MSA MEDICAL SERVICES ADMINISTRATION

Bulletin

Michigan Department of Community Health

Bulletin Number: MSA 14-11

Distribution: All Providers

Issued: February 27, 2014

Subject: Healthy Michigan Plan

Effective: April 1, 2014

Programs Affected: Healthy Michigan Plan, Adult Benefits Waiver

Note: Beneficiaries in the Adult Benefits Waiver will be transitioned to the Healthy Michigan Plan effective April 1, 2014. In mid-March, the Michigan Department of Community Health will announce when the eligibility system will be ready for others to apply for the program. For updated information on new enrollments, visit www.michigan.gov/healthymichiganplan.

The Healthy Michigan Plan is a new category of eligibility authorized under the Patient Protection and Affordable Care Act and Michigan Public Act 107 of 2013 that will begin April 1, 2014. The benefit design of the Healthy Michigan Plan ensures beneficiary access to quality health care, encourages utilization of high-value services, and promotes adoption of healthy behaviors. The purpose of this bulletin is to inform providers of this new eligibility category and to provide information regarding the services available to Healthy Michigan Plan beneficiaries. Currently enrolled providers are automatically providers for the Healthy Michigan Plan.

Eligibility

The Healthy Michigan Plan provides health care coverage for individuals who:

- Are age 19-64 years
- Have income at or below 133% of the federal poverty level under the Modified Adjusted Gross Income methodology
- Do not qualify for or are not enrolled in Medicare
- Do not qualify for or are not enrolled in other Medicaid programs
- Are not pregnant at the time of application
- Are residents of the State of Michigan

Eligibility for the Healthy Michigan Plan is determined through the Modified Adjusted Gross Income methodology, coordinated through the Department of Human Services. All criteria for the Modified Adjusted Gross Income eligibility must be met to be eligible for the Healthy Michigan Plan. Refer to bulletin MSA 13-35 for additional information on the Modified Adjusted Gross Income methodology.

A mihealth card will be mailed to the beneficiary when they become eligible for the Healthy Michigan Plan as long as the beneficiary was not previously issued a mihealth card. The beneficiary will also receive an additional health plan identification card when they enroll in a health plan. Prior to rendering services, providers must verify beneficiary Healthy Michigan Plan benefit coverage. The mihealth card does not contain eligibility information and does not guarantee eligibility. The provider can use the mihealth card to access a beneficiary's eligibility

information using the Community Health Automated Medicaid Processing System eligibility inquiry, directly or through a vendor, prior to rendering services.

The following new benefit plans have been added to identify beneficiaries with Healthy Michigan Plan coverage:

- MA-HMP (Healthy Michigan Plan)
- MA-HMP-MC (Healthy Michigan Plan Managed Care)
- MA-HMP-ESO (Healthy Michigan Plan Emergency Services Only)
- MA-HMP-INC (Healthy Michigan Plan Incarceration)

Transition of Current Adult Benefits Waiver Beneficiaries into the Healthy Michigan Plan

Current Adult Benefits Waiver beneficiaries will be automatically transitioned into the Healthy Michigan Plan effective April 1, 2014. Those who are currently Adult Benefits Waiver eligible will meet the financial requirements of this new plan, so no redetermination for this program will be necessary at the time of this transition.

Many Adult Benefits Waiver beneficiaries are expected to have existing provider relationships and treatment plans already in place. Health plans are required to honor prior authorizations in place at the time of enrollment until appropriate prior authorizations can be established by the beneficiary's chosen health plan without interruption of ongoing services. Health plans and Prepaid Inpatient Health Plans are working to assure there is continuity in the care provided to Adult Benefits Waiver beneficiaries who are receiving behavioral health services through a Prepaid Inpatient Health Plan as they are transitioned to the Healthy Michigan Plan.

Delivery System

All Healthy Michigan Plan beneficiaries, with the exception of some beneficiaries (e.g., Native Americans), are required to enroll into a health plan. Enrollees will select their health plan with assistance from MI Enrolls. In addition, behavioral health and substance use disorders will be administered in accordance with the current service delivery model.

Prior to enrollment into a health plan, beneficiaries will be eligible to receive Healthy Michigan Plan services through the fee-for-service system. Providers can submit claims through the Community Health Automated Medicaid Processing System.

Beneficiaries enrolled in a health plan will receive their dental coverage through the health plan. For those beneficiaries who are not enrolled in a health plan, dental services will be provided by currently enrolled dental providers on a fee-for-service basis. Beneficiaries who are 19 and 20 years old and are not enrolled in a health plan and who live in one of the "Healthy Kids Dental" participating counties will receive dental services from Delta Dental.

Healthy Michigan Plan beneficiaries are required to contact their primary care physician within 60 days of enrollment to schedule an appointment. When contacted by the beneficiary, providers are expected to make reasonable efforts to promptly schedule an initial appointment.

Health Risk Assessment

For Healthy Michigan Plan beneficiaries enrolled in a health plan, the Michigan Department of Community Health has developed a standard Health Risk Assessment to be completed annually. It will assess a broad range of health issues and behaviors including, but not limited to, the following:

- physical activity,
- nutrition,
- alcohol, tobacco, and substance use,
- mental health and
- flu vaccination.

Separate parts of the Health Risk Assessment will be completed by the beneficiary and the provider. The provider will return the completed Health Risk Assessment to the health plan.

The Healthy Michigan Plan rewards beneficiaries for addressing and maintaining behaviors necessary for improving health. Attestations from primary care providers are the basis upon which eligibility for reductions in cost-sharing is based. Beneficiaries will be eligible for reductions in cost-sharing only when a Health Risk Assessment is completed. More information on this process will be provided at a future date.

Health Plans – Beneficiary Cost Sharing Requirements

Beneficiaries enrolled in the Healthy Michigan Plan through a contracted health plan are required to satisfy cost-sharing contributions through a MI Health Account. Cost sharing requirements, which include co-pays and additional contributions based on a beneficiary's federal poverty level, will be monitored through the MI Health Account by the health plan. These requirements will begin after the beneficiary has been enrolled in a health plan for six months. Beneficiaries enrolled in a health plan will have the opportunity for reductions and/or elimination of cost sharing responsibilities to promote access to care if certain healthy behaviors are attained. If the amount contributed by the beneficiary is less than the amount due for a service received, the provider will still be paid in full for the services provided. Additional information about the MI Health Account will be provided at a future date.

Co-pay Requirements

Beneficiaries enrolled in a health plan are not responsible for co-pays at the point of service as long as the health care service is covered by the health plan. These costs will be tracked and collected from the beneficiary on a monthly basis. The total co-pay experience for the initial six months of services will be calculated and the average amount will be the beneficiary's monthly payment obligation. Average co-pay amount will be recalculated every six months. Healthy Michigan Plan services not covered by the beneficiary's health plan will be subject to co-pays, as listed in Table 1 below, and must be collected at the point of service.

Beneficiaries receiving services through the Healthy Michigan Plan will be responsible for the co-pays as stated in Table 1 below. There is no co-pay for the preventive services (described in the Covered Services section, Table 2) or for beneficiaries with select chronic conditions. Chronic conditions will be communicated by the health plan.

Table 1: Co-pays for Healthy Michigan Plan Beneficiaries

Covered Services	Co-pay
Physician Office Visits (including Free-Standing Urgent Care Centers)	$ 2
Outpatient Hospital Clinic Visit	$ 1
Emergency Room Visit for Non-Emergency Services • Co-pay ONLY applies to non-emergency services • There is no co-pay for true emergency services	$ 3
Inpatient Hospital Stay (with the exception of emergent admissions)	$ 50
Pharmacy	$ 1 generic $ 3 brand
Chiropractic Visits	$ 1
Dental Visits	$ 3
Hearing Aids	$ 3 per aid
Podiatric Visits	$ 2
Vision Visits	$ 2

Contribution Requirements

Beneficiaries at 100-133% of the federal poverty level are also required to pay a monthly contribution into a MI Health Account. This contribution will be required after the first six months of enrollment and will be based on 2% of their annual income. While beneficiaries have an obligation to contribute to their MI Health Account, they are not obligated to fully fund the account in order to receive needed healthcare services.

Covered Services

Table 2: Covered Services for Healthy Michigan Plan Beneficiaries

Healthy Michigan Plan Covered Services
Ambulatory patient services
• Primary care provider services • Specialist/Referral care services • Outpatient hospital services including Ambulatory Surgical Center services • Home health care services • Hospice care • Podiatry care • Chiropractic services
Emergency services
• Emergency room services • Emergency transportation/ambulance • Urgent Care Centers or facilities
Hospitalization
• Inpatient hospital services (e.g., hospital stay, physician and surgical services)
Maternity care
• Prenatal and postpartum care • Delivery and inpatient services for maternity care
Mental health and substance use disorder services, including behavioral health treatment
• Mental/behavioral health inpatient services • Mental/behavioral health outpatient services (includes treatment in approved residential programs, peer delivered supports and services, and other program defined community based services) • Substance use disorder inpatient services (acute detoxification in medical setting) • Substance use disorder outpatient services (includes treatment in approved residential programs, peer delivered supports and services, and other program defined community based services)
Prescription drugs
• Prescription drugs and supplies (Refer to the Michigan Department of Community Health website (http://www.michigan.gov/mdch) and to the Pharmacy Benefits Manager website (https://michigan.fhsc.com) for lists of prescription drugs that are carved-out of health plans. Providers must collect co-pays for these carved-out drugs at the point-of-sale.)
Rehabilitative and habilitative* services and devices
• Inpatient rehabilitation services • Outpatient rehabilitation and habilitative services • Skilled Nursing Facility (Consistent with 42 CFR §440.315(f)) • Durable medical equipment, medical supplies, prosthetics and orthotics
Laboratory services
• Laboratory testing services

Table 2: Covered Services for Healthy Michigan Plan Beneficiaries

Healthy Michigan Plan Covered Services
Preventive and wellness services and chronic disease management
• All United States Preventive Services Task Force grade A and B services http://www.uspreventiveservicestaskforce.org/uspstf/uspsabrecs.htm • Advisory Committee on Immunization Practices recommended vaccines http://www.cdc.gov/vaccines/hcp/acip-recs/index.html • Institute of Medicine recommended preventive services for women http://www.iom.edu/Reports/2011/Clinical-Preventive-Services-for-Women-Closing-the-Gaps.aspx • For 19 and 20 year olds, Early and Periodic Screening, Diagnosis and Treatment services as defined in the current periodicity schedule by the American Academy of Pediatrics http://brightfutures.aap.org/clinical_practice.html
Pediatric services, including oral and vision care (19 & 20 year olds)
• General pediatric care • Vision screening • Eye glasses and dental check-up services
Additional services
• Services provided in a Rural Health Clinic or Federally Qualified Health Center • Non-Emergency Medical Transportation • Family planning and reproductive health services and supplies • Vision and optometrist services (e.g., eyeglasses, therapies, refractions) • Hearing services (e.g., hearing aids and adjustments) • Home Help services/personal care services • Adult dental services • Nursing facility services (Consistent with 42 CFR §440.315(f)) • Maternal Infant Health Program • Program of All Inclusive Care for the Elderly (Consistent with 42 CFR §440.315(f))
*** Habilitative Services** Michigan has adopted the National Association of Insurance Commissioners definition of habilitative services, which are described as services that help a person keep, learn or improve skills and functioning for daily living. These services may include physical and occupational therapy and speech-language pathology for people with disabilities in the outpatient setting. **Covered Services and Limits** All services must be provided under the written order of a Medical Doctor, Doctor of Osteopathic Medicine, or other qualified health professional as defined by law according to a written treatment plan established by that provider. Physical and occupational therapy services in the outpatient setting will be limited to 144 units (15 minute increments) in a consecutive 12 month period without prior authorization. Evaluations and re-evaluations will be limited to 2 per year without prior authorization. Speech therapy services in the outpatient setting will be limited to 36 visits in a consecutive 12 month period without prior authorization. Evaluations and re-evaluations will be limited to 2 per year without prior authorization. A new state defined modifier, U7, must be reported in addition to the procedure code for all habilitative services submitted either on prior authorization requests or for claim adjudication to ensure proper payment. **Non-Covered Services** Respite care, day care, recreational care, residential treatment, social services, custodial care, or services for vocational or educational purposes are not covered as habilitative services.

Table 2: Covered Services for Healthy Michigan Plan Beneficiaries

Healthy Michigan Plan Covered Services
Note: Habilitative services provided as part of a mental health or substance use disorder person-centered planning process are subject to the Mental Health Specialty Services and Supports program criteria. **Prior Authorization** When billing fee-for-service, providers must obtain prior authorization to continue therapy beyond the maximum benefit. Requests for prior authorization must be submitted on the Occupational Therapy-Physical Therapy-Speech Therapy Prior Approval Request/Authorization form (MSA-115). Prior authorization requirements for beneficiaries enrolled in a health plan may differ from those described in this policy for fee-for-service. Providers should contact the individual plans regarding their authorization requirements. **Place of Service** Habilitative services may be provided to beneficiaries of all ages by properly qualified and credentialed professionals in the outpatient hospital setting.

Providers can reference the applicable Medicaid Provider Manual sections for further information regarding:

- Services excluded from health plan coverage, but still covered by the Healthy Michigan Plan
- Billing for services
- Services and populations excluded from co-pays

The Michigan Department of Community Health will continue to provide updates as the requirements of Michigan Public Act 107 of 2013 are implemented.

Manual Maintenance

Retain this bulletin until the information has been incorporated into the Michigan Medicaid Provider Manual.

Questions

Any questions regarding this bulletin should be directed to Provider Inquiry, Department of Community Health, P.O. Box 30731, Lansing, Michigan 48909-8231, or e-mail at ProviderSupport@michigan.gov. When you submit an e-mail, be sure to include your name, affiliation, and phone number so you may be contacted if necessary. Providers may phone toll-free 1-800-292-2550.

Approved

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