DEPARTMENT POLICY

MA Only

The Healthy Michigan Plan (HMP) is based on Modified Adjusted Gross Income (MAGI) methodology.

The Healthy Michigan Plan provides health care coverage for a category of eligibility authorized under the Patient Protection and Affordable Care Act and Michigan Public Act 107 of 2013 effective April 1, 2014.

Targeted Population

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

- Are 19-64 years of age.
- 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.
- Meet Michigan residency requirements.
- Meet Medicaid citizenship requirements.
- Have income at or below 133% Federal Poverty Level (FPL).

Cost Sharing.

The Healthy Michigan Plan has beneficiary cost sharing obligations. Cost sharing includes copays and contributions based on income, when applicable.

Copayments for services may apply to HMP beneficiaries. Prior to enrollment in a health plan, beneficiaries are eligible to receive Healthy Michigan Plan services through the Fee-for-Service system.

Copays are collected at the point of service, with the exception of chronic conditions and preventive services.

Healthy Michigan Plan beneficiaries, who are exempt from cost sharing requirements by law, are exempt from Healthy Michigan Plan cost-sharing obligations. Similarly, services that are exempt from any cost-sharing by law, such as preventive and family planning services are also exempt for Healthy Michigan Plan beneficiaries.

MI HEALTH ACCOUNTS

Healthy Michigan Plan managed care members are required to satisfy cost-sharing contributions through a MI Health Account. Cost sharing requirements, which include copays and additional contributions based on a beneficiary's income level, will be monitored through the MI Health Account by the health plan.

These requirements 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.

FEE-FOR-SERVICE BENEFICIARIES

For Healthy Michigan Plan beneficiaries who are exempt from enrollment in managed care plans or who have yet to enroll in a managed care plan, copayments for services may apply. Fee-For-Service (FFS) beneficiaries will not be assigned a MI Health Account.

Copayments may be required and due at the point of service for office visits, pharmacy, inpatient hospital stays, outpatient hospital visits, and non-emergency visits to the Emergency Department for beneficiaries age 21 years and older.

MI Marketplace Option

Healthy Michigan Plan beneficiaries will be enrolled in a MI Marketplace Option health plan if they meet the following criteria:

- Enrolled in a Healthy Michigan Plan health plan for twelve (12) consecutive months or more.
- Have not chosen a healthy behavior as part of a Health Risk Assessment (HRA).
- Are age 21 or older.
- Are not pregnant.
- Are not Native American or Alaskan Native.
- Are not cost share exempt.
- Have income over 100 percent of the Federal Poverty Level (FPL), and
- Are not medically exempt or exempt for another reason such as:
  - A resident of a medical or nursing facility.
  - Receive home help or hospice services.
  - Have a medical or behavioral health condition that needs frequent monitoring, limits the ability to work, attend school, or take care of daily needs; bathing, dressing or daily chores.

The MI Marketplace Option health plans do not cover dental, vision, or hearing aids. The drugs that are covered by these plans may be different. Providers who work with each plan may be different.

Health Risk Assessment

MDHHS has developed a Healthy Michigan Plan Health Risk Assessment that encompasses a broad range of health issues and behaviors including, but not limited to:

- Physical activity.
- Nutrition.
- Alcohol, tobacco, and substance use.
- Mental health.
- Influenza vaccination.
- Chronic conditions.
- Recommended cancer or other preventative screenings.

The DCH-1315, Health Risk Assessment, form is available through the health plans or at www.michigan.gov/Assistance Programs/Health Care Coverage/ Healthy Michigan Plan.

NONFINANCIAL ELIGIBILITY FACTORS

The Medicaid eligibility factors in the following items must be met.

- BEM 220, Residence.
- BEM 221, Identity.
- BEM 223, Social Security Numbers.
- BEM 225, Citizenship/Alien Status.
- BEM 255, Child Support.
- BEM 256, Spousal/Parental Support.
- BEM 257, Third Party Resource Liability.
- BEM 265, Institutional Status.
- BEM 270, Pursuit of Benefits.

Credible Coverage

Parents requesting health care coverage for themselves must provide proof that their children have credible coverage, even if not applying for the children.

Credible coverage is health insurance coverage under any of the following:

- Group health plan, individual or student health insurance.
- Medicare or Medicaid.
- TRICARE/CHAMPUS.
- CHIP (MIChild in Michigan).
- Federal Employees Health Benefit Program.
- Indian Health Service.
- Peace Corps.
- Public Health Plan (any plan established or maintained by a State, the U.S. government, or a foreign country)
- A state health insurance high-risk pool.

Assets

The Healthy Michigan Plan does not have an asset test.

Income

Modified adjusted gross income must be at or below 133 percent of the Federal Poverty Level (FPL).

Legal Base

Patient Protection and Affordable Care Act 1902(a)(10)(A)(i)(VIII) of the Social Security Act.

Michigan Public Act 107 of 2013.