TO BILL, OR NOT TO BILL MEDICAID…THAT IS THE QUESTION

Early On Conference
November 12, 2015
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OBJECTIVES FOR TODAY

1. Provide introductory information on how Medicaid services can be billed for Early On.
2. Provide a description of how EO personnel are, and which personnel, are identified as eligible to bill for Medicaid.
3. Provide information on what EO services can be billed to Medicaid.
4. Explain at least three advantages of a district billing Medicaid for Early On services.
5. Describe the similarities, if any, between the education and certification/licensure requirements for EO personnel and those of the Michigan Medicaid program.
6. List at least four EO services that can be billed to the Michigan Medicaid program.

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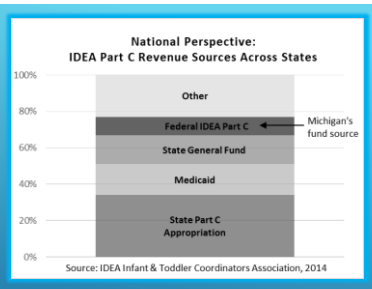

In 2014, the national Infant and Toddler Coordinators Association conducted a finance study surveying all states on how they finance their IDEA Part C services. That study found that nationally, Medicaid is the second largest source of revenue for IDEA Part C services, and state appropriations ranked first. Neither of these are a factor in Michigan: Medicaid is not utilized fully and NO $$ is appropriated by the legislature. In fact, the three largest sources of revenue for IDEA Part C across the states do not currently support *Early On* in Michigan.

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MEDICAID OVERVIEW
Jane Reagan, MDE

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WHAT IS MEDICAID?

- **NOT Medicare** (for persons over 65; mostly federally funded by appropriations, your earnings taxes, member premiums/deductibles; growing fast as baby boomers reach 65); 45million enrollees
- **Medicaid**
  - For low-income families, including children; over 62 million enrollees; largest health care program in US
  - Jointly funded by State and Federal governments to pay for health care and long term care assistance

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HOW MEDICAID WORKS

- Incredibly complex statute, regulations, enforcement, like IDEA!
- Costs shared between state and federal govt.
  - Federal government pays between 50-80%
  - Federal share formula: state's per capita income, other factors
  - Federal share for Michigan:
    - 1998 53.58%
    - 2009 60.27%
    - 2010 73.27% (ARRA bumped up everyone for 2 yrs)
    - 2011 71.24% avg.
    - 2014 66.32%
    - 2015 66.54%

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Each state has its own Medicaid program

- Much discretion by states
- Each state administers, establishes: What (services covered), Who (eligibility standards), How Much (scope of services), Payment (method and amount of payment for services) and, **the State expects you to know their rules**
- Some services are mandatory (NHs, physician) some services are optional (SBS, Rx, dental)
- When services provided, Medicaid is "billed" $100, Dr., hospital, etc. receive $100 ($66 federal, $34 MI)
- School administrators, staff need to know BOTH Special Education AND Medicaid requirements!

HOW REGULAR MEDICAID WORKS

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- Took an Act of Congress, 1988, MI began 1993
  - To reimburse for some ISD costs for some Medicaid-eligible students with IEPs or IFSPs for some health-related services
- For SBS program, reimbursement is different
- ISDs are paid only federal share of Medicaid $$ coming to state
  - Rationale: school aid (state general fund) is the 'state match'
  - In MI, Federal $ are split 60% to ISDs, 40% to MI Medicaid
  - **Medicaid reimburses only for expenditures from state or local sources—never bill Medicaid for federally-funded services**
- SBS program brings federal Medicaid $ to MI
  - Your costs are $100, you'll receive ~ $36

HOW MEDICAID SBS WORKS

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- Two components based on Federal Medicaid statute (Social Security Act) and its regulations (42 CFR), also state laws, rules, published guidelines
  - **Direct (Related) Services** –OT, O & M, PT, SLP, Psych, Counseling, SW, Dev Testing, RN, MD/DO, PC, TCM (aka service coordination), Transportation
  - **Administrative Outreach Program** (AOP)—helping families access Medicaid services via referral, planning, monitoring, coordinating program, etc.)

MI MEDICAID SBS PROGRAM

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- Four statewide time studies (12,200 moments/3 months) to measure staff time spent doing services Medicaid pays:
  - Administrative Outreach
  - Targeted Case Management (service coordination)
  - Personal Care (para professional, aide)
  - Direct Services (related services by clinicians)
- Financial information of staff (salaries, benefits)
- Annual cost report (MAER) is ISD/LEA specific
- Your partners—DCH (Medicaid); MDE; ISDs; PCG (statewide contractor for time studies)

MI MEDICAID SBS PROGRAM 10

QUESTIONS?

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MORE ABOUT MEDICAID SCHOOL BASED SERVICES

Mike Grasseschi, PCG

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- **Reimbursement Formula**
  - Allowable Costs (includes ISD Medicaid ICR from MDE)
  - x Time Study Results: %, statewide
  - x SE Medicaid Eligibility Rate, health services (ISD)
  - x Federal Share (66.54% in 2015)
  - x ISD Reimbursement Rate (60%)
  - = Net Dollars to ISD
- ISD staff can impact just one of these factors—time study results; 'compliance' been decreasing

MI MEDICAID SBS PROGRAM 13

	Jul-Sept 2011	Oct-Dec 2011	Jan-Mar 2012	Apr-Jun 2012	Annual	Jul-Sept 2012
AOP	1.45%	3.39%	2.30%	1.65%		3.06%
Direct Service	55.24%	62.79%	65.88%	68.44%	**74.14%**	65.60%
TCM	5.07%	5.37%	5.03%	4.44%	**5.80%**	2.70%
Personal Care	14.83%	22.30%	20.34%	18.42%	**22.00%**	23.40%

Above rates do not include allocation for general administration

MEDICAID TIME STUDY RESULTS 14

	Direct Service		Targeted Case Management		Personal Care	
2008-09	68.10%		8.02%		19.99%	
2009-10	77.74%	+ 14.2%	10.97%	+ 36.8%	31.17%	+ 55.9%
2010-11	72.41%	- 6.9%	9.02%	- 17.80%	20.94%	- 32.8%
2011-12	74.14%	+ 2.4%	5.80%	- 35.70%	22.00%	+ 5.1%
2012-13	75.64%	+ 1.5	4.37%	-1.43	22.11%	+ 0.11

Above rates include allocation for general administration

MI MEDICAID TIME STUDY-ANNUAL RESULTS 15

- Every Time Study Counts in MI: STATEWIDE results
- Make sure the right people are participating in Medicaid billing/time studies
  - Are they doing Medicaid-covered services or grading papers?
  - Are they state-local funded?
  - Who is assigned to bill Medicaid WILL impact revenue
- ALL Time Studies must be completed—**only have 5 days**—if not completed, decreases % results
  - Medicaid SBS Coordinator needs support: Special Education Director= ***Enforcer***
  - Be part of reminders: *staff > supervisor > > superintendent*
- Staff must be trained initially and periodically WHY and how to complete the time study questionnaires

ROLES OF ISD ADMINISTRATORS/STAFF

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Federal

- Payment Error Rate Measurement (PERM) Audits
  - Results are used to produce Nat'l and State-specific error rates
  - If selected in 3 yr cycle, letter will come to ISD from federal Medicaid (Centers for Medicare and Medicaid Services)
  - If more documentation needed, ISD would be contacted directly, or no further communication
- OIG (Office of Inspector General from fed HHS)
- **Many more**

State

- Common Findings
- Missing Documentation
  - ISDs/LEAs must cooperate fully with any auditor's request
  - Records (IFSP, clinicians', not available (must keep for 7 years)
- Records/notes did not support a student was in attendance
  - Contradicting documentation supporting attendance does not supersede the official attendance records
- Inadequate "Progress" Notes

AUDITS

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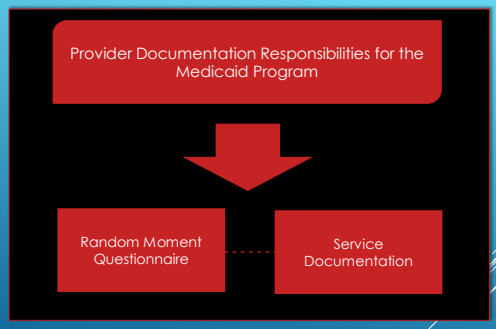

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The Random Moment Time Study (RMTS) is an important component in determining the Medicaid reimbursement to your ISD

- Each quarter, 12,200 moments are randomly-selected statewide (July-September: 3,200)
- Staff are notified prior to the date of the moment via e-mail or paper with a link to the RMTS website
- Once the moment has passed, staff members click on the link and answer the following questions:
  - Who was with you?
  - What were you doing?
  - Why were you doing it?
  - Does the student have an IEP/IFSP in place for the services you were performing?
  - Are you the student's case manager (case management pool only)?
- Staff members must describe what activity they were doing during the moment and how it applied to what is prescribed in the IEP/IFSP as well as to the medically-related service

RANDOM MOMENT TIME STUDY

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Treatment Plan (IFSP)	• Must contain medically related outcomes/goals that are measurable and time related • Service must be written with frequency and duration to achieve the goals (not consultative or "as needed")
Provider Qualifications	• Medicaid requirements may be different from school requirements • Service must be performed by the qualified staff (not the family or other staff)
Physician Authorization	• Needed annually for OT, PT, O&M, Nursing, Speech
Service Log Documentation	• Must be able to recreate the service based on the service log notes
Parental Consent to bill for Medicaid	• One-time signature plus annual notice

MEDICAID REQUIREMENTS

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Clarity:

- The service logs or provider notes should be understandable by someone who may not be in the service profession, such as an auditor
- The service logs should be specific enough to individualize and recreate the service

Content:

- Logs should indicate the students progress toward the IFSP outcome they are working toward
- Logs should be able to answer the following questions
  - What was done?
  - How did the student respond?
- Logs should not be repeated or copied for multiple services or multiple students

SERVICE LOG CRITERIA

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- Provider/Service notes are crucial in determining what actually occurred on the date of service and the results of the service
- Provider/Service notes should be documented well enough that individuals with basic knowledge would be able to answer questions such as:
  - ¨ Who was providing and receiving the service?
  - ¨ Is the student making progress? (Should new goals be made?)
  - ¨ How does the service relate to IEP goals and how are they measured

PROVIDER/SERVICE NOTES

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- Vague examples:

  Student is making steady progress toward goals

  Some progress toward objective

- Good example:

Student arrived on time and appeared ready to begin therapy. He produced /s/ in all positions during conversational speech with minimal auditory cueing. His progress on /s/ production objectives suggests he is beginning to master this skill. Plan to remove all cueing during /s/ activity to see if successful production can be maintained.

PROVIDER SERVICE NOTES

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- Good Example

Student was seen in the classroom to work on fine motor skills to prepare for scissors. She worked on a fruit loop bracelet activity for 20 minutes. She used tongs (in preparation for scissors) to pull 15 fruit loops out of the cup one at a time and then place each one over a pipe cleaner. 5 verbal cues were required for task completion. She manipulates tongs well and exhibits a good awareness of positioning of tongs within her hands, which is an indicator that proper scissor use will be attained soon. Continue prehension activities 1 time a week until proper scissor use goal is achieved.

PROVIDER SERVICE NOTES

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QUESTIONS?

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SERVICE PROVIDER QUALIFICATIONS

Nicole LaRue, Ingham ISD

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PROVIDER QUALIFICATIONS – LIMITED LICENSE

- **UNDER THE DIRECTION OF – OTA, PTA, Limited License Speech Pathologist**
  - Certain specified services may be provided under the direction of another clinician. For the supervising clinician, "under the direction of" means that the clinician is supervising the individual's care which, at a minimum, includes:
    - seeing the individual initially,
    - prescribing the type of care to be provided,
    - reviewing the need for continued services throughout treatment,
    - assuring professional responsibility for services provided,
    - and ensuring that all services are medically necessary.
  - "Under the direction of" requires face-to-face contact by the clinician at least at the beginning of treatment and periodically thereafter.

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- **UNDER THE SUPERVISION OF – Limited license social worker, psychologist**
  - Certain specified services may be provided under the supervision of another clinician. "Supervision of" limited-licensed mental health professionals consists of the practitioner meeting regularly with another professional, at an interval described within the professional administrative rules, to discuss casework and other professional issues in a structured way (this is often known as clinical or counseling supervision or consultation).
  - The purpose is to assist the practitioner to learn from his or her experience and expertise, as well as to ensure good service to the client or patient.

PROVIDER QUALIFICATIONS – LIMITED LICENSE

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2.2 Occupational Therapy (Includes Orientation and Mobility Services and Assistive Technology Device Services)

2.2.A. Occupational Therapy Services

Definition	**Occupational Therapy:** Occupational therapy (OT) must be rehabilitative, active or restorative and designed to correct or compensate for a medical problem interfering with age-appropriate functional performance. Occupational therapy services must require the skills, knowledge, and education of a licensed occupational therapist, licensed occupational therapy assistant, or Orientation and Mobility specialist.
Prescription	Occupational therapy services must be prescribed by a physician and updated annually. A stamped physician signature is not acceptable.
Provider Qualifications	OT services may be reimbursed when provided by: • A licensed occupational therapist (OT); or • A licensed occupational therapy assistant (OTA) under the direction of a licensed occupational therapist (OT). NOTE: The OTA's services must follow the evaluation and treatment plan developed by the OT. The OT must supervise and monitor the OTA's performance with continuous assessment of the beneficiary's progress. All documentation must be reviewed and signed by the supervising OT.

OCCUPATIONAL THERAPY

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2.3 Physical Therapy Services (Includes Assistive Technology Device Services)

2.3.A. Physical Therapy Services

Definition	Physical therapy (PT) must be rehabilitative, active or restorative and designed to correct or compensate for a medical problem. Physical therapy services must require the skills, knowledge and education of a PT or PTA to provide therapy. Treatment is performed through the use of therapeutic exercises and rehabilitative procedures.
Prescription	Physical therapy services must be prescribed by a physician or licensed physician's assistant and updated annually. A stamped physician signature is not acceptable.
Provider Qualifications	PT services may be reimbursed when provided by: • A licensed physical therapist (PT); or • A licensed physical therapy assistant (PTA) under the direction of a licensed physical therapist (PT) (i.e., the PT supervises and monitors the PTA's performance with continuous assessment of the beneficiary's progress). All documentation must be reviewed and signed by the supervising PT.

PHYSICAL THERAPY

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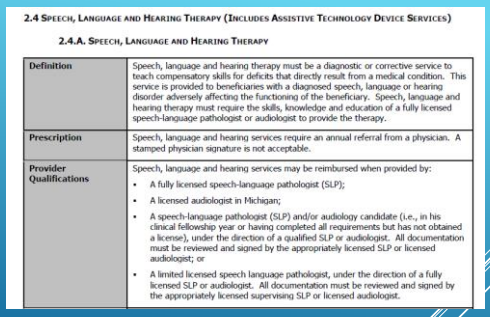

2.4 Speech, Language and Hearing Therapy (Includes Assistive Technology Device Services)

2.4.A. Speech, Language and Hearing Therapy

Definition	Speech, language and hearing therapy must be a diagnostic or corrective service to teach compensatory skills for deficits that directly result from a medical condition. This service is provided to beneficiaries with a diagnosed speech, language or hearing disorder adversely affecting the functioning of the beneficiary. Speech, language and hearing therapy must require the skills, knowledge and education of a fully licensed speech-language pathologist or audiologist to provide the therapy.
Prescription	Speech, language and hearing services require an annual referral from a physician. A stamped physician signature is not acceptable.
Provider Qualifications	Speech, language and hearing services may be reimbursed when provided by: • A fully licensed speech-language pathologist (SLP); • A licensed audiologist in Michigan; • A speech-language pathologist (SLP) and/or audiology candidate (i.e., in his clinical fellowship year or having completed all requirements but has not obtained a license), under the direction of a qualified SLP or audiologist. All documentation must be reviewed and signed by the appropriately licensed SLP or licensed audiologist; or • A limited licensed speech language pathologist, under the direction of a fully licensed SLP or audiologist. All documentation must be reviewed and signed by the appropriately licensed supervising SLP or licensed audiologist.

SPEECH PATHOLOGISTS AND AUDIOLOGISTS

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TARGETED CASE MANGEMENT/SERVICE COORDINATION

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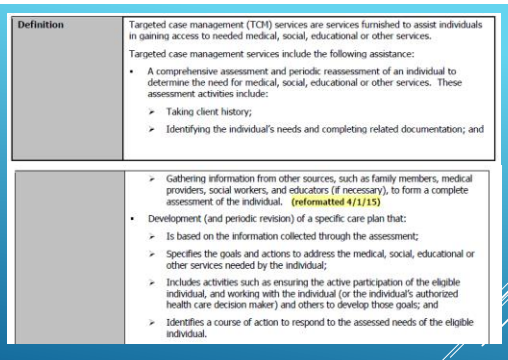

Definition	Targeted case management (TCM) services are services furnished to assist individuals in gaining access to needed medical, social, educational or other services. Targeted case management services include the following assistance: • A comprehensive assessment and periodic reassessment of an individual to determine the need for medical, social, educational or other services. These assessment activities include: ➢ Taking client history; ➢ Identifying the individual's needs and completing related documentation; and
	➢ Gathering information from other sources, such as family members, medical providers, social workers, and educators (if necessary), to form a complete assessment of the individual. **(reformatted 4/1/15)** • Development (and periodic revision) of a specific care plan that: ➢ Is based on the information collected through the assessment; ➢ Specifies the goals and actions to address the medical, social, educational or other services needed by the individual; ➢ Includes activities such as ensuring the active participation of the eligible individual, and working with the individual (or the individual's authorized health care decision maker) and others to develop those goals; and ➢ Identifies a course of action to respond to the assessed needs of the eligible individual.

TARGETED CASE MANAGEMENT

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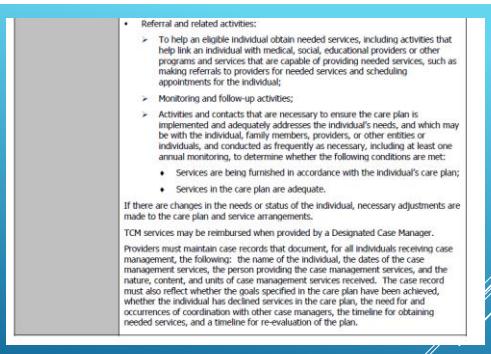


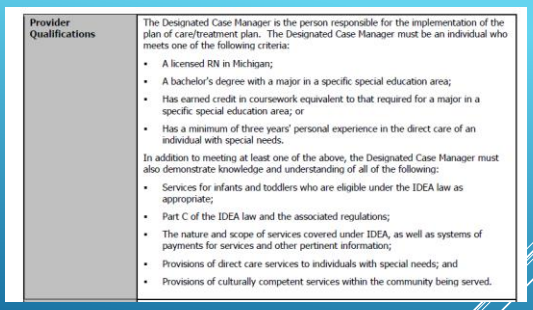
- Referral and related activities:
  - To help an eligible individual obtain needed services, including activities that help link an individual with medical, social, educational providers or other programs and services that are capable of providing needed services, such as making referrals to providers for needed services and scheduling appointments for the individual;
  - Monitoring and follow-up activities;
  - Activities and contacts that are necessary to ensure the care plan is implemented and adequately addresses the individual's needs, and which may be with the individual, family members, providers, or other entities or individuals, and conducted as frequently as necessary, including at least one annual monitoring, to determine whether the following conditions are met:
    - Services are being furnished in accordance with the individual's care plan;
    - Services in the care plan are adequate.

If there are changes in the needs or status of the individual, necessary adjustments are made to the care plan and service arrangements.

TCM services may be reimbursed when provided by a Designated Case Manager.

Providers must maintain case records that document, for all individuals receiving case management, the following: the name of the individual, the dates of the case management services, the person providing the case management services, and the nature, content, and units of case management services received. The case record must also reflect whether the goals specified in the care plan have been achieved, whether the individual has declined services in the care plan, the need for and occurrences of coordination with other case managers, the timeline for obtaining needed services, and a timeline for re-evaluation of the plan.

TARGETED CASE MANAGEMENT 34

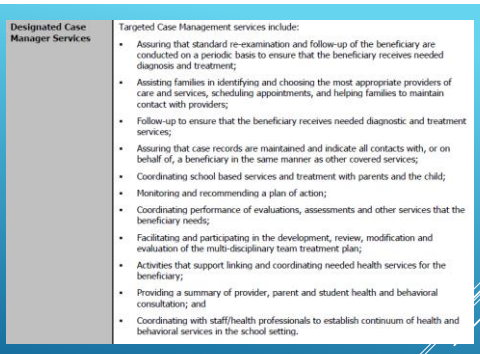


Provider Qualifications	The Designated Case Manager is the person responsible for the implementation of the plan of care/treatment plan. The Designated Case Manager must be an individual who meets one of the following criteria: • A licensed RN in Michigan; • A bachelor's degree with a major in a specific special education area; • Has earned credit in coursework equivalent to that required for a major in a specific special education area; or • Has a minimum of three years' personal experience in the direct care of an individual with special needs. In addition to meeting at least one of the above, the Designated Case Manager must also demonstrate knowledge and understanding of all of the following: • Services for infants and toddlers who are eligible under the IDEA law as appropriate; • Part C of the IDEA law and the associated regulations; • The nature and scope of services covered under IDEA, as well as systems of payments for services and other pertinent information; • Provisions of direct care services to individuals with special needs; and • Provisions of culturally competent services within the community being served.

TARGETED CASE MANAGEMENT 35

- Children with special needs have access to services available in both outpatient and school-based treatment settings. If treatment is provided in both settings, the goals and purpose for the two must be distinct.
- Collaboration between the school and the community providers is mandated to coordinate treatment, prevent duplication of services and to assure continuity of care to the Medicaid beneficiary. This collaboration may take the form of phone calls, written communication logs, or participation in team meetings such as the IEP/IFSP meeting.

SERVICE COORDINATION AND COLLABORATION 36



TARGETED CASE MANAGEMENT SERVICES

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- Assuring that standard **re-examination and follow-up** of the child are conducted on a periodic basis to ensure that the child receives needed diagnosis and treatment;
  - **Communication** with specialty clinics, therapists and audiologists,
- Assisting families in **identifying and choosing** the most appropriate providers of care and services, scheduling appointments, and helping families to maintain contact with providers;
  - Wrap around services
  - Service Coordination
  - Letters for Court (if family not meeting the needs related to service)
  - DHS/CPS
  - Connection to child care, therapy, health care clinics
  - Interpreting
- **Follow-up** to ensure that the child receives needed diagnostic and treatment services;
  - Communication with specialty clinics, therapists and audiologists

TARGETED CASE MANAGEMENT SERVICE EXAMPLES

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- Assuring that **case records are maintained** and indicate all contacts with, or on behalf of, a child in the same manner as other covered services;
- **Coordinating school based services and treatment** with parents and the child;
  - Arrange transportation for playgroups
  - Part C service requests
  - Review of IFSP to add/delete services/consultations
- **Monitoring and recommending** a plan of action;
  - IFSP meetings
  - Reviewing response to treatment
  - Discussing progress with therapists
- **Coordinating performance** of evaluations, assessments and other services that the child needs;
  - Communication and coordination activities regarding initial evaluations, annual evaluations, ongoing assessments and REEDs for children with health services

TARGETED CASE MANAGEMENT SERVICE EXAMPLES

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- **Facilitating and participating** in the development, review, modification and evaluation of the multi-disciplinary team IFSP;
- Activities that support **linking and coordinating** needed health services for the child;
  - Sharing evaluation and assessment reports
  - Sharing IFSPs
  - Communicating with developmental assessment clinics
  - Communicating with outside therapists
- **Providing a summary** of provider, parent and student health and behavioral consultation
  - 6 month and annual IFSP reviews
  - Other updates regarding services and progress
- **Coordinating with staff/health professionals** to establish continuum of health and behavioral services in the school setting.
  - Service Coordination and/or Part C service requests for 1 time consultations

TARGETED CASE MANAGEMENT SERVICE EXAMPLES

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- *Early On* providers tend to provide a broader range of services than a traditional school setting provider
- No matter how many different roles or responsibilities you have, Medicaid will only pay for **one category** of services, even though you may be providing more than one type. For example: a speech pathologist may be providing both clinical speech therapy and service coordination/case management. Medicaid will only pay for one of those, so the speech therapist may be directed to only log for Medicaid, his/her speech services.

POTENTIAL OBSTACLES

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QUESTIONS?

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How can some ISD's bill Medicaid for EO services and others say they can't? How do those service areas who want to try Medicaid billing proceed?

- Each ISD participates in the 22-year old MI Medicaid program. The special education director, business office and Medicaid SBS coordinator have very likely analyzed which LEAs and which program areas are best to be billing for Medicaid.
- Are Early On services paid for by state or local funds? If no, STOP.
- Are the Early On costs incurred by the ISD? If no, STOP.
- Does IFSP meet Medicaid criteria?
  - Is there a present level of education performance (PLEP/PLAAFP) type section? Is the IFSP written in 'family outcomes' language with no reference to child's disability, medical diagnoses, developmental delays stated?
- Are all therapies and services the child is receiving covered by Medicaid? NO, e.g., Medicaid does NOT cover nutritional counseling, music therapy.

QUESTIONS FROM EARLY ON® 43

Are there differences between clinical and education services eligible for Medicaid?

- Medicaid is like health insurance company and their national standard is, it only pays for 'medically necessary' services
- Medicaid likely has a difficult time understanding how schools or school-based programs can really, truly deliver real health care. National issue.
- The only difference is the *setting* between PT delivered in private clinic vs. a nursing home, vs. a school, vs. a child's home: still need a licensed PT
- Distinction is in documentation—well-written IFSP and clinician's notes will meet both IDEA and Medicaid criteria for the common ground of the programs

Does Medicaid focus on the type of service vs the outcomes and strategies? Or both? Should the outcomes be functional?

- Both. There are two parts to everything billed: the medical necessity and the delivery, including outcomes, that Medicaid calls 'progress'
- Medicaid verifies all this via CPA auditors who know little about health care special education or children with disabilities—all records must be understood

QUESTIONS FROM EARLY ON® 44

Related to Family Outcomes on an IFSP and Medicaid billing: We know we can't use 'parent report' or 'parent satisfaction' as a measure for child outcomes to bill for Medicaid. What can we use if the provider doesn't observe the child outcome?

- For every child with an IFSP who is receiving Medicaid covered services from licensed health professionals, (PT, OT, SLP), those professionals have developed 'medical' or 'traditional' outcomes for the services the child is receiving. Those are what Medicaid auditors are looking for. We know about the good intentions of family outcomes, but alone they do not meet Medicaid requirements. We recommend the clinicians/professionals involved with this child integrate their 'medical' outcomes somewhere in the IFSP to meet Medicaid documentation requirements. Otherwise, Medicaid will not pay for the services.

FAMILY OUTCOMES 45

Are there certain provider roles that get a higher reimbursement?

- Medicaid reimburses ISDs based on annual cost reports that contain these factors: salaries/benefits, time study results, indirect cost rate and number of Medicaid children/students in the district.
- So the higher the salaries, the higher the reimbursement. But what if the highly paid clinician or administrator never does anything Medicaid pays for? Time study results will be lower.
- Medicaid coordinator's role of determining *which staff should participate in Medicaid billing* then, is an art and a science! Must ask most important: WHO are the individuals providing the most Medicaid-covered services?

I understand families/children flow in and out of Medicaid eligibility; does this cause a lot of extra work for the provider and their documentation?

- In-and-out of Medicaid eligibility should not cause problems to the ISDs. First, eligibility checks are automated, and since 2007 the reimbursement to ISDs is based on an annual cost report, NOT a fee-for-service

QUESTIONS FROM EARLY ON®

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Can a child have special education Medicaid services and clinical/hospital Medicaid services at the same time?

- Yes. Example: child with IEP breaks her leg, will need non-IFSP services and Medicaid will pay for both AS LONG AS the child's HMO documents that the PT they're delivering is related to the broken leg

Who should be educating Michigan Medicaid about Early On?

- That's the job of ALL OF US– knowledge is power: state employees at MDE and MDHHS; ISD and LEA Early On Coordinators; Special Ed directors; business officials; and currently, the MI Medicaid folks are very open to learn

QUESTIONS FROM EARLY ON®

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1. Begin appropriating state dollars to support *Early On*.

2. Conduct a study to identify how Michigan can maximize federal Medicaid funds to support *Early On*.

RECOMMENDATIONS
FROM MICHIGAN'S CHILDREN

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RESOURCES

- www.Michigan.gov/MedicaidProviders
  - Policy and Forms (for 1800+ page provider manual—SBS is 100 pages within)
  - Reimbursement (for results of time studies)
- General Q about what is covered/required
  - Internal Medicaid Coordinator/Implementer to your ISD
- MDE
  - Jane Reagan (ReaganJ@michigan.gov) 517-335-2250
- PCG
  - Mike Grasseschi (mgrasseschi@pcgus.com 517-827-6112

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