DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-01-16
Baltimore, Maryland 21244-1850

Children and Adults Health Programs Group

August 29, 2014

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

Dear Mr. Fitton:

The Centers for Medicare & Medicaid Services (CMS) is issuing technical corrections to the Michigan section 1115 Medicaid demonstration, entitled "Healthy Michigan Section 1115 Demonstration," (Project No. 11-W-00245/5), approved on December 30, 2013, under the authority of section 1115(a) of the Social Security Act (the Act). The technical corrections serve to ensure consistency through the Special Terms and Conditions (STCs), and that the STCs accurately reflect how the state operates its demonstration. The technical corrections include several changes requested by the state, as well as some changes identified by CMS as necessary for consistency throughout the document.

Changes made to the STCs include:

- Revising STC 28(a) to maintain consistency with STC 33(k).
- Revising STC 29(f) for clarity of language.
- Revising STC 30 to reflect the following changes:
    - Clarifying requirements for a phased approach to the copayment liability and premium payments implementation; and
    - Clarifying requirements for the state to explain when beneficiaries will be responsible for copayments and how beneficiaries will be notified.
- Revising STC 35(b)(iv) to remove a technical requirement pertaining to the auto-assignment algorithm for managed care organizations, as the state already maintains its own CMS-approved algorithm that is compliant with 42 CFR 438.50(f).
- Revising STC 46 to permit all prior authorizations initiated under the Adult Benefit Waiver (ABW) demonstration to be honored for a period of 30 days, after which they will be evaluated and extended if medically necessary. In the event that under the new demonstration, an ABW beneficiary is assigned to a Medicaid Health Plan that does not contain the beneficiary's existing provider, the beneficiary will be allowed to see that provider until he or she may be safely brought into the Medicaid Health Plan network. These changes reflect common practice within the state's existing managed care operations.
- Revising STC 69(a)(v) to reflect the requirement to study the impact of increased communication with beneficiaries about their copayment obligations.

The state also requested confirmation that providing CMS with draft managed care contracts with a minimum of 60 days for review would fulfill the requirements in STC 37, which states, "The state must provide CMS with a minimum of 60 days to review and approve changes." CMS confirms that the state's interpretation of STC 37 is accurate.

Additionally, CMS approves the Contributions Accounts and Infrastructure Operational Protocol and Healthy Behaviors Incentives Program Operational Protocol, as submitted by the on May 30, 2014 and June 3, 2014 respectively, with revisions made based on our subsequent discussions. Consistent with paragraphs 28 and 32 of the STCs, the state may implement these provisions 30 days after the date of this approval letter.

CMS has incorporated the above technical changes into the latest version of the STCs. Additionally, the approved protocols have been added to the STCs as Attachments E and F. A copy of the STCs that includes the technical changes and the new attachments is enclosed with this letter.

If you have any questions, please do not hesitate to contact your project officer, Ms. Megan Stacy. Ms. Stacy can be reached at (410) 786-4113, or at megan.stacy@cms.hhs.gov.

We look forward to continuing to work with your staff on the administration of this demonstration.

Sincerely,

/s/

Angela D. Garner
Acting Director
Division of State Demonstrations and Waivers

Enclosures

Cc: Eliot Fishman, CMCS
Verlon Johnson, Associate Regional Administrator, Region V
Leslie Campbell, CMS Chicago Regional Office
Megan Stacy, CMCS

CENTERS FOR MEDICARE AND MEDICAID SERVICES
SPECIAL TERMS AND CONDITIONS

NUMBER: 11-W-00245/5

TITLE: Healthy Michigan Section 1115 Demonstration

AWARDEE: Michigan Department of Community Health

I. PREFACE

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

The STCs have been arranged into the following subject areas:

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

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

Attachment A: Quarterly Progress Report Content and Format
Attachment B: Demonstration Evaluation Plan (reserved)

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

II. PROGRAM DESCRIPTION AND OBJECTIVES

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

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

On April 1, 2014, Michigan will expand its Medicaid program to include adults with income up to 133 percent of the FPL. To accompany this expansion, the Michigan "Adult Benefits Waiver" is amended and transformed to establish the Healthy Michigan program, through which the state will test innovative approaches to beneficiary cost sharing and financial responsibility for care for the new adult eligibility group. The new adult population with incomes above 100 percent of the FPL will be required to make contributions equal to two percent of their family income toward the cost of their health care. In addition, all newly eligible adults from 0 to 133 percent of the FPL, regardless of their income, will pay required Medicaid copayments through a credit facility operated in coordination with the Medicaid Health plan. An MI Health Account will be established for each enrolled individual to track beneficiaries' contributions and how they were expended. Beneficiaries will receive quarterly statements that summarize the MI Health Account funds balance and flows of funds into and out of the account, and the use of funds for health care service copayments. Beneficiaries will have opportunities to reduce their regular or average utilization based contribution by demonstrating achievement of recommended Healthy

Behaviors. Healthy Michigan Program beneficiaries will receive a full health care benefit package as required under the Affordable Care Act and will include all of the Essential Health Benefits as required by federal law and regulation, and there will not be any limits on the number of individuals who can enroll. It is expected that an additional 300,000 to 500,000 Michigan citizens will receive coverage from the expansion of Medicaid as the new adult group. Beneficiaries receiving coverage under the sunsetting ABW program will transition to the state plan and the Healthy Michigan Program on April 1, 2014.

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

The state reports that the overarching themes used in the benefit design will be increasing access to quality health care, encouraging the utilization of high-value services, promoting beneficiary adoption of healthy behaviors and using evidence-based practice initiatives. Organized service delivery systems will be utilized to improve coherence and overall program efficiency.

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

- Improve access to healthcare for uninsured or underinsured low-income Michigan citizens;
- Improve the quality of healthcare services delivered;
- Reduce uncompensated care;
- Encourage individuals to seek preventive care and encourage the adoption of healthy behaviors;
- Help uninsured or underinsured individuals manage their health care issues;
- Encourage quality, continuity, and appropriate medical care; and
- Study the effects of a demonstration model that infuses market-driven principles into a public healthcare insurance program by examining:
    - The extent to which the increased availability of health insurance reduces the costs of uncompensated care borne by hospitals;
    - The extent to which availability of affordable health insurance results in a reduction in the number of uninsured/underinsured individuals who reside in Michigan;
    - Whether the availability of affordable health insurance, which provides coverage for preventive and health and wellness activities, will increase healthy behaviors and improve health outcomes; and
    - The extent to which beneficiaries feel that the Healthy Michigan Program has a positive impact on personal health outcomes and financial well-being.

This document provides details of both the Healthy Michigan Program and the sunsetting Michigan Adults Benefit Waiver (ABW) Program. The ABW Program was implemented as a Title XIX demonstration on January 1, 2010 and the associated STCs for the ABW program as

included as a component of the Healthy Michigan demonstration remain in effect until this portion of the demonstration sunsets on April 1,.

III. GENERAL PROGRAM REQUIREMENTS

1. **Compliance with Federal Non-Discrimination Statutes.** The state must comply with all applicable Federal statutes relating to non-discrimination. These include, but are not limited to, the Americans with Disabilities Act of 1990, Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, and the Age Discrimination Act of 1975.

2. **Compliance with Medicaid Law, Regulation, and Policy.** All requirements of the Medicaid program, expressed in law, regulation, and policy statement, not expressly waived or identified as not applicable in the waiver and expenditure authority documents (of which these terms and conditions are part), apply to this demonstration.

3. **Changes in Medicaid Law, Regulation, and Policy.** The state must, within the timeframes specified in law, regulation, or policy statement, come into compliance with any changes in Federal law, regulation, or policy affecting the Medicaid program that occur during this demonstration approval period, unless the provision being changed is expressly waived or identified as not applicable. In addition, CMS reserves the right to amend the STCs to reflect such changes and/or changes as needed without requiring the state to submit an amendment to the demonstration under paragraph 7. CMS will notify the state 30 days in advance of the expected approval date of the amended STCs to allow the state to provide comment. Changes will be considered in force upon issuance of the approval letter by CMS. The state must accept the changes in writing.

4. **Impact of Changes in Federal Law, Regulation, and Policy on the Demonstration.**

    a. To the extent that a change in Federal law, regulation, or policy requires either a reduction or an increase in Federal financial participation (FFP) for expenditures made under this demonstration, the state must adopt, subject to CMS approval, a modified budget neutrality agreement for the demonstration as necessary to comply with such change. The modified budget neutrality agreement will be effective upon the implementation of the change. The trend rates for the budget neutrality agreement are not subject to change under this subparagraph.

    b. If mandated changes in the Federal law require state legislation, the changes must take effect on the day such state legislation becomes effective, or on the last day such legislation was required to be in effect under the law.

5. **State Plan Amendments.** The state will not be required to submit Title XIX state plan amendments (SPAs) for changes affecting any populations made eligible solely through the demonstration. If a population eligible through the Medicaid state plan is affected by a change to the demonstration, a conforming amendment to the appropriate state plan is

required, except as otherwise noted in these STCs. In all such cases, the Medicaid state plan governs.

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

7. **Amendment Process.** Requests to amend the demonstration must be submitted to CMS for approval no later than 120 days prior to the planned date of implementation of the change and may not be implemented until approved. CMS reserves the right to deny or delay approval of a demonstration amendment based upon non-compliance with these STCs, including but not limited to failure by the state to submit required elements of a viable amendment request as found in these STCs, required reports and other deliverables required in the approved STCs in a timely fashion according to the deadlines specified herein. Amendment requests must include, but are not limited to, the following:

    a. Demonstration of Public Notice 42 CFR §431.408 and tribal consultation: The state must provide documentation of the state's compliance with public notice process as specified in 42 CFR §431.408 and documentation that the tribal consultation requirements outlined in paragraph 15 have been met. Such documentation shall include a summary of public comments and identification of proposal adjustments made to the amendment request due to the public input;

    b. Demonstration Amendment Summary and Objectives: The state must provide a detailed description of the amendment, including what the state intends to demonstrate via this amendment as well as the impact on beneficiaries, with sufficient supporting documentation, the objective of the change and desired outcomes including a conforming Title XIX and/or Title XXI SPA, if necessary;

    c. Waiver and Expenditure Authorities: The state must provide a list waivers and expenditure authorities that are being requested or terminated, along with the reason, need and the citation along with the programmatic description of the waivers and expenditure authorities that are being requested for the amendment;

    d. A budget neutrality data analysis worksheet: The state must provide a worksheet which identifies the specific "with waiver" impact of the proposed amendment on

the current budget neutrality agreement, including the underlying spreadsheet calculation formulas. Such analysis shall include current total computable "with waiver" and "without waiver" status on both a summary and detailed level through the current approval period using the most recent actual expenditures, as well as summary and detailed projections of the change in the "with waiver" expenditure total as a result of the proposed amendment, which isolates (by Eligibility Group, or feature) the impact of the amendment;

e. Updates to existing demonstration reporting, quality and evaluation plans: A description of how the evaluation design, comprehensive quality strategy and quarterly and annual reports will be modified to incorporate the amendment provisions, as well as the oversight, monitoring and measurement of the provisions.

8. **Extension of the Demonstration.** States that intend to request demonstration extensions under Sections 1115(e) or 1115(f) are advised to observe the timelines contained in those statutes. Otherwise, no later than 12 months prior to the expiration date of the demonstration, the governor or chief executive officer of the state must submit to CMS either a demonstration extension request or a transition and phase-out plan consistent with the requirements of paragraph 9.

   a. Compliance with Transparency Requirements at 42 CFR §431.412. As part of the demonstration extension requests the state must provide documentation of compliance with the transparency requirements 42 CFR §431.412 and the public notice and Tribal consultation requirements outlined in paragraph 15.

   b. Upon application from the state, CMS reserves the right to temporarily extend the demonstration including making any amendments deemed necessary to effectuate the demonstration extension including but not limited to bringing the demonstration into compliance with changes to federal law, regulation and policy.

9. **Demonstration Transition and Phase Out.** The state may only suspend or terminate this demonstration in whole, or in part, consistent with the following requirements.

   a. Notification of Suspension or Termination. The state must promptly notify CMS in writing of the reason(s) for the suspension or termination, together with the effective date and a transition and phase-out plan. The state must submit its notification letter and a draft transition and phase-out plan to CMS no less than six (6) months before the effective date of the demonstration's suspension or termination. Prior to submitting the draft plan to CMS, the state must publish on its website the draft transition and phase-out plan for a 30-day public comment period. In addition, the state must conduct tribal consultation in accordance with its approved tribal consultation SPA. Once the 30-day public comment period has ended, the state must provide a summary of each public comment received, the

state's response to the comment and how the state incorporated the received comment into the revised phase-out plan.

b. The state must obtain CMS approval of the transition and phase-out plan prior to the implementation of the phase-out activities. Implementation of phase-out activities must be no sooner than 14 days after CMS approval of the phase-out plan.

c. Transition and Phase-out Plan Requirements: The state must include, at a minimum, in its phase-out plan the process by which it will notify affected beneficiaries, the content of said notices (including information on the beneficiary's appeal rights), the process by which the state will conduct administrative reviews of Medicaid eligibility prior to the termination of the program for the affected beneficiaries including any individuals on demonstration waiting lists, and ensure ongoing coverage for those beneficiaries determined eligible for ongoing coverage, as well as any community outreach activities including community resources that are available.

d. Phase-out Procedures: The state must comply with all notice requirements found in 42 CFR §431.206, §431.210, and §431.213. In addition, the state must assure all appeal and hearing rights afforded to demonstration beneficiaries as outlined in 42 CFR §431.220 and §431.221. If a demonstration participant beneficiary requests a hearing before the date of action, the state must maintain benefits as required in 42 CFR §431.230. In addition, the state must conduct administrative renewals for all affected beneficiaries in order to determine if they qualify for Medicaid eligibility under a different eligibility category.

e. Exemption from Public Notice Procedures 42.CFR Section 431.416(g). CMS may expedite the federal and state public notice requirements in the event it determines that the objectives of Title XIX and XXI would be served or under circumstances described in 42 CFR §431.416(g).

f. Federal Financial Participation (FFP): If the project is terminated or any relevant waivers suspended by the state, FFP shall be limited to normal closeout costs associated with terminating the demonstration including services and administrative costs of disenrolling beneficiaries.

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

    a. **Expiration Requirements:** The state must include, at a minimum, in its demonstration expiration plan the process by which it will notify affected

beneficiaries, the content of said notices (including information on the beneficiary's appeal rights), the process by which the state will conduct administrative reviews of Medicaid eligibility for the affected beneficiaries, and ensure ongoing coverage for eligible individuals, as well as any community outreach activities.

b. **Expiration Procedures:** The state must comply with all notice requirements found in 42 CFR §431.206, §431.210 and §431.213. In addition, the state must assure all appeal and hearing rights afforded to demonstration beneficiaries as outlined in 42 CFR §431.220 and §431.221. If a demonstration participant beneficiary requests a hearing before the date of action, the state must maintain benefits as required in 42 CFR §431.230. In addition, the state must conduct administrative renewals for all affected beneficiaries in order to determine if they qualify for Medicaid eligibility under a different eligibility category.

c. **Federal Public Notice:** CMS will conduct a 30-day federal public comment period consistent with the process outlined in 42 CFR §431.416 in order to solicit public input on the state's demonstration expiration plan. CMS will consider comments received during the 30-day period during its review and approval of the state's demonstration expiration plan. The state must obtain CMS approval of the demonstration expiration plan prior to the implementation of the expiration activities. Implementation of expiration activities must be no sooner than 14 days after CMS approval of the plan.

d. **Federal Financial Participation (FFP):** FFP shall be limited to normal closeout costs associated with the expiration of the demonstration including services and administrative costs of disenrolling beneficiaries.

11. **CMS Right to Amend, Terminate or Suspend.** CMS may amend, suspend or terminate the demonstration in whole or in part at any time before the date of expiration, whenever it determines, following a hearing that the state has materially failed to comply with the terms of the project. CMS will promptly notify the state in writing of the determination and the reasons for the suspension or termination, together with the effective date.

12. **Finding of Non-Compliance.** The state does not relinquish its rights to challenge CMS' finding that the state materially failed to comply.

13. **Withdrawal of Waiver Authority.** CMS reserves the right to withdraw waivers or expenditure authorities at any time it determines that continuing the waivers or expenditure authorities would no longer be in the public interest or promote the objectives of Title XIX or Title XXI. CMS will promptly notify the state in writing of the determination and the reasons for the withdrawal, together with the effective date, and afford the state an opportunity to request a hearing to challenge CMS' determination prior to the effective date. If a waiver or expenditure authority is withdrawn, FFP is

limited to normal closeout costs associated with terminating the waiver or expenditure authority, including services and administrative costs of disenrolling beneficiaries.

14. **Adequacy of Infrastructure.** The state must ensure the availability of adequate resources for implementation and monitoring of the demonstration, including education, outreach, and enrollment; maintaining eligibility systems; compliance with cost sharing requirements; and reporting on financial and other demonstration components.

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

    a. In states with federally recognized Indian Tribes, consultation must be conducted in accordance with the consultation process outlined in the July 17, 2001 letter or the consultation process in the state's approved Medicaid state plan if that process is specifically applicable to consulting with tribal governments on waivers (42 C.F.R. §431.408(b)(2)).

    b. In states with federally recognized Indian Tribes, Indian Health Services programs, and/or Urban Indian Organizations, the state is required to submit evidence to CMS regarding the solicitation of advice from these entities prior to submission of any demonstration proposal, amendment and/or renewal of this demonstration (42 CFR.§431.408(b)(3)).

    c. The state must also comply with the Public Notice Procedures set forth in 42 CFR §447.205 for changes in statewide methods and standards for setting payment rates.

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

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

IV. ELIGIBILITY FOR THE DEMONSTRATION

18. **Eligibility Groups Affected By the Demonstration.** This demonstration affects mandatory Medicaid state plan populations as well as the sunsetting of the ABW population eligible for benefits only through the demonstration. The criteria for demonstration eligibility are outlined in the Eligibility Table at the end of this section, which shows each specific group of individuals; under what authority they are made eligible, the name of the eligibility and expenditure group under which expenditures are reported to CMS and the budget neutrality expenditure agreement is constructed, and the corresponding demonstration program under which benefits are provided. Mandatory and optional state plan groups derive their eligibility through the Medicaid state plan, and are subject to all applicable Medicaid laws and regulations in accordance with the Medicaid state plan, except as expressly waived in this demonstration and as described in these STCs. Any Medicaid eligibility standards and methodologies for these eligibility groups, including the conversion to a modified adjusted gross income standard January 1, 2014, will apply to this demonstration.

19. **Mandatory Eligibility Groups Included in the Medicaid State Plan.** Eligibility for all mandatory eligibility groups follow what is in the approved state plan. Should the state amend the state plan to make any changes to eligibility for Medicaid mandatory populations, upon submission of the SPA, the state must notify CMS in writing of the pending SPA. The Medicaid Eligibility Groups (MEGs) listed in the Reporting and the Budget Neutrality Sections of the STCs will be updated upon approval of changes to state plan eligibility and will be considered a technical change to the STCs.

20. **Demonstration Expansion Eligibility Group.** The beneficiary eligibility group described below which is made eligible for the demonstration by virtue of the expenditure authorities expressly granted in this demonstration (Michigan's ABW) are subject to Medicaid laws or regulations, unless otherwise specified in the not applicable expenditure authorities for this demonstration until the program sunsets on March 31, 2014.

21. **ABW Eligibility.** Childless adults eligible for the sunsetting ABW coverage under this demonstration (reported under Waiver Name "Michigan's Adult Benefit Waiver") are defined as individuals ages 19 through 64 years with income that is at or below 35 percent of the FPL. They are individuals who are not pregnant, disabled, or qualified for any other Medicaid, Medicare or Children's Health Insurance Program (CHIP). A childless adult is an individual who does not have children or dependents living in his/her home. An applicant must meet the following eligibility requirements in order to enroll for coverage under this demonstration:

    a. Must be at least 19 but no more than 64 years of age;

    b. Must not have any children or dependents living in his/her home;

c. Must not be pregnant;

d. Must not be eligible for Medicaid, CHIP, or Medicare;

e. Must have gross family income at or below 35 percent of the FPL;

f. Income test - An earned income disregard of $200 plus 20 percent of the remaining earned income is applied to the income of the demonstration applicant prior to conducting the income test.

g. Asset Limit - An asset limit of $3,000 will be applied to applicants who meet the above income requirement. Cash assets include, but are not limited to, checking accounts. Investments and retirement plans are also counted towards this $3000 asset limit.

h. Must not have access to other creditable health insurance. The state defines "creditable health insurance" as coverage for medical care obtained by a participant beneficiary as an individual, via group health plans (self-funded or fully-insured), a state high risk pool, Medicare, Medicaid, Federal Employee Health Benefit Program, military sponsored healthcare program (CHAMPUS or Tri Care), medical program of Indian Health Services or tribal organization public health plan or coverage under the Peace Corps;

i. Must provide verification, including documentation, of U.S. citizenship and Social Security number (or proof of application for an SSN) in accordance with Section 1903(x) of the Act;

j. Must be a Michigan resident.

22. **ABW Enrollment.** The following terms and conditions apply to enrollment and disenrollment processes for the sunsetting Adult Benefit Waiver Program and remain in effect until the implementation of the Medicaid expansion under section 1902(a)(10)(A)(i)(VIII) of the Act and the successful transition of all ABW program beneficiaries.

    a. **Application Processing and Enrollment Procedures.** Applicants for enrollment in the ABW program will use the same application and enrollment procedures required of other individuals applying for other Medicaid programs.

    b. **Screening for Eligibility for Medicaid and/or CHIP.** All applicants for the ABW program must receive a pre-screening in order to determine possible eligibility for either Medicaid or CHIP programs before eligibility determination is performed for the demonstration.

c. **Effective Date of Coverage - No Retroactive Eligibility.** Enrollees who qualify for the ABW program will not receive retroactive coverage. The beginning effective date of coverage under the demonstration will be the first day of the month in which the application was received. After the application is processed, the enrollee will be enrolled in a county health plan (CHP) on the first day of the next month available for enrollment in the 72 counties that operate this type of delivery system. If the enrollee resides in a county that does not have CHP, that enrollee will continue to obtain services through Medicaid Fee for Service (FFS).

d. **Redetermination of Eligibility.** Enrollees who are eligible for the ABW program will have eligibility redetermined at least every 12 months. The state will send eligibility renewal notification to the enrollee prior to the end of the enrollee's current eligibility period.

e. **Intermittent Periods of Open Enrollment to the Demonstration.** The state is responsible to determine and maintain the appropriate enrollment levels in order to remain under the annual budget neutrality limit/ceiling established for the ABW program. Therefore, the state will determine the timeframe for opening enrollment for the ABW program based upon the capacity and amount of available budgetary resources. The state will provide written notification to CMS at least 15 days before closing or re-opening enrollment to the ABW program. The state should report to CMS via the quarterly progress and annual reports the status of enrollment and provide a description of the enrollment management process. In addition, the State will provide CMS with Monthly Enrollment Reports as described in paragraph XX.

f. **Disenrollment.** An enrollee in the Adult Benefits Waiver may be disenrolled if he/she:

   i. Exceeds the income limit of 35 percent of the FPL;

   ii. Becomes eligible for Medicare, Medicaid, or CHIP coverage;

   iii. No longer resides in the State of Michigan;

   iv. Obtains health insurance coverage;

   v. Attains age 65; or

   vi. Voluntarily requests closure of his/her case.

23. **Populations Excluded from "Healthy MI Adults" Group.** The term Healthy MI Adults will be used to refer to Medicaid beneficiaries who are members of the new adult group and who will be affected by this demonstration. The term includes all individuals

in the category indicated in the table below, except for those that are described by any of the following:

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

Eligibility Table

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

V. BENEFITS

24. **Demonstration Programs.** The demonstration provides health care benefits to eligible individuals and families through the following specific programs. The demonstration program for which an individual is eligible is based on the criteria outlined in the Eligibility Table A in Section IV.

25. **ABW Limited Benefit Package.** Enrollees under the demonstration in the ABW Program receive a limited benefit package that includes outpatient hospital services, physician services, diagnostic services, pharmacy, mental health and substance abuse services. The enrollees may be required to receive prior authorization (PA) from the state or their Community Health Plan (CHP) assigned provider before accessing certain ambulatory services. Attachment J describes the specific benefit coverage.

26. **Healthy Michigan Benefit Package.** Healthy Michigan beneficiaries enrolled under this demonstration in the new adult group (i.e., Healthy MI Adults) will receive the benefits in the approved Alternative Benefit Plan (ABP) SPA.

27. **ABW Cost Sharing.** ABW program enrollees are required to pay copayments in order to receive certain ambulatory benefits, as shown in Attachment J until the program sunsets.

VI. CONTRIBUTIONS TO MI HEALTH ACCOUNTS AND HEALTHY BEHAVIORS INCENTIVES

This section provides an overview and planned framework development that will be used to further define the programmatic features of the Healthy Michigan demonstration. All cost sharing must be in compliance with Medicaid requirements that are set forth in statute, regulation and policies, except as modified by the waivers and terms and conditions granted for this demonstration. Following the development and subsequent approval of the Contributions Accounts and Payments Infrastructure Operational Protocol and the Healthy Behaviors Incentives Program Operational Protocol, beneficiaries enrolled in the demonstration will have responsibility to make contributions to, as well as the opportunity to earn rewards for taking responsibility for their healthy behaviors. The state may request changes to the Protocols, which must be approved by CMS, and which will be effective prospectively. Changes may be subject to an amendment to the STCs in accordance with paragraph 7, depending upon the nature of the proposed change.

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

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

    b. Beneficiaries with incomes at or below 100 percent of the FPL will be responsible for copayment liability based upon the prior 6 months of copayment experience for the beneficiary. Beneficiaries will be notified of the copayment liability by the provider, but will be billed for such copayments only at the end of quarter, with payments due in accordance with the approved protocol. No interest will be due on accrued copayment liability if paid timely. In addition, reductions for healthy behavior incentives can be applied to the copayment liability due. No premiums will be paid by this population.

29. **Healthy Michigan Beneficiary Contribution Protections.**

    a. No individual may lose eligibility for Medicaid or be denied eligibility for Medicaid, be denied enrollment in a Healthy Michigan health plan, or be denied access to services for failure to pay premiums or copayment liabilities.

    b. Providers may not deny services for failure to receive beneficiary copayments.

    c. Beneficiaries described in 42 CFR 447.56(a) must be exempt from all cost sharing and contribution requirements.

    d. Beneficiaries may not incur family cost sharing or monthly contributions that exceeds 5 percent of the family's income, following rules established in 42 CFR 447.56(f).

    e. Copayment amounts will be consistent with federal requirement regarding Medicaid cost sharing and with the state's approved state plan (except for any reductions to copayments due to Healthy Behaviors).

    f. Beneficiaries' can be billed for copayment liability in any 6-month experience period after the first six months of enrollment. Maximum billed amounts must be equal to or less than the average of the beneficiary's incurred copayments for the previous 6-month period (except for any reductions to copayments due to Healthy Behaviors).

30. **Contributions Accounts and Payments Infrastructure Operational Protocol.** The state must submit a draft Contributions Accounts and Payments Infrastructure Operational Protocol to CMS for review and approval prior to implementing the MI Health Accounts program within the Healthy Michigan program. The state's submission must be no later than 90 days prior to the planned implementation. The state may not implement the provisions regarding contributions described in paragraph 28(a) and (b) above until 30 days after receiving CMS approval for the Contributions Accounts and Payments Infrastructure Operational Protocol. The protocol must include, at a minimum, the following items:

    a. The copayment liability and premium payments strategy and implementation plan, including a phased approach to implementation for beneficiaries beginning six months after enrollment in Healthy Michigan,, that allows for milestones related to successful accounting for funds, data collection for incentives, education and other critical operations to be met prior to inclusion of all Healthy Michigan beneficiaries into the payment and reward program. The plan must clearly explain when beneficiaries are responsible for payments and how beneficiaries will be engaged in the payment process, including when and under what circumstances payments will be required.

b. A description of how third parties(i.e. the beneficiary's employer, the state, and/or private and public entities) may contribute on the beneficiary's behalf, including how this is operationalized, and how the contributions will be treated in so far as ensuring such funds are not considered beneficiary income or resources.

c. The strategy, operational and implementation plan to ensure that the beneficiary will not be charged a copayment by a Medicaid healthcare provider when covered benefits are provided.

d. Rules to ensure that account funds may only be disbursed for items or services covered under the individual's Medicaid benefit, and as approved in the Operational Protocol.

e. The strategy and the description of the operational processes to define how and to provide assurances that ensure that account debits and credits will be accurately tracked on a per visit basis, as well as quarterly and annual statements that will be provided to the beneficiary. The purpose of this requirement is to promote beneficiary awareness and understanding of the interaction between health care utilization and potential future copayment obligations or reductions due to healthy behaviors. At a minimum, this must provide for the following: Notices will be required at the time of service, also with quarterly, biannual and annual frequency. The impact of the statements will be considered in the evaluation of the demonstration.

f. A description, strategy and implementation plan of the beneficiary education and assistance process including copies of beneficiary notices, a description of beneficiaries' rights and responsibilities, appeal rights and processes and instructions for beneficiaries about how to interact with state officials for discrepancies or other issues that arise regarding the beneficiaries' MI Health Account.

g. Assurance that the account balances will not be counted as assets for the beneficiary and that funds returned to the beneficiary will not be treated as income, and a plan for whether interest will accrue to account balances.

h. A strategy for educating beneficiaries on how to use the statements, and understand that their health care expenditures will be covered.

i. For beneficiaries that are determined no longer eligible for the demonstration, a method for the remaining balance of the account to either be paid to the beneficiary or used to provide employer-based or Marketplace coverage.

31. **Assurance of Compliance.** Within 90 days of implementation of the MI Health Account, the state shall provide CMS with an accounting for review to verify that the

accounts are operating in accord with the approved protocol. Should the program be out of compliance, standard penalties may apply including a corrective action plan, disallowance, or program suspension until all operations are compliant.

32. **Healthy Behaviors Incentives Program.** Following CMS approval of the Healthy Behaviors Incentive program operational protocol, all individuals enrolled in the Healthy Michigan Program are eligible to receive incentive payments to offset cost sharing liability via reductions in their copayment liability if certain healthy behaviors are maintained or attained. The purpose of this incentive program is to encourage beneficiaries to their improve health outcomes as well as to maintain and implement additional healthy behaviors as identified in collaboration with their health care provider or providers via consultation as well as via a health risk assessment.

33. **Healthy Behaviors Incentives Program Operational Protocol.** The state may not implement the Healthy Behaviors Incentives program until April 1, 2014, or if later, until 30 days have passed following CMS approval of the protocol pertaining to the program (Attachment G). The state may not implement the Healthy Behaviors Incentives Program until after receiving CMS approval for the Healthy Behaviors Incentives Program Operational Protocol. The state must submit a draft protocol to CMS at least 90 days prior to the planned date of implementation of the program, to allow sufficient time for CMS review and discussion with Michigan. The protocol must, at a minimum, include the following:

    a. The uniform standards for healthy behaviors incentives including, but not limited to, a health risk assessment to identify behavior that the initiative is targeting, for example: routine ER use for non-emergency treatment, multiple comorbities, alcohol abuse, substance use disorders, tobacco use, obesity, and deficiencies in immunization status.

    b. A selection of targeted healthy behaviors that is sufficiently diverse and a strategy to measure access to necessary providers to ensure that all beneficiaries have an opportunity to receive healthy behavior incentives.

    c. A list of stakeholders as well as documentation of the public processes or meetings that occurred during the development of the protocol, the accompanying health risk assessment tool and uniform standards.

    d. The data driven strategy of how healthy behaviors will be tracked and monitored at the enrollee and provider level including standards of accountability for providers. This must include the timeline for development and/or implementation of a systems based approach which shall occur prior to implementing the Healthy Behaviors initiative.

    e. A beneficiary and provider education strategy and timeline for completion prior to program implementation.

f. The ongoing structured interventions that will be provided to assist beneficiaries in improving healthy behaviors as identified through the health risk assessment

g. A description of how the state will ensure that adjustments to premiums or average utilization copayment contributions are accurate and accounted for based upon the success in achieving healthy behaviors.

h. A strategy and implementation plan of how healthy behaviors will be tracked and monitored at the beneficiary and provider levels, including standards of accountability for providers.

i. An ongoing strategy of education and outreach post implementation regarding the Healthy Behaviors Incentives program including strategies related to the ongoing engagement of stakeholders and the public in the state.

j. A description of other incentives in addition to reductions in cost sharing or premiums that the state will implement.

k. The methodology describing how healthy behavior incentives will be applied to reduce premiums or copayments.

VII. DELIVERY SYSTEM

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

    a. County Health Plans (CHP) - The CHPs are capitated health plans that provide the primary and preventive care services in an ambulatory/outpatient setting. The CHPs have been a long-standing delivery system created to serve the childless adults enrolled in the ABW. Demonstration enrollees will be required to continue to enroll in the CHPs in 72 of the 83 counties in the state. The demonstration enrollees will have the choice of provider within the CHPs. In counties where CHPs do not currently operate, the state must provide a Medicaid card or other means to access the Medicaid qualified providers under Fee-for-Service (FFS). Tribal members are exempt from mandatory enrollment into CHPs, but may choose to participate in CHPs on a voluntary basis.

    b. Mental Health and Substance Abuse Provider Network. The state will continue to provide mental health and substance abuse services using a capitated managed care provider network through the state's Public Mental Health System (PMHS). The mental health and substance abuse network consists of local agencies

including Community Mental Health Services Programs (CMHSP) and Substance Abuse Coordinating Agencies. The mental health and substance abuse services will be provided based upon medical necessity and applicable benefit restrictions.

c. Contracts. All contracts and modifications of existing contracts between the state and the CHPs and Mental Health and Substance Providers must be approved by CMS prior to the effective date of the contract or modification of an existing contract. Upon the initial implementation of the demonstration the state will be provided a 90-day grace period to meet the above requirements. If the contract requirements are not met within the specified timeframe, CMS reserves the right as a corrective action to withhold FFP (either partial or full) for the demonstration until the contract compliance requirement is met.

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

    a. **Types of Health Plans.** The state will use two different types of health plans to provide the full Alternative Benefit Plan for the demonstration population:

        i. Comprehensive Health Plans: These will be Managed Care Organizations (MCOs) (which herein are also referred to as Medicaid Health Plans, or MHPs) that provide acute care, physical health services and most pharmacy benefits on a statewide basis. These MCOs will be the same MCOs that provide acute care and physical health coverage for other Medicaid populations.

        ii. Behavioral Health Plans: These will be Pre-paid Inpatient Health Plans (PIHPs) that provide inpatient and outpatient mental health, substance use disorder, and developmental disability services statewide to all enrollees in the demonstration. The PIHPs will be the same entities that serve other Medicaid populations.

        iii. The County Health Plan (CHP) structure of the ABW demonstration will not be utilized to serve the New Adults Medicaid population, although many of these providers contracted with the CHPs are also contracted with the MHPs, which will facilitate continuity of care.

    b. **Healthy Michigan Enrollment Requirements.** The state may require Healthy MI Adults to enroll in MCOs and PIHPs (with the exception of those beneficiaries who meet the MHP enrollment exemption criteria or those beneficiaries who meet the voluntary enrollment criteria).

        i. Mandatory enrollment may occur only when the MCOs or PIHPs have been determined by the state to meet readiness and network requirements to ensure sufficient access, quality of care, and care coordination for

beneficiaries as established by the state, consistent with 42 CFR §438 and as approved by CMS.

ii. New eligible will initially be placed in fee-for-service, during which the individual will be responsible for paying all copayments, in amounts that are in accord with the state plan, at the time of service.

iii. The state will use an enrollment broker to assist individuals with selection of a Medicaid Health Plan (MHP) managed care organization before relying on auto-assignments.

iv. Any individual that does not make an active selection will be assigned, by default, to a participating Healthy Michigan Program MCO. The state should develop an auto-assignment algorithm which is compliant with 42 CFR §438.50(f).

v. Individuals will have choice of Healthy Michigan MCOs in all areas except the rural counties that are not defined as urban by the Executive Office of Management and Budget. In rural counties, the state will only contract with 1 MCO to serve those beneficiaries, consistent with the standards in section 1932(a)(3)(B) of the Act. In all areas of the state, individuals will only be permitted to enroll in the 1 PIHP that serves their area of residence.

vi. Upon completion of the 90-day disenrollment period, individuals that are mandatorily enrolled into a Healthy Michigan MCO will be locked into that MCO for a period of 12 months, unless they have a for-cause reason for disenrollment, as defined by the state. Individuals that are voluntarily enrolled into a MCO will be permitted to disenroll at any time.

vii. All individuals will be automatically assigned to the single PIHP that serves beneficiaries in their area of residence in order to access services in the behavioral health system, provided the PIHP has been determined to meet readiness and network requirements, as described above.

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

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

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

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

39. **Network Requirements.** The state must ensure the delivery of all covered benefits, including high quality care. Services must be delivered in a culturally competent manner, and the MCO or PIHP network must be sufficient to provide access to covered services to the low-income population. In addition, the MCO/PIHP must coordinate health care services for demonstration populations. The following requirements must be included in the state's MCO/PIHP contracts:

    a. **Special Health Care Needs.** Enrollees with special health care needs must have direct access to a specialist, as appropriate for the individual's health care condition, as specified in 42 C.F.R. §438.208(c)(4).

    b. **Out of Network Requirements.** Each MCO/PIHP must provide demonstration populations with all demonstration program benefits under their contract and as described within these STCs and must allow access to non-network providers when services cannot be provided consistent with the timeliness standards required by the state.

40. **Demonstrating Network Adequacy.** Annually, each MCO/PIHP must provide adequate assurances that it has sufficient capacity to serve the expected enrollment in its service area and offers an adequate range of providers necessary to provide covered services for the anticipated number of enrollees in the service area.

a. The state must verify these assurances by reviewing demographic, utilization and enrollment data for enrollees in the demonstration as well as:

    i. The number and types of primary care, pharmacy, behavioral health, and specialty providers available to provide covered services to the demonstration population

    ii. The number of network providers accepting the new demonstration population; and

    iii. The geographic location of providers and demonstration populations, as shown through GeoAccess or similar software.

b. The state must submit the documentation required in subparagraphs i – iii above to CMS with initial MCO/PIHP contract submission as well as at each contract renewal or renegotiation, or at any time that there is a significant impact to each MCO/PIHP's operation, including service area expansion or reduction and population expansion.

41. **Managed Care Encounter Data Requirements.** All MCO/PIHPs shall maintain an information system that collects, analyzes, integrates and reports data as set forth at 42 CFR §438.242 in a standardized format. Encounter data requirements shall include the following:

    a. Encounter Data (MCO/PIHP Responsibilities) – Each MCO/PIHP must collect, maintain, validate and submit data for services furnished to its enrollees as required by state contract.

    b. Encounter Data (State Responsibilities) - The state shall develop mechanisms for the collection, reporting, and analysis of these, as well as a process to validate that each plan's encounter data are timely, complete and accurate. The state will take appropriate actions to identify and correct deficiencies identified in the collection of encounter data. The state shall have contractual provisions in place to impose financial penalties if accurate data are not submitted in a timely fashion. Additionally, the state shall contract with its EQRO to validate encounter data through medical record review.

    c. Encounter Data Validation Study for New Capitated Managed Care Plans - If the state contracts with new MCOs or PIHPs throughout the lifetime of the demonstration, the state shall conduct a validation study 18 months after the effective date of the contract to determine completeness and accuracy of encounter data. The initial study shall include validation through a sample of medical records of MCO/PIHP enrollees.

42. **AI/AN Access to Behavioral Health Services.** Native American Indian beneficiaries may elect to obtain Medicaid mental health and substance abuse services directly from Medicaid enrolled Indian Health Service (IHS) facilities and Tribal Health Centers (THCs). For mental health and substance abuse services provided to Native American beneficiaries, the IHS facilities and THCs will be reimbursed directly for those services by the state under the memorandum of agreement (MOA) as specified in the Michigan Medicaid Provider Manual. If the IHS facility or THC provides services to non-Native American persons, the IHS facility or THC must become part of the PIHP provider panel in order to receive reimbursement for specialty services provided to non-Native American persons from the PIHP. Any Native American Indian beneficiary who needs specialty mental health, developmental disability or substance abuse services may also elect to receive such care under this demonstration through the PIHP. The PIHPs have been specifically instructed by MDCH to assure that Indian health programs are included in the PIHP provider panel, to ensure culturally competent specialty care for the beneficiaries in those areas.

VIII. TRANSITION OF INDIVIDUALS

43. **Initial Transition Planning.** Within 15 days of the award of the Healthy Michigan Program amendment, the state is required to submit, or revise, a Transition Plan, for CMS review, that addresses the state's process for transitioning individuals between various coverage options. The Transition Plan will at a minimum address the following:
    (a) All ABW enrollees will be automatically transitioned into Medicaid without an additional redetermination, in accord with Michigan's 1902(e)(14) waiver. Each transitioned beneficiary will retain his or her original redetermination date;
    (b) The state must assure the continuity of care for persons transitioning from ABW to Medicaid;
    (c) The state will use Medicaid and Marketplace applications submitted after October 1, 2013 to identify individuals who may be eligible for Medicaid as of April 1, 2014, and will send the applicants an eligibility notice and enrollment packet;
    (d) The state will identify individuals between 100 – 133 percent of FPL who are enrolled in a Qualified Health Plan and will work to enroll these individuals in the demonstration and to the extent possible, ensure continuity of care; and
    (e) The state will work with beneficiaries with complex health needs, such as those receiving HIV or substance abuse treatment, to ensure continuity of care with providers and current medications.

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

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

46. **Transition of Adult Benefit Waiver Program Enrollees.** In addition to all prior authorizations initiated under the ABW demonstration being honored for a period of 30 days in the new Medicaid Health Plans, individuals transitioning from the Adult Benefits Waiver MCOs will be matched to a Medicaid Health Plan with their existing preferred provider to the extent possible. In the event that a person is assigned to a Medicaid Health Plan that does not have their existing provider, the individuals will be afforded the following protections:

    a. The state shall inform the Medicaid Health Plan of the existing provider relationship so the Medicaid Health Plan can make every effort to get that provider in their network

    b. The state shall inform the individual in writing that his or her current provider is not in the Medicaid Health Plan's network and they should work with the enrollment broker and the Medicaid Health Plan to pick a new preferred provider.

    c. The Medicaid Health Plan will allow the individual to see that provider, even on an out of network basis, until the individual may be safely brought into network.

IX GENERAL REPORTING REQUIREMENTS

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

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

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

Healthy MI Adults			

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

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

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

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

    a. An updated budget neutrality monitoring spreadsheet;

    b. Events occurring during the quarter or anticipated to occur in the near future that affect health care delivery, including, but not limited to: benefits, enrollment and disenrollment, complaints and grievances, quality of care, and access that is relevant to the demonstration, pertinent legislative or litigation activity, and other operational issues;

    c. Updates on the post award forums required under paragraph 51.

d. Action plans for addressing any policy, administrative, or budget issues identified;

e. Monthly enrollment reports for demonstration beneficiaries, that include the member months and end of quarter, point-in-time enrollment for each demonstration population;

f. Number of beneficiaries who chose an MCO and the number of beneficiaries who change plans after being auto-assigned; and

g. Information on beneficiary complaints, grievances and appeals filed during the quarter by type including; access to urgent, routine, and specialty services, and a description of the resolution and outcomes. Evaluation activities and interim findings. The state shall include a summary of the progress of evaluation activities, including key milestones accomplished as well as challenges encountered and how they were addressed. The discussion shall also include interim findings, when available; status of contracts with independent evaluator(s), if applicable; status of Institutional Review Board approval, if applicable; and status of study participant beneficiary recruitment, if applicable.

h. Identify any quality assurance/monitoring activity in current quarter. As part of the annual report, pursuant to paragraph 53, the state must also report on the implementation and effectiveness of the updated comprehensive Quality Strategy as it impacts the demonstration.

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

    a. All items included in the Quarterly Progress Report pursuant to paragraph 52 must be summarized to reflect the operation/activities throughout the DY;

    b. Total annual expenditures for the demonstration population for each DY, with administrative costs reported separately

    c. Yearly enrollment reports for demonstration enrollees for each DY (enrollees include all individuals enrolled in the demonstration) that include the member months, as required to evaluate compliance with the budget neutral agreement;

    d. **Managed Care Delivery System.** The state must document accomplishments, project status, quantitative and case study findings, interim evaluation findings, utilization data, progress on implementing cost containment initiatives and policy and administrative difficulties in the operation of the demonstration. The state

must provide the CAHPS survey, outcomes of any focused studies conducted and what the state intends to do with the results of the focused study, outcomes of any reviews or interviews related to measurement of any disparities by racial or ethnic groups, annual summary of network adequacy by plan including an assessment of the provider network pre and post implementation and MCO compliance with provider 24/7 availability, summary of outcomes of any on-site reviews including EQRO, financial, or other types of reviews conducted by the state or a contractor of the state, summary of performance improvement projects being conducted by the state and any outcomes associated with the interventions, outcomes of performance measure monitoring, summary of plan financial performance. \

54. **Final Report.** Within 120 days following the end of the demonstration, the state must submit a draft final report to CMS for comments. The state must take into consideration CMS' comments for incorporation into the final report. The final report is due to CMS no later than 90 days after receipt of CMS' comments.

XI. GENERAL FINANCIAL REQUIREMENTS

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

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

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

    a. **Tracking Expenditures.** In order to track expenditures under this demonstration, the state will report demonstration expenditures through the Medicaid and State Children's Health Insurance Program Budget and Expenditure System (MBES/CBES); following routine CMS-64 reporting instructions outlined in Section 2500 and Section 2115 of the State Medicaid Manual. All demonstration expenditures subject to budget neutrality limits must be reported each quarter on separate Forms CMS-64.9 WAIVER and/or 64.9P WAIVER, identified by the demonstration project number assigned by CMS (including the project number extension, which indicates the DY in which services were rendered or for which capitation payments were made). For monitoring purposes, cost settlements must be recorded on the appropriate prior period adjustment schedules (Forms CMS-64.9 Waiver) for the Summary Line 10B, in lieu of Lines 9 or l0C. For any other

cost settlements (i.e., those not attributable to this demonstration), the adjustments should be reported on lines 9 or 10C, as instructed in the State Medicaid Manual. The term, "expenditures subject to the budget neutrality limit," is defined below in paragraph 57.

b. **Cost Settlements.** For monitoring purposes, cost settlements attributable to the demonstration must be recorded on the appropriate prior period adjustment schedules (Form CMS-64.9P Waiver) for the Summary Sheet Line 10B, in lieu of Lines 9 or 10C. For any cost settlement not attributable to this demonstration, the adjustments should be reported as otherwise instructed in the State Medicaid Manual.

c. **Premium and Cost Sharing Contributions.** Premiums and other applicable cost sharing contributions that are collected by the state from enrollees under the demonstration must be reported to CMS each quarter on Form CMS-64 Summary Sheet line 9.D, columns A and B. In order to assure that these collections are properly credited to the demonstration, premium and cost-sharing collections (both total computable and federal share) should also be reported separately by DY on the Form CMS-64 Narrative. In the calculation of expenditures subject to the budget neutrality expenditure limit, premium collections applicable to demonstration populations will be offset against expenditures. These Section 1115 premium collections will be included as a manual adjustment (decrease) to the demonstration's actual expenditures on a quarterly basis.

d. **Mandated Increase in Physician Payment Rates in 2013 and 2014.** Section 1202 of the Health Care and Education Reconciliation Act of 2010 (Pub. Law 110-152) requires state Medicaid programs to pay physicians for primary care services at rates that are no less than what Medicare pays, for services furnished in 2013 and 2014. The federal government provides a federal medical assistance percentage of 100 percent for the claimed amount by which the minimum payment exceeds the rates paid for those services as of July 1, 2009. The state may (at its option) exclude from the budget neutrality test for this demonstration the portion of the mandated increase for which the federal government pays 100 percent. Should the state elect this, these amounts must be reported on the base forms CMS-64.9, 64.21, or 64.21U (or their "P" counterparts), and not on any waiver form.

e. **Pharmacy Rebates.** The state may propose a methodology for assigning a portion of pharmacy rebates to the demonstration populations, in a way that reasonably reflects the actual rebate-eligible pharmacy utilization of those populations, and which reasonably identifies pharmacy rebate amounts with DYs. Use of the methodology is subject to the approval in advance by the CMS Regional Office, and changes to the methodology must also be approved in advance by the Regional Office. The portion of pharmacy rebates assigned to the demonstration using the approved methodology will be reported on the

appropriate Forms CMS-64.9 Waiver for the demonstration and not on any other CMS 64.9 form to avoid double –counting. Each rebate amount must be distributed as state and Federal revenue consistent with the Federal matching rates under which the claim was paid.

f. **Use of Waiver Forms for Medicaid.** For each DY, separate Forms CMS-64.9 Waiver and/or 64.9P Waiver shall be submitted reporting expenditures for individuals enrolled in the demonstration, subject to the budget neutrality limits (Section X of these STCs). The state must complete separate waiver forms for the following Medicaid eligibility groups/waiver names:

   i. MEG 1 – "Michigan's Adult Benefit Waiver" (implemented January 1, 2010) (all health care expenditures for Michigan's Adult Benefit Waiver)

   ii. MEG 2 – "Healthy MI Adults" (all health care expenditures for Healthy MI Adults, starting April 1, 2014, without regard to actual implementation date for Healthy Michigan)

g. **Demonstration Years.** Demonstration Years (DYs) will be defined as follows:

Demonstration Year 1 (DY 1)	January 1, 2010 – September 30, 2010
Demonstration Year 2 (DY 2)	October 1, 2010 – September 30, 2011
Demonstration Year 3 (DY 3)	October 1, 2011 – September 30, 2012
Demonstration Year 4 (DY 4)	October 1, 2012 – September 30, 2013
Demonstration Year 5 (DY 5)	October 1, 2013 – December 31, 2014
Demonstration Year 6 (DY 6)	January 1, 2015 – December 31, 2015
Demonstration Year 7 (DY 7)	January 1, 2016 – December 31, 2016
Demonstration Year 8 (DY 8)	January 1, 2017 – December 31, 2017
Demonstration Year 9 (DY 9)	January 1, 2018 – December 31, 2018

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

a. All demonstration medical assistance expenditures (including those authorized through the Medicaid state plan, and through the Section 1115 waiver and expenditures authorities), but excluding the increase expenditures resulting from

the mandated increase in payments to physicians per paragraph 57(d) made on behalf of all demonstration beneficiaries listed in Section IV, Eligibility, with dates of services within the demonstration's approval period; and

b. All expenditures that are subject to the budget neutrality agreement are considered demonstration expenditures and must be reported on Forms CMS-64.9 Waiver and /or 64.9P Waiver.

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

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

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

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

    b. To permit full recognition of "in-process" eligibility, reported counts of member months may be subject to revisions after the end of each quarter. Member month counts may be revised retrospectively as needed.

    c. The term "eligible member months" refers to the number of months in which persons are eligible to receive services. For example, a person who is eligible for 3 months contributes 3 eligible member months to the total. Two individuals who are eligible for 2 months each contribute 2 eligible member months to the total, for a total of 4 eligible member months.

61. **Standard Medicaid Funding Process.** The standard Medicaid funding process must be used during the demonstration. The state must estimate matchable demonstration

expenditures (total computable and federal share) subject to the budget neutrality expenditure cap and separately report these expenditures by quarter for each federal fiscal year (FFY) on the Form CMS-37 for both the Medical Assistance Payments (MAP) and State and Local Administration Costs (ADM). CMS will make federal funds available based upon the state's estimate, as approved by CMS. Within 30 days after the end of each quarter, the state must submit the Form CMS-64 quarterly Medicaid expenditure report, showing Medicaid expenditures made in the quarter just ended. The CMS will reconcile expenditures reported on the Form CMS-64 quarterly with federal funding previously made available to the state, and include the reconciling adjustment in the finalization of the grant award to the state.

62. **Extent of FFP for the Demonstration.** Subject to CMS approval of the source(s) of the non-federal share of funding, CMS will provide FFP at the applicable federal matching rate for the demonstration as a whole as outlined below, subject to the limits described in Section XI:

    a. Administrative costs, including those associated with the administration of the demonstration.

    b. Net expenditures and prior period adjustments of the Medicaid program that are paid in accordance with the approved state plan.

    c. Medical Assistance expenditures made under Section 1115 demonstration authority, including those made in conjunction with the demonstration, net of enrollment fees, cost sharing, pharmacy rebates, and all other types of third party liability or CMS payment adjustments.

63. **Sources of Non-Federal Share.** The state must certify that the matching non-federal share of funds for the demonstration is state/local monies. The state further certifies that such funds shall not be used as the match for any other federal grant or contract, except as permitted by law. All sources of non-federal funding must be compliant with Section 1903(w) of the Act and applicable regulations. In addition, all sources of the non-federal share of funding are subject to CMS approval.

    a. CMS may review the sources of the non-federal share of funding for the demonstration at any time. The state agrees that all funding sources deemed unacceptable by CMS shall be addressed within the time frames set by CMS.

    b. Any amendments that impact the financial status of the program shall require the state to provide information to CMS regarding all sources of the non-federal share of funding.

    c. The state assures that all health care-related taxes comport with Section 1903(w) of the Act and all other applicable federal statutory and regulatory provisions, as well as the approved Medicaid state plan.

d. State Certification of Funding Conditions. The state must certify that the following conditions for non-federal share of demonstration expenditures are met:

i. Units of government, including governmentally operated health care providers, may certify that state or local tax dollars have been expended as the non-federal share of funds under the demonstration.

ii. To the extent the state utilizes certified public expenditures (CPEs) as the funding mechanism for Title XIX (or under Section 1115 authority) payments, CMS must approve a cost reimbursement methodology. This methodology must include a detailed explanation of the process by which the state would identify those costs eligible under Title XIX (or under Section 1115 authority) for purposes of certifying public expenditures.

iii. To the extent the state utilizes CPEs as the funding mechanism to claim federal match for payments under the demonstration, governmental entities to which general revenue funds are appropriated must certify to the state the amount of such tax revenue (state or local) used to satisfy demonstration expenditures. The entities that incurred the cost must also provide cost documentation to support the state's claim for federal match.

e. The state may use intergovernmental transfers to the extent that such funds are derived from state or local tax revenues and are transferred by units of government within the state. Any transfers from governmentally operated health care providers must be made in an amount not to exceed the non-federal share of Title XIX payments.

f. Under all circumstances, health care providers must retain 100 percent of the reimbursement amounts claimed by the state as demonstration expenditures. Moreover, no pre-arranged agreements (contractual or otherwise) may exist between the health care providers and the state and/or local government to return and/or redirect any portion of the Medicaid payments. This confirmation of Medicaid payment retention is made with the understanding that payments that are the normal operating expenses of conducting business (such as payments related to taxes—including health care provider-related taxes—fees, and business relationships with governments that are unrelated to Medicaid and in which there is no connection to Medicaid payments) are not considered returning and/or redirecting a Medicaid payment.

XI. MONITORING BUDGET NEUTRALITY FOR THE DEMONSTRATION

64. **Budget Neutrality for ABW.** The state will continuing to apply the following budget neutrality methodology, based on the requirements as set forth in Section 112 of the Children's Health Insurance Program Reauthorization Act of 2009, for the establishment

of the demonstration's budget neutrality limit until the implementation of the Medicaid expansion on April 1, 2014, and the successful transition of all ABW program beneficiaries:

a. **Limit on Federal Title XIX Funding.** The state will be subject to annual limits on the amount of Federal Title XIX funding that the state may receive for ABW program.

b. **Risk.** The state shall be at risk for both the number of ABW beneficiaries as well as the per capita cost for ABW beneficiaries under this budget neutrality agreement.

c. **Budget Neutrality Expenditure Limit.** The following describes how the annual budget neutrality expenditure limits are determined for ABW, consistent with Section 2111(a)(3)(C) of the Act.

    i. **Record of Budget Neutrality Expenditure Limit.** Attachment D provides a table that gives preliminary Annual Limits (defined below) for all of the approved DYs, based on information available at the time of the initial award of this demonstration. The table also provides a framework for organizing and documenting updates to the Annual Limits as new information is received, and for eventual publication of the final Annual limit for each DY. Updated versions of Attachment B may be approved by CMS through letter correspondence, and do not require that the demonstration be amended.

    ii. **Budget Neutrality Update.** Prior to April 1 of each year, the state must submit to CMS an updated budget neutrality analysis, which includes the following elements:

        A. Projected expenditures and Annual Limits for each DY through the end of the approval period;

        B. A proposed computation of the Trend Factor (defined below) that will be used to calculate the Annual Limit for the DY immediately following, and the Annual Limit for the immediately following DY that would be determined by that Trend Factor;

        C. A proposed updated version of Attachment B. The state may request technical assistance from CMS for the calculation of the Annual Limits and Trend Factors prior to its submission of the updated budget neutrality analysis. CMS will respond by either confirming the state's calculations or by working with the state to determine an accurate calculation of the Trend Factor and Annual Limit for the coming DY. CMS will ensure that the final Trend

Factors for each DY are the same for all CHIPRA Medicaid childless adult waivers. The annual budget neutrality limit for each DY will be finalized by CMS by the following date, whichever is later: (1) 120 days prior to the start of the DY; or (2) two months following the date of the most recent publication of the National Health Expenditure projections occurring prior to the start of the DY.

iii. **Base Year Expenditure.** The Base Year Expenditure will be equal to the total amount of FFP paid to the state for health care services or coverage provided to nonpregnant childless adults under the Michigan Adult Benefits Waiver (21-W-00017/5), as reported on CMS-21 and CMS-21P Waiver forms submitted by the state in the four quarters of FFY 2009. A preliminary Base Year Expenditure total appears in Attachment B. A final Base Year Expenditure total will be determined by CMS following CMS receipt of the Budget Neutrality Update that the state must provide by April 1, 2010.

iv. **Adjustments to the Base Year Expenditure.** CMS reserves the right to adjust the Base Year Expenditure in the event that any future audit or examination shows that any of the expenditures included in the Base Year Expenditure total were not expenditures for health care services, health insurance premiums, or premium assistance for nonpregnant childless adults participating in the Michigan Adult Benefits Waiver (21-W-00017/5).

v. **Special Calculation for FFY 2010.** The FFY 2010 Expenditure Projection will be equal to the Base Year Expenditure increased by 3.7 percent, which is the percentage increase in the projected nominal per capita amount of National Health Expenditures for 2010 over 2009, as published by the Secretary in February 2009.

vi. **Annual Limit for DY 1.** To account for the fact that this demonstration will be active for only three-quarters of FFY 2010, the Annual Limit for DY 1 will be equal to the FFY 2010 Expenditure Projection (as calculated under subparagraph (e) times 75 percent. The Annual Limit for DY 1 will be finalized at the same time that the Base Year Expenditure is finalized.

vii. **Annual Limit for DY 2.** The Annual Limit for DY 2 will be equal to the FFY 2010 Expenditure Projection (as calculated under subparagraph (e), and prior to multiplication by three-quarters as indicated in subparagraph (f)), increased by the percentage increase (if any) in the projected nominal per capita amount of National Health Expenditures for 2011 over 2010, as published by the Secretary in February 2010. The Annual Limit for DY 2 can be finalized once the Trend factor for DY 2 is finalized.

viii. **Annual Limit for DY 3 and Subsequent Years.** The Annual Limit for DY 3 and the DYs that follow will be equal to the prior year's Annual Limit, increased by the percentage increase (if any) in the projected nominal per capita amount of National Health Expenditures for the year beginning January 1 of the DY over the year preceding that year, as published by the Secretary in the February prior to the start of the DY. Program

ix. **Calculation of the Trend Factor.** The percentage increase (if any) in the projected nominal per capita amount of National Health Expenditures for the year beginning January 1 of a DY (PERCAP2) over the preceding year(PERCAP1) to be referred to as the Trend Factor) will be calculated to one decimal place of precision (example: 3.7 percent) using computer spreadsheet rounding. (A sample formula for this calculation in Microsoft Excel reads as follows:

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

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

65. **Budget Neutrality for Healthy Michigan.**

a. **Limit on Title XIX Funding.** The state shall be subject to a limit on the amount of federal Title XIX funding that the state may receive on selected Medicaid expenditures during the period of approval of the demonstration. The limit is determined by using the per capita cost method described in paragraph 65(c), and budget neutrality expenditure limits are set on a yearly basis with a cumulative budget neutrality expenditure limit for the length of the entire demonstration. The data supplied by the state to CMS to set the annual caps is subject to review and audit, and if found to be inaccurate, will result in a modified budget neutrality expenditure limit. CMS' assessment of the state's compliance with these annual limits will be done using the Schedule C report from the CMS-64.

b. **Risk.** The state will be at risk for the per capita cost (as determined by the method described below) for the Healthy Michigan Program demonstration populations as defined in paragraph 21, but not at risk for the number of beneficiaries in the demonstration population. By providing FFP without regard to enrollment in the demonstration populations, CMS will not place the state at risk for changing economic conditions that impact enrollment levels. However, by placing the state

at risk for the per capita costs of current eligibles, CMS assures that the demonstration expenditures do not exceed the levels that would have been realized had there been no demonstration.

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

i. The MEG listed in the table below is included in the calculation of the budget neutrality limit for Healthy Michigan Program.

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

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

iii. The budget neutrality limit is calculated by taking the PMPM cost projection for the above group in each DY, times the number of eligible member months for that group and DY, and adding the products together across groups and DYs. The federal share of the budget neutrality limit is

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

obtained by multiplying total computable budget neutrality limit by the Composite Federal Share.

iv. The Healthy Michigan Program budget neutrality test is a comparison between the federal share of the budget neutrality limit and total FFP reported by the state for "Healthy MI Adults."

d. **Composite Federal Share Ratio.** The Composite Federal Share is the ratio calculated by dividing the sum total of federal financial participation (FFP) received by the state on actual demonstration expenditures during the approval period, as reported through the MBES/CBES and summarized on Schedule C (with consideration of additional allowable demonstration offsets such as, but not limited to, premium collections) by total computable demonstration expenditures for the same period as reported on the same forms. Should the demonstration be terminated prior to the end of the extension approval period (see paragraphs 9 and 11), the Composite Federal Share will be determined based on actual expenditures for the period in which the demonstration was active. For the purpose of interim monitoring of budget neutrality, a reasonable estimate of Composite Federal Share may be developed and used through the same process or through an alternative mutually agreed upon method.

e. **Lifetime Demonstration Budget Neutrality Limit.** The lifetime (overall) budget neutrality limit for the Healthy Michigan Program component of the demonstration is the sum of the annual budget neutrality limits calculated in subparagraph (c).

f. **Future Adjustments to the Budget Neutrality Expenditure Limit.** CMS reserves the right to adjust the budget neutrality expenditure limit to be consistent with enforcement of impermissible provider payments, health care related taxes, new federal statutes, or policy interpretations implemented through letters, memoranda, or regulations with respect to the provision of services covered under the demonstration.

g. **Enforcement of Budget Neutrality.** CMS shall enforce budget neutrality over the life of the demonstration rather than on an annual basis. However, if the state's expenditures exceed the calculated cumulative budget neutrality expenditure cap by the percentage identified below for any of the demonstration years, the state must submit a corrective action plan to CMS for approval. The state will subsequently implement the approved corrective action plan.

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

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

XII. EVALUATION OF THE DEMONSTRATION

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

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

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

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

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

69. **Evaluation Design.**

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

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

        i. Uncompensated Care Analysis - This evaluation project will examine the impact of reducing the number of uninsured individuals on uncompensated care costs to hospitals in Michigan through the expansion of subsidized insurance.

        ii. Reduction in the Number of Uninsured - The Healthy Michigan Program will test the hypothesis that, when affordable health insurance is made available and the application for insurance is simplified (through both an exchange and the state's existing eligibility process), the uninsured population will decrease significantly. This evaluation will examine insured/uninsured rates in general and more specifically by select population groups (e.g., income levels, geographic areas, and race/ethnicity).

        iii. Impact on Healthy Behaviors and Health Outcomes - The Healthy Michigan Program will evaluate what impact incentives for healthy behavior and the completion of an annual health risk assessment have on increasing healthy behaviors and improving health outcomes. This evaluation will analyze selected indicators, such as emergency room utilization rates, inpatient hospitalization rates, use of preventive services and health and wellness programs, and the extent to which beneficiaries report an increase in their overall health status. Clear milestone reporting

on the Healthy Behavior Incentives initiative must be summarized and provided to CMS once per year.

iv. Participant Beneficiary Views on the Impact of the Healthy Michigan Program - The Healthy Michigan Program will evaluate whether access to a low-cost (modest co- payments, etc.) primary and preventive health insurance benefit will encourage beneficiaries to maintain their health through the use of more basic health care services in order to avoid more costly acute care services.

v. Impact of Contribution Requirements – The Healthy Michigan Program will plan will evaluate whether requiring beneficiaries to make contributions toward the cost of their health care results in individuals dropping their coverage, and whether collecting an average utilization component from beneficiaries in lieu of copayments at point of service affects beneficiaries' propensity to use services. The impact of increased communication to beneficiaries about their required contributions (in the form of point of service notices of potential copayment liability and quarterly and annual statements) must be evaluated.

vi. Impact of MI Health Accounts – The Healthy Michigan Program will evaluate whether providing a MI Health Account into which beneficiaries' contributions are deposited, that provides quarterly statements detailing account contributions and health care utilization, and that allows for reductions in future contribution requirements when funds roll over, deters beneficiaries from receiving needed health care services, or encourages beneficiaries to be more cost conscious.

b. Measures - The draft evaluation design must discuss the outcome measures that shall be used in evaluating the impact of the demonstration during the period of approval, including:

i. A description of each outcome measure selected, including clearly defined numerators and denominators, and National Quality Forum (NQF) numbers (as applicable);

ii. The measure steward;

iii. The baseline value for each measure;

iv. The sampling methodology for assessing these outcomes; and

c. Sources of Measures - CMS recommends that the state use measures from nationally-recognized sources and those from national measures sets (including

CMS's Core Set Core Set of Health Care Quality Measures for Medicaid-Eligible Adults).

d. The evaluation design must also discuss the data sources used, including the use of Medicaid encounter data, enrollment data, electronic health record (EHR) data, and consumer and provider surveys. The draft evaluation design must include a detailed analysis plan that describes how the effects of the demonstration shall be isolated from other initiatives occurring in the state. The evaluation designs proposed for each question may include analysis at the beneficiary, provider, and aggregate program level, as appropriate, and include population stratifications to the extent feasible, for further depth and to glean potential non-equivalent effects on different sub-groups.

70. **Final Evaluation Design and Implementation.** CMS shall provide comments on the draft design update and the draft evaluation strategy within 60 days of receipt, and the state shall submit a final design within 60 days of receipt of CMS' comments. The state must implement the evaluation design and submit its progress in each of the Quarterly Progress Reports and Annual Reports.

71. **Interim Evaluation Report.** The state must submit an interim evaluation report to CMS as part of any future request to extend the demonstration, or by June 30, 2018 if no extension request has been submitted by that date. The interim evaluation report will discuss evaluation progress and present findings to date.

72. **Healthy Michigan Program Final Evaluation Report.** The state must submit to CMS a draft of the Evaluation Final Report by May 1, 2019. The state must submit the Final Evaluation Report within 60 days after receipt of CMS' comments. The final report must include the following:

    a. An executive summary;

    b. A description of the demonstration, including programmatic goals, interventions implemented, and resulting impact of these interventions;

    c. A summary of the evaluation design employed, including hypotheses, study design, measures, data sources, and analyses;

    d. A description of the population included in the evaluation (by age, gender, race/ethnicity, etc.);

    e. Final evaluation findings, including a discussion of the findings (interpretation and policy context); and

    f. Successes, challenges, and lessons learned.

73. **Completion of ABW Evaluation.** By August 1, 2014, the state must submit a draft final evaluation report on ABW to CMS, based on the evaluation design approved by CMS in 2010. CMS will provide comments within 60 days after receipt of the report, and the state must submit the final evaluation report within 60 days after receipt of CMS's comments.

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

74. **External Quality Review (EQR).** The state is required to meet all requirements for external quality review (EQR) found in 42 C.F.R. Part 438, subpart E. In addition to routine encounter data validation processes that take place at the MCO/PIHP and state level, the state must maintain its contract with its external quality review organization (EQRO) to require the independent validation of encounter data for all MCOs and PIHPs at a minimum of once every three years.

    a. The state should generally have available its final EQR technical report to CMS and the public, in a format compliant with Section 508 of the Rehabilitation Act (29 U.S.C. § 794d), by April 30th of each year, for data collected within the prior 15 months. This submission timeframe will align with the collection and annual reporting on managed care data by the Secretary of Health and Human Services each September 30th, which is a requirement under the Affordable Care Act [Sec. 2701 (d)(2)].

    b. Consumer Health Plan Report Cards. On an annual basis, the state must create and make readily available to beneficiaries, providers, and other interested stakeholders, a health plan report card, in a format compliant with Section 508 of the Rehabilitation Act (29 U.S.C. § 794d), that is based on performance data on each health plan included in the annual EQR technical report. Each health plan report card must be posted on the state's website and present an easily understandable summary of quality, access, and timeliness regarding the performance of each participating health plan. The report cards must also address the performance of subcontracted dental plans.

75. **Measurement Activities.** The state must ensure that each participating health plan is accountable for metrics on quality and access, including measures to track progress in identified quality improvement focus areas, measures to track quality broadly, and measures to track access. The state must set performance targets that equal or exceed the 75th percentile national Medicaid performance level.

76. **Data Collection.** The state must collect data and information on dental care utilization rates, the CMS Medicaid and CHIP adult and child core measures, and must align with other existing federal measure sets where possible to ensure ongoing monitoring of individual well-being and plan performance. The state will use this information in

ongoing monitoring and quality improvement efforts, in addition to quality reporting efforts.

77. **Comprehensive State Quality Strategy.** The state shall adopt and implement a comprehensive and holistic, continuous quality improvement strategy that focuses on all aspects of quality improvement in Medicaid, including FFS populations; and capitated managed care plans. The Comprehensive Quality Strategy (CQS) shall meet all the requirements of 42 CFR 438 Subparts D and E. The CQS must also address the following elements:

    a. The state's goals for improvement, identified through claims and encounter data, quality metrics and expenditure data. The goals should align with the three part aim but should be more specific in identifying specific pathways for the state to achieve these goals.

    b. The associated interventions for improvement in the goals. (See November 22, 2013 CMS letter to State Health Official.)

    c. The specific quality metrics for measuring improvement in the goals. The metrics should be aligned with the Medicaid and CHIP adult and child core measures, and should also align with other existing Medicare and Medicaid federal measure sets where possible. The metrics should go beyond HEDIS and CAHPS data, and should reflect cost of care. Metrics should be measured at the following levels of aggregation: the state Medicaid agency, each health plan, and each direct health services provider. The state will work with CMS to further define what types of metrics will be measured for direct service providers. (See November 22, 2013 CMS letter to State Health Official.)

    d. The specific methodology for determining benchmark and target performance on these metrics for each aggregated level identified above (state, plan and provider).

    e. Performance improvement accountability – i.e., the state must determine if the current plans for financial incentives adequately align with the specific goals and targeted performance, and whether enhancements to these incentives are necessary (increased or restructured financial incentives, in-kind incentives, contract management, etc.). The state must present the findings of the determination to CMS.

    f. Specific metrics related to each population covered by the Medicaid program.

    g. Monitoring and evaluation. This should include specific plans for continuous quality improvement, which includes transparency of performance on metrics and structured learning, and also a rigorous and independent evaluation of the demonstration, as described in paragraph 69. The evaluation should reflect all the programs covered by the CQS as mentioned above.

h. The CQS should include a timeline that considers metric development and specification, contract amendments, data submission and review, incentive disbursement (if available), and the re-basing of performance data.

i. The CQS must include state Medicaid agency and any contracted service providers' responsibilities, including managed care entities, and providers enrolled in the state's FFS program. The state Medicaid agency must retain ultimate authority and accountability for ensuring the quality of and overseeing the operations of the program. The CQS must include distinctive components for discovery, remediation, and improvement.

j. The first draft of this CQS is due to CMS no later than 120 days following the approval of the Healthy Michigan Program amendment. CMS will review this draft and provide feedback to the state. The state must revise and resubmit the CQS to CMS for approval within 45 days of receipt of CMS comment. The state must revise (and submit to CMS for review and approval) their CQS whenever significant changes are made to the associated Medicaid programs and the content of the CQS. Any further revisions must be submitted accordingly:

    i. Modifications to the CQS due to changes in the Medicaid operating authorities must be submitted concurrent with the proposed changes to the operating authority (e.g., state plan or waiver amendments or waiver renewals); and/or

    ii. Changes to an existing, approved CQS due to fundamental changes to the CQS must be submitted for review and approval to CMS no later than 60 days prior to the contractual implementation of such changes. If the changes to the CQS do not impact any provider contracts, the revisions to the CQS may be submitted to CMS no later than 60 days following the changes. The state must solicit for and obtain the input of beneficiaries, the Medical Care Advisory Committee (MCAC), and other stakeholders in the development of its CQS and make the initial CQS, as well as any significant revisions, available for public comment prior to implementation. Pursuant to paragraph 53 Annual Report, the state must also provide CMS with annual reports on the implementation and effectiveness of their CQS as it impacts the demonstration.

k. As required by 42 C.F.R. §438.360(b)(4), the state must identify in the CQS any standards for which the EQRO will use information from private accreditation reviews to complete the compliance review portion of EQR for participating MCOs or PIHPs. The state must, by means of a crosswalk included in the CQS, set forth each standard that the state deems as duplicative to those addressed under accreditation and explain its rationale for why the standards are duplicative.

l. Upon approval by CMS, the state will finalize the CQS to be fully compliant with Section 508 of the Rehabilitation Act (29 U.S.C. § 794d).

XIV. SCHEDULE OF STATE DELIVERABLES DURING THE DEMONSTRATION

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

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

ATTACHMENT A
Quarterly Progress Report Content and Format

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

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

NARRATIVE REPORT FORMAT:

Title Line One – Michigan Adult Coverage Demonstration
Title Line Two – Section 1115 Quarterly Report
Demonstration/Quarter Reporting Period:
[Example: Demonstration Year: 7 (1/1/2015 – 12/31/2016)
Federal Fiscal Quarter:
Footer: Date on the approval letter through December 31, 2018

Introduction

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

Enrollment and Benefits Information

Discuss the following:

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

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

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

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

ATTACHMENT A
Quarterly Progress Report Content and Format

Enrollment Counts for Quarter and Year to Date
Note: Enrollment counts should be unique enrollee counts, not beneficiary months

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

IV. Outreach/Innovative Activities to Assure Access
Summarize marketing, outreach, or advocacy activities to potential eligibles and/or promising practices for the current quarter to assure access for demonstration beneficiaries or potential eligibles.

V. Collection and Verification of Encounter Data and Enrollment Data
Summarize any issues, activities, or findings related to the collection and verification of encounter data and enrollment data.

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

IX. Financial/Budget Neutrality Development/Issues
Identify all significant developments/issues/problems with financial accounting, budget neutrality, and CMS 64 and budget neutrality reporting for the current quarter. Identify the state's actions to address these issues.

X. Beneficiary Month Reporting
Enter the beneficiary months for each of the MEGs for the quarter.

A. For Use in Budget Neutrality Calculations

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

XI. Consumer Issues

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

XII. Quality Assurance/Monitoring Activity

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

XIII. Managed Care Reporting Requirements

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

XIV. Lessons Learned

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

XV. Demonstration Evaluation

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

XVI. Enclosures/Attachments

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

XVII. State Contact(s)

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

XVIII. Date Submitted to CMS

ATTACHMENT B
Demonstration Evaluation Plan

(reserved)

ATTACHMENT C
Comprehensive Quality Strategy for the Healthy Michigan Program

(reserved)

ATTACHMENT D
ABW Childless Adults - Record of Budget Neutrality Expenditure Limit

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

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

The "Recorded On" date indicates the date in which a particular number or percentage was first incorporated (or, "recorded") into an approved version of Attachment B.

ATTACHMENT E
Operational Protocol for the MI Health Accounts

I. Purpose

This document describes the background, along with the requirements for development, implementation and operation of the MI Health Account. These requirements apply to the Department of Community Health ("Department"), the Department's contracted health plans, and Department's selected MI Health Account vendor[2] as further described below.

II. Background

All individuals enrolled in the Healthy Michigan Plan through the Department's contracted health plans will have access to a MI Health Account. The MI Health Account is a unique health care savings vehicle through which various cost-sharing requirements, which include co-pays and additional contributions for beneficiaries with higher incomes, will be satisfied, monitored and communicated to the beneficiary. The Department has established uniform standards and expectations for the MI Health Account's operation through this Operational Protocol and by contract as appropriate.

III. Cost Sharing

Cost-sharing, as described further below, includes both co-pays and, when applicable to the beneficiary, contributions based on income. Once enrolled in a health plan, most cost-sharing obligations will be satisfied through the MI Health Account. However, point of service co-pays may be required for a limited number of services that are carved out of the health plans, such as certain drugs.

Beneficiaries that are exempt from cost-sharing requirements by law, regulation or program policy will be exempt from cost-sharing obligations via the MI Health Account (e.g. individuals receiving hospice care, pregnant women receiving pregnancy related services). Similarly, services that are exempt from cost sharing by law, regulation or program policy (e.g. preventive and family planning services), or as defined by the State's Healthy Behaviors Incentives Operational Protocol, will also be exempt for Healthy Michigan Plan beneficiaries.

In addition, those services that are considered private and confidential under the Department's Explanation of Benefits framework will be excluded from the MI Health Account statement and therefore will be exempt from cost sharing for these Healthy Michigan Plan enrollees. The Department, in cooperation with its Data Warehouse vendor, will ensure that the claims information submitted to the MI Health Account

[2] There is a single vendor that all of the Department's contracted health plans will use for the MI Health Account function. This vendor is designated as a mandatory subcontractor for the health plans, and each of the plans will contract with the MI Health Account vendor to provide services related to the MI Health Account, consistent with this protocol. The Department also holds a contract with the MI Health Account vendor which lays out the vendor's obligation to both the Department and the health plans with respect to the MI Health Account function.

vendor for use in preparing the MI Health Account statement excludes those confidential services and/or medications outlined in this framework. The Department's Explanation of Benefits framework is updated by the Department at least annually, is shared with the contracted health plans for use in preparing Explanation of Benefits documents for federal health care program beneficiaries, and is available to other providers upon request. Finally, unless otherwise specified by this Operational Protocol or the Healthy Behaviors Incentives Operational Protocol, co-pay amounts will be consistent with Michigan's State Plan.

A. Co-pays

The Healthy Michigan Plan utilizes an innovative approach to co-pays that is intended to reduce barriers to valuable health care services and promote consumer engagement. During a Healthy Michigan Plan beneficiary's first six months of enrollment in a health plan, there will be no co-pays collected at the point of service for health plan covered services. At the end of the six month period, an average monthly co-pay experience for the beneficiary will be calculated. The initial look-back period will include encounters during the first three months of enrollment in a health plan in order to account for claim lag and allow for stabilization of the encounter data. Analysis of the beneficiary's co-pay experience will be recalculated on a quarterly basis going forward. The following examples, along with the attached **Appendix 1** (which is a more general, visual representation of a beneficiary enrolling with a health plan in May) provide further clarification.

During her first three months in a Healthy Michigan Plan health plan, a beneficiary has the following services: In April 2014, she visits her physician for a sinus infection ($2 co-pay). In May (2014), she visits the dentist for a filling ($3 co-pay), and fills one generic prescription for antibiotics at the pharmacy ($1). The beneficiary will receive notice of these potential co-pay amounts at the time the services are rendered. All of the above claims are paid by the health plan in June 2014. The MI Health Account vendor receives claim information on this beneficiary from the Department's Data Warehouse vendor in early October 2014, which includes claims paid during April, May and June of 2014 for services that occurred on or after April 1, 2014. This claim information includes the above services with the related co-pay amounts.

The MI Health Account vendor calculates the average monthly co-pay experience for that beneficiary to be $2.00 ($6 in expenditures divided over a 3 month period equals an average of $2 per month). Therefore, this beneficiary will be required to remit $2 per month into the MI Health Account for the next three months. The beneficiary will receive her first quarterly MI Health Account statement on or about October 15, 2014 with her first payment of $2.00 due November 15, 2014; her second payment due December 15, 2014 and her third payment due January 15, 2015. The beneficiary (and all other Healthy Michigan Plan beneficiaries) will also

have the option to pay the entire amount due all at once. The MI Health Account vendor will recalculate the average monthly co-pay experience for the beneficiary in January 2014, which will be based on the beneficiary's copayments from July, August, and September of 2014. The beneficiary will then be notified of her new monthly copayment obligation in January 2015, which will be in effect during February, March, and April of 2015.

During another beneficiary's first three months in a Healthy Michigan Plan health plan, a beneficiary has the following services: A visit to her doctor for a preventive visit ($0) in April of 2014; a visit to an endocrinologist to assess and control her diabetes in May of 2014($0); and finally, she fills a diabetes related prescription ($0) in June of 2014. All of the above claims are paid by the health plan in June 2014. The MI Health Account vendor receives claim information on this beneficiary from the Department's Data Warehouse vendor in early October 2014, which includes claims paid during April, May and June of 2014 for services that occurred on or after April 1, 2014. This claim information includes the above services with the related co-pay amounts.

The MI Health Account vendor calculates the average monthly co-pay experience for this beneficiary to be $0 because none of these services have co-pays associated with them. This beneficiary will not be required to remit any funds to the MI Health Account for co-pays over the next 3 months, but will receive a quarterly MI Health Account statement detailing her services for educational purposes.

The average co-pay amount is re-calculated every three months to reflect the beneficiary's current utilization of healthcare services, consistent with available data. The Department will use the date of payment of the claim to determine the beneficiary's experience and calculate the co-pay amount going forward. These co-pay amounts will be based on encounter data submitted by the health plans to the Department, and will be shared via interface with the MI Health Account vendor. The MI Health Account vendor is then responsible for communicating the co-pay amounts due to the beneficiary via a quarterly account statement as described in Section VII.A.1. This account statement will include a summary of account activity and any future amounts due, as well as a detailed (encounter level) explanation of services received. As noted earlier, one important exception to the amount of encounter level detail provided is that confidential services will not be shown on the MI Health Account statement; therefore the beneficiary will have no cost-sharing associated with those services. The provision of this encounter level data to the beneficiary is key to engaging the beneficiary as a more active consumer of health care services, and will also provide sufficient information for the beneficiary to recognize and pursue resolution of any discrepancies through the grievance process described in Section X. The Department is in the process of working with the MI Health Account vendor to develop a sample account statement

that contains all relevant financial information and sufficient encounter level detail, while being respectful of varying levels of health literacy. The Department has shared a copy of a proposed statement with the Centers for Medicare & Medicaid Services (CMS)**.** Because the Department is committed to ensuring that the format and content of the account statement are both responsive to the needs of the beneficiary and support the purpose of the demonstration as a whole, the Department reserves the right to modify the account statement at any time, in consultation with CMS.

The co-pay amounts collected from the beneficiary by the MI Health Account vendor will be disbursed to the health plans and will not accumulate in the MI Health Account. In addition, there will be no distribution of funds from the MI Health Account to the beneficiary to pay co-pays. However, information regarding co-pays owed and paid will be included as an informational item on the MI Health Account quarterly statement, as further defined and described in Section VII.A.1. Ensuring that beneficiaries are aware of the amounts owed, or why payment was not required (i.e. a preventive service was provided), is a key component of the Healthy Michigan Plan. The health plans, in cooperation with the State and MI Health Account vendor, will be responsible for beneficiary education and engagement consistent with Section VII.

Reductions in co-pays will be implemented consistent with the State's Healthy Behaviors Incentives Operational Protocol. The MI Health Account vendor is responsible for determining when each beneficiary has reached the two percent threshold that enables co-pay reductions to occur. The MI Health Account vendor will also communicate co-pay reductions to the beneficiary as part of the MI Health Account statement (see Section V for further discussion).

B. Required Contributions

In addition to any relevant co-pays, a monthly contribution is also required for beneficiaries whose income places them above 100 percent of the Federal Poverty Level. Consistent with state law, contributions are not required during the first six months the individual is enrolled in a health plan. However, the MI Health Account vendor will notify the beneficiary, via the MI Health Account statement, a welcome letter and when applicable, through scripts used by the vendor's customer service representatives, that contributions will be required on a monthly basis starting in month seven.

The contribution amount will not exceed two percent of the amount that represents the beneficiary's percentage of the Federal Poverty Level, though in practice, the Department plans to consider family composition when calculating contribution amounts. For example, when a beneficiary with several dependents qualifies for the Healthy Michigan Plan, the Department will consider that fact when assessing their contribution amount. For example:

A beneficiary with three dependents has an annual income of around $28,000. A beneficiary with no children has an annual income of around $14,000. Both apply for the Healthy Michigan Plan. Due to difference in their family size, both beneficiaries would be eligible for the Healthy Michigan Plan at 120 percent of the federal poverty level. The contribution for both will be $23 per month because some income from the beneficiary with three dependents will be recognized as support for these dependents.

In addition, the Department intends to consider the fact that multiple Healthy Michigan Plan covered individuals reside in the same household when calculating contribution amounts. For example, if both individuals in a married couple qualify for the Healthy Michigan Plan at 101 percent of the Federal Poverty Level, each would be required to pay $13 per month for their individual coverage (or $26 per month for the household). This modification is intended to align the amounts contributed by the household more closely with that of the federal exchange as well as existing regulatory limits on household cost-sharing.

The MI Health Account vendor will calculate the required contribution amount and communicate this to the beneficiary, along with instructions for payment, as part of the MI Health Account quarterly statement.

IV. Impact of Healthcare Services Received on the MI Health Account

Beneficiary contributions to the MI Health Account are not the first source of payment for health care services rendered. The health plans are responsible for 'first dollar' coverage of any health plan covered services the beneficiary receives up to a specified amount, though that amount will vary from person to person. For example:

- For individuals at or below 100 percent of the Federal Poverty Level, because co-pays will not accumulate in the account, the health plans will be responsible for payment of all health plan covered services.

- For individuals above 100 percent of the Federal Poverty Level (who make additional monthly contributions to the account), the health plan may utilize beneficiary funds from the MI Health Account once the beneficiary has received a certain amount and type of health care services.

    - This means that the amount the health plans must pay before tapping beneficiary contributions will vary from beneficiary to beneficiary based on his or her annual contribution amount.

- The amount of health plan responsibility for these beneficiaries will be based on the following formula:

$1000 – (amount of beneficiary's annual contribution) =

Health Plan "First Dollar" Coverage Amount

To further explain this calculation, if an individual has a required annual contribution of $300 per year, the health plan will be responsible for the first $700 of services before using any beneficiary contributions. In addition, given the limitations on cost-sharing and the importance of maintaining beneficiary confidentiality, the impact of various services on funds in the MI Health Account will vary. The following are examples of how the health plans will determine the amount of MI Health Account funds, if any, that may be used to offset the cost of certain services covered by the plan.

A beneficiary has a monthly contribution requirement of $25, which he remits as required. The beneficiary receives no services for the first 9 months he is in the health plan. Therefore, the beneficiary has contributed $75 (no contributions for the first 6 months, followed by 3 months of contributions) into the MI Health Account and none of those funds have been utilized by the health plan. The beneficiary's total annual contribution is expected to be $300.

In month 10, the beneficiary contracts strep throat and visits his primary care provider for evaluation and treatment. Per the above formula, the health plan will be responsible for payment of the first $700 in services. The cost of the office visit, strep test and antibiotic are less than $700, therefore the health plan is responsible for the cost of all of those services and may not receive funds from the MI Health Account.

A beneficiary has a monthly contribution requirement of $20, which she remits as required. The beneficiary does not receive any services in the first 9 months she is in the health plan. Therefore, the beneficiary has contributed $60 (no contributions for the first 6 months plus 3 months of contributions) and none of those funds have been utilized by the health plan. The beneficiary's total annual contribution is expected to be $240.

In month 10, the beneficiary develops appendicitis and requires surgery. Per the above formula, the health plan will be responsible for the first $760 in services. The fees for the surgery are more than $760. After the health plan pays for the first $760 of services, it may receive funds from the MI Health Account (in this case, $60). The beneficiary will continue to owe $20 per month until her remaining obligation ($180) is satisfied. In the interim, the health plan will pay the providers involved the remaining fees for the services provided, and may receive the next $180 remitted by the beneficiary.

In addition, as noted above, only services covered by the health plans will impact the MI Health Account. As a result, any items or services that are carved out of the health plans (e.g. psychotropic drugs, PIHP services) will not impact the MI Health Account or be reflected on any account statement. The Department and the contracted health plans identify the services that will be carved out of the health plans scope of coverage via the managed care contracts. These contracts are available via the State's website. The MI Health Account statement will also clarify for the beneficiary that the statement may not reflect all health care services that they received (i.e. because the service was confidential, the claim was not submitted or the health plan does not cover the service).

The following scenario illustrates a beneficiary requiring a carved-out service and the cost-sharing impact:

A beneficiary has a monthly contribution of $20, and he pays timely for 3 months (for a total of $60). The beneficiary fills a prescription for a psychotropic drug at his local pharmacy. The beneficiary will be responsible for paying any applicable co-payment for that drug at the pharmacy (point of service). The health plan will not be responsible for payment for the psychotropic drug as this is a service that is carved out from the health plans, and there will be no impact on the MI Health Account as a result. In addition, no funds from the MI Health Account will be distributed to the beneficiary to pay any required co-pay at the point of service.

Finally, any services considered confidential under the Department's Explanation of Benefits framework or otherwise excluded from cost sharing based on law, regulation or program policy will not be subject to any cost-sharing through the MI Health Account. This limitation includes the use of beneficiary contributions by the health plans once the plan's first dollar responsibility is exceeded. While no confidential services may be reflected on the MI Health Account statement, services that do not require suppression but are exempt from cost sharing of any type must be reflected on the statement as a service for which no payment is required, such as preventive services which are described in the following example.

> A beneficiary has a monthly contribution of $20, and she pays timely for 3 months (for a total of $60). The following month, the beneficiary has colonoscopy and mammogram screenings that result in fees in excess of $1000. The health plan must pay for these preventive services and may not seek funds from the MI Health Account for those services. The MI Health Account statement will reflect that preventive services are exempt from any cost sharing on the part of the beneficiary.

V. Cost-Sharing Reductions

Both types of cost sharing (co-pays and contributions) may be reduced if certain requirements are met. First, the health plans must waive co-pays if doing so promotes greater access to services that prevent the progression of and complications related to chronic disease, consistent with the following. The Department has provided the plans with a list of services, which includes both diagnosis codes and drug classes, for which co-pays must be waived for all Healthy Michigan Plan beneficiaries. These lists are included as **Appendix 2**. The health plans may suggest additions or revisions to this list, and the Department will review these suggestions annually. However, any additions must be approved in advance by the Department and shared with the MI Health Account vendor and all other contracted health plans to ensure consistency and appropriate calculation and collection of amounts owed. The Department will continue to engage stakeholders on this issue and ensure transparency and access to information surrounding these lists, which will include both provider and beneficiary education and outreach, policy bulletins when appropriate and online availability of the lists. Any reductions to the list must be approved in advance by CMS.

Co-pays and contributions may also be reduced if certain healthy behaviors are being addressed, though co-pays must reach 2 percent of the beneficiary's income before this specific reduction can occur.[3] The evaluation period for determining satisfaction of the

[3] While the Healthy Behaviors Incentives Operational Protocol contains the relevant details of the incentives program, for purposes of the MI Health Account protocol, all individuals are eligible for a reduction in copays once the 2 percent threshold is met. Only those individuals who pay a contribution (those above 100 percent

two percent threshold for co-pays will be the beneficiary's enrollment year. This means that the beneficiary will have one year to make progress toward the 2 percent threshold of co-payments before that threshold resets. Once the threshold is reached, the reductions will be processed and reflected on the next available MI Health Account statement. The health plans, along with the MI Health Account vendor and the Department, are responsible for ensuring that the calculation and collection of all cost-sharing amounts is performed in accordance with the Healthy Behaviors Incentives Operational Protocol with respect to the waiver or reduction of any required cost sharing. This includes, but is not limited to, the existence of appropriate interfaces between the Department, the health plans and the MI Health Account vendor to transmit account information, encounter data and any other beneficiary information necessary to provide an accurate accounting of amounts due, received and expended from the MI Health Account. Testing of these interfaces will occur prior to the first group of beneficiaries using the MI Health Account (slated to begin October 1, 2014), with adequate testing and demonstrated success required prior to implementation. See the Healthy Behaviors Incentives Operational Protocol for further information.

VI. Account Administration

The Healthy Michigan Plan's unique cost-sharing framework means that the MI Health Account will become operational on October 1, 2014 for the initial group of beneficiaries (who are below 100 percent of the Federal Poverty Level) enrolled in the Healthy Michigan Plan. Testing of the MI Health Account will occur in late summer 2014, with demonstrated success (as evidenced through appropriate testing outcomes) required prior to implementation. The Department has finalized both the initial Statement of Work for the MI Health Account vendor and the initial system and design requirements. The health plans, the MI Health Account vendor and the Department are jointly responsible for ensuring that procedures and system requirements are in place to ensure appropriate account functions, consistent with the following:

- Interest on account balances is not required.

- Upon a beneficiary's death, the balance of any funds in the MI Health Account will be returned to the State after an appropriate claims run-off period (120 days is the planned claims run-off period).

- State law limits the return of funds contributed by the beneficiary to the beneficiary only for the purchase of private insurance.

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of the Federal Poverty Level) will be eligible for a contribution reduction. Those individuals under 100 percent of the Federal Poverty Level are eligible to receive a gift card.

- When the beneficiary is no longer eligible for any State health care program, the balance of any funds contributed by the beneficiary will be issued to the beneficiary for the purchase of private health insurance coverage. The Department will work closely with the MI Health Account vendor to implement this requirement. The vendor will utilize information provided via the Department's claims and eligibility systems, along with its own account expenditure information, to determine whether or not a beneficiary qualifies for a voucher.

- The MI Health Account vendor must modify the amount of required cost sharing if the beneficiary reports a change in income, and communicate any changes in amounts owed to the beneficiary, the health plan and the Department, as appropriate. Beneficiaries are required to notify their Department of Human Services specialist of any changes, and are made aware of this requirement in both the rights and responsibilities section of the beneficiary handbook, communications from the Department of Human Services and the MI Health Account statement. Neither the Department nor the MI Health Account vendor may serve as the system of record for these changes, but the MI Health Account vendor will receive updated information via the Department's eligibility system shortly after these changes are reported.

- All amounts received from the beneficiary will be credited to any balance owed, and will be reflected on the next available quarterly statement. Similarly, disbursement of funds by the MI Health Account vendor to the health plans from the MI Health Account (when applicable) is required in a timely manner, following appropriate verification of claims for covered services.

- The MI Health Account vendor is responsible for tracking all cost sharing (in cooperation with the claims information provided via the Department and the health plans) to ensure that beneficiaries subject to cost sharing (which includes co-pays and contributions as described herein) do not incur family cost sharing that exceeds 5 percent of the household's income, consistent with 42 CFR §447.56(f).

- The MI Health Account vendor will be responsible for the transfer of funds and appropriate credit and debit information in the event a beneficiary changes plans, after an appropriate claims run off period.

- Beneficiaries lack a property interest in MI Health Account funds contributed by them. To that end, any amounts in the MI Health Account are not considered income to the beneficiary upon distribution and will not be counted as assets.

- No interest may be charged to the beneficiary on accrued copay or contribution liabilities. Beneficiary consequences for failure to pay are described in this Operational Protocol and may not include loss of eligibility, enrollment or access to services.

- Any amounts remaining in the account after the first year will not offset the beneficiary's contribution requirement for the next year. In addition, the amount that must be covered by the health plan as 'first dollar' will decrease in each subsequent enrollment year when beneficiary contributions remain in the account. For example, if a beneficiary contributes $250 in the first year and this amount rolls over to the next year, in year 2, the beneficiary will contribute $250 and the health plan will be responsible for the first *$500* in services (consistent with the framework described herein).

- The maximum amount of beneficiary funds that may accumulate in a MI Health Account is capped at $1000.00. If a beneficiary's contributions in the MI Health Account reach $1000, his or her contributions will be suspended until the account falls below $1000. The health plans may utilize these funds for services rendered consistent with this Operational Protocol.

- The MI Health Account vendor must provide multiple options for the beneficiary to remit co-pays and contributions due. These options must include at a minimum check, money order, electronic transfer (e.g. Automated Clearing House or ACH), and may include other payments through a designated partner such as Western Union, Walmart or Meijer. Any such partner must be free or low cost and prior approved by the Department.

- Months 7-18 of enrollment in a health plan will constitute the first year for MI Health Account accounting purposes.

- The MI Health Account vendor has a process in place to accept third party contributions to the MI Health Account on behalf of the beneficiary. This includes ensuring that any amounts received are credited to the appropriate beneficiary and the remitter (or individual who made the payment) is tracked, and providing multiple options for individuals or entities to make contributions on behalf of a beneficiary (e.g. money order, check, online ACH, etc.). Because the amount of beneficiary funds that can accumulate in the MI Health Account is capped at $1000, third parties may not contribute amounts in excess of that limit. State law does not limit which individuals or entities may contribute to the MI Health Account on the beneficiary's behalf, and any third party's contribution will be applied directly to the beneficiary's contribution requirement. Because the beneficiary lacks a property interest in any amounts in the MI Health Account, including his or her own contributions, the

contributions of any third party are not considered income, assets or resources of the beneficiary for any purpose.

- In the event contributions are received from a third party as a part of a Federal health initiative, such as the Ryan White Program, all excess funds must be returned to the appropriate remitter (i.e. the person or program who made the payment), if required by relevant law and regulation.

The Department will monitor both the health plans and the MI Health Account vendor for compliance with the above requirements.

VII. Beneficiary and Provider Engagement

A. Beneficiaries

1. *MI Health Account Statements*

A primary method of increasing awareness of health care costs and promoting consumer engagement in this population will be through the use of a quarterly MI Health Account Statement. These MI Health Account statements will be easy to understand and drafted at the appropriate grade reading level and will reflect the principles outlined in this Operational Protocol, as well as the Healthy Behaviors Incentives Operational Protocol when applicable.

The MI Health Account vendor must provide the beneficiary with at least the following information on a quarterly basis (along with year to date information when appropriate):

- MI Health Account balance
- Expenditures from the MI Health Account for health plan covered services over the past three months
- Co-pay amount due for next three months
- Co-pays collected in previous three months
- Past due amounts
- Contribution amount due for the next three months
- Contributions collected in previous three months
- Reduction to co-pays applied when calculating the amount due for the next three months due to beneficiary compliance with healthy behaviors (as applicable)
- Reduction to contributions applied when calculating the amount owed due to beneficiary compliance with healthy behaviors (as applicable)

- An appropriate subset of encounter-level information regarding services received, including (but not limited to) the following:
  - A description of the procedure, drug or service received
  - Date of service
  - Co-payment amount assigned to that service
  - Provider information
  - Amount paid for the service

The MI Health Account statement must contain the above information, and be in a form and format approved by the Department, in consultation with CMS. Hard copies of these statements must be sent to beneficiaries through U.S. mail on a quarterly basis, though beneficiaries may elect to receive electronic statements as approved by the Department. In terms of expenditure information, the MI Health Account statement will reflect only those services provided by the health plans and will only share utilization details consistent with privacy and confidentiality laws and regulations. The MI Health Account statement will also include information for beneficiaries on what to do if they have questions or concerns about the services or costs shown on the statement. Beneficiaries will also have the option to utilize the health plan's grievance process, as appropriate. Additional detail regarding beneficiary rights in this regard is contained in Section X.

2. *Beneficiary Education*

Both the health plans and the MI Health Account vendor will be responsible for beneficiary education regarding the role of the MI Health Account and the beneficiary's cost-sharing responsibilities. While the MI Health Account statements are designed to provide beneficiaries with information on health care costs and related financial responsibilities, it is important that the beneficiary also receive information that helps them become a more informed health care consumer.

The Department's contract with the health plans requires the plans' member services staff to have general knowledge of the MI Health Account, appropriate contact information for the MI Health Account vendor for more specific questions, and the ability to address any complaints members have regarding the MI Health Account vendor. In addition, because the MI Health Account vendor is a subcontractor of the health plans, the plans are required by contract to monitor the MI Health Account vendor's operations.

The MI Health Account vendor will be responsible for providing sufficient staffing and other administrative support to handle beneficiary questions regarding the MI Health Account, and will be obligated to educate

beneficiaries (via in person, telephone, written or electronic communication) regarding these topics. This education must include information on how to use the statements and make required contributions and co-pays, and address any questions or complaints regarding the beneficiary's use of the MI Health Account. The health plans are responsible for providing members with handbooks that include information about the Healthy Michigan Plan generally, including the MI Health Account and its cost-sharing mechanism. Finally, the Department will work with the health plans and the provider community to ensure that information on potential cost-sharing amounts is provided to the beneficiary at the point of service.

B. Providers

The health plans, on behalf of the state, will be responsible for education within their provider networks regarding the unique cost-sharing framework of the MI Health Account as it applies to the Healthy Michigan Plan. This may include in-person contact (on an individual or group basis), as well as information provided in newsletters, email messages and provider portals. This education must include, but is not limited to, the following topics:

- The co-payment mechanism and the impact on provider collection;
- The importance of providing services without collection of payment at the point of service for all health plan covered services;
- Options for reducing required contributions to the MI Health Account (as more fully described in the Healthy Behaviors Incentives Operational Protocol), including provider responsibilities associated with those reductions; and
- The elimination of co-pays (through the MI Health Account mechanism) for certain chronic conditions (as more fully described in the Healthy Behaviors Incentives Operational Protocol), as well the scope of coverage and cost-sharing exemptions for preventive services.

The Department has partnered with various professional associations within the state, as well as its provider outreach division, to ensure that education regarding the Healthy Michigan Plan and the MI Health Account occurs consistent with procedures already in place to address education needs in light of program changes.

C. Ongoing Strategy

The Department will receive regular reports from the MI Health Account vendor and the health plans regarding the operation of the MI Health Account. For example, the MI Health Account vendor will provide regular reports to the Department and

the health plans regarding MI Health Account collections and disbursements, and may provide additional information regarding beneficiary engagement and understanding as reflected through the vendor's call center operations upon the Department's request. This information will allow the Department, the health plans and the MI Health Account vendor to identify opportunities for improvement, make any needed adjustments and evaluate the success of any changes.

The Department will also continue to elicit feedback from the health plans, providers, beneficiaries and other stakeholders about the MI Health Account. Account operations information will be shared and/or discussed, as appropriate, with various stakeholders, including the Medical Care Advisory Council, the Michigan Association of Health Plans, the Michigan State Medical Society and the health plans themselves. The Department meets with the Medical Care Advisory Council and the Michigan State Medical Society quarterly, and the health plans and their trade association generally on a monthly basis. In addition, a beneficiary survey, which will include questions regarding the operation of the MI Health Account, will be performed as part of the program evaluation process required by the Special Terms and Conditions, and is planned for 2015. Stakeholder input will be considered for any program changes, and feedback will be accepted on an ongoing basis via the Department's dedicated Healthy Michigan Plan email address.

Finally, the health plans will be evaluated on the success of cost-sharing collections as required by State law. This measure will be monitored through the Department's annual health plan compliance review process, with the opportunity for program changes to address any identified deficiencies.

VIII. Consequences

State law requires that the Department develop a range of consequences for those beneficiaries who consistently fail to meet payment obligations under the Healthy Michigan Plan. These consequences will impact those beneficiaries whose payment history meets the Department's definition of non-compliance with respect to cost-sharing. For the purposes of initiating the consequences described below, non-compliant means either: 1) That the beneficiary has not made any cost-sharing payments (co-pays or contributions) in more than 90 consecutive calendar days; or 2) that the beneficiary has met less than 50 percent of his or her cost-sharing obligations as calculated over a one year period. However, the Department will not initiate consequences for beneficiaries owing less than $3.00 to the MI Health Account.

In addition to the consequences described herein, the Department is in the process of evaluating limitations to potential reductions for those who fail to pay required cost-sharing (as this consequence is required by State law). As described in the Healthy Behaviors Incentives Protocol, a member who has earned a reduction but was found to

be in "consistently fail to pay" status will lose that reduction for the remained of the year in which it was earned.

All beneficiaries who are non-compliant with cost-sharing obligations will be subject to the following consequences. First, the MI Health Account vendor will prepare targeted messaging for the beneficiary regarding his or her delinquent payment history and the amounts owed. This may occur via the MI Health Account Statement or other written or electronic forms of correspondence, and may include telephone contact as appropriate. The Department will work with the MI Health Account vendor to implement this process, which may include but is not limited to, template development for written communications and scripting for any telephone communications.

In addition, State law requires the Department to work with the State's Department of Treasury to garnish state tax returns, and access lottery winnings when applicable, for beneficiaries who consistently fail to meet payment obligations. The Department is pursuing a formal arrangement with the Department of Treasury to provide garnishment services for individuals who fail to pay required cost-sharing and have not responded to the messaging strategy outlined above**.** The Department is also considering additional methods for pursuing these funds, including through its internal collection and program support process. All beneficiaries will have access to appropriate due process, including as outlined in Section VIII, prior to the initiation of any collection or garnishment process, and these debts will not be reported to credit reporting agencies. The health plans may receive recovered funds, but only to the extent that the plan would have been entitled had the beneficiary paid as required. All other funds recovered will revert to the State. The Department also plans to allow the health plans to pursue additional beneficiary consequences for non-payment, consistent with the State law authorizing the creation of the Healthy Michigan Plan, subject to formal approval prior to any implementation. However, loss of eligibility, denial of enrollment in a health plan, or denial of services is not permitted.

Finally, regardless of the consequences pursued by the Department or the health plans, providers may not deny services for failure to pay required cost-sharing amounts. The health plans are responsible for communicating this to their contracted providers through the plan's provider education process, and for monitoring provider practices to ensure that access to services is not denied for non-payment of cost sharing.

IX. Reporting Requirements

Both the health plans and the MI Health Account vendor are required to develop, generate and distribute reports to the Department, and make information available to each other as necessary to support the functioning of the MI Health Account, both as specified in this Operational Protocol, and upon the Department's request. The specific reports required are still under development, however, the following information is expected to be available and shared as described herein:

- By December 1, 2014, the health plans, in cooperation with the MI Health Account vendor, must provide to the Department an accounting for review to verify that the MI Health Account function is operating in accordance with this Operational Protocol; and

- On a quarterly basis, the MI Health Account vendor will provide the Department with information on co-pays and contributions due, reductions applied, and collections by enrollee.

In addition, the timing of interfaces among the plans, the Department and the MI Health Account vendor is currently being finalized. The timeline for the proposed interface deadlines is attached as **Appendix 3**.

X. Grievances

Healthy Michigan Plan beneficiaries will have the opportunity to contest various facets of the MI Health Account function through the grievance processes operated by the health plans and in accordance with federal law and regulations. Any dispute arising over amounts paid or owed will be treated as a grievance, while any action taken by the health plans that serves to limit access to covered services would be considered an adverse action and entitle the beneficiary to the full complement of appeal rights permitted by law and/or contract. Given that no individual may lose eligibility or have their benefits curtailed for failure to pay co-pays or contributions, the Department expects that all MI Health Account related complaints will move through the grievance process.

The health plans are required by contract to inform beneficiaries of the grievance and appeals process at the time of enrollment, any time an enrollee files a grievance, and any time the plan takes an action that would entitle the beneficiary to appeal rights. Health plan member handbooks also contain instructions on how to file a grievance, and information on how to contest amounts paid or owed will be provided on the MI Health Account Statement.

ATTACHMENT F
Healthy Behaviors Incentives Program Protocol

The Michigan Department of Community Health (the Department, or DCH), in consultation with stakeholders, has developed an incentives program specific to the Healthy Michigan Plan Managed care population. As required by the Centers for Medicare & Medicaid Services (CMS), the following operational protocol describes each section of the program as outlined. Please note that responses to the following sections are written together: (a) and (b), (d) and (h), (e) and (i).

a. The uniform standards for healthy behaviors incentives including, but not limited to, a health risk assessment to identify behavior that the initiative is targeting, for example: routine ER use for non-emergency treatment, multiple comorbidities, alcohol abuse, substance use disorders, tobacco use, obesity, and deficiencies in immunization status.

See b.

b. A selection of targeted healthy behaviors that is sufficiently diverse and a strategy to measure access to necessary providers to ensure that all beneficiaries have an opportunity to receive healthy behavior incentives.

The Department has created the Healthy Behaviors Incentives Program to reward Healthy Michigan Plan Managed Care members for their conscientious use of services. Incentives, which the Department defines as both reductions in cost-sharing responsibilities and select financial rewards, can be earned by Healthy Michigan Plan managed care members on the basis of their active, appropriate participation in the health care delivery system. Uniform standards have been developed to ensure that all Healthy Michigan Plan managed care members will have the opportunity to earn incentives and that those incentives are applied properly by the managed care plans or their vendor. Further operational details of these MI Health Accounts and incentives are found in Attachment H.

As detailed below, each Healthy Michigan Plan managed care member will have the opportunity to earn incentives for their successful engagement with their new health care system. Members who acknowledge the need for behavior change and agree to address those behaviors will earn a reduction in cost-sharing. The Department has developed a Health Risk Assessment (Appendix 4) that assesses a broad range of health issues and behaviors including, but not limited to, the following:

- Physical activity
- Nutrition
- Alcohol, tobacco, and substance use
- Mental health
- Flu vaccination

The health risk assessment will be available for completion by all Healthy Michigan Plan managed care members. Members will complete a portion of the assessment on their own, with the assistance of the enrollment broker, MIEnrolls, or with assistance from

their selected health plan. The enrollment vendor, health plans, and provider offices must convey consistent messages to beneficiaries regarding the completion of the health risk assessment. To ensure consistency, member engagement scripts with healthy behaviors incentives program information have been developed and shared with the enrollment vendor and the health plans. Members may call any of those entities to request assistance in filling out the health risk assessment. This portion includes assessment of engagement in healthy behaviors. Members answer questions that indicate how much assistance they may need to achieve health in regards to particular issues. The final portion of the health risk assessment will be done in the primary care provider office and includes attestations by the provider that the member has acknowledged changes in behavior that may need to be made, and the members' willingness/ability to address those behaviors.

Successful entry into any health care system includes an initial visit to a primary care provider, especially for those who may have unmet health needs. For Healthy Michigan Plan managed care members, this initial appointment will include a conversation about the healthy behaviors identified in the health risk assessment, member concerns about their own health needs, member readiness to change, and provider attestations of members' willingness/ability to address health needs. Healthy Michigan Plan beneficiaries are expected to contact their PCP within 60 days of enrollment or the date of this approved protocol to schedule a well care appointment and complete the HRA, though there is no penalty on beneficiaries for their failure to do so. When this initial appointment is kept and a Health Risk Assessment is completed for a new member (which includes provider attestations of healthy behaviors and/or changes), that member may be eligible for incentives. The Department will develop an Access to Care measure specific to the Healthy Michigan Plan managed care population to determine how many new members completed an initial appointment within 150 days of enrollment into the plan. This measure will be based on encounter data extracted from the data warehouse and will be tracked by region, health plan, and as a state overall. In SFY2016, this measure will be included in the Performance Bonus for the managed care plans. Healthy Michigan Plan managed care members who complete an appointment along with an HRA after the 150-day timeframe are still eligible to receive incentives described in Appendix 5.

Healthy Michigan Plan members may receive services, including the initial appointment and completion of the Health Risk Assessment, through Fee-For-Service (FFS) before they are enrolled in a managed care plan. Given the short time period (usually one month) that enrollees are in FFS before enrollment in a plan, the Department expects there to be relatively few instances of a FFS provider completing the initial appointment and the HRA. When it does occur, the managed care plans will be responsible for either working directly with the FFS provider to obtain the HRA or assisting the member in getting the necessary HRA information from the provider. Providers have also been instructed to give each beneficiary a copy of their completed assessment at the initial appointment, so the beneficiary can forward a copy of their completed HRA to their health plan after enrollment. Beneficiaries who complete the HRA during the FFS period

are eligible for the incentives upon enrollment into a managed care plan. The eligibility criteria are the same as described in Appendix 5.

The Department also requires each Healthy Michigan managed care plan to pay an incentive to providers who complete the HRA with their Healthy Michigan Plan members. Details of the provider incentive and payment mechanism are plan-specific and will be made available to providers by the health plans with which they participate. Providers who work with patients to complete the HRA during the FFS period will also be eligible for the managed care plan provider incentives once the member has enrolled in the health plan. In order to receive the provider incentive, the PCP must submit the completed HRA to the health plan using a secure method, as designated by the health plan. The provider incentive is paid for completion of the HRA, not for the member choosing to address a healthy behavior.

Access to care for Medicaid members is critical. The Department has and will continue to measure access to necessary providers, especially primary care providers upon whom Healthy Michigan Plan managed care members will rely to earn their incentives. Upon passage of the Healthy Michigan Plan legislation, network adequacy reports were developed for each county in the state based on the potential enrollment of new members into the Healthy Michigan Plan. Given our estimates of potential enrollment, there were no counties that required an increased network to fall within the Department's required primary care provider to member ratio of 1:750. In the future, if enrollment into the Healthy Michigan Plan is greater than expected in a particular county and the required primary care provider to member ratio of 1:750 is no longer attainable, the Department will open that county for service area expansion. Managed care plans would have the opportunity to request expansion into that county if they can demonstrate that their provider network would create increased access.

c. A list of stakeholders as well as documentation of the public processes or meetings that occurred during the development of the protocol, the accompanying health risk assessment tool and uniform standards.

The Department began planning the incentive program in December 2013. Since then, the Department has held a bi-weekly meeting with managed care plans to discuss the health risk assessment, incentive program, cost-sharing, and the MI Health account. The Michigan State Medical Society and the Michigan Osteopathic Association participated in several meetings throughout the development of the program as well. In February 2014, the healthy behaviors program including the Health Risk Assessment and uniform standards was discussed with the Medical Care Advisory Committee. See the February 2014 meeting agenda (Appendix 6). This meeting includes staff from the Department, Medicaid Health Plans, local health departments, medical, oral, and mental health providers, various advocacy groups, and Medicaid beneficiaries. Discussion was held at the meeting and comments received in writing will be considered in the final program design.

Informational presentations have been made to stakeholder and advocacy groups, as well as Tribal partners. The Department published the Healthy Behaviors Incentives Operational Protocol on its website and allowed for public comment during the period of May 2- May 27, 2014. Comments were received from various individuals, advocacy organizations, and stakeholder groups. The Department considered each comment and made changes and clarifications to the protocols as appropriate. The Department also published responses to public comments on the Departmental website (michigan.gov/healthymichiganplan) on August 7, 2014.

d. The data driven strategy of how healthy behaviors will be tracked and monitored at the enrollee and provider level including standards for accountability for providers. This must include the timeline for development and/or implementation of a systems based approach which shall occur prior to implementing the Healthy Behaviors initiative.

The Department began planning how Health Risk Assessment data would be tracked and monitored in January 2014. All of the Health Risk Assessment data will be put into electronic file formats and stored in the State's data warehouse. The identification of appropriate IT systems and the file format to securely transfer the data from the enrollment broker to the data warehouse and health plans were finalized in February 2014. The file format to securely transfer Health Risk Assessment data from the plans back to DCH has been developed and testing was completed in August 2014. Because beneficiary data from the Health Risk Assessments will be shared only with partners that participate in the treatment, payment, or operations of healthcare benefits, no separate authorization for data exchange is required.

The files include member name and ID number, the member's Medicaid Health Plan and the name and National Provider Identifier of the primary care provider who completed the Health Risk Assessment so that Health Risk Assessment data can be tracked and monitored at the enrollee, provider and plan level. The development of queries to pull Health Risk Assessment data monthly already began with the department's data warehouse vendor, Optum, in January 2014. These queries will allow the department to track enrollee and plan level data over time. It will be possible to query on all aspects of the Health Risk Assessment data, and to cross-reference this with care provided to beneficiaries through encounter data. Testing of these systems began in spring 2014 and was implemented in August 2014. Cross-referencing with encounter data will also assist with monitoring provider accountability. Managed care plans will be required to set standards for accountability for their provider networks.
Healthy Michigan Plan managed care members will have the opportunity to contest any information reported on the Health Risk Assessment. Any dispute arising between the beneficiary and the primary care provider and/or health plan regarding information reported on the Health Risk Assessment or appropriate application of earned incentives will be treated as a grievance. The managed care plans are contractually obligated to inform their members of the grievance process at the time of enrollment. Instructions on how to file a grievance are detailed in the Member Handbook for each managed care plan. If a member has questions or concerns about services, charges, or incentives related

to the MI Health Account or listed on the quarterly statement, the beneficiary helpline telephone number will be listed on each page of the statement in English, Spanish, and Arabic. Beneficiary helpline staff can also inform members on how to file a grievance.

e. A beneficiary and provider education strategy and timeline for completion prior to program implementation.

Consistent, uniform standards for eligibility and distribution of incentives are paramount to appropriate outreach and education efforts. The Department has developed a four-pronged education strategy that will ensure members hear the same message across different entities, and will maximize the potential for member engagement in healthy behaviors and achievement of incentives. At all potential points of contact in the enrollment process (the enrollment broker MIEnrolls, the Department, managed care plans, and providers), members will receive information about the incentives program including eligibility requirements.

The Department has included language in the Healthy Michigan Plan handbook to inform beneficiaries about potential reductions in their cost-sharing based on their engagement in healthy behaviors. This language will be included in Healthy Michigan Plan brochures and other member communications as well.

The Department's enrollment broker, MIEnrolls, will facilitate member questions on the Health Risk Assessment, and will inform beneficiaries about the incentives for members who engage in healthy behaviors. Members are able to choose their primary care provider at the time of enrollment into a managed care Plan. As required in the managed care contract, plans must offer enrollees freedom of choice in selecting a primary care provider. If a member does not pick a primary care provider at the time of enrollment into the plan, the plan may assign the member to a primary care provider. All plans have written policies and procedures describing how enrollees choose and are assigned to a primary care provider, and how they may change their primary care provider. These materials are sent by the health plan to each new Healthy Michigan Plan member in the new member packet, along with a health plan identification card. MIEnrolls will furnish new members with contact information for their new provider and encourage them to schedule and complete their initial appointment.

When managed care plans make welcome calls to new Healthy Michigan Plan members, their scripts will include information about the incentives program. During these calls, plans will assist members in scheduling an initial appointment and can arrange for transportation if necessary. All managed care plans send welcome packets to new members within 10 days of enrollment into the plan. These packets will include written information on the incentives program at no higher than a 6.9 grade level. Managed care plans will also include Healthy Behaviors Incentives program information on their website and in their member newsletters. The MI Health Account quarterly statement received by each Healthy Michigan Plan member is intended to be an educational tool that will present information regarding any reductions earned via the Healthy Behaviors

Incentives program. The detailed contents of the MI Health Account statement are discussed in the MI Health Account Operational Protocol.

The Department will work with the Michigan State Medical Society, the Michigan Osteopathic Association, and the Michigan Primary Care Association to hold educational trainings for their members about the Healthy Michigan Plan Healthy Behaviors Incentives program. These partners will include the information in their newsletters and on their websites. They will hold trainings in assessing readiness to change, and provide their members with consistent messaging on the incentives program. The Department sent a letter to all practitioners, Federally Qualified Health Centers, Tribal Health Centers, Rural Health Centers, and health plans on June 13, 2014. This letter included detailed information about the Healthy Behaviors incentives program so that a consistent message will be heard by beneficiaries from providers across the state of Michigan. A policy bulletin (14-39) was distributed to all providers on August 28 , 2014 with similar clarifying information. Not only will this ensure that providers are adequately educated on the incentives program, but that they are able to share a consistent message with members.

The Department is also in the process of developing a voluntary, web-based training for providers on the Healthy Michigan Plan Health Risk Assessment, incentives, and associated processes. The training will be available for completion online and will have continuing education units associated with it. The Department will monitor usage and success rates for providers participating in the online training.

The Department will continue to elicit feedback from managed care plans, providers and other stakeholders about the Healthy Behaviors Incentives program. Results from data analysis will be discussed annually during both the Clinical Advisory Committee and Medical Care Advisory Council meetings and stakeholder input will be considered for any program changes.

The Department received approval from CMS to move forward with the state's planned messaging strategy for the incentives program on 4/11/2014. Since then, MIEnrolls, all managed care plans and the DCH call center have been sharing the same message about the incentives program including eligibility requirements and potential rewards. Providers have received the same messaging to share with beneficiaries. The educational messaging will continue as more Michigan residents apply for the Healthy Michigan Plan.

f. The ongoing structured interventions that will be provided to assist beneficiaries in improving healthy behaviors as identified through the health risk assessment.

Beneficiaries will have structured ongoing support in their efforts to improve healthy behaviors as identified through the Health Risk Assessment.
All managed care plans have robust care management programs to assist their members in obtaining health goals. For example, all managed care plans have a diabetes case

management program which includes information on nutrition and physical activity. The information gleaned from the Health Risk Assessment can be used by the plans to determine suitability for member enrollment into this type of program, or for referral for other covered-services that will assist the member in changing unhealthy behaviors or maintaining current healthy activities.

All managed care plans are contractually obligated to cover smoking cessation counseling and treatment in accordance with Treating Tobacco Use and Dependence: 2008 Update, issued by the US Department of Health and Human Services. This includes counseling (individual, telephone, and group), over-the-counter and prescription medications, and combination therapy.

Addressing obesity is a priority in Michigan. In 2012, Governor Rick Snyder, with support from the Department, launched Michigan's strategic plan to fight obesity, commonly referred to as the 4x4 plan. The plan includes a robust public outreach campaign which includes messaging on four specific healthy behaviors that are all included in the Health Risk Assessment (diet, exercise, annual physical, and avoiding tobacco use) and a 'know your numbers' component that focuses on knowing four clinical values--blood pressure, cholesterol, blood glucose, and body mass index. Influenza vaccination and treatments for alcohol use, substance use disorder and mental health issues are covered services under the Healthy Michigan Plan. Once a member has been identified as in need of any of these services, plans will coordinate care with necessary providers to ensure that timely, appropriate services are rendered. The Department expects health plans to adhere to recognized clinical practice guidelines for the treating Healthy Michigan Plan members.

Financial barriers to appropriate care can influence the health-seeking behaviors of low-income populations. Per the Healthy Michigan Plan legislation (Public Act 107 of 2013), and in an effort to remove barriers to necessary care for Healthy Michigan Plan members, the Department has eliminated copays 'to promote greater access to services that prevent the progression of and complications related to chronic diseases'. The Department believes that by eliminating copays for services related to chronic disease and the associated pharmaceuticals, members will be better able to achieve their health goals. A list of these chronic disease and associated codes is attached (Appendix 2).
Healthy Michigan Plan members will have access to all of the supports currently available from managed care plans.

g. A description of how the state will ensure that adjustments to premiums or average utilization copayment contributions are accurate and accounted for based upon the success in achieving healthy behaviors.

Attestations from primary care providers are the basis for eligibility for incentives. The provider will return the completed Health Risk Assessment to the Managed Care Plan, which will share member level details on provider attestations with the Department. If a beneficiary disputes the information reported on the health risk assessment, they may

utilize their health plan's existing procedures for the resolution of a grievance. This procedure is explained in the member handbook that is sent to members upon enrollment in the health plan.

The Department will also receive from the MI Health Account vendor the amount of cost-sharing expected and received by each Healthy Michigan Plan member. On a quarterly basis, the Department will cross reference a sample of beneficiaries who earned a reduction based on the attestation on their Health Risk Assessment with beneficiaries who had reductions processed. A sample of each managed care plan's population will be pulled. Results will be processed and reports will be developed to determine the accurate application of cost-sharing reductions. Plans found to be in non-compliance with processes and procedures related to application of cost-sharing reductions will be subject to established remedies and sanctions, per the managed care contract.

The Department is currently developing an interface for the managed care plans to submit member level Health Risk Assessment and cost-sharing data to the data warehouse. Data transfer will be tested extensively prior to implementation to ensure the fidelity and confidentiality of the data.

h. A strategy and implementation plan of how healthy behaviors will be tracked and monitored at the beneficiary and provider levels, including standards of accountability for providers.

See d.

i. An ongoing strategy of education and outreach post implementation regarding the Healthy Behaviors Incentives program including the strategies related to the ongoing engagement of stakeholders and the public in the state.

See Section e., which relates to implementation, and is meant to be the ongoing strategy section of the document.

The Department intends to continue education and outreach efforts on the incentives program for the duration of the demonstration. As long as there are new beneficiaries coming onto the Healthy Michigan Plan managed care program, they will be eligible to incentives if they meet the established criteria. The Department will continue to monitor feedback on the program from the beneficiary helpline, provider helpline, and all advocacy and stakeholder groups. The Department will continue to monitor the managed care plans' implementation of the incentives program to ensure that adequate outreach and education efforts are maintained throughout the demonstration. The Department will report on the incentives program each year to our stakeholder groups. Through the formal evaluation, the department will publish reports on increased access to care, improvements in self-reported health status, and other relevant measures of success and engagement.

j. A description of other incentives in addition to reductions in cost sharing or premiums that the state will implement.

For those beneficiaries who are not required to pay monthly contributions (because their income is at or below 100 percent of the federal poverty level, or FPL), a $50 gift card will be distributed instead of a 50 percent reduction in monthly contributions. The eligibility requirements to earn this incentive are the same as those beneficiaries earning between above 100 percent of the FPL. They must attend an appointment with their primary care provider, complete the health risk assessment, and agree to address or maintain a healthy behavior. Once the beneficiary has paid 2 percent of their income in copays, they will also be eligible for a 50 percent reduction in their copays. This process is described in Appendix 5.

k. The methodology describing how healthy behavior incentives will be applied to reduce premiums or copayments.

Healthy Michigan Plan Managed Care members will be rewarded for addressing behaviors necessary for improving health. Completion of an initial appointment with a primary care provider (along with requisite attestations) is necessary to be eligible for reductions in cost-sharing. While the Department encourages the managed care plans to work with their provider networks to ensure timely access for Healthy Michigan Plan members, there is no 'window of opportunity' in which the initial appointment and HRA needs to be done for the beneficiary to be eligible for the incentive. Once the initial appointment and HRA are complete the primary care provider will send a copy of the Health Risk Assessment and attestations to the managed care plans, which will apply incentives/reductions to cost-sharing in accordance with Appendix 5.

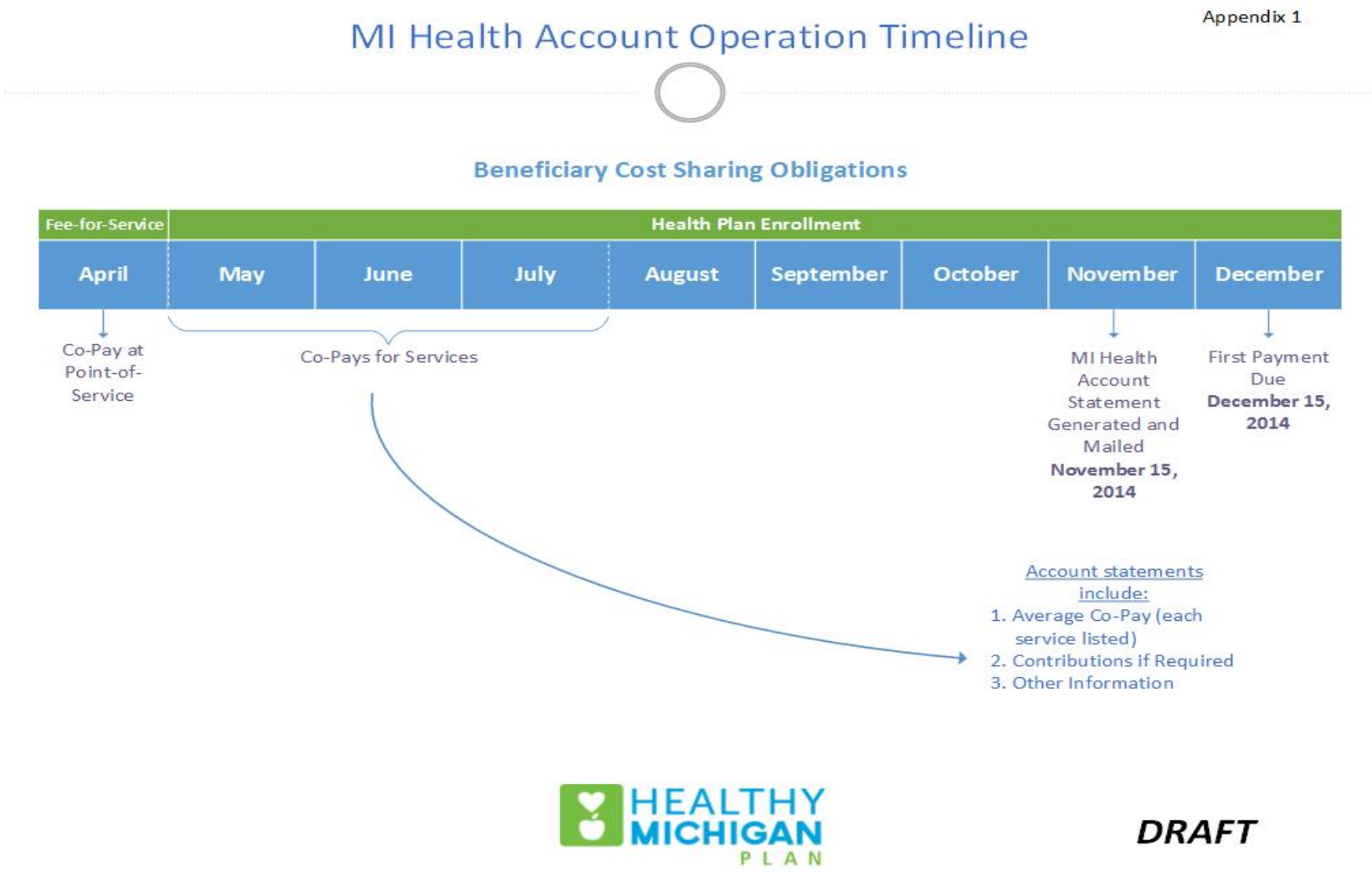
The Department has worked with a behavioral economist to develop an innovative approach to incentivizing members to complete the initial appointment and agree to address/maintain healthy behaviors. The Department believes that this approach will serve as an innovative model that rewards members for appropriate use of their new health care benefits.

Appendix 5 graphically describes the following recommendations of the Department:
Managed Care members who complete a Health Risk Assessment with a primary care provider attestation and agree to address or maintain healthy behaviors will receive an incentive. All individuals receiving an incentive are eligible for a reduction in copays once the 2 percent threshold is met. Those individuals who pay a contribution (those above 100 percent of the FPL) will also be eligible for a 50 percent reduction in their monthly contribution. Those individuals at or below 100 percent of the FPL will receive a $50 gift card. Members who do not complete the Health Risk Assessment or who complete it but decline to engage in healthy behaviors will not be eligible for any reductions or incentives.
Members who complete an assessment and initial appointment and acknowledge that changes are necessary but who have significant physical, mental or social barriers to

addressing them at this time (as attested by the primary care provider) are also eligible for the incentives.

Note: Members may complete more than one Health Risk Assessment during a year, but may only receive an incentive once per year. Members who initially decline to address behavior change may become eligible if they return to the provider, complete the assessment, and agree to address one or more behavior changes, as attested to by their primary care provider. Members do NOT have to complete the initial appointment or assessment during a specific window of time to be eligible for the incentive. The clock on the annual incentive (either a gift card or a reduction in contributions) begins when the member completes the initial appointment and assessment. If a member never visits their primary care provider and does not complete the HRA, the member will not be eligible for the incentives. All Healthy Michigan Plan Managed Care members, regardless of income, who agree to maintain healthy behaviors or address at least one behavior change will be eligible for a reduction in copays. The administration of the MI Health Account, through which the cost-sharing reductions will be applied, is detailed in the MI Health Account Operational Protocol. Consistent with State law, the Department is in the process of evaluating limitations to potential reductions based on a members' failure to pay required cost-sharing. That is, a member who has earned a reduction in cost-sharing, but is subsequently found to be in 'consistent failure to pay' status, will lose that reduction for the remainder of year in which it was earned. A member has consistently failed to pay when either of the following has occurred; no payments have been received for 90 consecutive calendar days, or less than 50 percent of total cost-sharing requirements have been met by the end of the year. This limitation is required by State law. However, a member will not be found in consistent failure to pay status when the amount owed to the MI Health Account is less than $3.

ATTACHMENT F
Healthy Behaviors Incentives Program Protocol
Appendix 1: MI Health Account Operation Timeline



ATTACHMENT F
Healthy Behaviors Incentives Program Protocol
Appendix 2: Chronic Conditions ICD-9

Condition	ICD-9 Codes	Comments
Alcohol Use Disorder	291	
	303	
	305.0	
	571.0-571.3, 535.3	
Asthma	493	
Chronic Kidney Disease	016.0	
	095.4	
	249.4	
	250.4	
	274.10	
	283.11	
	403.01, 403.11, 403.91	
	404.02, 404.03, 404.12, 404.13, 404.92, 404.93	
	440.1	
	442.1	
	572.4	
	580.0, 580.4, 580.81, 580.89, 580.9	
	581-583	
	584.5-588	
	591	
	753.12-753.2	
Chronic Obstructive Pulmonary Disease and Bronchiectasis	490-492	
	494	
	496	
Deep Venous Thrombosis (DVT) (while on anticoagulation)/Pulmonary Embolism (PE) (chronic anticoagulation)	415.1	To meet the chronic anticoagulation requirement, the diagnosis codes provided would need to be reported with V58.61.
	416.2	
	451.1	
	453.4-453.5	
Depression	296.2-296.3	
	296.51-296.56	
	296.6	
	296.89	
	298.0	
	300.4	

ATTACHMENT F
Healthy Behaviors Incentives Program Protocol
Appendix 2: Chronic Conditions ICD-9

Condition	ICD-9 Codes	Comments
	309.1	
	311	
Diabetes Mellitus	249-250	
	357.2	
	362.0	
	366.41	
Heart Failure	398.91	
	402.01, 402.11, 402.91, 404.01, 404.03, 404.11, 404.13, 404.91, 404.93	
	428	
HIV	042	
	V08	
Hyperlipidemia	272.0-272.4	
Hypertension	362.11	
	401-405	
	437.2	
Ischemic Heart Disease	410-413	
	414.0	
	414.12, 414.2, 414.3, 414.8, 414.9	
Obesity	278.0	
Schizophrenia	295	
Stroke/Transient Ischemic Attack	430-431	
	433.01, 433.11, 433.21, 433.31, 433.81, 433.91	
	434.00, 434.01, 434.10, 434.11, 434.90, 434.91	
	435.0, 435.1, 435.3, 435.8, 435.9	
	436	
	997.02	
Substance Use Disorder	292	
	304	
	305.2-305.9	

ATTACHMENT F
Healthy Behaviors Incentives Program Protocol
Appendix 2: Chronic Conditions ICD-9

Condition	ICD-9 Codes	Comments
Tobacco Use Disorder	305.1	

ATTACHMENT F
Healthy Behaviors Incentives Program Protocol
Appendix 2: Chronic Conditions ICD-10

Condition	ICD-10 Code	Comments
Alcohol Use Disorder	F10.1-F10.2	
	K29.2	
	K70	
Asthma	J45	
Chronic Kidney Disease	A18.11	
	A52.75	
	B52.0	
	D59.3	
	E08.2, E09.2, E10.2, E11.2, E13.2	
	I12.0, I13.11, I13.2	
	I70.1	
	I72.2	
	K76.7	
	M10.3	
	M32.14-M32.15	
	N00-N08	
	N13.1-N13.3	
	N14	
	N15	
	N16	
	N17-N19	
	N25	
	N26.1, N26.9	
	Q61.02	
	Q61.11	
	Q61.19	
	Q61.2	
	Q61.3	
	Q61.4	
	Q61.5	
	Q61.8	
	Q62.0	
	Q62.1	
	Q62.2	
	Q62.3	

Chronic Obstructive Pulmonary Disease and Bronchiectasis	J40-J42	
	J43	
	J44	
	J47	
Condition	**ICD-10 Code**	**Comments**
Deep Venous Thrombosis (DVT) (while on anticoagulation)/Pulmonary Embolism (PE) (chronic anticoagulation)	I26	
	I27.82	
	I80.1-I80.2	To meet the chronic anticoagulation requirement, the diagnosis codes provided would need to be reported with Z79.01.
	I82.4	
	I82.5	
Depression	F31.3-F31.6	
	F31.75-F31.78	
	F31.81	
	F32	
	F33	
	F34.1	
	F43.21	
Diabetes Mellitus	E08-E13	
Heart Failure	I09.81	
	I11.0, I13.0, I13.2	
	I50	
HIV	B20	
	Z21	
Hyperlipidemia	E78.0-E78.5	
Hypertension	H35.03	
	I10-I15	
	I67.4	
Ischemic Heart Disease	I20-I22	
	I24	
	I25.1	
	I25.2	
	I25.42	
	I25.5	
	I25.6	
	I25.7	
	I25.81-I25.83, I25.89, I25.9	
Obesity	E66	
Schizophrenia	F20	

ATTACHMENT F
Healthy Behaviors Incentives Program Protocol
Appendix 2: Chronic Conditions ICD-10

Condition	ICD-10 Code	Comments
Stroke/Transient Ischemic Attack	G45	
	G46.0-G46.2	
	I60-I61	
	I63	
	I66	
	I67.84, I67.89	
	I97.81-I97.82	
Substance Use Disorder	F11-F16	
	F18-F19	
Tobacco Use Disorder	F17	
	Z72.0	

ATTACHMENT F
Healthy Behaviors Incentives Program Protocol
Appendix 2: Chronic Conditions Copay Exempt Drug Class Codes

Treatment Category	Drug Class	Description	Chronic Condition(s) Treated
Behavioral Health/Substance Abuse	C0D	Anti Alcoholic Preparations	Alcohol Dependence
	H2D	BARBITURATES	Anxiety
	H2E	SEDATIVE-HYPNOTICS,NON-BARBITURATE	Alcohol Dependence and Depression
	H2F	ANTI-ANXIETY DRUGS	Alcohol Dependence and Depression
	H2G	ANTI-PSYCHOTICS,PHENOTHIAZINES	Schizophrenia
	H2H	MONOAMINE OXIDASE(MAO) INHIBITORS	Depression
	H2M	BIPOLAR DISORDER DRUGS	Depressiion
	H2S	SELECTIVE SEROTONIN REUPTAKE INHIBITOR (SSRIS)	Depression
	H2U	TRICYCLIC ANTIDEPRESSANTS & REL. NON-SEL. RU-INHIB	Depression
	H2W	TRICYCLIC ANTIDEPRESSANT/PHENOTHIAZINE COMBINATNS	Depression
	H2X	TRICYCLIC ANTIDEPRESSANT/BENZODIAZEPINE COMBINATNS	Depression
	H3T	NARCOTIC ANTAGONISTS	Alcohol Dependence
	H4B	ANTICONVULSANTS	Depression
	H7B	ALPHA-2 RECEPTOR ANTAGONIST ANTIDEPRESSANTS	Depression
	H7C	SEROTONIN-NOREPINEPHRINE REUPTAKE-INHIB (SNRIS)	Depression
	H7D	NOREPINEPHRINE AND DOPAMINE REUPTAKE INHIB (NDRIS)	Depression
	H7E	SEROTONIN-2 ANTAGONIST/REUPTAKE INHIBITORS (SARIS)	Depression
	H7J	MAOIS - NON-SELECTIVE & IRREVERSIBLE	Depression
	H7O	ANTIPSYCHOTICS,DOPAMINE ANTAGONISTS,BUTYROPHENONES	Schizophrenia
	H7P	ANTIPSYCHOTICS,DOPAMINE ANTAGONISTS,	Schizophrenia

Treatment Category	Drug Class	Description	Chronic Condition(s) Treated
		THIOXANTHENES	
	H7S	ANTIPSYCHOTICS,DOPAMINE ANTAGONST,DIHYDROINDOLONES	Schizophrenia
	H7T	ANTIPSYCHOTICS,ATYPICAL,DOPAMINE,& SEROTONIN ANTAG	Schizophrenia and Depression
	H7U	ANTIPSYCHOTICS, DOPAMINE & SEROTONIN ANTAGONISTS	Schizophrenia
	H7X	ANTIPSYCHOTICS, ATYP, D2 PARTIAL AGONIST/5HT MIXED	Schizophrenia and Depression
	H7Z	SSRI & ANTIPSYCH,ATYP,DOPAMINE&SEROTONIN ANTAG CMB	Depression
	H8P	SSRI & 5HT1A PARTIAL AGONIST ANTIDEPRESSANT	Depression
	H8T	SSRI & SEROTONIN RECEPTOR MODULATOR ANTIDEPRESSANT	Depression
Chronic Cardiovascular Disease	A1A	DIGITALIS GLYCOSIDES	Heart Failure
	A1C	INOTROPIC DRUGS	Heart Failure
	A2C	ANTIANGINAL & ANTI-ISCHEMIC AGENTS,NON-HEMODYNAMIC	Ischemic Heart Disease
	A4A	ANTIHYPERTENSIVES, VASODILATORS	Hypertension
	A4B	ANTIHYPERTENSIVES, SYMPATHOLYTIC	Hypertension
	A4C	ANTIHYPERTENSIVES, GANGLIONIC BLOCKERS	Hypertension
	A4D	ANTIHYPERTENSIVES, ACE INHIBITORS	Hypertension, Ischemic Heart Disease and Heart Failure
	A4F	ANTIHYPERTENSIVES, ANGIOTENSIN RECEPTOR ANTAGONIST	Hypertension, Ischemic Heart Disease and Heart Failure
	A4H	ANGIOTENSIN RECEPTOR ANTGNST & CALC.CHANNEL BLOCKR	Hypertension, Ischemic Heart Disease and Heart Failure
	A4I	ANGIOTENSIN RECEPTOR ANTAG./THIAZIDE DIURETIC COMB	Hypertension, Ischemic Heart Disease and Heart Failure

ATTACHMENT F
Healthy Behaviors Incentives Program Protocol
Appendix 2: Chronic Conditions Copay Exempt Drug Class Codes

Treatment Category	Drug Class	Description	Chronic Condition(s) Treated
	A4J	ACE INHIBITOR/THIAZIDE & THIAZIDE-LIKE DIURETIC	Hypertension, Ischemic Heart Disease and Heart Failure
	A4K	ACE INHIBITOR/CALCIUM CHANNEL BLOCKER COMBINATION	Hypertension
	A4T	RENIN INHIBITOR, DIRECT	Hypertension
	A4U	RENIN INHIBITOR,DIRECT AND THIAZIDE DIURETIC COMB	Hypertension
	A4V	ANGIOTEN.RECEPTR ANTAG./CAL.CHANL BLKR/THIAZIDE CB	Hypertension
	A4W	RENIN INHIBITOR,DIRECT & ANGIOTENSIN RECEPT ANTAG.	Hypertension
	A4X	RENIN INHIBITOR, DIRECT & CALCIUM CHANNEL BLOCKER	Hypertension
	A4Y	ANTIHYPERTENSIVES, MISCELLANEOUS	Hypertension
	A4Z	RENIN INHIB, DIRECT& CALC.CHANNEL BLKR & THIAZIDE	Hypertension
	A7B	VASODILATORS,CORONARY	Ischemic Heart Disease and Heart Failure
	A7C	VASODILATORS,PERIPHERAL	Ischemic Heart Disease and Stroke/Transient Ischemic Attack
	A7H	VASOACTIVE NATRIURETIC PEPTIDES	Hypertension and Heart Failure
	A7J	VASODILATORS, COMBINATION	Heart Failure
	A9A	CALCIUM CHANNEL BLOCKING AGENTS	Hypertension, Ischemic Heart Disease and Heart Failure
	C4A	ANTIHYPERGLY.DPP-4 INHIBITORS &HMG COA RI(STATINS)	Ischemic Heart Disease
	C6N	NIACIN PREPARATIONS	Hyperlipidemia
Chronic Cardiovascular Disease (cont.)	D7L	BILE SALT SEQUESTRANTS	Hyperlipidemia
	J7A	ALPHA/BETA-ADRENERGIC BLOCKING AGENTS	Hypertension and Heart Failure
	J7B	ALPHA-ADRENERGIC BLOCKING AGENTS	Hypertension

ATTACHMENT F
Healthy Behaviors Incentives Program Protocol
Appendix 2: Chronic Conditions Copay Exempt Drug Class Codes

Treatment Category	Drug Class	Description	Chronic Condition(s) Treated
	J7B	ALPHA-ADRENERGIC BLOCKING AGENTS	Hypertension
	J7C	BETA-ADRENERGIC BLOCKING AGENTS	Heart Failure and Ischemic Heart Disease
	J7E	ALPHA-ADRENERGIC BLOCKING AGENT/THIAZIDE COMB	Hypertension
	J7H	BETA-ADRENERGIC BLOCKING AGENTS/THIAZIDE & RELATED	Hypertension
	M4D	ANTIHYPERLIPIDEMIC - HMG COA REDUCTASE INHIBITORS	Hyperlipidemia and Ischemic Heart Disease
	M4E	LIPOTROPICS	Hyperlipidemia and Ischemic Heart Disease
	M4E	LIPOTROPICS	Ischemic Heart Disease
	M4I	ANTIHYPERLIP - HMG-COA&CALCIUM CHANNEL BLOCKER CB	Hyperlipidemia, Hypertension, Ischemic Heart Disease
	M4L	ANTIHYPERLIPIDEMIC-HMG COA REDUCTASE INHIB.&NIACIN	Hyperlipidemia and Ischemic Heart Disease
	M4M	ANTIHYPERLIP.HMG COA REDUCT INHIB&CHOLEST.AB.INHIB	Hyperlipidemia and Ischemic Heart Disease
	M9D	ANTIFIBRINOLYTIC AGENTS	Ischemic Heart Disease
	M9E	THROMBIN INHIBITORS,SEL.,DIRECT,&REV.-HIRUDIN TYPE	DVT and Ischemic Heart Disease
	M9F	THROMBOLYTIC ENZYMES	DVT and Stroke/Transient Ischemic Attack
	M9K	HEPARIN AND RELATED PREPARATIONS	DVT and Ischemic Heart Disease
	M9L	ANTICOAGULANTS,COUMARIN TYPE	DVT and Ischemic Heart Disease
	M9P	PLATELET AGGREGATION INHIBITORS	Ischemic Heart Disease and Stroke/Transient Ischemic Attack
	M9T	THROMBIN INHIBITORS,SELECTIVE,DIRECT, & REVERSIBLE	DVT and Ischemic Heart Disease
	M9V	DIRECT FACTOR XA INHIBITORS	DVT

ATTACHMENT F
Healthy Behaviors Incentives Program Protocol
Appendix 2: Chronic Conditions Copay Exempt Drug Class Codes

Treatment Category	Drug Class	Description	Chronic Condition(s) Treated
	R1E	CARBONIC ANHYDRASE INHIBITORS	Hypertension and Heart Failure
	R1F	THIAZIDE AND RELATED DIURETICS	Hypertension and Heart Failure
	R1H	POTASSIUM SPARING DIURETICS	Hypertension and Heart Failure
	R1L	POTASSIUM SPARING DIURETICS IN COMBINATION	Hypertension and Heart Failure
	R1M	LOOP DIURETICS	Hypertension and Heart Failure
Chronic Pulmonary Disease	A1B	XANTHINES	Asthma and COPD
	A1D	GENERAL BRONCHODILATOR AGENTS	Asthma and COPD
	B6M	GLUCOCORTICOIDS, ORALLY INHALED	Asthma and COPD
	J5A	ADRENERGIC AGENTS,CATECHOLAMINES	Asthma and COPD
	J5D	BETA-ADRENERGIC AGENTS	Asthma and COPD
	J5G	BETA-ADRENERGIC AND GLUCOCORTICOID COMBINATIONS	Asthma and COPD
	J5J	BETA-ADRENERGIC AND ANTICHOLINERGIC COMBINATIONS	COPD
	Z2F	MAST CELL STABILIZERS	Asthma
	Z2X	PHOSPHODIESTERASE-4 (PDE4) INHIBITORS	COPD
	Z4B	LEUKOTRIENE RECEPTOR ANTAGONISTS	Asthma
Diabetes	C4B	ANTIHYPERGLYCEMIC-GLUCOCORTICOID RECEPTOR BLOCKER	Diabetes Mellitus
	C4C	ANTIHYPERGLY,DPP-4 ENZYME INHIB &THIAZOLIDINEDIONE	Diabetes Mellitus
	C4D	ANTIHYPERGLYCEMC-SOD/GLUC COTRANSPORT2(SGLT2)INHIB	Diabetes Mellitus
	C4F	ANTIHYPERGLYCEMIC,DPP-4 INHIBITOR & BIGUANIDE COMB	Diabetes Mellitus
	C4G	INSULINS	Diabetes Mellitus
	C4H	ANTIHYPERGLYCEMIC, AMYLIN ANALOG-TYPE	Diabetes Mellitus

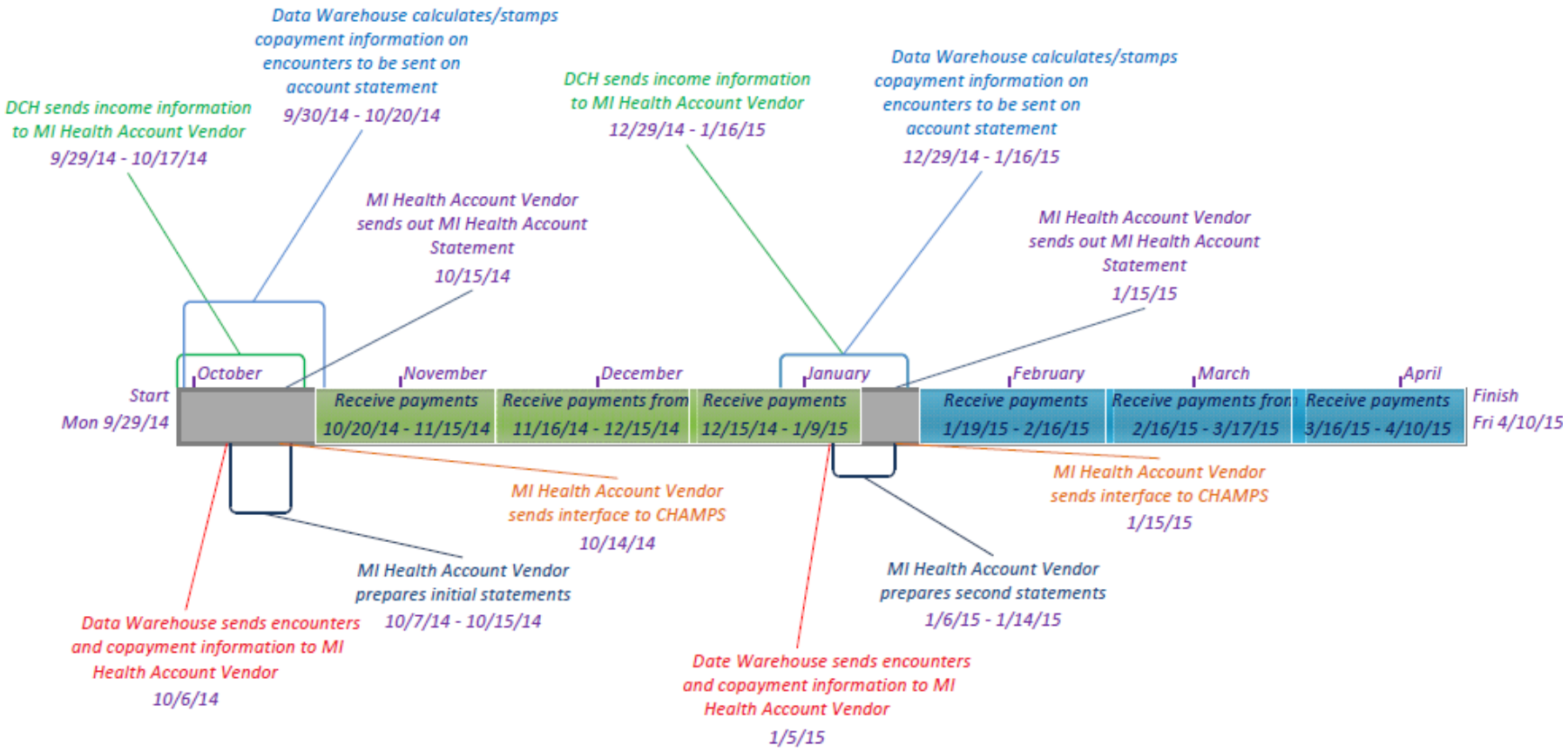
ATTACHMENT F
Healthy Behaviors Incentives Program Protocol
Appendix 2: Chronic Conditions Copay Exempt Drug Class Codes

Treatment Category	Drug Class	Description	Chronic Condition(s) Treated
	C4I	ANTIHYPERGLY,INCRETIN MIMETIC(GLP-1 RECEP.AGONIST)	Diabetes Mellitus
	C4J	ANTIHYPERGLYCEMIC, DPP-4 INHIBITORS	Diabetes Mellitus
	C4K	ANTIHYPERGLYCEMIC, INSULIN-RELEASE STIMULANT TYPE	Diabetes Mellitus
	C4L	ANTIHYPERGLYCEMIC, BIGUANIDE TYPE	Diabetes Mellitus
	C4M	ANTIHYPERGLYCEMIC, ALPHA-GLUCOSIDASE INHIBITORS	Diabetes Mellitus
	C4N	ANTIHYPERGLYCEMIC,THIAZOLIDINEDIONE(PPARG AGONIST)	Diabetes Mellitus
	C4R	ANTIHYPERGLYCEMIC,THIAZOLIDINEDIONE & SULFONYLUREA	Diabetes Mellitus
	C4S	ANTIHYPERGLYCEMIC,INSULIN-REL STIM.& BIGUANIDE CMB	Diabetes Mellitus
	C4T	ANTIHYPERGLYCEMIC,THIAZOLIDINEDIONE & BIGUANIDE	Diabetes Mellitus
	C4V	ANTIHYPERGLYCEMIC - DOPAMINE RECEPTOR AGONISTS	Diabetes Mellitus
HIV	W5C	ANTIVIRALS, HIV-SPECIFIC, PROTEASE INHIBITORS	HIV
	W5I	ANTIVIRALS, HIV-SPECIFIC, NUCLEOTIDE ANALOG, RTI	HIV
	W5J	ANTIVIRALS, HIV-SPECIFIC, NUCLEOSIDE ANALOG, RTI	HIV
	W5K	ANTIVIRALS, HIV-SPECIFIC, NON-NUCLEOSIDE, RTI	HIV
	W5L	ANTIVIRALS, HIV-SPEC., NUCLEOSIDE ANALOG, RTI COMB	HIV
	W5M	ANTIVIRALS, HIV-SPECIFIC, PROTEASE INHIBITOR COMB	HIV
	W5N	ANTIVIRALS, HIV-SPECIFIC, FUSION INHIBITORS	HIV
	W5O	ANTIVIRALS, HIV-SPEC, NUCLEOSIDE-NUCLEOTIDE ANALOG	HIV

ATTACHMENT F
Healthy Behaviors Incentives Program Protocol
Appendix 2: Chronic Conditions Copay Exempt Drug Class Codes

Treatment Category	Drug Class	Description	Chronic Condition(s) Treated
	W5P	ANTIVIRALS, HIV-SPEC, NON-PEPTIDIC PROTEASE INHIB	HIV
	W5Q	ARTV CMB NUCLEOSIDE,NUCLEOTIDE,&NON-NUCLEOSIDE RTI	HIV
	W5T	ANTIVIRALS, HIV-SPECIFIC, CCR5 CO-RECEPTOR ANTAG.	HIV
	W5U	ANTIVIRALS,HIV-1 INTEGRASE STRAND TRANSFER INHIBTR	HIV
	W5X	ARV CMB-NRTI,N(T)RTI, INTEGRASE INHIBITOR	HIV
Obesity	D5A	FAT ABSORPTION DECREASING AGENTS	Obesity
	J5B	ADRENERGICS, AROMATIC, NON-CATECHOLAMINE	Obesity
	J8A	ANTI-OBESITY - ANOREXIC AGENTS	Obesity
	J8C	ANTI-OBESITY SEROTONIN 2C RECEPTOR AGONISTS	Obesity
Smoking Cessation	J3A	SMOKING DETERRENT AGENTS (GANGLIONIC STIM,OTHERS)	Tobacco Use Disorder
	J3C	SMOKING DETERRENT-NICOTINIC RECEPT.PARTIAL AGONIST	Tobacco Use Disorder

ATTACHMENT F
Healthy Behaviors Incentives Program Protocol
Appendix 3: Interface Timeline



Health Risk Assessment

INSTRUCTIONS

The Healthy Michigan Plan is very interested in helping you get healthy and stay healthy. We want to ask you a few questions about your current health and encourage you to see your doctor for a check-up as soon as possible after you enroll with a health plan, and at least once a year after that. Take this form with you when you go. An annual check-up appointment is a covered benefit of the Healthy Michigan Plan and your health plan can help you with a ride to and from this appointment. Your doctor and your health plan will use this information to better meet your health needs. The information you provide in this form is personal health information protected by federal and state law and will be kept confidential. It CANNOT be used to deny health care coverage.

If you need assistance with completing this form, contact your health plan. You can also call the Beneficiary Help Line at 1-800-642-3195 or TTY 1-866-501-5656 if you have questions.

Instructions for completing this Health Risk Assessment for Healthy Michigan Plan:

- Answer the questions in sections 1-3 as best you can. You are not required to answer all of the questions.
- Call your doctor's office to schedule an annual check-up appointment. Take this form with you to your appointment.
- Your doctor or other primary care provider will complete section 4. He or she will send your results to your health plan.

After your appointment, keep a copy or printout of this form that has your doctor's signature on it. This is your record that you completed your annual Health Risk Assessment.

For questions and/or problems, or help to translate, call the Beneficiary Help Line at 1-800-642-3195 or TTY 1-866-501-5656.

Spanish: Si necesita ayuda para traducir o entender este texto, por favor llame al telefono, 1-800-642-3195 or TTY 1-866-501-5656

Arabic: TTY 1-866-501-5656

إذا كان لديكم أيّ سؤال، يرجى الإتصال بخط المساعدة على الرقم المجاني ٣١٩٥-٦٤٢-٨٠٠-١

HEALTHY MICHIGAN PLAN

Health Risk Assessment

First Name, Middle Name, Last Name, and Suffix				Date of Birth (mm/dd/yyyy)
Mailing Address		Apartment or Lot Number		**mihealth** Card Number
City	State	Zip Code	Phone Number	Other Phone Number

SECTION 1 - Initial assessment questions (check one for each question)

1. **In general, how would you rate your health?** ☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

2. **In the last 7 days, how often did you exercise for at least 20 minutes in a day?**
   ☐ Every day ☐ 3-6 days ☐ 1-2 days ☐ 0 days

   Exercise includes walking, housekeeping, jogging, weights, a sport or playing with your kids. It can be done on the job, around the house, just for fun or as a work-out.

3. **In the last 7 days, how often did you eat 3 or more servings of fruits or vegetables in a day?**
   ☐ Every day ☐ 3-6 days ☐ 1-2 days ☐ 0 days

   Each time you ate a fruit or vegetable counts as one serving. It can be fresh, frozen, canned, cooked or mixed with other foods.

4. **In the last 7 days, how often did you have (5 or more for men, 4 or more for women) alcoholic drinks at one time?**
   ☐ Never ☐ Once a week ☐ 2-3 times a week ☐ More than 3 times during the week

   1 drink is 1 beer, 1 glass of wine, or 1 shot.

5. **In the last 30 days have you smoked or used tobacco?** ☐ Yes ☐ No

   If YES, Do you want to quit smoking or using tobacco?
   ☐ Yes ☐ I am working on quitting or cutting back right now ☐ No

6. **In the last 30 days, how often have you felt tense, anxious or depressed?**
   ☐ Almost every day ☐ Sometimes ☐ Rarely ☐ Never

7. **Do you use drugs or medications (other than exactly as prescribed for you) which affect your mood or help you to relax?**
   ☐ Almost every day ☐ Sometimes ☐ Rarely ☐ Never

   This includes illegal or street drugs and medications from a doctor or drug store if you are taking them <u>differently</u> than exactly how your doctor told you to take them.

8. **The flu vaccine can be a shot in the arm or a spray in the nose. Have you had a flu shot or flu spray in the last year?**
   ☐ Yes ☐ No

9. A checkup is a visit to a doctor's office that is NOT for a specific problem. How long has it been since your last checkup?

☐ Within the last year ☐ Between 1-3 years ☐ More than 3 years

Take this form to your check-up and complete the rest of the form with your doctor at this appointment.

First Name, Middle Name, Last Name, and Suffix	mihealth Card Number

SECTION 2 - Annual appointment

A routine checkup is an important part of taking care of your health. An annual check-up appointment is a covered benefit of the Healthy Michigan Plan and your health plan can help you with a ride to and from this appointment.

ıat month did you first schedule this appointment? _____ (Month)

Date of appointment: _____ (mm/dd/yyyy)

At my appointment, I would most like to talk with my doctor about:

_____

An annual appointment gives you a chance to talk to your doctor and ask any questions you may have about your health including questions about medications or tests you might need.

Section 3 - Readiness to change

Your Healthy Behavior

Small everyday changes can have a big impact on your health. Think about the changes you would be most interested in making over the next year**.** Look at the list below and **CHOOSE ONE or MORE**:

- ☐ Exercise regularly, eat better, and/or lose weight
- ☐ Cut back or quit smoking or using tobacco
- ☐ Get a flu shot
- ☐ Return to the doctor to get tested for high blood pressure, high cholesterol and diabetes OR if I already have any of them, return to the doctor for check-ups for these conditions
- ☐ Cut back or quit drinking alcohol
- ☐ Seek treatment for drug or substance abuse
- ☐ I will commit to keep up all of the healthy things I do now
- ☐ Other:

Changes like drinking water rather than soda or walking every day can help you stay healthy or help you better control illnesses you may already have. You can learn new ways to handle stress or quit smoking. Remember, even small changes can be difficult and take a long time. It may be helpful to get support from your family, friends, community or your doctor. Your health plan may have programs that can help you.

Now that you have selected your healthy behavior(s) above, answer questions 1 - 3. For each question, use the scale provided and pick a number from 0 through 5.

	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
1. Thinking about your healthy behavior(s), do you want to make some small lifestyle changes in this area to improve your health?	I don't want to make changes now		I want to learn more about changes I can make		Yes, I know the changes I want to start making	
2. How much support do you think you would get from family or friends if they knew you were trying to make some changes?	I don't think family or friends would help me		I think I have some support		Yes, I think family or friends would help me	
3. How much support would you						

like from your doctor or your health plan to make these changes?	**0**	**1**	**2**	**3**	**4**	**5**
	I do not want to be contacted		I want to learn more about programs that can help me		Yes, I am interested in signing up for programs that can help me	

ATTACHMENT F
Healthy Behaviors Incentives Program Protocol
Appendix 4: Health Risk Assessment

First Name, Middle Name, Last Name, and Suffix	mihealth Card Number

Section 4 – To be completed by your primary care provider

Primary care providers should fill out this form for Healthy Michigan Plan beneficiaries enrolled in Managed Care Plans only. Fill in the Member Results, select a Healthy Behavior statement in discussion with the member, and sign the Primary Care Provider Attestation. Blood pressure, BMI and tobacco use status will be known from the appointment. For all other Member Results, marking the result as unknown and indicating whether the screening or immunization is recommended satisfies the requirements for a complete Health Risk Assessment. All three parts of Section 4 must be filled in for the attestation to be considered complete.

Member Results

Blood Pressure	(xxx/xxx mmHg)	Patient diagnosed with hypertension? ☐ Yes ☐ No
BMI	_____Ht _____Wt. BMI _____ (xx.x)	In the context of all relevant clinical factors, does this BMI indicate need for weight management? ☐ Yes ☐ No
Tobacco Use Status	☐ Never used tobacco ☐ Previous tobacco user ☐ Current tobacco cessation ☐ Starting tobacco cessation ☐ Tobacco user	
Cholesterol	Cholesterol known? ☐ Yes ☐ No	Patient diagnosed with high cholesterol? ☐ Yes ☐ No
	If cholesterol known is **Yes**: Date of most recent test results:	Total cholesterol: _____ LDL: _____ HDL: _____ Triglycerides:
	If cholesterol known is **No**:	☐ Screening not recommended ☐ Screening Ordered
Blood Sugar	Blood sugar known? ☐ Yes ☐ No	Patient diagnosed with diabetes? ☐ Yes ☐ No
	If blood sugar known is **Yes**: Date of most recent test results:	FBS (xxx mg/dl): _____ A1C (xx.x%): _____
	If blood sugar known is **No**:	☐ Screening not recommended ☐ Screening Ordered
Influenza Vaccine	Annual Influenza Vaccination? ☐ Yes ☐ No	
	If Influenza vaccination is **Yes**:	Date of most recent vaccination: _____
	If Influenza vaccination is **No**:	☐ Vaccination not recommended ☐ Vaccination recommended

ATTACHMENT F
Healthy Behaviors Incentives Program Protocol
Appendix 4: Health Risk Assessment

First Name, Middle Name, Last Name, and Suffix	mihealth Card Number

Healthy Behaviors - Choose one of the following statements (**1** - **4**)

☐ **1. Patient does not have health risk behaviors that need to be addressed at this time.**

☐ **2. Patient has identified at least one behavior to address over the next year to improve their health (choose one or more below):**

- ☐ ***Increase physical activity, learn more about nutrition and improve diet, and/or weight loss***
- ☐ ***Reduce/quit tobacco use***
- ☐ ***Annual influenza vaccine***
- ☐ ***Agrees to follow-up appointment for screening or management (if necessary) of hypertension, cholesterol and/or diabetes***
- ☐ ***Reduce/quit alcohol consumption***
- ☐ ***Treatment for Substance Use Disorder***
- ☐ ***Other: explain*** _____

☐ **3. Patient has a serious medical, behavioral or social condition(s) which precludes addressing unhealthy behaviors at this time.**

☐ **4. Unhealthy behaviors have been identified, patient's readiness to change has been assessed, and patient is not ready to make changes at this time.**

Primary Care Provider Attestation

I certify that I have examined the patient named above and the information is complete and accurate to the best of my knowledge. I have provided a copy of this Health Risk Assessment to the member listed above.

Print Name (First Name, Last Name)	National Provider Identifier (NPI)
Signature	Date

Submission Instructions:

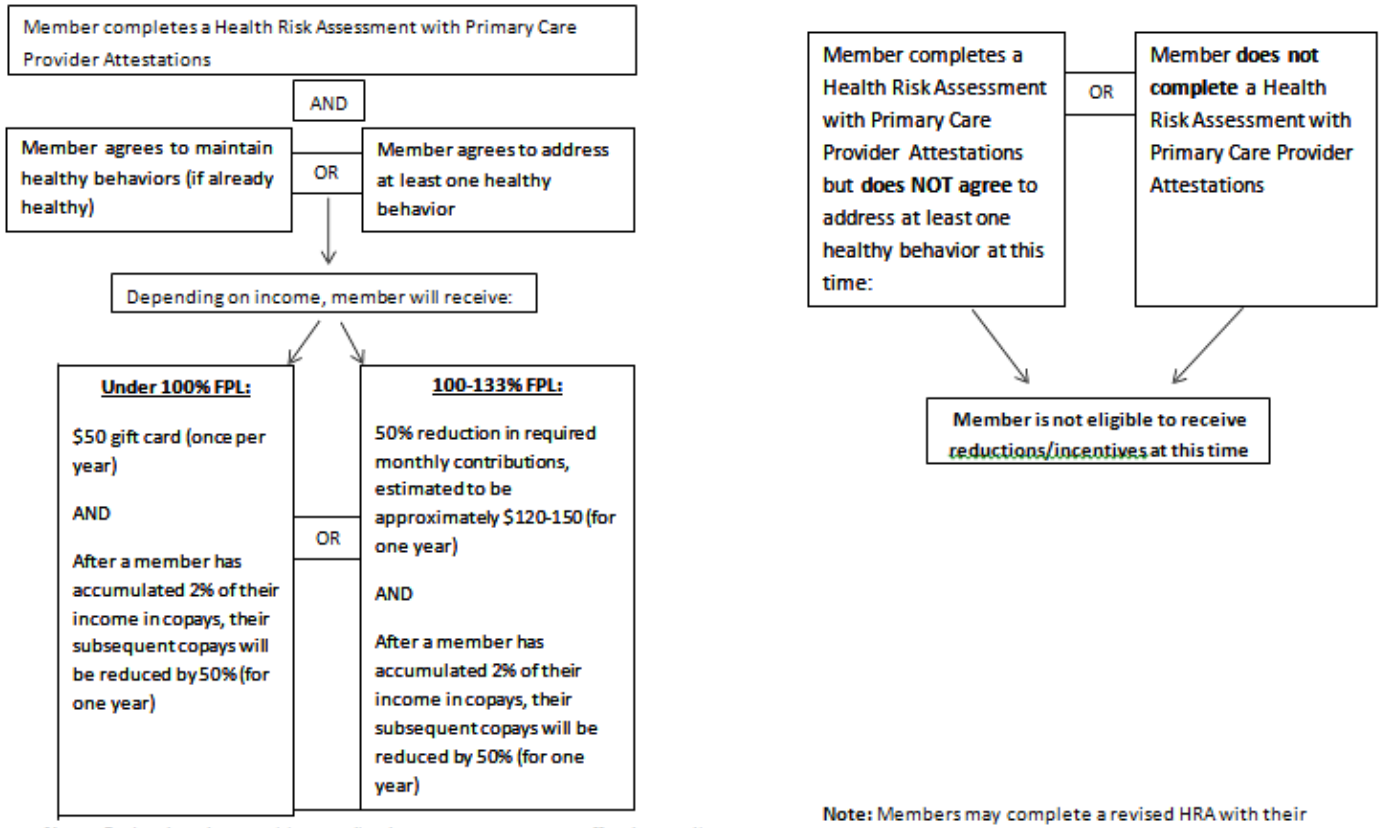
- Submit completed forms in the secure manner specified by the member's Managed Care Plan.

Authority: MCL 400.105(d)(1)(e)

Completion: Of this form provides information to better meet the health needs of Healthy Michigan Plan beneficiaries in Managed Care Plans.

Michigan Department of Community Health is an equal opportunity employer.

ATTACHMENT F
Healthy Behaviors Incentives Program Protocol
Appendix 5: Healthy Michigan Plan Healthy Behaviors Incentives Eligibility and Distribution



Note: Reductions in monthly contributions or copays are not effective until payments begin to be made, after 6 months of enrollment.

Note: Members may complete a revised HRA with their primary care provider at any time during the year to become eligible for the incentives program.

Note: Members who complete an assessment and initial appointment and acknowledge that changes are necessary but who have significant physical, mental or social barriers to addressing them at this time (as attested by the primary care provider) are also eligible for the incentives.

08/14/14

Michigan Department of Community Health
Rick Snyder, Governor
James K. Haveman, Director

Health

Michigan Department of Community
Appendix 6
Medical Services Administration

MEMORANDUM

Medical Care Advisory Council
AGENDA

DATE: **Tuesday February 11, 2014**
TIME: **1:30 pm – 4:30 pm (NOTE LATER START TIME)**
WHERE: **Michigan Public Health Institute (MPHI)**
2436 Woodlake Circle
Okemos, MI
517-324-8326

1. Welcome and Introductions ……..…….……...…….Jan Hudson
2. Affordable Care Act Implementation
    a. Healthy Michigan Plan...…… Staff
        i. Waiver Status – Terms and Conditions
        ii. Outreach and Enrollment Plans
        iii. Coordination with DHS
        iv. MAGI Implementation Update
        v. Symposium on High Emergency Room Utilizers – Follow-up
    b. Dual Eligibles Integration Project – Update
    c. SIM Update
3. FY2015 Executive Budget Recommendation ……..……..…… Staff
4. Mental Health Commission Recommendations ……. Staff
5. Policy Updates ……..…….. Staff

4:30 – Adjourn

Next Meeting: May 14, 2014

ATTACHMENT G
Annual Update of Rural Counties Not Required to Provide a Choice of Managed Care Plans

Health Plan Choice

The state will comply with Section 1932(a)(3) of the Social Security Act and the Code of Federal Regulations at 42 CFR §438.52, which requires beneficiaries to enroll in a Medicaid Health Plan, but gives the choice of at least two entities, with some exceptions. In rural counties, the state will employ the "rural exception" where beneficiaries will only have one choice of a Medicaid Health Plan, but given the choice of individual providers. The state will use the rural exception in the following counties:

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

Healthy Michigan Program beneficiaries will be given their choice of plans and providers consistent with federal law and regulation. For those populations who are currently voluntary or exempt from enrollment into a Medicaid Health Plan (e.g., Native Americans, beneficiaries who have other Health Maintenance Organization or Preferred Provider Organization coverage, etc.), they will remain a voluntary or exempt population from managed care under this demonstration.

ATTACHMENT H
Final Report Framework

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

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

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

Objectives, goals and hypotheses of the demonstration
- Description
- How met/not met

Lessons learned

Operational/policy developments and issues

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

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

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

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

Cost sharing
- Variations from state plan
- Changes that occurred during the demonstration

Impact of any changes

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

Other influences – actions and impact
- Legislature
- Advocates and other stakeholders
- Other (environmental, economic, etc.)

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

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

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

Health Benefit Plan and Cost Sharing for Adult Benefits Waiver

Service Type	Description of Coverage	Copayments
Ambulance	Limited to emergency ground transportation to the hospital Emergency Department (ED).	
Case Management	Not covered.	
Chiropractor	Not covered.	
Dental	Not covered, except for services of oral surgeons as covered under the current Medicaid physician benefit for the relief of pain or infection.	
Emergency Department	Covered per current Medicaid policy. For CHPs, prior authorization may be required for nonemergency services provided in the emergency department.	
Eyeglasses	Not covered.	
Family Planning	Covered. Services may be provided through referral to local Title X designated Family Planning Program.	
Hearing Aids	Not covered.	
Home Health	Not covered.	
Home Help (personal care)	Not covered.	
Hospice	Not covered.	
Inpatient Hospital	Not covered.	
Laboratory and Radiology	Covered if ordered by MD, DO, or NP for diagnostic and treatment purposes. Prior authorization may be required by the CHP.	
Medical Supplies / Durable Medical Equipment (DME)	Limited Coverage: • Medical supplies are covered except for the following non-covered categories: gradient surgical garments, formula and feeding supplies, and supplies related to any uncovered DME item. • DME items are non-covered except for glucose monitors	
Mental Health	Covered: Services must be provided through the Prepaid Inpatient Health	

	Plans (PIHP)/Community Mental Health Services Programs (CMHSP).	
Outpatient Hospital (Nonemergency Department)	Covered: Diagnostic and treatment services and diabetes education services. Prior authorization may be required for some services by the CHPs. Noncovered: Therapies, labor room, and partial hospitalization.	Maximum $3 copayment for professional services
Pharmacy	Covered: • Products included on the Michigan Pharmaceutical Product List (except enteral formulas) that are ordered by an MD, DO, NP or type 10–enrolled oral surgeon. Prior authorization may be required by the CHPs. • Psychotropic medications are provided under the FFS benefit. Refer to Michigan Dept. of Community Health (MDCH) Pharmacy Benefit Manager (PBM) website for current list. Noncovered: injectable drugs used in clinics or physician offices.	Maximum $1 copayment per prescription There are no copayments for family planning or pregnancy related drug products.
Physician Services	Covered per Medicaid policy.	Maximum $3 copayment for office visits
Nurse Practitioner	Covered per Medicaid policy.	Maximum $3 copayment for office visits
Oral Surgeon	Covered per Medicaid policy.	Maximum $3 copayment for office visits
Medical Clinic	Covered per Medicaid policy.	Maximum $3 copayment for office visits
Podiatrist	Not covered.	
Prosthetics/Orthotics	Not covered.	
Private Duty Nursing	Not covered.	
Substance Abuse	Covered through the Substance Abuse Coordinating Agencies (CAs).	

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