STATE OF MICHIGAN
DEPARTMENT OF COMMUNITY HEALTH
LANSING

RICK SNYDER
GOVERNOR

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January 28, 2014

Ms. Marilyn Tavenner, Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Mail Stop 314-G
200 Independence Avenue S.W.
Washington, D.C. 20201

Dear Ms. Tavenner:

This letter serves as the State of Michigan's formal acceptance of the Special Terms and Conditions for the Section 1115 Demonstration known as the Healthy Michigan Plan, as provided to the State in your December 30, 2013 correspondence. The State acknowledges the time and effort you and your colleagues at the Centers for Medicare and Medicaid Services have provided as we worked together to move the State's vision for the Healthy Michigan Plan through the waiver approval process.

We understand from previous discussions with our federal partners that technical corrections to the Special Terms and Conditions may be requested by the State following approval of the demonstration, therefore the State wishes to take the opportunity in this acceptance letter to do so. We look forward to discussing these items with your colleagues as we continue to work to implement the Healthy Michigan Plan.

MI Health Account Operational Protocol (Paragraph 30)

The State appreciates the opportunity to work with the Centers for Medicare and Medicaid Services to provide further detail with respect to the MI Health Account through the development of an operational protocol. However, given the requirements of the State law authorizing the creation of the Healthy Michigan Plan and its related MI Health Account, and transition plans associated with existing Adult Benefits Waiver beneficiaries, the State seeks the following revisions.

The Special Terms and Conditions reference a phased implementation for the MI Health Account that begins with individuals above 100% of the Federal Poverty Level. While the State intends to take a stepped approach to MI Health Account operations, it will instead begin with those individuals below 100% of the Federal Poverty Level. Existing Adult Benefits Waiver Beneficiaries, of which there are approximately 60,000 individuals with incomes not exceeding 35% of the Federal Poverty Level, will be the first group transitioned to the Medicaid health plans and the first group to interact with a MI Health Account in October of 2014. Other eligible individuals will follow suit on a rolling enrollment basis. For this reason, the State requests that Paragraph 30(a) be corrected to reflect a phased in approach that begins with individuals *below* 100% of the Federal Poverty Level, rather than *above*.

The State also requests that the reference to a notice requirement 'at the time of service' be eliminated with respect to the cost-sharing obligations described in Paragraph 30(e). State law authorizing the creation of the Healthy Michigan Plan essentially eliminates the remittance of co-payments at the time of service in order to ease the burden on providers, remove a barrier to access and promote beneficiary accountability. Instead, co-payments for health plan covered services will be collected on a delayed basis through the MI Health Account, with opportunities for reductions in any amounts owed if the service provided is one that promotes health, or if the beneficiary achieves healthy behaviors in a manner that merits a reduced charge. Given the law's requirements, the provider's office will not have the information necessary to inform the beneficiary of the amounts owed and credited to them at the time of a service. However, the State intends to facilitate education of Healthy Michigan

Plan participants and providers, in collaboration with the Medicaid health plans, to ensure that all parties understand how co-payments will be assessed and collected, and that services cannot be reduced or denied for failure to pay. While the State looks forward to working with CMS to develop the operational protocol for the MI Health Account, this change is requested in advance of this collaboration.

Delivery System (Paragraph 35)

Paragraph 35, Section(b)(iv) of the Special Terms and Conditions requires an auto assignment process that first considers the individual's history with the relevant health plan, followed by the plan's affiliation of the individual's historic providers. Michigan is a mature managed care state, having nearly two decades of experience and success working in partnership with our Medicaid health plans. As such, the State has an auto-assignment algorithm in place, which is compliant with 42 CFR § 438.50(f) and approved by the Centers for Medicare and Medicaid Services, that relies on quality data rather than historical individual provider data. Because Michigan intends to use as much of its existing managed care infrastructure to implement the Healthy Michigan Plan as possible, and historical provider information is not incorporated into the existing algorithm, the State requests that the last sentence of Paragraph 35, Section (b)(iv) be deleted in its entirety.

Managed Care Contracts (Paragraph 37)

As previously discussed with our federal partners, the State wishes to reiterate its intention to submit draft contracts to the Centers for Medicare and Medicaid Services with a minimum of 60 days for review and approval. The State would appreciate formal acknowledgement that this is sufficient to meet the requirements of paragraph 37, and that this approach would permit the receipt of all Federal Financial Participation to which the State is entitled.

Transitions of Adult Benefit Waiver Beneficiaries (Paragraph 46)

The State recognizes that it is of the utmost importance to ensure timely access to care for Adult Benefits Waiver beneficiaries transitioning to the Healthy Michigan Plan, and that honoring existing provider relationships and treatment plans is a way to achieve that goal. However, the Special Terms and Conditions directive that the Medicaid health plans honor all prior authorizations initiated under the Adult Benefits Waiver program for a period of 90 days, as well as the requirement for the plans to permit services by an out of network provider for 90 days, are not necessary to support continuity of care and access to care during the transition period, and are inconsistent with the State's existing managed care operations.

Instead, the State believes that safe transitions of care may occur with the following requirements for out-of-network services and prior authorizations. First, the State will direct all Medicaid Health Plans to allow out of network services until such time that the beneficiary may be safely brought into network. This is a common approach to care transitions within managed care generally, and is consistent with existing practices in the State. Medicaid health plans will also be required to honor prior authorizations in place at the time of enrollment until appropriate prior authorizations can be established by the enrollee's chosen Medicaid health plan, without interruption of ongoing services. The State anticipates that all prior authorizations will be evaluated after 30 days, and would be extended at that point if medically necessary.

Given the above, the State requests that the first sentence of Paragraph 46 be revised to read as follows:

> *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.*

Similarly, the State requests that Paragraph 46, Section (c) be revised as follows:

> *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.*

The State is grateful for the assistance you and your colleagues have already provided and looks forward to continued collaboration. If you have any questions or require any additional information, please do not hesitate to contact Jackie Prokop at (517) 335-5184 or by e-mail at prokopj@michigan.gov.

Stephen Fitton, Director
Medical Services Administration

cc: Diane Gerrits
Paul Boben
Verlon Johnson