October 2, 2015

The Honorable Sylvia Mathews Burwell, Secretary
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, DC 20201

Dear Secretary Burwell,

The undersigned organizations write in response to your request for public comments on Michigan's proposed amendment to its Section 1115 Medicaid demonstration, the Healthy Michigan Plan. We appreciate the opportunity to provide public comment on the amendment as it raises significant public policy questions. As we have previously recommended, public comment at both the state and federal levels should be *required* before approval of amendments like this, and we urge you to amend 42 CFR 431.416(g) to ensure that public comments are required in the future.

Healthy Michigan has been enormously successful in providing vital health coverage and financial security to the approximately 600,000 adults currently enrolled in the program. Its continued existence is critical to the health of low-income individuals and families in the state.

We believe, however, that the changes described in the proposed amendment are ill-conceived and could potentially undermine the success of the current demonstration project. We remain optimistic that CMS and the state of Michigan will successfully negotiate a waiver agreement that allows the Healthy Michigan program to continue providing coverage in a way that is compatible with the goals and objectives of the Medicaid program.

As Medical Services Administration Acting Director Stiffler notes in her cover letter, state law (PA 107) requires that she submit an amendment to the current waiver and specifies what should be proposed. But there is no stated policy rationale for these proposed changes in PA 107 or in Michigan's amendment proposal. In fact, implementation of the amendment would undermine the state's goals in the current Healthy Michigan demonstration, especially the goals of improving access to healthcare for uninsured or underinsured low-income Michigan citizens and encouraging "quality, continuity and appropriate medical care."

The proposed changes would add administrative complexity and costs for the state, providers and beneficiaries, while the new eligibility and cost-sharing requirements would impose additional and unacceptable burdens on enrollees. Moreover, the key elements of the proposal are vague, with a lack of sufficient detail to allow for an appropriate assessment and analysis of the proposal's policy and practical implications. Our specific comments on the components of the proposed amendment follow:

48 month trigger: Establishing a time limit of any kind is inconsistent with both the Medicaid statute and the Affordable Care Act (ACA) and would set a dangerous precedent even if some form of coverage continues after the 48 cumulative months. The purpose of the Affordable Care Act is to assure continuous coverage and time limits are not compatible

with this intent. To our knowledge, the terms and conditions of a beneficiary's participation in Medicaid have never been based on how long he or she has been enrolled.

While we appreciate that the amendment does not propose to terminate coverage at the 48-month mark, it would make changes in the way benefits are administered and costs are incurred. In addition, the proposal is not clear regarding how an enrollee's 48 cumulative months will be defined and tracked and whether there will be exemptions for hardship. Attachment D suggests that the time limit provision only applies to those whose incomes exceed 100 percent of the poverty line for 48 months, but this is not clear in the proposed amendment, which could be read as applying the time limit based on people's income at the point they have been enrolled for 48 months.

Regardless of how the 48-month limit is applied, tracking enrollment and income will create unnecessary administrative complexity and costs for both beneficiaries and the state. Moreover, as noted, the 48-month limit would undermine the underlying demonstration's goal of providing continuous coverage to low-income Michiganders.

Coverage options following the 48-month trigger:

Option 1: The amendment requests permission to enroll beneficiaries who reach the 48-month limit in Qualified Health Plans (QHPs). If this request is approved, we urge you to ensure that beneficiaries remain eligible for the full range of benefits and cost-sharing protections that they would remain eligible for as Medicaid beneficiaries. The proposal's language stating that beneficiaries selecting Option 1 "would change their Medicaid Health Plan eligibility status" should be read to comply with past guidance from CMS which has stressed that individuals enrolled in premium assistance arrangements like that proposed in Option 1 remain Medicaid beneficiaries and continue to be entitled to all benefits and cost-sharing protections.[1]

Option 2: Michigan should not be allowed to impose cost-sharing up to 7 percent of income and premiums at 3.5 percent as proposed for Option 2. Cost-sharing at this level is inconsistent with the Medicaid statute, and goes beyond previous demonstrations allowing states to charge beneficiaries with incomes above the poverty line premiums at 2 percent of income on the rationale that they would pay similar premiums in the Marketplace. Allowing beneficiaries to be charged premiums of 3.5 percent would result in them paying *higher* premiums than those with similar incomes in the Marketplace.

Moreover, this request is improper because cost-sharing changes that exceed statutory authority such as raising the aggregate cap to 7 percent must be submitted through a 1916(f) waiver, which must meet a number of clearly defined statutory requirements that are not included in this proposal. Page four of the proposal states that the state is pursuing waiver authority for "Cost Sharing §1902(a)(14) as it incorporates §§1916 and 1916(A) - To the extent necessary to enable the State to impose co-pays and contributions in the amounts described herein." This is insufficient to justify the state's approach as states must seek waiver authority under Section 1916(f), which requires that states show that they are testing a

[1] See for example "Medicaid and the Affordable Care Act: Premium Assistance," March 2013, available at http://medicaid.gov/Federal-Policy-Guidance/Downloads/FAQ-03-29-13-Premium-Assistance.pdf

new use of copayments through a carefully designed experiment with a control group and that the demonstration last no longer than two years.

The amendment notes that cost-sharing requirements "may be reduced" if healthy behavior activities criteria are met, but scant detail is provided about what these criteria would be. We urge CMS to ensure that any final agreement establishes specific criteria for how cost sharing requirements are reduced through healthy behavior incentives. Further, these incentives ought to be based on proven methods of improving health outcomes in Medicaid and/or explain the demonstration rationale for new approaches.[2]

In light of these issues, we are especially concerned that those who do not make an active choice are defaulted into Option 2, as noted on page 3 of the proposal.

Benefits: The proposed amendment states that: "All beneficiaries will remain eligible for services consistent with the ABP as described in the Medicaid State Plan. *Individuals selecting coverage through the Marketplace will receive the essential health benefits through their QHP's.*" (emphasis added, p. 3) While we are pleased that the state does not seem to be requesting any specific benefit waivers, the proposal is unclear as there is no guarantee that the benefits provided through a QHP are consistent with Medicaid benefits. Attachment D compounds the confusion. Following a question as to whether wrap-around services will be provided for beneficiaries who choose to receive their health coverage through the Marketplace (Option 1), the attachment states that "MDHHS expects that beneficiaries who maintain Healthy Michigan Plan eligibility would continue to receive comprehensive services consistent with the State Plan." However, given the aforementioned differences in benefits under Medicaid and QHPs, it is unclear how the state would ensure that all benefits are provided.

Michigan's proposed waiver amendment would make significant and imprudent policy changes. Along with the problems detailed above, it lacks the detailed planning and evaluation components that we would expect to find in a waiver proposal. We urge CMS to work with Michigan to arrive at a waiver agreement that continues the state's Medicaid expansion and maintains the integrity of its Medicaid program.

Thank you for your willingness to consider our comments. If you would like any additional information, please contact Joan Alker (jca25@georgetown.edu) or Judy Solomon (Solomon@cbpp.org).

American Association on Health and Disability
American Cancer Society Cancer Action Network
American Federation of State, County & Municipal Employees
American Heart Association/American Stroke Association
American Music Therapy Association
Center on Budget and Policy Priorities
Community Catalyst

[2] See for example J. Schubel and J. Solomon, "States Can Improve Health Outcomes and Lower Costs in Medicaid Using Existing Flexibility," Center on Budget and Policy Priorities, April 9, 2015, available at http://www.cbpp.org/research/health/states-can-improve-health-outcomes-and-lower-costs-in-medicaid-using-existing

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