

Bulletin Number: MSA 14-39

Distribution: All Providers

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Programs Affected: Healthy Michigan Plan

The purpose of this bulletin is to provide additional information about the Healthy Michigan Plan, which began April 1, 2014. This bulletin serves as a follow-up to Bulletin MSA 14-11, issued February 27, 2014, and provides additional information on the promotion of healthy behaviors, cost-sharing requirements and special coverage provisions.

Promotion of Healthy Behaviors

Overview

Encouraging health and wellness is a primary goal of the Healthy Michigan Plan. The Michigan Department of Community Health is supporting this goal through policies that foster beneficiary engagement in the health care system, remove certain financial barriers to care, and encourage beneficiaries to maintain or address healthy behaviors. To promote the overall health and well-being of Healthy Michigan Plan beneficiaries, the Michigan Department of Community Health has developed a Health Risk Assessment which, when completed, provides health plan beneficiaries the opportunity to earn incentives for actively engaging with the health care system. In addition, Healthy Michigan Plan beneficiaries will be exempt from select cost-sharing requirements for services and medications that promote or maintain health.

Initial Primary Care Provider Appointment

Successful entry into any health care system includes an initial visit with a primary care provider. To foster timely engagement with a primary care provider, Healthy Michigan Plan beneficiaries are expected to contact their primary care provider within 60 days of enrollment in a health plan to schedule an appointment. When contacted by the beneficiary, primary care providers are expected to make reasonable efforts to promptly schedule an initial appointment. The initial appointment may include completion of a Health Risk Assessment as described below.

Health Risk Assessment – For Health Plan Beneficiaries

The Health Risk Assessment is available for completion by all Healthy Michigan Plan health plan beneficiaries and assesses 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
- Flu vaccination

Beneficiaries will receive a Health Risk Assessment form in their Healthy Michigan Plan health plan new member packet. Beneficiaries and providers may also obtain a copy of the Health Risk Assessment form from their health plans or online from the Michigan Department of Community Health at: www.michigan.gov/healthymichiganplan >> Health Risk Assessment.

Beneficiaries enrolled in a health plan may complete a portion of the assessment on their own, with the assistance of MI Enrolls, or with assistance from their health plan. The final portion of the Health Risk Assessment must be completed in the beneficiary's primary care provider office and includes provider attestations of beneficiary healthy behaviors and/or changes.

Once complete, the primary care provider must give each beneficiary a copy of their Health Risk Assessment and securely submit a copy to the beneficiary's health plan. Each health plan has developed submission instructions, including a process for secure transmission of the Health Risk Assessment.

All Healthy Michigan Plan health plans offer beneficiaries the opportunity to receive a reduction in cost-sharing, an incentive or both based on submission of a completed Health Risk Assessment. Beneficiaries may complete more than one Health Risk Assessment during a year, but are only eligible for one incentive per year.

- A cost-sharing reduction, incentive or both may apply to Healthy Michigan Plan health plan beneficiaries who agree to address or maintain healthy behaviors. In addition, beneficiaries who acknowledge that changes are necessary, but who have significant physical, mental or social barriers to addressing them at the time may also be eligible for this reduction, incentive or both.
- Healthy Michigan Plan health plan beneficiaries who do not complete a Health Risk Assessment, or who complete it but decline to engage in addressing health risk behaviors, are not eligible for the cost-sharing reduction or incentive. However, these individuals may become eligible if they return to the provider, complete the assessment, and agree to address one or more behavior change, as attested to by their primary care provider.

All Healthy Michigan Plan health plans have an incentive for providers who complete and return the Health Risk Assessment form for their Healthy Michigan Plan beneficiaries. These incentives vary by health plan. Providers should contact the health plans they participate with for details regarding provider incentives and questions related to the Health Risk Assessment.

For provider incentives related to Health Risk Assessments completed for beneficiaries not yet enrolled in a health plan, refer to the Health Risk Assessment – For Fee-for-Service Beneficiaries section below.

Health Risk Assessment – For Fee-for-Service Beneficiaries

Healthy Michigan Plan beneficiaries may receive services, including the initial primary care provider appointment and completion of the Health Risk Assessment, with a Fee-for-Service provider prior to enrolling in a health plan. When this occurs, the health plan and the provider are responsible for working together to ensure that the Health Risk Assessment is received by the health plan. Fee-for-Service providers should give each beneficiary a copy of their completed assessment at the initial appointment and forward a copy to the beneficiary's health plan after enrollment. Providers should periodically check the Community Health Automated Medicaid Processing System for health plan enrollment information. Beneficiaries who complete the Health Risk Assessment during the Fee-for-Service period are eligible for the health plan cost-sharing reduction, incentive or both upon enrollment in a health plan.

The Health Risk Assessment incentives do not apply to beneficiaries who do not enroll in a health plan and remain in Fee-for-Service. However, these beneficiaries and their providers may choose to complete the assessment to identify health risks and opportunities for healthy behavior change. Health Risk Assessments that are completed for these individuals do not need to be submitted to the Michigan Department of Community Health and can remain in the medical file.

Fee-for-Service will reimburse providers for covered services provided to the beneficiary prior to the effective date of enrollment in a health plan. However, health plans are required to disburse the provider incentive for Health

Risk Assessment forms completed during the Fee-for-Service period when the form is submitted to the health plan after beneficiary enrollment. Incentives to non-network providers will be at the discretion of the health plans. Providers must utilize the date of submission of the Health Risk Assessment form to the health plans as the date of service in order to be eligible for provider incentives.

Web-Based Module for Providers

The Michigan Department of Community Health has developed a voluntary, web-based training for providers on the Healthy Michigan Plan Health Risk Assessment, incentives, and associated processes. A link to this training will be available on the Michigan Department of Community Health website at: www.michigan.gov/healthymichiganplan.

Copay Exceptions for Services Related to Chronic Conditions

The Healthy Michigan Plan seeks to promote greater access to services that prevent the progression of, and complications related to, chronic diseases. To further this goal, a specified list of chronic conditions and related drug classes has been identified for the Healthy Michigan Plan. When services that are generally subject to copays are related to a specified chronic condition, the service will be exempt from copays. Specifically, if the beneficiary's visit is related to one of the program-specified chronic conditions and the primary diagnosis on the claim reflects this chronic condition, there is no copay for the visit. Providers are expected to submit claims in compliance with the International Classification of Diseases coding guidelines and conventions.

The list of chronic condition diagnosis codes and associated drug class and treatment categories subject to the copay exemption will be maintained on the Michigan Department of Community Health website at: www.michigan.gov/healthymichiganplan. The Department plans to review and update this listing at least annually, but may do so at any time. No notice of changes to the list will be issued directly to providers.

The list of chronic conditions that are exempt from copays includes the following:

- Alcohol Use Disorder
- Asthma
- Chronic Kidney Disease
- Chronic Obstructive Pulmonary Disease and Bronchiectasis
- Deep Venous Thrombosis (while on anticoagulation)/Pulmonary Embolism (chronic anticoagulation)
- Depression
- Diabetes
- Heart Failure
- HIV
- Hyperlipidemia
- Hypertension
- Ischemic Heart Disease
- Obesity
- Schizophrenia
- Stroke/Transient Ischemic Attack
- Substance Use Disorder
- Tobacco Use Disorder

The list of drug treatment categories that are exempt from copays includes the following:

- Behavioral Health/Substance Use Disorder
- Chronic Cardiovascular Disease
- Chronic Pulmonary Disease
- Diabetes
- HIV
- Obesity
- Smoking Cessation

The copay exemptions described above apply to all Healthy Michigan Plan beneficiaries whether they are in a health plan or Fee-for-Service.

- For beneficiaries enrolled in a health plan, all participating Healthy Michigan Plan health plans will adhere to the Michigan Department of Community Health's list of specified chronic conditions and associated drug treatment categories. For these beneficiaries, applicable copays will not be collected though the beneficiary's MI Health Account and noted in the beneficiary's MI Health Account quarterly account statement as appropriate. (Refer to the Cost-Sharing Requirements section of this bulletin for additional information on the MI Health Account).
- Effective October 1, 2014, for beneficiaries in Fee-for-Service, if the beneficiary's visit is related to one of the program-specified chronic conditions and the primary diagnosis on the claim reflects this chronic condition, providers should not collect a copayment at the point of service.

Copay Exceptions for Services Related to Preventive Services

For all Healthy Michigan Plan beneficiaries, both Fee-for-Service and those enrolled in a health plan, there is no copay for preventive services. The Michigan Department of Community Health considers preventive services to include the following:

- All United States Preventive Services Task Force grade A and B services:
www.uspreventiveservicestaskforce.org/uspstf/uspsabrecs.htm
- Advisory Committee on Immunization Practices recommended vaccines:
www.cdc.gov/vaccines/hcp/acip-recs/index.html
- Institute of Medicine recommended preventive services for women:
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

It is the provider's responsibility to review these websites for the most current guidelines for preventive services.

One preventive medicine Evaluation and Management service is covered for all adult beneficiaries annually. For beneficiaries less than 21 years of age, Early and Periodic Screening, Diagnosis and Treatment services are covered according to the American Academy of Pediatrics Recommendations for Preventive Pediatric Health Care and Centers for Medicare & Medicaid Services requirements.

In addition, the Healthy Michigan Plan covers breastfeeding equipment and supplies as a preventive service benefit. For covered equipment and supplies refer to the Medical Supplier database at: www.michigan.gov/medicaidproviders >> Billing and Reimbursement >> Provider Specific Information >> Medical Supplier.

Cost-Sharing Requirements

The Healthy Michigan Plan has beneficiary cost-sharing obligations. Cost-sharing includes both copays and contributions based on income, when applicable. Table 1 below lists both Healthy Michigan Plan Fee-for-Service and Healthy Michigan Plan health plan beneficiary copay responsibilities.

Prior to enrollment in a health plan, beneficiaries are eligible to receive Healthy Michigan Plan services through the Fee-for-Service system where copays are collected at the point of service (with the exception of chronic conditions and preventive services, as described above). Health plan beneficiary cost-sharing requirements and collections may be satisfied through the MI Health Account. The MI Health Account is a unique health care savings vehicle where copays and additional contributions will be monitored and communicated to the beneficiary via a quarterly statement. Providers will also be required to provide beneficiaries with notice of potential copays

at the time of service. Additional information on this process will be available at a future date. Refer to Bulletin MSA 14-11 for additional information on Healthy Michigan Plan health plan beneficiary cost-sharing requirements.

Healthy Michigan Plan beneficiaries who are exempt from cost-sharing requirements by law (e.g., individuals receiving hospice care, pregnant women receiving pregnancy related services) are exempt from Healthy Michigan Plan cost-sharing obligations. Similarly, services that are exempt from any cost-sharing by law (e.g., preventive and family planning services) are also exempt for Healthy Michigan Plan beneficiaries. Providers should refer to the Medicaid Provider Manual, General Information for Providers Chapter, for additional information regarding exempt populations and services. The manual can be found at: www.michigan.gov/medicaidproviders >> Policy and Forms >> Medicaid Provider Manual. In addition, those services considered private and confidential under the Michigan Department of Community Health's Explanation of Benefits framework are also exempt from cost-sharing for Healthy Michigan Plan health plan beneficiaries.

Table 1: Copays for Healthy Michigan Plan Beneficiaries

Covered Services	Copays
Physician Office Visits (including Free-Standing Urgent Care Centers)	\$ 2
Outpatient Hospital Clinic Visit	\$ 1
Emergency Room Visit for Non-Emergency Services <ul style="list-style-type: none"> Copay ONLY applies to non-emergency services There is no copay 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

Special Coverage Provisions

Information regarding Healthy Michigan Plan coverage requirements for certain services is provided below. Additional information regarding covered services can be found in relevant chapters of the Medicaid Provider manual, which is available online at: www.michigan.gov/medicaidproviders >> Policy and Forms >> Medicaid Provider Manual.

Dental Services

Beneficiaries enrolled in a health plan will receive their dental benefits through their health plan. Each health plan contracts with a dental provider group or vendor to provide dental services administered according to the contract. The contract is between the health plan and the dental provider group or vendor and beneficiaries must receive services from a participating provider to be covered. Questions regarding eligibility, prior authorization or the provider network should be directed to the beneficiary's health plan. It is important to verify eligibility before providing dental services at every appointment. Dental services provided to an ineligible beneficiary will not be reimbursed.

For those beneficiaries who are not enrolled in a health plan, dental services will be provided by currently enrolled Medicaid 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 through the *Healthy Kids Dental* program administered by Delta Dental.

Habilitative Services

Effective July 1, 2014, the Centers for Medicare & Medicaid Services established modifier "SZ-Habilitative Services." Modifier SZ must be reported in addition to the procedure code for all habilitative services submitted on prior authorization requests and for claim adjudication to ensure proper payment effective with dates of service on and after July 1, 2014. Providers should no longer use the state-defined modifier U7 to report habilitative services on prior authorization requests or claims as indicated in Bulletin MSA 14-11.

Hearing Aids

The Healthy Michigan Plan covers hearing aid services for all beneficiaries when provided by a licensed hearing aid dealer or licensed audiologist affiliated with a hearing center. Providers should refer to the Medicaid Provider Manual, Hearing Aid Dealer Chapter, for additional guidance regarding hearing aid coverage. The manual can be found at: www.michigan.gov/medicaidproviders >> Policy and Forms >> Medicaid Provider Manual.

Nursing Facility Services

Beneficiaries eligible for the Healthy Michigan Plan have comprehensive nursing facility coverage consistent with the policies and procedures established by the traditional Medicaid Program. This benefit is included for individuals in accordance with 42 CFR 440.315(f). Providers should refer to the Medicaid Provider Manual, Nursing Facility Chapter for additional guidance regarding nursing facility services covered for beneficiaries.

Healthy Michigan Plan beneficiaries who are receiving nursing facility services in a licensed nursing facility are excluded from enrollment in a health plan. Healthy Michigan Plan beneficiaries who begin receiving nursing facility services after enrollment in a health plan may be dis-enrolled from the health plan under certain conditions. Providers should refer to the Medicaid Provider Manual, Beneficiary Eligibility Chapter, Medicaid Health Plans Section for additional guidance regarding nursing facility services provided to health plan enrollees. The manual can be found at: www.michigan.gov/medicaidproviders >> Policy and Forms >> Medicaid Provider Manual.

Mental Health and Substance Use Disorder Treatment Services

Healthy Michigan Plan beneficiaries have an array of behavioral health services available to treat mental health and substance use disorders.

Mental Health Benefits

Health plans will provide mental health services under the Mental Health Outpatient benefit, consistent with the policies and procedures established by the traditional Medicaid program. For mental health needs that do not meet established criteria or are beyond the 20-visit limitation, health plans must coordinate with the appropriate Prepaid Inpatient Health Plan to ensure that medically necessary mental health services are provided. Beneficiaries who are not enrolled in a health plan will receive their outpatient mental health services through Fee-for-Service, and may include Prepaid Inpatient Health Plan services, as described in the Medicaid Provider Manual.

Additional mental health services (e.g., inpatient hospitalization, intensive crisis stabilization, etc.) are covered benefits consistent with the policies and procedures established by the Medicaid program.

Substance Use Disorder Services

Substance use disorder services and supports are covered by the Healthy Michigan Plan when delivered under the auspices of an approved Prepaid Inpatient Health Plan.

For Healthy Michigan Plan beneficiaries, substance use disorder services will be provided in the same manner and in coordination with the mental health services and supports. Prepaid Inpatient Health Plans are responsible for providing the substance use disorder benefit, consistent with the policies and procedures established by the traditional Medicaid program. Eligibility for these services is based on medical necessity, individual need and/or the type of substance being used resulting in the need for treatment.

Behavioral Health Community-Based Services

The Healthy Michigan Plan covers medically necessary supports and services that promote community inclusion and participation, independence, and/or productivity when identified in the individual plan of service.

These services include the following:

- Assistive Technology
- Community Living Supports
- Enhanced Pharmacy
- Environmental Modifications
- Family Support and Training
- Housing Assistance
- Peer-Delivered or Operated Support Services
- Prevention-Direct Service Models
- Respite Care Services
- Skill-Building Assistance
- Support and Service Coordination
- Supported/Integrated Employment Services
- Fiscal Intermediary Services

Program coverage for community-based services and supports are described in the Medicaid Provider Manual, Mental Health/Substance Abuse Chapter. In compliance with Section 1915(i) of the Social Security Act, these services may be limited to individual program criteria and are based upon the following:

- The services are provided in settings that meet home and community-based service setting requirements.
- The services meet the person-centered service planning requirements.
- Individuals receiving these services meet the state-established needs-based criteria that are not related solely to age, disability, or diagnosis, and are less stringent than criteria for entry into institutions. Services can be accessed as needed, even if the individuals have needs that are below institutional level of care.

The following benefit plan has been added to the Community Health Automated Medicaid Processing System beneficiary eligibility information to identify beneficiaries with Healthy Michigan Plan coverage:

- PIHP-HMP (PIHP Healthy Michigan Plan)

Additional program coverage and criteria for all mental health and substance use disorder services and supports are described in further detail in the Medicaid Provider Manual, Mental Health/Substance Abuse Chapter.

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

A handwritten signature in black ink that reads "Stephen Fitton". The signature is written in a cursive style with a large initial 'S' and 'F'.

Stephen Fitton, Director
Medical Services Administration