msa MEDICAL SERVICES ADMINISTRATION

Bulletin

Michigan Department of Community Health

Distribution: Health Care Eligibility Policy 03-02

Issued: June 1, 2003

Subject: Adult Benefits Waiver

Effective: July 1, 2003

Programs Affected: State Medical Program

Effective July 1, 2003, the State will implement the Adult Benefits Waiver to convert the SMP program to a Title XXI coverage.

In order to complete the conversion of the State Medical Program from a State-only funded program to SCHIP (Title XXI), it is necessary to implement a §1115(a)(1) waiver. This policy will closely resemble the current SMP policy but will have all changes clearly defined.

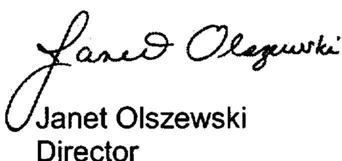
Manual Maintenance

Retain this bulletin for future reference.

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 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.

Approval



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LEGAL BASIS

Medicaid:
1115(a)(1) of the Social Security Act
Title XXI of the Social Security Act

Application Used:
FIA-1171, Assistance Application
County Health Plan Application

TARGET POPULATION

Childless Adults, aged 18 through 64 years old, and with countable income at or below 35% of the federal poverty level who are uninsured may be eligible for this category.

Eligibility begins the first day of the calendar month in which the application was submitted, provided all eligibility criteria are met.

All eligibility factors in this item must be met in the calendar month being tested.

Excluded Population

Applicants and beneficiaries who do not meet the above-stated criteria or who are eligible for Medicaid through any other category are excluded from eligibility in this category.

Retroactive Coverage

There is no retroactive coverage for months prior to month of application for this category.

ELECTRONIC VERIFICATION SYSTEM (EVS) IDENTIFIERS

To be determined.

NONFINANCIAL FACTORS

Consider eligibility for Medicaid under every other category before authorizing this coverage. Applicants and beneficiaries eligible for Medicaid under any other program are not eligible for this category.

The nonfinancial eligibility factors in the following items also must be met according to Medicaid guidelines:

- Citizenship
- Residence
- Social Security Number
- Potential Resources
- Living Arrangement
- Institutional Status (If a person is in a hospital or long term care setting for more than 30 days, there is **NO** patient-pay amount determination. The case should be re-evaluated for other Medicaid categories, and a disability determination should be completed. The person remains eligible for this program while the eligibility determination for other Medicaid categories is being done. There is no Long Term Care coverage for this program but there **is** inpatient hospitalization coverage.)

Applicants/Beneficiaries who have comprehensive health insurance are not eligible. If an applicant/beneficiary has access to comprehensive employer-sponsored health insurance, there are state-sponsored options to allow the applicant/beneficiary to join the employer-sponsored plan. See "Private/Employer Insurance Options" below.

FINANCIAL FACTORS

Fiscal group's total countable income cannot exceed 35% of the Federal Poverty Level (FPL).

Income eligibility cannot be established with a spend down.

The countable asset limit is $3,000.

Asset eligibility exists when the eligibility criteria for assets are met as defined in Chapter I, Section 11 (Low Income Families) of the Health Care Eligibility Policy Manual (HCEP).

FISCAL GROUP COMPOSITION

The fiscal group consists of:

- The applicant/beneficiary and
- The applicant/beneficiary's spouse who lives with the applicant/beneficiary and is not an SSI recipient.

"Lives with" means sharing a home except for a temporary absence. A temporarily absent person is considered in the home.

A person's absence is temporary when:

- His location is known; AND
- There is a definite plan for his return; AND
- He lived with the group before the absence; AND
- The absence lasted, or is expected to last, 30 days or less.

Exceptions to temporary absences:

- A person in a medical hospital is considered in the home
- A person is considered in the home when absent for training or education

If the applicant/beneficiary and/or spouse refuse to provide required information or verification, then neither is eligible.

BUDGETING

Use the FIP-related Medicaid policy to determine countable income.

Budget period is one month.

Averaged income is income received in one month but is intended to cover several months. Divide the income by the number of months it is intended to cover to determine the monthly countable income.

At application, use actual income received during the month of application or amount expected to be received if the application month is also the processing month and additional income is forthcoming for that month.

Base estimates of daily income on a 30-day month.

Earned Income Disregard

Deduct $200 from the person's countable earnings. Then, deduct an additional 20% from the person's remaining earnings.

Paid-Out Child Support Disregard

Disregard court-ordered support paid for a child outside the home by a fiscal group member from the group's remaining combined earned and unearned income. The disregard cannot be greater than the amount ordered for the month; arrearage payments are not deducted.

Special Living Arrangement Disregard

If the applicant/beneficiary has any of the following living arrangements, apply the stated disregard:

Adult Foster Home - Personal Care	$710 – 35% of FPL
Adult Foster Home - Domiciliary Care	$639 – 35% of FPL
Home for the Aged	$427- 35% of FPL

COVERAGES

Adult Benefits Waiver Coverage

Service	Coverage
Ambulance	Limited to emergency ground ambulance transport to the hospital ED.
Case Management	Non-covered
Chiropractor	Non-covered
Dental	Non-covered except for services of oral surgeons as covered under the current Medicaid physician benefit for the relief of pain or infection.
Emergency Department	Covered per current Medicaid policy. For county-administered plans, prior authorization may be required for non-emergency services provided in the emergency department. A $25 co-payment charged by the facility is required if the emergency room visit does not result in admission.
Eyeglasses	Non-covered
Family Planning	Covered; services may be provided through referral to local Title X designated Family Planning Program.
Hearing Aids	Non-covered
Home Health	Non-covered

Adult Benefits Waiver Coverage

Service	Coverage
Home Help (personal care)	Non-covered
Hospice	Non-covered
Inpatient Hospital	Covered; a case rate will be paid on a per admission basis.
Lab & X-Ray	Covered if ordered by an MD, DO, or NP for diagnostic and treatment purposes. Prior authorization may be required by the county-administered health plan.
Medical Supplies/DME	Limited coverage. *Medical supplies are covered except for the following non-covered categories: gradient surgical garments, formulas & feeding supplies, and supplies related to any non-covered DME item.* *DME items are non-covered except for glucose monitors.*
Mental Health Services	Covered; services must be provided through the CMHSP.
Nursing Facility	Non-covered
Optometrist	Non-covered
Outpatient Hospital (non-emergency department)	Diagnostic & treatment services are covered. Diabetes education services are covered in the outpatient setting. Prior authorization may be required for some services. A $3 co-payment for professional services is required.* *OT/PT/Speech are not covered.* *Labor room and partial hospitalization are excluded from outpatient coverage.*
Pharmacy	Products included on the Michigan Pharmaceutical Products List (except enteral formulas) and that are prescribed by an MD, DO, NP or type 10-enrolled oral surgeon. PA may be required. Rx must be billed to the DCH or County Plan, as appropriate. **NOTE:** Psychotropic medications will be provided under the fee-for-service benefit. Injectables used in clinics or physician offices are NOT a pharmacy benefit, except for select psychotropics as noted on the MDCH web site. A $5 co-payment is required for non-branded generic drugs and those listed on the Michigan Preferred Drug List (PDL) or the County Health Plan formularies. A $10 co-payment is required for all other drugs. Beneficiaries may not be charged more for a co-payment than the cost of an individual prescription.

Adult Benefits Waiver Coverage

Service	Coverage
Physician, Nurse Practitioner, Oral Surgeon, Medical Clinic	The following services are covered per current Medicaid policy: Annual physical exams (including a pelvic and breast exam, and pap test). Women who qualify for screening/services under the Breast and Cervical Cancer Program administered by the Local Health Department (LHD) may be referred to that program for services as appropriate. Diagnostic & treatment services. May refer to LHD for TB, STD, or HIV-related services as available. Immunizations per current ACIP guidelines. May be referred to LHD. Travel immunizations are excluded. Injections administered in a physician's office per current Medicaid policy; county plans may require PA for some injections. Prior authorization may be required for some services. A $3 co-payment is required for office visits (professional services).*
Podiatrist	Non-covered
Prosthetics/Orthotics	Non-covered
Private Duty Nursing	Non-covered
Substance Abuse	Covered through local Community Mental Health Services Program
Therapies (OT/PT/Speech)	Non-covered in any setting.
Transportation (non-ambulance)	Non-covered
Urgent Care Clinic	Professional services provided in a freestanding facility are covered; county-administered plans may require authorization by the primary care physician or plan administrator. A $3 co-payment is required.*
*Professional services requiring a co-payment are defined by the following evaluation and management procedure codes: 92002-92014, 99201-99205, 99211-99215, 99241-99245, 99341-99345, 99347-99350, 99385-99387, 99395-99397	

DEPARTMENT REVIEWS

Requests for Department Review, complaints, and grievances regarding **eligibility** for the *Adult Benefits Waiver (ABW)* will be resolved through the Department Review Process.

The family must be notified of the eligibility decision. Included with the notification is the applicant/beneficiary's right to request a Department Review.

The family has the right to appeal the eligibility decision made by the Department.

PRIVATE/EMPLOYER INSURANCE OPTIONS

If an eligible person has access to employer-sponsored health insurance that provides coverage for physician services, pharmacy and inpatient hospital services, the state may provide the person with a voucher (equal in value to the state's cost of providing service) that can be used to join the employer-sponsored plan. Enrollment in the employer-sponsored plan would be in lieu of receiving benefits through the state plan.

The application for coverage will include a box for applicants to check who wish to enroll in employer-sponsored health coverage in lieu of enrollment in the state health plan. Staff operating the voucher program will contact individuals who check the box. Information will then be collected on the employer plan, the employee's share of the cost, eligible persons to be covered under the employer plan, and open enrollment opportunities. The applicant will have the opportunity to discuss the benefits of choosing employer-sponsored coverage versus the state plan coverage so that they may make an informed decision. The applicant will also be provided information regarding his or her responsibilities to maintain coverage through the employer and to report immediately any change related to the employer coverage. Once enrolled in the voucher program, the beneficiary will receive a monthly check for the amount of the employee share of the coverage obtained or the cost of placing the eligible beneficiaries in a state offered health plan, whichever is less.

To ensure the employer-sponsored coverage is actually purchased by the beneficiary, the State will do tape matches with the State's largest insurer (Blue Cross and Blue Shield of Michigan (BCBSM)) and will audit a sample of cases where BCBSM is not the employer's carrier. Those selected in the audit sample will be required to provide copies of pay stubs or other verification that all eligible beneficiaries are enrolled as agreed upon between the state and the beneficiary. Persons who are found not to have purchased the employer-sponsored coverage as agreed will be required to pay back the amount received in premium assistance for months where the coverage was not in place. The beneficiary will also be excluded from future participation in the voucher program.

To ensure that the cost of the employer-sponsored coverage does not exceed the cost of providing coverage through a health plan under contract with the State Medicaid Program, staff will monitor the cost of buying-in on a per beneficiary level. The cost of buying-in to the employer-sponsored coverage will be compared with the cost to the State and federal governments of purchasing coverage through the State plan. If the employer-sponsored coverage were more expensive than the monthly cost of the State plan or the county health plan, the beneficiary will not be allowed to buy-in. If the cost of buying-in is less than or equal to the cost of the State plan, the beneficiary will be allowed to buy-in to the employer-sponsored coverage. The State's monitoring of each buy-in decision will ensure the cost effectiveness of the buy-in program and ensure that the costs to the federal government are no greater than they would have been without the buy-in.