



DEC 30 2013

Administrator
Washington, DC 20201

Mr. Stephen Fitton
Director
Michigan Medical Services Administration
Capitol Commons
400 S. Pine
Lansing, MI 48909

Dear Mr. Fitton:

The Centers for Medicare & Medicaid Services (CMS) is approving Michigan's request to amend the Medicaid demonstration, entitled "Healthy Michigan Section 1115 Demonstration (Project No. 11-W-00245/5)," formerly known as the Medicaid Nonpregnant Childless Adults Waiver [Adult Benefits Waiver (ABW)]. The amendment provides approval for the state to establish and operate the Healthy Michigan program for adults who will become eligible for Medicaid under section 1902(a)(10)(A)(i)(VIII) of the Social Security Act (the Act). Through these demonstrations and associated state plan amendments, effective April 1, 2014, the state will provide Medicaid coverage to all adults in Michigan with incomes up to and including 133 percent of the federal poverty level (FPL). This amendment is approved in accordance with section 1115(a) of the Act, and is effective as of the date of the signed approval through December 31, 2018.

Healthy Michigan will initially provide transitional coverage for beneficiaries served under the ABW demonstration; after the April 1, 2014 implementation of the new adult group, Healthy Michigan will enable the state to design, test and evaluate policy related to cost sharing, premiums and healthy behaviors incentives. On April 1, 2014, existing ABW program participants will transition to Medicaid, and the ABW program will sunset. Beginning April 1, 2014, under the demonstration individuals above 100 percent of the FPL will make premium contributions, and all beneficiaries will be subject to cost sharing at levels consistent with Medicaid requirements.

In addition to approval for the amendment, this letter also provides the annual update to the budget neutrality limit for the ABW program, as required by section 2111(a)(3)(C)(ii) of the Act. This section requires that the budget neutrality limit for each federal fiscal year (FFY) for a Medicaid Non-Pregnant Childless Adult Waiver is determined by increasing the prior year's limit by the percentage increase (if any) in the projected nominal per capita amount of National Health Expenditures (NHE) for the calendar year that begins during the year involved over the preceding calendar year, as most recently published by the Secretary. On September 18, 2013, CMS published new NHE projections, which showed that nominal per capita NHE will increase by 5.2 percent in 2014. Applying this percentage increase to the approved limit for FFY 2013

results in a FFY 2014 (demonstration year 5) annual limit of \$159,737,844 in federal funds. These funds may be used for health services expenditures for ABW enrollees with dates of service through September 30, 2014, although it is anticipated that there will be no dates of service subsequent to the phase-out of the ABW program as of April 1, 2014.

The CMS approval of the demonstration is conditioned upon compliance with the enclosed set of STCs defining the nature, character, and extent of anticipated federal involvement in the project. The award is subject to our receiving your written acknowledgement of the award and acceptance of these STCs within 30 days of the date of this letter. A copy of the STCs, waiver, and expenditure authorities are enclosed.

Your project officer for this demonstration is Kelly Heilman. She is available to answer any questions concerning your section 1115 demonstration, and her contact information is as follows:

Centers for Medicare & Medicaid Services
Center for Medicaid & CHIP Services
Mail Stop: S2-01-16
7500 Security Boulevard
Baltimore, MD 21244-1850
Telephone: (410) 786-1451
E-mail: kelly.heilman@cms.hhs.gov

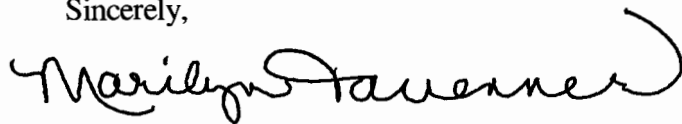
Official communications regarding program matters should be sent simultaneously to Ms. Verlon Johnson, Associate Regional Administrator in our Chicago Regional Office. Ms. Johnson's contact information is as follows:

Ms. Verlon Johnson
Associate Regional Administrator
Centers for Medicare & Medicaid Services
Division of Medicaid and Children Health Operations
233 N. Michigan Avenue, Suite 600
Chicago, IL 60601-5519

If you have questions regarding this approval, please contact Mr. Eliot Fishman, Director, Children and Adults Health Programs Group, Center for Medicaid & CHIP Services, at (410) 786-5647.

Thank you for all your work with us, as well as stakeholders in Michigan, over the past several months on developing this important demonstration, and congratulations on its approval.

Sincerely,



Marilyn Tavenner

Enclosures

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cc: Verlon Johnson, ARA, Chicago Regional Office

**CENTERS FOR MEDICARE & MEDICAID SERVICES
WAIVER LIST**

NUMBER: 11-W-00245/5
TITLE: Healthy Michigan Section 1115 Demonstration
AWARDEE: Michigan Department of Community Health

All requirements of the Medicaid program expressed in law, regulation and policy statement, not expressly waived or identified as not applicable in accompanying expenditure authorities, shall apply to the demonstration project effective December 30, 2013 through December 31, 2018. In addition, these waivers may only be implemented consistent with the approved Special Terms and Conditions (STCs).

Under the authority of section 1115(a)(1) of the Social Security Act (the Act), the following waivers of state plan requirements contained in section 1902 of the Act are granted subject to the STCs for the Michigan Adult Coverage section 1115 demonstration.

1. Premiums **Section 1902(a)(14) insofar as it
incorporates Sections 1916 and 1916A**

To the extent necessary to enable the state to require monthly premiums for individuals with incomes between 100 and 133 percent of the Federal Poverty Level (FPL).

2. 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.

3. Freedom of Choice **Section 1902(a)(23)(A)**

To the extent necessary to enable the State to restrict freedom of choice of provider for the demonstration-eligible population. No waiver of freedom of choice is authorized for family planning providers.

4. Proper and Efficient Administration **Section 1902(a)(4)**

To enable the State to require beneficiaries to use a single prepaid inpatient health plan or prepaid ambulatory health plan in a region or region(s) and restrict disenrollment from them.

**5. 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 enrolled in a Medicaid Health Plan that are additional benefits (e.g., such as case management, health education), in accord with the approved Michigan Alternative Benefit Plan.

6. Comparability

Section 1902(a)(17)

To the extent necessary to enable the state to impose lower contributions for individuals who achieve Healthy Behaviors incentives and rewards.

**CENTERS FOR MEDICARE & MEDICAID SERVICES
EXPENDITURE AUTHORITY**

NUMBER: 11-W-00245/5

TITLE: Healthy Michigan Section 1115 Demonstration

AWARDEE: Michigan Department of Community Health

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

The following expenditure authority is provided to the State of Michigan in order to operate the Healthy Michigan section 1115 demonstration.

1. Expenditures for Healthy Behaviors Program incentive payments to offset beneficiary cost sharing liability.

The following expenditure authorities, which are provided to the State of Michigan in order to operate the Adult Benefit Waiver (ABW) program, will remain effective through March 31, 2014.

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

All requirements of the Medicaid program expressed in law, regulation, and policy statement, not expressly identified as not applicable in the list below, shall apply to expenditure authorities through December 31, 2018.

Title XIX Requirements Not Applicable to Expenditure Authorities 2 and 3:

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

2. **Amount, Duration, and Scope** **Section 1902(a)(10)(B)**
To the extent necessary to enable the state to offer a different benefit package to the Demonstration-Eligible Population that varies in amount, duration, and scope from the benefits offered under the State Plan.

3. **Freedom of Choice** **Section 1902(a)(23)(A)**
To the extent necessary to enable the state to restrict freedom of choice of provider for the Demonstration-Eligible Population to single county- administered health plans in the counties where these plans exist. The Demonstration-Eligible Population may change providers within the plan. No waiver of freedom of choice is authorized for family planning providers.

4. **Retroactive Eligibility** **Section 1902(a)(34)**
To the extent necessary to enable the state to not provide coverage for the Demonstration-Eligible Population for any time prior to the first day of the month in which the application was received by the State.

5. **Eligibility Standards** **Section 1902(a)(17)**
To the extent necessary to enable the state to apply different eligibility methodologies and standards to the Demonstration-Eligible Population than are applied under the State plan.

6. **Methods of Administration: Transportation** **Section 1902(a)(4), insofar as it incorporates 42 CFR 431.53**
To the extent necessary to enable the state to not assure transportation to and from providers for the Demonstration-Eligible Population.

7. **Dental, Hearing and Vision Services** **Section 1902(a)(43)**
To the extent necessary to enable the state to not provide coverage of dental, hearing and vision services to 19- and 20-year-old individuals in the Demonstration-Eligible Population.

8. **Payment to Federally Qualified Health Centers
Rural Health Centers** **Section 1902(a)(15)**

To the extent necessary to enable the state to not reimburse FQHCs and RHCs the full cost reimbursement for services provided to the Demonstration Eligible Population.

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

NUMBER: 11-W-00245/5

TITLE: Healthy Michigan Section 1115 Demonstration

AWARDEE: Michigan Department of Community Health

I. PREFACE

The following are the Special Terms and Conditions (STCs) for Michigan’s “Healthy Michigan” Section 1115(a) Medicaid demonstration (hereinafter referred to as “demonstration”) to enable the Michigan (hereinafter “state”) to operate this demonstration. The Centers for Medicare & Medicaid Services (CMS) has granted waivers of requirements under Section 1902(a) of the Social Security Act (Act), and expenditure authorities authorizing federal matching of demonstration costs not otherwise matchable, which are separately enumerated. These STCs set forth in detail the nature, character, and extent of federal involvement in the demonstration and the state’s obligations to CMS during the life of the demonstration. The STCs are effective as of the date of award of the Healthy Michigan amendment unless otherwise specified. This demonstration is approved through December 31, 2018.

The STCs have been arranged into the following subject areas:

- I. Preface
- II. Program Description And Objectives
- III. General Program Requirements
- IV. Eligibility for the Demonstration
- V. Benefits
- VI. Contributions and Healthy Behaviors Incentives
- VII. Delivery System
- VIII. Transition of Individuals
- IX. General Reporting Requirements
- X. General Financial Requirements
- XI. Monitoring Budget Neutrality for the Demonstration
- XII. Evaluation of the Demonstration
- XIII. Measurement of Quality of Care and Access to Care Improvement
- XIV. Schedule of State Deliverables During the Demonstration

Additional attachments have been included to provide supplementary information and guidance for specific STCs.

Attachment A: Quarterly Progress Report Content and Format

Attachment B: Demonstration Evaluation Plan (reserved)

Attachment C: Comprehensive Quality Strategy (reserved)

- Attachment D: ABW – Record of Budget Neutrality Limit
- Attachment E: MI Health Accounts Operational Protocol (reserved)
- Attachment F: Healthy Behaviors Incentives Program Operational Protocol (reserved)
- Attachment G: Annual Update of Rural Counties Not Required To Provide a Choice of Managed Care Plans
- Attachment H: Final Report Framework
- Attachment J: ABW Health Benefits and Cost Sharing

II. PROGRAM DESCRIPTION AND OBJECTIVES

In January 2004, the “Adult Benefits Waiver” (ABW) (21-W-00017/5) was initially approved and implemented as a Title XXI funded Section 1115 demonstration. The ABW provided a limited ambulatory benefit package to previously uninsured, low-income non-pregnant childless adults ages 19 through 64 years with incomes at or below 35 percent of the Federal poverty level (FPL) who are not eligible for Medicaid. The ABW services were provided to beneficiaries through a managed healthcare delivery system utilizing a network of county administered health plans (CHPs) and Public Mental Health and Substance Abuse provider network.

In December 2009, Michigan was granted approval by CMS for a new Medicaid Section 1115 demonstration, entitled “Michigan Medicaid Nonpregnant Childless Adults Waiver (Adult Benefits Waiver)” (11-W-00245/5), to allow the continuation of the ABW health coverage program after December 31, 2009. Section 112 of the Children’s Health Insurance Program Reauthorization Act of 2009 (CHIPRA) prohibited the use of Title XXI funds for childless adults’ coverage after December 31, 2009, but allowed the states that were affected to request a new Medicaid demonstration to continue their childless adult coverage programs in 2010 and beyond using Title XIX funds. The new “Adult Benefits Waiver” demonstration allowed Michigan to continue offering the ABW coverage program through September 30, 2014, under terms and conditions similar to those provided in the original Title XXI demonstration.

On April 1, 2014, Michigan will expand its Medicaid program to include adults with income up to 133 percent of the FPL. To accompany this expansion, the Michigan “Adult Benefits Waiver” is amended and transformed to establish the Healthy Michigan program, through which the state will test innovative approaches to beneficiary cost sharing and financial responsibility for care for the new adult eligibility group. The new adult population with incomes above 100 percent of the FPL will be required to make contributions equal to two percent of their family income toward the cost of their health care. In addition, all newly eligible adults from 0 to 133 percent of the FPL, regardless of their income, will pay required Medicaid copayments through a credit facility operated in coordination with the Medicaid Health plan. An MI Health Account will be established for each enrolled individual to track beneficiaries’ contributions and how they were expended. Beneficiaries will receive quarterly statements that summarize the MI Health Account funds balance and flows of funds into and out of the account, and the use of funds for health care service copayments. Beneficiaries will have opportunities to reduce their regular or average utilization based contribution by demonstrating achievement of recommended Healthy Behaviors. Healthy Michigan Program beneficiaries will receive 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, and there will not be any limits on the number of individuals who can enroll. It is expected that an additional 300,000 to 500,000 Michigan citizens will receive coverage from the expansion of Medicaid as the new adult group. Beneficiaries receiving coverage under the sunseting ABW program will transition to the state plan and the Healthy Michigan Program on April 1, 2014.

To reflect its expanded purpose, the name of the demonstration is changed to Healthy Michigan. This demonstration includes the transition from the ABW program to the Healthy Michigan Program by subsuming all of the appropriate programmatic authorities and special terms and conditions into these STCs.

The state reports that 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.

The state's goals in amending the demonstration are to:

- Improve access to healthcare for uninsured or underinsured low-income Michigan citizens;
- Improve the quality of healthcare services delivered;
- Reduce uncompensated care;
- Encourage individuals to seek preventive care and encourage the adoption of healthy behaviors;
- Help uninsured or underinsured individuals manage their health care issues;
- Encourage quality, continuity, and appropriate medical care; and
- Study the effects of a demonstration model that infuses market-driven principles into a public healthcare insurance program by examining:
 - 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; and
 - The extent to which beneficiaries feel that the Healthy Michigan Program has a positive impact on personal health outcomes and financial well-being.

This document provides details of both the Healthy Michigan Program and the sunseting Michigan Adults Benefit Waiver (ABW) Program. The ABW Program was implemented as a Title XIX demonstration on January 1, 2010 and the associated STCs for the ABW program as included as a component of the Healthy Michigan demonstration remain in effect until this portion of the demonstration sunsets on April 1,.

III. GENERAL PROGRAM REQUIREMENTS

1. **Compliance with Federal Non-Discrimination Statutes.** The state must comply with all applicable Federal statutes relating to non-discrimination. These include, but are not limited to, the Americans with Disabilities Act of 1990, Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, and the Age Discrimination Act of 1975.
2. **Compliance with Medicaid Law, Regulation, and Policy.** All requirements of the Medicaid program, expressed in law, regulation, and policy statement, not expressly waived or identified as not applicable in the waiver and expenditure authority documents (of which these terms and conditions are part), apply to this demonstration.
3. **Changes in Medicaid Law, Regulation, and Policy.** The state must, within the timeframes specified in law, regulation, or policy statement, come into compliance with any changes in Federal law, regulation, or policy affecting the Medicaid program that occur during this demonstration approval period, unless the provision being changed is expressly waived or identified as not applicable. In addition, CMS reserves the right to amend the STCs to reflect such changes and/or changes as needed without requiring the state to submit an amendment to the demonstration under paragraph 7. CMS will notify the state 30 days in advance of the expected approval date of the amended STCs to allow the state to provide comment. Changes will be considered in force upon issuance of the approval letter by CMS. The state must accept the changes in writing.
4. **Impact of Changes in Federal Law, Regulation, and Policy on the Demonstration.**
 - a. To the extent that a change in Federal law, regulation, or policy requires either a reduction or an increase in Federal financial participation (FFP) for expenditures made under this demonstration, the state must adopt, subject to CMS approval, a modified budget neutrality agreement for the demonstration as necessary to comply with such change. The modified budget neutrality agreement will be effective upon the implementation of the change. The trend rates for the budget neutrality agreement are not subject to change under this subparagraph.
 - b. If mandated changes in the Federal law require state legislation, the changes must take effect on the day such state legislation becomes effective, or on the last day such legislation was required to be in effect under the law.
5. **State Plan Amendments.** The state will not be required to submit Title XIX state plan amendments (SPAs) for changes affecting any populations made eligible solely through the demonstration. If a population eligible through the Medicaid state plan is affected by a change to the demonstration, a conforming amendment to the appropriate state plan is required, except as otherwise noted in these STCs. In all such cases, the Medicaid state plan governs.

6. **Changes Subject to the Amendment Process.** Changes related to demonstration features, such as eligibility, enrollment, benefits, enrollee rights, delivery systems, cost sharing, evaluation design, sources of non-Federal share of funding, budget neutrality, and other comparable program elements must be submitted to CMS as amendments to the demonstration. All amendment requests are subject to approval at the discretion of the Secretary in accordance with Section 1115 of the Act. The state must not implement or begin operational changes to these elements without prior approval by CMS of the amendment to the demonstration. In certain instances, amendments to the Medicaid state plan may or may not require amendment to the demonstration as well. Amendments to the demonstration are not retroactive and federal financial participation (FFP) will not be available for changes to the demonstration that have not been approved through the amendment process set forth in paragraph 7.

7. **Amendment Process.** Requests to amend the demonstration must be submitted to CMS for approval no later than 120 days prior to the planned date of implementation of the change and may not be implemented until approved. CMS reserves the right to deny or delay approval of a demonstration amendment based upon non-compliance with these STCs, including but not limited to failure by the state to submit required elements of a viable amendment request as found in these STCs, required reports and other deliverables required in the approved STCs in a timely fashion according to the deadlines specified herein. Amendment requests must include, but are not limited to, the following:
 - a. **Demonstration of Public Notice 42 CFR §431.408 and tribal consultation:** The state must provide documentation of the state’s compliance with public notice process as specified in 42 CFR §431.408 and documentation that the tribal consultation requirements outlined in paragraph 15 have been met. Such documentation shall include a summary of public comments and identification of proposal adjustments made to the amendment request due to the public input;
 - b. **Demonstration Amendment Summary and Objectives:** The state must provide a detailed description of the amendment, including what the state intends to demonstrate via this amendment as well as the impact on beneficiaries, with sufficient supporting documentation, the objective of the change and desired outcomes including a conforming Title XIX and/or Title XXI SPA, if necessary;
 - c. **Waiver and Expenditure Authorities:** The state must provide a list waivers and expenditure authorities that are being requested or terminated, along with the reason, need and the citation along with the programmatic description of the waivers and expenditure authorities that are being requested for the amendment;
 - d. **A budget neutrality data analysis worksheet:** The state must provide a worksheet which identifies the specific “with waiver” impact of the proposed amendment on the current budget neutrality agreement, including the underlying spreadsheet calculation formulas. Such analysis shall include current total computable “with waiver” and “without waiver” status on both a summary and detailed level through the current approval period using the most recent actual expenditures, as

well as summary and detailed projections of the change in the “with waiver” expenditure total as a result of the proposed amendment, which isolates (by Eligibility Group, or feature) the impact of the amendment;

- e. Updates to existing demonstration reporting, quality and evaluation plans: A description of how the evaluation design, comprehensive quality strategy and quarterly and annual reports will be modified to incorporate the amendment provisions, as well as the oversight, monitoring and measurement of the provisions.
8. **Extension of the Demonstration.** States that intend to request demonstration extensions under Sections 1115(e) or 1115(f) are advised to observe the timelines contained in those statutes. Otherwise, no later than 12 months prior to the expiration date of the demonstration, the governor or chief executive officer of the state must submit to CMS either a demonstration extension request or a transition and phase-out plan consistent with the requirements of paragraph 9.
- a. Compliance with Transparency Requirements at 42 CFR §431.412. As part of the demonstration extension requests the state must provide documentation of compliance with the transparency requirements 42 CFR §431.412 and the public notice and Tribal consultation requirements outlined in paragraph 15.
 - b. Upon application from the state, CMS reserves the right to temporarily extend the demonstration including making any amendments deemed necessary to effectuate the demonstration extension including but not limited to bringing the demonstration into compliance with changes to federal law, regulation and policy.
9. **Demonstration Transition and Phase Out.** The state may only suspend or terminate this demonstration in whole, or in part, consistent with the following requirements.
- a. Notification of Suspension or Termination. The state must promptly notify CMS in writing of the reason(s) for the suspension or termination, together with the effective date and a transition and phase-out plan. The state must submit its notification letter and a draft transition and phase-out plan to CMS no less than six (6) months before the effective date of the demonstration’s suspension or termination. Prior to submitting the draft plan to CMS, the state must publish on its website the draft transition and phase-out plan for a 30-day public comment period. In addition, the state must conduct tribal consultation in accordance with its approved tribal consultation SPA. Once the 30-day public comment period has ended, the state must provide a summary of each public comment received, the state’s response to the comment and how the state incorporated the received comment into the revised phase-out plan.
 - b. The state must obtain CMS approval of the transition and phase-out plan prior to the implementation of the phase-out activities. Implementation of phase-out

activities must be no sooner than 14 days after CMS approval of the phase-out plan.

- c. **Transition and Phase-out Plan Requirements:** The state must include, at a minimum, in its phase-out plan the process by which it will notify affected beneficiaries, the content of said notices (including information on the beneficiary's appeal rights), the process by which the state will conduct administrative reviews of Medicaid eligibility prior to the termination of the program for the affected beneficiaries including any individuals on demonstration waiting lists, and ensure ongoing coverage for those beneficiaries determined eligible for ongoing coverage, as well as any community outreach activities including community resources that are available.
- d. **Phase-out Procedures:** The state must comply with all notice requirements found in 42 CFR §431.206, §431.210, and §431.213. In addition, the state must assure all appeal and hearing rights afforded to demonstration beneficiaries as outlined in 42 CFR §431.220 and §431.221. If a demonstration participant beneficiary requests a hearing before the date of action, the state must maintain benefits as required in 42 CFR §431.230. In addition, the state must conduct administrative renewals for all affected beneficiaries in order to determine if they qualify for Medicaid eligibility under a different eligibility category.
- e. **Exemption from Public Notice Procedures 42.CFR Section 431.416(g).** CMS may expedite the federal and state public notice requirements in the event it determines that the objectives of Title XIX and XXI would be served or under circumstances described in 42 CFR §431.416(g).
- f. **Federal Financial Participation (FFP):** If the project is terminated or any relevant waivers suspended by the state, FFP shall be limited to normal closeout costs associated with terminating the demonstration including services and administrative costs of disenrolling beneficiaries.

10. Expiring Demonstration Authority and Transition. For demonstration authority that expires prior to the overall demonstration's expiration date, the state must submit a demonstration authority expiration plan to CMS no later than 6 months prior to the applicable demonstration authority's expiration date, consistent with the following requirements:

- a. **Expiration Requirements:** The state must include, at a minimum, in its demonstration expiration plan the process by which it will notify affected beneficiaries, the content of said notices (including information on the beneficiary's appeal rights), the process by which the state will conduct administrative reviews of Medicaid eligibility for the affected beneficiaries, and ensure ongoing coverage for eligible individuals, as well as any community outreach activities.

- b. **Expiration Procedures:** The state must comply with all notice requirements found in 42 CFR §431.206, §431.210 and §431.213. In addition, the state must assure all appeal and hearing rights afforded to demonstration beneficiaries as outlined in 42 CFR §431.220 and §431.221. If a demonstration participant beneficiary requests a hearing before the date of action, the state must maintain benefits as required in 42 CFR §431.230. In addition, the state must conduct administrative renewals for all affected beneficiaries in order to determine if they qualify for Medicaid eligibility under a different eligibility category.
 - c. **Federal Public Notice:** CMS will conduct a 30-day federal public comment period consistent with the process outlined in 42 CFR §431.416 in order to solicit public input on the state’s demonstration expiration plan. CMS will consider comments received during the 30-day period during its review and approval of the state’s demonstration expiration plan. The state must obtain CMS approval of the demonstration expiration plan prior to the implementation of the expiration activities. Implementation of expiration activities must be no sooner than 14 days after CMS approval of the plan.
 - d. **Federal Financial Participation (FFP):** FFP shall be limited to normal closeout costs associated with the expiration of the demonstration including services and administrative costs of disenrolling beneficiaries.
11. **CMS Right to Amend, Terminate or Suspend.** CMS may amend, suspend or terminate the demonstration in whole or in part at any time before the date of expiration, whenever it determines, following a hearing that the state has materially failed to comply with the terms of the project. CMS will promptly notify the state in writing of the determination and the reasons for the suspension or termination, together with the effective date.
12. **Finding of Non-Compliance.** The state does not relinquish its rights to challenge CMS’ finding that the state materially failed to comply.
13. **Withdrawal of Waiver Authority.** CMS reserves the right to withdraw waivers or expenditure authorities at any time it determines that continuing the waivers or expenditure authorities would no longer be in the public interest or promote the objectives of Title XIX or Title XXI. CMS will promptly notify the state in writing of the determination and the reasons for the withdrawal, together with the effective date, and afford the state an opportunity to request a hearing to challenge CMS’ determination prior to the effective date. If a waiver or expenditure authority is withdrawn, FFP is limited to normal closeout costs associated with terminating the waiver or expenditure authority, including services and administrative costs of disenrolling beneficiaries.
14. **Adequacy of Infrastructure.** The state must ensure the availability of adequate resources for implementation and monitoring of the demonstration, including education, outreach, and enrollment; maintaining eligibility systems; compliance with cost sharing requirements; and reporting on financial and other demonstration components.

15. Public Notice, Tribal Consultation, and Consultation with Interested Parties. The state must comply with the State Notice Procedures set forth in 59 Fed. Reg. 49249 (September 27, 1994). The state must also comply with the Tribal consultation requirements in Section 1902(a)(73) of the Act as amended by Section 5006(e) of the American Recovery and Reinvestment Act (ARRA) of 2009, the implementing regulations for the Review and Approval Process for Section 1115 demonstrations at 42 CFR. §431.408, and the Tribal consultation requirements contained in the state’s approved state plan, when any program changes to the demonstration, including (but not limited to) those referenced in paragraph 7, are proposed by the state.

- a. In states with federally recognized Indian Tribes, consultation must be conducted in accordance with the consultation process outlined in the July 17, 2001 letter or the consultation process in the state’s approved Medicaid state plan if that process is specifically applicable to consulting with tribal governments on waivers (42 C.F.R. §431.408(b)(2)).
- b. In states with federally recognized Indian Tribes, Indian Health Services programs, and/or Urban Indian Organizations, the state is required to submit evidence to CMS regarding the solicitation of advice from these entities prior to submission of any demonstration proposal, amendment and/or renewal of this demonstration (42 CFR. §431.408(b)(3)).
- c. The state must also comply with the Public Notice Procedures set forth in 42 CFR §447.205 for changes in statewide methods and standards for setting payment rates.

16. Federal Financial Participation (FFP). No federal matching for expenditures (administrative or services) for this demonstration will be available until the approval date identified in the demonstration approval letter, or a later date if so identified elsewhere in these STCs or in the lists of waiver or expenditure authorities.

17. Transformed Medicaid Statistical Information Systems Requirements (T-MSIS). The state shall comply with all data reporting requirements under Section 1903(r) of the Act, including but not limited to Transformed Medicaid Statistical Information Systems Requirements. More information on T-MSIS is available in the August 23, 2013 State Medicaid Director Letter.

IV. ELIGIBILITY FOR THE DEMONSTRATION

18. Eligibility Groups Affected By the Demonstration. This demonstration affects mandatory Medicaid state plan populations as well as the sunseting of the ABW population eligible for benefits only through the demonstration. The criteria for demonstration eligibility are outlined in the Eligibility Table at the end of this section, which shows each specific group of individuals; under what authority they are made eligible, the name of the eligibility and expenditure group under which expenditures are reported to CMS and the budget neutrality expenditure agreement is constructed, and the

corresponding demonstration program under which benefits are provided. Mandatory and optional state plan groups derive their eligibility through the Medicaid state plan, and are subject to all applicable Medicaid laws and regulations in accordance with the Medicaid state plan, except as expressly waived in this demonstration and as described in these STCs. Any Medicaid eligibility standards and methodologies for these eligibility groups, including the conversion to a modified adjusted gross income standard January 1, 2014, will apply to this demonstration.

19. **Mandatory Eligibility Groups Included in the Medicaid State Plan.** Eligibility for all mandatory eligibility groups follow what is in the approved state plan. Should the state amend the state plan to make any changes to eligibility for Medicaid mandatory populations, upon submission of the SPA, the state must notify CMS in writing of the pending SPA. The Medicaid Eligibility Groups (MEGs) listed in the Reporting and the Budget Neutrality Sections of the STCs will be updated upon approval of changes to state plan eligibility and will be considered a technical change to the STCs.
20. **Demonstration Expansion Eligibility Group.** The beneficiary eligibility group described below which is made eligible for the demonstration by virtue of the expenditure authorities expressly granted in this demonstration (Michigan's ABW) are subject to Medicaid laws or regulations, unless otherwise specified in the not applicable expenditure authorities for this demonstration until the program sunsets on March 31, 2014.
21. **ABW Eligibility.** Childless adults eligible for the sunseting ABW coverage under this demonstration (reported under Waiver Name "Michigan's Adult Benefit Waiver") are defined as individuals ages 19 through 64 years with income that is at or below 35 percent of the FPL. They are individuals who are not pregnant, disabled, or qualified for any other Medicaid, Medicare or Children's Health Insurance Program (CHIP). A childless adult is an individual who does not have children or dependents living in his/her home. An applicant must meet the following eligibility requirements in order to enroll for coverage under this demonstration:
 - a. Must be at least 19 but no more than 64 years of age;
 - b. Must not have any children or dependents living in his/her home;
 - c. Must not be pregnant;
 - d. Must not be eligible for Medicaid, CHIP, or Medicare;
 - e. Must have gross family income at or below 35 percent of the FPL;
 - f. Income test - An earned income disregard of \$200 plus 20 percent of the remaining earned income is applied to the income of the demonstration applicant prior to conducting the income test.

- g. Asset Limit - An asset limit of \$3,000 will be applied to applicants who meet the above income requirement. Cash assets include, but are not limited to, checking accounts. Investments and retirement plans are also counted towards this \$3000 asset limit.
 - h. Must not have access to other creditable health insurance. The state defines “creditable health insurance” as coverage for medical care obtained by a participant beneficiary as an individual, via group health plans (self-funded or fully-insured), a state high risk pool, Medicare, Medicaid, Federal Employee Health Benefit Program, military sponsored healthcare program (CHAMPUS or Tri Care), medical program of Indian Health Services or tribal organization public health plan or coverage under the Peace Corps;
 - i. Must provide verification, including documentation, of U.S. citizenship and Social Security number (or proof of application for an SSN) in accordance with Section 1903(x) of the Act;
 - j. Must be a Michigan resident.
22. **ABW Enrollment.** The following terms and conditions apply to enrollment and disenrollment processes for the sunseting Adult Benefit Waiver Program and remain in effect until the implementation of the Medicaid expansion under section 1902(a)(10)(A)(i)(VIII) of the Act and the successful transition of all ABW program beneficiaries.
- a. **Application Processing and Enrollment Procedures.** Applicants for enrollment in the ABW program will use the same application and enrollment procedures required of other individuals applying for other Medicaid programs.
 - b. **Screening for Eligibility for Medicaid and/or CHIP.** All applicants for the ABW program must receive a pre-screening in order to determine possible eligibility for either Medicaid or CHIP programs before eligibility determination is performed for the demonstration.
 - c. **Effective Date of Coverage - No Retroactive Eligibility.** Enrollees who qualify for the ABW program will not receive retroactive coverage. The beginning effective date of coverage under the demonstration will be the first day of the month in which the application was received. After the application is processed, the enrollee will be enrolled in a county health plan (CHP) on the first day of the next month available for enrollment in the 72 counties that operate this type of delivery system. If the enrollee resides in a county that does not have CHP, that enrollee will continue to obtain services through Medicaid Fee for Service (FFS).
 - d. **Redetermination of Eligibility.** Enrollees who are eligible for the ABW program will have eligibility redetermined at least every 12 months. The state

will send eligibility renewal notification to the enrollee prior to the end of the enrollee’s current eligibility period.

- e. **Intermittent Periods of Open Enrollment to the Demonstration.** The state is responsible to determine and maintain the appropriate enrollment levels in order to remain under the annual budget neutrality limit/ceiling established for the ABW program. Therefore, the state will determine the timeframe for opening enrollment for the ABW program based upon the capacity and amount of available budgetary resources. The state will provide written notification to CMS at least 15 days before closing or re-opening enrollment to the ABW program. The state should report to CMS via the quarterly progress and annual reports the status of enrollment and provide a description of the enrollment management process. In addition, the State will provide CMS with Monthly Enrollment Reports as described in paragraph XX.
- f. **Disenrollment.** An enrollee in the Adult Benefits Waiver may be disenrolled if he/she:
 - i. Exceeds the income limit of 35 percent of the FPL;
 - ii. Becomes eligible for Medicare, Medicaid, or CHIP coverage;
 - iii. No longer resides in the State of Michigan;
 - iv. Obtains health insurance coverage;
 - v. Attains age 65; or
 - vi. Voluntarily requests closure of his/her case.

23. Populations Excluded from “Healthy MI Adults” Group. The term Healthy MI Adults will be used to refer to Medicaid beneficiaries who are members of the new adult group and who will be affected by this demonstration. The term includes all individuals in the category indicated in the table below, except for those that are described by any of the following:

- a. Non-citizens only eligible for emergency medical services – 1903(v);
- b. Program for All-Inclusive Care for the Elderly (PACE) Participants– 1934; and
- c. Individuals residing in ICFs/IID - 1905 (a)(15).

Eligibility Table

Medicaid Mandatory State Plan Group Description	Federal Poverty Level and/or Other Qualifying Criteria	Funding Stream	Expenditure Group Reporting Name	Demonstration Specific Program
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Adults age 19 through 64 (effective beginning April 1, 2014)	Up to 133 percent FPL receiving ABP benefits	Title XIX	Healthy MI Adults	Healthy Michigan
Effective through March 31, 2014, Childless Adults Age 19 through 64 who are uninsured and not otherwise eligible for Medicaid (ABW)	0 – 35 percent FPL, see paragraph 2, benefits defined in Attachment J	Title XIX	Michigan’s Adult Benefit Waiver	ABW

V. BENEFITS

24. **Demonstration Programs.** The demonstration provides health care benefits to eligible individuals and families through the following specific programs. The demonstration program for which an individual is eligible is based on the criteria outlined in the Eligibility Table A in Section IV.
25. **ABW Limited Benefit Package.** Enrollees under the demonstration in the ABW Program receive a limited benefit package that includes outpatient hospital services, physician services, diagnostic services, pharmacy, mental health and substance abuse services. The enrollees may be required to receive prior authorization (PA) from the state or their Community Health Plan (CHP) assigned provider before accessing certain ambulatory services. Attachment J describes the specific benefit coverage.
26. **Healthy Michigan Benefit Package.** Healthy Michigan beneficiaries enrolled under this demonstration in the new adult group (i.e., Healthy MI Adults) will receive the benefits in the approved Alternative Benefit Plan (ABP) SPA.
27. **ABW Cost Sharing.** ABW program enrollees are required to pay copayments in order to receive certain ambulatory benefits, as shown in Attachment J until the program sunsets.

VI. CONTRIBUTIONS TO MI HEALTH ACCOUNTS AND HEALTHY BEHAVIORS INCENTIVES

This section provides an overview and planned framework development that will be used to further define the programmatic features of the Healthy Michigan demonstration. All cost sharing must be in compliance with Medicaid requirements that are set forth in statute, regulation and policies, except as modified by the waivers and terms and conditions granted for this demonstration. Following the development and subsequent approval of the Contributions Accounts and Payments Infrastructure Operational Protocol and the Healthy Behaviors Incentives Program Operational Protocol, beneficiaries enrolled in the demonstration will have responsibility to make contributions to, as well as the opportunity

to earn rewards for taking responsibility for their healthy behaviors. The state may request changes to the Protocols, which must be approved by CMS, and which will be effective prospectively. Changes may be subject to an amendment to the STCs in accordance with paragraph 7, depending upon the nature of the proposed change.

28. Healthy Michigan Contributions to MI Health Accounts and Healthy Behaviors

Incentive Components. The state may require Healthy Michigan beneficiaries to pay premiums and cost sharing that will be reflected in MI Health accounts once the protocols are approved. These MI Health accounts will operate to track and record beneficiary payments and liabilities. Beneficiaries will also have the opportunity to receive rewards or incentives for healthy behaviors, which will be represented as credits to the MI Health accounts, as specified in the protocols. These protocols, once approved will be found in Attachments E and F. The state may require Healthy Michigan beneficiaries to make contributions and receive rewards or incentives as described below:

- a. Beneficiaries with incomes above 100 percent of the FPL through 133 percent of the FPL will be responsible for copayment liability based upon the prior 6 months of copayment experience for the beneficiary and a monthly premium that shall not exceed 2 percent of income once the protocol is approved. In addition, reductions for healthy behavior incentives can be applied to the copayment liability. Beneficiaries will be notified of the copayment liability by the provider, but will be billed for such copayments only at the end of quarter, with copayment liability payments due in accordance with the approved protocol. No interest will be due on accrued copayment liability if paid timely.
- b. Beneficiaries with incomes at or below 100 percent of the FPL will be responsible for copayment liability based upon the prior 6 months of copayment experience for the beneficiary. Beneficiaries will be notified of the copayment liability by the provider, but will be billed for such copayments only at the end of quarter, with payments due in accordance with the approved protocol. No interest will be due on accrued copayment liability if paid timely. In addition, reductions for healthy behavior incentives can be applied to the copayment liability due. No premiums will be paid by this population.

29. Healthy Michigan Beneficiary Contribution Protections.

- a. No individual may lose eligibility for Medicaid or be denied eligibility for Medicaid, be denied enrollment in a Healthy Michigan health plan, or be denied access to services for failure to pay premiums or copayment liabilities.
- b. Providers may not deny services for failure to receive beneficiary copayments.
- c. Beneficiaries described in 42 CFR 447.56(a) must be exempt from all cost sharing and contribution requirements.

- d. Beneficiaries may not incur family cost sharing or monthly contributions that exceeds 5 percent of the family's income, following rules established in 42 CFR 447.56(f).
- e. Copayment amounts will be consistent with federal requirement regarding Medicaid cost sharing and with the state's approved state plan (except for any reductions to copayments due to Healthy Behaviors).
- f. Beneficiaries' can be billed for copayment liability in any 6-month experience period after the first six months of enrollment. Billed amounts that are equal to or less than the beneficiary's incurred copayments for the previous 6-month period (except for any reductions to copayments due to Healthy Behaviors).

30. Contributions Accounts and Payments Infrastructure Operational Protocol. The state must submit a draft Contributions Accounts and Payments Infrastructure Operational Protocol to CMS for review and approval prior to implementing the MI Health Accounts program within the Healthy Michigan program. The state's submission must be no later than 90 days prior to the planned implementation. The state may not implement the provisions regarding contributions described in paragraph 29(a) and (b) above until 30 days after receiving CMS approval for the Contributions Accounts and Payments Infrastructure Operational Protocol. The protocol must include, at a minimum, the following items:

- a. The copayment liability and premium payments strategy and implementation plan, including a phased approach to implementation beginning with beneficiaries above 100 percent of the FPL, allowing for milestones related to successful accounting for funds, data collection for incentives, education and other critical operations to be met prior to inclusion of all Healthy Michigan beneficiaries into the payment and reward program.
- b. A description of how third parties, i.e. the beneficiary's employer, the state, and/or private and public entities may contribute on the beneficiary's behalf, including how this is operationalized, and how the contributions will be treated in so far as ensuring such funds are not considered beneficiary income or resources.
- c. The strategy, operational and implementation plan to ensure that the beneficiary will not be charged a copayment by a Medicaid healthcare provider when covered benefits are provided.
- d. Rules to ensure that account funds may only be disbursed for items or services covered under the individual's Medicaid benefit, and as approved in the Operational Protocol.
- e. The strategy and operational description to define how and to provide assurances that ensure that account debits and credits will be accurately tracked on a per visit,

as well as quarterly and annual statements that will be provided to the beneficiary. Notices will be required at the time of service, also with quarterly, biannual and annual frequency.

- f. A description, strategy and implementation plan of the beneficiary education and assistance process including copies of beneficiary notices, a description of beneficiaries' rights and responsibilities, appeal rights and processes and instructions for beneficiaries about how to interact with state officials for discrepancies or other issues that arise regarding the beneficiaries' MI Health Account.
 - g. Assurance that the account balances will not be counted as assets for the beneficiary and that funds returned to the beneficiary will not be treated as income, and a plan for whether interest will accrue to account balances.
 - h. A strategy for educating beneficiaries on how to use the statements, and understand that their health care expenditures will be covered.
 - i. For beneficiaries that are determined no longer eligible for the demonstration, a method for the remaining balance of the account to either be paid to the beneficiary or used to provide employer-based or Marketplace coverage.
31. **Assurance of Compliance.** Within 90 days of implementation of the MI Health Account, the state shall provide CMS with an accounting for review to verify that the accounts are operating in accord with the approved protocol. Should the program be out of compliance, standard penalties may apply including a corrective action plan, disallowance, or program suspension until all operations are compliant.
32. **Healthy Behaviors Incentives Program.** Following CMS approval of the Healthy Behaviors Incentive program operational protocol, all individuals enrolled in the Healthy Michigan Program are eligible to receive incentive payments to offset cost sharing liability via reductions in their copayment liability if certain healthy behaviors are maintained or attained. The purpose of this incentive program is to encourage beneficiaries to their improve health outcomes as well as to maintain and implement additional healthy behaviors as identified in collaboration with their health care provider or providers via consultation as well as via a health risk assessment.
33. **Healthy Behaviors Incentives Program Operational Protocol.** The state may not implement the Healthy Behaviors Incentives program until April 1, 2014, or if later, until 30 days have passed following CMS approval of the protocol pertaining to the program (Attachment G). The state may not implement the Healthy Behaviors Incentives Program until after receiving CMS approval for the Healthy Behaviors Incentives Program Operational Protocol. The state must submit a draft protocol to CMS at least 90 days prior to the planned date of implementation of the program, to allow sufficient time for CMS review and discussion with Michigan. The protocol must, at a minimum, include the following:

- a. The uniform standards for healthy behaviors incentives including, but not limited to, a health risk assessment to identify behavior that the initiative is targeting, for example: routine ER use for non-emergency treatment, multiple comorbidities, alcohol abuse, substance use disorders, tobacco use, obesity, and deficiencies in immunization status.
- b. A selection of targeted healthy behaviors that is sufficiently diverse and a strategy to measure access to necessary providers to ensure that all beneficiaries have an opportunity to receive healthy behavior incentives.
- c. A list of stakeholders as well as documentation of the public processes or meetings that occurred during the development of the protocol, the accompanying health risk assessment tool and uniform standards.
- d. The data driven strategy of how healthy behaviors will be tracked and monitored at the enrollee and provider level including standards of accountability for providers. This must include the timeline for development and/or implementation of a systems based approach which shall occur prior to implementing the Healthy Behaviors initiative.
- e. A beneficiary and provider education strategy and timeline for completion prior to program implementation.
- f. The ongoing structured interventions that will be provided to assist beneficiaries in improving healthy behaviors as identified through the health risk assessment
- g. A description of how the state will ensure that adjustments to premiums or average utilization copayment contributions are accurate and accounted for based upon the success in achieving healthy behaviors.
- h. A strategy and implementation plan of how healthy behaviors will be tracked and monitored at the beneficiary and provider levels, including standards of accountability for providers.
- i. An ongoing strategy of education and outreach post implementation regarding the Healthy Behaviors Incentives program including strategies related to the ongoing engagement of stakeholders and the public in the state.
- j. A description of other incentives in addition to reductions in cost sharing or premiums that the state will implement.
- k. The methodology describing how healthy behavior incentives will be applied to reduce premiums or copayments.

VII. DELIVERY SYSTEM

34. Delivery System for ABW Beneficiaries. The following paragraphs describe the delivery system that will sunset on March 31, 2014 that provides benefits and services to ABW program beneficiaries and remain in effect until the implementation of the Healthy Michigan Program and the successful transition of all ABW program beneficiaries.

- a. **County Health Plans (CHP)** - The CHPs are capitated health plans that provide the primary and preventive care services in an ambulatory/outpatient setting. The CHPs have been a long-standing delivery system created to serve the childless adults enrolled in the ABW. Demonstration enrollees will be required to continue to enroll in the CHPs in 72 of the 83 counties in the state. The demonstration enrollees will have the choice of provider within the CHPs. In counties where CHPs do not currently operate, the state must provide a Medicaid card or other means to access the Medicaid qualified providers under Fee-for-Service (FFS). Tribal members are exempt from mandatory enrollment into CHPs, but may choose to participate in CHPs on a voluntary basis.
- b. **Mental Health and Substance Abuse Provider Network.** The state will continue to provide mental health and substance abuse services using a capitated managed care provider network through the state's Public Mental Health System (PMHS). The mental health and substance abuse network consists of local agencies including Community Mental Health Services Programs (CMHSP) and Substance Abuse Coordinating Agencies. The mental health and substance abuse services will be provided based upon medical necessity and applicable benefit restrictions.
- c. **Contracts.** All contracts and modifications of existing contracts between the state and the CHPs and Mental Health and Substance Providers must be approved by CMS prior to the effective date of the contract or modification of an existing contract. Upon the initial implementation of the demonstration the state will be provided a 90-day grace period to meet the above requirements. If the contract requirements are not met within the specified timeframe, CMS reserves the right as a corrective action to withhold FFP (either partial or full) for the demonstration until the contract compliance requirement is met.

35. Delivery System for Healthy MI Adults. Services for Healthy MI Adults will be provided through a managed care delivery system.

- a. **Types of Health Plans.** The state will use two different types of health plans to provide the full Alternative Benefit Plan for the demonstration population:
 - i. **Comprehensive Health Plans:** These will be Managed Care Organizations (MCOs) (which herein are also referred to as Medicaid Health Plans, or MHPs) that provide acute care, physical health services and most pharmacy benefits on a statewide basis. These MCOs will be the same MCOs that provide acute care and physical health coverage for other Medicaid populations.

- ii. Behavioral Health Plans: These will be Pre-paid Inpatient Health Plans (PIHPs) that provide inpatient and outpatient mental health, substance use disorder, and developmental disability services statewide to all enrollees in the demonstration. The PIHPs will be the same entities that serve other Medicaid populations.
 - iii. The County Health Plan (CHP) structure of the ABW demonstration will not be utilized to serve the New Adults Medicaid population, although many of these providers contracted with the CHPs are also contracted with the MHPs, which will facilitate continuity of care.
- b. **Healthy Michigan Enrollment Requirements.** The state may require Healthy MI Adults to enroll in MCOs and PIHPs (with the exception of those beneficiaries who meet the MHP enrollment exemption criteria or those beneficiaries who meet the voluntary enrollment criteria).
- i. Mandatory enrollment may occur only when the MCOs or PIHPs have been determined by the state to meet readiness and network requirements to ensure sufficient access, quality of care, and care coordination for beneficiaries as established by the state, consistent with 42 CFR §438 and as approved by CMS.
 - ii. New eligible will initially be placed in fee-for-service, during which the individual will be responsible for paying all copayments, in amounts that are in accord with the state plan, at the time of service.
 - iii. The state will use an enrollment broker to assist individuals with selection of a Medicaid Health Plan (MHP) managed care organization before relying on auto-assignments.
 - iv. Any individual that does not make an active selection will be assigned, by default, to a participating Healthy Michigan Program MCO. The state should develop an auto-assignment algorithm which is compliant with 42 CFR §438.50(f). Such algorithm must first take into account the individual's prior (or current) history with the MCO, then the MCO affiliation of the individual's historic providers.
 - v. Individuals will have choice of Healthy Michigan MCOs in all areas except the rural counties that are not defined as urban by the Executive Office of Management and Budget. In rural counties, the state will only contract with 1 MCO to serve those beneficiaries, consistent with the standards in section 1932(a)(3)(B) of the Act. In all areas of the state, individuals will only be permitted to enroll in the 1 PIHP that serves their area of residence.

- vi. Upon completion of the 90-day disenrollment period, individuals that are mandatorily enrolled into a Healthy Michigan MCO will be locked into that MCO for a period of 12 months, unless they have a for-cause reason for disenrollment, as defined by the state. Individuals that are voluntarily enrolled into a MCO will be permitted to disenroll at any time.
- vii. All individuals will be automatically assigned to the single PIHP that serves beneficiaries in their area of residence in order to access services in the behavioral health system, provided the PIHP has been determined to meet readiness and network requirements, as described above.

c. **Healthy Michigan Managed Care Benefit Package.** Individuals enrolled in Healthy Michigan Program will receive from the managed care program the benefits in the approved Alternative Benefit Plan (ABP) SPA. Covered benefits should be delivered and coordinated in an integrated fashion, using an interdisciplinary care team, to coordinate all physical and behavioral health services. Care coordination and management is a core expectation for these services. MCOs/PIHPs will refer and/or coordinate enrollees' access to needed services that are excluded from the managed care delivery system but available through a fee-for-service (FFS) delivery system (e.g. Home Help services or certain psychotropic medications).

36. **Managed Care Requirements.** The state must comply with the managed care regulations published at 42 CFR §438, except as waived herein. Capitation rates shall be developed and certified as actuarially sound, in accordance with 42 CFR §438.6. The certification shall identify historical utilization of services that are the same as outlined in the corresponding Alternative Benefit Plan and used in the rate development process.

37. **Managed Care Contracts.** No FFP is available for activities covered under contracts and/or modifications to existing contracts that are subject to 42 CFR §438 requirements prior to CMS approval of this demonstration authority as well as such contracts and/or contract amendments. The state shall submit any supporting documentation deemed necessary by CMS. The state must provide CMS with a minimum of 60 days to review and approve changes. CMS reserves the right, as a corrective action, to withhold FFP (either partial or full) for the demonstration, until the contract compliance requirement is met.

38. **Public Contracts.** Payments under contracts with public agencies, that are not competitively bid in a process involving multiple bidders, shall not exceed the documented costs incurred in furnishing covered services to eligible individuals (or a reasonable estimate with an adjustment factor no greater than the annual change in the consumer price index).

39. **Network Requirements.** The state must ensure the delivery of all covered benefits, including high quality care. Services must be delivered in a culturally competent manner, and the MCO or PIHP network must be sufficient to provide access to covered services to

the low-income population. In addition, the MCO/PIHP must coordinate health care services for demonstration populations. The following requirements must be included in the state's MCO/PIHP contracts:

- a. **Special Health Care Needs.** Enrollees with special health care needs must have direct access to a specialist, as appropriate for the individual's health care condition, as specified in 42 C.F.R. §438.208(c)(4).
 - b. **Out of Network Requirements.** Each MCO/PIHP must provide demonstration populations with all demonstration program benefits under their contract and as described within these STCs and must allow access to non-network providers when services cannot be provided consistent with the timeliness standards required by the state.
40. **Demonstrating Network Adequacy.** Annually, each MCO/PIHP must provide adequate assurances that it has sufficient capacity to serve the expected enrollment in its service area and offers an adequate range of providers necessary to provide covered services for the anticipated number of enrollees in the service area.
- a. The state must verify these assurances by reviewing demographic, utilization and enrollment data for enrollees in the demonstration as well as:
 - i. The number and types of primary care, pharmacy, behavioral health, and specialty providers available to provide covered services to the demonstration population
 - ii. The number of network providers accepting the new demonstration population; and
 - iii. The geographic location of providers and demonstration populations, as shown through GeoAccess or similar software.
 - b. The state must submit the documentation required in subparagraphs i – iii above to CMS with initial MCO/PIHP contract submission as well as at each contract renewal or renegotiation, or at any time that there is a significant impact to each MCO/PIHP's operation, including service area expansion or reduction and population expansion.
41. **Managed Care Encounter Data Requirements.** All MCO/PIHPs shall maintain an information system that collects, analyzes, integrates and reports data as set forth at 42 CFR §438.242 in a standardized format. Encounter data requirements shall include the following:
- a. Encounter Data (MCO/PIHP Responsibilities) – Each MCO/PIHP must collect, maintain, validate and submit data for services furnished to its enrollees as required by state contract.

- b. Encounter Data (State Responsibilities) - The state shall develop mechanisms for the collection, reporting, and analysis of these, as well as a process to validate that each plan's encounter data are timely, complete and accurate. The state will take appropriate actions to identify and correct deficiencies identified in the collection of encounter data. The state shall have contractual provisions in place to impose financial penalties if accurate data are not submitted in a timely fashion. Additionally, the state shall contract with its EQRO to validate encounter data through medical record review.
 - c. Encounter Data Validation Study for New Capitated Managed Care Plans - If the state contracts with new MCOs or PIHPs throughout the lifetime of the demonstration, the state shall conduct a validation study 18 months after the effective date of the contract to determine completeness and accuracy of encounter data. The initial study shall include validation through a sample of medical records of MCO/PIHP enrollees.
42. **AI/AN Access to Behavioral Health Services.** Native American Indian beneficiaries may elect to obtain Medicaid mental health and substance abuse services directly from Medicaid enrolled Indian Health Service (IHS) facilities and Tribal Health Centers (THCs). For mental health and substance abuse services provided to Native American beneficiaries, the IHS facilities and THCs will be reimbursed directly for those services by the state under the memorandum of agreement (MOA) as specified in the Michigan Medicaid Provider Manual. If the IHS facility or THC provides services to non-Native American persons, the IHS facility or THC must become part of the PIHP provider panel in order to receive reimbursement for specialty services provided to non-Native American persons from the PIHP. Any Native American Indian beneficiary who needs specialty mental health, developmental disability or substance abuse services may also elect to receive such care under this demonstration through the PIHP. The PIHPs have been specifically instructed by MDCH to assure that Indian health programs are included in the PIHP provider panel, to ensure culturally competent specialty care for the beneficiaries in those areas.

VIII. TRANSITION OF INDIVIDUALS

43. **Initial Transition Planning.** Within 15 days of the award of the Healthy Michigan Program amendment, the state is required to submit, or revise, a Transition Plan, for CMS review, that addresses the state's process for transitioning individuals between various coverage options. The Transition Plan will at a minimum address the following:
- (a) All ABW enrollees will be automatically transitioned into Medicaid without an additional redetermination, in accord with Michigan's 1902(e)(14) waiver. Each transitioned beneficiary will retain his or her original redetermination date;
 - (b) The state must assure the continuity of care for persons transitioning from ABW to Medicaid;

- (c) The state will use Medicaid and Marketplace applications submitted after October 1, 2013 to identify individuals who may be eligible for Medicaid as of April 1, 2014, and will send the applicants an eligibility notice and enrollment packet;
- (d) The state will identify individuals between 100 – 133 percent of FPL who are enrolled in a Qualified Health Plan and will work to enroll these individuals in the demonstration and to the extent possible, ensure continuity of care; and
- (e) The state will work with beneficiaries with complex health needs, such as those receiving HIV or substance abuse treatment, to ensure continuity of care with providers and current medications.

44. Administrative Reviews to Determine Alternative Medicaid Eligibility Category.

The state must conduct administrative renewals for all affected beneficiaries in order to determine if they qualify for Medicaid eligibility under a different Medicaid eligibility category as discussed in the October 1, 2010 State Health Official Letter #10-008 before beginning the transition process to the Market Place.

45. Notice and Hearings and Appeals. The state must comply with all notice requirements found in 42 CFR §431.206, §431.210, and §431.213. In addition, the state must assure all appeal and hearing rights afforded to demonstration beneficiaries as outlined in 42 CFR §431.220 and §431.221. If a demonstration participant beneficiary requests a hearing before the date of action, the state must maintain benefits as required in 42 CFR §431.230.

46. Transition of Adult Benefit Waiver Program Enrollees. In addition to all prior authorizations initiated under the ABW demonstration being honored for a period of 90 days in the new Medicaid Health Plans, individuals transitioning from the Adult Benefits Waiver MCOs will be matched to a Medicaid Health Plan with their existing preferred provider to the extent possible. In the event that a person is assigned to a Medicaid Health Plan that does not have their existing provider, the individuals will be afforded the following protections:

- a. The state shall inform the Medicaid Health Plan of the existing provider relationship so the Medicaid Health Plan can make every effort to get that provider in their network
- b. The state shall inform the individual in writing that his or her current provider is not in the Medicaid Health Plan’s network and they should work with the enrollment broker and the Medicaid Health Plan to pick a new preferred provider.
- c. The Medicaid Health Plan will allow the individual to see that provider, even on an out of network basis for a transition period of 90 days if the individual so chooses.

IX GENERAL REPORTING REQUIREMENTS

47. **General Financial Requirements.** The state must comply with all general financial requirements under Title XIX, including reporting requirements related to monitoring budget neutrality, set forth in Section X of these STCs.

48. **Monthly Enrollment Report.** Within 20 days following the first day of each month, the state must report demonstration enrollment figures for the month just completed to the CMS Project Officer and Regional Office contact via e-mail, using the table below. The data requested under this subparagraph are similar to the data requested for the Quarterly Progress Report in Attachment A under Enrollment Count, except that they are compiled on a monthly basis.

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

49. **Reporting Requirements Related to Budget Neutrality.** The state must comply with all reporting requirements for monitoring budget neutrality set forth in Section XIII of these STCs, including the submission of corrected budget neutrality data upon request.

50. **Monitoring Calls.** CMS will convene periodic conference calls with the state. The purpose of these calls is to discuss any significant actual or anticipated developments affecting the demonstration. Areas to be addressed include, but are not limited to: transition and implementation activities, MCO operations and performance, enrollment, cost sharing, quality of care, access, the benefit package, audits, lawsuits, financial reporting and budget neutrality issues, progress on evaluations, legislative developments, and any demonstration amendments the state is considering submitting. CMS will provide updates on any amendments or concept papers under review, as well as federal policies and issues that may affect any aspect of the demonstration. The state and CMS will jointly develop the agenda for the calls.

51. **Post Award Forum.** Within six months of the demonstration’s implementation, and annually thereafter, the state will afford the public with an opportunity to provide meaningful comment on the progress of the demonstration. At least 30 days prior to the date of the planned public forum, the state must publish the date, time and location of the forum in a prominent location on its website. The state can use either its Medical Care Advisory Committee, or another meeting that is open to the public and where an interested party can learn about the progress of the demonstration to meet the requirements of these STCs. The state must include a summary of the comments and issues raised by the public at the forum and include the summary in the quarterly progress report, as specified in paragraph 52, associated with the quarter in which the forum was held. The state must also include the summary in its annual report as required in paragraph 53.

52. Quarterly Progress Reports. The state must submit quarterly progress reports in accordance with the guidelines in Attachment A no later than 60 days following the end of each quarter. The intent of these reports is to present the state's analysis and the status of the various operational areas. These quarterly progress and annual reports must include the following, but are not limited to:

- a. An updated budget neutrality monitoring spreadsheet;
- b. Events occurring during the quarter or anticipated to occur in the near future that affect health care delivery, including, but not limited to: benefits, enrollment and disenrollment, complaints and grievances, quality of care, and access that is relevant to the demonstration, pertinent legislative or litigation activity, and other operational issues;
- c. Updates on the post award forums required under paragraph 51.
- d. Action plans for addressing any policy, administrative, or budget issues identified;
- e. Monthly enrollment reports for demonstration beneficiaries, that include the member months and end of quarter, point-in-time enrollment for each demonstration population;
- f. Number of beneficiaries who chose an MCO and the number of beneficiaries who change plans after being auto-assigned; and
- g. Information on beneficiary complaints, grievances and appeals filed during the quarter by type including; access to urgent, routine, and specialty services, and a description of the resolution and outcomes. Evaluation activities and interim findings. The state shall include a summary of the progress of evaluation activities, including key milestones accomplished as well as challenges encountered and how they were addressed. The discussion shall also include interim findings, when available; status of contracts with independent evaluator(s), if applicable; status of Institutional Review Board approval, if applicable; and status of study participant beneficiary recruitment, if applicable.
- h. Identify any quality assurance/monitoring activity in current quarter. As part of the annual report, pursuant to paragraph 53, the state must also report on the implementation and effectiveness of the updated comprehensive Quality Strategy as it impacts the demonstration.

53. Demonstration Annual Report. The annual report must, at a minimum, include the requirements outlined below. The state will submit the draft Annual Report no later than 90 days after the end of each demonstration year. Within 30 days of receipt of comments from CMS, a final Annual Report must be submitted for the demonstration year (DY) to CMS.

- a. All items included in the Quarterly Progress Report pursuant to paragraph 52 must be summarized to reflect the operation/activities throughout the DY;
 - b. Total annual expenditures for the demonstration population for each DY, with administrative costs reported separately
 - c. Yearly enrollment reports for demonstration enrollees for each DY (enrollees include all individuals enrolled in the demonstration) that include the member months, as required to evaluate compliance with the budget neutral agreement;
 - d. **Managed Care Delivery System.** The state must document accomplishments, project status, quantitative and case study findings, interim evaluation findings, utilization data, progress on implementing cost containment initiatives and policy and administrative difficulties in the operation of the demonstration. The state must provide the CAHPS survey, outcomes of any focused studies conducted and what the state intends to do with the results of the focused study, outcomes of any reviews or interviews related to measurement of any disparities by racial or ethnic groups, annual summary of network adequacy by plan including an assessment of the provider network pre and post implementation and MCO compliance with provider 24/7 availability, summary of outcomes of any on-site reviews including EQRO, financial, or other types of reviews conducted by the state or a contractor of the state, summary of performance improvement projects being conducted by the state and any outcomes associated with the interventions, outcomes of performance measure monitoring, summary of plan financial performance. \
54. **Final Report.** Within 120 days following the end of the demonstration, the state must submit a draft final report to CMS for comments. The state must take into consideration CMS' comments for incorporation into the final report. The final report is due to CMS no later than 90 days after receipt of CMS' comments.

XI. GENERAL FINANCIAL REQUIREMENTS

This project is approved for Title XIX expenditures applicable to services rendered during the demonstration period. This Section describes the general financial requirements for these expenditures.

- 55. **Quarterly Financial Reports.** The state must provide quarterly Title XIX expenditure reports using Form CMS-64, to separately report total Title XIX expenditures for services provided through this demonstration under Section 1115 authority. This project is approved for expenditures applicable to services rendered during the demonstration period. CMS shall provide Title XIX FFP for allowable demonstration expenditures, only as long as they do not exceed the pre-defined limits on the costs incurred, as specified in Section XIII of the STCs.

56. Reporting Expenditures under the Demonstration. The following describes the reporting of expenditures subject to the budget neutrality agreement:

- a. **Tracking Expenditures.** In order to track expenditures under this demonstration, the state will report demonstration expenditures through the Medicaid and State Children's Health Insurance Program Budget and Expenditure System (MBES/CBES); following routine CMS-64 reporting instructions outlined in Section 2500 and Section 2115 of the State Medicaid Manual. All demonstration expenditures subject to budget neutrality limits must be reported each quarter on separate Forms CMS-64.9 WAIVER and/or 64.9P WAIVER, identified by the demonstration project number assigned by CMS (including the project number extension, which indicates the DY in which services were rendered or for which capitation payments were made). For monitoring purposes, cost settlements must be recorded on the appropriate prior period adjustment schedules (Forms CMS-64.9 Waiver) for the Summary Line 10B, in lieu of Lines 9 or 10C. For any other cost settlements (i.e., those not attributable to this demonstration), the adjustments should be reported on lines 9 or 10C, as instructed in the State Medicaid Manual. The term, "expenditures subject to the budget neutrality limit," is defined below in paragraph 57.
- b. **Cost Settlements.** For monitoring purposes, cost settlements attributable to the demonstration must be recorded on the appropriate prior period adjustment schedules (Form CMS-64.9P Waiver) for the Summary Sheet Line 10B, in lieu of Lines 9 or 10C. For any cost settlement not attributable to this demonstration, the adjustments should be reported as otherwise instructed in the State Medicaid Manual.
- c. **Premium and Cost Sharing Contributions.** Premiums and other applicable cost sharing contributions that are collected by the state from enrollees under the demonstration must be reported to CMS each quarter on Form CMS-64 Summary Sheet line 9.D, columns A and B. In order to assure that these collections are properly credited to the demonstration, premium and cost-sharing collections (both total computable and federal share) should also be reported separately by DY on the Form CMS-64 Narrative. In the calculation of expenditures subject to the budget neutrality expenditure limit, premium collections applicable to demonstration populations will be offset against expenditures. These Section 1115 premium collections will be included as a manual adjustment (decrease) to the demonstration's actual expenditures on a quarterly basis.
- d. **Mandated Increase in Physician Payment Rates in 2013 and 2014.** Section 1202 of the Health Care and Education Reconciliation Act of 2010 (Pub. Law 110-152) requires state Medicaid programs to pay physicians for primary care services at rates that are no less than what Medicare pays, for services furnished in 2013 and 2014. The federal government provides a federal medical assistance percentage of 100 percent for the claimed amount by which the minimum payment exceeds the rates paid for those services as of July 1, 2009. The state

may (at its option) exclude from the budget neutrality test for this demonstration the portion of the mandated increase for which the federal government pays 100 percent. Should the state elect this, these amounts must be reported on the base forms CMS-64.9, 64.21, or 64.21U (or their “P” counterparts), and not on any waiver form.

- e. **Pharmacy Rebates.** The state may propose a methodology for assigning a portion of pharmacy rebates to the demonstration populations, in a way that reasonably reflects the actual rebate-eligible pharmacy utilization of those populations, and which reasonably identifies pharmacy rebate amounts with DYs. Use of the methodology is subject to the approval in advance by the CMS Regional Office, and changes to the methodology must also be approved in advance by the Regional Office. The portion of pharmacy rebates assigned to the demonstration using the approved methodology will be reported on the appropriate Forms CMS-64.9 Waiver for the demonstration and not on any other CMS 64.9 form to avoid double –counting. Each rebate amount must be distributed as state and Federal revenue consistent with the Federal matching rates under which the claim was paid.
- f. **Use of Waiver Forms for Medicaid.** For each DY, separate Forms CMS-64.9 Waiver and/or 64.9P Waiver shall be submitted reporting expenditures for individuals enrolled in the demonstration, subject to the budget neutrality limits (Section X of these STCs). The state must complete separate waiver forms for the following Medicaid eligibility groups/waiver names:
 - i. MEG 1 – “Michigan’s Adult Benefit Waiver” (implemented January 1, 2010) (all health care expenditures for Michigan’s Adult Benefit Waiver)
 - ii. MEG 2 – “Healthy MI Adults” (all health care expenditures for Healthy MI Adults, starting April 1, 2014, without regard to actual implementation date for Healthy Michigan)
- g. **Demonstration Years.** Demonstration Years (DYs) will be defined as follows:

Demonstration Year 1 (DY 1)	January 1, 2010 – September 30, 2010
Demonstration Year 2 (DY 2)	October 1, 2010 – September 30, 2011
Demonstration Year 3 (DY 3)	October 1, 2011 – September 30, 2012
Demonstration Year 4 (DY 4)	October 1, 2012 – September 30, 2013
Demonstration Year 5 (DY 5)	October 1, 2013 – December 31, 2014
Demonstration Year 6 (DY 6)	January 1, 2015 – December 31, 2015

Demonstration Year 7 (DY 7)	January 1, 2016 – December 31, 2016
Demonstration Year 8 (DY 8)	January 1, 2017 – December 31, 2017
Demonstration Year 9 (DY 9)	January 1, 2018 – December 31, 2018

57. **Expenditures Subject to the Budget Neutrality Limits.** For purposes of this Section, the term “expenditures subject to the budget neutrality limit” must include:

- a. All demonstration medical assistance expenditures (including those authorized through the Medicaid state plan, and through the Section 1115 waiver and expenditures authorities), but excluding the increase expenditures resulting from the mandated increase in payments to physicians per paragraph 57(d) made on behalf of all demonstration beneficiaries listed in Section IV, Eligibility, with dates of services within the demonstration’s approval period; and
- b. All expenditures that are subject to the budget neutrality agreement are considered demonstration expenditures and must be reported on Forms CMS-64.9 Waiver and /or 64.9P Waiver.

58. **Administrative Costs.** Administrative costs will not be included in the budget neutrality limit, but the state must separately track and report additional administrative costs that are directly attributable to the demonstration, using Forms CMS-64.10 Waiver and/or 64.10P Waiver, with waiver name “ADM”.

59. **Claiming Period.** All claims for expenditures subject to the budget neutrality limit (including any cost settlements) must be made within 2 years after the calendar quarter in which the state made the expenditures. Furthermore, all claims for services during the demonstration period (including any cost settlements) must be made within 2 years after the conclusion or termination of the demonstration. During the latter 2-year period, the state must continue to identify separately net expenditures related to dates of service during the operation of the Section 1115 demonstration on the Form CMS-64 in order to properly account for these expenditures in determining budget neutrality.

60. **Reporting Member Months.** The following describes the reporting of member months for demonstration populations:

- a. For the purpose of calculating the budget neutrality expenditure cap and for other purposes, the state must provide to CMS, as part of the Quarterly Progress Report required under paragraph 52, the actual number of eligible member months for the demonstration populations defined in paragraph 21. The state must submit a statement accompanying the Quarterly Progress Report, which certifies the accuracy of this information. Member months must be reported for Healthy MI Adults starting April 1, 2014.

- b. To permit full recognition of “in-process” eligibility, reported counts of member months may be subject to revisions after the end of each quarter. Member month counts may be revised retrospectively as needed.
 - c. The term “eligible member months” refers to the number of months in which persons are eligible to receive services. For example, a person who is eligible for 3 months contributes 3 eligible member months to the total. Two individuals who are eligible for 2 months each contribute 2 eligible member months to the total, for a total of 4 eligible member months.
- 61. Standard Medicaid Funding Process.** The standard Medicaid funding process must be used during the demonstration. The state must estimate matchable demonstration expenditures (total computable and federal share) subject to the budget neutrality expenditure cap and separately report these expenditures by quarter for each federal fiscal year (FFY) on the Form CMS-37 for both the Medical Assistance Payments (MAP) and State and Local Administration Costs (ADM). CMS will make federal funds available based upon the state's estimate, as approved by CMS. Within 30 days after the end of each quarter, the state must submit the Form CMS-64 quarterly Medicaid expenditure report, showing Medicaid expenditures made in the quarter just ended. The CMS will reconcile expenditures reported on the Form CMS-64 quarterly with federal funding previously made available to the state, and include the reconciling adjustment in the finalization of the grant award to the state.
- 62. Extent of FFP for the Demonstration.** Subject to CMS approval of the source(s) of the non-federal share of funding, CMS will provide FFP at the applicable federal matching rate for the demonstration as a whole as outlined below, subject to the limits described in Section XI:
- a. Administrative costs, including those associated with the administration of the demonstration.
 - b. Net expenditures and prior period adjustments of the Medicaid program that are paid in accordance with the approved state plan.
 - c. Medical Assistance expenditures made under Section 1115 demonstration authority, including those made in conjunction with the demonstration, net of enrollment fees, cost sharing, pharmacy rebates, and all other types of third party liability or CMS payment adjustments.
- 63. Sources of Non-Federal Share.** The state must certify that the matching non-federal share of funds for the demonstration is state/local monies. The state further certifies that such funds shall not be used as the match for any other federal grant or contract, except as permitted by law. All sources of non-federal funding must be compliant with Section 1903(w) of the Act and applicable regulations. In addition, all sources of the non-federal share of funding are subject to CMS approval.

- a. CMS may review the sources of the non-federal share of funding for the demonstration at any time. The state agrees that all funding sources deemed unacceptable by CMS shall be addressed within the time frames set by CMS.
- b. Any amendments that impact the financial status of the program shall require the state to provide information to CMS regarding all sources of the non-federal share of funding.
- c. The state assures that all health care-related taxes comport with Section 1903(w) of the Act and all other applicable federal statutory and regulatory provisions, as well as the approved Medicaid state plan.
- d. State Certification of Funding Conditions. The state must certify that the following conditions for non-federal share of demonstration expenditures are met:
 - i. Units of government, including governmentally operated health care providers, may certify that state or local tax dollars have been expended as the non-federal share of funds under the demonstration.
 - ii. To the extent the state utilizes certified public expenditures (CPEs) as the funding mechanism for Title XIX (or under Section 1115 authority) payments, CMS must approve a cost reimbursement methodology. This methodology must include a detailed explanation of the process by which the state would identify those costs eligible under Title XIX (or under Section 1115 authority) for purposes of certifying public expenditures.
 - iii. To the extent the state utilizes CPEs as the funding mechanism to claim federal match for payments under the demonstration, governmental entities to which general revenue funds are appropriated must certify to the state the amount of such tax revenue (state or local) used to satisfy demonstration expenditures. The entities that incurred the cost must also provide cost documentation to support the state's claim for federal match.
- e. The state may use intergovernmental transfers to the extent that such funds are derived from state or local tax revenues and are transferred by units of government within the state. Any transfers from governmentally operated health care providers must be made in an amount not to exceed the non-federal share of Title XIX payments.
- f. Under all circumstances, health care providers must retain 100 percent of the reimbursement amounts claimed by the state as demonstration expenditures. Moreover, no pre-arranged agreements (contractual or otherwise) may exist between the health care providers and the state and/or local government to return and/or redirect any portion of the Medicaid payments. This confirmation of Medicaid payment retention is made with the understanding that payments that are the normal operating expenses of conducting business (such as payments

related to taxes—including health care provider-related taxes—fees, and business relationships with governments that are unrelated to Medicaid and in which there is no connection to Medicaid payments) are not considered returning and/or redirecting a Medicaid payment.

XI. MONITORING BUDGET NEUTRALITY FOR THE DEMONSTRATION

64. **Budget Neutrality for ABW.** The state will continue to apply the following budget neutrality methodology, based on the requirements as set forth in Section 112 of the Children’s Health Insurance Program Reauthorization Act of 2009, for the establishment of the demonstration’s budget neutrality limit until the implementation of the Medicaid expansion on April 1, 2014, and the successful transition of all ABW program beneficiaries:

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

following, and the Annual Limit for the immediately following DY that would be determined by that Trend Factor;

- C. A proposed updated version of Attachment B. The state may request technical assistance from CMS for the calculation of the Annual Limits and Trend Factors prior to its submission of the updated budget neutrality analysis. CMS will respond by either confirming the state's calculations or by working with the state to determine an accurate calculation of the Trend Factor and Annual Limit for the coming DY. CMS will ensure that the final Trend Factors for each DY are the same for all CHIPRA Medicaid childless adult waivers. The annual budget neutrality limit for each DY will be finalized by CMS by the following date, whichever is later: (1) 120 days prior to the start of the DY; or (2) two months following the date of the most recent publication of the National Health Expenditure projections occurring prior to the start of the DY.
- iii. **Base Year Expenditure.** The Base Year Expenditure will be equal to the total amount of FFP paid to the state for health care services or coverage provided to nonpregnant childless adults under the Michigan Adult Benefits Waiver (21-W-00017/5), as reported on CMS-21 and CMS-21P Waiver forms submitted by the state in the four quarters of FFY 2009. A preliminary Base Year Expenditure total appears in Attachment B. A final Base Year Expenditure total will be determined by CMS following CMS receipt of the Budget Neutrality Update that the state must provide by April 1, 2010.
- iv. **Adjustments to the Base Year Expenditure.** CMS reserves the right to adjust the Base Year Expenditure in the event that any future audit or examination shows that any of the expenditures included in the Base Year Expenditure total were not expenditures for health care services, health insurance premiums, or premium assistance for nonpregnant childless adults participating in the Michigan Adult Benefits Waiver (21-W-00017/5).
- v. **Special Calculation for FFY 2010.** The FFY 2010 Expenditure Projection will be equal to the Base Year Expenditure increased by 3.7 percent, which is the percentage increase in the projected nominal per capita amount of National Health Expenditures for 2010 over 2009, as published by the Secretary in February 2009.
- vi. **Annual Limit for DY 1.** To account for the fact that this demonstration will be active for only three-quarters of FFY 2010, the Annual Limit for DY 1 will be equal to the FFY 2010 Expenditure Projection (as calculated

under subparagraph (e) times 75 percent. The Annual Limit for DY 1 will be finalized at the same time that the Base Year Expenditure is finalized.

- vii. **Annual Limit for DY 2.** The Annual Limit for DY 2 will be equal to the FFY 2010 Expenditure Projection (as calculated under subparagraph (e), and prior to multiplication by three-quarters as indicated in subparagraph (f)), increased by the percentage increase (if any) in the projected nominal per capita amount of National Health Expenditures for 2011 over 2010, as published by the Secretary in February 2010. The Annual Limit for DY 2 can be finalized once the Trend factor for DY 2 is finalized.
- viii. **Annual Limit for DY 3 and Subsequent Years.** The Annual Limit for DY 3 and the DYs that follow will be equal to the prior year's Annual Limit, increased by the percentage increase (if any) in the projected nominal per capita amount of National Health Expenditures for the year beginning January 1 of the DY over the year preceding that year, as published by the Secretary in the February prior to the start of the DY. Program
- ix. **Calculation of the Trend Factor.** The percentage increase (if any) in the projected nominal per capita amount of National Health Expenditures for the year beginning January 1 of a DY (PERCAP2) over the preceding year (PERCAP1) to be referred to as the Trend Factor) will be calculated to one decimal place of precision (example: 3.7 percent) using computer spreadsheet rounding. (A sample formula for this calculation in Microsoft Excel reads as follows:

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

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

65. Budget Neutrality for Healthy Michigan.

- a. **Limit on Title XIX Funding.** The state shall be subject to a limit on the amount of federal Title XIX funding that the state may receive on selected Medicaid expenditures during the period of approval of the demonstration. The limit is determined by using the per capita cost method described in paragraph 65(c), and budget neutrality expenditure limits are set on a yearly basis with a cumulative budget neutrality expenditure limit for the length of the entire demonstration. The data supplied by the state to CMS to set the annual caps is subject to review and audit, and if found to be inaccurate, will result in a modified budget neutrality

expenditure limit. CMS' assessment of the state's compliance with these annual limits will be done using the Schedule C report from the CMS-64.

- b. **Risk.** The state will be at risk for the per capita cost (as determined by the method described below) for the Healthy Michigan Program demonstration populations as defined in paragraph 21, but not at risk for the number of beneficiaries in the demonstration population. By providing FFP without regard to enrollment in the demonstration populations, CMS will not place the state at risk for changing economic conditions that impact enrollment levels. However, by placing the state at risk for the per capita costs of current eligibles, CMS assures that the demonstration expenditures do not exceed the levels that would have been realized had there been no demonstration.

- c. **Overall Calculation of the Budget Neutrality Limit for Healthy Michigan Program.** For the purpose of calculating the overall budget neutrality limit for the demonstration, separate annual budget limits will be calculated for each DY on a total computable basis. The annual limits will then be added together to obtain a budget neutrality limit for the entire demonstration period. The federal share of this limit will represent the maximum amount of FFP that the state may receive during the demonstration period for the types of demonstration expenditures described below. The federal share will be calculated by multiplying the total computable budget neutrality limit by the Composite Federal Share, which is defined in (d) below. The demonstration expenditures subject to the budget neutrality limit are those reported under the Waiver Name "Healthy MI Program."
 - i. The MEG listed in the table below is included in the calculation of the budget neutrality limit for Healthy Michigan Program.

MEG	TREND	DY 5 – PMPM	DY 6 – PMPM	DY7 – PMPM	DY8 – PMPM	–DY9 – PMPM
Healthy MI Adults ¹	5.1%	\$515.85	\$542.15	\$569.80	\$598.86	\$629.40

- ii. If the state's experience of the take up rate for the Healthy MI Adults and other factors that affect the costs of this population indicates that the PMPM limit described above in subparagraph (i) may underestimate the actual costs of medical assistance for the Healthy MI Adults, the state may submit an adjustment to subparagraph (i) for CMS review without submitting an amendment pursuant to paragraph 7. Adjustments to the PMPM limit for a demonstration year must be submitted to CMS no later

¹ The PMPMs for Healthy MI Adults are the sum of a Base Rate and Morbidity Co-factor.

than the end of the third quarter of the demonstration year for which the adjustment would take effect.

- iii. The budget neutrality limit is calculated by taking the PMPM cost projection for the above group in each DY, times the number of eligible member months for that group and DY, and adding the products together across groups and DYs. The federal share of the budget neutrality limit is obtained by multiplying total computable budget neutrality limit by the Composite Federal Share.
 - iv. The Healthy Michigan Program budget neutrality test is a comparison between the federal share of the budget neutrality limit and total FFP reported by the state for “Healthy MI Adults.”
- d. **Composite Federal Share Ratio.** The Composite Federal Share is the ratio calculated by dividing the sum total of federal financial participation (FFP) received by the state on actual demonstration expenditures during the approval period, as reported through the MBES/CBES and summarized on Schedule C (with consideration of additional allowable demonstration offsets such as, but not limited to, premium collections) by total computable demonstration expenditures for the same period as reported on the same forms. Should the demonstration be terminated prior to the end of the extension approval period (see paragraphs 9 and 11), the Composite Federal Share will be determined based on actual expenditures for the period in which the demonstration was active. For the purpose of interim monitoring of budget neutrality, a reasonable estimate of Composite Federal Share may be developed and used through the same process or through an alternative mutually agreed upon method.
 - e. **Lifetime Demonstration Budget Neutrality Limit.** The lifetime (overall) budget neutrality limit for the Healthy Michigan Program component of the demonstration is the sum of the annual budget neutrality limits calculated in subparagraph (c).
 - f. **Future Adjustments to the Budget Neutrality Expenditure Limit.** CMS reserves the right to adjust the budget neutrality expenditure limit to be consistent with enforcement of impermissible provider payments, health care related taxes, new federal statutes, or policy interpretations implemented through letters, memoranda, or regulations with respect to the provision of services covered under the demonstration.
 - g. **Enforcement of Budget Neutrality.** CMS shall enforce budget neutrality over the life of the demonstration rather than on an annual basis. However, if the state’s expenditures exceed the calculated cumulative budget neutrality expenditure cap by the percentage identified below for any of the demonstration years, the state must submit a corrective action plan to CMS for approval. The state will subsequently implement the approved corrective action plan.

Year	Cumulative target definition	Percentage
DY 5	Cumulative budget neutrality limit for DY 5 plus:	2.0 percent
DY 6	Cumulative budget neutrality limit for DY 5 and DY 6 plus:	1.5 percent
DY 7	Cumulative budget neutrality limit for DY 5 through DY 7 plus:	1.0 percent
DY 8	Cumulative budget neutrality limit for DY 5 through DY 8 plus:	0.5 percent
DY 9	Cumulative budget neutrality limit for DY 5 through DY 9 plus:	0 percent

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

XII. EVALUATION OF THE DEMONSTRATION

67. Submission of Draft Evaluation Design Update. The state must submit to CMS for approval, within 120 days of the approval date of the Healthy Michigan Program amendment a draft evaluation design update that builds and improves upon the evaluation design that was approved by CMS in 2010. At a minimum, the draft design must include a discussion of the goals, objectives and specific testable hypotheses, including those that focus specifically on target populations for the demonstration, and more generally on beneficiaries, providers, plans, market areas and public expenditures. The analysis plan must cover all elements in paragraph 69. The updated design should be described in sufficient detail to determine that it is scientifically rigorous. The data strategy must be thoroughly documented.

The design should describe how the evaluation and reporting will develop and be maintained to assure its scientific rigor and completion. In summary, the demonstration evaluation will meet all standards of leading academic institutions and academic journal peer review, as appropriate for each aspect of the evaluation, including standards for the evaluation design, conduct, interpretation, and reporting of findings. Among the characteristics of rigor that will be met are the use of best available data; controls for and reporting of the limitations of data and their effects on results; and the generalizability of results.

The updated design must describe the state’s process to contract with an independent evaluator, ensuring no conflict of interest.

The design, including the budget and adequacy of approach, to assure the evaluation meets the requirements of paragraph 69, is subject to CMS approval. The budget and approach must be adequate to support the scale and rigor reflected in the paragraph above. The rigor also described above also applies as appropriate throughout Sections XX and [XV].

68. Cooperation with Federal Evaluators. Should HHS undertake an evaluation of any component of the demonstration, the state shall cooperate fully with CMS or the evaluator selected by HHS in addition, the state shall submit the required data to HHS or its contractor.

69. Evaluation Design.

- a. Domains of Focus – The state must propose as least one research question that it will investigate within each of the domains listed below.

The state proposes several projects will be conducted to evaluate the success of the Healthy Michigan Program. These include the following:

- i. 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.
- ii. Reduction in the Number of Uninsured - The Healthy Michigan Program 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).
- iii. Impact on Healthy Behaviors and Health Outcomes - The Healthy Michigan Program 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 beneficiaries report an increase in their overall health status. Clear milestone reporting on the Healthy Behavior Incentives initiative must be summarized and provided to CMS once per year.

- iv. Participant Beneficiary Views on the Impact of the Healthy Michigan Program - The Healthy Michigan Program will evaluate whether access to a low-cost (modest co- payments, etc.) primary and preventive health insurance benefit will encourage beneficiaries to maintain their health through the use of more basic health care services in order to avoid more costly acute care services.
 - v. Impact of Contribution Requirements – The Healthy Michigan Program will plan will evaluate whether requiring beneficiaries to make contributions toward the cost of their health care results in individuals dropping their coverage, and whether collecting an average utilization component from beneficiaries in lieu of copayments at point of service affects beneficiaries’ propensity to use services.
 - vi. Impact of MI Health Accounts – The Healthy Michigan Program will evaluate whether providing a MI Health Account into which beneficiaries’ contributions are deposited, that provides quarterly statements detailing account contributions and health care utilization, and that allows for reductions in future contribution requirements when funds roll over, deters beneficiaries from receiving needed health care services, or encourages beneficiaries to be more cost conscious.
- b. Measures - The draft evaluation design must discuss the outcome measures that shall be used in evaluating the impact of the demonstration during the period of approval, including:
- i. A description of each outcome measure selected, including clearly defined numerators and denominators, and National Quality Forum (NQF) numbers (as applicable);
 - ii. The measure steward;
 - iii. The baseline value for each measure;
 - iv. The sampling methodology for assessing these outcomes; and
- c. Sources of Measures - CMS recommends that the state use measures from nationally-recognized sources and those from national measures sets (including CMS’s Core Set Core Set of Health Care Quality Measures for Medicaid-Eligible Adults).
- d. The evaluation design must also discuss the data sources used, including the use of Medicaid encounter data, enrollment data, electronic health record (EHR) data, and consumer and provider surveys. The draft evaluation design must include a detailed analysis plan that describes how the effects of the demonstration shall be isolated from other initiatives occurring in the state. The evaluation designs

proposed for each question may include analysis at the beneficiary, provider, and aggregate program level, as appropriate, and include population stratifications to the extent feasible, for further depth and to glean potential non-equivalent effects on different sub-groups.

70. **Final Evaluation Design and Implementation.** CMS shall provide comments on the draft design update and the draft evaluation strategy within 60 days of receipt, and the state shall submit a final design within 60 days of receipt of CMS' comments. The state must implement the evaluation design and submit its progress in each of the Quarterly Progress Reports and Annual Reports.
71. **Interim Evaluation Report.** The state must submit an interim evaluation report to CMS as part of any future request to extend the demonstration, or by June 30, 2018 if no extension request has been submitted by that date. The interim evaluation report will discuss evaluation progress and present findings to date.
72. **Healthy Michigan Program Final Evaluation Report.** The state must submit to CMS a draft of the Evaluation Final Report by May 1, 2019. The state must submit the Final Evaluation Report within 60 days after receipt of CMS' comments. The final report must include the following:
 - a. An executive summary;
 - b. A description of the demonstration, including programmatic goals, interventions implemented, and resulting impact of these interventions;
 - c. A summary of the evaluation design employed, including hypotheses, study design, measures, data sources, and analyses;
 - d. A description of the population included in the evaluation (by age, gender, race/ethnicity, etc.);
 - e. Final evaluation findings, including a discussion of the findings (interpretation and policy context); and
 - f. Successes, challenges, and lessons learned.
73. **Completion of ABW Evaluation.** By August 1, 2014, the state must submit a draft final evaluation report on ABW to CMS, based on the evaluation design approved by CMS in 2010. CMS will provide comments within 60 days after receipt of the report, and the state must submit the final evaluation report within 60 days after receipt of CMS's comments.

XIII. MEASUREMENT OF QUALITY OF CARE AND ACCESS TO CARE IMPROVEMENT

74. **External Quality Review (EQR).** The state is required to meet all requirements for external quality review (EQR) found in 42 C.F.R. Part 438, subpart E. In addition to routine encounter data validation processes that take place at the MCO/PIHP and state level, the state must maintain its contract with its external quality review organization (EQRO) to require the independent validation of encounter data for all MCOs and PIHPs at a minimum of once every three years.
- a. The state should generally have available its final EQR technical report to CMS and the public, in a format compliant with Section 508 of the Rehabilitation Act (29 U.S.C. § 794d), by April 30th of each year, for data collected within the prior 15 months. This submission timeframe will align with the collection and annual reporting on managed care data by the Secretary of Health and Human Services each September 30th, which is a requirement under the Affordable Care Act [Sec. 2701 (d)(2)].
 - b. **Consumer Health Plan Report Cards.** On an annual basis, the state must create and make readily available to beneficiaries, providers, and other interested stakeholders, a health plan report card, in a format compliant with Section 508 of the Rehabilitation Act (29 U.S.C. § 794d), that is based on performance data on each health plan included in the annual EQR technical report. Each health plan report card must be posted on the state's website and present an easily understandable summary of quality, access, and timeliness regarding the performance of each participating health plan. The report cards must also address the performance of subcontracted dental plans.
75. **Measurement Activities.** The state must ensure that each participating health plan is accountable for metrics on quality and access, including measures to track progress in identified quality improvement focus areas, measures to track quality broadly, and measures to track access. The state must set performance targets that equal or exceed the 75th percentile national Medicaid performance level.
76. **Data Collection.** The state must collect data and information on dental care utilization rates, the CMS Medicaid and CHIP adult and child core measures, and must align with other existing federal measure sets where possible to ensure ongoing monitoring of individual well-being and plan performance. The state will use this information in ongoing monitoring and quality improvement efforts, in addition to quality reporting efforts.
77. **Comprehensive State Quality Strategy.** The state shall adopt and implement a comprehensive and holistic, continuous quality improvement strategy that focuses on all aspects of quality improvement in Medicaid, including FFS populations; and capitated managed care plans. The Comprehensive Quality Strategy (CQS) shall meet all the

requirements of 42 CFR 438 Subparts D and E. The CQS must also address the following elements:

- a. The state's goals for improvement, identified through claims and encounter data, quality metrics and expenditure data. The goals should align with the three part aim but should be more specific in identifying specific pathways for the state to achieve these goals.
- b. The associated interventions for improvement in the goals. (See November 22, 2013 CMS letter to State Health Official.)
- c. The specific quality metrics for measuring improvement in the goals. The metrics should be aligned with the Medicaid and CHIP adult and child core measures, and should also align with other existing Medicare and Medicaid federal measure sets where possible. The metrics should go beyond HEDIS and CAHPS data, and should reflect cost of care. Metrics should be measured at the following levels of aggregation: the state Medicaid agency, each health plan, and each direct health services provider. The state will work with CMS to further define what types of metrics will be measured for direct service providers. (See November 22, 2013 CMS letter to State Health Official.)
- d. The specific methodology for determining benchmark and target performance on these metrics for each aggregated level identified above (state, plan and provider).
- e. Performance improvement accountability – i.e., the state must determine if the current plans for financial incentives adequately align with the specific goals and targeted performance, and whether enhancements to these incentives are necessary (increased or restructured financial incentives, in-kind incentives, contract management, etc.). The state must present the findings of the determination to CMS.
- f. Specific metrics related to each population covered by the Medicaid program.
- g. Monitoring and evaluation. This should include specific plans for continuous quality improvement, which includes transparency of performance on metrics and structured learning, and also a rigorous and independent evaluation of the demonstration, as described in paragraph 69. The evaluation should reflect all the programs covered by the CQS as mentioned above.
- h. The CQS should include a timeline that considers metric development and specification, contract amendments, data submission and review, incentive disbursement (if available), and the re-basing of performance data.
- i. The CQS must include state Medicaid agency and any contracted service providers' responsibilities, including managed care entities, and providers enrolled in the state's FFS program. The state Medicaid agency must retain

ultimate authority and accountability for ensuring the quality of and overseeing the operations of the program. The CQS must include distinctive components for discovery, remediation, and improvement.

- j. The first draft of this CQS is due to CMS no later than 120 days following the approval of the Healthy Michigan Program amendment. CMS will review this draft and provide feedback to the state. The state must revise and resubmit the CQS to CMS for approval within 45 days of receipt of CMS comment. The state must revise (and submit to CMS for review and approval) their CQS whenever significant changes are made to the associated Medicaid programs and the content of the CQS. Any further revisions must be submitted accordingly:
 - i. Modifications to the CQS due to changes in the Medicaid operating authorities must be submitted concurrent with the proposed changes to the operating authority (e.g., state plan or waiver amendments or waiver renewals); and/or
 - ii. Changes to an existing, approved CQS due to fundamental changes to the CQS must be submitted for review and approval to CMS no later than 60 days prior to the contractual implementation of such changes. If the changes to the CQS do not impact any provider contracts, the revisions to the CQS may be submitted to CMS no later than 60 days following the changes. The state must solicit for and obtain the input of beneficiaries, the Medical Care Advisory Committee (MCAC), and other stakeholders in the development of its CQS and make the initial CQS, as well as any significant revisions, available for public comment prior to implementation. Pursuant to paragraph 53 Annual Report, the state must also provide CMS with annual reports on the implementation and effectiveness of their CQS as it impacts the demonstration.
- k. As required by 42 C.F.R. §438.360(b)(4), the state must identify in the CQS any standards for which the EQRO will use information from private accreditation reviews to complete the compliance review portion of EQR for participating MCOs or PIHPs. The state must, by means of a crosswalk included in the CQS, set forth each standard that the state deems as duplicative to those addressed under accreditation and explain its rationale for why the standards are duplicative.
- l. Upon approval by CMS, the state will finalize the CQS to be fully compliant with Section 508 of the Rehabilitation Act (29 U.S.C. § 794d).

XIV. SCHEDULE OF STATE DELIVERABLES DURING THE DEMONSTRATION

The state is held to all reporting requirements outlined in the STCs; this schedule of deliverables should serve only as a tool for informational purposes only.

Per award letter - Within 30 days of the date of award	Confirmation Letter to CMS Accepting Demonstration STCs
Per paragraph 43	Revised Transition Plan
Per paragraph 69	Submit Draft Evaluation Design
Per paragraph 8	Submit Demonstration Extension Application
Per paragraph 71	Submit Interim Evaluation Report
Per paragraph - Within 6 months of amendment implementation	Post-award Forum Transparency deliverable –
Per paragraph 33	Healthy Behaviors Protocol
Per paragraph 30	MI Health Account Protocol
Monthly	Deliverable
Per paragraph 48	Monthly Enrollment Reports
Quarterly	Deliverable
Per paragraph 52	Quarterly Progress Reports
Per paragraph 52(e)	Quarterly Enrollment Reports
Per paragraph 61	Quarterly Expenditure Reports
Annual	Deliverable
Per paragraph 51	Annual Forum Transparency deliverable
Per paragraph 53	Draft Annual Report
Renewal/Close Out	Deliverable
Per paragraph 53	Close-Out Report
Per paragraph 71	Draft Final Evaluation
Per paragraph 72	Final Evaluation

ATTACHMENT A. QUARTERLY PROGRESS REPORT CONTENT AND FORMAT

Pursuant to paragraph 52 (Quarterly Progress Report) of these STCs, the state is required to submit Quarterly Progress Reports to CMS. The purpose of the Quarterly Progress Report is to inform CMS of significant demonstration activity from the time of approval through completion of the demonstration. The reports are due to CMS 60 days after the end of each quarter.

The following report guidelines are intended as a framework and can be modified when agreed upon by CMS and the state. A complete Quarterly Progress Report must include an updated budget neutrality monitoring workbook. An electronic copy of the report narrative, as well as the Microsoft Excel workbook must be provided.

NARRATIVE REPORT FORMAT:

Title Line One – Michigan Adult Coverage Demonstration

Title Line Two – Section 1115 Quarterly Report

Demonstration/Quarter Reporting Period:

[Example: Demonstration Year: 7 (1/1/2015 – 12/31/2016)

Federal Fiscal Quarter:

Footer: Date on the approval letter through December 31, 2018

Introduction

Present information describing the goal of the demonstration, what it does, and the status of key dates of approval/operation.

Enrollment and Benefits Information

Discuss the following:

Trends and any issues related to eligibility, enrollment, disenrollment, access, and delivery network.

Any changes or anticipated changes in populations served and benefits. Progress on implementing any demonstration amendments related to eligibility or benefits.

Information about the beneficiary rewards program, including the number of people participating, credits earned, and credits redeemed.

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

Enrollment Counts for Quarter and Year to Date

Note: Enrollment counts should be unique enrollee counts, not beneficiary months

Demonstration Populations	Total Number of Demonstration beneficiaries Quarter Ending – MM/YY	Current Enrollees (year to date)	Disenrolled in Current Quarter
ABW Childless Adults			
Healthy MI Adults			

IV. Outreach/Innovative Activities to Assure Access

Summarize marketing, outreach, or advocacy activities to potential eligibles and/or promising practices for the current quarter to assure access for demonstration beneficiaries or potential eligibles.

V. Collection and Verification of Encounter Data and Enrollment Data

Summarize any issues, activities, or findings related to the collection and verification of encounter data and enrollment data.

VI. Operational/Policy/Systems/Fiscal Developments/Issues

A status update that identifies all other significant program developments/issues/problems that have occurred in the current quarter or are anticipated to occur in the near future that affect health care delivery, including but not limited to program development, quality of care, approval and contracting with new plans, health plan contract compliance and financial performance relevant to the demonstration, fiscal issues, systems issues, and pertinent legislative or litigation activity.

IX. Financial/Budget Neutrality Development/Issues

Identify all significant developments/issues/problems with financial accounting, budget neutrality, and CMS 64 and budget neutrality reporting for the current quarter. Identify the state’s actions to address these issues.

X. Beneficiary Month Reporting

Enter the beneficiary months for each of the MEGs for the quarter.

A. For Use in Budget Neutrality Calculations

Eligibility Group	Month 1	Month 2	Month 3	Total for Quarter Ending XX/XX
Healthy Michigan Adults				

XI. Consumer Issues

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

XII. Quality Assurance/Monitoring Activity

Identify any quality assurance/monitoring activity or any other quality of care findings and issues in current quarter.

XIII. Managed Care Reporting Requirements

Address network adequacy reporting from plans including GeoAccess mapping, customer service reporting including average speed of answer at the plans and call abandonment rates; summary of MCO appeals for the quarter including overturn rate and any trends identified; enrollee complaints and grievance reports to determine any trends; and summary analysis of MCO critical incident report which includes, but is not limited to, incidents of abuse, neglect and exploitation. The state must include additional reporting requirements within the Annual Report as outlined in paragraph 53.

XIV. Lessons Learned

Discuss problems encountered, method of identification, and solution implemented. As Section 1115 demonstrations are “learning laboratories” whereby federal and state statutes, regulations, policy, court decisions, and operations are constantly changing and evolving, this Section highlights state actions taken to resolve anticipated and unanticipated challenges encountered in administering the Medicaid demonstration. This Section is not intended to be punitive, but instead highlights the skill and dedication of state personnel to rapidly adapt to new challenges. This Section also serves to inform policy makers and to share these lessons learned with other states seeking to pursue similar programmatic waivers.

XV. Demonstration Evaluation

Discuss progress of evaluation plan and planning, evaluation activities, and interim findings.

XVI. Enclosures/Attachments

Identify by Title the budget neutrality monitoring tables and any other attachments along with a brief description of what information the document contains.

XVII. State Contact(s)

Identify the individual(s) by name, Title, phone, fax, and address that CMS may contact should any questions arise.

XVIII. Date Submitted to CMS

ATTACHMENT B: Demonstration Evaluation Plan (*reserved*)

ATTACHMENT C: Comprehensive Quality Strategy for the Healthy Michigan Program
(reserved)

ATTACHMENT D: ABW Childless Adults - Record Of Budget Neutrality Expenditure Limit

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

	Initial Preliminary Estimates		Revised Preliminary Estimates		Final Amounts	
	<u>Trend Factor</u>	<u>Amount</u>	<u>Trend Factor</u>	<u>Amount</u>	<u>Trend Factor</u>	<u>Amount</u>
Base Year Expenditure (Paragraphs IX.45(c) and (d))	N/A	\$132,072,780 Recorded On: 12/22/2009	N/A	N/A	N/A	\$132,072,780 Recorded On: 6/1/2010
FFY 2010 Expenditure Projection (Paragraph IX.45(e))	3.7% Recorded On: 12/22/2009	\$136,959,473 Recorded On: 12/22/2009	N/A	N/A	3.7% Recorded On: 12/22/2009	\$136,959,473 Recorded On: 6/1/2010
Annual Limit, DY 1 (Paragraph IX.45(f))	N/A	\$102,719,605 Recorded On: 12/22/2009	N/A	N/A	N/A	\$102,719,605 Recorded On: 6/1/2010
Annual Limit, DY 2 (Paragraphs IX.45(g) and (i))	4.6% Recorded On: 12/22/2009	\$143,259,609 Recorded On: 12/22/2009	N/A	N/A	4.3% Recorded On: 6/1/2010	\$142,848,730 Recorded On: 6/1/2010
Annual Limit, DY 3 (Paragraphs IX.45(h) and (i))	4.9% Recorded On: 12/22/2009	\$150,279,330 Recorded On: 12/22/2009	4.5% Recorded On: 6/1/2010	\$149,276,923 Recorded On: 6/1/2010	3.3% Recorded On: 8/11/2011	\$147,562,738 Recorded On: 8/11/2011
Annual Limit, DY 4 (Paragraphs IX.45(h) and (i))	5.2% Recorded On: 12/22/2009	\$158,093,855 Recorded On: 12/22/2009	4.6% Recorded On: 8/11/2011	\$154,350,624 Recorded On: 8/11/2011	2.9% Recorded On: 10/9/2012	\$151,842,057 Recorded On: 10/9/2012
Annual Limit, DY 5 (Paragraphs	5.6% Recorded On:	\$166,947,111 Recorded On: 12/22/2009	6.4% Recorded On: 10/9/2012	\$161,559,949 Recorded On: 10/9/2012	5.2% Recorded On: 12/30/2013	\$159,737,844 Recorded On: 12/30/2013

IX.45(h) and (i)	12/22/2009					
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The “Recorded On” date indicates the date in which a particular number or percentage was first incorporated (or, “recorded”) into an approved version of Attachment B.

ATTACHMENT E: Operational Protocol for the MI Health Accounts *(reserved)*

ATTACHMENT F: Healthy Behaviors Incentives Program Protocol (*reserved*)

ATTACHMENT G: Annual Update Of Rural Counties Not Required To Provide A Choice Of Managed Care Plans

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:

1. Alger;
2. Baraga;
3. Chippewa;
4. Delta;
5. Dickinson;
6. Gogebic;
7. Houghton;
8. Iron;
9. Keweenaw;
10. Luce;
11. Mackinac;
12. Marquette;
13. Menominee;
14. Ontonagon; and
15. Schoolcraft.

Healthy Michigan Program beneficiaries will be given their choice of plans and providers consistent with 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.

ATTACHMENT H: Final Report Framework

The final Demonstration Evaluation (draft report), in accord with the Special Terms and Conditions, should accompany the Final Report (draft) for CMS review.

The Final Report is the same as the final annual report if the document addresses:

Introduction

- Summarize history and state's experience
- Waivers (rationale and impact)
- Timeline for renewals, amendments, and other significant changes

Objectives, goals and hypotheses of the demonstration

- Description
- How met/not met

Lessons learned

- Operational/policy developments and issues
- Challenges/problems encountered and how addressed
 - Rationale for amendments and other significant changes
 - Innovative activities and/or promising practices
 - Examples: including ABD individuals in managed care;
 - pros/cons of a single MCO;
 - transition to multiple MCOs (challenges/lessons learned)
 - methodology
 - number of beneficiaries transitioned out and returning to Passport

Beneficiaries

- Who was enrolled
- Enrollment numbers charted over time
- Outreach and enrollment efforts (success and challenges)

Benefits

- Variations from state plan
- Utilization data and trends over time
- Consumer issues (types of complaints or problems identified; trends; resolution of complaints and any actions taken to prevent other occurrences)

Delivery system

- Providers – working with and monitoring providers
 - FQHCs/RHCs - role and impact
- Health Plans – working with and monitoring providers
- Performance improvement focus(es) and changes over time

Cost sharing

- Variations from state plan

Changes that occurred during the demonstration
Impact of any changes

Quality

- Quality Assurance and monitoring activities
- Quality Reports (names, dates and how to access reports)
 - Selections of quality indicators and data reporting
 - Quality improvement focus(es) and outcomes over time
- Beneficiary surveys and findings
- Provider surveys and findings

Other influences – actions and impact

- Legislature
- Advocates and other stakeholders
- Other (environmental, economic, etc.)

Budget Neutrality

- Actual budget neutrality (based on claim paid as of a specified date)
- Estimated final budget neutrality
 - Expenditure estimates for the demonstration based on historical data
 - Methodology for determining expenditure estimates

(Note: For temporary extension periods, use PMPM and trend rates from the last formal renewal)

Attachment I – ABW Benefits and Cost Sharing (effective through March 31, 2014)

Health Benefit Plan and Cost Sharing for Adult Benefits Waiver

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

	Plans (PIHP)/Community Mental Health Services Programs (CMHSP).	
Outpatient Hospital (Nonemergency Department)	Covered: Diagnostic and treatment services and diabetes education services. Prior authorization may be required for some services by the CHPs. Noncovered: Therapies, labor room, and partial hospitalization.	Maximum \$3 copayment for professional services
Pharmacy	Covered: <ul style="list-style-type: none"> • Products included on the Michigan Pharmaceutical Product List (except enteral formulas) that are ordered by an MD, DO, NP or type 10-enrolled oral surgeon. Prior authorization may be required by the CHPs. • Psychotropic medications are provided under the FFS benefit. Refer to Michigan Dept. of Community Health (MDCH) Pharmacy Benefit Manager (PBM) website for current list. Noncovered: injectable drugs used in clinics or physician offices.	Maximum \$1 copayment per prescription There are no copayments for family planning or pregnancy related drug products.
Physician Services	Covered per Medicaid policy.	Maximum \$3 copayment for office visits
Nurse Practitioner	Covered per Medicaid policy.	Maximum \$3 copayment for office visits
Oral Surgeon	Covered per Medicaid policy.	Maximum \$3 copayment for office visits
Medical Clinic	Covered per Medicaid policy.	Maximum \$3 copayment for office visits
Podiatrist	Not covered.	
Prosthetics/Orthotics	Not covered.	
Private Duty Nursing	Not covered.	
Substance Abuse	Covered through the Substance Abuse Coordinating Agencies (CAs).	

PT,OT, SP Therapy Evaluation	Occupational, physical and speech therapy evaluations are covered when provided by physicians or in the outpatient hospital setting. Therapy services are not covered in any setting.	Maximum \$3 copayment for office visits
Transportation (non-ambulance)	Not covered.	
Urgent Care Clinic	Professional services provided in a freestanding facility are covered. CHPs may require authorization by the primary care physician or plan administrator.	Maximum \$3 Copayment per visit