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State/Territory Name: MI

State Plan Amendment (SPA)#: 19-1001

**SPA: Certified Nurse Midwife EPSDT School Based Services
Simplification ABP SPA**

This file contains the following documents in the order listed:

- 1) Approval Letter
- 2) Summary Form (with 179-like data)
- 3) CNM and EPSDT SBS Simplification ABP SPA Pages from MMDL

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
233 N. Michigan Avenue, Suite 600
Chicago, Illinois 60601-5519



Regional Operations Group

August 9, 2019

Kate Massey
State Medicaid Director
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 Ms. Massey:

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

- Transmittal #:19-1001 – Certified Nurse Midwives and EPSDT/School Based Services Simplification
- Effective: January 1, 2019
- Approval Date: August 8, 2019

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

Sincerely,

/s/

Ruth A. Hughes
Deputy Director
Center for Medicaid & CHIP Services
Regional Operations Group

Enclosures

Medicaid Alternative Benefit Plan: Summary Page (CMS 179)

State/Territory name: **Michigan**

Transmittal Number:

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

MI-19-1001

Proposed Effective Date

01/01/2019 (mm/dd/yyyy)

Federal Statute/Regulation Citation

Section 1937 of the Social Security Act

Federal Budget Impact

	Federal Fiscal Year	Amount
First Year	2019	\$ 0.00
Second Year	2020	\$ 0.00

Subject of Amendment

This State Plan Amendment (SPA) is submitted to make changes to ABP5 to modify the description for EPSDT to be consistent with the Medicaid State Plan effective 1/1/19 (related SPA 18-0013). In addition, the SPA updates ABP 5 to modify the description for

Governor's Office Review

- Governor's office reported no comment Comments of Governor's office received

Describe:

- No reply received within 45 days of submittal Other, as specified

Describe:

Kathleen Stiffler, Acting Director
Medical Services Administration

Signature of State Agency Official

Submitted By: **Erin Black**
Last Revision Date: **Aug 6, 2019**
Submit Date: **Mar 28, 2019**

Medicaid Alternative Benefit Plan

Medicaid Alternative Benefit Plan: General Information

State/Territory name: **Michigan**
 Transmittal Number: **MI-19-1001**

General Information:

Submission Title:

short (under 100 characters) label used to identify this submission in the web application

MI Alternative Benefit Plan (ABP) MI-19-1001

Description:

SPA estab Alternative Benefit Plan(ABP) MI uses to implement requirements of the Healthy Michigan Plan(HMP)as stated in MI's PA 107 of 2013.

Public notice has been conducted prior to SPA submission pursuant to 42 CFR 440.386.

ABP Screening Statements to Indicate Required Forms

Select one of the following options for eligibility group coverage:

- The population group for this Alternative Benefit Plan includes only the adult group under section 1902(a)(10)(A)(i)(VIII) of the Act. If the state selects this option, the state must complete form ABP2a to indicate agreement to voluntary benefit package selection assurances for the adult group.**
- The population group for this Alternative Benefit Plan includes the adult group under section 1902(a)(10)(A)(i)(VIII) of the Act, and also includes other groups. If the state selects this option, the state must complete forms ABP2a and ABP2b to indicate agreement to voluntary benefit package selection assurances for the adult group and voluntary enrollment assurances for other eligibility groups.**
- The population for this Alternative Benefit Plan does not include the adult group under section 1902(a)(10)(A)(i)(VIII) of the Act. If the state selects this option, the state must complete form ABP2b to indicate agreement to voluntary enrollment assurances for these eligibility groups.**

Enrollment is mandatory for some or all participants. *If selected, the state must complete form ABP2c to indicate agreement to mandatory enrollment assurances.*

Specify the number of **benchmark** benefit packages that will be created or amended with this submission. *The state must submit one version of forms ABP3, ABP4, ABP5, and ABP8 for each benchmark benefit package.*

1

Specify the number of **benchmark-equivalent** benefit packages that will be created or amended with this submission. *The state must submit one version of forms ABP3, ABP4, ABP6, and ABP8 for each benchmark-equivalent benefit package.*

0

Medicaid Alternative Benefit Plan: File Management Summary

State/Territory name: **Michigan**
 Transmittal Number: **MI-19-1001**

Form Code	Form Name	Uploaded Form Count
ABP1	Alternative Benefit Plan Populations	1
ABP2a	Voluntary Benefit Package Selection Assurances - Eligibility Group under Section 1902(a)(10)(A)(i)(VIII) of the Act	1
ABP2b	Voluntary Enrollment Assurances for Eligibility Groups other than the Adult Group under Section 1902(a)(10)(A)(i)(VIII) of the Act	0
ABP2c	Enrollment Assurances - Mandatory Participants	0
ABP3	Selection of Benchmark Benefit Package or Benchmark-Equivalent Benefit Package	1
ABP4	Alternative Benefit Plan Cost-Sharing	1

Form Code	Form Name	Uploaded Form Count
ABP5	Benefits Description	1
ABP6	Benchmark-Equivalent Benefit Package	0
ABP7	Benefits Assurances	1
ABP8	Service Delivery Systems	1
ABP9	Employer Sponsored Insurance and Payment of Premiums	1
ABP10	General Assurances	1
ABP11	Payment Methodology	1

Medicaid Alternative Benefit Plan: File Management Detail

Form ABP1: Alternative Benefit Plan Populations

ABP1 Forms List

Form
Please provide a short description of this ABP1 form: This state plan page identifies and defines eligible Medicaid populations that will receive their Medicaid coverage through an Alternative Benefit Plan (ABP).
Uploaded Form Name: ABP1 Alternative Benefit Plan Populations FINAL (1-22-14).pdf
Date Uploaded: 01/22/2014

Support Documents

Document
Please provide a short description of this support document: MI Public Notice regarding a State Plan Amendment for an Alternative Benefit Plan for an Expanded Adult Population
Uploaded Document Name: ABP State Plan Amendment Public Notice_438191_7.pdf
Date Uploaded: 03/21/2014

Form ABP2a: Voluntary Benefit Package Selection Assurances - Eligibility Group under Section 1902(a)(10)(A)(i)(VIII) of the Act

ABP2a Forms List

Form
Please provide a short description of this ABP2a form: This is the first in the series of Alternative Benefit Plan (ABP) fillable PDFs (state plan pages) in which the state or territory provides assurances concerning the enrollment of Medicaid beneficiaries
Uploaded Form Name: ABP2a Voluntary Benefit Package Selection Assurances FINAL (03-14-14).pdf
Date Uploaded: 01/22/2014

Support Documents

Document

Form ABP2b: Voluntary Enrollment Assurances for Eligibility Groups other than the Adult Group under Section 1902(a)(10)(A)(i)(VIII) of the Act

ABP2b Forms List

Form

Support Documents

Document

Form ABP2c: Enrollment Assurances - Mandatory Participants

ABP2c Forms List

Form

Support Documents

Document

Form ABP3: Selection of Benchmark Benefit Package or Benchmark-Equivalent Benefit Package

ABP3 Forms List

Form

Please provide a short description of this ABP3 form:

This state plan page selects the Alternative Benefit Plan's (ABP) section 1937 coverage option and its base benchmark plan that Michigan used to establish the benefit package provided through the ABP. //

Uploaded Form Name:

Date Uploaded: 01/22/2014

ABP3 Selection of Benchmark Benefit Package or Benchmark Equivalent Package FINAL (3-14-14).pdf

Support Documents

Document

Form ABP4: Alternative Benefit Plan Cost-Sharing

ABP4 Forms List

Form

Please provide a short description of this ABP4 form:

This state plan page provides the State's assurances related to the imposition of any cost-sharing or premium requirements on beneficiaries participating in the Alternative Benefit Plan (ABP). //

Uploaded Form Name:

Date Uploaded: 01/22/2014

ABP4 Alternative Benefit Plan Cost Sharing FINAL (3-14-14).pdf

Support Documents

Document

Form ABP5: Benefits Description

TN: 19-1001

Michigan

Approval Date: 08/08/2019

Effective Date: 1/1/19

ABP5 Forms List

Form
Please provide a short description of this ABP5 form: This state plan page is used to indicate that Michigan's Alternative Benefit Plan's (ABP) benefits are provided as part of a benchmark benefit package. It also provides details concerning the benefits that
Uploaded Form Name: ABP5_Benefits_Description 3-20-19 Simplify.pdf
Date Uploaded: 01/22/2014

Support Documents

Document
Please provide a short description of this support document: Public Notice Dated 12/30/18 - Newspaper Clip
Uploaded Document Name: C5-Clip GR.pdf
Date Uploaded:

Form ABP6: Benchmark-Equivalent Benefit Package

ABP6 Forms List

Form

Support Documents

Document

Form ABP7: Benefits Assurances

ABP7 Forms List

Form
Please provide a short description of this ABP7 form: This state plan page provides a number of assurances concerning the benefits provided under the Alternative Benefit Plan (ABP).
Uploaded Form Name: ABP7 Benefits Assurances FINAL (1-22-14).pdf
Date Uploaded: 01/22/2014

Support Documents

Document

Form ABP8: Service Delivery Systems

ABP8 Forms List

Form

Form

Please provide a short description of this ABP8 form:

This state plan page indicates and describes the service delivery system(s) Michigan will use to deliver benefits to its Alternative Benefit Plan's (ABP) participants.

Uploaded Form Name:

Date Uploaded: 01/22/2014

ABP8 Service Delivery Systems FINAL 4-22-14 v2.pdf

Support Documents

Document

Form ABP9: Employer Sponsored Insurance and Payment of Premiums

ABP9 Forms List**Form**

Please provide a short description of this ABP9 form:

This state plan page indicates the State's decision to provide Alternative Benefit Plan (ABP) coverage, in whole or in part, by paying for employer sponsored health plans for individuals with

Uploaded Form Name:

Date Uploaded: 01/22/2014

ABP9 Employer Sponsored Insurance and Payment of Premiums FINAL (1-22-14).pdf

Support Documents

Document

Form ABP10: General Assurances

ABP10 Forms List**Form**

Please provide a short description of this ABP10 form:

This state plan page provides Michigan's assurances concerning compliance with general Medicaid requirements for a section 1937 Alternative Benefit Plan (ABP) state plan submission.

Uploaded Form Name:

Date Uploaded: 01/22/2014

ABP10 General Assurances FINAL (1-22-14).pdf

Support Documents

Document

Form ABP11: Payment Methodology

ABP11 Forms List**Form**

Form

Please provide a short description of this ABP11 form:

This state plan page provides Michigan's assurances concerning payment methodologies that will be used for the Alternative Benefit Plan's (ABP) benefits when the benefits are provided through a

Uploaded Form Name:**Date Uploaded: 01/22/2014**

ABP11 Payment Methodology FINAL (1-22-14).pdf

Support Documents**Document****Medicaid Alternative Benefit Plan: Tribal Input****State/Territory name:****Michigan****Transmittal Number:****MI-19-1001** **One or more Indian Health Programs or Urban Indian Organizations furnish health care services in this State.** **This State Plan Amendment is likely to have a direct effect on Indians, Indian health programs or Urban Indian Organizations.** **The State has solicited advice from Indian Health Programs, Urban Indian Organizations, and/or Tribal governments prior to submission of this State Plan Amendment.***Complete the following information regarding any tribal consultation conducted with respect to this submission:***Tribal consultation was conducted in the following manner. States are not required to consult with Indian tribal governments, but if such consultation was conducted voluntarily, provide information about such consultation below:** **Indian Tribes** **Indian Health Programs** **Urban Indian Organization****The state must upload copies of documents that support the solicitation of advice in accordance with statutory requirements, including any notices sent to Indian Health Programs and/or Urban Indian Organizations, as well as attendee lists if face-to-face meetings were held. Also upload documents with comments received from Indian Health Programs or Urban Indian Organizations and the state's responses to any issues raised. Alternatively indicate the key issues and summarize any comments received below and describe how the state incorporated them into the design of its program.****Document**

Please provide a short description of this support document:

Michigan's Tribal Notification letter dated December 20, 2018.

Uploaded Document Name:**Date Uploaded: 01/22/2014**

L 18-75.pdf

Please provide a short description of this support document:

Michigan's Tribal Notification letter dated September 26, 2018.

Uploaded Document Name:**Date Uploaded:**

L 18-51.pdf

Please provide a short description of this support document:

Michigan's Tribal Notification letter dated November 16, 2018.

Uploaded Document Name:**Date Uploaded:**

L_18-65_638699_7.pdf

Indicate the key issues raised in Indian consultative activities:

TN: 19-1001

Michigan

Approval Date: 08/08/2019

Effective Date: 1/1/19

Access

Summarize Comments

Summarize Response

Quality

Summarize Comments

Summarize Response

Cost

Summarize Comments

Summarize Response

Payment methodology

Summarize Comments

Summarize Response

Eligibility

Summarize Comments

Summarize Response

Benefits

Summarize Comments

Summarize Response

Service delivery

Summarize Comments

Summarize Response

Other Issue

TN: 19-1001

Michigan

Approval Date: 08/08/2019

Effective Date: 1/1/19

Medicaid Alternative Benefit Plan: Summary Page (CMS 179)

State/Territory name:

Michigan

Transmittal Number:

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

MI-19-1001