ATTACHMENT C
Operational Protocol for the MI Health Accounts
Proposed Amendment: Revised July 9, 2018

I. Purpose

This document describes the background, along with the requirements for development, implementation and operation of the MI Health Account. These requirements apply to the Michigan Department of Health and Human Services ("Department"), the Department's contracted health plans, and the Department's selected MI Health Account vendor[1] as further described below.

II. Background

All individuals enrolled in the Healthy Michigan Plan through the Department's contracted Medicaid health plans will have access to a MI Health Account. The MI Health Account is a unique health care savings vehicle through which various cost-sharing requirements, which include co-pays and additional contributions for beneficiaries with higher incomes, will be satisfied, monitored and communicated to the beneficiary. The Department has established uniform standards and expectations for the MI Health Account's operation through this Operational Protocol and by contract as appropriate.

III. Cost-Sharing

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

Beneficiaries who are exempt from cost-sharing requirements by law, regulation or program policy will be exempt from cost-sharing obligations via the MI Health Account (e.g. individuals receiving hospice care, pregnant women receiving pregnancy-related services, individuals eligible for Children's Special Health Care Services, Native Americans in compliance with 42 CFR 447.56, etc.). Similarly, services that are exempt from cost sharing by law, regulation or program policy (e.g. preventive and family planning services), or as defined by the State's Healthy Behaviors Incentives Operational Protocol, will also be exempt for Healthy Michigan Plan beneficiaries.

In addition, those services that are considered private and confidential under the Department's Explanation of Benefits framework will be excluded from the MI Health Account statement and, therefore, will be exempt from cost sharing for these Healthy Michigan Plan enrollees. The Department, in cooperation with its Data Warehouse vendor, will ensure that the claims information submitted to the MI Health Account vendor for use

[1] There is a single vendor that all of the Department's contracted Medicaid health plans use for the MI Health Account function. This vendor is designated as a mandatory subcontractor for the health plans, and each of the plans contract with the MI Health Account vendor to provide services related to the MI Health Account, consistent with this protocol. The Department also holds a contract with the MI Health Account vendor which lays out the vendor's obligation to both the Department and the health plans with respect to the MI Health Account function.

in preparing the MI Health Account statement excludes those confidential services and/or medications outlined in this framework. The Department's Explanation of Benefits framework is updated by the Department at least annually, is shared with the contracted health plans for use in preparing Explanation of Benefits documents for federal health care program beneficiaries and is available to other providers upon request. Finally, unless otherwise specified by this Operational Protocol or the Healthy Behaviors Incentives Operational Protocol, co-pay amounts will be consistent with Michigan's State Plan.

A. Co-pays

The Healthy Michigan Plan utilizes an innovative approach to co-pays that is intended to reduce barriers to valuable health care services and promote consumer engagement. During a Healthy Michigan Plan beneficiary's first six months of enrollment in a health plan, there will be no co-pays collected at the point of service for health plan covered services. At the end of the six-month period, an average monthly co-pay experience for the beneficiary will be calculated. The initial look-back period will include encounters during the first three months of enrollment in a health plan in order to account for claim lag and allow for stabilization of the encounter data. Analysis of the beneficiary's co-pay experience will be recalculated on a quarterly basis going forward. The following examples, along with the attached **Appendix 1** (which is a more general, visual representation of a beneficiary enrolling with a health plan in May) provide further clarification.

During her first three months in a Healthy Michigan Plan health plan, a beneficiary has the following services: In April 2014, she visits her physician for a sinus infection ($2 co-pay). In May (2014), she visits the dentist for a filling ($3 co-pay), and fills one preferred prescription for antibiotics at the pharmacy ($1). The beneficiary will receive notice of these potential co-pay amounts at the time the services are rendered. All of the above claims are paid by the health plan in June 2014. The MI Health Account vendor receives claim information on this beneficiary from the Department's Data Warehouse vendor in early October 2014, which includes claims paid during April, May and June of 2014 for services that occurred on or after April 1, 2014. This claim information includes the above services with the related co-pay amounts.

The MI Health Account vendor calculates the average monthly co-pay experience for that beneficiary to be $2.00 ($6 in expenditures divided over a 3-month period equals an average of $2 per month). Therefore, this beneficiary will be required to remit $2 per month into the MI Health Account for the next three months. The beneficiary will receive her first quarterly MI Health Account statement on or about October 15, 2014 with her first payment of $2.00 due November 15, 2014; her second payment due December 15, 2014 and her third payment due January 15, 2015. The beneficiary (and all other Healthy Michigan Plan beneficiaries) will also have the option to pay the entire amount due all at once. The MI Health Account vendor will recalculate the average monthly co-pay experience for the beneficiary in January 2015, which will be based on the beneficiary's copayments from July, August, and September of 2014. The

beneficiary will then be notified of her new monthly copayment obligation in January 2015, which will be in effect during February, March, and April of 2015.

During another beneficiary's first three months in a Healthy Michigan Plan health plan, a beneficiary has the following services: A visit to her doctor for a preventive visit ($0) in April of 2014; a visit to an endocrinologist to assess and control her diabetes in May of 2014($0); and finally, she fills a diabetes related prescription ($0) in June of 2014. All of the above claims are paid by the health plan in June 2014. The MI Health Account vendor receives claim information on this beneficiary from the Department's Data Warehouse vendor in early October 2014, which includes claims paid during April, May and June of 2014 for services that occurred on or after April 1, 2014. This claim information includes the above services with the related co-pay amounts.

The MI Health Account vendor calculates the average monthly co-pay experience for this beneficiary to be $0 because none of these services have co-pays associated with them. This beneficiary will not be required to remit any funds to the MI Health Account for co-pays over the next 3 months, but will receive a quarterly MI Health Account statement detailing her services for educational purposes.

The average co-pay amount is re-calculated every three months to reflect the beneficiary's current utilization of healthcare services, consistent with available data. The Department will consider the dates of service and adjudication date for claims received to determine the beneficiary's experience and calculate the co-pay amount going forward. These co-pay amounts will be based on encounter data submitted by the health plans to the Department, and will be shared via interface with the MI Health Account vendor. The MI Health Account vendor is then responsible for communicating the co-pay amounts due to the beneficiary via a quarterly account statement as described in Section VII.A.1. This account statement will include a summary of account activity and any future amounts due, as well as a detailed (encounter level) explanation of services received. As noted earlier, one important exception to the amount of encounter level detail provided is that confidential services will not be shown on the MI Health Account statement; therefore, the beneficiary will have no cost-sharing associated with those services. The provision of this encounter level data to the beneficiary is key to engaging the beneficiary as a more active consumer of health care services and will also provide sufficient information for the beneficiary to recognize and pursue resolution of any discrepancies through the process described in Section X. The Department reserves the right to modify the account statement at any time, in consultation with CMS.

The co-pay amounts collected from the beneficiary by the MI Health Account vendor will be disbursed to the health plans and will not accumulate in the MI Health

Account. In addition, there will be no distribution of funds from the MI Health Account to the beneficiary to pay co-pays. However, information regarding co-pays owed and paid will be included as an informational item on the MI Health Account quarterly statement, as further defined and described in Section VII.A.1. Ensuring that beneficiaries are aware of the amounts owed, or why payment was not required (i.e., a preventive service was provided), is a key component of the Healthy Michigan Plan. The health plans, in cooperation with the State and MI Health Account vendor, will be responsible for beneficiary education and engagement consistent with Section VII.

Reductions in co-pays will be implemented consistent with the State's Healthy Behaviors Incentives Operational Protocol. The MI Health Account vendor is responsible for determining when each beneficiary has reached the threshold that enables co-pay reductions to occur. The MI Health Account vendor will also communicate co-pay reductions to the beneficiary as part of the MI Health Account statement (see Section V for further discussion).

B. Required Contributions

In addition to any relevant co-pays, a monthly contribution is also required for beneficiaries whose income places them above 100% of the Federal Poverty Level. Consistent with state law, contributions are not required during the first six months the individual is enrolled in a health plan. However, the MI Health Account vendor will notify the beneficiary, via the MI Health Account statement, a welcome letter and, when applicable, through scripts used by the vendor's customer service representatives, that contributions will be required on a monthly basis starting in month seven.

~~After April 1, 2018, consistent with the revisions to the Special Terms and Conditions and the Healthy Behaviors Incentives Operational Protocol, the contribution amount will not exceed two percent of the amount that represents the beneficiary's percentage of the Federal Poverty Level, with reductions occurring for Healthy Behaviors as described therein. However, in practice,~~ The Department plans to consider family composition when calculating contribution amounts. For example, when a beneficiary with several dependents qualifies for the Healthy Michigan Plan, the Department will consider that fact when assessing their contribution amount. For example:

A beneficiary with three dependents has an annual income of around $28,000. A beneficiary with no children has an annual income of around $14,000. Both apply for the Healthy Michigan Plan. Due to difference in their family size, both beneficiaries would be eligible for the Healthy Michigan Plan at 120 percent of the Federal Poverty Level. The contribution for both will not exceed $23 per month because some income from the beneficiary with three dependents will be recognized as support for these dependents.

In addition, the Department intends to consider the fact that multiple Healthy Michigan Plan covered individuals reside in the same household when calculating contribution amounts. For example, if both individuals in a married couple qualify for the Healthy Michigan Plan at 101 percent of the Federal Poverty Level, each would be required to pay no more than $13 per month for their individual coverage (or $26 per month for the household). This modification is intended to align the amounts contributed by the household more closely with that of the federal exchange as well as existing regulatory limits on household cost-sharing.

The MI Health Account vendor will calculate the required contribution amount and communicate this to the beneficiary, along with instructions for payment, as part of the MI Health Account quarterly statement.

IV. Impact of Healthcare Services Received on the MI Health Account

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

- For individuals at or below 100 percent of the Federal Poverty Level, because co-pays will not accumulate in the account, the health plans will be responsible for payment of all health plan covered services.

- For individuals above 100 percent of the Federal Poverty Level (who make additional monthly contributions to the account), the health plan may utilize beneficiary funds from the MI Health Account once the beneficiary has received a certain amount and type of health care services.

    - This means that the amount the health plans must pay before tapping beneficiary contributions will vary from beneficiary to beneficiary based on his or her annual contribution amount.
    - The amount of health plan responsibility for these beneficiaries will be based on the following formula:

$1000 – (amount of beneficiary's annual contribution) =

Health Plan "First Dollar" Coverage Amount

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

Health Account vendor will determine the amount of MI Health Account funds, if any, that may be used to offset the cost of certain services covered by the health plan.

A beneficiary has a monthly contribution requirement of $25, which he remits as required. The beneficiary receives no services for the first 9 months he is in the health plan. Therefore, the beneficiary has contributed $75 (no contributions for the first 6 months, followed by 3 months of contributions) into the MI Health Account and none of those funds have been utilized by the health plan. The beneficiary's total annual contribution is expected to be $300.

In month 10, the beneficiary contracts strep throat and visits his primary care provider for evaluation and treatment. Per the above formula, the health plan will be responsible for payment of the first $700 in services. The cost of the office visit, strep test and antibiotic are less than $700, therefore, the health plan is responsible for the cost of all of those services and may not receive funds from the MI Health Account.

A beneficiary has a monthly contribution requirement of $20, which she remits as required. The beneficiary does not receive any services in the first 9 months she is in the health plan. Therefore, the beneficiary has contributed $60 (no contributions for the first 6 months plus 3 months of contributions) and none of those funds have been utilized by the health plan. The beneficiary's total annual contribution is expected to be $240.

In month 10, the beneficiary develops appendicitis and requires surgery. Per the above formula, the health plan will be responsible for the first $760 in services. The fees for the surgery are more than $760. After the health plan pays for the first $760 of services, it may receive funds from the MI Health Account (in this case, $60). The beneficiary will continue to owe $20 per month until her remaining obligation ($180) is satisfied. In the interim, the health plan will pay the providers involved the remaining fees for the services provided, and may receive the next $180 remitted by the beneficiary.

In addition, as noted above, only services covered by the health plans will impact the MI Health Account. As a result, any items or services that are carved out of the health plans (e.g. psychotropic drugs, PIHP services) will not impact the MI Health Account or be reflected on any account statement. The Department and the contracted health plans identify the services that will be carved-out of the health plan's scope of coverage via the managed care contracts. These contracts are available via the State's website. The MI Health Account statement will also clarify for the beneficiary that the statement may not reflect all health care services that they received (i.e., because the service was confidential, the claim was not submitted or the health plan does not cover the service).

The following scenario illustrates a beneficiary requiring a carved-out service and the cost-sharing impact:

A beneficiary has a monthly contribution of $20, and he pays timely for 3 months (for a total of $60). The beneficiary fills a prescription for a psychotropic drug at his local pharmacy. The beneficiary will be responsible for paying any applicable co-payment for that drug at the pharmacy (point of service). The health plan will not be responsible for payment for the psychotropic drug as this is a service that is carved out from the health plans, and there will be no impact on the MI Health Account as a result. In addition, no funds from the MI Health Account will be distributed to the beneficiary to pay any required co-pay at the point of service.

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

A beneficiary has a monthly contribution of $20, and she pays timely for 3 months (for a total of $60). The following month, the beneficiary has colonoscopy and mammogram screenings that result in fees in excess of $1000. The health plan must pay for these preventive services and may not seek funds from the MI Health Account for those services. The MI Health Account statement will reflect that preventive services are exempt from any cost sharing on the part of the beneficiary.

V. Cost-Sharing Reductions

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

A. Reductions Related to Chronic Conditions

The health plans must waive co-pays if doing so promotes greater access to services that prevent the progression of and complications related to chronic disease, consistent with the following. The Department has provided the plans with lists of conditions and services, which include both diagnosis codes and drug classes, for which co-pays must be waived for all Healthy Michigan Plan beneficiaries. These lists are included as **Appendix 2**. The health plans may suggest additions or revisions to these lists, and the Department will review these suggestions annually. However, any additions must be approved in advance by the Department and shared with the MI Health Account vendor and all other contracted health plans to ensure consistency and appropriate calculation and collection of amounts owed. The Department will continue to engage

stakeholders on this issue and ensure transparency and access to information surrounding these lists, which will include both provider and beneficiary education and outreach, policy bulletins when appropriate and online availability of the lists. Any reductions to the lists must be approved in advance by CMS.

B. Healthy Behavior Cost-Sharing Reductions

1. Co-Pays

Co-pays may also be reduced if a beneficiary engages in certain healthy behaviors, as detailed in the Healthy Behaviors Incentives Operational Protocol. Before co-pays may be reduced, a beneficiary's co-payments must reach a two percent (2%) threshold ~~percentage of the beneficiary's~~ of their income. ~~Beginning on April 1, 2018, co-pay reductions may occur when the following thresholds are reached:~~

- ~~For beneficiaries whose income is between 100% and 133% of the Federal Poverty Level: When annual accumulated co-pays reach three percent (3%) of income;~~

- ~~For beneficiaries whose income is at or below 100% of the Federal Poverty Level: When annual accumulated co-pays reach two percent (2%) of income.~~

The evaluation period for determining whether a beneficiary has satisfied the threshold for co-pay reduction will be the beneficiary's enrollment year. This means that the beneficiary will have one year to make progress toward the threshold of co-payments before that threshold resets. Once the threshold is reached, the reductions will be processed and reflected on the next available MI Health Account statement. Additional information on the criteria for earning these reductions is included in the Healthy Behaviors Incentives Operational Protocol.

2. Contribution Reductions

~~Healthy Michigan Plan beneficiaries may be required to receive services through a Qualified Health Plan (QHP) participating on the federal **market**place or a health plan meeting the criteria for QHP certification, if they do not satisfy the Department's Healthy Behavior Incentives Requirements. These individuals will have a full 12 months of enrollment in a Medicaid health plan to complete the healthy behavior requirements detailed in the Healthy Behaviors Incentives Operational Protocol. During this grace period, contribution amounts will not exceed 2% of income. Contribution reductions for beneficiaries outside of the grace period will occur consistent with the Healthy Behaviors Incentives Operational Protocol.~~

The MI Health Account vendor, with participation by and oversight from the health plans and the Department, is responsible for ensuring that the calculation and collection of all cost-sharing amounts is performed in

accordance with the Healthy Behaviors Incentives Operational Protocol with respect to the waiver or reduction of any required cost sharing. This includes, but is not limited to, the existence of appropriate interfaces between the Department, the health plans and the MI Health Account vendor to transmit account information, encounter data and any other beneficiary information necessary to provide an accurate accounting of amounts due, received and expended from the MI Health Account. See the Healthy Behaviors Incentives Operational Protocol for further information.

C. Cost Sharing Reduction Changes - Post 48 Months Cumulative Enrollment

1. Beneficiaries with an income at or below 100% of the FPL

   HMP beneficiaries who are at or below 100% of the FPL will continue to have eligibility coverage and cost-sharing responsibilities consistent with the process outlined in the Healthy Michigan Healthy Behaviors Incentives Protocol. No changes post 48 months cumulative enrollment will impact this population.

2. Beneficiaries with an income between 100% and 133% of the FPL:

   After 48 months of HMP Eligibility Coverage

   In order to maintain eligibility for HMP, individuals with an income between 100% and 133% of the FPL who have had 48 months of cumulative eligibility coverage must:

   - Complete or commit to an annual healthy behavior with effort given to making the healthy behaviors in subsequent years incrementally more challenging; and
   - Pay a premium of 5% of their income (no copays required), not to exceed limits defined in 42 CFR 447.56(f).

   After 48 months of cumulative HMP eligibility coverage, beneficiaries will not be eligible for any cost-sharing reductions, and their MIHA will no longer be utilized for cost-sharing liabilities.

3. Suspension of Coverage and Additional Provisions

   Beneficiaries above 100% of the FPL who have not met the program's healthy behavior or cost-sharing requirements will have their coverage under HMP suspended consistent with the HMP waiver renewal amendment as approved by CMS. Beneficiaries will be notified of this action 60 days before the end of their 48th month. Beneficiaries described in 42 CFR 440.315 will be exempt from the 48 months cumulative enrollment suspension of coverage and from the 5% premiums provision.

VI. Account Administration

The health plans, the MI Health Account vendor and the Department are jointly responsible for ensuring that procedures and system requirements are in place to ensure appropriate account functions, consistent with the following:

- Interest on account balances is not required.

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

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

- When the beneficiary is no longer eligible for the Healthy Michigan Plan, the balance of any funds contributed by the beneficiary will be issued to the beneficiary, after a 120-day claims run-off period, for the purchase of private health insurance coverage. The vendor will utilize information provided via the Department's claims and eligibility systems, along with its own account expenditure information, to determine whether or not a beneficiary qualifies for a voucher.

- The MI Health Account vendor must modify the amount of required cost sharing if the beneficiary reports a change in income, and communicate any changes in amounts owed to the beneficiary, the health plan and the Department, as appropriate. Beneficiaries are required to notify their Department of Health and Human Services specialist of any changes, and are made aware of this requirement in both the rights and responsibilities section of the beneficiary handbook, communications from the Department and the MI Health Account statement. The Department is the system of record for these changes, and the MI Health Account vendor will make adjustments as needed via information received from the Department's eligibility system.

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

- The MI Health Account vendor will be responsible for the transfer of funds and appropriate credit and debit information in the event a beneficiary changes plans.

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

- No interest may be charged to the beneficiary on accrued copay or contribution liabilities. Beneficiary consequences for failure to pay are described in this Operational Protocol and may not include loss of eligibility, enrollment or access to services.

- Any amounts remaining in the account after the first year will not offset the beneficiary's contribution requirement for the next year. In addition, the amount that must be covered by the health plan as 'first dollar' will decrease in each subsequent enrollment year when beneficiary contributions remain in the account. For example, if a beneficiary contributes $250 in the first year and this amount rolls over to the next year, in year 2, the beneficiary will contribute $250 and the health plan will be responsible for the first *$500* in services (consistent with the framework described herein).

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

- The MI Health Account vendor must provide multiple options for the beneficiary to remit co-pays and contributions due. These options must include, at a minimum check, money order, electronic transfer (e.g. Automated Clearing House or ACH), and may include other payments through a designated partner such as Western Union, Walmart or Meijer. Any such partner must be free or low cost and prior approved by the Department.

- Months 7-18 of enrollment in a health plan will constitute the first year for MI Health Account accounting purposes.

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

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

- After 48 months of cumulative HMP eligibility coverage, beneficiaries will not be eligible for any cost sharing reductions and their MI Health Account will no longer be utilized for cost sharing liabilities.

The Department will monitor both the health plans and the MI Health Account vendor for compliance with the above requirements.

VII. Beneficiary and Provider Engagement

A. Beneficiaries

1. MI Health Account Statements

A primary method of increasing awareness of health care costs and promoting consumer engagement in this population will be through the use of a quarterly MI Health Account Statement. These MI Health Account statements will be easy to understand and drafted at the appropriate grade reading level and will reflect the principles outlined in this Operational Protocol, as well as the Healthy Behaviors Incentives Operational Protocol when applicable.

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

- MI Health Account balance
- Expenditures by the health plan for covered services over the past three months
- Co-pay amount due for next three months
- Co-pays collected in previous three months
- Past due amounts
- Contribution amount due for the next three months
- Contributions collected in previous three months
- Reduction to co-pays applied when calculating the amount due for the next three months due to beneficiary compliance with healthy behaviors (as applicable)
- Reduction to contributions applied when calculating the amount owed due to beneficiary compliance with healthy behaviors (as applicable)

- An appropriate subset of encounter-level information regarding services received, including (but not limited to) the following:
  - A description of the procedure, drug or service received
  - Date of service
  - Co-payment amount assigned to that service
  - Provider information
  - Amount paid for the service

The MI Health Account statement must contain the above information, and be in a form and format approved by the Department, in consultation with CMS. Hard copies of these statements must be sent to beneficiaries through U.S. mail on a quarterly basis, though beneficiaries may elect to receive electronic statements as approved by the Department. In terms of expenditure information, the MI Health Account statement will reflect only those services provided by the health plans and will only share utilization details consistent with privacy and confidentiality laws and regulations. The MI Health Account statement will also include information for beneficiaries on what to do if they have questions or concerns about the services or costs shown on the statement. Beneficiaries will also have the option to utilize the health plan's grievance process, as appropriate. Additional detail regarding beneficiary rights in this regard is contained in Section X.

2. Beneficiary Education

Both the health plans and the MI Health Account vendor will be responsible for beneficiary education regarding the role of the MI Health Account and the beneficiary's cost-sharing responsibilities. While the MI Health Account statements are designed to provide beneficiaries with information on health care costs and related financial responsibilities, it is important that the beneficiary also receive information that helps them become a more informed health care consumer.

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

The MI Health Account vendor will be responsible for providing sufficient staffing and other administrative support to handle beneficiary questions regarding the MI Health Account, and will be obligated to educate beneficiaries (via in person, telephone, written or electronic communication) regarding these topics. This education must include information on how to use the statements and

make required contributions and co-pays, and address any questions or complaints regarding the beneficiary's use of the MI Health Account. The health plans are responsible for providing members with handbooks that include information about the Healthy Michigan Plan generally, including the MI Health Account and its cost-sharing mechanism. Finally, the Department will work with the health plans and the provider community to ensure that information on potential cost-sharing amounts is provided to the beneficiary at the point of service.

B. Providers

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

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

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

C. Ongoing Strategy

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

The Department will also continue to elicit feedback from the health plans, providers, beneficiaries and other stakeholders about the MI Health Account. Account operations information will be shared and/or discussed, as appropriate, with various stakeholders, including the Medical Care Advisory Council, the Michigan Association of Health Plans, the Michigan State Medical Society and the health plans themselves. The Department meets with the Medical Care Advisory Council and the Michigan State Medical Society quarterly, and the health plans and their trade association generally on a monthly basis. Stakeholder input will be considered for any program changes, and feedback will be accepted on an ongoing basis via the Department's dedicated Healthy Michigan Plan email address.

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

VIII. Consequences

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

In addition to the consequences described herein, the Department may limit potential reductions for those who fail to pay required cost-sharing (as this consequence is required by State law). Information on the impact of these consequences on any cost-sharing reductions is included in the Healthy Behaviors Incentives Operational Protocol.

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

In addition, State law requires the Department to work with the State's Department of Treasury to offset state tax returns, and access lottery winnings when applicable, for beneficiaries who consistently fail to meet payment obligations. The Department has a formal arrangement with the Department of Treasury to pursue a state tax return offset for individuals who fail to pay required cost-sharing and have not responded to the messaging strategy outlined above**.** The Department is also considering additional

methods for pursuing these funds, including through its internal collection and program support process. All beneficiaries will have access to due process, prior to the initiation of any tax offset process, and these debts will not be reported to credit reporting agencies. The health plans may receive recovered funds, but only to the extent that the plan would have been entitled had the beneficiary paid as required. All other funds recovered will revert to the State. The Department also plans to allow the health plans to pursue additional beneficiary consequences for non-payment, consistent with the State law authorizing the creation of the Healthy Michigan Plan, subject to formal approval prior to any implementation. However, loss of eligibility, denial of enrollment in a health plan, or denial of services is not permitted.

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

IX. Reporting Requirements

Both the health plans and the MI Health Account vendor are required to develop, generate and distribute reports to the Department, and make information available to each other as necessary to support the functioning of the MI Health Account, both as specified in this Operational Protocol, and upon the Department's request. The following information is available and shared as described herein:

- The health plans, in cooperation with the MI Health Account vendor, must provide to the Department an accounting for review to verify that the MI Health Account function is operating in accordance with this Operational Protocol; and

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

X. Grievances and Appeals

Healthy Michigan Plan beneficiaries will have the opportunity to contest various facets of the MI Health Account function through the relevant processes operated by the health plans, and the Department when appropriate, consistent with federal law and regulation and this operational protocol. Any dispute regarding the receipt of services (as shown on the MI Health Account statement) must be pursued through the relevant health plan and will be treated as a grievance, while any action taken by the health plans that serves to limit access to covered services would be considered an adverse action and entitle the beneficiary to the full complement of appeal rights permitted by law and/or contract.

Disputes regarding increases in cost-sharing amounts (outside of the variances in the average monthly co-pay experience described herein) will be investigated by the Department, in cooperation with the MI Health Account vendor, with right to a Medicaid Fair Hearing. Other concerns or complaints associated with the operation of the MI Health Account will be addressed by the Department, with the assistance of the MI Health Account vendor. The Department will provide beneficiaries with information on the appeals process for cost-sharing changes associated with the MI Health Account, as well as general information on how to address complaints or other concerns.

The health plans are required by contract to inform beneficiaries of the grievance and appeals process at the time of enrollment, any time an enrollee files a grievance, and any time the plan takes an action that would entitle the beneficiary to appeal rights. Health plan member handbooks also contain instructions on how to file a grievance.