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

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State of Michigan

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

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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.

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.

- 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.

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.

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.

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

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.

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.

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.

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

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 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 • Co-payment ONLY applies to non-emergency services • There is no co-payment for true emergency services	$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

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.

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.

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

assuring such services are available within the Medicaid Health Plan choices for new enrollees. Michigan enrolls 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

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

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.

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

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)**

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.

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.

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) 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

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

Benefits	***Small Group Base Benchmark***	***State Plan Services***	***The Healthy Michigan Plan***
	Priority Health (Health Maintenance Organization)	Current Medicaid State Plan Services	Proposed Alternative Benefit Plan Services
1. Ambulatory patient services - Federal Mandate			
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
2. Emergency Services - Federal Mandate			
Emergency Room Services	Yes	Yes	Yes
Emergency Transportation/Ambulance	Yes	Yes	Yes
Urgent Care Centers or Facilities	Yes	Yes	Yes
3. Hospitalization - Federal Mandate			
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.			
4. Maternity and newborn care - Federal Mandate			
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

Benefits	***Small Group Base Benchmark***	***State Plan Services***	***The Healthy Michigan Plan***
	Priority Health (Health Maintenance Organization)	Current Medicaid State Plan Services	Proposed Alternative Benefit Plan Services
5. Mental health and substance use disorder services, including behavioral health treatment - Federal Mandate			
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)
6. Prescription drugs - Federal Mandate			
Prescription Drugs and Supplies	Yes	Yes	Yes
7. *Rehabilitative and habilitative services and devices - Federal Mandate			
Inpatient Rehabilitation Services	Yes	Yes	Yes
Outpatient Rehabilitiation 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.			
8. Laboratory services - Federal Mandate			
Diagnostic and Therapeutic Radiology Services and Laboratory Testing	Yes	Yes	Yes
9. *Preventive and wellness services and chronic disease management - Federal Mandate			
Preventive Care/Screening/Immunization	Yes	Yes	Yes
*Preventive services are an essential health benefit and must be provided in compliance with federal law.			
10. Pediatric services, including oral and vision care - Federal Mandate (coverage is for beneficiaries ages 19 and 20)			
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

Benefits	***Small Group Base Benchmark***	***State Plan Services***	***The Healthy Michigan Plan***
	Priority Health (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.			

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. 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.

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

Distribution List for L 13-46
Septemer 3, 2013

Mr. Kurt Perron, Tribal Chairman, Bay Mills Indian Community
Ms. Vicki Newland, Health Director, Bay Mills (Ellen Marshall Memorial Center)
Mr. Alvin Pedwaydon, Tribal Chairman, Grand Traverse Band Ottawa & Chippewa Indians
Ms. Loi Chambers, Health Director, Grand Traverse Band Ottawa/Chippewa
Mr. Kenneth Meshigaud, Tribal Chairman, Hannahville Indian Community
Ms. G. Susie Meshigaud, Health Director, Hannahville Health Center
Mr. W. Chris Swartz, President, Keweenaw Bay Indian Community
Ms. Carole LaPointe, Health Director, Keweenaw Bay Indian Community - Donald Lapointe Health/Educ Facility
Mr. James Williams, Jr., Tribal Chairman, Lac Vieux Desert Band of Lake Superior Chippewa Indians
Ms. Terry Fox, Health Director, Lac Vieux Desert Band
Mr. Larry Romanelli, Ogema, Little River Band of Ottawa Indians
Mr. Robin Carufel, Health Director, Little River Band of Ottawa Indians
Mr. Dexter McNamara, Tribal Chairman, Little Traverse Bay Band of Odawa Indians
Ms. Sharon Sierzputowski, Health Director, Little Traverse Bay Band of Odawa
Mr. DK Sprague, Tribal Chairman, Match-E-Be-Nash-She-Wish Potawatomi Indians (Gun Lake Band)
Ms. Phyllis Davis, Health Director, Match-E-Be-Nash-She-Wish Potawatomi
Mr. Homer Mandoka, Vice Tribal Chairman, Nottawaseppi Huron Band of Potawatomi Indians
Ms. Rosalind Johnston, Health Director, Huron Potawatomi Inc.- Tribal Health Department
Mr. Matt Wesaw, Tribal Chairman, Pokagon Band of Potawatomi Indians
Mr. Arthur Culpepper, Health Director, Pokagon Potawatomi Health Services
Mr. Dennis V. Kequom Sr, Tribal Chief, Saginaw Chippewa Indian Tribe
Ms. Gail George, Health Director, Nimkee Memorial Wellness Center
Mr. Aaron Payment, Tribal Chairman, Sault Ste. Marie Tribe of Chippewa Indians
Ms. Bonnie Culfa, Health Director, Sault Ste. Marie Tribe of Chippewa Indians - Health Center

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

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5 YEARS OF HISTORIC DATA

SPECIFY TIME PERIOD AND ELIGIBILITY GROUP DEPICTED:

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

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

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

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

Attachment C

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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) DY 01	DY 02	DY 03	DY 04	DY 05	TOTAL WOW
Medicaid Pop 1										
Pop Type:	**Medicaid**									
Eligible Member Months	#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!	
Total Expenditure					#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Medicaid Pop 2										
Pop Type:	**Medicaid**									
Eligible Member Months	#DIV/0!	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!	
Total Expenditure					#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Medicaid Pop 3										
Pop Type:	**Medicaid**									
Eligible Member Months	#DIV/0!	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!	
Total Expenditure					#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Hypo 1										
Pop Type:	**Hypothetical**									
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
Hypo 2										
Pop Type:	**Hypothetical**									
Eligible Member Months										
PMPM Cost										
Total Expenditure					$ -	$ -	$ -	$ -	$ -	$ -

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

ELIGIBILITY GROUP	DY 00	DEMO TREND RATE	DEMONSTRATION YEARS (DY) DY 01	DY 02	DY 03	DY 04	DY 05	TOTAL WW
Medicaid Pop 1								
Pop Type:	**Medicaid**							
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!
Medicaid Pop 2								
Pop Type:	**Medicaid**							
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!
Medicaid Pop 3								
Pop Type:	**Medicaid**							
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!
Hypo 1								
Pop Type:	**Hypothetical**							
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
Hypo 2								
Pop Type:	**Hypothetical**							
Eligible Member Months			-	-	-	-	-	
PMPM Cost			$ -	$ -	$ -	$ -	$ -	
Total Expenditure			$ -	$ -	$ -	$ -	$ -	$ -
Exp Pop 1								
Pop Type:	**Expansion**							
Eligible Member Months								
PMPM Cost								
Total Expenditure			$ -	$ -	$ -	$ -	$ -	$ -
Exp Pop 2								
Pop Type:	**Expansion**							
Eligible Member Months								
PMPM Cost								
Total Expenditure			$ -	$ -	$ -	$ -	$ -	$ -

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

RECENT PAST FEDERAL FISCAL YEARS	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

FEDERAL FISCAL YEARS THAT OVERLAP DEMONSTRATION YEARS	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

FEDERAL FISCAL YEARS THAT OVERLAP DEMONSTRATION YEARS	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 Alltoment 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

DEMONSTRATION YEARS		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)		$ -	$ -	$ -	$ -	$ -

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Budget Neutrality Summary

Without-Waiver Total Expenditures

	DEMONSTRATION YEARS (DY)					TOTAL
	DY 01	DY 02	DY 03	DY 04	DY 05	
Medicaid Populations						
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!
DSH Allotment Diverted	$ -	$ -	$ -	$ -	$ -	$ -
Other WOW Categories						
Category 1						$ -
Category 2						$ -
TOTAL	#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	
Medicaid Populations						
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!
Expansion Populations						
Exp Pop 1	$ -	$ -	$ -	$ -	$ -	$ -
Exp Pop 2	$ -	$ -	$ -	$ -	$ -	$ -
Excess Spending From Hypotheticals						$ -
Other WW Categories						
Category 3						$ -
Category 4						$ -
TOTAL	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!

VARIANCE	#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	$ -	$ -	$ -	$ -	$ -	$ -
TOTAL	$ 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	$ -	$ -	$ -	$ -	$ -	$ -
TOTAL	$ 2,207,235,359	$ 2,961,703,184	$ 3,247,378,587	$ 3,359,391,810	$ 3,476,961,361	$ 15,252,670,302

HYPOTHETICALS VARIANCE	$ -	$ -	$ -	$ -	$ -	$ -