



JENNIFER GRANHOLM
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF COMMUNITY HEALTH
LANSING

JANET OLSZEWSKI
DIRECTOR

April 4, 2003

Ms. Julie Jones
CMS/CMSO/FCHPG/DSCHI
Mail Stop S2-0-16
7500 Security Blvd.
Baltimore, MD 21244

Dear Ms. Jones:

Attached is an amendment to the HIFA waiver that Michigan submitted in March of 2002. The previous administration had requested that CMS place approval of the waiver on hold awaiting the outcome of a ballot proposal. Michigan is now prepared to move forward with the waiver in an amended form.

The attached waiver material revises the previous submission to limit the waiver to a Title XXI expansion to provide coverage to childless adults under 35% of the federal poverty level. The previously submitted material also expanded Medicaid coverage to parents and caretakers of minor children at higher income levels than Michigan currently covers under Medicaid. These populations have been dropped from the amended proposal.

In addition to the attached copies of the waiver proposal, I will have my staff e-mail you an electronic copy of the amended waiver and its attachments. If you have questions related to the waiver program or to the narrative or attachments, please contact Robert Stampfly at (517) 335-5121. If you have questions related to the waiver budget (Attachment G) please contact Stephen Fitton at (517) 241-7192.

I look forward to CMS's approval of the waiver proposal so that Michigan can move forward with its plans to cover childless adults.

Sincerely,


Janet Olszewski

Attachments

CC: Hye Sun Lee, Region 5

Application Template for Health Insurance Flexibility and Accountability (HIFA) §1115 Demonstration Proposal

The State of **Michigan**, Department of **Community Health** proposes a section 1115 demonstration entitled **the Adult Benefits Waiver**, which will increase the number of individuals with health insurance coverage.

I. GENERAL DESCRIPTION OF PROGRAM

The **Adult Benefits Waiver**, which is scheduled to begin on **July 1, 2003**, will provide health insurance coverage to an additional **62,000** residents of the State of **Michigan** with **countable** incomes at or below **35%** of the federal poverty level. The increased coverage will be funded by **state general funds and an increased utilization of Michigan's SCHIP allocation to cover uninsured childless adults. The new program is an expansion of an existing state program and will provide additional benefits including an inpatient hospital case rate, mental health and substance abuse benefits, and will markedly improve access to care. The new Title XXI program will utilize the Medicaid administrative system (e.g., the Medicaid payment system and quality assurance systems) and the Medicaid provider network with the addition of county health plans (in counties where they exist) as managed care providers.**

II. DEFINITIONS

Income: In the context of the HIFA demonstration, income limits for coverage expansions are expressed in terms of gross income, excluding sources of income that cannot be counted pursuant to other statutes (such as Agent Orange payments.)

Mandatory Populations: Refers to those eligibility groups that a State must cover in its Medicaid State Plan, as specified in Section 1902(a)(10) and described at 42 CFR Part 435, Subpart B. For example, States currently must cover children under age 6 and pregnant women up to 133 percent of poverty.

Optional Populations: Refers to eligibility groups that can be covered under a Medicaid or SCHIP State Plan, i.e., those that do not require a section 1115 demonstration to receive coverage and who have incomes above the mandatory population poverty levels. Groups are considered optional if they can be included in the State Plan, regardless of whether they are included. The Medicaid optional groups are described at 42 CFR Part 435, Subpart C. Examples include children and pregnant women covered in Medicaid above the mandatory levels, children covered under SCHIP, and parents covered under Medicaid. For purposes of the HIFA demonstrations, Section 1902(r)(2) and Section 1931 expansions constitute optional populations.

Expansion Populations: Refers to any individuals who cannot be covered in an eligibility group under Title XIX or Title XXI and who can only be covered under Medicaid or SCHIP through the section 1115 waiver authority. Examples include pregnant women in SCHIP and childless non-disabled adults under Medicaid.

III. HIFA DEMONSTRATION STANDARD FEATURES

Please place a check mark beside each feature to acknowledge agreement with the standard features.

XX The HIFA demonstration will be subject to Special Terms and Conditions (STCs). The core set of STCs is included in the application package. Depending upon the design of its demonstration, additional STCs may apply.

XX Federal financial participation (FFP) will not be claimed for any existing State-funded program. If the State is seeking to expand participation or benefits in a State-funded program, a maintenance of effort requirement will apply.

XX Any eligibility expansion will be statewide, even if other features of the demonstration are being phased-in.

XX HIFA demonstrations will not result in changes to the rate for Federal matching payments for program expenditures. If individuals are enrolled in both Medicaid and SCHIP programs under a HIFA demonstration, the Medicaid match rate will apply to FFP for Medicaid eligibles, and the SCHIP enhanced match rate will apply to SCHIP eligibles.

XX Premium collections and other offsets will be used to reduce overall program expenditures before the State claims Federal match. Federal financial payments will not be provided for expenditures financed by collections in the form of pharmacy rebates, third party liability or premium and cost sharing contributions made by or on behalf of program participants.

XX The State has utilized a public process to allow beneficiaries and other interested stakeholders to comment on its proposed HIFA demonstration.

IV. STATE SPECIFIC ELEMENTS

A. Upper income limit

The upper income limit for the eligibility expansion under the demonstration is **35** percent of the FPL.

If the upper income limit is above 200 percent of the FPL, the State will demonstrate that focusing resources on populations below 200 percent of the FPL is unnecessary because the State already has high coverage rates in this income range, and covering individuals above 200 percent of the FPL under the demonstration will not induce individuals with private health insurance coverage to drop their current coverage. (Please include a detailed description of your approach as Attachment A to the proposal.)

Other. Please specify: _____

(If additional space is needed, please include a detailed discussion as Attachment B to your proposal and specify the upper income limits.)

C. Enrollment/Expenditure Cap

No

XX Yes

(If Yes) Number of participants

or dollar limit of demonstration

Benefits, eligibility criteria and cost sharing will be reviewed at least annually (through a public process that includes beneficiaries, advocates, providers and state officials) to ensure costs remain within the state's federal Title XXI allocation and the annual state appropriation for the program.

(Express dollar limit in terms of total computable program costs.)

D. Phase-in

Please indicate below whether the demonstration will be implemented at once or phased in.

XX The HIFA demonstration will be implemented at once.

The HIFA demonstration will be phased-in.

If applicable, please provide a brief description of the State's phase-in approach (including a timeline)

E. Benefit Package

Please use check marks to indicate which benefit packages you are proposing to provide to the various populations included in your HIFA demonstration.

1. Mandatory Populations

The benefit package specified in the Medicaid State Plan as of the date of the HIFA application.

2. Optional populations included in the existing Medicaid State Plan

The same coverage provided under the State's approved Medicaid State plan.

The benefit package for the health insurance plan this is offered by an HMO and has the largest commercial, non-Medicaid enrollment in the State
The standard Blue Cross/Blue Shield preferred provider option service benefit plan that is described in, and offered to Federal employees under 5 U.S.C. 8903(1). (Federal Employees Health Benefit Plan (FEHBP))
A health benefits coverage plan that is offered and generally available to State employees
A benefit package that is actuarially equivalent to one of those listed above
Secretary approved coverage. (The proposed benefit package is described in Attachment D.)

Note: For Secretary approved coverage, benefit packages must include these basic services: inpatient and outpatient hospital services, physicians surgical and medical services, laboratory and x-ray services, well-baby and well-child care, including age appropriate immunizations.

3. SCHIP populations, if they are to be included in the HIFA demonstration

States with approved SCHIP plans may provide the benefit package specified in Medicaid State plan, or may choose another option specified in Title XXI. (If the State is proposing to change its existing SCHIP State Plan as part of implementing a HIFA demonstration, a corresponding plan amendment must be submitted.) SCHIP coverage will consist of:

- plan.
- _____ The same coverage provided under the State's approved Medicaid State plan.
 - _____ The benefit package for the health insurance plan this is offered by an HMO and has the largest commercial, non-Medicaid enrollment in the State
 - _____ The standard Blue Cross/Blue Shield preferred provider option service benefit plan that is described in, and offered to Federal employees under 5 U.S.C. 8903(1). (Federal Employees Health Benefit Plan (FEHBP))
 - _____ A health benefits coverage plan that is offered and generally available to State employees
 - _____ A benefit package that is actuarially equivalent to one of those listed above
 - _____ Secretary approved coverage. (The proposed benefit package is described in Attachment C.)

Note: For Secretary approved coverage, benefit packages must include these basic services: inpatient and outpatient hospital services, physicians surgical and medical services, laboratory and x-ray services, well-baby and well-child care, including age appropriate immunizations.

4. New optional populations to be covered as a result of the HIFA demonstration

The same coverage provided under the State's approved Medicaid State plan.
The benefit package for the health insurance plan this is offered by an HMO and has the largest commercial, non-Medicaid enrollment in the State

The standard Blue Cross/Blue Shield preferred provider option service benefit plan that is described in, and offered to Federal employees under 5 U.S.C. 8903(1). (Federal Employees Health Benefit Plan (FEHBP))

A health benefits coverage plan that is offered and generally available to State employees

A benefit package that is actuarially equivalent to one of those listed above Secretary approved coverage. (The proposed benefit package is described in Attachment C.)

Note: For Secretary approved coverage, benefit packages must include these basic services: inpatient and outpatient hospital services, physicians surgical and medical services, laboratory and x-ray services, well-baby and well-child care, including age appropriate immunizations.

5. Expansion Populations – States have flexibility in designing the benefit package, however, the benefit package must be comprehensive enough to be consistent with the goal of increasing the number of insured persons in the State and must include at least a primary care benefit, which means all health care services customarily furnished by or through a general practitioner, family physician, internal medicine physician, obstetrician/gynecologist, or pediatrician. Please check the services to be included.

Childless Adults at or below 100% of the federal poverty level

Inpatient

Outpatient

Physician’s Surgical and Medical Services

Laboratory and X-ray Services

Pharmacy

Other (please specify) **Mental Health and Substance Abuse**

Please include a detailed description of any Secretary approved coverage or flexible expansion benefit package as Attachment C to your proposal. Please include a discussion of whether different benefit packages will be available to different expansion populations.

F. Coverage Vehicle

Please check the coverage vehicle(s) for all applicable eligibility categories in the chart below (check multiple boxes if more than one coverage vehicle will be used within a category):

Eligibility Category	Fee-For-Service	Medicaid or SCHIP Managed Care	Private health insurance coverage	Group health plan coverage	Other (specify)
Mandatory					

Optional – Existing					
Optional – Expansion					
Title XXI – Medicaid Expansion					
Title XXI – Separate SCHIP					
Existing section 1115 expansion					
New HIFA Expansion	XXXXXXXX	XXXXXXXX If Available			<p>XXXXXX County Health Plan must be used if available</p> <p>Mental health and substance abuse services will only be provided through a Community Mental Health Service Program statewide.</p>

Please include a detailed description of any private health insurance coverage options as Attachment D to your proposal.

G. Private health insurance coverage options

Coordination with private health insurance coverage is an important feature of a HIFA demonstration. One way to achieve this goal is by providing premium assistance or “buying into” employer-sponsored insurance policies. Description of additional activities may be provided in Attachment D to the State’s application for a HIFA demonstration. If the State is employing premium assistance, please use the section below to provide details.

_____ As part of the demonstration the State will be providing premium assistance for private health insurance coverage under the demonstration. Provide the information below for the relevant demonstration population(s):

The State elects to provide the following coverage in its premium assistance program: (Check all applicable, and describe benefits and wraparound arrangements, if applicable, in Attachment

D to the proposal if necessary. If the State is offering different arrangements to different populations, please explain in Attachment D.)

The same coverage provided under the State's approved Medicaid plan.

The same coverage provided under the State's approved SCHIP plan.

_____ The benefit package for the health insurance plan that is offered by an HMO, and has the largest commercial, non-Medicaid enrollment in the State.

_____ The standard Blue Cross/Blue Shield preferred provider option service benefit plan that is described in, and offered to Federal employees under 5 U.S.C. 8903(1). (Federal Employees Health Benefit Plan (FEHBP))

_____ A health benefits coverage plan that is offered and generally available to State employees.

_____ A benefit package that is actuarially equivalent to one of those listed above (please specify).

Secretary-Approved coverage.

_____ Other coverage defined by the State. (A copy of the benefits description must be included in Attachment C.)

_____ The State assures that it will monitor aggregate costs for enrollees in the premium assistance program for private health insurance coverage to ensure that costs are not significantly higher than costs would be for coverage in the direct coverage program. (A description of the Monitoring Plan will be included in Attachment D.)

_____ The State assures that it will monitor changes in employer contribution levels or the degree of substitution of coverage and be prepared to make modifications in its premium assistance program. (Description will be included as part of the Monitoring Plan.)

H. Cost Sharing

Please check the cost sharing rules for all applicable eligibility categories in the chart below:

Eligibility Category	Nominal Amounts Per Regulation	Up to 5 Percent of Family Income	State Defined
Mandatory			
Optional – Existing (Children)			
Optional – Existing (Adults)			
Optional – Expansion (Children)			
Optional – Expansion (Adults)			XXXX
Title XXI – Medicaid Expansion			
Title XXI – Separate SCHIP			
Existing section 1115 Expansion			

Cost-sharing for children

Only those cost-sharing amounts that can be attributed directly to the child (i.e. co-payments for the child’s physician visits or prescription drugs) must be counted against the cap of up to five percent of family income. Cost-sharing amounts that are assessed to a family group that includes adults, such as family premiums, do not need to be counted as ‘child cost-sharing’ for the purposes of the up to five percent cost-sharing limit. A premium covering only the children in a family must be counted against the cap.

Below, please provide a brief description of the methodology that will be used to monitor child-only cost-sharing expenses when the child is covered as part of the entire family and how those expenses will be limited to up to five percent of the family’s income.

Any State defined cost sharing must be described in Attachment E. In addition, if cost sharing limits will differ for participants in a premium assistance program or other private health insurance coverage option, the limits must be specified in detail in Attachment E to your proposal.

V. Accountability and Monitoring

Please provide information on the following areas

1. Insurance Coverage

The rate of uninsurance in your State as of **1999** for individuals below 200 percent of poverty and any other groups that will be covered under the demonstration project.

Uninsured adults 18 through 64 years-of-age 30.3% or 369,535 individuals

The coverage rates in your State for the insurance categories for individuals below 200 percent of poverty and any other groups that will be covered under the demonstration project:

Private Health Insurance Coverage Under a Group Health Plan

35.4% or 431,485 individuals

Other Private Health Insurance Coverage

9.1% or 110,446 individuals

Medicaid (please separately identify enrollment in any section 1906 or section 1115 premium assistance)

25.4% or 310,246 individuals

SCHIP (please separately identify any premium assistance)

0.0% Adults are not currently enrolled in SCHIP

Medicare

95.2% or 418,220 individuals

Other Insurance

5.3% or 64,868 individuals

Indicate the data source used to collect the insurance information presented above (the State may use different data sources for different categories of coverage, as appropriate):

XX The Current Population Survey

Other National Survey (please specify _____)

State Survey (please specify _____)

Administrative records (please specify _____)

Other (please specify _____)

Adjustments were made to the Current Population Survey or another national survey.

XX No

If yes, a description of the adjustments must be included in Attachment F.

A State survey was used.

XX No

If yes, provide further details regarding the sample size of the survey and other important design features in Attachment F.

If a State survey is used, it must continue to be administered through the life of the demonstration so that the State will be able to evaluate the impact of the demonstration on coverage using comparable data.

2. State Coverage Goals and State Progress Reports

The goal of the HIFA demonstration is to reduce the uninsured rate. For example, if a State was providing Medicaid coverage to families, a coverage goal could be that the State expects the uninsured rate for families to decrease by 5 percent. Please specify the State's goal for reducing the uninsured rate:

Attachment F must include the State's Plan to track changes in the uninsured rate and trends in sources of insurance as listed above. States should monitor whether there are unintended consequences of the demonstration such as high levels of substitution of private coverage and major decreases in employer contribution levels. (See the attached Special Terms and Conditions.)

XX Annual progress reports will be submitted to CMS six months after the end of each demonstration year which provide the information described in this plan for monitoring the uninsured rate and trends in sources of insurance coverage.

States are encouraged to develop performance measures related to issues such as access to care, quality of services provided, preventative care, and enrollee satisfaction. The performance plan must be provided in Attachment F.

VI. PROGRAM COSTS

A requirement of HIFA demonstrations is that they not result in an increase in federal costs compared to costs in the absence of the demonstration. Please submit expenditure data as

Attachment G to your proposal. For your convenience, a sample worksheet for submission of base year data is included as part of the application packet.

The base year will be trended forward according to one of the growth rates specified below. Please designate the preferred option:

_____ Medical Care Consumer Price Index, published by the Bureau of Labor Statistics. (Available at <http://stats.bls.gov>.) The Medical Care Consumer Price Index will only be offered to States proposing statewide demonstrations under the HIFA initiative. If the State chooses this option, it will not need to submit detailed historical data.

_____ Medicaid-specific growth rate. States choosing this option should submit five years of historical data for the eligibility groups included in the demonstration proposal for assessment by CMS staff, with quantified explanations of trend anomalies. A sample worksheet for submission of this information is included with this application package. The policy for trend rates in HIFA demonstrations is that trend rates are the lower of State specific history or the President's Budget Medicaid baseline for the eligibility groups covered by a State's proposal. This option will lengthen the review time for a State's HIFA proposal because of the data generation and assessment required to establish a State specific trend factor.

The State estimates the cost of this program will be **\$871,915,339** over its **five (5)** year approval period.

VII. WAIVERS AND EXPENDITURE AUTHORITY REQUESTED

A. Waivers

The following waivers are requested pursuant to the authority of section 1115(a)(1) of the Social Security Act (Please check all applicable):

Title XIX:

Statewideness 1902(a)(1)

To enable the State to phase in the operation of the demonstration.

Amount, Duration, and Scope 1902(a)(10)(B)

To permit the provision of different benefit packages to different populations in the demonstration. Benefits (i.e., amount, duration and scope) may vary by individual based on eligibility category.

Freedom of Choice 1902(a)(23)

To enable the State to restrict the choice of provider.

Title XXI:

XX **Benefit Package Requirements 2103**

To permit the State to offer a benefit package that does not meet the requirements of section 2103.

XX **Cost Sharing Requirements 2103(e)**

To permit the State to impose cost sharing in excess of statutory limits.

B. Expenditure Authority

Expenditure authority is requested under Section 1115(a)(2) of the Social Security Act to allow the following expenditures (which are not otherwise included as expenditures under Section 1903 or Section 2105) to be regarded as expenditures under the State's Title XIX or Title XXI plan.

Note: Checking the appropriate box(es) will allow the State to claim Federal Financial Participation for expenditures that otherwise would not be eligible for Federal match.

Expenditures to provide services to populations not otherwise eligible to be covered under the Medicaid State Plan.

Expenditures related to providing _____ months of guaranteed eligibility to demonstration participants

Expenditures related to coverage of individuals for whom cost-sharing rules not otherwise allowable in the Medicaid program apply.

Title XXI:

XX Expenditures to provide services to populations not otherwise eligible under a State child health plan.

Expenditures related to providing _____ months of guaranteed eligibility to demonstration participants.

XX Expenditures that would not be payable because of the operation of the limitations at 2105(c)(2) because they are not for targeted low-income children.

If additional waivers or expenditure authority are desired, please include a detailed request and justification as Attachment H to the proposal.

VIII. ATTACHMENTS

Place check marks beside the attachments you are including with your application.

Attachment A: Discussion of how the State will ensure that covering individuals above 200 percent of poverty under the waiver will not induce individuals with private health insurance coverage to drop their current coverage.

XX Attachment B: Detailed description of expansion populations included in the demonstration.

XX Attachment C: Benefit package description.

XX Attachment D: Detailed description of private health insurance coverage options, including premium assistance if applicable.

XX Attachment E: Detailed discussion of cost sharing limits.

XX Attachment F: Additional detail regarding measuring progress toward reducing the rate of uninsurance.

XX Attachment G: Budget worksheets.

XX Attachment H: Additional waivers or expenditure authority request and justification.

IX. SIGNATURE

Date

Janet D. Olszewski, Director

Name of Authorizing State Official (Typed)

Signature of Authorizing State Official

Attachment B—Detailed Description of Expansion Populations

Expansion Population

Michigan's HIFA proposal includes as an expansion population consisting of adults aged 18 through 64 at or below 35% of the federal poverty level who are currently uninsured. This group consists of an estimated 62,000 persons statewide.

Childless adults excluded from this group will include:

- Eighteen year-olds covered under the Healthy Kids program up to 150% of the federal poverty level
- Persons under 21 years of age who are eligible for the Under 21 Medicaid category
Eighteen year-olds covered under the state's SCHIP program (MICHild) from 151% through 200% of the federal poverty level
- Persons who meet the disability or Under 21 Group 2 criteria for full Medicaid coverage
- Pregnant women will not be covered under this eligibility group since they will qualify for full Medicaid under Healthy Kids

Attachment C—Benefit Plan

Health Benefit Plans

State Plan Services	Existing Medicaid Benefit in Michigan	Medicaid Adult Benefits Waiver
Inpatient Hospital Medical/Surgical	Covered	Covered—A case rate will be paid on a per admission basis.
Outpatient Hospital	Covered	Covered
RHC & FQHC Prospective Payment System Rate	Covered	
Lab & X-ray	Covered	Covered
Nurse Practitioner	Covered	Covered (\$3 Copay for office visits)
Nursing Facility & Home Health for Beneficiaries 21 and Older	Covered	
EPSDT for beneficiaries Under 21	Covered	(Children are not covered in this group since they would be eligible for Healthy Kids or MICHild.)
Family Planning	Covered	Covered
Physician	Covered	Covered (\$3 Copay for office visits)
Nurse Midwives	Covered	(Pregnant women are not covered in this group since they would be eligible under Healthy Kids.)
Maternity Services	Covered	(Pregnant women are not covered in this group since they would be eligible under Healthy Kids.)
Ambulance	Covered	Covered
Podiatrist	Covered (\$2 Copay)	
Optometrist	Covered (\$2 Copay)	
Chiropractor	Covered (\$2 Copay)	
Other Practitioner	Covered	
Dental	Covered (Nominal Copay)	
Physical Therapy	Covered	
Occupational Therapy	Covered	
Speech, Hearing & Language Disorders	Covered	

Attachment C—Benefit Plan

Prescribed Drugs	Covered (\$1 Copay)	Covered (Preferred Drug List & \$5 copay per Rx for preferred drugs/\$10 copay per Rx for non-preferred drugs per prescription)
Medical Supplies	Covered	Covered (Limited Coverage)
Dentures	Covered (Nominal Copay)	
Prosthetic/Orthotics	Covered	
Eyeglasses	Covered	
Hearing Aids	Covered (\$3 Copay)	
Diagnostic	Covered	
Rehabilitative	Covered	
	Covered	
Inpatient Psych for Beneficiaries Under 21	Covered	
Nursing Facility for Beneficiaries Under 21	Covered	
Hospital Emergency Department Services	Covered	\$25 copay for services that do not result in an admission
Personal Care	Covered	
Transportation	Covered	
	Covered	
	Covered	
	Covered	
Mental Health	Covered	Covered (Services Provided through the CMHSP)
Substance Abuse	Covered	Covered (Services Provided through the CMHSP)

Attachment D—Private/Employer Insurance Options

Private/Employer Insurance Options

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

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

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

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

Attachment E—Cost Sharing Limits

Cost Sharing Limits

The state has not included cost sharing limits in its waiver proposal. However, the state has asked its actuarial consultant to calculate average per member per month out-of-pocket expenses based on expected utilization of services and the state's first year cost sharing amounts. Using the data from the actuary and the average monthly income for the eligibility group, the state has calculated the following expected cost sharing percentages for the eligibility group:

Eligibility Group	Expected Cost Sharing as a Percent of Countable Monthly Income
Childless Adults at or Below 35% of the Federal Poverty Level	3.02%

Attachment F—Measuring Progress in Reducing Uninsurance

Measuring Progress in Reducing the Rate of Uninsurance

Michigan will utilize data drawn from the Current Population Survey to calculate an uninsured rate for the target population included in the state's HIFA waiver application. The rate calculated in the first year following implementation will be compared to the rate prior to implementation of the waiver to determine the first year's progress in reducing the rate of uninsurance among low-income adults aged 18 through 64. In each subsequent year, the calculated rate of uninsurance will be compared to the rate from the previous year to ensure the state continues to make progress in reducing the number of adults without health insurance. Data from 1999 is included in the state's HIFA application.

For each year of the waiver, the state will report on the rate of uninsurance for this population and will also monitor market penetration of employer-sponsored insurance and other private insurance for the waiver population to ensure that public coverage is not supplanting employer-sponsored or private coverage.

ATTACHMENT G

HIFA Demonstration Waiver Budget Template for States Using SCHIP Funds

	Fiscal Year 2003 (full year SCHIP, 3 mths Demonstration Yr 1)	Federal Fiscal Year 1 & 2, SFY 2004	Federal Fiscal Year 2 & 3, SFY 2005	Federal Fiscal Year 3 & 4, SFY 2006	Federal Fiscal Year 4 & 5, SFY 2007	Federal Fiscal Year 5 SFY 2008 (9 months demonstration)
State's Allotment	\$ 95,696,032	\$ 95,696,032	\$ 123,037,755	\$ 123,037,755	\$ 153,799,019	\$ 153,799,019
Funds Carried Over From Prior Year(s)	\$ 216,400,000	\$ 192,596,000	\$ 142,701,949	\$ 112,113,369	\$ 73,003,981	\$ 55,619,012
SUBTOTAL (Allotment + Funds Carried Over)	\$ 312,096,032	\$ 288,292,032	\$ 265,739,704	\$ 235,151,124	\$ 226,803,000	\$ 209,418,031
Reallocated Funds (Redistributed or Retained that are Currently Available)	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
TOTAL (Subtotal + Reallocated funds)	\$ 312,096,032	\$ 288,292,032	\$ 265,739,704	\$ 235,151,124	\$ 226,803,000	\$ 209,418,031
State's Enhanced FMAP Rate	68.79%	69.12%	69.12%	69.12%	69.12%	69.12%

COST PROJECTIONS OF APPROVED SCHIP PLAN							
Benefit Costs							
Insurance payments							
Managed care							
per member/per month rate @ # of eligibles							
Fee for Service	\$ 50,463,000	\$ 51,338,000	\$ 54,418,280	\$ 57,683,377	\$ 61,144,379	\$ 48,609,782	
Total Benefit Costs	\$ 50,463,000	\$ 51,338,000	\$ 54,418,280	\$ 57,683,377	\$ 61,144,379	\$ 48,609,782	
(Offsetting beneficiary cost sharing payments)							
Net Benefit Costs	\$ 50,463,000	\$ 51,338,000	\$ 54,418,280	\$ 57,683,377	\$ 61,144,379	\$ 48,609,782	
Administration Costs							
Personnel							
General administration							
Contractors/Brokers (e.g., enrollment contractors)		\$1,000,000	\$1,060,000	\$1,123,600	\$1,191,016	\$946,858	
Claims Processing							
Outreach/marketing costs							
Other							
Total Administration Costs	\$ 1,000,000	\$ 1,000,000	\$ 1,060,000	\$ 1,123,600	\$ 1,191,016	\$ 946,858	
10% Administrative Cap		\$5,233,800					
Federal Title XXI Share	\$ 35,401,399	\$ 35,176,026	\$ 38,346,587	\$ 40,647,382	\$ 43,086,225	\$ 34,253,549	
State Share	\$ 15,061,602	\$ 16,161,974	\$ 17,131,693	\$ 18,159,594	\$ 19,249,170	\$ 15,303,090	
TOTAL COSTS OF APPROVED SCHIP PLAN	\$ 51,463,000	\$ 52,338,000	\$ 55,478,280	\$ 58,806,977	\$ 62,335,395	\$ 49,556,639	

COST PROJECTIONS OF HIFA DEMONSTRATION PROPOSAL - SCHIP PROGRAMS							
	7/1/03 to 9/30/03					10/1/07 to 6/30/08	
Benefit Costs for SMP - Physical Health							
Insurance payments							
Managed care	\$23,605,260	\$94,421,040	\$100,086,302	\$106,091,481	\$112,456,969	\$89,403,291	
per member/per month rate @ # of eligibles							
Fee for Service (Pharmacy - psychotropics)	\$ 3,016,920	\$ 12,067,680	\$ 13,274,448	\$ 14,601,893	\$ 16,062,082	\$ 13,251,218	
Total Benefit Costs for Physical Health	\$ 26,622,180	\$ 106,488,720	\$ 113,360,750	\$ 120,693,373	\$ 128,519,051	\$ 102,654,509	
Benefit Costs for SMP - Inpatient							
Insurance payments							
Managed care	\$1,307,813	\$6,975,000	\$7,184,250	\$7,399,778	\$7,621,771	\$5,887,818	
per member/per month rate @ # of eligibles							
Fee for Service							
Total Benefit Costs for Inpatient	\$ 1,307,813	\$ 6,975,000	\$ 7,184,250	\$ 7,399,778	\$ 7,621,771	\$ 5,887,818	
Benefit Costs for SMP - Mental Health							
Insurance payments							
Managed care (CAH)	\$10,708,020	\$42,832,080	\$44,117,042	\$45,440,554	\$46,803,770	\$36,155,913	
per member/per month rate @ # of eligibles							
Fee for Service							
Total Benefit Costs for Mental Health	\$ 10,708,020	\$ 42,832,080	\$ 44,117,042	\$ 45,440,554	\$ 46,803,770	\$ 36,155,913	
Total Benefit Costs	\$ 38,638,013	\$ 156,295,800	\$ 164,662,043	\$ 173,533,705	\$ 182,944,593	\$ 144,698,239	
(Offsetting beneficiary cost sharing payments)							
Net Benefit Costs	\$ 38,638,013	\$ 156,295,800	\$ 164,662,043	\$ 173,533,705	\$ 182,944,593	\$ 144,698,239	
Administration Costs							
Personnel							
General administration							
Contractors/Brokers (e.g., enrollment contractors)							
Claims Processing							
Outreach/marketing costs							
Other (specify)							
Total Administration Costs	\$ 500,000	\$ 2,000,000	\$ 2,120,000	\$ 2,247,200	\$ 2,382,032	\$ 1,893,715	
10% Administrative Cap							
Federal Title XXI Share	\$ 26,923,039	\$ 109,414,057	\$ 115,279,748	\$ 121,499,761	\$ 128,097,763	\$ 101,324,359	
State Share	\$ 12,214,974	\$ 46,881,743	\$ 51,502,295	\$ 54,281,143	\$ 57,228,862	\$ 45,267,595	
TOTAL COSTS FOR DEMONSTRATION	\$ 39,138,013	\$ 158,295,800	\$ 166,782,043	\$ 175,780,905	\$ 185,326,625	\$ 146,591,954	
Federal Title XXI Share		\$ 145,590,083	\$ 153,626,335	\$ 162,147,144	\$ 171,183,988	\$ 135,577,908	
State Share		\$ 65,043,717	\$ 68,633,988	\$ 72,440,736	\$ 76,479,032	\$ 50,570,686	
TOTAL PROGRAM COSTS (State Plan + Demonstration)	\$ 90,601,013	\$ 210,633,800	\$ 222,260,323	\$ 234,587,881	\$ 247,662,020	\$ 196,148,594	

Total Federal Title XXI Funding Currently Available (Allotment + Reallocated Funds)	\$ 312,096,032	\$ 288,292,032	\$ 265,739,704	\$ 235,151,124	\$ 226,803,000	\$ 209,418,031
Total Federal Title XXI Program Costs (State Plan + Demonstration)	\$ 62,324,436	\$ 145,590,083	\$ 153,626,335	\$ 162,147,144	\$ 171,183,988	\$ 135,577,908
Unused Title XXI Funds Expiring (Allotment or Reallocated)	\$ 57,175,596	\$ -	\$ -	\$ -	\$ -	\$ -
Remaining Title XXI Funds to be Carried Over (Equals Available Funding - Costs - Expiring Funds)	\$ 192,596,000	\$ 142,701,949	\$ 112,113,369	\$ 73,003,981	\$ 55,619,012	\$ 73,840,123

Attachment H: Additional Waivers--Request and Justification

Additional Waivers--Request and Justification

The following additional waivers are requested by the State of Michigan for the populations included in this waiver pursuant to the authority of section 1115(a)(1) of the Social Security Act:

Retroactive Coverage Section 1902(a)(34)

The State of Michigan requests waiver of the requirement to provide retroactive coverage to the Adult Benefit Waiver beneficiaries. Currently, waiver beneficiaries in 17 counties will be provided health services through a county health plan. Enrollment in a plan will be prospective to ensure that the care is coordinated and managed through the beneficiary's health plan. The county plans do not have the capability to pay retroactive claims on a consistent basis—particularly where the provider was not participating in the health plan. Services will be covered for the month of application and for subsequent months for which eligibility has been determined by the State.

Payment for Federally Qualified Health Centers Sections (FQHCs) 1902(a)(15) & 1902(aa)

The State of Michigan requests waiver of the requirement to pay FQHCs based upon the prospective payment system (PPS) for the Medicaid Adult Benefits Waiver beneficiaries. The requirement to pay FQHCs based upon the prospective payment system would significantly increase costs for these groups and reduce the number of persons that could be provided coverage under the waiver. In addition, funding for this waiver is provided under Title XXI of the Social Security Act—Title XXI does not require FQHCs to be paid under the PPS.

Fair Hearings 1902(a)(3)

The State of Michigan requests waiver of the Fair Hearing requirement for the waiver population. In its place, the state will conduct departmental reviews under the authority of state statute. Adult Benefit Waiver beneficiaries will receive services under Title XXI of the Social Security Act—Title XXI does not require Medicaid Fair Hearings. The use of departmental reviews will also be consistent with the state's other Title XXI program, MICHild.