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State/Territory Name: MI

State Plan Amendment (SPA) #: 15-0015

This file contains the following documents in the order listed:

- 1) Approval Letter
- 2) CMS 179 Form/Summary Form (with 179-like data)
- 3) Approved SPA Pages

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



February 25, 2016

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

ATTN: Erin Black

Dear Mr. Priest:

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

- Transmittal #: 15-0015: Medicaid Expansion Cost Sharing
- Effective: January 1, 2016

If you have any questions, please contact Leslie Campbell at (312) 353-1557 or Leslie.Campbell@cms.hhs.gov.

Sincerely,

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

Enclosures

**TRANSMITTAL AND NOTICE OF APPROVAL OF
STATE PLAN MATERIAL
FOR: HEALTH CARE FINANCING ADMINISTRATION**

1. TRANSMITTAL NUMBER: 15 - 0015	2. STATE: Michigan
3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID) TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
4. PROPOSED EFFECTIVE DATE January 1, 2016	

TO: REGIONAL ADMINISTRATOR
HEALTH FINANCING ADMINISTRATION
DEPARTMENT OF HUMAN SERVICES

5. TYPE OF PLAN MATERIAL (Check One):

NEW STATE PLAN AMENDMENT TO BE CONSIDERED AS NEW PLAN AMENDMENT


COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate Transmittal for each amendment)

6. FEDERAL STATUTE/REGULATION CITATION:	7. FEDERAL BUDGET IMPACT: a. FFY 2016 \$0 b. FFY 2017 \$0
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Attachment 4.18-F, Pages 1,2,3,4	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable): New Attachment

10. SUBJECT OF AMENDMENT:
Establish a premium section due to transition from MIChild to Medicaid Expansion.

11. GOVERNOR'S REVIEW (Check One):

GOVERNOR'S OFFICE REPORTED NO COMMENT OTHER, AS SPECIFIED:
 COMMENTS OF GOVERNOR'S OFFICE ENCLOSED Chris Priest, Director
 NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL Medical Services Administration

12. SIGNATURE OF STATE AGENCY OFFICIAL: 	16. RETURN TO: Medical Services Administration Actuarial Division - Federal Liaison Capitol Commons Center - 7 th Floor 400 South Pine Lansing, Michigan 48933 Attn: Erin Black
13. TYPED NAME: Chris Priest	
14. TITLE: Director, Medical Services Administration	
15. DATE SUBMITTED: December 16, 2015	

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: December 16, 2015	18. DATE APPROVED: February 25, 2016
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PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: January 1, 2016	20. SIGNATURE OF REGIONAL OFFICIAL: /s/
21. TYPE NAME: Ruth A. Hughes	22. TITLE: Associate Regional Administrator

23. REMARKS:

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of MICHIGAN

It should be noted that States can select one or more options in imposing premiums.

A. For groups of individuals with family income at or below 100 percent of the FPL:

1. Premiums

a. / No premiums will be imposed for individuals with family income at or below 100 percent of the FPL.

/ Other (specify the premium amounts by group and income level).

B. For groups of individuals with family income above 100 percent but below 150 percent of the FPL:

1. Premiums

A No premiums may be imposed for individuals with family income above 100 percent but below 150 percent of the FPL.

TN No. 15-0015

Approval Date: 2/25/16

Effective Date: 1/01/2016

Supersedes

TN No. NEW

CMS-101090 (09/06)

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of MICHIGAN

C. For groups of individuals with family income above 150 percent of the FPL:

1. Premiums

- a. ___/ No premiums are imposed.
- b. **X/** Premiums are imposed under section 1916A of the Act as follows (specify the premium amount by group and income level.

Group of Individuals	Premium	Method for Determining Family Income (including monthly or quarterly period)
Optional targeted low income children as described in 1902(a)(10)(A)(9ii)(XIV) and 42 CFR 435.229 who are under 19 years of age and whose income is between 160-212 per cent of the Federal Poverty Level.	\$10.00 per month per family	Modified Adjusted Gross Income (MAGI) method is applied when determining eligibility for this Medicaid expansion group

Attach a schedule of the premium amounts for the various eligibility groups.

Not Applicable: The premium is set at \$10.00 per month per family.

b. Limitation:

- The total aggregate amount of premiums and cost sharing imposed for all individuals in the family may not exceed 5 percent of the family income of the family involved, as applied on a monthly or quarterly basis as specified by the State above.

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c. No premiums shall be imposed for the following individuals:

- Individuals under 18 years of age that are required to be provided medical assistance under section 1902(a)(10)(A)(i), and including individuals with respect to whom aid or assistance is made available under part B of title IV to children in foster care and individuals with respect to whom adoption or foster care assistance is made available under part E of such title, without regard to age;
- Pregnant women;
- Any terminally ill individual receiving hospice care, as defined in section 1905(o);
- Any individual who is an inpatient in a hospital, nursing facility, intermediate care facility, or other medical institution, if such individual is required, as a condition of receiving services in such institution under the State plan, to spend for costs of medical care all but a minimal amount of the individual's income required for personal needs; and
- Women who are receiving Medicaid by virtue of the application of sections 1902(a)(10)(A)(ii)(XVIII) and 1902(aa) of the Act.
- An Indian who is eligible to receive or has received an item or service furnished by an Indian health care provider or through referral under contract health services is exempt from premiums.

d. Enforcement

1. ___/ Prepayment required for the following groups of individuals who are applying for Medicaid:

2. **X**/ Eligibility terminated after failure to pay for 60 days for the following groups of individuals who are receiving Medicaid: Optional targeted low income children as described in 1902(a)(10)(A)(9ii)(XIV) and 42 CFR 435.229 who are under 19 years of age and whose income is between 160-212 per cent of the Federal Poverty Level.

3. ___/ Payment will be waived on case-by-case basis for undue hardship.

D. Period of determining aggregate 5 percent cap

Specify the period for which the 5 percent maximum would be applied.

___/ Quarterly

___/ Monthly

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

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