 1,521 since March 1, 2019**.

All Medicaid HMOs have CSHCS/Medicaid enrollees, although the numbers vary across plans. The plans with the highest enrollment in April were Meridian Health Plan of Michigan with more than 23 percent of the total, Molina Healthcare of Michigan with almost 23 percent, and UnitedHealthcare Community Plan with more than 13 percent of the total enrollees.

MIChild

There were **36,074 MIChild beneficiaries enrolled as of April 1, 2019** in Medicaid HMOs. As the table above reflects, the number of enrolled MIChild beneficiaries **increased by 214 between March 1, 2019 and April 1, 2019.**

All Medicaid HMOs have MIChild beneficiaries enrolled, although the numbers vary dramatically across plans. The plans with the highest enrollment in April were Meridian Health Plan of Michigan with more than 29 percent of the total, Molina Healthcare of Michigan with almost 16 percent, and UnitedHealthcare Community Plan with almost 14 percent of the total enrollees.

Medicare/Medicaid

Aside from Michigan's Medicare/Medicaid financial alignment demonstration, MI Health Link, there were an additional **38,645 Medicaid beneficiaries dually eligible for Medicare (duals) enrolled as of April 1, 2019** in Medicaid HMOs for their acute care Medicaid benefits. As the table above reflects, the number of enrolled duals **decreased by 111 between March 1, 2019 and April 1, 2019.**

All Medicaid HMOs have duals enrolled, although the numbers vary significantly across plans. The plans with the highest enrollment in April were Meridian Health Plan of Michigan with 31 percent of the total, Molina Healthcare of Michigan with more than 24 percent, and McLaren Health Plan with more than 15 percent of the total enrollees.

For additional information, contact Eileen Ellis, Senior Fellow Emeritus, or 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, operates in four regions of the state. The entire Upper Peninsula is one region; eight counties in the southwest corner of the state (Barry, Berrien, Branch, Calhoun, Cass, Kalamazoo, St. Joseph, and Van Buren) form another region; and Macomb County and Wayne County are two single-county regions. Medicaid and Medicare physical health care services (including long-term services and supports) are provided by HMOs that have contracts as Integrated Care Organizations (ICOs) to serve the duals.

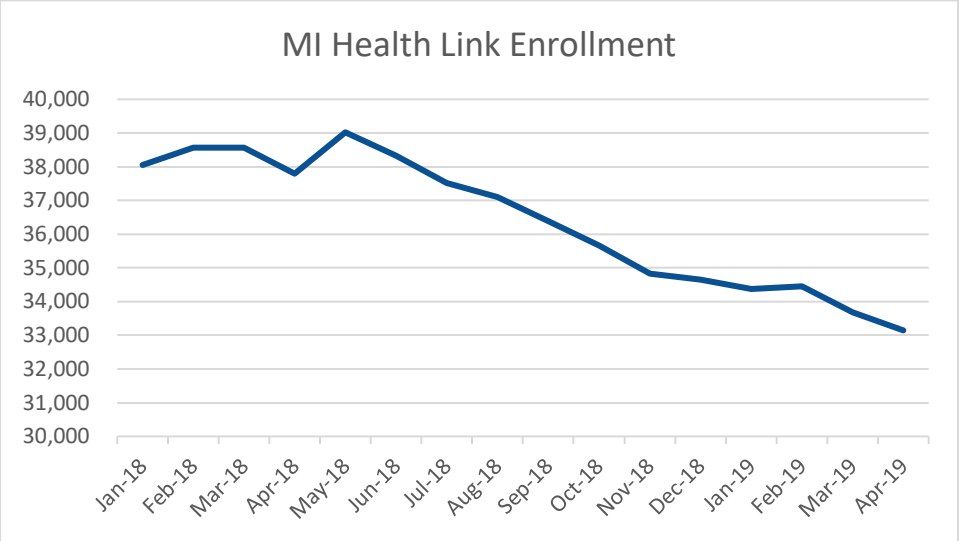
The number of MI Health Link enrollees continues to fluctuate, with increases in some months and decreases in others. The Michigan Department of Health and Human Services reports that **as of April 1, 2019, the MI Health Link enrollment total was 33,145, a decrease of 527 enrollees since March 1, 2019.**

The tables below illustrate the MI Health Link enrollment fluctuation by month during 2018 and early 2019. Note that the enrollment total for December 2018 was the lowest for the calendar year, more than 4,000 below the total for May, which was the highest monthly total for the year. The enrollment totals for January through April 2019 are all below totals for any month in 2018, and well below some of them.

Jan. 2018	Feb. 2018	March 2018	April 2018	May 2018	June 2018
38,045	38,571	38,562	37,798	39,021	38,327
July 2018	**August 2018**	**Sept. 2018**	**Oct. 2018**	**Nov. 2018**	**Dec. 2018**
37,518	37,103	36,394	35,651	34,827	34,655

Jan. 2019	Feb. 2019	March 2019	April 2019
34,367	34,444	33,672	33,145

The graph below shows the trend in MI Health Link enrollment since January 1, 2018.



There are seven ICOs serving one or more of the demonstration regions. The table below provides enrollment information by region for each ICO as of **April 1, 2019**.

MI Health Link Enrollment	Upper Pen. Region	SW MI Region	Macomb Region	Wayne Region	Total
Aetna Better Health of MI		2,834	699	2,581	6,114
AmeriHealth Michigan			522	1,930	2,452
HAP Empowered, Inc.			884	3,330	4,214
Meridian Health Plan of MI		4,699			4,699
MI Complete Health / Fidelis			412	1,633	2,045
Molina Healthcare of MI			1,688	8,155	9,843
Upper Peninsula Health Plan	3,778				3,778
Total	**3,778**	**7,533**	**4,205**	**17,629**	**33,145**

As of April 1, 2019, Molina Healthcare of Michigan had the most enrollees, both voluntarily and passively enrolled (30 percent of the combined total); Aetna Better Health of Michigan came in second with more than 18 percent; and Meridian Health Plan of Michigan was third with just over 14 percent of the total enrollees.

At present, a little more than 95 percent of the MI Health Link enrollees are living in a community setting, and a little less than 5 percent of the enrollees live in a nursing facility. Almost 6 percent of the total enrollees living in a community setting are receiving home and community-based long-term services and supports through the MI Health Link program waiver; however, a significant number of the other enrollees

living in a community setting receive in-home services and supports from the ICOs through the Medicaid State Plan personal care benefit.

While all plans have enrollees receiving care in nursing facilities, the Upper Peninsula Health Plan (UPHP) had the largest share during April 2019; almost 21 percent of the total enrollees residing in nursing facilities were part of UPHP. Molina Healthcare of Michigan placed second with 19 percent; and Aetna Better Health of Michigan came in third with 18 percent of the total enrollees residing in nursing facilities.

Although the majority of MI Health Link enrollees are passively enrolled, the percentage that voluntarily joined the demonstration has grown significantly over time. As of April 1, 2019, the voluntary enrollment percentage was 28.9.

MDHHS also reports that almost 60,000 duals eligible for participation in the demonstration have chosen to opt out. These individuals receive their Medicaid benefits on a fee-for-service basis but retain the option to voluntarily enroll in the demonstration at any time.

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

Three 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: Meridian Health Plan of Michigan, Molina Healthcare of Michigan, and UnitedHealthcare Community Plan. **As of April 1, 2019, these three D-SNPs had a combined enrollment of 21,948 duals** for whom they provide Medicare services.

About 56 percent of the duals enrolled in a Michigan D-SNP (12,287 individuals) in April 2019 are enrolled with Molina; almost 38 percent (8,268 duals) are enrolled with Meridian; and 1,393 duals are enrolled with United. None of these duals are participating in the MI Health Link demonstration. In addition to these three D-SNPs, beginning January 1, 2019, two additional health plans were approved as D-SNPs – Humana Medical Plan and Health Alliance Plan of Michigan (HAP). Humana had 211 enrollees as of April 1, 2019 but federal reports did not reflect any enrollees in April for HAP. The federal reports for 2019 also reflected an expanded service area in Michigan for Meridian.

Not all 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 additional information, contact Esther Reagan, Senior Consultant, at (517) 482-9236.

HEALTHY MICHIGAN PLAN ENROLLMENT

The Michigan Department of Health and Human Services reports enrollment counts for the Healthy Michigan Plan (HMP), its Medicaid expansion program for low-income non-elderly adults who do not meet eligibility criteria for traditional program coverage, at the beginning of each week on its website. Enrollment stood at **686,141 as of April 29, 2019**, the last counting day of the month. While this is 3,435 fewer enrollees than reported on the last Monday of March and 5,785 fewer enrollees than reported on the last Monday of February, it is higher than the "last Monday" enrollment numbers reported from June 2018 through January 2019.

Although the HMP caseload drops at the beginning of each month because of an annual eligibility redetermination requirement, it generally rebounds by the end of the month.

For additional information, contact Eileen Ellis, Senior Fellow Emeritus, or Esther Reagan, Senior Consultant, at (517) 482-9236.

CENTENE TO ACQUIRE WELLCARE

In the September 2018 edition of *The Michigan Update*, we reported that WellCare Health Plans, Inc. (WellCare) had completed its acquisition of Meridian Health Plan of Michigan, Inc., Meridian Health Plan of Illinois, Inc, and MeridianRx, a pharmacy benefit manager (collectively "Meridian").

On March 27, 2019, Centene Corporation and WellCare announced that Centene will acquire WellCare in a cash and stock transaction valued at $17.3 billion pursuant to terms of a definitive merger agreement. The transaction has been approved by the boards of both companies but will also require state regulatory review and approval. All reviews and approvals are anticipated to be completed during the first half of 2019. Upon completion of the transaction, if approved, Centene shareholders will own approximately 71 percent of the combined entity with WellCare shareholders owning approximately 29 percent.

The combined company will operate 31 NCQA accredited health plans across the country and serve more than 12 million Medicaid enrollees along with approximately 5 million Medicare enrollees. The company will operate a Medicare Prescription Drug Plan and will serve individuals enrolled in the Health Insurance Marketplace and the TRICARE program.

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

2019 KIDS COUNT DATA BOOK

The *2019 Kids Count in Michigan Data Book* was released April 23, 2019 by the Michigan League for Public Policy. For more than a quarter century, the Kids Count effort has evaluated the well-being of children in Michigan, looking at 16 key indicators across four domains: economic security, health and safety, family and community, and education.

This annual publication notes a significant increase in reported incidences of child abuse and neglect, with confirmed cases almost 30 percent higher in 2017 than in 2012. The report also notes that, while there was a drop of almost 21 percent in the child poverty rate between 2012 and 2017, there are still almost half a million children living in poverty in Michigan.

The percentage of pregnant women not receiving adequate prenatal care continues to rise, with an increase of 10.6 percent between 2012 and 2017. On a brighter note, there was a 30.9 percent reduction in teen births during this period, and the percentages of low-birthweight babies, infant mortality and child / teen deaths have remained about the same. In addition, although there has been a 16.6 percent drop in the rate of high school students not graduating on time, one in five still fails to do so. The report also notes that there are fewer children enrolled in preschool and fewer children in third grade proficient in reading.

It is still the case that children of color fare worse than White children for all of these indicators. More African American children are placed in foster care; African American babies are twice as likely to die before their first birthday as White babies; the infant mortality rate for Latinx babies has been increasing; and children of color are less likely to be proficient in reading by the third grade.

The report also ranks 82 of the 83 counties in the state for overall child well-being across 14 of the 16 measures (Keweenaw County lacked sufficient data). The top five counties for child well-being in 2019 (with highest ranked shown first) are Livingston, Clinton, Ottawa, Oakland, and Washtenaw. The bottom five counties in 2019 (with lowest ranked shown first) are Lake, Luce, Alcona, Schoolcraft, and Muskegon.

A printable publication with statewide data is available on the League's website; county-specific profiles can be generated.

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

NEW SUD TREATMENT WAIVER

On April 5, 2019, the Michigan Department of Health and Human Services announced that the Centers for Medicare & Medicaid Services had approved the state's application for a new Medicaid 1115 Demonstration Waiver for Substance Use Disorder (SUD) Services. The demonstration waiver will allow Michigan to broaden coverage of residential services in the state's existing network of SUD providers and to use Medicaid funding to pay for services in residential and withdrawal management treatment facilities that, without such waiver authority, would be excluded from federal Medicaid funding. Michigan will begin to provide services through this demonstration on October 1, 2019.

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

INNOVATIVE INTEGRATED CARE MODELS FOR DUALS

On April 24, 2019, the Centers for Medicare & Medicaid Services (CMS) announced release of a letter to State Medicaid Directors inviting them to partner with CMS to test innovative approaches to serving Medicaid beneficiaries dually eligible for Medicare (duals). The latest letter complements another letter released in December, which can be accessed via the announcement. The earlier letter suggested ten existing opportunities to integrate and improve care for duals. The new letter offers states three new opportunities to test state-driven approaches to integrating care for duals:

- A **capitated financial alignment model**, through which a full array of Medicare and Medicaid services is offered for a set capitated dollar amount.
- A **managed fee-for-service model**, that allows a state to share in Medicare savings from innovations where services are covered on a fee-for-service basis.
- A **state-specific model**, which could be a new innovative concept in a state that CMS would consider.

The announcement noted that these opportunities, as well as those available through the Primary Cares Initiative (see separate article in this newsletter), are intended to encourage states to work with CMS on transforming the health care delivery system for Medicare beneficiaries, including those who are dually eligible for Medicaid.

Michigan is one of the states currently operating a capitated financial alignment model – the MI Health Link program. The letter to State Medicaid Directors notes that, if certain criteria are met, CMS would be amenable to changing/expanding the geographic scope of the demonstration and/or extending the program. As indicated in the MI Health Link article in this newsletter, the current demonstration is available in four regions of the state, in a total of 25 counties. There are 83 counties in Michigan. At this time, we do not know whether the Michigan Department of Health and Human Services will choose to take advantage of the opportunity to modify the MI Health Link program.

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

PRIMARY CARES INITIATIVE

On April 22, 2019, US Department of Health and Human Services Secretary Alex Azar and Centers for Medicare & Medicaid Services (CMS) Administrator Seema Verma announced the **CMS Primary Cares Initiative**, a new set of payment models intended to transform primary care to deliver better value for Medicare beneficiaries while reducing administrative burdens on providers. The set of voluntary five-year payment options, that will reward value and quality by offering innovative payment structures other than volume-based fee-for-service, includes:

- Primary Care First
- Primary Care First – High Need Populations

- Direct Contracting – Global
- Direct Contracting – Professional
- Direct Contracting – Geographic

The Primary Care First models will focus on individual primary care practice sites serving a significant number of Medicare beneficiaries on a fee-for-service basis. The Direct Contracting models will focus on organizations with experience taking on financial risk and serving larger patient populations, such as Accountable Care Organizations, Medicare Advantage (MA) Plans, and Medicaid Managed Care Organizations (MCOs) that serve beneficiaries dually eligible for Medicare and Medicaid. The models are targeted to begin in January 2020 and will be offered in 26 regions across the country, including the entire state of **Michigan**. CMS will also encourage other payers – including MA Plans, commercial health insurers, Medicaid MCOs, and state Medicaid agencies – to align their payment, quality measurement, and data sharing with CMS in support of the initiative.

Included in the announcement are links to fact sheets with additional detail about the CMS Primary Cares Initiative. Note that CMS has not yet provided complete details on each of the models, but the agency has indicated that additional information will be provided through a Requests for Applications process which will begin in the coming months. One of the links in the announcement is to a Request for Information (RFI) on potential refinements for the Direct Contracting Geographic model, which will likely not launch until 2021. This model is contemplated to use a separate benchmarking methodology, based on historical fee-for-service spending, but this would be finalized based on responses to the RFI, which are due by May 23, 2019.

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

FEDERAL OIG TO FOCUS ON MEDICAID

The Office of Inspector General (OIG) in the US Department of Health and Human Services (HHS) recently updated its work plan to include a number of focus areas related to Medicaid. The work plan includes the following information:

- **Quality of Medicaid Encounter Data** – Although all states submit Transformed Medicaid Statistical Information System (T-MSIS) data, the OIG has consistently identified deficiencies in the quality of managed care encounter data, including inaccurate and missing information, which can render the data of limited use. The OIG will determine whether the encounter data for selected states contain the required elements and include the quality data needed to more effectively oversee the Medicaid program. The OIG will also determine what steps the states have taken to ensure that all required data elements are submitted to T-MSIS and identify any factors that contributed to data quality issues. This study will be based on a review of three to five states. [The states were not identified in the work plan.]

- **Review of State Uncompensated Care Pools** – Some state Medicaid agencies operate uncompensated care pools (UCPs) under Section 1115 waivers approved by HHS. The purpose of the UCPs is to pay providers for uncompensated cost incurred in caring for low-income (Medicaid and uninsured) patients. Through UCPs, states pay out hundreds of millions of dollars to providers and receive federal financial participation. However, in some states there has previously been little oversight of the payments. The OIG will determine whether selected states' Medicaid agencies made payments to hospitals under the UCPs that were in accordance with the terms and conditions of the waiver and with applicable federal regulations. [How many and which states will be reviewed was not specified in the work plan.]
- **Medicaid Managed Care Organization Denials** – The state Medicaid agency and the federal government are responsible for financial risk for the costs of Medicaid services. Managed care organizations (MCOs) contract with state Medicaid agencies to ensure that beneficiaries receive covered Medicaid services. The contractual arrangement shifts financial risk for the costs of Medicaid services from the state Medicaid agency and the federal government to the MCO, which can create an incentive to deny beneficiaries' access to covered services. The OIG will determine whether Medicaid MCOs complied with federal requirements when denying access to requested medical and dental services and drug prescriptions that required prior authorization.
- **Medicaid Personal Care Services** – Personal care services (PCS) is a Medicaid benefit for the elderly, people with disabilities, and people with chronic or temporary health conditions. These services assist them with activities of daily living and help them remain in their homes and communities. Examples of PCS include assistance with bathing, dressing, light housework, money management, meal preparation, and transportation. Prior OIG reviews identified significant problems with states' compliance with PCS requirements. Some reviews also showed that program safeguards intended to ensure medical necessity, patient safety, and quality, and prevent improper payments were often ineffective. The OIG will determine whether improvements have been made to the oversight and monitoring of PCS and whether those improvements have reduced the number of PCS claims not in compliance with federal and state requirements.
- **States' Compliance with FFS and MCO Provider Enrollment Requirements** – Provider enrollment is a key program integrity tool to protect Medicaid from fraudulent and abusive providers. The 21st Century Cures Act (the Cures Act) requires states to enroll all Medicaid providers, both those in Medicaid fee-for-service (FFS) and managed care organization (MCO) networks. This study, mandated by the Cures Act, will survey state Medicaid agencies about their enrollment of providers and implementation of required enrollment screening activities.

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

MEDICAID POLICIES

The Michigan Department of Health and Human Services (MDHHS) has released three final and three proposed policies that merit mention. They are available for review on the department's website.

- **MSA 19-05** advises **Bridges Eligibility Manual Holders** of clarified policy on **how to treat non-taxable annuity payments** for certain Medicaid eligibility groups.
- **MSA 19-08** informs **Practitioners, Durable Medical Equipment Providers, and Medicaid Health Plans** that effective May 1, 2019, **payment rules for osteogenesis stimulators** will change **from rental only to capped rental** (10 months of rental equals purchase).
- **MSA 19-09** notifies **Family Planning Clinics, Federally Qualified Health Centers, Hospitals, Practitioners** and others of **updated coverage policies for services** provided by licensed advanced practice registered nurses with the specialty certification of **Certified Nurse Midwife.**
- A proposed policy **(1910-Eligibility)** has been issued that would **modify Medicaid financial eligibility policy related to the treatment of promissory notes.** Comments are due to MDHHS by May 8, 2019.
- A proposed policy **(1908-Hospital)** has been issued that would, if a State Plan Amendment is approved by the federal government, **expand the Graduate Medical Education (GME) Innovations Sponsoring Institutions Program to include MIDOCS.** The GME MIDOCS program is supported by the state's medical schools and focuses on expanding residencies and retention efforts to address areas of the state where access to medical specialists is lacking. Comments are due to MDHHS by May 22, 2019.
- A proposed policy (**1909-Dental**) has been issued that would clarify Medicaid program **dental policy** related to the **use of nitrous oxide-oxygen sedation and locally administered anesthetics**. Comments are due to MDHHS by May 30, 2019.

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

- **L 19-09** was released April 18, 2019 as a notice to Tribal Chairs and Health Directors of the department's **intent to submit renewal applications** to the Centers for Medicare & Medicaid Services (CMS) for the **Children's Waiver** Program, the **Habilitation Supports** Waiver, and the **Waiver for Children with Serious Emotional Disturbances**. The letter also stated the department's **intent to submit a Section 1915(i) State Plan Amendment (SPA) for Community Support Services, an Alternative Benefit Plan SPA, and a Targeted Case Management SPA.**
- **L 19-16** was released April 18, 2019 as a notice to Tribal Chairs and Health Directors of the department's **intent to submit amendment applications** to CMS for the **Section 1115 Demonstration (Pathway to Integration)** and the **Comprehensive Health Care Plan for site implementation** associated with requirements in **Section 298** of Public Act 107 of 2017.

- **L 19-13** was released April 19, 2019 as a notice to Tribal Chairs and Health Directors of the department's **intent to submit a State Plan Amendment** to CMS to update the **reimbursement methodology for State Veterans' Homes** based on a change by CMS to the Skilled Nursing Facility Prospective Payment System methodology.
- **L 19-14** was released April 19, 2019 as a notice to Tribal Chairs and Health Directors of the department's **intent to submit a State Plan Amendment** to CMS to update **Medicaid nursing facility cost reporting audit and reimbursement processes** to comply with Michigan Public Act 612 of 2018 and to make various audit and reimbursement processes more efficient.
- **L 19-15** was released April 19, 2019 to **All Providers** as a reminder about the **symptoms** of and **Medicaid covered services** that are important in the **prevention and management of measles infections**.
- **L 19-10** was released April 23, 2019 to **Home Health Agencies**. The letter relates to policy released in May 2018 (**Bulletin MSA 18-12**) and serves to clarify the policy and notify providers of the department's intent to **review Medicaid claims and identify and recover any payments made to Medicaid providers found to be out of compliance with the policy.**

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

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