MEDICAID POLICY INFORMATION SHEET

Policy Analyst: Phil Kurdunowicz

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Initial ☐ Public Comment ☒ Final ☐

Brief description of policy:

The Michigan Department of Health and Human Services (MDHHS) will implement new work requirements beginning on January 1, 2020 for Medicaid beneficiaries who have Healthy Michigan Plan (HMP) health care coverage. The bulletin also provides updated information on the policy and operational processes for the administration of key elements of the HMP program.

Reason for policy (problem being addressed):

This policy and the related waiver are required by Public Act 208 of 2018.

Budget implication:

☐ budget neutral

☒ will cost MDHHS $ 20,723,500 . This estimate may be impacted by budgetary adjustments that occur through the FY 20 appropriations process.

☐ will save MDHHS $

Is this policy change mandated per federal requirements?

No.

Does policy have operational implications on other parts of MDHHS?

Yes, the Economic Stability Administration (ESA) will also be impacted by this change. ESA field staff and Central Office staff will be assuming new responsibilities as part of administering new work requirements.

Does policy have operational implications on other departments?

The Department of Treasury currently assists with MDHHS with pursuing tax off-sets for beneficiaries who have not paid co-pays and contributions. While the bulletin contains additional information on the process for administering cost-sharing requirements for HMP beneficiaries, the provisions of the bulletin related to tax off-sets reflect the current process and will therefore not impact the operations of the Department of Treasury.

Summary of input:

☒ controversial

☐ acceptable to most/all groups

☐ limited public interest/comment

Supporting Documentation:

State Plan Amendment Required: ☐ Yes ☒ No If Yes, please provide status: ☐ Approved ☐ Pending ☐ Denied Date: Approval Date:	Public Notice Required: ☐ Yes ☒ No If yes, Submission Date:

DRAFT FOR PUBLIC COMMENT Michigan Department of Health and Human Services		
	Project Number: 1926-HMP	**Date:** October 2, 2019

Comments Due: November 6, 2019
Proposed Effective Date: January 1, 2020
Direct Comments To: Phil Kurdunowicz
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Policy Subject: Healthy Michigan Plan Updates

Affected Programs: Healthy Michigan Plan

Distribution: All Providers, Bridges Eligibility Manual (BEM) and Bridges Administrative Manual (BAM) Holders

Summary: The Michigan Department of Health and Human Services (MDHHS) will implement new work requirements beginning on January 1, 2020 for Medicaid beneficiaries who have Healthy Michigan Plan (HMP) health care coverage. The purpose of this bulletin is to provide information regarding changes to the HMP program. MDHHS is implementing these requirements in compliance with Public Act 208 of 2018 and the Special Terms and Conditions of the Section 1115 Demonstration Waiver Amendment that was approved by the Centers for Medicare & Medicaid Services (CMS) on December 21, 2018. The bulletin also provides updated information on the policy and operational processes for the administration of key elements of the HMP program.

Purpose: This policy and the related waiver are required by Public Act 208 of 2018.

Cost Implications: MDHHS anticipates that the enactment of this policy will result in one-time implementation costs of $25,684,400 GF/GP and caseload savings of $4,960,900 GF. These estimates may be impacted by any budgetary adjustments that are enacted through the FY 20 appropriations process.

Potential Hearings & Appeal Issues: Individuals will receive appeal rights in the event they lose coverage for non-compliance. Hearings and appeals for loss of HMP health care coverage will be administered through the existing process.

State Plan Amendment Required: Yes ☐ **No** ☒ **If yes, date submitted:**	**Public Notice Required: Yes** ☐ **No** ☒ **Submitted date:**

Tribal Notification: Yes ☒ **No** ☐ - **Date:** July 16, 2019

THIS SECTION COMPLETED BY RECEIVER

☐ **Approved**	☐ **No Comments**
	☐ **See Comments Below**
☐ **Disapproved**	☐ **See Comments in Text**

Signature:	**Phone Number**
Signature Printed:	
Bureau/Administration *(please print)*	**Date**

Comment001 **Revised 6/16**

Proposed Policy Draft

Michigan Department of Health and Human Services
Medical Services Administration

Distribution: All Providers, Bridges Eligibility Manual (BEM) and Bridges Administrative Manual (BAM) Holders

Issued: December 1, 2019 (Proposed)

Subject: Healthy Michigan Plan Updates

Effective: January 1, 2020 (Proposed)

Programs Affected: Healthy Michigan Plan

The Michigan Department of Health and Human Services (MDHHS) will implement new work requirements beginning on January 1, 2020 for Medicaid beneficiaries who have Healthy Michigan Plan (HMP) health care coverage. The purpose of this bulletin is to provide information regarding changes to the HMP program. MDHHS is implementing these requirements in compliance with Public Act 208 of 2018 and the Special Terms and Conditions of the Section 1115 Demonstration Waiver Amendment that was approved by the Centers for Medicare & Medicaid Services (CMS) on December 21, 2018. HMP beneficiaries who are at least 19 but younger than 62 and do not meet exemption criteria will be subject to the new work requirements as a condition of eligibility.

The bulletin also provides updated information on the policy and operational processes for the administration of key elements of the HMP program:

- The Healthy Behaviors Incentives Program and administration of related healthy behavior requirements
- Co-pays and contributions obligations for HMP beneficiaries
- Identification process for HMP beneficiaries who are medically frail

I. HMP Work Requirements

Beginning on January 1, 2020, HMP beneficiaries who are at least 19 but younger than 62 will be required to complete and report 80 hours of work or other qualifying activities per month as a condition of eligibility unless they meet exemption criteria.

Beneficiaries who are enrolled on or after January 1, 2020 will be required to complete work or other qualifying activities for their second full month of having HMP health care coverage after they become eligible. In accordance with Public Act 50 of 2019, beneficiaries must report work or other qualifying activities for the previous month by the end of each current month.

A. Work and Other Qualifying Activities

Beneficiaries are required to complete and report 80 hours each month of any combination of work or other qualifying activities listed in the table below. Beneficiaries will be able to report work or other qualifying activities either (1) in-person at kiosks in MDHHS field offices, (2) online via the MI Bridges Portal, or (3) by phone via the Healthy Michigan Plan Work Requirement and Exemption Reporting Line.

Work or Other Qualifying Activities for HMP Eligibility	
Type of Work or Qualifying Activity	**Description**
Employment	Individuals who work for another individual or organization in exchange for money are considered to be employed.
Self-Employment	Self-employment includes: • Working in exchange for money. • Working in exchange for goods or services (in-kind). Work-In-Kind does not include the exchange of money.
Income Consistent with Being Employed or Self-Employed	This activity is defined as making money equal to earning the state-mandated minimum wage for 80 hours per month. Examples include earnings from a pension or retirement plan, rental income, or other types of income.
Education Directly Related to Employment	This activity includes participating in an educational program directly related to employment. The beneficiary can participate in person or online, and the beneficiary may also report study hours. Examples of educational programs include (1) preparing for and taking a High School Equivalency test such as the General Equivalency Diploma (GED) exam, (2) attending a basic skills program (e.g. English as a Second Language, computer skills, reading and writing skills), or (3) taking classes with the goal of getting a degree or certificate. The beneficiary can take classes at a university, college, community college, or other post-secondary school.
Job Training	This activity includes receiving training for the beneficiary's job from the beneficiary's employer. Job training can also include participating in job skills training, job training through a workforce program, training to become self-employed, or a job-training program at a community college.
Tribal Employment Program	If the beneficiary is a member of a federally recognized Tribe, the beneficiary can report hours spent in an employment program that has been authorized by the Tribe.
Vocational Training	This activity includes training for a specific type of job or trade. Examples include participating in an apprenticeship program; vocational training shorter than six months; or a full-time practicum, clinicals, or similar program. Vocational training can also include time spent in a classroom, laboratory, studying, or other related activity.

Work or Other Qualifying Activities for HMP Eligibility	
Type of Work or Qualifying Activity	**Description**
Unpaid Workforce Engagement	This activity includes working for a company or organization who is not the beneficiary's employer and developing experience or skills for a future job.
Participation in Substance Use Disorder (SUD) Treatment	This activity includes SUD treatment that is mandated by a court or prescribed by a licensed medical professional. Examples of related activities include participating in counseling, support group meetings or other recovery support programs, residential or inpatient treatment programs, intensive outpatient programs, or medication assisted treatment programs.
Community Service	This activity includes volunteering or providing community service. A beneficiary must volunteer or serve with a non-profit 501(c)(3) or 501(c)(4) organization. Examples include volunteering with a faith-based organization, homeless shelter, soup kitchen, animal shelter, or food bank. A beneficiary can only report this activity for three months per calendar year.
Job Search Related to Employment	This activity is related to looking and applying for jobs. Searching for a job includes searching for a job through a workforce program, completing a job skills assessment or job readiness workshop, preparing or submitting resumes or e-mail applications to apply for job openings, interviewing for jobs, or traveling to job interviews or job fairs.

In accordance with Public Act 50 of 2019, MDHHS will use administrative data when possible to deem that beneficiaries are currently complying with work or other qualifying activities. MDHHS will notify beneficiaries if they are currently deemed to be compliant with work requirements. Beneficiaries who have not received notification related to deeming of compliance should continue to report applicable work or other qualifying activities.

B. Exemptions from Work Requirements

Beneficiaries who meet one or more of the following exemption categories are not required to complete or report work or other qualifying activities. MDHHS will use administrative data to assign an exemption status to beneficiaries when available. Beneficiaries will also be able to report exemptions either (1) in-person at kiosks in MDHHS field offices, (2) online via the MI Bridges Portal, or (3) by phone via the Healthy Michigan Plan Work Requirement and Exemption Reporting Line. Exemptions will last for 12 months from the reported date or until the next health care coverage re-determination, whichever comes first. Based upon the results of the health care coverage re-determination, the beneficiary's exemption may either be extended or ended.

- Beneficiaries who are medically frail
- Beneficiaries who are a caretaker of a family member under 6 years of age. Only one parent at a time can claim this exemption per household.
- Beneficiaries who are receiving temporary or permanent long-term disability benefits from a private insurer or from the government
- Full-time students who are not a dependent of a parent or guardian or whose parent or guardian qualifies for Medicaid
- Beneficiaries who are pregnant or were pregnant within the last two months
- Beneficiaries who are a caretaker of a dependent with a disability who needs full-time care based on a licensed medical professional's order. Only one enrolled HMP beneficiary may claim this exemption per household.
- Beneficiaries who are a caretaker of an incapacitated individual even if the incapacitated individual is not a dependent of the caretaker
- Beneficiaries who have attested to meeting the good cause temporary exemption as defined under state law (MCL 400.107(a)(2)(d))
- Beneficiaries with a medical condition resulting in a work limitation according to a licensed medical professional's order
- Beneficiaries who have been incarcerated within the last six months
- Beneficiaries receiving unemployment benefits from the State of Michigan
- Beneficiaries under 21 years of age who had previously been in foster care placement in Michigan
- Beneficiaries who are in compliance with or exempt from the work requirements for the Supplemental Nutrition Assistance Program (SNAP) and Temporary Assistance for Needy Families (TANF) program

C. Penalties for Non-Compliance with Work Requirements

Beneficiaries who are non-compliant for three months in a single calendar year may be disenrolled and will be subject to a one-month penalty of non-coverage. Beneficiaries will not be disenrolled if the beneficiary can demonstrate good cause for non-compliance, demonstrate that he or she qualifies for an exemption, or satisfy the work requirement by reporting completion of 80 hours for a previous non-compliant month.

In accordance with Public Act 50 of 2019, beneficiaries will have the opportunity to "cure" previous months of non-compliance by reporting completion of the required number of hours of work or other qualifying activities for the specific month of non-compliance. Beneficiaries may cure previous months of non-compliance up to 60 days after the end of the current month.

Individuals who were disenrolled for non-compliance with HMP work requirements may re-apply for coverage. If the individual re-applies for HMP health care coverage, the individual must attest that he or she has completed 80 hours of work or other qualifying activities in a previously unreported month in the past 12 months before an individual's re-enrollment into HMP is approved. The individual may also report an exemption as part of the application process.

II. HMP Healthy Behavior Requirements

A. Current Healthy Behavior Requirements

MDHHS developed a Healthy Behaviors Incentives Program for HMP beneficiaries who are enrolled in a Medicaid Health Plan (MHP). 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 Health Risk Assessment (HRA). MDHHS encourages HMP beneficiaries to complete an HMP HRA on an annual basis, and beneficiaries are offered the opportunity to receive a reduction in cost sharing based on submission of a completed HRA. In addition to the HMP HRA, beneficiaries may also complete a healthy behavior and potentially qualify for incentives by:

- Completing an approved wellness program through an MHP. These programs can take many forms, such as evidence-based tobacco cessation support or health coaching services.
- Completing an appointment for one of the following preventive health services: (1) annual medical check-up, (2) dental check-up or cleaning, (3) recommended cancer screening, (4) recommended vaccination(s), and (5) other preventive care services.

B. Additional Information

Comprehensive information on the Healthy Behaviors Incentives Program and the administration of healthy behavior requirements can be found in the "Policy and Operational Process Document: Healthy Behavior Requirements" included with this bulletin.

III. Cost Sharing Requirements

MDHHS currently requires HMP beneficiaries who are enrolled in an MHP to satisfy cost sharing requirements through a MI Health Account. Cost sharing requirements, which include co-pays and additional contributions that are based on a beneficiary's income level, will be monitored through the MI Health Account.

Beginning January 1, 2020, beneficiaries who are medically frail will be exempt from future co-pays and contributions. Additional information on the administration of MI Health Accounts can be found in the "Policy and Operational Process Document: Co-Pays and Contributions for HMP Beneficiaries" included with this bulletin.

IV. Process for Identification of Medically Frail HMP Beneficiaries

HMP beneficiaries who are considered medically frail in accordance with 42 CFR 440.315(f) are exempt from the work requirements. MDHHS will identify medically frail beneficiaries by (1) self-attestation by the beneficiary and (2) retrospective claims

analysis. Additional information on the identification process can be found in the “Policy and Operational Process Document: Identification of Medically Frail Beneficiaries” included with this bulletin.

Policy and Operational Process Document: Healthy Behavior Requirements

I. INTRODUCTION

The Michigan Department of Health and Human Services (MDHHS) developed a Healthy Behaviors Incentives Program specific to the Healthy Michigan Plan (HMP) managed care population. 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 Health Risk Assessment (HRA).

Following evaluation and additional feedback from stakeholders, MDHHS is updating the Healthy Behaviors Incentives Program to promote greater beneficiary engagement and reward progress towards healthy behaviors over time. These changes are meant to strengthen the program's capacity to encourage behavior change for both new and existing enrollees. MDHHS modified the HMP HRA and the overall incentive framework in support of these goals, expanding the scope of services and medications deemed exempt from cost sharing as a way to reduce barriers to needed care, and detailing the impact of certain healthy activities on delivery system options as described below.

II. HEALTH RISK ASSESSMENT

HMP beneficiaries are expected to remain actively engaged with the Healthy Behaviors Incentives Program each year that they are in HMP. MDHHS has developed a 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

The HRA is available for completion by all HMP managed care enrollees. New beneficiaries will continue to be informed about the program when they first enroll by the enrollment broker and in the welcome packets they receive from their MHP. In order to remain relevant and appropriate for members who have completed multiple annual HRAs, the form accounts for consideration of progress on the previous year's goals for existing members, as attested by the primary care provider. Additional healthy behaviors have been added to the HRA, such as recommended cancer screenings and preventive dental care, to ensure the selection of targeted healthy behaviors is sufficiently diverse for members who have already achieved multiple healthy behavior goals. As some healthy behavior goals may require significant annual effort to maintain (i.e., not regressing into prior tobacco use), an additional goal of maintaining a previously achieved healthy behavior goal(s) has also been added. The revised HRA will be posted on the department's website at www.michigan.gov/healthymichiganplan.

Assistance with completion of the HRA is available to new and existing beneficiaries. To start the HRA, members can answer the first self-report portion on their own, with the assistance of the enrollment broker or with assistance from their selected MHP. Another

option is that members can answer the first portion of the HRA online through a secure statewide beneficiary portal called the MyHealthButton. The HRA has also been translated into Spanish and Arabic. The self-report sections include assessment of engagement in healthy behaviors and questions that indicate how much assistance beneficiaries may need to achieve health in regard to particular issues. The final portion of the HRA will be done in the primary care provider's office and includes attestations by the provider that the beneficiary has acknowledged changes in behavior that may need to be made, and the member's willingness/ability to address those behaviors.

Successful entry into any health care system includes an initial visit to a primary care provider, especially for beneficiaries who may have unmet health needs. For HMP managed care enrollees, this initial appointment can include a conversation about the healthy behaviors identified in the HRA, member concerns about their own health needs, member readiness to change, and provider attestations of the member's willingness/ability to address health needs. HMP beneficiaries are expected to contact their primary care provider within 60 days of enrollment to schedule a well care appointment and complete the HRA, though there is no penalty for beneficiaries who choose not to do so.

An annual preventive visit is a benefit of the HMP and existing members are encouraged to complete an annual HRA with their primary care provider. As the program matures, HMP members will increasingly be at different stages of behavior change. The revisions to the HRA are designed to keep the program meaningful for both newly enrolled members and those who have begun to make significant lifestyle changes.

III. ADDITIONAL MECHANISMS TO DOCUMENT HEALTHY BEHAVIOR ACTIVITIES

To improve the ability of individuals to participate in the Healthy Behaviors Incentives Program, additional mechanisms to document healthy behaviors have been added for individuals who may have completed healthy behavior activities but do not have a submitted HRA for documentation. The documentation includes claims/encounters data and documented participation in wellness and population health management programs, including those submitted by an MHP.

MDHHS will use claims and encounter data to document healthy behaviors for managed care enrollees 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
- Advisory Committee on Immunization Practices (ACIP) recommended vaccination(s)
- Other preventive screenings

The associated codes for the health services listed above will be posted on the department's website at www.michigan.gov/healthymichiganplan. This mechanism to document healthy behaviors will primarily involve the review of historical claims information (from the preceding 12 months) for the presence of the selected codes.

In addition, with the introduction of the new managed care contract in January 2016, all MHPs must ensure their members 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. The MHPs are also required to provide population health management programs which address social determinants of health such as food security or health literacy. These kinds of programs play an important role in helping members achieve their healthy behavior goal(s) and provide important skills and resources so that individuals can self-manage their health. To encourage participation in these valuable programs, members with documented participation in approved MHP wellness and population health management programs will also be eligible for Healthy Behaviors Incentives.

IV. HEALTHY BEHAVIORS INCENTIVES

HMP managed care enrollees will be rewarded for addressing behaviors necessary for improving health. MDHHS believes that this approach serves as an innovative model that rewards members for appropriate use of their health care benefits. Managed care enrollees who complete an HRA with a primary care provider attestation and agree to address or maintain healthy behaviors will receive an incentive. Existing members must also review their progress on their previous year's goal(s) with their primary care provider, who must attest on the HRA that the individual achieved or made significant progress towards their selected healthy behavior goal(s) over the last year to be eligible for an incentive. All individuals receiving an incentive are eligible for a 50 percent reduction in co-pays for the rest of the year once the enrollee has paid 2 percent of their income in co-pays. Individuals who pay a contribution (those above 100 percent of the FPL) will also be eligible for a reduction in their monthly contribution to 1 percent of income. To encourage consistent multi-year participation in the Healthy Behaviors Incentives Program, individuals who pay a contribution (those above 100 percent of the FPL) will have their monthly contribution waived in its entirety if they complete an annual HRA on time each year over two or more years. Members who complete an assessment 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.

MHP enrollees who complete the HRA but decline to engage in healthy behaviors are not eligible for incentives.

Members may complete more than one HRA during a year, but may only receive an incentive once per year. Members who initially decline to address behavior change may become eligible if they return to the provider, complete the assessment, and agree to address one or more behavior changes, as attested to by their primary care provider. Members do NOT have to complete the initial appointment or assessment during a specific window of time to be eligible for the incentive. The clock on the annual incentive begins when the member completes the initial appointment and assessment.

Individuals who do not complete a HRA but are identified as completing a healthy behaviors activity (as documented through specific claims/encounters data or documented participation in wellness and population health management programs) will earn the same contribution and co-pay reductions as individuals who complete the HRA and agree to address or maintain a healthy behavior.

Any earned reductions in cost sharing will be applied through the MI Health Account, as detailed in the "Policy and Operational Process Document: Co-Pays and Contributions for HMP Beneficiaries." Consistent with state law, a member who has earned a reduction in cost sharing but is subsequently found to be in 'consistently failed to pay' status will lose all or a portion of that reduction for the remainder of the year in which it was earned. All individuals will lose the 50 percent reduction in co-pays. Those individuals who pay a contribution (those above 100 percent of the FPL) will lose eligibility for the reduction in their monthly contribution to 1 percent of income, but their monthly contribution will not exceed 2 percent of income. A member has consistently failed to pay when either of the following has occurred: no payments have been received for 90 consecutive calendar days, or less than 50 percent of total cost sharing requirements have been met by the end of the year.

V. STRUCTURED INTERVENTIONS TO ASSIST WITH IDENTIFIED HEALTHY BEHAVIORS

Beneficiaries will have access to structured ongoing support in their efforts to improve healthy behaviors as identified through the Healthy Behaviors Incentives Program. All MHPs are required to have policies in place indicating how they use the HRA data to identify members who have identified healthy behaviors goal(s) and their process for outreach and education to these members. They are also required to report annually on the members reached and provide documentation of the support services, education or other interventions provided by the MHP. Examples of these interventions include patient education, health coaching and linkages to community programs. In addition, all MHPs have robust care management programs to assist their members in obtaining health goals. For example, all MHPs have a diabetes case management program which includes information on nutrition and physical activity. The information gleaned from the HRA can be used by the MHPs to determine suitability for member enrollment into this type of care management program, or for referral for other covered services that will assist the member in changing unhealthy behaviors or maintaining current healthy activities.

Once a member has been identified as in need of any covered services, MHPs coordinate care with necessary providers to ensure that timely, appropriate services are rendered. The MHPs are contractually obligated to cover smoking cessation counseling and treatment in accordance with the Treating Tobacco Use and Dependence: 2008 Update, issued by the U.S. Department of Health and Human Services. It includes counseling, telephonic quit line support, over-the-counter and prescription medications, and combination therapy. Annual preventive visits, Advisory Committee on Immunization Practices (ACIP) recommended vaccinations and treatments for alcohol use, SUD and mental health issues are covered services under HMP. MHPs also cover maternity care and dental services for HMP enrollees. MDHHS expects MHPs to adhere to recognized clinical practice guidelines for the treatment of HMP members.

VI. REDUCING ACCESS BARRIERS

Access to care for Medicaid members is critical. MDHHS has and will continue to measure access to necessary providers, especially primary care providers upon whom HMP managed care enrollees rely to earn their incentives. With passage of the HMP legislation, network adequacy reports were developed for each county in the state based on the potential enrollment of new members into HMP.

In addition, HMP members may receive services, including the initial appointment and completion of the HRA, through Fee-For-Service (FFS) before they are enrolled in an MHP. Given the short time period (usually one month) that new enrollees are in FFS before enrollment in an MHP, MDHHS expects there to be relatively few instances of an FFS provider completing the initial appointment and the HRA. When it does occur, the MHPs are responsible for either working directly with the FFS provider to obtain the HRA or assisting the member in getting the necessary HRA information from the provider. Providers have also been instructed to give each beneficiary a copy of their completed assessment at the initial appointment so the beneficiary can forward a copy of their completed HRA to their MHP after enrollment. Beneficiaries who complete the HRA during the FFS period are eligible for the incentives upon enrollment into an MHP.

VII. EDUCATION AND OUTREACH STRATEGY

MDHHS has developed a four-pronged education strategy that will ensure members hear the same message across different entities and will maximize the potential for member engagement in healthy behaviors and achievement of incentives. At all potential points of contact in the enrollment process (the enrollment broker, MDHHS, MHPs, and providers), members will receive information about the Healthy Behaviors Incentives Program, including eligibility requirements. To ensure consistency, member engagement scripts with Healthy Behaviors Incentives Program information will be developed and shared with the enrollment broker and the MHPs.

Language has been included in the HMP handbook, brochures and other member communications to inform beneficiaries about potential reductions in their cost sharing based on their engagement in healthy behaviors.

The department's enrollment broker can facilitate member questions on the HRA, inform beneficiaries about the Healthy Behaviors Incentives, assist them with choosing a primary care provider, and encourage them to schedule and complete their initial appointment. When MHPs make welcome calls to new HMP members, their scripts include information about the Healthy Behaviors Incentives Program. During these calls, MHPs will assist members in scheduling an initial appointment and can arrange for transportation if necessary. MHPs can also assist the member to complete the HRA telephonically with a registered nurse, Certified Health Education Specialist (CHES), or other appropriately credentialed personnel as directed and approved by MDHHS. MHPs send welcome packets to new members within 10 days of enrollment into the plan. These packets will include written information on the Healthy Behaviors Incentives Program at no higher than a 6.9 grade level. MHPs will also include Healthy Behaviors Incentives Program information on their website and in their member newsletters.

Information about the Healthy Behaviors Incentives Program and how to participate is also included in the mobile application for beneficiaries, the MyHealthButton. It includes an online option for starting the HRA, a repository where beneficiaries can see their completed HRA results submitted by their primary care provider, and tools and resources to assist them with achieving their selected healthy behavior goal(s).

VIII. PROVIDER STRATEGY

MDHHS developed a voluntary, web-based training for providers which covered the HMP HRA, Healthy Behaviors Incentives, and associated processes in 2014. The training was available for completion online and had continuing medical education (CME) units associated with it. Given the many updates to the Healthy Behaviors Incentives Program, MDHHS is now developing new multi-media materials for providers to educate them about the upcoming changes to the program.

MHP provide current information about the Healthy Behaviors Incentives Program to the providers in their networks through provider newsletters and provider portals. MHPs are also required to pay an incentive to providers who complete the HRA with their HMP members. Details of the provider incentive and payment mechanism are plan-specific and are made available to providers by the MHPs with which they participate. Providers who work with patients to complete the HRA during the FFS period are eligible for the MHP provider incentive once the member has enrolled in the MHP.

Currently, the HRA submission process for providers is different for each MHP. MDHHS implemented two secure statewide submission processes to streamline the process for providers. These new processes allow providers to submit completed HRAs via a central MDHHS fax line or through a direct data entry option within CHAMPS via a new HRA Provider Profile. When a provider completes an HRA for a managed care enrollee utilizing either the central MDHHS fax or through direct data entry into CHAMPS, the completed HRA is securely routed to the appropriate MHP for application of incentives.

IX. DATA SYSTEMS AND MONITORING PROCESSES

HRA data is put into electronic file formats and securely transferred from the enrollment broker and MHPs to the department's data warehouse where it is then stored. The files include member name and ID number, the enrollee's MHP, and the name and National Provider Identifier of the primary care provider who completed the HRA so that HRA data can be tracked and monitored at the beneficiary, provider and plan level. HRA data can be cross referenced with care provided to beneficiaries through encounter data. HRA data is monitored monthly and MDHHS developed a measure of HRA completion which is reported quarterly. This measure was also included in the performance bonus for MHPs starting in SFY2016.

The healthy behaviors file will now be expanded to include the new Healthy Behaviors Incentives Program data. MHPs will generate a list of members who are eligible for incentives because the member participated in approved wellness programs. This information will be submitted to MDHHS through modification of the healthy behaviors file. MDHHS will identify the members who are eligible for incentives because the member utilized identified wellness health services documented through claims/encounters. This

data will then be stored in the department's data warehouse. Just like the HRA data, it will be possible to query all aspects of the program data, and new queries and performance measures will be developed for tracking and monitoring at the beneficiary, provider and plan level.

Cross-referencing with encounter data also assists with monitoring provider accountability. MHPs are required to set standards for accountability for their provider networks. In addition, MDHHS developed an Access to Care measure specific to the HMP managed care population to determine how many new members completed an initial appointment within 150 days of enrollment into the MHP. This measure is based on encounter data extracted from the department's data warehouse and is tracked by region, MHP, and as a state overall. In SFY2016, this measure was included in the Performance Bonus for the MHPs as well.

MDHHS receives the amount of cost sharing expected and received by each HMP member from the department's selected payment vendor. On a quarterly basis, MDHHS cross references a sample of beneficiaries with records in the department's data warehouse indicating they had earned a reduction with beneficiaries who had reductions processed. A sample of each MHP's population is pulled. Results are processed and reported to confirm accurate application of cost sharing reductions. MHPs found to be in non-compliance with processes and procedures related to application of cost sharing reductions are subject to established remedies and sanctions per the MHP contract.

Policy and Operational Process Document: Co-Pays and Contributions for HMP Beneficiaries

I. INTRODUCTION

This document outlines the policy and operational process for Healthy Michigan Plan (HMP) co-pays and contributions. These requirements apply to the Michigan Department of Health and Human Services (MDHHS), the department's contracted MHPs, and the department's selected payment vendor[1] as further described herein.

The department's payment vendor will establish a MI Health Account for all beneficiaries who are enrolled in HMP through the MHPs. The MI Health Account is a unique health care savings vehicle through which various cost sharing requirements, which include co-pays and additional contributions for beneficiaries with higher incomes, will be satisfied, monitored and communicated to the beneficiary.

II. MI HEALTH ACCOUNT POLICY AND OPERATIONAL PROCESS

Cost sharing, as described further below, includes both co-pays and contributions based on income. Once enrolled in an HMP MHP, most cost sharing obligations will be satisfied through the MI Health Account. However, point of service co-pays may be required for a limited number of services that are carved out of the MHPs, such as certain drugs.

Beneficiaries who are exempt from cost sharing requirements by law, regulation, or program policy will be exempt from cost sharing obligations via the MI Health Account (e.g. individuals who are medically frail, individuals receiving hospice care, pregnant women receiving pregnancy-related services, individuals eligible for Children's Special Health Care Services, American Indians and Alaska Natives in compliance with 42 CFR 447.56, etc.). Similarly, services that are exempt from cost sharing by law, regulation or program policy (e.g., preventive and family planning services), or as defined by the "Policy and Operational Process Document: Healthy Behavior Requirements", will also be exempt for HMP beneficiaries. Finally, beneficiaries cannot be charged more than 5 percent of their total income through any combination of co-pays and contributions.

In addition, those services that are considered private and confidential under the department's Explanation of Benefits framework will be excluded from the Healthy Michigan Plan Statement and, therefore, will be exempt from cost sharing for these HMP enrollees. MDHHS, in cooperation with its Data Warehouse vendor, will ensure that claims information submitted to the payment vendor for use in preparing the Healthy Michigan Plan Statement excludes those confidential services and/or medications outlined in this framework. The department's Explanation of Benefits framework is updated by MDHHS at least annually. The Explanation of Benefits framework is also shared with the MHPs for

[1] There is a single vendor that all of the MHPs use for the billing and processing of payment function. This vendor is designated as a mandatory subcontractor for the MHPs, and each of the plans contract with the payment vendor to provide services related to the MI Health Account processing, consistent with the document. MDHHS also holds a contract with the payment vendor which lays out the vendor's obligation to both MDHHS and the MHPs with respect to these functions.

use in preparing Explanation of Benefits documents for federal health care program beneficiaries. The framework is available to other providers upon request. Finally, unless otherwise specified by this document or the "Policy and Operational Process Document: Healthy Behavior Requirements", co-pay amounts will be consistent with Michigan's State Plan.

A. Required Co-Pays

HMP utilizes an innovative approach to co-pays that is intended to reduce barriers to valuable health care services and promotes consumer engagement. During an HMP beneficiary's first six months of enrollment in an MHP, there will be no co-pays collected at the point of service for MHP covered services. At the end of the six-month period, an average monthly co-pay experience for the beneficiary will be calculated. The initial look-back period will include encounters during the first three months of enrollment in the MHP in order to account for claim lag and allow for stabilization of the encounter data. Analysis of the beneficiary's co-pay experience will be recalculated on a quarterly basis going forward.

The average co-pay amount is re-calculated every three months to reflect the beneficiary's current utilization of health care services, consistent with available data. MDHHS will consider the dates of service and adjudication date for claims received to determine the beneficiary's experience and calculate the co-pay amount going forward. These co-pay amounts will be based on encounter data submitted by the MHPs to MDHHS and will be shared via interface with the payment vendor. The payment vendor is then responsible for communicating the co-pay amounts due to the beneficiary via a quarterly account statement as described in Section V. This account statement will include a summary of account activity and any future amounts due, as well as a detailed (encounter level) explanation of services received. As noted earlier, one important exception to the amount of encounter level detail provided is that confidential services will not be shown on the Healthy Michigan Plan Statement; therefore, the beneficiary will have no cost sharing associated with those services. The provision of this encounter level data to the beneficiary is key to engaging the beneficiary as a more active consumer of health care services and will also provide sufficient information for the beneficiary to recognize and pursue resolution of any discrepancies. MDHHS reserves the right to modify the statement at any time, in consultation with the Centers for Medicare & Medicaid Services (CMS).

The co-pay amounts collected from the beneficiary by the payment vendor will be disbursed to the MHPs and will not accumulate in the MI Health Account. In addition, there will be no distribution of funds from the MI Health Account to the beneficiary to pay co-pays. However, information regarding co-pays owed and paid will be included as an informational item on the quarterly Healthy Michigan Plan Statement, as further defined and described in Section V. Ensuring that beneficiaries are aware of the amounts owed or why payment was not required (i.e., a preventive service was provided) is a key component of HMP. The MHPs, in cooperation with MDHHS and the payment vendor, will be responsible for beneficiary education and engagement consistent with Section VII.

Reductions in co-pays will be implemented consistent with the "Policy and Operational Process Document: Healthy Behavior Requirements". The payment vendor is responsible for determining when each beneficiary has reached the threshold that enables co-pay reductions to occur. The payment vendor will also communicate co-pay reductions to the beneficiary as part of the Healthy Michigan Plan Statement.

B. Required Contributions

In addition to any relevant co-pays, a monthly contribution is also required for beneficiaries who have an income greater than 100 percent of the FPL. Consistent with state law, contributions are not required during the first six months the individual is enrolled in an MHP. However, the payment vendor will notify the beneficiary, via the Healthy Michigan Plan Statement, a welcome letter and, when applicable, through scripts used by the vendor's customer service representatives, that contributions will be required on a monthly basis starting in month seven.

Consistent with the Special Terms and Conditions and the "Policy and Operational Process Document: Healthy Behavior Requirements", the contribution amount will not exceed 2 percent of the amount that represents the beneficiary's percentage of the FPL, with reductions occurring for Healthy Behaviors as described therein. However, in practice, MDHHS plans to consider family composition when calculating contribution amounts. For example, when a beneficiary with several dependents qualifies for the HMP, MDHHS will consider that fact when assessing their contribution amount.

In addition, MDHHS intends to consider the fact that multiple HMP beneficiaries may reside in the same household when calculating contribution amounts. This modification is intended to align the amounts contributed by the household more closely with that of the federal exchange as well as existing regulatory limits on household cost sharing.

The payment vendor will calculate the required contribution amount and communicate this to the beneficiary, along with instructions for payment, as part of the MI Health Account quarterly statement. More information about the process for calculating contributions can be found on the department's website at: www.michigan.gov/healthymichiganplan >> click on "MI Health Account."

C. Impact of Health Care Services Received on the MI Health Account

Beneficiary contributions to the MI Health Account are not the first source of payment for health care services rendered. The MHPs are responsible for 'first dollar' coverage of any MHP covered services that the beneficiary receives up to a specified amount, but the amount will vary from person to person. For example:

- For individuals at or below 100 percent of the FPL, co-pays will accumulate in the account, and the MHPs will be responsible for payment of all MHP covered services.

- For individuals above 100 percent of the FPL (who make additional monthly contributions to the account), the MHPs may utilize beneficiary funds from the MI

Health Account once the beneficiary has received a certain amount and type of health care services.

- This means that the amount that the MHPs must pay before tapping beneficiary contributions will vary from beneficiary to beneficiary based on his or her annual contribution amount.

- The amount of MHP responsibility for these beneficiaries will be based on the following formula:

  $1000 – (amount of beneficiary's annual contribution) =
  MHP "First Dollar" Coverage Amount

To further explain this calculation, if an individual has a required annual contribution of $300 per year, the MHP will be responsible for the first $700 of services before using any beneficiary contributions. In addition, given the limitations on cost sharing and the importance of maintaining beneficiary confidentiality, the impact of various services on funds in the MI Health Account will vary.

In addition, as noted above, only services covered by the MHPs will impact the MI Health Account. As a result, any items or services that are carved out of the MHPs (e.g. psychotropic drugs, Prepaid Inpatient Health Plan [PIHP] services) will not impact the MI Health Account or be reflected on any account statement. MDHHS and the MHPs have identified the services that will be carved-out of the MHP's scope of coverage via the managed care contracts. These contracts are available via the department's website. The Healthy Michigan Plan Statement will also clarify for the beneficiary that the statement may not reflect all health care services that they received (i.e., because the service was confidential, the claim was not submitted, or the MHP does not cover the service).

Finally, any services considered confidential under the department's Explanation of Benefits framework or otherwise excluded from cost sharing based on law, regulation or program policy will not be subject to any cost sharing through the MI Health Account. This limitation includes the use of beneficiary contributions by the MHPs once the plan's first dollar responsibility is exceeded. While no confidential services may be reflected on the Healthy Michigan Plan Statement, services that do not require suppression but are exempt from cost sharing of any type must be reflected on the statement as a service for which no payment is required, such as preventive services which are described in the following example.

D. MI Health Account Cost Sharing Reductions

Both types of cost sharing (co-pays and contributions) may be reduced if certain requirements are met.

1) MI Health Account Reductions Related to Chronic Conditions

   The MHPs must waive co-pays if doing so promotes greater access to services that prevent the progression of and complications related to chronic disease consistent

with the following. MDHHS has provided the MHPs with lists of conditions and services, which include both diagnosis codes and drug classes, for which co-pays must be waived for all HMP beneficiaries. These lists will be posted on the department's website at www.michigan.gov/healthymichiganplan. The MHPs may suggest additions or revisions to these lists, and MDHHS will review these suggestions annually. However, any additions must be approved in advance by MDHHS and shared with the payment vendor and all other MHPs to ensure consistency and appropriate calculation and collection of amounts owed. MDHHS will continue to engage stakeholders on this issue and ensure transparency and access to information surrounding these lists, which will include both provider and beneficiary education and outreach, policy bulletins when appropriate, and online availability of the lists. Any reductions to the lists must be approved in advance by CMS.

2) MI Health Account Healthy Behavior Cost Sharing Reductions

a. Co-Pays

Co-pays may also be reduced if a beneficiary engages in certain healthy behaviors, as detailed in the "Policy and Operational Process Document: Healthy Behavior Requirements". Before co-pays may be reduced, a beneficiary's co-payments must reach a 2 percent threshold of their income. Beneficiaries are only eligible for reductions when they are in good standing in terms of payment of co-pays and contributions.

The evaluation period for determining whether a beneficiary has satisfied the threshold for co-pay reduction will be the beneficiary's enrollment year. This means that the beneficiary will have one year to make progress toward the threshold of co-payments before that threshold resets. Once the threshold is reached, the reductions will be processed and reflected on the next available Healthy Michigan Plan Statement. Additional information on the criteria for earning these reductions is included in the "Policy and Operational Process Document: Healthy Behavior Requirements".

b. Contribution Reductions

The payment vendor, with participation by and oversight from the MHPs and MDHHS, is responsible for ensuring that the calculation and collection of all cost sharing amounts is performed in accordance with the "Policy and Operational Process Document: Healthy Behavior Requirements" with respect to the waiver or reduction of any required cost sharing. This includes, but is not limited to, the existence of appropriate interfaces between MDHHS, the MHPs and the payment vendor to transmit account information, encounter data and any other beneficiary information necessary to provide an accurate accounting of amounts due, received and expended from the MI Health Account. Refer to the "Policy and Operational Process Document: Healthy Behavior Requirements" for further information.

III. ACCOUNT ADMINISTRATION

The MHPs, the payment vendor and MDHHS are jointly responsible for ensuring that procedures and system requirements are in place to ensure appropriate account functions consistent with the following:

- Interest on account balances is not required.

- Upon a beneficiary's death, the balance of any funds in the MI Health Account will be returned to MDHHS after a 120-day claims run-off period.

- State law limits the return of funds contributed by the beneficiary to the beneficiary only for the purchase of private insurance.

- When the beneficiary is no longer eligible for HMP health care coverage, the balance of any funds contributed by the beneficiary will be issued to the beneficiary after a 120-day claims run-off period from the encounter transaction date for the purchase of private health insurance coverage. The payment vendor will utilize information provided via the department's claims and eligibility systems, along with the vendor's own account expenditure information, to determine whether a beneficiary qualifies for a voucher.

- The payment vendor must modify the amount of required cost sharing if the beneficiary reports a change in income and communicate any changes in amounts owed to the beneficiary, the MHP and MDHHS, as appropriate. Beneficiaries are required to notify their MDHHS eligibility specialist of any changes and are made aware of this requirement in both the rights and responsibilities section of the beneficiary handbook, communications from MDHHS, and the Healthy Michigan Plan Statement. MDHHS is the system of record for these changes, and the payment vendor will make prospective adjustments as needed. Adjustments will be made based upon information received from the department's eligibility system. Adjustments will also be made based upon the reported date of the change in income.

- All amounts received from the beneficiary will be credited to any balance owed and will be reflected on the next available quarterly statement. Similarly, disbursement of funds by the payment vendor to the MHPs from the MI Health Account (when applicable) is required in a timely manner, following appropriate verification of claims for covered services.

- The payment vendor will be responsible for the transfer of funds and appropriate credit and debit information in the event a beneficiary changes his or her MHP.

- Beneficiaries lack a property interest in MI Health Account funds contributed by them. To that end, any amounts in the MI Health Account are not considered income to the beneficiary upon distribution and will not be counted as assets.

- No interest may be charged to the beneficiary on accrued co-pay or contribution liabilities.

- Any amounts remaining in the account after the first year will not offset the beneficiary's contribution requirement for the next year. In addition, the amount that must be covered by the MHP as 'first dollar' will decrease in each subsequent enrollment year when beneficiary contributions remain in the account.

- The maximum amount of beneficiary funds that may accumulate in a MI Health Account is capped at $1000. If a beneficiary's MI Health Account balance reaches $1000, his or her contributions will be suspended until the account balance falls below $1000. The MHP may utilize these funds for services rendered consistent with this document.

- The payment vendor must provide multiple options for the beneficiary to remit co-pays and contributions due. These options must include, at a minimum, a check, money order, and electronic transfer (e.g. Automated Clearing House or ACH). Any such partner must be free or low cost and prior approved by MDHHS.

- Months 7-18 of enrollment in an MHP will constitute the first year for MI Health Account accounting purposes.

- The payment vendor has a process in place to accept third party contributions to the MI Health Account on behalf of the beneficiary. This includes ensuring that any amounts received are credited to the appropriate beneficiary and the remitter (or individual who made the payment) is tracked, and providing multiple options for individuals or entities to make contributions on behalf of a beneficiary (e.g. money order, check, online ACH, etc.). Because the amount of beneficiary funds that can accumulate in the MI Health Account is capped at $1000, third parties may not contribute amounts in excess of that limit. State law does not limit which individuals or entities may contribute to the MI Health Account on the beneficiary's behalf, and any third party's contribution will be applied directly to the beneficiary's contribution requirement. Because the beneficiary lacks a property interest in any amounts in the MI Health Account, including his or her own contributions, the contributions of any third party are not considered income, assets or resources of the beneficiary for any purpose.

- In the event contributions are received from a third party as part of a federal health initiative (such as the Ryan White Program) all excess funds must be returned to the appropriate remitter (i.e., the person or program who made the payment) if required by relevant law and regulation.

MDHHS will monitor both the MHPs and the payment vendor for compliance with the above requirements.

IV. BENEFICIARY AND PROVIDER ENGAGEMENT

A. Beneficiaries

1) Healthy Michigan Plan Statements and MI Health Account Costs

A primary method of increasing awareness of health care costs and promoting consumer engagement in this population will be through the use of a quarterly Healthy Michigan Plan Statement. These Healthy Michigan Plan Statements will be drafted at the appropriate grade reading level and will reflect the principles outlined in this document, as well as the "Policy and Operational Process Document: Healthy Behavior Requirements" when applicable.

The payment vendor must provide the beneficiary with at least the following information on a quarterly basis (along with year-to-date information when appropriate):

- MI Health Account balance
- Expenditures by the MHP for covered services over the past three months
- Co-pay amount due for next three months
- Co-pays collected in previous three months
- Past due amounts
- Contribution amount due for the next three months
- Contributions collected in previous three months
- Reduction to co-pays applied when calculating the amount due for the next three months due to beneficiary compliance with healthy behaviors (as applicable)
- Reduction to contributions applied when calculating the amount owed due to beneficiary compliance with healthy behaviors (as applicable)
- An appropriate subset of encounter-level information regarding services received, including (but not limited to) the following:
  - A description of the procedure, drug or service received
  - Date of service
  - Co-payment amount assigned to that service
  - Provider information
  - Amount paid for the service

The Healthy Michigan Plan Statement must contain the above information and be in a form and format approved by MDHHS, in consultation with CMS. Hard copies of these statements must be sent to beneficiaries through U.S. mail on a quarterly basis, though beneficiaries may elect to receive electronic statements as approved by MDHHS. In terms of expenditure information, the Healthy Michigan Plan Statement will reflect only those services provided by the MHPs and will only share utilization details consistent with privacy and confidentiality laws and regulations. The Healthy Michigan Plan Statement will also include information for beneficiaries on what to do if they have questions or concerns about the services or costs shown on the statement. Beneficiaries will also have the option to utilize the MHP's grievance process, as appropriate.

V. BENEFICIARY EDUCATION FOR MI HEALTH ACCOUNT

The MHPs and the payment vendor will be responsible for beneficiary education regarding the role of the MI Health Account and the beneficiary's cost sharing responsibilities. While the Healthy Michigan Plan Statements are designed to provide beneficiaries with

information on health care costs and related financial responsibilities, it is important that the beneficiary also receive information that helps them become a more informed health care consumer.

The department's contract with the MHPs requires the plans' member services staff to have general knowledge of the MI Health Account, appropriate contact information for the payment vendor for more specific questions, and the ability to address any complaints members have regarding the payment vendor. In addition, because the payment vendor is a subcontractor of the MHPs, the plans are required by contract to monitor the payment vendor's operations.

The payment vendor will be responsible for providing sufficient staffing and other administrative support to handle beneficiary questions regarding the MI Health Account and will be obligated to educate beneficiaries (via in person, telephone, or written communication) regarding these topics. This education must include information on how to use the statements and make required contributions and co-pays and address any questions or complaints regarding the beneficiary's use of the MI Health Account. The MHPs are responsible for providing members with handbooks that include information about HMP generally, including the MI Health Account and its cost sharing mechanism. Finally, MDHHS will work with the MHPs and the provider community to ensure that information on potential cost sharing amounts is provided to the beneficiary at the point of service.

A. Providers and MHPs

The MHPs, on behalf of MDHHS, will be responsible for education within their provider networks regarding the unique cost sharing framework of the MI Health Account as it applies to HMP. This may include in-person contact (on an individual or group basis), as well as information provided in newsletters, email messages and provider portals. This education must include, but is not limited to, the following topics:

- The co-payment mechanism and the impact on provider collection;
- The importance of providing services without collection of payment at the point of service for all MHP covered services;
- Options for reducing required contributions to the MI Health Account (as more fully described in the "Policy and Operational Process Document: Healthy Behavior Requirements"), including provider responsibilities associated with those reductions; and
- The elimination of co-pays (through the MI Health Account mechanism) for certain chronic conditions (as more fully described in the "Policy and Operational Process Document: Healthy Behavior Requirements"), as well as the scope of coverage and cost sharing exemptions for preventive services.

MDHHS has partnered with various professional associations within the state, as well as its provider outreach division, to ensure that education regarding HMP and the MI Health Account occurs consistent with procedures already in place to address education needs in light of program changes.

B. Ongoing Strategy

MDHHS will receive regular reports from the payment vendor and the MHPs regarding the operation of the MI Health Account. For example, the payment vendor will provide regular reports to MDHHS and the MHPs regarding MI Health Account collections and disbursements and may provide additional information regarding beneficiary engagement and understanding as reflected through the payment vendor's call center operations upon the department's request. This information will allow MDHHS, the MHPs, and the payment vendor to identify opportunities for improvement, make any needed adjustments and evaluate the success of any changes.

Finally, the MHPs will be evaluated on the success of cost sharing collections as required by state law through the cost sharing bonus. This measure will be monitored by MDHHS annually, with the opportunity for program changes to address any identified deficiencies.

VI. CONSEQUENCES

State law requires that MDHHS develop a range of consequences for those beneficiaries who consistently fail to meet payment obligations under the HMP program. These consequences will impact those beneficiaries whose payment history meets the department's definition of non-compliance with respect to cost sharing. For the purposes of initiating the consequences described below, non-compliant means either: 1) That the beneficiary has not made any cost sharing payments (co-pays or contributions) in more than 90 consecutive calendar days; or 2) that the beneficiary has met less than 50 percent of his or her cost sharing obligations as calculated over a one-year period.

In addition to the consequences described herein, MDHHS may limit potential reductions for those who fail to pay required cost sharing (as this consequence is required by state law). Information on the impact of these consequences on any cost sharing reductions is included in the "Policy and Operational Process Document: Healthy Behavior Requirements".

All beneficiaries who are non-compliant with cost sharing obligations will be subject to the following consequences. First, the payment vendor will prepare targeted messaging for the beneficiary regarding his or her delinquent payment history and the amounts owed. This may occur via the Healthy Michigan Plan Statement or other written or electronic forms of correspondence and may include telephone contact as appropriate.

In addition, state law requires MDHHS to work with the Michigan Department of Treasury to offset state tax returns, and access lottery winnings when applicable, for beneficiaries who consistently fail to meet payment obligations. MDHHS has a formal arrangement with the Department of Treasury to pursue a state tax return offset for individuals who fail to pay required cost sharing and have not responded to the messaging strategy outlined above. All beneficiaries will have access to due process prior to the initiation of any tax offset process, and these debts will not be reported to credit reporting agencies. The MHPs may receive recovered funds, but only to the extent that the plan would have been entitled had the beneficiary paid as required. All other funds recovered will revert to MDHHS. MDHHS also plans to allow the MHPs to pursue additional beneficiary consequences for non-

payment, consistent with the state law authorizing the creation of HMP, subject to formal approval prior to any implementation. However, loss of eligibility, denial of enrollment in an MHP, or denial of services is not permitted for failure to pay required co-pays or contributions.

Finally, regardless of the consequences pursued by MDHHS or the MHPs, providers may not deny services for failure to pay required cost sharing amounts. The MHPs are responsible for communicating this to their contracted providers through the plan's provider education process, and for monitoring provider practices to ensure that access to services is not denied for non-payment of cost sharing.

VII. REPORTING REQUIREMENTS

The MHPs and the payment vendor are required to develop, generate and distribute reports to the MDHHS, and make information available to each other as necessary to support the functioning of the MI Health Account obligations, both as specified in this document and upon the department's request. The following information is available and shared as described herein:

- The MHPs, in cooperation with the payment vendor, must provide to MDHHS an accounting for review to verify that the MI Health Account function is operating in accordance with this document; and

- On a monthly basis, the payment vendor will provide MDHHS with information on co-pays and contributions due, reductions applied, and collections by enrollee.

Policy and Operational Process Document: Identification of Medically Frail Beneficiaries

BACKGROUND

Healthy Michigan Plan (HMP) beneficiaries who are considered medically frail in accordance with 42 CFR 440.315(f) are exempt from work requirements. Beneficiaries who are medically frail may have any of the following:

- A physical, mental, or emotional health condition that limits a daily activity (like bathing, dressing, daily chores, etc.)
- A physical, intellectual, or developmental disability that impairs the ability to perform one or more activities of daily living
- A physical, mental, or emotional health condition that requires frequent monitoring
- A disability determination based on Social Security criteria (SSDI)
- A chronic substance use disorder
- A serious and complex medical conditions or special medical needs
- Is in a nursing home, hospice, or is receiving home help services
- Is homeless
- Is a survivor of domestic violence

Beneficiaries identified as medically frail will remain exempt for 12 months from the reported date or until their next health care coverage redetermination date, whichever comes first. Based upon the results of the redetermination, the exemptions may either be extended or will end. Medically frail beneficiaries will be identified by the following methods:

Self-Identification

Individuals may report and self-attest to their medically frail status through any of the medical assistance program applications: Application for Health Coverage & Help Paying Costs (DCH-1426), the all programs Assistance Application (MDHHS-1171), and the online MI Bridges Application. A telephone option for application is also available.

Application processes include questions that allow individuals to report and attest that they have physical, mental, or emotional health conditions that limit their daily activities, such as bathing, dressing, or daily chores; or limit their ability to work, attend school, or take care of daily needs. Additionally, questions will allow the individual to report they reside in a medical or nursing facility. Applications will also include an appendix allowing individuals to report and attest to any of the exemptions for work requirements as applicable.

If beneficiaries become medically frail during a period of eligibility, they may update their application information. In addition to the paper and online applications, there will be an HMP Work Requirement and Exemption Reporting Line (telephone option) that will allow beneficiaries to report and attest to exemptions at any time.

Retrospective Claims Analysis

When available, MDHHS will review health care claims data available within the Community Health Automated Medicaid Processing System (CHAMPS) from the preceding 12 months for the presence of select diagnosis codes to identify beneficiaries considered medically frail. The list of codes is included as Appendix A. MDHHS may pursue updates to this list on an annual basis, in consultation with CMS as appropriate. The claims data to be reviewed include the following:

a. ICD-10 diagnosis codes (over 350 codes selected) that identify:
    - Individuals with disabling mental disorders;
    - Individuals with serious and complex medical conditions; and
    - Individuals with a physical, intellectual or developmental disability that significantly impairs their ability to perform one or more activities of daily living.
b. Whether a beneficiary is in a nursing home, hospice, or is receiving home help services.
c. Whether a beneficiary is homeless.
d. Whether a beneficiary is a survivor of domestic violence.

Appendix A: Medically Frail Diagnosis Codes

CODE	DESCRIPTION
A170	TUBERCULOUS MENINGITIS
A171	MENINGEAL TUBERCULOMA
A1781	TUBERCULOMA OF BRAIN AND SPINAL CORD
A1782	TUBERCULOUS MENINGOENCEPHALITIS
A1783	TUBERCULOUS NEURITIS
A1789	OTHER TUBERCULOSIS OF NERVOUS SYSTEM
A179	TUBERCULOSIS OF NERVOUS SYSTEM UNSPECIFIED
A1801	TUBERCULOSIS OF SPINE
A1802	TUBERCULOUS ARTHRITIS OF OTHER JOINTS
A1803	TUBERCULOSIS OF OTHER BONES
A1809	OTHER MUSCULOSKELETAL TUBERCULOSIS
A1810	TUBERCULOSIS OF GENITOURINARY SYSTEM UNSPECIFIED
A1811	TUBERCULOSIS OF KIDNEY AND URETER
A1812	TUBERCULOSIS OF BLADDER
A1813	TUBERCULOSIS OF OTHER URINARY ORGANS
A1814	TUBERCULOSIS OF PROSTATE
A1815	TUBERCULOSIS OF OTHER MALE GENITAL ORGANS
A1816	TUBERCULOSIS OF CERVIX
A1817	TUBERCULOUS FEMALE PELVIC INFLAMMATORY DISEASE
A1818	TUBERCULOSIS OF OTHER FEMALE GENITAL ORGANS
A182	TUBERCULOUS PERIPHERAL LYMPHADENOPATHY
A1831	TUBERCULOUS PERITONITIS
A1832	TUBERCULOUS ENTERITIS
A1839	RETROPERITONEAL TUBERCULOSIS
A184	TUBERCULOSIS OF SKIN AND SUBCUTANEOUS TISSUE
A1850	TUBERCULOSIS OF EYE UNSPECIFIED

CODE	DESCRIPTION
A1851	TUBERCULOUS EPISCLERITIS
A1852	TUBERCULOUS KERATITIS
A1853	TUBERCULOUS CHORIORETINITIS
A1854	TUBERCULOUS IRIDOCYCLITIS
A1859	OTHER TUBERCULOSIS OF EYE
A186	TUBERCULOSIS OF INNER MIDDLE EAR
A187	TUBERCULOSIS OF ADRENAL GLANDS
A1881	TUBERCULOSIS OF THYROID GLAND
A1882	TUBERCULOSIS OF OTHER ENDOCRINE GLANDS
A1883	TUBERCULOSIS OF DIGESTIVE TRACT ORGANS NEC
A1884	TUBERCULOSIS OF HEART
A1885	TUBERCULOSIS OF SPLEEN
A1889	TUBERCULOSIS OF OTHER SITES
B20	HUMAN IMMUNODEFICIENCY VIRUS HIV DISEASE
B900	SEQUELAE OF CENTRAL NERVOUS SYSTEM TUBERCULOSIS
B901	SEQUELAE OF GENITOURINARY TUBERCULOSIS
B902	SEQUELAE OF TUBERCULOSIS OF BONES AND JOINTS
B908	SEQUELAE OF TUBERCULOSIS OF OTHER ORGANS
D5700	HB-SS DISEASE WITH CRISIS, UNSPECIFIED
D5701	HB-SS DISEASE WITH ACUTE CHEST SYNDROME
D5702	HB-SS DISEASE WITH SPLENIC SEQUESTRATION
D571	SICKLE-CELL DISEASE WITHOUT CRISIS
D5720	SICKLE-CELL/HB-C DISEASE WITHOUT CRISIS
D57211	SICKLE-CELL/HB-C DISEASE WITH ACUTE CHEST SYNDROME
D57212	SICKLE-CELL/HB-C DISEASE WITH SPLENIC SEQUESTRATION
D57219	SICKLE-CELL/HB-C DISEASE WITH CRISIS, UNSPECIFIED
D5740	SICKLE-CELL THALASSEMIA WITHOUT CRISIS
D57411	SICKLE-CELL THALASSEMIA WITH ACUTE CHEST SYNDROME
D57412	SICKLE-CELL THALASSEMIA WITH SPLENIC SEQUESTRATION
D57419	SICKLE-CELL THALASSEMIA WITH CRISIS, UNSPECIFIED
D5780	OTHER SICKLE-CELL DISORDERS WITHOUT CRISIS
D57811	OTHER SICKLE-CELL DISORDERS WITH ACUTE CHEST SYNDROME
D57812	OTHER SICKLE-CELL DISORDERS WITH SPLENIC SEQUESTRATION
D57819	OTHER SICKLE-CELL DISORDERS WITH CRISIS, UNSPECIFIED
D808	OTHER IMMUNODEF W/PREDOMINANTLY ANTIBODY DEFECTS
D809	IMMUNODEF W/PREDOMINANTLY ANTIBODY DEFECTS UNS
D810	SEVERE COMBINED IMMUNODEF W/RETICULAR DYSGENESIS
D811	SEVERE COMBINED IMMUNODEF LOW T & B-CELL NUMBERS
D812	SEVERE COMBINED IMMUNODEF W/NORMAL B-CELL NUMBRS
D8130	ADENOSINE DEAMINASE DEFICIENCY, UNSPECIFIED
D8131	SEVERE COMBINED IMMUNODEF DUE TO ADENOSINE DEAMINASE DEFIC
D8132	ADENOSINE DEAMINASE 2 DEFICIENCY
D8139	OTHER ADENOSINE DEAMINASE DEFICIENCY
D814	NEZELOFS SYNDROME

CODE	DESCRIPTION
D815	PURINE NUCLEOSIDE PHOSPHORYLASE DEFICIENCY
D816	MAJ HISTOCOMPATIBILITY COMPLX CLASS I DEFICIENCY
D817	MAJ HISTOCOMPATIBILTY COMPLX CLASS II DEFICIENCY
D81810	BIOTINIDASE DEFICIENCY
D81818	OTHER BIOTIN-DEPENDENT CARBOXYLASE DEFICIENCY
D81819	BIOTIN-DEPENDENT CARBOXYLASE DEFICIENCY UNS
D8189	OTHER COMBINED IMMUNODEFICIENCIES
D819	COMBINED IMMUNODEFICIENCY UNSPECIFIED
D820	WISKOTT-ALDRICH SYNDROME
D821	DI GEORGES SYNDROME
D823	IMMUNODEFIC FLW HEREDITARY DEFECT RESPONS TO EBV
D828	IMMUNODEFIC ASSOCIATED W/OTH SPEC MAJOR DEFECT
D829	IMMUNODEFICIENCY ASSOCIATED W/MAJOR DEFECTS UNS
D830	CVI W/PREDOMINANT ABN OF B-CELL NUMBERS & FUNCT
D831	CVI W/PREDOMINANT IMMUNOREGULATORY T-CELL D/O
D832	CVI WITH AUTOANTIBODIES TO B- OR T-CELLS
E701	OTHER HYPERPHENYLALANINEMIAS
E7502	TAY-SACHS DISEASE
E7521	FABRY-ANDERSON DISEASE
E7522	GAUCHER DISEASE
E7523	KRABBE DISEASE
E75240	NIEMANN-PICK DISEASE TYPE A
E75241	NIEMANN-PICK DISEASE TYPE B
E75242	NIEMANN-PICK DISEASE TYPE C
E75243	NIEMANN-PICK DISEASE TYPE D
E75248	OTHER NIEMANN-PICK DISEASE
E75249	NIEMANN-PICK DISEASE UNSPECIFIED
E7525	METACHROMATIC LEUKODYSTROPHY
E7529	OTHER SPHINGOLIPIDOSIS
E840	CYSTIC FIBROSIS WITH PULMONARY MANIFESTATIONS
E8419	CYSTIC FIBROSIS W/OTH INTESTINAL MANIFESTATIONS
E848	CYSTIC FIBROSIS WITH OTHER MANIFESTATIONS
E849	CYSTIC FIBROSIS UNSPECIFIED
E8840	MITOCHONDRIAL METABOLISM DISORDER UNSPECIFIED
F0150	VASCULAR DEMENTIA WITHOUT BEHAVIORAL DISTURBANCE
F0151	VASCULAR DEMENTIA WITH BEHAVIORAL DISTURBANCE
F0280	DEMENTIA OTH DZ CLASS ELSW W/O BEHAVRL DISTURB
F0281	DEMENTIA OTH DISEAS CLASS W/BEHAVIORAL DISTURB
F0390	UNSPEC DEMENTIA WITHOUT BEHAVIORAL DISTURBANCE
F0391	UNSPECIFIED DEMENTIA WITH BEHAVIORAL DISTURBANCE
F04	AMNESTIC DISORDER DUE KNOWN PHYSIOLOGICAL COND
F060	PSYCHOTIC DISORDER W HALLUCIN DUE TO KNOWN PHYSIOL CONDITION
F061	CATATONIC DISORDER DUE TO KNOWN PHYSIOLOGICAL CONDITION
F062	PSYCHOTIC DISORDER W DELUSIONS DUE TO KNOWN PHYSIOL COND

CODE	DESCRIPTION
F0631	MOOD DISORDER DUE TO KNOWN PHYSIOL COND W DEPRESSV FEATURES
F0632	MOOD DISORD D/T PHYSIOL COND W MAJOR DEPRESSIVE-LIKE EPSD
F0633	MOOD DISORDER DUE TO KNOWN PHYSIOL COND W MANIC FEATURES
F0634	MOOD DISORDER DUE TO KNOWN PHYSIOL COND W MIXED FEATURES
F064	ANXIETY DISORDER DUE TO KNOWN PHYSIOLOGICAL CONDITION
F200	PARANOID SCHIZOPHRENIA
F201	DISORGANIZED SCHIZOPHRENIA
F202	CATATONIC SCHIZOPHRENIA
F203	UNDIFFERENTIATED SCHIZOPHRENIA
F205	RESIDUAL SCHIZOPHRENIA
F2081	SCHIZOPHRENIFORM DISORDER
F2089	OTHER SCHIZOPHRENIA
F209	SCHIZOPHRENIA UNSPECIFIED
F21	SCHIZOTYPAL DISORDER
F22	DELUSIONAL DISORDERS
F23	BRIEF PSYCHOTIC DISORDER
F24	SHARED PSYCHOTIC DISORDER
F250	SCHIZOAFFECTIVE DISORDER BIPOLAR TYPE
F251	SCHIZOAFFECTIVE DISORDER DEPRESSIVE TYPE
F258	OTHER SCHIZOAFFECTIVE DISORDERS
F259	SCHIZOAFFECTIVE DISORDER UNSPECIFIED
F28	OTH PSYCHOT D/O NOT DUE SUBSTANCE/PHYSIOLOG COND
F29	UNS PSYCHOSIS NOT DUE SUBSTANCE/PHYSIOLOG COND
F3012	MANIC EPISODE WITHOUT PSYCHOTIC SYMPTOMS, MODERATE
F3013	MANIC EPISODE, SEVERE, WITHOUT PSYCHOTIC SYMPTOMS
F302	MANIC EPISODE, SEVERE WITH PSYCHOTIC SYMPTOMS
F3112	BIPOLAR DISORD, CRNT EPISODE MANIC W/O PSYCH FEATURES, MOD
F3113	BIPOLAR DISORD, CRNT EPSD MANIC W/O PSYCH FEATURES, SEVERE
F312	BIPOLAR DISORD, CRNT EPISODE MANIC SEVERE W PSYCH FEATURES
F3132	BIPOLAR DISORDER, CURRENT EPISODE DEPRESSED, MODERATE
F314	BIPOLAR DISORD, CRNT EPSD DEPRESS, SEV, W/O PSYCH FEATURES
F315	BIPOLAR DISORD, CRNT EPSD DEPRESS, SEVERE, W PSYCH FEATURES
F3162	BIPOLAR DISORDER, CURRENT EPISODE MIXED, MODERATE
F3163	BIPOLAR DISORD, CRNT EPSD MIXED, SEVERE, W/O PSYCH FEATURES
F3164	BIPOLAR DISORD, CRNT EPISODE MIXED, SEVERE, W PSYCH FEATURES
F321	MAJOR DEPRESSIVE DISORDER, SINGLE EPISODE, MODERATE
F322	MAJOR DEPRESSV DISORD, SINGLE EPSD, SEV W/O PSYCH FEATURES
F323	MAJOR DEPRESSV DISORD, SINGLE EPSD, SEVERE W PSYCH FEATURES
F331	MAJOR DEPRESSIVE DISORDER, RECURRENT, MODERATE
F332	MAJOR DEPRESSV DISORDER, RECURRENT SEVERE W/O PSYCH FEATURES
F333	MAJOR DEPRESSV DISORDER, RECURRENT, SEVERE W PSYCH SYMPTOMS
F4001	AGORAPHOBIA WITH PANIC DISORDER
F410	PANIC DISORDER [EPISODIC PAROXYSMAL ANXIETY]
F4311	POST-TRAUMATIC STRESS DISORDER, ACUTE

CODE	DESCRIPTION
F4312	POST-TRAUMATIC STRESS DISORDER, CHRONIC
F440	DISSOCIATIVE AMNESIA
F441	DISSOCIATIVE FUGUE
F444	CONVERSION DISORDER WITH MOTOR SYMPTOM OR DEFICIT
F445	CONVERSION DISORDER WITH SEIZURES OR CONVULSIONS
F446	CONVERSION DISORDER WITH SENSORY SYMPTOM OR DEFICIT
F447	CONVERSION DISORDER WITH MIXED SYMPTOM PRESENTATION
F4481	DISSOCIATIVE IDENTITY DISORDER
F4522	BODY DYSMORPHIC DISORDER
F481	DEPERSONALIZATION-DEREALIZATION SYNDROME
F600	PARANOID PERSONALITY DISORDER
F601	SCHIZOID PERSONALITY DISORDER
F71	MODERATE INTELLECTUAL DISABILITIES
F72	SEVERE INTELLECTUAL DISABILITIES
F73	PROFOUND INTELLECTUAL DISABILITIES
F801	EXPRESSIVE LANGUAGE DISORDER
F840	AUTISTIC DISORDER
F845	ASPERGERS SYNDROME
F848	OTHER PERVASIVE DEVELOPMENTAL DISORDERS
F849	PERVASIVE DEVELOPMENTAL DISORDER UNSPECIFIED
F952	TOURETTES DISORDER
G041	TROPICAL SPASTIC PARAPLEGIA
G114	HEREDITARY SPASTIC PARAPLEGIA
G1221	AMYOTROPHIC LATERAL SCLEROSIS
G130	PARANEOPLASTIC NEUROMYOPATHY AND NEUROPATHY
G131	OTH SYSTEM ATROPHY PRIM AFFECT CNS NEOPLASTIC DZ
G231	PROGRESSIVE SUPRANUCLEAR OPHTHALMOPLEGIA
G300	ALZHEIMERS DISEASE WITH EARLY ONSET
G301	ALZHEIMERS DISEASE WITH LATE ONSET
G308	OTHER ALZHEIMERS DISEASE
G309	ALZHEIMERS DISEASE UNSPECIFIED
G3109	OTHER FRONTOTEMPORAL DEMENTIA
G3183	DEMENTIA WITH LEWY BODIES
G35	MULTIPLE SCLEROSIS
G450	VERTEBRO-BASILAR ARTERY SYNDROME
G451	CAROTID ARTERY SYNDROME HEMISPHERIC
G452	MULTIPLE & BILATERAL PRECEREBRAL ARTERY SYND
G453	AMAUROSIS FUGAX
G454	TRANSIENT GLOBAL AMNESIA
G458	OTH TRANSIENT CERBRL ISCHEMIC ATTACKS & REL SYND
G459	TRANSIENT CEREBRAL ISCHEMIC ATTACK UNSPECIFIED
G460	MIDDLE CEREBRAL ARTERY SYNDROME
G461	ANTERIOR CEREBRAL ARTERY SYNDROME
G462	POSTERIOR CEREBRAL ARTERY SYNDROME

CODE	DESCRIPTION
G7100	MUSCULAR DYSTROPHY, UNSPECIFIED
G7101	DUCHENNE OR BECKER MUSCULAR DYSTROPHY
G7102	FACIOSCAPULOHUMERAL MUSCULAR DYSTROPHY
G7109	OTHER SPECIFIED MUSCULAR DYSTROPHIES
G731	LAMBERT-EATON SYNDROME IN NEOPLASTIC DISEASE
G800	SPASTIC QUADRIPLEGIC CEREBRAL PALSY
G801	SPASTIC DIPLEGIC CEREBRAL PALSY
G802	SPASTIC HEMIPLEGIC CEREBRAL PALSY
G803	ATHETOID CEREBRAL PALSY
G804	ATAXIC CEREBRAL PALSY
G808	OTHER CEREBRAL PALSY
G809	CEREBRAL PALSY UNSPECIFIED
G8100	FLACCID HEMIPLEGIA AFFECTING UNSPECIFIED SIDE
G8101	FLACCID HEMIPLEGIA AFFECTING RIGHT DOMINANT SIDE
G8102	FLACCID HEMIPLEGIA AFFECTING LEFT DOMINANT SIDE
G8103	FLACCID HEMIPLEGIA AFFECTING RT NONDOMINANT SIDE
G8104	FLACCID HEMIPLEGIA AFFECTING LT NONDOMINANT SIDE
G8110	SPASTIC HEMIPLEGIA AFFECTING UNSPECIFIED SIDE
G8111	SPASTIC HEMIPLEGIA AFFECTING RIGHT DOMINANT SIDE
G8112	SPASTIC HEMIPLEGIA AFFECTING LEFT DOMINANT SIDE
G8113	SPASTIC HEMIPLEGIA AFFECTING RT NONDOMINANT SIDE
G8114	SPASTIC HEMIPLEGIA AFFECTING LT NONDOMINANT SIDE
G8190	HEMIPLEGIA UNS AFFECTING UNSPECIFIED SIDE
G8191	HEMIPLEGIA UNS AFFECTING RIGHT DOMINANT SIDE
G8192	HEMIPLEGIA UNS AFFECTING LEFT DOMINANT SIDE
G8193	HEMIPLEGIA UNS AFFECTING RIGHT NONDOMINANT SIDE
G8194	HEMIPLEGIA UNS AFFECTING LEFT NONDOMINANT SIDE
G8220	PARAPLEGIA UNSPECIFIED
G8221	PARAPLEGIA COMPLETE
G8222	PARAPLEGIA INCOMPLETE
G8250	QUADRIPLEGIA UNSPECIFIED
G8251	QUADRIPLEGIA C1-C4 COMPLETE
G8252	QUADRIPLEGIA C1-C4 INCOMPLETE
G8253	QUADRIPLEGIA C5-C7 COMPLETE
G8254	QUADRIPLEGIA C5-C7 INCOMPLETE
G830	DIPLEGIA OF UPPER LIMBS
G8310	MONOPLEGIA LOWER LIMB AFFECTING UNSPECIFIED SIDE
G8311	MONOPLEGIA LOWER LIMB RIGHT DOMINANT SIDE
G8312	MONOPLEGIA LOWER LIMB LEFT DOMINANT SIDE
G8313	MONOPLEGIA LOWER LIMB RIGHT NONDOMINANT SIDE
G8314	MONOPLEGIA LOWER LIMB LEFT NONDOMINANT SIDE
G8320	MONOPLEGIA UPPER LIMB AFFECTING UNSPECIFIED SIDE
G8321	MONOPLEGIA UPPER LIMB RIGHT DOMINANT SIDE
G8322	MONOPLEGIA UPPER LIMB LEFT DOMINANT SIDE

CODE	DESCRIPTION
G8323	MONOPLEGIA UPPER LIMB RIGHT NONDOMINANT SIDE
G8324	MONOPLEGIA UPPER LIMB LEFT NONDOMINANT SIDE
G8330	MONOPLEGIA UNS AFFECTING UNSPECIFIED SIDE
G8331	MONOPLEGIA UNS AFFECTING RIGHT DOMINANT SIDE
G8332	MONOPLEGIA UNS AFFECTING LEFT DOMINANT SIDE
G8333	MONOPLEGIA UNS AFFECTING RIGHT NONDOMINANT SIDE
G8334	MONOPLEGIA UNS AFFECTING LEFT NONDOMINANT SIDE
H4930	TOTAL EXTERNAL OPHTHALMOPLEGIA UNSPECIFIED EYE
H4931	TOTAL EXTERNAL OPHTHALMOPLEGIA RIGHT EYE
H4932	TOTAL EXTERNAL OPHTHALMOPLEGIA LEFT EYE
H4933	TOTAL EXTERNAL OPHTHALMOPLEGIA BILATERAL
H4940	PROGRESSIVE EXTERNAL OPHTHALMOPLEGIA UNS EYE
H4941	PROGRESSIVE EXTERNAL OPHTHALMOPLEGIA RIGHT EYE
H4942	PROGRESSIVE EXTERNAL OPHTHALMOPLEGIA LEFT EYE
H4943	PROGRESSIVE EXTERNAL OPHTHALMOPLEGIA BILATERAL
H5120	INTERNUCLEAR OPHTHALMOPLEGIA UNSPECIFIED EYE
H5121	INTERNUCLEAR OPHTHALMOPLEGIA RIGHT EYE
H5122	INTERNUCLEAR OPHTHALMOPLEGIA LEFT EYE
H5123	INTERNUCLEAR OPHTHALMOPLEGIA BILATERAL
H52511	INTERNAL OPHTHALMOPLEGIA COMPLETE TOTAL RT EYE
H52512	INTERNAL OPHTHALMOPLEGIA COMPLETE TOTAL LT EYE
H52513	INTERNAL OPHTHALMOPLEGIA COMPLETE TOTAL BILAT
H52519	INTERNAL OPHTHALMOPLEGIA COMPLETE TOTAL UNS EYE
I120	HYPERTENSIVE CKD W/STAGE 5 CKD OR ESRD
I1311	HTN HEART & CKD W/O HF W/STAGE 5 CKD OR ESRD
I132	HTN HEART & CKD W/HF W/STAGE 5 CKD OR ESRD
I69351	HEMIPLEGIA FLW CEREBRAL INFARCT AFF RT DOM SIDE
I69352	HEMIPLEGIA FLW CEREBRAL INFARCT AFF LT DOM SIDE
I69353	HEMIPLEGIA FLW CEREBRAL INFARCT AFF RT NON-DOM
I69354	HEMIPLEGIA FLW CEREBRAL INFARCT AFF LT NON-DOM
I69359	HEMIPLEGIA FLW CEREBRAL INFARCT AFFCT UNS SIDE
M623	IMMOBILITY SYNDROME PARAPLEGIC
N184	CHRONIC KIDNEY DISEASE STAGE 4 SEVERE
N185	CHRONIC KIDNEY DISEASE STAGE 5
N186	END STAGE RENAL DISEASE
Q050	CERVICAL SPINA BIFIDA WITH HYDROCEPHALUS
Q051	THORACIC SPINA BIFIDA WITH HYDROCEPHALUS
Q052	LUMBAR SPINA BIFIDA WITH HYDROCEPHALUS
Q053	SACRAL SPINA BIFIDA WITH HYDROCEPHALUS
Q054	UNSPECIFIED SPINA BIFIDA WITH HYDROCEPHALUS
Q055	CERVICAL SPINA BIFIDA WITHOUT HYDROCEPHALUS
Q056	THORACIC SPINA BIFIDA WITHOUT HYDROCEPHALUS
Q057	LUMBAR SPINA BIFIDA WITHOUT HYDROCEPHALUS
Q058	SACRAL SPINA BIFIDA WITHOUT HYDROCEPHALUS

CODE	DESCRIPTION
Q059	SPINA BIFIDA UNSPECIFIED
Q900	TRISOMY 21, NONMOSAICISM (MEIOTIC NONDISJUNCTION)
Q901	TRISOMY 21, MOSAICISM (MITOTIC NONDISJUNCTION)
Q902	TRISOMY 21, TRANSLOCATION
Q909	DOWN SYNDROME, UNSPECIFIED
Q910	TRISOMY 18, NONMOSAICISM (MEIOTIC NONDISJUNCTION)
Q911	TRISOMY 18, MOSAICISM (MITOTIC NONDISJUNCTION)
Q912	TRISOMY 18, TRANSLOCATION
Q913	TRISOMY 18, UNSPECIFIED
Q914	TRISOMY 13, NONMOSAICISM (MEIOTIC NONDISJUNCTION)
Q915	TRISOMY 13, MOSAICISM (MITOTIC NONDISJUNCTION)
Q916	TRISOMY 13, TRANSLOCATION
Q917	TRISOMY 13, UNSPECIFIED
Q920	WHOLE CHROMOSOME TRISOMY, NONMOSAICISM (MEIOTIC NONDISJUNCTION)
Q921	WHOLE CHROMOSOME TRISOMY, MOSAICISM (MITOTIC NONDISJUNCTION)
Q922	PARTIAL TRISOMY
Q925	DUPLICATIONS WITH OTHER COMPLEX REARRANGEMENTS
Q9261	MARKER CHROMOSOMES IN NORMAL INDIVIDUAL
Q9262	MARKER CHROMOSOMES IN ABNORMAL INDIVIDUAL
Q927	TRIPLOIDY AND POLYPLOIDY
Q928	OTHER SPECIFIED TRISOMIES AND PARTIAL TRISOMIES OF AUTOSOMES
Q929	TRISOMY AND PARTIAL TRISOMY OF AUTOSOMES, UNSPECIFIED
Q930	WHOLE CHROMOSOME MONOSOMY, NONMOSAICISM (MEIOTIC NONDISJUNCTION)
Q931	WHOLE CHROMOSOME MONOSOMY, MOSAICISM (MITOTIC NONDISJUNCTION)
Q932	CHROMOSOME REPLACED WITH RING, DICENTRIC OR ISOCHROMOSOME
Q937	DELETIONS WITH OTHER COMPLEX REARRANGEMENTS
Q9381	VELO-CARDIO-FACIAL SYNDROME
Q9388	OTHER MICRODELETIONS
Q9389	OTHER DELETIONS FROM THE AUTOSOMES
Q939	DELETION FROM AUTOSOMES, UNSPECIFIED
Q952	BALANCED AUTOSOMAL REARRANGEMENT IN ABNORMAL INDIVIDUAL
Q953	BALANCED SEX/AUTOSOMAL REARRANGEMENT IN ABNORMAL INDIVIDUAL
Q992	FRAGILE X CHROMOSOME
R532	FUNCTIONAL QUADRIPLEGIA
T7411XA	ADULT PHYSICAL ABUSE, CONFIRMED, INITIAL ENCOUNTER
T7411XD	ADULT PHYSICAL ABUSE, CONFIRMED, SUBSEQUENT ENCOUNTER
T7411XS	ADULT PHYSICAL ABUSE, CONFIRMED, SEQUELA
T7421XA	ADULT SEXUAL ABUSE, CONFIRMED, INITIAL ENCOUNTER
T7421XD	ADULT SEXUAL ABUSE, CONFIRMED, SUBSEQUENT ENCOUNTER
T7421XS	ADULT SEXUAL ABUSE, CONFIRMED, SEQUELA
T7431XA	ADULT PSYCHOLOGICAL ABUSE, CONFIRMED, INITIAL ENCOUNTER
T7431XD	ADULT PSYCHOLOGICAL ABUSE, CONFIRMED, SUBSEQUENT ENCOUNTER

CODE	DESCRIPTION
T7431XS	ADULT PSYCHOLOGICAL ABUSE, CONFIRMED, SEQUELA
T7451XA	ADULT FORCED SEXUAL EXPLOITATION, CONFIRMED, INIT
T7451XD	ADULT FORCED SEXUAL EXPLOITATION, CONFIRMED, SUBS
T7451XS	ADULT FORCED SEXUAL EXPLOITATION, CONFIRMED, SEQUELA
T7611XA	ADULT PHYSICAL ABUSE, SUSPECTED, INITIAL ENCOUNTER
T7611XD	ADULT PHYSICAL ABUSE, SUSPECTED, SUBSEQUENT ENCOUNTER
T7611XS	ADULT PHYSICAL ABUSE, SUSPECTED, SEQUELA
T7621XA	ADULT SEXUAL ABUSE, SUSPECTED, INITIAL ENCOUNTER
T7621XD	ADULT SEXUAL ABUSE, SUSPECTED, SUBSEQUENT ENCOUNTER
T7621XS	ADULT SEXUAL ABUSE, SUSPECTED, SEQUELA
T7631XA	ADULT PSYCHOLOGICAL ABUSE, SUSPECTED, INITIAL ENCOUNTER
T7631XD	ADULT PSYCHOLOGICAL ABUSE, SUSPECTED, SUBSEQUENT ENCOUNTER
T7631XS	ADULT PSYCHOLOGICAL ABUSE, SUSPECTED, SEQUELA
T7651XA	ADULT FORCED SEXUAL EXPLOITATION, SUSPECTED, INIT
T7651XD	ADULT FORCED SEXUAL EXPLOITATION, SUSPECTED, SUBS
T7651XS	ADULT FORCED SEXUAL EXPLOITATION, SUSPECTED, SEQUELA
Z510	ENCOUNTER FOR ANTINEOPLASTIC RADIATION THERAPY
Z5111	ENCOUNTER FOR ANTINEOPLASTIC CHEMOTHERAPY
Z5112	ENCOUNTER FOR ANTINEOPLASTIC IMMUNOTHERAPY
Z590	HOMELESSNESS
Z6911	ENCNTR FOR MNTL HLTH SERV FOR VICTIM OF SPOUS OR PRTNR ABUSE
Z6981	ENCOUNTER FOR MENTAL HEALTH SERVICES FOR VICTIM OF OTH ABUSE
Z7682	AWAITING ORGAN TRANSPLANT STATUS
Z9911	DEPENDENCE ON RESPIRATOR VENTILATOR STATUS
Z9981	DEPENDENCE ON SUPPLEMENTAL OXYGEN