ADULT BENEFITS WAIVER

Until further notice, an enrollment freeze is in effect for this program.

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SECTION 1 – GENERAL INFORMATION

This chapter applies to all providers.

The Adult Benefits Waiver (ABW) provides health care benefits for Michigan's childless adult residents (age 19 through 64) with an annual income at or below 35 percent of the Federal Poverty Level (FPL). Covered services and maximum copayments for beneficiaries in this eligibility category are detailed in the following sections. Unless noted in Medicaid provider-specific chapters, service coverage and authorization requirements for the fee-for-service (FFS) beneficiaries enrolled in the ABW program mirror those required for Medicaid. Only those providers enrolled to provide services through the Michigan Medicaid Program may provide services for FFS ABW beneficiaries.

The Michigan Department of Human Services (MDHS) may also refer to the ABW as the Adult Medical Program.

1.1 COUNTY-ADMINISTERED HEALTH PLANS

ABW beneficiaries enrolled in County-Administered Health Plans (CHPs) are subject to the requirements of the respective CHP. In those counties operating nonprofit CHPs, all covered services for ABW beneficiaries must be provided through the health plan. CHPs administering the ABW program are required to provide the services noted in the Coverage and Limitations Section of this chapter to ensure that benefits are consistent for all ABW beneficiaries across the FFS and CHP programs.

An up-to-date list of CHPs is maintained on the Michigan Department of Community Health (MDCH) website. (Refer to the Directory Appendix for website information.) CHPs may:

- Require that services be provided through their contracted provider network and may institute prior authorization (PA) requirements beyond those required for the FFS ABW program.
- Require beneficiaries to obtain certain services from the Local Health Departments (LHDs) or other community resources. When such referrals are made, the CHP is responsible for the beneficiary's share of the fee minus any applicable copayments.

CHP providers rendering services to ABW beneficiaries enrolled in a CHP are not required to enroll as providers in the Medicaid program, but they must comply with all Medicaid provider requirements as detailed in this manual. This includes the prohibition on balance billing beneficiaries for the difference between the provider's charge and the CHP reimbursement.

1.2 ABW ELIGIBILITY DETERMINATION AND VERIFICATION

The local DHS office determines eligibility for ABW beneficiaries who are identified in the eligibility response with a Benefit Plan ID of ABW (Full coverage) or ABW-ESO (Emergency Services Only). The Benefit Plan ID of ABW-MC identifies that the ABW beneficiary is enrolled in a CHP. If the eligibility response indicates a Benefit Plan ID of ABW ***without*** ABW-MC, this identifies a FFS ABW beneficiary. CHAMPS issues a **mihealth** card for new ABW beneficiaries once DHS opens the ABW case. CHPs may also issue membership cards to their enrollees.

Providers must verify beneficiary eligibility prior to rendering services. (Refer to the Beneficiary Eligibility chapter for additional information.)

Medical authorization from the local MDHS office for individual services is not required for ABW beneficiaries.

Questions regarding ABW coverage and FFS billing should be directed to MDCH Provider Inquiry. (Refer to the Directory Appendix for contact information.)

1.3 REIMBURSEMENT

Services provided to beneficiaries enrolled in CHPs are billable to the CHP except for:

- H7Z class psychotropic drugs
- Anti-retroviral classes
- Anti-psychotic classes

A list of the specific medications is maintained on the MDCH pharmacy benefit manager's website and is subject to change without notice. (Refer to the Directory Appendix for website information.) These medications should be billed through the MDCH pharmacy benefit manager's point-of-sale reimbursement system for all ABW beneficiaries. Providers billing for these services must be Medicaid enrolled.

Reimbursement for services rendered to FFS ABW beneficiaries is the current Medicaid fee screen or the provider's charge, whichever is less. Services for ABW beneficiaries enrolled in a CHP are reimbursed at a rate negotiated by the CHP with its network providers. Services provided to ABW beneficiaries by Federally Qualified Health Centers and Rural Health Clinics are not subject to the prospective payment reimbursement rate.

ABW beneficiaries may not be billed for services except in the following situations:

- A copayment is required. However, a provider cannot refuse to render service if the beneficiary is unable to pay the required copayment on the date of service.
- If the beneficiary requests a service not covered by the ABW, the provider may charge the beneficiary for the service if the beneficiary has been told prior to rendering the service that it was not covered by the ABW. If the beneficiary is not informed of the ABW noncoverage until after the services have been rendered, the provider cannot bill the beneficiary.
- The provider chooses not to accept the beneficiary as an ABW beneficiary and the beneficiary had prior knowledge of the situation. The beneficiary is responsible for payment.

It is recommended that providers obtain the beneficiary's written acknowledgement of payment responsibility prior to rendering any nonauthorized or noncovered service the beneficiary elects to receive. For additional information about billing the beneficiary, refer to the Billing Beneficiaries Section of the General Information for Providers Chapter.

1.4 Notification and Appeal

ABW applicants or beneficiaries must be provided written notice for each proposed action to deny, reduce, suspend or terminate any ABW covered benefit. Applicants and beneficiaries must be offered the opportunity to appeal the action whether they are enrolled in a CHP or receiving services through the FFS program.

The notice of proposed action must include:

- Statement of the action to be taken;
- Reasons for the intended action;
- Specific regulations supporting the action;
- An explanation of the individual's right to a hearing; and
- The circumstances under which assistance or service is continued if a hearing is requested.

Appeals related to such action are subject to the CHP complaint/grievance process and/or the administrative hearing process administered by the Appeals Section for the MDCH. Information pertaining to the administrative hearing process can be found on the MDCH website in the State Office of Administrative Hearings and Rules (SOAHR) for the MDCH Policy and Procedures Manual. (Refer to the Directory Appendix for website information.)

1.5 Copayment

FFS ABW beneficiaries are charged a copayment for some covered benefits as specified in the Coverage and Limitations section of this chapter. No copayments are required for family planning or pregnancy related services or prescriptions.

The respective CHPs may elect to use different copayment amounts, but the copays may not exceed those listed nor may copayments exceed the Medicaid fee screen for a specific service.

SECTION 2 – COVERAGE AND LIMITATIONS

The table below outlines beneficiary coverage under ABW. Special instructions for CHP beneficiaries are noted when applicable.

Service	Coverage
Ambulance	Limited to emergency ground ambulance transport to the hospital Emergency Department (ED).
Case Management	Noncovered
Chiropractor	Noncovered
Dental	Noncovered
Emergency Department	Covered per current Medicaid policy. For CHPs, PA may be required for nonemergency services provided in the Emergency Department.
Eyeglasses	Noncovered
Family Planning	Covered. Services may be provided through referral to local Title X designated Family Planning Program.
Hearing Aids	Noncovered
Home Health	Noncovered
Home Help (personal care)	Noncovered
Hospice	Noncovered
Inpatient Hospital	Noncovered
Lab & X-Ray	Covered if ordered by an MD, DO, or NP for diagnostic and treatment purposes. PA may be required by the CHP.

Service	Coverage
Medical Supplies/ Durable Medical Equipment (DME)	Limited coverage. ▪ Medical supplies are covered except for the following noncovered categories: gradient surgical garments, formulas and feeding supplies, and supplies related to any noncovered DME item. ▪ DME items are noncovered except for glucose monitors.
Mental Health Services	Covered: Services must be provided through the PIHP/CMHSP. (Refer to the Mental Health/Substance Abuse Coverage section of this chapter.)
Nursing Facility	Noncovered
Optometrist	Noncovered
Outpatient Hospital (Nonemergency Department)	Covered: Diagnostic and treatment services and diabetes education services. PA may be required for some services. A $3 copayment for professional services is required. * Noncovered: Therapies, labor room and partial hospitalization.
Pharmacy	Covered: ▪ Products included on the Michigan Pharmaceutical Products List (except enteral formulas) that are prescribed by an MD, DO, NP or oral-maxillofacial surgeon. PA may be required. Products must be billed to MDCH or CHP, as appropriate. ▪ Psychotropic medications are provided under the FFS benefit. (Refer to the MDCH Pharmacy Benefits Manager (PBM) website for a list of psychotropic drug classes to be billed to MDCH. Refer to the Directory Appendix for website information.) The list of drugs covered under the carveout is updated as necessary. Drugs are added and deleted on a regular basis so it is imperative that the provider review this website frequently. Noncovered: Injectable drugs used in clinics or physician offices. Copayment: $1 per prescription
Physician **Nurse Practitioner (NP)** **Oral-Maxillofacial Surgeon** **Medical Clinic**	The following services are covered per current Medicaid policy: ▪ Annual physical exams (including a pelvic and breast exam, and pap test). Women who qualify for screening/services under the Breast and Cervical Cancer Program administered by the LHD may be referred to that program for services as appropriate. ▪ Diagnostic and treatment services. May refer to LHD for TB, STD, or HIV-related services, as available.

* Professional services requiring a copayment are defined by the following Evaluation and Management (E&M) procedure codes. 92002-92014, 99201-99205, 99211-99215, 99241-99245, 99341-99345, 99347-99350, 99385-99387, 99395-99397. No copayment may be charged for family planning or pregnancy related services.

Service	Coverage
	▪ General ophthalmological services (procedure codes 92002-92014) ▪ Immunizations per current Advisory Committee on Immunization Practices (ACIP) guidelines. May be referred to LHD. Travel immunizations are excluded. ▪ Injections administered in a physician's office per current Medicaid policy. CHPs may require PA for some injections. Specific psychotropic injectable drugs administered through a PIHP/CMHSP clinic to an ABW beneficiary are reimbursed by MDCH on a fee-for-service basis when the following criteria is met: ➢ The beneficiary has an open case with the PIHP/CMHSP; and ➢ The beneficiary receives the injections on a scheduled or routine basis as part of the PIHP/CMHSP treatment/support regimen; and ➢ The PIHP/CMHSP physician has determined that the beneficiary may not comply with the medication regimen if the injections were not administered through the PIHP/CMHSP clinic and that this non-compliance could adversely affect the beneficiary; and ➢ The PIHP/CMHSP clinic notifies the beneficiary's CHP or primary care physician that this service is being rendered; or ➢ The injectable drug is listed on the MDCH PIHP/CMHSP Physician Injectable Drug Coverage Database available on the MDCH website. (Refer to the Directory Appendix for website information.) Injectables that do not meet the above criteria remain the responsibility of the CHP, and the CHP's prior authorization requirements must be followed. The specific injectable drugs are only covered by MDCH through fee-for-service basis **if** provided by a physician as part of his affiliation with a PIHP/CMHSP and must be billed using the NPI number associated with the PIHP/CMHSP. Payments made to a physician for injectable drugs administered to an ABW beneficiary that are not billed under the NPI number not associated with a PIHP/CMHSP physician group will be subject to recovery. ▪ Services performed by oral-maxillofacial surgeons are covered under the current Medicaid physician benefit. Limited emergent/urgent dental procedures, as identified on the MDCH Oral-Maxillofacial Surgeon Database (available on the MDCH website), performed by oral-maxillofacial surgeons are only covered for the relief of pain and/or infection. (Refer to the Directory Appendix for website information.) PA may be required for some services. A $3 copayment is required for office visits (professional services).* Noncovered: Services provided in an inpatient hospital setting.
Podiatrist	Noncovered

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Service	Coverage
Prosthetics/ Orthotics	Noncovered
Private Duty Nursing	Noncovered
Substance Abuse	Covered through the Prepaid Inpatient Health Plan (PIHP). (Refer to the Mental Health/Substance Abuse Coverage section of this chapter.)
Therapies	Occupational, physical, and speech therapy evaluations are covered when provided by physicians or in the outpatient hospital setting. Therapy services are not covered in any setting.
Transportation (nonambulance)	Noncovered
Urgent Care Clinic	Professional services provided in a freestanding facility are covered. CHPs may require authorization by the primary care physician or plan administrator. A $3 copayment is required. *

* Professional services requiring a copayment are defined by the following Evaluation and Management (E&M) procedure codes. 92002-92014, 99201-99205, 99211-99215, 99241-99245, 99341-99345, 99347-99350, 99385-99387, 99395-99397. No copayment may be charged for family planning or pregnancy related services.

SECTION 3 - MENTAL HEALTH/SUBSTANCE ABUSE COVERAGE

Mental health and substance abuse services for ABW beneficiaries are the responsibility of the Prepaid Inpatient Health Plans (PIHPs) and the Community Mental Health Services Programs (CMHSPs) as outlined in this section.

ABW mental health and substance abuse coverage is limited both in scope and amount to those that are medically necessary and conform to professionally accepted standards of care consistent with the Michigan Mental Health Code. Utilization control procedures, consistent with the medical necessity criteria/service selection guidelines specified by MDCH and in best practice standards, must be used.

3.1 MENTAL HEALTH SERVICES

PIHPs/CMHSPs are responsible for the provision of the following mental health services to ABW beneficiaries when medically necessary and within applicable benefit restrictions:

- Crisis interventions for mental health-related emergency situations and/or conditions.
- Identification, assessment and diagnostic evaluation to determine the beneficiary's mental health status, condition and specific needs.
- Inpatient hospital psychiatric care for mentally ill beneficiaries who require care in a 24-hour medically-structured and supervised licensed facility.
- Other medically necessary mental health services:
  - Psychotherapy or counseling (individual, family, group) when indicated;
  - Interpretation or explanation of results of psychiatric examination, other medical examinations and procedures, or other accumulated data to family or other responsible persons, or advising them how to assist the beneficiary;
  - Pharmacological management, including prescription, administration, and review of medication use and effects; or
  - Specialized community mental health clinical and rehabilitation services, including case management, psychosocial interventions and other community supports, as medically necessary, and when utilized as an approved alternative to more restrictive care or placement.

Any beneficiary liability for the cost of covered services shall be determined by each CMHSP, according to the ability-to-pay provisions of the Michigan Mental Health Code and applicable administrative rules.

3.2 SUBSTANCE ABUSE SERVICES

The Prepaid Inpatient Health Plan (PIHP) is responsible for the following substance abuse services for ABW beneficiaries when medically necessary and within applicable benefit limitations:

- Initial assessment, diagnostic evaluation, referral and patient placement;
- Outpatient Treatment;
- Intensive Outpatient Treatment;

- Federal Food and Drug Administration (FDA) approved pharmacological supports for Levo-Alpha-Acetyl-Methadol (LAAM) and Methadone only; or
- Other substance abuse services that may be provided, at the discretion of the PIHP, to enhance outcomes.