STATE OF MICHIGAN
DEPARTMENT OF HEALTH AND HUMAN SERVICES
LANSING

RICK SNYDER
GOVERNOR

NICK LYON
DIRECTOR

September 1, 2015

Eliot Fishman, Director
State Demonstrations Group
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-01-16
Baltimore, Maryland 21244-1850

Dear Dr. Fishman,

The State of Michigan hereby submits its formal application to amend the State's current Section 1115 Demonstration Program known as the Healthy Michigan Plan. The State is seeking approval of this amendment in order to implement certain directives contained in the State law known as Public Act 107 of 2013 and in turn, continue to provide affordable and accessible health care coverage for approximately 600,000 Michigan citizens.

The Healthy Michigan Plan is a model for providing a comprehensive benefit package while managing health care costs. Specifically, the benefit design aims to assist individuals in managing their health care needs while encouraging them to maintain or attain healthy behaviors and utilize high value services whenever possible.

As required by PA 107 of 2013, the State respectfully requests approval of the proposed amendment by December 31, 2015.

We appreciate the assistance both you and your colleagues at the Centers for Medicare & Medicaid Services have already provided, and look forward to working together to achieve our mutual goal of improving the health and well-being of Michigan's citizens.

Sincerely,

Kathy Stiffler, Acting Director
Medical Services Administration

cc: Leila Ashkeboussi, CMS
Paul Boben, CMS
Andrea Casart, CMS
Tonya Moore, CMS

Enclosure

Amendment to Michigan's Section 1115 Demonstration Known as the

"Healthy Michigan Plan"

Submitted Under Authority of Section 1115 of the Social Security Act

to the

Centers for Medicare & Medicaid Services

US Department of Health and Human Services

September 1, 2015

State of Michigan

Rick Snyder, Governor

Nick Lyon, Director
Michigan Department of Health and Human Services
Capitol View Building
201 Townsend Street
Lansing, MI 48913

I. Overview

The State of Michigan seeks approval of a Section 1115 waiver amendment from the Centers for Medicare & Medicaid Services to modify the health care coverage program known as the Healthy Michigan Plan. Approval of this request would allow the State of Michigan to maintain coverage for approximately 600,000 individuals currently enrolled in the program.

State law, MCL 400.105d(20), directs the Michigan Department of Health and Human Services (Department) to seek a waiver that requires individuals who are between 100% and 133% of the federal poverty level and have had Healthy Michigan Plan coverage for 48 cumulative months to choose one of the two options described below. A copy of the State law is provided in Attachment A.

a. **Option 1 – Receive Services Through the Federal Marketplace**

Beneficiaries selecting Option 1 would change their Medicaid Health Plan eligibility status to receive services from a Qualified Health Plan (QHP) through the Federal Marketplace. Consistent with federal law, amounts comparable to the beneficiary's advanced premium tax credits and a cost sharing subsidy in the form of premium assistance will be used to pay for their health coverage. Beneficiaries will pay premiums consistent with the current specifications of the Affordable Care Act and cost-sharing will be administered as required through the QHP.

b. **Option 2 – Receive Services Through a Medicaid Health Plan**

Under this option, individuals will continue to receive services through a Medicaid Health Plan, but they will be subject to an increased limit on their total cost-sharing up to 7% of income and an increase in their contributions to 3.5% of income. The beneficiary's contribution amounts will be factored into the 7% of the total cost-sharing limit. These cost-sharing and contribution requirements may be reduced if the beneficiary participates in healthy behavior activities as currently allowed in the Healthy Michigan Plan.

The Department will also pursue an expansion of healthy behavior activities for those beneficiaries affected by the increased cost-sharing and contribution requirements described in this proposed waiver amendment. This expansion may include cost-sharing and contribution reductions for beneficiary's historical receipt of preventive services and evidence of appropriate service utilization patterns. Beneficiaries meeting these healthy behavior criteria in the preceding 12 months may receive the reduction of the cost-sharing and contribution requirements.

Individuals who do not make an affirmative choice between Option 1 and Option 2 will remain in the Healthy Michigan Plan and be subject to the proposed increased cost-sharing and contribution requirements as described under Option 2.

Medically Frail individuals described in 42 CFR §440.315 are not subject to the provisions of this waiver amendment and will remain in the Healthy Michigan Plan, and will continue to be subject to the cost-sharing and contribution requirements of the underlying waiver.

II. Eligibility, Benefits and Delivery Systems

a. Eligibility and Enrollment

For the population remaining in Option 2, the State's enrollment broker will continue to facilitate enrollment in a Medicaid Health Plan either by assisting beneficiaries as they select their health plan or through the auto-assignment process. All other health plan enrollment processes set forth in the State's approved §1915(b) comprehensive waiver will be used. Individuals who select Option 1 will be enrolled in a QHP offered in the Marketplace.

b. Benefits

All beneficiaries covered by Option 1 and Option 2 under the proposed amendment will remain eligible for services consistent with the Alternative Benefit Plan as described in the Medicaid State Plan. Individuals selecting coverage through the Marketplace will receive the essential health benefits through their QHPs.

c. Delivery System

Under Option 1, individuals electing coverage through the Marketplace will receive services through the QHPs consistent with the requirements and standards of the Affordable Care Act and state insurance laws, and in a manner consistent with their plan choice.

Individuals selecting Option 2 will receive services through the Healthy Michigan Plan managed care plans. Covered services for this population will be provided consistent with the authorities granted under the State's approved §1915(b) comprehensive health plan waiver and any other applicable waiver(s) relevant to the State's existing Healthy Michigan Plan §1115 demonstration.

III. Implementation

State law requires approval of the proposed amendment by December 31, 2015. The Department requests an implementation date of April 1, 2018, the first date in which an individual could reach the cumulative 48 month enrollment requirement.

IV. Evaluation

The Department will ensure that its evaluation design for the current Section 1115 demonstration is updated to reflect the changes described herein. Specifically, the

Department will evaluate the modifications to the cost-sharing requirements and the impact on utilization as well as the choice of coverage for the subset of beneficiaries affected by the above changes. Updates and additions will also be incorporated into the State's quality strategy as appropriate, and timely and accurate reporting on the implementation process will occur through the State's existing Section 1115 waiver reporting process, consistent with directives from the Centers for Medicare & Medicaid Services.

V. Budget Neutrality

The proposed amendment is not anticipated to have a material impact on the current budget neutrality agreement. The State will manage the aggregate waiver per-member-per-month expenditure within the applicable budget neutrality cap.

VI. Waivers and Expenditure Authorities

The Department seeks waiver of the following requirements of the Social Security Act:

- *Cost Sharing §1902(a)(14) as it incorporates §§1916 and 1916(A)*

  To the extent necessary to enable the State to impose co-pays and contributions in the amounts described herein.

- *Comparability §1902(a)(17) or § 1902(a)(10)(B)*

  To the extent necessary to vary the premiums, aggregate cost-sharing caps, and healthy behavior reduction options depending on an individual's income and whether or not that individual is in their first 48 months of coverage.

- *Prior Authorization Requirements §1902(a)(54) insofar as it incorporates §1927(d)(5)*

  To the extent necessary, to waive the 72 hour requirement for those electing to enroll in a QHP.

- *Freedom of Choice §1902(a)(23)(A)*

  To the extent necessary, to limit choice of providers to those in the marketplace option.

- *Payment to Providers §1902(a)(13) and §1902(a)(30)*

  To the extent necessary, to pay providers market based rates as determined by the QHP.

VII. Public Notice Process

a. Public Notice, Comment and Hearings Process

The Department began discussions on the proposed amendment in November of 2014 at the Medical Care Advisory Council meeting. The Department continued to provide updates on the progress and proposed content of the amendment at meetings of this group throughout 2015 (February 19th, May 5th and August 12th). Copies of the relevant agendas are included as Attachment B.

The Department extended its engagement with the public on May 29, 2015 with the creation of a dedicated webpage accessed via the State's longstanding demonstration web address at www.michigan.gov/healthymichiganplan. The Department developed this webpage to inform the public and stakeholders about the waiver amendment process, which included public notice and hearing information, and provided opportunities for and instructions on how to submit comments. The webpage and its related documents also included detailed information on the proposed amendment, a description of the program, information on the impacted populations, cost-sharing and benefits information, the relevant waiver and expenditure authorities, expected financial impacts and proposed evaluation design modifications (among other items).

Public notice was also published in select newspapers throughout the state on or around June 12, 2015, which included, among other information, details regarding the proposed amendment as well as website, hearing and public comment information. A copy of this notice is included as Attachment C.

A public hearing regarding the proposed waiver amendment was held on June 24, 2015 in Lansing, MI. In addition to the notice procedures described above, the Department emailed providers, stakeholders and the media of this event, and information also appeared in the State's legislative news services publication. This hearing had telephone, webinar and in-person capability (with sign language interpretation available for those present in Lansing). The hearing was well attended by stakeholders as well as the media. The Department was encouraged by the level of support offered for the Healthy Michigan Plan during this hearing, as well as the thoughtful comments on cost-sharing relief and benefit plan design, to name a select few, that resulted from this event.

Comments were accepted until July 31, 2015, with a majority being letters of support for the Healthy Michigan Plan. As required by the existing Special Terms and Conditions, the Department includes a summary of the comments received, with notes of any changes to the proposal as a result, as Attachment D.

b. Tribal Consultation

Consistent with the State Plan, the Department issued a letter on June 1, 2015 notifying the Tribal Chairs and Health Directors of the plan to submit the proposed

waiver amendment. A copy of this notice is included as Attachment E. This letter also informed recipients of a conference call, held on June 26, 2015, to seek consultation regarding the proposed amendment and answer any questions. Several Department staff participated on this conference call, along with Tribal members and representatives of the Centers for Medicare & Medicaid Services. Tribal members and their colleagues were engaged during the presentation of the proposed amendment and asked a number of pointed questions, including clarification of the potential impacts of the increased cost-sharing requirements on the Native American population and the differences between the Medicaid program and the Federal Marketplace. Department staff clarified the current regulatory exemption framework for Native American beneficiaries in response to these comments, and encouraged participants to share comments or suggestions and offered additional consultation opportunities upon request.

Department staff also presented the proposed amendment in person at the quarterly Tribal Health Director's Meeting in the State's Upper Peninsula on July 15, 2015. This meeting was well attended, resulting in comments and questions regarding the impacts to all beneficiaries if the waiver amendment is not approved, as well as the impacts of the proposed changes (to cost-sharing and other program elements) for Native Americans.

A second Tribal consultation call was held on August 17, 2015, during which the Department provided a status update on the waiver amendment process, a review of current cost-sharing requirements for Healthy Michigan Plan and Tribal members, and the opportunity for Tribal members to advise the Department on this matter.

Tribal members expressed concern over the possibility that they may be required to go to the Marketplace for health care services, and requested that they be exempt from this requirement and continue to receive services through the Healthy Michigan Plan. Tribal members also requested that they continue to be exempt from cost-sharing and contributions consistent with law, regulation and policy. Furthermore, they requested the Department continue to keep them apprised of waiver-related developments as part of standing consultation processes.

A copy of the relevant agendas from the above consultation events is included as Attachment F. The Department considered the questions and comments raised during its preparation of the proposed amendment.

c. Additional Stakeholder Engagement

The Department has also discussed the proposed amendment in additional venues as part of its ongoing outreach and engagement with its stakeholders. The following is a listing of locations and events at which the Department addressed the proposed amendment.

- Michigan State Medical Society Quarterly Meeting – March 16, 2015

- Health Plan CEO meeting – April 1, 2015
- Michigan Commission on Aging – May 15, 2015
- National Kidney Foundation – May 20, 2015
- Foundations Meeting – May 21, 2015
- Health Plan CEO meeting – June 3, 2015
- Michigan Elder Justice Summit – June 9, 2015
- Michigan Oral Health Conference – June 11, 2015
- Michigan State Medical Society Quarterly Meeting – June 23, 2015
- Local Health Department Presentation (Manistee, MI) – June 25, 2015
- WDET Radio Interview – June 26, 2015
- Michigan Hospital Association – June 26, 2015
- Michigan Association of Health Plans Summer Conference – July 16, 2015
- Health Center Presentation (Hannahville Health Center) –July 21, 2015
- Michigan Primary Care Association – July 24, 2015
- Michigan Association of Health Plans – July 24, 2015
- WXYZ Channel 7 Interview – June 28, 2015
- Medicaid Health Plans Monthly Operations Meeting– August 4, 2015
- Federally Qualified Health Centers Council of Southeast Michigan National Health Center Week Symposium – August 6, 2015
- Health Plan CEO meeting – August 12, 2015

VIII. Attachments

- Attachment A: State of Michigan Law
- Attachment B: MCAC Agendas
- Attachment C: Public Notice
- Attachment D: Comment Summary
- Attachment E: Tribal Notice
- Attachment F: Tribal Consultation Agendas

THE SOCIAL WELFARE ACT (EXCERPT)
Act 280 of 1939

400.105d Medical assistance program; waiver; acceptance of medicare rates by hospital as payments in full; submission of approved waiver provisions to legislature; enrollment plan; pharmaceutical benefit; cost-sharing compliance bonus pool; medicaid hospital cost report; baseline uncompensated care report; insurance rates and insurance rate change filings; evaluation by department of insurance and financial services; reports; financial incentives; performance bonus incentive pool; limitation on administrative costs; uniform procedures and compliance metrics; distribution of funds from performance bonus incentive pool; substance abuse disorders; options after 48 cumulative months of medical assistance coverage; availability of data to vendor; failure to receive waivers; inapplicability of section; offset of state tax refunds; liability; emergency department overutilization and improper usage; symposium and report; review of reports by independent third party vendor; "legislature" defined; definitions.

Sec. 105d. (1) The department of community health shall seek a waiver from the United States department of health and human services to do, without jeopardizing federal match dollars or otherwise incurring federal financial penalties, and upon approval of the waiver shall do, all of the following:

(a) Enroll individuals eligible under section 1396a(a)(10)(A)(i)(VIII) of title XIX who meet the citizenship provisions of 42 CFR 435.406 and who are otherwise eligible for the medical assistance program under this act into a contracted health plan that provides for an account into which money from any source, including, but not limited to, the enrollee, the enrollee's employer, and private or public entities on the enrollee's behalf, can be deposited to pay for incurred health expenses, including, but not limited to, co-pays. The account shall be administered by the department of community health and can be delegated to a contracted health plan or a third party administrator, as considered necessary. The department of community health shall not begin enrollment of individuals eligible under this subdivision until January 1, 2014 or until the waiver requested in this subsection is approved by the United States department of health and human services, whichever is later.

(b) Ensure that contracted health plans track all enrollee co-pays incurred for the first 6 months that an individual is enrolled in the program described in subdivision (a) and calculate the average monthly co-pay experience for the enrollee. The average co-pay amount shall be adjusted at least annually to reflect changes in the enrollee's co-pay experience. The department of community health shall ensure that each enrollee receives quarterly statements for his or her account that include expenditures from the account, account balance, and the cost-sharing amount due for the following 3 months. The enrollee shall be required to remit each month the average co-pay amount calculated by the contracted health plan into the enrollee's account. The department of community health shall pursue a range of consequences for enrollees who consistently fail to meet their cost-sharing requirements, including, but not limited to, using the MIChild program as a template and closer oversight by health plans in access to providers. The department of community health shall report its plan of action for enrollees who consistently fail to meet their cost-sharing requirements to the legislature by June 1, 2014.

(c) Give enrollees described in subdivision (a) a choice in choosing among contracted health plans.

(d) Ensure that all enrollees described in subdivision (a) have access to a primary care practitioner who is licensed, registered, or otherwise authorized to engage in his or her health care profession in this state and to preventive services. The department of community health shall require that all new enrollees be assigned and have scheduled an initial appointment with their primary care practitioner within 60 days of initial enrollment. The department of community health shall monitor and track contracted health plans for compliance in this area and consider that compliance in any health plan incentive programs. The department of community health shall ensure that the contracted health plans have procedures to ensure that the privacy of the enrollees' personal information is protected in accordance with the health insurance portability and accountability act of 1996, Public Law 104-191.

(e) Require enrollees described in subdivision (a) with annual incomes between 100% and 133% of the federal poverty guidelines to contribute not more than 5% of income annually for cost-sharing requirements. Cost-sharing includes co-pays and required contributions made into the accounts authorized under subdivision (a). Contributions required in this subdivision do not apply for the first 6 months an individual described in subdivision (a) is enrolled. Required contributions to an account used to pay for incurred health expenses shall be 2% of income annually. Notwithstanding this minimum, required contributions may be reduced by the contracting health plan. The reductions may occur only if healthy behaviors are being addressed as attested to by the contracted health plan based on uniform standards developed by the department of community health

in consultation with the contracted health plans. The uniform standards shall include healthy behaviors that must include, but are not limited to, completing a department of community health approved annual health risk assessment to identify unhealthy characteristics, including alcohol use, substance use disorders, tobacco use, obesity, and immunization status. Co-pays can be reduced if healthy behaviors are met, but not until annual accumulated co-pays reach 2% of income except co-pays for specific services may be waived by the contracted health plan if the desired outcome is to promote greater access to services that prevent the progression of and complications related to chronic diseases. If the enrollee described in subdivision (a) becomes ineligible for medical assistance under the program described in this section, the remaining balance in the account described in subdivision (a) shall be returned to that enrollee in the form of a voucher for the sole purpose of purchasing and paying for private insurance.

(f) By July 1, 2014, design and implement a co-pay structure that encourages use of high-value services, while discouraging low-value services such as nonurgent emergency department use.

(g) During the enrollment process, inform enrollees described in subdivision (a) about advance directives and require the enrollees to complete a department of community health-approved advance directive on a form that includes an option to decline. The advance directives received from enrollees as provided in this subdivision shall be transmitted to the peace of mind registry organization to be placed on the peace of mind registry.

(h) By April 1, 2015, develop incentives for enrollees and providers who assist the department of community health in detecting fraud and abuse in the medical assistance program. The department of community health shall provide an annual report that includes the type of fraud detected, the amount saved, and the outcome of the investigation to the legislature.

(i) Allow for services provided by telemedicine from a practitioner who is licensed, registered, or otherwise authorized under section 16171 of the public health code, 1978 PA 368, MCL 333.16171, to engage in his or her health care profession in the state where the patient is located.

(2) For services rendered to an uninsured individual, a hospital that participates in the medical assistance program under this act shall accept 115% of medicare rates as payments in full from an uninsured individual with an annual income level up to 250% of the federal poverty guidelines. This subsection applies whether or not either or both of the waivers requested under this section are approved, the patient protection and affordable care act is repealed, or the state terminates or opts out of the program established under this section.

(3) Not more than 7 calendar days after receiving each of the official waiver-related written correspondence from the United States department of health and human services to implement the provisions of this section, the department of community health shall submit a written copy of the approved waiver provisions to the legislature for review.

(4) By September 30, 2015, the department of community health shall develop and implement a plan to enroll all existing fee-for-service enrollees into contracted health plans if allowable by law, if the medical assistance program is the primary payer and if that enrollment is cost-effective. This includes all newly eligible enrollees as described in subsection (1)(a). The department of community health shall include contracted health plans as the mandatory delivery system in its waiver request. The department of community health also shall pursue any and all necessary waivers to enroll persons eligible for both medicaid and medicare into the 4 integrated care demonstration regions beginning July 1, 2014. By September 30, 2015, the department of community health shall identify all remaining populations eligible for managed care, develop plans for their integration into managed care, and provide recommendations for a performance bonus incentive plan mechanism for long-term care managed care providers that are consistent with other managed care performance bonus incentive plans. By September 30, 2015, the department of community health shall make recommendations for a performance bonus incentive plan for long-term care managed care providers of up to 3% of their medicaid capitation payments, consistent with other managed care performance bonus incentive plans. These payments shall comply with federal requirements and shall be based on measures that identify the appropriate use of long-term care services and that focus on consumer satisfaction, consumer choice, and other appropriate quality measures applicable to community-based and nursing home services. Where appropriate, these quality measures shall be consistent with quality measures used for similar services implemented by the integrated care for duals demonstration project. This subsection applies whether or not either or both of the waivers requested under this section are approved, the patient protection and affordable care act is repealed, or the state terminates or opts out of the program established under this section.

(5) By September 30, 2016, the department of community health shall implement a pharmaceutical benefit that utilizes co-pays at appropriate levels allowable by the centers for medicare and medicaid services to encourage the use of high-value, low-cost prescriptions, such as generic prescriptions when such an alternative exists for a branded product and 90-day prescription supplies, as recommended by the enrollee's

prescribing provider and as is consistent with section 109h and sections 9701 to 9709 of the public health code, 1978 PA 368, MCL 333.9701 to 333.9709. This subsection applies whether or not either or both of the waivers requested under this section are approved, the patient protection and affordable care act is repealed, or the state terminates or opts out of the program established under this section.

(6) The department of community health shall work with providers, contracted health plans, and other departments as necessary to create processes that reduce the amount of uncollected cost-sharing and reduce the administrative cost of collecting cost-sharing. To this end, a minimum 0.25% of payments to contracted health plans shall be withheld for the purpose of establishing a cost-sharing compliance bonus pool beginning October 1, 2015. The distribution of funds from the cost-sharing compliance pool shall be based on the contracted health plans' success in collecting cost-sharing payments. The department of community health shall develop the methodology for distribution of these funds. This subsection applies whether or not either or both of the waivers requested under this section are approved, the patient protection and affordable care act is repealed, or the state terminates or opts out of the program established under this section.

(7) By June 1, 2014, the department of community health shall develop a methodology that decreases the amount an enrollee's required contribution may be reduced as described in subsection (1)(e) based on, but not limited to, factors such as an enrollee's failure to pay cost-sharing requirements and the enrollee's inappropriate utilization of emergency departments.

(8) The program described in this section is created in part to extend health coverage to the state's low-income citizens and to provide health insurance cost relief to individuals and to the business community by reducing the cost shift attendant to uncompensated care. Uncompensated care does not include courtesy allowances or discounts given to patients. The medicaid hospital cost report shall be part of the uncompensated care definition and calculation. In addition to the medicaid hospital cost report, the department of community health shall collect and examine other relevant financial data for all hospitals and evaluate the impact that providing medical coverage to the expanded population of enrollees described in subsection (1)(a) has had on the actual cost of uncompensated care. This shall be reported for all hospitals in the state. By December 31, 2014, the department of community health shall make an initial baseline uncompensated care report containing at least the data described in this subsection to the legislature and each December 31 after that shall make a report regarding the preceding fiscal year's evidence of the reduction in the amount of the actual cost of uncompensated care compared to the initial baseline report. The baseline report shall use fiscal year 2012-2013 data. Based on the evidence of the reduction in the amount of the actual cost of uncompensated care borne by the hospitals in this state, beginning April 1, 2015, the department of community health shall proportionally reduce the disproportionate share payments to all hospitals and hospital systems for the purpose of producing general fund savings. The department of community health shall recognize any savings from this reduction by September 30, 2016. All the reports required under this subsection shall be made available to the legislature and shall be easily accessible on the department of community health's website.

(9) The department of insurance and financial services shall examine the financial reports of health insurers and evaluate the impact that providing medical coverage to the expanded population of enrollees described in subsection (1)(a) has had on the cost of uncompensated care as it relates to insurance rates and insurance rate change filings, as well as its resulting net effect on rates overall. The department of insurance and financial services shall consider the evaluation described in this subsection in the annual approval of rates. By December 31, 2014, the department of insurance and financial services shall make an initial baseline report to the legislature regarding rates and each December 31 after that shall make a report regarding the evidence of the change in rates compared to the initial baseline report. All the reports required under this subsection shall be made available to the legislature and shall be made available and easily accessible on the department of community health's website.

(10) The department of community health shall explore and develop a range of innovations and initiatives to improve the effectiveness and performance of the medical assistance program and to lower overall health care costs in this state. The department of community health shall report the results of the efforts described in this subsection to the legislature and to the house and senate fiscal agencies by September 30, 2015. The report required under this subsection shall also be made available and easily accessible on the department of community health's website. The department of community health shall pursue a broad range of innovations and initiatives as time and resources allow that shall include, at a minimum, all of the following:

(a) The value and cost-effectiveness of optional medicaid benefits as described in federal statute.

(b) The identification of private sector, primarily small business, health coverage benefit differences compared to the medical assistance program services and justification for the differences.

(c) The minimum measures and data sets required to effectively measure the medical assistance program's return on investment for taxpayers.

(d) Review and evaluation of the effectiveness of current incentives for contracted health plans, providers, and beneficiaries with recommendations for expanding and refining incentives to accelerate improvement in health outcomes, healthy behaviors, and cost-effectiveness and review of the compliance of required contributions and co-pays.

(e) Review and evaluation of the current design principles that serve as the foundation for the state's medical assistance program to ensure the program is cost-effective and that appropriate incentive measures are utilized. The review shall include, at a minimum, the auto-assignment algorithm and performance bonus incentive pool. This subsection applies whether or not either or both of the waivers requested under this section are approved, the patient protection and affordable care act is repealed, or the state terminates or opts out of the program established under this section.

(f) The identification of private sector initiatives used to incent individuals to comply with medical advice.

(11) By December 31, 2015, the department of community health shall review and report to the legislature the feasibility of programs recommended by multiple national organizations that include, but are not limited to, the council of state governments, the national conference of state legislatures, and the American legislative exchange council, on improving the cost-effectiveness of the medical assistance program.

(12) By January 1, 2014, the department of community health in collaboration with the contracted health plans and providers shall create financial incentives for all of the following:

(a) Contracted health plans that meet specified population improvement goals.

(b) Providers who meet specified quality, cost, and utilization targets.

(c) Enrollees who demonstrate improved health outcomes or maintain healthy behaviors as identified in a health risk assessment as identified by their primary care practitioner who is licensed, registered, or otherwise authorized to engage in his or her health care profession in this state. This subsection applies whether or not either or both of the waivers requested under this section are approved, the patient protection and affordable care act is repealed, or the state terminates or opts out of the program established under this section.

(13) By October 1, 2015, the performance bonus incentive pool for contracted health plans that are not specialty prepaid health plans shall include inappropriate utilization of emergency departments, ambulatory care, contracted health plan all-cause acute 30-day readmission rates, and generic drug utilization when such an alternative exists for a branded product and consistent with section 109h and sections 9701 to 9709 of the public health code, 1978 PA 368, MCL 333.9701 to 333.9709, as a percentage of total. These measurement tools shall be considered and weighed within the 6 highest factors used in the formula. This subsection applies whether or not either or both of the waivers requested under this section are approved, the patient protection and affordable care act is repealed, or the state terminates or opts out of the program established under this section.

(14) The department of community health shall ensure that all capitated payments made to contracted health plans are actuarially sound. This subsection applies whether or not either or both of the waivers requested under this section are approved, the patient protection and affordable care act is repealed, or the state terminates or opts out of the program established under this section.

(15) The department of community health shall maintain administrative costs at a level of not more than 1% of the department of community health's appropriation of the state medical assistance program. These administrative costs shall be capped at the total administrative costs for the fiscal year ending September 30, 2016, except for inflation and project-related costs required to achieve medical assistance net general fund savings. This subsection applies whether or not either or both of the waivers requested under this section are approved, the patient protection and affordable care act is repealed, or the state terminates or opts out of the program established under this section.

(16) By October 1, 2015, the department of community health shall establish uniform procedures and compliance metrics for utilization by the contracted health plans to ensure that cost-sharing requirements are being met. This shall include ramifications for the contracted health plans' failure to comply with performance or compliance metrics. This subsection applies whether or not either or both of the waivers requested under this section are approved, the patient protection and affordable care act is repealed, or the state terminates or opts out of the program established under this section.

(17) Beginning October 1, 2015, the department of community health shall withhold, at a minimum, 0.75% of payments to contracted health plans, except for specialty prepaid health plans, for the purpose of expanding the existing performance bonus incentive pool. Distribution of funds from the performance bonus incentive pool is contingent on the contracted health plan's completion of the required performance or compliance metrics. This subsection applies whether or not either or both of the waivers requested under this section are approved, the patient protection and affordable care act is repealed, or the state terminates or opts out of the program established under this section.

(18) By October 1, 2015, the department of community health shall withhold, at a minimum, 0.75% of

payments to specialty prepaid health plans for the purpose of establishing a performance bonus incentive pool. Distribution of funds from the performance bonus incentive pool is contingent on the specialty prepaid health plan's completion of the required performance of compliance metrics, which shall include, at a minimum, partnering with other contracted health plans to reduce nonemergent emergency department utilization, increased participation in patient-centered medical homes, increased use of electronic health records and data sharing with other providers, and identification of enrollees who may be eligible for services through the veterans administration. This subsection applies whether or not either or both of the waivers requested under this section are approved, the patient protection and affordable care act is repealed, or the state terminates or opts out of the program established under this section.

(19) The department of community health shall measure contracted health plan or specialty prepaid health plan performance metrics, as applicable, on application of standards of care as that relates to appropriate treatment of substance use disorders and efforts to reduce substance use disorders. This subsection applies whether or not either or both of the waivers requested under this section are approved, the patient protection and affordable care act is repealed, or the state terminates or opts out of the program established under this section.

(20) By September 1, 2015, in addition to the waiver requested in subsection (1), the department of community health shall seek an additional waiver from the United States department of health and human services that requires individuals who are between 100% and 133% of the federal poverty guidelines and who have had medical assistance coverage for 48 cumulative months beginning on the date of their enrollment into the program described in subsection (1) to choose 1 of the following options:

(a) Change their medical assistance program eligibility status, in accordance with federal law, to be considered eligible for federal advance premium tax credit and cost-sharing subsidies from the federal government to purchase private insurance coverage through an American health benefit exchange without financial penalty to the state.

(b) Remain in the medical assistance program but increase cost-sharing requirements up to 7% of income. Required contributions shall be deposited into an account used to pay for incurred health expenses for covered benefits and shall be 3.5% of income but may be reduced as provided in subsection (1)(e). The department of community health may reduce co-pays as provided in subsection (1)(e), but not until annual accumulated co-pays reach 3% of income.

(21) The department of community health shall notify enrollees 60 days before the end of the enrollee's forty-eighth month that coverage under the current program is no longer available to them and that, in order to continue coverage, the enrollee must choose between the options described in subsection (20)(a) or (b).

(22) The department of community health shall implement a system for individuals who fail to choose an option described under subsection (20)(a) or (b) within a specified time determined by the department of community health that enrolls those individuals into the option described in subsection (20)(b).

(23) If the waiver requested under subsection (20) is not approved by the United States department of health and human services by December 31, 2015, medical coverage for individuals described in subsection (1)(a) shall no longer be provided. If the waiver is not approved by December 31, 2015, then by January 31, 2016, the department of community health shall notify enrollees that the program described in subsection (1) shall be terminated on April 30, 2016. If a waiver requested under subsection (1) or (20) is approved and is required to be renewed at any time after approval, medical coverage for individuals described in subsection (1)(a) shall no longer be provided if either renewal request is not approved by the United States department of health and human services or if a waiver is canceled after approval. The department of community health shall give enrollees 4 months' advance notice before termination of coverage based on a renewal request not being approved as described in this subsection. A notification described in this subsection shall state that the enrollment was terminated due to the failure of the United States department of health and human services to approve the waiver requested under subsection (20) or renewal of a waiver described in this subsection.

(24) Individuals described in 42 CFR 440.315 are not subject to the provisions of the waiver described in subsection (20).

(25) The department of community health shall make available at least 3 years of state medical assistance program data, without charge, to any vendor considered qualified by the department of community health who indicates interest in submitting proposals to contracted health plans in order to implement cost savings and population health improvement opportunities through the use of innovative information and data management technologies. Any program or proposal to the contracted health plans must be consistent with the state's goals of improving health, increasing the quality, reliability, availability, and continuity of care, and reducing the cost of care of the eligible population of enrollees described in subsection (1)(a). The use of the data described in this subsection for the purpose of assessing the potential opportunity and subsequent development and submission of formal proposals to contracted health plans is not a cost or contractual obligation to the

department of community health or the state.

(26) If the department of community health does not receive approval for both of the waivers required under this section before December 31, 2015, the program described in this section is terminated. The department of community health shall request written documentation from the United States department of health and human services that if the waivers described in this section are rejected causing the medical assistance program to revert back to the eligibility requirements in effect on the effective date of the amendatory act that added this section, excluding any waivers that have not been renewed, there shall be no financial federal funding penalty to the state associated with the implementation and subsequent cancellation of the program created in this section. If the department of community health does not receive this documentation by December 31, 2013, the department of community health shall not implement the program described in this section.

(27) This section does not apply if either of the following occurs:

(a) If the department of community health is unable to obtain either of the federal waivers requested in subsection (1) or (20).

(b) If federal government matching funds for the program described in this section are reduced below 100% and annual state savings and other nonfederal net savings associated with the implementation of that program are not sufficient to cover the reduced federal match. The department of community health shall determine and the state budget office shall approve how annual state savings and other nonfederal net savings shall be calculated by June 1, 2014. By September 1, 2014, the calculations and methodology used to determine the state and other nonfederal net savings shall be submitted to the legislature.

(28) The department of community health shall develop, administer, and coordinate with the department of treasury a procedure for offsetting the state tax refunds of an enrollee who owes a liability to the state of past due uncollected cost-sharing, as allowable by the federal government. The procedure shall include a guideline that the department of community health submit to the department of treasury, not later than November 1 of each year, all requests for the offset of state tax refunds claimed on returns filed or to be filed for that tax year. For the purpose of this subsection, any nonpayment of the cost-sharing required under this section owed by the enrollee is considered a liability to the state under section 30a(2)(b) of 1941 PA 122, MCL 205.30a.

(29) For the purpose of this subsection, any nonpayment of the cost-sharing required under this section owed by the enrollee is considered a current liability to the state under section 32 of the McCauley-Traxler-Law-Bowman-McNeely lottery act, 1972 PA 239, MCL 432.32, and shall be handled in accordance with the procedures for handling a liability to the state under that section, as allowed by the federal government.

(30) By November 30, 2013, the department of community health shall convene a symposium to examine the issues of emergency department overutilization and improper usage. By December 31, 2014, the department of community health shall submit a report to the legislature that identifies the causes of overutilization and improper emergency service usage that includes specific best practice recommendations for decreasing overutilization of emergency departments and improper emergency service usage, as well as how those best practices are being implemented. Both broad recommendations and specific recommendations related to the medicaid program, enrollee behavior, and health plan access issues shall be included.

(31) The department of community health shall contract with an independent third party vendor to review the reports required in subsections (8) and (9) and other data as necessary, in order to develop a methodology for measuring, tracking, and reporting medical cost and uncompensated care cost reduction or rate of increase reduction and their effect on health insurance rates along with recommendations for ongoing annual review. The final report and recommendations shall be submitted to the legislature by September 30, 2015.

(32) For the purposes of submitting reports and other information or data required under this section only, "legislature" means the senate majority leader, the speaker of the house of representatives, the chairs of the senate and house of representatives appropriations committees, the chairs of the senate and house of representatives appropriations subcommittees on the department of community health budget, and the chairs of the senate and house of representatives standing committees on health policy.

(33) As used in this section:

(a) "Patient protection and affordable care act" means the patient protection and affordable care act, Public Law 111-148, as amended by the federal health care and education reconciliation act of 2010, Public Law 111-152.

(b) "Peace of mind registry" and "peace of mind registry organization" mean those terms as defined in section 10301 of the public health code, 1978 PA 368, MCL 333.10301.

(c) "State savings" means any state fund net savings, calculated as of the closing of the financial books for the department of community health at the end of each fiscal year, that result from the program described in this section. The savings shall result in a reduction in spending from the following state fund accounts: adult

benefit waiver, non-medicaid community mental health, and prisoner health care. Any identified savings from other state fund accounts shall be proposed to the house of representatives and senate appropriations committees for approval to include in that year's state savings calculation. It is the intent of the legislature that for fiscal year ending September 30, 2014 only, $193,000,000.00 of the state savings shall be deposited in the roads and risks reserve fund created in section 211b of article VIII of 2013 PA 59.

(d) "Telemedicine" means that term as defined in section 3476 of the insurance code of 1956, 1956 PA 218, MCL 500.3476.

History: Add. 2013, Act 107, Eff. Mar. 14, 2014.

Compiler's note: Enacting section 1 of Act 107 of 2013 provides:

"Enacting section 1. This amendatory act does not do either of the following:

"(a) Authorize the establishment or operation of a state-created American health benefit exchange in this state related to the patient protection and affordable care act, Public Law 111-148, as amended by the federal health care and education reconciliation act of 2010, Public Law 111-152.

"(b) Convey any additional statutory, administrative, rule-making, or other power to this state or an agency of this state that did not exist before the effective date of the amendatory act that added section 105d to the social welfare act, 1939 PA 280, MCL 400.105d, that would authorize, establish, or operate a state-created American health benefit exchange."

Popular name: Act 280

Michigan Department of Community Health
Rick Snyder, Governor
Nick Lyon, Director

Michigan Department of Community Health
Medical Services Administration

ATTACHMENT B

MEMORANDUM

Medical Care Advisory Council
AGENDA

DATE: November 19, 2014
TIME: 1:00 pm – 4:30 pm
WHERE: Michigan Public Health Institute (MPHI)
1436 Woodlake Circle
Okemos, MI
517-324-8326

1. Welcome and Introductions ……..……..…….Jan Hudson
2. Managed Care Rebid …….. Kathy Stiffler
3. Healthy Michigan Plan ……..…….…… Steve/Staff
    a. Eligibility Issues and Fixes
    b. Changes to Eligibility Determination System
    c. Protocols – Healthy Behaviors
    d. MIHealth Account Statements and Payments
    e. Second Waiver Development
4. Medicaid Caseload Decline ……..……..…….... All
5. Integrated Care for Dual Eligibles……..……..…….Staff
6. ER High Utilizers Project …….. ……Staff
7. Policy Updates ……..…….. Staff
8. Member Terms/Chairperson for 2015 ……..……Jan
9. Medicaid Enactment 50th Anniversary July 30, 2015 ……..……..Jan

4:30 – Adjourn

Next Meeting: To be scheduled

ATTACHMENT B

Michigan Department of Community Health
Rick Snyder, Governor
Nick Lyon, Director

Michigan Department of Community Health
Medical Services Administration

MEMORANDUM

Medical Care Advisory Council
AGENDA

DATE: February 19, 2015
TIME: 1:00 pm – 4:30 pm
WHERE: Michigan Public Health Institute (MPHI)
1436 Woodlake Circle
Okemos, MI
517-324-8300

1. Welcome and Introductions ……..…….. Jan Hudson
2. Managed Care Rebid …… Kathy Stiffler
3. Budget ……..Steve/Chuck
    a. FY2015 adjustments
    b. FY2016 Executive Budget
4. Merger of DCH and DHS - Department of Health and Human Services … Steve
5. Healthy Michigan Plan ……..…….…… Steve/Staff
    a. Eligibility Issues and Fixes
    b. Healthy Behaviors Update
    c. Data on Utilization
    d. MIHealth Account Statements and Payments
    e. Second Waiver Development
    f. High ER Utilizer report
6. Integrated Care for Dual Eligibles……..……..…… Staff
7. Behavioral Health Initiatives ……..…….. …… Staff
8. Policy Updates ……..…… Staff
9. Medicaid Enactment 50th Anniversary July 30, 2015 ……..……..Jan

4:30 – Adjourn

Next Meeting: May 4, 2015

ATTACHMENT B

Michigan Department of Health and Human Service
Medical Services Administration

MEMORANDUM

Medical Care Advisory Council
AGENDA

DATE: May 5, 2015
TIME: 1:00 pm – 4:30 pm
WHERE: Michigan Health and Hospital Association Headquarters
2112 University Park Dr.
Okemos, MI
517-703-8617

1. Welcome and Introductions ……..……..Jan Hudson
2. Healthy Michigan Plan ……..…… Steve/Staff
    a. Eligibility Issues and Fixes – Schedule for fixes
    b. Second Waiver Development
    c. MIHealth Account Payments
    d. High Utilizer report
3. Integrated Care for Dual Eligibles (MI Health Link)……..…….Susan Yontz
4. Managed Care Rebid …… Kathy Stiffler
5. FY2016 Budget …….. Steve
    a. CHIP extension
6. Merger of DCH and DHS - Department of Health and Human Services … Tim Becker
7. SIM Grant Implementation …… Elizabeth Hertel
8. Consolidation of 1915B&C waivers to 1115 waiver…….. ……..Staff
9. Policy Updates ……..…… Staff
10. Medicaid Enactment 50th Anniversary July 30, 2015 ……..……..Jan

4:30 – Adjourn

Next Meeting: August 12, 2015

Michigan Department of Health and Human Services
Medical Services Administration

ATTACHMENT B

MEMORANDUM

Medical Care Advisory Council
AGENDA

DATE: August 12, 2015
TIME: 1:00 pm – 4:30 pm
WHERE: Michigan Public Health Institute (MPHI)
2436 Woodlake Circle
Okemos, MI
517-324-8300

1. Welcome and Introductions ……..……..…….. Jan Hudson
2. FY2016 Budget Implementation and FY2017 Development …… Farah Hanley
    a. Adult Dental remains fee-for-service
3. Medicaid Director Search …….. Kathy Stiffler
4. Healthy Michigan Plan ……..…….…… Kathy/Staff
    a. Second Waiver Development/Progress
    b. Eligibility Issues and Fixes
    c. MIHealth Account Payments
5. Managed Care Rebid ……. Kathy Stiffler
    a. Common Formulary Development
6. Integrated Care for Dual Eligibles (MI Health Link)……..…….…… Dick Miles
7. Merger of DCH and DHS – Issues …….. … Members
8. Implementation of Home Help Program Changes …….. Dick Miles
9. Behavior Health Initiatives …..……... Lynda Zeller
10. Policy Updates ……..…….. Staff
11. Chairperson and Consumer Representation for 2016 ……Jan

4:30 – Adjourn

Next Meeting: November 18, 2015

ATTACHMENT C

PUBLIC NOTICE

Michigan Department of Health and Human Services
Medical Services Administration

Proposed Healthy Michigan Plan Waivers

The Michigan Department of Health and Human Services (MDHHS) seeks approval from the federal government to modify the health care coverage program known as the Healthy Michigan Plan. Approval of this request would allow the State of Michigan to maintain coverage for approximately 600,000 individuals currently enrolled in the program.

State law requires MDHHS to seek a waiver that would allow individuals who are between 100% and 133% of the federal poverty level, and who have had Healthy Michigan Plan coverage for 48 cumulative months, to choose one of the following options: 1) purchase private insurance through the federal Marketplace (with eligibility for advanced premium tax credits and cost sharing reductions), or 2) remain in the Healthy Michigan Plan with increased cost-sharing up to 7% of income. The cost-sharing changes associated with the second option include an increase in enrollee contributions to 3.5% of income (with the opportunity for reductions). Individuals who fail to make an affirmative choice will remain in the Healthy Michigan Plan and be subject to the increased cost-sharing requirements.

MDHHS plans to submit a Section 1115 waiver amendment, and as needed a Section 1332 waiver request, to implement the above requirements. The proposed Section 1115 waiver amendment will primarily address the cost-sharing and eligibility-related modifications, while a Section 1332 waiver would seek to waive the provisions of 36B(c)(2)(B) of the Internal Revenue Code to allow the above-referenced beneficiaries to be eligible for federal advanced premium tax credits and cost sharing subsidies when choosing coverage.

Individuals who choose coverage through the Marketplace will receive the essential health benefits through a qualified health plan, as required by the Affordable Care Act. Services available to beneficiaries who choose to remain in the Healthy Michigan Plan will be consistent with existing program benefits under the State Plan.

If so directed by the federal government, and consistent with federal regulations, MDHHS will conduct economic and actuarial analysis to verify that the coverage provided under the proposed Section 1332 waiver will be at least as comprehensive, affordable, and comparable as coverage available under the Affordable Care Act.

Consistent with federal law and the Michigan Medicaid State Plan, written notice regarding the Section 1115 waiver amendment and Section 1332 waiver was provided to the Michigan Tribes on June 1, 2015.

MDHHS plans to hold a public hearing on June 24, 2015 to provide an overview and discussion of the proposed waivers. Information regarding the public hearing process will be provided on the Healthy Michigan Plan web page at http://www.michigan.gov/healthymichiganplan on the MDHHS website.

Any comments on this notice may be submitted in writing to: Michigan Department of Health and Human Services, Program Policy Division, Bureau of Medicaid Policy and Health System Innovation, Attention Medicaid Policy, P.O. Box 30479, Lansing, Michigan 48909-7979, or via email at healthymichiganplan@michigan.gov. Copies of information related to the proposed waivers, as well as written comments regarding the proposed waivers may be reviewed by the public at Capitol Commons Center, 400 South Pine Street, Lansing, Michigan. Additionally, copies of information related to the proposed waivers are available on the Healthy Michigan Plan web page: http://www.michigan.gov/healthymichiganplan. The web page will be updated as appropriate. All comments should include a "Second Waiver" reference somewhere in the written submission, or in the subject line if email is used. Comments will be accepted until July 31, 2015.

Michigan Department of Health and Human Services **ATTACHMENT D**
Healthy Michigan Plan
1115 Demonstration Amendment

Public Comments and Responses
July 31, 2015

General

Comment: Many comments expressed support for the Healthy Michigan Plan and for the approval of the second waiver.

Response: The Michigan Department of Health and Human Services **(**MDHHS) appreciates the supportive comments.

Comment: If the second waiver is approved by the federal government, when it would expire?

Response: If approved, the required Section 1115 waiver amendment would expire in 2018, along with the current waiver. If a Section 1332 waiver is submitted and approved, it would expire 3-5 years after taking effect in 2017.

Comment: Has the Centers for Medicare & Medicaid Services (CMS) provided any feedback on the concept paper submitted?

Response: MDHHS has been in communication with CMS regarding the second waiver proposal. Additional consultation with CMS will continue throughout this process.

Comment: What can providers do to help the state with getting the second waiver approved?

Response: The State welcomes any and all comments or suggestions regarding the waiver process. Comments can be submitted in writing to: Michigan Department of Health and Human Services, Program Policy Division, Bureau of Medicaid Policy and Health System Innovation, Attention Medicaid Policy, P.O. Box 30479, Lansing, Michigan 48909-7979, or via email at healthymichiganplan@michigan.gov.

Cost-Sharing

Comment: Do copayments count toward the 7% cost-sharing limit?

Response: Yes, copayments would be included as part of the total limit on cost-sharing.

Comment: If the state is permitted to increase contributions and cost-sharing requirements as outlined in the proposed second waiver, it will have a drastic impact and cause reduced enrollment and barriers to accessing health care.

Response: MDHHS acknowledges the commenter's concerns. The cost-sharing provisions in the proposed second waiver are consistent with current state law, MCL 400.105d(20). MDHHS will be working with its federal partners to address these concerns.

MI Health Account

Comment: How do Healthy Michigan beneficiaries pay their monthly contributions?

Response: After the beneficiary has been enrolled in a Healthy Michigan Plan managed care plan for six months, they will begin receiving a MI Health Account Statement every quarter that indicates the amount they are required to pay per month as cost-sharing (which includes co-pays and may include contributions). The total cost-sharing amount is re-calculated each quarter. Beneficiaries may make on-line payments or send payments through the US mail.

Comment: Are Healthy Michigan Plan beneficiaries required to make a lump-sum payment on their MI Health Account statements, or do they have an option to make monthly or quarterly payments?

Response: Beneficiaries may either pay the entire balance on their MI Health Account statements at once, or make monthly payments.

Comment: What types of payment does the MI Health Account accept?

Response: Payments may be made on-line, by check, or by money order.

Beneficiaries above 100 percent of the Federal Poverty Level (FPL)

Comment: Several comments raised the question about how the 48-month period will be calculated and tracked, especially in light of potential beneficiary income fluctuations.

Response: State law MCL 400.105d(20), directs that a beneficiary's income must be above 100% of the FPL for 48 *cumulative* months. MDHHS will be working with its federal partners on how to best operationalize this provision of state law and expects that the questions and concerns raised will be addressed through the waiver amendment process.

Comment: The proposed time limit of 48 months undermines the objectives of the Medicaid Program and is arbitrary.

Response: This time limit was mandated by current state law, MCL 400.105d(20) and, therefore, MDHHS is required to seek this second waiver with the specific 48 cumulative month provision.

Comment: Is MDHHS able to verify that the beneficiary's income was above 100% of the FPL during this period.

Response: MDHHS will rely on the beneficiary's self-attested or reported income that has been verified with the federally trusted data sources to determine an individual's FPL percentage.

Comment: How will the second waiver address this issue to help eliminate coverage gaps, since the FFM and Healthy Michigan Plan may not always operate under the same eligibility rules regarding family structure and income levels?

Response: Michigan operates in partnership with the FFM in determining eligibility and expects this to continue under the second waiver. All applications submitted via the FFM are also evaluated for Medicaid eligibility.

Comment: How is a woman's Medicaid eligibility impacted, under the second waiver, if she elects to purchase insurance on the FFM and then becomes pregnant?

Response: If an individual meets all other eligibility criteria, a person in this situation may be eligible for coverage under Medicaid and would be exempt from contributions and co-payments for pregnancy-related services.

Comment: The concept paper submitted to CMS indicates that MDHHS is seeking to eliminate the "reasonable promptness" requirement. In which situations this would apply for individuals who elect to enroll in FFM coverage and have incomes above 100% of the FPL after 48 cumulative months of Healthy Michigan Plan enrollment?

Response: The waiver of the "reasonable promptness" requirement may be a way to allow individuals with incomes above 100% of the FPL to waive their Medicaid eligibility after 48 cumulative months of enrollment if they subsequently choose to enroll in FFM coverage. MDHHS will work with CMS to determine how individuals may receive coverage through the exchange.

Comment: Several comments inquired whether wrap-around services will be provided for those beneficiaries who choose to receive their health coverage through the FFM.

Response: MDHHS expects that beneficiaries who maintain Healthy Michigan Plan eligibility would continue to receive comprehensive services consistent with the State Plan.

Comment: Several commenters expressed a desire to allow beneficiaries to re-enter the healthy Michigan Plan if the coverage obtained through the FFM does not sufficiently meet their needs.

Response: MDHHS appreciates this comment and will explore suitable options for beneficiaries to maintain or change their health care coverage in compliance with applicable federal and state laws; it will be considered for upcoming discussions with CMS about the second waiver.

Hardship Exemption

Comment: Several comments asked the State to allow beneficiaries to seek hardship exemptions if they have difficulty meeting increased cost-sharing requirements.

Response: The State will take this comment under advisement.

Fair Hearings and Ex Parte Reviews

Comment: The proposed second waiver does not guarantee fair hearing rights.

Response: Beneficiaries will be afforded fair hearings in compliance with applicable state and federal laws as well as the Special Terms and Conditions of the existing Section 1115 Demonstration known as the Healthy Michigan Plan.

Comment: If the second waiver is not approved by CMS, the state law directs that enrollees be given notice by January 31, 2016 that their coverage ends as of April 30, 2016. Termination of benefits without conducting ex parte reviews violates federal rights of all Healthy Michigan Plan beneficiaries.

Response: MDHHS acknowledges this concern. The Special Terms and Conditions of the existing Healthy Michigan Plan demonstration require MDHHS to conduct ex parte reviews prior to any phase-out of the program.

Health Risk Assessment & Healthy Behaviors

Comment: Have many Healthy Michigan beneficiaries reduced their cost-sharing obligations as a result of completing the Health Risk Assessment (HRA) process?

Response: MDHHS publishes a monthly HRA report with this information. It can be accessed on the MDHHS website at www.michigan.gov/healthymichiganplan >> Health Risk Assessment. To receive a reduction in cost-sharing obligations, beneficiaries must also attest to pursuing or maintaining a healthy behavior.

Comment: Have providers been receptive to the HRA process?

Response: Yes. As part of the Healthy Michigan Plan Demonstration Evaluation, MDHHS will be conducting a provider survey on a variety of related topics, including the HRA process.

Provider outreach activities continue on the Healthy Michigan Plan including the promotion of the beneficiary engagement in healthy behaviors and completion of the Health Risk Assessment.

Comment: What types of healthy behaviors may beneficiaries engage in to lower their monthly contributions?

Response: Beneficiaries may elect to engage in (or maintain) one or more healthy behaviors which may include increasing physical activity, reducing or quitting tobacco use, receiving an annual influenza vaccination, reducing or quitting alcohol consumption, undergoing treatment for substance use disorders, or any other pertinent healthy behavior as described by the beneficiary's primary care provider.

Comment: The proposed second waiver should commit the state to assessing a "premium" of 1% of income for people in the target population who meet the statutory requirement of an annual health risk assessment and engage in at least one healthy behavior.

Response: MDHHS appreciates this comment and expects to work with its federal partners to design a program that promotes Healthy Michigan Plan beneficiaries engagement in healthy behaviors and provides opportunities for cost-sharing reductions, consistent with applicable federal and state laws as well as the Special Terms and Conditions of the existing Section 1115 waiver.

Other

Comment: With all of the projects and changes occurring within MDHHS, are all of the affected areas working well together to implement the changes?

Response: Although implementing many major projects at once can be challenging, all affected areas of MDHHS have been communicating very well throughout the process.

Comment: How does the King v. Burrell court decision impact the implementation of the second waiver?

Response: In light of the ruling in the recent United States Supreme Court decision, MDHHS does not foresee a significant impact on the State's submission of the second waiver.

Comment: Some commenters suggested that MDHHS should seek an amendment of the state law rather than requesting waiver approval from CMS for a program that meets the requirements as defined by state law.

Response: As mandated by current state law, MCL 400.105d(20), MDHHS is required to seek this second waiver with the highly specific provisions contained herein.

ATTACHMENT D

Comment: It is vital that the department collect data on the experiences of consumers in the target population to inform future policy decisions.

Response: MDHHS agrees and acknowledges that evaluating consumer experience is important. By their nature, Section 1115 demonstration waivers can have a significant impact on beneficiaries, providers, States, Tribes, and local governments. As such, MDHHS intends to conduct an independent evaluation of this demonstration.

ATTACHMENT E

STATE OF MICHIGAN

RICK SNYDER
GOVERNOR

DEPARTMENT OF HEALTH AND HUMAN SERVICES
LANSING

NICK LYON
DIRECTOR

June 1, 2015

NAME
TITLE
ADDRESS
CITY STATE ZIP

Dear Tribal Chair and Health Director:

RE: Section 1115 Waiver Amendment Regarding Cost-Sharing Requirements

This letter, in compliance with Section 1902(a)(73) and Section 2107(e)(1)(C) of the Social Security Act, serves as Notice of Intent to all Tribal Chairs and Health Directors of the request by the Michigan Department of Health and Human Services (MDHHS) to submit a Section 1115 waiver amendment to the Centers for Medicare and Medicaid Services (CMS) regarding the Healthy Michigan Plan.

The purpose of the amendment is to implement Michigan State law MCL 400.105d. The law requires individuals who have incomes between 100% and 133% of the federal poverty guidelines and who have had medical assistance coverage for 48 cumulative months beginning on the date of their enrollment into the program to choose either to change their eligibility status and purchase private insurance through the exchange, or to remain in the medical assistance program with increased cost-sharing requirements up to 7% of income, with required contributions of 3.5% of income. It is anticipated that the amendment will have minimal impact on Native Americans pursuant to the exemptions set forth under 42 CFR §447.56(a)(1)(x).

Telephonic consultation regarding the waiver amendment is scheduled to occur at 9:00 a.m. on June 26, 2015. The consultation will provide an overview and discussion of the waiver amendment. Contact information for participating in the telephonic consultation will be distributed in the near future. Additionally, persons may contact Lorna Elliott-Egan, MDHHS Liaison to the Michigan Tribes, at 517-373-4963, or via email at Elliott-EganL@michigan.gov to obtain contact information regarding the telephonic consultation. Input regarding this waiver amendment is highly encouraged, and comments regarding this Notice of Intent may be submitted to Lorna Elliott-Egan at the telephone number or email address provided above. **Please provide all input regarding the waiver amendment by July 31, 2015.**

In addition, MDHHS is offering to set up group or individual meetings for the purposes of consultation in order to discuss this waiver amendment, according to the tribes' preference. This consultation meeting will allow tribes the opportunity to address any concerns and voice any suggestions, revisions, or objections to be relayed to the author of the proposal. If you would like additional information or wish to schedule a consultation meeting, please contact Lorna Elliott-Egan at the telephone number or email address provided above.

ATTACHMENT E

MDHHS appreciates the continued opportunity to work collaboratively with you to care for the residents of our state.

Sincerely,

Stephen Fitton, Director
Medical Services Administration

cc: Leslie Campbell, Region V, CMS
Pamela Carson, Region V, CMS
Ashley Tuomi, MHPA, Executive Director, American Indian Health and Family Services of Southeastern Michigan
L. John Lufkins, Executive Director, Inter-Tribal Council of Michigan, Inc.
Jenny Jenkins, Acting Area Director, Indian Health Service - Bemidji Area Office
Lorna Elliott-Egan, MDHHS

Distribution List for L 15-35
June 1, 2015

ATTACHMENT E

Mr. Levi Carrick, Sr., Tribal Chairman, Bay Mills Indian Community
Ms. Audrey Breakie, Health Director, Bay Mills (Ellen Marshall Memorial Center)
Mr. Alvin Pedwaydon, Tribal Chairman, Grand Traverse Band Ottawa & Chippewa Indians
Ms. Loi Chambers, Health Director, Grand Traverse Band Ottawa/Chippewa
Mr. Kenneth Meshigaud, Tribal Chairman, Hannahville Indian Community
Ms. G. Susie Meshigaud, Health Director, Hannahville Health Center
Mr. Donald Shalifoe Sr., President, Keweenaw Bay Indian Community
Ms. Carole LaPointe, Health Director, Keweenaw Bay Indian Community - Donald Lapointe Health/Educ Facility
Mr. James Williams, Jr., Tribal Chairman, Lac Vieux Desert Band of Lake Superior Chippewa Indians
Ms. Sadie Valliere, Health & Human Services Director, Lac Vieux Desert Band
Mr. Larry Romanelli, Ogema, Little River Band of Ottawa Indians
Ms. Jessica Burger, Acting Health Director, Little River Band of Ottawa Indians
Mr. Fred Kiogima, Tribal Chairman, Little Traverse Bay Band of Odawa Indians
Ms. Sharon Sierzputowski, Health Director, Little Traverse Bay Band of Odawa
Mr. DK Sprague, Tribal Chairman, Match-E-Be-Nash-She-Wish Potawatomi Indians (Gun Lake Band)
Ms. Phyllis Davis, Health Director, Match-E-Be-Nash-She-Wish Potawatomi
Mr. Homer Mandoka, Tribal Chairman, Nottawaseppi Huron Band of Potawatomi Indians
Mr. Travis Parashonts, Chief Executive Officer, Nottawaseppi Huron Band of Potawatomi Indians
Ms. Rosalind Johnston, Health Director, Huron Potawatomi Inc.- Tribal Health Department
Mr. John Warren, Tribal Chairman, Pokagon Band of Potawatomi Indians
Mr. Matt Clay, Health Director, Pokagon Potawatomi Health Services
Mr. Steve Pego, Tribal Chief, Saginaw Chippewa Indian Tribe
Mrs. Karmen Fox, Executive Health Director, Nimkee Memorial Wellness Center
Mr. Aaron Payment, Tribal Chairman, Sault Ste. Marie Tribe of Chippewa Indians
Ms. Bonnie Culfa, Health Director, Sault Ste. Marie Tribe of Chippewa Indians - Health Center

CC: Leslie Campbell, Region V, CMS
Pamela Carson, Region V, CMS
Ashley Tuomi, MHPA, Executive Director, American Indian Health and Family Services of Southeastern Michigan
L. John Lufkins, Executive Director, Inter-Tribal Council of Michigan, Inc.
Jenny Jenkins, Acting Area Director, Indian Health Service - Bemidji Area Office
Lorna Elliott-Egan, MDHHS

ATTACHMENT F

STATE OF MICHIGAN
DEPARTMENT OF HEALTH AND HUMAN SERVICES
LANSING

RICK SNYDER
GOVERNOR

NICK LYON
DIRECTOR

AGENDA

Michigan Department of Health & Human Services

Quarterly Tribal Consultation/Conference Call

June 26, 2015 @ 9:00 a.m.

Call In Number: 888-808-6929

Access Code: 1129906

AGENDA ITEMS:

1. Update on the Healthy Michigan Plan
2. State law requiring a second waiver for Healthy Michigan Plan
3. Section 1115 waiver amendment
4. Section 1332 waiver
5. Timeline for comments
6. Moving MIChild into a Medicaid expansion
    a. Impact on Native Americans
    b. Premiums
    c. Timeline
7. Cost Sharing
8. Other

ATTACHMENT F

STATE OF MICHIGAN
DEPARTMENT OF HEALTH AND HUMAN SERVICES
LANSING

RICK SNYDER
GOVERNOR

NICK LYON
DIRECTOR

AGENDA

Michigan Department of Health & Human Services

Quarterly Tribal Consultation/Conference Call

August 17, 2015 @ 2:00 p.m.

Call In Number: 888-808-6929

Access Code: 1129906

AGENDA ITEMS:

- Review of MAGI Application and Appendix B (attached)
- Healthy Michigan Plan 1115 Waiver Status Update
    - Waiver amendment overview
    - Impact on Tribal members
    - Comments or suggestions on waiver content or processes
    - Process for submitting comments
    - State of Michigan's Timeline for Submission
    - Future Consultation and Updates