REPORT ON ALL POLICY CHANGES IMPLEMENTED

(FY2008 Appropriation Bill - Public Act 123 of 2007)

April 1, 2008

Section 215: (1) The department shall report no later than April 1, 2008 on each specific policy change made to implement a public act affecting the department that took effect during the prior calendar year to the house and senate appropriations subcommittees on the budget for the department, the joint committee on administrative rules, and the senate and house fiscal agencies. (2) Funds appropriated in part 1 shall not be used by the department to adopt a rule that will apply to a small business and that will have a disproportionate economic impact on small businesses because of the size of those businesses if the department fails to reduce the disproportionate economic impact of the rule on small businesses as provided under section 40 of the administrative procedures act of 1969, 1969 PA 306, MCL 24.240. (3) As used in this section: (a) "Rule" means that term as defined under section 7 of the administrative procedures act of 1969, 1969 PA 306, MCL 24.207. (b) "Small business" means that term as defined under section 7a of the administrative procedures act of 1969, 1969 PA 306, MCL 24.207a.

Michigan Department of Community Health

MDCH

Jennifer M. Granholm, Governor

Janet Olszewski, Director

MDCH REPORT TO THE LEGISLATURE
PURSUANT TO SECTION 215 OF P.A. 123 OF 2007

Accordingly, DCH policy changes undertaken to implement 2007 Public Acts include the following:

A. Quality Assurance Assessment Program (QAAP):
Background:
In recent years, Michigan established the Quality Assurance Assessment Program (QAAP) as a mechanism to leverage additional Medicaid matching funds. By doing so, it allowed the state to implement a Medicaid rate increase to hospitals, nursing homes, and managed care organizations. Implemented in 2002, this type of assessment to health care providers was able to finance an increase in the amount paid to Medicaid providers, while at the same time offsetting the state GF/GP revenues necessary to support the program.

The following Public Acts relate to QAAP revenue:

1. **P.A. 5** of 2007 amended MCL 333.20161 of the Public Health Code to specify that the actual amount of hospital QAAP revenue – the amount realized in FY 2005-06 - can be retained by the state.

   Activities to Date:
   Internal fiscal settlement; hospital QAAP retained, no policy change required.

2. **P.A. 85** of 2005 amended MCL 333.20161 of the Public Health Code that pertains to nursing facilities participation in the QAAP when delinquent assessments are levied. In addition to addressing QAAP payments, the Public Act requires that nursing home and hospital long-term care units who do not pay their debt will be ineligible to receive the increased per diem reimbursement rate from Medicaid.

   Activities to Date:
   The Department has a proposed policy draft to implement the provisions of P.A. 85 whereby the facility remains ineligible to receive the Quality Assurance Supplement (QAS) payment until a payment plan is worked out so that the delinquent QAAP assessment and penalty amounts will be paid. The Policy Bulletin is scheduled to be issued May 1, 2008 with an effective date of June 1, 2008 upon approval from CMS.

3. **P.A. 88 of 2007** amended MCL 500.224b of the Insurance Code to extend the date to October 1, 2008 for when the quality assurance assessment fee will no longer be assessed or collected.

   Activities to Date:
   The QAAP has continued on without a required policy change.

4. **P.A. 2 of 2007** amended MCL 18.1371 and 18.1395 of the Management and Budget Act concerning year-end appropriation expenditures, to clarify that a department must spend federal, state restricted, local or private funds appropriated only up to the levels actually received.

5. **P.A. 169 of 2007** amended MCL 18.1395 of the Management and Budget Act to provide for a technical change in how federal state restricted, local or private funding is accounted for in the state's accounting system.

   Activities to Date:
   With the release of policy bulletin MSA 07-42 issued August 2, 2007 (effective September 1, 2007), the Department reduced Quality Assurance Supplement payments to accommodate the state and federal share of the unpaid QAAP taxes.

B. Medicaid Incentives
P.A. 100 of 2007 added section 400.105b to the Social Welfare Act to require the Department of Community Health to do all of the following:

- Create incentives for medical assistance recipients who practice positive health behaviors. Those incentives could include expanded benefits and incentives on premiums, benefits or co-pays to get people to take better care of their health such as quitting smoking, losing weight, eating healthier and exercising
- Create pay-for-performance incentives for contracted Medicaid health maintenance organizations. The incentives would be for meeting health outcome targets for chronic diseases and patient compliance
- Establish a preferred product and service formulary program for durable medical equipment
- Provide financial support for electronic health records and prescriptions and other health information technology programs
- Include the incentive programs in federal waiver requests

Background:
MSA has had a contractor *performance bonus* process since 2002, financed through a capitation withhold. Plan performance in several clinical health target areas is compared to national benchmarks. The clinical indicators include measures of preventive care for children and women, as well as measures of chronic care management for selected conditions (i.e. diabetes and asthma.) MSA has expanded the FY 08 health plan performance incentive to include additional measures related to tobacco cessation strategies and management of persons with high blood pressure.

Activities to Date:
The Medical Services Administration (MSA) has taken initial steps toward the implementation of the P.A. 100 requirements. All contracted Medicaid HMOs are required to submit descriptive information by June 30, 2008 which summarizes beneficiary incentives currently in place for healthy behaviors in accordance with PA 100. MSA is developing a process to assess beneficiary reported information regarding

specific lifestyle factors at the time of enrollment. The data will be reported to the health plans and they will be required to target beneficiaries for wellness and prevention programs and other services based on individual risk. Specifics will include member incentives, health coaches and other evidenced-based incentives for healthy behaviors.

C. Durable Medical Equipment

P.A. 100 also requires the establishment of a preferred product and service formulary program for durable medical equipment.

Background:

Section 1735 of P.A. 330 of 2006 (DCH appropriation bill for FY 2006-07) required that the Department establish a committee to identify possible Medicaid program savings associated with the creation of a preferred provider program – or alternative program – for durable medical equipment, prosthetics, and orthotics (DMEPOS). Section 1735 further required the department to report the Senate and House or representatives subcommittees on community health, the state budget director, and the department on possible durable medical equipment contracting opportunities and anticipated Medicaid savings.

On April 1, 2007 the Department completed and submitted the required report on DMEPOS purchasing arrangement options. (*Report attached).* The committee considered 5 proposed options in addition to implementations of other activities. One of the activities considered is the Centers for Medicare and Medicaid Services (CMS) and the current Medicaid Health Plans DMEPOS contracts.

Activities to Date:

The final April 1, 2007 report from the committee indicated preference for any option that would preserve established provider network and access for beneficiaries, and recommends monitoring of DMEPOS proposals to determine the value of reimbursement revisions. Similar to the requirement of P.A. 100 of 2007, the committee reviewed CMS's intention to phase in implementation of the Medicare DMEPOS Competitive Bidding Program for certain covered items in select areas in 2007, which included Detroit. After implementation, results from the CMS bidding program will be used to determine prices for certain DMEPOS covered by Medicare Part B, and reduce reimbursement to coincide with a competitive market. It was determined by the Department to wait for the Medicare pricing results before pursuing any reimbursement change.

D. Estate Recovery

P.A. 73 of 2007 amended MCL 700.3805 of the Estates and Protected Individuals Code to require payment from descendant's estate in accordance with the estate recovery program for Medicaid.

P.A. 74 of 2007 added sections to the Social Welfare Act (400.1 to 400.119b) to require DCH to work with state and federal departments to review options for the development of a voluntary estate recovery program.

Background:
Since 1993, federal law has required states to recover some Medicaid expenditures from the estates of deceased Medicaid recipients. The federal law requires that states pursue the recovery of Medicaid expenditures made to a nursing home or hospital, home-based long term care and for prescription drugs. States that require legislative action were given until December 31, 1994 to implement the law. While 49 states have such programs, Michigan is the only state that does not. As a result, the Centers for Medicaid and State Operations (CMS) has recently notified the state that Michigan is not in compliance with such enabling legislation, and a recommendation to the Administrator will be made to initiate compliance action.

Activities to Date:
A State Plan amendment (SPA) for an Estate Recovery program was submitted to the Centers for Medicare and Medicaid Services (CMS) on December 21, 2007 with a requested effective date of October 1, 2007. CMS acknowledged receipt of the requested amendment and on February 6, 2008 sent an informal Request for Additional Information (RAI) followed by a formal request dated 3/5/08.

The Department's Medical Services Administration (MSA) has formed a work-group to develop the amendment to be in line with both the State legislation and Federal regulations. With 90 days to respond (6/3/08), the work-group is in the process of responding to CMS' questions and comments. In developing the program amendment in conjunction with CMS, MSA is also developing policy. Upon receipt of our response to the RAI, CMS will have 90 days to approve or deny the amendment. If approved, the Department expects to have a target implementation date of 10-1-09.

E. Health Disparities
P.A. 653 of 2006 effective January 9, 2007 added section 333.2227 to the Public Health Code to require the Department to take specified actions to address racial and ethnic health disparities in this state, and to submit to the Legislature an annual report on the bill's impact. Under P.A. 653 the Department must:

- Develop and implement a structure to address racial and ethnic health disparities in this state
- Monitor minority health progress
- Establish minority health policy
- Develop and implement an effective statewide strategic plan for the reduction of racial and ethnic health disparities
- Utilize federal, state, and private resources, as available and within the limits of appropriations, to fund minority health programs, research, and other initiatives.
- Promote the development and networking of minority health coalitions
- Identify and assist in the implementation of culturally and linguistically appropriate health promotion and disease prevention programs that would emphasize prevention and incorporate an accessible, affordable, and acceptable early detection and intervention component

Background:
The Department currently devotes financial and administrative resources to address disparities in health outcomes for racial and ethnic minorities. These efforts are largely coordinated through the Health Disparities Reduction and Minority Health Section of the Department of Community Health. Roughly $1.5 million gross and $900,000 in state funds (Healthy Michigan Fund) are devoted to reducing health disparities in Michigan. The Department must devote additional staff and financial resources to fulfill P.A. 653. Resources are needed to provide data, support and outreach to community organizations, create a web page, and fulfill reporting requirements.

Activities to Date:
The 2007 Minority Health Report was completed on February 20, 2008. It offers a comprehensive review of work to date taken by the Department Bureaus and Administrations to diminish health disparities among Michigan's racial and ethnic populations. Each subject matter raised in the legislation is outlined in the report, and is followed by a descriptive summary of program activities related to that subject matter.

This report will soon be made available to all interested parties through the MDCH website (http://www.michigan.gov/mdch/0,1607,7-132-2940_2955_2985---,00.html).

F. Breast Cancer Prevention and Treatment
Under P.A. 134 of 2007, the Amanda's Fund for Breast Cancer Prevention and Treatment is created in the Department to expand the breast and cervical cancer program implemented in 1991 under a grant from the federal Centers for Disease Control and Prevention.

Background:
P.A. 133 of 2007 amended the Income Tax Act to allow an individual to designate on his or her annual tax return to allow for four new income tax check-offs. Beginning in the 2008 tax year, taxpayers are allowed to contribute at $5, $10, or more of an income tax refund to the Prostate Cancer Research Fund; Amanda's Fund for Breast Cancer Research; the Animal Welfare Fund; and the Michigan Housing and Community Development Fund. Three of these funds were created in separate public acts.

P.A. 134 permits expanded access to certain women for cancer screening services and follow-up care, and to provide direct services to current program participants. Under P.A. 134, DCH is to:

- Support the development of a statewide breast cancer research plan.
- Provide information to the public about the value of breast cancer research and early detection.
- Develop and publicize criteria for proposals to be funded under the bill.
- Review and approve proposals to be funded.

Activities to Date:
In order to implement activities related to the fund, the Department of Treasury must first create a schedule of the specified contribution designations (check-offs) to include as part of the 2008 annual income tax return form. DCH is not able to disperse from the fund until 2008 tax year check-off contributions are received from the Department of Treasury in 2009.

G. Body Art Facilities
P.A. 149 of 2007 amended MCL 333.13101 of the Public Health Code and added sections to require the department to establish a new class of health facility called *Body Art Facility* and require all tattooing, branding and body piercing to occur at such licensed facilities.

Background:
P.A. 149 was effective December 13, 2007. However, as of January 1, 2009, a person cannot engage in tattooing, branding or body piercing for compensation unless these activities occur in a licensed facility.

Activities to Date:
The Department's Bureau of Epidemiology staff solicited recommendations and finalized names of local health department staff to form a working group to implement this Act. The workgroup had its first meeting in February to begin to outline mutual issues related to the Act's implementation. The next meeting is scheduled for April 17, 2008. A survey has been sent to local health departments to estimate the number of body art facilities in their jurisdiction. A Bureau staff person has moved from part-time to full time work with the extra hours being spent on implementation of the Act. The added hours are being funded based on anticipation of future licensing revenues that are expected in fiscal year 2008. Bureau staff has also had discussions with the Bureau of Health Professional Licensing to determine whether or not a body art facility licensing module could be added to their electronic licensing application system.

H. Lead Jewelry
P.A. 162 of 2007 added sections MCL 333.5478 and MCL 333.5479 to the Public Health Code to add 7 more commission members to the Childhood Lead Commission. The Act also extended the sunset on the Michigan Childhood Lead Poisoning Prevention and Control Commission to July 1, 2010.

Background:
P.A. 162 was enacted along with three other Acts that amend the Public Health Code at MCL 333.1101 to 333.25211 and took effect on March 20, 2008:

- **P.A. 159 of 2007** prohibits the manufacture, sale or exchange of toys with lead content in excess of federal regulation
- **P.A. 160 of 2007** prohibits the sale of lead-based lunch boxes, and

- **P.A. 161 of 2007** prohibits a person from using or applying any such lead bearing substance in or on children's jewelry

Activities to Date:
Staff from the Bureaus of Epidemiology and of Family, Maternal and Child Health met to review and submit recommendations for additional Lead Commission members to the Governor's office. Members were scheduled to be appointed on March 13, 2008.

Activities related to toys, jewelry, etc., involve educating the public by screening for lead in toys at various home building shows. Information on lead contaminated items, including recalls has also been included on the Department's web site.

I. Single Point of Entry
P.A. 634 of 2006 authorized MDCH to conduct a Single Point of Entry (SPE) demonstration project to improve access and choices for using long term care services and supports. Effective on January 4 2007, Act 634 governs structure & operations of an SPE to include:

- Provide consumers unbiased information promoting consumer choice and understanding of all long term care options
- Access eligibility for all Medicaid long-term care programs
- Assist with necessary forms and documents to streamline Medicaid financial eligibility determination
- Develop a long-term care support plan using a person-centered planning process
- Authorize access to Medicaid programs for which the consumer is eligible as identified in their long term care supports plan
- Upon request, facilitate needed transition services for consumers living in long-term care settings

Background:
The demonstration project is also known as Long Term Care Connection (LTCC). Accordingly, the Department has designated four pilot regional LTCC agencies that encompass thirty-four Michigan counties and portions of Wayne County. Activities related to Level of Care Determination and the MI Choice waiting list were detailed with the release of Policy Bulletin MSA 07-45 effective November 1, 2007. These four demonstration sites cover 52% of the population, and serve as access points by providing information and referral for all long term care options, services and supports.

Activities to Date:
Demonstration projects across the state are currently running. The SPE indicators of activity performed from January 2007 through January 2008 include the following:

- Information & Assistance 29,500
- Options Counseling Cases 6,500
- Assisted with transition from

Nursing Facility Residence	100
• Level of Care Determinations	3,000
• Resource Data Base	3,500

J. Foreign Nurse Licensing

P.A. 19 of 2007 that added MCL 333.17213 to the Public Health Code provides for licensure of graduates from a nursing education program outside the United States who do not have a certificate from the Commission on Graduates of Foreign Nursing Schools.

Background:

Prior to passage of P.A. 19, a foreign-educated nurse that applied for a Michigan RN license and taken and passed the NCLEX credentialing exam in another state, he/she must have held an active license or registration for at least five years in another state, have no previous disciplinary action, submit CGFNS credentialing information and demonstrate English proficiency. Because the CGFNS qualifying exam is only offered four times each year, foreign-educated nurses have experienced very lengthy delays in being scheduled to take this exam. P.A. 19 of 2007 added section 333.17213 to provide for licensure of graduates from a nursing education program outside the United States who do not have a certificate from the Commission on Graduates of Foreign Nursing Schools. While the graduates still must have their education evaluated by CGFNS for equivalency, the qualifying examination is no longer required.

Activities to Date:

By September 1, 2007, the DCH Bureau of Health Professions had amended the current application and modified the process to accommodate foreign nurses that are affected with passage of P.A. 19.

K. Mental Health

P.A. 112 of 2007 amends MCL 330.2003 of the Mental Health Code to allow the Department of Corrections to contract with the Department <u>or</u> third-party providers to operate the corrections mental health program.

Background:

Prior to passage of P.A. 112, the Department was *both* the provider and overseer of the mental health services provided to prisoners. The Department will no longer be required to fulfill these functions, as a third party provider may be chosen for one or more of the functions.

Activities to Date:

The Department has convened a DCH-DOC Mental Health Workgroup to develop enhanced methods to identify prisoners with mental health issues. The focus areas for this workgroup are: Pre-Prison, Intake, Incarceration, and Preparation for Release/Aftercare. As of this date, the two departments are in the process of scheduling a meeting to iron out the finalized language for an updated interdepartmental contract.