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State/Territory Name: MI

State Plan Amendment (SPA) #: 13-0016

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Chicago Regional Office
233 N. Michigan
Suite 600
Chicago, Illinois 60601

August 11, 2016

Chris Priest
Medical Services Administration
Michigan Department of Health and Human Services
400 South Pine Street, P.O. Box 30479
Lansing, Michigan 48909-7979

ATTN: Erin Black

Dear Mr. Priest:

Enclosed for your records is an approved copy of the following State Plan Amendment:

- Transmittal #: 13-0016 Cost Sharing
- Effective Date: January 1, 2014

If you have any questions, please contact Keri Toback at (312) 353-1754 or keri.toback@cms.hhs.gov.

Sincerely,

/s/
Ruth A. Hughes
Associate Regional Administrator
Division of Medicaid & Children's Health Operations

cc: Erin Black, MDHHS

Medicaid Premiums and Cost Sharing: Summary Page (CMS 179)

State/Territory name: **Michigan**

Transmittal Number:

Please enter the Transmittal Number (TN) in the format ST-YY-0000 where ST= the state abbreviation, YY = the last two digits of the submission year, and 0000 = a four digit number with leading zeros. The dashes must also be entered.

MI-13-0016

Proposed Effective Date

01/01/2014 *(mm/dd/yyyy)*

Federal Statute/Regulation Citation

42 CFR 447.56

Federal Budget Impact

	Federal Fiscal Year	Amount
First Year	2014	$62000.00
Second Year	2015	$83000.00

Subject of Amendment

This State Plan Amendment (SPA) is being submitted to exempt certain groups from Medicaid Copayment responsibilities. The original submission date was 12/30/13. In addition, the SPA addresses general cost sharing provisions. Note that the effective date for some provisions may be different from that proposed above and, if so, the date is noted within the template.

Governor's Office Review

- ○ **Governor's office reported no comment**
- ○ **Comments of Governor's office received**
  Describe:
- ○ **No reply received within 45 days of submittal**
- ◉ **Other, as specified**
  Describe:
  Chris Priest, Director
  Medical Services Administration
  Michigan Department of Community Health

Signature of State Agency Official

Submitted By:	**Erin Black**
Last Revision Date:	**Aug 10, 2016**
Submit Date:	**May 17, 2016**

DATE RECEIVED: May 17, 2016	DATE APPROVED: August 11, 2016
PLAN APPROVED – ONE COPY ATTACHED	
EFFECTIVE DATE OF APPROVED MATERIAL: January 1, 2014	SIGNATURE OF REGIONAL OFFICIAL: /s/
TYPED NAME: Ruth A. Hughes	TITLE: Associate Regional Administrator
REMARKS:	

Medicaid Premiums and Cost Sharing

State Name: Michigan

OMB Control Number: 0938-1148

Transmittal Number: MI - 13 - 0016

Expiration date: 10/31/2014

Cost Sharing Requirements — G1

1916
1916A
42 CFR 447.50 through 447.57 (excluding 447.55)

The state charges cost sharing (deductibles, co-insurance or co-payments) to individuals covered under Medicaid. Yes

☑ The state assures that it administers cost sharing in accordance with sections 1916 and 1916A of the Social Security Act and 42 CFR 447.50 through 447.57.

General Provisions

☑ The cost sharing amounts established by the state for services are always less than the amount the agency pays for the service.

■ No provider may deny services to an eligible individual on account of the individual's inability to pay cost sharing, except as elected by the state in accordance with 42 CFR 447.52(e)(1).

■ The process used by the state to inform providers whether cost sharing for a specific item or service may be imposed on a beneficiary and whether the provider may require the beneficiary to pay the cost sharing charge, as a condition for receiving the item or service, is (check all that apply):

☒ The state includes an indicator in the Medicaid Management Information System (MMIS)

☒ The state includes an indicator in the Eligibility and Enrollment System

☒ The state includes an indicator in the Eligibility Verification System

☐ The state includes an indicator on the Medicaid card, which the beneficiary presents to the provider

☐ Other process

■ Contracts with managed care organizations (MCOs) provide that any cost-sharing charges the MCO imposes on Medicaid *enrollees are in accordance with the cost sharing specified in the state plan and the requirements set forth in 42 CFR 447.50* through 447.57.

Cost Sharing for Non-Emergency Services Provided in a Hospital Emergency Department

The state imposes cost sharing for non-emergency services provided in a hospital emergency department. Yes

☑ The state ensures that before providing non-emergency services and imposing cost sharing for such services, that the hospitals providing care:

■ Conduct an appropriate medical screening under 42 CFR 489.24, subpart G to determine that the individual does not need emergency services;

■ Inform the individual of the amount of his or her cost sharing obligation for non-emergency services provided in the emergency department;

■ Provide the individual with the name and location of an available and accessible alternative non-emergency services provider;

- ▣ Determine that the alternative provider can provide services to the individual in a timely manner with the imposition of a lesser cost sharing amount or no cost sharing if the individual is otherwise exempt from cost sharing; and
- ▣ Provide a referral to coordinate scheduling for treatment by the alternative provider.

☑ The state assures that it has a process in place to identify hospital emergency department services as non-emergency for purposes of imposing cost sharing. This process does not limit a hospital's obligations for screening and stabilizing treatment of an emergency medical condition under section 1867 of the Act; or modify any obligations under either state or federal standards relating to the application of a prudent-layperson standard for payment or coverage of emergency medical services by any managed care organization.

The process for identifying emergency department services as non-emergency for purposes of imposing cost sharing is:

The State defines non-emergency services consistent with 42 CFR 447.51, as it refers to 42 CFR 438.114 and the prudent layperson standard. With respect to cost-sharing, the State incorporates the requirements of 42 CFR 447.54 into its guidance to providers regarding imposing cost-sharing in the hospital emergency department. The State defers to the medical judgment of health care professionals for determining what is and is not a condition that requires emergency treatment.

The State expects that hospitals providing emergency department services develop cost-sharing and referral policies and procedures that are consistent with the above regulatory requirements and existing policy.

In Michigan, the vast majority of beneficiaries are enrolled in Managed Care Organizations (MCOs). Enrollment in an MCO requires the beneficiary to choose or be assigned a Primary Care Provider (PCP). The State's contracted MCOs are also required to operate clinically supported toll-free assistance lines 24 hours per day, which may facilitate referrals or assist with care coordination with the beneficiary's assigned PCP. Hospitals may also refer beneficiaries to nearby Federally Qualified Health Centers or Rural Health Clinics, as the State has a robust network of these providers and many offer extended hours and can accommodate timely follow-up for non-emergency care.

The State will perform outpatient post-payment reviews per published Medicaid hospital policy to assess provider compliance with the requirements.

Beneficiaries may call the beneficiary help line and submit a beneficiary complaint form to report any inappropriate charges for cost sharing. All complaints received are investigated. Upon completion of an investigation, a response is mailed to the beneficiary that includes the findings of the investigation, the beneficiary's hearing rights and how the beneficiary can request an administrative hearing before an administrative law judge if they do not agree with the findings of the investigation.

Cost Sharing for Drugs

The state charges cost sharing for drugs. Yes

The state has established differential cost sharing for preferred and non-preferred drugs. Yes

- ▣ The state identifies which drugs are considered to be non-preferred.
- ☑ The state assures that it has a timely process in place to limit cost sharing to the amount imposed for a preferred drug in the case of a non-preferred drug within a therapeutically equivalent or similar class of drugs, if the individual's prescribing provider determines that a preferred drug for treatment of the same condition either will be less effective for the individual, will have adverse effects for the individual, or both. In such cases, reimbursement to the pharmacy is based on the appropriate cost sharing amount.

Beneficiary and Public Notice Requirements

☑ Consistent with 42 CFR 447.57, the state makes available a public schedule describing current cost sharing requirements in a manner that ensures that affected applicants, beneficiaries and providers are likely to have access to the notice. Prior to submitting a SPA which establishes or substantially modifies existing cost sharing amounts or policies, the state provides the public with advance notice of the SPA, specifying the amount of cost sharing and who is subject to the charges, and provides reasonable opportunity for stakeholder comment. Documentation demonstrating that the notice requirements have been met are submitted with the SPA. The state also provides opportunity for additional public notice if cost sharing is substantially modified during the SPA approval process.

Other Relevant Information

PRA Disclosure Statement

V 20140415

Medicaid Premiums and Cost Sharing

State Name: Michigan

OMB Control Number: 0938-1148

Transmittal Number: MI - 13 - 0016

Expiration date: 10/31/2014

Cost Sharing Amounts - Categorically Needy Individuals — G2a

1916
1916A
42 CFR 447.52 through 54

The state charges cost sharing to all categorically needy (Mandatory Coverage and Options for Coverage) individuals. Yes

Services or Items with the Same Cost Sharing Amount for All Incomes

	Service or Item	Amount	Dollars or Percentage	Unit	Explanation	
+	Physician Office Visit	2.00	$	Visit		X
+	Outpatient Hospital Clinic Visit	1.00	$	Visit		X
+	Emergency Room visit for Non-Emergency Service	3.00	$	Visit		X
+	Inpatient Hospital Stay	50.00	$	Entire Stay	No co-payment for emergent admissions.	X
+	Chiropractic Visit	1.00	$	Visit		X
+	Dental visit	3.00	$	Visit		X
+	Podiatric Visit	2.00	$	Visit		X
+	Vision Visit	2.00	$	Visit		X
+	Hearing Aids	3.00	$	Item		X
+	Pharmacy, Preferred Drug	1.00	$	Prescription		X
+	Pharmacy, Non-Preferred Drug	3.00	$	Prescription		X
+	Urgent Care Center	2.00	$	Visit		X

Services or Items with Cost Sharing Amounts that Vary by Income

Service or Item:

Remove Service or Item

Indicate the income ranges by which the cost sharing amount for this service or item varies.

	Incomes Greater than	Incomes Less than or Equal to	Amount	Dollars or Percentage	Unit	Explanation	
+							X

Add Service or Item

Cost Sharing for Non-preferred Drugs Charged to Otherwise Exempt Individuals

If the state charges cost sharing for non-preferred drugs (entered above), answer the following question:

The state charges cost sharing for non-preferred drugs to otherwise exempt individuals.	No

Cost Sharing for Non-emergency Services Provided in the Hospital Emergency Department Charged to Otherwise Exempt Individuals

If the state charges cost sharing for non-emergency services provided in the hospital emergency department (entered above), answer the following question:

The state charges cost sharing for non-emergency services provided in the hospital emergency department to otherwise exempt individuals.	No

PRA Disclosure Statement

V 20140415

Medicaid Premiums and Cost Sharing

State Name: Michigan

Transmittal Number: MI - 13 - 0016

OMB Control Number: 0938-1148

Expiration date: 10/31/2014

Cost Sharing Amounts - Medically Needy Individuals	G2b
1916 1916A 42 CFR 447.52 through 54	
The state charges cost sharing to all medically needy individuals.	Yes
The cost sharing charged to medically needy individuals is the same as that charged to categorically needy individuals.	Yes

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 40 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

V 20140415

Medicaid Premiums and Cost Sharing

State Name: Michigan

OMB Control Number: 0938-1148

Transmittal Number: MI - 13 - 0016

Expiration date: 10/31/2014

Cost Sharing Amounts - Targeting,	G2c
1916 1916A 42 CFR 447.52 through 54	
The state targets cost sharing to a specific group or groups of individuals.	No

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 40 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

V 20140415

Medicaid Premiums and Cost Sharing

State Name: Michigan

OMB Control Number: 0938-1148

Transmittal Number: MI - 13 - 0016

Expiration date: 10/31/2014

Cost Sharing Limitations — G3

42 CFR 447.56
1916
1916A

☑ The state administers cost sharing in accordance with the limitations described at 42 CFR 447.56, and 1916(a)(2) and (j) and 1916A(b) of the Social Security Act, as follows:

Exemptions

Groups of Individuals - Mandatory Exemptions

The state may not impose cost sharing upon the following groups of individuals:

- ■ Individuals ages 1 and older, and under age 18 eligible under the Infants and Children under Age 18 eligibility group (42 CFR 435.118).
- ■ Infants under age 1 eligible under the Infants and Children under Age 18 eligibility group (42 CFR 435.118), whose income does not exceed the higher of:
  - ■ 133% FPL; and
  - ■ If applicable, the percent FPL described in section 1902(l)(2)(A)(iv) of the Act, up to 185 percent.
- ■ Disabled or blind individuals under age 18 eligible for the following eligibility groups:
  - ■ SSI Beneficiaries (42 CFR 435.120).
  - ■ Blind and Disabled Individuals in 209(b) States (42 CFR 435.121).
  - ■ Individuals Receiving Mandatory State Supplements (42 CFR 435.130).
- ■ Children for whom child welfare services are made available under Part B of title IV of the Act on the basis of being a child in foster care and individuals receiving benefits under Part E of that title, without regard to age.
- ■ Disabled children eligible for Medicaid under the Family Opportunity Act (1902(a)(10)(A)(ii)(XIX) and 1902(cc) of the Act).
- ■ Pregnant women, during pregnancy and through the postpartum period which begins on the last day of pregnancy and extends through the end of the month in which the 60-day period following termination of pregnancy ends, except for cost sharing for services specified in the state plan as not pregnancy-related.
- ■ Any individual whose medical assistance for services furnished in an institution is reduced by amounts reflecting available income other than required for personal needs.
- ■ An individual receiving hospice care, as defined in section 1905(o) of the Act.
- ■ Indians who are currently receiving or have ever received an item or service furnished by an Indian health care provider or through referral under contract health services.
- ■ Individuals who are receiving Medicaid because of the state's election to extend coverage to the Certain Individuals Needing Treatment for Breast or Cervical Cancer eligibility group (42 CFR 435.213).

Groups of Individuals - Optional Exemptions

The state may elect to exempt the following groups of individuals from cost sharing:

The state elects to exempt individuals under age 19, 20 or 21, or any reasonable category of individuals 18 years of age or over. Yes

Indicate below the age of the exemption:

- ○ Under age 19
- ○ Under age 20
- ○ Under age 21
- ◉ Other reasonable category

Description:

• The state elects to exempt individuals under the age of 21 from cost sharing.

• The State elects to exempt individuals dually eligible for Medicaid and Children's Special Health Care Services from cost-sharing. Individuals age 21 and over may be covered by this exemption due to their complex, chronic health conditions.

NOTE: The exemption for Native American/Alaska Natives is effective 10/1/15. The exemption for individuals who are receiving Medicaid because of the state's election to extend coverage to the Certain Individuals Needing Treatment for Breast or Cervical Cancer eligibility group is effective 1/1/14.

The state elects to exempt individuals whose medical assistance for services furnished in a home and community-based setting is reduced by amounts reflecting available income other than required for personal needs. No

Services - Mandatory Exemptions

The state may not impose cost sharing for the following services:

- ☑ Emergency services as defined at section 1932(b)(2) of the Act and 42 CFR 438.114(a).
- ☑ Family planning services and supplies described in section 1905(a)(4)(C) of the Act, including contraceptives and pharmaceuticals for which the state claims or could claim federal match at the enhanced rate under section 1903(a)(5) of the Act for family planning services and supplies.
- ☑ Preventive services, at a minimum the services specified at 42 CFR 457.520, provided to children under 18 years of age regardless of family income, which reflect the well-baby and well child care and immunizations in the Bright Futures guidelines issued by the American Academy of Pediatrics.
- ☑ Pregnancy-related services, including those defined at 42 CFR 440.210(a)(2) and 440.250(p), and counseling and drugs for cessation of tobacco use. All services provided to pregnant women will be considered pregnancy-related, except those services specificially identified in the state plan as not being related to pregnancy.
- ☑ Provider-preventable services as defined in 42 CFR 447.26(b).

Enforceability of Exemptions

The procedures for implementing and enforcing the exemptions from cost sharing contained in 42 CFR 447.56 are (check all that apply):

- [■] To identify that American Indians/Alaskan Natives (AI/AN) are currently receiving or have ever received an item or service furnished by an Indian health care provider or through referral under contract health services in accordance with 42 CFR 447.56(a)(1)(x), the state uses the following procedures:
  - [☒] The state accepts self-attestation
  - [ ] The state runs periodic claims reviews
  - [ ] The state obtains an Active or Previous User Letter or other Indian Health Services (IHS) document
  - [☒] The Eligibility and Enrollment and MMIS systems flag exempt recipients
  - [ ] Other procedure

  Additional description of procedures used is provided below (optional):

  The State accepts self-attestation as part of the application process. The application for health care coverage asks American Indian/Alaska Natives sufficient information to determine whether the regulatory exemptions apply.

- [■] To identify all other individuals exempt from cost sharing, the state uses the following procedures (check all that apply):
  - [☒] The MMIS system flags recipients who are exempt
  - [☒] The Eligibility and Enrollment System flags recipients who are exempt
  - [ ] The Medicaid card indicates if beneficiary is exempt
  - [☒] The Eligibility Verification System notifies providers when a beneficiary is exempt
  - [ ] Other procedure

  Additional description of procedures used is provided below (optional):

Payments to Providers

- [☑] The state reduces the payment it makes to a provider by the amount of a beneficiary's cost sharing obligation, regardless of whether the provider has collected the payment or waived the cost sharing, except as provided under 42 CFR 447.56(c).

Payments to Managed Care Organizations

The state contracts with one or more managed care organizations to deliver services under Medicaid. Yes

- [☑] The state calculates its payments to managed care organizations to include cost sharing established under the state plan for beneficiaries not exempt from cost sharing, regardless of whether the organization imposes the cost sharing on its recipient members or the cost sharing is collected.

Aggregate Limits

☑ Medicaid premiums and cost sharing incurred by all individuals in the Medicaid household do not exceed an aggregate limit of 5 percent of the family's income applied on a quarterly or monthly basis.

■ The percentage of family income used for the aggregate limit is:

- ◉ 5%
- ○ 4%
- ○ 3%
- ○ 2%
- ○ 1%
- ○ Other: [ ] %

■ The state calculates family income for the purpose of the aggregate limit on the following basis:

- ◉ Quarterly
- ○ Monthly

The state has a process to track each family's incurred premiums and cost sharing through a mechanism that does not rely on beneficiary documentation. Yes

■ Describe the mechanism by which the state tracks each family's incurred premiums and cost sharing (check all that apply):

☐ As claims are submitted for dates of services within the family's current monthly or quarterly cap period, the state applies the incurred cost sharing for that service to the family's aggregate limit. Once the family reaches the aggregate limit, based on incurred cost sharing and any applicable premiums, the state notifies the family and providers that the family has reached their aggregate limit for the current monthly or quarterly cap period, and are no longer subject to premiums or cost sharing.

☐ Managed care organization(s) track each family's incurred cost sharing, as follows:

☒ Other process:

Effective 1/1/16, the State's MMIS system is responsible for tracking incurred premiums and cost-sharing toward the family's aggregate limit as claims are adjudicated and other premiums and cost-sharing are incurred. This includes premiums and cost-sharing associated with the Healthy Michigan Plan, as well as the adjudication (and attendant tracking) of Fee-for-Service claims and the exchange of information with other vendors, such as the State's Pharmacy Benefits Manager and Healthy Michigan Plan vendor, regarding costs incurred. Once the limit is met, the MMIS system will indicate as such and notification will occur as described below.

NOTE: MIChild premiums may only be charged to families between 160% and 212% of the FPL and there are no co-payments. The only other eligibility group within this FPL range in the State is for pregnant women. The State does not charge premiums to pregnant women and pregnancy related services have no copays. Therefore, the State anticipates the only Medicaid cost sharing in a CHIP household would be the $10 per family per month premium, and is not tracking of the 5% aggregate limit for CHIP households.

☑ Describe how the state informs beneficiaries and providers of the beneficiaries' aggregate family limit and notifies beneficiaries and providers when a beneficiary has incurred premiums and cost sharing up to the aggregate family limit and individual family members are no longer subject to premiums or cost sharing for the remainder of the family's current monthly or quarterly cap period:

Notice #1: New Beneficiaries

The State will provide an initial written notice to affected beneficiaries who are newly eligible. This notice will describe the quarterly aggregate limit and how it impacts the cost-sharing incurred by their household, and will include an estimated quarterly aggregate limit for the upcoming year. This notice will also explain that beneficiaries are not responsible for tracking costs and will inform them that once the aggregate limit is met, they are no longer subject to cost-sharing for the remainder of the relevant quarter. Finally, this notice will inform beneficiaries of the range of options they may use to access or receive the most up to date information on the quarterly cap amount, progress toward that cap and any modifications to the amount, so that they can select the option that works best for them. The options for beneficiaries to choose from include the following:

(1) Toll-free telephone access to this information through the State's beneficiary helpline. This includes an option for individuals who are hearing impaired. (2) Online (or smartphone) access as part of the State's innovative beneficiary portal. The myHealthButton is a mobile application that can be used from a smartphone and the myHealthPortal is an online application that can be used from any device with internet access. These applications allow members to access information about their health care benefits and services, including cost-sharing information, with email notifications tied to when the cost-sharing limit is met.

Beneficiaries are also informed that providers will have cost-sharing information available at the point of service to ensure that charges are not incurred in excess of the limit. Finally, this notice provides information on the beneficiary's right to request a reassessment of the aggregate limit.

Notice #2: Existing Beneficiaries

Affected beneficiaries will be provided written notice on an annual basis. This notice will include an estimated quarterly aggregate limit for the upcoming year. If a beneficiary has met his or her aggregate limit at any time in the past year, this will also be included on the notice. The notice will remind beneficiaries of the options for accessing the most up to date information regarding their quarterly cap amount, including calls to the State's beneficiary help line prior to accessing health care if they choose. The options available are described in Notice #1.

Cost-sharing information will be available to providers in the State's MMIS system. Once the aggregate limit is reached, an indicator will appear in the State's MMIS system that beneficiaries will be exempt from cost-sharing for the remainder of the quarter. Providers will also be able to notify beneficiaries that this cost-sharing has been met, and the State's contracted health plans will also receive cost-sharing information.

The state has a documented appeals process for families that believe they have incurred premiums or cost sharing over the aggregate limit for the current monthly or quarterly cap period. Yes

Describe the appeals process used:

The State has a process in place for beneficiary complaints and requests for further review. Beneficiaries who believe that they have incurred cost sharing in excess of the aggregate limit will be entitled to utilize this process as appropriate.

☒ Describe the process used to reimburse beneficiaries and/or providers if the family is identified as paying over the aggregate limit for the month/quarter:

Providers will be responsible for facilitating any refunds for beneficiaries who have exceeded the aggregate limit for the quarter. The remittance advice will inform the provider whether or not a copay was ultimately deducted from the payment amount at the time of adjudication, and direct the provider to refund the beneficiary when appropriate.

☒ Describe the process for beneficiaries to request a reassessment of their family aggregate limit if they have a change in circumstances or if they are being terminated for failure to pay a premium:

Beneficiaries will follow the existing process as described above. Beneficiaries are currently obligated to report changes in income, household and several other circumstances, and may do so online, in person or by phone. The State's MMIS system will also recalculate the aggregate limit in response to reported changes impacting that limit and adjust the cost-sharing indicator as appropriate.

The state imposes additional aggregate limits, consistent with 42 CFR 447.56(f)(5). No

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of MICHIGAN

RESERVED

Citation	4.18	Recipient Cost Sharing and Similar Charges
42 CFR 447.51 thru 447.58	(a)	Unless a waiver under 42 CFR 431.55(g) applies, deductibles, coinsurance rates, and copayments do not exceed the maximum allowable charges under 42 CFR 447.54.
1916(a) and (b) of the Act	(b)	Except as specified in items 4.18(b)(4), (5), and (6) below, with respect to individuals covered as categorically needy or as qualified Medicare beneficiaries (as defined in section 1905(p)(1) of the Act under the plan: (1) No enrollment fee, premium, or similar charge is imposed under the plan. (2) No deductible, coinsurance, copayment, or similar charge is imposed under the plan for the following: (i) Services to individuals under age 18, or under ☐ Age 19 ☐ Age 20 ☒ Age 21 Reasonable categories of individuals who are 18 or older, but under age 21, to whom charges apply are listed below, if applicable. (ii) Services to pregnant woman related to the pregnancy or any other medical condition that may complicate the pregnancy.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of MICHIGAN

RESERVED

Citation	**4.18(b)(2)**	**(Continued)**
42 CFR 447.51 thru 447.58	(iii)	All services furnished to pregnant woman. ☒ Not applicable. Charges apply for services to pregnant woman unrelated to the pregnancy. (iv) Services furnished to any individual who is an inpatient in a hospital, long-term care facility, or other medical institution, if the individual is required, as a condition of receiving services in the institution to spend for medical care costs all but a minimal amount of his or her income required for personal needs. (v) Emergency services if the services meet the requirements in 42 CFR 447.53(b)(4). (vi) Family planning services and supplies furnished to individuals of childbearing age. (vii) Services furnished by a managed care organization, health insuring organization prepaid inpatient health plan, or prepaid ambulatory health plan in which the individual is enrolled, unless they meet the requirements of 42 CFR 447.60.
42 CFR 438.108 42 CFR 447.60		☒ Managed care enrollees are charged deductibles, coinsurance rates, and copayments in an amount equal to the State Plan cost sharing. ☐ Managed care enrollees are not charged deductibles, coinsurance rates, and copayments.
1916 of the Act, P.L. 99-272, (Section 9505)	(viii)	Services furnished to an individual receiving hospice care, as defined in section 1905(o) of the Act.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of MICHIGAN

RESERVED

~~Citation~~ ~~4.18(b)~~ ~~(Continued)~~

~~42 CFR 447.51 thru 447.48~~

~~(3) Unless a waiver under 42 CFR 431.55(g) applies, nominal deductible, coinsurance, copayment, or similar charges are imposed for services that are not excluded from such charges under item (b) (2) above.~~

☐ ~~Not applicable. No such charges are imposed.~~

~~(i) For any service, no more than one type of charge is imposed.~~

~~(ii) Charges apply to services furnished to the following age groups:~~

- ☐ ~~18 or older~~
- ☐ ~~19 or older~~
- ☐ ~~20 or older~~
- ☒ ~~21 or older~~

☐ ~~Charges apply to services furnished to the following reasonable categories of individuals listed below who are 18 years of age or older but under the age 21.~~

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of MICHIGAN

RESERVED

~~Citation~~	~~4.18(b)(3)~~	~~(Continued)~~
~~42 CFR 447.51 thru 447.58~~	~~(iii)~~	~~For the categorically needy and qualified Medicare beneficiaries, ATTACHMENT 4.18-A specifies the:~~ ~~A. Service(s) for which a charge(s) is applied;~~ ~~B. Nature of the charge imposed on each service~~ ~~C. Amount(s) of the basis for determining the charge(s);~~ ~~D. Method used to collect the charge(s);~~ ~~E. Basis for determining whether an individual is unable to pay the charge and the means by which such an individual is identified to providers;~~ ~~F. Procedures for implementing and enforcing the exclusions from cost sharing contained in 42 CFR 447.53(b); and~~ ~~G. Cumulative maximum that applies to all deductible, coinsurance or copayment charges imposed on a specified time period.~~ ~~Not applicable. There is no maximum.~~

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of MICHIGAN

RESERVED

~~Citation~~ ~~4.18(c)~~ ☒ ~~Individuals are covered as medically needy under the plan.~~

~~42 CFR 447.51 through 447.58~~ ~~(1)~~ ☐ ~~An enrollment fee, premium or similar charge is imposed. ATTACHMENT 4.18-B specifies the amount of and liability period for such charges subject to the maximum allowable charges in 42 CFR 447.52(b) and defines the State's policy regarding the effect on recipients of non-payment of the enrollment fee, premium, or similar charge.~~

~~447.51 through 447.58~~ ~~(2)~~ ~~No deductible, coinsurance, copayment, or similar charge is imposed under the plan for the following:~~

~~(i) Services to individuals under age 18, or under:~~

~~☐ Age 19~~
~~☐ Age 20~~
~~☒ Age 21~~

~~Reasonable categories of individuals who are age 18, but under age 21, to whom charges apply are listed below, if applicable:~~

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of MICHIGAN

RESERVED

~~**Citation**~~ ~~**4.18(c)(2)**~~ ~~**(Continued)**~~

~~42 CFR 447.51 through 447.58~~

~~(ii) Services to pregnant woman related to the pregnancy or any other medical condition that may complicate the pregnancy.~~

~~(iii) All services furnished to pregnant women.~~

~~☒ Not applicable. Charges apply for services to pregnant woman unrelated to the pregnancy.~~

~~(iv) Services furnished to any individual who is an inpatient in a hospital, long-term care facility, or other medical institution, if the individual is required, as a condition of receiving services in the institution, to spend for medical care costs all but a minimal amount of his income required for personal needs.~~

~~(v) Emergency services if the services meet the requirements in 42 CFR 447.53(b)(4).~~

~~(vi) Family planning services and supplies furnished to individuals of childbearing age.~~

~~1916 of the Act, P.L. 99-272 (Section 9505)~~

~~447.51 through 447.58~~

~~(vii) Services furnished to an individual receiving hospice care, as defined in section 1905(o) of the Act.~~

~~(viii) Services provided by a health maintenance organization (HMO) to enrolled individuals.~~

~~☐ Not applicable. No such charges are imposed.~~

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of MICHIGAN

RESERVED

~~Citation~~ ~~4.18(c)(3)~~ ~~Unless a waiver under 42 CFR 431.55(g) applies, nominal deductible, coinsurance, copayment, or similar charges are imposed on services that are not excluded from such charges under item (b)(2) above.~~

~~☐ Not applicable. No such charges are imposed.~~

~~(i) For any service, no more than one type of charge is imposed.~~

~~(ii) Charges apply to services furnished to the follow age group:~~

~~☐ 18 or older~~
~~☐ 19 or older~~
~~☐ 20 or older~~
~~☐ 21 or older~~

~~Reasonable categories of individuals who are 18 years of age, but under 21, to whom charges apply are listed below, if applicable.~~

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of MICHIGAN

RESERVED

~~Citation~~	~~4.18(c)(3)~~	~~(Continued)~~
~~447.51 through 447.58~~	~~(iii)~~	~~For the medically needy, and other optional groups, ATTACHMENT 4.18-C specifies the:~~ ~~A. Service(s) for which charge(s) is applied;~~ ~~B. Nature of the charge imposed on each service;~~ ~~C. Amount(s) of and basis for determining the charge(s);~~ ~~D. Method used to collect the charge(s);~~ ~~E. Basis for determining whether an individual is unable to pay the charge(s) and the means by which such an individual is identified to providers;~~ ~~F. Procedures for implementing and enforcing the exclusion from cost sharing contained in 42 CFR 447.53(b); and~~ ~~G. Cumulative maximum that applies to all deductible, coinsurance, or copayment charges imposed on a family during a specified time period.~~ ~~☒ Not applicable. There is no maximum.~~

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of MICHIGAN

Cost Sharing and Similar Charges

A. The following charges are imposed on the categorically and medically needy for services other than those provided under section 1905 (a)(1) through (5) and (7) of the Act.

Services covered for certain ambulatory beneficiaries age 21 and over:	Type Charge	Amount
	Deduct—Co-insurance—Copay	
Vision Services	X	$2.00 per each reimbursable visit (average payment $27.00).
Dental Services	X	$3.00 per each reimbursable visit (average payment $110.00).
Podiatric Services	X	$2.00 per each reimbursable visit (average payment $32.00).
Hearing Aids	X	$3.00 on each hearing aid (average payment $340.00).
Pharmacy Services Specified by the Department	X	$1.00 for each generic drug (average payment $15.00) and $3.00 for each brand drug (average payment $105.00) dispensed.
Chiropractic Services	X	$1.00 for each reimbursable visit (average payment is $11.00).
Physician Office Visit	X	$2.00 for each reimbursable visit (average payment $35.00)
Hospital Emergency Department Visit	X	$3.00 for each non-emergency reimbursable visit (average payment $70.00)
In-patient Hospital	X	$50.00 for the first day of each reimbursable inpatient hospital stay (average payment $1265)
Out-patient Hospital	X	$1.00 for each reimbursable visit (average payment $18.00)

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of MICHIGAN

Charges Imposed on Categorically and Medically Needy

B. The method used to collect cost sharing charges:

☒ Providers are responsible for collecting the cost sharing charges from individuals.

☐ The agency reimburses providers the full Medicaid rate for a service and collects the cost sharing charges from individuals.

C. The basis for determining whether an individual is unable to pay the charge, and the means by which an individual is identified to providers, is described below:

Providers cannot deny services to beneficiaries unable to pay copayments.

The method for determining whether a beneficiary is unable to pay is the beneficiary's assertion that he or she is unable to pay the co-payment. Any uncollected copayment amount is considered a debt to the provider.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

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D. The procedures for implementing and enforcing the exclusions from cost sharing contained in 42 CFR 447.53(b) are described below:

The Invoice Processing system will not deduct a copayment for any of the exemptions identified below. Additionally, all affected providers have been notified of these exemptions. For all other services where a copayment is involved, the Invoice Processing system will automatically deduct the copayment amount from the provider's claim.

Pregnant Women - All drugs that are specifically identifiable to a pregnant condition are excluded from the copayment policy.

Institutionalized Individuals - All individuals in a long-term care facility are excluded from the copayment policy.

Children - The copayment policy does not apply to individuals under the age of 21 years.

Family Planning - The copayment policy does not apply to family planning drugs and supplies.

Emergency Services - The copayment policy does not apply to emergency services.

Health Maintenance Organization (HMO) Enrollees - HMO enrollees are not charged a copayment by the Medicaid program and the Invoice Processing system is set up to not charge any copayments toward the HMO capitation rate.

E. Cumulative maximums on charges:

☒ State policy does not provide for cumulative maximums.

☐ Cumulative maximums have been established as described below:

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of MICHIGAN

~~A. The following charges are imposed on the medically needy for services:~~

~~Services~~	~~Type Charge Deduct Coins Copay~~	~~Amount and Basis for Determination~~
~~Vision services provided to recipients age 21 and over~~	~~X~~	~~$2.00/each reimbursable visit. The average payment for service for recipients age 21 and over is $27.00.~~
~~Dental services provided to recipients age 21 and over~~	~~X~~	~~$3.00/each reimbursable visit. The average payment for service for recipients age 21 and over is $110.00.~~
~~Podiatric services provided to recipients age 21 and over.~~	~~X~~	~~$2.00/each reimbursable visit. The average payment for services for recipients age 21 and over is $32.~~
~~Hearing aids provided to recipients age 21 and over.~~	~~X~~	~~$3.00 on each hearing aid. The average payment for a hearing aid for recipients age 21 and over is $340.00.~~
~~Pharmacy services specified by the Department for certain ambulatory recipients age 21 and over~~	~~X~~	~~$1.00/each prescription. The average payment for service for recipients age 21 and over is $15.90.~~
~~Chiropractic services provided to recipients 21 and older~~	~~X~~	~~$1.00/each reimbursable visit. The average payment for service for recipients age 21 and over is $11.~~

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of MICHIGAN

B. The method used to collect cost sharing charges for medically needy individuals:

☒ Providers are responsible for collecting the cost sharing charges from individuals.

☐ The agency reimburses providers the full Medicaid rate for services and collects the cost sharing charges from individuals.

C. The basis for determining whether an individual is unable to pay the charge, and the means by which such an individual is identified to providers, is described below:

It is the recipient's responsibility to inform the provider that he or she cannot afford to pay the copayment. The medical providers have been notified through the program's bulletin process that they cannot refuse to treat an individual because of the inability to pay the copayment.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of MICHIGAN

D. The procedures for implementing and enforcing the exclusions from cost sharing contained in 42 CFR 44 7.53(b) are described below:

The Invoice Processing system will not deduct a copayment for any of the exemptions identified below. Additionally, all affected providers have been notified of these exemptions. For all other services where a copayment is involved, the Invoice Processing system will automatically deduct the copayment amount from the provider's claim.

Pregnant Women - All drugs that are specifically identifiable to a pregnant condition are excluded from the copayment policy.

Institutionalized Individuals - All individuals in a long-term care facility are excluded from the copayment policy.

Children - The copayment policy does not apply to individuals under the age of 21 years.

Family Planning - The copayment policy does not apply to family planning drugs and supplies.

Emergency Services - The copayment policy does not apply to emergency services.

Health Maintenance Organization (HMO) Enrollees - HMO enrollees are not charged a copayment by the Medicaid program, and the Invoice Processing system is set up to not charge any copayments toward the HMO capitation rate. However, the HMO may charge a copayment of the same amount as Medicaid or of a lesser amount for the same services that Medicaid is charging a copayment on.

E. Cumulative maximums on charges:

☒ State policy does not provide for cumulative maximums.

☐ Cumulative maximums have been established as described below: