

MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES

NOTICE OF PROPOSED POLICY

Public Act 280 of 1939, as amended, and consultation guidelines for Medicaid policy provide an opportunity to review proposed changes in Medicaid policies and procedures.

Please review the policy summary and the attached materials that describe the specific changes being proposed. Let us know why you support the change or oppose the change.

Submit your comments to the analyst by the due date specified. Your comments must be received by the due date to be considered for the final policy bulletin.

Thank you for participating in the consultation process.

Meghan Sigmund Vanderstelt

**Director, Bureau of Policy and Strategic Engagement
Health Services Administration**

Project Number:	2636-Eligibility	Comments Due:	November 23, 2026	Proposed Effective Date:	January 1, 2027
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Mail Comments to: Kayla Lowers

Telephone Number:

Fax Number:

E-mail Address: LowersK@michigan.gov

Policy Subject: Healthy Michigan Plan (HMP) Work Requirements, HMP Six-Month Renewals and Retroactive Coverage Changes

Affected Programs: Healthy Michigan Plan, Medicaid

Distribution: Bridges Administrative Manual Holders, Bridges Eligibility Manual Holders, All Providers

Policy Summary: This policy implements work requirements for HMP beneficiaries. It also limits retroactive Medicaid requests to one month for HMP and two months for all other Medicaid programs. Finally, it shortens the HMP eligibility period to six months.

Purpose: This policy brings Michigan into compliance with H.R.1 sections 71107, 71112, and 71119.

Proposed Policy Draft

Michigan Department of Health and Human Services
Health Services

Distribution: Bridges Eligibility Manual Holders, Bridges Administrative Manual Holders, All Providers

Issued: December 1, 2026 (proposed)

Subject: Healthy Michigan Plan (HMP) Work Requirements, HMP Six-Month Renewals and Retroactive Coverage Changes

Effective: January 1, 2027 (proposed)

Programs Affected: Healthy Michigan Plan, All Modified Adjusted Gross Income Medicaid Eligibility Groups

Note: Implementation of this policy is contingent upon approval of a State Plan Amendment (SPA) by the Centers for Medicare & Medicaid Services (CMS).

Beginning on January 1, 2027, the Michigan Department of Health and Human Services (MDHHS) will implement work requirements and six-month renewals for all Healthy Michigan Plan (HMP) beneficiaries. Additionally, all Medicaid programs, including HMP, will be limited to receiving one or two months of retroactive coverage instead of the current three months. MDHHS is implementing these changes to come into compliance with sections 71107, 71112, and 71119 of Pub. L. No. 119-21 (H.R.1). The purpose of this bulletin is to provide information regarding these changes.

I. Healthy Michigan Plan Work Requirements

Beginning January 1, 2027, HMP applicants and beneficiaries between 19 and 64 years of age will be required to complete 80 hours of qualifying activities in a month as a condition of eligibility unless they meet the criteria for an exemption or exclusion. Compliance with the requirement must be verified for any application or renewal on or after January 1, 2027.

A. Qualifying Activities

Applicants and beneficiaries can demonstrate compliance with Medicaid work requirements by working, performing community service, participating in a work program, or going to school for not less than 80 hours per month. They may also comply by completing a combination of those activities that together total 80 or more hours.

1. Work

An individual is considered compliant with work requirements if they are employed, self-employed, or work for in-kind payments for at least 80 hours per month.

2. Monthly Income

In some cases, MDHHS may be able to determine compliance with work requirements for an individual based on their monthly Modified Adjusted Gross Income (MAGI) if that income is greater than or equal to the federal minimum wage multiplied by 80. If an individual does not have MAGI income over the threshold of the federal minimum wage multiplied by 80 and does not report their hours worked in a month, then their monthly MAGI income will be divided by the federal minimum wage to determine the number of hours of work they completed in a month. These work hours will then be combined with any of the other qualifying activities completed in a month to determine compliance. For individuals who are employed on a seasonal basis, MDHHS will divide their yearly MAGI income by 12 to determine an average monthly income.

3. Education

An individual who is attending school is considered compliant with work requirements if they are attending at least half time. The determination of whether a student is attending school on a full-time, half-time, or less than half-time basis is up to the criteria set by the institution they are attending.

If an individual attends school less than half time, any hours of education completed will need to be combined with other qualifying activities to reach the 80-hour threshold. For individuals attending institutions that use credit hours, one credit hour will be equivalent to three education activity hours per week. The number of education activity hours completed in a week will be multiplied by 4.33 to determine the number of education hours completed in a month. This monthly amount will then be combined with the hours of other activities completed.

For institutions that do not use credit hours, any hour spent attending class or participating in other instructional activities will equal one hour of education qualifying activity time.

4. Community Service

In order to qualify as a work requirements activity, the community service completed by the individual must:

- be unpaid work;
- directly benefit the community; and
- be at the direction of a public or nonprofit organization.

Community service activities that are completed due to a court mandate can be counted towards Medicaid work requirements. The organization that an individual volunteers with must provide oversight of the activity and have a process to track the dates and hours volunteered. Additionally, there must be someone at the organization who can be contacted to verify the hours and dates an individual has volunteered.

5. Work Program

Work program qualifying activity hours must be completed with a work program administered by Michigan Works! Association.

B. Demonstrating Compliance at Application and at Renewal

Individuals must demonstrate compliance with work requirements both at application and at renewal. The review period is the window of time that an individual must demonstrate compliance within. At application, the review period is either the month of application or the month immediately before application. If an individual demonstrates compliance in the month before their application and is approved for coverage, that coverage will begin on the first day of the month of their application. If an individual demonstrates compliance with work requirements in the month of their application, their coverage will begin on the first day of the month following the month of their application.

Work Requirements Compliance - Coverage Start Date Example

Application Month	Compliance Month	Coverage Start
April	March	April 1
April	April	May 1

At renewal, the review period is the time between a beneficiary's last renewal or determination and their current renewal. The beneficiary must show compliance in one month in the review period. Individuals may choose which month they would like to provide proof of compliance.

For example, if a beneficiary's HMP renewal date is in September, they can provide proof of compliance with work requirements in any month between their last renewal in March (April, May, June, July, August, or September) and their current renewal in September.

C. Specified Excluded Individuals

A specified excluded individual is someone who does not need to demonstrate compliance with work requirements in order to be eligible for HMP. MDHHS can determine an individual to be excluded at application, at renewal, or when new information is reported to MDHHS. To be considered a specified excluded individual, a person must meet one of the following criteria:

Specified Excluded Individuals	
Former foster children	Individuals who are not eligible for Michigan's Foster Care Transition Medicaid group who aged out of foster care in another state on or before December 31, 2022.
American Indian/Alaska Native (AI/AN)	Individuals who are members of a federally-recognized tribe.
Parent, guardian, caretaker relative, or family caregiver of: <ul style="list-style-type: none"> • A child under age 14. • A disabled individual of any age. 	<p>Parent – Natural, adopted, or step-parent.</p> <p>Guardian – Individual appointed by the court to make personal decisions for someone who cannot care for themselves.</p> <p>Caretaker Relative – Family member of the disabled individual or child by blood, adoption, or marriage who lives with the individual and assumes primary responsibility for them.</p> <p>Family Caregiver – An adult family member, or other individual with a significant relationship to the disabled individual or child, who provides a broad range of assistance for at least 80 hours per month.</p>
A veteran with a permanent or temporary disability	A veteran with a permanent or temporary disability rated as 100% (total) under 38 U.S.C. 1155.
Medically Frail	<p>An individual whose physical, mental, or other behavioral health condition significantly impairs the individual's ability to comply with work requirements. MDHHS will create and maintain a list of conditions that meet the definition of medically frail for the purposes of work requirements.</p> <p>(Refer to the Identification of Medically Frail Individuals subsection below for more information.)</p>
Individuals who are compliant with Temporary Assistance for Needy Families (TANF) work requirements and individuals not exempt from Supplemental Nutrition Assistance Program (SNAP) work requirements	Individuals who are compliant with TANF work requirements and SNAP recipients who are not exempt from SNAP work requirements.
Participants in a drug or alcohol rehabilitation or treatment program	An individual who participates in a drug addiction or alcoholic treatment and rehabilitation program run by a private non-profit organization or publicly-operated community mental health (CMH) center that provides treatment that can lead to the rehabilitation of drug addicts or alcoholics.

Specified Excluded Individuals	
Inmates of a public institution	Individuals who are in custody and held involuntarily by law enforcement in a federal or state prison, local jail, detention facility, or other incarcerated setting.
Pregnant and postpartum individuals	Individuals who are pregnant or in their 12-month postpartum period.

1. Identification of Medically Frail Individuals

HMP beneficiaries who are considered medically frail in accordance with H.R.1 are exempt from work requirements. In accordance with federal regulations, medically frail conditions include:

- Blindness or disability as defined in section 1614 of the Social Security Act.
- Substance use disorder or in sustained recovery for less than five years.
- Disabling mental disorder.
- Physical, intellectual or developmental disability that significantly impairs the ability to perform one or more activities of daily living (ADL).
- Serious or complex medical condition.

Medically frail beneficiaries will be identified by the following methods:

Claim, Encounter and Data Analysis

MDHHS will review healthcare data from the preceding 12 months for the presence of select diagnosis and procedure codes, facility admissions, and other program and waiver enrollment to identify beneficiaries considered medically frail. Data will be continuously analyzed to identify and flag medically frail conditions. Data to be reviewed includes the following:

- a. International Classification of Diseases (ICD) -10 diagnosis, Healthcare Common Procedure Coding System (HCPCS) and Current Procedural Terminology (CPT) codes that identify:
 - i. Category 1 – ICD-10 diagnosis codes that represent inherently medically frail conditions that do not require additional indicators of severity to verify medical frailty.
 - ii. Category 2 - conditions that may significantly impair an individual's ability to comply but require additional indicators of severity to verify medical frailty. The condition list paired with patterns of utilization serve as valid indicators of condition severity that would reasonably be expected to impair an individual's ability to comply with community engagement requirements. Medical frailty is established if a condition from the list is reported on:
 1. one inpatient hospitalization; or

2. at least two outpatient or professional services of moderate-to-high clinical intensity, including home health, private duty nursing, and certain durable medical equipment.

The list of category 1 and category 2 codes is available online at www.michigan.gov/healthymiplan/medical-frailty.

- b. Whether a beneficiary has been in a general hospital, nursing home or hospice for over 30 days.
- c. Enrollment in the Program of All-Inclusive Care for the Elderly (PACE), MI Choice waiver, and Habilitation Support waiver.

Medically frail conditions identified through healthcare data will remain available for 12 months and may be used in the individual's next healthcare coverage redetermination. If a new claim, encounter, admission or enrollment is not identified after 12 months, the exemption will expire and will not be applied during subsequent renewals.

Self-Attestation

Individuals may report and self-attest to their medically frail status through any of the medical assistance program applications, eligibility renewals, or the online MI Bridges application. Applications include questions that allow individuals to report and attest that they have a medically frail condition as defined above.

In 2027, MDHHS will accept this attestation, under penalty of perjury, to verify an applicant or beneficiary is medically frail.

D. Mandatory Exceptions

Certain individuals may be deemed to be in compliance with Medicaid work requirements for a month if they meet any of the following criteria:

- Under age 19;
- Entitled to or enrolled for benefits under Medicare part A;
- Enrolled for benefits under Medicare part B;
- Eligible for another mandatory Medicaid group described in 1902(a)(10)(A)(i)(I)-(VII);
- Who meets the federal definition of a specified excluded individual; or
- Who at any point during the three-month period ending on the first day of the month was an inmate of a public institution.

Applicants and beneficiaries will be deemed to be in compliance with Medicaid work requirements if they meet the criteria for any exception during any part of a month in the compliance review period at application or at renewal. For example, if an individual turns 19 in February, at their next renewal in June they will be deemed in compliance

with work requirements even if they did not complete any qualifying activities because they met exception criteria in a month during the review period. They will then be required to complete qualifying activities before their next renewal in December when the exception ends.

E. Short-Term Hardship Events

Applicants and beneficiaries will be deemed in compliance with Medicaid work requirements if they experience one of the following short-term hardship events during all or part of a month in the application or renewal compliance review period:

- The individual receives inpatient hospital services, nursing facility services, services in an intermediate care facility for individuals with intellectual disabilities, inpatient psychiatric hospital services, or other services of a similar acuity.
- The individual resides in a county where an emergency disaster has been declared by the President.
- The individual resides in a county where the unemployment rate is at or above the lesser of 8% or 1.5 times the national unemployment rate.
- The HMP applicant/beneficiary or their dependent must travel outside of their community of residence for an extended period of time to receive medical services for a serious or complex medical condition that are not available in their community of residence.

MDHHS will determine if an individual resides in a county where a disaster has been declared or the unemployment rate exceeds the lesser of 8% or 1.5 times the national average and apply the hardship exemption to applicable individuals automatically after Centers for Medicare & Medicaid Services (CMS) has approved Michigan's request to use these hardship exemptions for the affected counties or areas.

Individuals who have received inpatient hospital services, or services of a similar acuity, and those who must travel outside of their community of residence to receive medical services for a serious or complex medical condition may request a hardship exemption from MDHHS.

F. Verification of Compliance

MDHHS will use already available data to attempt to verify qualifying activities, exclusions, exemptions, and hardships before requesting the applicant or beneficiary provide verification. For the 2027 calendar year, if no electronic data or paper verification sources exist, MDHHS will use available reliable information provided by the applicant or beneficiary on their application or renewal form for information about completed qualifying activities.

G. Noncompliance

At application and at renewal, when an individual fails to report or verify compliance activities, exclusions, exemptions, or hardships, MDHHS will send a noncompliance notice that informs the individual how to come into compliance and how to provide verification of that compliance to the Department. Individuals will have 30 days to return the form and any necessary documentation. If after 30 days the individual fails to respond to this form, they will be found ineligible for HMP due to noncompliance. Existing beneficiaries will have their coverage terminated upon the expiration of this 30-day period.

Individuals may reapply for benefits after a denial or termination without penalty or delay. However, compliance with work requirements must be met as outlined above to be eligible for HMP.

II. Six-Month Healthy Michigan Plan Renewals

Beginning January 1, 2027, all beneficiaries who are enrolled in HMP will be required to complete renewals of eligibility every six months instead of the current 12 months. When an individual renews their Medicaid coverage for the first time on or after January 1, 2027, they will be provided with a six-month renewal period. Additionally, any applicant that is approved for HMP coverage on or after January 1, 2027, will receive a six-month eligibility period.

AI/AN individuals enrolled in HMP are exempt from the six-month renewal schedule and will still have their Medicaid coverage renewed every 12 months. MDHHS will continue to redetermine an individual's eligibility at any time outside of their regular renewal schedule if they report a change to MDHHS that potentially affects their eligibility.

III. Limited Retroactive Medicaid Coverage

Beginning January 1, 2027, applicants and beneficiaries of HMP will only be able to request retroactive coverage for the one month immediately prior to their application month. Applicants and beneficiaries of all other Medicaid groups will only be able to request retroactive coverage for their choice of either one or two months immediately prior to their application month.