



STATE OF MICHIGAN

DEPARTMENT OF COMMUNITY HEALTH  
LANSING

RICK SNYDER  
GOVERNOR

JAMES K. HAVEMAN  
DIRECTOR

January 28, 2014

Ms. Marilyn Tavenner, Administrator  
Centers for Medicare and Medicaid Services  
Department of Health and Human Services  
Mail Stop 314-G  
200 Independence Avenue S.W.  
Washington, D.C. 20201

Dear Ms. Tavenner:

This letter serves as the State of Michigan's formal acceptance of the Special Terms and Conditions for the Section 1115 Demonstration known as the Healthy Michigan Plan, as provided to the State in your December 30, 2013 correspondence. The State acknowledges the time and effort you and your colleagues at the Centers for Medicare and Medicaid Services have provided as we worked together to move the State's vision for the Healthy Michigan Plan through the waiver approval process.

We understand from previous discussions with our federal partners that technical corrections to the Special Terms and Conditions may be requested by the State following approval of the demonstration, therefore the State wishes to take the opportunity in this acceptance letter to do so. We look forward to discussing these items with your colleagues as we continue to work to implement the Healthy Michigan Plan.

*MI Health Account Operational Protocol (Paragraph 30)*

The State appreciates the opportunity to work with the Centers for Medicare and Medicaid Services to provide further detail with respect to the MI Health Account through the development of an operational protocol. However, given the requirements of the State law authorizing the creation of the Healthy Michigan Plan and its related MI Health Account, and transition plans associated with existing Adult Benefits Waiver beneficiaries, the State seeks the following revisions.

The Special Terms and Conditions reference a phased implementation for the MI Health Account that begins with individuals above 100% of the Federal Poverty Level. While the State intends to take a stepped approach to MI Health Account operations, it will instead begin with those individuals below 100% of the Federal Poverty Level. Existing Adult Benefits Waiver Beneficiaries, of which there are approximately 60,000 individuals with incomes not exceeding 35% of the Federal Poverty Level, will be the first group transitioned to the Medicaid health plans and the first group to interact with a MI Health Account in October of 2014. Other eligible individuals will follow suit on a rolling enrollment basis. For this reason, the State requests that Paragraph 30(a) be corrected to reflect a phased in approach that begins with individuals *below* 100% of the Federal Poverty Level, rather than *above*.

The State also requests that the reference to a notice requirement 'at the time of service' be eliminated with respect to the cost-sharing obligations described in Paragraph 30(e). State law authorizing the creation of the Healthy Michigan Plan essentially eliminates the remittance of co-payments at the time of service in order to ease the burden on providers, remove a barrier to access and promote beneficiary accountability. Instead, co-payments for health plan covered services will be collected on a delayed basis through the MI Health Account, with opportunities for reductions in any amounts owed if the service provided is one that promotes health, or if the beneficiary achieves healthy behaviors in a manner that merits a reduced charge. Given the law's requirements, the provider's office will not have the information necessary to inform the beneficiary of the amounts owed and credited to them at the time of a service. However, the State intends to facilitate education of Healthy Michigan

Plan participants and providers, in collaboration with the Medicaid health plans, to ensure that all parties understand how co-payments will be assessed and collected, and that services cannot be reduced or denied for failure to pay. While the State looks forward to working with CMS to develop the operational protocol for the MI Health Account, this change is requested in advance of this collaboration.

Delivery System (Paragraph 35)

Paragraph 35, Section(b)(iv) of the Special Terms and Conditions requires an auto assignment process that first considers the individual's history with the relevant health plan, followed by the plan's affiliation of the individual's historic providers. Michigan is a mature managed care state, having nearly two decades of experience and success working in partnership with our Medicaid health plans. As such, the State has an auto-assignment algorithm in place, which is compliant with 42 CFR § 438.50(f) and approved by the Centers for Medicare and Medicaid Services, that relies on quality data rather than historical individual provider data. Because Michigan intends to use as much of its existing managed care infrastructure to implement the Healthy Michigan Plan as possible, and historical provider information is not incorporated into the existing algorithm, the State requests that the last sentence of Paragraph 35, Section (b)(iv) be deleted in its entirety.

Managed Care Contracts (Paragraph 37)

As previously discussed with our federal partners, the State wishes to reiterate its intention to submit draft contracts to the Centers for Medicare and Medicaid Services with a minimum of 60 days for review and approval. The State would appreciate formal acknowledgement that this is sufficient to meet the requirements of paragraph 37, and that this approach would permit the receipt of all Federal Financial Participation to which the State is entitled.

Transitions of Adult Benefit Waiver Beneficiaries (Paragraph 46)

The State recognizes that it is of the utmost importance to ensure timely access to care for Adult Benefits Waiver beneficiaries transitioning to the Healthy Michigan Plan, and that honoring existing provider relationships and treatment plans is a way to achieve that goal. However, the Special Terms and Conditions directive that the Medicaid health plans honor all prior authorizations initiated under the Adult Benefits Waiver program for a period of 90 days, as well as the requirement for the plans to permit services by an out of network provider for 90 days, are not necessary to support continuity of care and access to care during the transition period, and are inconsistent with the State's existing managed care operations.

Instead, the State believes that safe transitions of care may occur with the following requirements for out-of-network services and prior authorizations. First, the State will direct all Medicaid Health Plans to allow out of network services until such time that the beneficiary may be safely brought into network. This is a common approach to care transitions within managed care generally, and is consistent with existing practices in the State. Medicaid health plans will also be required to honor prior authorizations in place at the time of enrollment until appropriate prior authorizations can be established by the enrollee's chosen Medicaid health plan, without interruption of ongoing services. The State anticipates that all prior authorizations will be evaluated after 30 days, and would be extended at that point if medically necessary.

Given the above, the State requests that the first sentence of Paragraph 46 be revised to read as follows:

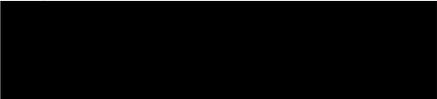
*In addition to all prior authorizations initiated under the ABW demonstration being honored for a period of 30 days in the new Medicaid Health Plans, individuals transitioning from the Adult Benefits Waiver MCOs will be matched to a Medicaid Health Plan with their existing preferred provider to the extent possible.*

Ms. Marilyn Tavenner  
January 28, 2014  
Page 3

Similarly, the State requests that Paragraph 46, Section (c) be revised as follows:

*The Medicaid Health Plan will allow the individual to see that provider, even on an out of network basis, until the individual may be safely brought into network.*

The State is grateful for the assistance you and your colleagues have already provided and looks forward to continued collaboration. If you have any questions or require any additional information, please do not hesitate to contact Jackie Prokop at (517) 335-5184 or by e-mail at [prokopj@michigan.gov](mailto:prokopj@michigan.gov).



Stephen Fitton, Director  
Medical Services Administration

cc: Diane Gerrits  
Paul Boben  
Verlon Johnson



STATE OF MICHIGAN  
DEPARTMENT OF COMMUNITY HEALTH  
LANSING

RICK SNYDER  
GOVERNOR

JAMES K. HAVEMAN  
DIRECTOR

November 8 2013

Ms. Cindy Mann  
Deputy Administrator of the Centers for Medicare & Medicaid Services  
and Director of the Centers for Medicaid and CHIP Services  
Department of Health and Human Services  
7500 Security Boulevard  
Mail Stop S2-26-12  
Baltimore, MD 21244

Dear Ms. Mann:

The State of Michigan is pleased to submit its formal application to amend the State's current Section 1115 Adult Benefits Waiver Demonstration Program. The State requests approval of this amendment in order to implement certain directives contained in the State law known as Public Act 107 of 2013 and in turn, make health care affordable and accessible for 300,000 to 500,000 Michigan citizens.

This program, known as the "Healthy Michigan Plan" is intended to be a model for providing a comprehensive benefit package while managing health care costs. Specifically, the proposed benefit design aims to assist individuals in managing their health care needs while encouraging them to maintain or attain healthy behaviors and utilize high value services whenever possible. The State is enthusiastic about the impact this program could have on not only the numbers of the uninsured, but also on health behaviors and outcomes throughout the State.

In order to implement the Healthy Michigan Plan consistent with the timeframes required by State law, we are requesting approval by December 31, 2013.

We appreciate the assistance both you and your colleagues at CMS have already provided, and look forward to continuing to work together in order to achieve our mutual goal of improving the health and well-being of low-income Michigan citizens.

Sincerely,

Stephen Fitton, Director  
Medical Services Administration

enclosure

cc: Paul Boben, CMS  
Diane Gerrits, CMS

**Healthy Michigan Plan**  
**A Waiver Amendment Request Submitted Under Authority of**  
**Section 1115 of the Social Security Act**

**to the**

**Centers for Medicare and Medicaid Services**  
**US Department of Health and Human Services**

**November 8, 2013**

**State of Michigan**  
**Rick Snyder, Governor**

James K. Haveman, Director  
Michigan Department of Community Health  
Capitol View Building  
201 Townsend Street  
Lansing, Michigan 48913

# Healthy Michigan Plan Waiver Amendment Request Section 1115 Waiver and Health Care Reform

## Table of Contents

I.	Program Description .....	1
	A. Executive Summary.....	1
	B. Rationale.....	2
	C. Evaluation and Hypotheses.....	2
	1. Project Goals and Evaluation Objectives .....	2
	2. Overview of Hypotheses and Approach to Research .....	3
	a. Uncompensated Care Analysis .....	3
	b. Reduction in the Number of Uninsured .....	3
	c. Impact on Healthy Behaviors and Health Outcomes .....	3
	d. Participant Views on the Impact of the Healthy Michigan Plan.....	4
	D. Geographic Coverage Area.....	4
	E. Implementation Timeline.....	4
II.	Eligibility .....	4
	A. Eligible Population .....	4
	B. Standards and Methodologies.....	5
	C. Enrollment Limits.....	5
	D. Projected Enrollment .....	5
	E. Application and Enrollment Process .....	5
	F. Transition of Current Adult Benefits Waiver Beneficiaries .....	5
	G. Review of Previous Modified Adjusted Gross Income Applications.....	6
	H. Medicaid Categories for Alternative Benefit Plan.....	7
III.	Healthy Michigan Plan Benefits .....	7
	A. Benefits Compared to Current Medicaid State Plan.....	7
	B. Health Benefit Plan for the Healthy Michigan Waiver.....	8
IV.	MI Health Account .....	8
	A. Account Management.....	8
	B. Cost Sharing Requirements .....	9
	1. Account Contributions.....	9

**Healthy Michigan Plan Waiver Amendment Request  
Section 1115 Waiver and Health Care Reform**

2. Copayment Obligations .....	10
C. Incentives for Healthy Behaviors .....	12
D. Consequences for Failure to Comply with Cost-Sharing Requirements .....	12
V. Delivery System.....	13
A. Medicaid Health Plans.....	13
1. Access.....	13
2. Health Plan Choice.....	14
3. Benefits Provided by the Health Plans .....	14
4. Continuity of Care .....	14
5. Quality Monitoring.....	15
6. Marketing .....	15
7. Enrollment.....	15
8. Disenrollment, Grievances and Appeals .....	16
B. Mental Health Services and Substance Use Disorder Services .....	16
1. Benefit Expansion for Healthy Michigan Plan Beneficiaries.....	17
2. Adult Benefits Waiver Transition and Continuity of Care.....	17
3. Community Support Services.....	17
C. Dental Services.....	18
D. Maternal Infant Health Program.....	18
E. Vision.....	18
F. Home Help.....	19
G. Non-Emergency Medical Transportation .....	19
H. Early and Periodic Screening, Diagnosis and Treatment Services.....	19
I. Pharmacy Services.....	19
VI. Implementation and Outreach.....	19
A. Implementation.....	19
B. Outreach.....	20
VII. Cost Effectiveness and Budget Neutrality .....	20

**Healthy Michigan Plan Waiver Amendment Request  
Section 1115 Waiver and Health Care Reform**

VIII. Statutory Waivers and Expenditure Authority Requests ..... 20

    A. Michigan Statutory Waiver Requests ..... 20

    B. Expenditure Authority ..... 21

IX. Public Notice..... 22

    A. Discussions with Stakeholders ..... 22

    B. Website ..... 23

    C. Tribal Consultation ..... 23

    D. Toll-free Number ..... 23

X. Summary ..... 24

XI. Attachments ..... 24

    A. Proposed Healthy Michigan Benefit Plan..... 24

    B. Tribal Notification ..... 24

    C. Budget Documents ..... 24

# Healthy Michigan Plan Waiver Amendment Request

## Section 1115 Waiver and Health Care Reform

### I. Program Description

#### A. Executive Summary

The State of Michigan seeks a Section 1115 waiver amendment approval from the Centers for Medicare and Medicaid Services to implement a program that will make quality health care affordable and accessible for all Michigan citizens up to 133% of the federal poverty level who are otherwise not eligible for Medicaid at the time of enrollment. This program, known as the Healthy Michigan Plan, provides a framework for comprehensive medical benefits and health care reform in Michigan.

The central features of this waiver program are to extend health care coverage to low-income Michigan citizens who are uninsured or underinsured and to implement systemic innovations to improve quality and stabilize health care costs. Other key features include: the advancement of health information technology; structural incentives for healthy behaviors and personal responsibility; encouraging use of high value services; and promoting the overall health and well-being of Michigan citizens. From the economic perspective, these working individuals will now have health care coverage creating a healthier workforce. A healthier workforce attracts new business and helps existing businesses grow and expand.

The Michigan Department of Community Health has been a leader in implementing cost containment initiatives to control health care program costs. Of the non-dual caseload, 75% are enrolled in capitated, Health Maintenance Organization managed care plans with plan rates that are among the most cost effective and efficient in the country. In addition, the Michigan Department of Community Health's program has been extremely aggressive in pursuing strategies to control the cost of Medicaid reimbursed services, which include provider contracts that allow for bulk purchasing, new pharmacy initiatives in an effort to achieve cost savings, enrollment of urgent care providers, and implementation of the Michigan Primary Care Transformation grant to enhance coordination of care. Even with these far-reaching, cost saving initiatives, Medicaid expenditures have continued to rise due to the sustained growth in program enrollment.

While Michigan has been extremely successful in finding and enrolling beneficiaries who meet current Medicaid and Children's Health Insurance Program eligibility requirements, the State has been limited in providing health care services to childless adults between 19 and 64 years old. Michigan currently has a Section 1115 waiver, known as the Adult Benefits Waiver, that provides a limited health care benefit to individuals in this age group whose income is less than or equal to 35% of the federal poverty level. The funding for this program is limited and, as a result, Michigan has to carefully monitor and manage the enrollment process by freezing Adult Benefits Waiver enrollment for long periods of time. Historically, Michigan has only opened enrollment for one to two months annually. However, each time Michigan opens Adult Benefits Waiver enrollment, the State has received an overwhelming response as evidenced by a high volume of applications resulting in increased enrollment from roughly 30,000 beneficiaries to 90,000 beneficiaries.

# Healthy Michigan Plan Waiver Amendment Request

## Section 1115 Waiver and Health Care Reform

### **B. Rationale**

Approval of this waiver amendment will allow Michigan to augment the current Adult Benefits Waiver program by expanding both the benefits to currently enrolled Adult Benefits Waiver beneficiaries and the eligibility income criterion for this adult population overall, from 35% to 133% of the federal poverty level using the new Modified Adjusted Gross Income methodology. Implementation of this waiver amendment will result in the provision of health care services to an estimated 300,000 to 500,000 Michigan citizens. Furthermore, this waiver will provide a full health care benefit package as required under the Affordable Care Act and will include all of the Essential Health Benefits as required by federal law and regulation. The overarching themes used in the benefit design will be increasing access to quality health care, encouraging the utilization of high-value services, promoting beneficiary adoption of healthy behaviors and using evidence-based practice initiatives. Organized service delivery systems will be utilized to improve coherence and overall program efficiency.

### **C. Evaluation and Hypotheses**

The Healthy Michigan Plan will provide affordable health insurance, thereby significantly improving access to health care services, for up to 500,000 Michigan residents who are under 133% federal poverty level. The State is committed to evaluating the impact of the Healthy Michigan Plan on consumers, providers and the small business community. Michigan intends to use the information obtained through the evaluation as a means to guide programmatic and policy change decisions in both the short and long term in an effort to implement health care reform.

The State has identified overall evaluation objectives, key research questions, hypotheses, data sources and methodologies that can serve as a framework for evaluation.

#### **1. Project Goals and Evaluation Objectives**

The goal of this amendment is to improve the health and well-being of low-income Michigan citizens. The planned benefit design will significantly help uninsured or underinsured individuals manage their health care issues and encourage them to adopt healthy behaviors through the availability of preventive care services.

The Healthy Michigan Plan provides both Michigan and the Centers for Medicare and Medicaid Services with an opportunity to implement an innovative and market-driven approach to using Medicaid funds to increase access to care. The State expects to gain valuable information about the effects of a model that infuses market-driven principles into a public healthcare insurance program. In particular, the State has identified the following evaluation objectives:

- The extent to which the increased availability of health insurance reduces the costs of uncompensated care borne by hospitals.
- The extent to which availability of affordable health insurance results in a reduction in the number of uninsured/underinsured individuals who reside in Michigan.

## **Healthy Michigan Plan Waiver Amendment Request Section 1115 Waiver and Health Care Reform**

- Whether the availability of affordable health insurance, which provides coverage for preventive and health and wellness activities, will increase healthy behaviors and improve health outcomes.
- The extent to which participants feel that the Healthy Michigan Plan has a positive impact on personal health outcomes and financial well-being.

### **2. Overview of Hypotheses and Approach to Research**

Several projects will be conducted to evaluate the success of the Healthy Michigan Plan. These include the following:

#### **a. Uncompensated Care Analysis**

This evaluation project will examine the impact of reducing the number of uninsured individuals on uncompensated care costs to hospitals in Michigan through the expansion of subsidized insurance. Specifically, the Healthy Michigan Plan will test the hypothesis that, as more people receive health insurance coverage that includes inpatient hospital care; there will be a corresponding decrease in the amount of uncompensated care. The reduction in uncompensated care will help to promote financial stability in the health care system. The current Michigan Adult Benefits Waiver has a more limited benefit and does not include an inpatient hospital benefit. Understanding the impact of the Healthy Michigan Plan and the role that hospitals play in providing unreimbursed health care services is needed as health care costs continue to rise. To evaluate this program, Michigan proposes to use annual hospital data from filed hospital cost reports, the Michigan Health & Hospital Association (or other sources), and census-based data to account for both hospital characteristics and county-based factors. Through the application of a multi-level modeling methodology, Michigan will measure the effect of the Healthy Michigan Plan on hospital uncompensated care spending.

#### **b. Reduction in the Number of Uninsured**

The Healthy Michigan Plan will test the hypothesis that, when affordable health insurance is made available and the application for insurance is simplified (through both an exchange and the State's existing eligibility process), the uninsured population will decrease significantly.

This evaluation will examine insured/uninsured rates in general and more specifically by select population groups (e.g., income levels, geographic areas, and race/ethnicity).

#### **c. Impact on Healthy Behaviors and Health Outcomes**

The Healthy Michigan Plan will evaluate what impact incentives for healthy behavior and the completion of an annual health risk assessment have on increasing healthy behaviors and improving health outcomes.

## **Healthy Michigan Plan Waiver Amendment Request Section 1115 Waiver and Health Care Reform**

This evaluation will analyze selected indicators, such as emergency room utilization rates, inpatient hospitalization rates, use of preventive services and health and wellness programs, and the extent to which participants report an increase in their overall health status.

### **d. Participant Views on the Impact of the Healthy Michigan Plan**

The Healthy Michigan Plan will evaluate whether access to a low-cost (modest co-payments, etc.) primary and preventive health insurance benefit will encourage participants to maintain their health through the use of more basic health care services in order to avoid more costly acute care services. For example, access to affordable prescription medications and routine physician services is expected to enable individuals to maintain their health and, in turn, improve the quality of life for enrolled beneficiaries by removing cost as a barrier to preventive or chronic health services.

## **D. Geographic Coverage Area**

This program will provide health care coverage for all beneficiaries enrolled under this waiver program statewide.

## **E. Implementation Timeline**

Michigan's goal is to obtain approval of this waiver amendment and implement this program effective April 1, 2014. Michigan understands the great opportunity provided by the Centers for Medicare and Medicaid Services in providing a 100% Federal Medicaid Assistance Percentage for this population during calendar years 2014, 2015 and 2016.

## **F. Benefits to the State of Michigan**

The Healthy Michigan Plan provides an opportunity to reform Medicaid and the broader health care system in Michigan. The Healthy Michigan Plan promises to extend beyond the offer of affordable health care coverage to Michigan's citizens. It will serve as a catalyst for innovation through its modeling of benefit design principles based on value and use of financial incentives to reward healthy behaviors and personal responsibility.

# **II. Eligibility**

## **A. Eligible Population**

Through this demonstration project, Michigan will offer eligibility for the Healthy Michigan Plan to adults 19-64 years of age, who are not covered by or eligible for Medicaid at the time of application, who have family incomes at or below 133% of the federal poverty level, and who are not eligible for or enrolled in Medicare, consistent with federal law. Coverage will be limited to adults who reside in Michigan and meet Medicaid citizenship requirements.

## **Healthy Michigan Plan Waiver Amendment Request Section 1115 Waiver and Health Care Reform**

### **B. Standards and Methodologies**

The Medical Services Administration is the single-state agency that administers the Medicaid program within the Michigan Department of Community Health. Eligibility for this program will be determined through the Modified Adjusted Gross Income methodology.

Michigan will collaborate with the Centers for Medicare and Medicaid Services in submitting a State Plan Amendment specific to the Healthy Michigan Plan's eligibility parameters and requirements. Michigan anticipates submitting the State Plan Amendment concurrently with the submission of this waiver amendment.

### **C. Enrollment Limits**

A continuous open enrollment will be implemented to accommodate new enrollees into the Healthy Michigan Plan. Michigan will no longer freeze enrollment for the people served under this waiver effective April 1, 2014.

### **D. Projected Enrollment**

It is estimated that approximately 300,000 – 500,000 individuals will meet these eligibility requirements.

### **E. Application and Enrollment Process**

Michigan will implement the same streamlined application and eligibility process that is utilized for other Medicaid programs (with the exception of the aged, blind and disabled population). Michigan will also apply the new Modified Adjusted Gross Income methodology when determining eligibility for the Healthy Michigan Plan population. Eligibility determinations will not be made retroactive prior to April 1, 2014.

All applicants will be screened to determine if they are eligible for one of Michigan's current categorical groups that provide the existing Medicaid benefit package. Should an applicant for this program be eligible for full Medicaid, they will be enrolled in the applicable categorical program. If an applicant is eligible for this demonstration and for Michigan's family planning program demonstration called "Plan First!," they will be enrolled in the Healthy Michigan Plan as it offers a more comprehensive health care benefit package and is in the best interest of the health and well-being of the individual.

### **F. Transition of Current Adult Benefits Waiver Beneficiaries**

Current Adult Benefits Waiver beneficiaries will be automatically transitioned into the Healthy Michigan Plan to place them into the new waiver group effective April 1, 2014. Those who are currently Adult Benefits Waiver eligible will meet the financial requirements of this new plan, so no redetermination for this program will be necessary at the time of this transition. Redeterminations will happen at their regularly scheduled intervals.

## **Healthy Michigan Plan Waiver Amendment Request Section 1115 Waiver and Health Care Reform**

While the County Health Plan structure will not be utilized as a delivery system once the Adult Benefits Waiver beneficiaries' transition, many County Health Plan providers are also contracted with one or more of the Medicaid Health Plans who will primarily serve this expanded population in the Healthy Michigan Plan. This will help to maintain continuity and coordination of care as Adult Benefits Waiver beneficiaries select their Medicaid Health Plan as part of the Healthy Michigan Plan enrollment process. Michigan's enrollment broker will assist the beneficiaries in selecting a Medicaid Health Plan that contracts with their primary care physician. In the event a beneficiary's primary care physician does not contract with one of the existing Medicaid Health Plans, the enrollment broker will assist the beneficiary with selecting a new primary care physician.

Beneficiaries will be afforded ample opportunity to personally select a Medicaid Health Plan, consistent with existing managed care policies and procedures regarding plan selection and, when applicable, automatic assignment. Additionally, any prior authorizations initiated under the current Adult Benefits Waiver program will be honored for a set period of time in order to ensure a smooth transition for these particular beneficiaries. Prepaid Inpatient Health Plan participation will also be honored during the transition to promote continuity of care. Overall, Michigan plans to work with the Centers for Medicare and Medicaid Services to resolve any operational issues as a result of the transition of this population to the Healthy Michigan Plan post-waiver approval.

### **G. Review of Previous Modified Adjusted Gross Income Applications**

Beginning in March of 2014, Michigan will identify all applications submitted on and after October 1, 2013 that received a denial for Medicaid using the Modified Adjusted Gross Income methodology. These applications will be resent through Michigan's Modified Adjusted Gross Income rules engine to determine eligibility for the Healthy Michigan Plan. If the applicant is found eligible, they will receive an eligibility notification and their eligibility will begin on April 1, 2014. Michigan will send each applicant an enrollment packet.

Michigan, in coordination and partnership with the Centers for Medicare and Medicaid Services and the Center for Consumer Information and Insurance Oversight will also seek out applications that were submitted through the federal Health Insurance Marketplace to determine if applicants would be eligible for the Healthy Michigan Plan. These applications will be routed through Michigan's Modified Adjusted Gross Income rules engine in an effort to determine eligibility for the Healthy Michigan Plan. Michigan's goal is to find and determine eligibility for all applicants who are eligible for the Healthy Michigan Plan. If the applicant is found eligible, they will receive notice of that eligibility and an enrollment packet.

Michigan will work with the federal Health Insurance Marketplace to identify people between 100% and 133% of the federal poverty level who may be receiving health care services through a Qualified Health Plan on the exchange. Michigan will work with our federal partners to transition these enrollees to the Healthy Michigan Plan. All beneficiaries who transition from the federal Health Insurance Marketplace will receive an enrollment packet from the Michigan Department of Community Health to help them select a Medicaid Health Plan and will follow the process as described in II(F) "Transition of Current Adult Benefits

## **Healthy Michigan Plan Waiver Amendment Request Section 1115 Waiver and Health Care Reform**

Waiver Beneficiaries.” Michigan will work with the Centers for Medicare and Medicaid Services to further define this process post-waiver approval.

### **H. Medicaid Categories for Alternative Benefit Plan**

This benefit plan will only be used for the Medicaid category of the adult group as described under the Eligibility Section of this waiver document. This benefit plan will not be applied to or used for other Medicaid eligibility categories currently provided by the Michigan Medicaid program.

## **III. Healthy Michigan Plan Benefits**

As required by the Affordable Care Act, an Alternative Benefit Plan must consist of a Section 1937 benchmark plan or a benchmark-equivalent plan with the assurance that all 10 Essential Health Benefit categories of service are covered. If the benchmark plan does not include all 10 Essential Health Benefits, then the Alternative Benefit Plan must be supplemented to ensure coverage of the Essential Health Benefits.

Michigan intends to amend its Medicaid State Plan benefit package to seek a Secretary Approved benchmark plan for this demonstration population. Michigan will use the Priority Health Plan as its base benchmark plan.

### **A. Benefits Compared to Current Medicaid State Plan**

The Healthy Michigan Plan benefit package will include all 10 Essential Health Benefits as required by the Affordable Care Act and additional benefits that align with the state base benchmark plan services in amount, duration and scope. All services covered under this waiver will be equal in scope and coverage to services provided to our current Medicaid beneficiaries and will qualify for 100% federal matching funds.

Michigan will work with our federal partners by submitting the requisite State Plan Amendment for the creation and approval of an Alternative Benefit Plan for the Healthy Michigan Plan. The details of the plan and assurance of meeting all federal requirements will be completed through the State Plan Amendment approval process. The information provided in this waiver application will provide the Centers for Medicare and Medicaid Services with an overview of the proposed benefit package.

The Healthy Michigan Plan population will also receive three additional benefits that are not covered through the current State Plan. This includes habilitative services, hearing aids and the full complement of preventive health care services. For the Alternative Benefit Plan, the same amount, duration and scope of coverage that currently applies to rehabilitative services under the State Plan will be applied to habilitative services. Michigan will cover the services listed in Attachment A and will cover any additional State Plan services that are determined medically necessary in accordance with 42 CFR §440.315(f), in an effort to assure we are meeting the health care needs of the Healthy Michigan Plan population.

## **Healthy Michigan Plan Waiver Amendment Request Section 1115 Waiver and Health Care Reform**

### **B. Health Benefit Plan for the Healthy Michigan Waiver**

Attachment A identifies the services that will be covered for the Healthy Michigan Plan population as well as a comparison of Michigan's benchmark plan to State Plan services currently available to Medicaid beneficiaries.

### **IV. MI Health Account**

The Healthy Michigan Plan will employ the conceptual framework of the MI Health Account. These accounts will be a component of health care reform that will assist in the reduction of the growth of health care costs and increase the efficiency of the health care system. This concept allows individuals who may not be familiar with purchasing health care services to become actively engaged in their health care experience. This account is intended to be a tool to encourage beneficiaries to become more active consumers of their health care, to save for future healthcare expenses and become more aware of the cost of the services they receive. By encouraging and fostering consumer engagement, Michigan believes that beneficiaries will become more involved and accountable with making health care decisions that will improve health outcomes.

The MI Health Account will provide the beneficiary with information on the amounts available in the account on a quarterly basis, along with expenditures and any amounts owed by the beneficiary for applicable cost-sharing. The quarterly statements will also provide health care cost transparency and service utilization information. Account balances will not be tax deductible and will not accrue interest. Michigan will work with the Centers for Medicare and Medicaid Services post-waiver approval in outlining further details of how the MI Health Account will operate.

#### **A. Account Management**

In accordance with Michigan's Public Act 107 of 2013, the account shall be administered by the Michigan Department of Community Health and can be delegated to a Medicaid Health Plan or third party administrator. The Michigan Department of Community Health is planning to collaborate with the Medicaid Health Plans or a third party administrator in the design and implementation of the MI Health Account. The administration and operation of the MI Health Accounts will be designed to encourage beneficiaries to use high-value services, while discouraging low-value services such as non-urgent use of the emergency room.

Account funds will not be disbursed for items or services not covered under the benefit plan for this demonstration waiver. In addition, the account will not be subject to costs incurred for preventive services or certain services considered confidential under applicable laws, such as family planning or behavioral health services. Finally, services that are provided outside of the Medicaid Health Plans, such as those services provided through existing carve-outs or other approved arrangements (e.g. Prepaid Inpatient Health Plan services) will not reach the account. Therefore, account balances will not be impacted by the beneficiary's receipt of these services, and further, the provision of confidential services will not be reflected on the account statements, consistent with applicable laws and existing policy.

## **Healthy Michigan Plan Waiver Amendment Request Section 1115 Waiver and Health Care Reform**

Payment will be sought from funds in the account using the following priority order: 1) State contributions; 2) contributions from any other non-State source; and 3) contributions made by the beneficiary. Beneficiaries, who are no longer eligible for the Healthy Michigan Plan, will receive the balance of their individual contributions to the MI Health Account in the form of a voucher to be used for the sole purpose of purchasing and paying for private insurance.

### **B. Cost Sharing Requirements**

All individuals enrolled in the Healthy Michigan Plan through a contracted Medicaid Health Plan will receive a MI Health Account into which money from any source, including (but not limited to) the beneficiary, his or her employer, and/or private and public entities on the beneficiary's behalf, may be deposited for the beneficiary's use in paying for incurred health expenses. Cost-sharing requirements, which include co-pays and additional contributions based on a beneficiary's federal poverty level, will be monitored through the use of this MI Health Account.

While beneficiaries have an obligation to contribute to their MI Health Account, they are not obligated to fully fund the account in order to receive needed healthcare services. The State will make contributions to the account: (a) in amounts varied based on the beneficiary's existing contributions and circumstances, (b) in a manner that ensures beneficiaries are able to obtain necessary health care services, (c) to assure providers are paid for the covered health care services they provide, and (d) to ensure that cost transparency is maintained for the beneficiary's benefit. Through the quarterly statement notification, beneficiaries will be informed on how much money is available and how it is being spent, thus creating a more informed health care consumer.

Participation in the Healthy Michigan Plan requires beneficiaries to comply with various cost-sharing requirements, based on their income level. Cost-sharing, as described below, includes both co-pays and, when applicable to the beneficiary, contributions based on income to the MI Health Account. The total amount of the beneficiary's annual cost-sharing, which includes co-payments and any required contributions, will not exceed 5% of the beneficiary's annual income. This will be monitored by the Michigan Department of Community Health or the agency the Department elects to delegate the MI Health Account organization and administration.

Populations that are exempt from cost-sharing requirements per current federal law and regulations will be exempt from cost-sharing obligations under this waiver demonstration (e.g. Native Americans and pregnant women will not be required to pay co-pays or the contributions).

#### **1. Account Contributions**

Cost sharing in the form of co-pays will be applied to all Healthy Michigan Plan beneficiaries. Individuals between 100% and 133% of the federal poverty level will be required to make an additional contribution to their MI Health Account. This amount will be limited to 2% of annual income, and must be contributed on a monthly basis.

## **Healthy Michigan Plan Waiver Amendment Request Section 1115 Waiver and Health Care Reform**

For example, an individual with an annual income of \$12,000 per year will be obligated to contribute 2% to his or her MI Health Account, or \$240, over the course of a year. This results in a beneficiary contribution of \$20 per month into the beneficiary's account.

These contributions will not be required during the first six months the individual is enrolled in the Healthy Michigan Plan. In addition, required contributions may be reduced to an amount less than 2% by the relevant Medicaid Health Plan in the event certain health behaviors are being addressed (as described further below).

The money deposited into an individual's MI Health Account may come from any source, including the beneficiary, the beneficiary's employer, and private or public entities on the beneficiary's behalf. However, the State will commit to making contributions to the account in the amount necessary to cover the beneficiary's health care expenditures, minus the beneficiary's individual cost-sharing contributions. This means that in practice, the MI Health Account will be sufficiently funded to meet the beneficiary's incurred health care expenses.

The MI Health Account will track beneficiary health care expenses and will use the beneficiary's contribution to pay for services after the beneficiary has incurred a set amount in health care services. The set amount will be based on the beneficiary's income. Any contributions left in their account after the end of the year will roll-over to the next year and will be used to offset future contribution amounts. Quarterly statements from the MI Health Account will be used to track beneficiary health care expenses.

### **2. Copayment Obligations**

Healthcare services received by Healthy Michigan Plan beneficiaries will be subject to co-pays, consistent with the framework established by the relevant Medicaid Health Plan or as established by the State's current fee-for-service system prior to managed care enrollment. Co-pay amounts will be consistent with Michigan's current State Plan and the co-pay amounts will not exceed the amounts outlined in the Affordable Care Act cost-sharing regulations. In accordance with federal regulations, there will be no co-pay requirements for preventive services, emergency services or emergent hospital admissions. Co-pay amounts may be reduced if certain healthy behaviors are maintained or attained (as described further below). Table 1 identifies the service specific maximum co-pays that may be incurred by all Healthy Michigan Plan beneficiaries.

Once the beneficiary is enrolled in a Medicaid Health Plan, healthcare providers will not be responsible for collecting co-pays directly from the beneficiary at the point of service. Instead, this will be a function of the Medicaid Health Plan's collection of the beneficiary's cost-sharing account contributions. Michigan believes that by eliminating the co-pay requirement at point of service, beneficiaries will be assured of receiving

## **Healthy Michigan Plan Waiver Amendment Request Section 1115 Waiver and Health Care Reform**

needed health care services. There will be no distribution of funds from the MI Health Account to the beneficiary to meet these obligations. Healthcare providers will be directed to seek reimbursement for both the patient co-pay and the encounter expenses from the contracted Medicaid Health Plan. All applicable co-pays incurred by beneficiaries enrolled in a Medicaid Health Plan will be satisfied through the MI Health Account mechanism.

During the Healthy Michigan Plan beneficiary's first six months of enrollment in a Medicaid Health Plan, the beneficiary is not required to remit funds for any co-payment amounts incurred, regardless of his or her income. However, each beneficiary will have the co-pays they incur for the first six months tracked by the relevant Medicaid Health Plan, and at the end of the six month period, an average monthly co-pay experience for the beneficiary will be calculated. The beneficiary will then be required to remit this amount each month into his or her MI Health Account going forward. In practice, this mechanism delays the imposition of co-payments for a six month period and allows the beneficiary to spread his or her payment obligation over a longer period of time. This may be particularly helpful for beneficiaries who receive services requiring a more significant financial contribution, by allowing them to pay their share of the cost over a six month period.

For example, if during the first six months, a Healthy Michigan Plan beneficiary visits his or her physician once (\$2 co-pay), dentist once (\$3 co-pay), and fills one generic prescription (\$1), the average monthly co-pay experience for that beneficiary will be \$1.00 (\$6 in expenditures divided over a six month period equals an average of \$1 per month). Therefore, that beneficiary will be required to remit \$1 per month into his or her MI Health Account. The average co-pay amount shall be re-calculated every six months to reflect the beneficiary's current utilization of healthcare services. In overseeing the operation of the MI Health Accounts, the Michigan Department of Community Health will take steps to assure that information regarding the amounts owed and paid follow beneficiaries moving between Medicaid Health Plans in order to prevent overcharging of the beneficiaries and ensure compliance with the Plan's requirements. The Department will also assure that beneficiaries have appropriate options for submitting the funds needed to meet their financial obligations.

# Healthy Michigan Plan Waiver Amendment Request Section 1115 Waiver and Health Care Reform

## Healthy Michigan Co-Pay Recommendations – Table 1

Service	*0-133% of the federal poverty level Co-Pays
Physician Office Visits (including free-standing Urgent Care Centers)	\$2
Outpatient Hospital Clinic Visit	\$1
Emergency Room Visit for Non-Emergency Services <ul style="list-style-type: none"> <li>• Co-payment ONLY applies to non-emergency services</li> <li>• There is no co-payment for true emergency services</li> </ul>	\$3
Inpatient Hospital Stay (with the exception of emergent admissions)	\$50
Pharmacy	\$1 generic \$3 brand
Chiropractic Visits	\$1
Dental Visits	\$3
Hearing Aids	\$3/aid
Podiatric Visits	\$2
Vision Visits	\$2

\*Current Medicaid co-pays.

### C. Incentives for Healthy Behaviors

All beneficiaries receiving benefits under this waiver demonstration will be eligible to receive reductions in their cost-sharing obligations if certain healthy behaviors are maintained or attained. Reductions in cost-sharing requirements will be available for co-payments and, for those beneficiaries at 100-133% of the federal poverty level, the required additional contributions. The Michigan Department of Community Health will work with its stakeholders to identify uniform standards for those healthy behaviors that will be eligible for the reductions. These uniform standards will include, at a minimum, completing a Michigan Department of Community Health approved annual health-risk assessment to identify unhealthy characteristics, including alcohol use, substance use disorders, tobacco use, obesity, and deficiencies in immunization status. In developing these uniform standards, the Michigan Department of Community Health will design incentives that are innovative, evidence-based and population focused, and will address the current health status of all beneficiaries, including those with healthy lifestyles and those dealing with chronic illnesses.

### D. Consequences for Failure to Comply with Cost-Sharing Requirements

The Michigan Department of Community Health will develop and pursue a range of consequences for beneficiaries who consistently fail to meet their cost-sharing requirements. No beneficiary, regardless of income level, may be removed from the Healthy Michigan Plan for failure to pay contributions or co-pays. Michigan may opt to collect unpaid contributions

## **Healthy Michigan Plan Waiver Amendment Request Section 1115 Waiver and Health Care Reform**

or co-pays through a lien on the individual's tax refunds or place the beneficiary in the beneficiary monitoring program until the cost-sharing obligations are met. Michigan will work with the Centers for Medicare and Medicaid Services post-waiver approval in outlining further details of the consequences for not complying with cost-sharing requirements.

### **V. Delivery System**

Upon eligibility determination for the Healthy Michigan Plan, beneficiaries will immediately begin their health plan enrollment selection process. The Michigan Department of Community Health will provide beneficiaries with the necessary assistance to select their preferred health plan. Each eligible Healthy Michigan Plan beneficiary will be enrolled into a Medicaid Health Plan. The administration of the Medicaid Health Plan delivery system will be conducted in accordance with Michigan's current §1915 (b) Comprehensive Managed Care Waiver. In the event a beneficiary needs a health care service prior to selecting their health plan, they will be able to receive services through the current Medicaid fee-for-service structure.

#### **A. Medicaid Health Plans**

All beneficiaries will be mandatorily enrolled into a Medicaid Health Plan (with the exception of those few beneficiaries who meet the Medicaid Health Plan enrollment exemption criteria or those beneficiaries who meet the voluntary enrollment criteria). Enrollees will go through the same health plan selection process that the current Medicaid populations follow to ensure beneficiaries have adequate time to choose their Medicaid Health Plan.

Currently, Michigan has 1.2 million people enrolled in our Medicaid Health Plans. Michigan projects that the Healthy Michigan Plan will add another 300,000 to 500,000 new enrollees to Michigan's contracted Medicaid Health Plans. Given the expected size of the Medicaid Health Plan population following implementation of the Healthy Michigan Plan, Michigan anticipates that, through economies of scale, competitive rates will be available not only for the Healthy Michigan Plan population, but also for the current Medicaid population. This facilitates administrative simplification in many areas and promotes efficient implementation.

##### **1. Access**

With the potential churning of beneficiaries between Medicaid programs, it is most efficient to use the current Medicaid Health Plan system of coverage for this newly eligible adult population. Currently, under existing §1915(b) waiver approval from the Centers for Medicare and Medicaid Services, the Michigan Department of Community Health contracts with 13 Medicaid Health Plans to provide a comprehensive set of health care services for over 1.2 million of the State's Medicaid beneficiaries. Medicaid Health Plans have the capacity and willingness to accept the newly eligible population. Consistent with existing policy, the Healthy Michigan Plan managed care enrollees will have assured access to care, predictable costs and improved customer satisfaction from reliable, successful health plans accountable to the State.

## **Healthy Michigan Plan Waiver Amendment Request Section 1115 Waiver and Health Care Reform**

Primary care physicians throughout the State overwhelmingly anticipate having capacity to serve more patients with all forms of health coverage, including Medicaid. A recent survey concluded that the State's primary care system will have sufficient capacity to match the growing resource requirements of a State Medicaid expansion such as the Healthy Michigan Plan. *Center for Healthcare Research & Transformation Policy Brief, January 2013.*

### **2. Health Plan Choice**

The State will comply with section 1932(a)(3) of the Social Security Act and the Code of Federal Regulations at 42 CFR §438.52, which requires beneficiaries to enroll in a Medicaid Health Plan, but gives the choice of at least two entities, with some exceptions. In rural counties, the State will employ the "rural exception" where beneficiaries will only have one choice of a Medicaid Health Plan, but given the choice of individual providers. The State will use the rural exception in the following counties: Alger, Baraga, Chippewa, Delta, Dickinson, Gogebic, Houghton, Iron, Keweenaw, Luce, Mackinac, Marquette, Menominee, Ontonagon, and Schoolcraft.

Healthy Michigan Plan participants will be given their choice of plans and providers consistent with the existing approved §1915(b) waiver, federal law and regulation. For those populations who are currently voluntary or exempt from enrollment into a Medicaid Health Plan (e.g., Native Americans, beneficiaries who have other Health Maintenance Organization or Preferred Provider Organization coverage, etc.), they will remain a voluntary or exempt population from managed care under this demonstration.

### **3. Benefits Provided by the Health Plans**

The State will assure that services under the demonstration will be available in the same amount, duration, and scope as they are under the State Plan per 42 CFR §438.210(a)(2). Beneficiaries will have access to emergency services as per section 1932(b)(2) of the Act and 42 CFR §438.114. Beneficiaries will also have access to family planning services per section 1905(a)(4) of the Act and 42 CFR §431.51. The managed care programs(s) will comply with the relevant requirements related to the Early and Periodic Screening, Diagnosis, and Treatment program. Medicaid Health Plans will follow the processes as currently identified in Michigan's §1915(b) managed care waiver.

Currently, the services covered by the Medicaid Health Plans include the 10 Essential Health Benefit categories of service, with the exception of habilitative services. In addition, the Medicaid Health Plans will also cover hearing aids and dental care. Habilitative support services will be added to the Medicaid Health Plan contracts as a covered benefit.

### **4. Continuity of Care**

By taking a managed care approach to this population, enrollees will be able to remain in the same Medicaid Health Plan and maintain their relationship with their providers if their eligibility changes from one Medicaid category to another.

## **Healthy Michigan Plan Waiver Amendment Request Section 1115 Waiver and Health Care Reform**

### **5. Quality Monitoring**

Consistent with the State's existing managed care demonstration materials, the Michigan Department of Community Health will ensure that performance measurement, tracking and related incentive programs will continue for the Healthy Michigan Plan population, and expects continued success in this regard. In addition, the Michigan Department of Community Health will ensure that participating Medicaid Health Plans provide timely access, sufficient capacity, availability of services and appropriate communication and assistance for all enrollees. The Michigan Department of Community Health will also continue its regular review of the Medicaid Health Plans overall performance, provider networks, member materials and other processes as described in Michigan's §1915 (b) waiver in addition to all other relevant compliance review activity.

The Medicaid Health Plans will continue to follow the quality standards as outlined in the §1915(b) waiver and as applicable per federal and state regulations. Michigan will continue such quality assessment and performance improvement activities to ensure the Medicaid Health Plans are delivering quality health care to the Healthy Michigan population.

### **6. Marketing**

Managed care entities will adhere to the marketing regulations as identified in the §1915 (b) managed care waiver. The State will have a mechanism in place to help enrollees and potential enrollees understand the managed care program. Marketing materials must be available in languages appropriate to the beneficiaries being served within the county. All material must be culturally appropriate and available in alternative formats in accordance with the Americans with Disabilities Act.

Marketing materials and provider information are available from the enrollment broker, MI Enrolls, upon request of a potential enrollee. Health fairs, ads, radio and television spots are also marketing alternatives that are reviewed by the Michigan Department of Community Health before presentation.

### **7. Enrollment**

Enrollment Counseling is provided by Maximus (herein referred to as MI Enrolls) through telephone access, face-to-face meetings and via information distributed in the mail. MI Enrolls holds subcontracts with local agencies that provide both information sessions as well as opportunities for individual counseling. All counselors hired by MI Enrolls receive initial training that addresses the special needs of the Medicaid population, such as referral to community mental health agencies and other local agencies that provide services for that population. They also receive desk references that provide the information that can be utilized after training is completed. MI Enrolls maintains a dedicated phone line for hearing impaired. The regional coordinators, who oversee the field staff, are also available to provide assistance for beneficiaries and their families in accessing necessary services, coordinating with local agencies and in

## **Healthy Michigan Plan Waiver Amendment Request Section 1115 Waiver and Health Care Reform**

assuring such services are available within the Medicaid Health Plan choices for new enrollees. Michigan enrollees will receive additional training as it relates to the Healthy Michigan Plan.

### **8. Disenrollment, Grievances and Appeals**

Michigan will follow all current applicable enrollment, disenrollment, grievance, fair hearing rights, and appeals processes consistent with existing waiver approval, federal law and regulation. Michigan will follow the current lock-in process for the mandatory populations and the lock-in process for the voluntary populations.

## **B. Mental Health Services and Substance Use Disorder Services**

In accordance with the Mental Health Parity and Addiction Equity Act, the State intends to include the services provided by the Prepaid Inpatient Health Plans to current Medicaid beneficiaries for the Healthy Michigan Plan beneficiaries. The Healthy Michigan Plan will allow for increased funding of the mental health system that will improve access to care, early problem identification, and care coordination and treatment.

Pursuant to Michigan's State Plan and federally approved §1915(b) waiver, community-based specialized mental health and substance use disorder services and supports are covered by Medicaid when delivered under the auspices of an approved Prepaid Inpatient Health Plan. In order to be an approved Medicaid provider, a Prepaid Inpatient Health Plan must be certified as a Community Mental Health Services Program by the Michigan Department of Community Health in accordance with state law. A Prepaid Inpatient Health Plan may be either a single Community Mental Health Services Program, or the regional entity in an affiliation of Community Mental Health Services Programs approved by the Specialty Services Selection Panel. Service providers may contract with the Prepaid Inpatient Health Plan or an affiliate of the Prepaid Inpatient Health Plan, but the Prepaid Inpatient Health Plans must also be enrolled with the Michigan Department of Community Health as Medicaid providers. The Prepaid Inpatient Health Plan must offer, either directly or under contract, a comprehensive array of services, as specified in state law and Michigan Department of Community Health policy.

For the Specialty Services and Supports Program, the Centers for Medicare and Medicaid Services granted Michigan authority and funding to provide both Section §1915(b) services as authorized by the Medicaid State Plan and §1915(b)(3) that are in addition to the State Plan services. Since a person-centered planning process is used in Michigan, services selected during that process may vary, depending on the specific services that best meet an individual's needs. It is expected that the Prepaid Inpatient Health Plans will offer evidence-based and promising practices as part of the Medicaid covered specialty services where applicable. Prepaid Inpatient Health Plans shall also assure that these practices are provided in an appropriate manner by trained staff in a way that meets the individual's needs and assists in achieving the individual's goals.

Serving this newly eligible population with a stable, already proven system will promote expansion planning. Additionally, following the current system will help to ensure parity for

# Healthy Michigan Plan Waiver Amendment Request

## Section 1115 Waiver and Health Care Reform

mental health services and substance use disorder services. Services provided under the Healthy Michigan Plan will receive 100% federal match.

### **1. Benefit Expansion for Healthy Michigan Plan Beneficiaries**

In preparing to meet the needs of the individuals eligible for the Healthy Michigan Plan, Michigan is planning to significantly enhance services provided to beneficiaries in need of substance use disorder services. Services for substance use disorders will be provided in the same manner and in coordination with the mental health services and supports. All services will be identified and provided to best meet the needs of the beneficiary through person-centered planning.

Services will focus on prevention, wellness and chronic disease management (including caretaker education and support services), health coaching, relapse prevention and care coordination. In the outpatient arena, there will be more intense effort spent on screening and assessment, early intervention, evidence-based complimentary services, and intensive case management. Recovery and Rehabilitative Support Services staff will coordinate with case management, peer and community supports programs. In cases where maternal services are needed to support newborns and children in the home, there will be intensive home based treatment, caretaker coaching, therapeutic mentoring and specifically focused early intervention services.

### **2. Adult Benefits Waiver Transition and Continuity of Care**

Michigan will ensure that any Adult Benefits Waiver beneficiary who has established a relationship with a provider participating in their Prepaid Inpatient Health Plan/Community Mental Health Services Provider will be able to continue their relationship with that provider during and after they transition to the Healthy Michigan Plan. This is true for both mental health and substance use disorder services that were in place through the Prepaid Inpatient Health Plan/Community Mental Health Services Provider at the time the Healthy Michigan Plan is implemented. For those beneficiaries newly eligible (not transitioning from the Adult Benefits Waiver) the services will be provided as stated through coordination with the individual Medicaid Health Plan, fee-for-service and the Prepaid Inpatient Health Plan/Community Mental Health Services Provider.

### **3. Community Support Services**

Michigan also intends to provide the Healthy Michigan Plan population with medically necessary supports and services that promote community inclusion and participation, independence, and/or productivity when identified in the individual plan of service. These services are currently covered under the §1915(b) mental health and substance use disorder services. These will be included as one or more of the goals developed during the person-centered planning process. These services include the following: Assistive Technology; Community Living Supports; Enhanced Pharmacy; Environmental Modifications; Crisis Observation Care; Family Support and Training; Housing

## **Healthy Michigan Plan Waiver Amendment Request Section 1115 Waiver and Health Care Reform**

Assistance; Peer-Delivered or Operated Support Services; Prevention-Direct Service Models; Respite Care Services; Skill-Building Assistance; Support and Service Coordination; Supported/Integrated Employment Services; Wraparound Services for Children and Adolescents; Fiscal Intermediary Services; Sub-Acute Detoxification; and Residential Treatment. Michigan intends to work with the Centers for Medicare and Medicaid Services to determine the appropriate authority (i.e., state plan authority or waiver authority) under which these services may be provided to Healthy Michigan Plan participants.

### **C. Dental Services**

The Healthy Michigan Plan will cover dental services for this waiver population through the Medicaid Health Plans (or fee-for-service when the eligible individual is not enrolled in a Medicaid Health Plan). Michigan intends to add the dental benefit to the Medicaid Health Plan benefit for those beneficiaries enrolled in a Medicaid Health Plan. Michigan believes that by including the dental benefit in the Medicaid Health Plans, it will ensure better access to dental services and will improve on the health plans ability to coordinate and manage the care of the Healthy Michigan Plan population. Proper dental care has proven to be one of the first lines of defense in identifying health issues and facilitating referral for proper medical treatment before more serious conditions or illnesses present themselves.

### **D. Maternal Infant Health Program**

Maternal Infant Health Program is a service currently provided to pregnant women and infants enrolled in Medicaid as a fee-for-service benefit. Women who become pregnant while in the Healthy Michigan Plan are allowed to remain in this population category or move to regular Medicaid for pregnant women. Expanding the home visitation program for this population is included in the Governors' Infant Mortality Reduction Plan and would allow these services to be available regardless of the program these women choose. Offering this program through the current fee-for-service delivery system will provide continuity with these beneficiaries' current health plan benefits.

This program's objective is to promote healthy pregnancies, positive birth outcomes, and healthy infant growth and development. This will help to reach Michigan's goal of reducing infant morbidity and mortality.

### **E. Vision**

Vision services, including access to prescription eyeglasses, are essential in maintaining quality of life. A routine eye examination may detect previously undiagnosed chronic health issues such as diabetes, hypertension, glaucoma and other systemic diseases. These medical conditions can lead to greater health care costs if left undetected and untreated. For the Healthy Michigan Plan population, vision services will be administered using the existing delivery systems identified in the State Plan for current Medicaid beneficiaries. This will be a part of the Medicaid Health Plan benefit as well.

## **Healthy Michigan Plan Waiver Amendment Request Section 1115 Waiver and Health Care Reform**

### **F. Home Help**

Michigan's home help program has the dual distinction of being both the most widely utilized and the most cost-effective long-term care related service offered by Medicaid. It plays a significant role in reducing more costly nursing facility placements and allows the State to offer long term-care services in the least restrictive setting, consistent with the Olmstead decision. Home help services will be provided through Michigan's fee-for-service program.

### **G. Non-Emergency Medical Transportation**

The Medicaid Health Plans will provide non-emergency medical transportation for those services covered by the Medicaid Health Plan. For those services not covered by the Medicaid Health Plan, non-emergency medical transportation will be covered through the current Medicaid arrangements.

Federal law requires that individual state Medicaid agencies "ensure necessary transportation for recipients to and from providers." Non-emergency medical transportation services help ensure that beneficiaries can access medical, preventive, prenatal, and behavioral health services.

### **H. Early and Periodic Screening, Diagnosis and Treatment Services**

The Medicaid Health Plans will provide Early and Periodic Screening, Diagnosis and Treatment services to beneficiaries aged 19 and 20 as specified in the State Plan. The State will identify individuals under 21 years of age who qualify for these services and assure that these services are provided to those who qualify.

### **I. Pharmacy Services**

Healthy Michigan Plan pharmacy benefits will include the same coverage of medications and will follow the same administration pattern that is currently in place for the Medicaid population. Medicaid beneficiaries enrolled in a Medicaid Health Plan will receive the pharmacy benefit as part of their health plan services, with the exception of the psychotropic carve-out medications. These medications are provided on a fee-for-service basis. This is also true for the physician injectable psychotropic medications that are administered in the physician's office.

## **VI. Implementation and Outreach**

### **A. Implementation**

The implementation for the Healthy Michigan Plan is being planned for April 1, 2014. Given the federally mandated scope of benefits, the various delivery systems that exist in the State today and the direction contained in Michigan's Public Act 107 of 2013, the Michigan Department of Community Health anticipates pursuing a number of operational and administrative modifications in order to meet its goals for this demonstration project as well as

## **Healthy Michigan Plan Waiver Amendment Request Section 1115 Waiver and Health Care Reform**

its legal obligations. To that end, the Department intends to seek available enhanced as well as current Federal financial participation for any new or amended contracts or other agreements resulting from the implementation of this waiver amendment, as permitted by federal laws and regulations. The State anticipates needing contractual assistance in establishing the MI Health Accounts, program evaluation, a healthy behavior structure, and the other unique elements of this waiver.

### **B. Outreach**

Michigan will engage in a robust outreach plan to enroll new beneficiaries under this Medicaid category. Michigan will be conducting a media campaign that may include any or all of the following: the creation of a website devoted towards health care reform; utilization of radio advertising, television broadcasting, public service announcements and social media; and the creation of a new benefit brochure.

Given that this Medicaid category will include a wide age range of individuals, the State will be using current research-based sources, which provide details regarding the most effective outreach tools to use in an effort to reach this population. This campaign will be conducted statewide.

Additionally, Michigan is already networking with different Medicaid providers and advocacy groups through the public notice process to solicit information on education and outreach activities. The response has been overwhelmingly positive in terms of partnering with Michigan in identifying eligible people for the Healthy Michigan Plan.

## **VII. Cost Effectiveness and Budget Neutrality**

The completed budget neutrality template for the Healthy Michigan Plan under this Section 1115 waiver amendment is included as Attachment C. The development of the projected cost of this population incorporates all services that are intended to be covered by a managed care payment (both physical and behavioral health) as well as any services that may be covered under a fee-for-service arrangement. Aggregate costs are based on the current non-disabled Medicaid adult population with adjustments for morbidity, pent-up demand, co-pays and contributions and trend after the first year of the waiver.

## **VIII. Statutory Waivers and Expenditure Authority Requests**

### **A. Michigan Statutory Waiver Requests**

Michigan seeks waiver of the following requirements of the Social Security Act:

- **Statewideness - Section 1902(a)(1)**  
To the extent necessary to enable the State to operate the demonstration and provide managed care plans, only in certain geographical areas.
  
- **Proper and Efficient Administration - Section 1902(a)(4)**

## **Healthy Michigan Plan Waiver Amendment Request Section 1115 Waiver and Health Care Reform**

To enable the State to mandate beneficiaries into a single prepaid inpatient health plan or prepaid ambulatory health plan, Medicaid Health Plan and prohibit disenrollment from them.

- **Freedom of Choice - Section 1902(a)(23)**  
To the extent necessary to enable the State to restrict freedom of choice of provider for the demonstration-eligible population as provided herein. Beneficiaries will be required to obtain medical assistance from any qualified provider in the state. Under this program, free choice of providers is restricted. That is, beneficiaries enrolled in the program must receive services through a Medicaid Health Plan or a Prepaid Inpatient Health Plan. The Michigan Department of Community Health may place beneficiaries in the beneficiary monitoring program if they fail to meet their cost-sharing obligations or if they show high rates of inappropriate over utilization of services.
- **Amount, Duration and Scope of Services and Comparability - Section 1902(a)(10)(B)**  
To the extent necessary to enable the State to offer services to the demonstration-eligible population as described herein. The section requires all services for categorically needy individuals to be equal in amount, duration, and scope. Beneficiaries enrolled in a Medicaid Health Plan may receive additional benefits such as case management and health education that will not be available to beneficiaries not enrolled in the Medicaid Health Plans.
- **Cost-Sharing - Section 1902(a)(14) insofar as it incorporates Sections 1916 and 1916A**  
To the extent necessary to enable the State to impose cost-sharing obligations, including average monthly co-pays and contributions, on the demonstration eligible population as described in this waiver amendment.
- **Choice of Coverage - Section 1932(a)(3)**  
To the extent necessary to assign beneficiaries in the demonstration-eligible population to prepaid inpatient health plans based on geography and to permit beneficiary choice of provider, but not plan. Note that the State employs the rural exception under Section 1932(a)(3)(B) and related regulations with respect to choice of managed care organizations as described herein.

### **B. Expenditure Authority**

In addition, under the expenditure authority of section 1115(a)(2) of the Social Security Act (the Act), expenditures made by the State for the items identified section V(B)(3) under the heading of Community Supports Services of this waiver amendment (which would not otherwise be included as matchable expenditures under section 1903 of the Act) shall, for the period beginning April 1, 2014 through the end of this waiver, unless otherwise specified, be regarded as matchable expenditures either under this waiver authority or under the State's Medicaid State Plan. The Michigan Department of Community Health staff are working with our federal partners to determine which authority these services will be covered.

# Healthy Michigan Plan Waiver Amendment Request

## Section 1115 Waiver and Health Care Reform

### IX. Public Notice

#### A. Discussions with Stakeholders

The Michigan Department of Community Health staff has presented to legislative committees on multiple occasions throughout the process of development of House Bill 4714, which was the bill authorizing the funding and implementation of the Healthy Michigan Plan and the basis for Public Act 107 of 2013, the resulting state law. There have been briefings with individual legislators and congressional staff.

The Michigan Department of Community Health has conducted public notice by meeting with various stakeholders, advocacy groups and the general public to discuss the Healthy Michigan Plan and the need for this amended waiver application. Relevant dates of past and future meetings with stakeholders include:

1. August 22, 2013 – Medical Care Advisory Council
2. September 16, 2013 – The Michigan Department of Community Health staff attended a town hall meeting in Sterling Heights, Michigan. The Michigan Department of Community Health staff met with Representative Yanez to discuss health care reform, the federal Health Insurance Marketplace and the Healthy Michigan Plan waiver amendment with the public.
3. September 24, 2013 – Michigan State Medical Society (advocacy group for Michigan physicians)
4. September 24, 2013 – Federally Qualified Health Centers
5. September 26, 2013 – Substance Abuse and Mental Health Services Administration
6. September 27, 2013 – Prepaid Inpatient Health Plans (this includes staff from the Community Mental Health Services Programs and the Coordinating Agencies.
7. October 15, 2013 – The Michigan Department of Community Health staff met again with the Medical Care Advisory Council to provide them with greater detail regarding the Healthy Michigan Plan and proposed implementation.
8. October 21, 2013 – The Michigan Department of Community Health staff presented the Healthy Michigan Plan at the Michigan Association of Community Mental Health Boards annual fall conference.
9. December 6, 2013 – Representatives from the Michigan Department of Community Health will be meeting with several local Community Mental Health Services Programs to discuss the Healthy Michigan Plan.

## **Healthy Michigan Plan Waiver Amendment Request Section 1115 Waiver and Health Care Reform**

### **B. Website**

The State has launched a webpage devoted to disseminating information pertaining to the Healthy Michigan Plan. This webpage will allow the public and stakeholder organizations to be apprised as the initiative progresses. It will serve as a communication medium to provide advance notice of public meetings and will make briefing materials and other information available. In addition, the State intends to use this website as a tool to continue to obtain input from the public.

The webpage provides information related to the Healthy Michigan Plan proposed waiver amendment and related State Plan Amendments. In addition, the Michigan Department of Community Health has created a new mailbox ([healthymichiganplan@michigan.gov](mailto:healthymichiganplan@michigan.gov)) to allow the public to send questions or comments regarding the Healthy Michigan Plan. This mailbox will be checked daily during normal business hours. The Michigan Department of Community Health went live with the webpage and mailbox, and issued a public notice on both the webpage and in selected newspapers, in mid-October of 2013.

### **C. Tribal Consultation**

The Michigan Department of Community Health has provided a summary of the Healthy Michigan Plan to the tribal communities during the regularly scheduled quarterly meetings, which occurred during calendar year 2013. The status of House Bill 4714 and the Michigan Department of Community Health's intent regarding this waiver amendment were also discussed. State of Michigan staff presented the Healthy Michigan Plan on October 9, 2013, during a regularly scheduled Quarterly Tribal Health Directors meeting where there was representation from each tribe in the State of Michigan.

In addition, Michigan sent a letter notifying the Tribal Council of Michigan's plan to submit a Section 1115 waiver amendment and two State Plan Amendments as part of the Healthy Michigan Plan approval process. Please see Attachment B for a copy of the notice provided.

### **D. Toll-free Number**

Michigan has created a new toll-free Michigan Health Care Helpline telephone number that can assist various stakeholders or applicants with questions related to health care reform. This number has a call tree specifically designed for providers, businesses, prospective applicants, or any other interested party to call for more information regarding health care reform. This number will be augmented to provide information specific to the Healthy Michigan Plan upon waiver amendment approval.

In addition, Michigan has also created a new toll-free Modified Adjusted Gross Income Application Assistance line that helps applicants fill out the new Michigan version of the streamlined application. This number will also be augmented to help potential Healthy Michigan Plan applicants apply for the program and to answer any questions they may have regarding the program. Once a person becomes enrolled in the program, they may also

## **Healthy Michigan Plan Waiver Amendment Request Section 1115 Waiver and Health Care Reform**

contact the current Medicaid Beneficiary Helpline should they need assistance. This telephone number is displayed on their MI Health Card.

### **X. Summary**

Michigan is well positioned to implement this health care reform demonstration waiver project to allow an estimated 300,000 – 500,000 individuals who are otherwise uninsured or underinsured to have access to health care through the Healthy Michigan Plan. Michigan is enthusiastic about the opportunity to partner with the Centers for Medicare and Medicaid Services in obtaining this waiver amendment approval in an effort to align with the principles and vision of the Affordable Care Act in decreasing the rate of the uninsured, implementing health care reform, and improving the health of Americans.

Through the innovative features outlined in this waiver amendment, Michigan seeks consumer engagement in the health care decision making process to improve health care outcomes. The overarching themes used in the benefit design will be increasing access to quality health care, encouraging the utilization of high-value services, promoting beneficiary adoption of healthy behaviors and using evidence-based practice initiatives. This will be accomplished through an organized service delivery system in an effort to improve coordination of care, continuity of care, and overall program efficiency. Michigan strives to be a leader in the health care industry.

### **XI. Attachments**

- A. Proposed Healthy Michigan Benefit Plan**
- B. Tribal Notification**
- C. Budget Documents**

## Proposed Comparison of the Healthy Michigan Plan to the Michigan Benchmark Plan

Grouped in the 10 categories of Essential Health Benefits required by the Affordable Care Act.  
 See <http://www.healthcare.gov/news/factsheets/2011/12/essential-health-benefits12162011a.html>

<b>Benefits</b>	<b>Small Group Base Benchmark</b>	<b>State Plan Services</b>	<b>The Healthy Michigan Plan</b>
	<a href="#">Priority Health</a> (Health Maintenance Organization)	Current Medicaid State Plan Services	Proposed Alternative Benefit Plan Services
<b>1. Ambulatory patient services - Federal Mandate</b>			
Primary Care Provider Services; Specialist, Referral Care Services; and other Practitioner Services (e.g. Nurse Practitioners, Physician Assistant)	Yes	Yes	Yes
Outpatient Hospital Services: Physician/Surgical Services/Facility Services; includes Ambulatory Surgical Center Services	Yes	Yes	Yes
Home Health Care Services	Yes	Yes	Yes
Hospice Care	Yes	Yes	Yes
Podiatry Care	Yes	Yes	Yes
<b>2. Emergency Services - Federal Mandate</b>			
Emergency Room Services	Yes	Yes	Yes
Emergency Transportation/Ambulance	Yes	Yes	Yes
Urgent Care Centers or Facilities	Yes	Yes	Yes
<b>3. Hospitalization - Federal Mandate</b>			
Inpatient Hospital Services (e.g., Hospital stay, physician and surgical services)	Yes	Yes	Yes
Skilled Nursing Facility	Yes Maximum of 45 days per contract year	Yes	*Yes Maximum of 45 days per contract year
*In accordance with 42 CFR 440.315(f), exceptions may be made on an individual basis to provide additional services when medically necessary.			
<b>4. Maternity and newborn care - Federal Mandate</b>			
Prenatal and Postnatal Care	Yes	Yes	Yes
Delivery and All Inpatient Services for Maternity Care	Yes	Yes	Yes
Note - Maternal Infant Health Program services will be covered for women who may become pregnant while enrolled in the Healthy Michigan Plan.			

## Proposed Comparison of the Healthy Michigan Plan to the Michigan Benchmark Plan

<b>Benefits</b>	<b>Small Group Base Benchmark</b>	<b>State Plan Services</b>	<b>The Healthy Michigan Plan</b>
	<a href="#">Priority Health</a> (Health Maintenance Organization)	Current Medicaid State Plan Services	Proposed Alternative Benefit Plan Services
<b>5. Mental health and substance use disorder services, including behavioral health treatment - Federal Mandate</b>			
Mental/Behavioral Health Inpatient Services	Yes up to 20 days per contract year	Yes (includes residential services)	Yes (includes residential services)
Mental/Behavioral Health Outpatient Services	Yes up to 20 days per contract year	Yes	Yes
Substance Use Disorder Inpatient Services	Yes	Yes	Yes
Substance Use Disorder Outpatient Services	Yes	Yes	Yes (includes prevention services)
<b>6. Prescription drugs - Federal Mandate</b>			
Prescription Drugs and Supplies	Yes	Yes	Yes
<b>7. *Rehabilitative and habilitative services and devices - Federal Mandate</b>			
Inpatient Rehabilitation Services	Yes	Yes	Yes
Outpatient Rehabilitation and Habilitative Services, including Chiropractic Services	Yes	Yes	Yes
Durable Medical Equipment, Medical Supplies, Prosthetics and Orthotics;	Yes	Yes	Yes
*Habilitative services are an essential health benefit and must be provided in the Healthy Michigan Plan in compliance with federal law.			
<b>8. Laboratory services - Federal Mandate</b>			
Diagnostic and Therapeutic Radiology Services and Laboratory Testing	Yes	Yes	Yes
<b>9. *Preventive and wellness services and chronic disease management - Federal Mandate</b>			
Preventive Care/Screening/Immunization	Yes	Yes	Yes
*Preventive services are an essential health benefit and must be provided in compliance with federal law.			
<b>10. Pediatric services, including oral and vision care - Federal Mandate (coverage is for beneficiaries ages 19 and 20)</b>			
General Pediatric Care	Yes	Yes	Yes
Vision Screening for Children	Yes	Yes	Yes
Eye glasses and dental check-up services for children will align with current Medicaid state plan benefits.			

## Proposed Comparison of the Healthy Michigan Plan to the Michigan Benchmark Plan

<b>Benefits</b>	<b>Small Group Base Benchmark</b>	<b>State Plan Services</b>	<b>The Healthy Michigan Plan</b>
	<a href="#">Priority Health</a> (Health Maintenance Organization)	Current Medicaid State Plan Services	Proposed Alternative Benefit Plan Services

**Additional State Plan Mandated Benchmark Covered Services; Social Security Act § 1937**

In compliance with federal law, the following services and providers must be covered: (1) Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services for enrollees under age 21, (2) services provided in a Rural Health Clinic and Federally Qualified Health Center, (3) Non-Emergency Medical Transportation, and (4) family planning services and supplies/reproductive health services.

**Additional State Plan Benchmark Covered Services**

Michigan is also proposing to cover adult dental services, vision/optometrist services (including eyeglasses, therapies, refractions, etc.), hearing services including hearing aids and adjustments, and Home Help services/personal care services (these services will be covered fee-for-service).

In accordance with 42 CFR 440.315(f), exceptions may be made on an individual basis to provide additional state plan services when medically necessary.

**DRAFT and CONFIDENTIAL**

**5 YEARS OF HISTORIC DATA**

**SPECIFY TIME PERIOD AND ELIGIBILITY GROUP DEPICTED:**

<u>Medicaid Pop 1</u>	<u>HY 1</u>	<u>HY 2</u>	<u>HY 3</u>	<u>HY 4</u>	<u>HY 5</u>	<u>5-YEARS</u>	
<b>TOTAL EXPENDITURES</b>						\$	-
<b>ELIGIBLE MEMBER MONTHS</b>							
<b>PMPM COST</b>	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!		
<b>TREND RATES</b>	<b>ANNUAL CHANGE</b>					<b>5-YEAR AVERAGE</b>	
TOTAL EXPENDITURE		#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	
ELIGIBLE MEMBER MONTHS		#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	
PMPM COST		#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	

<u>Medicaid Pop 2</u>	<u>HY 1</u>	<u>HY 2</u>	<u>HY 3</u>	<u>HY 4</u>	<u>HY 5</u>	<u>5-YEARS</u>	
<b>TOTAL EXPENDITURES</b>						\$	-
<b>ELIGIBLE MEMBER MONTHS</b>							
<b>PMPM COST</b>	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!		
<b>TREND RATES</b>	<b>ANNUAL CHANGE</b>					<b>5-YEAR AVERAGE</b>	
TOTAL EXPENDITURE		#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	
ELIGIBLE MEMBER MONTHS		#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	
PMPM COST		#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	

<u>Medicaid Pop 3</u>	<u>HY 1</u>	<u>HY 2</u>	<u>HY 3</u>	<u>HY 4</u>	<u>HY 5</u>	<u>5-YEARS</u>	
<b>TOTAL EXPENDITURES</b>						\$	-
<b>ELIGIBLE MEMBER MONTHS</b>							
<b>PMPM COST</b>	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!		
<b>TREND RATES</b>	<b>ANNUAL CHANGE</b>					<b>5-YEAR AVERAGE</b>	
TOTAL EXPENDITURE		#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	
ELIGIBLE MEMBER MONTHS		#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	
PMPM COST		#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	

<u>Other Data</u>	<u>HY 1</u>	<u>HY 2</u>	<u>HY 3</u>	<u>HY 4</u>	<u>HY 5</u>	<u>5-YEARS</u>	
<b>TOTAL EXPENDITURES</b>						\$	-
<b>ELIGIBLE MEMBER MONTHS</b>							
<b>PMPM COST</b>	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!		
<b>TREND RATES</b>	<b>ANNUAL CHANGE</b>					<b>5-YEAR AVERAGE</b>	
TOTAL EXPENDITURE		#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	
ELIGIBLE MEMBER MONTHS		#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	
PMPM COST		#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	

**DRAFT and CONFIDENTIAL**

**DEMONSTRATION WITHOUT WAIVER (WOW) BUDGET PROJECTION: COVERAGE COSTS FOR POPULATIONS**

ELIGIBILITY GROUP	TREND RATE 1	MONTHS OF AGING	BASE YEAR DY 00	TREND RATE 2	DEMONSTRATION YEARS (DY)					TOTAL WOW
					DY 01	DY 02	DY 03	DY 04	DY 05	
<b>Medicaid Pop 1</b>										
<b>Pop Type: Medicaid</b>										
Eligible Member Months	#DIV/0!		#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
PMPM Cost	#DIV/0!	0	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Total Expenditure					#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
<b>Medicaid Pop 2</b>										
<b>Pop Type: Medicaid</b>										
Eligible Member Months	#DIV/0!	0	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
PMPM Cost	#DIV/0!	0	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Total Expenditure					#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
<b>Medicaid Pop 3</b>										
<b>Pop Type: Medicaid</b>										
Eligible Member Months	#DIV/0!	0	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
PMPM Cost	#DIV/0!	0	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Total Expenditure					#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
<b>Hypo 1</b>										
<b>Pop Type: Hypothetical</b>										
Eligible Member Months					3,849,113	5,399,149	5,910,988	5,910,988	5,910,988	
Base PMPM Cost					\$487.25	\$502.25	\$516.19	\$535.14	\$555.03	
Morbidity and Pent-Up Demand PMPM Cost					\$86.19	\$46.30	\$33.19	\$33.19	\$33.19	
Total Expenditure					\$ 2,207,235,359	\$ 2,961,703,184	\$ 3,247,378,587	\$ 3,359,391,810	\$ 3,476,961,361	\$ 15,252,670,302
<b>Hypo 2</b>										
<b>Pop Type: Hypothetical</b>										
Eligible Member Months										
PMPM Cost										
Total Expenditure					\$ -	\$ -	\$ -	\$ -	\$ -	\$ -

**DRAFT and CONFIDENTIAL**

**DEMONSTRATION WITH WAIVER (WW) BUDGET PROJECTION: COVERAGE COSTS FOR POPULATIONS**

ELIGIBILITY GROUP	DY 00	DEMO TREND RATE	DEMONSTRATION YEARS (DY)					TOTAL WW
			DY 01	DY 02	DY 03	DY 04	DY 05	
<b>Medicaid Pop 1</b>								
<b>Pop Type: Medicaid</b>								
Eligible Member Months	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	
PMPM Cost	#DIV/0!		#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	
Total Expenditure			#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
<b>Medicaid Pop 2</b>								
<b>Pop Type: Medicaid</b>								
Eligible Member Months	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	
PMPM Cost	#DIV/0!		#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	
Total Expenditure			#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
<b>Medicaid Pop 3</b>								
<b>Pop Type: Medicaid</b>								
Eligible Member Months	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	
PMPM Cost	#DIV/0!		#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	
Total Expenditure			#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
<b>Hypo 1</b>								
<b>Pop Type: Hypothetical</b>								
Eligible Member Months			3,849,113	5,399,149	5,910,988	5,910,988	5,910,988	
Base PMPM Cost			\$487.25	\$502.25	\$516.19	\$535.14	\$555.03	
Morbidity and Pent-Up Demand PMPM Cost			\$86.19	\$46.30	\$33.19	\$33.19	\$33.19	
Total Expenditure			\$ 2,207,235,359	\$ 2,961,703,184	\$ 3,247,378,587	\$ 3,359,391,810	\$ 3,476,961,361	\$ 15,252,670,302
<b>Hypo 2</b>								
<b>Pop Type: Hypothetical</b>								
Eligible Member Months			-	-	-	-	-	
PMPM Cost			\$ -	\$ -	\$ -	\$ -	\$ -	
Total Expenditure			\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
<b>Exp Pop 1</b>								
<b>Pop Type: Expansion</b>								
Eligible Member Months								
PMPM Cost								
Total Expenditure			\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
<b>Exp Pop 2</b>								
<b>Pop Type: Expansion</b>								
Eligible Member Months								
PMPM Cost								
Total Expenditure			\$ -	\$ -	\$ -	\$ -	\$ -	\$ -



**DRAFT and CONFIDENTIAL**

**Panel 1: Historic DSH Claims for the Last Five Fiscal Years:**

<b>RECENT PAST FEDERAL FISCAL YEARS</b>					
	20__	20__	20__	20__	20__
State DSH Allotment (Federal share)					
State DSH Claim Amount (Federal share)					
DSH Allotment Left Unspent (Federal share)	\$ -	\$ -	\$ -	\$ -	\$ -

**Panel 2: Projected Without Waiver DSH Expenditures for FFYs That Overlap the Demonstration Period**

<b>FEDERAL FISCAL YEARS THAT OVERLAP DEMONSTRATION YEARS</b>						
	FFY 00 (20__)	FFY 01 (20__)	FFY 02 (20__)	FFY 03 (20__)	FFY 04 (20__)	FFY 05 (20__)
State DSH Allotment (Federal share)						
State DSH Claim Amount (Federal share)						
DSH Allotment Projected to be Unused (Federal share)	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -

**Panel 3: Projected With Waiver DSH Expenditures for FFYs That Overlap the Demonstration Period**

<b>FEDERAL FISCAL YEARS THAT OVERLAP DEMONSTRATION YEARS</b>						
	FFY 00 (20__)	FFY 01 (20__)	FFY 02 (20__)	FFY 03 (20__)	FFY 04 (20__)	FFY 05 (20__)
State DSH Allotment (Federal share)	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
State DSH Claim Amount (Federal share)						
Maximum DSH Allotment Available for Diversion (Federal share)						
Total DSH Allotment Diverted (Federal share)	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
DSH Allotment Available for DSH Diversion Less Amount Diverted (Federal share, must be non-negative)	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
DSH Allotment Projected to be Unused (Federal share, must be non-negative)	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -

**Panel 4: Projected DSH Diversion Allocated to DYs**

<b>DEMONSTRATION YEARS</b>					
	DY 01	DY 02	DY 03	DY 04	DY 05
DSH Diversion to Leading FFY (total computable)					
FMAP for Leading FFY					
DSH Diversion to Trailing FFY (total computable)					
FMAP for Trailing FFY					
Total Demo Spending From Diverted DSH (total computable)	\$ -	\$ -	\$ -	\$ -	\$ -

**DRAFT and CONFIDENTIAL**

**Budget Neutrality Summary**

**Without-Waiver Total Expenditures**

	DEMONSTRATION YEARS (DY)					TOTAL
	DY 01	DY 02	DY 03	DY 04	DY 05	
<u>Medicaid Populations</u>						
Medicaid Pop 1	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Medicaid Pop 2	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Medicaid Pop 3	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
<u>DSH Allotment Diverted</u>	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
<u>Other WOW Categories</u>						
Category 1						\$ -
Category 2						\$ -
<b>TOTAL</b>	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!

**With-Waiver Total Expenditures**

	DEMONSTRATION YEARS (DY)					TOTAL
	DY 01	DY 02	DY 03	DY 04	DY 05	
<u>Medicaid Populations</u>						
Medicaid Pop 1	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Medicaid Pop 2	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Medicaid Pop 3	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
<u>Expansion Populations</u>						
Exp Pop 1	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Exp Pop 2	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
<u>Excess Spending From Hypotheticals</u>						\$ -
<u>Other WW Categories</u>						
Category 3						\$ -
Category 4						\$ -
<b>TOTAL</b>	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!

<b>VARIANCE</b>	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
-----------------	---------	---------	---------	---------	---------	---------

**HYPOTHETICALS ANALYSIS**

**Without-Waiver Total Expenditures**

	DEMONSTRATION YEARS (DY)					TOTAL
	DY 01	DY 02	DY 03	DY 04	DY 05	
Hypo 1	\$ 2,207,235,359	\$ 2,961,703,184	\$ 3,247,378,587	\$ 3,359,391,810	\$ 3,476,961,361	\$ 15,252,670,302
Hypo 2	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
<b>TOTAL</b>	\$ 2,207,235,359	\$ 2,961,703,184	\$ 3,247,378,587	\$ 3,359,391,810	\$ 3,476,961,361	\$ 15,252,670,302

**With-Waiver Total Expenditures**

	DEMONSTRATION YEARS (DY)					TOTAL
	DY 01	DY 02	DY 03	DY 04	DY 05	
Hypo 1	\$ 2,207,235,359	\$ 2,961,703,184	\$ 3,247,378,587	\$ 3,359,391,810	\$ 3,476,961,361	\$ 15,252,670,302
Hypo 2	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
<b>TOTAL</b>	\$ 2,207,235,359	\$ 2,961,703,184	\$ 3,247,378,587	\$ 3,359,391,810	\$ 3,476,961,361	\$ 15,252,670,302

<b>HYPOTHETICALS VARIANCE</b>	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
-------------------------------	------	------	------	------	------	------



STATE OF MICHIGAN  
DEPARTMENT OF COMMUNITY HEALTH  
LANSING

RICK SNYDER  
GOVERNOR

JAMES K. HAVEMAN  
DIRECTOR

September 3, 2013

NAME  
TITLE  
ADDRESS  
CITY STATE ZIP

Dear Tribal Chair and Health Director:

**RE:** The Submission a Section 1115 Waiver and two State Plan Amendments for Healthy Michigan Plan

This letter, in compliance with Section 6505 of the Affordable Care Act (ACA), serves as notice of intent to all Tribal Chairs and Health Directors of the request by the Michigan Department of Community Health (MDCH) to submit a Section 1115 Waiver Amendment to implement the Healthy Michigan Plan. As part of this process, MDCH will also be submitting two state plan amendments (SPA). The first SPA will be for eligibility determinations and the second SPA will be for the Alternative Benefit Plan for the Healthy Michigan Plan population.

Through this waiver amendment and the two SPAs, MDCH will expand Medicaid eligibility to people ages 19-64 who meet the Medicaid Expansion eligibility requirements as defined by the ACA. The program will be implemented as stated in Michigan Law.

You may submit comments regarding this Notice of Intent to [msapolicy@michigan.gov](mailto:msapolicy@michigan.gov). If you would like to discuss the Notice of Intent, please contact Lorna Elliott-Egan, Medicaid Liaison to the Michigan Tribes. Lorna can be reached at (517) 373-4963 or via e-mail at [Elliott-EganL@michigan.gov](mailto:Elliott-EganL@michigan.gov).

There is no public hearing scheduled for this waiver.

Sincerely,

Stephen Fitton, Director  
Medical Services Administration

cc: Leslie Campbell, Region V, CMS  
Pamela Carson, Region V, CMS  
Ashley Tuomi, MHPA, Executive Director, American Indian Health and Family Services of Southeastern Michigan  
L. John Lufkins, Executive Director, Inter-Tribal Council of Michigan, Inc.  
Jenny Jenkins, Acting Area Director, Indian Health Service - Bemidji Area Office  
Lorna Elliott-Egan, MDCH



*Administrator*  
Washington, DC 20201

**DEC 22 2009**

Mr. Stephen Fitton Acting Director  
Medical Services Administration  
Department of Community Health  
Capital Commons Center 400 South Pine, 7th Floor Lansing, MI 48909

Dear Mr. Fitton:

We are pleased to inform you that Michigan's section 1115 Medicaid Demonstration project, entitled "Medicaid Nonpregnant Childless Adults Waiver (Adult Benefits Waiver)" (Project No. 11-W-00245/5) has been approved, beginning January 1, 2010, through September 30, 2014, under the authority of section 1115(a) of the Social Security Act (the Act).

Section 2111(a)(3)(C) of the Act and this new demonstration will allow Michigan to continue offering coverage to non-pregnant childless adults (at or below 35 percent of the Federal poverty level) who currently are served by the Adult Benefits Waiver Demonstration Project No. 21-W-00017/5.

With respect to expenditures for dates of service that were incurred prior to the approval of this Demonstration, the State must follow routine CMS-64.21 reporting instructions as outlined in section 2115 and 2500 of the State Medicaid Manual.

Our approval of the Medicaid Non-pregnant Childless Adults Waiver (Adult Benefits Waiver) section 1115(a) demonstration project is limited to the extent of granting approval for the necessary expenditure authorities in the accompanying list, and is conditioned upon compliance with the enclosed Special Terms and Conditions (STCs). The STCs set forth in detail the nature, character, and extent of Federal involvement in the demonstration. The STCs are effective January 1, 2010, unless otherwise specified. All the requirements of the Medicaid program expressed in law, regulation, and policy statement, not expressly waived or identified as not applicable in the enclosed expenditure authority list, shall apply to the demonstration.

Written notification to our office of your acceptance of this award must be received within 30 days after your receipt of this letter. Your project officer is Ms. Wanda Pigatt-Canty. She is available to answer any questions concerning this demonstration project. Ms. Pigatt-Canty's contact information is as follows:

Center for Medicare & Medicaid Services  
Center for Medicaid and State Operations  
7500 Security Boulevard  
Mailstop S2-01-16  
Baltimore, MD 21214-1850  
Telephone: 410-786-6177  
Facsimile: 410-786-5882  
Email: [wanda.pigatt-canty@cms.hhs.gov](mailto:wanda.pigatt-canty@cms.hhs.gov)

Official communications regarding program matters should be sent simultaneously to Ms. Pigatt-Canty and Ms. Verlon Johnson, Associate Regional Administrator in our Chicago Regional Office. Ms. Johnson's contract information is as follows:

Centers for Medicare & Medicaid Services  
233 N. Michigan Avenue, Suite 600  
Chicago, IL 60601-5519

If you have questions regarding this correspondence, please contact Ms. Victoria Wachino, Acting Director, Family and Children's Health Programs Group, Center for Medicaid and State Operations, at (410) 786-5647

We look forward to continuing to work with you and your staff.

Sincerely,

/Charlene Frizzera/

Charlene Frizzera  
Acting Administrator

Enclosure

cc: Jacqueline Coleman – Michigan, Department of Community Health  
Verlon Johnson – CMS, Region V  
Leslie Campbell – CMS, Region V

**CENTERS FOR MEDICARE & MEDICAID SERVICES  
SPECIAL TERMS AND CONDITIONS**

**NUMBER:** 11-W-00245/5

**TITLE:** Michigan Medicaid Nonpregnant Childless Adults Waiver (Adult Benefits Waiver) Section 1115 Demonstration

**AWARDEE:** Michigan Department of Community Health

**I. PREFACE**

The following are the Special Terms and Conditions (STCs) for Michigan’s Adult Benefits Waiver section 1115(a) Medicaid Demonstration (hereinafter referred to as “Demonstration”). The parties to this agreement are the Michigan Department of Community Health (“State”) and the Centers for Medicare & Medicaid Services (CMS). The STCs set forth in detail the nature, character, and extent of Federal involvement in the Demonstration and the State’s obligations to CMS during the life of the Demonstration. The STCs are effective January 1, 2010, unless otherwise specified. This Demonstration is approved through September 30, 2014.

The STCs have been arranged into the following subject areas: Program Description and Objectives; General Program Requirements; Eligibility Determination; Enrollment and Disenrollment; Benefits and Cost Sharing; Delivery Systems; General Reporting Requirements; General Financial Requirements; Monitoring Budget Neutrality; Evaluation of the Demonstration; and Schedule of Deliverables for the Demonstration Extension Period.

**II. PROGRAM DESCRIPTION AND OBJECTIVES**

In January 2004, the Adult Benefits Waiver (ABW) was initially approved and implemented as a title XXI funded section 1115 Demonstration. The ABW provides a limited ambulatory benefit package to previously uninsured, low-income non-pregnant childless adults ages 19 through 64 years with incomes at or below 35 percent of the Federal poverty level (FPL) who are not eligible for Medicaid. The ABW services are provided to beneficiaries through a managed healthcare delivery system utilizing a network of county administered health plans (CHPs) and Public Mental Health and Substance Abuse provider network. The programmatic goals for the ABW Demonstration include:

- Improve access to healthcare;
- Improve the quality of healthcare services delivered;
- Reduce uncompensated care;
- Encourage individuals to seek preventive care and choose a healthy lifestyle; and
- Encourage quality, continuity, and appropriate medical care.

**III. GENERAL PROGRAM REQUIREMENTS**

1. **Compliance with Federal Non-Discrimination Statutes.** The State must comply with all applicable Federal statutes relating to non-discrimination. These include, but are not limited to, the Americans with Disabilities Act of 1990, title VI of the Civil Rights Act of 1964, section 504 of the Rehabilitation Act of 1973, and the Age Discrimination Act of 1975.
2. **Compliance with Medicaid Law, Regulation, and Policy.** All requirements of the Medicaid program expressed in law, regulation, and policy statement, not expressly waived or identified as not applicable in the waiver and expenditure authority documents (of which these terms and conditions are part), must apply to the Demonstration.
3. **Changes in Medicaid Law, Regulation, and Policy.** The State must, within the timeframes specified in law, regulation, or policy statement, come into compliance with any changes in Federal law, regulation, or policy affecting the Medicaid program that occur during this demonstration approval period, unless the provision being changed is expressly waived or identified as not applicable.
4. **Impact on Demonstration of Changes in Federal Law, Regulation, and Policy.**
  - a. To the extent that a change in Federal law, regulation, or policy requires either a reduction or an increase in Federal financial participation (FFP) for expenditures made under this Demonstration, the State must adopt, subject to CMS approval, a modified budget neutrality agreement for the Demonstration as necessary to comply with such change. The modified agreement will be effective upon the implementation of the change.
  - b. If mandated changes in the Federal law require State legislation, the changes must take effect on the day such State legislation becomes effective, or on the last day such legislation was required to be in effect under the law.
5. **State Plan Amendments.** The State will not be required to submit title XIX State plan amendments for changes affecting any populations made eligible solely through the Demonstration. If a population eligible through the Medicaid State Plan is affected by a change to the Demonstration, a conforming amendment to the appropriate State Plan may be required, except as otherwise noted in these STCs.
6. **Changes Subject to the Amendment Process.** Changes related to eligibility, enrollment, benefits, cost sharing, sources of non-Federal share of funding, budget neutrality, and other comparable program elements must be submitted to CMS as amendments to the Demonstration. All amendment requests are subject to approval at the discretion of the Secretary in accordance with section 1115 of the Social Security Act (the Act). The State must not implement changes to these elements without prior approval by CMS. Amendments to the Demonstration are not retroactive and FFP will not be available for changes to the Demonstration that have not been approved through the amendment process set forth in paragraph 7 below.

7. **Amendment Process.** Requests to amend the Demonstration must be submitted to CMS for approval no later than 120 days prior to the planned date of implementation of the change and may not be implemented until approved. CMS reserves the right to deny or delay approval of a demonstration amendment based on non-compliance with these STCs, including but not limited to failure by the State to submit required reports and other deliverables in a timely fashion according to the deadlines specified herein. Amendment requests must include, but are not limited to, the following:
- a. An explanation of the public process used by the State, consistent with the requirements of paragraph 15, to reach a decision regarding the requested amendment;
  - b. A data analysis which identifies the specific “with waiver” impact of the proposed amendment on the current budget neutrality agreement. Such analysis shall include current Federal share “with waiver” and “without waiver” status on both a summary and detailed level through the current approval period using the most recent actual expenditures, as well as summary and detailed projections of the change in the “with waiver” expenditure total as a result of the proposed amendment, which isolates (by Eligibility Group) the impact of the amendment;
  - c. A detailed description of the amendment, including impact on beneficiaries, with sufficient supporting documentation; and
  - d. If applicable, a description of how the evaluations design will be modified to incorporate the amendment provisions.
8. **Extension of the Demonstration.** States that intend to request demonstration extensions under sections 1115(e) or 1115(f) of the Act are advised to observe the timelines contained in those statutes. Otherwise, no later than 12 months prior to the expiration date of the Demonstration, the chief executive officer of the State must submit to CMS either a Demonstration extension request or a phase-out plan consistent with the requirements of paragraph 9.

As part of the Demonstration extension request, the State must provide documentation of compliance with the public notice requirements outlined in paragraph 15, as well as include the following supporting documentation:

- a. **Demonstration Summary and Objectives:** The State must provide a narrative summary of the demonstration project, reiterate the objectives set forth at the time the Demonstration was proposed and provide evidence of how these objectives have been met as well as future goals of the program. If changes are requested, a narrative of the changes being requested along with the objective of the change and desired outcomes must be included.
- b. **Special Terms and Conditions (STCs):** The State must provide documentation of its compliance with each of the STCs. Where appropriate, a brief explanation may be accompanied by an attachment containing more detailed information. Where the STCs address any of the following areas ((c) through (f) below), they

need not be documented a second time. Consistent with Federal law, CMS reserves the right to deny approval for a requested extension based on non-compliance with these STCs, including but not limited to failure by the State to submit required reports and other deliverables in a timely fashion according to the deadlines specified herein.

- c. **Waiver and Expenditure Authorities:** The State must provide a list along with a programmatic description of the waivers and expenditure authorities that are being requested in the extension.
  - d. **Quality:** The State must provide summaries of External Quality Review Organization (EQRO) reports, managed care organization (MCO) and State quality assurance monitoring, and any other documentation of the quality of care provided under the Demonstration.
  - e. **Compliance with the Budget Neutrality Cap:** The State must provide financial data (as set forth in the current STCs) demonstrating the State's detailed and aggregate, historical and projected budget neutrality status for the requested period of the extension. CMS will work with the State to ensure that Federal expenditures under the extension of this project do not exceed the Federal expenditures that would otherwise have been made. In addition, the State must provide up-to-date responses to the CMS Financial Management standard questions.
  - f. **Draft report with Evaluation Status and Findings:** The State must provide a narrative summary of the evaluation design, status (including evaluation activities and findings to date), and plans for evaluation activities during the extension period. The narrative is to include, but not be limited to, describing the hypotheses being tested and any results available.
9. **Demonstration Phase-Out.** The State may suspend or terminate this Demonstration in whole, or in part, at any time prior to the date of expiration. The State must promptly notify CMS in writing of the reason(s) for the suspension or termination, together with the effective date. In the event the State elects to phase out the Demonstration, the State must submit a phase-out plan to CMS at least six months prior to initiating phase-out activities. Consistent with the enrollment limitation requirement in paragraph 10 a phase-out plan shall not be shorter than six months unless such action is necessitated by emergent circumstances. The phase-out plan is subject to CMS approval. If the project is terminated or any relevant waivers suspended by the State, FFP shall be limited to normal closeout costs associated with terminating the Demonstration including services and administrative costs of disenrolling participants.
10. **Enrollment Limitation During Demonstration Phase-Out.** If the State elects to suspend, terminate, or not renew this Demonstration as described in paragraph 9, during the last 6 months of the Demonstration, individuals who would not be eligible for Medicaid under the current Medicaid State plan must not be enrolled unless the Demonstration is extended by CMS. Enrollment must be suspended if CMS notifies the State in writing that the Demonstration will not be renewed.

11. **CMS Right to Terminate or Suspend.** CMS may suspend or terminate the Demonstration (in whole or in part) at any time before the date of expiration, whenever it determines, following a hearing, that the State has materially failed to comply with the terms of the project. CMS will promptly notify the State in writing of the determination and the reasons for the suspension or termination, together with the effective date.
12. **Finding of Non-Compliance.** The State does not relinquish its rights to challenge the CMS finding that the State materially failed to comply.
13. **Withdrawal of Waiver Authority.** CMS reserves the right to withdraw waivers or expenditure authorities at any time it determines that continuing the waivers or expenditure authorities would no longer be in the public interest or promote the objectives of title XIX. CMS will promptly notify the State in writing of the determination and the reasons for the withdrawal, together with the effective date, and afford the State an opportunity to request a hearing to challenge CMS' determination prior to the effective date. If a waiver or expenditure authority is withdrawn, FFP is limited to normal closeout costs associated with terminating the waiver or expenditure authority, including services and administrative costs of disenrolling participants.
14. **Adequacy of Infrastructure.** The State must ensure the availability of adequate resources for implementation and monitoring of the Demonstration, including education, outreach, and enrollment; maintaining eligibility systems; compliance with cost sharing requirements; and reporting on financial and other Demonstration components.
15. **Public Notice, Tribal Consultation, and Consultation with Interested Parties.** The State must continue to comply with the State Notice Procedures set forth in 59 Fed. Reg. 49249 (September 27, 1994) and the tribal consultation requirements pursuant to section 1902(a)(73) of the Act as amended by section 5006(e) of the American Recovery and Reinvestment Act of 2009, when the State proposes any program changes to the Demonstration, including, but not limited to, those referenced in STC 6. In States with Federally recognized Indian tribes, Indian health programs, and/or Urban Indian organizations, the State is required to submit evidence to CMS regarding the solicitation of advice from these entities prior to submission of any waiver proposal, amendment, and/or renewal of this Demonstration. In the event that the State conducts additional consultation activities consistent with these requirements prior to the implementation of the demonstration, documentation of these activities must be provided to CMS.
16. **FFP.** No Federal matching funds for expenditures for this Demonstration will take effect until the effective date identified in the Demonstration approval letter.
17. **Compliance with Managed Care Regulations.** The State must comply with the managed care regulations at 42 CFR section 438 et. seq., except as expressly waived or identified as not applicable in the expenditures incorporated into the STCs. Capitation rates must be developed and certified as actuarially sound in accordance with 42 CFR section 438.6.

#### IV. ELIGIBILITY DETERMINATION, ENROLLMENT, AND DISENROLLMENT

18. **Eligibility.** Childless adults eligible for coverage under this Demonstration are defined as individuals ages 19 through 64 years with income that is at or below 35 percent of the FPL. They are individuals who are not pregnant, disabled, or qualified for any other Medicaid, Medicare or Children's Health Insurance Program (CHIP). A childless adult is an individual who does not have children or dependents living in his/her home.

An applicant must meet the following eligibility requirements in order to enroll for coverage under this Demonstration:

- a. Must be at least 19 but no more than 64 years of age;
- b. Must not have any children or dependents living in his/her home;
- c. Must not be pregnant;
- d. Must not be eligible for Medicaid, CHIP, or Medicare;
- e. Must have gross family income at or below 35 percent of the FPL;
- f. Income test - An earned income disregard of \$200 plus 20 percent of the remaining earned income is applied to the income of the Demonstration applicant prior to conducting the income test.
- g. Asset Limit - An asset limit of \$3,000 will be applied to applicants who meet the above income requirement. Cash assets include, but are not limited to, checking accounts. Investments and retirement plans are also counted towards this \$3000 asset limit.
- h. Must not have access to other creditable health insurance. The State defines "creditable health insurance" as coverage for medical care obtained by a participant as an individual, via group health plans (self-funded or fully-insured), a State high risk pool, Medicare, Medicaid, Federal Employee Health Benefit Program, military sponsored healthcare program (CHAMPUS or Tri Care), medical program of Indian Health Services or tribal organization public health plan or coverage under the Peace Corps;
- i. Must provide verification, including documentation, of U.S. citizenship and Social Security number (or proof of application for an SSN) in accordance with section 1903(x) of the Act;
- j. Must be a Michigan resident.

19. **Application Processing and Enrollment Procedures.** Enrollees under this Demonstration will use the same application and enrollment procedures required of other individuals applying for other Medicaid programs.

20. **Screening for Eligibility for Medicaid and/or CHIP.** All applicants must receive a pre-screening in order to determine possible eligibility for either Medicaid or CHIP programs before eligibility determination is performed for the Demonstration.
21. **Effective Date of Coverage - No Retroactive Eligibility.** Enrollees who qualify for coverage under this Demonstration will not receive retroactive coverage. The beginning effective date of coverage under the Demonstration will be the first day of the month in which the application was received. After the application is processed, the enrollee will be enrolled in a county health plan (CHP) on the first day of the next month available for enrollment in the 72 counties that operate this type of delivery system. If the enrollee resides in a county that does not have CHP, that enrollee will continue to obtain services through Medicaid Fee for Service (FFS).
22. **Redetermination of Eligibility.** Enrollees who are eligible for coverage under this Demonstration will have eligibility redetermined at least every 12 months. The State will send eligibility renewal notification to the enrollee prior to the end of the enrollee's current eligibility period.
23. **Intermittent Periods of Open Enrollment to the Demonstration.** The State is responsible to determine and maintain the appropriate enrollment levels in order to remain under the annual budget neutrality limit/ceiling established for the Demonstration. Therefore, the State will determine the timeframe for opening enrollment for the Demonstration based upon the capacity and amount of available budgetary resources. The State will provide written notification to CMS at least 15 days before closing or re-opening enrollment to the Demonstration. The State should report to CMS via the quarterly and annual reports the status of enrollment and provide a description of the enrollment management process. In addition, the State will provide CMS with Monthly Enrollment Reports as described in paragraph 31.
24. **Disenrollment.** An enrollee in the Adult Benefits Waiver may be disenrolled if he/she:
  - a. Exceeds the income limit of 35 percent of the FPL;
  - b. Becomes eligible for Medicare, Medicaid, or CHIP coverage;
  - c. No longer resides in the State of Michigan;
  - d. Obtains health insurance coverage;
  - e. Attains age 65; or
  - f. Voluntarily requests closure of his/her case.

## V. BENEFITS AND COST SHARING

25. **Limited Benefit Package.** Enrollees under the Demonstration will continue to receive a limited benefit package that includes outpatient hospital services, physician services, diagnostic services, pharmacy, mental health and substance abuse services. The enrollees may be required to receive prior authorization (PA) from the State or their CHP assigned provider before accessing certain ambulatory services. The chart below describes the specific benefit coverage.

**Health Benefit Plan for Adult Benefits Waivers**

<b>Service Type</b>	<b>Description of Coverage</b>	<b>Co-Payments</b>
Ambulance	Limited to emergency ground transportation to the hospital Emergency Department (ED).	
Case Management	Not covered.	
Chiropractor	Not covered.	
Dental	Not covered, except for services of oral surgeons as covered under the current Medicaid physician benefit for the relief of pain or infection.	
Emergency Department	Covered per current Medicaid policy.  For CHPs, prior authorization may be required for nonemergency services provided in the emergency department.	
Eyeglasses	Not covered.	
Family Planning	Covered. Services may be provided through referral to local Title X designated Family Planning Program.	
Hearing Aids	Not covered.	
Home Health	Not covered.	
Home Help (personal care)	Not covered.	
Hospice	Not covered.	
Inpatient Hospital	Not covered.	
Laboratory and Radiology	Covered if ordered by MD, DO, or NP for diagnostic and treatment purposes. Prior authorization may be required by the CHP.	
Medical Supplies / Durable Medical Equipment (DME)	Limited Coverage: <ul style="list-style-type: none"> <li>• Medical supplies are covered except for the following non-covered categories: gradient surgical garments, formula and feeding supplies, and supplies related to any uncovered DME item.</li> <li>• DME items are non-covered except for glucose monitors</li> </ul>	

Mental Health	Covered: Services must be provided through the Prepaid Inpatient Health Plans (PIHP)/Community Mental Health Services Programs (CMHSP).	
Outpatient Hospital (Nonemergency Department )	Covered: Diagnostic and treatment services and diabetes education services. Prior authorization may be required for some services by the CHPs. Noncovered: Therapies, labor room, and partial hospitalization.	Maximum \$3 co-payment for professional services
Pharmacy	Covered: <ul style="list-style-type: none"> <li>• Products included on the Michigan Pharmaceutical Product List (except enteral formulas) that are ordered by an MD, DO, NP or type 10–enrolled oral surgeon. Prior authorization may be required by the CHPs.</li> <li>• Psychotropic medications are provided under the FFS benefit. Refer to Michigan Dept. of Community Health (MDCH) Pharmacy Benefit Manager (PBM) website for current list.</li> </ul> Noncovered: injectable drugs used in clinics or physician offices.	Maximum \$1 co-payment per prescription
Physician Services	Covered per Medicaid policy.	Maximum \$3 co-payment for office visits
Nurse Practitioner	Covered per Medicaid policy.	Maximum \$3 co-payment for office visits
Oral Surgeon	Covered per Medicaid policy.	Maximum \$3 co-payment for office visits
Medical Clinic	Covered per Medicaid policy.	Maximum \$3 co-payment for office visits
Podiatrist	Not covered.	
Prosthetics/Orthotics	Not covered.	
Private Duty Nursing	Not covered.	
Substance Abuse	Covered through the Substance Abuse Coordinating Agencies (CAs).	

PT,OT, SP Therapy Evaluation	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.	Maximum \$3 co-payment for office visits
Transportation (non-ambulance)	Not covered.	
Urgent Care Clinic	Professional services provided in a freestanding facility are covered. CHPs may require authorization by the primary care physician or plan administrator.	Maximum \$3 Co-payment per visit

26. **Cost Sharing.** Enrollees under the Demonstration are required to pay co-payments in order to receive certain ambulatory benefits as follows:

Service Type	Co-Payment Required
Outpatient Hospital	Maximum \$3 co-pay for professional services
Nurse Practitioner	Maximum \$3 co-pay for office visits
Physician	Maximum \$3 co-pay for office visits
Prescribed Drugs	Maximum \$1 co-pay per prescribed drug *

\*There are no co-pays for family planning or pregnancy related drug products.

## VI. DELIVERY SYSTEMS

27. **County Health Plans (CHP)** - The CHPs are capitated health plans that provide the primary and preventive care services in an ambulatory/outpatient setting. The CHPs have been a long-standing delivery system created to serve the childless adults enrolled in the ABW. Demonstration enrollees will be required to continue to enroll in the CHPs in 72 of the 83 counties in the State. The Demonstration enrollees will have the choice of provider within the CHPs. In counties where CHPs do not currently operate, the State must provide a Medicaid card or other means to access the Medicaid qualified providers under Fee-for-Service (FFS). Tribal members are exempt from mandatory enrollment into CHPs, but may choose to participate in CHPs on a voluntary basis.

28. **Mental Health and Substance Abuse Provider Network.** The State will continue to provide mental health and substance abuse services using a capitated managed care provider network through the State's Public Mental Health System (PMHS). The mental health and substance abuse network consists of local agencies including Community Mental Health Services Programs (CMHSP) and Substance Abuse Coordinating Agencies. The mental health and substance abuse services will be provided based upon medical necessity and applicable benefit restrictions.

29. **Contracts.** All contracts and modifications of existing contracts between the State and the CHPs and Mental Health and Substance Providers must be approved by CMS prior to the effective date of the contract or modification of an existing contract. Upon the initial

implementation of the Demonstration the State will be provided a 90-day grace period to meet the above requirements. If the contract requirements are not met within the specified timeframe, CMS reserves the right as a corrective action to withhold FFP (either partial or full) for the Demonstration until the contract compliance requirement is met.

**VII. GENERAL REPORTING REQUIREMENTS**

- 30. **General Financial Requirements.** The State must comply with all general financial requirements, including reporting requirements related to monitoring budget neutrality set forth in section IX of these STCs. The State must submit any corrected budget and/or allotment neutrality data upon request.
- 31. **Monthly Enrollment Report.** Within 20 days following the first day of each month, the State must report Demonstration enrollment figures for the month just completed to the CMS Project Officer and Regional Office contact via e-mail, using the table below. The data requested under this subparagraph are similar to the data requested for the Quarterly Report in Attachment A under Enrollment Count, except that they are compiled on a monthly basis.

<b>Demonstration Populations (as hard-coded in the CMS-64)</b>	<b>Point In Time Enrollment (last day of month)</b>	<b>Newly Enrolled Last Month</b>	<b>Disenrolled Last Quarter</b>
<b>Childless Adults</b>			

- 32. **Bi-Monthly Calls.** CMS will schedule conference calls with the State. The purpose of these calls is to discuss any significant actual or anticipated developments affecting the Demonstration. Areas to be addressed include, but are not limited to, health care delivery, enrollment, cost sharing, quality of care, access, the benefit package, audits, lawsuits, financial reporting and budget neutrality issues, progress on evaluations, legislative developments, and any demonstration amendments the State is considering submitting. CMS will provide updates on any amendments or concept papers under review, as well as Federal policies and issues that may affect any aspect of the Demonstration. The State and CMS will jointly develop the agenda for the calls.
- 33. **Quarterly Progress Reports.** The State must submit progress reports in accordance with the guidelines in Attachment A no later than 60 days following the end of each quarter. The intent of these reports is to present the State’s analysis and the status of the various operational areas. These quarterly reports must include, but not be limited to:
  - a. An updated budget neutrality monitoring spreadsheet;
  - b. A discussion of events occurring during the quarter or anticipated to occur in the near future that affect health care delivery, including, but not limited to: approval

and contracting with new plans, benefits, enrollment and disenrollment, grievances, quality of care, access, health plan contract compliance and financial performance that is relevant to the Demonstration, pertinent legislative or litigation activity, and other operational issues;

- c. Action plans for addressing any policy, administrative, or budget issues identified;
  - d. Quarterly enrollment reports for Demonstration eligibles that include the member months and end of quarter, point-in-time enrollment for each Demonstration population, and other statistical reports listed in Attachment A; and
  - e. Evaluation activities and interim findings.
34. **Annual Report.** The State must submit a draft annual report documenting accomplishments, project status, quantitative and case study findings, interim evaluation findings, and policy and administrative difficulties and solutions in the operation of the Demonstration. The State must submit the draft annual report no later than 120 days after the close of the Demonstration Year (DY). Within 30 days of receipt of comments from CMS, a final annual report must be submitted.

## VIII. GENERAL FINANCIAL REQUIREMENTS

35. **Quarterly Expenditure Reports for Title XIX.** The State must provide quarterly expenditure reports using Form CMS-64 to separately report total expenditures that are subject to budget neutrality for services provided through this Demonstration under section 1115 authority. This project is approved for expenditures applicable to services rendered during the demonstration period. CMS shall provide FFP for allowable Demonstration expenditures only as long as they do not exceed the pre-defined limits on the costs incurred as specified in section IX of these STCs.
36. **Expenditures Subject to the Title XIX Budget Neutrality Expenditure Limit.** All expenditures for health care services for Demonstration participants (as defined in section IV above) are subject to the budget neutrality expenditure limit.
37. **Reporting Expenditures Subject to the Title XIX Budget Neutrality Expenditure Limit.** The following describes the reporting of expenditures subject to the budget neutrality expenditure limit:
- a. **Use of Waiver Forms.** In order to track expenditures under this Demonstration, the State must report Demonstration expenditures through the Medicaid and Children's Health Insurance Program Budget and Expenditure System (MBES/CBES), following routine CMS-64 reporting instructions outlined in section 2500 of the State Medicaid Manual (SMM). All Demonstration expenditures claimed under the authority of title XIX of the Act and subject to the budget neutrality expenditure limit must be reported each quarter on separate Forms CMS-64.9 Waiver and/or 64.9P Waiver, identified by the Demonstration Project Number (**11-W-00245/5**) assigned by CMS.

- b. **Reporting By Date of Service.** In each quarter, Demonstration expenditures (including prior period adjustments) must be totaled and reported on separate Forms CMS-64.9 Waiver and/or 64.9P Waiver by Demonstration Year (DY). The DY for which expenditures are reported is identified using the project number extension (a 2-digit number appended to the Demonstration Project Number). Expenditures are to be assigned to DYs on the basis of date of service. DY 1 will correspond with Federal fiscal year (FFY) 2010, DY 2 with FFY 2011, and so on.
  - c. **Waiver Name.** The State must identify the Forms CMS-64.9 Waiver and/or 64.9P Waiver that report Demonstration population expenditures by using waiver name “ABW Adults.”
  - d. **Pharmacy Rebates.** The State may propose a methodology for assigning a portion of pharmacy rebates to the Demonstration, in a way that reasonably reflects the actual rebate-eligible pharmacy utilization of the Demonstration population, and which reasonably identifies pharmacy rebate amounts with DYs. Use of the methodology is subject to the approval in advance by the CMS Regional Office, and changes to the methodology must also be approved in advance by the Regional Office. The portion of pharmacy rebates assigned to the Demonstration using the approved methodology will be reported on the appropriate Forms CMS-64.9 Waiver for the Demonstration and not on any other CMS 64.9 form to avoid double –counting. Each rebate amount must be distributed as State and Federal revenue consistent with the Federal matching rates under which the claim was paid.
  - e. **Cost Settlements.** For monitoring purposes, cost settlements related to the Demonstration must be recorded on Line 10.B, in lieu of Lines 9 or 10.C. For any other cost settlements (that is, those not attributable to this Demonstration), the adjustments should be reported on lines 9 or 10.C, as instructed in the State Medicaid Manual.
38. **Title XIX Administrative Costs.** Administrative costs will not be subject to the budget neutrality expenditure limit, but the State must separately track and report additional administrative costs that are directly attributable to the Demonstration. All such administrative costs will be identified on the Forms CMS-64.10 Waiver and/or 64.10P Waiver, using waiver name “ABW Adults Admin.”
39. **Claiming Period.** All claims for expenditures subject to the budget neutrality expenditure limit (including any cost settlements) must be made within 2 years after the calendar quarter in which the State made the expenditures. Furthermore, all claims for services during the demonstration period (including any cost settlements) must be made within 2 years after the conclusion or termination of the Demonstration. During the latter 2-year period, the State must continue to identify separately net expenditures related to dates of service during the operation of the section 1115 demonstration on the CMS-64 waiver forms in order to properly account for these expenditures in determining budget neutrality.

40. **Standard Medicaid Funding Process.** The standard Medicaid funding process shall be used during the Demonstration. The State must estimate matchable Medicaid expenditures on the quarterly form CMS-37. In addition, the estimate of matchable Demonstration expenditures (total computable and Federal share) subject to the budget neutrality agreement must be separately reported by quarter for each FFY on the form CMS-37.12 for both the medical assistance program and administrative costs. CMS shall make Federal funds available based upon the State's estimate, as approved by CMS. Within 30 days after the end of each quarter, the State must submit the Form CMS-64 quarterly Medicaid expenditure report, showing Medicaid expenditures made in the quarter just ended. CMS shall reconcile expenditures reported on the Form CMS-64 with Federal funding previously made available to the State, and include the reconciling adjustment in the finalization of the grant award to the State.
41. **Extent of Title XIX FFP for the Demonstration.** Subject to CMS approval of the source(s) of the non-Federal share of funding, CMS shall provide FFP at the applicable Federal matching rates for the Demonstration as a whole as outlined below, subject to the limits described in section IX of these STCs:
- a. Administrative costs, including those associated with the administration of the Demonstration;
  - b. Net expenditures and prior period adjustments, made under approved Expenditure Authorities granted through section 1115(a)(2) of the Act for childless adults, with dates of service during the operation of the Demonstration.
42. **Sources of Non-Federal Share.** The State certifies that the source of non-Federal share of funds for the Demonstration is State/local monies. The State further certifies that such funds shall not be used as the non-Federal share for any other Federal grant or contract, except as permitted by law. All sources of non-Federal funding must be compliant with title XIX of the Act and applicable regulations. In addition, all sources of the non-Federal share of funding are subject to CMS approval.
- a. CMS shall review the sources of the non-Federal share of funding for the Demonstration at any time. The State agrees that all funding sources deemed unacceptable by CMS shall be addressed within the time frames set by CMS.
  - b. The State shall provide information to CMS regarding all sources of the non-Federal share of funding for any amendment that impacts the financial status of the program.
  - c. Under all circumstances, health care providers must retain 100 percent of the reimbursement amounts claimed by the State as Demonstration expenditures. Moreover, no pre-arranged agreements (contractual or otherwise) may exist between the health care providers and the State and /or local government to return and/or redirect any portion of the Medicaid or Demonstration payments. This confirmation of Medicaid and Demonstration payment retention is made with the

understanding that payments that are the normal operating expenses of conducting business (such as payments related to taxes—including health care provider-related taxes—fees, and business relationships with governments that are unrelated to Medicaid or the Demonstration and in which there is no connection to Medicaid payments) are not considered returning and/or redirecting a Medicaid or Demonstration payment.

43. **Monitoring the Demonstration.** The State will provide CMS with information to effectively monitor the Demonstration, upon request, in a reasonable time frame.

## IX. MONITORING BUDGET NEUTRALITY

44. **Limit on Federal Title XIX funding.** The State will be subject to annual limits on the amount of Federal title XIX funding that the State may receive for expenditures subject to the budget neutrality agreement.
45. **Risk.** The State shall be at risk for both the number of enrollees in the Demonstration as well as the per capita cost for Demonstration eligibles under this budget neutrality agreement.
46. **Budget Neutrality Expenditure Limit.** The following describes how the annual budget neutrality expenditure limits are determined, consistent with section 2111(a)(3)(C) of the Act.
- a. **Record of Budget Neutrality Expenditure Limit.** Attachment B provides a table that gives preliminary Annual Limits (defined below) for all of the approved DYs, based on information available at the time of the initial award of this Demonstration. The table also provides a framework for organizing and documenting updates to the Annual Limits as new information is received, and for eventual publication of the final Annual limit for each DY. Updated versions of Attachment B may be approved by CMS through letter correspondence, and do not require that the Demonstration be amended.
  - b. **Budget Neutrality Update.** Prior to April 1 of each year, the State must submit to CMS an updated budget neutrality analysis, which includes the following elements:
    - i. Projected expenditures and Annual Limits for each DY through the end of the approval period;
    - ii. A proposed computation of the Trend Factor (defined below) that will be used to calculate the Annual Limit for the DY immediately following, and the Annual Limit for the immediately following DY that would be determined by that Trend Factor;
    - iii. A proposed updated version of Attachment B.

The State may request technical assistance from CMS for the calculation of the Annual Limits and Trend Factors prior to its submission of the updated budget neutrality analysis. CMS will respond by either confirming the State's calculations or by working with the State to determine an accurate calculation of the Trend Factor and Annual Limit for the coming DY. CMS will ensure that the final Trend Factors for each DY are the same for all CHIPRA Medicaid childless adult waivers. The annual budget neutrality limit for each DY will be finalized by CMS by the following date, whichever is later: (1) 120 days prior to the start of the DY; or (2) two months following the date of the most recent publication of the National Health Expenditure projections occurring prior to the start of the DY.

- c. **Base Year Expenditure.** The Base Year Expenditure will be equal to the total amount of FFP paid to the State for health care services or coverage provided to nonpregnant childless adults under the **Michigan Adult Benefits Waiver (21-W-00017/5)**, as reported on CMS-21 and CMS-21P Waiver forms submitted by the State in the four quarters of FFY 2009. A preliminary Base Year Expenditure total appears in Attachment B. A final Base Year Expenditure total will be determined by CMS following CMS receipt of the Budget Neutrality Update that the State must provide by April 1, 2010.
- d. **Adjustments to the Base Year Expenditure.** CMS reserves the right to adjust the Base Year Expenditure in the event that any future audit or examination shows that any of the expenditures included in the Base Year Expenditure total were not expenditures for health care services, health insurance premiums, or premium assistance for nonpregnant childless adults participating in the **Michigan Adult Benefits Waiver (21-W-00017/5)**.
- e. **Special Calculation for FFY 2010.** The FFY 2010 Expenditure Projection will be equal to the Base Year Expenditure increased by 3.7 percent, which is the percentage increase in the projected nominal per capita amount of National Health Expenditures for 2010 over 2009, as published by the Secretary in February 2009.
- f. **Annual Limit for DY 1.** To account for the fact that this Demonstration will be active for only three-quarters of FFY 2010, the Annual Limit for DY 1 will be equal to the FFY 2010 Expenditure Projection (as calculated under subparagraph (e)) times 75 percent. The Annual Limit for DY 1 will be finalized at the same time that the Base Year Expenditure is finalized.
- g. **Annual Limit for DY 2.** The Annual Limit for DY 2 will be equal to the FFY 2010 Expenditure Projection (as calculated under subparagraph (e)), and prior to multiplication by three-quarters as indicated in subparagraph (f)), increased by the percentage increase (if any) in the projected nominal per capita amount of National Health Expenditures for 2011 over 2010, as published by the Secretary in February 2010. The Annual Limit for DY 2 can be finalized once the Trend factor for DY 2 is finalized.
- h. **Annual Limit for DY 3 and Subsequent Years.** The Annual Limit for DY 3 and the DYs that follow will be equal to the prior year's Annual Limit, increased

by the percentage increase (if any) in the projected nominal per capita amount of National Health Expenditures for the year beginning January 1 of the DY over the year preceding that year, as published by the Secretary in the February prior to the start of the DY.

- i. **Calculation of the Trend Factor.** The percentage increase (if any) in the projected nominal per capita amount of National Health Expenditures for the year beginning January 1 of a DY (PERCAP2) over the preceding year (PERCAP1) to be referred to as the Trend Factor) will be calculated to one decimal place of precision (example: 3.7 percent) using computer spreadsheet rounding. (A sample formula for this calculation in Microsoft Excel reads as follows:

“=ROUND(100\*(PERCAP2-PERCAP1)/PERCAP1,1)”

47. **Enforcement of Budget Neutrality.** CMS will enforce budget neutrality on an annual basis. The amount of FFP that the State receives for Demonstration expenditures each DY cannot exceed the Annual Limit applicable to that DY. If for any DY the State receives FFP in excess of the Annual Limit, the State must return the excess funds to CMS. All expenditures above the Annual Limit applicable to each DY will be the sole responsibility of the State.

48. **Impermissible DSH, Taxes or Donations.** The CMS reserves the right to adjust the budget neutrality expenditure limit in order to be consistent with enforcement of impermissible provider payments, health care related taxes, new Federal statutes, or with policy interpretations implemented through letters, memoranda, or regulations. CMS reserves the right to make adjustments to the budget neutrality expenditure limit if CMS determines that any health care-related tax that was in effect during the base year, or provider-related donation that occurred during the base year, is in violation of the provider donation and health care related tax provisions of section 1903(w) of the Act. Adjustments to the budget neutrality agreement will reflect the phase-out of impermissible provider payments by law or regulation, where applicable.

## **X. EVALUATION OF THE DEMONSTRATION**

49. **Submission of Draft Evaluation Design.** The State must submit to CMS for approval a draft evaluation design for an overall evaluation of the Demonstration no later than 120 days after the effective date of the Demonstration. At a minimum, the draft design must include a discussion of the goals and objectives set forth in section II of these STCs, as well as the specific hypotheses that are being tested. The draft design must discuss the outcome measures that will be used in evaluating the impact of the Demonstration during the period of approval. It shall discuss the data sources and sampling methodology for assessing these outcomes. The draft evaluation design must include a detailed analysis plan that describes how the effects of the Demonstration must be isolated from other initiatives occurring in the State. The draft design must identify whether the State will conduct the evaluation, or select an outside contractor for the evaluation.

50. **Interim Evaluation Reports.** In the event the State requests to extend the Demonstration beyond the current approval period under the authority of section 1115(a),

(e), or (f) of the Act, the State must submit an interim evaluation report as part of the State's request for each subsequent renewal.

51. **Final Evaluation Design and Implementation.** CMS will provide comments on the draft evaluation design within 60 days of receipt, and the State shall submit a final design within 60 days after receipt of CMS comments. The State must implement the evaluation design and submit its progress in each of the quarterly and annual progress reports.
52. **Final Evaluation Report.** The State must submit to CMS a draft of the evaluation report within 120 days after expiration of the Demonstration. CMS must provide comments within 60 days after receipt of the report. The State must submit the final evaluation report within 60 days after receipt of CMS' comments.
53. **Cooperation with Federal Evaluators.** Should CMS undertake an independent evaluation of any component of the Demonstration, the State shall cooperate fully with CMS or the independent evaluator selected by CMS. The State shall submit the required data to CMS or its contractor.

**XI. SCHEDULE OF DELIVERABLES FOR THE DEMONSTRATION EXTENSION PERIOD**

<b>Date</b>	<b>Deliverable</b>
Within 30 days of the date of award	Confirmation Letter to CMS Accepting Demonstration STCs
Per paragraph 49	Submit Draft Evaluation Design
Per paragraph 8	Submit Demonstration Extension Application
Per paragraph 50	Submit Interim Evaluation Report
<b>Monthly</b>	<b>Deliverable</b>
Per paragraph 31	Monthly Enrollment Reports
<b>Quarterly</b>	<b>Deliverable</b>
Per paragraph 33	Quarterly Progress Reports
Per paragraph 33	Quarterly Enrollment Reports
Per paragraph 35	Quarterly Expenditure Reports
<b>Annual</b>	<b>Deliverable</b>
Per paragraph 34	Draft Annual Report
Per paragraph 46	National Health Expenditure Projection and Revised BN Analysis

**ATTACHMENT A  
QUARTERLY REPORT FORMAT AND CONTENT**

Under section VII, paragraph 33, the State is required to submit quarterly progress reports to CMS. The purpose of the quarterly report is to inform CMS of significant demonstration activity from the time of approval through completion of the Demonstration. The reports are due to CMS 60 days after the end of each quarter.

The following report guidelines are intended as a framework and can be modified when agreed upon by CMS and the State. A complete quarterly progress report must include an updated budget neutrality monitoring workbook.

**NARRATIVE REPORT FORMAT:**

**Title Line One** – Michigan Medicaid Nonpregnant Childless Adults Waiver (Adult Benefits Waiver) Section 1115 Demonstration

**Title Line Two - Section 1115 Quarterly Report**

**Demonstration/Quarter Reporting Period:**

Example:

Demonstration Year: 1 (01/01/10-09/30/10)

Federal Fiscal Quarter: 2/2010 (01/01/10 – 03/31/10)

**Introduction**

Information describing the goal of the Demonstration, what it does, and key dates of approval/operation. (This should be the same for each report.)

**Enrollment Information**

Please complete the following table that outlines all enrollment activity under the Demonstration. The State should indicate “N/A” where appropriate. If there was no activity under a particular enrollment category, the State should indicate that by “0.”

**Enrollment Count**

**Note:** Enrollment counts should be person counts, not member months.

<b>Demonstration Populations (as hard-coded in the CMS-64)</b>	<b>Current Enrollment (last day of quarter)</b>	<b>Newly Enrolled in Current Quarter</b>	<b>Disenrolled in Current Quarter</b>
<b>Childless Adults</b>			

**Member Month Reporting**

Enter the member months for the quarter.

<b>Eligibility Group</b>	<b>Month 1</b>	<b>Month 2</b>	<b>Month 3</b>	<b>Total for Quarter Ending XX/XX</b>
<b>Childless adults</b>				

### **Update on Enrollment Management**

Provide an update of the current status of open versus closed enrollment under the Demonstration. This update should describe the status for each month included in the report period and any anticipated changes in the near future.

### **Outreach/Innovative Activities**

Summarize outreach activities and/or promising practices for the current quarter.

### **Operational/Policy Developments/Issues**

Identify all significant program developments/issues/problems that have occurred in the current quarter, including, but not limited to, approval and contracting with new plans, benefit changes, and legislative activity.

### **Financial/Budget Neutrality Developments/Issues**

Identify all significant developments/issues/problems with financial accounting, budget neutrality, and CMS-64 reporting for the current quarter. Identify the State's actions to address these issues. Specifically, provide an update on the progress of implementing the corrective action plan.

### **Consumer Issues**

A summary of the types of complaints or problems consumers identified about the program in the current quarter. Include any trends discovered, the resolution of complaints, and any actions taken or to be taken to prevent other occurrences.

### **Quality Assurance/Monitoring Activity**

Identify any quality assurance/monitoring activity in current quarter.

### **Status of Benefits and Cost Sharing**

Provide update regarding any changes to benefits or cost sharing during the quarter.

### **Demonstration Evaluation**

Discuss progress of evaluation design and planning.

**Enclosures/Attachments**

Identify by title any attachments along with a brief description of what information the document contains.

**State Contact(s)**

Identify individuals by name, title, phone, fax, and address that CMS may contact should any questions arise.

**Date Submitted to CMS**

**ATTACHMENT B**  
**RECORD OF BUDGET NEUTRALITY EXPENDITURE LIMIT**

Effective Date: Date of Initial Award (DOIA)

A blank preceding a percent sign (%) or following a dollar sign (\$) or “Effective:” indicates that a value is to be entered there some time in the future.

	<b>Initial Preliminary Estimates</b>		<b>Revised Preliminary Estimates</b>		<b>Final Amounts</b>	
	<b><u>Trend Factor</u></b>	<b><u>Amount</u></b>	<b><u>Trend Factor</u></b>	<b><u>Amount</u></b>	<b><u>Trend Factor</u></b>	<b><u>Amount</u></b>
Base Year Expenditure  (Paragraphs IX.46(c) and (d))	N/A	\$132,072,780  Effective: DOIA	N/A	N/A	N/A	\$  Effective:
FFY 2010 Expenditure Projection  (Paragraph IX.46(e))	3.7%  Effective: DOIA	\$136,959,473  Effective: DOIA	N/A	\$  Effective:	3.7%  Effective: DOIA	\$  Effective:
Annual Limit, DY 1  (Paragraph IX.46(f))	N/A	\$102,719,605  Effective: DOIA	N/A	\$  Effective:	N/A	\$  Effective:
Annual Limit, DY 2  (Paragraphs IX.46(g) and (i))	4.6%  Effective: DOIA	\$143,259,609  Effective: DOIA	%  Effective:	\$  Effective:	%  Effective:	\$  Effective:
Annual Limit, DY 3  (Paragraphs IX.46(h) and (i))	4.9%  Effective: DOIA	\$150,279,330  Effective: DOIA	%  Effective:	\$  Effective:	%  Effective:	\$  Effective:
Annual Limit, DY 4  (Paragraphs IX.46(h) and (i))	5.2%  Effective: DOIA	\$158,093,855  Effective: DOIA	%  Effective:	\$  Effective:	%  Effective:	\$  Effective:

Annual Limit, DY 5  (Paragraphs IX.46(h) and (i))	5.6%  Effective: DOIA	\$166,947,111  Effective: DOIA	%  Effective:	\$  Effective:	%  Effective:	\$  Effective
--	--------------------------------	---	---------------------	----------------------	---------------------	---------------------

CENTERS FOR MEDICARE & MEDICAID SERVICES  
EXPENDITURE AUTHORITY

**NUMBER:** 11-W-00245/5

**TITLE:** Michigan Medicaid Nonpregnant Childless Adults Waiver (Adult Benefits Waiver) Section 1115 Demonstration

**AWARDEE:** Michigan Department of Community Health

Under the authority of section 1115(a)(2) of the Social Security Act (the Act), expenditures made by the State for the items identified below, which are not otherwise included as expenditures under section 1903 of the Act, incurred during the period of this Demonstration, shall be regarded as expenditures under the State's title XIX plan.

The following expenditure authorities shall enable the State to operate its section 1115 Medicaid Non-Pregnant Childless Adults Demonstration:

1. Expenditures for health care-related costs for non-pregnant, childless, adults ages 19 through 64 years who have family income at or below 35 percent of the Federal poverty level (FPL), who are not otherwise eligible under the Medicaid State plan, and who do not have other health benefits coverage.
2. Expenditures for capitation payments for services furnished to the non-pregnant, childless adult population described in Expenditure Authority No. 1 above, through the 27 county – administered health plans currently operating in 72 of Michigan's 83 counties in rural and non-rural areas, even though enrollees do not have a choice between at least two such plans , as required under section 1932(a)(3) of the Act, and even though the plans do not meet the requirements under section 1903(m)(2)(A)(vi) and section 1932(a)(4) because they restrict enrollee rights to disenroll within 90 days of enrollment.

All requirements of the Medicaid program expressed in law, regulation, and policy statement, not expressly identified as not applicable in the list below, shall apply to the Demonstration Population beginning January 1, 2010, through September 30, 2014.

**Title XIX Requirements Not Applicable to the Demonstration Population:**

1. **Reasonable Promptness** **Section 1902(a)(3) and 1902(a)(8)**  
To the extent necessary to enable the State to cap enrollment for the Demonstration-Eligible Population in order to remain under the annual budget neutrality limits under the demonstration.

2. **Amount, Duration, and Scope** **Section 1902(a)(10)(B)**  
 To the extent necessary to enable the State to offer a different benefit package to the Demonstration-Eligible Population that varies in amount, duration, and scope from the benefits offered under the State Plan.
  
3. **Freedom of Choice** **Section 1902(a)(23)**  
 To the extent necessary to enable the State to restrict freedom of choice of provider for the Demonstration-Eligible Population to single county- administered health plans in the counties where these plans exist. The Demonstration-Eligible Population may change providers within the plan.
  
4. **Retroactive Eligibility** **Section 1902(a)(34)**  
 To the extent necessary to enable the State to not provide coverage for the Demonstration-Eligible Population for any time prior to the first day of the month in which the application was received by the State.
  
5. **Eligibility Standards** **Section 1902(a)(17)**  
 To the extent necessary to enable the State to apply different eligibility methodologies and standards to the Demonstration-Eligible Population than are applied under the State plan.
  
6. **Methods of Administration: Transportation** **Section 1902(a)(4), insofar as it incorporates 42 CFR 431.53**  
 To the extent necessary to enable the State to not assure transportation to and from providers for the Demonstration-Eligible Population.
  
7. **Dental, Hearing and Vision Services** **Section 1902(a)(43)**  
 To the extent necessary to enable the State to not provide coverage of dental, hearing and vision services to 19- and 20-year-old individuals in the Demonstration-Eligible Population.
  
8. **Payment to Federally Qualified Health Centers  
Rural Health Centers** **Section 1902(a)(15)**  
 To the extent necessary to enable the State to not reimburse FQHCs and RHCs the full cost reimbursement for services provided to the Demonstration Eligible Population.