MDHHS Michigan Department of Health & Human Services

Medical Services Administration
BULLETIN MSA

Bulletin Number: MSA 18-05

Distribution: All Providers

Issued: March 1, 2018

Subject: MI Marketplace Option and Healthy Michigan Plan Updates

Effective: April 1, 2018

Programs Affected: Healthy Michigan Plan, MI Marketplace Option

This bulletin provides information regarding the new MI Marketplace Option benefit plan and Healthy Michigan Plan program updates. As required by the Section 1115 Demonstration Waiver Amendment approved by the Centers for Medicare & Medicaid Services (CMS) and Public Act 107 of 2013, certain Healthy Michigan Plan beneficiaries are required to obtain health care coverage through the MI Marketplace Option. The transition of Healthy Michigan Plan beneficiaries to the MI Marketplace Option will begin on April 1, 2018. Beneficiaries enrolled in the MI Marketplace Option will receive health care benefits in accordance with the MI Marketplace Option Alternative Benefit Plan (ABP). Benefits will be provided to beneficiaries through enrollment in participating MI Marketplace Option health plans. These health plans will be distinct from the current Healthy Michigan Plan health plans. Additionally, certain services not covered under MI Marketplace Option health plans may be covered through Medicaid Fee-for-Service (FFS). Beneficiaries who are not required to enroll in the MI Marketplace Option will continue to receive their health care benefits through Healthy Michigan Plan health plans.

Providers who want to participate with MI Marketplace Option health plans will be required to enroll with each health plan.

I. MI Marketplace Option

A. MI Marketplace Option Eligibility

A select population of Healthy Michigan Plan beneficiaries will be required to transition to the MI Marketplace Option if they meet all of the following criteria:

- Have been enrolled in a Healthy Michigan Plan health plan for twelve (12) consecutive months or more (note: this does not apply to beneficiaries in FFS),
- Have incomes above 100% of the federal poverty level (FPL) under the Modified Adjusted Gross Income methodology,
- Are age 21 years or older,
- Are not pregnant,

- Are not American Indian or Alaska Native,
- Do not have cost-share exempt status,
- Have not completed a healthy behavior as described in the Updates to the Healthy Behaviors Incentives Program section of this bulletin, and
- Are not medically exempt.

Beneficiaries who are not otherwise excluded, have income above 100% FPL, and have satisfied the State's healthy behaviors requirements will also be given the option to transition to the MI Marketplace Option.

B. MI Marketplace Option Medical Exemption

Individuals who are considered medically exempt are not eligible for the MI Marketplace Option. To determine medically exempt status, the Michigan Department of Health and Human Services (MDHHS) will allow individuals to self-attest to medically frail status using the application for health care coverage or by completing a medical exemption form (MSA-745; MI Marketplace Option Medical Exemption Request). MDHHS will also be conducting a retrospective claims review for the presence of select diagnosis codes identifying individuals who have serious and/or complex medical and behavioral health conditions. In addition, MDHHS will accept medical exemption referrals initiated by providers. Details on the State's three-pronged strategy for the identification of these individuals are included in the Healthy Michigan Plan Marketplace Option Operational Protocol, including a list of the diagnosis codes. The Healthy Michigan Plan Marketplace Option Operational Protocol can be accessed on the MDHHS website at www.michigan.gov/healthymichiganplan >> Healthy Michigan Plan Second Waiver Operational Protocols.

Providers are encouraged to assist beneficiaries who meet the medically exempt qualifications with completing and submitting the medical exemption form. Form MSA-745 will be included as part of the beneficiary transition notification package. Beneficiaries can obtain the form on the MDHHS website at www.michigan.gov/mimarketplaceoption or by calling MICHIGAN ENROLLS at 1-800-975-7630, TTY 1-888-263-5897.

C. Transition of Current Healthy Michigan Plan Beneficiaries into the MI Marketplace Option

MI Marketplace Option benefits are managed through MI Marketplace Option health plans. MI Marketplace Option health plans are not Healthy Michigan Plan or Medicaid health plans. MDHHS will utilize MICHIGAN ENROLLS to facilitate enrollment into MI Marketplace Option health plans. Beneficiaries may enroll online, by phone, or by mailing in their application, but must select a MI Marketplace Option health plan within the timeframe identified in their enrollment letter which gives them the MI Marketplace Option health plans available in their area. If the beneficiary does not choose a MI Marketplace Option health plan, they will be auto-assigned into a plan.

MI Marketplace Option health plans will provide a more limited benefit package, consistent with the Affordable Care Act's Essential Health Benefits (EHB), and will have their own provider networks and prescription drug formularies. MDHHS will identify Healthy Michigan Plan beneficiaries who meet the criteria for enrollment in the MI Marketplace Option and notify them of the required transition. MDHHS will also provide information on the healthy behaviors requirements and medical exemption process, including how beneficiaries may utilize these options to remain in, or return to, the Healthy Michigan Plan.

Once a beneficiary is enrolled in the MI Marketplace Option, they will remain there until at least the next MI Marketplace Option open enrollment period unless they lose Medicaid eligibility, are determined medically exempt, or become eligible for another health care coverage program administered by MDHHS. MDHHS will review the information available on all MI Marketplace Option beneficiaries and determine whether they meet the criteria for continued enrollment in the MI Marketplace Option or may transition back to the Healthy Michigan Plan.

The transition of care will also be critical for ensuring continuity of care. MI Marketplace Option health plans will have their own prior authorization (PA) requirements and will not be required to honor PAs issued by a beneficiary's previous Healthy Michigan Plan health plan. Providers will need to work with MI Marketplace Option health plans to secure new PAs when required.

D. MI Marketplace Option Benefit Plans and Program Enrollment Type (PET) Codes

The eligibility response through the Community Health Automated Medicaid Processing System (CHAMPS) provider portal or the HIPAA 270/271 transaction format will contain benefit plan data for the requested date of service. The following new benefit plans have been added to identify beneficiaries with MI Marketplace Option coverage:

- MKPL-MC: This capitated program provides benefits to MI Marketplace Option beneficiaries through enrollment in a participating MI Marketplace Option health plan. Wrap-around benefits not covered under this plan could be covered through MA-MKPL FFS.
- MA-MKPL: This benefit plan provides limited health care wrap-around benefits to MI Marketplace Option beneficiaries who are enrolled in MKPL-MC.

New PET codes will also be reported along with the applicable benefit plan. The PET code information alerts providers to a beneficiary admission or Managed Care enrollment for the requested date of service. Providers will continue to utilize the Benefit Plan ID(s) indicated in the eligibility response to determine a beneficiary's program coverage and related covered services for a specific date of service.

E. Covered Services for MI Marketplace Option Beneficiaries

1. Essential Health Benefits (EHB)

MI Marketplace Option beneficiaries will receive EHB in accordance with the Affordable Care Act and its implementing regulations. Beneficiaries will obtain these EHBs through their MI Marketplace Option health plan's provider network. MI Marketplace Option health plans do not cover dental, vision, or other non-EHB services. Additionally, MI Marketplace Option beneficiaries will have a limited number of benefits provided by Medicaid FFS. EHB covered by the MI Marketplace Option health plan network include:

a. Ambulatory patient services

- Primary care provider services
- Specialist/Referral care services
- Outpatient hospital services, including Ambulatory Surgical Center (ASC) services
- Home health care services
- Hospice care
- Podiatry care
- Chiropractic services

b. Emergency services

- Emergency room services
- Emergency transportation/ambulance
- Urgent Care Centers (UCC) or facilities

c. Hospitalization

- Inpatient hospital services (e.g., hospital stay, physician and surgical services)

d. Maternity care

- Prenatal and postpartum care
- Delivery and inpatient services for maternity care

e. Mental health and substance use disorder services, including behavioral health treatment

- Mental/behavioral health inpatient services
- Mental/behavioral health outpatient services
- Substance use disorder inpatient services
- Substance use disorder outpatient services

f. Prescription drugs

- Prescription drugs and supplies (Plans available under the MI Marketplace Option may have drug formularies and coverage policies that differ from those under the Healthy Michigan Plan. In order to minimize disruptions in their drug therapy, MI Marketplace Option beneficiaries may want to review a plan's drug coverage policies prior to enrollment.)

g. Rehabilitative and habilitative services and devices

- Inpatient rehabilitative services
- Outpatient rehabilitative and habilitative services
- Skilled Nursing Facility
- Durable medical equipment, medical supplies, prosthetics and orthotics

h. Laboratory services

- Laboratory testing services

i. Preventive and wellness services and chronic disease management

- All United States Preventive Services Task Force Grade A and B services
- Advisory Committee on Immunization Practices (ACIP) recommended vaccines
- Services recommended as part of the Health Resources & Services Administration (HRSA) supported Women's Preventive Services Guidelines

2. Wrap-Around Benefits

Beneficiaries in the MI Marketplace Option also have coverage of additional wrap-around benefits covered by Medicaid FFS including:

a. Non-Emergency Medical Transportation (NEMT)

MDHHS will provide access to transportation services directly to MI Marketplace Option beneficiaries for program-covered services when the beneficiary has no other means of transportation. NEMT includes authorization and reimbursement for mileage, meals and lodging, special transportation needs (e.g., wheelchair lift-equipped vehicles, Medi-Van vehicles, medically necessary attendants), and other travel expenses (e.g., tolls, parking). In some instances, medical necessity criteria must be met.

MI Marketplace Option beneficiaries may access NEMT through the following sources depending on the county of residence:

- Wayne, Oakland, and Macomb counties – MDHHS has contracted with a transportation brokerage company, currently LogistiCare Solutions, to administer transportation. Beneficiaries residing in these counties should contact LogistiCare Solutions at 1-866-569-1902, Monday through Friday, from 8:00 a.m. to 5:00 p.m.

- All other counties – NEMT is administered by the county MDHHS office. Beneficiaries residing in counties other than Wayne, Oakland, and Macomb should contact the MDHHS office in their county of residence for transportation assistance.

The beneficiary's need for transportation must be evaluated before NEMT services are authorized. Refer to the Non-Emergency Medical Transportation chapter of the Medicaid Provider Manual for additional information regarding coverage and authorization requirements. The Medicaid Provider Manual can be accessed on the MDHHS website at www.michigan.gov/medicaidproviders >> Policy, Letters & Forms.

b. Out-of-Network Family Planning Services

Participating MI Marketplace Option health plan network providers must bill the MI Marketplace Option health plan for family planning services and supplies. MDHHS will provide coverage for family planning services and supplies from any Medicaid enrolled provider outside of the MI Marketplace Option health plan network. If the provider is not part of the MI Marketplace Option health plan network, they may bill Medicaid FFS through CHAMPS.

3. Clinic Reimbursement

Rural Health Clinic (RHC) and Federally Qualified Health Center (FQHC) providers will be entitled to the clinic's current prospective payment system rate on eligible MI Marketplace Option health plan paid encounters. Furthermore, Tribal Health Centers (THC) will receive the Indian Health Services (IHS) all-inclusive rate for all eligible MI Marketplace Option health plan paid encounters.

F. MI Marketplace Option Cost-Sharing

Beneficiaries in the MI Marketplace Option will be responsible for contributing to the cost of their coverage. A monthly premium that will not exceed 2% of income and an average monthly co-pay amount will be charged. Total premiums and co-pay amounts will not exceed the cost-sharing limits described in 42 CFR 447.56(f). MI Marketplace Option beneficiaries will receive monthly invoices from MICHIGAN ENROLLS if there is a balance due. The invoice will show premium amounts and average co-pay amounts owed along with current balances.

Additional cost-sharing information will be available on the MDHHS website at www.michigan.gov/mimarketplaceoption.

Beneficiaries who fail to pay required cost-sharing amounts may have their state income tax refunds and lottery winnings offset by the Michigan Department of Treasury. Beneficiaries identified for tax offset will receive a letter notifying them of the process and provide them 30 days to appeal the tax and lottery offset determination. MI Marketplace Option enrollees will not lose coverage for failing to pay cost-sharing requirements. Providers will not be responsible for the collection of MI Marketplace Option enrollee cost-sharing.

Exemptions, and any other changes to the contributions, premiums, or co-pay amounts because of changes in income or other demographic information, will be processed by the MI Health Account vendor. **Please note, this applies to both Healthy Michigan Plan and MI Marketplace Option health plans.**

G. MI Marketplace Option Incentive Program

MI Marketplace Option beneficiaries are eligible to complete a Healthy Michigan Plan Health Risk Assessment (HRA) and receive an incentive. MI Marketplace Option beneficiaries who satisfy the healthy behaviors requirements outlined in the State's Healthy Behaviors Incentives Protocol, found at www.michigan.gov/healthymichiganplan >> Healthy Michigan Plan Second Waiver Operational Protocols, will earn a 50 percent MI Marketplace Option premium reduction for the remainder of the enrollment period. In addition, beneficiaries who complete a Healthy Michigan Plan HRA will be eligible to return to the Healthy Michigan Plan the next available calendar year.

H. MI Marketplace Option Appeals

MI Marketplace Option beneficiaries will use the appeals process established by their health plan to appeal a denial of covered benefits. MI Marketplace Option beneficiaries will have access to an internal review by their health plan and an external review by the Department of Insurance and Financial Services (DIFS). Furthermore, MI Marketplace Option beneficiaries will have access to a Medicaid Fair Hearing in the event they do not agree with the DIFS decision. MI Marketplace Option health plans will be required to honor the outcome of an external review. All MI Marketplace Option health plans must comply with federal and state standards governing internal and external insurance coverage appeals.

Additionally, MI Marketplace Option beneficiaries will use the Medicaid appeals process for denials of wrap-around benefits covered by Medicaid FFS. Appeals related to a beneficiary's eligibility for the MI Marketplace Option will follow the Medicaid FFS appeals process.

II. Healthy Michigan Plan Updates

A. Updates to the Healthy Behaviors Incentives Program

The purpose of the Healthy Behaviors Incentives Program is to encourage beneficiaries to maintain and implement healthy behaviors as identified in collaboration with their health care provider primarily via a standardized HRA. Uniform standards were developed to ensure that all Healthy Michigan Plan managed care beneficiaries have the opportunity to earn incentives and that those incentives are applied consistently by the managed care plans.

Healthy Michigan Plan beneficiaries are expected to remain actively engaged with the Healthy Behaviors Incentives Program each year that they are in the Healthy Michigan Plan. In addition to the Healthy Michigan Plan HRA, there are two additional ways to participate in a healthy behavior. The new healthy behaviors are outlined in the State's Healthy Behaviors Incentives Protocol found on the MDHHS website at the address noted above, and include utilizing a preventive visit or joining an MDHHS approved health and wellness program. Beneficiaries who complete one of the healthy behaviors described below will receive an incentive in accordance with the Healthy Behaviors Incentives Protocol. Beneficiaries who complete an HRA and acknowledge that changes are necessary but who have significant physical, mental or social barriers to addressing them at this time (as attested by the primary care provider) are also eligible for the incentives.

1. Health Risk Assessment

   MDHHS has revised the Healthy Michigan Plan HRA that 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
   - Influenza vaccination
   - Chronic conditions
   - Recommended cancer or other preventive screenings

   Beneficiaries can start an HRA at any time. Beneficiaries have the option to start the HRA telephonically or online and share this information securely with their health care providers through CHAMPS.

To help facilitate the HRA submission process, MDHHS has implemented a statewide fax at 517-763-0200. Providers can use this fax to submit completed HRAs directly to MDHHS rather than submitting them to the beneficiary's health plan. The latest version of the Health Risk Assessment (form DCH-1315) can be found on the MDHHS website at www.michigan.gov/healthymichiganplan or by calling MICHIGAN ENROLLS at 1-800-975-7630, TTY 1-888-263-5897.

2. Preventive Health Services

MDHHS will use claims and encounter data to document healthy behaviors for managed care beneficiaries who utilize preventive and wellness services that meet the following criteria.

- Make and keep an appointment for any of the following:
  - Annual preventive visit
  - Preventive dental services
  - Appropriate cancer screening
  - Tobacco cessation
  - ACIP recommended vaccination(s)
  - Other preventive screening

3. Healthy Michigan Plan Health and Wellness Program Participation

All managed care plans must ensure their beneficiaries have access to evidence based/best practices wellness programs to reduce the impact of common risk factors such as obesity or hypertension. These programs can take many forms such as evidence-based tobacco cessation support, health coaching services, and free or reduced cost gym memberships. Managed care plan health and wellness programs must be approved by MDHHS to be eligible for inclusion in the Healthy Behaviors Incentives Program.

B. CHAMPS Profile for Health Risk Assessments

MDHHS has created a new CHAMPS profile for providers to complete a Healthy Michigan Plan HRA and attest to the beneficiary's willingness/ability to address health needs online. The new profile name is: HRA Provider Profile. Providers will need to add the new profile to their CHAMPS username in order to view shared beneficiary HRA data, attest online to a beneficiary's HRA, or see historical HRA data.

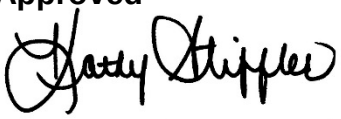
Manual Maintenance

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

Questions

Any questions regarding this bulletin should be directed to Provider Inquiry, Department of Health and Human Services, P.O. Box 30731, Lansing, Michigan 48909-8231, or e-mailed to 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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