DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

DEC 2 1 2018

The Honorable Rick Snyder
Governor
P.O. Box 30013
Lansing, MI 48909

Dear Governor Snyder:

I am pleased to inform you that the Centers for Medicare & Medicaid Services (CMS) is approving Michigan's request to extend its section 1115 demonstration project, "Healthy Michigan Plan." The details of this approval will be transmitted to Kathy Stiffler, Acting Medicaid Director.

I want to express my appreciation for the hard work and commitment to innovation that your team has displayed during this process. At CMS, we are dedicated to empowering states to better serve their residents through state-led reforms that improve health and help lift individuals out of poverty. Your efforts through this demonstration help us fulfill that promise.

Congratulations to the entire Michigan team on reaching approval. We look forward to our continued work together through the implementation of these important reforms.

Sincerely,

[redacted]

Seema Verma

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

DEC 2 1 2018

Kathy Stiffler
Acting Director
State of Michigan, Department of Health and Human Services
Capitol Commons Center
400 South Pine
Lansing, MI 48913

Dear Ms. Stiffler:

Under section 1115 of the Social Security Act (the Act), the Secretary of Health and Human Services may approve any experimental, pilot or demonstration project that, in the judgment of the Secretary, is likely to assist in promoting the objectives of certain programs under the Act, including Medicaid. Congress enacted section 1115 of the Act to ensure that federal requirements did not "stand in the way of experimental projects designed to test out new ideas and ways of dealing with the problems of public welfare recipients." S. Rep. No. 87-1589, at 19 (1962), *as reprinted in* 1962 U.S.C.C.A.N. 1943, 1961. As relevant here, section 1115(a)(1) of the Act allows the Secretary to waive compliance with the Medicaid program requirements of section 1902 of the Act, to the extent and for the period he finds necessary to carry out the demonstration project. In addition, section 1115(a)(2) of the Act allows the Secretary to provide federal financial participation for demonstration costs that would not otherwise be considered as federally matchable expenditures under section 1903 of the Act, to the extent and for the period prescribed by the Secretary.

For the reasons discussed below, the Centers for Medicare & Medicaid Services (CMS) is approving Michigan's request for extension and amendment of its Medicaid demonstration project entitled, "Healthy Michigan Plan" (Project No. 11-W-00245/5), in accordance with section 1115(a) of the Act. Consistent with the Secretary's authority, this approval (the "approval"), among other things, extends the operation of Michigan's Medicaid demonstration past its current expiration of December 31, 2018. This statewide demonstration is approved effective January 1, 2019 through December 31, 2023, upon which date, unless extended or otherwise amended, all authorities granted to operate this demonstration will expire. CMS's approval is subject to the limitations specified in the attached waivers and special terms and conditions (STCs). The state may deviate from Medicaid state plan requirements only to the extent those requirements have been listed as waived.

Objectives of the Medicaid Program

As noted above, the Secretary may approve a demonstration project under section 1115 of the Act if, in his judgment, the project is likely to assist in promoting the objectives of title XIX. The purposes of Medicaid include an authorization of appropriation of funds to "enabl[e] each [s]tate, as far as practicable under the conditions in such [s]tate, to furnish (1) medical assistance

on behalf of families with dependent children and of aged, blind, or disabled individuals, whose income and resources are insufficient to meet the costs of necessary medical services, and (2) rehabilitation and other services to help such families and individuals attain or retain capability for independence or self-care." Act § 1901. This provision makes clear that an important objective of the Medicaid program is to furnish medical assistance and other services to vulnerable populations. But there is little intrinsic value in paying for services if those services are not advancing the health and wellness of the individual receiving them, or otherwise helping the individual attain independence. Therefore, we believe an objective of the Medicaid program, in addition to furnishing services, is to advance the health and wellness needs of its beneficiaries, and that it is appropriate for the state to structure its demonstration project in a manner that prioritizes meeting those needs.

Section 1115 demonstration projects present an opportunity for states to experiment with reforms that go beyond just routine medical care and focus on evidence-based interventions that drive better health outcomes and quality of life improvements, and that may increase beneficiaries' financial independence. Such policies may include those designed to address certain health determinants and those that encourage beneficiaries to engage in health-promoting behaviors and to strengthen engagement by beneficiaries in their personal health care plans. These tests will necessarily mean a change to the status quo. They may have associated administrative costs, particularly at the initial stage, and section 1115 acknowledges that demonstrations may "result in an impact on eligibility, enrollment, benefits, cost-sharing, or financing." Act § 1115(d)(1). But in the long term they may create incentives and opportunities that help enable many beneficiaries to enjoy the numerous personal benefits that come with improved health and financial independence.

Section 1115 demonstration projects also provide an opportunity for states to test policies that ensure the fiscal sustainability of the Medicaid program, better "enabling each [s]tate, as far as practicable under the conditions in such [s]tate" to furnish medical assistance, Act § 1901, while making it more practicable for states to furnish medical assistance to a broader range of persons in need. For instance, measures designed to improve health and wellness may reduce the volume of services consumed, as healthier, more engaged beneficiaries tend to consume fewer medical services and are generally less costly to cover. Further, measures that have the effect of helping individuals secure employer-sponsored or other commercial coverage or otherwise transition from Medicaid eligibility may decrease the number of individuals who need financial assistance from the state. Such measures may enable states to stretch their resources further and enhance their ability to provide medical assistance to a broader range of persons in need, including by expanding the services and populations they cover.[1] By the same token, such measures may also

[1] States have considerable flexibility in the design of their Medicaid programs, within federal guidelines. Certain benefits are mandatory under federal law, but many benefits may be provided at state option, such as prescription drug benefits, vision benefits, and dental benefits. Similarly, states have considerable latitude to determine whom their Medicaid programs will cover. Certain eligibility groups must be covered under a state's program, but many states opt to cover additional eligibility groups that are optional under the Medicaid statute. The optional groups include a new, non-elderly adult population (ACA expansion population) that was added to the Act at section 1902(a)(10)(A)(i)(VIII) by the Patient Protection and Affordable Care Act (ACA). Coverage of the ACA expansion population became optional as a result of the Supreme Court's decision in *NFIB v. Sebelius*, 567 U.S. 519 (2012). Accordingly, several months after the *NFIB* decision was issued, CMS informed the states that they "have flexibility

preserve states' ability to continue to provide the optional services and coverage they already have in place.

Our demonstration authority under section 1115 of the Act allows us to offer states more flexibility to experiment with different ways of improving health outcomes and strengthening the financial independence of beneficiaries. Demonstration projects that seek to improve beneficiary health and financial independence improve the well-being of Medicaid beneficiaries and, at the same time, allow states to maintain the long-term fiscal sustainability of their Medicaid programs and to provide more medical services to more Medicaid beneficiaries. Accordingly, such demonstration projects advance the objectives of the Medicaid program.

Background on Medicaid Coverage in Michigan

Michigan's Medicaid and CHIP programs provide health coverage to over 2.3 million individuals. The Medicaid program in Michigan includes non-mandatory populations, such as the medically needy and optional targeted low income children, in addition to the mandatory eligibility groups. The state also covers several categories of non-mandatory services, including prescription drugs, dental services, and vision benefits, in addition to mandatory services. In addition, on April 1, 2014, Michigan expanded its Medicaid program to include the ACA expansion population (adults with income up to 133 percent of the federal poverty level (FPL)). To accompany this expansion, the Healthy Michigan Plan (HMP) demonstration was approved, through which the state has been able to test innovative approaches to beneficiary cost sharing and financial responsibility for care for the ACA expansion population. Individuals in the ACA expansion population with income above 100 percent of the FPL were required to make contributions not to exceed two percent of their family income toward the cost of their health care. In addition, all newly eligible adults with income from 0 to 133 percent of the FPL pay required Medicaid copayments as specified in the Medicaid state plan. A MI Health Account was established for each beneficiary enrolled in a Medicaid health plan to track beneficiaries' contributions and how they were expended. Beneficiaries have opportunities to reduce their regular monthly contributions or copayments by demonstrating achievement of recommended healthy behaviors. HMP beneficiaries receive a full health care benefit package as required under the ACA, which includes all of the Essential Health Benefits and which satisfies the requirements for an alternative benefit plan, as required by federal law and regulation, and there are no limits on the number of individuals who can enroll. As of September 2018, more than 655,000 Michigan citizens receive coverage through the HMP.

Extent and Scope of Demonstration

The HMP demonstration provides coverage to individuals, ages 19 through 64, who are members of the ACA expansion population described in section 1902(a)(10)(A)(i)(VIII) of the Act. Central elements of the demonstration, as amended, are described below.

---

to start or stop the expansion." CMS, *Frequently Asked Questions on Exchanges, Market Reforms, and Medicaid* at 11 (Dec. 10, 2012). In addition to expanding Medicaid coverage by covering optional eligibility groups and benefits beyond what the Medicaid statute requires, many states also choose to cover benefits beyond what is authorized by statute by using expenditure authority under section 1115(a)(2) of the Act. For example, recently, many states have been relying on this authority to expand the scope of services they offer to address substance use disorders beyond what the statute explicitly authorizes.

Michigan will implement a community engagement requirement (described in STCs 28-34), beginning no sooner than January 1, 2020, as a condition of eligibility for adult beneficiaries ages 19 to 62 enrolled in the HMP demonstration, with exemptions for various groups that the state has determined are unlikely to be able to reasonably comply with the requirements, including: pregnant women, primary caregivers of a family member under six years of age (limited to one caregiver per household), caretakers of a dependent with a disability who needs full-time care (allowed for one enrollee per household if there is only one dependent with a disability who meets the criteria specified above in the household); caretakers of an incapacitated individual even if the incapacitated individual is not a dependent of the caretaker; beneficiaries considered medically frail; beneficiaries currently receiving temporary or permanent long-term disability benefits from a private insurer or from the government; beneficiaries diagnosed with an acute medical condition that would prevent them from complying with the requirements; beneficiaries who have been incarcerated within the last six months; beneficiaries currently receiving unemployment benefits from the state; beneficiaries under 21 years of age who had previously been in foster care placement in this state; and full-time students. CMS is giving the state flexibility to exempt these populations. Other individuals will have the opportunity to request exemption from the community engagement requirement for good cause.

To remain eligible for coverage, non-exempt beneficiaries must complete and report 80 hours per calendar month of community engagement activities, such as employment, education, job training, job search activities, participation in substance use disorder treatment (SUD), and community service. Beneficiaries who fail to report compliance with the community engagement requirement or who are non-compliant for three months in a 12-month period will be disenrolled at the end of the fourth month and will be subject to one month of disenrollment unless the beneficiary can demonstrate good cause for the failure; demonstrate that he or she qualifies for an exemption; or satisfy the community engagement requirement by reporting completion of 80 hours in the fourth month. If a disenrolled individual re-applies for coverage within the same 12-month period, that individual must demonstrate that he or she has completed 80 hours of qualifying activities in a calendar month before an individual's enrollment into HMP is approved. Michigan will provide procedural protections for affected beneficiaries, and will also provide opportunities for beneficiaries to demonstrate good cause in certain circumstances for failing to meet the requirement. Additionally, beneficiaries can re-activate Medicaid coverage if, during a disenrollment, they become eligible for an exemption from the community engagement requirement, or become eligible under a Medicaid eligibility category not subject to the requirement.

In addition, CMS is providing authority to allow the state to implement new conditions of eligibility for beneficiaries with income above 100 percent of the FPL through 133 percent of the FPL who have been enrolled in HMP for 48 or more cumulative months from April 1, 2014. Specifically, beginning no sooner than January 1, 2020, these beneficiaries will be required to:

- Complete a health risk assessment (HRA) or have completed a healthy behavior within the previous year (described in STC 24). Qualifying healthy behaviors are outlined in Attachment E of the STCs and include activities such as annual preventive visits, receiving appropriate vaccines, and a number of preventive screenings; and

- Pay a premium of five percent of income (in lieu of co-payments, coinsurance, and similar payments, as described in STC 23), not to exceed the limits defined in 42 CFR 447.56(f).

CMS also is approving continuation of several previously approved demonstration features, including:

- Contributions at two percent of income for beneficiaries with income above 100 percent of the FPL through 133 percent of the FPL with fewer than 48 months of cumulative HMP enrollment (described in STC 22);
- The Healthy Behaviors Incentives Program, which provides cost sharing reduction incentives on copayments and contributions for completion of specified healthy behaviors for beneficiaries at or below 100 percent of the FPL and for beneficiaries with income above 100 percent of the FPL through 133 percent of the FPL with fewer than 48 months of cumulative HMP enrollment (described in STC 24); and
- The MI Health Account, which tracks and records beneficiary payments and liabilities (described in STC 21).

At the state's request, CMS also is withdrawing the authorities previously approved for the Marketplace Option, which was never implemented. Finally, there are two requests from Michigan which CMS is not approving at this time: (1) demonstration authority to impose a one year non-eligibility period on beneficiaries who are found to have misrepresented their compliance with the community engagement requirement; and (2) demonstration authority to require escalating healthy behaviors as a condition of eligibility for beneficiaries with income above 100 percent of the FPL through 133 percent of the FPL who have been enrolled in HMP for 48 or more cumulative months. CMS will continue to discuss these requests with the state following this approval.

Determination that the demonstration project is likely to assist in promoting Medicaid's objectives

For reasons discussed below, the Secretary has determined that the HMP demonstration, as amended, is likely to assist in promoting the objectives of the Medicaid program.

The demonstration promotes beneficiary health and financial independence.

With this approval of the demonstration, Michigan and CMS will be able to evaluate the effectiveness of various policies that are designed to improve the health of Medicaid beneficiaries, encourage them to make responsible decisions about their health and accessing health care, and promote beneficiary financial independence. Promoting beneficiary health and independence advances the objectives of the Medicaid program. Indeed, in 2012, HHS specifically encouraged states to develop demonstration projects "aimed at promoting healthy behaviors" and "individual ownership in health care decisions" as well as "accountability tied to improvement in health outcomes."[2]

[2] CMS, *Frequently Asked Questions on Exchanges, Market Reforms, and Medicaid* at 15 (Dec. 10, 2012) (noting also that "states have considerable flexibility under … [existing] law to design benefits for the new adult group and to impose cost-sharing, particularly for those individuals above 100%of the federal poverty level").

Michigan's community engagement requirement is designed to encourage beneficiaries to obtain employment and/or undertake other community engagement activities that may lead to improved health and wellness. Additionally, Michigan's Healthy Behaviors Incentives Program and the requirement for some beneficiaries to complete an HRA unless they completed one of a number of specified healthy behaviors in the prior year as a condition of continued eligibility is also designed to encourage more individuals to actively engage in their healthcare, which may help improve beneficiary health.

Under the prior demonstration period, CMS approved the Healthy Behaviors Incentives Program. The purpose of this program was to encourage beneficiaries to improve their 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 completion of an HRA. To encourage participation, beneficiaries could earn incentives for maintaining or attaining certain healthy behaviors, which would result in cost sharing reductions applied to the beneficiary's copayments and, if applicable, premiums. These incentives would also be reflected in the beneficiary's MI Health Account, a cost sharing tool discussed in further detail below. This approval will extend the state's authority to implement the Healthy Behaviors Incentives Program, including the cost-sharing reductions, with one modification: beneficiaries with income above 100 percent of the FPL through 133 percent of the FPL who have 48 or more cumulative months in HMP, must complete an HRA at redetermination, unless the beneficiary completed at least one of the identified healthy behaviors within the year preceding redetermination.

Data from Michigan's interim evaluation for the HMP demonstration's Healthy Behavior Incentive Program from the previous demonstration approval period indicate the program may be having positive effects on beneficiary health and wellness. The state found that beneficiaries who had attested to completing an HRA as part of the Healthy Behaviors Incentive Program were more likely than those who did not make the same attestation to: (1) have had a preventive health visit (84 percent versus 50 percent); and (2) have had a preventive screening (93 percent versus 71 percent).[3] While beneficiaries who complete HRAs are more likely also to complete healthy behaviors, the interim evaluation could not determine if the HRAs alone increased these behaviors or if they were also the result of a physician visit. Michigan will continue to evaluate the program in the next approval period.

Additionally, a prior evaluation of another demonstration project with beneficiary engagement components has shown some promise that beneficiary engagement strategies, such as premiums, can have a positive impact on beneficiary behavior. Interim evaluation findings regarding premiums in one state found that beneficiaries who paid premiums are more likely to obtain primary care and preventive care, have better drug adherence, and rely less on the emergency room for treatment compared to those who do not. [4]

[3]Michigan Domain V/VI Report (page 27) https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/mi/mi-healthy-michigan-pa3.pdf.

[4] The Lewin Group, Indiana Healthy Indiana Plan 2.0 Interim Evaluation Report (2016), available at: https://www.in.gov/fssa/files/Lewin_IN%20HIP%202%200%20Interim%20Evaluation%20Report_FINAL.pdf.

Overall, the research findings on the effects of healthy behavior incentives in Medicaid, including in Michigan, have shown some promising results but require further study. Therefore, Michigan will continue to evaluate whether extension of its current Healthy Behaviors Incentive Program and existing opportunities for beneficiaries who avoid or manage certain health risk behaviors to receive incentives to offset cost-sharing responsibilities will strengthen beneficiary engagement in their personal health care plan and provide an incentive structure to support responsible consumer decision-making about accessing care and services. Michigan will also begin to evaluate whether the incentives created by the amendment in this approval, specifically, the requirement that, as a condition of eligibility, beneficiaries with incomes above 100 percent of the FPL through 133 percent of the FPL who have 48 or more cumulative months in HMP complete an HRA or complete a healthy behavior within the year preceding the redetermination, will provide stronger encouragement for beneficiaries to engage in healthy behaviors than the incentive of the cost-sharing reductions. In addition, as part of this approval, Michigan will increase its efforts to ensure beneficiary awareness of these policies and their purpose. For beneficiaries who did not, at least in the year prior, engage in a "healthy behavior," requiring these individuals to complete an HRA as a condition of continued eligibility may encourage them to become more engaged with their health. By limiting this condition of eligibility to beneficiaries with 48 or more cumulative months of HMP eligibility, this policy will allow beneficiaries to have experience with healthy behaviors for several years before completing an HRA becomes a condition of their continued eligibility, as healthy behaviors and cost sharing have both been key components of the HMP demonstration since September 2014. Michigan will include evaluation of the outcomes associated with these requirements in its evaluation design to further enrich the evidence regarding beneficiary engagement strategies.

The HMP demonstration also is likely to promote the objective of helping beneficiaries attain or retain financial independence. The community engagement provisions generally require beneficiaries to work, look for work, or engage in activities that enhance their employability, such as job-skills training, education, and community service. SUD treatment also qualifies as a community engagement activity, which supports beneficiaries' health needs, and therefore should improve their health and better enable them to attain and sustain employment, which is incentivized through this demonstration. The demonstration will help the state and CMS evaluate whether the community engagement requirement helps adults in HMP transition from Medicaid to financial independence, thus reducing dependency on public assistance.

Because the demonstration is intended to encourage beneficiaries to attain greater levels of financial independence, it contains policies designed to prepare people for the commercial health insurance market, including to prepare them for the federally subsidized insurance that is available through the Exchanges. The HMP demonstration seeks to provide beneficiaries the tools to utilize commercial market health insurance successfully, thereby removing potential obstacles to a successful transition from Medicaid to commercial coverage. Under the prior demonstration period and continuing under this approval, HMP beneficiaries will have a MI Health Account. The MI Health Account is intended to be a tool to educate beneficiaries about cost sharing requirements, which include co-payments and additional contributions for beneficiaries with higher incomes. The MI Health Account provides information regarding cost sharing payments owed and made by the individual beneficiary; this information will be monitored and communicated to the beneficiary. The MI Health Account also will reflect any

rewards or incentives earned by certain beneficiaries via the Healthy Behaviors Incentives Program (described in STC 24). During the previous demonstration period, the state surveyed a subset of beneficiaries about features of the HMP demonstration in part to evaluate the effectiveness of this tool; 68.2 percent of those surveyed indicated that they received a statement for the MI Health Account, and of those, 88.4 percent agreed that the statements help them be more aware of the cost of health care.[5]

Similar to how commercial coverage operates, premium payments will be a condition of eligibility under the HMP for beneficiaries with income above 100 percent of the FPL through 133 percent of the FPL who have 48 or more cumulative months in HMP. This approval seeks to provide beneficiaries with the tools to successfully utilize commercial market health insurance, thereby removing potential obstacles to a successful transition from Medicaid to commercial coverage, removing incentives for remaining on Medicaid, and enhancing the sustainability of Michigan's medical assistance program. Limiting this policy to beneficiaries with 48 or more cumulative months of HMP eligibility allows beneficiaries to have experience with cost-sharing responsibilities for several years before it becomes a condition of their continued eligibility. Furthermore, limiting the impact of this eligibility condition to beneficiaries with income above 100 percent of the FPL ensures that the beneficiaries who may face undue financial hardship meeting the requirement are not affected. Michigan has taken steps to protect beneficiaries by exempting the following populations from disenrollment for failure to pay premiums: American Indians/Alaskan Natives (consistent with 42 CFR 447.56(a)); children under 21 years of age (consistent with 42 CFR 447.56(a)); pregnant women (consistent with 42 CFR 447.56(a)); beneficiaries who are identified or self-report as medically frail (as described in 42 CFR 440.315); beneficiaries not enrolled in an HMP managed health plan; and beneficiaries who are enrolled in the Flint Michigan section 1115 demonstration. Non-exempt beneficiaries will have an opportunity to demonstrate that they had good cause for failing to pay premiums for a month and therefore avoid the consequences of non-payment. The state will also conduct outreach and education to ensure beneficiaries understand program policies.

Beneficiaries who were disenrolled for failing to make premium payments may reapply for coverage after paying the missed premium payment(s) accumulated by the beneficiary while he or she was enrolled.

The demonstration will furnish medical assistance in a manner that improves the sustainability of the safety net.

CMS has determined that the HMP demonstration is likely to promote the objective of furnishing medical assistance because it provides coverage beyond what Michigan is required to provide. Michigan expects that the reforms included in the demonstration will enable the state to continue to offer Medicaid to the ACA expansion population. Michigan has stated that if it is unable to move forward with its HMP demonstration amendment and extension, based on its interpretation of state law, it will be required to discontinue coverage for the this group, a step that it is entitled to take following the *NFIB* decision. Per the state's interpretation, Michigan state law conditions

[5] 2016 Healthy Michigan Voices Enrollee Survey (page 16) https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/mi/mi-healthy-michigan-pa2.pdf.

the continued coverage for the ACA expansion population on federal approval of the demonstration amendments altering healthy behavior and premium requirements as conditions of continued eligibility for beneficiaries with income above 100 percent of the FPL through 133 percent of the FPL who have 48 or more cumulative months in HMP. *See* Michigan Public Act No. 208 of 2018, amending Mich. Comp. Law § 400.105d(22)-(25), at http://legislature.mi.gov/doc.aspx?mcl-400-105d (included as Attachment A to the state's demonstration application).

The demonstration includes policies, such as the community engagement requirement as a condition of eligibility, as well as the requirements around completing an HRA at redetermination or completing a healthy behavior within the year preceding the redetermination and paying premiums as conditions of continued eligibility for some beneficiaries, that may impact overall coverage levels if the individuals subject to these demonstration provisions choose not to comply with them. However, the demonstration as a whole is expected to provide greater access to coverage for low-income individuals than would be available absent the demonstration. It furthers the Medicaid program's objectives to allow states to experiment with innovative means of deploying their limited state resources in ways that may allow them to provide services beyond the statutory minimum. Enhancing fiscal sustainability allows the state to provide services to Medicaid beneficiaries that it could not otherwise provide.

By incentivizing healthy behaviors, as described above, the HMP demonstration also is designed to lead to higher quality care at a sustainable cost. Promoting improved health and wellness ultimately helps to keep health care costs at sustainable levels. To the extent that the policies discussed above, including the community engagement requirement, help individuals achieve improved health and financial independence, the demonstration may make these individuals less costly for Michigan to care for, thus further advancing the objectives of the Medicaid program by helping Michigan stretch its limited Medicaid resources, ensure the long-term fiscal sustainability of the program, and ensure that the health care safety net is available to those Michigan residents who need it most. And, to the extent the community engagement requirement helps individuals achieve financial independence and transition to commercial coverage, the demonstration may reduce dependency on public assistance, while still promoting Medicaid's purpose of helping states to furnish medical assistance.

While CMS and the state are testing the effectiveness of incentive structures that attach penalties to failure to take certain measures, the program is designed to make compliance with its requirements achievable. Michigan has taken steps to include adequate beneficiary protections to ensure that the demonstration's requirements apply only to those beneficiaries who can reasonably be expected to meet them, to notify beneficiaries of their responsibilities under the demonstration, and to provide an opportunity to regain Medicaid coverage by coming back into compliance with the program. Any individual whose coverage is terminated for failure to meet the requirements, or who experiences any other adverse action, will have the right to appeal the state's decision as with other types of coverage terminations, consistent with all existing appeal and fair hearing protections. Furthermore, the incentives to meet the requirements, if effective, may result in individuals becoming ineligible because they have attained financial independence – a positive result for the individual.

As described in the STCs, if monitoring or evaluation data indicate that demonstration features are not likely to assist in promoting the objectives of Medicaid, CMS reserves the right to require the state to submit a corrective action plan to CMS for approval. Further, 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 beneficiaries' interest or promote the objectives of Medicaid.

Consideration of public comments

To increase the transparency of demonstration projects, section 1115(d)(1) and (2) of the Act direct the Secretary to issue regulations providing for two periods of public comment on a state's application for a section 1115 project that would result in an impact on eligibility, enrollment, benefits, cost-sharing, or financing. The first comment period occurs at the state level before submission of the section 1115 application and the second occurs at the federal level after the application is received by the Secretary.

Section 1115(d)(2)(A) and (C) of the Act further specify that comment periods should be "sufficient to ensure a meaningful level of public input," but the statute imposes no additional requirement on the states or the Secretary to address those comments, as might otherwise be required under a general rulemaking. Accordingly, the implementing regulations issued in 2012 provide that CMS will review and consider all comments received by the deadline, but will not provide written responses to public comments.[6]

CMS received approximately 674 comments during the two federal comment periods[7] on Michigan's proposals to amend and extend the HMP demonstration. Although CMS is not legally required to provide written responses to comments, CMS is addressing some of the central issues raised by the comments and summarizing CMS's analysis of those issues for the benefit of stakeholders. After carefully reviewing the public comments submitted during the most recent public comment period, CMS has concluded that the HMP demonstration, as amended, is likely to advance the objectives of Medicaid.

General comments

The vast majority of the comments CMS received were from individuals who opposed either both the amendment and extension of the demonstration as a whole, or certain features of it. Many of those comments expressed general concerns that the demonstration will result in many poor citizens losing Medicaid. Commenters also expressed concern about the impact of the demonstration on beneficiaries with mental illness, immigrants, refugees, non-native English speakers, beneficiaries with substance use disorders, Native Americans, elderly beneficiaries, beneficiaries who are medically frail, and beneficiaries with disabilities. Other commenters expressed concern that the demonstration will exacerbate racial health disparities, particularly in

[6] 42 CFR § 431.416(d)(2); see also Medicaid Program; Review and Approval Process for Section 1115 Demonstrations; Application, Review, and Reporting Process for Waivers for State Innovation; Final Rules, 77 Fed. Reg. 11678, 11685 (Feb. 27, 2012) (final rule).

[7] CMS received 3 public comments during the federal public comment period for the state's initial extension request. CMS received 671 public comments during the federal public comment period for the state's amendment request.

Native American communities. CMS shares the commenters' concern that everyone who needs Medicaid and is eligible for it should have access to it. CMS also shares the public's interest in health outcomes. As previously stated, however, CMS believes the features of this demonstration are worth testing to determine whether there is a more effective way to furnish medical assistance to the extent practicable under the conditions in Michigan. That is why CMS has carefully reviewed the demonstration as a whole to ensure it is likely to promote sometimes competing Medicaid objectives.

Specifically, this demonstration is designed to extend coverage. As discussed above, per the state's interpretation, Michigan state law conditions the continued coverage for the ACA expansion population on federal approval of the demonstration amendments altering healthy behavior and premium requirements for beneficiaries with income above 100 percent of the FPL through 133 percent of the FPL who have 48 or more cumulative months in HMP, as included in the proposed extension of this demonstration. *See* Michigan Public Act No. 208 of 2018, amending Mich. Comp. Law § 400.105d(22)-(25), at http://legislature.mi.gov/doc.aspx?mcl-400-105d (included as Attachment A to the state's demonstration application). The demonstration is also designed to improve health outcomes by requiring completion of an HRA at redetermination or completing a healthy behavior within the year preceding the redetermination as a condition of continued eligibility for HMP. However, CMS has worked together with Michigan to include guardrails that will protect beneficiaries. These guardrails, which are contained in a series of assurances in the STCs (described in STC 26, 27, and 34), include requirements that the state: screen beneficiaries and determine eligibility for other categories of Medicaid eligibility prior to disenrollment, review for eligibility for insurance affordability programs prior to disenrollment, provide full appeal rights prior to disenrollment, and maintain a system that provides reasonable modifications related to meeting the community engagement requirements to beneficiaries with disabilities, among other assurances. The STCs include a provision granting CMS the authority to discontinue the demonstration if the agency determines that it is not promoting Medicaid's objectives. Moreover, CMS will regularly monitor the HMP demonstration and will work with the state to resolve any issues that arise as Michigan works to implement the demonstration. Monitoring metrics will cover enrollment, disenrollment by specific demographics and reason, participation in community engagement qualifying activities, access to care, and health outcomes through the monitoring reports to see how the demonstration impacts beneficiaries.

Some comments argued that a demonstration cannot advance the Medicaid program's objectives if the project is expected to reduce Medicaid enrollment or Medicaid spending. We recognize that some individuals may choose not to comply with the conditions of eligibility imposed by the demonstration, and therefore may lose coverage, as may occur when individuals fail to comply with other requirements like participating in the redetermination process. But the goal of these policies is to incentivize compliance, not reduce coverage. Indeed, CMS has incorporated safeguards into the STCs intended to minimize coverage loss due to noncompliance, and CMS is committed to partnering with Michigan to ensure that the demonstration advances the objectives of Medicaid. Furthermore, we anticipate that some beneficiaries' income will increase above the Medicaid eligibility thresholds as a result of the community engagement incentives and that they will obtain employer sponsored coverage or other commercial coverage once they no longer qualify for the Medicaid program. Finally, we note that in some cases, reductions in Medicaid costs can further the Medicaid program's objectives, such as when the reductions stem from

reduced need for the safety net or reduced costs associated with healthier, more independent beneficiaries. These outcomes promote the best interests of the beneficiaries whose health and independence are improved, while also helping states stretch limited Medicaid resources and ensure the long-term fiscal sustainability of the states' Medicaid programs.

In a similar vein, some comments suggested that it is impermissible for a demonstration to rely on disenrollment as an incentive for compliance with the project's requirements. As noted above, section 1115 of the Act explicitly contemplates that demonstrations may "result in an impact on eligibility"; furthermore, the amended demonstration as a whole is expected to provide greater access to coverage for low-income individuals than would be available absent the demonstration. Other comments predicted that HMP will fail to achieve its intended effects. For instance, some comments argued that beneficiaries subject to the community engagement requirement will be unable to comply. To some extent, these comments reflect a misunderstanding of the nature of the community engagement requirement, which the comments described as a work requirement. In fact, the community engagement requirement is designed to help beneficiaries achieve success, and CMS and Michigan have made every effort to devise a requirement that beneficiaries should be able to meet. For example, the community engagement requirement may be satisfied through an array of activities, including education, job skills training, job search activities, and community service.

On a related point, many commenters opposed the state's proposal to require premiums of five percent of income and requiring the completion of healthy behaviors as conditions of eligibility for beneficiaries with income above 100 percent of the FPL through 133 percent of the FPL who have 48 or more cumulative months in HMP. As noted earlier, while preliminary, initial findings on the impact of healthy behaviors seem promising, and making certain healthy behavior requirements (completion of an HRA at redetermination or completion of a healthy behavior within the year preceding the redetermination) a condition of eligibility for healthy behaviors to a targeted subset of HMP beneficiaries will allow the state to evaluate if an incentive provides greater encouragement to beneficiaries to engage in healthy behaviors than does the incentive of cost-sharing reductions. Regarding the application of premiums as a condition of eligibility for this subpopulation, the state will be able to evaluate the impact of a policy that, over time, familiarizes people with the obligation to incur a monthly fee to retain coverage, which would be a structure more similar to the premium obligations of commercial coverage that beneficiaries may encounter as their independence and income rises. By limiting these conditions of eligibility to beneficiaries with 48 or more cumulative months of HMP eligibility, this policy will allow beneficiaries to have experience with both healthy behaviors and cost-sharing for several years before they become a condition of continued eligibility. Furthermore, limiting the impact of these eligibility conditions to beneficiaries with income above 100 percent of the FPL ensures that the most vulnerable beneficiaries are not adversely impacted.

More generally, some comments also reflect a misunderstanding of the nature of a demonstration project. It is not necessary for a state to show in advance that a proposed demonstration will in fact achieve particular outcomes; the purpose of a demonstration is to test hypotheses and develop data that may inform future decision-making. As HHS previously explained, demonstrations can "influence policy making at the [s]tate and Federal level, by testing new approaches that can be models for programmatic changes nationwide or in other [s]tates." 77

Fed. Reg. at 11680. For example, the Temporary Assistance for Needy Families (TANF) work requirements that Congress enacted in 1996 were informed by prior demonstration projects. *See, e.g., Aguayo v. Richardson*, 473 F.2d 1090 (2d Cir. 1973) (upholding a section 1115 demonstration project that imposed employment requirements as conditions of AFDC eligibility). Regardless of the degree to which Michigan's demonstration project succeeds in achieving the desired results, the information it yields will provide policymakers real-world data on the efficacy of such policies. That in itself promotes the objectives of the Medicaid statute.

Comments addressing coverage losses

Some commenters expressed concern that the state's requested changes to the demonstration will cause some individuals to lose Medicaid coverage, and for that reason, the demonstration cannot be considered consistent with the objectives of the Medicaid program. In assessing the beneficiary impact of proposed demonstration features in its amendment application, the state noted that of the approximately 655,000 individuals covered under the current HMP demonstration, approximately 400,000 beneficiaries could be subject to the proposed demonstration amendments (including those related to healthy behaviors, premiums, and community engagement requirements). It is not possible to predict the percentage of this group of beneficiaries who will not comply with the demonstration amendments affecting eligibility, but in its application, the state noted that it "will undertake active outreach to beneficiaries and partner with community stakeholders to ensure that beneficiaries understand program requirements and do not lose coverage as a result of noncompliance" and that the state "will actively monitor enrollment over the course of the demonstration."[8]

We note that the demonstration provides coverage to individuals that the state is not required to cover. Any potential loss of coverage that may result from a demonstration is properly considered in the context of a state's substantial discretion to eliminate non-mandatory benefits or to eliminate coverage for existing (but non-mandatory) populations, such as (in light of the Supreme Court's ruling in *NFIB v. Sebelius*) the ACA adult expansion population. As of September 2018, more than 655,000 individuals received medical assistance under Michigan's state plan as a result of Michigan's decision to participate in the ACA adult eligibility expansion. Michigan's ACA expansion population includes not only childless adults but also many parents of dependent children who are not eligible for coverage under the Michigan state plan unless their household income is equal to or less than 54 percent of the federal poverty level. As discussed above, per the state's interpretation, Michigan state law conditions the continued coverage for the ACA expansion population on federal approval of the demonstration amendment altering certain eligibility conditions relating to health engagement and premiums for beneficiaries with income above 100 percent of the FPL through 133 percent of the FPL who have 48 or more cumulative months in HMP, as submitted as part of the state's extension request. Moreover, conditioning eligibility for Medicaid coverage on compliance with certain measures is an important element of the state's efforts, through experimentation, to improve beneficiaries' health and independence and enhance programmatic sustainability. To create an effective incentive for beneficiaries to take measures that promote health and independence, it

[8] Michigan, Healthy Michigan Plan (HMP) Section 1115 Demonstration Extension Application Amendment (2018), page 17, available at https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/mi/mi-healthy-michigan-pa3.pdf.

may be necessary for states to attach penalties to failure to take those measures, including with conditions designed to promote health and financial independence. This may mean that beneficiaries who fail to comply will lose Medicaid coverage, at least temporarily. However, the incentives included in this demonstration are not designed to encourage this result; rather, they are intended to incorporate achievable conditions of continued coverage. And any loss of coverage as the result of noncompliance must be weighed against the benefits Michigan hopes to achieve through the demonstration project, including both the improved health and independence of the beneficiaries who comply and the state's enhanced ability to stretch its Medicaid resources and maintain the fiscal sustainability of the program.

It would be counterproductive to deny states the flexibility they need to implement demonstration projects designed to examine innovative ways to incentivize beneficiaries to engage in desired behaviors that improve outcomes and lower healthcare costs, as well as innovative ways to stretch limited state resources, given that states have the prerogative to terminate coverage for non-mandatory services and populations. Because a demonstration project, by its nature, is designed to test innovations, it is not possible to know in advance the actual impact that its policies will have on enrollment. That is one of the metrics to be measured. But even assuming that HMP would result in the loss of coverage for some individuals, and even assuming that most of these individuals would not transition to commercial coverage, any potential coverage losses would likely be dwarfed by the over 655,000 newly eligible adults who stand to lose coverage if Michigan elects to terminate the non-mandatory ACA expansion.

Furthermore, the Michigan state plan covers other non-mandatory populations such as the medically needy, as well as non-mandatory services such as prescription drug, dental, and vision benefits. As a matter of federal law, it is a state's prerogative to reduce or eliminate non-mandatory coverage. Such judgments are left to the policy preferences of the state government and its electorate, and states are to be given great latitude in making tradeoffs in how the state furnishes medical assistance "as far as practicable under the conditions" in the state. Act § 1901. In evaluating Michigan's demonstration project, it is appropriate to consider the possibility of coverage loss against the benefits that may accrue to the population included in the HMP demonstration, as well as benefits that may accrue to the state's other Medicaid eligibility groups as a result of the population in the HMP demonstration growing more independent, healthier, and less expensive to cover. Michigan will measure actual effects on enrollment as part of the demonstration, and that information should be useful in informing future Medicaid policy.

Commenters also expressed concerns that the demonstration's community engagement reporting requirements are complex and burdensome, and will cause beneficiaries to lose Medicaid coverage because of failure to report their qualifying activity hours or because of clerical errors by the state. In those cases, we note that prior to disenrollment for failure to report compliance with the community engagement requirements, individuals will be notified and given the opportunity to halt the termination process by reporting compliance with the community engagement requirements to the state. After being disenrolled for at least one calendar month, an individual may reenroll after completing and reporting 80 hours of qualifying activities within a single calendar month, effective the first day of that calendar month. An individual may also reenroll in Medicaid immediately if the individual qualifies for an exemption, demonstrates good cause for the non-compliance, or becomes eligible for Medicaid under a different eligibility

category not subject to the community engagement requirements. CMS has worked closely with Michigan to ensure there are substantial beneficiary protections in place. The STCs provide for Michigan to educate and reach out to beneficiaries and contain assurances that Michigan will seek data from other sources, including SNAP, TANF, and other existing systems to permit beneficiaries to efficiently report community engagement hours. Clerical errors can occur in any program and are not reason to deny approval at the outset. Further, individuals who believe their coverage has been terminated in error will have access to appeals and fair hearings consistent with statutory and regulatory requirements. Moreover, CMS will monitor the demonstration, and the STCs provide that CMS can amend or withdraw waivers if it determines that continuing the demonstration would no longer be in the public interest or promote Medicaid's objectives.

Comments addressing individual demonstration features

The community engagement requirement

Some comments suggest that a community engagement requirement that many people will fulfill by working one or multiple part-time, minimum-wage jobs or through unpaid means (volunteering), will not directly lead to financial independence. CMS disagrees with that conclusion. While some of the activities that meet the community engagement requirement may not immediately cause all beneficiaries to be financially independent, those activities are nonetheless positive steps for beneficiaries to take on their path to financial independence. In addition, participation in these activities may reduce social isolation, which multiple studies have linked to higher rates of mortality.[9] At the very least, whether Michigan's community engagement requirement will lead to beneficiaries' financial independence is an open question, which is why this demonstration project is necessary to test whether the incentive structure will have the desired effect. That is also why CMS will regularly evaluate the effects of the HMP on affected beneficiaries and reserves the right to discontinue specific waiver and expenditure authorities if CMS determines that it would no longer be in the public interest or promote Medicaid's objectives to continue them. Moreover, even if those activities do not cause beneficiaries to become financially independent, they are nevertheless linked to improved health outcomes, which itself furthers Medicaid's objectives.

Some commenters also suggest that terminating eligibility for beneficiaries who fail to comply with the community engagement requirement will make it harder for beneficiaries to find employment, and some cited research that shows a correlation between individuals' access to health coverage and their ability to find employment. CMS has reviewed and considered the research cited by commenters and notes that other research also shows a positive link between community engagement and improved health outcomes.[10] None of the existing research,

[9] Julianne Holt-Lunstad, et al., *Loneliness and Social Isolation as Risk Factors for Mortality: A Meta-Analytic Review*, 10 Persp. on Psychol. Sci. 227 (2015).

[10] Waddell, G. and Burton, AK. Is Work Good For Your Health And Well-Being? (2006) EurErg Centre for Health and Social Care Research, University of Huddersfield, UK;
Van der Noordt, M, Jzelenberg, H, Droomers, M, and Proper,K. Health effects of employment: a systemic review of prospective studies. BMJournals. Occupational and Environmental Medicine. 2014: 71 (10).

however, definitively shows whether a community engagement requirement as a condition for continued Medicaid coverage will help beneficiaries attain financial independence and improve health outcomes. Thus, CMS has determined that it is appropriate to permit states to use section 1115 demonstration projects to determine whether they can achieve such an outcome using community engagement requirements.

Commenters also expressed concern regarding beneficiaries they believed to be subject to the community engagement requirement. Commenters opposed the requirement because they believed that it would negatively impact pregnant women, the elderly, caregivers to minor dependent children, beneficiaries who are medically frail, beneficiaries with disabilities, and other vulnerable populations. Commenters also expressed concern that community engagement will exacerbate racial health disparities, particularly in Native American communities. CMS and Michigan provide several protections for vulnerable beneficiaries who cannot meet the requirement or who may need assistance to meet the requirement. The HMP demonstration provides exemptions from the community engagement requirement for several populations, including pregnant women, beneficiaries who are medically frail, primary caregivers of a child under six years old or a dependent that needs full-time care, beneficiaries over the age of 62, and beneficiaries with disabilities. Michigan also provides beneficiaries with the opportunity to avoid the consequences for failure to comply with the requirement by demonstrating that they had a good cause not to meet it, and provides reasonable modifications for beneficiaries with disabilities protected by the ADA, Section 504 of the Rehabilitation Act, and Section 1557 of the Patient Protection and Affordable Care Act. Regarding the potential impact on Native Americans, we note that tribal employment training programs are included in the list of qualifying activities. Therefore, CMS believes that the demonstration adequately protects beneficiaries with circumstances which could prevent them from meeting the community engagement requirement. Where individuals among these groups are capable of satisfying the community engagement requirement, CMS believes that including these individuals advances the purposes of Medicaid by improving beneficiary health and financial independence and enhancing the program's fiscal sustainability.

Premiums and Healthy Behaviors

Of the comments received on premiums, all of the commenters were opposed to the new requirement to increase premiums to five percent of income for those beneficiaries with income over 100 percent of the FPL through 133 percent of the FPL with 48 months or more of cumulative enrollment in the HMP demonstration. Commenters were concerned that this increased monthly premium obligation creates a substantial financial burden on beneficiaries,

---

Crabtree, S. In U.S., Depression Rates Higher for Long-Term Unemployed. (2014). Gallup. http://news.gallup.com/poll/171044/depression-rates-higher-among-long-term-unemployed.aspx.
United Health Group. Doing good is good for you. 2013 Health and Volunteering Study.
Jenkins, C. Dickens, A. Jones, K. Thompson-Coon, J. Taylor, R. and Rogers, M. Is volunteering a public health intervention? A systematic review and meta-analysis of the health and survival of volunteers BMC Public Health 2013. 13 (773).
Chetty R, Stepner M, Abraham S, et al. The association between income and life expectancy in the United States, 2001-2014. JAMA. 2016; 315(16):1750-1766.

and creates a potential negative impact on health coverage and health outcomes. However, Michigan designed the premium requirement in a way that minimizes potential impacts on beneficiaries, and the state provides a number of protections for vulnerable beneficiaries, such as allowing beneficiaries to avoid the consequences of nonpayment if they can demonstrate a good cause for not meeting their premium obligation and by exempting certain populations (including American Indian/Alaskan Natives and children under 21 years of age who are exempt from paying premiums pursuant to 42 CFR 447.56(a), pregnant women who are exempt from paying premiums pursuant to 42 CFR 447.56(a), beneficiaries who are identified or self-report as medically frail as described in 42 CFR 440.315, beneficiaries not enrolled in a HMP managed health plan, and beneficiaries enrolled in the Flint Michigan section 1115 demonstration). Additionally, only beneficiaries with income above 100 percent of the federal poverty level and with 48 months or more of cumulative enrollment in the HMP demonstration are subject to the five percent premium requirement and subject to disenrollment for failure to meet the requirement. This limitation ensures that beneficiaries have experience with cost-sharing responsibilities for several years before making premium payments a condition of eligibility. Furthermore, limiting the impact of this eligibility condition to beneficiaries with income above 100 percent of the FPL ensures that the most vulnerable beneficiaries are not impacted.

A few commenters noted that premiums of five percent of income for beneficiaries with income above 100 percent of the FPL through 133 percent of the FPL exceed the maximum limit of two percent for premium share of cost applicable to individuals at this income level in the Exchanges, where premiums for this income level are limited to approximately two percent of household income after application of premium tax credits. While it is true that individuals at this income level may be able to purchase coverage on the Exchanges with a premium that is limited to approximately two percent of income, those individuals are also subject to copayments and other cost sharing obligations, the total of which could exceed two percent of household income. Beneficiaries in the HMP subject to the two percent premium level do not incur any other cost sharing, so their total obligation does not exceed five percent. Further, individuals who transition to employer-sponsored coverage may be subject to premiums of five percent of income, or higher.

Commenters also argued that premiums are inconsistent with the objectives of the Medicaid program, and do not have research value. CMS disagrees with this assertion. CMS has implemented premium obligations in several states and is currently evaluating the requirement; there is not sufficient evidence to assert that premium requirements do not advance the objectives of Medicaid. On the contrary, interim evaluation findings regarding premiums in one state found that beneficiaries who paid premiums are more likely to obtain primary care and preventive care, have better drug adherence, and rely less on the emergency room for treatment compared to those who do not.[11] Additionally, premiums, when viewed as a component of the broader HMP demonstration, merit additional research and evaluation when viewed in conjunction with other demonstration features which, together, seek to encourage beneficiaries to engage in health-promoting behaviors and to strengthen engagement by beneficiaries in their personal health care plans. The state will be able to evaluate the impact of a policy that, over time, familiarizes

[11] The Lewin Group, Indiana Healthy Indiana Plan 2.0 Interim Evaluation Report (2016), available at: https://www.in.gov/fssa/files/Lewin_IN%20HIP%202%200%20Interim%20Evaluation%20Report_FINAL.pdf.

people with the obligation to incur a monthly fee to retain coverage, which would be a structure more similar to the premium obligations of commercial coverage that beneficiaries may encounter as their independence and income rises. Michigan will evaluate the premium requirement, and CMS reserves the right to withdraw its authority if it is determined that premiums negatively impact health coverage or health outcomes.

Some comments expressed concerns with requiring completion of a healthy behavior as a condition of eligibility for beneficiaries with income over 100 percent of the FPL through 133 percent of the FPL who have been enrolled in the HMP demonstration for 48 or more cumulative months. Commenters were concerned that people could be negatively impacted by losing Medicaid eligibility as a result of noncompliance with this policy. While CMS and the state understand commenters' concerns, we believe it is appropriate to test inclusion of various activities that may increase health engagement and improve health as a condition of eligibility. Under this approval, Michigan will have the authority to require that beneficiaries with incomes above 100 percent of the FPL through 133 percent of the FPL who have 48 or more cumulative months in HMP complete an HRA at redetermination or complete a healthy behavior within the year preceding the redetermination as a condition of continued eligibility. Responses to questions on the HRA will not impact an individual's Medicaid eligibility. This will allow the state to evaluate whether this structure will provide more effective encouragement for beneficiaries to better understand potential health risk areas in their lives than does the incentive of the cost-sharing reductions. By limiting this condition of eligibility to beneficiaries with 48 or more cumulative months of HMP eligibility, this policy will allow beneficiaries to have experience with completion of an HRA and healthy behaviors for several years before making it a condition of eligibility. Furthermore, limiting the impact of this eligibility condition to beneficiaries with income above 100 percent of the FPL ensures that the most vulnerable beneficiaries are not impacted. Additionally, the demonstration includes guardrails that will protect beneficiaries and provide procedural protections for affected beneficiaries as well as opportunities for beneficiaries to avoid the consequences of noncompliance by demonstrating a good cause for failing to meet the requirement. As mentioned above, previous evaluation of the HMP demonstration's Healthy Behaviors Incentive Program has shown some promise that the demonstration's prior healthy behavior strategies can have a positive impact on beneficiary behavior and increase beneficiary engagement in their personal health care, and therefore CMS believes it is appropriate to test amendments that further expand and develop these policies.

Other Information

CMS's approval of this demonstration is conditioned upon compliance with the enclosed list of waivers and the STCs defining the nature, character and extent of anticipated federal involvement in the project. The approval is also subject to your written acknowledgement of the award and acceptance of the STCs within 30 calendar days of the date of this letter; please send your written acceptance to your project officer, Ms. Shanna Janu. Ms. Janu is available to answer any questions concerning your section 1115(a) demonstration and may be contacted as follows:

Centers for Medicare & Medicaid Services
Center for Medicaid and CHIP Services
Mail Stop: S2-25-26
7500 Security Boulevard
Baltimore, MD 21244-1850
E-mail: shanna.janu@cms.hhs.gov

Official communication regarding official matters should be simultaneously sent to Ms. Janu and Ms. Ruth Hughes, Associate Regional Administrator for the Division of Medicaid and Children's Health Operations in our Chicago Regional Office. Ms. Hughes's contact information is as follows:

Ms. Ruth Hughes
Associate Regional Administrator
Centers for Medicare & Medicaid Services
233 North Michigan Avenue, Suite 600
Chicago, Illinois 60601-5519
Telephone: (404) 562-7359
E-mail: Ruth.Hughes@cms.hhs.gov

If you have any questions regarding this approval, please contact Ms. Judith Cash, Director, State Demonstrations Group, Centers for Medicaid and CHIP Services at (410) 786-9686.

Sincerely,

[redacted]

Seema Verma

Enclosures

CENTERS FOR MEDICARE & MEDICAID SERVICES
WAIVER LIST

NUMBER: **11-W-00245/5**

TITLE: **Healthy Michigan Plan Section 1115 Demonstration**

AWARDEE: **Michigan Department of Health and Human Services**

All requirements of the Medicaid program expressed in law, regulation and policy statement, not expressly waived, shall apply to the demonstration project effective January 1, 2019 through December 31, 2023. In addition, these waivers may only be implemented consistent with the approved Special Terms and Conditions (STCs).

Under the authority of section 1115(a)(1) of the Social Security Act (the Act), the following waivers of state plan requirements contained in section 1902 of the Act are granted subject to the STCs for the Healthy Michigan Plan section 1115 demonstration.

1. Premiums **Section 1902(a)(14) insofar as it incorporates Sections 1916 and 1916A**

To the extent necessary to enable the state to require monthly premiums for individuals eligible in the adult population described in section 1902(a)(10)(A)(i)(VIII) of the Act, who have incomes between 100 and 133 percent of the federal poverty level (FPL).

2. Statewideness **Section 1902(a)(1)**

To the extent necessary to enable the state to require enrollment in managed care plans only in certain geographical areas for those eligible in the adult population described in section 1902(a)(10)(A)(i)(VIII) of the Act.

3. Freedom of Choice **Section 1902(a)(23)(A)**

To the extent necessary to enable the state to restrict freedom of choice of provider for those eligible in the adult population described in section 1902(a)(10)(A)(i)(VIII) of the Act. No waiver of freedom of choice is authorized for family planning providers.

4. Proper and Efficient Administration **Section 1902(a)(4)**

To the extent necessary to enable the state to limit beneficiaries to enrollment in a single prepaid inpatient health plan or prepaid ambulatory health plan in a region or region(s) and restrict disenrollment from them.

5. Comparability **Sections 1902(a)(10)(B) and 1902(a)(17)**

To the extent necessary to enable the state to vary the premiums, cost-sharing and healthy behavior reduction options as described in these terms and conditions.

6. Provision of Medical Assistance **Section 1902(a)(8) and 1902(a)(10)**

To the extent necessary to enable Michigan to disenroll, and not make medical assistance available to, HMP beneficiaries who fail to comply with community engagement requirements, as described in these STCs, unless the beneficiary is exempted as described in STC 29.

To the extent necessary to enable Michigan to disenroll, and not make medical assistance available to, HMP beneficiaries with incomes above 100 percent of the FPL who have had 48 months of cumulative HMP eligibility and who do not complete a health risk assessment (HRA) or have not completed a healthy behavior, as described in these STCs, within the past twelve months.

7. Eligibility **Section 1902(a)(10)**

To the extent necessary to enable Michigan to require community engagement as described in these STCs.

To the extent necessary to enable Michigan to disenroll, prohibit re-enrollment, and deny eligibility to HMP beneficiaries with income above 100 percent of the FPL who have had 48 months of cumulative HMP eligibility and who do not complete a HRA or have not completed a healthy behavior, as described in these STCs, within the past twelve months.

To the extent necessary to enable Michigan to disenroll, prohibit re-enrollment, and deny eligibility to HMP beneficiaries with income above 100 percent of the FPL who have had 48 months of cumulative HMP eligibility and who do not pay the monthly five percent premium, as described in these STCs.

CENTERS FOR MEDICARE & MEDICAID SERVICES
SPECIAL TERMS AND CONDITIONS

NUMBER: 11-W-00245/5

TITLE: Healthy Michigan Plan Section 1115 Demonstration

AWARDEE: Michigan Department of Health and Human Services

I. PREFACE

The following are the Special Terms and Conditions (STCs) for the "Healthy Michigan Plan" section 1115(a) Medicaid demonstration (hereinafter demonstration) to enable the Michigan Department of Health and Human Services (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), 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 related to this demonstration. The Healthy Michigan Plan (HMP) demonstration will be statewide and is approved for a 5-year period, from January 1, 2019 through December 31, 2023. The demonstration provides approval for the state to require, beginning no sooner than January 1, 2020, (1) beneficiaries to complete and report 80 hours per month of community engagement as a condition of eligibility, (2) beneficiaries who have been enrolled in the demonstration more than 48 months to pay a monthly premium of five percent of income for continued eligibility, and (3) beneficiaries who have been enrolled in the demonstration more than 48 months to complete a health risk assessment (HRA) at redetermination or complete a healthy behavior in the previous 12 months, as a condition of eligibility.

The STCs have been arranged into the following subject areas:

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

Attachment A: Developing the Evaluation Design
Attachment B: Preparing the Evaluation Report
Attachment C: Implementation Plan
Attachment D: Monitoring Protocol
Attachment E: Healthy Behaviors List

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 were 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 Non-pregnant 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 expanded its Medicaid program to include adults with income up to 133 percent of the FPL. To accompany this expansion, the Michigan "Adult Benefits Waiver" was amended and transformed to establish the HMP, through which the state intended to test innovative approaches to beneficiary cost sharing and financial responsibility for care for the new adult eligibility group, which was authorized under section 1902(a)(10)(A)(i)(VIII) of the Act (the "adult group"). Beneficiaries receiving coverage under the sunsetting ABW program transitioned to the state plan and the Healthy Michigan Plan on April 1, 2014. Individuals in the new adult population with incomes above 100 percent of the FPL are 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 with income from 0 to 133 percent of the FPL are required to pay copayments through an account operated in coordination with the Medicaid Health Plan (MHP). A MI Health Account was established for each enrolled individual to track beneficiaries' contributions and how they were expended. Beneficiaries receive quarterly statements that summarized 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 have opportunities to reduce their regular monthly contributions or average utilization based contributions by demonstrating achievement of recommended Healthy Behaviors. HMP beneficiaries receive a full health care benefit package as required under the Affordable Care Act, which includes all of the Essential Health Benefits and the requirements for an alternative benefit plan, as required by federal law and regulation, and there are no limits on the number of individuals who can enroll.

In September 2015, the state sought CMS approval of an amendment to HMP to implement additional directives contained in the state law (Public Act 107 of 2013). CMS approved the amendment on December 17, 2015, which effectuated the Marketplace Option, a premium assistance program for a subset of HMP eligible beneficiaries. However, the Marketplace Option was never implemented.

In December 2017, the state submitted an application to extend the HMP demonstration. In September 2018, the state submitted an additional application to amend certain elements of the HMP to comply with new state law provisions, including a community engagement requirement, and changes to eligibility for health care coverage and cost-sharing requirements for certain beneficiaries. The state also requested to end the Marketplace Option program. As approved, beneficiaries in the demonstration between 100 percent and 133 percent of the FPL who have had 48 months of cumulative eligibility for health care coverage through HMP will be required to pay premiums of five percent of income and have completed a health risk assessment (HRA) at their next redetermination or have engaged in specified healthy behaviors within the twelve-month period prior to the annual redetermination deadline as conditions of eligibility. Additionally, beneficiaries ages 19 through 62 will be required to meet a community engagement requirement as a condition of HMP eligibility.

III. GENERAL PROGRAM REQUIREMENTS

1. **Compliance with Federal Non-Discrimination Laws.** The state must comply with applicable federal civil rights laws relating to non-discrimination in services and benefits in its programs and activities. These include, but are not limited to, the Americans with Disabilities Act of 1990 (ADA), Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973 (Section 504), the Age Discrimination Act of 1975, and Section 1557 of the Affordable Care Act (Section 1557). Such compliance includes providing reasonable modifications to individuals with disabilities under the ADA, Section 504, and Section 1557 in eligibility and documentation requirements, to ensure they understand program rules and notices, in establishing eligibility for an exemption from community engagement requirements on the basis of disability, and to enable them to meet and document community engagement requirements, as well as meeting other program requirements necessary to obtain and maintain benefits.

2. **Compliance with Medicaid Law, Regulation, and Policy.** All requirements of the Medicaid program, expressed in federal law, regulation, and written policy, 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 the demonstration.

3. **Changes in Medicaid Law, Regulation, and Policy.** The state must, within the timeframes specified in federal law, regulation, or written policy, 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 of an operational nature without requiring the state to submit an amendment to the demonstration under STC 7. CMS will notify the state 30 calendar days in advance of the expected approval date of the amended STCs to allow the state to provide comment.

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

    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. Further, the state may seek an amendment to the demonstration (as per STC 7 of this section) as a result of the change in FFP.

    b. If mandated changes in the federal law require state legislation, unless otherwise prescribed by the terms of the federal law, 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 federal law, whichever is sooner.

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

6. **Changes Subject to the Amendment Process.** If not otherwise specified in these STCs, changes related to eligibility, enrollment, benefits, beneficiary rights, delivery systems, cost sharing, 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 changes to these elements without prior approval by CMS either through an approved amendment to the Medicaid state plan or amendment to the demonstration. Amendments to the demonstration are not retroactive and no FFP of any kind, including for administrative or medical assistance

expenditures, will be available under changes to the demonstration that have not been approved through the amendment process set forth in STC 7, except as provided in STC 3.

7. **Amendment Process.** Requests to amend the demonstration must be submitted to CMS for approval no later than 120 calendar 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 on non-compliance with these STCs, including but not limited to failure by the state to submit required elements of a complete amendment request as described in this STC, and failure by the state to submit reports required in the approved STCs and other deliverables in a timely fashion according to the deadlines specified herein. Amendment requests must include, but are not limited to, the following:

    a. A detailed description of the amendment, including impact on beneficiaries, with sufficient supporting documentation;

    b. A data analysis worksheet which identifies the specific "with waiver" impact of the proposed amendment on the current budget neutrality agreement. Such analysis shall include 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 detail projections of the change in the "with waiver" expenditure total as a result of the proposed amendment, which isolates (by Eligibility Group) the impact of the amendment;

    c. An explanation of the public process used by the state consistent with the requirements of STC 13; and,

    d. If applicable, a description of how the evaluation design will be modified to incorporate the amendment provisions.

8. **Extension of the Demonstration.** States that intend to request a demonstration extension under sections 1115(e) or 1115(f) of the Act must submit extension applications in accordance with the timelines contained in statute. Otherwise, no later than twelve (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 that meets federal requirements at 42 CFR 431.412(c) or a transition and phase-out plan consistent with the requirements of STC 9.

9. **Demonstration 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 a

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 transition and phase-out 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 STC 13, if applicable. Once the 30-day public comment period has ended, the state must provide a summary of the issues raised by the public during the comment period and how the state considered the comments received when developing the revised transition and phase-out plan.

b. Transition and Phase-out Plan Requirements. The state must include, at a minimum, in its transition and 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 demonstration for the affected beneficiaries, and ensure ongoing coverage for eligible beneficiaries, as well as any community outreach activities the state will undertake to notify affected beneficiaries, including community resources that are available.

c. Transition and Phase-out Plan Approval. The state must obtain CMS approval of the transition and phase-out plan prior to the implementation of transition and phase-out activities. Implementation of transition and phase-out activities must be no sooner than 14 calendar days after CMS approval of the transition and phase-out plan.

d. Transition and Phase-out Procedures. The state must comply with all applicable notice requirements found in 42 CFR, part 431 subpart E, including sections 431.206, 431.210, 431.211, and 431.213. In addition, the state must assure all applicable appeal and hearing rights are afforded to beneficiaries in the demonstration as outlined in 42 CFR, part 431 subpart E, including sections 431.220 and 431.221. If a beneficiary in the demonstration 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 prior to termination as discussed in October 1, 2010, State Health Official Letter #10-008 and as required under 42 C.F.R. 435.916(f)(1). For individuals determined ineligible for Medicaid, the state must determine potential eligibility for other insurance affordability programs and comply with the procedures set forth in 42 CFR 435.1200(e).

e. Exemption from Public Notice Procedures 42 CFR Section 431.416(g). CMS may expedite the federal and state public notice requirements under circumstances described in 42 CFR 431.416(g).

f. Enrollment Limitation during Demonstration Phase-Out. If the state elects to suspend, terminate, or not extend this demonstration, during the last six months of the demonstration, enrollment of new individuals into the demonstration must be suspended. The limitation of enrollment into the demonstration does not impact the state's obligation to determine Medicaid eligibility in accordance with the approved Medicaid state plan.

g. Federal Financial Participation (FFP). FFP will be limited to normal closeout costs associated with the termination or expiration of the demonstration including services, continued benefits as a result of beneficiaries' appeals, and administrative costs of disenrolling beneficiaries.

10. Expiring Demonstration Authority. For demonstration authority that expires prior to the demonstration's expiration date, the state must submit a demonstration authority expiration plan to CMS no later than six (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 authority 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 prior to the termination of the demonstration authority for the affected beneficiaries, and ensure ongoing coverage for eligible beneficiaries, as well as any community outreach activities.

b. Expiration Procedures. The state must comply with all applicable notice requirements found in 42 CFR, part 431 subpart E, including sections 431.206, 431.210, 431.211, and 431.213. In addition, the state must assure all applicable appeal and hearing rights are afforded to beneficiaries in the demonstration as outlined in 42 CFR, part 431 subpart E, including sections 431.220 and 431.221. If a beneficiary in the demonstration 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 prior to termination as discussed in October 1, 2010, State Health Official Letter #10-008 and as required under 42 CFR 435.916(f)(1). For individuals determined ineligible for Medicaid, the state must determine potential eligibility for other insurance affordability programs and comply with the procedures set forth in 42 CFR 435.1200(e).

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 authority expiration plan. CMS will consider

comments received during the 30-day period during its review of the state's demonstration authority expiration plan. The state must obtain CMS approval of the demonstration authority expiration plan prior to the implementation of the expiration activities. Implementation of expiration activities must be no sooner than fourteen (14) calendar days after CMS approval of the demonstration authority expiration plan.

d. Federal Financial Participation (FFP). FFP will be limited to normal closeout costs associated with the expiration of the demonstration authority including services, continued benefits as a result of beneficiaries' appeals, and administrative costs of disenrolling beneficiaries.

11. Withdrawal of Waiver or Expenditure Authority. CMS reserves the right to withdraw waivers and/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. CMS must 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, continued benefits as a result of beneficiary appeals, and administrative costs of disenrolling beneficiaries.

12. 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.

13. Public Notice, Tribal Consultation, and Consultation with Interested Parties. The state must comply with the state notice procedures as required in 42 CFR 431.408 prior to submitting an application to extend the demonstration. For applications to amend the demonstration, the state must comply with the state notice procedures set forth in 59 Fed. Reg. 49249 (September 27, 1994) prior to submitting such request.

The state must also comply with tribal and Indian Health Program/Urban Indian Health Organization consultation requirements at section 1902(a)(73) of the Act, 42 CFR 431.408(b), State Medicaid Director Letter #01-024, or as contained in the state's approved Medicaid State Plan, when any program changes to the demonstration, either through amendment as set out in STC 7 or extension, are proposed by the state.

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.

14. **Federal Financial Participation (FFP).** No federal matching for state expenditures under this demonstration, including for administrative and medical assistance expenditures, will be available until the effective date identified in the demonstration approval letter, or if later, as expressly stated within these STCs.

15. **Common Rule Exemption.** The state shall ensure that the only involvement of human subjects in research activities that may be authorized and/or required by this demonstration is for projects which are conducted by or subject to the approval of CMS, and that are designed to study, evaluate, or otherwise examine the Medicaid program – including procedures for obtaining Medicaid benefits or services, possible changes in or alternatives to Medicaid programs and procedures, or possible changes in methods or levels of payment for Medicaid benefits or services. The Secretary has determined that this demonstration as represented in these approved STCs meets the requirements for exemption from the human subject research provisions of the Common Rule set forth in 45 CFR 46.101(b)(5).

IV. ELIGIBILITY FOR THE DEMONSTRATION

16. **Eligibility Groups Affected By the Demonstration.** Only beneficiaries eligible for Medicaid under an eligibility group listed in Table 1 are subject to the provisions within this demonstration; these beneficiaries will be referred to as "HMP beneficiaries." State plan groups derive their eligibility through the Medicaid state plan, and coverage for this group is 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.

Table 1. Medicaid Eligibility Groups Affected by the Demonstration

Eligibility Group	Citations
New Adult Group	1902(a)(10)(A)(i)(VIII) 42 CFR 435.119

17. **Beneficiaries with income above 100 percent through 133 percent of the FPL and 48 Months of Eligibility.** In order to maintain eligibility for HMP, HMP beneficiaries enrolled in MHPs with income between 100 percent and 133 percent of the FPL, who have had 48 months of cumulative HMP eligibility since April 1, 2014, must**:**

    a. Complete all required questions on a HRA or have completed a healthy behavior in the prior 12 months, as described in STC 24; and

b. Pay a premium of five percent of income (in lieu of copayments, coinsurance, and similar payments), not to exceed limits defined in 42 CFR 447.56(f), as described in STC 23(a).

18. Beneficiaries with income at or below 100 percent of the FPL and 48 months of Eligibility. HMP beneficiaries with income at or below 100 percent of the FPL who have had 48 months of cumulative HMP eligibility from April 1, 2014 will continue to be subject to the cost-sharing responsibilities as described in STC 22(d).

V. BENEFITS

19. Healthy Michigan Plan Benefits. HMP beneficiaries will receive benefits as provided in the state's approved Alternative Benefit Plan for HMP.

VI. COST SHARING, CONTRIBUTIONS, AND HEALTHY BEHAVIORS

20. Cost Sharing: General Requirements. All cost sharing must be in compliance with Medicaid requirements that are set forth in federal statute, regulation, the state plan, and policies, except as modified by the waivers and STCs granted for this demonstration.

21. MI Health Account. The state may require each HMP beneficiary to have a MI Health Account that tracks and records beneficiary payments and liabilities.

22. Cost Sharing for Beneficiaries with Fewer than 48 Cumulative Months in the HMP. All HMP beneficiaries with fewer than 48 months of cumulative HMP eligibility from April 1, 2014, are subject to the following cost-sharing requirements:

a. Copayments. All HMP beneficiaries with fewer than 48 months of cumulative eligibility in HMP are required to pay nominal copayment requirements as specified in the Medicaid state plan.

i. Copayments during the initial six months of enrollment. During a beneficiary's first six months of enrollment in a MHP, there will be no copayments collected at the point of service for health plan covered services.

ii. Quarterly copayments. At the end of the initial six-month enrollment period, the state will calculate an average monthly co-payment for the beneficiary, based on the beneficiary's first six months of enrollment. The beneficiary will be billed for his or her average monthly copayments only at the end of each quarter. Beneficiaries can be billed for copayment liability in any six month 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 six month period

(except for any reductions to copayments due to Healthy Behaviors, described in STC 22(b)). Beneficiary cost-sharing must be compliant with the rules established in 42 CFR 447.56.

b. Healthy Behaviors: Cost sharing reductions. Beneficiaries in this category are eligible to receive incentive payments to offset cost sharing liability via reductions in their copayment liability and a 50 percent reduction in their monthly contribution if certain healthy behaviors are maintained or attained (described in STC 24).

c. Cost-sharing: beneficiaries with income above 100 percent of the FPL through 133 percent of the FPL. Beneficiaries in this category will be responsible for copayment liability based upon the prior six months of utilization for the beneficiary (see STC 22(b)) and a monthly contribution that shall not exceed two percent of income. In addition, reductions for healthy behavior incentives will be applied to the copayment liability (after the beneficiary has reached two percent of income in copayments), monthly contribution, or both, through the MI Health Account. Beneficiaries will be notified of the copayment liability by the provider, but will be billed for such copayments only at the end of quarter. No interest will be due on accrued copayment liability. Beneficiary cost-sharing must be compliant with the rules established in 42 CFR 447.56. No beneficiary with income from 100 percent of the FPL through 133 percent of the FPL and fewer than 48 cumulative months in the HMP may lose eligibility for Medicaid or be denied eligibility for Medicaid, be denied enrollment in a MHP or be denied access to services for failure to pay premiums or copayment liabilities.

d. Cost-sharing: beneficiaries with income at or below 100 percent of the FPL. Beneficiaries in this category will be responsible for copayment liability based upon the prior six months of copayment experience for the beneficiary (see STC 22(b)). Beneficiaries will be notified of the copayment liability by the provider, but will be billed for such copayments only at the end of quarter. No interest will be due on accrued copayment liability. In addition, reductions for healthy behavior incentives will be applied to the copayment liability due after the beneficiary has reached two percent of income in copayments. No premiums will be paid by this population. Beneficiary cost-sharing must be compliant with the rules established in 42 CFR 447.56. No beneficiary with income at or below 100 percent of the FPL will lose eligibility for Medicaid or be denied eligibility for Medicaid, be denied enrollment in a MHP or be denied access to services for failure to pay copayment liabilities.

23. Cost sharing for Beneficiaries with 48 or More Cumulative Months in the HMP. Effective on or after January 1, 2020 all HMP beneficiaries with 48 or more months of cumulative eligibility are subject to the following cost-sharing requirements:

a. Cost-sharing: beneficiaries with income above 100 percent of the FPL through 133 percent of the FPL. Beneficiaries in this category are not subject to the copayment requirements specified in the Medicaid state plan and are not eligible for any cost-sharing reductions related to healthy behavior completion incentives. Instead, beneficiaries in this category are subject to a monthly premium requirement that shall not exceed five percent of income beginning the first day of the calendar month following the beneficiary's 48th month of cumulative HMP eligibility, but no earlier than January 1, 2020. Sixty days before a beneficiary reaches 48 months of cumulative enrollment, (or, for beneficiaries who have already reached 48 months of cumulative enrollment by January 1, 2020, 60 days prior to January 1, 2020), the beneficiary will be noticed of the five percent premium requirement. No sooner than 60 days after the invoice date of the missed premium, beneficiaries who fail to pay the monthly contribution will be terminated from coverage after proper notice. Disenrolled beneficiaries must pay the missed premium payment(s) accumulated by the beneficiary while enrolled prior to being re-enrolled, at which point the individual will be eligible to re-apply and begin receiving coverage, so long as the individual is otherwise eligible. Beneficiaries who are disenrolled as a result of non-payment of premiums but who, during that disenrollment, would become exempt from premiums or otherwise become eligible for Medicaid under an eligibility group not subject to the premium requirement, may re-enroll with an effective date consistent with the beneficiary's eligibility category without paying owed premiums.

b. Cost-sharing: beneficiaries with income at or below 100 percent of the FPL. Beneficiaries in this category will continue to be subject to the cost-sharing requirements described in STC 22(a) and 22(d).

24. Healthy Behaviors Incentives Program. The Healthy Behaviors Incentives Program incentivizes beneficiaries to engage in certain healthy behaviors. Beneficiaries who complete a HRA and agree to address or maintain healthy behaviors will receive an incentive described below. Incentives are reflected in a beneficiary's MI Health Account statement (as described in STC 21).

a. Beneficiaries with incomes at or below 100 percent of the FPL. Beneficiaries in this category who have paid two percent of their income in copayments are eligible for a 50 percent reduction in their copayment liability if certain healthy behaviors are maintained or attained.

b. Beneficiaries with incomes above 100 percent of the FPL through 133 percent of the FPL with less than 48 cumulative months in HMP. Beneficiaries in this category who have paid two percent of their income in copayments are eligible for a 50 percent reduction in their copayment liability. In addition,

beneficiaries are eligible for a 50 percent reduction in their monthly contribution if certain healthy behaviors are maintained or attained.

c. Beneficiaries with income above 100 percent of the FPL through 133 percent of the FPL with 48 or more cumulative months in HMP. Beneficiaries with 48 months of eligibility in this category must complete the required questions on a HRA or complete a healthy behavior prior to beneficiary's next redetermination as a condition of continued eligibility. Responses to questions on the HRA will not impact an individual's Medicaid eligibility. Beneficiaries will be sent individual written notices about the requirement 60 days before the beneficiary reaches 48 months cumulative enrollment. If a beneficiary does not complete an HRA or if the state cannot confirm completion of a healthy behavior (see Attachment E for the complete list of qualifying healthy behaviors) in the 12 months preceding the beneficiary's annual redetermination, then the beneficiary will be disenrolled from HMP and must complete an HRA prior to being re-enrolled, at which point the beneficiary will be eligible to re-enroll and begin receiving coverage the first day of the month in which the beneficiary applied. If a beneficiary fails to answer all required questions on the HRA, eligibility for the demonstration will be denied. Beneficiaries who are disenrolled as a result of non-completion of an HRA or a healthy behavior, but who, during that disenrollment, would become exempt from the healthy behavior requirement or otherwise become eligible for Medicaid under an eligibility group not subject to the healthy behavior requirement, may re-enroll with an effective date consistent with the beneficiary's eligibility category without completing a HRA or healthy behavior. Beneficiaries in this category will not receive any reductions in copayment liability or monthly contributions for completion of healthy behaviors.

25. Beneficiaries Exempt from the 48 Month Cost-Sharing and Healthy Behaviors Requirements.

a. American Indian/Alaska Natives and children under 21 years of age are exempt from paying premiums pursuant to 42 CFR 447.56(a), but will still be required to complete an HRA or complete an annual healthy behavior in order to remain on HMP.
b. Pregnant women are exempt from paying premiums pursuant to 42 CFR 447.56(a), and while they are encouraged to participate in the Healthy Behavior Incentives Program, they will not be subject to loss of eligibility for failure to comply with the HRA or annual healthy behavior requirement.
c. Beneficiaries who are identified or self-report as medically frail, as described in 42 CFR 440.315, will be exempt from paying premiums and from the requirement to complete an HRA or complete an annual healthy behavior.
d. Beneficiaries who are not enrolled in a MHP are exempt from the premiums and from the requirement to complete an HRA or complete an annual healthy behavior.

e. Beneficiaries who are enrolled in the Flint Michigan section 1115 demonstration are exempt from the premiums and from the requirement to complete an HRA or complete an annual healthy behavior.

26. Premiums: State Assurances. The state shall:

a. Permit the state's premium vendor to attempt to collect the unpaid premiums from the beneficiary, but the state's premium vendor may not report the premium amount owed to credit reporting agencies, place a lien on a beneficiary's home, refer the case to debt collectors, file a lawsuit, or seek a court order to seize a portion of the beneficiary's earnings for enrollees at any income level. The state will not "sell" the obligation for collection by a third-party. Further, while the amount is collectible by the state, re-enrollment is not conditioned upon repayment, except for beneficiaries described in STC 23(a);
b. Monitor that beneficiaries do not incur household cost sharing and premiums that, combined, exceed five percent of the aggregate household income, in accordance with 42 CFR 447.56(f);
c. Ensure that the state, or its designee, does not pass along the cost of any surcharge associated with processing payments to the beneficiary. Any surcharges or other fees associated with payment processing are considered an administrative expense by the state;
d. Ensure that all payments from the beneficiary, or on behalf of the beneficiary, are accurately credited toward unpaid premiums in a timely manner, and provide the beneficiary an opportunity to review and seek correction of the payment history;
e. Ensure that the state has a process to refund any premiums paid for a month in which the beneficiary is ineligible for Medicaid services for that month;
f. Ensure that a beneficiary will not be charged a higher premium the following month due to nonpayment or underpayment of a premium in the previous month/s, except that amounts outstanding and due from the previous month/s may be reflected separately on subsequent invoices;
g. Ensure the state ends monthly billing of premiums to beneficiaries who have been disenrolled for failure to meet the community engagement and/or HRA/healthy behaviors requirements, and provide written notice to prevent overpayment of premiums;
h. Conduct outreach and education to beneficiaries to ensure that they understand the program policies regarding premiums and associated consequences for nonpayment. Beneficiaries must be provided individual written notice of how premium payments should be made; the potential impact of a change in income on premium payments owed; the consequences of failure to report a change in income or circumstances that affect eligibility; the time period over which income is calculated (e.g., monthly income); the deadline for reporting changes in circumstances; and how to re-enroll if disenrolled for non-payment of premiums;
i. Provide opportunities to demonstrate good cause for failure to pay premiums that would allow beneficiaries to avoid the consequences for non-payment described

in STC 23(a). Good cause circumstances must include, at a minimum, the following:

i. The beneficiary was hospitalized, otherwise incapacitated, or has a disability as defined by the ADA, section 504 of the Rehabilitation Act, or section 1557 of the Patient Protection and Affordable Care Act and as a result is unable to pay premiums, or is a person with a disability who was not provided with reasonable modifications needed to pay the premium, or is a person with a disability and there were no reasonable modifications that would have enabled the individual to pay premiums;
ii. A member of the beneficiary's immediate family who was living in the home with the beneficiary was institutionalized or died or the immediate family member has a disability as defined by the ADA, section 504 of the Rehabilitation Act, or section 1557 of the Patient Protection and Affordable Care Act and caretaking or other disability-related responsibilities resulted in an inability to pay the premiums;
iii. The birth of a family member living with the beneficiary;
iv. The beneficiary experienced a family emergency;
v. The beneficiary experienced a life changing event (e.g., divorce, domestic violence);
vi. The beneficiary experienced a temporary illness or injury.
vii. The beneficiary was evicted from their home or experienced homelessness, or
viii. The beneficiary was the victim of a natural disaster, such as a flood, storm, earthquake, or serious fire.

j. Provide all applicants and beneficiaries with timely and adequate written notices of any decision affecting their eligibility, including an approval, denial, termination, or suspension of eligibility or a denial or change in benefits and services pursuant to 42 CFR 435.917. The state will also make program information available and accessible in accordance with 42 CFR 435.901 and 435.905. The state will provide beneficiaries with 10 days advance notice for any adverse action prior to the date of action pursuant to 42 CFR 431.211;
k. Provide notice to beneficiaries, prior to adverse action, about the disenrollment, and explaining what this status means, including but not limited to: their right to appeal, their opportunity to cure, their right to apply for Medicaid on a basis not affected by this status, what this status means with respect to their ability to access other coverage (such as coverage in a qualified health plan through the Exchange, or access to premium tax credits through the Exchange), what they should do if their circumstances change such that they may be eligible for coverage in another Medicaid category, as well as any implications with respect to whether they have minimum essential coverage;
l. Provide beneficiaries with written notice of the rights of people with disabilities to receive reasonable modifications related to premium payment; and

m. Maintain a system that identifies, validates, and provides reasonable modifications related to the obligation to pay premiums to beneficiaries with disabilities protected by the ADA, section 504 of the Rehabilitation Act, and section 1557 of the Patient Protection and Affordable Care Act.

27. Healthy Behaviors: State Assurances. The state shall:

a. Develop uniform standards for healthy behavior incentives including, but not limited to, a health risk assessment to identify behavior that the initiative is targeting. Such targeted behaviors could include: routine ER use for non-emergency treatment, multiple co-morbidities, alcohol abuse, substance use disorders, tobacco use, obesity, and deficiencies in immunization status.
b. Include 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 a meaningful opportunity to receive healthy behavior incentives, taking into account individual physical and mental health status.
c. Implement a comprehensive pre-implementation education and outreach strategy regarding the Healthy Behaviors Incentive Program including strategies related to the ongoing engagement of stakeholders and the public in the state;
d. Provide written notice to beneficiaries regarding:
    i. The rights of people with disabilities to receive reasonable modifications related to engaging in healthy behaviors;
    ii. What specific healthy behaviors will qualify to meet the requirement;
    iii. How beneficiaries can report engagement in healthy behaviors, in accordance with 42 CFR 435.907(a); and
    iv. Prior to adverse action, information about disenrollment from HMP and an explanation of what this status means, including but not limited to: their right to appeal, their right to cure, their right to apply for Medicaid on a basis not affected by this status, what this status means with respect to their ability to access other coverage (such as coverage in a qualified health plan through the Exchange, or access to premium tax credits through the Exchange), what they should do if their circumstances change such that they may be eligible for coverage in another Medicaid category, as well as any implications with respect to whether they have minimum essential coverage.
e. Develop a data driven strategy of how healthy behaviors will be tracked and monitored at the beneficiary 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.
f. Develop a beneficiary and provider education strategy and timeline for completion prior to program implementation.
g. For beneficiaries who complete the HRA, provide those beneficiaries with information about ongoing structured interventions that will assist beneficiaries in improving health outcomes.

h. Maintain ongoing education and outreach post implementation regarding the Healthy Behaviors Incentive Program including strategies related to the ongoing engagement of stakeholders and the public in the state;
i. Determine how the MHP will coordinate with the beneficiaries and the state in ensuring the beneficiaries understand the impact of failing to engage in healthy behaviors, including the impact on cost-sharing and the potential for disenrollment;
j. Develop a description of other incentives in addition to reductions in cost sharing or premiums that the state will implement;
k. Develop a process to inform beneficiaries how to remedy not answering all the required questions on the HRA and the consequences if they do not;
l. Provide opportunities to demonstrate good cause for failure to pay complete the HRA or healthy behavior that would allow beneficiaries to avoid the consequences for that failure described in STC 24(c). Good cause circumstances must include, at a minimum, the following; and:

    i. The beneficiary was hospitalized, otherwise incapacitated, or has a disability as defined by the ADA, section 504 of the Rehabilitation Act, or section 1557 of the Patient Protection and Affordable Care Act and as a result is unable to pay premiums, or is a person with a disability who was not provided with reasonable modifications needed to pay the premium, or is a person with a disability and there were no reasonable modifications that would have enabled the individual to pay premiums;
    ii. A member of the beneficiary's immediate family who was living in the home with the beneficiary was institutionalized or died, or the immediate family member has a disability as defined by the ADA, section 504 of the Rehabilitation Act, or section 1557 of the Patient Protection and Affordable Care Act and caretaking or other disability-related responsibilities resulted in an inability to pay the premiums;
    iii. The birth of a family member living with the beneficiary;
    iv. The beneficiary experienced a family emergency;
    v. The beneficiary experienced a life changing event (e.g., divorce, domestic violence);
    vi. The beneficiary experienced a temporary illness or injury.
    vii. The beneficiary was evicted from their home or experienced homelessness, or
    viii. The beneficiary was the victim of a natural disaster, such as a flood, storm, earthquake, or serious fire that occurred.

m. Ensure that this healthy behaviors feature of the demonstration is implemented in a way that does not discriminate against people with disabilities on the basis of disability in violation of the ADA, Section 504, Section 1557 or any other federal civil rights laws.

VII. COMMUNITY ENGAGEMENT REQUIREMENT

28. Overview. Beginning no sooner than January 1, 2020, the state will implement a community engagement requirement as a condition of eligibility for adult beneficiaries in HMP who are not otherwise subject to an exemption described in STC 29. Once implemented, beneficiaries, age 19 to 62 years old, must work or engage in specified educational, job training, or community service activities for at least 80 hours per month to remain covered through the HMP unless they qualify for an exemption. HMP beneficiaries who are subject to the community engagement requirement will be required to demonstrate that they are meeting the requirements through monthly verification. Beneficiaries who fail to meet the requirements will be disenrolled and not be able to re-enroll until the beginning of month following when they report becoming compliant (as described in STC 32(b)).

29. Exempt Populations. The following individuals are exempt from the community engagement requirement:

a. A caretaker of a family member under six years of age (only one parent at a time can claim this exemption);
b. Beneficiaries currently receiving temporary or permanent long-term disability benefits from a private insurer or from the government;
c. A full-time student who is not a dependent or whose parent/guardian qualifies for Medicaid;
d. Pregnant women;
e. A caretaker of a dependent with a disability who needs full-time care based on a licensed medical professional's order (this exemption is allowed for one enrollee per household if there is only one dependent with a disability who meets the criteria specified above in the household);
f. A caretaker of an incapacitated individual even if the incapacitated individual is not a dependent of the caretaker;
g. Beneficiaries designated as medically frail;
h. Beneficiaries with a medical condition resulting in a work limitation according to a licensed medical professional order;
i. Beneficiaries who have been incarcerated within the last six months;
j. Beneficiaries currently receiving unemployment benefits from the State of Michigan;
k. Any person with a disability under the ADA, section 504 of the Rehabilitation Act, or 1557 of the Affordable Care Act who is unable to meet this requirement due to the disability; and
l. Beneficiaries under 21 years of age who had previously been in foster care placement in this state.

Additionally, beneficiaries in compliance with or exempt from the work requirements of the Supplemental Nutrition Assistance Program or Temporary Assistance for Needy Families Program are deemed compliant with or exempt from the community engagement requirement outlined above. Additional reporting will not be required.

30. Qualifying Activities. The following is the list of qualifying activities:

a. Employment, self-employment, or having income consistent with being employed or self-employed (makes at least minimum wage for an average of 80 hours per month);
b. Education directly related to employment (e.g., high school equivalency test preparation, postsecondary education);
c. Job training;
d. Tribal employment programs;
e. Vocational training directly related to employment;
f. Unpaid workforce engagement directly related to employment (e.g., internship);
g. Participation in a substance use disorder (SUD) treatment court ordered, prescribed by a licensed medical professional, or Medicaid-funded SUD treatment;
h. Community service completed with a non-profit 501(c)(3) or 501(c)(4) organization (can only be used as a qualifying activity for up to three months in a 12-month period); and
i. Job search activities.

31. Hour Requirements. Demonstration beneficiaries who do not meet exemption criteria described in STC 29 or who not need a reasonable modification related to this hour requirement as described in STC 33 will be required to participate in and report 80 hours per calendar month of one, or any combination, of the qualifying activities listed in STC 30 per month. Beneficiaries subject to the community engagement requirement will be required to self-attest to compliance with, or exemption from, the community engagement requirement to the state on a monthly basis unless the state has data to indicate that the beneficiary is compliant with or exempt from the community engagement requirement.

32. Non-Compliance. A beneficiary is allowed three months of non-compliance within a 12-month calendar year. After three months of non-compliance, a beneficiary who remains non-compliant will be disenrolled from the HMP demonstration at the end of the fourth month and will remain disenrolled for at least one calendar month. After being disenrolled for at least one calendar month, the beneficiary can be re-enrolled by completing 80 hours of qualifying activities in one calendar month before an individual's enrollment into HMP is approved on the first of the month in which the beneficiary applies and documents completion of the 80 hours. Before a beneficiary is disenrolled, the state will confirm the beneficiary is not eligible for another Medicaid category. If an individual has been disenrolled from the HMP program, reapplies, and is found eligible for another Medicaid category, they may begin receiving services under the other Medicaid category once their eligibility for the other category is confirmed.

a. **Opportunity to Cure and Disenrollment Effective Date.** If a beneficiary fails to comply with the community engagement requirement for three months, the state will send a written notice in the fourth month informing the beneficiary that he or she will be disenrolled effective the first day of the month after the month in

which the notice is sent, unless, before the disenrollment would take effect, the beneficiary:

i. Demonstrates good cause for the failure;
ii. Demonstrates that he or she qualifies for an exemption; or
iii. Satisfies the community engagement requirement by completing and reporting 80 hours of qualifying activities in the fourth month prior to disenrollment.

b. **Re-enrollment Following Non-Compliance.** Following disenrollment for non-compliance, an individual may re-enroll after being disenrolled for at least one calendar month on the first day of the month following completion of 80 hours of qualifying activities in one calendar month. If the individual meets the qualifications for an exemption listed at STC 29, demonstrates good cause for the earlier non-compliance as described in subsection (c) of this STC, or becomes eligible for Medicaid under an eligibility category that is not subject to the community engagement requirement, the individual can re-enroll immediately and their eligibility will have an effective date consistent with the beneficiary's new eligibility category or status. An individual who has been disenrolled for non-compliance and is subsequently re-enrolled maintains the three months of non-compliance and must maintain monthly compliance through the rest of the calendar year to avoid being disenrolled again.

c. **Good Cause.** The state will waive disenrollment for beneficiaries who failed to meet the community engagement hours for a month but who demonstrate good cause for failing to meet the requirement in that month. Beneficiaries may report a good cause for the state's approval up to 10 days prior to disenrollment. The recognized good cause circumstances include, but are not limited to, at a minimum, the following verified circumstances:

i. The beneficiary has a disability as defined by the ADA, section 504 of the Rehabilitation Act, or section 1557 of the Patient Protection and Affordable Care Act and was unable to meet the requirement for reasons related to that disability; or has an immediate family member in the home with a disability under federal disability rights laws and was unable to meet the requirement for reasons related to the disability of that family member; or the beneficiary or an immediate family member who was living in the home with the beneficiary experiences a hospitalization or serious illness.

33. Reasonable Modifications. The state must provide reasonable modifications related to meeting community engagement requirements for beneficiaries with disabilities as defined under the ADA, Section 504, or Section 1557, when necessary, to enable them to have an equal opportunity to participate in, and benefit from, the program. The state must also provide reasonable modifications for program requirements and procedures, including but

not limited to assistance with demonstrating eligibility for an exemption from community engagement requirements on the basis of disability; demonstrating good cause; appealing disenrollment; documenting community engagement activities and other documentation requirements; understanding notices and program rules related to community engagement requirements; navigating ADA compliant web sites as required by 42 CFR 435.1200(f); and other types of reasonable modifications.

Reasonable modifications must include exemptions from participation where a beneficiary is unable to participate for disability-related reasons, modification in the number of hours of participation required where a beneficiary is unable to participate for the otherwise-required number of hours, and provision of support services necessary to participate, where participation is possible with supports. In addition, the state should evaluate each beneficiary's ability to participate and the types of reasonable modifications and supports needed.

34. Community Engagement: State Assurances. Prior to implementation of community engagement requirements as a condition of eligibility, the state shall:

a. Maintain mechanisms to stop payments to an MHP when a beneficiary is terminated for failure to comply with program requirements.
b. Ensure that there are processes and procedures in place to seek data from other sources, including SNAP and TANF, and systems to permit beneficiaries to efficiently report community engagement hours or obtain an exemption, in accordance with 42 CFR 435.907(a), and 435.945, and to permit the state to monitor compliance.
c. If a beneficiary has requested a good cause, that the good cause has been approved or denied, with an explanation of the basis for the decision and how to appeal a denial.
d. Assure that termination, disenrollment, or denial of eligibility will only occur after an individual has been screened and determined ineligible for all other bases of Medicaid eligibility and reviewed for eligibility for insurance affordability programs in accordance with 435.916(f).
e. Ensure that there are timely and adequate beneficiary notices provided in writing, including but not limited to:
    i. When community engagement requirements will commence for that specific beneficiary;
    ii. Whether a beneficiary is exempt, how to request an exemption, and under what conditions the exemption would end;
    iii. A list of the specific activities that may be used to satisfy the community engagement requirements and a list of the specific activities that beneficiaries can engage in, as described in STC 30;
    iv. The specific number of community engagement hours per month that a beneficiary is required to complete to meet the requirement, and when and how the beneficiary must report participation or request an exemption;

v. Information about resources that help connect beneficiaries to opportunities for activities that would meet the community engagement requirement, and information about the community supports that are available to assist beneficiaries in meeting the community engagement requirement;
vi. Information about how community engagement hours will be counted and documented;
vii. What gives rise to a termination of eligibility, what a termination would mean for the beneficiary, and how to avoid a termination, including how and when to apply for good cause, and what kinds of circumstances might give rise to good cause;
viii. How beneficiaries are expected to report the hours and exemptions and that this is communicated to the beneficiaries;
ix. If a beneficiary's eligibility is terminated, how to appeal the termination; and
x. How to re-enroll after a beneficiary has been terminated.

f. Ensure application assistance is available to beneficiaries (in person and by phone).
g. Maintain an annual redetermination process, including systems to complete ex parte redeterminations and use of notices that contain prepopulated information known to the state, consistent with all applicable Medicaid requirements.
h. Maintain ability to report on and process applications in-person, via phone, via mail, and electronically;
i. Provide full appeal rights as required under 42 CFR, part 431 subpart E prior to termination of eligibility, and observe all requirements for due process for beneficiaries whose eligibility will be terminated for failure to meet the community engagement requirement, including allowing beneficiaries the opportunity to raise additional issues in a hearing, including whether the beneficiary should be subject to the suspension or termination, and provide additional documentation through the appeals process;
j. Make good faith efforts to connect beneficiaries to existing community supports that are available to assist beneficiaries in meeting the community engagement requirement, including available non-Medicaid assistance with transportation, child care, language access services and other supports;
k. Ensure the state will assess areas within the state that experience high rates of unemployment, areas with limited economies and/or educational opportunities, and areas that lack public transportation to determine whether there should be further exemptions from the community engagement requirement and/or additional mitigation strategies, so that the community engagement requirement will not be unreasonably burdensome for beneficiaries to meet;
l. Provide each beneficiary who has been disenrolled from HMP with information on how to access primary care and preventive care services at low or no cost to the individual. This material will include information about free health clinics and community health centers, including clinics that provide

behavioral health and substance use disorder services. Michigan shall also maintain such information on its public-facing website and employ other broad outreach activities that are specifically targeted to beneficiaries who have lost coverage; and

m. Make the general assurance that the state is in compliance with protections for beneficiaries with disabilities under the ADA, Section 504, or Section 1557.

VIII. DELIVERY SYSTEM

35. Healthy Michigan Plan. Services for Healthy Michigan Plan adults will be provided through a managed care delivery system.

a. **Types of Health Plans.** The state will use two different types of managed care plans to provide the full Alternative Benefit Plan for the demonstration population:
   i. Comprehensive Health Plans: MHPs that provide acute care, physical health services and most pharmacy benefits on a statewide basis. These MHPs will be the same MHPs 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.

36. Healthy Michigan Plan Enrollment Requirements. The state may require HMP beneficiaries to enroll in MHPs and PIHPs (with the exception of those beneficiaries who meet the MHP enrollment exemption criteria or those beneficiaries who meet the voluntary enrollment criteria).

a. Mandatory enrollment may occur only when the MHPs 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.
b. Newly eligible beneficiaries will initially be placed in fee-for-service (FFS), 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.
c. The state will use an enrollment broker to assist individuals with selection of a MHP before relying on auto-assignments.
d. Any individual that does not make an active selection will be assigned, by default, to a participating MHP.
e. Individuals will have choice of MHPs 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 one MHP to serve those

beneficiaries, consistent with the standards in section 1932(a)(3)(B) of the Act. In those rural areas that qualify for only one plan, the state will ensure the choice of providers as detailed in 42 CFR. 438.52(b)(1). In all areas of the state, individuals will only be permitted to enroll in the one PIHP that serves their area of residence.

f. Upon completion of the 90-day disenrollment period, during which time individuals may choose a different MHP, individuals that are mandatorily enrolled into a MHP will be locked into that MHP for a period of no longer than 12 months, unless they have a for-cause reason for disenrollment, as defined by the state. Individuals that are voluntarily enrolled into a MHP will be permitted to disenroll at any time.
g. 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.
h. Mandatory enrollment cannot include individuals specifically exempted from mandatory enrollment in managed care under section 1932 of the Act. These individuals may elect to receive benefits through a FFS delivery system.
i. Notice Information. The state must provide transition notice to any beneficiaries impacted by a change in delivery system at least 30 days in advance of the change. Notices will be written in simple and understandable terms and in a manner that is accessible to persons who are limited English proficient and individuals living with disabilities.
j. Transition Period. When beneficiaries transition delivery systems, beneficiaries in active treatment (including but not limited to chemotherapy, pregnancy, drug regime or a scheduled procedure) with a non-participating/non-contracted provider shall be allowed to continue receiving treatment from the nonparticipating/non-contracted provider through the duration of their prescribed treatment.

37. Healthy Michigan Plan Managed Care Benefit Package. Individuals enrolled in Healthy Michigan Plan will receive from the managed care program the benefits in the approved Alternative Benefit Plan (ABP) SPA that aligns with the benefit package in the state plan. 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. MHPs/PIHPs will refer and/or coordinate enrollees' access to needed services that are excluded from the managed care delivery system but available through a FFS delivery system (e.g. Home Help services or certain psychotropic medications).

38. 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 438.5. 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.

39. 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 CMS approval of 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.

40. 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).

41. AI/AN Access to Behavioral Health Services. American Indian/Alaska Native 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 in accordance with the applicable rates in the approved state plan and the Michigan Medicaid Provider Manual. 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 the state 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.

IX. GENERAL REPORTING REQUIREMENTS

42. Deferral for Failure to Submit Timely Demonstration Deliverables. CMS may issue deferrals in accordance with 42 CFR part 430 subpart C, in the amount of $5,000,000 per deliverable (federal share) when items required by these STCs (e.g., required data elements, analyses, reports, design documents, presentations, and other items specified in these STCs (hereafter singularly or collectively referred to as "deliverable(s)") are not submitted timely to CMS or are found to not be consistent with the requirements approved by CMS. A deferral shall not exceed the value of the federal amount for the current demonstration period. The state does not relinquish its rights provided under 42 CFR part 430 subpart C to challenge any CMS finding that the state materially failed to comply with the terms of this agreement.

The following process will be used: 1) Thirty (30) days after the deliverable was due if the state has not submitted a written request to CMS for approval of an extension as described

in subsection (b) below; or 2) Thirty days after CMS has notified the state in writing that the deliverable was not accepted for being inconsistent with the requirements of this agreement and the information needed to bring the deliverable into alignment with CMS requirements.

a. CMS will issue a written notification to the state providing advance notification of a pending deferral for late or non-compliant submission of required deliverable(s).

b. For each deliverable, the state may submit to CMS a written request for an extension to submit the required deliverable that includes a supporting rationale for the cause(s) of the delay and the state's anticipated date of submission. Should CMS agree to the state's request, a corresponding extension of the deferral process can be provided. CMS may agree to a corrective action as an interim step before applying the deferral, if corrective action is proposed in the state's written extension request.

c. If CMS agrees to an interim corrective process in accordance with subsection (b), and the state fails to comply with the corrective action steps or still fails to submit the overdue deliverable(s) that meets the terms of this agreement, CMS may proceed with the issuance of a deferral against the next Quarterly Statement of Expenditures reported in Medicaid Budget and Expenditure System/State Children's Health Insurance Program Budget and Expenditure System (MBES/CBES) following a written deferral notification to the state.

d. If the CMS deferral process has been initiated for state non-compliance with the terms of this agreement for submitting deliverable(s) and the state submits the overdue deliverable(s), and such deliverable(s) are accepted by CMS as meeting the standards outlined in these STCs, the deferral(s) will be released.

As the purpose of a section 1115 demonstration is to test new methods of operation or service delivery, a state's failure to submit all required reports, evaluations, and other deliverables will be considered by CMS in reviewing any application for an extension, amendment, or for a new demonstration.

43. Submission of Post-Approval Deliverables. The state must submit all deliverables as stipulated by CMS and within the timeframes outlined within these STCs.

44. Compliance with Federal Systems Updates. As federal systems continue to evolve and incorporate additional 1115 demonstration reporting and analytics functions, the state will work with CMS to:

a. Revise the reporting templates and submission processes to accommodate timely compliance with the requirements of the new systems;

b. Ensure all 1115, T-MSIS, and other data elements that have been agreed to for reporting and analytics are provided by the state; and

c. Submit deliverables to the appropriate system as directed by CMS.

45. Implementation Plan. The state must submit an Implementation Plan to CMS no later than 90 calendar days after approval of the demonstration. The Implementation Plan must cover at least the key policies being tested under this demonstration, including community engagement, cost-sharing, and healthy behaviors. Once determined complete by CMS, the Implementation Plan will be incorporated into the STCs, as Attachment C. At a minimum, the Implementation Plan must include definitions and parameters of key policies, and describe the state's strategic approach to implementing the policies, including timelines for meeting milestones associated with these key policies. Other topics to be discussed in the Implementation Plan include application assistance, reporting, and processing; notices; coordinated agency responsibilities; coordination with other insurance affordability programs; appeals; renewals; coordination with other state agencies; beneficiary protections; and outreach.

46. Monitoring Protocol. The state must submit to CMS a Monitoring Protocol no later than 150 calendar days after approval of the demonstration. Once approved, the Monitoring Protocol will be incorporated into the STCs, as Attachment D.

At a minimum, the Monitoring Protocol will affirm the state's commitment to conduct quarterly and annual monitoring in accordance with CMS' template. Any proposed deviations from CMS' template should be documented in the Monitoring Protocol. The Monitoring Protocol will describe the quantitative and qualitative elements on which the state will report through quarterly and annual monitoring reports. For quantitative metrics (e.g., performance metrics as described in STC 47(b) below), CMS will provide the state with a set of required metrics, and technical specifications for data collection and analysis covering the key policies being tested under this demonstration, including but not limited to community engagement, cost-sharing, and healthy behaviors. The Monitoring Protocol will specify the methods of data collection and timeframes for reporting on the state's progress as part of the quarterly and annual monitoring reports. For the qualitative elements (e.g, operational updates as described in STC 47(a) below), CMS will provide the state with guidance on narrative and descriptive information which will supplement the quantitative metrics on key aspects of the demonstration policies. The quantitative and qualitative elements will comprise the state's quarterly and annual monitoring reports.

47. Monitoring Reports. The state must submit three (3) Quarterly Reports and one (1) Annual Report each DY. The fourth-quarter information that would ordinarily be provided in a separate quarterly report should be reported as distinct information within the Annual Report. The Quarterly Reports are due no later than sixty (60) calendar days following the end of each demonstration quarter. The Annual Report (including the fourth-quarter information) is due no later than ninety (90) calendar days following the

end of the DY. The reports will include all required elements as per 42 CFR 431.428, and should not direct readers to links outside the report. Additional links not referenced in the document may be listed in a Reference/Bibliography section. The Monitoring Reports must follow the framework to be provided by CMS, which will be organized by milestones. The framework is subject to change as monitoring systems are developed/evolve, and will be provided in a structured manner that supports federal tracking and analysis.

a. Operational Updates. The operational updates will focus on progress towards meeting the milestones identified in CMS' framework. Additionally, per 42 CFR 431.428, the Monitoring Reports must document any policy or administrative difficulties in operating the demonstration. The reports shall provide sufficient information to document key challenges, underlying causes of challenges, how challenges are being addressed, as well as key achievements and to what conditions and efforts successes can be attributed. The discussion should also include any issues or complaints identified by beneficiaries; lawsuits or legal actions; unusual or unanticipated trends; legislative updates; and descriptions of any public forums held. The Monitoring Report should also include a summary of all public comments received through post-award public forums regarding the progress of the demonstration.

b. Performance Metrics. The performance metrics will provide data to demonstrate how the state is progressing towards meeting the milestones identified in CMS' framework which includes the following key policies under this demonstration -- community engagement, cost-sharing, and healthy behaviors. The performance metrics will also reflect all other components of the state's demonstration. For example, these metrics will cover enrollment, disenrollment or suspension by specific demographics and reason, participation in community engagement qualifying activities, access to care, and health outcomes.

   Per 42 CFR 431.428, the Monitoring Reports must document the impact of the demonstration in providing insurance coverage to beneficiaries and the uninsured population, as well as outcomes of care, quality and cost of care, and access to care. This may also include the results of beneficiary satisfaction surveys, if conducted, grievances and appeals.

   The required monitoring and performance metrics must be included in the Monitoring Reports, and will follow the CMS framework provided by CMS to support federal tracking and analysis.

c. Budget Neutrality and Financial Reporting Requirements. Per 42 CFR 431.428, the Monitoring Reports must document the financial performance of the demonstration. The state must provide an updated budget neutrality workbook with every Monitoring Report that meets all the reporting requirements for

monitoring budget neutrality set forth in the General Financial Requirements section of these STCs, including the submission of corrected budget neutrality data upon request. In addition, the state must report quarterly and annual expenditures associated with the populations affected by this demonstration on the Form CMS-64. Administrative costs for this demonstration should be reported separately on the CMS-64.

d. Evaluation Activities and Interim Findings. Per 42 CFR 431.428, the Monitoring Reports must document any results of the demonstration to date per the evaluation hypotheses. Additionally, 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.

48. Corrective Action. If monitoring indicates that demonstration features are not likely to assist in promoting the objectives of Medicaid, CMS reserves the right to require the state to submit a corrective action plan to CMS for approval. This may be an interim step to withdrawing waivers or expenditure authorities, as outlined in STC 11.

49. Close Out Report. Within 120 calendar days after the expiration of the demonstration, the state must submit a draft Close Out Report to CMS for comments.

a. The draft report must comply with the most current guidance from CMS.

b. The state will present to and participate in a discussion with CMS on the Close-Out report.

c. The state must take into consideration CMS' comments for incorporation into the final Close Out Report.

d. The final Close Out Report is due to CMS no later than thirty (30) calendar days after receipt of CMS' comments.

e. A delay in submitting the draft or final version of the Close Out Report may subject the state to penalties described in STC 46.

51. Monitoring Calls. CMS will convene periodic conference calls with the state.

a. The purpose of these calls is to discuss ongoing demonstration operation, to include (but not limited to), any significant actual or anticipated developments affecting the demonstration. Examples include implementation activities, trends in reported data on metrics and associated mid-course adjustments, budget neutrality, and progress on evaluation activities.

b. CMS will provide updates on any pending actions, as well as federal policies and issues that may affect any aspect of the demonstration.

c. The state and CMS will jointly develop the agenda for the calls.

52. Post Award Forum. Pursuant to 42 CFR 431.420(c), within six (6) months of the demonstration's implementation, and annually thereafter, the state shall afford the public with an opportunity to provide meaningful comment on the progress of the demonstration. At least thirty (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 must also post the most recent Annual Report on its website with the public forum announcement. Pursuant to 42 CFR 431.420(c), the state must include a summary of the comments in the Monitoring Report associated with the quarter in which the forum was held, as well as in its compiled Annual Report.

X. 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.

53. General Financial Requirements. The state must comply with all general financial requirement under Title XIX, as well as any applicable reporting requirement related to monitoring budget neutrality, set forth in Section XI of these STCs.

XI. MONITORING BUDGET NEUTRALITY FOR THE DEMONSTRATION

54. Budget Neutrality. Consistent with the August 22, 2018, State Health Official Letter #18-009, CMS has determined that this demonstration is budget neutral based on CMS's assessment that the waiver authorities granted for the demonstration are unlikely to result in any increase in federal Medicaid expenditures for medical assistance, and that no expenditure authorities are associated with the demonstration. The state will not be allowed to obtain budget neutrality "savings" from this demonstration. The demonstration will not include a budget neutrality expenditure limit, and no further test of budget neutrality will be required. CMS reserves the right to request budget neutrality worksheets and analyses from the state whenever the state seeks a change to the demonstration, per STC 7.

XII. EVALUATION OF THE DEMONSTRATION

55. Cooperation with Federal Evaluators. As required under 42 CFR 431.420(f), the state shall cooperate fully and timely with CMS and its contractors in any federal evaluation of the demonstration or any component of the demonstration. This includes, but is not limited to: commenting on design and other federal evaluation documents; providing data and

analytic files to CMS; entering into a data use agreement that explains how the data and data files will be exchanged; and providing a technical point of contact to support specification of the data and files to be disclosed, as well as relevant data dictionaries and record layouts. The state shall include in its contracts with entities that collect, produce, or maintain data and files for the demonstration, a requirements that they make data available for the federal evaluation as is required under 42 CFR 431.420(f) to support federal evaluation. The state may claim administrative match for these activities. Failure to comply with this STC may result in a deferral being issued as outlined in STC 46.

56. Independent Evaluator. Upon approval of the demonstration, the state must begin to arrange with an independent party to conduct an evaluation of the demonstration to ensure that the necessary data is collected at the level of detail needed to research the approved hypotheses. The state must require the independent party to sign an agreement that the independent party will conduct the demonstration evaluation in an independent manner in accord with the CMS-approved Evaluation Design. When conducting analyses and developing the evaluation reports, every effort should be made to follow the approved methodology. However, the state may request, and CMS may agree to, changes in the methodology in appropriate circumstances.

57. Draft Evaluation Design. The state must submit, for CMS comment and approval, a draft Evaluation Design, no later than 180 calendar days after approval of the demonstration.

Any modifications to an existing approved Evaluation Design will not affect previously established requirements and timelines for report submission for the demonstration, if applicable.

The draft Evaluation Design must be developed in accordance with the following CMS guidance (including but not limited to):

a. All applicable Evaluation Design guidance, including guidance about community engagement, cost-sharing, and healthy behaviors. Community engagement hypotheses will include (but not be limited to): effects on enrollment and continuity of enrollment; and effects on employment levels, income, transition to commercial health insurance, health outcomes, and Medicaid program sustainability. Hypotheses for cost-sharing and healthy behaviors will include (but not be limited to): effects on access to care; and health outcomes. Hypotheses applicable to the demonstration as a whole, and to all key policies referenced above, will include (but will not be limited to): the effects of the demonstration on health outcomes; the financial impact of the demonstration (for example, such as an assessment of medical debt and uncompensated care costs); and the effect of the demonstration on Medicaid program sustainability.

b. Attachment A (Developing the Evaluation Design) of these STCs, technical assistance for developing SUD Evaluation Designs (as applicable, and as

provided by CMS), and all applicable technical assistance on how to establish comparison groups to develop a Draft Evaluation Design.

58. **Evaluation Design Approval and Updates.** The state must submit a revised draft Evaluation Design within sixty (60) calendar days after receipt of CMS' comments. Upon CMS approval of the draft Evaluation Design, the document will be included as an attachment to these STCs. Per 42 CFR 431.424(c), the state will publish the approved Evaluation Design within thirty (30) days of CMS approval. The state must implement the Evaluation Design and submit a description of its evaluation implementation progress in each of the Monitoring Reports. Once CMS approves the Evaluation Design, if the state wishes to make changes, the state must submit a revised Evaluation Design to CMS for approval.

59. **Evaluation Questions and Hypotheses.** Consistent with Attachments A and B (Developing the Evaluation Design and Preparing the Evaluation Report) of these STCs, the evaluation documents must include a discussion of the evaluation questions and hypotheses that the state intends to test. Each demonstration component should have at least one evaluation question and hypothesis. The hypothesis testing should include, where possible, assessment of both process and outcome measures. Proposed measures should be selected from nationally-recognized sources and national measures sets, where possible. Measures sets could include CMS's Core Set of Health Care Quality Measures for Children in Medicaid and CHIP, CMS's measure sets for eligibility and coverage (including community engagement), Consumer Assessment of Health Care Providers and Systems (CAHPS), the Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults, and/or measures endorsed by National Quality Forum (NQF).

60. **Evaluation Budget**. A budget for the evaluation shall be provided with the draft Evaluation Design. It will include the total estimated cost, as well as a breakdown of estimated staff, administrative, and other costs for all aspects of the evaluation such as any survey and measurement development, quantitative and qualitative data collection and cleaning, analyses, and report generation. A justification of the costs may be required by CMS if the estimates provided do not appear to sufficiently cover the costs of the design or if CMS finds that the design is not sufficiently developed, or if the estimates appear to be excessive.

61. **Interim Evaluation Report.** The state must submit an Interim Evaluation Report for the completed years of the demonstration, and for each subsequent renewal or extension of the demonstration, as outlined in 42 CFR 431.412(c)(2)(vi). When submitting an application for renewal, the Evaluation Report should be posted to the state's website with the application for public comment.

    a. The Interim Evaluation Report will discuss evaluation progress and present findings to date as per the approved Evaluation Design.

b. For demonstration authority that expires prior to the overall demonstration's expiration date, the Interim Evaluation Report must include an evaluation of the authority as approved by CMS.

c. If the state is seeking to renew or extend the demonstration, the draft Interim Evaluation Report is due when the application for renewal is submitted. If the state made changes to the demonstration in its application for renewal, the research questions and hypotheses, and how the design was adapted, should be included. If the state is not requesting a renewal for a demonstration, an Interim Evaluation report is due one (1) year prior to the end of the demonstration. For demonstration phase outs prior to the expiration of the approval period, the draft Interim Evaluation Report is due to CMS on the date that will be specified in the notice of termination or suspension.

d. The state must submit the final Interim Evaluation Report 60 calendar days after receiving CMS comments on the draft Interim Evaluation Report and post the document to the state's website.

e. The Interim Evaluation Report must comply with Attachment B (Preparing the Evaluation Report) of these STCs.

62. Summative Evaluation Report. The draft Summative Evaluation Report must be developed in accordance with Attachment B (Preparing the Evaluation Report) of these STCs. The state must submit a draft Summative Evaluation Report for the demonstration's current approval period within 18 months of the end of the approval period represented by these STCs. The Summative Evaluation Report must include the information in the approved Evaluation Design.

a. Unless otherwise agreed upon in writing by CMS, the state shall submit the final Summative Evaluation Report within 60 calendar days of receiving comments from CMS on the draft.

b. The final Summative Evaluation Report must be posted to the state's Medicaid website within 30 days of approval by CMS.

63. Corrective Action Plan Related to Evaluation. If evaluation findings indicate that demonstration features are not likely to assist in promoting the objectives of Medicaid, CMS reserves the right to require the state to submit a corrective action plan to CMS for approval. These discussions may also occur as part of a renewal process when associated with the state's Interim Evaluation Report. This may be an interim step to withdrawing waivers or expenditure authorities, as outlined in STC 11.

64. State Presentations for CMS. CMS reserves the right to request that the state present and

participate in a discussion with CMS on the Evaluation Design, the Interim Evaluation Report, and/or the Summative Evaluation Report.

65. **Public Access**. The state shall post the final documents (e.g., Monitoring Reports, Close-Out Report, approved Evaluation Design, Interim Evaluation Report, and Summative Evaluation Report) on the state's Medicaid website within 30 calendar days of approval by CMS.

66. **Additional Publications and Presentations.** For a period of twelve (12) months following CMS approval of the final reports, CMS will be notified prior to presentation of these reports or their findings, including in related publications (including, for example, journal articles), by the state, contractor, or any other third party directly connected to the demonstration over which the state has control. Prior to release of these reports, articles, or other publications, CMS will be provided a copy including any associated press materials. CMS will be given ten (10) business days to review and comment on publications before they are released. CMS may choose to decline to comment or review some or all of these notifications and reviews. This requirement does not apply to the release or presentation of these materials to state or local government officials.

Attachment A: Developing the Evaluation Design

Introduction

For states that are testing new approaches and flexibilities in their Medicaid programs through section 1115 demonstrations, evaluations are crucial to understand and disseminate what is or is not working and why. The evaluations of new initiatives seek to produce new knowledge and direction for programs and inform Medicaid policy for the future. While a narrative about what happened during a demonstration provides important information, the principal focus of the evaluation of a section 1115 demonstration should be obtaining and analyzing data on the process (e.g., whether the demonstration is being implemented as intended), outcomes (e.g., whether the demonstration is having the intended effects on the target population), and impacts of the demonstration (e.g., whether the outcomes observed in the targeted population differ from outcomes in similar populations not affected by the demonstration). Both state and federal governments need rigorous quantitative and qualitative evidence to inform policy decisions.

Expectations for Evaluation Designs

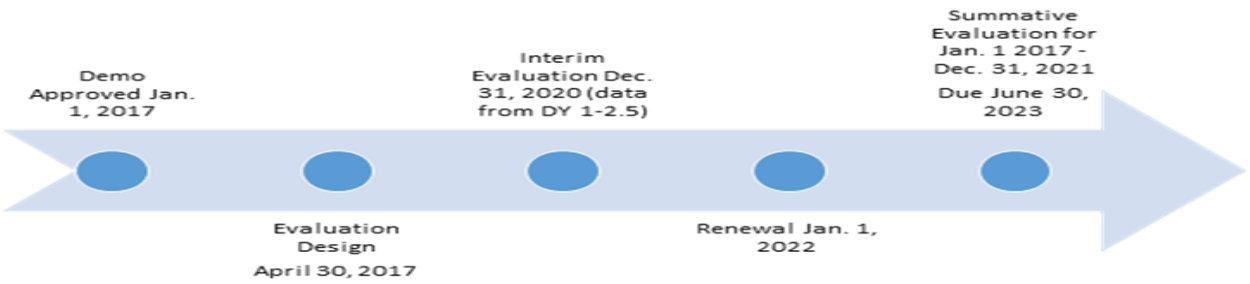
All states with Medicaid section 1115 demonstrations are required to conduct an evaluation, and the Evaluation Design is the roadmap for conducting the evaluation. The roadmap begins with the stated goals for the demonstration followed by the measurable evaluation questions and quantifiable hypotheses, all to support a determination of the extent to which the demonstration has achieved its goals. When conducting analyses and developing the evaluation reports, every effort should be made to follow the approved methodology. However, the state may request, and CMS may agree to, changes in the methodology in appropriate circumstances.

The format for the Evaluation Design is as follows:

A. General Background Information;
B. Evaluation Questions and Hypotheses;
C. Methodology;
D. Methodological Limitations;
E. Attachments.

Submission Timelines

There is a specified timeline for the state's submission of Evaluation Design and Reports. (The graphic below depicts an example of this timeline). In addition, the state should be aware that section 1115 evaluation documents are public records. The state is required to publish the Evaluation Design to the state's website within 30 days of CMS approval, as per 42 CFR 431.424(e). CMS will also publish a copy to the Medicaid.gov website.



Required Core Components of All Evaluation Designs
The Evaluation Design sets the stage for the Interim and Summative Evaluation Reports. It is important that the Evaluation Design explain the goals and objectives of the demonstration, the hypotheses related to the demonstration, and the methodology (and limitations) for the evaluation. A copy of the state's Driver Diagram (described in more detail in paragraph B2 below) should be included with an explanation of the depicted information.

A. General Background Information – In this section, the state should include basic information about the demonstration, such as:

1) The issue/s that the state is trying to address with its section 1115 demonstration and/or expenditure authorities, the potential magnitude of the issue/s, and why the state selected this course of action to address the issue/s (e.g., a narrative on why the state submitted an 1115 demonstration proposal).

2) The name of the demonstration, approval date of the demonstration, and period of time covered by the evaluation;

3) A brief description of the demonstration and history of the implementation, and whether the draft Evaluation Design applies to an amendment, extension, renewal, or expansion of, the demonstration;

4) For renewals, amendments, and major operational changes: A description of any changes to the demonstration during the approval period; the primary reason or reasons for the change; and how the Evaluation Design was altered or augmented to address these changes.

5) Describe the population groups impacted by the demonstration.

B. Evaluation Questions and Hypotheses – In this section, the state should:

1) Describe how the state's demonstration goals are translated into quantifiable targets for improvement, so that the performance of the demonstration in achieving these targets could be measured.
2) Include a Driver Diagram to visually aid readers in understanding the rationale behind the cause and effect of the variants behind the demonstration features and intended outcomes. A driver diagram is a particularly effective modeling tool when working to improve health and health care through specific interventions. The diagram includes information about the goal of the demonstration, and the features of the demonstration. A driver diagram depicts the relationship between the aim, the primary drivers that contribute directly to achieving the aim, and the secondary drivers that are necessary to achieve the primary drivers for the demonstration. For an example and more information on driver diagrams: https://innovation.cms.gov/files/x/hciatwoaimsdrvrs.pdf

3) Identify the state's hypotheses about the outcomes of the demonstration:
   a. Discuss how the evaluation questions align with the hypotheses and the goals of the demonstration;
   b. Address how the research questions / hypotheses of this demonstration promote the objectives of Titles XIX and/or XXI.

C. Methodology – In this section, the state is to describe in detail the proposed research methodology. The focus is on showing that the evaluation meets the prevailing standards of scientific and academic rigor, and the results are statistically valid and reliable, and that where appropriate it builds upon other published research (use references).

This section provides the evidence that the demonstration evaluation will use the best available data; reports on, controls for, and makes appropriate adjustments for the limitations of the data and their effects on results; and discusses the generalizability of results. This section should provide enough transparency to explain what will be measured and how. Specifically, this section establishes:

1) *Evaluation Design* – Provide information on how the evaluation will be designed. For example, will the evaluation utilize a pre/post comparison? A post-only assessment? Will a comparison group be included?

2) *Target and Comparison Populations* – Describe the characteristics of the target and comparison populations, to include the inclusion and exclusion criteria. Include information about the level of analysis (beneficiary, provider, or program level), and if populations will be stratified into subgroups. Additionally discuss the sampling methodology for the populations, as well as support that a statistically reliable sample size is available.

3) *Evaluation Period* – Describe the time periods for which data will be included.

4) *Evaluation Measures* – List all measures that will be calculated to evaluate the demonstration. Include the measure stewards (i.e., the organization(s) responsible for the evaluation data elements/sets by "owning", defining, validating; securing; and submitting for endorsement, etc.) Include numerator and denominator information. Additional items to ensure:
    a. The measures contain assessments of both process and outcomes to evaluate the effects of the demonstration during the period of approval.
    b. Qualitative analysis methods may be used, and must be described in detail.
    c. Benchmarking and comparisons to national and state standards, should be used, where appropriate.
    d. Proposed health measures could include CMS's Core Set of Health Care Quality Measures for Children in Medicaid and CHIP, Consumer Assessment of Health Care Providers and Systems (CAHPS), the Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults and/or measures endorsed by National Quality Forum (NQF).
    e. Proposed performance metrics can be selected from nationally recognized metrics, for example from sets developed by the Center for Medicare and Medicaid Innovation or for meaningful use under Health Information Technology (HIT).
    f. Among considerations in selecting the metrics shall be opportunities identified by the state for improving quality of care and health outcomes, and controlling cost of care.

5) *Data Sources* – Explain where the data will be obtained, and efforts to validate and clean the data. Discuss the quality and limitations of the data sources.

    If primary data (data collected specifically for the evaluation) – The methods by which the data will be collected, the source of the proposed question/responses, the frequency and timing of data collection, and the method of data collection. (Copies of any proposed surveys must be reviewed with CMS for approval before implementation).

6) *Analytic Methods* – This section includes the details of the selected quantitative and/or qualitative measures to adequately assess the effectiveness of the demonstration. This section should:
    a. Identify the specific statistical testing which will be undertaken for each measure (e.g., t-tests, chi-square, odds ratio, ANOVA, regression). Table A is an example of how the state might want to articulate the analytic methods for each research question and measure.
    b. Explain how the state will isolate the effects of the demonstration (from other initiatives occurring in the state at the same time) through the use of comparison groups.

c. A discussion of how propensity score matching and difference in differences design may be used to adjust for differences in comparison populations over time (if applicable).
d. The application of sensitivity analyses, as appropriate, should be considered.

7) *Other Additions* – The state may provide any other information pertinent to the Evaluation Design of the demonstration.

Table A. Example Design Table for the Evaluation of the Demonstration

Research Question	Outcome measures used to address the research question	Sample or population subgroups to be compared	Data Sources	Analytic Methods
Hypothesis 1				
Research question 1a	-Measure 1 -Measure 2 -Measure 3	-Sample e.g. All attributed Medicaid beneficiaries -Beneficiaries with diabetes diagnosis	-Medicaid fee-for-service and encounter claims records	-Interrupted time series
Research question 1b	-Measure 1 -Measure 2 -Measure 3 -Measure 4	-sample, e.g., PPS patients who meet survey selection requirements (used services within the last 6 months)	-Patient survey	Descriptive statistics
Hypothesis 2				
Research question 2a	-Measure 1 -Measure 2	-Sample, e.g., PPS administrators	-Key informants	Qualitative analysis of interview material

D. Methodological Limitations – This section provides detailed information on the limitations of the evaluation. This could include the design, the data sources or collection process, or analytic methods. The state should also identify any efforts to minimize the limitations. Additionally, this section should include any information about features of the demonstration that effectively present methodological constraints that the state would like CMS to take into consideration in its review.

E. Special Methodological Considerations – CMS recognizes that there may be certain instances where a state cannot meet the rigor of an evaluation as expected by CMS. In these instances, the state should document for CMS why it is not able to incorporate key components of a rigorous evaluation, including comparison groups and baseline data analyses. Examples of considerations include:

When the demonstration is considered successful without issues or concerns that would require more regular reporting, such as:

a. Operating smoothly without administrative changes; and
b. No or minimal appeals and grievances; and
c. No state issues with CMS 64 reporting or budget neutrality; and

d. No Corrective Action Plans (CAP) for the demonstration.

F. Attachments

1) **Independent Evaluator.** This includes a discussion of the state's process for obtaining an independent entity to conduct the evaluation, including a description of the qualifications that the selected entity must possess, and how the state will assure no conflict of interest. Explain how the state will assure that the Independent Evaluator will conduct a fair and impartial evaluation, prepare an objective Evaluation Report, and that there would be no conflict of interest. The evaluation design should include a "No Conflict of Interest" statement signed by the independent evaluator.

2) **Evaluation Budget.** A budget for implementing the evaluation shall be provided with the draft Evaluation Design. It will include the total estimated cost, as well as a breakdown of estimated staff, administrative, and other costs for all aspects of the evaluation. Examples include, but are not limited to: the development of all survey and measurement instruments; quantitative and qualitative data collection; data cleaning and analyses; and reports generation. A justification of the costs may be required by CMS if the estimates provided do not appear to sufficiently cover the costs of the draft Evaluation Design or if CMS finds that the draft Evaluation Design is not sufficiently developed.

3) **Timeline and Major Milestones.** Describe the timeline for conducting the various evaluation activities, including dates for evaluation-related milestones, including those related to procurement of an outside contractor, if applicable, and deliverables. The Final Evaluation Design shall incorporate an Interim and Summative Evaluation. Pursuant to 42 CFR 431.424(c)(v), this timeline should also include the date by which the Final Summative Evaluation report is due.

Attachment B: Preparing the Evaluation Report

Introduction

For states that are testing new approaches and flexibilities in their Medicaid programs through section 1115 demonstrations, evaluations are crucial to understand and disseminate what is or is not working and why. The evaluations of new initiatives seek to produce new knowledge and direction for programs and inform Medicaid policy for the future. While a narrative about what happened during a demonstration provides important information, the principal focus of the evaluation of a section 1115 demonstration should be obtaining and analyzing data on the process (e.g., whether the demonstration is being implemented as intended), outcomes (e.g., whether the demonstration is having the intended effects on the target population), and impacts of the demonstration (e.g., whether the outcomes observed in the targeted population differ from outcomes in similar populations not affected by the demonstration). Both state and federal governments need improved quantitative and qualitative evidence to inform policy decisions.

Expectations for Evaluation Reports

Medicaid section 1115 demonstrations are required to conduct an evaluation that is valid (the extent to which the evaluation measures what it is intended to measure), and reliable (the extent to which the evaluation could produce the same results when used repeatedly). To this end, the already approved Evaluation Design is a map that begins with the demonstration goals, then transitions to the evaluation questions, and to the specific hypotheses, which will be used to investigate whether the demonstration has achieved its goals. States should have a well-structured analysis plan for their evaluation. With the following kind of information, states and CMS are best poised to inform and shape Medicaid policy in order to improve the health and welfare of Medicaid beneficiaries for decades to come. When conducting analyses and developing the evaluation reports, every effort should be made to follow the approved methodology. However, the state may request, and CMS may agree to, changes in the methodology in appropriate circumstances. When submitting an application for renewal, the interim evaluation report should be posted on the state's website with the application for public comment. Additionally, the interim evaluation report must be included in its entirety with the application submitted to CMS.

Intent of this Attachment

Title XIX of the Social Security Act (the Act) requires an evaluation of every section 1115 demonstration. In order to fulfill this requirement, the state's submission must provide a comprehensive written presentation of all key components of the demonstration, and include all required elements specified in the approved Evaluation Design. This Attachment is intended to assist states with organizing the required information in a standardized format and understanding the criteria that CMS will use in reviewing the submitted Interim and Summative Evaluation Reports.

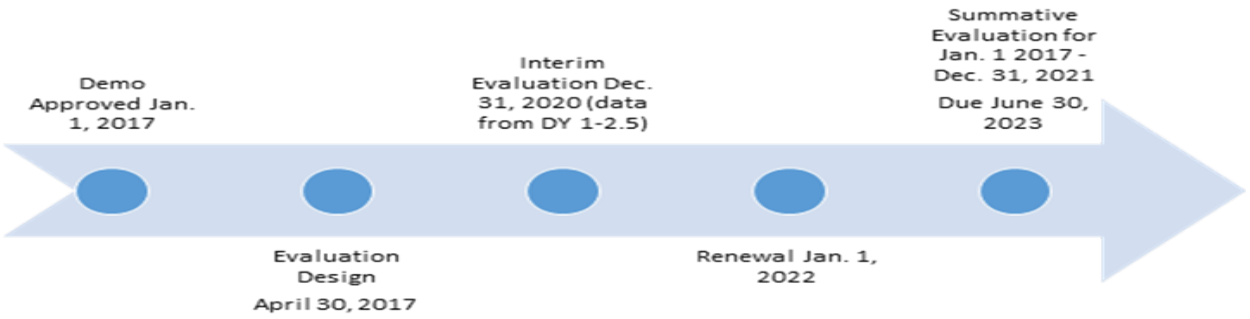
The format for the Interim and Summative Evaluation reports is as follows:

A. Executive Summary;
B. General Background Information;
C. Evaluation Questions and Hypotheses;

D. Methodology;
E. Methodological Limitations;
F. Results;
G. Conclusions;
H. Interpretations, and Policy Implications and Interactions with Other State Initiatives;
I. Lessons Learned and Recommendations; and
J. Attachment(s).

Submission Timelines

There is a specified timeline for the state's submission of Evaluation Designs and Evaluation Reports. These dates are specified in the demonstration Special Terms and Conditions (STCs). (The graphic below depicts an example of this timeline). In addition, the state should be aware that section 1115 evaluation documents are public records. In order to assure the dissemination of the evaluation findings, lessons learned, and recommendations, the state is required to publish the evaluation design and reports to the state's website within 30 days of CMS approval, as per 42 CFR 431.424(d). CMS will also publish a copy to the Medicaid.gov website.



Required Core Components of Interim and Summative Evaluation Reports

The section 1115 Evaluation Report presents the research about the section 1115 Demonstration. It is important that the report incorporate a discussion about the structure of the Evaluation Design to explain the goals and objectives of the demonstration, the hypotheses related to the demonstration, and the methodology for the evaluation. A copy of the state's Driver Diagram (described in the Evaluation Design Attachment) must be included with an explanation of the depicted information. The Evaluation Report should present the relevant data and an interpretation of the findings; assess the outcomes (what worked and what did not work); explain the limitations of the design, data, and analyses; offer recommendations regarding what (in hindsight) the state would further advance, or do differently, and why; and discuss the implications on future Medicaid policy. Therefore, the state's submission must include:

A. Executive Summary – A summary of the demonstration, the principal results, interpretations, and recommendations of the evaluation.

B. General Background Information about the Demonstration – In this section, the state should include basic information about the demonstration, such as:

1) The issues that the state is trying to address with its section 1115 demonstration and/or expenditure authorities, how the state became aware of the issue, the potential magnitude of the issue, and why the state selected this course of action to address the issues.
2) The name of the demonstration, approval date of the demonstration, and period of time covered by the evaluation;
3) A brief description of the demonstration and history of the implementation, and if the evaluation is for an amendment, extension, renewal, or expansion of, the demonstration;
4) For renewals, amendments, and major operational changes: A description of any changes to the demonstration during the approval period; whether the motivation for change was due to political, economic, and fiscal factors at the state and/or federal level; whether the programmatic changes were implemented to improve beneficiary health, provider/health plan performance, or administrative efficiency; and how the Evaluation Design was altered or augmented to address these changes.
5) Describe the population groups impacted by the demonstration.

C. Evaluation Questions and Hypotheses – In this section, the state should:

1) Describe how the state's demonstration goals were translated into quantifiable targets for improvement, so that the performance of the demonstration in achieving these targets could be measured. The inclusion of a Driver Diagram in the Evaluation Report is highly encouraged, as the visual can aid readers in understanding the rationale behind the demonstration features and intended outcomes.
2) Identify the state's hypotheses about the outcomes of the demonstration;
    a. Discuss how the goals of the demonstration align with the evaluation questions and hypotheses;
    b. Explain how this Evaluation Report builds upon and expands earlier demonstration evaluation findings (if applicable); and
    c. Address how the research questions / hypotheses of this demonstration promote the objectives of Titles XIX and XXI.

D. Methodology – In this section, the state is to provide an overview of the research that was conducted to evaluate the section 1115 demonstration consistent with the approved Evaluation Design. The evaluation Design should also be included as an attachment to the report. The focus is on showing that the evaluation builds upon other published research (use references), and meets the prevailing standards of scientific and academic rigor, and the results are statistically valid and reliable.

An interim report should provide any available data to date, including both quantitative and qualitative assessments. The Evaluation Design should assure there is appropriate

data development and collection in a timely manner to support developing an interim evaluation.

This section provides the evidence that the demonstration evaluation used the best available data and describes why potential alternative data sources were not used; reported on, controlled for, and made appropriate adjustments for the limitations of the data and their effects on results; and discusses the generalizability of results. This section should provide enough transparency to explain what was measured and how. Specifically, this section establishes that the approved Evaluation Design was followed by describing:

1) *Evaluation Design*—Will the evaluation be an assessment of: pre/post, post-only, with or without comparison groups, etc?
2) *Target and Comparison Populations*—Describe the target and comparison populations; include inclusion and exclusion criteria.
3) *Evaluation Period*—Describe the time periods for which data will be collected.
4) *Evaluation Measures*—What measures are used to evaluate the demonstration, and who are the measure stewards?
5) *Data Sources*—Explain where the data will be obtained, and efforts to validate and clean the data.
6) *Analytic Methods*—Identify specific statistical testing which will be undertaken for each measure (t-tests, chi-square, odds ratio, ANOVA, regression, etc.).
7) *Other Additions* – The state may provide any other information pertinent to the evaluation of the demonstration.

E. Methodological Limitations

This section provides sufficient information for discerning the strengths and weaknesses of the study design, data sources/collection, and analyses.

F. Results – In this section, the state presents and uses the quantitative and qualitative data to show to whether and to what degree the evaluation questions and hypotheses of the demonstration were achieved. The findings should visually depict the demonstration results (tables, charts, graphs). This section should include information on the statistical tests conducted.

G. Conclusions – In this section, the state will present the conclusions about the evaluation results.

1) In general, did the results show that the demonstration was/was not effective in achieving the goals and objectives established at the beginning of the demonstration?

2) Based on the findings, discuss the outcomes and impacts of the demonstration and identify the opportunities for improvements. Specifically:
    a. If the state did not fully achieve its intended goals, why not? What could be done in the future that would better enable such an effort to more fully achieve those purposes, aims, objectives, and goals?

H. Interpretations, Policy Implications and Interactions with Other State Initiatives – In this section, the state will discuss the section 1115 demonstration within an overall Medicaid context and long range planning. This should include interrelations of the demonstration with other aspects of the state's Medicaid program, interactions with other Medicaid demonstrations, and other federal awards affecting service delivery, health outcomes and the cost of care under Medicaid. This section provides the state with an opportunity to provide interpretation of the data using evaluative reasoning to make judgments about the demonstration. This section should also include a discussion of the implications of the findings at both the state and national levels.

I. Lessons Learned and Recommendations – This section of the Evaluation Report involves the transfer of knowledge. Specifically, the "opportunities" for future or revised demonstrations to inform Medicaid policymakers, advocates, and stakeholders is just as significant as identifying current successful strategies. Based on the evaluation results:

1) What lessons were learned as a result of the demonstration?
2) What would you recommend to other states which may be interested in implementing a similar approach?

J. Attachment

1) Evaluation Design: Provide the CMS-approved Evaluation Design

Attachment C: Implementation Plan
[To be incorporated after CMS approval.]

Attachment D: Monitoring Protocol
[To be incorporated after CMS approval.]

Attachment E: Healthy Behaviors List

PREVENTIVE DENTAL SERVICES	
PROCEDURE	**DIAGNOSIS CODE**
D0120	Z0120, Z0121, Z1384
D0191	Z0120, Z0121, Z1384
D1110	Z0120, Z0121, Z1384
D1354	Z0120, Z0121

ACIP VACCINES	
PROCEDURE	**DIAGNOSIS CODE**
90620	NA
90621	NA
90630	NA
90632	NA
90636	NA
90649	NA
90650	NA
90651	NA
90654	NA
90656	NA
90658	NA
90661	NA
90670	NA
90673	NA
90674	NA
90686	NA
90688	NA
90707	NA
90714	NA
90715	NA
90716	NA
90732	NA
90733	NA
90734	NA
90736	NA
90740	NA
90744	NA
90746	NA
90747	NA
G0008	NA
G0009	NA
G0010	NA
Q2034	NA
Q2035	NA
Q2036	NA
Q2037	NA
Q2038	NA

Q2039	NA

ANNUAL PREVENTIVE VISIT	
PROCEDURE	**DIAGNOSIS CODE**
99385	NA
99386	NA
99395	NA
99396	NA
99401	NA
99402	NA

CANCER SCREENING: BREAST	
PROCEDURE	**DIAGNOSIS CODE**
77063	NA
77067	NA
G0202	NA

CANCER SCREENING: CERVICAL/VAGINAL	
PROCEDURE	**DIAGNOSIS CODE**
87623	NA
87624	NA
87625	NA
88141	NA
88142	NA
88143	NA
88147	NA
88148	NA
88155	NA
88164	NA
88165	NA
88166	NA
88167	NA
88174	NA
88175	NA
G0101	NA
G0476	NA
Q0091	NA

CANCER SCREENING: COLORECTAL	
PROCEDURE	**DIAGNOSIS CODE**
45330	Z1211, Z1212, Z1213, Z800, Z8371,
45331	Z1211, Z1212, Z1213, Z800, Z8371,
45333	Z1211, Z1212, Z1213, Z800, Z8371,
45338	Z1211, Z1212, Z1213, Z800, Z8371,
45346	Z1211, Z1212, Z1213, Z800, Z8371,
45378	Z1211, Z1212, Z1213, Z800, Z8371,
45380	Z1211, Z1212, Z1213, Z800, Z8371,
45384	Z1211, Z1212, Z1213, Z800, Z8371,

45385	Z1211, Z1212, Z1213, Z800, Z8371,
45388	Z1211, Z1212, Z1213, Z800, Z8371,
81528	NA
82270	NA
82274	Z1211, Z1212, Z1213, Z800, Z8371,
G0104	NA
G0105	NA
G0121	NA
G0328	NA

CANCER SCREENING: LUNG	
PROCEDURE	**DIAGNOSIS CODE**
71250	F172, Z122, Z720, Z87891
G0297	NA

CANCER SCREENING: PROSTATE	
PROCEDURE	**DIAGNOSIS CODE**
84152	Z125, Z8042
84153	Z125, Z8042
84154	Z125, Z8042
G0102	NA
G0103	NA

HEP C VIRUS INFECTION SCREENING	
PROCEDURE	**DIAGNOSIS CODE**
86803	NA
G0472	NA

HIV SCREENING	
PROCEDURE	**DIAGNOSIS CODE**
86689	Z114
86701	Z114
86702	Z114
86703	Z114
87389	Z114
87390	Z114
87391	Z114
87534	Z114
87535	Z114
87536	Z114
87537	Z114
87538	Z114
87539	Z114
87806	Z114
G0432	NA
G0433	NA
G0435	NA

OSTEOPOROSIS SCREENING	
PROCEDURE	**DIAGNOSIS CODE**
76977	Z13820, Z8262
77078	Z13820, Z8262
77080	Z13820, Z8262
77081	Z13820, Z8262

STI SCREENING: CHLAMYDIA	
PROCEDURE	**DIAGNOSIS CODE**
87110	NA
87270	NA
87320	NA
87490	NA
87491	NA
87492	NA
87810	NA

STI SCREENING: GONORRHEA	
PROCEDURE	**DIAGNOSIS CODE**
87590	NA
87591	NA
87592	NA
87850	NA

STI SCREENING: HEP B (NONPREGNANT)	
PROCEDURE	**DIAGNOSIS CODE**
86704	NA
86705	NA
86706	NA
87340	NA
G0499	NA

STI SCREENING: SYPHILIS (NONPREGNANT)	
PROCEDURE	**DIAGNOSIS CODE**
86592	NA
86593	NA

TUBERCULOSIS SCREENING	
PROCEDURE	**DIAGNOSIS CODE**
86480	Z111, Z201
86481	Z111, Z201
86580	Z111, Z201
87116	Z111, Z201