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State/Territory Name: Michigan

State Plan Amendment (SPA)#: 23-0500

This file contains the following documents in the order listed

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
601 E. 12th St., Room 355
Kansas City, Missouri 64106

CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

Medicaid and CHIP Operations Group

March 22, 2024

Meghan E. Groen
Senior Deputy Director
Behavioral and Physical Health and Aging Services Administration
Michigan Department of Health and Human Services
400 S Pine St 7th Fl
Lansing, MI 48933-2250

Re: Michigan State Plan Amendment (SPA) 23-0500

Dear Director Groen:

The Centers for Medicare & Medicaid Services (CMS) reviewed your State Plan Amendment (SPA) submitted under transmittal number (TN) 23-0500. This SPA updates G2c and G3 templates to eliminate the Healthy Michigan Plan copay tier and modify the cost sharing limitation language to remove the references to the Healthy Michigan Plan.

We conducted our review of your submittal according to the statutory requirements at Sections 1916 and 1916A of the Social Security Act and 42 CFR 447.52 through .57. We hereby inform you that Medicaid State plan amendment 23-0500 is approved effective January 1, 2024. We are enclosing the CMS-179 and the amended plan pages. Please note that CMS is approving MI 23-0500 at the same time as the MI SPA 24-0500. MI SPA 24-0500 supersedes some cost sharing policy approved in 23-0500.

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

Sincerely,

Digitally signed by James G. Scott -S
Date: 2024.03.22 15:26:15 -05'00'

James G. Scott, Director
Division of Program Operations

Enclosures

cc: Erin Black

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

State/Territory name: **Michigan**

Transmittal Number:

Enter the Transmittal Number (TN), including dashes, in the format SS-YY-NNNN or SS-YY-NNNN-xxxx (with xxxx being optional to specific SPA types), where SS = 2-character state abbreviation, YY = last 2 digits of submission year, NNNN = 4-digit number with leading zeros, and xxxx = OPTIONAL, 1- to 4-character alpha/numeric suffix.

MI-23-0500

Proposed Effective Date

01/01/2024 *(mm/dd/yyyy)*

Federal Statute/Regulation Citation

Sections 1916 and 1916A of SSA and 42 CFR 447.52 through .57

Federal Budget Impact

	Federal Fiscal Year	Amount
First Year	2024	$ 0.00
Second Year	2025	$ 0.00

Subject of Amendment

This State Plan Amendment (SPA) is being submitted to update G2c and G3 templates to eliminate the HMP copay tier and modify the cost sharing limitation language to remove the HMP references.

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:

  Meghan Groen, Director
  Behavioral and Physical Health and Aging Services Administration

Signature of State Agency Official

Submitted By:	**Erin Black**
Last Revision Date:	**Feb 27, 2024**
Submit Date:	**Dec 22, 2023**

Medicaid Premiums and Cost Sharing

State Name: Michigan

OMB Control Number: 0938-1148

Transmittal Number: MI - 23 - 0500

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

PRA Disclosure Statement

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

V.20181119

Medicaid Premiums and Cost Sharing

State Name: Michigan

OMB Control Number: 0938-1148

Transmittal Number: MI - 23 - 0500

Expiration date: 10/31/2014

Cost Sharing Limitations G3

42 CFR 447.56
1916
1916A

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

Exemptions

Groups of Individuals - Mandatory Exemptions

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

■ Individuals ages 1 and older, and under age 18 eligible under the Infants and Children under Age 18 eligibility group (42 CFR 435.118).

■ Infants under age 1 eligible under the Infants and Children under Age 18 eligibility group (42 CFR 435.118), whose income does not exceed the higher of:

- ■ 133% FPL; and
- ■ If applicable, the percent FPL described in section 1902(l)(2)(A)(iv) of the Act, up to 185 percent.

■ Disabled or blind individuals under age 18 eligible for the following eligibility groups:

- ■ SSI Beneficiaries (42 CFR 435.120).
- ■ Blind and Disabled Individuals in 209(b) States (42 CFR 435.121).
- ■ Individuals Receiving Mandatory State Supplements (42 CFR 435.130).

■ Children for whom child welfare services are made available under Part B of title IV of the Act on the basis of being a child in foster care and individuals receiving benefits under Part E of that title, without regard to age.

■ Disabled children eligible for Medicaid under the Family Opportunity Act (1902(a)(10)(A)(ii)(XIX) and 1902(cc) of the Act).

■ Pregnant women, during pregnancy and through the postpartum period which begins on the last day of pregnancy and extends through the end of the month in which the 60-day period following termination of pregnancy ends, except for cost sharing for services specified in the state plan as not pregnancy-related.

■ Any individual whose medical assistance for services furnished in an institution is reduced by amounts reflecting available income other than required for personal needs.

■ An individual receiving hospice care, as defined in section 1905(o) of the Act.

■ Indians who are currently receiving or have ever received an item or service furnished by an Indian health care provider or through referral under contract health services.

■ Individuals who are receiving Medicaid because of the state's election to extend coverage to the Certain Individuals Needing Treatment for Breast or Cervical Cancer eligibility group (42 CFR 435.213).

Groups of Individuals - Optional Exemptions

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

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

Indicate below the age of the exemption:

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

Description:

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

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

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

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

Services - Mandatory Exemptions

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

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

Medicaid Premiums and Cost Sharing

Enforceability of Exemptions

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

■ To identify that American Indians/Alaskan Natives (AI/AN) are currently receiving or have ever received an item or service furnished by an Indian health care provider or through referral under contract health services in accordance with 42 CFR 447.56(a)(1)(x), the state uses the following procedures:

- ☒ The state accepts self-attestation
- ☐ The state runs periodic claims reviews
- ☐ The state obtains an Active or Previous User Letter or other Indian Health Services (IHS) document
- ☒ The Eligibility and Enrollment and MMIS systems flag exempt recipients
- ☐ Other procedure

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

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

■ To identify all other individuals exempt from cost sharing, the state uses the following procedures (check all that apply):

- ☒ The MMIS system flags recipients who are exempt
- ☒ The Eligibility and Enrollment System flags recipients who are exempt
- ☐ The Medicaid card indicates if beneficiary is exempt
- ☒ The Eligibility Verification System notifies providers when a beneficiary is exempt
- ☐ Other procedure

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

Payments to Providers

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

Payments to Managed Care Organizations

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

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

Aggregate Limits

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

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

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

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

- ◉ Quarterly
- ○ Monthly

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

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

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

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

☒ Other process:

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

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

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

Notice #1: New Beneficiaries

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

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

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

Notice #2: Existing Beneficiaries

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

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

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

Describe the appeals process used:

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

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

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

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

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

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

PRA Disclosure Statement

V.20140415