STATE OF MICHIGAN
EXECUTIVE OFFICE
LANSING

RICK SNYDER
GOVERNOR

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June 20, 2016

Ms. Victoria Wachino
Centers for Medicare & Medicaid Services
Children and Adults Health Programs Group
Mail Stop: S2-01-16
7500 Security Boulevard
Baltimore, MD 21244

RE: Proposed §1115 Demonstration, Pathway to Integration

Dear Ms. Wachino:

The Michigan Department of Health and Human Services (MDHHS) is requesting approval of its proposed §1115 Demonstration, Pathway to Integration.

This proposed §1115 Demonstration will allow MDHHS to integrate the coverages of all services and supports eligible populations served through our current multiple §1915(b) and §1915(c) waivers that serve individuals with serious mental illness, substance use disorders, intellectual and developmental disabilities, and serious emotional disturbances.

This demonstration waiver will raise the bar on physical and behavioral health integration, strengthen the SUD continuum of services and promote further value based payment methodologies between Medicaid Health Plans (MHPs) and Prepaid Inpatient Health Plans (PIHPs) serving this specialty service population.

If you have any questions, please contact Jacqueline Coleman at (517) 241-7172 or via e-mail at ColemanJ@michigan.gov.

Thank you for your consideration of this request.

Sincerely,

Rick Snyder
Governor

cc: Nick Lyon, Director, MDHHS

Pathway to Integration
Michigan's §1115 Waiver Proposal for Persons with Severe Mental Illness, Substance use Disorders, Intellectual and Developmental Disabilities and Children with Serious Emotional Disturbances
To the
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
June 21, 2016

State of Michigan
Rick Snyder Governor

Nick Lyon, Director
Michigan Department of Health and Human Services

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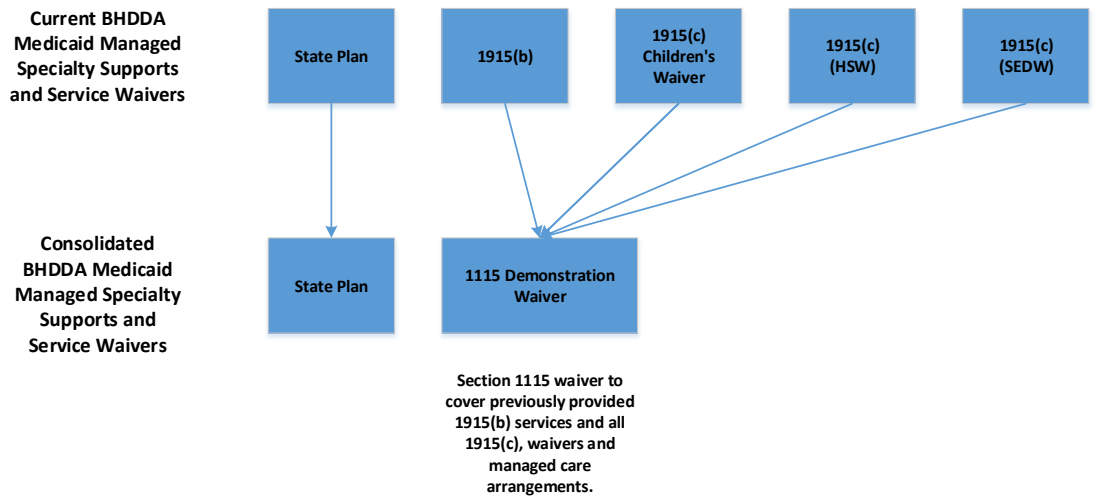
I. Introduction

Michigan has a long standing commitment to community supports and inclusion. The state continues to focus on enhancing systems capacity to further improve the functioning, capabilities, and recovery/resiliency for persons with Severe Mental Illness (SMI), Substance Use Disorders (SUD), Intellectual/Developmental Disabilities (I/DD), and Children with Serious Emotional Disturbances (SED)[1]. With this commitment and focus in mind, the State of Michigan is seeking approval from the Centers for Medicare and Medicaid Services (CMS) for a §1115 Demonstration Waiver that will combine under a single waiver authority all services and eligible populations served through its §1915(b) and its multiple §1915(c) waivers. Under this consolidated waiver authority, Michigan is seeking broad flexibility to further develop and evaluate the outcomes associated with quality and value-based payment and financing approaches for integrated care (physical, behavioral and SUD) initiatives for all Specialty Service Populations on a statewide basis. The chart below, describes the current waivers and populations consolidated under this §1115 Waiver application.

Pathway to Integration Waiver Consolidation



[1] Also known as Specialty Service System/Populations.

Since 1998, Michigan has operated a behavioral health carve-out for the Specialty Service Populations using county-sponsored Prepaid Inpatient Health Plans (PIHPs). Physical healthcare, including a benefit for persons with mild and/or moderate behavioral health disorders, is operated through profit and not-for-profit Medicaid Health Plans (MHPs). Funding for SUD services was traditionally managed by regional Coordinating Agencies (CAs), which contracted for the delivery of SUD services. In 2013, to better integrate behavioral health and SUD services, CAs were dissolved and incorporated into the PIHP management and governance structures. Currently, the PIHPs are responsible for all SUD service and supports (except for certain medically monitored supports) regardless of severity of condition.

II. Program Description

1) Provide a summary of the proposed Demonstration program, and how it will further the objectives of title XIX and/or title XXI of the Social Security Act (the Act).

Since 2011, Michigan has been reinventing its healthcare system on multiple payer and provider levels. In 2013, Michigan was awarded the Centers for Medicare and Medicaid Services (CMS), State Innovation Model (SIM) Design award that resulted in the development of Michigan's "Blueprint for Health Innovation" (Blueprint)[2]. The Blueprint's overarching vision is to provide better health and better care at lower costs for every Michigan citizen. Michigan was also one of the early States to seek and expand Medicaid coverage through its Healthy Michigan Plan (HMP). The HMP now covers over 580,000 Michigan citizens and provides access to the full array of Specialty Services included in this application.

Through the development of both the Blueprint and HMP, it was identified that a major driver of unnecessary hospital/emergency department utilization was related to service access patterns of persons with behavioral health and/or substance use disorders. These facts, combined with the acknowledgement of the need for introducing incentives to reward performance and the achievement of improved health outcomes, the Medical Services Administration (MSA) and the Behavioral Health and Developmental Disabilities Administration (BHDDA) of the Michigan Department of Health and Human Services (MDHHS) engaged in numerous discussions regarding the efficiency and effectiveness of its multiple Specialty Service waivers. As a result of these discussions, MDHHS determined that the broader flexibility allowed through a §1115 Waiver will enable the state to incentivize the Specialty Services System to better align with other healthcare providers and improve the population health objectives for this very vulnerable and often underserved population.

In 2013, to better integrate behavioral health and SUD, MDHHS combined the former SUD CAs funding and service responsibility within ten (10) PIHPs. This multi-year effort has improved the effectiveness of the benefit design as well as the treatment and support services provided to

[2] http://www.michigan.gov/documents/mdch/Michigan_Blueprint_APPENDICES_REMOVED_454499_7.pdf

individuals who have SUD. To further our efforts, MDHHS has been engaged in the Centers for Medicare and Medicaid Services (CMS) Innovation Accelerator Program (IAP) for SUD and is committed to further develop and improve on the state's comprehensive array of effective treatment and supports (including the access to the array of behavioral health services as deemed medically necessary) for persons with co-occurring disorders, and to ensure more consistent use of industry-standard benchmarks for refining medical necessity criteria, promoting the use of evidence-based services and strengthening provider qualifications and state oversight. The flexibilities permitted under a §1115 Waiver will not only enable the state to consolidate multiple programs and streamline payment systems, but will also give the state expenditure authority for coverage of a broader array of residential services (regardless of facility size), expand other behavioral health services, and begin the development of value-based incentives that reward achievement of performance objectives.

Building upon the strong foundation of covered benefits, evidence based practices (EBPs) and service delivery infrastructure, the state believes that offering a full continuum of SUD treatment and recovery supports based on American Society of Addiction Medicine (ASAM) criteria, will result in improved outcomes and sustained recovery for this Specialty Services population.

The state of Michigan seeks to accomplish these efforts by:

- Enhancing provider competency related to the use of ASAM criteria through access to care procedures and within treatment programs;
- Expanding the treatment continuum of residential care including medically necessary use of qualified residential treatment facilities regardless of the size of the facility, withdrawal management programming and medication assisted treatment and recovery;
- Expanding the use of recovery coach delivered support services; and
- Establishing coordination of care models between SUD providers, primary care and other behavioral health providers.

2) Include the rationale for the §1115 Demonstration.

Since 1998, Michigan has financed and delivered the majority of its Specialty Service System through managed care arrangements, although the multiple behavioral health §1915(c) Waivers are slightly outside the traditional §1915(b) managed care payment structure. Currently, all of Michigan's behavioral health §1915(c) Waivers include enrollment caps and eligibility requirements based on institutional levels of care. The Children's Waiver Program (CWP) and the Waiver for Children with Serious Emotional Disturbances (SEDW) are still operated by the state under a Fee-for-Service (FFS) arrangement. Each of these waivers require separate actuarial payments, separate reporting of expenditures, and various cost settlement arrangements based on the actual services delivered. Through this §1115 Waiver authority, Michigan intends to remove and/or expand certain enrollment caps (based on legislative

appropriation and who meets eligibility criteria), advance the use of needs-based eligibility criteria, and to finance these programs under a single managed care arrangement. In order to maintain budget neutrality, current enrollment caps for the §1915(c) Waivers will not be changed.

When approved, this consolidated waiver will result in seamless coordinated care and resolve the cost effectiveness issue related to the current §1915(b) Managed Specialty Service and Supports (MSS&S) Waiver.

Additionally, Michigan seeks to enhance the effectiveness of its SUD treatment and recovery system. The benefit design, service access, and quality enhancements proposed as part of this demonstration are intended to supports three areas of strategic focus:

Strategic Focus One: Physical Health Integration and Care Coordination Design
The integration of behavioral health and physical health care is a statewide priority and is the crux of the demonstration of this waiver application. Over the past several years, the state has received a SIM grant and a planning grant for Certified Community Behavioral Health Clinics (CCBHC) as evidence of the state's overall commitment to physical health/behavioral health integration. The MDHHS has supported and funded the establishment of learning communities within the behavioral health service system that are providing guidance on integration and coordination of care practices at the regional level. This work has focused on mental health and SUD services. It has led to the acceptance of behavioral health workers in primary care clinics, community health clinics, and even emergency departments. As a result, Screening, Brief Intervention, and Referral to Treatment (SBIRT) is increasingly utilized for adults and adolescents within the primary care environment.

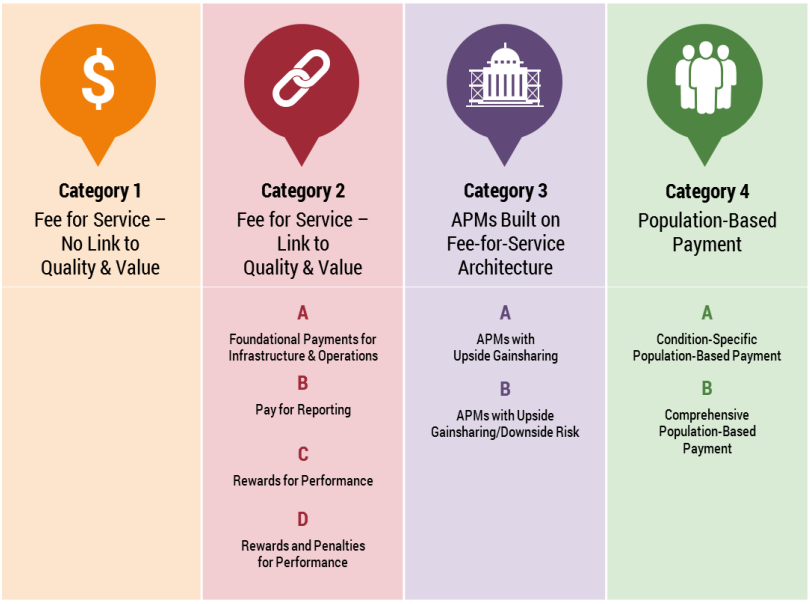
Through this waiver, Michigan also intends to adapt and test an established model of care coordination to further expand integrated care between systems and providers. The Collaborative Care Model (CCM) is an evidence-based approach that has proven to be clinically sound and cost-effective for a variety of behavioral health conditions. This model utilizes the integration of primary care providers, care managers, and psychiatric consultants to provide care and monitor progress. This model provides proven consumer supports and focuses on connecting community agencies, hospital-based services, behavioral health, and medical specialists as part of the provision of care. Michigan's overall healthcare system will begin to formalize this model of care as part of this waiver and through the grant work that is underway. It will formalize the process of referrals and level of care transitions that will decrease the number of people who do not follow through at these critical times in care. Additionally, Peer Recovery Coaches will be used to enhance the referral and care transition process for an added layer of support for the SUD service system.

Strategic Focus Two: Strengthening the SUD Care Continuum
Through participation in the CMS IAP, the state has received technical assistance and exposure to national experts on a number of topics relevant to Michigan's goals to strengthen the

continuum of SUD services throughout the state. While Michigan has historically maintained a robust network of SUD providers and services, the prohibition against Medicaid reimbursement for services provided to certain adults in an Institution for Mental Disease (IMD) setting has resulted in a disjointed benefit package and the inability to ensure access to needed services.

This waiver application seeks to remove treatment gaps through coverage of residential services, initially focusing on ensuring capacity to ASAM levels 3.1 and 3.2 and throughout the demonstration expanding statewide capacity for higher-end ASAM levels (i.e., 3.7 and 4). In addition to rounding out SUD residential services, the state will also develop incentives to ensure coordination within and across levels of care by utilizing the Collaborative Care Model, recovery supports and other SUD services to improve care transitions, referrals and promote provider collaborations.

Finally, Michigan intends to utilize the §1115 Waiver authority to align requirements for use of ASAM criteria and development of care coordination requirements to test various value-based payment opportunities as described in the Health Care Payment & Learning Access Network (HCP-LAN) Alternative Payment Model (APM) Framework white paper. The state will coordinate SIM, CCBHC and behavioral health redesign efforts to advance populations based payment mechanisms such as those listed in 'Category 4 below:



Strategic Focus Three: Promoting Value-Based Payment

Michigan has a long history of implementing Medicaid managed care models for both the physical health and specialty behavioral health benefits, seeking to reward value versus volume of services. Historically, however, value-based reimbursement has largely been focused within these separate areas rather than across them. With Michigan's recent re-procurement of Medicaid managed care physical health and mild/moderate behavioral health services, the state implemented additional integration of care standards that are mirrored in the Specialty

Services Prepaid Inpatient Health Plan contracts as well. These standards require specific integration and collaboration efforts in order to receive withheld performance bonuses. For the current fiscal year, these standards are being jointly operationalized and are presently focused on adults living with Severe Mental Illness (SMI) and limited to process measures. The state intends to build from this foundation to apply value-based payment principles to Medicaid contracting across populations and promote downstream value-based payment designs between managed care organizations and their provider networks. This will be inclusive of individuals with SUD, DD, and children with SED, where applicable and where appropriate consents are obtained. The state also intends to move to increasingly value-based payment based upon process measures to incentivize population health outcomes measures.

A consolidated §1115 Waiver design will support the testing and application of value-based payment design across these populations, including the testing, adaptation, and expansion of evidence-based care coordination and integration models across populations that historically have received less focus in integrated care modeling (i.e. SUD and I/DD populations). This approach also recognizes the individualization of supports for beneficiaries by recognizing overall healthcare needs versus the need to specifically slot beneficiaries into discrete populations in order to access necessary supports and services. Recognizing these overall healthcare needs, the virtual integration of plans and providers as noted in the white paper by the Health Care Payment & Learning Access Network (HCP-LAN) Alternative Payment Model (APM), "Category 4 represents the furthest departure from traditional FFS payments, while simultaneously ensuring that providers possess the strongest possible incentives to deliver high quality and efficient care."

3) Describe the hypotheses that will be tested/evaluated during the Demonstration's approval period and the plan by which the State will use to test them.

This proposal is not solely focused on cost savings, but rather on improving upon Michigan's robust coverage and service array, including the expanded use of peer recovery supports for persons with SUD, self-determined arrangements, and SUD delivery reforms. The goal of this demonstration is to create an evaluation that tests and creates incentives for both quality and cost outcomes between traditional MHPs and Michigan's Specialty Services System[3]. These incentives would be specifically targeted for persons with SMI, SUD, I/DD and SED. Key indicators would include:

- Joint identification and tracking of high risk/utilizing populations
- Prevention of modifiable risk factors[4]
- Access to care incentives
- Pilot demonstrations through Accountable Systems of Care
- Enhancement of co-occurring (SMI/SUD) services

[3] Integrated Care Resource Center, Technical Assistance Brief: State Options for Integrating Physical and Behavioral Health Care, MCO/PCCM and BHO Partnership Facilitated by Financial Alignment.

[4] Obesity, smoking cessation, homelessness, substance use, diabetes and cardiovascular disease management.

- Use of “Specialized Complex Care Managers” for individuals considered “High Utilizers”

Since many of the cost drivers related to “High Utilizers” occur from increased emergency department usage or inpatient hospital utilization, testing what quality and clinical measures actually decrease utilization and tracking where savings actually accrues (hospitals, health plans and PIHP’s) for this population will be one of the demonstration’s major evaluation components.

Additionally, as Michigan aligns its full continuum of SUD treatment and recovery supports services based on ASAM criteria and utilizing Evidence Based Practices (EBPs), Michigan will evaluate the impact of this new continuum by measuring the change in the number of people engaged in in recovery support services, the length of time in formal treatment, and improvement in overall physical health.

To meet these objectives, Michigan has recently implemented an integrated care analytics program (known as Care Connect 360or CC 360) that enables the state and providers to access retrospective Medicaid claims and encounter data for both behavioral health and physical healthcare services, including prescription drug information. Through an existing contract, Michigan will conduct an evaluation to measure and monitor the outcomes for the Pathway to Integration Waiver. The following is a partial list of quality indicators to be refined and measured during the demonstration with additional CMS technical assistance specifically for the enhanced SUD services.

- Enhance/incentivize the ability of Specialty Service System payers and providers to work with traditional MHPs and to jointly develop measures to identify high risk populations within this Specialty Service System. This includes strategies to identify individuals with substance use issues or disorders.
- Develop linkages that directly impact social determinants of health, including the use and dissemination of models to prevent homelessness and early intervention models that promote clinical practices for serving youth and adults with SUD.
- Increase rate of outpatient services including assignment of a primary care physician, physician office, or clinic visits (including home health and urgent care) per 1000 member months.
- Decrease rate of Emergency Department (ED) visits per 1,000 member months.
- Decrease in hospital admissions for these specific populations (both medical and psychiatric).
- Track the rate of follow up appointments kept with Specialty Service System providers.

In addition to the quality data measures already captured, Michigan will incorporate several quality measures related to the effectiveness of SUD treatment services including those required by CMS as described in SMD # 15-003 Regarding New Service Delivery Opportunities for Individuals with Substance Use Disorder.

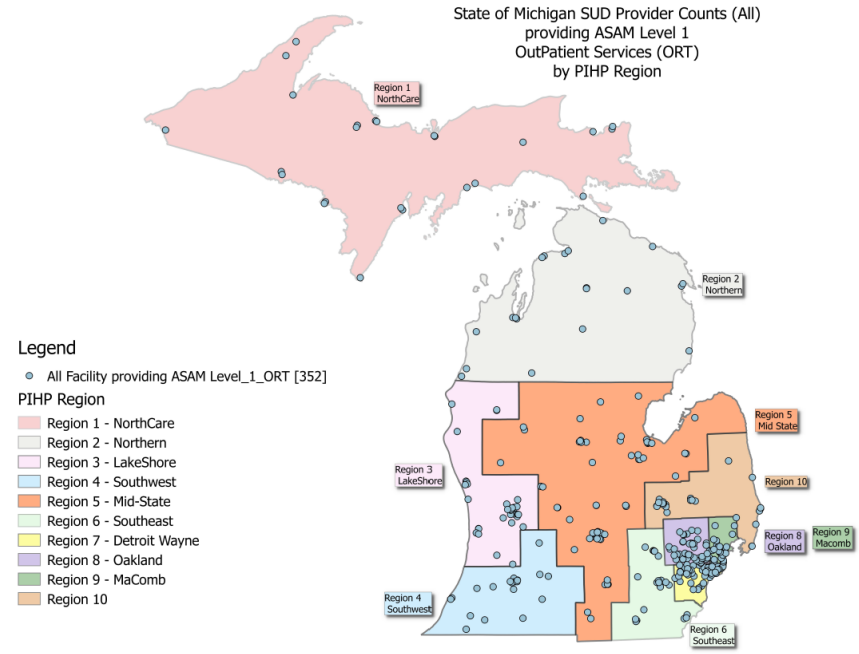
4. Describe where the 1115 Demonstration will operate, i.e., statewide, or in specific regions within the State. If the 1115 Demonstration will not operate statewide, please indicate the geographic areas/regions of the State where the 1115 Demonstration will operate.

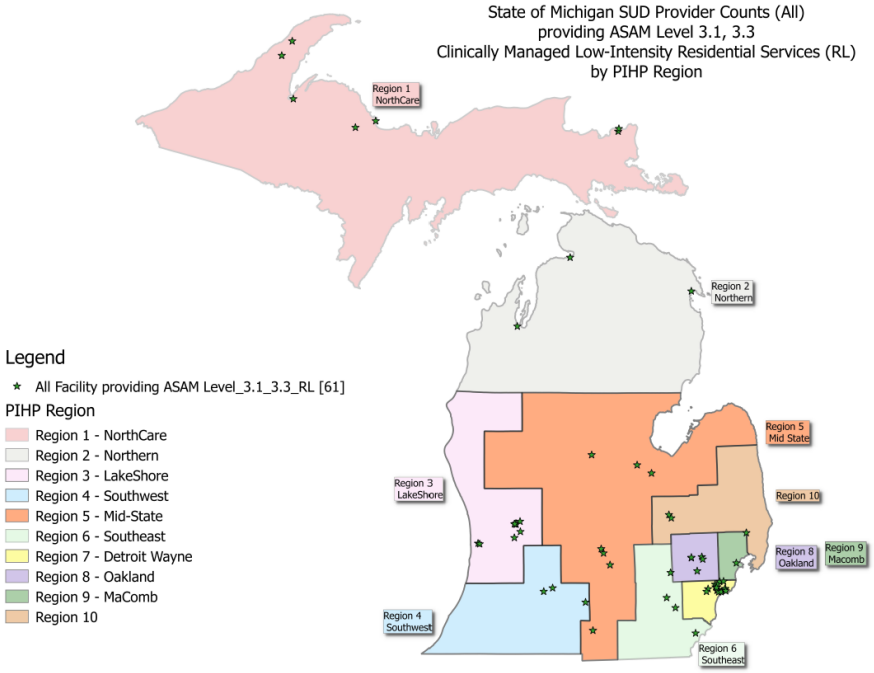
The Demonstration will operate statewide.

5. Include the proposed timeframe for the §1115 Demonstration

Michigan proposes to implement this §1115 Waiver on October 1, 2016. Demonstration Year (DY) 1, will include the development of the evaluation, collection of baseline data, and preparation of the system to develop care management systems/protocols for "High Utilizers" between the traditional Medicaid Health Plans and the Specialty Service System. Building off of the care management systems/protocols, DY 1 will also include care coordination agreements between MHPs, PIHPs, and the Specialty Service System providers (if not already in place) including for persons with SUD. DY 1 will also focus on ensuring statewide capacity for ASAM level 3.1 and developing an approach for expanding provider and service capacity for ASAM levels up to and including 3.7 and 4.

Michigan's decision to focus DY1 on ASAM level 3.1 arose after a recent exercise conducted by the state from CMS IAP SUD initiatives, which revealed an opportunity to increase SUD residential services capacity for this level of care. Using data from the most recently completed National Survey of Substance Abuse Treatment Services (N-SSATS) questionnaire, the state conducted an inventory of SUD services across ASAM levels to identify by PIHP region where services currently exist. The resulting maps (*see an example below*) reflect all of the Michigan providers that responded to the NSSATs survey in 2015 that identified as substance abuse facilities. Note that the inventory does not include facilities providing substance abuse services that identified as both mental health and substance abuse facilities, so the results are likely underrepresenting SUD capacity. 352 unduplicated facilities were associated with one of the 10 PIHP regions. Duplicates were identified through the same or similar latitude and longitude coordinates. Facilities with identical addresses were also considered duplicates.





NSSATs is an annual survey that is administered to government and privately-owned facilities that provide substance abuse treatment services by the Substance Abuse and Mental Health Services Administration (SAMHSA) and provides information on the location, characteristics, and use of alcohol and drug abuse treatment facilities and services throughout the 50 states. Included in NSSATs is a searchable database of facilities approved by state substance abuse agencies for the provision of substance abuse treatment, which is the source for the attached maps. (http://findtreatment.samhsa.gov) One limitation of the survey is its voluntary nature. A

second limitation of the survey is that it represents a point-in-time look at each responding facility by asking the facility to report on their system and clients on a particular day.

As part of participation in the CMS IAP for SUD, Michigan continues to identify additional resources for conducting an inventory of SUD provider and service capacity with the goal of using state licensing and claims/encounter data to inform where and how the state should either seek to identify residential providers that are not currently accepting Medicaid or otherwise develop SUD residential capacity.

DY 2 will build off of the expanding treatment continuum of residential care, outpatient withdrawal management, and medication assisted treatment for persons with SUD and the development of shared savings/risk models between PIHPs and MHPs. This phased approach will also align the Specialty Service System with other state initiatives including the implementation of the Blueprints Accountable Systems of Care (ACS) and Michigan's desire to be one of the pilot states to develop CCBHCs and the implementation of a Prospective Payment System (PPS) for certain populations covered under the application.

6. Describe whether the 1115 Demonstration will affect and/or modify other components of the State's current Medicaid and CHIP programs outside of eligibility, benefits, cost sharing or delivery systems.

This Demonstration will not change or modify other components of the State's current Medicaid program and Children's Health Insurance Program (CHIP).

III. Demonstration Eligibility

1) Include a chart identifying any populations whose eligibility will be affected by the 1115 Demonstration.

No eligibility changes will be affected by this demonstration.

2) Describe the standards and methodologies the state will use to determine eligibility for any populations whose eligibility is changed under the 1115 Demonstration, to the extent those standards or methodologies differ from the State plan.

No new eligibility changes will be affected by this demonstration. Previous eligibility changes for persons enrolled in the SEDW and the CWP will be transferred and included in this application.

3) Specify any enrollment limits that apply for expansion populations under the 1115 Demonstration.

There are no enrollment limits for expansion populations under this Demonstration.

4) Provide the projected number of individuals who would be eligible for the 1115 Demonstration, and indicate if the projections are based on current state programs (i.e., Medicaid State plan, or populations covered using other waiver authority, such as 1915(c)). If applicable, please specify the size of the populations currently served in those programs.

As stated above, Michigan intends to maintain the current service array and where possible explore the expansion of enrollment caps for certain services previously provided through its §1915(c) CWP and SEDW programs. All current HSW enrollee's and services (including HSW enhanced payments) will now be covered under this §1115 waiver authority. Anticipated beneficiaries served under this waiver and current enrolment caps are outlined below:

- §1915(c) HSW = 8268
- §1915(c) SEDW = 969
- §1915(c) CWP = 469
- Estimated Demonstration Including §1915(b)/(c) Populations = 220,000

5) To the extent that long term services and supports are furnished (either in institutions or the community), describe how the §1115 Demonstration will address post-eligibility treatment of income, if applicable. In addition, indicate whether the §1115 Demonstration will utilize spousal impoverishment rules under section 1924, or will utilize regular post-eligibility rules under 42 CFR 435.726 (SSI State and section 1634) or under 42 CFR 435.735 (209b State) (if additional space is needed, please supplement your answer with a Word attachment).

Michigan will apply spousal impoverishment rules for individuals receiving HCBS under the §1115 Demonstration.

6) Describe any changes in eligibility procedures the State will use for populations under the §1115 Demonstration, including any eligibility simplifications that require §1115 authority (such as continuous eligibility or express lane eligibility for adults or express lane eligibility for children after 2013) (if additional space is needed, please supplement your answer with a Word attachment).

None.

7) If applicable, describe any eligibility changes that the state is seeking to undertake for the purposes of transitioning Medicaid or CHIP eligibility standards to the methodologies or standards applicable in 2014 (such as financial methodologies for determining eligibility based on modified adjusted gross income), or in light of other changes in 2014 (if additional space is needed, please supplement your answer with a Word attachment).

Not Applicable.

IV. Demonstration Benefits and Cost Sharing Requirements

1) Indicate whether the benefits provided under the §1115 Demonstration differ from those provided under the Medicaid and/or CHIP State plan:

_X_Yes __No (if no, please skip questions 3-7)

2) Indicate whether the cost sharing requirements under the §1115 Demonstration differ from those provided under the Medicaid and/or CHIP State plan:

__ Yes _X_No (if no, please skip questions 8-11)

There are no cost sharing requirements under this Demonstration.

3) If changes are proposed, or if different benefit packages will apply to different eligibility groups affected by the §1115 Demonstration, please include a chart specifying the benefit package that each eligibility group will receive under the §1115 Demonstration:

Individuals who qualify for Specialty Services are also covered for all mandatory and optional services as approved in the Michigan state plan or as authorized or modified under this waiver. All state plan, former §1915(b) and §1915(c) waiver services are covered under this §1115 waiver. This includes individuals with Autism Spectrum Disorder and individuals eligible for Michigan Special Children's Special Health Insurance Program (aka MIChild) and the Healthy Michigan Plan (HMP). The eligibility criteria described in this section only applies to the services previously covered by the §1915(b) Waiver and multiple §1915(c) waivers. Michigan is not reducing or limiting any benefits previously offered. Michigan will be developing and adding coverage of Permanent Supportive Housing services targeted at individuals with chronic homelessness and high utilizing populations within the Specialty Service System.

Specialty Service and Supports Eligibility Criteria and Service Array (formally known as Section 1915(b)(3) Supports) for individuals with SMI, SED, or I/DD.

Medicaid beneficiaries with mental illness, serious emotional disturbance or intellectual/developmental disabilities are eligible for services within the Specialty Service System when their needs exceed the benefits provided by traditional MHPs. Eligibility to

receive services is based on medical necessity criteria as outlined below and described in the established Medicaid guidelines. All Specialty Services are provided through the PIHPs.

Medical Necessity Criteria

Mental health, intellectual/developmental disabilities, and co-occurring substance use disorder services are supports, services, and treatments:

- Necessary for screening and assessing the presence of a mental illness, developmental disability and/or
- Required to identify and evaluate a mental illness, developmental disability and/or
- Intended to treat, ameliorate, diminish or stabilize the symptoms of mental illness, developmental disability.
- Expected to arrest or delay the progression of a mental illness, developmental disability; and/or
- Designed to assist the beneficiary to attain or maintain a sufficient level of functioning in order to achieve his goals of community inclusion and participation, independence, recovery, or productivity.

Determination Criteria

The determination of a medically necessary support, service or treatment must be:

- Based on information provided by the beneficiary, beneficiary's family, and/or other individuals (e.g., friends, personal assistants/aides) who know the beneficiary;
- Based on clinical information from the beneficiary's primary care physician or health care professionals with relevant qualifications who have evaluated the beneficiary;
- For beneficiaries with mental illness or developmental disabilities, based on person-centered planning, and for beneficiaries with substance use disorders, individualized treatment planning;
- Made by appropriately trained mental health, developmental disabilities, or substance abuse professionals with sufficient clinical experience;
- Made within federal and state standards for timeliness;
- Sufficient in amount, scope and duration of the service(s) to reasonably achieve its/their purpose; and
- Documented in the individual plan of service.

The following table has been developed to assist health plans and PIHPs in making coverage determination decisions related to outpatient mental health care for MHP beneficiaries. Generally, as the beneficiary's psychiatric signs, symptoms and degree/extent of functional impairment increase in severity, complexity and/or duration, the more likely it becomes that the beneficiary will require specialized services and supports available through the PIHP/CMHSP. For all coverage determination decisions, it is presumed that the beneficiary has a diagnosable mental illness or emotional disorder as defined in the most recent Diagnostic and Statistical Manual of the Mental Disorders published by the American Psychiatric Association.

In general, MHPs are responsible for outpatient mental health in the following situations:	**In general, PIHPs/CMHSPs are responsible for outpatient mental health in the following situations:**
-The beneficiary is experiencing or demonstrating mild or moderate psychiatric symptoms or signs of sufficient intensity to cause subjective distress or mildly disordered behavior, with minor or temporary functional limitations or impairments (self-care/daily living skills, social/interpersonal relations, educational/vocational role performance, etc.) and minimal clinical (self/other harm risk) instability. -The beneficiary was formerly significantly or seriously mentally ill at some point in the past. Signs and symptoms of the former serious disorder have substantially moderated or remitted and prominent functional disabilities or impairments related to the condition have largely subsided (there has been no serious exacerbation of the condition within the last 12 months). The beneficiary currently needs ongoing routine medication management without further specialized services and supports.	-The beneficiary is currently or has recently been (within the last 12 months) seriously mentally ill or seriously emotionally disturbed as indicated by diagnosis, intensity of current signs and symptoms, and substantial impairment in ability to perform daily living activities (or for minors, substantial interference in achievement or maintenance of developmentally appropriate social, behavioral, cognitive, communicative or adaptive skills). -The beneficiary does not have a current or recent (within the last 12 months) serious condition but was formerly seriously impaired in the past. Clinically significant residual symptoms and impairments exist and the beneficiary requires specialized services and supports to address residual symptomatology and/or functional impairments, promote recovery and/or prevent relapse. -The beneficiary has been treated by the MHP for mild/moderate symptomatology and temporary or limited functional impairments and has exhausted the 20-visit maximum for the calendar year. (Exhausting the 20-visit maximum is not necessary prior to referring complex cases to PIHP/CMHSP.) The MHP's mental health consultant and the PIHP/CMHSP medical director concur that additional treatment through the PIHP/CMHSP is medically necessary and can reasonably be expected to achieve the intended purpose (i.e., improvement in the beneficiary's condition) of the additional treatment.

Specialty Service and Supports for SMI, SED, I/DD Populations
Community Living Supports
Enhanced Medical Equipment Supplies
Enhanced Pharmacy
Environmental Modifications (including vehicle modifications)
Family Support and Training
Fiscal Intermediary Services
Housing Assistance
Peer Directed and Operated Support Services (MH or DD)
Personal Emergency Response System (PERS)
Prevention Services – Direct Model
Respite Care
Skill Building Assistance
Supported Employment Services
Supports Coordination
Transportation
Additional Coverages
Permanent Supportive Housing

Specialty Service and Supports Eligibility, Service Reforms and Service Array for Persons with Substance Use Disorders (SUD).

Any Medicaid beneficiary with SUD is eligible for services within the Specialty Service System. Eligibility to receive services is based on medical necessity criteria that are outlined below and described in the Medicaid established guidelines.

Medical Necessity Criteria

The medical necessity criteria are to be applied in the following manner when determining the needs of an individual:

- Necessary for screening and assessing the presence of substance use disorder; and/or
- Required to identify and evaluate substance use disorder; and/or
- Intended to treat, ameliorate, diminish or stabilize the symptoms of substance use disorder; and/or
- Expected to arrest or delay the progression of substance use disorder; and/or
- Designed to assist the beneficiary to attain or maintain a sufficient level of functioning in order to achieve his goals of community inclusion and participation, independence, recovery, or productivity.

Determination Criteria

The determination of a medically necessary support, service or treatment must be:

- Based on information provided by the beneficiary, beneficiary's family, and/or other individuals (e.g., friends, personal assistants/aides) who know the beneficiary;
- Based on clinical information from the beneficiary's primary care physician or health care professionals with relevant qualifications who have evaluated the beneficiary;
- For beneficiaries with mental illness or developmental disabilities, based on person-centered planning, and for beneficiaries with substance use disorders, individualized treatment planning;
- Made by appropriately trained mental health, developmental disabilities, or substance abuse professionals with sufficient clinical experience;
- Made within federal and state standards for timeliness;
- Sufficient in amount, scope and duration of the service(s) to reasonably achieve its/their purpose; and
- Documented in the individual plan of service.

Additional Eligibility Reforms

Regardless of severity, all Medicaid beneficiaries for SUD services will qualify for the reformed benefit package based upon their medical need for service. It is the intent that fidelity to the amount, scope, and duration of the continuum of services outlined below will be monitored and align with ASAM criteria. Modifications to SUD state plan services are outlined in Appendix A. Under this demonstration, Michigan's reformed SUD benefit will build on the state's current comprehensive, evidence-based approach to service design and will be modified to align with the array of SUD services under the HMP. The specific services that will be offered as part of the SUD service continuum include:

- Early Intervention
- Outpatient Therapy – inclusive of ASAM Levels 1, 2.1 and 2.5
- Residential Treatment – inclusive of ASAM Levels 3.1, 3.3, 3.5 and 3.7
- Withdrawal Management – inclusive of ASAM Levels 1-WM, 2-WM, 3.2-WM and 3.7-WM
- Opioid Treatment Program (Level 1)

The Early Intervention level of care (0.5) is currently offered as a benefit and will continue to be included as part of this continuum with a more formal designation than it has now. The access systems are required to provide education and resource information as part of their programming already. This is consistent with ASAM expectations for individuals who are at risk of developing a SUD yet there is not sufficient information to document a formal SUD diagnosis after an assessment has been completed. Similar to how SBIRT works, the individual will be able to return to the assessment center/component of a program for a set number of brief follow up visits for more education and information gathering to assist in determining if more intensive interventions are needed.

Outpatient Therapy and Residential Treatment are currently available and will continue to be offered. The descriptions will be delineated to reflect the areas as described by ASAM so the dimensions can be accurately utilized. Level 4 services are available through the physical health care system that all Medicaid beneficiaries receive. Medication assisted treatment, with methadone, through Opioid Treatment Programs will continue as a service in the continuum. Additionally, other medications that can be used to treat opioid addiction (Buprenorphine, Vivitrol, etc.) through office based settings will continue to be available through the established pharmacy benefit that is part of the overall Medicaid benefit. The following tables detail the medication and authorization requirements and the specific assessment guidelines and benefit descriptions for SUD services based on specific assessment guidelines. No predetermined limits of care will be established for these services.

Medication	Prior Authorization/Limit	Availability
Methadone	No	Opioid Treatment Program only
Buprenorphine	Yes, unless provided in OTP – 12 months initial	Pharmacy Benefit
Naltrexone long acting injection	No	Pharmacy Benefit, physician administered
Acamprosate	No	Pharmacy Benefit
Naloxone	No	Pharmacy Benefit

ASAM Level of Care	Title	Service Description	Treatment Methods and Supports	Provider
0.5	Early Intervention	Assessment and education for at-risk individuals. Screening, Brief Intervention, and Referral to Treatment (SBIRT).	Assessment/screening Didactics/education Medically managed care	Network access/assessment service. Managed care/fee for service physical health care system.
1	Outpatient Services	Less than 9 hours of service/week (adults); less than 6 hours/week (adolescents) for recovery or motivational enhancement therapies/strategies.	Assessment Treatment planning Individual, group, family therapy Didactic/education Psychiatric evaluation Medication review Peer supports Recovery supports Case management Crisis Intervention	State licensed outpatient program; accredited by national organization; and state licensed and/or certified staff.

2.1	Intensive Outpatient Services	9 or more hours of service/week (adults); 6 or more hours/week (adolescents) to treat multidimensional instability.	Assessment Treatment planning Individual, group, family therapy Didactic/education Psychiatric evaluation Medication review Peer supports Recovery supports Case management Crisis Intervention	State licensed outpatient program; accredited by national organization; and state licensed and/or certified staff.
2.5	Partial Hospitalization Services	20 or more hours of service/week for multidimensional instability not requiring 24-hour care.	Assessment Treatment planning Individual, group, family therapy Didactic/education Psychiatric evaluation Medication review Peer supports Recovery supports Case management Crisis Intervention	State licensed outpatient program; accredited by national organization; and state licensed and/or certified staff.
3.1	Clinically Managed Low-Intensity Residential Services	24-hour structure with available trained personnel; at least 5 hours of clinical service/week and prepare for outpatient treatment.	SUD/health/nursing assessment Treatment planning Individual, group, family therapy Didactic/education Psychiatric evaluation Medication review Peer supports Recovery supports Case management Crisis Intervention	State licensed residential program; accredited by national organization; and state licensed and/or certified staff. This may include settings regardless of bed size that are within the definition of IMDs at 42 CFR 435.1010.
3.3	Clinically Managed Population-Specific High-Intensity Residential Services	24-hour care with trained counselors to stabilize multidimensional imminent danger. Less intense milieu and group treatment for those with cognitive or other impairments unable to use full active milieu or therapeutic community and prepare for outpatient treatment.	SUD/health/nursing assessment Treatment planning Individual, group, family therapy Didactic/education Psychiatric evaluation Medication review Peer supports Recovery supports Case management Crisis Intervention	State licensed residential program; accredited by national organization; and state licensed and/or certified staff. This may include settings regardless of bed size that are within the definition of IMDs at 42 CFR 435.1010.
3.5	Clinically Managed High-Intensity Residential Services	24-hour care with trained counselors to stabilize multidimensional imminent danger and	SUD/health/nursing assessment Treatment planning Individual, group, family therapy	State licensed residential program; accredited by national organization; and state licensed and/or certified staff. This may

		prepare for outpatient treatment. Able to tolerate and use full milieu or therapeutic community.	Didactic/education Psychiatric evaluation Medication review Peer supports Recovery supports Case management Crisis Intervention	include settings regardless of bed size that are within the definition of IMDs at 42 CFR 435.1010.
3.7	Medically Monitored Intensive Inpatient Services	24-hour nursing care with physician availability for significant problems in Dimensions 1, 2, or 3. 16 hour/day counselor availability.	SUD/health/nursing assessment Treatment planning Individual, group, family therapy Didactic/education Psychiatric evaluation Medication review Peer supports Recovery supports Case management Crisis Intervention	State licensed residential program; accredited by national organization; and state licensed and/or certified staff. This may include settings regardless of bed size that are within the definition of IMDs at 42 CFR 435.1010.
4	Medically Managed Intensive Inpatient Services*	24-hour nursing care and daily physician care for severe, unstable problems in Dimensions 1, 2, or 3. Counseling available to engage patient in treatment.	Medically managed care	Licensed inpatient hospital setting, managed care/fee for service physical health care system. This may include settings regardless of bed size that are within the definition of IMDs at 42 CFR 435.1010.
OTP	Opioid Treatment Program	Daily or several times weekly opioid agonist medication and counseling available to maintain multidimensional stability for those with severe opioid use disorder.	SUD/health/nursing assessment Treatment planning Individual, group, family therapy Didactic/education Psychiatric evaluation Medication review Peer supports Recovery supports Case management Crisis Intervention	State licensed and federally certified Opioid Treatment Program (Methadone); and state licensed and/or certified staff.
1-WM	Ambulatory Withdrawal Management Without On-site Monitoring	Mild withdrawal with daily or less than daily outpatient supervision.	SUD/health/nursing assessment Treatment planning Didactic/education Psychiatric evaluation Peer supports Recovery supports Case management	State licensed detoxification program; accredited by national organization; and state licensed and/or certified staff.
2-WM	Ambulatory Withdrawal Management with Extended	Moderate withdrawal with all day withdrawal management and support and supervision;	SUD/health/nursing assessment Treatment planning Didactic/education Psychiatric evaluation	State licensed detoxification program; accredited by national organization; and state

	On-Site Monitoring	at night has supportive family or living situation.	Peer supports Recovery supports Case management	licensed and/or certified staff.
3.2-WM	Clinically Managed Residential Withdrawal Management	Moderate withdrawal, but needs 24-hour support to complete withdrawal management and increase likelihood of continuing treatment or recovery.	SUD/health/nursing assessment Treatment planning Didactic/education Psychiatric evaluation Peer supports Recovery supports Case management	State licensed detoxification program; accredited by national organization; and state licensed and/or certified staff. This may include settings regardless of bed size that are within the definition of IMDs at 42 CFR 435.1010.
3.7-WM	Medically Monitored Inpatient Withdrawal Management	Severe withdrawal, needs 24-hour nursing care & physician visits; unlikely to complete withdrawal management without medical monitoring.	SUD/health/nursing assessment Treatment planning Didactic/education Psychiatric evaluation Peer supports Recovery supports Case management	State licensed detoxification program; accredited by national organization; and state licensed and/or certified staff. This may include settings regardless of bed size that are within the definition of IMDs at 42 CFR 435.1010.
4-WM	Medically Managed Intensive Inpatient Withdrawal Management*	Severe, unstable withdrawal and needs 24-hour nursing care and daily physician visits to modify withdrawal management regimen and manage medical instability.	Medically managed care	Licensed inpatient hospital setting, managed care/fee for service physical health care system. This may include settings regardless of bed size that are within the definition of IMDs at 42 CFR 435.1010.

*Benefit is available through the physical health care benefits of Medicaid coverage, not part of the specialty behavioral health system

The SUD service system will provide the necessary treatment and support services to office based opioid treatment provided through the primary care system. Withdrawal Management, currently referenced in our system as “sub-acute detoxification,” will continue to be a service and will be expanded in scope to reference all levels. Level 4 services, like those for inpatient care, will continue to be available through the physical healthcare system regardless of the size of facility.

In addition, Michigan Medicaid will continue to provide a full array of primary and acute care treatment services as described under the state plan and elsewhere in this waiver, including inpatient hospital services, outpatient pharmacy services, and SBIRT.

To support the use of the established medical necessity criteria, and make them more representative of “clinical necessity” that is needed for SUD treatment, the Six Dimensions of Multidimensional Assessment, part of the ASAM Criteria, will be incorporated into the

assessment process for any individual seeking SUD related services. These dimensions include a detailed review of the following areas:

1. Dimension 1 – Acute Intoxication and/or Withdrawal Potential
2. Dimension 2 – Biomedical Conditions and Complications
3. Dimension 3 – Emotional, Behavioral, or Cognitive Conditions and Complications
4. Dimension 4 – Readiness to Change
5. Dimension 5 – Relapse, Continued Use, or Continued Problem Potential
6. Dimension 6 – Recovery/Living Environment

There are numerous considerations that need to be addressed in each dimension. These considerations fit within the established framework of the assessment process and the required medical necessity criteria. The ASAM dimensions will be incorporated so that each area is a standard part of the assessment and level of care determination process. The assessment procedures that are required through accreditation and licensing standards do not conflict with the information that is needed to make a level of care determination based on ASAM, therefore no barriers exists for the system to make this change. This effort will be supported through the training process that was described in network development above.

The benefits available in this demonstration will not have preset limits or fee capitations placed on them. There will be individual determination of medical and clinical necessity for each beneficiary for initial and ongoing care needs. The PIHP will employ its established utilization management system for continued stay reviews which will also apply the ASAM criteria to support individual treatment and support needs.

The following treatment services must be provided to all eligible beneficiaries for the identified level of care in each managed care region of the state. Michigan's SUD benefits include a continuum of care that ensures that individuals can enter SUD treatment at a level appropriate to their needs and step up or down to a different intensity of treatment based on their responses. This list also reflects the various services and supports that are available within each level of care.

Intensive Home and Community Based Supports and **Service Eligibility Criteria for Adults and Children with Intellectual and Development Disabilities (Formerly known as Habilitation Supports Waiver (HSW) and Children's Waiver Program (CWP).**

The following eligibility criteria combines the §1915(c) HSW and §1915(c) CWP populations that are to be consolidated into this §1115 Waiver. Enrollment caps and specific eligibility criteria for services still remain and are outlined in section III of this application.

Eligibility Criteria

Current assessments of the participant reflect evidence of a developmental disability based on either **1 or 2 and** the participant must also have needs that meet the requirements in **3**, below.

1) The participant (of any age) has a severe, chronic condition that meets **all** of the following requirements:
   a) Is attributable to a mental or physical impairment or a combination of mental and physical impairments;
   b) Is manifested before the beneficiary is 22 years old;
   c) Is likely to continue indefinitely;
   d) Results in substantial functional limitations in 3 or more of the following areas of major life activity:
      i) Self-care
      ii) Receptive and expressive language
      iii) Learning
      iv) Mobility
      v) Self-direction
      vi) Capacity for independent living (applies to children age 16 and older)
      vii) Economic self-sufficiency (applies to children age 16 and older)
   e) Reflects the beneficiary's need for a combination and sequence of special, interdisciplinary, or generic care.
2) The participant is age birth to age 9 and has a substantial developmental delay or a specific congenital or acquired condition with a high probability of resulting in developmental disability as defined in 1 above if services are not provided.

3) The participant's intellectual or functional limitations indicate that s/he would be eligible for health, habilitative, and active treatment services provided at the Intermediate Care Facilities for Individuals with Intellectual Disability (ICF/IID) level of care. The following are the eligibility criteria:

   - Habilitative services are designed to assist individuals in acquiring, retaining and improving the self-help, socialization, and adaptive skills necessary to reside successfully in home and community-based settings.
   - Active treatment includes aggressive and consistent implementation of a program of specialized and generic training, treatment, health services, and related services.
   - Active treatment is directed toward the acquisition of behaviors necessary for the participant to function with as much self-determination and independence as possible, and the prevention or deceleration of regression or loss of current optimal functional status.
   - Active treatment does not include services to maintain generally independent clients who are able to function with little supervision or in the absence of a continuous active treatment program.

- Necessary services include, for those participants who lack them, training in personal skills essential for privacy and independence (including, but not limited to, toilet training, personal hygiene, dental hygiene, self-feeding, bathing, dressing, grooming, and communication of basic needs) until it has been demonstrated that the participant is developmentally incapable of acquiring them.
- Participants must need and be receiving training targeted toward amelioration of these basic skill deficit areas.
- The participant must live full-time in a community based setting (not in a hospital, ICF/IID, nursing facility, correctional facility or child caring institution) while receiving services.
- The participant must receive support and service coordination (and/or Targeted Case Management for persons in the CWP) and at least one other community-based Long Term Service and Support each month to maintain eligibility.
- Must reside in a facility that is 12 beds or fewer.

Additional Eligibility Criteria for Intensive Home and Community Based Supports Service

The participant must be one of the following:

a. Eligible for MICHILD
b. Eligible for the former HSW benefit package, eligible for Medicaid full scope and coverage under any of the "regular" Medicaid programs (e.g., Healthy Michigan, SSI, TANF, Healthy Kids, Transitional MA, etc.) **OR**
c. Qualify for Medicaid services as a family of one for individuals under age 18, living full time in the community with their birth or adoptive parent or with a legal guardian who is a relative and eligible for Medicaid as a "family-of-one" because they meet these needs-based clinical criteria and also meet the disability criteria for SSI.

Habilitation Support Services
Community Living Supports
Enhanced Medical Equipment Supplies
Enhanced Pharmacy
Environmental Modifications
Family Training
Goods and Services
Non Family Training
Out of Home Non-Vocational Habilitation
Prevocational Services
Personal Emergency Response System (PERS)
Respite

Private Duty Nursing
Supported Employment
Supports Coordination

Services for Children with Intellectual/Developmental Disability
Community Living Supports
Specialized Medical Equipment & Supplies
Environmental Modifications (including vehicle modifications)
Family Training
Fiscal Intermediary Services
Non Family Training
Specialty Services/Therapies (Music, Recreational, Art, massage)
Respite
Enhanced Transportation
Non Family Training
Fencing

SED Service Eligibility Criteria and Service Array

The child/youth must meet all MDHHS criteria for the state psychiatric hospital for children, as specified in the Michigan Medicaid Provider Manual - INPATIENT ADMISSION CRITERIA: CHILDREN THROUGH AGE 21. The consumer must meet all elements of three admission criteria: diagnosis, Severity of Illness (signs, symptoms, functional impairments and risk potential) and Intensity of Service.

In addition, the child/youth must demonstrate serious functional limitations that impair the ability to function in the community. As appropriate for age, functional limitation is identified using the Child and Adolescent Functional Assessment Scale (CAFAS®), the Preschool and Early Childhood Functional Assessment Scale (PECFAS®) or the Devereux Early Childhood Assessment Scales (DECA):

- CAFAS® score of 90 or greater for children age 7 to 12; OR
- CAFAS® score of 120 or greater for children age 13 to 18; OR
- For children age 4 to 7, elevated PECFAS® subscale scores in at least one of these areas: self-harmful behaviors, mood / emotions, thinking / communicating or behavior towards others; OR
- For children age 2-4, scores in the concern range across Devereux Early Childhood Assessment (DECA) Clinical Version scales: Protective factor scales (initiative, self-control, and attachment) that are in the Concern Range with a Total Protective Factor T-score of 40 or below and/or elevated scores on one or more of the behavioral concerns

scales (Attention Problems, Aggression, Withdrawal/Depression, Emotional Control Problems) with a T-score of 60 or above.

- The participant must live in a community based setting (not in a hospital, ICF/IID, nursing facility, correctional facility or child caring institution) while receiving services.
- The participant must receive Wraparound and at least one other community-based Long Term Service and Support each month to maintain eligibility.

Additional Eligibility Criteria

The participant must be one of the following:

a. Eligible for MIChild
b. Eligible for Medicaid full scope and coverage under any of the "regular" Medicaid programs (e.g., Healthy Michigan, SSI, TANF, Healthy Kids, Transitional MA, etc.) **OR**
c. Under age 18, living full time in the community with their birth or adoptive parent or with a legal guardian who is a relative and eligible for Medicaid as a "family-of-one" because they meet these needs-based clinical criteria and also meet the disability criteria for SSI.
d. Be under the age of 18 when approved for the 1115. If the child turns 18 and continues to meet all non-age related eligibility criteria, and continues to need the additional supports and services covered by the Waiver for this target population, the child can remain on the waiver up to their 21st birthday.

Services for Children with Serious Emotional Disturbance
Community Living Supports
Family Support and Training
Non Family Training
Children's Therapeutic Foster Care
Therapeutic Overnight Camping
Transitional Services
Wraparound
Specialty Therapies (Music, Recreational and Art)
Family Training
Respite

4) If electing benchmark-equivalent coverage for a population, please indicate which standard is being used?

Federal Employees Health Benefit Package
State Employee Coverage
Commercial Health Maintenance Organization

Secretary Approved

The Demonstration will not include benchmark-equivalent coverage.

5) In addition to the Benefit Specifications and Qualifications form: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/Downloads/Interim1115-Benefit-Specifications-and-Provider-Qualifications.pdf, please complete the following chart if the 1115 Demonstration will provide benefits that differ from the Medicaid or CHIP State plan.

Although the benefits specifications and qualification for Medicaid or CHIP state plan services will not differ, the SUD service and supports will require that the authorization and utilization of services align with the ASAM criteria as outlined in section III of the application. Appendix A outlines the SUD services that require state licensure and align services with the ASAM criteria. The SUD services that also overlap with the LTSS will remain unchanged by this application. All SUD state plan and former §1915(b) services will continue to be based on the medical necessity to receive those services.

6) Indicate whether Long Term Services and Supports will be provided.

_X__ Yes (if yes, please check the services that are being offered) ___ No

X	Long Term Service and Supports
X	Respite
X	Community Living Supports
X	Private Duty Nursing
X	Supported/Integrated Employment
X	Out of Home Non Vocational Habilitation
X	Goods and Services
X	Environmental Modifications (Home Accessibility Adaptations)
X	Supports and Service Coordination
X	Enhanced Pharmacy
X	Personal Emergency Response System (PERS)
X	Community Transition Services
X	Enhanced Medical Equipment and Supplies (Including Vehicle Modifications)
X	Family Training
X	Non Family Training
X	Specialty Therapies (Music, Art, Massage)
X	Children Therapeutic Foster Care

X	Therapeutic Overnight Camping
X	Transitional Services
X	Fiscal Intermediary Services
X	Prevocational Services

7) Indicate whether premium assistance for employer-sponsored coverage will be available through the §1115 Demonstration.

__Yes (if yes, please address the questions below)
_X_No (if no, please skip this question)

a) Describe whether the State currently operates a premium assistance program and under which authority, and whether the state is modifying its existing program or creating a new program.

b) Include the minimum employer contribution amount.

c) Describe whether the Demonstration will provide wrap-around benefits and cost-sharing.

d) Indicate how the cost effectiveness test will be met.

8) If different from the State Plan, provide the premium amounts by eligibility group and income level.

There are no premium amounts included in this Demonstration.

9) Include a table if the Demonstration will require copayments, coinsurance and/or deductibles that differ from the Medicaid State Plan (an example is provided).

The Demonstration will not require copayments, coinsurance and/or deductibles.

10) Indicate if there are any exemptions from the proposed cost sharing.

Cost sharing is not a component of this Demonstration.

V. Delivery System and Payment Rates for Services

1) Indicate whether the delivery system used to provide benefits to Demonstration participants will differ from the Medicaid and/or CHIP State plan:

__Yes
_X_ No

2) Describe the delivery system reforms that will occur as a result of the Demonstration, and if applicable, how they will support the broader goals for improving quality and value in the health care system. Specifically, include information on the proposed Demonstration's expected impact on quality, access, cost of care and potential to improve the health status of the populations covered by the Demonstration. Also include information on which populations and geographic areas will be affected by the reforms.

A vital component of this demonstration is the alignment of quality and financial incentives between traditional Medicaid Health Plans and Michigan's Specialty Service System. Michigan, in concert with the development of the ASC and its pursuit to be one of the pilot demonstration states for the Certified Community Behavioral Health Clinic Services, intends to advance integrated care services for the entire Specialty Services population. These changes will require PIHPs and their CMHSP providers to meet quality reporting requirements, develop and expand SUD provider systems, and partner with traditional health plans to ensure access for persons with mild and moderate behavioral health disorders. These linkages are intended to identify and provide education, prevention, and treatment of modifiable health risk factors, provide SBIRT for SUD at primary care settings, provide housing first initiatives, provide incentives for increased access to primary care, and the coordinated tracking of "High Utilizers" of emergency department usage and hospital admissions/readmissions.

In order to further standardize the SUD assessment process and level of care criteria, there will be ongoing training and education on the application of the ASAM at all levels of SUD care. The PIHPs will be required to ensure that their providers and/or the intake agencies within their networks are all appropriately trained/educated in the application and use. PIHPs will provide evidence of initial training and ongoing training of providers during site reviews conducted by MDHHS. Additionally, as part of quality monitoring during DHHS site reviews, records will be reviewed to determine appropriate application and fidelity to the established assessment and early intervention processes and to determine if the PIHP is appropriately monitoring providers and taking necessary corrective action.

3) Indicate the delivery system that will be used in the Demonstration by checking one or more of the following boxes:

- ☐ Managed care
- ☐ Managed Care Organization (MCO)
- X Prepaid Inpatient Health Plans (PIHP)
- ☐ Prepaid Ambulatory Health Plans (PAHP)
- ☐ Primary Care Case Management (PCCM)
- ☐ Health Homes
- ☐ Other (please describe)

4) If multiple delivery systems will be used, please include a table that depicts the delivery system that will be utilized in the Demonstration for each eligibility group that participates in the Demonstration (an example is provided). Please also include the appropriate authority if the Demonstration will use a delivery system (or is currently seeking one) that is currently authorized under the State plan, section 1915(a) option, section 1915(b) or section 1932 option

Michigan's will continue to use a single Specialty Service System on a statewide basis for State Plan and the former §1915(b) and §1915(c) Waiver beneficiaries who meet Specialty Service Criteria. This includes persons enrolled in the MICHILD program and expansion populations.

5) If the Demonstration will utilize a managed care delivery system:

The Demonstration will use Medicaid PIHPs

a) Indicate whether enrollment be voluntary or mandatory. If mandatory, is the state proposing to exempt and/or exclude populations (if additional space is needed, please supplement your answer with a Word attachment)?

Enrollment into the Michigan's Specialty Service System will continue to be mandatory based on the criteria described in Section II.

b) Indicate whether managed care will be statewide, or will operate in specific areas of the state (if additional space is needed, please supplement your answer with a Word attachment);

The managed care delivery system will be statewide

c) Indicate whether there will be a phased-in rollout of managed care (if managed care is not currently in operation or in specific geographic areas of the state. If additional space is needed, please supplement your answer with a Word attachment);

There will not be a phased in or rollout of managed care within this Demonstration. Michigan has operated its specialty Service System using PIHPs since 1998.

d) Describe how will the state assure choice of MCOs, access to care and provider network adequacy (if additional space is needed, please supplement your answer with a Word attachment); and

This §1115 Waiver will maintain the use of a managed care delivery structure using ten (10) recently procured PIHPs[5] who contract for service delivery with forty-six (46) CMHSP's and other non-for profit providers. As outlined in the table below, seven (7) of the PIHPs are formed by multiple CMHSP's (aka. Regional Entities) and three (3) are stand-alone PIHPs/CMHSPs.

CMHSP's/County/City	Type of program	Name of Entity
Pathways CMH **(Alger, Delta, Luce, Marquette) Copper Country CMH (Baraga, Houghton, Keewanaw, Ontonagon)** Hiawatha CMH **(Chippewa, Mackinac, Schoolcraft)** Northpointe CMH **(Menominee, Dickinson, Iron) Gogebic CMH**	**PIHP**	**Northcare Network**
AuSable CMH **(Oscoda, Ogemaw, Iosco) Central Wellness Network (Manistee, Benzie)** North Country CMH **(Antrim, Charlevoix, Cheboygan, Emmet, Kalkaska, Otsego)** Northern Lakes CMH **(Crawford, Grand Traverse, Leelanau, Missaukee, Roscommon, Wexford)** Northeast CMH **(Alcona, Alpena, Montmorency, Presque Isle)**	**PIHP**	**Northern Michigan Regional Entity**
Allegan CMH	**PIHP**	**Lake Shore Regional Entity**

[5] See 2013 Application for Participation for Specialty Prepaid Inpatient Health Plans

CMHSP's/County/City	Type of program	Name of Entity
Muskegon CMH Network 180 **(Kent) Ottawa CMH West MI CMH (Lake, Mason, Oceana)**		
Barry CMH Berrien CMH Kalamazoo CMH Pines CMH **(Branch)** St. Joseph CMH Summit Pointe CMH **(Calhoun)** Van Buren CMH Woodlands CMH **(Cass)**	**PIHP**	**Southwest Michigan Behavioral Health**
Bay-Arenac CMH **(Bay, Arenac)** CMH for Central MI **(Clare, Gladwin, Isabella, Mecosta, Midland, Osceola)** CEI CMH **(Clinton, Eaton, Ingham) Gratiot CMH Huron** CMH Ionia CMH LifeWays CMH **(Jackson, Hillsdale)** Montcalm CMH Newaygo CMH Saginaw CMH Shiawassee CMH Tuscola CMH	**PIHP**	**Mid State Health Network**
Washtenaw CMH Lenawee CMH Livingston CMH Monroe CMH	**PIHP**	**CMH Partnership of Southeast Michigan**
Detroit-Wayne CMH	**PIHP**	**Detroit-Wayne Mental Health Authority**
Oakland CMH	**PIHP**	**Oakland County CMH Authority**
Macomb CMH	**PIHP**	**Macomb County CMH Services**
Genesee Health System Lapeer CMH Sanilac CMH St. Clair CMH	**PIHP**	**Region 10 PIHP**

Timeliness of access to services is monitored quarterly through Michigan's Mission Based Performance Indicator System (MMBPIS) and verified through the Quality Assessment and Performance Improvement Program via an External Quality Review (EQR). Adequacy of the provider network is monitored by the State Agency, EQR and by the PIHPs through comprehensive network capacity assessments.

Although freedom of choice will continue to be waived, PIHPs will be required (as non-provider entities) to arrange Medicaid service contracts to ensure the independent evaluation of eligibility, assessment, and the development of the Individual Plan of Service to ensure compliance with Home and Community Based Setting (HBCS) final rules. Although model configuration may be optional (based on state approval), the independent evaluation of eligibly and assessment does not include the provision of emergency services that may result in a preliminary plan of service or functions related to hospital preadmission screening or discharge planning. For PIHPs who contract with CMHSPs, the PIHP will be required to monitor the CMHSP's self-referral and utilization patterns related to consumer choice and best value criteria. MDHHS will play a vital role in the policy development and promulgation of these rules as part of its HBCS statewide transition plan.

e) Describe how the managed care providers will be selected/procured (if additional space is needed, please supplement your answer with a Word attachment).

In April 2013, Michigan required its 18 PIHPs to consolidate to 10 through an Application for Participation of Specialty Prepaid Inpatient Health Plans. As outlined above, Michigan intends to continue the use of this managed care delivery system within this §1115 application but holds the ability to contract outside of the PIHP and CMHSP system if the managed care entity and/or providers cannot meet the service delivery, quality, financial and reporting requirements as determined by the state.

6) Indicate whether any services will not be included under the proposed delivery system and the rationale for the exclusion.

All State Plan and Waiver services will be included as part of this §1115 Demonstration.

7) If the Demonstration will provide personal care and/or long term services and supports, please indicate whether self-direction opportunities are available under the Demonstration. If yes, please describe the opportunities that will be available, and also provide additional information with respect to the person-centered services in the Demonstration and any financial management services that will be provided under the Demonstration

_X__Yes
___ No

The Demonstration will provide personal care and long term services and supports including options for both self-direction/determination models including the use of fiscal intermediaries. Waiver participants have opportunities for both employer and budget authority. Participants may elect to control their individual budget for all services or can direct a single service for which participant direction is an option. Fiscal Intermediaries are available to provide financial management services.

The participant may also exercise employer authority to directly employ or contract with chosen providers. There are two options for participants choosing to directly employ workers, the Choice Voucher System and/or Agency with Choice. A participant may select one or both options. Through a Purchase of Service Agreement, a participant may directly contract with a professional provider or an agency provider.

In the first option, the participant is employer of record and the Fiscal Intermediary (FI) serves as Employer Agent to handle. The FI processes payroll and performs other administrative and support functions. In this model the participant directly recruits, hires and manages employees. Detailed guidance to PIHP entities is provided in the Self-Determination Implementation Technical Advisory.

In the Agency with Choice model, participants may contract with an agency that splits the employer duties between the agency and participant. The participant is the managing employer and has the authority to select, hire, supervise and terminate workers. As co-employer, the agency is the employer of record and handles the administrative and legal employer functions. The agency may provide assistance in recruiting and hiring workers. Detailed guidance to PIHP entities is provided in the Self-Determination Implementation Technical Advisory.

PIHPs and their contract providers are the primary entities that support participants who direct their services. Supports coordinators, supports coordinator assistants, or independent support brokers (or other qualified provider chosen by the participant) are responsible for providing support to participants in arrangements that support self-determination by working with them through the Person Centered Planning (PCP) process to develop an IPOS and an individual budget. The supports coordinator, supports coordinator assistant, or independent supports broker is responsible for obtaining authorization of the individual budget and IPOS and for monitoring the IPOS, individual budget, and arrangements. Supports coordinators, supports coordinator assistants, or independent supports brokers (or other qualified provider chosen by the participant) make sure that participants receive the services to which they are entitled and that the arrangements are implemented smoothly. A variety of options for independent advocacy are available. These options include: utilizing a network of allies in the PCP process, using an Independent Facilitator to facilitate the planning process and retaining an independent supports broker for assistance throughout the planning and implementing the IPOS and individual budget. The primary roles of the independent supports broker are to assist the participant in determining the best way to implement the participant's IPOS and acquire

services and supports. The supports broker helps the participant explore the availability of community services and supports, access housing and employment, and makes the necessary arrangements to link the participant with those supports. Supports brokerage services offer practical skills training to enable participants to remain independent, including the provision of information on recruiting/hiring/managing workers, effective communication, and problem solving. When a participant uses an independent supports broker, the supports coordinator or supports coordinator assistant has a more limited role in planning and implementation of arrangements so that the assistance provided is not duplicated. Authorization of the IPOS and individual budget cannot be delegated to an independent supports broker by the PIHP.

Through its contract with MDHHS, each PIHP is required to offer information and education to participants on participant direction. Each PIHP also offers support to participants in these arrangements. This support can include offering training for workers, offering peer-to-peer discussion forums on how to be a better employer, or providing one-on-one assistance when a problem arises. Each PIHP is required to contract with fiscal intermediaries to provide financial management services. A fiscal intermediary performs a number of essential tasks to support participant direction while assuring accountability for the public funds allotted to support those arrangements. The fiscal intermediary has four basic areas of performance:

- Function as the employer agent for participants directly employing workers to assure compliance with payroll tax and insurance requirements
- Ensure compliance with requirements related to management of public funds, the direct employment of workers by participants, and contracting for other authorized goods and services
- Facilitate successful implementation of the arrangements by monitoring the use of the budget and providing monthly budget status reports to participant and agency
- Offer supportive services to enable participants to direct the services and supports they need

8) If fee-for-service payment will be made for any services, specify any deviation from State plan provider payment rates. If the services are not otherwise covered under the State plan, please specify the rate methodology.

There will be no fee-for-service payments made under this Demonstration.

9) If payment is being made through managed care entities on a capitated basis, specify the methodology for setting capitation rates, and any deviations from the payment and contracting requirements under 42 CFR Part 438.

The MDHHS has retained Milliman Inc. to develop actuarially sound rates using published guidance from the American Academy of Actuaries (AAA), the Actuarial Standards Board, CMS,

and federal regulations to ensure compliance with 42 CFR §438.6(c). Capitation rates will include all State Plan, §1915(b) and §1915(c) Waivers as outlined in Exhibit 1. Capitation rate values will be developed using PIHP submitted encounter data and Medicaid Utilization Net Cost Reports (MUNC) and will vary by benefit type and program code. Program code categories include the TANF, and the Aged, Blind, and Disabled (DAB) populations. Rate adjustment factors will be developed to reflect age, gender and geographic region for each benefit category. As with the current §1915(b) and §1915(c) Waivers, PIHPs are responsible for all Medicaid beneficiaries within a geographic catchment area who meet criteria for the Specialty Service System. Because of this broad responsibility, the Per Member Per Month (PMPM) payments will be based on the entire Medicaid eligible population as opposed to enrolled beneficiaries.

10) If quality-based supplemental payments are being made to any providers or class of providers, please describe the methodologies, including the quality markers that will be measured and the data that will be collected.

Quality based payments related to the Demonstration goals as outlined in section I, will be developed as part of phase 2 of the demonstration. MDHHS intends to hold back up to 1.0% of capitation payments to be redistributed based on meeting the demonstration expectations through the implementation of complex care management, joint PIHP and MHP performance incentives, and meeting quality/cost indicators to be further defined in the evaluation component of the demonstration. MDHHS plans to continue incentive payments outside of the normal capitation methodology to PIHPs who service foster children and children in Child Protective Services (CPS) with Serious Emotional Disturbances under this §1115 Demonstration.

VI. Implementation of Demonstration

1) Describe the implementation schedule. If implementation is a phase-in approach, please specify the phases, including starting and completion dates by major component/milestone.

Upon submission and anticipated approval of October 1, 2016 Michigan proposes to implement the benefit and spending authority effective October 1, 2016. Phase 1 of the demonstration will include the development of the demonstration based on CMS's timeframe to submit final evaluation. This will include the collection of baseline data and preparing the system to develop care management systems/protocols for "High Utilizers" between the traditional Medicaid Health Plans and the Specialty Service System. Phase 1 will also include care coordination agreements between MHPs, PIHPs and the Specialty Service System providers (if not already in place) including for persons with SUD. The enhancement of provider competency related to the use of ASAM criteria, the expanded use of recovery coaches and the use of residential treatment facilities regardless of the size of the facility.

Phase 2 will build off of the expanding treatment continuum of residential care, outpatient withdrawal management, medication assisted treatment for persons with SUD, and the development of shared savings/risk models between PIHPs and MHPs. Phase 2 (which may span demonstration years 2 and 3) will include the development of bundled funding and quality incentives for ASC and the implementation of a prospective payment system for Certified Community Behavioral Health Clinics (if chosen as a demonstration state). Beginning on or before January 1, 2017, both traditional health plans and PIHPs will be contractually required to monitor certain quality and integrated care outcomes that lead toward the tracking and implementation of potential shared savings models between traditional health plans, PIHP's and their respective provider networks.

2) Describe how potential participants will be notified/enrolled into the demonstration.

As done currently, new Medicaid beneficiaries will be notified of their Specialty Service System benefits upon enrollment.

3) If applicable describe how the state will contract with managed care organizations to provide demonstration benefits, including whether the state needs to conduct procurement action.

Michigan has contracted with PIHPs for the delivery of Specialty Services since 1998. This §1115 Waver will maintain the use of a managed care delivery structure using ten (10) recently procured PIHPs who contract for service delivery with forty-six (46) CMHSP's and other non-for profit providers.

VII. Demonstration Financing and Budget Neutrality

This section reflects Michigan's approach for showing budget neutrality, including the data and assumptions used in the development of the cost estimates supporting this §1115 Waiver application.

Required financing and budget neutrality documentation can be found in Appendix C.

VIII. List of proposed Waivers and Expenditure Authorities

Michigan will seek additional CMS guidance to determine what if any other waiver authorities and/or expenditure authorities are needed to ensure the proper administration of the Demonstration.

1) Provide a list of proposed waivers and expenditure authorities.

- Proper and Efficient Administration
  §1902(a)(4)
  Rationale for Authority: Mandate beneficiaries into a single Prepaid Inpatient Health Plan

- Comparability
  §1902(a)(17)
  Rationale for Authority: This waiver program includes benefits specific to eligibility criteria as described in Section II that will not be available to other Medicaid beneficiaries.

- Amount, Duration, and Scope
  §1902(a)(10)(B)
  To enable the State to offer a different benefit package to the Demonstration participants that varies in amount, duration, and scope from the benefits offered under the State Plan.

- Freedom of Choice
  §1902(a)(23)(A)

To enable the State to restrict Demonstration participants to receive benefits through PIHPs and CMHSPs.
Rationale for Authority: beneficiaries enrolled in the program must receive services through a PIHP

- Choice of Coverage
  §1932(a)(3)
  Rationale for Authority: To enable the State to assign Demonstration participants to PIHPs based on geography and to permit participant choice of provider, but not plan.

- Reasonable Promptness Section
  §1902(a)(8)
  To enable the State to limit enrollment for Demonstration eligible population in order to remain under the annual budget neutrality limits under the Demonstration.

- Methods of Administration: Transportation §1902(a)(4), insofar as it incorporates 42 CFR 431.53
  To enable the State to assure transportation to and from providers for the Demonstration participants.

- Eligibility Standards
  §1902(a)(17)
  To enable the State to apply different eligibility methodologies and standards to the Demonstration eligible population than are applied under the State Plan.

- Retroactive Eligibility Section
  §1902(a)(34)
  To enable the State to not provide coverage for the Demonstration eligible population for any time prior to the first day of the month in which the application was received by the State.

2) Describe why the state is requesting the waiver or expenditure authority, and how it will be used.

- Expenditure authority under contracts with managed care entities.

Rationale for Authority: To allow alternative provider payment methodologies for reimbursement on the basis of quality outcomes and to incentivize coordination between traditional health plans and Prepaid Inpatient Health Plans for physical and behavioral healthcare integration.

- IMD Expenditure Authority
  To support access to a full continuum of care to most effectively treat SUD and support recovery for individuals with SUD, Michigan is proposing to extend coverage for services in inpatient and/or residential settings that are within the definition of IMDs at 42 CFR 435.1010. Therefore, Michigan is proposing that CMS grant expenditure authority in qualified facilities for services provided to Medicaid-eligible individuals, regardless of the size of the facility providing SUD treatment.

Appendix A

Substance Use Disorder Benefits and Service Array

The following Substance Use Disorder (SUD) benefits include the full array of state plan and §1915(b) benefits that are being modified to reflect their utilization within the ASAM criteria. The services that require substance use disorder licensure and/or the use of specific ASAM criteria include the service description, provider specifications and qualification for the benefit and service.

Notes: These notes apply to the entire document.

1. Prior authorization is required at the PIHP level for all services therefore we have not specifically addressed prior authorizations for each service in the grid. Decisions regarding the authorization of SUD services the and the medical necessity criteria fall within the ASAM level of care criteria as also described in section III of the waiver titled Specialty Service and Supports Eligibility, Service Reforms and Service Array for persons with SUD.
2. Unless otherwise specified in the grid, the limit on the amount and duration of the service is guided by medical necessity and individual's IPOS.
3. Unless specified in the grid, individuals and agencies must meet the provider requirements and assure its employees are knowledgeable in the unique abilities, preferences and needs of the individual(s) being served.

Individual Assessments

Service: Substance Use Disorder Individual Assessments
Scope/Description: Alcohol and/or Drug Service Assessments including: Psychiatric Evaluation, Psychological Testing, Other Assessments and Testing

The following limitation(s) applies to the scope of the service:

Limitations on the amount of service	Limitations on the duration of the service	Provider Category(s):	The service may be provided by a:	Description of allowable providers:
Per X Day ☐Week ☐ Month ☐Year Other: One per day	_____Day(s) _____Week(s) _____Month(s) Other: None	X Individual X Agency	Legally Responsible Person Relative/Legal Guardian: N/A	Provider agency licensed and accredited as substance abuse treatment program. Service provided by Substance Abuse Treatment Specialist (SATS) or Substance Abuse Treatment Practitioner (SATP) when working under the supervision of a SATS.

Outpatient Care

Service: Substance Use Disorder Outpatient Care (ASAM Levels 1 and 2)
Scope/Description: Behavioral Health Counseling & Therapy, Medication Administration and Review, Group & Family Counseling, Intensive Outpatient, Early Intervention, Crisis Intervention, Recovery Coach (Peer Supports), Brief Intervention & Care Coordination, Recovery Supports and Treatment Planning.

The following limitation(s) applies to the scope of the service:

Limitations on the amount of service	Limitations on the duration of the service	Provider Category(s):	The service may be provided by a:	Description of allowable providers:
Per ☐ Day ☐ Week ☐ Month ☐ Year X Other, Describe: ASAM Levels 1 and 2	_____Day(s) Week(s) Month(s) Other: None	X Individual X Agency	Legally Responsible Person Relative/Legal Guardian: N/A	Service provided by Substance Abuse Treatment Specialist (SATS) or Clinical Service provided by Substance Abuse Treatment Practitioner (SATP) when working under the supervision of a SATS. Non-clinical services can be provided by appropriately trained staff when working under the supervision of a SATS or SATP A recovery coach or SUD peer specialist must be certified through MDHHS-approved training program.

Methadone Treatment

Service: Substance Use Disorder, Methadone
Scope/Description: Methadone Administration

The following limitation(s) applies to the scope of the service:

Limitations on the amount of service	Limitations on the duration of the service	Provider Category(s):	The service may be provided by a:	Description of allowable providers:
Per ☐ Day ☐ Week ☐ Month ☐ Year Other:	_____Day(s) _____Week(s) _____Month(s) Other:	Individual (list types): X Agency (list types of agencies):	Legally Responsible Person Relative/Legal Guardian: N/A	Provider agency licensed and accredited as a methadone clinic. Supervision by licensed physician. Administration by a MD, DO, licensed PA, RN, LPN or pharmacist.

Sub-Acute Detoxification (Medically Monitored)

Service: Substance Use Disorder, Sub-Acute Detoxification (ASAM III.7-D)
Scope/Description: Alcohol and/or drug services; sub-acute detoxification; medically monitored residential detox

The following limitation(s) applies to the scope of the service:

Limitations on the amount of service	Limitations on the duration of the service	Provider Category(s):	The service may be provided by a:	Description of allowable providers:
Per ☐ Day ☐ Week ☐ Month ☐ Year X Other: ASAM III.7-D	_____Day(s) _____Week(s) _____Month(s) Other:	Individual (list types): X Agency (list types of agencies): Residential settings regardless of size that are within the definition of IMDs at 42 CFR 435.1010.	Legally Responsible Person Relative/Legal Guardian: N/A	Provider agency licensed and accredited as substance abuse residential detoxification program. Supervision by a licensed physician. Staffed 24-hours-per-day, 7 days a week by licensed physician or by a representative of a licensed physician.

Sub-Acute Detoxification (Clinically Monitored)

Service: Substance Use Disorder, Sub-Acute Detoxification (ASAM III.2-D)
Scope/Description: Alcohol and/or drug services; sub-acute detoxification; clinically monitored residential detox; non-medical or social detox setting.

The following limitation(s) applies to the scope of the service:

Limitations on the amount of service	Limitations on the duration of the service	Provider Category(s):	The service may be provided by a:	Description of allowable providers:
Per ☐ Day ☐ Week ☐ Month ☐ Year X Other: ASAM III.2-D	_____Day(s) _____Week(s) _____Month(s) Other:	Individual (list types): X Agency (list types of agencies): Residential settings regardless of size that are within the definition of IMDs at 42 CFR 435.1010.	Legally Responsible Person Relative/Legal Guardian: N/A	Provider agency licensed and accredited as substance abuse residential detoxification program. Supervision by a licensed physician. Provided under the supervision of a substance abuse treatment specialist. Must have access to licensed medical personal.

Sub-Acute Detoxification (Ambulatory)

Service: Substance Use Disorder, Sub-Acute Detoxification Ambulatory (ASAM I-D & ASAM II-D)
Scope/Description: Alcohol and/or drug services; ambulatory detoxification without and with extended on-site monitoring. .

The following limitation(s) applies to the scope of the service:

Limitations on the amount of service	Limitations on the duration of the service	Provider Category(s):	The service may be provided by a:	Description of allowable providers:
Per ☐ Day ☐ Week ☐ Month ☐ Year X Other: ASAM I-D and II-D	_____Day(s) _____Week(s) _____Month(s) Other:	X Individual (list types): X Agency (list types of agencies): Residential settings regardless of size that are within the definition of IMDs at 42 CFR 435.1010.	Legally Responsible Person Relative/Legal Guardian: N/A	Provided under the supervision of a Substance Abuse Treatment Specialist. Must have arrangements for access to licensed medical personnel as needed. Appropriately certified licensed nurses must monitor ASAM level II-D ambulatory detoxification services.

Residential Services

Service: Substance Use Disorder, Residential Services (ASAM III-3 & III-5)
Scope/Description: Alcohol and/or drug services; short term residential (non-hospital residential treatment program).

The following limitation(s) applies to the scope of the service:

Limitations on the amount of service	Limitations on the duration of the service	Provider Category(s):	The service may be provided by a:	Description of allowable providers:
Per ☐ Day ☐ Week ☐ Month ☐ Year X Other: ASAM III-3 and III-5	_____Day(s) _____Week(s) _____Month(s) Other:	Individual (list types): X Agency (list types of agencies): Residential settings regardless of size that are within the definition of IMDs at 42 CFR 435.1010.	Legally Responsible Person Relative/Legal Guardian: N/A	Provider agency licensed and accredited as substance abuse treatment program. The clinical program must be provided under the supervision of a SATS with licensure as a psychologist, master's level social worker, licensed or limited-licensed marriage and family therapist.

Targeted Case Management

Service: Targeted Case Management

Scope/Description: Standalone program specific for SUD. Targeted case management is a covered service that assists beneficiaries to design and implement strategies for obtaining services and supports that are goal-oriented and individualized. Services include assessment, planning, linkage, advocacy, coordination and monitoring to assist beneficiaries in gaining access to needed health and dental services, financial assistance, housing, employment, education, social services, and other services and natural supports developed through the person-centered planning process.

The following limitation(s) applies to the scope of the service:

Limitations on the amount of service	Limitations on the duration of the service	Provider Category(s):	The service may be provided by a:	Description of allowable providers:
Per ☐ Day ☐ Week ☐ Month ☐ Year Other:	_____Day(s) _____Week(s) _____Month(s) Other:	X Individual (list types): X Agency (list types of agencies):	Legally Responsible Person Relative/Legal Guardian: N/A	Service provided by Substance Abuse Treatment Specialist (SATS) or Clinical Service provided by Substance Abuse Treatment Practitioner (SATP) when working under the supervision of a SATS.

Crisis Residential Services

Service: Crisis Residential Services

Scope/Description: Crisis residential services are intended to provide a short-term alternative to inpatient psychiatric services for beneficiaries experiencing an acute psychiatric crisis when clinically indicated. Services may only be used to avert an inpatient psychiatric admission, or to shorten the length of an inpatient stay.

The following limitation(s) applies to the scope of the service:

Limitations on the amount of service	Limitations on the duration of the service	Provider Category(s):	The service may be provided by a:	Description of allowable providers:
Per ☐ Day ☐ Week ☐ Month ☐ Year Other:	_____Day(s) _____Week(s) _____Month(s) Other:	X Individual (list types): X Agency (list types of agencies): Residential settings regardless of size that are within the definition of IMDs at 42 CFR 435.1010.	Legally Responsible Person Relative/Legal Guardian: N/A	Specialized Residential Licensure. On site medication review by a physician, licensed physician assistant, or nurse practitioner under the supervision of a psychiatrist. The program must under the immediate direction of a mental health professional who is on site 8 hours per-day.

Appendix B

Long Term Service and Supports

Administration, Quality and Service Plan Development

Please complete this form if you indicated in Section III that the Demonstration will provide long term services and supports (LTSS).

Indicate the Population(s) that the following long-term services and support description applies to:

Enter Populations Here: Persons with Serious Mental Illness (SMI), Substance Use Disorders (SUD), Intellectual & Developmental Disabilities (IDD) and Children with Serious Emotional Disturbances (SED).

Administration of the Long Term Services and Supports Program

Will the LTSS component of the Demonstration be operated by one or more State agencies other than the Medicaid agency? ☐ Yes ☒ No

If yes, please provide the contact information of the key contacts at those agencies, including name, title, name of agency, address, telephone number, email address and fax number. Also describe the specific sub-population associated with the contact:

Do other State agencies, that are not part of the Single State Medicaid Agency, perform Demonstration operational and administrative functions on behalf of the Medicaid agency?

☐ Yes ☒ No

Do any contracted entities, including managed care organizations, perform Demonstration operational and administrative functions on behalf of the Medicaid agency or the waiver operating agency (if applicable)?

☒ Yes ☐ No

Do any local or regional non-state entities perform Demonstration operational and administrative functions?

☒ Yes ☐ No

If yes to any of the questions above, specify the types of State agencies, contracted entities and/or local/regional non-state entities and describe the specific functions that they perform. This includes individual enrollment, management of any enrollment or expenditure limits, level of care evaluation, review of service plans, prior authorization of services, utilization management, provider enrollment and agreements, rate methodologies, rules, policies and procedures, and quality assurance and improvement activities. Please describe how the Single State Agency oversees the performance of these non-State entities:

Michigan uses a managed care delivery structure including 10 Prepaid Inpatient Health Plans (PIHPs) who contract for service delivery with forty six (46) Community Mental Health Service Programs (CMHSP's) and other non-for profit providers. Through a combination of different PIHP and CMHSP management and service delivery models, CMHSP are normally contracted to directly provide or contract for the majority of direct service including evaluation, service plan development/authorization, and certain quality improvement activities related to clinical service delivery. The State Agency develops rate methodologies for the 10 PIHPs who distribute funds and manage or provide oversight of the provider network including any State Agency delegated functions. By law, the State Agency certifies Community Mental Health Programs every three years, contracts for an External Quality Review and directly completes site reviews of PIHPs/CMHSP's and contract providers every two years. For additional site review protocol, please see the Quality Improvement Strategies section below.

Consolidation of Existing Waivers or Authorities into the Demonstration
Are existing State waivers or programs operating under other authorities are being consolidated into the Demonstration Program?
☒ Yes ☐ No
If yes, identify the existing waiver(s) (1915(b),(c),(d),(e) or State Plan authorities (1915(a), (i), (j), (k), 1932) that are being consolidated into the 1115 Demonstration, including the names of the waivers or programs and identifying waiver numbers. Also indicate the current status of these waivers or authorities.

As outlined in the introduction above, Exhibit 1 outlines the Waivers consolidated under this application. The §1915(b) Managed Specialty Supports and Services Waiver (MI-14.R06.M02) expires on September 30, 2016, the §1915(b)/(c) Children's Waiver Program (MI-16.R01)/ (4119.R05.01)and the Habilitation Supports Waiver (0167.R05.01) expire on June 26, 2016. The §1915(b)/(4) Waiver for Children with Serious Emotional Disturbances (MI-17.R01.M01) expires on June 30, 2016 and the §1915(c) Waiver for Children with Serious Emotional Disturbances
(0438.R02.01) expires on September 30, 2018. The §1915(i) SPA for Applied Behavioral Analysis will be discontinued as of 12-31-15 and the services will be included as part of EPSDT benefit under Michigan's Medicaid State Plan.

Describe how individuals in these programs will be transitioned to the 1115 Demonstration program and assured a comparable level of services, quality and continuity of care.

All former §1915(b) and §1915(c) Waiver services and eligible populations will be included as part of the Demonstration. Transition and continuity of care will be seamless.

Level of Care to Qualify for the Program
This Demonstration is requested in order to provide LTSS to individuals who, but for the provision of such services, would require the following level(s) of care, the costs of which should be reimbursed under the approved Medicaid state plan:
There is no request for additional LTSS to be reimbursed under this Demonstration*.*
Indicate and describe the level of care criteria for participants in the Long Term Services and Supports Demonstration program, such as hospital, nursing facility, ICF-MR, IMD-hospital, IMD-nursing facility, or needs-based criteria. Identify which entity performs the initial and subsequent level of care evaluations and the frequency of such reevaluations:

The level of care criteria for all service and supports (including LTSS) is described in section III of this application. This §1115 Waver will maintain the use of a managed care delivery structure using ten (10) recently procured PIHPs who contract for service delivery with forty-six (46) CMHSP's and other non-for profit providers. Initial and subsequent level of care evaluations are done by the PIHP and/or their CMHSP provider network. Frequency of evaluations is ultimately determined by the Person Centered Plan but done at least annually.

This Demonstration does not cover hospital, nursing facility or ICF-MR facilities for LTSS.

Individual Cost Limits

Do individual cost limits apply when determining whether to deny LTSS or entrance to the Demonstration to an otherwise eligible individual ☐ Yes ☒ No

If yes, indicate the type of cost limit that applies and describe any additional requirements pertaining to the indicated limit:

☐ **Cost Limit in Excess of Institutional Costs. The State refuses entrance to the Demonstration to any otherwise eligible individual when the State reasonably expects that the cost of the LTSS furnished to that individual would exceed the cost of a level of care specified for the Demonstration up to an amount specified by the State.**

☐ **Institutional Cost Limit. The State refuses entrance to the Demonstration to any otherwise eligible individual when the State reasonably expects that the cost of the LTSS furnished to that individual would exceed 100% of the cost of the level of care specified for the waiver.**

☐ **Cost Limit Lower Than Institutional Costs. The State refuses entrance to the Demonstration to any otherwise qualified individual when the State reasonably expects that the cost of LTSS furnished to that individual would exceed an amount specified by the State that is less than the cost of a level of care specified for the Demonstration. Specify the basis of the limit, including evidence that the limit is sufficient to assure the health and welfare of Demonstration individuals.**

Long Term Services and Supports – Outreach, Education, Enrollment and Screening

Describe the Demonstration program's approach to Outreach, Education, Enrollment and Screening, including any coordination with a Money Follows the Person program. Include a description of the roles of the State and other entities in the processes.

There is no Money Follows the Person program included in this Demonstration. Medicaid eligibility and enrollment is determined by the State Agency and screening for the eligibility of Specialty Service System supports is determined by the PIHPs and the CMHSP's. Eligibility Criteria for Specialty Services is included in Section III of this application.

Person-Centered Planning

Indicate who is responsible for collaborating with the individual in developing the Demonstration's person-centered service plan and for its final development:

☒ Case Manager ☒ Social Worker

☐

X Other (please describe, include qualifications)

Staff Qualifications are outlined below:

Mental Health Professional

An individual who is trained and experienced in the area of mental illness or developmental disabilities and who is one of the following: a physician, psychologist, registered professional

nurse licensed or otherwise authorized to engage in the practice of nursing under part 172 of the public health code (1978 PA 368, MCL 333.17201 to 333.17242),
licensed master's social worker licensed or otherwise authorized to engage in the practice of social work at the master's level under part 185 of the public health code (1978 PA 368, MCL 333.18501 to 333.18518), licensed professional counselor licensed or otherwise authorized to engage in the practice of counseling under part 181 of the public health code (1978 PA 368, MCL 333.18101 to 333.18177), or a marriage and family therapist licensed or otherwise authorized to engage in the practice of marriage and family therapy under part 169 of the public health code (1978 PA 368, MCL 333.16901 to 333.16915).

NOTE: The approved licensures for disciplines identified as a Mental Health Professional include the full, limited and temporary limited categories.

Child Mental Health Professional (CMHP):
Individual with specialized training and one year of experience in the examination, evaluation, and treatment of minors and their families and who is a physician, psychologist, licensed or limited-licensed master's social worker, licensed or limited-licensed professional counselor, or registered nurse; or an individual with at least a bachelor's degree in a mental health-related field from an accredited school who is trained and has three years supervised experience in the examination, evaluation, and treatment of minors and their families; or an individual with at least a master's degree in a mental health-related field from an accredited school who is trained and has one year of experience in the examination, evaluation and treatment of minors and their families. For the Behavioral Health Treatment (BHT)/Applied Behavior Analysis (ABA) services individuals must be a BCBA or BCaBA or Psychologist working within their scope of practice with extensive knowledge and training on behavior analysis and BCBA certified by 9/30/2020.

Qualified Intellectual Disability Professional (QIDP):
Individual with specialized training or one year experience in treating or working with a person who has intellectual disability; **and** is a psychologist, physician, educator with a degree in education from an accredited program, social worker, physical therapist, occupational therapist, speech-language pathologist, audiologist, registered nurse, registered dietician, therapeutic recreation specialist, a licensed or limited-licensed professional counselor or a human services professional with a bachelor's degree or higher in a human services field (including but not limited to criminal justice, psychology, or sociology) in which the curriculum provided a good understanding of human behavior and the needs of population that they will be serving, as well as training in intervention methods that are useful in the public behavioral health system.

An individual with a bachelor's degree in a human services field who was hired prior to January 1, 2008 and performed in the role of a QMHP prior to January 1, 2008 would also qualify.
NOTE: If an individual was hired and performed the role of a QIDP prior to January 1, 2008 and later transfers to a new agency, his/her QIDP status will be grandfathered in to the new agency.
Qualified Behavioral Health Professional (QBHP):
QBHP must meet one of the following state requirements:

• Must be a physician or licensed practitioner with specialized training and one year of experience in the examination, evaluation, and treatment of children with ASD.

OR
• Hold a minimum of a master's degree in a mental health-related field or a BACB approved degree category from an accredited institution who is trained and has one year of experience in the examination, evaluation, and treatment of children with ASD. Must be BCBA certified by 9/30/2020. Works within their scope of practice and have extensive knowledge and training in behavior analysis. Extensive knowledge is defined as having taken documented course work at the graduate level at an accredited university in at least three of the six following areas:

1. Ethical considerations.
2. Definitions & characteristics and principles, processes & concepts of behavior.
3. Behavioral assessment and selecting interventions outcomes and strategies.
4. Experimental evaluation of interventions.
5. Measurement of behavior and developing and interpreting behavioral data.
6. Behavioral change procedures and systems supports.

Social Worker
Individual who possesses Michigan full or limited licensure as a master's social worker or a bachelor's social worker. Social workers with limited licenses must be supervised by a fully-licensed master's social worker.

Targeted Case Manager:
QIDP or QMHP: specified bachelor's degree and one year of experience with the population the targeted case manager will be serving. If targeted case manager has only specified bachelor's degree without specialized training or experience, they must be supervised by a QMHP or QIDP for one year. Services must be provided by a CMHP to any child beneficiary with SED. Services to children ages 7-17 with SED must be provided by a CMHP trained in CAFAS. Services rendered to children ages 4-6 with SED must be provided by a CMHP trained in PECAFAS.

Supports Coordinator:
QIDP or QMHP: specified bachelor's degree and one year of experience with the population the supports coordinator will be serving. If the supports coordinator has only the degree without one year of experience, they must be supervised by a QMHP or QIDP for one year. Services must be provided by a CMHP to any child beneficiary with serious emotional disturbance. Services to children ages 7-17 with SED must be provided by a CMHP trained in CAFAS. Services rendered to children ages 4-6 with SED must be provided by a CMHP trained in PECAFAS.

Essential Elements for Person/Family Centered Planning
The Michigan Mental Health Code (the Code) establishes the right for all individuals to have an Individual Plan of Service (IPOS) developed through a person-centered planning process

(Section 712, added 1996). Through the MDHHS/PIHP contract, MDCH delegates the responsibility for development of the IPOS to the PIHP. The PIHP shall implement person-centered planning in accordance with the MDHHS Person-Centered Planning Practice Guideline (P 4.4.1.1). PIHPs and their subcontractors (such as CMHSPs) may provide direct waiver services. The development of the IPOS through the person-centered planning (PCP) process is led by the participant with the involvement of allies chosen by the participant to ensure that the service plan development is conducted in the best interests of the participant.

Each PIHP, through its Customer Services Handbook and the one-on-one involvement of a supports coordinator, supports coordinator assistant, or independent supports broker are required to provide full information and disclosure to participants about the array of services and supports available and the choice of providers. The participant has the option to choose his or her supports coordinator employed by a PIHP or subcontractor, or can choose an independent supports coordinator (not employed directly by or affiliated with the PIHP except through the provider network) or select a supports coordinator assistant or independent supports broker. This range of flexible options enables the participant to identify who he or she wants to assist with service plan development that meets the participant's interests and needs.

Michigan law and policy provide guidance as to how PCP is implemented, including Administrative Regulations and the MDCH/PIHP contract attachment entitled "The Person-Centered Planning Policy and Practice Guideline". As described below, there is a separate process and guideline for minor children called the Family-Driven/Youth Guided Policy and Practice Guideline. The following essential elements of the PCP process have been identified to measure the effectiveness of the process in ensuring that participants are directly and actively engaged:

- **Person-Directed.** The individual directs the planning process (with necessary supports and accommodations) and decides when and where planning meetings are held, what is discussed, and who is invited.

- **Family Driven/Youth Guided Practice**. The organization supports a family driven youth-guided approach to service delivery for children and their families. A family driven youth-guided approach recognizes that service and supports impact the entire family; not just the identified youth receiving mental health services. IN the case of minors, the child and the family is the focus of service planning, and family members are integral to a successful planning process.

- **Person-Centered.** The planning process focuses on the individual, not the system or the individual’s family, guardian, or friends. The individual’s goals, interests, desires, and preferences are identified with an optimistic view of the future and plans for a satisfying life. The planning process is used whenever the individual wants or needs it, rather than viewed as an annual event.

- **Outcome-Based.** Outcomes in pursuit of the individual's preferences and goals are identified as well as services and supports that enable the individual to achieve his or her goals, plans, and desires and any training needed for the providers of those services and supports. The way for measuring progress toward achievement of outcomes is identified.

- **Information, Support and Accommodations**. As needed, the individual receives comprehensive and unbiased information on the array of mental health services, community resources, and available providers. Support and accommodations to assist the individual to participate in the process are provided.

- **Independent Facilitation.** Individuals have the information and support to choose an independent facilitator to assist them in the planning process.

- **Pre-Planning**. The purpose of pre-planning is for the individual to gather all of the information and resources (e.g. people, agencies) necessary for effective person-centered planning and set the agenda for the process. Each individual (except for those individuals who receive short-term outpatient therapy only, medication only, or those who are incarcerated) is entitled to use pre-planning to ensure successful PCP. Pre-planning, as individualized for the person's needs, is used anytime the PCP process is used.

The following items are addressed through pre-planning with sufficient time to take all necessary/preferred actions (i.e. invite desired participants):

a. When and where the meeting will be held,
b. Who will be invited (including whether the individual has allies who can provide desired meaningful support or if actions need to be taken to cultivate such support),
c. What will be discussed and not discussed,
d. What accommodations the individual may need to meaningfully participate in the meeting (including assistance for individuals who use behavior as communication),
e. Who will facilitate the meeting,
f. Who will record what is discussed at the meeting.

- **Wellness and Well-Being.** Issues of wellness, well-being, health and primary care coordination or integration, supports needed for an individual to continue to live independently as he or she desires, and other concerns specific to the individual's personal health goals or support needed for the individual to live the way they want to live are discussed and plans to address them are developed. If so desired by the individual, these issues can be addressed outside of the PCP meeting.

- **Participation of Allies.** Through the pre-planning process, the individual selects allies (friends, family members and others) to support him or her through the person-centered planning process. Pre-planning and planning help the individual explore who is currently in his or her life and what needs to be done to cultivate and strengthen desired relationships.

Independent (External) Facilitation

In Michigan, individuals receiving support through the public mental health system have a right to choose an independent or external facilitator of the person-centered planning process, unless the individual is receiving short-term outpatient therapy or medication only. The PIHP or CMHSP must make available a choice of at least two independent facilitators to individuals interested in using independent facilitation. The facilitator is chosen by the individual and serves as the individual's guide (and for some individuals, their voice) throughout the process, making sure that his or her hopes, interests, desires, preferences and concerns are heard and addressed. The facilitator helps the individual with the pre-planning activities and co-leads any PCP meeting(s) with the individual. The independent facilitator must not have any other role within the CMHSP. The independent facilitator must personally know or get to know the individual who is the focus of the planning including what he or she likes and dislikes as well as personal preferences, goals, modes of communication, and who supports or is important to the individual.

Individual Plan of Service

The Michigan Mental Health Code establishes the right for all individuals to develop individual plans of services (IPOS) through a person-centered planning process regardless of disability or residential setting. However, an IPOS needs to be more than the services and supports authorized by the community mental health system; it must include all of the components described below. The PCP process must be used at any time the individual wants or needs to use the process.

The agenda for each PCP meeting should be set by the individual through the pre-planning process, not by agency or by the fields or categories in a form or an electronic medical record

Once an individual has developed an IPOS through the PCP process, the IPOS shall be kept current and modified when needed (reflecting changes in the intensity of the individual's needs, changes in the individual's condition as determined through the PCP process or changes in the individual's preferences for support). Assessment may be used to inform the PCP process, but is not a substitute for the process.

The individual and his or her case manager or supports coordinator should work on and review the IPOS on a routine basis as part of their regular conversations. An individual or his/her guardian or authorized representative may request and review the IPOS at any time. A formal review of the plan with the beneficiary and his/her guardian or authorized representative shall occur not less than annually through the PCP process to review progress toward goals and objectives and to assess beneficiary satisfaction. Reviews will work from the existing plan to amend or update it as circumstances, needs, preferences or goals change or to develop a

completely new plan if so desired by the individual. Use of the PCP process in the review of the plan incorporates all of the Essential Elements as desired by the individual.

The individual decides who will take notes or minutes about what is discussed during the person-centered planning process. In addition, documentation maintained by the CMHSP within the Individual Plan of Service must include:

(1) A description of the individual's strengths, abilities, goals, plans, hopes, interests, preferences and natural supports;
(2) The outcomes identified by the individual and how progress toward achieving those outcomes will be measured;
(3) The services and supports needed by the individual to work toward or achieve his or her outcomes including those available through the CMHSP, other publicly funded programs (such as Home Help, Michigan Rehabilitation Services (MRS)), community resources, and natural supports;
(4) The amount, scope, and duration of medically necessary services and supports authorized by and obtained through the community mental health system.
(5) The estimated/prospective cost of services and supports authorized by the community mental health system.
(6) The roles and responsibilities of the individual, the supports coordinator or case manager, the allies, and providers in implementing the plan.
(7) Any other documentation required by Section R 330.7199 Written plan of services of the Michigan Administrative Code.

The individual must be provided with a written copy of his or her plan within 15 business days of conclusion of the PCP process. This timeframe gives the case manager/ supports coordinator a sufficient amount of time to complete the documentation described above.

Organizational Standards

The following characteristics are essential for organizations responsible for providing supports and services through PCP:

- Individual Awareness and Knowledge: The organization provides accessible and easily understood information, support and when necessary, training, to individuals using services and supports and those who assist them so that they are aware of their right to PCP, the essential elements of PCP, the benefits of this approach and the support available to help them succeed (including, but not limited, pre-planning and independent facilitation).
- Person-Centered Culture: The organization provides leadership, policy direction, and activities for implementing person-centered planning at all levels of the organization. Organizational language, values, allocation of resources, and behavior reflect a person-centered orientation.

- Training: The organization has a process to identify and train staff at all levels on the philosophy of PCP. Staff who are directly involved in PCP are provided with additional training.
- Roles and Responsibilities: As an individualized process, PCP allows each individual to identify and work with chosen allies and other supports. Roles and responsibilities for facilitation, pre-planning, and developing the IPOS are identified; the IPOS describes who is responsible for implementing and monitoring each component of the IPOS.
- Quality Management: The QA/QM System includes a systemic approach for measuring the effectiveness of PCP and identifying barriers to successful person-centered planning. The best practices for supporting individuals through PCP are identified and implemented (what is working and what is not working in supporting individuals). Organizational expectations and standards are in place to assure support the individual directs the PCP process and ensures that PCP is consistently done well.

Dispute Resolution

Individuals who have a dispute about the PCP process or the IPOS that results from the process have the rights to grievance, appeals and recipient rights as set forth in detail in the Contract Attachment 6.4.1.1 Grievance and Appeal Technical Requirement/PIHP Grievance System for Medicaid Beneficiaries. As described in this Contract Attachment, some of the dispute resolution options are limited to Medicaid beneficiaries and limited in the scope of the grievance (such as a denial, reduction, suspension or termination of services). Other options are available to all recipients of Michigan mental health services and supports.

Supports Coordinators, Case Managers and Customer Services at PIHP/CMHSPs must be prepared to help people understand and negotiate dispute resolution processes.

Criminal History and/or Background Investigations
Specify the State's policies concerning the conduct of criminal history and/or background investigations of individuals who provide Demonstration services:
Are criminal history and/or background investigations required? ☒ Yes ☐ No

If yes, indicate the types of positions for which such investigations must be conducted:

☒ Administrative Staff ☒ Transport Staff

☒ Staff, providers and others who have direct contact with the individual

Others (please describe)
Indicate the scope of such investigations:

☐ National (FBI) criminal records check ☒ State criminal records check only

☐ Other (please describe)

Abuse Registry Screening Does the State maintains an abuse registry and requires the screening of individuals through this registry

Yes ☐
No ☒

If yes, specify the entity (entities) responsible for maintaining the abuse registry:

Indicate the types of positions for which abuse registry screenings must be

conducted:

☐ Administrative Staff ☐ Transport Staff

☐ Staff, providers and others who have direct contact with the individual

☐ Others (please describe)

Allowable Settings

Are Demonstration services provided in facilities subject to §1616(e) of the Act?

☐ Yes ☒ No

If yes, indicate the types of facilities where Demonstration services may be provided, any capacity limits for such facilities, the home and community based services that may be provided in such facilities, and how a home and community character is maintained in these settings.

Individual Rights

In addition to fair hearings, does the State operate other systems for dispute resolution, grievances or complaints concerning the operation of the Demonstration program's home and community-based services component?

☐ Yes ☒ No

Quality Improvement Strategies

Provide a description of the quality improvement strategies to be employed in the operation of the Demonstration. In particular describe strategies to ensure the health and welfare of individuals to be served with Home and Community-Based Services, including the prevention of abuse, neglect and exploitation (e.g., critical incident management system, utilization review, case management visits, etc.), the single State Medicaid Agency oversight and involvement. Please also include the self-direction strategy if the Demonstration allows for self-direction.

The State require***s*** that each specialty Prepaid Inpatient Health Plan (PIHP) to have a quality assessment and performance improvement program (QAPIP). The Guidelines for Internal Quality Assurance Programs as distributed by then Health Care Financing Administration's (HCFA) Medicaid Bureau in its guide to states in July of 1993; the Balanced Budget Act of 1997 (BBA), Public Law 105-33; and 42 Code of Federal Regulations (CFR) 438.358 of 2002.

In addition to the QAPIP, the MDHHS, Quality Management and Planning (QMP) site review team completes on site reviews of PIHPs and their provider networks on a biennial basis assuring the service needs, including the health and welfare are met for the section 1115 population. A more detailed review of the QAPIP standards, critical incident management, the MDHHS site review process and an overview of Michigan's self-determinations strategy is outlined below.

OAPIP Standards

I. The PIHP must have a written description of its QAPIP which specifies 1) an adequate organizational structure which allows for clear and appropriate administration and evaluation of the QAPIP; 2) the components and activities of the QAPIP, including those as required below; 3) the role for recipients of service in the QAPIP; and 4) the mechanisms or procedures to be used for adopting and communicating process and outcome improvement.

II. The QAPIP must be accountable to a Governing Body that is a Community Mental Health Services Program Board of Directors. Responsibilities of the Governing Body for monitoring, evaluating, and making improvements to care include:

    A. Oversight of QAPIP - There is documentation that the Governing Body has approved the overall QAPIP and an annual QI plan.

    B. QAPIP progress reports - The Governing Body routinely receives written reports from the QAPIP describing performance improvement projects undertaken, the actions taken and the results of those actions.

    C. Annual QAPIP review - The Governing Body formally reviews on a periodic basis (but no less frequently than annually) a written report on the operation of the QAPIP.

    D. The Governing Body submits the written annual report to MDHHS following its review. The report will include a list of the members of the Governing Body.

III. There is a designated senior official responsible for the QAPIP implementation.

IV. There is active participation of providers and consumers in the QAPIP processes.

V. The PIHP measures its performance using standardized indicators based upon the systematic, ongoing collection and analysis of valid and reliable data.

    A. PIHP must utilize performance measures established by the department in the areas of access, efficiency and outcome and report data to the state as

established in contract.

B. The PIHP may establish and monitor other performance indicators specific to its own program for the purpose of identifying process improvement projects.

VI. The PIHP utilizes its QAPIP to assure that it achieves minimum performance levels on performance indicators as established by the department and defined in the contract and analyzes the causes of negative statistical outliers when they occur.

VII. The PIHP's QAPIP includes affiliation-wide performance improvement projects that achieve through ongoing measurement and intervention, demonstrable and sustained improvement in significant aspects of clinical and non-clinical services that can be expected to have a beneficial effect on health outcomes and consumer satisfaction.

A. Performance improvement projects must address clinical and non-clinical aspects of care.

1. Clinical areas would include, but not be limited to, high-volume services, high-risk services, and continuity and coordination of care.

2. Non-clinical areas would include, but not be limited to, appeals, grievances and trends and patterns of substantiated Recipient Rights complaints; and access to, and availability of, services.

B. Project topics should be selected in a manner which takes into account the prevalence of a condition among, or need for a specific service by, the organization's consumers; consumer demographic characteristics and health risks; and the interest of consumers in the aspect of service to be addressed.

C. Performance improvement projects may be directed at state or PIHP-established aspects of care. Future state-directed projects will be selected by MDHHS with consultation from the Quality Improvement Council and will address performance issues identified through the external quality review, the Medicaid site reviews, or the performance indicator system.

D. PIHPs may collaborate with other PIHPs on projects, subject to the approval of the department.

E. The PIHP must engage in at least two projects during the waiver renewal period.

VIII. The QAPIP describes, and the PIHP implements or delegates, the process of the review and follow-up of sentinel events and other critical incidents and events that put people at risk of harm.

A. At a minimum, sentinel events as defined in the department's contract must be reviewed and acted upon as appropriate. The PIHP or its delegate has three business days after a critical incident occurred to determine if it is a sentinel event. If the critical incident is classified as a sentinel event, the PIHP or its delegate has two subsequent business days to commence a root cause analyses of the event.

B. Persons involved in the review of sentinel events must have the appropriate credentials to review the scope of care. For example, sentinel events that involve client death, or other serious medical conditions, must involve a physician or nurse.

C. All unexpected* deaths of Medicaid beneficiaries, who at the time of their deaths were receiving specialty supports and services, must be reviewed and must include:

1. Screens of individual deaths with standard information (e.g., coroner's report, death certificate)
2. Involvement of medical personnel in the mortality reviews
3. Documentation of the mortality review process, findings, and recommendations
4. Use of mortality information to address quality of care
5. Aggregation of mortality data over time to identify possible trends.

* "Unexpected deaths" include those that resulted from suicide, homicide, an undiagnosed condition, were accidental, or were suspicious for possible abuse or neglect.

D. Following immediate event notification to MDHHS (See Section 6.1 of this contract) the PIHP will submit information on relevant events through the Critical Incident Reporting System described below.

E. Critical Incident Reporting System
The critical incident reporting system collects information on critical incidents that can be linked to specific service recipients.
This critical incident reporting system became fully operational and contractually required October 1, 2011 (see Attachment 7.7.1.1).

The Critical Incident Reporting System captures information on five specific reportable events: suicide, non-suicide death, emergency medical treatment due to injury or medication error, hospitalization due to injury or medication error, and arrest of consumer. The population on which these events must be reported differs slightly by type of event.

The QAPIP must describe how the PIHP will analyze at least quarterly the critical incidents, sentinel events, and risk events (see below) to determine what action needs to be taken to remediate the problem or situation and to prevent the occurrence of additional events and

incidents. MDHHS will request documentation of this process when performing site visits.

MDHHS has developed formal procedures for analyzing the event data submitted through this system. This includes criteria and processes for Department follow-up on individual events as well as processes for systemic data aggregation, analysis and follow-up with individual PIHPs.

F. Risk Events Management

The QAPIP has a process for analyzing additional critical events that put individuals (in the same population categories as the critical incidents above) at risk of harm. This analysis should be used to determine what action needs to be taken to remediate the problem or situation and to prevent the occurrence of additional events and incidents. MDHHS will request documentation of this process when performing site visits.

These events minimally include:

- Actions taken by individuals who receive services that cause harm to themselves
- Actions taken by individuals who receive services that cause harm to others
- Two or more unscheduled admissions to a medical hospital (not due to planned surgery or the natural course of a chronic illness, such as when an individual has a terminal illness) within a 12-month period

Following immediate event notification to MDHHS the PIHP will submit to MDHHS, within 60 days after the month in which the death occurred, a written report of its review/analysis of the death of every Medicaid beneficiary whose death occurred within one year of the recipient's discharge from a state-operated service.

IX. The QAPIP quarterly reviews analyses of data from the behavior treatment review committee where intrusive or restrictive techniques have been approved for use with beneficiaries and where physical management or 911 calls to law enforcement have (see F above) been used in an emergency behavioral crisis. Only the techniques permitted by the Technical Requirement for Behavior Treatment Plans and that have been approved during person-centered planning by the beneficiary or his/her guardian, may be used with beneficiaries. Data shall include numbers of interventions and length of time the interventions were used per person.

X. The QAPIP includes periodic quantitative (e.g., surveys) and qualitative (e.g., focus groups) assessments of member experiences with its services. These assessments must be representative of the persons served and the services and supports offered.

A. The assessments must address the issues of the quality, availability, and

accessibility of care.

B. As a result of the assessments, the organization:
    1. Takes specific action on individual cases as appropriate;
    2. Identifies and investigates sources of dissatisfaction;
    3. Outlines systemic action steps to follow-up on the findings; and
    4. Informs practitioners, providers, recipients of service and the governing body of assessment results.

C. The organization evaluates the effects of the above activities.

D. The organization insures the incorporation of consumers receiving long-term supports or services (e.g., persons receiving case management or supports coordination) into the review and analysis of the information obtained from quantitative and qualitative methods.

XI. The QAPIP describes the process for the adoption, development, implementation and continuous monitoring and evaluation of practice guidelines when there are nationally accepted, or mutually agreed-upon (by MDHHS and the PIHPs) clinical standards, evidence-based practices, practice-based evidence, best practices and promising practices that are relevant to the persons served.

XII. The QAPIP contains written procedures to determine whether physicians and other health care professionals, who are licensed by the state and who are employees of the PIHP or under contract to the PIHP, are qualified to perform their services. The QAPIP also has written procedures to ensure that non-licensed providers of care or support are qualified to perform their jobs. The PIHP must have written policies and procedures for the credentialing process which are in compliance with MDHHS's Credentialing and Re-credentialing Processes, Attachment P.7.1.1, and includes the organization's initial credentialing of practitioners, as well as its subsequent re-credentialing, recertifying and/or reappointment of practitioners. These procedures must describe how findings of the QAPIP are incorporated into this re-credentialing process.

The PIHP must also insure, regardless of funding mechanism (e.g., voucher):

1. Staff shall possess the appropriate qualifications as outlined in their job descriptions, including the qualifications for all the following:

    a. Educational background
    b. Relevant work experience
    c. Cultural competence
    d. Certification, registration, and licensure as required by law

2. A program shall train new personnel with regard to their responsibilities, program policy, and operating procedures.

3. A program shall identify staff training needs and provide in-service training, continuing education, and staff development activities.

XIII. The written description of the PIHP's QAPIP must address how it will verify whether services reimbursed by Medicaid were actually furnished to enrollees by affiliates (as applicable***),*** providers and subcontractors.

1. The PIHP must submit to the state for approval its methodology for verification.

2. The PIHP must annually submit its findings from this process and provide any follow up actions that were taken as a result of the findings.

XIV. The organization operates a utilization management program.

A. Written Plan - Written utilization management program description that includes, at a minimum, procedures to evaluate medical necessity, criteria used, information sources and the process used to review and approve the provision of medical services.

B. Scope - The program has mechanisms to identify and correct under-utilization as well as over-utilization.

C. Procedures - Prospective (preauthorization), concurrent and retrospective procedures are established and include:

1. Review decisions are supervised by qualified medical professionals. Decisions to deny or reduce services are made by health care professionals who have the appropriate clinical expertise to treat the conditions.
2. Efforts are made to obtain all necessary information, including pertinent clinical information, and consult with the treating physician as appropriate.
3. The reasons for decisions are clearly documented and available to the member.
4. There are well-publicized and readily-available appeals mechanisms for both providers and service recipients. Notification of denial is sent to both the beneficiary and the provider. Notification of a denial includes a description of how to file an appeal.
5. Decisions and appeals are made in a timely manner as required by the exigencies of the situation.
6. There are mechanisms to evaluate the effects of the program using data on member satisfaction, provider satisfaction or other appropriate measures.
7. If the organization delegates responsibility for utilization management, it has mechanisms to ensure that these standards are met by the delegate.

XV. The PIHP annually monitors its provider network(s), including any affiliates or sub-contractors to which it has delegated managed care functions, including service and

support provision. The PIHP shall review and follow-up on any provider network monitoring of its subcontractors.

XVI. The PIHPs, shall continually evaluate its oversight of "vulnerable" people in order to determine opportunities for improving oversight of their care and their outcomes. MDHHS will continue to work with PIHP to develop uniform methods for targeted monitoring of vulnerable people.

The PIHP shall review and approve plans of correction that result from identified areas of non-compliance and follow up on the implementation of the plans of correction at the appropriate interval. Reports of the annual monitoring and plans of correction shall be subject to MDHHS review.

MDHHS Quality Management and Planning Site Review Process

The MDHHS Quality Management and Planning (QMP) Site Review team conducts comprehensive biennial reviews of the 10 PIHPs. This site visit strategy includes rigorous standards for assuring the needs, including health and welfare of the current and proposed waiver populations included under this §1115 Waiver. The comprehensive reviews includes: consistent, uniform, person-centered and medical necessity/needs assessments from clinical record reviews, administrative reviews, consumer/stakeholder meetings and consumer interviews.

In addition to the full biennial site review, the QMP Site Review Team members also conduct a follow-up review approximately 90 days after the issuance of the approved corrective action plan (CAP) to assess the status and effectiveness of the PIHPs implementation of their CAP. Below are the performance measures that the site review team will be focusing on for the combined §1115 Waiver population:

- Number and percent of reviewed participants where the IPOS includes services and supports that align with the individual's assessed needs.

- Number and percent of reviewed participants where the IPOS had adequate strategies to address their assessed health and safety risks.

- Number and percent of reviewed participants where the IPOS reflect their goals and preferences.

- Number and percent of IPOS for reviewed participants in which services and supports are provided as specified in the plan, including type, amount, scope, duration and frequency.

- Number and percent of participants requiring hospitalization due to injury related to the use of physical management.

- How the number of beneficiaries within the PIHP boundaries are identified and tracked including how interventions are addressed in the IPOS including the prevention of modifiable risk factors and access to physical healthcare for individuals considered "High Utilizers".

- Number and percent of participants requiring hospitalization due to medication error.

- Number and percent of participants being reviewed where the BTPRC policy was followed.

- MDHHS is in the process of developing performance measures to assess the settings' status in getting into compliance with the HCBS final rule, person-centered planning process and requirements around conflict free case management.

A standard site review protocol is used at the time of each site visit. The protocol is used to record and document findings during the site review. The findings are sent to the PIHPs which are required to submit a CAP to MDHHS within 30 days. The CAP is reviewed and approved by MDHHS. The PIHP has 90 days after the CAP has been approved to provide evidence to MDHHS that all issues have been remediated. The remediation process continues until all concerns have been appropriately addressed.
If, during a QMP on-site visit, the site review team member identifies an issue that places a participant in imminent risk to health or welfare, the site review team would invoke an immediate review and response by the PIHP.

MDHHS Self Determination Overview

In Michigan, we use the term Self-Determination to embrace the concept that the purpose of self-direction opportunities is for individuals to have the support to pursue a meaningful life in the community. The MDHHS BH&DDA Self-Determination Policy and Practice Guideline (SD Guideline) states: "Self-determination is the value that people served by the public mental health system must be supported to have a meaningful life in the community. The components of a meaningful life include: work or volunteer activities that are chosen by and meaningful to person, reciprocal relationships with other people in the community, and daily activities that are chosen by the individual and support the individual to connect with others and contribute to his or her community. With arrangements that support self-determination, individuals have control over an individual budget for their mental health services and supports to live the lives they want in the community. The public mental health system must offer arrangements that support self-determination, assuring methods for the person to exert direct control over how, by whom, and to what ends they are served and supported."

The Self-Determination Policy and Practice Guideline requires that PIHP/CMHSPs "assure that full and complete information about self-determination and the manner in which it may be accessed and applied is available to each consumer. This shall include specific examples of alternative ways that a consumer may use to control and direct an individual budget, and the obligations associated with doing this properly and successfully. (I.C. page 4). Moreover, the policy states: "A CMHSP shall actively support and facilitate a consumer's application of the

principles of self-determination in the accomplishment of his/her plan of services." (I.E.. page 4). Arrangements that support self-determination are developed through the person-centered planning process (see below).

Waiver participants have opportunities for both employer and budget authority. Participants may elect either or both budget authorities and can direct a single service or all of their services for which participant direction is an option. The participant may direct the budget and directly contract with chosen providers. Typically, the individual budget is transferred to a fiscal intermediary (this is the Michigan term for an agency that provides financial management services or FMS) which administers the funds and makes payment upon participant authorization. However, the SD Guideline provides options for use of arrangements that support self-determination without utilizing a fiscal intermediary.

There are two options for participants choosing to exercise employer authority: the direct employment model and Agency with Choice. Through the direct employment model, the participant is the common law employer and delegates' performance of the fiscal/employer agent functions to the fiscal intermediary, which processes payroll and performs other administrative and support functions. The participant directly recruits, hires and manages employees. In the Agency with Choice model, participants may contract with an agency with choice and split the employer duties with the agency. The participant is the managing employer and has the authority to select, hire, supervise and terminate workers. As co-employer, the agency is the common law employer, which handles the administrative and human resources functions and provides other services and supports needed by the participant. The agency may provide assistance in recruiting and hiring workers. A participant may select one or both options. For example, a participant may want to directly employ a good friend to provide support during the week and Agency with Choice to provide support on the weekends.

Through its contract with MDHHS, each PIHP is required to offer information and education to participants on arrangements that support self-determination. MDHHS offers technical guidance, training and prototype documents. Each PIHP also offers support to participants in these arrangements. This support can include offering required training for workers, offering peer-to-peer discussion forums on how to be a better employer, or providing one-on-one assistance when a problem arises. . The participants are given information regarding the responsibilities and benefits of self-determination prior to the PCP process. Participants interested in arrangements that support self-determination start the process by letting their supports coordinator or other chosen qualified provider know of their interest.

PIHPs (and CMHSPs) are the primary entities that support participants who use arrangements that support self-determination. Supports coordinators, supports coordinator assistants, or independent support brokers (or other qualified provider chosen by the participant) are responsible for providing support to participants in arrangements that support self-determination. The supports coordinator, supports coordinator assistant, or independent supports broker is responsible for obtaining authorization of the budget and plan and monitoring the plan, budget and arrangements. Supports coordinators, supports coordinator

assistants, or independent supports brokers (or other qualified provider chosen by the participant) make sure that participants receive the services to which they are entitled and that the arrangements are implemented smoothly. An individual plan of service (IPOS) will be developed through this process with the participant, supports coordinator or other chosen qualified provider, and allies chosen by the participant. The plan will include the waiver services needed by and appropriate for the participant. An individual budget is developed based on the services and supports identified in the IPOS and must be sufficient to implement the IPOS.

Each PIHP is required to contract with fiscal intermediaries to provide financial management services. Fiscal Intermediary Services has been a service in the state's §1915(b) Waiver, which will continue in the 1115 waiver. The fiscal intermediary performs a number of essential tasks to support participant direction while assuring accountability for the public funds allotted to support those arrangements. The fiscal intermediary has four basic areas of performance:

- function as the employer agent for participants directly employing workers to assure compliance with payroll tax and insurance requirements;
- ensure compliance with requirements related to management of public funds, the direct employment of workers by participants, and contracting for other authorized goods and services;
- facilitate successful implementation of the arrangements by monitoring the use of the budget and providing;
- monthly budget status reports to participant and agency.

Appendix C

Long Term Services & Supports (LTSS) Benefit Specifications and Provider Qualifications

For each Long Term Service and Support (home and community-based service) that the State proposes to include in the Demonstration, provide a description of the amount, duration and scope of the service and any authorization requirements under the Demonstration. Also provide the provider specifications and qualifications for the benefit or service.

Notes: These notes apply to the entire document.

1. Prior authorization is required at the PIHP level for all services therefore we have not specifically addressed prior authorizations for each service in the grid. Decisions regarding the authorization of Long Term Service and Supports for individuals who meet the Specialty Service and Supports Eligibility Criteria may take into account the PIHP's documented capacity to reasonably and equitably serve other Medicaid populations as further outlined in the Medicaid provider manual.
2. Unless otherwise specified in the grid, the limit on the amount and duration of the service is guided by medical necessity and individual's IPOS.
3. Unless otherwise specified in the grid, agencies must meet the PIHP's provider requirements and assure its employees are knowledgeable in the unique abilities, preferences and needs of the individual(s) being served.

Community Living Supports (CLS)

Service: Community Living Supports (CLS)

Scope/Description:

Community Living Supports are used to increase or maintain personal self-sufficiency, facilitating an individual's achievement of his goals of community inclusion and participation, independence or productivity. The supports may be provided in the participant's residence or in community settings (including, but not limited to, libraries, city pools, camps, etc.).

Coverage includes:

- Assisting (that exceeds state plan for adults), prompting, reminding, cueing, observing, guiding and/or training in the following activities:
- meal preparation
- laundry
- routine, seasonal, and heavy household care and maintenance
- activities of daily living (e.g., bathing, eating, dressing, personal hygiene)
- shopping for food and other necessities of daily living

CLS services may not supplant services otherwise available to the beneficiary through a local educational agency under the Individuals with Disabilities Education Act (IDEA) or the Rehabilitation Act of 1973 or state plan services, e.g., Personal Care (assistance with ADLs in a certified specialized residential setting) and Home Help or Expanded Home Help (assistance in the individual's own, unlicensed home with meal preparation, laundry, routine household care and maintenance, activities of daily living and shopping). If such assistance appears to be needed, the beneficiary must request Home Help and, if necessary, Expanded Home Help from MDHHS. CLS may be used for those activities while the beneficiary awaits determination by MDHHS of the amount, scope and duration of Home Help or Expanded Home Help. If the beneficiary requests it, the PIHP case manager or supports coordinator must assist him/her in requesting Home Help or in filling out and sending a request for Fair Hearing when the beneficiary believes that the MDHHS authorization of amount, scope and duration of Home Help does not appear to reflect the beneficiary's needs based on the findings of the MDHHS assessment.

Staff assistance, support and/or training with activities such as:

- money management
- non-medical care (not requiring nurse or physician intervention) socialization and relationship building

- transportation from the beneficiary's residence to community activities, among community activities, and from the community activities back to the beneficiary's residence (transportation to and from medical appointments is excluded)
- participation in regular community activities and recreation opportunities (e.g., attending classes, movies, concerts and events in a park; volunteering; voting)
- attendance at medical appointments
- acquiring or procuring goods, other than those listed under shopping, and non-medical services
- Reminding, observing and/or monitoring of medication administration
- Staff assistance with preserving the health and safety of the individual in order that he/she may reside or be supported in the most integrated, independent community setting.

CLS may be provided in a licensed specialized residential setting as a complement to, and in conjunction with, state plan coverage Personal Care in Specialized Residential Settings. Transportation to medical appointments is covered by Medicaid through MDHHS or the Medicaid Health Plan. Payment for CLS services may not be made, directly or indirectly, to responsible relatives (i.e., spouses, or parents of minor children), or guardian of the beneficiary receiving community living supports.

CLS assistance with meal preparation, laundry, routine household care and maintenance, activities of daily living and/or shopping may be used to complement Home Help or Expanded Home Help services when the individual's needs for this assistance have been officially determined to exceed the DHS's allowable parameters. CLS may also be used or those activities while the beneficiary awaits the decision from a Fair Hearing of the appeal of a MDHHS decision. Reminding, observing, guiding, and/or training of these activities are CLS coverages that do not supplant Home Help or Expanded Home Help.

Community Living Supports (CLS) provides support to a beneficiary younger than 18, and the family in the care of their child, while facilitating the child's independence and integration into the community. This service provides skill development related to activities of daily living, such as bathing, eating, dressing, personal hygiene, household chores and safety skills; and skill development to achieve or maintain mobility, sensory motor, communication, socialization and relationship-building skills, and participation in leisure and community activities. These supports must be provided directly to, or on behalf of, the child. These supports may serve to reinforce skills or lessons taught in school, therapy, or other settings. For children and adults up to age 26 who are enrolled in school, CLS services are not intended to supplant services provided in school or other settings or to be provided during the times when the child or adult would typically be in school but for the parent's choice to home-school.

The following limitation(s) applies to the scope of the service:
The CLS do not include the costs associated with room and board.

Limitations on the amount of service	Limitations on the duration of the service	Provider Category(s):	The service may be provided by a:	Description of allowable providers:	Description of allowable providers:	Description of allowable providers:
____ Per **☐ Day** **☐Week** **☐ Month** **☐Year** **☐ Other, Describe:**	**____Day(s)** **____Week(s)** **Month(s)** **____Other:** See note No.2 Page 1.	**☒ Individual (list types):** Personal assistant, CLS aide **☒ Agency (list types of agencies):** Home care agency, staffing agency, or other PIHP network provider agency licensed children's foster care, licensed adult foster care	**☐ Legally Responsible Person** **☒Relative** Payments for CLS may not be made, directly or indirectly, to responsible relatives (i.e., spouses or parents of minor children) or the legal guardian.	**Provider Type:** Personal assistant, CLS aide **License Required:** **☐ Yes ☒ No** **Certificate Required:** **☐ Yes ☒ No** **Describe:** **Other Qualifications Required for this Provider Type (please describe):**	**Provider Type:** Home care agency, staffing agency, or other PIHP network provider agency **License Required:** **☐ Yes ☐ No** **Certificate Required:** **☐ Yes ☐ No** **Describe:** **Other Qualifications Required for this Provider Type (please describe):** For services delivered in the community, the	**Provider Type:** Licensed children's foster care, licensed adult foster care **License Required:** **☒ Yes ☐ No** Act 116 of 1973 as amended (children), Act 218 of 197 as amended (adults), Administrative Rules R400.4101-.14601, R400.15101-.15411, R400.2231-.2246, R400.1151-.1153, R400.1901-1906 and R400.2101-2475, MCL 722.115-118(a) **Certificate Required:** **☐ Yes ☒ No** **Describe:**

Limitations on the amount of service	Limitations on the duration of the service	Provider Category(s):	The service may be provided by a:	Description of allowable providers:	Description of allowable providers:	Description of allowable providers:
				Aides must meet criteria specified in the Michigan PIHP/CMHSP Provider Qualification Code Chart:	agency must assure its employees are knowledgeable in the community opportunities available in the area.	**Other Qualifications Required for this Provider Type (please describe):** n/a

Enhanced Medical Equipment and Supplies

Service: Enhanced medical equipment and supplies

Scope/Description:

Enhanced medical equipment and supplies include devices, supplies, controls, or appliances that are not available under regular Medicaid coverage or through other insurances. All enhanced medical equipment and supplies must be specified in the individual plan of service, and must enable the participant to increase his abilities to perform activities of daily living; or to perceive, control, or communicate with the environment. The plan must document that, as a result of the treatment and its associated equipment or adaptation, institutionalization of the participant will be prevented. There must be documented evidence that the item is the most cost-effective alternative to meet the participant's need. All items must be ordered on a prescription. An order is valid one year from the date it was signed. This coverage includes:

- Adaptations to vehicles;
- Items necessary for life support;
- Ancillary supplies and equipment necessary for proper functioning of such items;
- Durable and non-durable medical equipment not available under the Medicaid State Plan.

Generators may be covered for an individual who is ventilator dependent or requires daily use of an oxygen concentrator. The size of a generator will be limited to the wattage required to provide power to essential life sustaining equipment (typically 5,000 watts) and is not intended to provide power for the entire home. The request for approval of a generator must include a documented history of power outages, including frequency and duration.

Assessments and specialized training needed in conjunction with the use of such equipment, as well as warranted upkeep and repair, shall be considered as part of the cost of the services. Covered items must meet applicable standards of manufacture, design, and installation. There must be documentation that the best value in warranty coverage was obtained for the item at the time of purchase. The PIHP should have a process in place that gives notice to a medical equipment supplier that purchase of the equipment or supply has been authorized.

Repairs to enhanced medical equipment that are not covered benefits through other insurances may be covered. There must be documentation in the individual plan of services that the enhanced medical equipment continues to be of direct medical or remedial benefit. All applicable warranty and insurance coverage must be sought and denied before paying for repairs. The PIHP must document the repair is the most cost-effective solution when compared with replacement or purchase of a new item. If the

equipment requires repairs due to misuse or abuse, the PIHP must provide evidence of training in the use of the equipment to prevent future incidents.

The following limitation(s) applies to the scope of the service:
Items that are not of direct medical or remedial benefit, or that are considered to be experimental to the participant are excluded from coverage.

- "Direct medical or remedial" benefit is a prescribed specialized treatment and its associated equipment or environmental accessibility adaptation that are essential to the implementation of the individual plan of service.
- "Experimental" means that the validity of the use of the item has not been supported in one or more studies in a refereed professional journal.

Coverage excludes:

- Furnishings (e.g., furniture, appliances, bedding) and other non-custom items (e.g., wall and floor coverings, and decorative items) that are routinely found in a home;
- Items that are considered family recreational choices;
- Purchase or lease of a vehicle and routine repair and maintenance to the vehicle;
- Educational supplies that are required to be provided by the school as specified in the child's Individualized Education Plan; and
- Eye glasses, hearing aids, and dentures are not covered.

Limitations on the amount of service	Limitations on the duration of the service	Provider Category(s):	The service may be provided by a:	Description of allowable providers:	Description of allowable providers:	Description of allowable providers:
____ Per ☐ Day ☐Week ☐ Month ☐Year ☐ Other, Describe:	Day(s) Week(s) Month(s) Other: See note No.2 Page 1.	☐ Individual (list types): ☒ Agency (list types of agencies): Medicaid Enrolled Durable Medical Equipment and Supplies Provider Licensed builder or contractor Other vendor as appropriate to the service or supply	☐ Legally Responsible Person ☐Relative/Legal Guardian:	**Provider Type:** Durable Medical Equipment and Supplies Provider **License Required:** ☐ Yes ☒ No **Certificate Required:** ☐ Yes ☒ No **Describe:** **Other Qualifications Required for this Provider Type (please describe):** The durable medical equipment and supplies (DMES) provider must meet any requirements by	**Provider Type:** Licensed builder or contractor **License Required:** ☒ Yes ☐ No Licensed builder or contractor who holds current Michigan license under MCL 339.601(1); MCL 339.601.2401; MCL 339.601.2403(3) **Certificate Required:** ☐ Yes ☒ No **Describe:** **Other Qualifications Required for this Provider Type (please describe):**	**Provider Type:** Other vendor as appropriate to the service or supply **License Required:** ☐ Yes ☒ No **Certificate Required:** ☐ Yes ☒ No **Describe:** **Other Qualifications Required for this Provider Type (please describe):**

Limitations on the amount of service	Limitations on the duration of the service	Provider Category(s):	The service may be provided by a:	Description of allowable providers:	Description of allowable providers:	Description of allowable providers:
				private insurance, Medicare or Medicaid as appropriate.		

Enhanced Pharmacy

Service: Enhanced Pharmacy
Scope/Description:

The intent of this service is to fund medically necessary supports that promote community inclusion and participation, independence, and/or productivity when identified in the individual plan of service as one or more goals developed during person-centered planning.
Enhanced pharmacy items are physician-ordered, nonprescription "medicine chest" items as specified in the individual's plan of service. There must be documented evidence that the item is not available through Medicaid or other insurances, and is the most cost effective alternative to meet the beneficiary's need. Items that are not of direct medical or remedial benefit to the beneficiary are not allowed.

The following items are covered only for adult beneficiaries living in independent settings (i.e., own home, apartment where deed or lease is signed by the beneficiary):

- Cough, cold, pain, headache, allergy, and/or gastrointestinal distress remedies
- First aid supplies (e.g., Band-Aids, iodine, rubbing alcohol, cotton swabs, gauze, antiseptic cleansing pads); and
- Special items (i.e., accommodating common disabilities -- longer, wider handles), tweezers and nail clippers.

The following items are covered for beneficiaries living in independent settings, with family, or in licensed dependent care settings:

- Special oral care products to treat specific oral conditions beyond routine mouth care (e.g., special toothpaste, tooth brushes, anti-plaque rinses, antiseptic mouthwashes)
- Vitamins and minerals
- Special dietary juices and foods that augment, but do not replace, a regular diet
- Thickening agents for safe swallowing when the beneficiary has a diagnosis of dysphagia and either:
    - A history of aspiration pneumonia, or
    - Documentation that the beneficiary is at risk of insertion of a feeding tube without the thickening agents for safe swallowing.

The following limitation(s) applies to the scope of the service:

Coverage excludes routine cosmetic products (e.g., make-up base, aftershave, mascara, and similar products). However, products necessary to ameliorate negative visual impact of serious facial disfigurements (e.g., massive scarring) and/or skin conditions (including exposed area eczema, psoriasis, and/or acne) will be covered.

Limitations on the amount of service	**Limitations on the duration of the service**	**Provider Category(s):**	**The service may be provided by a:**	**Description of allowable providers:**
Per **☐ Day** **☐Week** **☐ Month** **☐Year** **☐Other, Describe:**	**_____Day(s)** **_____Week(s)** **_____Month(s)** **Other:** See note No.2 Page 1.	**☐ Individual (list types):** **☒ Agency (list types of agencies):** Retailers	**☐ Legally Responsible Person** **☐Relative/Legal Guardian:**	**Provider Type:** Retailers **License Required:** **☐ Yes ☒ No** **Certificate Required:** **☐ Yes ☒ No** **Describe:** **Other Qualifications Required for this Provider Type (please describe):** Retailers must sell the enhanced pharmacy items. Participants may freely select the provider based on location or other factors.

Environmental Modification

Service: Environmental Modification
Scope/Description:

The intent of this service is to fund medically necessary supports that promote community inclusion and participation, independence, and/or productivity when identified in the individual plan of service as one or more goals developed during person-centered planning.
Physical adaptations to the beneficiary's own home or apartment and/or work place. There must be documented evidence that the modification is the most cost-effective alternative to meet the beneficiary's need/goal based on the results of a review of all options, including a change in the use of rooms within the home or alternative housing, or in the case of vehicle modification, alternative transportation. All modifications must be prescribed by a physician. Prior to the environmental modification being authorized, PIHP may require that the beneficiary apply to all applicable funding sources (e.g., housing commission grants, MSHDA, and community development block grants), for assistance. It is expected that the PIHP case manager/supports coordinator will assist the beneficiary in his pursuit of these resources. Acceptances or denials by these funding sources must be documented in the beneficiary's records. Medicaid is a funding source of last resort.

Coverage includes:

- The installation of ramps and grab-bars.
- Widening of doorways.
- Modification of bathroom facilities.
- Special floor, wall or window covering that will enable the beneficiary more independence or control over his environment, and/or ensure health and safety.
- Installation of specialized electrical and plumbing systems that are necessary to accommodate the medical equipment and supplies necessary for the welfare of the beneficiary.
- Assessments by an appropriate health care professional and specialized training needed in conjunction with the use of such environmental modifications.
- Central air conditioning when prescribed by a physician and specified as to how it is essential in the treatment of the beneficiary's illness or condition. This supporting documentation must demonstrate the cost-effectiveness of central air compared to the cost of window units in all rooms that the beneficiary must use.
- Environmental modifications that are required to support proper functioning of medical equipment, such as electrical upgrades, limited to the requirements for safe operation of the specified equipment.

- Adaptations to the work environment limited to those necessary to accommodate the beneficiary's individualized needs.

Coverage excludes:

- Adaptations or improvements to the home that are not of direct medical or remedial benefit to the beneficiary, or do not support the identified goals of community inclusion and participation, independence or productivity.
- Adaptations or improvements to the home that are of general utility or cosmetic value and are considered to be standard housing obligations of the beneficiary. Examples of exclusions include, but are not limited to, carpeting (see exception above), roof repair, sidewalks, driveways, heating, central air conditioning, garages, raised garage doors, storage and organizers, landscaping and general home repairs.
- Cost for construction of a new home or new construction (e.g., additions) in an existing home.
- Environmental modifications costs for improvements exclusively required to meet local building codes.
- Adaptations to the work environment that are the requirements of Section 504 of the Rehabilitation Act, the Americans with Disabilities Act, or are the responsibilities of Michigan Rehabilitation Services.

The PIHP must assure there is a signed contract with the builder for an environmental modification and the homeowner. It is the responsibility of the PIHP to work with the beneficiary and the builder to ensure that the work is completed as outlined in the contract and that issues are resolved among all parties. In the event that the contract is terminated prior to the completion of the work, Medicaid capitation payments may not be used to pay for any additional costs resulting from the termination of the contract. The existing structure must have the capability to accept and support the proposed changes. The "infrastructure" of the home (e.g., electrical system, plumbing, well/septic, foundation, heating/cooling, smoke detector systems, roof) must be in compliance with all local codes. If the home is not code compliant, other funding sources must be secured to bring the home into compliance.

The environmental modification must incorporate reasonable and necessary construction standards and comply with applicable state or local building codes. The adaptation cannot result in valuation of the structure significantly above comparable neighborhood real estate values.

Adaptations may be made to rental properties when the landowner agrees to the adaptation in writing. A written agreement between the landowner and the beneficiary must specify any requirements for restoration of the property to its original condition if the occupant moves, and must indicate that Medicaid is not obligated for any restoration costs.

If a beneficiary purchases an existing home while receiving Medicaid services, it is the beneficiary's responsibility to assure that the home will meet basic needs, such as having a ground floor bath/bedroom if the beneficiary has mobility limitations. Medicaid funds may be authorized to assist with the adaptations noted above (e.g., ramps, grab bars, widening doorways) for a recently purchased existing home.

Environmental modifications for licensed settings includes only the remaining balance of previous environmental modification costs that accommodate the specific needs of current waiver beneficiaries, and will be limited to the documented portion being amortized in the mortgage, or the lease cost per bed. Environmental modifications exclude the cost of modifications required for basic foster care licensure or to meet local building codes

Limitations on the amount of service	Limitations on the duration of the service	Provider Category(s):	The service may be provided by a:	Description of allowable providers:
Per **☐ Day** **☐Week** **☐ Month** **☐Year** **☐Other, Describe:**	**_____Day(s)** **_____Week(s)** **Month(s)** **Other:** See note No.2 Page 1.	**☐ Individual (list types):** **☒ Agency (list types of agencies):** Licensed Building Contractor	**☐ Legally Responsible Person** **☐Relative/Legal Guardian**	**Provider Type:** Licensed Building Contractor **License Required:** **☒ Yes ☐ No** MCL 339.601(1); MCL 339.601.2401; MCL 339.601.2403(3) **Certificate Required:** **☐ Yes ☒ No** **Describe:** **Other Qualifications Required for this Provider Type (please describe):** n/a

Family and Support Training

Service: Family Support and Training
Scope/Description:

Family Support and Training is an EPSDT service for persons under age 21. So the grid details apply to persons age 21 and older. For persons 21 and older, the intent of this service is to fund medically necessary supports that promote community inclusion and participation, independence, and/or productivity when identified in the individual plan of service as one or more goals developed during person-centered planning.
Family-focused services provided to family (natural or adoptive parents, spouse, children, siblings, relatives, foster family, in-laws, and other unpaid caregivers) of persons with serious mental illness, serious emotional disturbance or developmental disability for the purpose of assisting the family in relating to and caring for a relative with one of these disabilities. The services target the family members who are caring for and/or living with an individual receiving mental health services. The service is to be used in cases where the beneficiary is hindered or at risk of being hindered in his ability to achieve goals of:

- performing activities of daily living;
- perceiving, controlling, or communicating with the environment in which he lives; or
- improving his inclusion and participation in the community or productive activity, or opportunities for independent living.

The training and counseling goals, content, frequency and duration of the training must be identified in the beneficiary's individual plan of service, along with the beneficiary's goal(s) that are being facilitated by this service.
Coverage includes:
Education and training, including instructions about treatment regimens, and use of assistive technology and/or medical equipment needed to safely maintain the person at home as specified in the individual plan of service.
Counseling and peer support provided by a trained counselor or peer one-on-one or in group for assistance with identifying coping strategies for successfully caring for or living with a person with disabilities.
Family Psycho-Education (SAMHSA model -- specific information is found in the GUIDE TO FAMILY PSYCHOEDUCATION, Requirements for Certification, Sustainability, and Fidelity) for individuals with serious mental illness and their families. This evidence-based practice includes family educational groups, skills workshops, and joining.
Parent-to-Parent Support is designed to support parents/family of children with serious emotional disturbance or developmental disabilities as part of the treatment process to be empowered, confident and have skills that will enable them to assist their child to improve in functioning. The trained parent support partner, who has or had a child with special mental health needs, provides education, training, and support and augments the assessment and mental health treatment process. The parent support partner

provides these services to the parents and their family. These activities are provided in the home and in the community. The parent support partner is to be provided regular supervision and team consultation by the treating professionals.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Not included are individuals who are employed to provide waiver services for the participant.

Limitations on the amount of service	Limitations on the duration of the service	Provider Category(s):	The service may be provided by a:	Description of allowable providers:		Description of allowable providers:
Per **☐ Day** **☐Week** **☐ Month** **☐Year** **☐Other, Describe:**	**Day(s)** **Week(s)** **Month(s)** **Other:** See note No.2 Page 1.	**☒ Individual (list types):** Clinical professional (psychologist, social worker, family therapist, licensed professional counselor, occupational therapist, physical therapist, speech therapist, nurse), Board Certified Behavioral Analyst (BCBA). Trained parent support partner	**☐ Legally Responsible Person** **☐Relative/Legal Guardian**	**Provider Type:** Clinical professional (psychologist, social worker, family therapist, licensed professional counselor, occupational therapist, physical therapist, speech therapist, nurse, BCBA) **License Required:** **☒ Yes ☐ No** The provider must maintain any current registration, license, certification or credentialing required by his or her profession to practice in the State of Michigan. **Certificate Required:** **☐ Yes ☒ No** **Describe:**	**Provider Type:** Trained parent support partner **License Required:** **☐ Yes ☒ No** **Certificate Required:** **☐ Yes ☒ No** **Describe:** **Other Qualifications Required for this Provider Type (please describe):**	**Provider Type:** Home care agencies, clinic service agency providers, outpatient clinics **License Required:** **☒ Yes ☐ No** The provider must maintain any current registration, license, certification or credentialing required by his or her profession to practice in the State of Michigan. **Certificate Required:** **☒ Yes ☐ No** **Describe:** The social worker credential must be a "licensed master's social worker" as defined by Section 18509 of PA 368 of 1978.

Limitations on the amount of service	Limitations on the duration of the service	Provider Category(s):	The service may be provided by a:	Description of allowable providers:		Description of allowable providers:
		☒ Agency (list types of agencies): Home care agencies, clinic service agency providers, outpatient clinics		**Other Qualifications Required for this Provider Type (please describe):** Training must be provided by a professional within the scope of their practice and in good standing with any applicable state and national licensing, certifications, or registrations.	The Trained parent support partner must complete the MDHHS-approved statewide training curriculum and be provided regular supervision and team consultation by the treating professionals. Completion of the training curriculum is documented by a Certificate of Completion which must be maintained in the parent support partner's personnel file.	**Other Qualifications Required for this Provider Type (please describe):** Training being provided must fall within the scope of practice of the agency personnel providing the service.

Fiscal Intermediary

Service: Fiscal Intermediary
The intent of this service is to fund medically necessary supports that promote community inclusion and participation, independence, and/or productivity when identified in the individual plan of service as one or more goals developed during person-centered planning.

Scope/Description:

Fiscal Intermediary Services is defined as services that assist the adult beneficiary or a representative identified in the beneficiary's individual plan of services, to meet the beneficiary's goals of community participation and integration, independence or productivity while controlling his individual budget and choosing staff who will provide the services and supports identified in the IPOS and authorized by the PIHP. The fiscal intermediary helps the beneficiary manage and distribute funds contained in the individual budget. Fiscal intermediary services include, but are not limited to:

- Facilitation of the employment of service workers by the beneficiary, including federal, state and local tax withholding/payments, unemployment compensation fees, wage settlements, and fiscal accounting;
- Tracking and monitoring participant-directed budget expenditures and identifying potential over- and under-expenditures;
- Assuring adherence to federal and state laws and regulations; and
- Ensuring compliance with documentation requirements related to management of public funds.

The fiscal intermediary may also perform other supportive functions that enable the beneficiary to self-direct needed services and supports. These functions may include selecting, contracting with or employing and directing providers of services, verification of provider qualifications (including reference and background checks), and assisting the beneficiary to understand billing and documentation requirements.

A fiscal intermediary is an independent legal entity – organization or individual – that acts as the fiscal agent of the PIHP for the purpose of assuring fiduciary accountability for the funds authorized to purchase specific services identified in the consumer's individual plan of service (IPOS). The fiscal intermediary acts as an employer agent when the consumer's representative directly employs staff or other service providers.

The fiscal intermediary can be an agency or organization (e.g., financial management services agency, accounting firm, local ARC or other advocacy organization) or individual (e.g., accountant, financial advisor/manager, and attorney). The fiscal intermediary must meet requirements as identified in the MDHHS Managed Mental Health Supports and Services Contract with the PIHP.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Fiscal intermediary services may not be authorized for use by a beneficiary's representative where that representative is not conducting tasks in ways that fit the beneficiary's preferences, and/or do not promote achievement of the goals contained in the beneficiary's plan of service so as to promote independence and inclusive community living for the beneficiary, or when they are acting in a manner that is in conflict with the interests of the beneficiary.

Fiscal intermediary services must be performed by entities with demonstrated competence in managing budgets and performing other functions and responsibilities of a fiscal intermediary. Providers of other covered services to the beneficiary, family members, or the beneficiaries' guardians cannot provide fiscal intermediary services to the beneficiary.

Limitations on the amount of service	Limitations on the duration of the service	Provider Category(s):	The service may be provided by a:	Description of allowable providers:	Description of allowable providers:
_____ **Per** ☐ **Day** ☐ **Week** ☐ **Month** ☐ **Year** ☐ **Other, Describe:**	_____**Day(s)** _____**Week(s)** _____**Month(s)** **Other:** See note No.2 Page 1.	☒**Individual (list types):** Examples include: accountant, financial advisor/manager, and attorney ☒ **Agency (list types of agencies):** Examples include: financial management services agency, accounting firm, local ARC, other advocacy organization, other non-profit agencies	☐ **Legally Responsible Person** ☐ **Relative/Legal Guardian**	**Provider Type: Individual** **License Required:** ☐ **Yes** ☐ **No** **Certificate Required:** ☐ **Yes** ☐ **No** **Describe:** **Other Qualifications Required for this Provider Type (please describe):** The license and certificate requirements depend upon the type of provider.	**Provider Type: Agency** **License Required:** ☐ **Yes** ☐ **No** **Certificate Required:** ☐ **Yes** ☐ **No** **Describe:** **Other Qualifications Required for this Provider Type (please describe):** The license and certificate requirements depend upon the type of agency.

Goods and Services

Service: Goods and Services

Scope/Description:

The purpose of the Goods and Services is to promote individual control over and flexible use of the individual budget by the participant using arrangements that support self-determination and facilitate creative use of funds to accomplish the goals identified in the individual plan of services (IPOS) through achieving better value or an improved outcome. Goods and services must (1) increase independence, facilitate productivity, or promote community inclusion and (2) substitute for human assistance (such as personal care, community living supports, and other one-to-one behavioral health supports) to the extent that individual budget expenditures would otherwise be made for the human assistance.

A Goods and Services item must be identified using a person-centered planning process, meet medical necessity criteria, and be documented in the IPOS.

Purchase of a warranty may be included when it is available for the item and is financially reasonable.

The following limitation(s) applies to the scope of the service:

This coverage may not be used to acquire goods or services that are prohibited by federal or state laws or regulations, e.g., purchase or lease or routine maintenance of a vehicle. Goods and Services are available only to individuals participating in arrangements of self-determination whose individual budget is lodged with a fiscal intermediary.

Limitations on the amount of service	Limitations on the duration of the service	Provider Category(s):	The service may be provided by a:	Description of allowable providers:
Per **☐ Day** **☐Week** **☐ Month** **☐Year** **☐Other, Describe:**	**_____Day(s)** **_____Week(s)** **_____Month(s)** **Other:** See note No.2 Page 1.	**☐ Individual (list types):** **☒ Agency (list types of agencies):** Goods and services provider	**☐ Legally Responsible Person** **☐Relative/Legal Guardian**	**Provider Type:** Goods and services provider **License Required:** **☐ Yes ☒ No** **Certificate Required:** **☐ Yes ☒ No** **Describe:** **Other Qualifications Required for this Provider Type (please describe):** Provider must be reputable and able to provide the good or service necessary.

Non-Family Training

Service: Non-Family Training
Scope/Description:

This service provides coaching, training, supervision and monitoring of Community Living Supports (CLS) and respite staff by clinicians working within the scope of their practice. Professional staff work with CLS and respite staff to implement the consumer's IPOS, with focus on all behavioral health services designed to assist the consumer in acquiring, retaining and improving self-help, socialization and adaptive skills necessary to reside successfully in home and community-based settings. The activities of the professional staff ensure the appropriateness of services delivered by CLS and respite staff and continuity of care. The service provider is selected on the basis of his/her competency in the aspect of the IPOS on which training is conducted.

Limitations on the amount of service	Limitations on the duration of the service	Provider Category(s):	The service may be provided by a:	Description of allowable providers:	Description of allowable providers:
4 sessions **Per** **☒ Day** **☐Week** **☐ Month** **☐Year** **☒ Other, Describe:** 12 sessions per 90 days; Reportable encounter must be at least 45 minutes .	**____Day(s)** **____Week(s)** **Month(s)** **____Other:** See note No.2 Page 1.	**☒ Individual (list types):** Clinicians: licensed psychologist, Master's level social worker, nurse, occupational therapist, physical therapist, speech therapist, Child Mental Health Professional, Qualified Mental Health Professional, Qualified Intellectual Disability Professional, Board Certified Behavior Analyst (BCBA).	**☐ Legally Responsible Person** **☐Relative/Legal Guardian:**	**Provider Type:** Individual Clinician **License Required:** **☒ Yes ☐ No** As applicable to the clinician, and as detailed in the Michigan PIHP/CMHSP Provider Qualification Code Chart, must hold a current Michigan license **Certificate Required:** **☐ Yes ☒ No** **Describe:** **Other Qualifications Required for this Provider Type (please describe):** Child Mental Health Professional, Qualified Mental Health Professional, Qualified Intellectual Disability Professional: must meet criteria specified in the Michigan PIHP/CMHSP Provider Qualification Code Chart All clinicians must provide non-family training within the scope of their professional practice	**Provider Type:** Agency **License Required:** **☐ Yes ☐ No** **Certificate Required:** **☐ Yes ☐ No** **Describe:** **Other Qualifications Required for this Provider Type (please describe):** Agency qualifications are dependent on the type of agency and are not specific to this service. The individual hands-on clinical provider must meet professional credentialing requirements as specified in this section and must provide services within the scope of their professional practice.

Limitations on the amount of service	Limitations on the duration of the service	Provider Category(s):	The service may be provided by a:	Description of allowable providers:	Description of allowable providers:
		☒ **Agency (list types of agencies):** Staffing agency, home care agency, clinical service agency, out-patient clinic, other PIHP network provider agency			

Out-of-Home Non-Vocational Habilitation

Service: Out-of-Home Non-Vocational Habilitation
Scope/Description:

Assistance with acquisition, retention, or improvement in self-help, socialization, and adaptive skills; and the supports services, including transportation to and from, incidental to the provision of that assistance that takes place in a non-residential setting, separate from the home or facility in which the participant resides. Examples of incidental support include:

- Aides helping the participant with his mobility, transferring, and personal hygiene functions at the various sites where habilitation is provided in the community.
- When necessary, helping the participant to engage in the habilitation activities (e.g., interpreting).

The following limitation(s) applies to the scope of the service:

Payments for Out-of-Home Non-Vocational Habilitation may not be made, directly or indirectly, to responsible relatives (i.e., spouses or parents of minor children) or the legal guardian.

Limitations on the amount of service	Limitations on the duration of the service	Provider Category(s):	The service may be provided by a:	Description of allowable providers:	Description of allowable providers:	Description of allowable providers:
4 or more hours Per **☒ Day** **☐Week** **☐ Month** **☐Year** **☒Other, Describe:** Service must be provided on a regularly scheduled basis for one or more days per week unless provided as an adjunct to other day activities included in the participant's plan of service.	**Day(s)** **Week(s)** **Month(s)** **Other:** See note No.2 Page 1.	**☒ Individual (list types):** Aide **☒ Agency (list types of agencies):** Staffing agency, home care agency or other subcontractor Community-based non-residential settings operated by CMHSP or other subcontractor	**☐ Legally Responsible Person** **Relative** Payments for Out-of-Home Non-Vocational Habilitation may not be made, directly or indirectly, to responsible relatives (i.e., spouses or parents of minor children) or the legal guardian.	**Provider Type:** Aide **License Required:** **☐ Yes ☒ No** **Certificate Required:** **☐ Yes ☒ No** **Describe:** **Other Qualifications Required for this Provider Type (please describe):** Aides must meet criteria specified in the Michigan PIHP/CMHSP Provider Qualification Code Chart.	**Provider Type:** Staffing agency, home care agency or other subcontractor **License Required:** **☐ Yes ☐ No** **Certificate Required:** **☐ Yes ☐No** **Describe:** **Other Qualifications Required for this Provider Type (please describe):** For services delivered in the community, the agency must assure its employees are knowledgeable in the community opportunities available in the area.	**Provider Type:** Community-based non-residential settings operated by CMHSP or other subcontractor **License Required:** **☐ Yes ☒ No** **Certificate Required:** **☐ Yes ☒ No** **Describe:** **Other Qualifications Required for this Provider Type (please describe):** For services delivered in the community, the agency must assure its employees are knowledgeable in the community opportunities available in the area.

Personal Emergency Response System (PERS)

Service: Personal Emergency Response System (PERS)
Scope/Description:

PERS is an electronic device that enables certain individuals at high risk of institutionalization to secure help in an emergency. The individual may also wear a portable "help" button to allow for mobility. The system is connected to the participant's phone and programmed to signal a response center once a "help" button is activated. The response center is staffed by trained professionals. This service includes a one-time installation and up to twelve monthly monitoring services per year.

The following limitation(s) applies to the scope of the service:

PERS services are limited to those participants who live alone (or living with a roommate who does not provide supports), or who are alone for significant parts of the day, and have no regular caregiver support/service provider for extended periods of time, and who would otherwise require extensive routine supervision and guidance.

Limitations on the amount of service	Limitations on the duration of the service	Provider Category(s):	The service may be provided by a:	Description of allowable providers:
Per **☐ Day** **☐Week** **☐ Month** **☐Year** **☐Other, Describe:**	**_____Day(s)** **_____Week(s)** **_____Month(s)** **Other:** See note No.2 Page 1.	**☐ Individual (list types):** **☒ Agency (list types of agencies):** PERS provider	**☐ Legally Responsible Person** **☐Relative/Legal Guardian**	**Provider Type:** **License Required:** **☐ Yes ☒ No** **Certificate Required:** **☐ Yes ☒ No** **Describe:** **Other Qualifications Required for this Provider Type (please describe):** a. The Federal Communication Commission must approve the equipment used for the response system. The equipment must meet UL® safety standards 1637 specifications for Home Health Signaling Equipment. b. The provider must staff the response center with trained personnel 24 hours per day, 365 days per year. The response center will provide accommodations for persons with limited English proficiency. c. The response center must maintain the monitoring capacity to respond to all incoming emergency signals. d. The response center must have the ability to accept multiple signals simultaneously. The response center must not disconnect calls for a return call or put in a first call, first serve basis.

Prevocational Services

Service: Prevocational Services
Scope/Description:

Prevocational services involve the provision of learning and work experiences where a participant can develop general, non-job-task-specific strengths and skills that contribute to employability in paid employment in integrated, community settings. Services are expected to occur over a defined period of time and provided in sufficient amount and scope to achieve the outcome, as determined by the participant and his/her care planning team in the ongoing person-centered planning process. Services are expected to specifically involve strategies that enhance a participant's employability in integrated, community settings. Competitive employment or supported employment are considered successful outcomes of prevocational services. However, participation in prevocational services is not a required pre-requisite for competitive employment or receiving supported employment services.

Prevocational services should enable each participant to attain the highest possible wage and work which is in the most integrated setting and matched to the participant's interests, strengths, priorities, abilities, and capabilities. Services are intended to develop and teach general skills that lead to employment including but not limited to: ability to communicate effectively with supervisors, co-workers and customers; generally accepted community workplace conduct and dress; ability to follow directions; ability to attend to tasks; workplace problem solving skills and strategies; general workplace safety and mobility training.

Support of employment outcomes is a part of the person-centered planning process, and emphasizes informed consumer choice. This process specifies the participant's personal outcomes toward a goal of productivity, identifies the services and items, including prevocational services and other employment-related services that advance achievement of the participant's outcomes, and addresses the alternatives that are effective in supporting his or her outcomes. From the alternatives, the participant selects the most cost-effective approach that will help him or her achieve the outcome.

Participants who receive prevocational services during some days or parts of days may also receive other waiver services, such as supported employment, out-of-home non-vocational habilitation, or community living supports at other times. Participants who are still attending school may receive prevocational training and other work related transition services through the school system and may also participate in prevocational services designed to complement and reinforce the skills being learned in the school program during portions of their day that are not the educational system's responsibility, e.g., after school or on weekends and school vacations. Prevocational services may be provided in a variety of community locations.

Participants participating in prevocational service may be compensated in accordance with applicable Federal laws and regulations, but the provision of prevocational services is intended to lead to a permanent integrated employment situation.

The following limitation(s) applies to the scope of the service:

Prevocational services furnished under the waiver are not available under a program funded under section 110 of the Rehabilitation Act of 1973 or section 602(16) and (17) of the Individuals with Disabilities Education Act (20 U.S.C. 1401(16 and 17).
Prevocational services may be provided to supplement, but may not duplicate, services provided under supported employment or out-of-home non-vocational habilitation services. Coordination with the participant's school is necessary to assure that prevocational services provided in the waiver do not duplicate or supplant transition services that are the responsibility of the educational program.
Transportation provided between the beneficiary's place of residence and the site of the prevocational services, or between habilitation sites, is included as part of the prevocational and/or habilitation services.
Assistance with personal care or other activities of daily living that are provided to a participant during the receipt of prevocational services may be included as part of prevocational services, or may be provided as a separate State Plan Home Help service or community living supports service under the waiver, but the same activity cannot be reported as being provided to more than one service.
Only activities that contribute to the participant's work experience, work skills, or work-related knowledge can be included in prevocational services.
Payments for Prevocational Services may not be made, directly or indirectly, to responsible relatives (i.e., spouses or parents of minor children) or the legal guardian.

Limitations on the amount of service	Limitations on the duration of the service	Provider Category(s):	The service may be provided by a:	Description of allowable providers:	Description of allowable providers:
Per **☐ Day** **☐Week** **☐ Month** **☐Year** **☐Other, Describe:** .	**_____Day(s)** **_____Week(s)** **_____Month(s)** **Other:** See note No.2 Page 1.	**☒ Individual (list types):** Prevocational support staff **☒ Agency (list types of agencies):** Community-based prevocational program operated by CMHSP or other subcontractor	**☐ Legally Responsible Person** **Relative** Payments for Prevocational Services may not be made, directly or indirectly, to responsible relatives (i.e., spouses or parents of minor children) or the legal guardian.	**Provider Type:** Prevocational support staff **License Required:** **☐ Yes ☒ No** **Certificate Required:** **☐ Yes ☒ No** **Describe:** **Other Qualifications Required for this Provider Type (please describe):** The support staff must, at a minimum, meet provider qualifications for an aide as specified in the PIHP/CMHSP Provider Qualification Code Chart. Additionally, the support staff must be knowledgeable about the unique abilities, preferences, and needs of the individual(s) served and be able to provide services directed toward the outcome of achieving competitive employment.	**Provider Type:** Community -based prevocational program operated by CMHSP or other subcontractor **License Required:** **☐ Yes ☒ No** **Certificate Required:** **☐ Yes ☒ No** **Describe:** **Other Qualifications Required for this Provider Type (please describe):** For services delivered in the community, the agency must assure its employees are knowledgeable in the community opportunities available in the area.

Skill Building Assistance

Service: Skill Building Assistance
Scope/Description:

Skill-building assistance consists of activities identified in the individual plan of services and designed by a professional within his/her scope of practice that assist a beneficiary to increase his economic self-sufficiency and/or to engage in meaningful activities such as school, work, and/or volunteering. The services provide knowledge and specialized skill development and/or support. Skill-building assistance may be provided in the beneficiary's residence or in community settings.

Documentation must be maintained by the PIHP that the beneficiary is not currently eligible for sheltered work services provided by Michigan Rehabilitation Services (MRS).

Information must be updated when the beneficiary's MRS eligibility conditions change.
Coverage includes:

- Out-of-home adaptive skills training: Assistance with acquisition, retention, or improvement in self-help, socialization, and adaptive skills; and supports services incidental to the provision of that assistance, including:
- Aides helping the beneficiary with his mobility, transferring, and personal hygiene functions at the various sites where adaptive skills training is provided in the community.
- When necessary, helping the person to engage in the adaptive skills training activities (e.g., interpreting).

Services must be furnished on a regularly scheduled basis (several hours a day, one or more days a week) as determined in the individual plan of services and should be coordinated with any physical, occupational, or speech therapies listed in the plan of supports and services. Services may serve to reinforce skills or lessons taught in school, therapy, or other settings.

- Work preparatory services are aimed at preparing a beneficiary for paid or unpaid employment, but are not job task-oriented. They include teaching such concepts as attendance, task completion, problem solving, and safety. Work preparatory services are provided to people not able to join the general workforce, or are unable to participate in a transitional sheltered workshop within one year (excluding supported employment programs).

Activities included in these services are directed primarily at reaching habilitative goals (e.g., improving attention span and motor skills), not at teaching specific job skills. These services must be reflected in the beneficiary's person-centered plan and directed to habilitative or rehabilitative objectives rather than employment objectives.

- Transportation from the beneficiary's place of residence to the skill building assistance training, between skills training sites if applicable, and back to the beneficiary's place of residence.

Coverage excludes:

Services that would otherwise be available to the beneficiary.

Limitations on the amount of service	Limitations on the duration of the service	Provider Category(s):	The service may be provided by a:	Description of allowable providers:	Description of allowable providers:
Per **☐ Day** **☐Week** **☐ Month** **☐Year** **☐Other, Describe:** .	**_____Day(s)** **_____Week(s)** **_____Month(s)** **Other:** See note No.2 Page 1.	**☒ Individual (list types):** Skill Building support staff **☒ Agency (list types of agencies):** Community-based Skill Building Services/ program operated by CMHSP or other subcontractor	**☐ Legally Responsible Person** **Relative** Payments for Skill Building Services may not be made, directly or indirectly, to responsible relatives (i.e., spouses or parents of minor children) or the legal guardian.	**Provider Type:** Skill Building support staff **License Required:** **☐ Yes ☒ No** **Certificate Required:** **☐ Yes ☒ No** **Describe:** **Other Qualifications Required for this Provider Type (please describe):** The support staff must, at a minimum, meet provider qualifications for an aide as specified in the PIHP/CMHSP Provider Qualification Code Chart. Additionally, the support staff must be knowledgeable about the unique abilities, preferences, and needs of the individual(s) served and be able to provide services directed toward the outcome of achieving competitive employment.	**Provider Type:** Community –Skill Building Services/programs operated by CMHSP or other subcontractor **License Required:** **☐ Yes ☒ No** **Certificate Required:** **☐ Yes ☒ No** **Describe:** **Other Qualifications Required for this Provider Type (please describe):** For services delivered in the community, the agency must assure its employees are knowledgeable in the community opportunities available in the area.

Specialty Services / Therapies

Service: Specialty Services/Therapies

Scope/Description:

Specialty Services are: Music Therapy, Recreation Therapy, Art Therapy and Massage Therapy and may include the following activities: Child and family training; coaching and supervision of staff; monitoring of progress related to goals and objectives; and recommending changes in the plan. These therapies may be used in addition to the traditional professional therapy model included in Medicaid. Services must be directly related to an identified goal in the individual plan of service and approved by the physician. Service providers must meet the applicable licensure/certification requirements.

The following limitation(s) applies to the scope of the service:

Massage therapy is not available to people under age 21 who meet the clinical needs based criteria for psychiatric hospital level of care. Music Therapy, Recreational Therapy and Art Therapy are only available to children under 18.

Limitations on the amount of service	Limitations on the duration of the service	Provider Category(s):	The service may be provided by a:	Description of allowable providers:	Description of allowable providers:
4 sessions Per ☐ **Day** ☐ **Week** ☒ **Month** ☐ **Year** ☒ **Other, Describe:**	**Day(s)** **Week(s)** **Month(s)** **____Other:** See note No.2 Page 1.	☒ **Individual (list types):** Massage Therapist, Therapeutic Recreation Specialist, Music Therapist, Art Therapist ☒ **Agency (list types of agencies):** Home care agency, clinical service agency, out-patient clinic, other PIHP network provider agency	☐ **Legally Responsible Person** ☐ **Relative/Legal Guardian:**	**Provider Type:** Individual Therapist **License Required:** ☒ **Yes** ☐ **No** Massage Therapists must hold a current Michigan license, issued pursuant to the Public Health Code as amended by Public Act 471 of 2008. **Certificate Required:** ☒ **Yes** ☐ **No** **Describe:** Therapeutic Recreation Specialist must be certified by the National Council for Therapeutic Recreation (NCTRC); Music Therapist must be Board Certified (MT-BC) National Music Therapy Registry (NMTR); Art Therapist must be a Registered Art Therapist (ATR); Massage Therapist must be Nationally Certified in Therapeutic Massage and Bodywork (NCBTMB).	**Provider Type:** Agency **License Required:** ☐ **Yes** ☐ **No** **Certificate Required:** ☐ **Yes** ☐ **No** **Describe:** **Other Qualifications Required for this Provider Type (please describe):** Agency qualifications are dependent on the type of agency and are not specific to this service.

Limitations on the amount of service	Limitations on the duration of the service	Provider Category(s):	The service may be provided by a:	Description of allowable providers:	Description of allowable providers:
				Other Qualifications Required for this Provider Type (please describe):	The hands-on Massage Therapist, Therapeutic Recreation Specialist, Music Therapist, Art Therapist must meet licensure or certification requirements as specified in this section and must provide services within the scope of their professional practice.

Supports and Service Coordination

Service: Supports and Service Coordination

Scope/Description:

Supports and Service Coordination is an EPSDT service for persons under age 21. So the grid details apply to persons age 21 and older. For persons 21 and older, the intent of this service is to fund medically necessary supports that promote community inclusion and participation, independence, and/or productivity when identified in the individual plan of service as one or more goals developed during person-centered planning.

Functions performed by a supports coordinator, supports coordinator assistant, services and supports broker, or otherwise designated representative of the PIHP that include assessing the need for support and service coordination, and assurance of the following:

- Planning and/or facilitating planning using person-centered principles
- Developing an individual plan of service using the person-centered planning process
- Linking to, coordinating with, follow-up of, advocacy with, and/or monitoring of Specialty Services and Supports and other community services/supports.
- Brokering of providers of services/supports
- Assistance with access to entitlements and/or legal representation
- Coordination with the Medicaid Health Plan, Medicaid fee-for-service, or other health care providers

The role of the supports coordinator assistant is to perform the functions listed above, as they are needed, in lieu of a supports coordinator or case manager. A beneficiary would have only one of the three possible options: targeted case manager, supports coordinator, or supports coordinator assistant. When a supports coordinator assistant is used, a qualified supports coordinator or targeted case manager must supervise the assistant. The role and qualifications of the targeted case manager are described in the Targeted Case Management section of this chapter.

A services and supports broker is used to explore the availability of community services and supports, housing, and employment and then to make the necessary arrangement to link the beneficiary with those supports. The role of the supports coordinator or supports coordinator assistant when a services and supports broker is used is to perform the remainder of the functions listed above as they are needed, and to assure that brokering of providers of services and supports is performed.

Whenever services and supports brokers provide any of the supports coordination functions, it is expected that the beneficiary will also have a supports coordinator or case manager, or their assistant, employed by the PIHP or its provider network who assures that the other functions above are in place.

If a beneficiary has both a supports coordinator or supports coordinator assistant AND a services and supports broker, the individual plan of service must clearly identify the staff who is responsible for each function. The PIHP must assure that it is not paying for the

supports coordinator (or supports coordinator assistant) and the services and supports broker to perform service brokering. Likewise, when a supports coordinator (or supports coordinator assistant) facilitates a person-centered planning meeting, it is expected that the PIHP would not "double count" the time of any services and supports broker who also attends. During its annual on-site visits, the MDHHS will review individual plans of service to verify that there is no duplication of service provision when both a supports coordinator assistant and a services and supports broker are assigned supports coordination responsibilities in a beneficiary's plan of service.

Supports strategies will incorporate the principles of empowerment, community inclusion, health and safety assurances, and the use of natural supports. Supports coordinators will work closely with the beneficiary to assure his ongoing satisfaction with the process and outcomes of the supports, services, and available resources.

Supports Coordination is reported only when there is face-to-face contact with the beneficiary. Related activities, such as telephone calls to schedule appointments or arrange supports, are functions that are performed by a supports coordinator but not reported separately. Supports coordination functions must assure:

- The desires and needs of the beneficiary are determined
- The supports and services desired and needed by the beneficiary are identified and implemented
- Housing and employment issues are addressed
- Social networks are developed
- Appointments and meetings are scheduled
- Person-centered planning is provided, and independent facilitation of person-centered planning is made available
- Natural and community supports are used
- The quality of the supports and services, as well as the health and safety of the beneficiary, are monitored
- Income/benefits are maximized
- Activities are documented
- Plans of supports/services are reviewed at such intervals as are indicated during planning

While supports coordination as part of the overall plan implementation and/or facilitation may include initiation of other coverage and/or short-term provision of supports, it shall not include direct delivery of ongoing day-to-day supports and/or training, or provision of other Medicaid services. Supports coordinators are prohibited from exercising the agency's authority to authorize or deny the provision of services. Supports coordination may not duplicate services that are the responsibility of another program.

The supports coordination functions to be performed and the frequency of face-to-face and other contacts are specified in the beneficiary's plan. The beneficiary's record must contain sufficient information to document the provision of supports coordination, including the nature of the service, the date, and the location of contacts, including whether the contacts were face-to-face. The frequency and scope of supports coordination contacts must take into consideration the health and safety needs of the individual.

The following limitation(s) applies to the scope of the service:
The participant cannot receive supports broker services provided by parents (of a minor-aged child) or spouse or legal guardian (of an adult participant). Independent supports broker services may be provided by other relatives of the participant that are not excluded in the preceding sentence.

Limitations on the amount of service	Limitations on the duration of the service	Provider Category(s):	The service may be provided by a:	Description of allowable providers:	Description of allowable providers:	Description of allowable providers:	Description of allowable providers:
Per **☐ Day** **☐Week** **☐ Month** **☐Year** **☐Other, Describe:**	**_____Day(s)** **_____Week(s)** **Month(s)** **Other:** See note No.2 Page 1.	**☒ Individual (list types):** Services and Supports Broker Supports Coordinator Assistant Supports Coordinator **☒ Agency (list types of agencies):** Supports Coordination Agency	**☐ Legally Responsible Person** **Relative** The participant cannot receive supports broker services provided by parents (of a minor-aged child) or spouse or legal guardian (of an adult participant). Independent supports	**Provider Type:** Service and Supports Broker **License Required:** **☐ Yes ☒ No** **Certificate Required:** **☐ Yes ☒ No** **Describe:**	**Provider Type:** Supports Coordinator Assistant **License Required:** **☐ Yes ☒ No** **Certificate Required:** **☐ Yes ☒ No** **Describe:**	**Provider Type:** Supports Coordinator **License Required:** **☒ Yes ☐ No** The supports coordinator must maintain any current registration, license, certification or credentialing required by his or her profession to practice in the State of Michigan. **Certificate Required:**	**Provider Type:** Supports Coordination Agency **License Required:** **☐ Yes ☒ No** **Certificate Required:** **☐ Yes ☒ No**

			broker services may be provided by other relatives of the participant that are not excluded in the preceding sentence.	**Other Qualifications Required for this Provider Type (please describe):** 1. Chosen by the participant. 2. Minimum of a high school diploma and demonstrated skills and knowledge to perform the functions. 3. Functions under the supervision of a supports coordinator.	**Other Qualifications Required for this Provider Type (please describe):** 1. Chosen by the participant. 2. Minimum of a high school diploma and one year of experience working directly with people who have developmental disabilities. 3. Functions under the supervision of a supports coordinator.	☐ **Yes** ☒ **No** **Describe:** **Other Qualifications Required for this Provider Type (please describe):** 1. Chosen by the participant. The independent supports coordinator must be a QIDP or QMHP: specified bachelor's degree and one year of experience with the population the supports coordinator will be serving. If the supports coordinator has only the degree without one year of experience, they must be supervised by a QMHP or QIDP for one year. Services must be	**Describe:** **Other Qualifications Required for this Provider Type (please describe):** The agency must meet provider requirements for the PIHP. The agency must assure its employees are knowledgeable in the unique abilities, preferences and needs of the individual(s) being served. In addition, the agency must maintain a pool of qualified supports coordinators from which the participant can choose. The supports

						provided by a CMHP to any child beneficiary with serious emotional disturbance. Services to children ages 7-17 with SED must be provided by a CMHP trained in CAFAS. Services rendered to children ages 4-6 with SED must be provided by a CMHP trained in PECAFAS. Assistants or brokers: high school diploma and one year experience, and supervised by a qualified supports coordinator or case manager. 2.	coordinator employed by an agency must be a QIDP as defined in the Michigan PIHP/CMHSP Provider Qualification Code Chart and maintain any current registration, license, certification or credentialing required by his or her profession to practice in the State of Michigan.

Respite

Service: Respite

Scope/Description:

The intent of this service is to fund medically necessary supports that promote community inclusion and participation, independence, and/or productivity when identified in the individual plan of service as one or more goals developed during person-centered planning.

Respite care services are provided to a waiver eligible participant on a short-term, intermittent basis to relieve the participant's family or other primary caregiver(s) from daily stress and care demands during times when they are providing unpaid care. "Short-term" means the respite service is provided during a limited period of time (e.g., a few hours, a few days, weekends, or for vacations). "Intermittent" means the respite service does not occur regularly or continuously. The service stops and starts repeatedly or with periods in between. "Primary" caregivers are typically the same people day after day who provide at least some unpaid supports. "Unpaid" means that respite may only be provided during those portions of the day when no one is being paid to provide the care, i.e., not a time when the participant is receiving a paid State Plan (e.g., home help) or waiver service (e.g., community living supports) or service through other programs (e.g., school). Since adult participants living at home typically receive home help services and hire their family members, respite is not available when the family member is being paid to provide the home help service, but may be available at other times throughout the day when the caregiver is not paid.

The following limitation(s) applies to the scope of the service:

Respite is not intended to be provided on a continuous, long-term basis where it is a part of daily services that would enable an unpaid caregiver to work full-time. In those cases, community living supports, or other services of paid support or training staff, should be used. The participant's record must clearly differentiate respite hours from community living support services. Decisions about the methods and amounts of respite are decided during the person-centered planning process and are specified in the individual plan of service.

Respite care may not be provided by a parent of a minor participant, the spouse of the participant, the participant's legal guardian, or the primary unpaid caregiver. Respite services may be provided in the following settings that are approved by the participant and identified in the individual plan of services:

- Participant's home
- Home of a friend or relative (not the parent of a minor or the spouse of the participant or the legal guardian)
- Licensed foster care home or respite care facility

- Licensed camp
- In community settings accompanied by a respite worker
- Facility approved by the State that is not a private residence, such as group home or licensed respite care facility

Cost of room and board must not be included as part of the respite care unless provided as part of the respite care in a facility that is not a private residence. Respite is not covered if the care is being provided in an institution (i.e., ICF/IID, nursing facility, or hospital) or MDHHS approved day program site.

Limitations on the amount of service	Limitations on the duration of the service	Provider Category(s):	The service may be provided by a:	Description of allowable providers:	Description of allowable providers:	Description of allowable providers:	Description of allowable providers:	Description of allowable providers:
____ Per **☐ Day** **☐Week** **☐ Month** **☐Year** **☐ Other, Describe:**	**____Day(s)** **Week(s)** **Month(s)** **____Other:** See note No.2 Page 1.	**☒ Individual (list types):** Independent Nurse (RN or LPN) Individual aide level respite provider **☒ Agency (list types of agencies):** Licensed Camp Staffing agency, home care agency, other PIHP network provider agency Licensed children's foster care, licensed	**☐ Legally Responsible Person** **☐Relative** Respite care may not be provided by a parent of a minor participant, the spouse of the participant, the participant's legal guardian, or the primary unpaid caregiver.	**Provider Type:** Independent Nurse (RN or LPN) **License Required:** **☒ Yes ☐ No** This service must be provided by either a Registered Nurse (RN) or a Licensed Practical Nurse (LPN) under the supervision of an RN. The nurse (RN or LPN) must have a current license in good standing with the State of Michigan under MCL 333.17211 **Certificate Required:**	**Provider Type:** Individual aide level respite provider **License Required:** **☐ Yes ☒ No** **Certificate Required:** **☐ Yes ☒ No** **Describe:** **Other Qualifications**	**Provider Type:** Licensed Camp **License Required:** **☒ Yes ☐ No** Children's Camps: MCL 722.111, MCL 330.1153, Act 116 of 1973, Act 218 of 1978 as amended, Administrative Rule 400.11101-.11413 Adult's Camps: MCL 400.703, Act 218 of 1979 as amended, Administrative Rule 400.11101-.11413 **Certificate Required:** **☐ Yes ☒ No**	**Provider Type:** Staffing agency, home care agency, other PIHP network provider agency **License Required:** **☒ Yes ☐ No** Hands-on provider must meet RN.LPN or aide level eligibility requirement specified in this section. **Certificate Required:** **☐ Yes ☒ No**	**Provider Type:** Licensed children's foster care, licensed adult foster care. **License Required:** **☒ Yes ☐ No** Act 116 of 1973 as amended (children), Act 218 of 197 as amended (adults), Administrative Rules R400.4101-.9506 and R400.1401-.15411 and R400.1901-1906, MCL 722.115-118(a) **Certificate Required:** **☒ Yes ☒ No**

		adult foster care		☐ **Yes** ☐ **No** **Describe:** **Other Qualifications Required for this Provider Type (please describe):** Nurses may provide respite only in situations where the participant's medical needs are such that a trained respite aide cannot care for the participant during times where the unpaid caregiver is requesting respite.	**Required for this Provider Type (please describe):** Aides must meet criteria specified in the Michigan PIHP/CMHSP Provider Qualification Code Chart:	**Describe:** **Other Qualifications Required for this Provider Type (please describe):** The camp must assure its employees are knowledgeable in the unique abilities, preferences and needs of the individual(s)	**Describe:** **Other Qualifications Required for this Provider Type (please describe):** The agency must assure its employees are knowledgeable in the unique abilities, preferences and needs of the individual(s) being served. For services delivered in the community, the agency must assure its employees are knowledgeable in the community opportunities available in the area.	**Describe:** **Other Qualifications Required for this Provider Type (please describe):** n/a

Private Duty Nursing (PDN)

Service: Private Duty Nursing (PDN)

Scope/Description:

PDN services are skilled nursing interventions provided to individuals age 21 and older, up to a maximum of 16 hours per day, to meet health needs that are directly related to the individual's developmental disability. PDN includes the provision of nursing assessment, treatment and observation provided by licensed nurses within the scope of the State's Nurse Practice Act, consistent with physician's orders and in accordance with the written health care plan which is part of the beneficiary's individual plan of services (IPOS). PDN services are for beneficiaries who require more individual and continuous care than periodic or intermittent nursing available through state plan services, e.g., Home Health. The individual receiving PDN must also require at least one of the following habilitative services, whether being provided by natural supports or through the waiver.

- Community living supports
- Out-of-home non-vocational habilitation
- Prevocational or supported employment

To be determined eligible for PDN services, the PIHP must find that the beneficiary meets Medical Criteria I or Medical Criteria II **AND** Medical Criteria III as defined by the MDHHS. (Note: Regardless of whether the beneficiary meets Medical Criteria I or II, the beneficiary must also meet Medical Criteria III.)

The amount of PDN hours authorized represents a monthly total determined by calculating an average amount of PDN per day multiplied by the number of days in the month. The beneficiary has the flexibility to use the hours as needed during the month, not to exceed the total monthly authorized amount.

The amount of PDN (i.e., the number of hours that can be authorized for a beneficiary) is determined through the person-centered planning process to address the individual's unique needs and circumstances. Factors to be considered should include the beneficiary's care needs which establish medical necessity for PDN; the beneficiary's and family's circumstances (e.g., the availability of natural supports); and other resources for daily care (e.g., private health insurance, trusts, bequests). Although the person-centered planning process is used to determine the exact amount of PDN specified in the IPOS, in general, a beneficiary who has Low Category PDN needs would require eight or fewer hours per day, a beneficiary who has Medium Category PDN needs would require 12 or fewer hours per day, and a beneficiary who has High Category PDN needs would require 16 or fewer hours per day.

The nurse may provide personal care only when incidental to the delivery of PDN, e.g. diaper changes, but may not provide routine personal care. The provision of personal care in unlicensed homes is through Home Help, a state plan service. If the beneficiary

receiving PDN services demonstrates the need for Home Help services, the IPOS must document coordination of Home Help and PDN to assure no duplication of services.

Licensed nurses provide the nursing treatments, observation, and/or teaching as ordered by a physician, and that are consistent with the written individual plan of services.

These services should be provided to a beneficiary at home or in the community. A physician's prescription is required.

The PIHP must assess and document the availability of all private health care coverage (e.g., private or commercial health insurance, Medicare, health maintenance organization, preferred provider organization, Champus, Worker's Compensation, an indemnity policy, automobile insurance) for private duty nursing and will assist the beneficiary in selecting a private duty nursing provider in accordance with available third-party coverage. This includes private health coverage held by, or on behalf of, a beneficiary.

If a beneficiary is attending school and the Individualized Educational Plan (IEP) identifies the need for PDN during transportation to and from school and/or in the classroom, the school is responsible for providing PDN during school hours. For adults up to age 26 who are enrolled in school, PDN services are not intended to supplant services provided in school or other settings or to be provided during the times when the beneficiary would typically be in school but for the parent's choice to home-school.

An exception process to ensure the beneficiary's health, safety and welfare is available if the beneficiary's needs exceed the 16-hours-per-day maximum for a time-limited period not to exceed six months. Factors underlying the need for additional PDN must be identified in the beneficiary's plan, including strategies directed toward resolving the factors necessitating the exception, if applicable. Documentation must substantiate all of the following:

- Current medical necessity for the exception; and
- Additional PDN services are essential to the successful implementation of the beneficiary's written plan of care, and are essential to maintain the beneficiary within the least restrictive, safe, and humane environment suitable to his condition.

Exceptions must be based on the increased identified medical needs of the beneficiary or the impact on the beneficiary's needs due to the unavailability of the primary unpaid caregiver. Consideration for an exception is limited to situations outside the beneficiary's or family's control that place the beneficiary in jeopardy of serious injury or significant deterioration of health status. Exceptions may be considered for either of the following general situations:

- A temporary alteration in the beneficiary's care needs, resulting in one or both of the following:

- A temporary increase in the intensity of required assessments, judgments, and interventions.
- A temporary need for additional training to enable the primary caregiver(s) to identify and meet the beneficiary's care needs.

The total number of additional PDN hours per day will be based on the physician's documentation of the extent and duration of the beneficiary's increased medical needs for a maximum of six months.

- The temporary inability of the primary unpaid caregiver(s) to provide the required care, as the result of one of the following:
  - In the event the caregiver is hospitalized, a maximum of 24 hours per day can be authorized for each day the caregiver is hospitalized. Upon discharge from the hospital, or in the event of an acute illness or injury of the caregiver, the total number of additional PDN hours per day will be based on the physician's documentation of the extent and duration of the caregiver's limitations and the needs of the beneficiary as it relates to those limitations, not to exceed six months.
  - The death of the primary caregiver. The initial amount of hours allowable under this exception is 24 hours per day for 14 days. Subsequent exceptions can be approved up to an additional 60 days, with monthly reviews thereafter by the PIHP/CMHSP.
  - The death of an immediate family member. "Immediate family member" is defined as the caregiver's spouse, partner, parent, sibling, or child. The maximum number of hours allowable under this exception criterion is 24 hours per day for a maximum of seven days.

"Inability" is defined as the caregiver is either unable to provide care, or is prevented from providing care.

"Primary caregiver" is defined as the caregiver who provides the majority of unpaid care.

"Unpaid care" is defined as care provided by a caregiver where no reimbursement is received for those services, e.g., is not being paid as a Home Help provider or Community Living Supports staff.

This exception is not available if the beneficiary resides in a licensed setting or in a home where all care is provided by paid caregivers.

In the event that a transition plan has been developed wherein PDN services are to be reduced or eliminated based on a determination of medical necessity, the PIHP may provide PDN for a period of time (not to exceed three months) for the purpose of training the CLS or respite aides or family and assuring a smooth transition. In those cases, the transition plan, including amount,

scope, frequency and duration of the training by nurses to aides, must be documented in the IPOS. A transition process is not intended to provide two-to-one (nurse and aide) staffing for any purpose other than for training (with limitations on duration and frequency noted in the IPOS) while the aide or family member becomes familiar with the beneficiary's care needs. This transition period is only permitted when it has been determined that PDN is not medically necessary and the beneficiary's care needs can be met by a trained CLS or respite aide.

The following limitation(s) applies to the scope of the service:

Payments for PDN may not be made, directly or indirectly, to responsible relatives (i.e., spouses or parents of minor children) or the legal guardian.

Limitations on the amount of service	Limitations on the duration of the service	Provider Category(s):	The service may be provided by a:	Description of allowable providers:	Description of allowable providers:
16 hours **Per** **☒ Day** **☐Week** **☐ Month** **☐Year** **☐ Other, Describe:** .	**____Day(s)** **____Week(s)** **____Month(s)** **____Other:** See note No.2 Page 1.	**☒ Individual (list types):** Private Duty Nurse (RN or LPN) **☒ Agency (list types of agencies):** Private duty nursing agency, home care agency	**☐ Legally Responsible Person** **☐Relative** Payments for PDN may not be made, directly or indirectly, to responsible relatives (i.e., spouses or parents of minor children) or the legal guardian.	**Provider Type:** Private Duty Nurse (RN or LPN) **License Required:** **☒ Yes ☐ No** The nurse (RN or LPN) must have a current license in good standing with the State of Michigan under MCL 333.17211 **Certificate Required:** **☐ Yes ☒ No** **Describe:** **Other Qualifications Required for this Provider Type (please describe):** A Licensed Practical Nurse (LPN) must be working under the supervision of an RN.	**Provider Type:** Home care agency, staffing agency, private duty nursing agency, or other PIHP network provider agency **License Required:** **☐ Yes ☐ No** **Certificate Required:** **☐ Yes ☐ No** **Describe:** **Other Qualifications Required for this Provider Type (please describe):** The agency should assure that personnel providing this service are knowledgeable in the unique abilities, preferences and needs of the individual(s) receiving the service.

Supported / Integrated Employment Services

Service: Supported/Integrated Employment Services

Scope/Description:

Supported/Integrated Employment Services is an EPSDT service for persons under age 21. So the grid details apply to persons age 21 and older. For persons 21 and older, the intent of this service is to fund medically necessary supports that promote community inclusion and participation, independence, and/or productivity when identified in the individual plan of service as one or more goals developed during person-centered planning.

Provide job development, initial and ongoing support services, and activities as identified in the individual plan of services that assist beneficiaries to obtain and maintain paid employment that would otherwise be unachievable without such supports. Support services are provided continuously, intermittently, or on a diminishing basis as needed throughout the period of employment. Capacity to intervene to provide assistance to the individual and/or employer in episodic occurrences of need is included in this service.

Supported/ integrated employment must be provided in community-based, integrated work settings where the beneficiary works alongside people who do not have disabilities.

The following limitation(s) applies to the scope of the service:

Coverage includes:

- Job development, job placement, job coaching, and long-term follow-along services required to maintain employment.
- Consumer-run businesses (e.g., vocational components of Fairweather Lodges, supported self-employment)
- Transportation provided from the beneficiary's place of residence to the site of the supported employment service, among the supported employment sites if applicable, and back to the beneficiary's place of residence.

Coverage excludes:

- Employment preparation.
- Services otherwise available to the beneficiary under the Individuals with Disabilities Education Act (IDEA).

Limitations on the amount of service	Limitations on the duration of the service	Provider Category(s):	The service may be provided by a:	Description of allowable providers:
_____ Per **☐ Day** **☐Week** **☐ Month** **☐Year** **☐ Other, Describe:** .	**____Day(s)** **____Week(s)** **____Month(s)** **____Other:** See note No.2 Page 1.	**☒ Individual (list types):** Employment specialist, Personal assistant, Individual job coach **☐ Agency (list types of agencies):**	**☐ Legally Responsible Person** **☐Relative**	**Provider Type:** Employment specialist, Personal assistant, Individual job coach **License Required:** **☐ Yes ☒ No** **Certificate Required:** **☐ Yes ☒ No** **Describe:** **Other Qualifications Required for this Provider Type (please describe):** Qualifications of providers depend upon the service

Child Therapeutic Foster Care

Service: Child Therapeutic Foster Care
Scope/Description:

This service is only available to people under age 21 who meet the clinical needs based criteria for psychiatric hospital level of care.

Child Therapeutic Foster Care (CTFC) is an evidence-based practice. It provides an intensive therapeutic living environment for a child with challenging behaviors. Important components of CTFC include:

- intensive parental supervision,
- positive adult-youth relationships,
- reduced contact with children with challenging behaviors, and
- family behavior treatment skills.

CTFC seeks to change the negative trajectory of a child's behavior by improving his social adjustment, family adjustment and peer group. CTFC attempts to decrease negative behavior, increase appropriate behavior, and build pro-social skills. Foster parents, teachers, therapists and other adults act as change agents for the child. The change agents contribute to the treatment of the child and the preparation of his family for the child's return to the home and community. Foster parents are specially recruited, trained and supervised. The total number of individuals (including beneficiaries served in the waiver) living in the home who are unrelated to the primary caregiver may not exceed one.

CTFC must be billed as a 'per diem' service. The per diem rate for Therapeutic Foster Care rate is comprised of 3 components, 2 of which earn FFP; one of which does not.

1. The daily rate covers $75.00 per day for the enhanced therapeutic rate to be paid to foster parents. This rate includes respite care (purchased by the foster parent), participation in wraparound team meetings, training and other treatment-oriented appointments for the youth and family, data collection required as part of implementing the POS (including a daily/weekly log and 24 hour supervision).
2. A portion of the daily rate is to be paid to the provider agency. This part of the daily rate includes recruitment, pre-service training and licensing of the foster parents for this specialized service; on-going support, monitoring, training and oversight of the foster home; as well as closely supervised home visits throughout the youth's placement in the foster home.

3. Room and Board rate paid to Foster Parents is separate from the enhanced therapeutic foster care rate and paid from a different funding source (e.g., Title IV-E); Medicaid cannot be used to pay this component. The room and board rate includes basic needs, including clothing, shelter, food and daily essentials.

The following limitation(s) applies to the scope of the service:

In addition to being licensed:

- All CTFC programs under this waiver are to be pre-enrolled by MDHHS to ensure they meet the requirements set forth in this policy.
- Separate payment will not be made for homemaker or chore services, for community living services provided by the foster parents, or for respite care furnished for the foster care parents to a child receiving CTFC services since these services are integral to, and inherent in, the provision of CTFC.

Limitations on the amount of service	Limitations on the duration of the service	Provider Category(s):	The service may be provided by a:	Description of allowable providers:
____ Per **☐ Day** **☐Week** **☐ Month** **☐Year** **☐ Other, Describe:**	**____Day(s)** **____Week(s)** **____Month(s)** **____Other:** See note No.2 Page 1.	**☐ Individual (list types):** **☒ Agency (list types of agencies):** A licensed family foster home contracted to the PIHP	**☐ Legally Responsible Person** **☐Relative/Legal Guardian:**	**Provider Type:** A licensed family foster home contracted to the PIHP **License Required:** **☒ Yes ☐ No** Child Therapeutic Foster Care (CTFC) providers are licensed by the Michigan Department of Licensing and Regulatory Affairs under MCL 722.122 **Certificate Required:** **☒ Yes ☐ No** **Describe:** CTFC providers must be certified by MDHHS. **Other Qualifications Required for this Provider Type (please describe):** The child foster care home must be contracted by the PIHP to provide child therapeutic foster care services.

Therapeutic Overnight Camping

Service: Therapeutic Overnight Camping
Scope/Description:

This service is only available to people under age 21 who meet the clinical needs based criteria for psychiatric hospital level of care.

A group recreational and skill building service in a camp setting aimed at meeting the goal(s) detailed in the beneficiary's IPOS. A session can be multiple days and must include at least one night.

Additional criteria:

- Camps are licensed by Michigan Department of Licensing and Regulatory Affairs; and
- Camp staff is trained in working with children with SED.

Coverage includes:

- Camp fees, including enrollment and other fees;
- Transportation to and from the camp; and
- Additional costs for staff with specialized training with this population.

The following limitation(s) applies to the scope of the service:

Coverage excludes: Room and board for the camp.

Limitations on the amount of service	Limitations on the duration of the service	Provider Category(s):	The service may be provided by a:	Description of allowable providers:
3 sessions **Per** **☐ Day** **☐Week** **☐ Month** **☒Year** **☐ Other, Describe:** A session can be multiple days but must include at least one night.	**____Day(s)** **____Week(s)** **____Month(s)** **____Other:** See note No.2 Page 1.	**☐ Individual (list types):** **☒ Agency (list types of agencies):** Camps	**☐ Legally Responsible Person** **☐Relative/Legal Guardian:**	**Provider Type:** Camps **License Required:** **☒ Yes ☐ No** Camps are licensed by Michigan Department of Licensing and Regulatory Affairs **Certificate Required:** **☐ Yes ☒ No** **Describe:** **Other Qualifications Required for this Provider Type (please describe):** Camp staff is trained in working with children with SED.

Transitional Services

Service: Transitional Services
Scope/Description:
This service is only available to people under age 21 who meet the clinical needs based criteria for psychiatric hospital level of care.

Transitional services is a one-time-only expense to assist beneficiaries returning to their family home and community while the family is in the process of securing other benefits (e.g., SSI) or resources (e.g., governmental rental assistance and/or home ownership programs) that may be available to assume these obligations and provide needed assistance.

Additional criteria for using Transitional Services:

- The beneficiary must have in his/her IPOS a goal to return to his/her home and community; and
- Documentation of the family's control (i.e., signed lease, rental agreement, deed) of their living arrangement in the family-centered plan of service; and
- Documentation of efforts (e.g., the family is on a waiting list) under way to secure other benefits (such as SSI) or public programs (e.g., governmental rental assistance, community housing initiatives and/or home ownership programs) so when these benefits become available, they will assume the obligation and provide the needed assistance.

Coverage includes:

- Assistance with utilities, insurance, and moving expenses where such expenses would pose a barrier to a successful transition to the beneficiary's family home;
- Interim assistance with utilities, insurance, or living expenses when the beneficiary's family, already living in an independent setting, experiences a temporary reduction or termination of their own or other community resources; and
- Home maintenance when, without a repair to the home or replacement of a necessary appliance, the beneficiary would be unable to move there or, if already living there, would be forced to leave for health and safety reasons.

All services provided must be in accordance with applicable state or local building codes. Standards of value purchasing must be followed. The home maintenance must be the most reasonable alternative, based on the results of a review of all options. The existing structure must have the capability to accept and support the proposed changes. The infrastructure of the home involved must be in compliance with any applicable local codes. The home maintenance involved shall exclude costs for improvements required exclusively to meet local building codes. The home maintenance must incorporate reasonable and necessary construction

standards, excluding cosmetic improvements. The home maintenance or repair cannot result in valuation of the structure significantly above comparable neighborhood real estate values.

The following limitation(s) applies to the scope of the service:
Coverage excludes those home maintenance or repairs to the home that are:

- Of general utility or are cosmetic;
- Considered to be standard housing obligations of the beneficiary's family;
- Not of direct medical or remedial benefit to the child;
- On-going housing costs; and
- Costs for room and board that are not directly associated with transition arrangements while securing other benefits.

Limitations on the amount of service	Limitations on the duration of the service	Provider Category(s):	The service may be provided by a:	Description of allowable providers:	Description of allowable providers:
____ Per **☐ Day** **☐Week** **☐ Month** **☐Year** **☒ Other, Describe:** Once per consumer	**____Day(s)** **Week(s)** **Month(s)** **Other:** See note No.2 Page 1.	**☒ Individual (list types):** As appropriate to the service, an individual contracted by the PIHP. **☒ Agency (list types of agencies):** As appropriate to the service, an agency contracted by the PIHP.	**☐ Legally Responsible Person** **☐Relative/Legal Guardian:**	**Provider Type:** As appropriate to the service, an individual contracted by the PIHP. **License Required:** **☒ Yes ☐ No** When appropriate to the service must be a licensed builder MCL 339.601 (1), MCL 339.601.2401, or MCL 339.601.2404 or a licensed utility company. **Certificate Required:** **☐ Yes ☒ No** **Describe:** **Other Qualifications Required for this Provider Type (please describe):**	**Provider Type:** As appropriate to the service, an agency contracted by the PIHP. **License Required:** **☒ Yes ☐ No** When appropriate to the service must be a licensed builder MCL 339.601 (1), MCL 339.601.2401, or MCL 339.601.2404 or a licensed utility company. **Certificate Required:** **☐ Yes ☒ No** **Describe:** **Other Qualifications Required for this Provider Type (please describe):**

Appendix D

Milliman Client Report

SECTION 1115 MEDICAID DEMONSTRATION WAIVER APPLICATION – BUDGET NEUTRALITY FORM RESPONSE

State of Michigan

Department of Health and Human Services

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I. BACKGROUND

Milliman, Inc. (Milliman) was retained by the State of Michigan, Department of Health and Human Services (MDHHS) to develop the response to the Budget Neutrality Form for the Section 1115 Medicaid Demonstration Waiver Application (1115 Waiver). The Centers for Medicare and Medicaid Services (CMS) requires all 1115 Waivers to demonstrate budget neutrality.
MDHHS is transitioning the following programs currently covered under the Specialty Services and Supports 1915 (b/c) waiver and other 1915(c) home and community-based waivers to the 1115 Waiver beginning on April 1, 2016.

- Aged, Blind, and Disabled (DAB) population
- TANF population
- 1915 (c) home and community-based services habilitation supports waiver, referred to as Waiver (c)
- 1915 (i) state plan home and community-based services Autism Benefit, which includes Medicaid and MIChild eligible members
- MIChild population
- 1915 (c) home and community-based services children's waiver program, referred to as Child Waiver
- 1915 (c) home and community-based services waiver for children with serious emotional disturbances, referred to as SED Waiver

The Healthy Michigan specialty services managed care program, currently covered under a separate 1115 Waiver, has also been included in this budget neutrality form for completeness.
This letter documents the narrative for the *"Interim Section 1115 Demonstration Application BN Table Shell.xlsx"* Excel Workbook, which provides supporting data demonstrating budget neutrality for the 1115 Waiver. It is our understanding that this letter will be incorporated into an overall response to CMS regarding the 1115 Waiver application.

II. BUDGET NEUTRALITY NARRATIVE

Milliman was asked to develop the response to the Budget Neutrality section of Michigan's Pathway to Integration Section 1115 Waiver. This narrative and budget neutrality expenditure projections follow CMS guidance. It should be noted that this Section 1115 application does not include new populations and disproportionate share hospital expenditure offsets.

I. Without- and With-Waiver Projections for Historical Medicaid Populations

A. Recent Historical Actual Data

We have provided the actual historic data for the last five years (state fiscal year (SFY) 2011 to SFY 2015) pertaining to each of the Medicaid Populations included in the 1115 Demonstration.

DAB, TANF, and HSW populations

For the DAB, TANF, and Waiver (c) populations, we have summarized historical capitation payment data paid by MDHHS to the PIHPs from October 1, 2010 through September 30, 2015. The capitation payments are inclusive of all mental health, substance abuse, and developmental disabilities service cost, administrative cost, taxes (claims and use), and the hospital reimbursement adjustment (HRA). These expenditures are consistent with amounts reported on the CMS-64.

In SFY 2015, the TANF population capitation payment to eligibility month ratio was lower than recent historical experience. As a result, the number of capitation payments processed during the SFY 2015 was materially lower than in prior fiscal years. MDHHS is currently making retroactive TANF payments that increase the PMPM rate in a budget neutral manner to account for the capitation payment to eligibility month ratio decrease. The first and second quarter SFY 2015 TANF population capitation rate amendment methodology is documented in our correspondence to MDHHS on October 5, 2015 entitled *Capitation Certification – SFY 2015 Q1-Q2 TANF Amendment.* We are currently assuming that the payment issues in SFY 2015 will be resolved in SFY 2016.

Autism Benefit

MDHHS began its 1915(i) State plan HCBS benefit for applied behavior analysis (ABA) services on April 1, 2013. This program includes both Medicaid and MI Child autism spectrum disorder (ASD) beneficiaries. We utilized PIHP submitted expenditures from the financial status report (FSR) from SFY 2013 and SFY 2014. This program only includes expenditures for applied behavioral analysis (ABA) and other Autism related services. These expenditures were included in the CMS-64.

To estimate the number of individuals being provided ASD related services in SFY 2013, we utilized the SFY 2014 PMPM (adjusted for trend) due to non-credible encounter data. We have estimated SFY 2015 member months using emerging encounter data through March 31, 2015. We have estimated the SFY 2015 PMPM cost based on trended SFY 2014 PMPM cost (using the composite DAB and TANF population trend).

Healthy Michigan (HMP) population

For the HMP population, we have summarized historical capitation payment data paid by MDHHS to the PIHPs from April 1, 2014 (program inception) through September 30, 2015. The capitation payments are inclusive of all mental health and substance abuse service

cost, as well as administrative cost and taxes (claims and use). These expenditures are consistent with what has been reported on the CMS-64.

MIChild, SED Waiver, and Child Waiver populations

For the remaining populations included in the 1115 Demonstration (the MI Child, SED Waiver, and Child Waiver populations), we utilized PIHP submitted expenditures from the FSR from SFY 2011 to SFY 2014. These expenditures were included in the CMS-64. The expenditures for these populations include mental health services, substance abuse services, support services for beneficiaries with developmental disabilities, and administrative cost. We have not included taxes or costs that are funded only by MDHHS (without federal match). These costs are included in the 'Demonstration with Waiver' and 'Demonstration Without Waiver' sections for the Child and SED Waiver populations as program changes. MDHHS plans to modify the structure of these programs to pull down the federal match on all expenditures.

We have estimated SFY 2015 expenditures for the Child and SED Waiver programs by trending the SFY 2014 expenditures at the composite DAB and TANF population trend. We estimated SFY 2015 membership to be consistent with SFY 2014 figures.

Beginning on October 1, 2014, Milliman began certifying actuarially sound capitation rates that MDHHS paid to the PIHPs for the MI Child population. The capitation rates included all historical expenditures incurred for services delivered to the MI Child population, including expenditures incurred for costs over the fee schedule. The capitation rates also included both claims and use tax. For the MI Child population in SFY 2015, we have summarized revenue and capitation payments from actual experience through July 2015. We have assumed no growth in the number of capitation payments in August and September of 2015.

B. Bridge Period

The bridge period is October 1, 2015 to March 31, 2015 (6 months).

C. Without-Waiver Trend Rates, PMPM costs and Member Months with Justification

DAB, TANF, and HSW Populations

Beginning on October 1, 2015, MDHHS modified its capitation payment system process to make one-month retroactive payments for individuals who become Medicaid eligible during the month. As a result, MDHHS will make October capitation payments (in the month of November) for individuals who become eligible during the month of October. We have reflected this change in our demonstration year projections. This is a budget neutral change from a revenue standpoint, as the policy increases the estimated number of capitation payments, while reducing the PMPM capitation rate. This change impacted the DAB, TANF, and Healthy Michigan populations. As a result of this change, we utilized capitation payment and PMPM costs consistent with the SFY 2016 certification estimates instead of historical experience for the "Base Year DY 00" figures.

As mentioned in section A. above, the DAB, TANF, and Waiver (c) historical expenditures includes both claims and use taxes. Over the historical period, the level of claims and use taxes has varied.

- Use tax 5.98%: effective 10/1/2010 – 7/1/2012, 4/1/2014 – present.
- Claims tax 1%: effective 10/1/2012 – 7/1/2014.
- Claims tax 0.75%: effective 7/1/2014 – present.

As a result of the varying tax scenarios, we have developed trend rates using only the service cost used to develop the capitation rates. We have also provided different enrollment trend rates than what is reflected in the historical data for the TANF and Waiver (c) populations. We have reflected no growth in the Waiver (c) population because it has a cap on enrollment. We have also modified the PMPM cost for the DAB and TANF populations to reflect the cost estimate associated with the expansion of the EPSDT benefit for ASD individuals.

Autism Benefit

In the historic experience, the 1915(i) HCBS Waiver for ABA services covered beneficiaries from 18 months up to age 6. We have not relied on the member months, PMPM cost, or trends from the historic experience to use in the With- and Without-Waiver sections of the Budget Neutrality form for the following reasons:

- MDHHS is expanding this benefit to include children up to age 21 by filing a state plan amendment (SPA).
- The network is not fully developed.
- The settlement process between MDHHS and the PIHPs is expected to change from settling on cost to settling on utilization and a fixed fee schedule.
- Utilization per recipient is immature and is expected to vary by age group.

We have included the build-up of the average monthly cost for the Autism Benefit by age group and diagnosis, as well as the projection of member months for the five year demonstration period by age group and diagnosis as part of the 1115 Demonstration Application. The build-up of the average monthly cost by age group and diagnosis is consistent with the SPA filed with CMS. We have trended the PMPM cost over the five year demonstration at the composite DAB and TANF population trend.

SED Waiver, and Child Waiver populations

We utilized different trend assumptions than the historic experience would suggest for these populations because there are a relatively small number of beneficiaries driving the cost from year to year. For the PMPM cost trend, we utilized a weighted average of the DAB and TANF population PMPM cost trends. For the Child Waiver population, we utilized no membership trend because the program enrollment has a cap. For the SED Waiver population, we utilized a 1% membership trend based on internal expectations of the future enrollment in the population.

We have also included the following program adjustments:

- We have included costs from the FSR that did not have a corresponding federal match. MDHHS intends to restructure the payments made for these populations to pull down the federal match on what is currently covered using state only funds. This will affect the SED Waiver, and Child Waiver populations.
- We have included claims and use tax in the demonstration years.
- In 2016, the SED Waiver population will be statewide. Historically, it has been limited to 85% of the State. The list of counties currently included in the SED Waiver can be found on the tab "Estimated Future SED Kids".

MI Child population

We utilized different trend assumptions than the historic experience would suggest for these populations because there are a relatively small number of beneficiaries driving the cost from year to year. For the PMPM cost trend, we utilized a weighted average of the DAB and TANF population PMPM cost trends.

We have also included a program adjustment for the PIHP system will no longer serve mild to moderately disabled children in the MI Child population. These children will be served by the Medicaid health plans (MHP). MDHHS estimates 66 kids will move to the MHPs.

Healthy Michigan (HMP) population

As mentioned in section A. above, HMP historical expenditures includes both claims and use taxes. We have developed trend rates using only the service cost used to develop the capitation rates.

D. Risk

E. Historical Medicaid Populations: With-Waiver PMPM Cost and Member Month Projections

The With-Waiver PMPM cost and member month projections are consistent with the Without-Waiver projections with the following exception. The With-Waiver projections for the DAB and TANF populations include the addition of Complex Case Managers into the provider system. We are assuming that the Complex Case Managers will manage the top 50% of high cost DD individuals who have an inpatient stay and the top 3% of all SMI individuals. We have estimated that the Complex Case Managers will save the system $1.3 million per year. .

F. Justification for With-Waiver Trend Rates, PMPM Costs and Member Months

Please see section E above.

III. LIMITATIONS

The services provided for this project were performed under the signed contract between Milliman and MDHHS approved June 30, 2015.
The information contained in this report, including the appendices, has been prepared for the State of Michigan, Department of Health and Human Services and their consultants and advisors. It is our understanding that the information contained in this report may be utilized in a public document. To the extent that the information contained in this report is provided to third parties, the report should be distributed in its entirety. Any user of the data must possess a certain level of expertise in actuarial science and healthcare modeling so as not to misinterpret the data presented.

Milliman makes no representations or warranties regarding the contents of this report to third parties. Likewise, third parties are instructed that they are to place no reliance upon this letter prepared for MDHHS by us that would result in the creation of any duty or liability under any theory of law by us or its employees to third parties.

Other parties receiving this report must rely upon their own experts in drawing conclusions about the MDHHSs capitation rates, assumptions, and trends. In performing this analysis, we relied on data and other information provided by MDHHS and its vendors. We have not audited or verified this data and other information. If the underlying data or information is inaccurate or incomplete, the results of our analysis may likewise be inaccurate or incomplete.
Differences between our projections and actual amounts depend on the extent to which future experience conforms to the assumptions made for this analysis. It is certain that actual experience will not conform exactly to the assumptions used in this analysis. Actual amounts will differ from projected amounts to the extent that actual experience deviates from expected experience.
Guidelines issued by the American Academy of Actuaries require actuaries to include their professional qualifications in all actuarial communications. I am a member of the American Academy of Actuaries, and I meet the qualification standards for performing the analyses in this report.

IV. BUDGET NEUTRALITY FORMS

5 YEARS OF HISTORIC DATA

SPECIFY TIME PERIOD AND ELIGIBILITY GROUP DEPICTED:

DAB	FY11	FY12	FY13	FY14	FY15	5-YEARS
TOTAL EXPENDITURES (MH + SA)	$ 1,548,051,935	$ 1,543,737,822	$ 1,550,779,963	$ 1,572,585,937	$ 1,677,779,613	$ 7,892,935,270
ELIGIBLE MEMBER MONTHS(Capitation Payments)	5,611,026	5,738,870	5,836,436	5,856,485	5,953,093	
PMPM COST	$ 275.89	$ 269.00	$ 265.71	$ 268.52	$ 281.83	
TREND RATES			ANNUAL CHANGE			5-YEAR AVERAGE
TOTAL EXPENDITURE		-0.28%	0.46%	1.41%		2.03%
ELIGIBLE MEMBER MONTHS		2.28%	1.70%	0.34%		1.49%
PMPM COST		-2.50%	-1.22%	1.06%		0.53%

TANF (including Healthy Kids)	FY11	FY12	FY13	FY14	FY15	5-YEARS
TOTAL EXPENDITURES (MH + SA)	$ 203,254,206	$ 193,531,783	$ 187,968,689	$ 195,361,698	$ 203,649,138	$ 983,765,514
ELIGIBLE MEMBER MONTHS(Capitation Payments)	13,707,932	13,584,362	13,476,439	13,482,446	11,872,630	
PMPM COST	$ 14.83	$ 14.25	$ 13.95	$ 14.49	$ 17.15	
TREND RATES			ANNUAL CHANGE			5-YEAR AVERAGE
TOTAL EXPENDITURE		-4.78%	-2.87%	3.93%		-0.99%
ELIGIBLE MEMBER MONTHS		-0.90%	-0.79%	0.04%		-0.41%
PMPM COST		-3.92%	-2.10%	3.89%		-0.57%

1915(c) Habilitation Supports Waiv	FY11	FY12	FY13	FY14	FY15	5-YEARS
TOTAL EXPENDITURES (MH + SA)	$ 421,659,510	$ 431,562,315	$ 418,413,184	$ 441,662,525	$ 448,724,360	$ 2,162,021,894
ELIGIBLE MEMBER MONTHS(Capitation Payments)	91,788	92,357	91,585	91,883	92,675	
PMPM COST	$ 4,593.84	$ 4,672.76	$ 4,568.58	$ 4,806.79	$ 4,841.91	
TREND RATES			ANNUAL CHANGE			5-YEAR AVERAGE
TOTAL EXPENDITURE		2.35%	-3.05%	5.56%		1.17%
ELIGIBLE MEMBER MONTHS		0.62%	-0.84%	0.33%		0.03%
PMPM COST		1.72%	-2.23%	5.21%		1.14%

Autism	FY11	FY12	FY13	FY14	FY15	5-YEARS
TOTAL EXPENDITURES (MH + SA)			$ 2,185,439	$ 15,318,187	$ 25,719,628	$ 43,223,254
ELIGIBLE MEMBER MONTHS(Capitation Payments)			883	6,067	9,991	
PMPM COST			$ 2,476.52	$ 2,524.84	$ 2,574.10	
TREND RATES			ANNUAL CHANGE			5-YEAR AVERAGE
TOTAL EXPENDITURE						1.00%
ELIGIBLE MEMBER MONTHS						1.00%
PMPM COST						1.00%

Child Waiver	FY11	FY12	FY13	FY14	FY15	5-YEARS
TOTAL EXPENDITURES (MH + SA)	$ 18,812,416	$ 16,564,078	$ 15,752,224	$ 14,100,068	$ 14,376,095	$ 79,604,882
ELIGIBLE MEMBER MONTHS(Capitation Payments)	4,657	4,859	4,603	4,868	4,868	
PMPM COST	$ 4,039.60	$ 3,408.95	$ 3,422.16	$ 2,896.48	$ 2,953.18	
TREND RATES			ANNUAL CHANGE			5-YEAR AVERAGE
TOTAL EXPENDITURE		-11.95%	-4.90%	-10.49%	1.96%	-6.95%
ELIGIBLE MEMBER MONTHS		4.34%	-5.27%	5.76%	0.00%	1.11%
PMPM COST		-15.61%	0.39%	-15.36%	1.96%	-7.98%

SED Waiver	FY11	FY12	FY13	FY14	FY15	5-YEARS
TOTAL EXPENDITURES (MH + SA)	$ 3,858,363	$ 5,064,808	$ 5,875,800	$ 5,858,356	$ 5,973,041	$ 26,630,368
ELIGIBLE MEMBER MONTHS(Capitation Payments)	2,039	2,910	3,438	3,684	3,684	
PMPM COST	$ 1,892.28	$ 1,740.48	$ 1,709.08	$ 1,590.22	$ 1,621.35	
TREND RATES			ANNUAL CHANGE			5-YEAR AVERAGE
TOTAL EXPENDITURE		31.27%	16.01%	-0.30%	1.96%	11.01%
ELIGIBLE MEMBER MONTHS		42.72%	18.14%	7.16%	0.00%	15.94%
PMPM COST		-8.02%	-1.80%	-6.95%	1.96%	-4.25%

MIChild	FY11	FY12	FY13	FY14	FY15	5-YEARS
TOTAL EXPENDITURES (MH + SA)	$ 3,745,114	$ 4,106,897	$ 4,111,794	$ 3,787,031	$ 7,916,418	$ 23,667,255
ELIGIBLE MEMBER MONTHS(Capitation Payments)	414,664	452,612	452,519	423,239	486,884	
PMPM COST	$ 9.03	$ 9.07	$ 9.09	$ 8.95	$ 16.26	
TREND RATES			ANNUAL CHANGE			5-YEAR AVERAGE
TOTAL EXPENDITURE		9.66%	0.12%	-7.90%	109.04%	0.28%
ELIGIBLE MEMBER MONTHS		9.15%	-0.02%	-6.47%	15.04%	0.51%
PMPM COST		0.47%	0.14%	-1.53%	81.71%	-0.23%

HMP	FY11	FY12	FY13	FY14	FY15	5-YEARS
TOTAL EXPENDITURES (MH + SA)				$ 125,340,454	$ 325,958,392	$ 451,298,847
ELIGIBLE MEMBER MONTHS(Capitation Payments)				1,788,286	6,216,251	
PMPM COST				$ 70.09	$ 52.44	
TREND RATES			ANNUAL CHANGE			5-YEAR AVERAGE
TOTAL EXPENDITURE					160.06%	1.00%
ELIGIBLE MEMBER MONTHS					247.61%	1.00%
PMPM COST					-25.19%	1.00%

DEMONSTRATION WITHOUT WAIVER (WOW) BUDGET PROJECTION: COVERAGE COSTS FOR POPULATIONS

ELIGIBILITY GROUP	TREND RATE 1	MONTHS OF AGING	BASE YEAR DY 00	TREND RATE 2	DEMONSTRATION YEARS (DY) DY 01	DY 02	DY 03	DY 04	DY 05	TOTAL WOW
DAB										
Pop Type:	**Medicaid**									
Eligible Member Months	1.5%	6	6,057,012	1.5%	6,101,970	6,192,889	6,285,163	6,378,812	6,473,857	
PMPM Cost	1.5%	6	$ 281.91	1.5%	$ 286.55	$ 290.85	$ 295.21	$ 299.64	$ 304.13	
Total Expenditure					$ 1,748,519,472	$ 1,801,201,836	$ 1,855,443,055	$ 1,911,347,295	$ 1,968,893,985	$9,285,405,643
TANF (including Healthy Kids)										
Pop Type:	**Medicaid**									
Eligible Member Months	0.5%	6	12,820,200	0.5%	12,852,211	12,916,472	12,981,054	13,045,959	13,111,189	
PMPM Cost	5.0%	6	$ 17.99	5.0%	$ 19.14	$ 20.10	$ 21.11	$ 22.17	$ 23.28	
Total Expenditure					$ 245,991,310	$ 259,621,079	$ 274,030,049	$ 289,228,916	$ 305,228,480	$1,374,099,834
1915(c) Habilitation Supports Waiver										
Pop Type:	**Medicaid**									
Eligible Member Months	0.0%	6	92,400	0.0%	92,400	92,400	92,400	92,400	92,400	
PMPM Cost	2.3%	6	$4,855.92	2.3%	$4,910.24	$ 5,020.72	$ 5,133.69	$ 5,249.20	$ 5,367.31	
Total Expenditure					$ 453,706,176	$ 463,914,528	$ 474,352,956	$ 485,026,080	$ 495,939,444	$2,372,939,184
Autism										
Pop Type:	**Medicaid**									
Eligible Member Months	1.0%	6	10,041	1.0%	15,750	24,614	31,975	32,825	32,825	
PMPM Cost	2.0%	6	$ 2,599.17	2.0%	$ 3,156.69	$ 2,991.58	$ 2,955.51	$ 3,005.01	$ 3,063.84	
Total Expenditure					$ 49,717,404	$ 73,633,908	$ 94,502,529	$ 98,638,584	$ 100,569,562	$ 417,061,987
Child Waiver										
Pop Type:	**Medicaid**									
Eligible Member Months	0.0%	6	4,868	0.0%	4,868	4,868	4,868	4,868	4,868	
PMPM Cost	2.0%	6	$ 2,981.95	2.0%	$ 4,089.57	$ 4,169.63	$ 4,251.26	$ 4,334.48	$ 4,419.33	
Total Expenditure					$ 19,908,027	$ 20,297,759	$ 20,695,134	$ 21,100,249	$ 21,513,298	$ 103,514,466
SED Waiver										
Pop Type:	**Medicaid**									
Eligible Member Months	1.0%	6	3,702	1.0%	4,343	4,386	4,430	4,474	4,519	
PMPM Cost	2.0%	6	$ 1,637.14	2.0%	$ 1,850.28	$ 1,886.50	$ 1,923.43	$ 1,961.08	$ 1,999.47	
Total Expenditure					$ 8,035,416	$ 8,274,640	$ 8,520,990	$ 8,774,661	$ 9,035,897	$ 42,641,603
MIChild										
Pop Type:	**Medicaid**									
Eligible Member Months	0.5%	6	488,123	0.5%	489,821	492,319	494,830	497,353	499,890	
PMPM Cost	2.0%	6	$ 16.42	2.0%	$ 16.74	$ 17.07	$ 17.40	$ 17.74	$ 18.09	
Total Expenditure					$ 8,199,602	$ 8,403,885	$ 8,610,039	$ 8,823,050	$ 9,043,009	$ 43,079,585
HMP										
Pop Type:	**Medicaid**									
Eligible Member Months	1.0%	6	6,962,400	1.0%	6,997,125	7,067,097	7,137,768	7,209,145	7,281,237	
PMPM Cost	2.0%	6	$ 37.03	2.0%	$ 37.39	$ 38.12	$ 38.87	$ 39.63	$ 40.41	
Total Expenditure					$ 261,622,519	$ 269,397,724	$ 277,445,027	$ 285,698,428	$ 294,234,777	$1,388,398,476

ELIGIBILITY GROUP	DY 00	DEMO TREND RATE	DEMONSTRATION YEARS (DY) DY 01	DY 02	DY 03	DY 04	DY 05	TOTAL WW
DAB								
Pop Type:	**Medicaid**							
Eligible Member Months	6,057,012	1.5%	6,101,970	6,192,889	6,285,163	6,378,812	6,473,857	
PMPM Cost	$ 281.91	1.5%	$ 286.23	$ 290.52	$ 294.88	$ 299.30	$ 303.79	
Total Expenditure			$ 1,746,566,842	$ 1,799,158,182	$ 1,853,368,951	$ 1,909,178,499	$ 1,966,692,874	$ 9,274,965,348
TANF (including Healthy Kids)								
Pop Type:	**Medicaid**							
Eligible Member Months	12,820,200	0.5%	12,852,211	12,916,472	12,981,054	13,045,959	13,111,189	
PMPM Cost	$ 17.99	5.0%	$ 19.08	$ 20.03	$ 21.03	$ 22.08	$ 23.18	
Total Expenditure			$ 245,220,177	$ 258,716,926	$ 272,991,565	$ 288,054,780	$ 303,917,361	$ 1,368,900,809
1915(c) Habilitation Supports Waiver								
Pop Type:	**Medicaid**							
Eligible Member Months	92,400	0.0%	92,400	92,400	92,400	92,400	92,400	
PMPM Cost	$ 4,855.92	2.3%	$ 4,910.24	$ 5,020.72	$ 5,133.69	$ 5,249.20	$ 5,367.31	
Total Expenditure			$ 453,706,176	$ 463,914,528	$ 474,352,956	$ 485,026,080	$ 495,939,444	$ 2,372,939,184
Autism								
Pop Type:	**Medicaid**							
Eligible Member Months	10,041	1.0%	15,750	24,614	31,975	32,825	32,825	
PMPM Cost	$ 2,599.17	2.0%	$ 3,156.69	$ 2,991.58	$ 2,955.51	$ 3,005.01	$ 3,063.84	
Total Expenditure			$ 49,717,404	$ 73,633,908	$ 94,502,529	$ 98,638,584	$ 100,569,562	$ 417,061,987
Child Waiver								
Pop Type:	**Medicaid**							
Eligible Member Months	4,868	0.0%	4,868	4,868	4,868	4,868	4,868	
PMPM Cost	$ 2,981.95	2.0%	$ 4,089.57	$ 4,169.63	$ 4,251.26	$ 4,334.48	$ 4,419.33	
Total Expenditure			$ 19,908,027	$ 20,297,759	$ 20,695,134	$ 21,100,249	$ 21,513,298	$ 103,514,466
SED Waiver								
Pop Type:	**Medicaid**							
Eligible Member Months	3,702	1.0%	4,343	4,386	4,430	4,474	4,519	
PMPM Cost	$ 1,637.14	2.0%	$ 1,850.28	$ 1,886.50	$ 1,923.43	$ 1,961.08	$ 1,999.47	
Total Expenditure			$ 8,035,416	$ 8,274,640	$ 8,520,990	$ 8,774,661	$ 9,035,897	$ 42,641,603
MIChild								
Pop Type:	**Medicaid**							
Eligible Member Months	488,123	0.5%	489,821	492,319	494,830	497,353	499,890	
PMPM Cost	$ 16.42	2.0%	$ 16.74	$ 17.07	$ 17.40	$ 17.74	$ 18.09	
Total Expenditure			$ 8,199,602	$ 8,403,885	$ 8,610,039	$ 8,823,050	$ 9,043,009	$ 43,079,585
HMP								
Pop Type:	**Medicaid**							
Eligible Member Months	6,962,400	1.0%	6,997,125	7,067,097	7,137,768	7,209,145	7,281,237	
PMPM Cost	$ 37.03	2.0%	$ 37.39	$ 38.12	$ 38.87	$ 39.63	$ 40.41	
Total Expenditure			$ 261,622,519	$ 269,397,724	$ 277,445,027	$ 285,698,428	$ 294,234,777	$ 1,388,398,476

Budget Neutrality Summary

Without-Waiver Total Expenditures

	DEMONSTRATION YEARS (DY) DY 01	DY 02	DY 03	DY 04	DY 05	TOTAL
Medicaid Populations						
DAB	$ 1,748,519,472	$ 1,801,201,836	$ 1,855,443,055	$ 1,911,347,295	$ 1,968,893,985	$ 9,285,405,643
TANF (including Healthy Kids)	$ 245,991,310	$ 259,621,079	$ 274,030,049	$ 289,228,916	$ 305,228,480	$ 1,374,099,834
1915(c) Habilitation Supports Waiver	$ 453,706,176	$ 463,914,528	$ 474,352,956	$ 485,026,080	$ 495,939,444	$ 2,372,939,184
Autism	$ 49,717,404	$ 73,633,908	$ 94,502,529	$ 98,638,584	$ 100,569,562	$ 417,061,987
Child Waiver	$ 19,908,027	$ 20,297,759	$ 20,695,134	$ 21,100,249	$ 21,513,298	$ 103,514,466
SED Waiver	$ 8,035,416	$ 8,274,640	$ 8,520,990	$ 8,774,661	$ 9,035,897	$ 42,641,603
MIChild	$ 8,199,602	$ 8,403,885	$ 8,610,039	$ 8,823,050	$ 9,043,009	$ 43,079,585
HMP	$ 261,622,519	$ 269,397,724	$ 277,445,027	$ 285,698,428	$ 294,234,777	$ 1,388,398,476
DSH Allotment Diverted	$ -	$ -	$ -	$ -	$ -	$ -
Other WOW Categories						
Category 1						$ -
Category 2						$ -
TOTAL	$ 2,795,699,925	$ 2,904,745,358	$ 3,013,599,779	$ 3,108,637,262	$ 3,204,458,454	$ 15,027,140,778

With-Waiver Total Expenditures

	DEMONSTRATION YEARS (DY) DY 01	DY 02	DY 03	DY 04	DY 05	TOTAL
Medicaid Populations						
DAB	$ 1,746,566,842	$ 1,799,158,182	$ 1,853,368,951	$ 1,909,178,499	$ 1,966,692,874	$ 9,274,965,348
TANF (including Healthy Kids)	$ 245,220,177	$ 258,716,926	$ 272,991,565	$ 288,054,780	$ 303,917,361	$ 1,368,900,809
1915(c) Habilitation Supports Waiver	$ 453,706,176	$ 463,914,528	$ 474,352,956	$ 485,026,080	$ 495,939,444	$ 2,372,939,184
Autism	$ 49,717,404	$ 73,633,908	$ 94,502,529	$ 98,638,584	$ 100,569,562	$ 417,061,987
Child Waiver	$ 19,908,027	$ 20,297,759	$ 20,695,134	$ 21,100,249	$ 21,513,298	$ 103,514,466
SED Waiver	$ 8,035,416	$ 8,274,640	$ 8,520,990	$ 8,774,661	$ 9,035,897	$ 42,641,603
MIChild	$ 8,199,602	$ 8,403,885	$ 8,610,039	$ 8,823,050	$ 9,043,009	$ 43,079,585
HMP	$ 261,622,519	$ 269,397,724	$ 277,445,027	$ 285,698,428	$ 294,234,777	$ 1,388,398,476
Expansion Populations						
Excess Spending From Hypotheticals						$ -
Other WW Categories						
Category 3						$ -
Category 4						$ -
TOTAL	$ 2,792,976,162	$ 2,901,797,552	$ 3,010,487,190	$ 3,105,294,330	$ 3,200,946,224	$ 15,011,501,458
VARIANCE	$ 2,723,763	$ 2,947,806	$ 3,112,588	$ 3,342,932	$ 3,512,230	$ 15,639,320

HYPOTHETICALS ANALYSIS

Without-Waiver Total Expenditures

	DEMONSTRATION YEARS (DY) DY 01	DY 02	DY 03	DY 04	DY 05	TOTAL
TOTAL	$ -	$ -	$ -	$ -	$ -	$ -

With-Waiver Total Expenditures

	DEMONSTRATION YEARS (DY) DY 01	DY 02	DY 03	DY 04	DY 05	TOTAL
TOTAL	$ -	$ -	$ -	$ -	$ -	$ -
HYPOTHETICALS VARIANCE	$ -	$ -	$ -	$ -	$ -	$ -

Appendix E

Public Notice Update with Attachments

The MDHHS developed multiple opportunities for public input and dialog during the waiver development process and prior to the submission of Michigan's §1115 Pathway to Integration Waiver application. The input and public notice process is consistent with the requirements outlined in 42 CFR Part 431 Subpart G.

Public Notice of Waiver Application

The MDHHS, BHDDA began discussions on the proposed §1115 waiver application to the Medical Care Advisory Council (MCAC) on 2/19/15. BHDDA staff, as regular members of the MCAC, continued to provide updates and receive input through their quarterly meetings in 2015 and 2016. BHDDA staff met with Tribal Health Centers on 4/15/15 and continued to provide updates and receive input at their quarterly meetings in 2015. BHDDA staff also met with the Tribal Health Centers on xx/xx/xxxx. From September, 2015 through November, 2015, the BHDDA held four Sounding Board Workgroups with the Michigan Association of Community Mental Health Boards (MACMHB), the Michigan ARC and the Behavioral Health Advisory Council (BHAC). Membership included PIHPs, CMHSPs, invited advocates and family members. These sounding board workgroups allowed open discussion regarding Michigan's current behavioral health system and the planned initiatives to be included in Michigan's §1115 demonstration waiver application.

On 12-18-15, the MDHHS published the Pathway to Integration §1115 waiver proposal on its Behavioral Health and Developmental Disabilities Administrations (BHDDA) website http://www.michigan.gov/mdhhs/0,5885,7-339-71550_2941_4868---,00.html. The web page included a complete copy of the §1115 waiver proposal, a waiver summary, stakeholder notice, and an email address for questions and comments and where to receive a hard copy of the waiver proposal. The website also included the dates and locations of the two public hearings. MDHHS also began its formal public notice process on 12-18-16 including a 45 day comment period for all interested parties. Notice was published in select newspapers throughout the state on or around 12-18-16. This notice included a brief summary of the proposal, the dates and times of public hearings, instructions on how to submit comments and questions including the link to where the application could be requested in hard copy or downloaded. A copy of the web posting, stake holder letter, and the public hearing power point is included as Appendix E, Attachment 1.

Michigan held two public hearings on the waiver application, one by webinar on 1-13-16 and one in person on 1-28-16 in Lansing Michigan. Combined attendance included over 150 participants from trade associations, family members' advocates, consumers and other interested individuals. Common themes and responses along with all written comments and responses received is included as Appendix E, Attachment 2.

Attachment 1

Stakeholder Notice and Public Hearing

December 18, 2015

Dear Stakeholders and Interested Parties:

RE: Section 1115 Waiver - Pathway to Integration Proposal

The Michigan Department of Health and Human Services (MDHHS) is seeking approval from the Centers for Medicare and Medicaid Services (CMS) for a §1115 Demonstration Waiver to combine under a single waiver authority all services and eligible populations served through its §1915(b) and its multiple §1915(c) waivers for persons with Serious Mental Illness (SMI), Substance Use Disorders (SUD), Intellectual & Developmental Disabilities (IDD) and Children with Serious Emotional Disturbances (SED). Under this consolidated waiver authority, Michigan is seeking broad flexibility to develop quality, financing and integrated care (physical and behavioral health care) initiatives for all Specialty Service Populations on a statewide basis.

In addition to aligning and expanding MDHHS integrated care initiatives for all Specialty Service Populations, the services covered under this §1115 Waver include the full array of mandatory and optional State Plan services for persons who meet the eligibility criteria for the Specialty Services System. Michigan is NOT reducing for limiting any benefits outlined in this waiver application.

The anticipated effective date of this waiver is April 1, 2016.

A copy of the complete §1115 waiver, stakeholder notice and waiver summary is available online at http://www.michigan.gov/mdhhs/0,5885,7-339-71550_2941_4868---,00.html. You may request a hard copy of the complete §1115 waiver, stakeholder notice and waiver summary by contacting Teri Baker at the address below. You may also submit questions or comments regarding the waiver to the address below or by email at MDHHS-Pathway1115@Michigan.gov. All comments on this topic should include a "Section 1115 – Pathway to Integration reference somewhere in the written submission or the subject line if by email.

Michigan Department of Health and Human Services
Bureau of Community Health Behavioral Health and Developmental Disabilities Administration
320 S. Walnut Street, Lewis Cass Building, 5th Floor
Lansing MI 48913

Two public hearings have been scheduled for following dates, times and locations:

- January 13th, 2016 1-2:30 pm Webinar:

https://connectpro14871085.adobeconnect.com/dualel/
U.S. Toll-Free Access Number: (877) 366-0711
Participant Passcode: 39535358

- January 28th Lansing Center, 10-11:30am
  333 Michigan Avenue
  Lansing MI 48933

Any questions regarding this letter should be directed to Provider Inquiry, Department of Health and Human Services, P.O. Box 30731, Lansing, Michigan 48909-8231, or e-mail at ProviderSupport@michigan.gov. When you submit an e-mail, be sure to include your name, affiliation, phone number so you may be contacted if necessary. Providers may phone toll-free at 1-800-292-2550.

We thank you in advance for your participation.

Sincerely,

Chris Priest, Acting Director
Medical Service Administration
Administration

Lynda Zeller, Director
Behavioral Health and Developmental Disabilities

Public Hearing PPT

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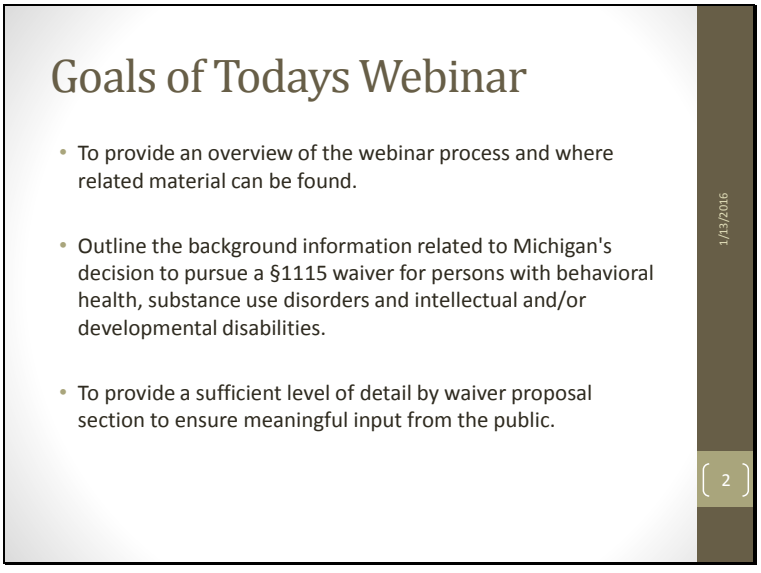

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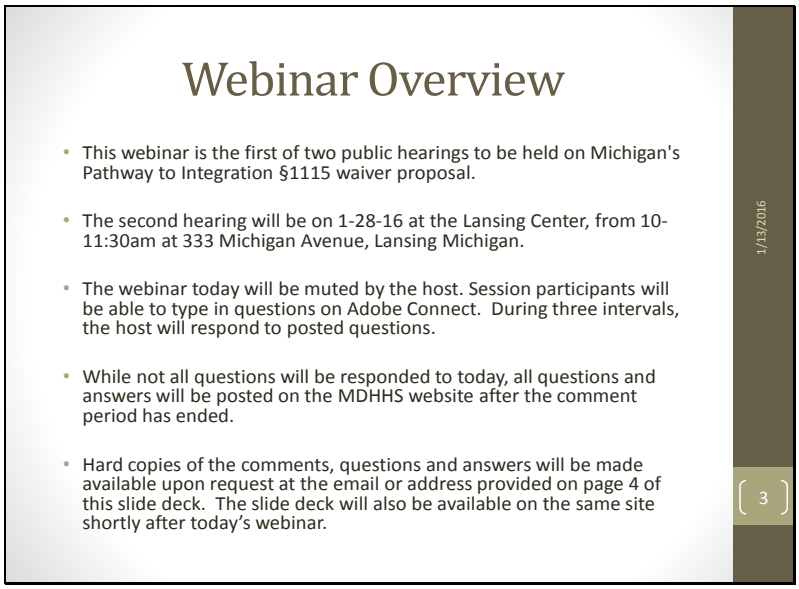

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Pathway to Integration Background

- Over the past the past 18 years, Michigan has operated under a Managed Specialty Service & Supports Waiver (MSS&SW) through a §1915(b) Managed Care Waiver.
- The MSS&SW has been the vehicle used to waive "Freedom of Choice" requirements and to mandate managed care enrollment (basically creating the structure of Prepaid Inpatient Health Plans).
- Connected to the MSS&SW are the §1915(b(4) Children's waiver Program (CWP), the §1915(b(4) waiver for Children with Severe Emotional Disturbances (SEDW) (both Fee for Service (FFS) programs) and the § 1915(c) Habilitation Supports Waiver (HSW) and all applicable State Plan services.

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The Desire and Need for Change

- With each §1915(b) waiver renewal and/or amendments over the past several years, Michigan has struggled to meet the *cost effectiveness* requirements of its §1915(b) waiver services.
- *Cost effectiveness* for the purposes of this proposal means the rate of increases in the costs of the §1915(b) waiver services cannot exceed the rate of increase in of other state plan services over the term of the waiver.
- Because Michigan provides one of the most robust set of community based supports in the country, the requirements for the §1915(b) waiver to be considered cost effective without limiting or moving benefit options has became difficult, if not impossible.
- Additionally, and building off of multiple statewide integrated physical and behavioral health care initiatives, Michigan desires to test integrated care initiatives specifically targeting the populations covered by this waiver proposal.

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Questions so far?

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Pathway to Integration Waiver Proposal

- Michigan has a long standing commitment to community supports and inclusion for persons with Severe Mental Illness (SMI), Substance Use Disorders (SUD), Intellectual and/or Developmental Disabilities (I/DD), and Children with Severe Emotional Disturbances (SED).
- The Pathway to Integration Waiver is intended to combine under a single waiver authority all services and eligible populations served through its current §1915(b), State Plan and its multiple §1915(c) waivers (aka. Specialty Service System/Populations).

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Waiver Rationale

- The §1115 waiver allows broad flexibility to combine existing waivers with differing eligibility and service arrays.
- The §1115 waiver is one of the only waiver models that did NOT require reducing current Medicaid eligible populations without adding additional waivers.
- The §1115 waiver allows the state to develop quality financing and integrated care initiatives specifically for the Specialty Service Populations.
- The §1115 waiver enhances the prospect of streamlining multiple payment and reporting requirements as we bring new populations into managed care arrangements.
- The §1115 waiver allows options for integrated service and delivery options for person with SUD.

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Hypotheses/Goal of Demonstration

- The goal of this Demonstration is to create a robust evaluation that tests both quality and cost outcomes between traditional Medicaid Health Plans (MHPs) and Michigan's Specialty Service System.
- Proposed Key indicators include:
  - Joint identification and tracking of High Utilizers.
  - Access to care incentives.
  - Pilot Demonstrations through the State Innovation Model (SIM) and Accountable Systems of Care (ASC).
  - Enhancement of co-occurring (SMI/SUD) services.
  - The use of Specialized Complex Care Managers for individuals considered High Utilizers.

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Medicaid Eligibility

- There are no eligibility changes proposed under this waiver that do not currently exist. These also Include eligible MI CHILD and Healthy Michigan Plan beneficiaries.
- Michigan intends to maintain the current service array and, where possible and explore the expansion of enrollment caps for certain services previously provided through its §1915(c) CWP and SEDW programs (as legislatively approved).
- All current HSW enrollees and services (including HSW enhanced payments) will be covered under this §1115 waiver authority.
- Anticipated beneficiaries served under this waiver and current enrolment caps are outlined below:
  - §1915(c) HSW = 8268
  - §1915(c) SEDW = 969
  - §1915(c) CWP = 469
  - Estimated Demonstration populations Including §1915(b)/(c) Populations = 230,000

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Demonstration Benefits

- The services covered under this §1115 waiver include the full array of mandatory and optional State Plan services for persons ***"who meet the eligibility and the needs assessment criteria for the Specialty Services System" (see pages 9-17 of the waiver proposal).***
- This includes individuals with Autism Spectrum Disorder, individuals eligible for Michigan's Special Health Insurance Program (aka MI CHILD) and expanded Medicaid Populations.
- Michigan is ***NOT reducing or limiting any benefits*** previously offered.
- Michigan will also be providing integrated SUD delivery systems and services and adding coverage for the inclusion of Permanent Supportive Housing for all eligible populations.

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Questions so far?

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Delivery Systems and Reforms

- Enrollment into the Michigan's Specialty Service System will continue to be mandatory based on the criteria described in Section II of the waiver proposal.
- Michigan will continue to use a single Specialty Service System (on a statewide basis) for State Plan and the former §1915(b) and §1915(c) waiver beneficiaries who meet Specialty Service Criteria. This includes persons previously enrolled in the MI CHILD program and expansion populations.
- The former CWP and SEDW programs will move from FFS delivery system to managed care.
- The alignment of quality and financial incentives between Medicaid Health Plans and Michigan's Specialty Service System.

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Delivery Systems and Reforms (cont.)

- The proposed delivery system changes will require PIHPs and their CMHSP providers to meet quality reporting requirements, develop enhanced SUD provider systems and provide or partner with Medicaid Health plans to improve access for persons with mild and moderate behavioral health disorders.
- These linkages are intended to:
  - Identify and provide education, prevention and treatment of modifiable health risk factors.
  - Provide Screening Brief Intervention Referral and Treatment (SBIRT) services for persons with SUD.
  - Provide housing first initiatives/models through permanent supportive housing models.
  - Provide incentives for increased access to primary care and the coordinated tracking of High Utilizers of emergency department usage and hospital admissions/readmissions.

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Long Term Service and Supports & Self Direction

- The Demonstration will provide personal care and Long Term Services and Supports (LTSS) including options for both self-direction/determination models, including the use of fiscal intermediaries.
- Waiver participants will have opportunities for both employer and budget authority.
- Participants may elect to control their individual budget for all services or can direct a single service for which participant direction is an option.
- The participant may direct the budget and directly contract with chosen providers.

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Payments to Managed Care Entities

- Capitation rates will include all State Plan, §1915(b) and §1915(c) waivers as outlined in Exhibit 1 of the proposal.
- Capitation rate values will be developed using PIHP submitted encounter data and Medicaid Utilization Net Cost Reports (MUNC) and will vary by benefit type and program code.
- Rate adjustment factors will be developed to reflect age, gender and geographic region for each benefit category.
- As with the current §1915(b) and §1915(c) waivers, PIHPs are responsible for all Medicaid beneficiaries within a geographic catchment area who meet criteria for the Specialty Service System.
- Questions regarding budget neutrality estimates outside of those outlined in Appendix C, will be answered and posted on the MDHHS website after the comment period has closed.

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Quality Based Supplemental Payments

- MDHHS intends to hold back up to 1.0% of capitation payments to be redistributed based on meeting the Demonstration expectations and/or other shared metrics.
- Current Quality based incentives include:
  - The implementation of complex care management.
  - joint PIHP and MHP performances incentives.
  - Incentives to PIHP regions who service foster children and children in Child Protective Services (CPS) with Serious Emotional Disturbances.

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Implementation of the Demonstration

- Phase 1 (Upon submission and anticipated approval):
  - The consolidation of the existing §1915(b) and §1915(c) Waivers.
  - The development of the demonstration evaluation and collection of baseline data.
  - The statewide evaluation and system readiness for a reformed SUD delivery system. Based on system readiness may be phased approach and include Demonstration years 2 and 3.
- Phase 2 (may span Demonstration years 2 and 3):
  - The development of bundled funding and other quality incentives for Accountable Systems of Care.
  - Medicaid Health Plans and PIHP will be contractually required to monitor certain quality and integrated care outcomes that lead toward the tracking and implementation of potential shared savings models.

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List of Proposed Waiver & Expenditure Authorities

- Proper and Efficient Administration §1902(a)(4)

  Rationale for Authority: Mandate beneficiaries into a single Prepaid Inpatient Health Plan
- Comparability §1902(a)(17)

  This waiver program includes benefits specific to eligibility criteria as described in Section II that will not be available to other Medicaid beneficiaries.
- Amount, Duration, and Scope §1902(a)(10)(B)

  To enable the State to offer a different benefit package to the Demonstration participants that varies in amount, duration, and scope from the benefits offered under the State Plan.

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List of Proposed Waiver & Expenditure Authorities

- Freedom of Choice §1902(a)(23)(A)
  - To enable the State to restrict Demonstration participants to receive benefits through PIHPs and CMHSPs.
  - Rationale for Authority – beneficiaries enrolled in the program must receive services through a PIHP.
- Choice of Coverage §1932(a)(3)
  - To enable the State to assign Demonstration participants to PIHPs based on geography and to permit participant choice of provider, but not plan.
- Reasonable Promptness Section §1902(a)(8)
  - To enable the State to limit enrollment for Demonstration eligible population in order to remain under the annual budget neutrality limits under the Demonstration.

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List of Proposed Waiver & Expenditure Authorities

- Methods of Administration: Transportation §1902(a)(4), insofar as it incorporates 42 CFR 431.53
  - To enable the State to assure transportation to and from providers for the Demonstration participants.
- Eligibility Standards §1902(a)(17)
  - To enable the State to apply different eligibility methodologies and standards to the Demonstration eligible population than are applied under the State Plan.
- Retroactive Eligibility Section §1902(a)(34)
  - To enable the State to not provide coverage for the Demonstration eligible population for any time prior to the first day of the month in which the application was received by the State.

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Appendix A LTSS

- As outlined in Section II, item 6, Michigan will be including LTSS that were previously provided through its §1915(b) and its multiple §1915(c) waivers.
- Appendix A outlines the MDHHS Quality Assessment and Performance Improvement Program (QAPIP) including the current risk management and critical incident reporting.
- Appendix A, also outlines MDHHS site review process and will include all §1115 waiver populations.

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Appendix B LTSS

- Appendix B provides a service description and provides a grid of all LTSS service descriptions and provider qualifications.
- Appendix B services mimic those included in the current §1915(b)/(c) and multiple 1915(c) waivers included in this proposal.

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Questions?

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Attachment 2

Common Themes and Written Comments Received

Common Themes and State Responses

Implementation of Conflict Free Case Management (CFCSM).
Conflict Free Case Management (CFCSM) went into immediate effect with the HCBS final rule in January, 2014. Policy and procedures related to rural counties along with the state's overall policy considerations are being developed and promulgated as part of a state sponsored CFCSM workgroup including both consumer, advocates and key stakeholders.

Persons directed supports, medical necessity and provider networks.
As outlined in Appendix B, Michigan has a long history of person directed supports through the person centered planning process (PCP). The PCP process is outlined in the Michigan Mental Health Code, the managed specialty services and supports contracts as well as numerous PCP and self –determination guidelines. The interplay with published medical necessity guidelines and the use of independent facilitation for planning and fiscal intermediary services, does not change with the Pathway to Integration Waiver application. The balance between consumer choice and reasonableness of service request and location of service should always be balanced based on the individual consumer needs, provider ethics and medical necessity for the services delivered. This process should always take into consideration of the living arrangements the wellbeing of the consumer and ultimately the health and safety of the individual beneficiary.

Pathway to Integration Waiver, quality of services and current delivery system and the potential to contract with other entities based on quality of performance.
The Pathway to Integration Waiver does not intend to undue the current managed care delivery system. The potential to contract outside of the current PIHP and CMHSP managed care structure is only intended if the current managed care entity cannot meet the service delivery, quality, financial and reporting requirements to serve the beneficiaries within a given region. This waiver application acknowledges the current efforts to consolidate managed care functions and will continue to support the current managed care arrangements and efforts to meet the waiver requirements.

Definition of Permanent Supportive Housing (PSH).
Permanent supportive Housing (PSH) is a service MDHHS plans to add as an additional benefit during the waiver demonstration. PSH, is a set of service and supports provided by a team that combines housing development and the support services for individual with SMI, SUD, or I/DD that require assistance to maintain consistent and permanent housing. Individuals targeted for this service are often frequent or high users of hospital emergency departments and inpatient and/or chronic homelessness.

Services to support housing retention include: Case management, service planning, nurse care coordination (physical and behavioral health), peer supports, counseling and supported employment. Targeted supports should include dispute resolution between landlord and tenant, assistance with transportation, legal assistance and benefit management.

Removal of enrollment caps and separate rates by person with Intellectual/Developmental Disabilities (I/DD).
MDHHS received a number of questions related to the consolidation of the multiple section 1915(c) waivers and the continued use of enrollment caps for the former Habilitation Supports Waiver (HSW), the Waiver for Children with Serious Emotional Disturbances (SEDW) and the Children's Waiver Program (CWP). Although MDHHS is desirous to potentially remove enrollment caps in the future, the SEDW and the CWP both waive parental income for individuals who meet specific eligibility requirements and Michigan must also continue to meet budget neutrality under the proposed demonstration. MDHHS also received questions related to development of a separate rate category for adult individuals with I/DD, which could eliminate the need for HSW enrollment caps. This is something MDHHS may consider in the future.

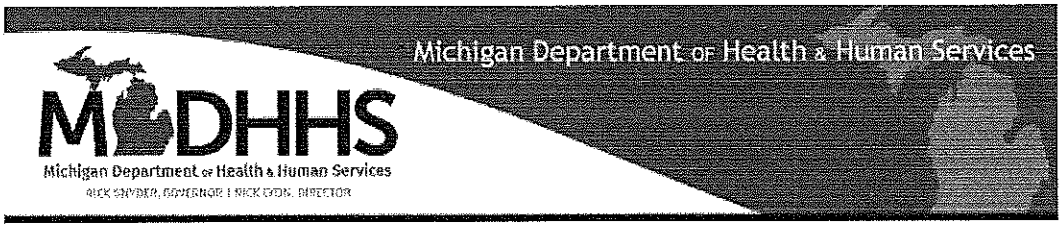
Inclusion of services to person with mild and moderate behavioral health disorders within the specialty services system.
MDHHS received numerous questions related to moving the benefit for persons with mild and/or moderate behavioral health disorders from the Medicaid Health Plans (MHPs) to the Prepaid Inpatient Health Plans (PIHPs). Although the coordination of care and access to needed behavioral health services for this population has been an ongoing concern, licensing and mental health parity require MHPs to provide certain behavioral health services.

Increase use of peer supports, recovery coaches and peer crisis services.
MDHHS covers and encourages the expanded use of peer supports within its specialty service system. In addition to the current coverages, MDHHS intends to have peer supports as part of permanent supportive housing teams as well as their expanded use for persons with substance use disorders. Specific peer support crisis models may be considered in the future, but MDHHS does currently encourage the use of peer supports within existing crisis teams.

Will the final waiver application reflect the New Service Delivery Opportunities for Individuals with Substance Use Disorder and the use of IMDs as outlined in the State Medicaid Director Letter # 15-003?
Yes, Michigan was one of the early states as part of the CMS Innovation Accelerator Program (IAP) and in conjunction with these ongoing efforts, the final application will include the goals of a transformed system including a comprehensive evidence based benefit design and the use of ASM to establish appropriate levels of care. Michigan will be specifically asking for expenditure authority for the use of IMDs.

Written Comments Received

(Please see separate PDF)



Pathway to Integration
Michigan's 1115 Waiver Proposal

Webinar, Public Hearing
And
Written Comments received

1115 Waiver Public Comment Webinar
January 13, 2016
Full Chat Log

ILC 2 2: Meeting will begin at 1pm

Kristi Bente: Housekeeping: The phone is enabled so participants may listen. However, all questions must be typed into the chat function. The presenter will not be able to hear participants talking on the phone.

Kristi Bente: Welcome! The webinar will start at 1:00 pm.

Kristi Bente: If you have computer speakers, you will not need to use the phone to hear the presenter.

Kristi Bente: We are waiting a minute or two for more people to log in . We will begin the presentation shortly.

ILC 2 2: if you are experiencing an echo mute the speaker in the meeting at the top left

Sheila Hibbs: What are examples of integrative health components?

Response: Healthcare screenings, assessment, co-location of behavioral health and physical healthcare care, medication reconciliations, etc.

Joan Deschamps: Please repeat location of the slides.

Kristi Bente: www.michigan.gov/mdhhs >> Keeping Michigan Healthy >> Behavioral Health & Developmental Disability >> Mental Health

Mark Witte: Confirming that the ppt is posted. I have downloaded it.

Kristi Bente: Thannk you, Mark.

Norman DeLisle: Here is the direct link to the page: http://www.michigan.gov/mdhhs/0,5885,7-339-71550_2941_4868-371813--,00.html

Kristi Bente: Thank you Norman.

Marge deblaay: People with a spend-down are those who have been mostt negatively impacted by changes in the last year, are they included in this program once the spend down has been met?

Response: Yes.

Jill Halevan: Does this affect the MI Choice Waiver as well?

Response: No.

Sandra: You may think the services are strong and serve the population but my son has mental illness and services were terminated because he had a Medicaid spend down. He ended up hospitalized

Sandra: Just reading the slides isn't especially helpful...some examples would be helpful

Jill Halevan: When will CMS approve/disapprove the 1115? What is the time line?

Response: Current timeline continues to be April 1st but this obviously a very aggressive timeline and is dependent on MDHHS's the submission of the final application and CMS approval.

Elmer CERANO: Is there a requirement that services be provided by either a CMH or a NON-PROFIT entity?

Response: Services will be managed by PIHPs and delivered through their CMHSP providers or other non for profit providers based on the PIHP configuration.

Sheila Hibbs: How will you compare mild/moderate behavioral health care provided by Medicaid Health Plans to the Specialty Behavioral Health system?

Response: Mild and Moderate behavioral healthcare will continue to be the responsibility of the MHPs with expected coordination between he PIHPs and their CMHSP provider networks as applicable.

Sheila Hibbs: What is the length of the 1115 waiver?

Response: Five years.

Ginny Reed: Will a Q & A from the webinar/hearings be published?

Response: yes.

Jill Halevan: Can you bill for services that occurred in the previous month? Currently you cannot bill after the month has passed even though the person becomes eligible after meeting a spend down?

Response: You can bill Medicaid as of the date the beneficiary meets their spend down/deductible requirements.

Catherine: You referenced inclusion of services for permanent supportive housing...what coverages will be added for PSH?

Response: PSH is a set of service to maintain an individual's housing. MDHHS is still in the process of defining the model of bundled supports. `

Tracey Hamlet: What is Michigan's plan to not reduce services (or limit services) since this plan, on the surface, appears to have added costs.

Response: The only additional service at this time is PSH, which is being covered by the expected reduction in inpatient utilization.

Marge deblaay: I know that a spend-down is not a waiver issue, but the state gets to set the income level, not the feds. Since almost all who lost services had SSDI income, as some states do not count this income in eligibility, is the state considering that?

Response: The state is looking into the issue and potentially seeking allowances under the waiver, but this also has a statewide cost issue that needs to be considered outside of this waiver proposal.

CMHPSM: Is Autism included in this waiver? Is not EPSDT?

Response: yes but is intended to be moved to the State Plan and is considered and EPSDT service.

CMHPSM: Is Healthy MI rolled into this waiver?

Response: yes.

Marge deblaay: Based on answer to autism waiver, does that mean an adult with autism would now be eligible for ABA services?

Response: No, ages 0-21.

Sandra: thanks for clarifying the expansion populations : -)

Pat: As the number of SED-W enrollee's increase, how will increases in payments be handled?

Response: Additional funding is being consider under the budget neutrality section of the waiver proposal (for the allotted enrollment slots).

Sheila Hibbs: Cite examples of quality and financial incentives between Medicaid Health Plans and Michigan's Specialty Services System.

Response: Please see page 6 of the waiver proposal.

CMHPSM: Regarding CWP and SEDW: Is the service array going to be incorporated in this waiver?

Response: Yes.

Jacqueline: Will the MI Health Link population be part of this waiver?

Elmer CERANO: Will self-direction include "independent facilitation of Person Centered Planning?

Response: Yes.

Jacqueline: Do you have an estimated cost of this Demo?

Response: Yes, please see page 129 of the waiver proposal.

Jill Halevan: How does this affect Private Duty Nursing (PDN) supports for individuals and can they directly hire their licensed nurse and not directly from a Nursing Agency?

Response: This waiver does not affect PDN services and they must be credentialed and on the PIHP panel.

Mark Witte: The reference to SBIRT screening for persons with SUD is a bit illogical, since the one does not identify the presence of a substance use disorder prior to screening (the "S" in SBIRT). Would you please consider revising this language to more accurately specify the beneficiary population?

Response: Yes.

Ron Hocking: When will hold back be settled in terms of payment?

Response: This is still being developed as part of the demonstration.

Marge deblaay: Does the inclusion of Healthy Michigan in this waiver make unused funds by HMP members available for use by all others in the waiver? Not having access to this money has been one cause of less funding being available to CMHs around the state.

Response: No.

Bill Riley: We see several existing waivers being merged into the 1115 (SEDW, HSW,etc.) . Does that mean that existing rules, processes, service, and reporting that existed under those waivers will now be outdated or will we manage the same or similar requirements for these waivers under the new 1115 Waiver?

Response: We are looking at efficiencies where we can but some of the program enrollment and reporting will remain separate.

Sheila Hibbs: What is envisioned in the development of bundled funding and other quality incentives for Accountable Systems of Care?

Response: The ASC is an emerging multiple payer model that will be driven by the local delivery systems. Quality incentives will be dependent on model but include prevention and population health outcomes. The ASC is referenced in this waiver as PIHP and CMHSPs may be included as either providers or partners. ASCs have not been chosen at this time.

Marge deblaay: Can Michigan at least identify in the waiver request the baseline of data they currently have in which they expect to see changes? In other words, what are the specific things the state expects to see improvements in?

Response. Please see page 6 of the waiver proposal and further details will be made available as the state develops its final demonstration evaluation.

Diane Pelts: With the expectation of integrated care between behavioral health and physical health providers, has there been discussion about having special billing codes for interdisciplinary integrated care?

Response: yes.

Adam: Long-acting injectable medications, for the treatment of Substance Abuse and Mental Health disorders, are currently not reimbursed under Medicaid during an in-patient/residential stay. "High

Utilizers" are often the patient population that can benefit most from these medications. Are changes being made in the waiver create special billing codes for these treatments?

Response: Not at this time.

Bill Riley: Will Care Coordination be a funded and reimbursable service in the 1115 waiver

Response: Yes, as an administrative expense unless provided directly as part of another reimbursable service.

Sandra: When reviewing the data to determine the size of a particular population, will those who have had services terminated due to Medicaid spend down be included for planning purposes?

The size of the population is based on a person having Medicaid depending on when they met their spenddown/deductible.

Marge deblaay: Under the QAPIP Standards, Item V.A. it says PIHPs must use performance measures established by the state with respect to access, efficiency and outcome measures. Are these already established, and if so, where can a copy be obtained? If not, when will they become available?

Response: Yes, under the MDHHS>>>>Behavioral Health and Developmental Disabilities Administration>>>>Reporting Requirements.

Steve Wiland: Per posted document on MDHHS website, "Total estimated waiver costs for the duration of the demonstration = $15,011,501,458"

Kristi Bente: http://www.michigan.gov/mdhhs/0,5885,7-339-71550_2941_4868-371813--,00.html

Steve Wiland: It is there

Bill Riley: Does the waiver speak to the use of Telemedicine as far as uses, requirements, limitation and reimbursement.

Response: No

guest: Will services exclusive to a particular waiver population remain as such, example: must one be enrolled in HSW for PDN?

Response: yes.

Bill Riley: Can the waiver be used as a method to pull down and access Medicare services, given the fact that a primary benefit is integrated care?

Response: No

Robert Sheehan: You mentioned that care coordination services will be covered. Do you think that these will be categorized in a way similar to health home costs - in that they are not direct service delivery costs nor administrative costs nor PIHP/MHP care management costs.

Response: Care Coordination will be considered and administrative cost unless delivered as part of another direct service.

Melissa: Appendix B states LTSS must be prior authorized at the PIHP level. Does this allow a PIHP to delegate some authorizations to the CMHSP level?

Response: Yes, at the PIHPs discretion.

Sandra: Do you have any additional info on the Housing First initiative?

Response: yes, more information will be made available as MDHHS further defines its model of practice.

Ed LaFrambiose: Will the hearing on the 28th be the same presentation?

Response: Yes.

Jill Halevan: thank you so much for this opportunity to inquire.

Robert Sheehan: Eric, do you see a formal tie between this waiver and the SIM and CCBHC initiatives? Or will the relationship be more informal - each citing each other?

Response: nether the SIM or the CCBHC (if awarded) will need specific waiver authority but will interplay with payment and incentive models.

Sheila Hibbs: Will there be any amendments to the state plan to assure compliance with budget neutrality requirements?

Response: No

Ed LaFrambiose: Thanks for the presentation.

BHDDA Public Comments
January 28, 2016
Presenter: Eric Kurtz

Attendees List

Lisa A Hotovy	West MI CMH
Judith Taylor	Advocate
Julia Griffith	Blue Cross Complete
Kih Batshe-Mckenzie	MDHHS
Michelle Hill	MDHHS
Jane Shand	ACNH
Angela Powell	MDHHS
Melie Osni	Community Living Services
Brenda Roberts	MALA (Michigan Assisted Living Association)
Chris Lerchen	The Arc NW Wayne County
Angela Martin	DDI/WSU
Norm DeLisle	MDRC
Elmer Cerano	MPAS
Brenda Stoneburner	MDHHS
Dohn Hoyle	The Arc MI
Robert White	Parent Advocate
Elizabeth Bauer	Parent Advocate
Mark McWiliams	MPAS
Joan Deschamps	MDHHS Retired
Rebecca Cienki	MPCA
Brett Williams	MDHHS
Paul Palman	MDHHS
Jill Gerrie	The Arc MI
Monica Hampton	Det. Wayne Mental Health Authority
Sara Lurie	CMHA-CEI
Jillian Trumbull	OCCMHA
Valerie Southall	StoneCrest Center
Colleen Healy	Michigan Primary Care Association
Raechel Broek	RWC Advocacy
Tiffany Cline	RWC Adocacy
Sue Germann	Pines Behavioral Health
Ellen Hyman	MDHHS
Kim Ross	Dykema
Stacia Chick	CMH-CEI

Transcript of Meeting Q & A

Transcriber's note: This transcript was recreated as faithfully as possible based on notes however certain words or phrases may have been unintelligible or changed to clarify the question and response. Every effort has been made to ensure the transcript accurately reflects the proceedings as close as possible.

Q: Is CMS going to fast track this for you?

> **Response:** No and there are no limits on their approval timelines by CMS. We have been working hand in hand with them on current extensions and this waiver application.
>
> **Q:** Are the current waivers under an extension?
>
> **Response:** yes till the end of March.

Judith Taylor: Several questions, Eric. With respect to what you just showed, as you know, the boundary management for services to individuals with mild and moderate disorders has been a challenging one for our system in terms of mental health responsibility vs. the public health plans' responsibility. We also know there are parity issues tied up with the way that is being characterized, so what exactly is going to happen with this 1115 waiver that is going to be different with respect to that population?

> **Response**: The movement of the mild and moderate behavioral health services from the MHPs to the PIHPs has been talked about for years licensing rules require HMOs to provide behavioral health services as well so the separation will continue for now. There is an identified gap in that population but it has also been shown that individuals that are considered mild to moderate for behavioral health series are also some of the High Utilizers of healthcare series, which will need to be addressed. The demonstration is intended to identify gaps in service and service coordination for this population. .

Judith Taylor: Second question related to the description of some of the waiver populations. Silos still exist under this umbrella, primarily with the existing HAB Waiver program. As you well know there are at least 3000 individuals that could be in the HAB Waiver, but there aren't enough slots in the state of Michigan. It feels like this proposal just continues to maintain that inequity and was there consideration of redefining the group of high-need persons with developmental disabilities as a category rather than just retaining this tag of a C waiver that no longer exists?

> **Response:** Yes, there has been consideration about creating a separate payment category for persons with Intellectual/Development Disabilities but currently we are keeping the current enrollment slots as do not want to reduce or even have the perception of any service reductions within this waiver proposal. This can also be looked at in future rate setting discussions and in further conversations with CMS.

Judith Taylor: Can you build that into the plan? This is a five-year plan, so a lot of it is talking about Year One, but is there the ability within the 1115 structure to really make out more five-year evolution of the system?

Response: We can consider that as an option.

Judith Taylor: Pick up on previous conversations, how can the Health Michigan Plan exist within two different waivers?

Response: The 1115 for the Healthy Michigan Plan (HMP) actually describes the expansion population. It references the delivery system for specialty services as the Pre-Paid Inpatient Health Plans. This Section 1115 proposal provides the delivery system for those services.

Elmer Cerano, Michigan Protection Advocacy: Actually I want to follow up on Judith's questions since I don't really understand the HMP and how it's going to be addressed. In the other 1115 where it talks about services provided by PHIPs, did you say that will remain as a part of this application?

Response: Yes, this application will include PIHPs as the managed care entity for the specialty service system.

Elmer Cerano, Michigan Protection Advocacy: Can you drill down a little bit? Under freedom of choice, is that still within the PIHPs?

Response: Yes.

Elmer Cerano, Michigan Protection Advocacy: The other question I have relates to Judith's concerns – when you talk about the tracking of high-need users? I'm just saying that we need to know where people are, but can you drill down a little bit into the definition of the tracking?

Response: The identification, tracking and services for individuals considered high utilizers is the crux of the section 1115 demonstration. Although high utilization often does relate to high need, and inversely high need does not necessarily equate to high utilization but dentifying high utilization and assigning complex care managers/care coordination is intended to better serve the individuals and where possible reduce unnecessary hospital ER/Hospitalizations.

Elmer Cerano, Michigan Protection Advocacy: Is there something built into the plan that, the fear again about the identification and the listing of the high users is that they're going to be the people that we push aside like 'oh we really can't treat them...'

Eric: No, actually, as I just described these are the individuals we are or should be serving.

Mike: Just reading ahead, and there's not another question session until the end - When you get to the next slide, can you talk about the alignment of financial and quality incentives to Medicaid Health Plans

and Michigan specialty services systems. It's a really mysterious statement to me about what that would look like.

Response: Alright, I'll make a note and I'll get there when we get there.

Response: [Returning to the topic upon reaching the mentioned slide.] Currently there is legislation that has a 1% hold back where we actually have joint quality indicators and metrics between MHPs and PIHPs. Building upon that model, the goal of this demonstration is to actually create a robust evaluation that tests both quality and cost outcomes between traditional Medicaid Health Plans (MHPs) and Michigan's Specialty Services System. These incentives would be specifically targeted for persons with SMI, SUD, IDD and SED.

Mike: A little bit? You said a little bit?

Eric: The little bit refers to the 1%.

Q: I have a couple of nuts and bolts questions. There used to be an assisted technology waiver service definition as part of the older waivers and I couldn't find it in the proposal, and I wondered what happened to it?

Q: there's business services, there's enhanced medical, there's DME, and I'm not sure where you put it.

Response: Both are still included in the proposal.

Q: I worked in Substance Use Disorder services and ran a crisis intervention center in the 70s, and we had a fair number of individuals with developmental disabilities and intellectual disabilities who showed up at the center for services. I found the language, particularly the part about emotional and cognitive capacity to benefit from treatment, to be a red flag. Since, I know that SUD services have improved over the decades, but at that time the mere existence of an intellectual disability would have been reason not to provide substance abuse services. And I don't know that you need the criteria but it looks like it came from somewhere, so maybe adding some language that made it clear that the mere existence of a disability didn't mean that you don't have the capacity to benefit from treatment.

Response: The language came right out of the Medicaid Provider manual but the intent is to NOT exclude based on an individual's presence of Intellectual/developmental disability.

Q: Do you have a particular definition of Permanent Supportive Housing?

Response: There are multiple definitions of Permanent Supportive Housing (PSH) and the evidence based practice and service guidelines will build off of the SAMSHA guide and tool kit and be defined in the Medicaid Provider Manual upon waiver approval. It should be noted that the service is not intended for the payment of housing but rather the supports and services surrounding an individual to maintain their housing. This need was also identified by the Mental Health Commission.

Q: And does the secondary criteria include compliance with CPS rules under the residential models and action programs, and is there any thought on how that's going to interact with this particular service?

> **Response:** PSH is primarily focused on independent housing needs but could also include supporting an individual's residential placement but if that is the case, it should directed toward individuals transitioning to independent housing.

Dawn Pischel with Community Housing Network: I just want to piggyback on the questions that that gentleman asked. In June CMS issued guidance to states, and I just wondered, is Michigan adopting that guidance, do they back it, and what is the waiver going to speak to specifically regarding supportive housing? Not just that it's important, and not just "these things *should* happen," but how is it going to be mandated?

> **Response:** MDHHS is aware of the June SMD letter. Our intents with PSH seem to line up with those initiatives.

Becky Cienki with Michigan Primary Care Association: Will the waiver address in any way concerns about who's responsible for paying for psychiatric consults for individuals who have been diagnosed with severe mental illness but have been deemed stable by a Community Mental Health Service Provider or PIHPs?

> **Response:** this should be being covered in some form or fashion right now, but is not necessarily addressed by this waiver application. This may require further follow up from the Medicaid Services Administration and/or coding related to 'consultation".

Becky Cienki with Michigan Primary Care Association: I think my other question then falls in that bucket, which is, I remain concerned about capacity for services throughout the state for all conditions and also I know that one of the limitations appears to be that Community Mental Health Service Providers are unable to care for the mild to moderate individuals and their limitation to contract with Medicaid health plans. I doubt that that's included in this waiver, it's probably a different population, but something I want to continue to keep at the forefront so that we can make sure that people do acknowledge that.

> **Response:** The issue has been referenced multiple times and is referenced as an area of need at a minimum for high utilizing populations.

Judith Taylor: One last question, there was a slide a few rolls back where you talked about the intent of this waiver covering new populations and I'm curious as to what you view as a new population?

> **Response:** Potentially expanding ASD services in particular.

Dohn Hoyle of The Arc MI: When it comes to quality – to say that it doesn't mean that what we're doing is bad or wrong, but I think what we're doing now is bad and wrong, or else we wouldn't have the

discrepancies we have. Put up self-determination; there are places in Michigan where that's not even offered, and people are instead told "we don't do that here." I think the discrepancy from one place to another in Michigan and even in one county, where you have managed care entities providing services, where you go from one MCPN to another, you can't get the same thing. I think we have a real serious issue about quality when it comes to person-centered planning. The fact that local quality control systems were supposed to address person-centered planning for a number of years are mandatory, but person-centered planning from one place to another is unrecognizable.

And I want to say that having a site visit every other year, when you only look at current C beneficiaries, is just appalling. The fact that we would believe somehow that accreditation means anything, I think it's a useless process- people are accredited who don't do what we ask them to do, people are accredited who do the wrong thing, and people are accredited who don't do person-centered planning. So I think when it comes to quality, I'm going to suggest that we really need to spell that out better. We need to talk about real common site reviews for everybody served, on a regular basis, frequently, not every other year. And relying on accreditation instead, that has to change. I'll go back to - my favorite story is when, on the same day that an institution in Arkansas was accredited, on the very same day, the federal government announced they weren't sending any more Medicaid money there because people weren't safe there. To say that accreditation means anything to the next person that comes along is absolutely false.

And I think that there's no substitute for really looking at things and getting down to individuals. I would even suggest that some people should be followed on a longitudinal basis, and not just a snapshot. So that maybe we should be doing site reviews that include some portion of people we see over again – so we can test progress for their clients. We really have to something about quality and the appalling difference based on which county you live in, or even which entity is serving you within the county. There's no excuse for it. How we could maintain to the federal government that this is statewide is a fallacy. I think that when you, to be supportive of any change, we have to say the change is going to benefit people. So that change needs to be how we assess things, what we report to the federal government on, and what people actually get.

> **Response**: Thank you Don, I think the pendulum on these things swings. As part of consolidating the separate waiver populations, all populations will be part of the site review process regardless of accreditation.

Mark McWilliams: I echo the comments from The Arc, and suggest among all the indicators might be some quality of life indicators that are easily measured, such as employment status, or other kinds of issues. The question I have is about notice – I know that many of the providers who are in the systems are going to remain the same among any of the waivers, but there will be a change from fee-for-service to managed care for the children's waiver, and the C/D waiver, I was wondering, do you foresee any notice issues with that?

> **Response**: They will be notified prior to implementation, but first and foremost there will be no change in their service due to this waiver proposal. Actually, the fee-for-service arrangement that we currently have, where general funds had to be used to supplement the FFS screens

actually constrain the current program (at least from a provider capacity standpoint). We are actually hoping that with Medicaid covering the full cost of services that future expansion could be considered.

Dohn Hoyle of The Arc MI: It was my understanding that in order to get a new waiver, Michigan had to already be in compliance with home and community-based rules that included person-centered planning and included conflict-free case management, etc. So I guess I want to know, when we ask this question as it relates to home and community based rules, we got a strange question about waiting for clarification when it comes to 1915(b) people. I'd like clarification now if it's the intent that every single person served under the waiver will be using home/community based funds will be tested against the rules that we had in place before – '19 or at least by 2019?

Response: I do believe there is communication going on regarding the former 1915(b) waiver populations and compliance. Depending on responses and clarification from CMS it is the intent that whatever populations need to come into compliance that we have the same timeframe that was given the former section 1915(c) population of at least five years.

Dohn Hoyle of The Arc MI: So they've given you leave to not be in compliance, or else you couldn't get the waiver?

Response: Well, everybody is supposed to be in immediate compliance with conflict free case management once the final rule was promulgated in 2014.

Dohn Hoyle of The Arc MI: All populations served by the waiver will be covered by home-and-community based rules?

Response: It is my understanding that they will depending on the series they receive.

Dohn Hoyle of the Arc MI: And by 2019?

Response: That's the question at hand and again we hope the newly identified populations will be allowed the same planning as the former section 1915(c) populations.

Dohn Hoyle of The Arc MI: From our perspective, dancing has what *has* been going on under the B waiver. And I believe that one population doesn't deserves scrutiny over the other and you'd think the state would want to make sure that everybody is receiving home and community based services. In fact they were informed I think '14, maybe it was '13, and that any managed care rules would be held to the same standard for home and community based services. Before the standard even came out, they were told that. And to indicate that they were told something else or that they weren't going to do the same thing, is to my mind, an indictment. I want to make sure that with supportive housing that we do not adopt MISHDA's statement on supportive housing. I think it would not comply with home and community based rules, I'm really pleased to hear you say "independent housing."

Response: Yes, that was the intent.

Q: I just want to reiterate also about the compliance with rights – I would strongly encourage you to make it part of your plan whether the feds give you clarity or not. It's simply the right thing to do. You're going to have to do it anyway and to build it into this application shows that the state is moving in the right direction – To me it's not a question of whether you have five years or more, to me it's do you have the three and a half years or 36 months that are left in that five-year plan, or is it immediate? And I think that it's reasonable to think that if it can fit into the 36 months that we have left of that five-year plan, that it should be understandable.

Response: Thanks.

Bret with DD council: My question is kind of two-fold. Can you explain a little further on just how are capitation rates established, and why they vary for different programs throughout the state, and two, could you dial in deeper into the 1% hold back and what the intent of that is?

Response: I'll start with the 1% holdback. The 1% holdback was actually put into legislation and was to be in place October 1st. The same contractual language exists in Medicaid Health Plans and PIHPs and the language is basically a starting point to developing the process. When the current language was put into the waiver, I didn't know that the legislative language existed, but in a majority of the demonstration waivers financial incentives are put into place. Basically doing what we committed to do and then rewarding that behavior. The process for the redistribution of how that works that will be further defined when that comes.

With the capitation rates, could you get a little more specific? We've been running under a capitated system since about 1998 at that time, at that time PM/PM capitation rates were paid directly to CMHSP as Prepaid Health Plans and in 2014 18 regions were created and designated as PIHPs. Capitation payment are paid based on a per member per month basis for each Medicaid enrollee within a region and the rate cells are separated by age, gender and Medicaid disability category.

Lisa Hotovy, Director of West Michigan CMH: I have three questions, Eric. The first one is on the phase two slide, you referenced bundled funding. Are you referring to case rate there or are you referring to something else? I didn't see it in the full 1115, I just saw it in the slide?

Response: It's referring to a couple different methods that may be tested either through the Accountable System of Care project and/or the CCBHC PPS rate if Michigan is awarded as one of the demonstration sites. How PIHPs and/or CMHSPs fit into these different models has not yet been determined and there are a couple of different options that currently exist. I would look at this language as a placeholder as our system changes over the next several years.

Lisa Hotovy: So it's tied to the accountable systems of care act?

Response: For the most part, yes.

Lisa Hotovy, Director of West Michigan CMH: The next question is around spend down and certain states like Indiana have been able to work spend down out of their system and include the full coverage for those individuals. I don't know the general rules around what the 1115 does and doesn't allow, but if it does, have we considered incorporating spend down into our 1115 submission to manage some gaps for those individuals?

> **Response:** I don't believe it's the 1115 that is the silver bullet for that. There is a state workgroup and initiative going to at least analyze the costs and ability of the state to address this issue. I'm not part of those workgroups but I know it is both a state and federal issue
>
> **Lisa Hotovy:** I think it's interesting that other states have been able to navigate that, and although it might not be the proper vehicle for doing that, and I know that the work groups are in progress, it seems pertinent to think about where vehicles for that might be, because it does continue to be a huge issue.

Lisa Hotovy, Director of West Michigan CMH: The last question is around the SUD expansion that's identified throughout the State Medicaid Director letter that came out. It offers a variety of opportunities for us, particularly because we're in an innovator accelerator state. Do we meet all of those requirements as identified in that SMD letter, and do we have any intention as a state to apply for the IMD exclusion?

> **Response:** We fall short in a couple of areas with regards to the use of the ASAM and some of the requirements for withdrawal management. This will be part of our final waiver application so Michigan can continue its use of IMDs and as the issues through the IAP get further identified and addressed.

Dohn Hoyle of The Arc MI: On pages 49 and 50 of actual proposal there are what I call "weasel words" that seem like they're being included from when we first did a policy on self-determination back in 2003. So now in 2016, 13 years later, I don't think that we should be saying "there are some people who aren't quite there, we have to give them time, we have to bring them along." That's crap. 13 years later we shouldn't be saying those very same things over again. Maybe you just put them in there because you adapted the policy, or used the policy, but those weasel words have got to go. That's not acceptable anymore, for someone to say "well it hasn't been tested, we haven't done it enough, we don't have the mechanism." We've come so far, that just an excuse people are using now. And it's thirteen years we should expect better behavior, and I just think that language needs to be removed.

> **Response**: Thanks Don, this language is in the process of being updated as well.

Elmer Cerano, Michigan Protection Advocacy: I wanted to say a couple of things on that comment from Don, because I think it's pretty clear as to what the standards for excellence are for the CMH and PIHP systems. But the question I have you may go into it later, or not, but does the application itself allow for, or prevent, or just remain silent on the for-profit agencies that provide services to the carve-out population?

Response: They've been providing services all along whether it be under the PIHP or through the CMHSP as part of the overall provider network. There's nothing that I can think of that would say that a PIHP or a CMHSP couldn't contract with for-profit entity.

Elmer Cerano, Michigan Protection Advocacy: Actually, I'm more concerned at the level before it gets to the PIHP or CMH, and it's run through the ICO or another entity. There's a couple concerning things, one is the for-profit issue and the limited use of available dollars, but the other is that the health care system has not historically understood anything about person-centered-planning or self-determination when it comes to full community access. Do you address it in this at all?

Response: I think that's actually good public input of why the system should be the way it is and is in support of the current delivery system model as outlined in the waiver proposal.

Elmer Cerano, Michigan Protection Advocacy: Yeah, they don't agree on some things, the MCPNs in Detroit that are for-profit corporations, that are also ICOS, so the health care side of it is a for-profit corporation, and because of some actions that have taken place in that area, it reverts back to a for-profit corporation.

Response: I agree, besides the different arrangement with the ICOs the state's not funding them directly.

Elmer Cerano: Does the waiver address that at all, the application?

Response: No.

Elmer Cerano: You might want to.

Liz Bauer: I'd just like to go a little further into what Elmer was just saying. You know we have the MI Health Link demonstration going on in various parts of the state, which is passively enrolling dually eligible Medicare/Medicaid beneficiaries, many of whom are also served by the PIHPs now, and there's a whole mess trying to coordinate those kinds of care. What I'm concerned about is rolling all of this up and the statement that this gets away from fee-for-service, where the 1915c waivers – are we on a path to passively enrolling everyone in ICOs that have to coordinate with the 10 PIHPS?

Response: No, that is not the intent nor are we on that path. Actually as I referenced before the previous FFS rates did not cover the full costs of services requiring the CMHSPs do devote other state or local fuds to maintain the program. This model actually constrained the provider network.

Liz Bauer: I guess I just wanted to ask, what happens *next*?

Response: And anybody who's Medicare or Medicaid for the various programs, they either have to vote with their feet to be in them – special needs plans or otherwise – so that's where that type of either passive or active enrollment comes into play.

Julia Griffith from Blue Cross Complete of Michigan: This might be the same question that MPCA was asking, but I just want to be sure it's stated from the health plan perspective. We made a number of attempts to pay embedded social workers and care management staff from the CMHs that are embedded in primary care offices, we've credentialed them, and we've attempted to be able to pay them for the work. The barrier we've hit is that they cannot – CMH cannot – accept less than full cost reimbursement, and we have to pay the Medicaid fee schedule for them, so we've been unable to pay for those services even though we want to. So will the waiver address this issue of CMH being able to accept Medicaid fee-screen rates for services to our employees? I mean, I kind of guess some money is better than no money, but apparently it can't be done.

Response: it's a little technical, From a CMHSP perspective anything that doesn't cover their cost of service it requires them to use other state and/or local funds therefore offsetting the liability of a private plan. On the other hand, the health plan has the ability to pay providers any rate regardless of what the fee screen is.

The waiver is not addressing this issue because it's more of a licensure issue, and I think some of these nuances are in payment issues between providers and the health plans. .

Judith Taylor: I've got a whole bunch of technical questions to get to, but I'm going to ask you a really obnoxious question to begin with. What's your opinion or position with respect to the recent statement that "The public mental health system has had its day and needs to be eliminated"?

Response: There are a lot of opinions floating around and as you can see the waiver proposal keeps the current system in place.

Judith Taylor: I recognize that it is an obnoxious question, it is challenging and problematic when you have a conflict between what it appears you're trying to do with 1115 and that requirement floating out there as to exactly what you're trying to do.

Response: I think this is trying to get the coordination going on between the MHPs and the PIHPs in a rational way for the betterment of our specialty services population that have limited access to primary care due to transportation, social behaviors or just a general lack of coordination at both the plan and service levels. .

Judith Taylor: And I do agree with the critical nature of us being real clear on what these populations need not being understood and overall responsible for that kind of behavior.

Judith Taylor: But moving back to my more technical questions. Is there any consideration regarding the boundary management in respect to services, home help services. Now and particularly with the particularly the MI Health Link pilots and enrollees – any consideration for how that boundary needs to

be cleared up? This is a 5-year specialty plan, I was just wondering whether you had any particular context in long-term supports part of it? Are you going to do anything with that mess?

> **Response**: That is a good comment, and again, make sure it is in writing. No this waiver application does not move any budget line related to home help services.

Judith Taylor: Just following up on the SUD funding and what method was used to establish the cost base. And I'm going to be really mean, again. I would hope you would do a better job than you just did on the autism rate setting, and so the concern that I have is that all of these appear to be shifting the risk down to public mental health system. "We think the funding is right, obviously we need to do something different." I'm putting a plug-in there that use more of the field help as we proceed with future rate setting.

> **Response**: with the Autism program, there wasn't as much data. SUD costs include all historical costs from FY 14 trended.
>
> **Judith Taylor:** But you didn't talk to us on what the productivity assumption would be for starters.
>
> **Judith Taylor**: Just as a side Both the CWP and SEDW previous waivers have some services in them that are odd, and are we trying to work or have you had the opportunity to look at how we may view case management for the former CWP and wraparound for the SED waiver defined differently from rest of our universe of services.

Judith Taylor: I'll just keep going down my list. I have a problem when using the terms incentives when it's really a withhold. And I'm deeply concerned about a withhold of 1% because, quite frankly, given some of the trending that's happening in terms of both our rates flattening down, eligible flattening, costs going up, populations are aging, more needy, higher penetration rates, the trend is totally inadequate for the primary populations. And then on top of that we get a 1% take away, and we may earn it back somewhere sometime, but I think that translates to a loss of 1% capacity for the delivery of services. So I know that you're stuck with this model, but I think it potentially has some problems attached to what that will actually translate down to at the field as Medicaid moneys get tighter and tighter.

> **Response**: I think we have to look at how the 1% withhold/incentive is implemented. As you know it is geared toward a shared incentive model and one side, the MHPs are allowed to retain earnings/profits and on the PIHPs side, if there is excess funding beyond its risk corridor it is sent back to the state.

Judith Taylor: And so second to that one is the use of the word "savings," particularly in terms of the integration. As you well know, as you've said in various places, we know that things that we do will significantly have positive effect on spending by the health plans. You allude to it within the waiver proposal but I would love to see that much more elaborated.

Response: Well I don't think it works out the gate, and this is where you use the five year demonstration period to analyze these savings/incentives. I think we all have a gut feeling that the social supports we provide as a behavioral health system impact the cost of services, both psychiatric admission and ER visits and hospital admissions. To prove that we need to do a demonstration and we need to identify what interventions and where savings actually accrue. Then I think you have a conversation related to the next steps and greater shared savings arrangements.

Judith Taylor: is it really trying to work out how to get the money out of the health plans.

Response: No but rather how shared savings is generated and where and how both systems can save and reinvest in services.

Judith Taylor: I am very concerned about financing trends for public mental health systems. The statements that there is more than enough money is totally not correct, and that with the flattening of the Medicaid eligible, and the failure to have type parity, and the rate increases that are provided to the public mental health system versus the health plans, add to the fact that our penetration rate is going up, people are staying longer, living longer, etc. etc. So our characteristics do not match at all the assumptions that are in the cost effectiveness page at the end of what the trend is. The only population there we're trending specifically is the autism population, and that's quite frankly okay if that's needed, but it's fairly unfortunate that it's at the expense of everybody else that we serve. So this whole health system is being financed, and the trend assumptions, at some stage all that we can see is tighten the belt, tighten the belt. More accountability, more things we have to do, more services, but in effect it's essentially less money. And so, we all know we've got this challenge, we've got to work on how collectively we can do that. And so back to, how do we make certain this 5-year whatever it is, becomes much more working together rather than some of what's happened in the past when you're off there doing your thing and not using the resources and the expertise and the knowledge and the caring and the passion that exists under you. Thank you very much.

Response: Very well said, thank you.

Q: Just wanted to piggyback on what Judith was saying about the shared savings models. The values document that was created jointly between the department and the board association about a year ago actually speaks to the values around that shared saving and the distribution of that savings: not necessarily back to the PIHP or to the CMH system, but back to the entity responsible for generating the savings. So I think that, I mean the fact that of the matter is that that could work either way, but I think it is of importance that it goes that way. Pennsylvania's models around that have all reinforced and figured out ways to get that money back in the communities and into other kinds of efforts, which I think is also how we can also some of the flat trend in funding that Judith was talking about.

Response: A lot of this model is right out of the Integrated Care Resource Center, which is footnoted in the waiver proposal.

Q: But I think that shared savings component- it's really important that we talk about that, whether we're talking carved in or carved out. The shared savings goes back to the entity that created the savings, regardless of who that is – and I think that is in fact the great incentive for both the health plans and the PIHPs and specialty services system to coordinate and collaborate together for better services for everyone.

Response: Yes, thanks.

Q: Just for clarity, what is the holdback, is that federal or state legislated?

Response: It was state. Tom and I know the number, but I can't remember...

Response: It was in last year's appropriations bill and if you send me an email I can send you the link.

Michigan Department of Health and Human Services
Behavioral Health and Developmental Disabilities Administration
Bureau of Community Health
320 S. Walnut Street, Lewis Cass Building, 5th Floor
Lansing, MI 48913

January 5, 2016

RE: Section 1115 – Pathway to Integration

To Whom It May Concern:

I am sending this correspondence in regards to the Michigan Department of Health and Human Services (MDHHS) request for approval from the Centers for Medicare and Medicaid Services (CMS) for a Section 1115 Demonstration Waiver. After reviewing some of the information in the request, from the perspective of a seasoned Community Mental Health and Prepaid Inpatient Health Plan board member, I have decided to submit to MDHHS some comments/concerns.

I think it is important to note that my perspective is informed by my lengthy service as a local Community Mental Health Board member (approximately 13 years), my active involvement in our state Association's conferences and activities, and my direct involvement in the creation and governance of two multi-county (and multiple CMH) regional Prepaid Inpatient Health Plans (the former Thumb Alliance PIHP and now the Region 10 PIHP). While the path that the state has taken in designing this system may not have been one that I would have chosen, I am very proud of what we have created and what we are continuing to build for the benefit of the people and communities we are privileged to serve in Sanilac County and throughout Region 10.

From that perspective, I was encouraged to see, in section IV., 5., (d) that MDHHS is planning to implement the Section 1115 Waiver using the existing 10 PIHP Agencies and Regions. My major point of concern arises from my review of the section that followed (section (e) below), most particularly the last sentence of that section:

IV. Delivery System and Payment Rates for Services
5) If the Demonstration will utilize a managed care delivery system:
The Demonstration will use Medicaid PIHPs
e) Describe how the managed care providers will be selected/procured (if additional space is needed, please supplement your answer with a Word attachment).
In April 2013, Michigan required its 18 PIHPs to consolidate to 10 through an Application for Participation of Specialty Prepaid Inpatient Health Plans. As outlined above, Michigan intends to continue the use of this managed care delivery system within this §1115 application but holds the ability to contract outside of the PIHP and CMHSP system if the managed care entity and/or providers cannot meet the service delivery, quality, financial and reporting requirements as determined by the state.

My question is, is the potential for contracting outside of the PIHP/CMHSP system an all or nothing proposition? If so, then each of the newly created legal regional entities and Community Mental Health Centers is potentially being placed at risk, regardless of their own performance, based upon the performance of other regional entities and Community Mental Health Centers over which they have no

control. This, to me, is a great cause for concern. As stated above, I am a veteran of the developmental and governance process related to two separate regional PIHPs. The development of the initial PIHP region was accomplished based upon massive amounts of effort by both Board members and staff. More importantly, the more difficult task was navigating the challenges related to forming a regional governance structure over what were once local resources. From the perspective of local CMH Boards as well as county commissioners, this was an incredibly large leap we were asked to make, and we did so for the best interests of those we serve. In this latest iteration of our PIHP system, even more was asked. Not only did we have to go through this developmental process again with (in our case) a new partner, we also were required to actually create, at no small cost, a new legal entity to administer the Medicaid benefit across our now expanded region. This has been an enormous task and again, while it may not have been a path we would have independently chosen, we have worked diligently to create a partnership that would first and foremost benefit the people we serve, but also maintain compliance with the state and federal standards related to the benefits we administer on their behalf.

Because of that, in addition to my desire to minimize disruption to those we serve and the dedicated labor force we employ to serve them, I would recommend two things in this section:

1) That MDHHS makes it clear that a path of correction and support would be followed to ensure that was has been put in place at great personal, financial, social, and governmental cost will not be readily discarded prior to truly diligent efforts to make it work; and,
2) That the MDHHS makes it clear in this waiver that each Regional PIHP will succeed or fail based upon their own efforts and merits and not based upon the performance of entities that are completely outside of their control.

Thank you for your review and consideration of my comments/concerns, please understand that they are provided by somebody who is, and has been, truly committed towards what is best for the people and the communities that we serve.

Sincerely,

Elva Mills
Chair, Sanilac County Community Mental Health Authority
Region 10 PIHP Board Member

CC: Sanilac County CMH Authority Board
Region 10 PIHP Board
Michael McCartan, Region 10 PIHP Executive Director
Jim Johnson, Sanilac County CMH Authority Executive Director

Michigan Department of Health and Human Services
Behavioral Health and Developmental Disabilities Administration
Bureau of Community Health
320 S. Walnut Street, Lewis Cass Building, 5th Floor
Lansing, MI 48913

January 8, 2016

RE: Section 1115 – Pathway to Integration

To Whom It May Concern:

I am sending this correspondence in regards to the Michigan Department of Health and Human Services (MDHHS) request for approval from the Centers for Medicare and Medicaid Services (CMS) for a Section 1115 Demonstration Waiver. After reviewing the information in the request, I have decided to submit to MDHHS some questions/concerns/suggestions.

1) My initial concern relates to some of the verbiage in Section IV., 5), (d) – which I have copied into this document (below):

IV. Delivery System and Payment Rates for Services
5) If the Demonstration will utilize a managed care delivery system:
The Demonstration will use Medicaid PIHPs

"Although freedom of choice will continue to be waived, PIHPs will be required (as non-provider entities) to arrange Medicaid service contracts to ensure the independent evaluation of eligibility, assessment and the development of the Individual Plan of Service to ensure compliance with Home and Community Based Setting (HBCS) final rules. Although model configuration may be optional (based on state approval), the independent evaluation of eligibly and assessment does not include the provision of emergency services that may result in a preliminary plan of service or functions related to hospital preadmission screening or discharge planning. For PIHPs who contract with CMHSPs, the PIHP will be required to monitor the CMHSP's self-referral and utilization patterns related to consumer choice and best value criteria. MDHHS will play a vital role in the policy development and promulgation of these rules as part of its HBCS statewide transition plan."

Concerns/Questions:

My initial and overarching concern is that this is not a very detailed explanation for how Michigan, within the Section 1115 Waiver, will deal with issues related to federal rules around Conflict Free Case Management (CFCM).

More specifically, what is meant in this section by "independent" evaluation of eligibility, assessment, and the development of the Individual Plan of Service? Does that mean those functions must be accomplished Independent from each other or that they must be done by independent entity(ies)? If it is an independent entity, then independent from whom?

How does this section reconcile with the existing CMHSP requirements to provide assessment and planning as they exist in the Mental Health Code (section 206 and section 712) and/or the requirements of the primary care provider (often the CMHSP) to complete the treatment plan as specified in the Code of Federal Regulations (42 CFR 438.210)?

The vague nature of this section represents a false vulnerability for our system as developed and implemented – both before and within the construct of this 1115 Waiver.

Suggestions/Response:

It seems that the basic risk that the Conflict Free Case Management standards are intended to mitigate is the risk inherent when a party that has a vested interest in the over (or under) utilization of services also has the authority to control the level of services provided. The one factor that seems to really muddy the waters in this area is the lack of clear universal definitions for a few key terms (case management, planning, and assessment).

What I would suggest here is that Michigan, in this waiver, should make clear the practical definitions for these functions as they exist in our system of care. More specifically, this section should delineate the difference between "eligibility determination" (assessment at the PIHP level), "care management" (case management at the PIHP level), and "treatment authorization" (planning at the PIHP level); as opposed to assessment (done comprehensively at the provider level, often involving multiple disciplines), case management (the "boots on the ground" functions provided by provider staff on an ongoing basis in the community), and treatment planning (done with providers on an as needed basis within the person-centered planning construct). Care management, eligibility determination and treatment authorization are managed care functions; while assessment, case management (relative to our service population) and treatment planning are most effectively and appropriately provided (not to mention often specifically required) at a CMHSP/provider level.

In leaving this section vague and not clearly defining Michigan's move towards compliance with the criteria of Conflict Free Case Management, we fail to recognize the elegant system of balanced incentives that Michigan created in developing our most current model. There should be clear explanation and support for how this model actually mitigates the risks targeted in the Conflict Free Case Management rules. Michigan should clearly identify the "free standing" PIHP, a separate legal regional entity, as not having a vested interest in either the over-serving or the under-serving of the covered population, pointing to the structure provided by operating in a capitated environment; the limited control over the use of savings (carry forward/re-invest, build risk reserve up to a specified limit, or lapse back excess revenues over expenses); the potentially negative impact that under-serving has on future rate development and compliance with performance measures; and, maybe most importantly, the absence of shareholders who would stand to collect dividends created by unspent revenues.

In summary, Michigan should point to the clear delineation between PIHP and CMHSP/provider functions in this system as a construct built to facilitate and enhance Conflict Free Case Management.

2) In subsection (e) of that same section, MDHHS spells out the potential for contracting "outside of the PIHP and CMHSP system if the managed care entity and/or providers cannot meet the service delivery, quality, financial and reporting requirements as determined by the state."

Questions/Concerns

My question is, is that an all or nothing proposition? If so, my strong concern is that newly formed legal regional entities and Community Mental Health Centers would be, in fact, placed at risk, regardless of their performance, based upon the performance of other regional entities and Community Mental Health Centers over which they have no control?

My perspective is based in large part on my having been a part of the developmental process related to two separate regional PIHPs. The development of the initial PIHP region was accomplished based upon massive amounts of effort by both Board members and staff. More importantly, the more difficult task was navigating the challenges related to forming a regional governance structure over what were once, from a practical perspective, local resources. From the perspective of local CMH Boards, as well as county commissioners and providers in our sub-networks, this was an incredibly large leap we were asked to make, and we did so for the best interests of those we serve. In this latest iteration of our PIHP system, even more was asked. Not only did we have to go through this developmental process again with (in our case) a new partner, we also were required to actually create, at no small cost, a new legal entity to administer the Medicaid benefit across our now expanded region. This has been an enormous task and we have worked diligently to create a partnership that would first and foremost benefit the people and communities we serve, but also maintain compliance with the state and federal standards related to the benefits we administer on their behalf.

Suggestion/Response

I believe it is in the best interests of the people we serve, our communities, and our panel of committed providers both in and outside of the actual CMHSP agencies to minimize disruption to those we serve and the networks that support them. Having said that, I would recommend two things in this section:

- That MDHHS makes it clear that in the event a PIHP/CMHSP is not meeting expectations in the domains listed above, a path of correction and support would be followed to ensure that was has been put in place at great personal, financial, social, and governmental cost will not be readily discarded prior to truly diligent efforts to make it work; and,
- That the MDHHS makes it clear in this waiver that each Regional PIHP/local CMHSP will succeed or fail based upon their own efforts and merits and not based upon the performance of entities that are completely outside of their control.

3) In Appendix A, under "Essential Elements for Person-Centered Planning and Service Plan Development", the request reads that "The following characteristics are essential to the successful use of the PCP process with an individual and his/her allies.
   1. **Person-Directed.** The individual directs the planning process (with necessary supports and accommodations) and decides when and where planning meetings are held, what is discussed, and who is invited."

Concern

For a variety of reasons, I am concerned with stating that the person unilaterally decides when and where meetings are held. While I would not anticipate a large volume of requests that would be incredibly disruptive to the system (wanting to have a meeting at 1:00 AM in a bar, for instance), I do think they could happen. In addition, our system and staff have to balance the needs and requests of many people and it is very possible that a given staff could be requested to meet by different people at the same time.

Suggestion

I would think it would be better to say that the person "suggests and approves" when and where planning meetings are held as opposed to "decides". I believe that still captures the intent that the person is driving the process and we are not making scheduling decisions that are prioritized based upon clinical convenience.

4) In the same section, #7 states "Wellness and Well-Being. Issues of wellness, well-being, health and primary care coordination or integration, supports needed for an individual to continue to live independently as he or she desires, and other concerns specific to the individual's personal health goals or support needed for the individual to live the way they want to live are discussed and plans to address them are developed. If so desired by the Individual, these issues can be addressed outside of the PCP meeting."

Question

Does this mean that the topics of wellness, coordination, integration, etc. are required elements of the process and must be addressed in the process (in our outside of the actual PCP meeting) regardless of whether the person wishes to address them? I am not recommending that they not be discussed/addressed, it is just that in #6 it appears that the person has complete control over what will be discussed and this section indicates some specific subject matter that the system states must be included.

5) In the Individual Plan of Service section, #4, it states "The amount, scope, and duration of medically necessary services and supports authorized by and obtained through the community mental health system."

Suggestion

I believe it should actually state that the amount, scope, and duration of medically necessary services and supports authorized by **the PIHP** and obtained through the community mental health system. That would better reflect a model that is compliant with Conflict Free Case Management guidelines.

6) In the QAPIP Standards, II reads "The QAPIP must be accountable to a Governing Body that is a Community Mental Health Services Program Board of Directors."

Suggestion

I believe this should read that the QAPIP must be accountable to a Governing Body that is a **Regional Entity/PIHP** Board of Directors

7) In QAPIP section XVI, it states "The PIHPs, shall continually evaluate its oversight of "vulnerable" people in order to determine opportunities for improving oversight of their care and their outcomes."

Suggestion

Need to define "vulnerable" relative to the rest of our service population who could all, in a sense, be described as vulnerable in some fashion.

8) In the MDHHS Self-Determination Overview, it states "The public mental health system must offer arrangements that support self-determination, assuring methods for the person to exert direct control over how, by whom, and to what ends they are served and supported."

Suggestion

I think this section should make it clear that services and supports funded through arrangements that support self-determination must still be fall within the context of medical necessity criteria that are related to an established diagnostic condition based upon the impact that relevant symptoms of that condition have on the person's abilities across specific life domains as well as the likelihood that the interventions will produce intended results.

9) Within the same section, regarding Qualified Providers it states "Qualified providers chosen by the beneficiary, but who are not currently in the network or on the provider panel, should be placed on the provider panel."

Question

Doesn't the BBA give the organization the ability (and responsibility) to control the size of the provider panel relative to need, cost, and quality consistent with the organization's responsibilities? Do those provisions not apply when there are arrangements that support self-determination?

Suggestion

If the BBA provisions do apply, then this seems too wide open. Perhaps "qualified" as used above (which appears to be a more narrow, credentials based definition) could be defined in a way that is not intended to arbitrarily limit choice but does offer the agency the ability to carry out its stewardship responsibilities in terms of panel providers that receive Medicaid funding.

10) Again, within the same section, it states "Some program approaches are not amenable to the use of arrangements that support self-determination because the funding and hiring of staff are controlled by the provider (for example, day programs and group homes) and thus, preclude individual employer or budget authority."

Question/Suggestion

Would programs like ACT, ABA, HBS, etc. also be examples of approaches not necessarily amenable to the use of arrangements that support self-determination due to the specialized training, supervision, team-based modality and model fidelity requirements? If so, my suggestion is that some other examples and criteria be listed here to provide guidance for the system. Some of these concerns may be more pertinent in smaller, rural areas than in large urban areas with robust provider panels (in and outside of the CMHSP system).

11) In Appendix C, section II., D – Risk – there is nothing written here

Question

Is this intentional or is there some information we should have here?

In closing, I would like to thank you for your efforts in putting together this waiver request, it truly represents a mammoth undertaking intended to improve the system of care for the people we serve and our communities. I would also like to thank you for taking the time to review my comments/concerns and suggestions, please understand that they are provided by somebody who is, and has been, truly committed towards what is best for the people and the communities that we serve.

Sincerely,

Jim Johnson
Executive Director
Sanilac County Community Mental Health Authority

CC: Sanilac County CMH Authority Board
Region 10 PIHP Board
Michael McCartan, Region 10 PIHP Executive Director
Dan Russell, Genesee Health Systems Executive Director
Deb Johnson, St Clair County Community Mental Health Executive Director
Robert Sprague, Lapeer County Community Mental Health Executive Director

St. Clair County Community Mental Health Authority

Promoting Opportunities for Discovery and Recovery

Debra B. Johnson
Executive Director

Malachy Browne, MD
Medical Director

Stephen Armstrong
Board Chairman

January 19, 2016

Mr. Eric Kurtz
Michigan Department of Health and Human Services
Behavioral Health and Developmental Disabilities Administration
Bureau of Community Health
320 S. Walnut Street, Lewis Cass Building, 5th Floor
Lansing, MI 48913

RE: Section 1115 – Pathway to Integration

Dear Mr. Kurtz:

Please receive this correspondence in response to the Michigan Department of Health and Human Services (MDHHS) request for approval from the Centers for Medicare and Medicaid Services (CMS) for a Section 1115 Demonstration Waiver. By and large, I want to convey my essential support for this waiver application. Also from this broad standpoint, I would also like to suggest that additional language be considered to reference current initiatives related to a) substance abuse and prevention (ROSC, Innovation Accelerator Program) and b) Medicaid Spend-down (changes to the income disallow). More specifically, I would like to highlight nine (9) concerns, presented in a Feedback and Suggestion format. They are discussed, as follows:

1) Section IV., 5), (d) – page 22: *Although freedom of choice will continue to be waived, PIHPs will be required (as non-provider entities) to arrange Medicaid service contracts to ensure the independent evaluation of eligibility, assessment and the development of the Individual Plan of Service to ensure compliance with Home and Community Based Setting (HBCS) final rules. Although model configuration may be optional (based on state approval), the independent evaluation of eligibility and assessment does not include the provision of emergency services that may result in a preliminary plan of service or functions related to hospital preadmission screening or discharge planning. For PIHPs who contract with CMHSPs, the PIHP will be required to monitor the CMHSP's self-referral and utilization patterns related to consumer choice and best value criteria. MDHHS will play a vital role in the policy development and promulgation of these rules as part of its HBCS statewide transition plan.*

   Feedback

   There appears to be little detail explaining how Michigan will deal with issues related to Federal rules pertaining to Conflict Free Case Management (CFCM). It is unclear what is meant by "independent" evaluation of eligibility, assessment, and the development of the Individual Plan of Service (independent tasks per se or performed by independent entities?). If it is the latter, then it is unclear what other entity is included. Moreover, it is unclear how this section may apply alongside existing CMHSP requirements (e.g. provider assessment and planning) as noted in the Mental

Health Code (section 206 and section 712), and as noted in the Code of Federal Regulations (42 CFR 438.210) (e.g. treatment planning).

Suggestion

Conflict Free Case Management standards are intended to mitigate the risk inherent when a party that has a vested interest in the over (or under) utilization of services also has the authority to control the level of services provided. Michigan's system clearly delineates PIHP and CMHSP/provider functions that promote Conflict Free Case Management. Accordingly, waiver language will need to clearly define key program functions (case management, service planning, and assessment) as such operate within our provider network. Waiver language will also need to delineate other key functions as per responsible entity. Here, care management, eligibility determination and treatment authorization are managed care (PIHP) functions; whereas assessment, case management (relative to service population) and treatment planning are most effectively and appropriately provided as required at the CMHSP/provider level. As an aside, such definition clarity will better reveal the system of balanced incentives already effectively operating within our current model. As separate legal regional entities, Michigan's PIHPs operate within a capitated environment and exercise limited control over the use of savings and, as such, simply do not have a vested interest in either over-serving or the under-serving of the covered population. Moreover, PIHPs operate without a shareholder arrangement, thus precluding the need to allocate unspent revenue into investor dividends.

2) In subsection (e) of that same section (page 22), MDHHS denotes the prospect of contracting *outside of the PIHP and CMHSP system if the managed care entity and/or providers cannot meet the service delivery, quality, financial and reporting requirements as determined by the state.*

Feedback

It is unclear whether this is an all or nothing proposition. If so, then newly formed legal regional entities and CMHSPs would be placed at risk, regardless of their performance, based upon the performance of other regional entities and CMHSPs over which they have no control. This prospect raises considerable concern. It is emphasized here that the current system has been put into place primarily to benefit the people and communities we serve, as well as to comply with the state and Federal standards.

Suggestion

It is essential that, in serving the best interests of our beneficiaries, our communities, and our panel of committed providers, we minimize disruption to those persons we serve and the networks that support them. In this regard, two recommendations are offered:

- MDHHS should clearly indicate its ongoing commitment to QI/QM constructs and practices that operate within progressive behavioral health systems. Thus, in the event a PIHP/CMHSP is not meeting expectations in the domains listed above, a path of correction and support for systems improvement should be followed to ensure an effective service system as well as avoid jeopardizing great personal, financial, social, and governmental costs.

- MDHHS should clearly indicate in this waiver that each Regional PIHP/local CMHSP will succeed or fail based upon their own efforts and merits and not based upon the performance of entities that are completely outside of their control.

3) In Appendix A, under *Essential Elements for Person-Centered Planning and Service Plan Development* (page 34), the request reads that *The following characteristics are essential to the successful use of the PCP process with an individual and his/her allies.*

1. ***Person-Directed.*** *The individual directs the planning process (with necessary supports and accommodations) and decides when and where planning meetings are held, what is discussed, and who is invited.*

Feedback

The prospect that the person-served should unilaterally decide when and where meetings are held is neither reasonable nor feasible. In practice, CMHSP staff must balance the needs and requests of many people across their respective case-loads. Moreover, meetings could possibly be held in places not conducive to team facilitation or privacy.

Suggestion

Alternative language should be inserted indicating that the person *suggests and approves* when and where planning meetings are held, as opposed to *decides*. Such language will doubtless incorporate the person's intent to drive the process as well as ensure that such decisions do not merely adhere to program convenience.

4) In the same section, #7 states *Wellness and Well-Being. Issues of wellness, well-being, health and primary care coordination or integration, supports needed for an individual to continue to live independently as he or she desires, and other concerns specific to the individual's personal health goals or support needed for the individual to live the way they want to live are discussed and plans to address them are developed. If so desired by the Individual, these issues can be addressed outside of the PCP meeting.*

Feedback / Suggestion

The language seems to state that the topics of wellness, coordination, integration, etc. are required elements of the process and must be addressed in the process (in our outside of the actual PCP meeting) regardless of whether the person wishes to address them. This seems to be inconsistent with other language in section #6 indicating that the person completely controls what will be discussed. It would appear that language is needed to incorporate consumer choice as well as medically-necessary approach to service assessment and planning.

5) In the Individual Plan of Service section (page 37), #4, it states *The amount, scope, and duration of medically necessary services and supports authorized by and obtained through the community mental health system.*

Feedback

Correction: the amount, scope, and duration of medically necessary services and supports are authorized by **the PIHP** and obtained through the community mental health system (and this is consistent with our current model that is compliant with Conflict Free Case Management guidelines).

6) In the QAPIP Standards (page 41), II reads *The QAPIP must be accountable to a Governing Body that is a Community Mental Health Services Program Board of Directors.*

Feedback / Suggestion

Possibly this is referring to QAPIP systems that also operate at the CMHSP level, but this should clearly read that the QAPIP must be accountable to a Governing Body at the level of a Regional Entity/PIHP Board of Directors.

7) QAPIP section XVI (page 47), states *The PIHPs, shall continually evaluate its oversight of "vulnerable" people in order to determine opportunities for improving oversight of their care and their outcomes.*

Feedback / Suggestion

The term, "vulnerable" may meaningfully apply to the entire CMHSP service population. If the term is meant to apply to certain populations, circumstances, etc. then it should be clearly defined.

8) The MDHHS Self-Determination Overview (pages 48 – 49) states *The public mental health system must offer arrangements that support self-determination, assuring methods for the person to exert direct control over how, by whom, and to what ends they are served and supported.*

Feedback / Suggestion

While the principle of Self-Determination helps drive the service system, other clinical considerations such as fidelity to Evidence-Based Practices and adherence to CMS Medical Necessity criteria for services and supports also combine to promote service efficiency and effectiveness and, accordingly, should be made explicit in this section.

9) Also in this section pertaining to Qualified Providers, it states that *Qualified providers chosen by the beneficiary, but who are not currently in the network or on the provider panel, should be placed on the provider panel.*

Feedback / Suggestion

This language seems too inclusive. Entities also have an essential responsibility to control the makeup of its provider panel, as per assessed community need, costs, and quality indicators. The term "qualified" should be defined so as to include the entity's responsibility to carry out its

stewardship responsibilities in terms of panel providers that receive Medicaid funding, as well as to offer consumer choice.

Thank you for taking the time to review this correspondence. I appreciate all the collaborative, good-faith efforts that have contributed to this important waiver request, and I appreciate having this timely opportunity to provide my feedback and suggestions. I enthusiastically support these collective efforts to improve the system of care for the people we serve and our communities.

Sincerely,

Debra B. Johnson
Executive Director

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cc: Ms. Lynda Zeller, MDHHS Deputy Director, BHDDH
St. Clair County CMH Authority Board
Region 10 PIHP Board
Michael McCartan, Chief Executive Officer, Region 10 PIHP
Dan Russell, Chief Executive Officer, Genesee Health Systems
Jim Johnson, Executive Director, Sanilac County Community Mental Health
Robert Sprague, Chief Executive Officer, Lapeer County Community Mental Health

Michigan Association of Community Mental Health Boards

Comments on the Michigan's 1115 Waiver Application (As issued by MDHHS on December 18, 2015)

January 2016

Below are the comments of the Michigan Association of Community Mental Health Boards (MACMHB) relative to Michigan's 1115 Waiver application, issued on December 18, 2015. These comments are composed of two segments: one segment addressing over-arching themes; the second segment commenting on specific sections of the application.

Some of these comments present support for the application's contents; some express concern; most contain recommendations for changes to the application.

In addition to these comments, individual members of the Association - those organizations that make up the state's Community Mental Health (CMHSP) system, the Prepaid Inpatient Health Plan (PIHP) system, and the statewide provider system – will be submitting comments directly to the Michigan Department of Health and Human Services.

A. Overarching themes

Because the following recommendations apply to a number of sections of the waiver application, specific sections of the application are not referenced.

1. Support for the application's inclusion of reference of three of the major large scale healthcare reform and redesign efforts in which the state is involved in the waiver application. These efforts include:

- State Innovations Model (SIM) including the Accountable Systems of Care (ASC) and the Community Health Innovations Regions (CHIR)
- Certified Community Behavioral Health Centers (CCBHC)
- Home and Community Based Services (HSBC) rule changes

2. Recommend that two initiatives related to substance use disorder prevention and treatment should also be referenced in the waiver application; they are:

- Recovery Oriented Systems of Care
- Innovation Accelerator Program

3. Support for the application's underscoring of the importance of person centered planning (especially evident in Appendix A, but echoed throughout the application)

4. Recommend, in addressing the hypotheses around which the demonstration is designed, the impact of physical and behavioral and intellectual/developmental disabilities services integration:

a. Expand the comprehensiveness and reach of the state's current Medicaid specialty/safety net/behavioral healthcare system and incentivize strong local fiscal and clinical risk management by:

- Examine the option of including the full specialty/behavioral healthcare benefit within the risk and care management responsibilities of the state's CMHSP/PIHP system, by including the 20 session outpatient benefit that is now outside of that system, into this comprehensive benefit (In addition to providing a seamless BHIDD benefit, this change makes uniform the treatment of Medicaid office-based SUD services (which are included in the PIHP/CMH managed specialty Medicaid benefit) and office-based MH services).

- the use of full-risk capitated contracts between MDHHS and the Medicaid specialty/safety net/behavioral healthcare system (as single payer Specialty/ Safety Net Accountable Systems of Care). The consideration of full risk options will support the further evolution of shared savings and incentive arrangements between Medicaid specialty/behavioral health system and the Medicaid physical healthcare communities of care.

b. Foster the development and implementation of shared savings and incentive arrangements and shared quality and outcome metrics systems, across the existing Medicaid specialty/behavioral health and the Medicaid physical healthcare systems (via the PIHPs and Medicaid Health Plans). These arrangements should be evolved in ways which encourage health care integration, accountable care and the triple aim at the most consumer-directed level of the healthcare experience – while ensuring that the expertise and integrity of the Medicaid specialty/safety net/behavioral healthcare system is strengthened.

- c. Physical and behavioral health care integration should be fostered, by this waiver, at the provider level (between CMHSPs, other BH and DD healthcare providers, and primary care and other physical healthcare providers). The waiver should promote a number of patient/practice-centered integration efforts, to facilitate the development of integrated planning, treatment, and disease management strategies, such as:

  - co-location of behavioral health providers in primary care settings
  - co-location of primary care providers in behavioral healthcare settings
  - integrated treatment teams
  - electronic bridges between EMRs
  - shared data analytics systems and efforts
  - ease of movement across healthcare systems
  - high- utilizer focused collaborative efforts
  - integrated/coordinated person centered plans

- imbedded pharmacies
- efforts to address the social determinants of health
- development of safety-net accountable systems of care

5. Recommend that changes to the income disallow and other components of the current Medicaid Spenddown system be made to allow access to Medicaid funded care for those Dual-Eligible Medically Needy enrollees who are prevented from accessing Medicaid coverage or who are provided such coverage only with the expenditure, by the CMHSP system, of significant amounts of the very limited level of State General Fund dollars within the CMHSP system. One consideration might be the authorization to use plan savings to provide Medicaid covered services to the dual-eligible medically needy population during the deductible period within the state-wide cost neutrality requirements of the 1115 waiver.

6. Recommend that the application address the need for increased access to community inpatient psychiatric beds and inpatient substance use disorder detoxification beds.

B. Section specific comments

Section IV.1: Recommend: The reference to SBIRT should reference the need to provide SBIRT services by both primary care and behavioral health/intellectual and developmental disability service providers.

Section IV. 5: This section describes a separation of functions that does not adequately integrate the requirements of the emerging Home and Community Based Services (HCBS) rule changes, the federal rules related to Conflict Free Case Management (CFCM), and the Michigan Mental Health Code. The latter is most clearly defined in the Code's requirement, of the CMHSP system, to provide assessment and planning (section 206 and section 712) and the requirements of the primary care provider (often the CMHSP) to complete the treatment plan as specified in the Code of Federal Regulations (42 CFR 438.210). The language in this section of the application inaccurately describes a change to a system which does not violate the HSBS nor CFCM requirements.

1. Recommend the recognition that the risk which is intended to be mitigated by the Conflict Free Case Management standards is the risk inherent when a party that can benefit financially (personally or corporately) from the over, or under, utilization of services also has the authority to control the level of services provided.

In line with such clarity on the risk to be mitigated, the waiver application's efforts (and those of other efforts being carried out by MDHHS) to address these federal standards would be significantly advanced through the development, by MDHHS, of a set of clear definitions of a few key terms (case management, planning, and assessment).

MDHHS should use, in this waiver application and other documents related to compliance with the CFCM standards, the definitions for these functions as they exist, in practice, in the

CMHSP and PIHP system. Specifically, this section should distinguish between "eligibility determination" (assessed at the PIHP or delegated to the CMHSP system within a PIHP region), "care management" (via authorizations carried out at the PIHP level or delegated to the CMHSP system within a PIHP region), and "planning" (treatment authorization at the PIHP level or delegated to the CMHSP system within a PIHP region); as opposed to assessment (done comprehensively at the CMHSP and provider level, often involving multiple disciplines), case management (the functions provided by CMHSP and provider staff on an ongoing basis with consumers relative to community-based care), and treatment planning (done by the CMHSP and provider staff within the person-centered planning construct). Care management, eligibility determination and treatment authorization are managed care functions (provided by or delegated by the PIHP); while assessment, case management, and treatment planning are most effectively and appropriately provided at the CMHSP/provider level.

2. Recommend that the application (and other HCBS and CFCM documents) clearly describe how Michigan's model actually mitigates the conflict of interest risks addressed in the Conflict Free Case Management rules, including:

- the use of a capitated financing system which does not incentivize self-referrals (as opposed to fee-for-service systems which do financially incentivize self-referrals)
- the limited use of Medicaid savings – limited to re-investment in service delivery, the maintenance of limited risk reserves, or the return, to MDHHS, of lapsed dollars
- the tools which MDHHS uses to ensure compliance with access, person-centered-planning, grievance and appeals, and other performance measures
- the absence of owners or shareholders who would stand to benefit financially from unspent revenues

Section IV. 5 and Section V. 1

These sections underscore the intent, of MDHHS, to use the current PIHP and CMHSP structure to manage and provide the Specialty Services described in the application, yet retains the ability to contract outside of the PIHP and CMHSP system:

> "This §1115 Waver will maintain the use of a managed care delivery structure using ten (10) recently procured PIHPs 5 who contract for service delivery with forty-six (46) CMHSP's and other non-for profit providers. As outlined in Exhibit 2, seven (7) of the PIHPs are formed by multiple CMHSP's (aka. Regional Entities) and three (3) are stand-alone PIHPs/CMHSPs"
>
> "In April 2013, Michigan required its 18 PIHPs to consolidate to 10 through an Application for Participation of Specialty Prepaid Inpatient Health Plans. As outlined above, Michigan intends to continue the use of this managed care delivery system within this §1115 application but holds the ability to contract outside of the PIHP and CMHSP system if the managed care entity and/or providers cannot meet the service delivery, quality, financial and reporting requirements as determined by the state."

"Michigan has contracted with PIHPs for the delivery of Specialty Services since 1998. This §1115 Waver will maintain the use of a managed care delivery structure using ten (10) recently procured PIHPs who contract for service delivery with forty-six (46) CMHSP's and other non-for profit providers. As part of the demonstration, the state does hold the ability to change or modify the managed care payment and service delivery structure as described in section V.1 above."

1. Recommend that if a PIHP or CMHSP fails to meet performance expectations that opportunities to correct the performance issues and both quality improvement and due process approaches must be applied in the efforts, by MDHHS and the involved PIHP or CMHSP, be used to achieve the desired level of performance. Only when these efforts have failed to bring about the desired performance improvements, can MDHHS go outside of the PIHP or CMHSP system to manage or provide the Specialty Services described in this waiver.

This recommendation is grounded in a number of factors: the PIHP and CMHSP system is an integral component in the local and regional health care and human services delivery system; has longstanding roots and partnerships in the communities that they serve; the need to ensure continuity of care for the vulnerable consumers served by this system; and the considerable investment which the State of Michigan and local governments have made in this system. In addition, any consideration of an alternative PIHP or regional arrangement must be anchored in the state's responsibility to support public mental health services through the CMHSP county-based system of care.

Section IV. 9 and 10; and Section VI

1. Recommend that MDHHS structure the capitation payments around specific groups of enrollees with complex BH and DD needs and very different service and supports utilization patterns, rather than the far too generic TANF and DAB groups. These populations include:

- Adults with serious mental illness
- Children and adolescents with serious emotional disturbance
- Adults with intellectual/developmental disabilities [1]
- Children and adolescents with intellectual/developmental disabilities
- Adults with substance use disorders

[1] The breakdown between I/DD adults and children/adolescents addresses two themes: the existence of I/DD children's waiver utilization data for use in the actuary's ratesetting work, which may influence the I/DD rates, and the recognition that the services provided to children and adolescents with I/DD, by the CMHSP/PIHP system, are significantly different (less intense, less comprehensive) than those provided to adults with I/DD.

- Children, and adolescents with substance use disorders

2. Recommend that as the b, b(3), and c waivers are integrated into a single 1115 waiver, the waiver application underscore the commitment by MDHHS to continue its maintenance of effort (clinical and fiscal obligation) to those persons currently enrolled in Habilitative Supports Waiver slots. This maintenance of effort would be carried out through the continued provision of funding to those CMHSPs/PIHPs with those enrolled consumers, while these current enrollees are being served (remain enrolled).

Equally important is the redistribution, over time, of available 1915(c) slots (Habilitative Supports Waiver slots, Children's DD Waiver slots, and Children with Serious Emotional Disturbance Waiver slots – in a way that moves towards the equitable distribution of those slots, based on need, while not eroding the funding base upon which the CMHSPs and PIHPs with those slots have built their system of care.

2a. Recommend that the application outline the method by which MDHHS will fund the system to serve those with needs equivalent to those on the Hab Waiver, but, due to the limit on the number of slots, have not been assigned a Hab Waiver slot. This could be done via the use of population specific (IDD) utilization and rates, which are recommended in the prior recommendation, above.

Section IV. 10.

1. Recommend that the incentives and withholds system should be outside of the actuarially sound rebasing process.

2. Recommend that, in addition to performance withholds and incentive payments, that the MHPs and PIHPs/CMHSPs be required to develop a system for the sharing of savings in physical healthcare costs (reduced Emergency Department visits, reduced physical health inpatient admissions and readmissions) brought about through healthcare integration efforts and efforts targeting high/super-utilizers of healthcare services.

Appendix A, Self Determination Overview

This section states, "The public mental health system must offer arrangements that support self-determination, assuring methods for the person to exert direct control over how, by whom, and to what ends they are served and supported."

1. Recommend that this section describe the need for the system to assure that the services and supports funded through arrangements that support self-determination meet medical necessity criteria (are related to an established diagnostic condition based upon the impact that relevant symptoms of that condition have on the person's abilities across specific life domains)

This section, regarding Qualified Providers, states that, "Qualified providers chosen by the beneficiary, but who are not currently in the network or on the provider panel, should be placed on the provider panel."

1a. Recommend that the application underscore, in this section, that the federal BBA gives the caremanagement organization the responsibility, and therefore the ability, to control the make-up and size of the provider panel relative to need, cost, and quality consistent with the organization's responsibilities. This section's use of the term, "qualified", must be defined to be broad enough to include credential-based requirements and those related to organizational stability, fiscal stewardship, and compliance with the contractual and performance requirements of the PIHP or CMHSP.

Appendix C, section II., D – Risk

1. Recommend that a discussion of risk be provided in this section.

Kurtz, Eric (DHHS)

From: Robert Sheehan <rsheehan@macmhb.org>
Sent: Thursday, January 28, 2016 11:39 AM
To: MDHHS-Pathway1115
Subject: SUD expansion via 1115: FW: SMD#15-003
Attachments: New Service Delivery Opportunities for Individuals with a Substance Use ....pdf

MDHHS staff,

A July 2015 CMS State Medicaid Director letter, see attached, provides some very concrete and innovative approaches, using a 1115 waiver, to expand substance use disorder treatment and prevention.

Recommend: MACMHB recommends that Michigan integrate the concepts contained in the SMD #15-003 (and similar concepts and approaches) into its 1115 waiver application, given the sound clinical inititiatives outlined in the letter and the encouragement of CMS for such proposals, as demonstrated by the distribution, by CMS, of this letter.

Robert Sheehan
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DEPARTMENT OF HEALTH & HUMAN SERVICES
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SMD # 15-003

July 27, 2015

Re: New Service Delivery Opportunities for Individuals with a Substance Use Disorder

Dear State Medicaid Director:

The purpose of this letter is to inform states of opportunities to design service delivery systems for individuals with substance use disorder (SUD), including a new opportunity for demonstration projects approved under section 1115 of the Social Security Act (Act) to ensure that a continuum of care is available to individuals with SUD. There are numerous federal authorities offering states the flexibility to implement system reforms that improve care, enhance treatment and offer recovery supports for SUD. Many states have made significant progress in achieving better outcomes for individuals with SUD through traditional Medicaid authorities. In addition, the Centers for Medicare & Medicaid Services (CMS) recently introduced the Medicaid Innovation Accelerator Program (IAP) for SUD to support participating states in improving their SUD delivery system. However, a few states may also want to consider proposing a section 1115 demonstration project in this context to undertake or complement broader SUD delivery system transformation efforts.

Section 1115 demonstration projects allow states to test innovative policy and delivery approaches that promote the objectives of the Medicaid program. States may receive federal financial participation (FFP) for costs not otherwise matchable, such as services delivered to targeted populations, in limited geographic areas, or in settings that are not otherwise covered under the Medicaid program. CMS recognizes the statutory payment exclusions for services provided to individuals who reside in specific settings may challenge states' abilities to offer a full continuum of care and effectively treat individuals with SUDs.[1] CMS supports state efforts to reform systems of care for individuals with SUD, such as by enhancing the availability of short-term acute care and recovery supports for individuals with SUD, improving care delivery, integrating behavioral and physical care, increasing provider capacity and raising quality standards. As stated, CMS is offering a new opportunity for Medicaid demonstration projects authorized under section 1115 to test Medicaid coverage of a full SUD treatment service array in the context of overall SUD service delivery system transformation, provided participating states meet specific requirements outlined below. This letter details the new demonstration opportunity, outlines our expectations of a transformed SUD service delivery system and explains how to submit an application for such a demonstration project.

[1] Cf. paragraph (B) following section 1905(a)(29) of the Act.

Background

Medicaid is playing an increasingly important role as a payer for services provided to individuals with SUD in the United States. An estimated 12 percent of adult Medicaid beneficiaries ages 18-64 have an SUD.[2] In addition, an estimated 15 percent of uninsured individuals who could be newly eligible for Medicaid coverage in the New Adult Group have an SUD.[3] CMS is committed to helping states effectively serve these individuals and introduce benefit, practice and payment reforms through the technical assistance and coverage initiatives described below.

States have compelling reasons to provide Medicaid coverage for the identification and treatment of SUD, many of which are given urgency by the national opioid epidemic. Untreated substance use disorders are associated with increased risks for a variety of mental and physical conditions that are costly. In 2009, health insurance payers spent $24 billion to treat SUD, of which Medicaid accounted for 21 percent of expenditures.[4] Two of the top ten reasons for Medicaid 30-day hospital readmissions are SUD-related.[5] Individuals with SUD and co-morbid medical conditions account for high Medicaid costs, such that $3.3 billion was expended in one year on behalf of 575,000 beneficiaries with SUD as a secondary diagnosis.[6] Beyond health care risk, the economic costs associated with SUD are significant. States and the federal government spend billions every year on the collateral impact associated with SUD, including criminal justice, public assistance and lost productivity costs.[7] Alarmingly, the rate of fatal drug overdose in the U.S. has quadrupled between 1999 and 2010.[8] Drug overdose has become the leading cause of injury death, causing more deaths than traffic crashes.[9] Other problems also relate to opioid prescribing including opioid exposed pregnancies, drugged driving, and increases in Hepatitis C and in some circumstances HIV from prescription opioid injection.

As states expand Medicaid coverage to millions of new beneficiaries that may have been previously uninsured, states are also expanding access to behavioral health services including

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[2] Substance Abuse and Mental Health Services Administration. Behavioral Health Treatment Needs Assessment Toolkit for States [online]. 2013. Retrieved from: http://store.samhsa.gov/shin/content/SMA13-4757/SMA13-4757.pdf, p.10.

[3] Busch, S, et al (2013). Characteristics of Adults with Substance Use Disorders Expected to be Eligible for Medicaid under the ACA. *Psychiatry Services*, 64(6).

[4] Substance Abuse and Mental Health Services Administration. National Expenditures for Mental Health Services and Substance Abuse Treatment, 1986–2009. HHS Publication No. SMA-13-4740. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2013.

[5] Hines, A, et al. *Conditions With the Largest Number of Adult Hospital Readmissions by Payer, 2011.* Healthcare Cost and Utilization Project. Statistical Brief #172. Agency for Healthcare and Quality, 2014.

[6] Bouchery, E, et al (2012). Medicaid Substance Abuse Treatment Spending: Findings Report. Retrieved from: http://aspe.hhs.gov/daltcp/reports/2012/msaspend.shtml.

[7] Heroin addiction costs the US $20 billion annually in crime, preventable medical costs and lost productivity. See University of Maryland, Baltimore County. *An Evaluation of Whether Medical Savings are Associated with Expanding Opioid Maintenance Therapy for Heroin Addiction in Baltimore City.* Center for Health Program Development and Management, 2007.

[8] *Results from the 2010 National Survey on Drug Use and Health: Detailed Tables.* Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services, September 2011, http://www.samhsa.gov/data/nsduh/2k10NSDUH/tabs/LOTSect7pe.htm#TopOfPage.

[9] Centers for Disease Control and Prevention. Web-based Injury Statistics Query and Reporting System (WISQARS) [online]. 2014. Retrieved from: http://www.cdc.gov/injury/wisqars/fatal.html.

covering these services in Alternative Benefit Plans as required by the Affordable Care Act. CMS has received a number of requests from states and stakeholders interested in enhancing care for individuals with SUD. Many requests center on short-term acute treatment services, including detoxification, intensive outpatient programs, and residential treatment services. However, there are other important service modalities and approaches vital to effectively treating SUD that we encourage states to provide, including screening and intervention services in a broad range of settings, integration with primary care, medication assisted treatment and recovery supports services such as peer recovery supports and recovery coaches. Providing these services will help achieve better health outcomes among individuals with SUD, helping them to lead healthier and longer lives.

Many states have already achieved notable success in improved care and lower costs for SUD services through benefit, practice and payment reform. For instance:

- Massachusetts found that monthly Medicaid expenditures were significantly less for beneficiaries receiving SUD treatment compared to diagnosed but untreated beneficiaries. Treatment included ambulatory detoxification and medication-assisted treatment services.[10]
- Washington found that Screening, Brief Intervention and Referral to Treatment (SBIRT) services significantly reduced healthcare costs among Medicaid beneficiaries, resulting in savings of $250 per member per month associated with inpatient hospitalization from emergency department admissions.[11]
- In addition, Washington tackled SUD and emergency department (ED) usage by adopting seven best practices. As a result, ED visits decreased by 9.9 percent; the number of people with frequent ED use dropped by 10.7 percent; and the number of visits resulting in narcotic prescription dropped by 24 percent. The state attributed savings of about $34 million.[12]
- For individuals in managed care with alcohol dependence, total healthcare costs were 30 percent less for individuals receiving medication-assisted treatment than for individuals not receiving medication-assisted treatment.[13]
- Medical costs for Medicaid patients in California decreased by one-third over three years following engagement in medication-assisted treatment. This includes reduced

[10] Clark, R.E., et al (2011). The Evidence Doesn't Justify Steps by State Medicaid Programs to Restrict Opioid Addiction Treatment with Buprenorphine. *Health Affairs*, 30(9), 1425-1433.
[11] Estee, S et al. *Medicaid Cost Outcomes.* Department of Social and Health Services, Research and Data Analysis Division. Olympia, Washington, 2006.
[12] Washington State Health Care Authority, Report to the Legislature: Emergency Department Utilization: Update on Assumed Savings from Best Practices Implementation, March 20, 2014. Retrieved from: http://www.hca.wa.gov/documents_legislative/EmergencyDeptUtilization.pdf.
[13] Baser, O., Chalk, M. Rawson, R. et al. (2001) Alcohol treatment dependence: comprehensive healthcare costs, utilization outcomes, and pharmacotherapy persistence. *The American Journal of Managed Care, 178*(8), S222-234.

> expenditures in all types of health care settings, including hospitals, emergency departments and outpatient clinics.[14]

CMS supports states' important efforts to improve care for individuals with SUD. Over the past several years, CMS has provided states with information and technical assistance to enhance coverage for behavioral health conditions. In July 2014, CMS released a joint Informational Bulletin in partnership with the Centers for Disease Control and Prevention, the National Institute of Health and the Substance Abuse and Mental Health Services Administration (SAMHSA) describing best practices, state-based initiatives and useful resources to help ensure proper delivery of medication assisted treatment (MAT) for SUD.[15] In January 2015, CMS released a joint Informational Bulletin in partnership with SAMHSA promoting behavioral health coverage opportunities for youth with SUD.[16]

While progress has been made, states report challenges in achieving better care for the SUD population. States cite a lack of data analytics to accurately identify prevalence and need in the Medicaid population, too few endorsed metrics for quality measurement, a lack of resources to collect and evaluate data, variation in provider qualifications, difficulties in integrating primary and substance use disorder care, and federal payment prohibitions as barriers to providing a comprehensive benefit package and delivery system.

To address these challenges, CMS recently launched the Medicaid Innovation Accelerator Program. The Innovation Accelerator Program supports state efforts to accelerate Medicaid innovations by offering technical assistance and expert resources to states engaged in Medicaid system redesign efforts. Based on our work with states and stakeholders, CMS identified SUD as the first area of focus for the Innovation Accelerator Program. As part of a strategy to improve the care and health outcomes and reduce costs for individuals with a SUD, CMS has begun engaging states to leverage IAP resources to introduce system reforms that better identify individuals with a SUD, expand coverage for effective SUD treatment, and enhance SUD practices to effectively treat beneficiaries.

Participation in the Innovation Accelerator Program is not a requirement for introducing SUD system reforms through the Medicaid authorities discussed in this letter. However, states participating in the Innovation Accelerator Program may request and receive technical assistance to identify and address the transformational activities set forth in this letter. For more information regarding Innovation Accelerator Program opportunities for substance use disorder, please visit http://medicaid.gov/state-resource-center/innovation-accelerator-program/reducing-substance-use-disorders/reducing-substance-use-disorders.html. Interested states should email MedicaidIAP@cms.hhs.gov. We encourage states to leverage the Innovation Accelerator Program's supports in areas where they currently do not meet the expectations for a transformed system as described below.

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[14] Walter, L. et al (2006). *Medicaid Chemical Dependency Patients in a Commercial Health Plan*, Robert Wood Johnson Foundation, Princeton, New Jersey, 2006.

[15] http://www.medicaid.gov/federal-policy-guidance/downloads/cib-07-11-2014.pdf

[16] http://medicaid.gov/federal-policy-guidance/downloads/cib-01-26-2015.pdf

Goals for the Section 1115 Demonstration Initiative

To complement the work to date, CMS is proposing an opportunity to allow states embarking on broad and deep system transformations in the area of SUD to pursue 1115 demonstrations to improve the care and outcomes for individuals with SUD. This new initiative would be available to states that are developing comprehensive strategies to ensure a full continuum of services, focusing greater attention to integration efforts with primary care and mental health treatment, and working to deliver services that are considered promising practices or have fidelity to evidence-based models consistent with industry standards. In addition, we seek to support states that are interested in developing new payment mechanisms and performance quality initiatives. As states take the necessary steps to design and implement major transformations to systems of care for individuals with SUD, this section 1115 demonstration initiative can support these efforts by addressing some of the barriers to providing effective care to individuals. Below, CMS sets forth the goals and expectations pursuant to this new section 1115 demonstration opportunity.

The aim of this initiative is to enable states that are pursuing significant delivery system transformation efforts in the area of SUD to better identify individuals with an SUD in the Medicaid population, increase access to care for these individuals, increase provider capacity, to deliver effective treatments for SUD, and use quality metrics to evaluate the success of these interventions. The specific goals of the initiative are to:

- Promote strategies to identify individuals with substance use issues or disorders.
- Enhance clinical practices and promote clinical guidelines and decision-making tools for serving youth and adults with SUD.
- Build aftercare and recovery support services, such as recovery coaching.
- Coordinate SUD treatment with primary care and long-term care.
- Coordinate with other sources of local, state and federal funds for an efficient use of resources consistent with program objectives.
- Encourage increased use of quality and outcome measures to inform benefit design and payment models.
- Identify strategies to address prescription and illicit opioid addiction, consistent with national efforts to curb this epidemic.

Reforms

CMS expects that states interested in pursuing a section 1115 demonstration in this area will promote both systemic and practice reforms in their efforts to develop a continuum of care that effectively treats the physical, behavioral and mental dimensions of SUD. Examples of systemic changes include:

- Promoting a definition of substance use disorders as a primary, chronic disease requiring long-term treatment to achieve recovery with relapse potential.
- Aligning Medicaid benefit packages, provider requirements, reimbursement, utilization review processes, medical necessity criteria, and quality indicators with Medicare and commercial plans.

- Introducing a comprehensive continuum of care based on industry standard patient placement criteria, including withdrawal management, short-term residential treatment, intensive outpatient treatment, medication assisted treatment and aftercare supports for long-term recovery such as transportation, employment, housing, and community and peer support services.
- Adding coverage of evidence-based and promising practices shown to effectively treat youth and adults for SUD that are not available through traditional Medicaid 1905(a) authority.
- Partnering with drug courts and juvenile justice systems to ensure referrals to SUD treatment are medically appropriate and effectively managed.
- Proposing payment models to support the goals of this project, such as shared savings, and managed care.[17]
- Collecting and reporting data to internal and external evaluators, including CMS, to assess the impact of the proposed changes.

Examples of practice changes include:

- Enhancing strategies for primary care and specialty practitioners to better identify and treat individuals with SUD in primary care through Screening, Brief Intervention and Referral to Treatment (SBIRT).
- Developing effective care coordination models to link individuals identified with SUD to appropriate providers.
- Improving efforts to enhance coordination models between SUD providers, primary care-including FQHC's, corrections systems, schools and long-term services and supports.
- Enhancing provider competencies to deliver SUD services with fidelity to industry standard models, such as the American Society for Addiction Medicine (ASAM) Criteria.
- Ensuring accreditation for residential and other SUD providers.
- Improving care transitions when individuals receive a course of treatment with various levels of care from different providers.
- Developing networks to provide long-term recovery services and supports to individuals with SUD following acute treatment regimens.
- Enhancing provider, plan, county and state capacity to secure, maintain, and utilize 42 CFR Part 2 compliant consent to disclose and/or re-disclose records on substance abuse treatment for the purposes of care coordination, population health management, research and evaluation.
- Increasing provider adoption of Office of the National Coordinator-certified health information technology products, allowing for interoperable health information exchange.

Introducing a comprehensive continuum of care will require states to ensure access to inpatient and short-term residential levels of care to provide SUD treatment and support recovery. CMS

[17] http://www.medicaid.gov/Federal-Policy-Guidance/Downloads/SMD-13-005.pdf

recognizes that in some instances these levels of care are offered in facilities defined as institutions for mental diseases (IMD) at 42 CFR 435.1010. While services provided to individuals residing in IMDs are excluded as medical assistance under a state plan, states can request authority for federal financial participation (FFP) for these expenditures if their proposal for a section 1115 demonstration project meets the programmatic expectations described below.

Expectations for a Transformed System

In addition to the standard requirements for an 1115 demonstration, states submitting proposals through this initiative must meet and will be subject to program requirements specific to SUD that will be incorporated into the Standard Terms and Conditions (STCs) of the waiver. These SUD-specific program requirements will reflect the following expectations, which we believe are hallmarks of a transformed system of care for individuals with SUD. The expectations to be incorporated into a state's state plan, Alternative Benefit Plan (ABP), 1915 waivers, or 1115 demonstration proposal and resulting STCs include:

Comprehensive Evidence-based Benefit Design
States will be asked to develop a substance use disorder benefit that guarantees a full continuum of evidence-based best practices designed to address the immediate and long-term physical, mental and SUD care needs of the individual. This includes better use of evidence based practices in the SUD field, including SBIRT, withdrawal management, MAT, care coordination, and long-term recovery supports and services. This can include short-term institutional services, including short-term inpatient and short-term residential SUD services for individuals in IMDs which supplement and coordinate with, but do not supplant, community-based services and supports.

Appropriate Standards of Care
States will be asked to use established standards of care in their design of the SUD benefit package, incorporating industry-standard benchmarks for defining medical necessity criteria, covered services and provider qualifications. For example, the ASAM Criteria is a nationally accepted set of treatment criteria for SUD care. States should use the ASAM Criteria as they develop a residential or inpatient SUD service continuum, and are encouraged to adopt the ASAM Criteria for other treatment modalities and levels of care as well.

In order to receive approval for a section 1115 demonstration under this opportunity, states must implement a process to assess and demonstrate that residential providers meet ASAM Criteria prior to participating in the Medicaid program under the demonstration and rendering services to beneficiaries. In addition, the assessment for all SUD services, level of care and length of stay recommendations must be performed by an independent third party that has the necessary competencies to use ASAM Patient Placement Criteria. Specifically, an entity other than the rendering provider will use the ASAM Criteria to perform a multidimensional assessment of beneficiaries, place beneficiaries at appropriate levels of care, and make recommendations for length of service.

States seeking to transform their SUD systems are encouraged to develop additional strategies adopted by health systems to ensure quality and consistent practices. One of the paths toward

this goal may be accreditation of their providers. Currently, some SUD providers are accredited by national organizations (e.g. the Joint Commission and the Commission on Accreditation of Rehabilitation Facilities).

Strong Network Development Plan
States will be asked to develop a network development and resource plan to ensure there is a sufficient network of knowledgeable providers in each of the levels of care recognized by ASAM and recovery support services. In addition, the state should have the resources to ensure that providers have the ability to deliver services consistent with the ASAM Criteria and provide evidence based SUD practices. The network should be sufficiently robust so that access can be assured in the event that some providers stop participating in Medicaid, are suspended or terminated.

Care Coordination Design
Coordination of care design is integral to SUD delivery reform. This entails developing processes to ensure seamless transitions and information sharing between levels and settings of care (withdrawal management, short-term inpatient, short-term residential, partial hospitalization, outpatient, post-discharge, recovery services and supports), as well as a collaboration between types of health care (primary, mental health , pharmacological, and long-term supports and services). CMS encourages states to test how to best achieve care transitions across the care continuum, including aftercare and recovery support services CMS encourages states to support electronic health information exchange, including the use of ONC-certified health IT products, to improve care coordination consistent with federal health privacy (HIPAA) and confidentiality (42 CFR Part 2) requirements.

Integration of Physical Health and SUD
State should have a clear approach for coordinating physical health and behavioral health services which could include the use of:

- Section 2703 health homes
- Integrated care models
- Accountable care organizations
- Primary care medical homes

States must specify a timeframe for integrating physical and behavioral health care for the population of individuals with SUD or a subpopulation, including committing to an approach within twelve months after 1115 SUD demonstration approval, producing a concept design within eighteen months after demonstration approval, and implementing within two years after demonstration approval.

Program Integrity Safeguards
As states strengthen their SUD benefit package, expand their Medicaid eligibility criteria and receive enhanced FMAP levels for expansion populations, the Medicaid program faces greater levels of risk of fraud and abuse. To be effective stewards of taxpayers' dollars, CMS and states must ensure there are rigorous program integrity protocols in place to safeguard against fraudulent billing. At a minimum, this should include conducting risk-based screening of all newly enrolling providers, as well as revalidating existing providers (including ordering and

referring practitioners) pursuant to provider screening rules at 42 CFR Part 455 Subpart E and accompanying guidance, ensuring SUD providers have entered into Medicaid provider agreements pursuant to 42 CFR 431.107, and ensuring that there is a process the state has put into place to address billing and other compliance issues.

Benefit Management
The provision of more clinically intensive services (including short-term inpatient and short-term residential treatment) must be managed with regular utilization review processes to ensure that these services are medically necessary. For example, these can include prior authorization, targeted post-payment claims review and billing system edits to deny claims beyond a time span, among others. States are encouraged to use capitated and managed fee-for-service approaches for their benefit management strategy. States that propose to introduce financial or treatment limitations must demonstrate compliance with the Mental Health Parity and Addiction Equity Act (MHPAEA).

Community Integration
In January 2014, CMS issued regulations regarding our Home and Community Based Services programs.[18] Those regulations set forth requirements regarding person-centered planning and the characteristics of home and community based settings. States should include how they will incorporate these requirements in their service planning and service delivery efforts, including adherence to the settings requirements, where applicable.

Strategies to Address Prescription Drug Abuse
The Centers for Disease Control and Prevention has classified prescription drug abuse as an epidemic. In 2011 the Administration published its Prescription Drug Abuse Prevention Plan, which outlined four pillars, education, monitoring, safe storage and disposal, and enforcement.[19] These were geared towards preventing non-medical prescription drug use and the consequences of the opioid epidemic and augmented the interagency efforts outlined in the National Drug Control Strategy concerning supply and demand reduction and consequence prevention. While there has been a marked decrease in the use of some illegal drugs like cocaine, data from the National Survey on Drug Use and Health show that nearly one-third of people aged 12 and over whom used drugs for the first time in 2009 began by using a prescription drug non-medically.[20] From 1999 to 2013, the rate for drug poisoning deaths involving opioid analgesics nearly quadrupled.[21]

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[18] Centers for Medicaid and CHIP Services. *Final Rule – CMS 2249-F – 1915(i) State Plan Home and Community-Based Services, 5-Year Period for Waivers, Provider Payment Reassignment, Setting Requirements for Community First Choice, and CMS 2296-F 1915(c) Home and Community-Based Services Waivers.* [2014]. Retrieved from: http://www.medicaid.gov/Federal-Policy-Guidance/downloads/CIB-01-10-14.pdf.

[19] Office of National Drug Control Policy. *Epidemic: Responding to America's Prescription Drug Abuse Crisis.* [2011]. Retrieved from: https://www.whitehouse.gov/sites/default/files/ondcp/issues-content/prescription-drugs/rx_abuse_plan.pdf.

[20] National Survey on Drug Use and Health. Retrieved From: http://www.samhsa.gov/data/population-data-nsduh

[21] Centers for Disease Control and Prevention. *QuickStats: Rates of Deaths from Drug Poisoning and Drug Poisoning Involving Opioid Analgesics — United States, 1999–2013.* MMWR Weekly. Retrieved from: http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6401a10.htm.

There are a variety of strategies that states and payers have put into place to address prescription drug abuse. These include issuing prescribing guidelines, introducing claims edits for equivalent opioid and concomitant benzodiazepine prescriptions, utilizing Prescription Drug Monitoring Programs (PDMPs), and supporting Electronic Prescribing of Controlled Substances (EPCS). CMS encourages states to promote and improve the use of PDMPs and to encourage adoption of EPCS. We are requesting that states develop and implement proven strategies to address prescription drug abuse at the state, plan, patient, pharmacy and provider level.

Strategies to Address Opioid Use Disorder
The abuse of and addiction to opioids is a serious and challenging public health problem. While the rate for drug-poisoning death involving opioid analgesics has leveled in the most recent years, the rate for deaths involving heroin nearly tripled between 2010 and 2013.[22]

On March 26, 2015, the U.S. Department of Health and Human Services announced a targeted initiative to decrease opioid overdoses, decrease overall overdose mortality, and decrease the prevalence of opioid use disorder. The Secretary's initiative targets three priority areas to combat opioid abuse:

- Opioid prescribing practices to reduce opioid use disorders and overdose
- Expanded use and distribution of naloxone
- Expansion of MAT to reduce opioid use disorders and overdose.

These three interventions align with the goal of this 1115 demonstration opportunity and reflect the expectations of a transformed system of care for individuals with SUD outlined in this letter. As described above, states should develop and issue opioid prescribing guidelines in concert with other interventions to address prescription drug abuse. States should expand the coverage of and access to naloxone in Medicaid, and should work in partnership with relevant social services and law enforcement agencies to design and deploy naloxone distribution strategies. States should also consider developing a robust benefit package and enhance clinical practices for MAT and other services to treat opioid addiction.

Services for Adolescents and Youth with an SUD
States will ensure that benefits are covered, services are available and access is timely for the youth and adolescent population with SUD. Pursuant to the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit, states are required to provide all 1905(a) coverable, appropriate, and medically necessary services needed to correct and ameliorate health conditions for Medicaid beneficiaries under the age of 21. Please visit http://www.medicaid.gov/Federal-Policy-Guidance/Downloads/CIB-01-26-2015.pdf for more information on Medicaid coverage for behavioral health services for youth with SUD.

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[22] Centers for Disease Control and Prevention. *Drug-poisoning Deaths Involving Heroin: United States, 2000-2013.* National Center for Health Statistics Data Brief #190 [2015]. Retrieved from: http://www.cdc.gov/nchs/data/databriefs/db190.pdf.

Reporting of Quality Measures
A critical component of evaluating the efforts that states undertake to transform care for individuals with SUD will rely on a state's ability to track quality measures. States will be required to report certain current quality measures as part of this demonstration project.

Specifically, states will be required to report the relevant quality measures from the Medicaid Adult and Children's Core Sets for individuals with SUD, including the Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (NQF #0004).[23] States submitting proposals under this opportunity will also be required to report the SUB-3 Alcohol and Other Drug Use Disorder Treatment Provided or Offered at Discharge and the SUB-3a Alcohol and Other Drug Use Disorder Treatment at Discharge (NQF #1664) measures. States are encouraged to use the Follow-up after Discharge from the Emergency Department for Mental Health or Alcohol or Other Drug Dependence (NQF #2605) measure in their evaluation design. States are also encouraged to include the Pharmacy Quality Alliance opioid performance measures in their design for evaluating efforts to reduce prescription opioid drug abuse.[24]

CMS is interested in evaluating the effectiveness of the services delivered through this demonstration initiative in terms of health outcomes, health care costs and service utilization. To that end, we ask that states to assess the impact of providing SUD services on:

- Readmission rates to the same level of care or higher;
- Emergency department utilization; and
- Inpatient hospital utilization.

Proposals should also include a framework to evaluate successful care transitions to outpatient care, including hand-offs between levels of care within the SUD care continuum as well as linkages with primary care upon discharge. For example, states may consider adapting and modifying the Timely Transmission of Transition Record (NQF #0648) or Transition Record With Specified Elements Received by Discharged Patients (NQF #0647) measures for appropriate application to SUD services.

States may also propose other quality or process measures they currently use or may be asked to use measures that become available for this population. The data collected and reported by states participating in this demonstrative initiative will contribute to setting an initial baseline and establishing a national benchmark for these vital behavioral health services.

Collaboration With Single State Agency for Substance Abuse
Achieving the goals of this system transformation initiative will take the combined efforts of stakeholders across the health care system. The state Medicaid agency will need to apply for changes to the approved state plan or for demonstration projects to implement this initiative. In doing so, state Medicaid agencies should coordinate with the state's substance use disorder

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[23] These measures can be found at http://www.medicaid.gov/medicaid-chip-program-information/by-topics/quality-of-care/downloads/2015-adult-core-set.pdf and http://www.medicaid.gov/medicaid-chip-program-information/by-topics/quality-of-care/downloads/2015-child-core-set.pdf.
[24] These measures can be found at http://pqaalliance.org/images/uploads/files/Memo_NewMeasures_Opioids_Final.pdf.

authority on the concept design for the system transformation. These authorities can provide valuable data sets, such as block grant encounter information, which may inform the concept design and may be integral to data analytics and evaluation strategies. As a condition for approval of any demonstration authority to implement this initiative, state Medicaid agencies are required to collaborate and coordinate funding with the state substance use disorder authority in their efforts to transform their SUD system. State Medicaid agencies should also work and partner with relevant local, state and federal social services agencies to ensure the overall welfare of beneficiaries is provided for so they are positioned to respond to treatment successfully.

Medicaid Authorities Including Section 1115 Demonstrations

Many traditional (non-demonstration) Medicaid authorities provide states the flexibilities necessary to implement desired coverage and delivery reforms. These include options for coverage under section 1905(a) of the Act and Alternative Benefit Plan authorities under section 1937 of the Act, health home programs with enhanced federal matching for the first 8 quarters under section 1945 of the Act, managed care options under sections 1915(b) and 1932 of the Act, and coverage of home and community-based services under sections 1915(c), (i) and (k) of the Act. States seeking to transform their SUD systems may consider these other authorities in lieu of or in addition to 1115 demonstration projects. Please visit http://www.medicaid.gov/medicaid-chip-program-information/by-topics/benefits/downloads/pathways-2-9-15.pdf for more information on pursuing SUD system transformation efforts through these and other pathways.

Section 1115 demonstrations may be designed to provide more effective treatment of SUD by extending coverage for services in inpatient and/or residential settings that are within the definition of IMDs at 42 CFR 435.1010. To the extent that a demonstration initiative is consistent with the expectations for a transformed SUD treatment system, CMS would specifically allow FFP for costs not otherwise matchable to provide coverage for services furnished to individuals residing in IMDs for short-term acute SUD treatment. Short-term acute SUD treatment may occur in inpatient settings and/or residential settings.

Inpatient services are described by the ASAM Criteria as occurring in Level 4.0 settings, which are medically managed services. Inpatient services are provided, monitored and observed by licensed physician and nursing staff when the acute biomedical, emotional, behavioral and cognitive problems are so severe that they require inpatient treatment or primary medical and nursing care. For short-term inpatient treatment for individuals with SUD in settings that meet the definition of an IMD, stays have been proposed to be limited to fifteen (15) days.

Residential services are provided in in ASAM Level 3.1, 3.3, 3.5 and 3.7 settings, which are clinically managed and medically monitored services typically provided in freestanding, appropriately licensed facilities or residential treatment facilities without acute medical care capacity. For short-term residential SUD treatment in settings that meet the definition of an IMD, stays will be limited to an average length of stay of thirty (30) days.

CMS remains committed to the underlying rationale of ensuring integrated and community-based care provided in right settings, so such inpatient and residential care should supplement

and coordinate with community-based care and be clinically appropriate. CMS encourages states continue to maintain its current funding commitment and levels to a continuum of community services consistent with SAMHSA's maintenance of effort requirements for its Substance Abuse Prevention and Treatment Block Grant, regardless of increased federal contributions. This SUD initiative should not reduce or divert state spending on mental and substance use disorder service as a result of available federal funding for services in IMDs.

In addition to promoting the objectives of the Medicaid program and improving care for low-income individuals, section 1115 demonstrations must be budget neutral. This means that the proposed demonstration cannot cost the federal government more than it would absent the demonstration. CMS will work closely with states in their efforts to determine the feasibility of their budget neutrality model while they are developing their conceptual demonstration project design.

Submission Process for Section 1115 Demonstration Projects
States should follow the usual process for submitting 1115 demonstration projects proposals. CMS requests that the proposal address each of the expectations set forth in this guidance. Generally, states must provide at least the information listed below:

- A demonstration program description, and goals and objectives that will be implemented under the demonstration project.
- The description of the proposed health care delivery system and benefit coverage.
- An estimate of the expected increase or decrease in annual aggregate expenditures by population group impacted by the demonstration. If available, include historic data for these populations.
- An estimate of historic coverage and enrollment data (as appropriate), and estimated projections expected over the term of the demonstration, for each category of beneficiary whose health care coverage is impacted by the demonstration.
- Other demonstration program features that require flexibilities within the Medicaid and CHIP programs.
- The types of waivers and expenditure authorities that the State believes to be necessary to authorize the demonstration.
- The research hypothesis or hypotheses that are related to the demonstration's proposed changes, goals, and objectives, a plan for testing the hypotheses in the context of an evaluation, and, if a quantitative evaluation design is feasible, the identification of appropriate evaluation indicators.

Section 1115 demonstration applications may be submitted electronically to 1115DemoRequests@cms.hhs.gov or by mail to:

Eliot Fishman
Centers for Medicare & Medicaid Services
Center for Medicaid & CHIP Services
Mail Stop: S2-01-16
7500 Security Boulevard
Baltimore, MD 21244-1850

Public Input
The Affordable Care Act required the Secretary to set forth transparency and public notice procedures for experimental, pilot, and demonstration projects approved under section 1115 of the Social Security Act that increase the public availability of information about Medicaid and CHIP demonstration applications and approved demonstration projects and promote public input as states develop and the federal government reviews these demonstrations. CMS issued a final regulation on February 27, 2012, outlining the new regulatory requirements for initial section 1115 demonstration applications and extension requests, public notice procedures, and reporting and evaluation requirements. The rule can be found at http://www.gpo.gov/fdsys/pkg/FR-2012-02-27/pdf/2012-4354.pdf.

The high rates of alcohol and substance use disorder, mental health disorders, suicide and behavior-related chronic diseases in American Indian and Alaska Native (AI/AN) communities are well documented. AI/ANs are significantly more likely to report past-year alcohol and substance use disorders than any other race.[25] As required by the transparency regulations cited above, states with Indian tribes and Indian health providers must consult with the tribes and solicit advice from the Indian health providers to assure access to these services is available and meets the unique and cultural needs of AI/AN individuals. In addition, states must solicit advice from the Indian health providers in the state as required by 1902(a)(73) of the Social Security Act. We encourage states to work collaboratively with the Indian health providers in the state to assure inclusion of providers that have the expertise to address the unique cultural needs of AI/AN.

We hope this information will be helpful. Questions regarding this guidance may be directed to Mr. John O'Brien, Senior Policy Advisor, Disabled and Elderly Health Program Group (John.O'Brien3@cms.hhs.gov), or Mr. Eliot Fishman, Director, State Demonstrations Group (Eliot.Fishman@cms.hhs.gov). We look forward to continuing our work together.

Sincerely

/s/

Vikki Wachino
Director

cc:

National Association of Medicaid Directors

National Academy for State Health Policy

[25] Indian Health Service. *Behavioral Health*. [2015]. Retrieved from: http://www.ihs.gov/newsroom/includes/themes/newihstheme/display_objects/documents/factsheets/BehavioralHealth.pdf.

National Governors Association

American Public Human Services Association

Association of State and Territorial Health Officials

Council of State Governments

Kurtz, Eric (DHHS)

From: Joseph Sedlock <joseph.sedlock@midstatehealthnetwork.org>
Sent: Thursday, January 28, 2016 1:38 PM
To: MDHHS-Pathway1115
Cc: Ed Woods; Amanda Horgan
Subject: Section 1115 – Pathway to Integration – Waiver Application Comments

Mid-State Health Network (MSHN) applauds the work of the Michigan Department of Health and Human Services (MDHHS), Behavioral Health and Developmental Disabilities Administration (BHDDA) in its work relating to the 1115 Pathway to Integration Waiver Application ("waiver application"). In particular, we applaud the commitments of MDHHS to maintain and expand the available array of services, to maintain eligibility criteria for services and supports, to expand enrollment caps for certain services and to maintain (neither reducing or limiting) any covered benefits previously in place in our State.

Many individuals and organizations have provided written questions, recommendations, criticisms or suggestions relating to the Waiver Application. In large measure, MSHN recognizes and endorses the intended outcomes of the 1115 waiver, in particular streamlined administration, clearly demonstrated support for the continuation of Michigan's long-standing commitment to community supports for populations served by Michigan's Community Mental Health Services Programs, increased flexibility in financing and quality management, expanded integrated care activities, and other benefits.

We offer the recommendation that the State consider including the full (mild/moderate to specialty) behavioral healthcare benefit within the risk and care management responsibilities of the state's PIHP/CMHSP system, by including the 20 session outpatient benefit that is now outside of that system, into this comprehensive benefit in this waiver application.

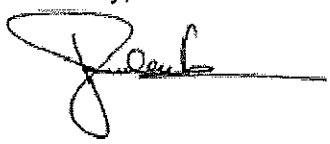
We also recommend that, if appropriate, the Medicaid Deductible/Spenddown issue be addressed, to the maximum extent possible, in this waiver application.

Because a major goal of the waiver is to test quality and cost outcomes between traditional Medicaid Health Plans and the Pre-Paid Inpatient Health Plans, we argue for key performance indicators that are more clear than those described in the waiver application itself even as we understand those may be operational concerns best addressed at a later date.

Finally, we would urge against gravitation toward a traditional health plan/medical model for the management of these highly social support/social network/human services systems. The very key to the traditional effectiveness of these systems are rooted in many public policy initiatives (including self-determination and person-centered planning as key examples) that tend not to fit well in traditional healthcare management scenarios.

Mid-State Health Network appreciates the partnership it experiences with the MDHHS/BHDDA and the opportunity to provide comments on the waiver application.

Sincerely,



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SAGINAW COUNTY
COMMUNITY MENTAL
HEALTH AUTHORITY

To: MDHHS <MDHHS-Pathway1115@Michigan.gov>

From: Sandra M. Lindsey, CEO
Saginaw County CMH Authority

Date: January 26, 2016

Re: Section 1115 – Pathways to Integration Public Comment on Submission

Public Comments from Saginaw County CMH Authority relative to Michigan's 1115 Waiver submission to the Centers for Medicare & Medicaid Services dated December 18, 2015:

We applaud the emphasis on Person Centered Planning throughout the submission. As you know, our system has led much of the country in the partnership our system has with consumers for support and treatment planning as required by the Michigan Mental Health Code. Although the 1115 Waiver submission represents the next evolution of public system design to serve the most disabled and vulnerable citizens in our state, person centered planning still remains fundamental to our systems success and the respectful engagement of consumers in plans for their individual futures.

We were also pleased to see the expansion on Self Determination arrangements in the submission. We have worked hard in Saginaw to promote SD options for both adults with intellectual and developmental disabilities as well as adults with serious mental illness. The submission proposal captures well the spirit and intent of these options continuing to be available which will serve these consumers well into the future.

The theme of healthcare integration, also a hallmark of the submission, is also one we support. Our experience with co-located arrangements with primary care and pediatrics has changed everything. We have a FQHC clinic inside our mental health center and the work we have done together to integrate behavioral health and primary care has been guided by both our experience as SAMHSA Primary and Behavioral Health Care Integration (PBHCI) grant site and our work with the 2703 Health Home Pilot. The 1115 Waiver application checks most all of the boxes to promote this evolution in service delivery and design. The proposed focus on "specialized complex care management" in particular for high utilizers of local hospital emergency departments, heavy inpatient utilization and high users of ambulance service is a focus that our system has really been preparing to impact for decades. Our agency experience with utilizing Care Connect 360 has promoted an ability to identify which of the consumers we serve are actually high utilizers or even super utilizers. This data based tool has permitted us to create actionable data from which to deploy staff and related health care integration services and strategies to address their unmet needs, resulting in reduction of high cost health care that was not meeting their needs anyway. The quality indicators related to this focus on page 6 of the full application are those that the specialty system can surely address.

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There are in addition however, places in the application that remain unclear or key system constructs that are simply missing. In some cases simple definition of terms and concepts may greatly add to the understanding and intent of the submission.

1. The submission has omitted any reference to "Recovery-Oriented Systems of Care" and "Innovation Accelerator Program". These are two initiatives related to substance use disorder prevention and treatment that should be included.

2. Section IV # 2 with regard to delivery system reforms that will result from the Waiver Demonstration

   There is reference to PIHP / CMH system partnering with traditional health plans to ensure access for persons with mild and moderate behavioral health disorders. A better recommendation and foundational system change would be to move the 20 session outpatient benefit that is now outside the specialty system to the PIHP / CMHSP system. The specialty system would not only be best equipped to manage the benefit to these persons but also would help it evolve to embrace evidence-based practices, move forward with integration models with primary care and develop prevention strategies.

   If the health plans were interested in fostering the evolution of behavioral and primary care they would have already done so as integration done well will save on total cost of care.

   Furthermore, the submission might be enhanced by unpacking the 20 visit outpatient benefit to differentiate between traditional office visits for therapy vs. behavioral health consultation to primary care and hospital settings.

3. Section IV # 5

   There are also concepts and ideas that would enhance the submission and the implementation of the new waiver itself that seem to be missing altogether or lack significant detail to truly understand the intent of the provision.

   It would be really helpful if in the submission MDHHS unpacked the federal rules related to Conflict-Free Case Management. On its face, the spirit and intent of Conflict-Free-Case Management would appear to be a valued consumer protection and way to address parties that would be able to inappropriately direct business for financial gain either personally or comparatively. It would seem timely if MDHHS used the 1115 waiver submission as a vehicle to inform both CMS and the field as to how Conflict-Free Case management is defined and operationalized for the PIHP / CMHSP system under capitated funding arrangements. Definition of key terms fundamental to our industry and foundational to understanding like "assessment", "planning", "case management" and "complex case management" in the context of this regulation would lend tremendous clarity.

4. Section IV # 10, addressed withholds from capitation payments and incentive payments outside the normal capitation methodology to PIHPs that serve kids in foster care or with open Child Protective Services cases.

With respect to withholds for performance, why wouldn't all of the various quality and performance measures framed for incentive payments be structured outside of normal capitation methodology and outside any cost settlement process?

In addition the waiver application should also include language that describes how PIHP / CMHSPs will share proportionally in total healthcare case savings, when behavioral health strategies for integrated care and treatment and/or complex case management has been applied to a defined high utilizer subpopulation.

5. Section V. Implementation Demonstration (page 25)
   What is meant by the phrase "reformed SUD delivery system"?

In closing, we at Saginaw CMH appreciate the opportunity to comment on the 1115 Medicaid Waiver submission by the Michigan Department of Health and Human Services.

Sandra M. Lindsey, CEO
Phone: 989-797-3505
Emails: slindsey@sccmha.org

REGION 10 PREPAID INPATIENT HEALTH PLAN

Promoting Opportunities for Recovery, Discovery, Health and Independence

January 22, 2016

Mr. Eric Kurtz
Michigan Department of Health & Human Services
32 South Walnut Street
Lewis Cass Building, 5th Floor
Lansing, MI 48913

Dear Mr. Kurtz:

Thank you for the opportunity to submit comments related to the Section 1115 Waiver submittal to the Centers for Medicare and Medicaid Services (CMS). We are certainly supportive of the desire to combine services for all eligible recipients under a single waiver. We agree that such a submittal allows for broader flexibility in the delivery of services to the targeted populations. We are also supportive of the opportunity to remove caps to enrollment or eligibility for some of our consumers.

Of particular interest is the desire to better integrate the behavioral and physical health care for our recipients. We have long been concerned about the challenges for integration of care particularly for high utilizers. Focus on these individuals should not only reduce cost, but lead to more effective, appropriate, community based care. Additionally, partnership with traditional health plans to assure behavioral health care services, including for persons with SUD and/or who have mild and moderate disorders will enhance the opportunity to provide better health outcomes to the population in general.

We are encouraged to see the plan include a commitment via the existing PIHP system and its partnership with the publicly funded Community Mental Health system. That partnership has a long track record of being able to effectively serve a unique population. Via the publicly funded system, Michigan has become a national leader. The current waiver proposal seeks to strengthen that relationship and expand it to provide a more meaningful partnership with traditional health plans. The citizens of Michigan will be the ultimate beneficiaries.

We look forward to a favorable outcome to the waiver request and stand ready to facilitate a speedy and effective implementation. Again, thank you for the opportunity for comment.

Sincerely,

Lori E. Curtiss

Lori Curtiss
Region 10 Board Chairman

Kurtz, Eric (DHHS)

From: deborah monroe <dmonroe@wowway.com>
Sent: Monday, February 01, 2016 9:24 PM
To: MDHHS-Pathway1115
Subject: Section 1115 - Pathway to intergration

Peer Respites need to be included, the research shows its cost effective and it would decrease the use of psychiatric hospitalization services Michigan should be a model in the country.

Thank you for your time

Deborah Monroe
Consumer of services and Certified Peer Support Specialist

Kurtz, Eric (DHHS)

From: Jane Shank <acmhjane@sbcglobal.net>
Sent: Tuesday, February 02, 2016 7:57 AM
To: MDHHS-Pathway1115
Subject: Public Comment
Attachments: 1115 Waiver Comments.docx

Attached is public comment from the Association for Children's Mental Health

Jane Shank
Executive Director
Association for Children's Mental Health
office 517-372-4016
cell 231-383-1595
acmhjane@sbcglobal.net

Kurtz, Eric (DHHS)

From: deborah monroe <dmonroe@wowway.com>
Sent: Monday, February 01, 2016 9:31 PM
To: MDHHS-Pathway1115
Subject: Section 1115 - Pathway to Intergration

Self Determination is a way for people to take control of their services but I believe that a person should be able to use their current budget to buy goods and services. it would not increase the budget I believe that in the long run it would lower it.

Thank you for your time
Deborah Monroe

Kurtz, Eric (DHHS)

From: jean dukarski <jeanthepig@yahoo.com>
Sent: Monday, February 01, 2016 9:44 PM
To: MDHHS-Pathway1115
Subject: Section 1115 - Pathway to Integration

Please consider my comments regarding Section 1115 - Pathway to Integration

Medicaid recipients in Michigan are in need of access to Peer Run Respite Centers. This service can provide crisis alternatives for people who are experiencing mental health challenges and need or want a supportive place to stay -- but want to avoid going a hospital. Support could be provided by people who have overcome mental health challenges themselves and can offer the supports in a safe, recovery focused, short term residential setting.

As a former recipient of Medicaid, access to Peer Respite and supports could have averted my homelessness and strengthened my personal recovery. Working as a Certified Peer Support Specialist today, I see individuals whose mental health recovery would be greatly enhanced by the availability of a Peer Run Respite Center.

Jean Dukarski
Certified Peer Support Specialist

Kurtz, Eric (DHHS)

From: info <info@recoveryconceptsofmi.com>
Sent: Monday, February 01, 2016 9:48 PM
To: MDHHS-Pathway1115
Subject: Section 1115-Pathway to intergration

Hello I would like to speak about the need for Peer Respites in our state. I attend a lot of webinars and read a lot of articles about Peer Respites in other states and how they really help people that are looking for alternative to being in a hospital and I wonder why Michigan is not able to provide Respites to the people that would benefit from them. I know that a respite would have helped me and many that I know if they were available.

Michelle

Kurtz, Eric (DHHS)

From: JOHN HALES <j.hales@sbcglobal.net>
Sent: Monday, February 01, 2016 10:28 PM
To: MDHHS-Pathway1115
Subject: Section 1115 - Pathway to Integration

I hope to bring awareness the importance of a Peer Run Respites that could redirect individual that otherwise utilizes emergency department for rest from stressful situation or other triggers. I am writing on how Peer Run Respites benefit individual in need of support, that do not meet criteria of inpatient psychiatric hospitalization; at that time, such as, brainstorming new coping skill with the guidance from Certified Peer Support Specialist or Certified Recovery Coach, boost their resilience by managing emotional triggers, providing rest from a stressful situation, education the importance of medication compliance, a safe place to rest, and added enlightenment with each individual as situation arise.

I have work with individuals in the crisis center at my employment for over four years that did not meet criteria of inpatient psychiatric hospitalization from their stressful situation. These individuals are med compliance, drug free or in recovery, no psychoses present; in need of a safe place to rest. Each individuals has the right to want from there self-determination in respect to able to use to buy goods and services without the increasing budget.

Thank you
John Hales, cpss, crc

Kurtz, Eric (DHHS)

From: Sara Lurie <luriesa@ceicmh.org>
Sent: Monday, February 01, 2016 11:26 PM
To: MDHHS-Pathway1115
Subject: "Section 1115 – Pathway to Integration"

Please accept the following comments on Michigan's 1115 Waiver Application:

Section IV. 5 and Section V. 1

These sections express the intent, of MDHHS, to use the current PIHP and CMHSP structure to manage and provide the Specialty Services described in the application, yet retains the ability to contract outside of the PIHP and CMHSP system:

Recommend that if a PIHP or CMHSP fails to meet performance expectations that opportunities to correct the performance issues and both quality improvement and due process approaches must be applied in the efforts, by MDHHS and the involved PIHP or CMHSP, be used to achieve the desired level of performance. **Only when these efforts have failed to bring about the desired performance improvements, can MDHHS go outside of the PIHP or CMHSP system to manage or provide the Specialty Services described in this waiver.**

Other General Recommendations:

1. Recommend that changes to the income disallow and other components of the current Medicaid Spenddown system be made to allow access to Medicaid funded care for those Dual-Eligible Medically Needy enrollees who are prevented from accessing Medicaid coverage or who are provided such coverage only with the expenditure, by the CMHSP system, of significant amounts of the very limited level of State General Fund dollars within the CMHSP system. One consideration might be the authorization to use plan savings to provide Medicaid covered services to the dual-eligible medically needy population during the deductible period within the state-wide cost neutrality requirements of the 1115 waiver.

2. Recommend that the application address the need for increased access to community inpatient psychiatric beds and inpatient substance use disorder detoxification beds.

3. Recommend that General Fund appropriations to CMHSP be protected in future state budgets to assure no further reduction in allocation. Should there be no other remedy to the spenddown system referenced in recommendation 1 above, assure increases to general fund appropriations to CMHSP to assure access for medically needy dual-eligible enrollees who are otherwise prevented from accessing Medicaid coverage.

Sara Lurie
Chief Executive Officer
Community Mental Health Authority of Clinton, Eaton, Ingham Counties

Community MENTAL HEALTH CLINTON • EATON • INGHAM

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website: www.ceicmh.org

DATE: February 2, 2016

TO: MDHHS

FROM: MORC, Inc.

RE: Section 1115 Pathway to Integration

MORC is a non-profit behavioral health company which serves over 4,500 individuals in the Southeast Michigan. Of the 4,500, people, we are providing services to approximately 1,200 individuals enrolled in the Habilitation Supports Waiver, 65 children enrolled in the Children's Waiver Program and 31 in the Autism Waiver program. From this perspective we wish to offer the following comments.

General

1. MORC is supportive of the intent to consolidate waivers for the identified purposes outlined in the application. However, it was hoped that the consolidation of the waivers, would also benefit individuals receiving services. Although the application eludes to future administrative simplification, it failed to provide any simplification for the individuals receiving these services.

2. There is a lack of public meetings/information on the new waiver for individuals and their family/advocates. This is especially true for children with I/DD, where there appears to be a merging of the children from the Hab Waiver and Children's Waiver (CW) into the new Intensive Home and Community Based Support Services for Children.

3. The application outlines desired administrative changes to address quality and cost within the system. There is an expectation that the specifics on achieving these goals will be developed during the course of the demonstration project. The application, however fails to provide an opportunity for public comment prior to implementation of the "specifics" that will certainly have an impact on individuals receiving services.

4. A review of the application found a change in eligibility and the elimination of a service.
    a) The eligibility criteria for the Intensive Home and Community Based Support Services for Children expands the current Michigan Mental Health Code definition of developmental disabilities by extending the age from 6 years to 9 years of age. The expected impact of the change was not discussed in the application.
    b) The current Children's Waiver Service of Fencing is not included in the application. It is not known if this was an oversight or an intentional exclusion.

5. Identified rate adjustment factors noted in the application are not sufficient for the I/DD population. Intensity of supports needed by an individual to maintain community living as required by the HCBS Community Rules should be a consideration.

Section 1115 – Pathway to Integration continued:

6. MORC agrees the public comment made by the Michigan Association of Community Mental Health Boards that the application fails to address the issue of Medicaid Spenddown. Consideration should be given to use planned savings to support the individual during the Medicaid Spenddown period or support the elimination of this requirement as currently implemented in the MI Choice Waiver Program.

7. The application identifies a single eligibility definition for the two categories under the heading of Intensive Home and Community Based Supports Service. Since eligibility is the same, it is assumed that children would only be eligible for the Intensive HCBSS for Children. If our assumption is correct, this would result in the expansion of services for children currently under the Hab Waiver. Under the new Intensive HCBSS for Children, they will be eligible to receive services currently exclusive to the Children Waiver program. The application does not discuss the anticipated impact on cost or how it would be funded.

8. The application speaks to incentivizing the Specialty Services System to improve the overall population health and decrease high utilizers. In order to accomplish this, the plan must take into consideration the long term care needs of the I/DD population. One such consideration should be to add a clinical interdisciplinary team to the current payment system. Historically this collaborative approach by clinicians provided an efficient way to quickly address complex care needs in the community, while preventing costlier institutional services.

Services

Although MORC supports one definition for each service across the waiver, it needs to be acknowledged that this consolidation does result in changes that may affect authorization/implementation of services. Service definitions in the current waivers address nuances associated with a particular population that at times have been eliminated in the consolidation process. Even minor changes in service description and eligibility may affect budget neutrality.

Below are questions/comments resulting from the consolidation of services within the application.

1. Fencing. As previously stated, this Children's Waiver services is not included in the current application.

2. Three services (Family Support and Training; Supports and Service Coordination: Supported/Integrated Employment Services) are noted in the application as EPSDT services for individuals under the age of 21. That application specifically states that the service descriptions and the associated grid are not relevant to this age group. The medical manual for EPSDT services does not address these services. If the application does not support the description for these services, where is this information located?

3. Community Living supports
   a. The definition does not include the CW or b3 language about school, parental responsibility.
   b. The Intensive Home and Community Based Supports and Services for Children does not include the category of care and decision grids contained in the current Children's Waiver.

4. Environmental Mods.
   The definition does not include the exclusions noted in the CW or Hab for whirlpool tubs and swimming pools.

5. Non Family training.
   Although this service expanded to both adult and children under the Intensive HCBS, it continues to exclude training of staff delivering skill building services. Staff training is a necessary component for implementation of the individual's plan of services.

Section 1115 – Pathway to Integration continued:

6. Family Training
   The grid attached to the service definition appears to have some conflicting information that may need clarification. First column of the grid labeled "description of allowable providers" designates a social worker as an eligible provider within the scope of their practice. The second column with the same label (last column) states social worker must be a licensed master's social worker."

7. Targeted Case Management
   Although not addressed in the 1115 waiver application, is it correct to assume that state plan Targeted Case Management will be used for all children (under age of 18) with a diagnosis of IDD or SED? This will be a change for children currently receiving services under the b3 waiver or enrolled in the 1915 c Hab Waiver Program.

8. Supports Coordination
   a) Specialty Services and Supports and the Intensive HCBSS (Habilitation Support Services) lists Supports Coordination as a service. However, the service description specifically states it is not for individuals under age 21 as it is an EPSDT service. Supports Coordination is not a listed EPSDT service in the Medicaid Manual. As the application provides no clarification, it is presumed that individuals between the age of 18-20 will only be eligible to receive the state plan service of Targeted Case Management. If our presumption is correct, this is a change to the current service array for 18-20 year olds currently enrolled in the Hab Waiver. If our presumption is incorrect, the statements about EPSDT services within this proposed waiver needs further clarification.

   b) Consideration should be given to allow Supports Coordination to be delivered by qualified professional under the supervision of a QIDP as allowed under Targeted Case Management. This would provide the necessary oversight while professionals earn their year of experience. The application still allows for the most vulnerable children to receive Targeted Case Management so it is not clear why this is not an option under the HCBSS – Habilitation Support Services. Bringing new professional into the field, is imperative to maintaining an experienced workforce.

9. PDN Services
   a. Consideration should be made to eliminate this from the purview of behavioral health. The need for PDN services is based on a medical need and should not be contingent upon the requirement for a habilitative service.
   b. The definition in the application does not include the necessary medical criteria and category of care descriptions in the current waiver.

February 2, 2016

Submitted via MDHHS-Pathway1115@Michigan.gov

Michigan Department of Health and Human Services
Behavioral Health and Developmental Disabilities Administration
Bureau of Community Health
320 S. Walnut Street, Lewis Cass Building, 5th Floor
Lansing, MI 48913

RE: Comments on Michigan's Section 1115 Waiver – Pathway to Integration Proposal

Dear Director Priest and Director Zeller:

The Michigan Primary Care Association (MPCA) appreciates the opportunity to comment on Michigan's Section 1115 Waiver – Pathway to Integration Proposal.

MPCA is the voice for 39 Health Center organizations which provide quality, affordable, comprehensive health care for more than 615,000 Michigan residents, including nearly 320,000 Medicaid beneficiaries and growing, at over 250 sites throughout Michigan. MPCA's member Health Centers provide a full range of primary health care services, including primary medical, dental, and behavioral health services, either through direct care or through community referrals. Health Centers are community-based organizations committed to serving all patients in their service area regardless of insurance status or ability to pay. In addition, they are uniquely equipped to integrate physical and behavioral health care because they provide and/or facilitate both types of services for their patients, often under one roof.

MPCA supports MDHHS's proposal to consolidate Michigan's existing § 1915(b) and (c) specialty supports and service waivers through a Section 1115 waiver as an initial step towards integration. In particular, we encourage the Department's effort to streamline administrative functioning and increase contractual flexibility, and we strongly support the Department's intent to develop and implement joint performance incentives for Prepaid Inpatient Health Plans (PIHPs) and Medicaid Health Plans (MHPs) to spur meaningful integration between payers. Given the inevitable barrier to integrated care that results from fragmented payment streams, however, MPCA believes the proposed waiver stops short of creating an environment truly conducive to seamless integration of care.

To promote full integration, MPCA urges that all behavioral health services should be carved in to the basic Medicaid health care benefits package. Many Michigan Health Centers currently

utilize integrated patient care teams staffed with care managers and community health workers, as well as strategic colocation with and/or referrals to community mental health service providers (CMHSPs), to provide coordinated care that meets the complex needs of vulnerable populations. Though Health Centers are leaders in integration, their efforts have been hampered by Michigan's bifurcated payment model which funnels payment for physical health services and behavioral health services for individuals with mild to moderate mental illness through MHPs, while payment for specialty services including behavioral health services for individuals with severe mental illness (SMI) is managed by PIHPs. This fragmented payment system yields poorly aligned financial incentives that continually thwart efforts to integrate care.

Consolidating funding streams so that one payer is responsible for each patient is essential to providing high quality and cost-effective whole person care. Until complete carve in of behavioral health services is accomplished, however, MPCA recommends MDHHS take several additional intermediate steps in the Pathway to Integration Proposal to "patch" the existing system. First, MPCA urges MDHHS to clarify whether MHPs or PIHPs are responsible for paying for services, specifically psychiatric consults, provided to individuals with stabilized SMI. Because the definition provided in the Medicaid Provider Manual (and replicated in the Pathway to Integration Proposal) does not clearly assign responsibility for this vulnerable patient population, payers frequently abdicate responsibility, rendering it nearly impossible for an individual with SMI to maintain a stabilized condition.

Second, MPCA recommends MDHHS require MHPs to pay reasonable rates to CMHSPs for outpatient services provided to Medicaid beneficiaries with mild to moderate mental illness. There currently remain several real and perceived barriers for CMHSPs in serving Medicaid beneficiaries through the Medicaid Health Plans. To ensure that patients with mild to moderate mental illness can receive services necessary to improve both their physical and mental health, it is important that CMHSPs are able to serve these patients alongside their colleagues at Michigan Health Centers and other local providers.

Thank you again for the opportunity to comment. Please don't hesitate to contact me at ksibilsky@mpca.net or 517-381-8001 if MPCA can provider further information.

Sincerely,

Kim Sibilsky
Chief Executive Officer
Michigan Primary Care Association

Elizabeth W. Bauer, M.A.
725 W Breckenridge Street
Ferndale, MI 48220-1251
248 677 4283
Ebauer7400@aol.com

February 2, 2016

Michigan Department of Health and Human Services
Behavioral Health and Developmental Disabilities Administration
Bureau of Community Health
320 S Walnut Street, Lewis Cass Building, 5th Floor
Lansing, MI 48913

Ref: Section 1115 – Pathway to Integration Proposal – Bauer Comments

Dear Sir/Madam:

Thank you for this opportunity to share my views on the Michigan Department of Health and Human Services (MDHHS) proposal to the Centers for Medicare and Medicaid Services (CMS) for a Section 1115 Demonstration Waiver to combine under a single waiver authority all services and eligible populations served through its Section 1915 (b) and its multiple Section 1915 (c) waivers for persons with Serious Mental Illness (SMI), Substance Use Disorders (SUD), Intellectual and Developmental Disabilities (IDD), Children with Serious Emotional Disturbances (SED), and Section 1915 (i) Applied Behavior Analysis(ABA).

The summary document graphic indicates the Section 1915(i) ABA waiver is included in the 1915 Demonstration Waiver. However, the text indicates that ABA is being moved to Early Periodic Screening, Diagnosis and Treatment (EPSDT). **Clarification is needed as to whether the Section 1915(i) waiver is or is not included in the demonstration.**

The goals of the proposal to align and expand MDHHS integrated care initiatives for all Specialty Service Populations, maintain the full array of mandatory and optional State Plan services for persons who meet the eligibility criteria for the Specialty Service Populations, eliminate the fee for service payment system for certain Section 1915(c) waivers, maintain the integrity of the Individual Plan of Service, support the principles and practices of Self-Determination, and NOT reduce or limit any benefits outlined in the waiver application while remaining budget neutral, does not compute, at least not for me.

I have great concern that while the current array of services is itemized in the application, there is no guarantee that the current scope of service will be or even can be maintained in this demonstration. Further, there is no discussion of the cost of compliance with the March 2014 Final Rule regarding Home and Community–Based Services and the intent of that Rule to eliminate segregated living, pre-vocational, vocational, and like environments. Compliance with the Final Rule is not optional and significant changes need to be made within the current service delivery system to meet specifications in the Rule. There will be added costs to do so.

I am also concerned that the 1115 Waiver Application relies so heavily for implementation on the existing PIHPs. Great disparity exists from one PIHP to another and between and among Community Mental Health Service Programs within the PIHPs. The Arc Michigan has commented extensively on the disparities that exist from one PIHP to another including the quality (or lack thereof) of the person-centered planning process, the availability of arrangements that support self-determination, and integrate living and day activity arrangements. I agree with The Arc leaders that any assurance that the current array of supports and services will continue to be offered, remains somewhat empty depending upon where in Michigan you live.

Regular, robust site reviews will need to be made to assure that self-determined services and supports as defined in the Individual Plan of Service are of high quality and equitable statewide. Deemed status and accreditation cannot be relied upon. Regular reviews by independent entities (not the PIHPs) are necessary. Accreditation is merely a review by peers paid for by the entity seeking accreditation. Having worked in "accredited" environments in the past, including state facilities, I know how the system can be gamed. Better to fund an independent entity with no conflicts of interest to regularly visit service sites without advance notice. Further, it would be wise to create more channels for participants (persons receiving services) to make their needs known. Fear of retaliation often dampens reporting of conditions that should be corrected.

Beneficiaries in the Section 1915(c) waiver programs who currently receive their health care on a fee for service basis have an array of providers from whom they have received services over the years. Much education will need to be done with these beneficiaries and their advocates/families/guardians to help them understand the implications of the change to a managed care situation. We have learned in the MI Health Link demonstration that beneficiaries do not fully understand what it means to be enrolled in an Integrated Care Organization. They go to their former provider only to be told he/she is not a participant in the ICO. Expecting waiver beneficiaries to persuade their former providers to become providers in the ICO is an unrealistic burden to place on them.

Michigan Protection and Advocacy Service, Inc. (MPAS) in its comments, recommends addition of specific notice requirements to children and their families on the current SED waiver and children's waiver (page 26). This notice must not only tell them of the change, but spell out the implications and how they can make their concerns known and have them addressed. There has to be a transparent, easily accessed system for information and appeals.

As mentioned before, there is a great variety of eligibility requirements and practices statewide. A service widely offered through one PIHP is denied in another. The Arc Michigan has suggested a "Mystery Shopper" program to stop the informal denials and lack of full information provided to beneficiaries and potential beneficiaries. I wholeheartedly support this suggestion.

The application states a desire to reduce the costs associated with "High Utilizers" further defined as those who use emergency department and inpatient hospitalization (Page 5).Testing what quality and clinical measures actually impact decreased utilization and tracking where savings actually accrues (hospitals, health plans, PIHP's) for this population with be one of the demonstration's major evaluation components. My concern is that the demonstration also includes the Section 1915(b) beneficiaries who

also have high costs in that more of their services and supports are of the long term care nature e.g. housing, pre-vocational and vocational training, supported employment, etc. Nothing is said about the costs associated with the Section 1915(b) waiver beneficiaries. The full array of services and supports is outlined in the application as being available. There is no assurance that the current scope of service for each beneficiary will be maintained. Example of a concern: a pre-vocational program which is currently enjoyed five days a week could still be available, but limited to three days a week to maintain budget neutrality. To allay this concern, there has to be a vibrant Individual Person Planning process guided by the principles of Self-Determination. The Individual Plan of Service must be an enforceable document as is the Individual Educational Plan for students eligible for special education services pursuant to the Individuals with Disabilities Education Act.

While I can understand the desire of MDHHS to combine all the waiver entities (Sections 1915(c), (b) and (i)) into a single Section 1115 waiver thereby streamlining the billing processes and more, I think it is particularly challenging to include the population of adults with intellectual and developmental disabilities. In most states their needs are handled by different state agencies and the Section 1115 waiver applications and demonstrations I have seen in other states do not include this population and the long term care services and supports like housing and vocational services. Most of the state applications/demonstrations deal with populations who use health care services e.g. doctors, hospitals, detox, rehab, etc.

We have some experience here in integrating adults who are eligible for both Medicaid and Medicare and who primarily use long term care services and supports into Integrated Care Organizations (MI Health Link demonstration). The ICOs do not have experience in addressing the full needs of these persons. The coordination with PIHPs has been difficult. This is a discussion for another paper, but it is important to understand the complexity of mixing a system of long term life services and supports and one of access to primary health care. It is worth trying, but there must be robust oversight and easily accessed avenues of appeal and remedy.

Thank you for this opportunity to comment.

Sincerely,

Elizabeth W. Bauer

Elizabeth W. Bauer, M.A.

Kurtz, Eric (DHHS)

From: Berna Welling <bwelling@miottawa.org>
Sent: Tuesday, February 02, 2016 12:28 PM
To: MDHHS-Pathway1115
Subject: Section 1115- Pathway to Integration

Having worked with adults with mental health diagnosis' for over 10 years and having seen that hospital admission criteria is becoming stricter, I see a real need for respite services. I believe that providing respite services would assist people who are in (or near crisis) and help them return to wellness faster possibly avoiding prolonged and expensive hospitalization.

Berna Welling, CPSS
Certified Peer Support Specialist
Advanced Level WRAP Facilitator

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MICHIGAN

MPAS "PROTECTING THE RIGHTS OF PERSONS WITH DISABILITIES"

PROTECTION & ADVOCACY SERVICE, INC.

Elmer L. Cerano, *Executive Director*

February 2, 2016

SUBMITTED ELECTRONICALLY
MDHHS-Pathway1115@Michigan.gov
AND VIA REGULAR MAIL

Eric Kurtz
Michigan Department of Health and Human Services
Bureau of Community Health
Behavioral Health/Developmental Disabilities Administration
320 South Walnut Street, Lewis Cass Building, 5th Floor
Lansing, MI 48913

RE: Comments by Michigan Protection & Advocacy Service, Inc. (MPAS) to *Pathway to Integration 1115 Waiver Application*

Dear Mr. Kurtz:

Michigan Protection & Advocacy Service, Inc. (MPAS) is the designated protection and advocacy agency mandated to advocate for people with disabilities in the Great Lakes State. MPAS is pleased to submit the following comments on the proposed "Pathway to Integration" Section 1115 Medicaid Waiver Application.

1. MPAS supports the measurement of "linkages that directly impact social determinants of health" as a program outcome (page 6).

2. MPAS supports the continuation of all current services under the new waiver (page 9). The service array must clarify that assistive technology is included.

3. MPAS supports adding coverage for permanent supportive housing (page 9). Permanent supportive housing must be "independent" housing consistent with HCBS principles, i.e. is not congregated and tends not to isolate individuals.

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MPAS website: www.mpas.org

4. MPAS supports inclusion of services for people experiencing substance use disorders (page 11). The waiver must include language that preserves access to person-centered planning for individuals with co-occurring substance use disorder and developmental disability or serious mental illness since the ASAM criteria do not clearly specify how service planning occurs for these individuals. In addition, the waiver language must clarify that "emotional, behavioral, and cognitive conditions [preventing] beneficiaries benefiting from this level of care" are not interpreted to deny services to people with developmental disabilities or serious mental illness.

5. MPAS supports the maintenance of a single, public specialty support system (page 19) served by nonprofit organizations (pages 20, 26, 30, 31). There is no room in the tight budgetary landscape for the added cost of profit-driven services.

6. MPAS supports the use of independent external facilitation in determining services (page 36).

7. MPAS recommends addition of specific notice and support requirements to children and their families on the current SED waiver and children's waiver (page 26). These service recipients will move from a fee-for-service to a managed care model and may lose their service providers if the providers do not join the managed care organization under the new waiver. MDHHS must ensure that service recipients who lose their providers due to transition from fee-for-service to managed care are provided with adequate advance notice and all necessary supports to locate new providers.

8. MPAS recommends strengthening the consumer survey component of the waiver application (page 44) to be a structured participant evaluation along the lines of the participant evaluation conducted in the HCBS state transition process. The HCBS transition survey revealed a glaring discrepancy between the participant and provider responses. This information is important in evaluating the quality and implementation of waiver supports.

9. MPAS supports inclusion of a broad standard for evaluating practice guidelines, including "promising practices" (page 45).

10. MPAS endorses the comments by The Arc Michigan regarding site review and quality assurance (pages 47-48). Site review is an important component of the waiver. The quality standard that services "reflect the goals and preferences" of the individual is good, as are the standards that mandate compliance with person-centered planning, HCBS community standards, and conflict-free case management. The site reviews must be objective, frequent (annual), and include all participants, including 1915(b) service recipients. They should include longitudinal reviews and should add non-medical quality standards that reflect quality of life, such as achievement of competitive integrated employment.

11. MPAS recommends removing the equivocal qualifying language in the description of self-determination (pages 49-50).

12. MPAS recommends that the waiver proposal address critical barriers to community services, such as the regional and local disparities in person-centered planning and self-determination identified in The Arc Michigan's comments and the nature of countable income in determining Medicaid spend-downs.

The Pathway to Integration Waiver Application is one part of a remarkable confluence of laws and policies, including the new Home- and Community-Based Services (HCBS) regulations, the Workforce Innovation and Opportunity Act (WIOA), and the Achieving a Better Life Experience (ABLE) Act, presenting a rare opportunity to advance the equality and independence of persons with disabilities. MP AS urges all agencies to take full advantage of the opportunity presented.

For more information, please contact me or Mark McWilliams, (800) 288-5923, ecerano@mpas.org, mmcwill@mpas.org.

Sincerely,

Elmer L. Cerano
Executive Director

ELC/mm

cc: MPAS Board of Directors
MPAS PAIMI Advisory Council
Nick Lyon, Director DHHS
Lt. Governor Brian Calley
Ralph Lollar, CMS

NORTHEAST MICHIGAN COMMUNITY MENTAL HEALTH AUTHORITY

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February 2, 2016

Michigan Department of Health and Human Services
Behavioral Health and Developmental Disabilities Administration,
Bureau of Community Health
320 S. Walnut Street,
Lewis Cass Building, 5th Floor
Lansing, Michigan 48913

RE: Section 1115 – Pathway to Integration

Dear Sirs and Madams:

In respect to the published Section 1115 – Pathway to Integration proposal, I respectfully request your consideration of the following:

Section IV.5
That the application clearly describe how Michigan's Conflict Free Case Management model actually mitigates the conflict of interest risks and might be accomplished in a rural setting.

Section IV.5 and Section V.1
Maintain the use of a managed care delivery structure using one or all of the currently established PIHPs (10) and all of the 46 CMHSPs who, along with the current private, not-for-profit agencies, who provide a high quality and effective specialized service delivery system.

Allow MDHHS to contract outside of the PIHP and CMHSP system only if the managed care entity and/or CMHSP cannot meet service delivery, quality, financial, and reporting requirements as contracted and then only after a reasonable opportunity has been granted to correct any failures in relationship to legitimate standards. At that time, and only when these steps have failed to restore quality, should MDHHS be permitted to seek other providers.

Section II. 4
Consider strengthening the commitment to the maintenance of effort related to all citizens currently on the Habilitation Support Waiver for the duration of the need for such level of services.

Appendix B. Page 53 Community Living Supports
The use of CLS to complement Home Help or Extended Home Help provides a clearer definition than is currently in the MA manual. The State might consider this definition for use in future Medicaid manuals.

Page 70 Goods and Services
Consider expanding the definition and include some samples of acceptable examples.

Pages 87-89 Supports and Service Coordination
The role of the Supports Broker is rather confusing in the description of this category. Please consider clarifying the role and consider the real possibility of family members serving in this capacity may create the same type of conflict of interest you are trying to avoid.

Thank you for the opportunity to comment and feel free to contact me with any questions you may have.

Sincerely,

Edwin M. LaFramboise
Director

EML:dmh

Comments on the 1115 Waiver Application from Mental Health Services to Children and Families

1. **SED = Serious Emotional Disturbance** per the Michigan Mental Health Code and SAMHSA. Please correct throughout.

2. Is the 1115 demonstration project proposed for five years? The time frame does not appear the application. Could this be added?

3. Why are case management qualifications spelled out in the application but the qualifications for any and all other service providers are not specified?

4. Although Peer Services are mentioned in the application, youth peer support is not specifically mentioned. Could this be added?

5. **Page 1, Exhibit 1** – Please explain why the chart separates the state plan services as if they are something different than 1915b services? Doesn't the 1915b represent all state plan specialty mental health services? The chart also makes it appear that state plan services are somehow outside of the 1115 Waiver which is not what is described in the executive summary directly above the chart.

6. On a similar note, the application does not appear to reference eligibility or state plan services for children. It seems to only include the eligibility criteria for the Waivers—SED and Children's Waiver—but not the general SED criteria that is an attachment to the contract for all the other children with SED that the PIHPs serve nor the I/DD criteria for all the other children with I/DD that the PIHPs serve outside of these small waivers. Can you please explain where services for all eligible children are explained in the application? Just to clarify, the SED Waiver and the Children's Waiver do not encompass all the children served by the PIHPs.
   Page 15 - looks like SED criteria but does not specify waiver
   Page 16 - it does not say SED Waiver for the services
   Pages 106-107 - lists services but the description specifies that these are only SED Waiver services

7. **Page 9** - "This includes individuals with Autism Spectrum Disorder and individuals eligible for Michigan Special Children's Special Health Insurance Program (aka. MICHILD) and expanded Medicaid Populations." Children's Special Health Care Services is one program and MiChild is a completely different program. Please clarify what program is being referenced in this sentence.

8. When discussing person centered planning, the application should also reference family driven/youth guided practice for children and youth. This is a policy that has been in place for many years and is an attachment to the contract with PIHPs.
   Specifically, page 38 – please add bullet to reflect family driven/youth guided. **Suggested language:** "Family Driven/Youth Guided Practice -The organization supports a family-driven and youth-guided approach to service delivery for children and their families. A family-driven and youth-guided approach recognizes that services and supports impact the entire family; not just the identified youth receiving mental health services. In the case of minors, the child and family is the focus of service planning, and family members are integral to a successful

planning process. The wants and needs of the child and his/her family are considered in the development of the Individual Plan of Service."

9. **Page 10, 14 & 16 in the charts** - Family Training needs to be replaced with FAMILY SUPPORT and TRAINING. Please correct throughout.

10. **Page 84 — "The following limitation(s) applies to the scope of the service:** Massage therapy is not available to people under age 21 who meet the clinical needs based criteria for psychiatric hospital level of care. Music Therapy, Recreational Therapy and Art Therapy are only available to children under 18."

    What is the rationale for restricting Massage Therapy to people over 21?

    How can Music Therapy, Recreational Therapy and Art Therapy be restricted to people under 18 when the SED Waiver goes to age 21 and these are covered SED Waiver services.

11. The 1115 Waiver needs to be clearer about the state plan EPSDT services when delivered to children birth-21 years as outlined in the Medicaid Manual, section 17.3, which include: CLS, Family Support and Training, Peer Delivered or Operated Support Services, Prevention-Direct Service Models: (1) for Children of Adults with MI/Integrated Services and (2) Parent Education, Skill Building Assistance, Support and Service Coordination and Supported/Integrated Employment.

RICK SNYDER
GOVERNOR

STATE OF MICHIGAN
MICHIGAN
DEVELOPMENTAL DISABILITIES COUNCIL
LANSING

KRISTEN E. COLUMBUS
CHAIRPERSON
VENDELLA M. COLLINS
EXECUTIVE DIRECTOR

February 2, 2016

Attention: Eric Kurtz
Michigan Department of Health and Human Services
Bureau of Community Health
Behavioral Health and Developmental Disabilities Administration
320 South Walnut Street, Lewis Cass Building, 5th Floor
Lansing, Michigan 48913

Dear Mr. Kurtz:

The Michigan Developmental Disabilities Council offers the following comments regarding the Pathway to Integration Section 1115 Waiver demonstration project. This project is designed to transition existing 1915(b), 1915(c) waivers including Children's Waiver Program (CWP), Habilitative Support Waiver (HSW), Severe Emotional Disturbance Waiver (SEDW) and 1915(i) Applied Behavioral Analysis (ABA) to 1115 demonstration waiver. With a thoughtfully coordinated and carefully crafted implementation, the proposed project could greatly improve the efficiencies and deliverables of these waivers.

Thank you for allowing us the opportunity to provide the Department with our comments pertaining to this project.

Should any clarity be needed, please feel free to contact me at collinsv1@michigan.gov or 517-335-3158.

Sincerely,

Vendella M. Collins,
Executive Director

The Michigan Developmental Disabilities Council (DDC) appreciates the department's efforts to promote stakeholder input on the 1115 Demonstration Waiver Project. The webinars and public forums provided several avenues for the sharing of information and community input.

As advocates for people with developmental disabilities (DD), we support any provision that continues to deliver or expand high quality supports and services to people with disabilities (PWD) and those that are designed to identify areas of opportunity for improvement. Below you will find our comments regarding this demonstration project.

1. We support that the department stipulates that this demonstration project will not reduce any services currently supplied under the multiple waivers being combined under this project (page 9).

2. It is important that the beneficiaries of the current Medicaid waivers that are being transitioned into the 1115 demonstration project, experience seamless transition with no lapse in coverage or services. We support the department's statement on page 31, "All former §1915(b) and §1915(c) Waiver services and eligible populations will be included as part of the Demonstration. Transition and continuity of care will be seamless."

3. We support the acknowledgement of expanding the use of peer supports and self-determination arrangements. However, history has taught us that self-determination lacks any consistency throughout the state. As the state moves forward on the implementation of the 1115 demonstration waiver, a strong focus needs to be in place ensuring that there are robust supports and services available to all, regardless of which part of the state you live.

4. On Page 9, the term permanent supportive housing lacks definition. There is not clear guidance that people residing in "permanent supportive housing" will receive their services in that location as required by Home and Community Based Services (HCBS) regulations. We feel that there needs to be language drafted that guarantees services will be delivered where the recipient resides. In addition, the term temporary housing needs to be included in this definition as well. The language should ensure that temporary housing is not excluded and those residing in this arrangement will receive their services in their residence as well.

5. Alongside the aforementioned, the duration for temporary housing needs to be defined

6. Several concerns arise with the Substance Use Disorder (SUD) treatment found on Page 11. First, the full eligibility requirements may eliminate people with DD

   from receiving treatment. One of the bullet points found on this page, "This service is limited to those beneficiaries who will benefit from treatment and have been determined to have...emotional, behavioral, and cognitive conditions that will not prevent the beneficiary benefiting from this level of care." Those with DD could be eliminated from receiving SUD treatments with this definition. A second concern rest that SUD treatment options that are not directly listed as an option in an individual's Person-Centered Plan (PCP). Even though on Page 35, point 4, it eludes to the inclusion of mental health services being included, we wish to ensure that SUD treatment is provided as an option in a beneficiaries PCP, and that if requested, it be made available to them regardless of their DD. We support the use and development of an Individual Plan of Service (IPOS) and PCP for all planned services.

7. There is a strong concern that Assistive Technology (AT) and access to it, is not addressed in this demonstration project under services and supports. Access to AT must be addressed under the services and supports section of this waiver application

8. We encourage and support the continuance of the Prepaid Inpatient Health Plan (PIHP) and Community Mental Health (CMH) structures currently in place (Page 26). With that, we also encourage the implementation of corrective action plans (Page 47) for those units who are found to be not providing service delivery, quality, or financial reporting as required by the state. We also strongly encourage that the department work closely with all current Medicaid fee-for-service beneficiaries in helping them transition into the managed care model. Being that this demonstration project promotes "seamless transition" it is imperative that the department ensures that those recipients transitioning from fee-for-service to managed care, are provided with an advanced notice of the potential need to change providers and are provided with all necessary supports to locate a participating provider under the managed care program.

9. Page 22, Paragraph 2, is referencing (c) waivers under HCBS. It is imperative that this language be clarified to explicitly define that this demonstration project covers all waivers, including (b) waivers.

10. On Page 23, Paragraph 3, we support the use and the inclusion of independent support brokers for providing support and services to the beneficiary if chosen by the participant which would "support self-determination by working with them through the person centered planning (PCP) process to develop an IPOS and an individual budget."

11. On Pages 29-30, we have consistently held the position that site reviews need to be completed annually rather than biennially and that the site review team must have a strong conflict of interest policy against any relationships with a PIHP or CMH.

12. An area of discrepancy was discovered between items on Page 9 and Page 31. Page 9 reads: "Michigan is NOT reducing or limiting any benefits previously offered and will be expanding through a State Plan Amendment Autism Spectrum Disorders services to children between the ages of 6-21, provide enhanced SUD delivery systems and add coverage for the inclusion of Permanent Supportive Housing." On Page 31 it reads: "There is no request for additional Long Term Support Services (LTSS) to be reimbursed under this Demonstration." We request clarification.

13. The Michigan DD Council strongly supports comprehensive PCP's. It is also imperative that each IPOS/PCP focuses on the individual, is directed by the individual, so that they can achieve their goals, interests, and desired life outcomes. Also supported is the use/option of an independent facilitator for the development process of the PCP. An additional area of support is that an independent facilitator "must not have any other role within the CMHSP" (Page 36).

14. Several items of concern are located in the section of "MDHHS Quality Management and Planning Site Review Process" (Page 48). The MDHHS Quality Management and Planning (QMP) site review team is scheduled to conduct "biennial reviews of the 10 PIHP's." We have consistently supported the concept of annual site reviews by an independent review team that adheres to a strong level of conflict of interest standards against any involvement with any PIHP/CMH. By conducting annual site inspections, it will provide a far greater level of quality control over the performance of the PIHP's. An additional area of concern rests in the gathering of data/information by the QMP. As discovered in the collection of data for the HCBS transition plan, there was a glaring discrepancy between the responses of the beneficiary and the setting itself, as well as how many of the participant surveys were actually filled out by the staff. It would be vitally important that the QMP team randomly select and interview participants to ensure all components of their Individual Plan of Service (IPOS) and their PCP are either being met or have been met to the satisfaction of the customer.

The extreme lack of consistency of services, IPOS, and PCP's that are developed throughout the state as well as the level of services offered are also areas of concern. An annual review of the PIHP that includes a comprehensive focus on the delivery of supports and services outlined in the person's PCP would help address this expanding problem. We cannot emphasize the importance of QMP interviewing the customer of supports and services to ensure all components of the IPOS and PCP are met to the satisfaction of the customer.

It is also essential that the individual understands that they have the ability to revisit their PCP at any time to ensure they have all the supports and services needed to achieve their desired outcomes.

There needs to be a structured interview process similar to those used in the HCBS Transition plan. Furthermore, customer interviews should be done in two phases. Firstly, there should be a "snap-shot" of the current level of the quality and delivery of support services outlined in a PCP. Secondly, there should be a measurement over time to establish if any progress is being made in fulfilling their customer's directives of their IPOS and PCP. The standard of supports and services needs to be extremely comprehensive and consistent throughout Michigan. There should be no difference in the level of supports and services from one PIHP to another; regardless of the part of the state one resides.

During the development of the "performance measures to assess the settings' status in getting into compliance with the HCBS final rule, person-centered planning process and requirements around conflict free case management," the department must ensure that this measurement plan is comprehensive with the central focus being on individual and the delivery of supports and services throughout the entire process.

15. An element of great concern rises on Page 39 regarding the use of an "abuse registry." Under current structures within the state, there is no adequate way to track "abusers" of vulnerable people. This lack of system protection for the recipients of support services needs immediate attention. It is our understanding that "abusers" who are investigated, disciplined, and possibly terminated without a criminal investigation are able to continue to provide support services by simply moving to a different provider. We strongly support and encourage the use of a "vulnerable person abuse registry" and require all actions that have any form of discipline be included in this registry. This will give individuals hiring support staff fully informed choice as to who they would like to hire. We should use this waiver request as an opportunity to address a vulnerable adult abuse registry system within our state statues.

16. On Page 41, Item V: "The PIHP measures its performance using standardized indicators based upon the systematic, ongoing collection and analysis of valid and reliable data." Once again, we want to ensure that the data collected is truly representative of the actual experiences of the customer. Data is only as good as the questions asked and how the [respondents] answered. We encourage the Quality Assessment and Performance Improvement Program (QAPIP) to include thorough interviews of random service customers to ensure their health and wellbeing, which include freedom from abuse and neglect and achievement of competitive integrated employment, are reflective of the data collected at the PIHP level.

Community
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February 2, 2016

SUBMITTED ELECTRONICALLY
MDHHS-Pathway1115@Michigan.gov
AND VIA REGULAR MAIL

Eric Kurtz
Michigan Department of Health and Human Services
Bureau of Community Health
Behavioral Health/Developmental Disabilities Administration
320 South Walnut Street, Lewis Cass Building, 5th Floor
Lansing, MI 48913

RE: **Comments by Community Housing Network, Inc. (CHN), to *Pathway to Integration 1115 Waiver Application***

Dear Mr. Kurtz,

The following are comments from **Community Housing Network, Incorporated (CHN),** on Michigan Department of Health and Human Services (MDHHS) Pathway to Integration 1115 Waiver Application.

CHN supports many initiatives MDHHS is pursuing throughout the state, including:

- State Innovations Model (SIM)
- Accountable Systems of Care (ASC)
- Community Health Innovation Regions (CHIR)
- 2703 of the Affordable Care Act State Plan for Health Homes
- Certified Community Behavioral Health Centers (CCBHC)
- Transition Plan for the Home and Community Based Services (HCBS) rule
- Efforts in interfaces with data systems statewide

As you are aware, Michigan has led the nation for decades in moving people from institutions to the community. Implicit in that movement is that commitment to both supportive services and community integration. Neither of these is possible without housing.

Given the Mental Health Commissions' goals and objectives to end homelessness and secure permanent housing we believe that the following services should be included, if not mandated within the Medicaid State Plan:

Tenancy Supports

- Outreach & Engagement

- Assistance in Finding Housing
- Collect Housing Application Materials
- Assist with Completing Housing Applications
- Assist with Subsidy applications/re-certifications
- Advocate on behalf of participant with landlords
- Negotiate master-lease and third-party payee
- Assist with Furniture Acquisition
- Purchase other household goods
- Assist with moving
- Tenant Education i.e. rights & responsibility
- Eviction Prevention including:
    - On-time payments
    - Conflict Resolution
    - Lease Requirements
    - Utilities Management
- Maintain landlord relationships
- Maintain Subsidy-provider relationships
- Make mental health beneficiaries aware of housing alternatives, including up to date data and navigation systems

Housing Case Management

- Develop Service Plans
- Monitor implementation and make necessary revisions
- Coordinate
    - Primary Care
    - Health Homes
    - Substance Use Treatment
    - Mental Health Providers
    - Vision Providers
    - Dental Providers
    - Hospital/Emergent Care
- Interventions
    - Crisis
    - Critical Time
    - Landlord Relationships
    - Law Enforcement Issues
    - Individual Counseling to de-escalate
- Motivational Interviews
- Trauma Informed Care
- Transport to appointments
- Assist with Entitlements

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- Assist with Independent Living Skills
- Provide links to education, job training, etc.
- End of Life Plans
- Re-engagement

As you are aware, there have been discussions at the federal level on housing and homelessness. Centers for Medicare and Medicaid issued a bulletin in July of 2015, informing states that Housing and Urban Development (HUD) may discontinue funding where it is felt Medicaid should be paying for these services within supportive housing. While this may be accurate, and some of these services may be reflected in the current waivers and state plan, unless MDHHS mandates through adequate contract requirements tied to performance outcomes and sanctions/penalties, many PIHP's, Medicaid Health Plans, and their provider networks may will continue to do business as usual.

To truly apply for a Pathway to Integration Waiver, the discuss and clear delineation of "payor" between the Medicaid Health Plans responsibility for persons with mental illness and substance use disorders, and PIHP's, needs further definition and contractual mandates.

It is the hope of CHN and many providers throughout the State of Michigan that MDHHS, particularly Behavioral Health and Developmental Disabilities Administration (BHDDA), considers the comments from providers and incorporates them into the 1115 Waiver application. Equally important, we urge that BHDDA incorporates mandatory performance outcomes in future PIHP contracts in promoting supportive community integrated housing.

Sincerely,

Marc Craig
President

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570 Kirts Blvd . Suite 231 . Troy . MI 48084 • communityhousingnetwork.org

Kurtz, Eric (DHHS)

From: Jill Gerrie <jill.gerrie@arcmi.org>
Sent: Tuesday, February 02, 2016 4:21 PM
To: MDHHS-Pathway1115
Subject: 1115 Waiver Proposal Comments
Attachments: Core Service Definition Individual Directed Goods and Services.docx

February 2, 2016

Eric Kurtz
Michigan Department of Health and Human Services
Bureau of Community Health
Behavioral Health/Developmental Disabilities Administration
320 South Walnut Street, Lewis Cass Building, Fifth Floor
Lansing, Michigan 48913

RE: Comments on the 1115 Waiver Proposal

Dear Mr. Kurtz,

Thank you for the opportunity to provide comments regarding Michigan's 1115 Waiver. I am the Program Coordinator for Michigan Partners for Freedom, a grassroots coalition of people with disabilities, family members, advocates, service providers, Community Mental Health organizations, and allies partnering to build statewide demand for Self-Determination, housed at The Arc Michigan.

In general, I support the proposal. I also agree with the comments made by my organization, Michigan Protection and Advocacy Services and United Cerebral Palsy of Michigan about issues of concern, but wish to make some comments on areas that may or may not have been addressed.

- **Person-Centered Planning:** It's been noted by others, but I wish to reiterate that person-centered planning on the whole is not being done in the manner it was intended. Last year I participated in a number of CMH site reviews by interviewing people about their person-centered plans via the agreement the Department has with The Arc Michigan. I was very troubled by the fact that most of those interviewed did not use independent facilitation for their plans, or even knew what it was! It was also clear that many Supports Coordinators and the people receiving support did not distinguish between the Individual Plan of Service and the person-centered plan. Also, plans varied depending upon where a person lived. Education and independent facilitation is very much needed.

- **Self-Determination:** As I'm sure you're aware, access to arrangements that support self-determination varies widely across the State. This has made it difficult for people to direct their services and has been extremely frustrating to Michigan Partners for Freedom. As a service that is outlined in policy and the contracts between the State and the mental health agencies, the inequity needs to end.

  I was also distressed by the comments made beginning at the bottom of page 49. By stating that, "Some program approaches are not amenable to the use of arrangements that support self-determination because the funding and staff are controlled by the provider…" a ready

excuse is provided to the CMHs who wish not to fund such services. The Michigan Partners for Freedom project has encouraged the use of self-direction or self-determination (S-D) by traveling around the State for the past 10 years doing presentations about the availability of the service and by teaching people using S-D services to do presentations in their communities. From experience we know that many areas are not letting people direct their own services, and in fact from data collected by the Center for Urban Studies at Wayne State University (from 404 reports), only 16% of people using CMH services used a fiscal intermediary (the only way we can track S-D currently, which isn't optimal), only three CMHs have over 20% of the people they served using fiscal intermediaries and eight CMHs had less than 1%.

- **Goods and Services:** The definition in the proposal for goods and services does not reflect the federal definition, which I have attached. As you know, goods and services help provide flexibility in needed supports for people using self-determination services, especially when developing individual budgets. Using the federal definition would assure that flexibility would be maintained.

- **Supported Housing:** While it is good to see housing included, the definition of Supported Housing needs not to include site specific supports, but rather supports attached to the person wherever they choose to live.

- **Independent Facilitation:** I was happy to see that independent facilitators..."must not have any other role within the CMHSP" (page 36), and that, "It is advisable that the CMHSP support independent facilitators in obtaining training in PCP, regardless of whether the independent facilitator is paid or unpaid." The last part of which should be required vs. advisable.

Again, thank you for this opportunity to comment. Should you have any questions, feel free to contact me at (517) 492-5029 or jill.gerrie@arcmi.org.

Sincerely,
Jill

Jill Gerrie
Project Coordinator
The Arc Michigan
1325 S. Washington Ave
Lansing, MI 48910
Direct Line: (517) 492-5029
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The Arc
Michigan

COMMUNITY MENTAL HEALTH
CMH OAKLAND COUNTY
AUTHORITY

WILLIE BROOKS, Executive Director and CEO

February 2, 2016

Re: Section 115 Waiver – Pathway to Integration Proposal

To Whom It May Concern,

On behalf of the Oakland County Community Mental Health Authority (OCCMHA), thank you for the opportunity to provide input relative to the 1115 Demonstration Waiver – Pathway to Integration. OCCMHA is supportive of waiver consolidation efforts that increase flexibility in developing quality, financing and integrated care (physical and behavioral health care) initiatives. The referenced reform and redesign efforts include:

- State Innovation Model (SIM)
- Certified Community Behavioral Health Centers (CCBHC)
- Home and Community Based Services (HCBS) Rule / Transition Plan

OCCMHA Comments / Questions include:

Person-Centered Planning: Person-Centered Planning remains the hub for all initiatives, and needs to be clearly defined, trained, and implemented in order to ensure statewide consistency in supports and services. While ensuring choice in models of Person-Centered Planning is important, so too is an understanding of the "Golden Thread," whereby authorized and delivered services reflect the goals, objectives and outcomes established in the Planning process. This ties together individualized planning, medical necessity, utilization management, and evaluation of services and costs.

Conflict Free Case Management: Conflict Free Case Management has yet to be clearly defined. Of interest is how it will integrate across the above noted reform and redesign efforts. What will be the test for Conflict Free Case Management, and how will 'firewalls' be established?

Self-Determination: OCCMHA leads the state in Self-Determination arrangements, and continues to support a public mental health system that assures "methods for the person to exert direct control over how, by whom, and to what ends they are served and supported." Since Self-Determination reflects specific values, principles, and best practices, does MDHHS see these arrangements as co-existing with the various congregate service models that are 'presumed to be institutions' under the HCBS Rule changes, as defined by the Bazelon Law Center? Under the definition of choice, can a public mental health system support such a wide variance in practices that yields very different community life experiences for people served?

Peer Services: People with lived experiences provide valuable Peer Directed Services. Peer services are listed on page 10 of the Application; however, it only references people with mental health concerns and developmental disabilities. Is it to be assumed that Parent Support Partners, Youth Peers and Recovery Coaches are included in this listing?

Involvement of People Served: Although there are expectations that people receiving services be involved in the planning, development, implementation and evaluation of 'the system,' there is no evidence of these expectations in the Application. In keeping with "Nothing about me without me," it is recommended that the document be written in a manner that people served can 'see themselves' in the Application.

Private Duty Nursing (PDN): A growing number of individuals have a need for private duty nursing. Oftentimes, these individuals do not have other habilitative needs, yet are referred to make a choice between the Habilitation Supports Waiver and the MI Choice Waiver. Individuals who require PDN ideally could receive PDN as a MI Choice Waiver support with any affiliated mental health system needs provided outside of the HSW.

Waiver 'Slots': It is OCCMHA's understanding that there will still be an enhanced payment for Habilitation Services Waiver (HSW) services, based on existing 'slots.' OCCMHA understands there is no current plan to increase 'slots' statewide or reallocate existing 'slots.' Some PIHPs, including OCCMHA, experience reduced funding because these 'slots' do not reflect the high number of people with developmental disabilities who have high intensity needs. For example, OCCMHA estimates to have approximately 600 people who meet the criteria for enrollment into the HSW, but for which no 'slots' are available in Oakland County. To address this issue, it is important that MDHHS develop a consistent statewide approach to assessing need, managing utilization, evaluating outcomes, and developing performance based contracting / payment methods.

Again, thank you for this opportunity to provide feedback. Please feel free to contact me should you have questions or comments.

Sincerely,

Kathleen Kovach, Deputy Executive Director / COO
Oakland County Community Mental Health Authority (OCCMHA)
(248) 975-9584
kovachk@occmha.org

Kurtz, Eric (DHHS)

From: Carol Wallace <carolwallace66@yahoo.com>
Sent: Tuesday, February 02, 2016 6:19 PM
To: MDHHS-Pathway1115
Cc: Deb Monroe
Subject: Peer Run Respite

To Whom This May Concern:

I'm sending this email in support of Peer Support Wellness and Respite Services. As a retired Community Mental Health Supervisor, I had the opportunity to visit a center located in Portland, Maine and saw first hand the benefits it could provide. It offers alternative support from Clubhouses and Hospitalization and is completely run and operated by individuals who have a shared life history. Participants reported the following:

- The importance of someone who understands, reassures, and is credible because of their lived experience of mental illness.
- . The vast improvement in discharge experience this time compared with earlier admissions.
- . The improved continuum of care created by peer support, often filling holes in the system.
- . Peers as positive role models of recovery for consumers, carers and staff.
- . The strength of linkage with community supports by ''walking with the person''.

Consumers said they felt more trusting of someone who knew what symptoms were actually like, especially psychotic symptoms, valuing peers' approach and non-medicalized language, and perceiving that they were genuinely being listened to.

Please consider this pilot program for Michigan. Thank you.
Carol Wallace, LBSW, MA, LPC
Consultant for Peer Directed Support
Michigan Department for Health and Human Services

Kurtz, Eric (DHHS)

From: Melissa F. Essig <mfe@riverwoodcenter.org>
Sent: Friday, January 29, 2016 1:22 PM
To: MDHHS-Pathway1115
Subject: Public Comment for 1115 Waiver

Feedback/Recommendations for the 1115 Waiver:

1. QIDP is defined on page 33 and again on page 34 under "Supports Coordinator QIDP. Page 33 indicates licensure is required in addition to experience. The definition on page 34 does not state Supports Coordinator would not require licensure (if not serving a child with SED). On page 91 it indicates licensure is required for Provider Type of Supports Coordinator, but not required in the Provider Type of Supports Coordination Agency. Please specify which page and definition is the correct one for both HSW and non-HSW Supports Coordination.
2. Housing Assistance is listed as a service for all populations on page 10, but is not included in Appendix B. Is it being replaced by Transitional Services, which is limited to under age 21 and requires meeting needs based criteria for psychiatric hospital level of care? Transitional Services is not listed in any of the service lists for Specialty Services, waivers or LTSS.
3. Transportation is listed as a service of its own on page 10, Specialty Service and Supports all Populations, but it is not defined in Appendix B. Please specify the description and limitations of transportation services. Although the 1115 does not include the State Plan services, is there an opportunity to add transportation to what is included in ABA/BHT services? Transportation is not currently included in the service description for ABA. It is for CLS. We have many barriers to accessing non-emergent transportation through DHS for children, especially when a child receives such intensive services at a high frequency. Including transportation in the ABA/BHT services would significantly increase accessibility for that service when the family desires the center based services instead of in-home services (or when the home environment is not conducive for treatment). Concerns have been raised with Nick Norcross. He confirmed the rules which create the barriers. When the family does not have family/friends that are willing to provide transportation for the mileage reimbursement, public transportation may be approved. However, a responsible adult is required to accompany a child under the age of 12. The adult will not be approved for 2 round trips. ABA/BHT often lasts 4-6 hours/3-5 days per week. This means the parent would need stay for the duration of treatment. Many parents are unable to do this due to work or having other children to care for at home. The families are not provided a written denial because DHS states they offered the benefit and it was declined.
4. Non-Family Training: It appears this service is only available if enrolled in the Hab Waiver, CWP or SEDW. Could this also be available under the Specialty Service and Supports all Populations? Many individuals who are not enrolled in a Waiver receive CLS or other supports where Non-Family Training is needed.
5. Personal Emergency Response System (PERS): Could this include a GPS device and the monthly subscription/service for an individual with Autism that would help locate the individual if he/she wandered away from their family home?
6. Recommendation: Allow the PIHP/CMHSP to administer the Home Help benefit when the individual is receiving long term services and supports instead of requiring someone to seek that through DHS. The current separation of CLS and Home Help creates unnecessary duplications of assessment, planning/linking, monitoring, training, claims/payroll, etc.. Often times the consumer has the same provider or staff do both the CLS and Home Help. It creates a great amount of confusion and additional work for the individual or their family. With the increased utilization of Supported Independent Housing

(in non-licensed settings) for individuals with significant disabilities, it is becoming increasingly more difficult and cumbersome to assure we are not providing CLS when Home Help should be utilized.

Thank you.

Melissa Essig
Program and Services Manager
Riverwood Center – Berrien Mental Health Authority
269-934-1631
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SECTION 1115 – PATHWAY TO INTEGRATION

COMMUNITY LIVING SERVICES, INC.'S
Comments on Pathway to Integration Michigan's 1115 Waiver Proposal for Persons with Severe Mental Illness, Substance use Disorders, Intellectual and Developmental Disabilities and Children with Severe Emotional Disturbances
January 29, 2016

Waiver Proposal

Overall Question

- Table of Contents the Appendix A and B talk about Long Terms Service and Supports – there is confusion on how this term is being used in the application. There is a need to clarify use of the term "Long Term Service and Support" in the application.
- The application needs to clarify which specialty services and supports Fiscal Intermediary services are (page 10) covered under. Other sections of the application do not include Fiscal Intermediary as a service (i.e. Habilitation Support Services Waiver p14).

Overall Recommendation

- This is a large document and the organization of the document is not user friendly making it challenging for review by the general public.
- All services should be indicated under the specific waiver service they are covered. It is not easy to understand (i.e. Fiscal Intermediary). Recommendation : Include a graph outlining all waivers and each service covered under the waiver.

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Appendix B

- Definition for CLS does not include definition for CLS related to children as provided for in Medicaid Manual currently.
- Goods and Services – This was historically limited to HSW program, is this still the case?

Page 3, 117

- What does it mean to move the ABA services to the State Plan? What is the difference between the State Plan and the State Health Plan? Please clarify. Will there be more funds coming for ABA services?

Page 5

- Please describe the role and qualifications of the 'Specialized Complex Care Managers', and identify if these staff will be housed at the PIHP or state level.
- Please define criteria used to designate an individual as a 'High Utilizer'.

Page 6

- Will the quality indicators regarding emergency department visits and hospital admissions take into account that many persons with an I/DD have medical and/or physical conditions that attribute to their meeting criteria for an I/DD, and as a result of the medical and/or physical

conditions, may require Emergency Department visits and hospital admissions at a higher rate than other populations intended to be served by the Demonstration Waiver?

- Will there be crisis residential locations available in all PIHPs for I/DD and what will they look like?

Page 7

- If a child clinically qualifies under Children's Waiver criteria, how will it be controlled if the parents' income level is not taken into account? Consider giving consideration to adding related parental income criterion (i.e. sliding fee scale) to eligibility determination.

Page 9, 10, 11

- Define "Permanent Supportive Housing" and what is the criterion for same?
- Is Permanent Supportive Housing only available to the SUD population or for all populations? If for all populations, please clarify this in the application.

Page 12 - 13

- The Mental Health Code reflects a different definition for eligibility for developmental disability. See MCL 330.1100a(25). Will the application use the Mental Health Code definition set out in MCL 300.1100a(25) or the definition as stated in the current version of the application?

Page 13

- #3 second bullet – define "Aggressive"
- #3 third bullet – states "... regression or loss of current optimal functional status." Consider inserting **"deceleration of temporary regression (for I/DD)"**
- #3 third bullet – change the wording and remove self-determination as this is being used as a general concept which is confusing to self-determination arrangements stated throughout this document.

Page 14

- Fiscal Intermediary is not a covered service under the HSW chart but is covered under the Children's chart. It appears with HSW, one would not receive Fiscal Intermediary service. With self-determination arrangements in place, why wouldn't fiscal intermediary services be covered?

Page 16

- Clarify the language regarding Long Term Services and Supports as the chart on page 17 includes Children Therapeutic Foster Care. Please clarify Long Term Services and Supports throughout the document.

Page 22

- Section E - Will the 'service delivery, quality, financial and reporting requirements' be made available to the PIHPs and CMHSPs prior to or upon implementation of the Demonstration Waiver?

Page 24

- Should the fiscal intermediary not be involved in both circumstances: 1) when a person hires his/her own staff, as well as 2) when the person has a provider agency?

Page 26

- Please describe the process by which participants will be notified of the transition to the Demonstration Waiver. Recommend that individual's contact information be confirmed by the CMHSP provider

Page 32

- Consider defining role of case manager.
- Should Supports Coordinator be added along with Case Manager and Social Worker? Also, what does Other stand for?

Page 33

- Should the "related mental health fields" be listed by way of example.
- Under CMHP, related to ASD, are you referring to the social worker/Supports Coordinator requiring a master's degree?

Page 39

- Recommend State consider establishing "abuse registry" with all necessary safeguards and criteria including due process.

Page 48

- Define "conflict free case management" and what are the requirements around this term?

Page 49

- Please describe the term 'qualified providers', does this include the provider meeting the credentialing requirements set forth by the PIHP?
- Is State considering creating incentives/plan for decreasing use of group homes so consumers live in more integrated community settings?
- Last paragraph – provide clarity if an individual is in a program that is not amenable to self-determination, what is the option? More elaboration should be provided for those not being considered for self-determination relationship due to the program they are currently living in. In addition, concern has been raised about an evaluation of a person's capacity to be in a self-determination relationship. We believe artificial barriers should not be put in place as people have support systems around them to assist people with decision making.

Page 50

- Please describe the plan including relevant timelines to continue dialogue with stakeholders.

Page 51

- Does Appendix B only apply for those under MI Choice Waiver for long-term care? We assume it does not, so the language needs to be clarified as it is confusing as stated currently.

Page 55

- Define "Items necessary for life supports", what items are being contemplated? Does the term "life supports" refer to life in the community?

Page 68

- State should consider developing guidelines for fiscal intermediaries to use in monitoring use of self-determination funds by beneficiary's representatives. What protection will be put in place to protect fiscal from liability when use of funds by beneficiary representative is denied? State should address this.

Pages 75, 80

- Consider exceptions to absolute prohibition against paying self-determination Dollars directly or indirectly to "responsible relatives". Should other legal representative types be included in the exclusionary list such as Power of Attorneys who have broad powers that could give rise to conflict of interest? Also add language regarding conflict of interest.

Page 82

- Will the workshop be an acceptable employment outcome for MRS?

Page 84

- Are these defined therapies only covered under Children's Waiver or open to all populations and at what age per therapy?

Page 87, 102

- There is confusion related to service being only available to EPSDT participants. Clarification is needed. What service is provided for those under the age of 21 given EPSDT?

Page 94

- Provide a list of the State approved licensed respite care facilities.

Page 97

- Clarify how PDN services apply to each population age groups.

Page 112

Appendix C is very difficult to analyze from a Developmentally Disabled Provider perspective because of the categorization used; Disabled, Aged and Blind (DAB) which could very well be part of our populous, but also other Medicaid recipients. Our population is buried into the much larger segment. Temporary Aid for Needy Families (TANF) could also have some of our population but again buried in a much larger segment. The only category that is complete is the 1915© HAB Waiver. Even though this is State wide averaging and having multiple rates they seem reasonable. The others; Autism, Child Waiver, SED, MI child and Healthy Michigan are all averaged and State wide which tends to mask our ability to understand the rate ramification.

MDHHS 1115 Waiver Proposal : Pathway to Integration

Comments and Questions from Judith Taylor, Ph.D - long time advocate for the public mental health services system in Michigan which is available for Michigan's most vulnerable residents. e-mail judithtaylor1@aol.com

Overarching Comments: What are we trying to accomplish?

As the introduction notes, this waiver is building on a 50 year history of a robust public mental health services system for subpopulations that are some of Michigan's most vulnerable residents. Michigan has developed one of the richest array of services for persons served by the CMH system. In large part this was due to Michigan's aggressive pursuit of non-traditional services and supports via a variety of Medicaid waivers since 1982, ie over 35 years.

The 1915 b/c combination waiver implemented October 1998, allowed Michigan to take a giant step forward in the provision of services that fully supported Person Centered Planning (added as the law in Michigan in 1996) as well as self-determination and the pursuit of full community inclusion.

Since then through a variety of ways, Michigan has also pushed for increased coordination between physical health care and the specialty services system. We have had requirements for coordination agreements with the Medicaid Health Plans since 1996. These have evolved into partnerships and co-location between the two systems as well as development of a number of IT solutions to sharing medical information for mutual consumers.

It is not totally clear to me what this step involves and promotes for the direction of the system for the next 5-10-15 years or for the continued emphasis on the values we hold now and as these evolve.

The power-point used for the webinar and public forum talked about a phased in model -- but the 1115 materials do not appear to reflect that focus. **Details on a 5 year strategy would help work out what we hope to accomplish over the next 5 years -- not just the first year.** My fear is that the first phase becomes the full phase and we miss this opportunity to reshape the system and be even more creative in meeting the needs of persons we serve, especially as funding becomes tighter and demands increase.

Critical Missing Theme

This 1115 waiver provided an opportunity to think through and **articulate values and outcomes and direction for EACH of the sub-populations.** This is completely missing for Adults with serious mental illness and SED children and their families, and non-HSW persons with I/DD.

It would have been nice to see each population addressed separately and setting up some key values and goals as to how the state wants these services and supports to evolve for each population. In particular, such an effort would have also **reshaped the funding model to support these values and desired outcomes** for each population. Instead we see a continuation of the same old rate cell structure in the funding. (see later)

Program Description Section

Page 4 - section 1 on Program Description. It is insulting to so many persons to state that it is only since 2011 that we have been "reinventing" the system.

In reality we introduced full management in 1981 to integrate state services with community care, and the Medicaid waiver in 1982 to provide more supports to persons in the community as well as for persons returning from state facilities, and the HSW waiver a few years later and PCP in 1996, and a "one of a kind nationally" shift to managed care in 1998 for populations that no other state was incorporating into managed care.
The only relevance of 2011 was a political shift with a new governor.

Page 4 - there is a reference to **redesign of the SUD system,** but it is very hard to find what that is. Given that the SUD Coordinating agencies were merged into Mental Health/IDD over a year ago (a major redesign) - what exactly are you planning? if it is to expand services, then that is very different than "redesign". Plus given that the financing appears to include nothing for enhanced services - this whole construct being proposed is very confusing.

Page 5 - reference to "**advance the use of needs based eligibility criteria**" -- what exactly does that mean? I assume it means eligibility for the specialty system. (see later re boundary management for persons with mild/moderate MH or IDD needs). What is DHHS proposing be used?

Page 5 **: High utilizers**. Comment -- the use of "high utilizers" term needs to be modified as it does not appear to cover PIHP high utilizers -- ie persons with I/DD who have high use of residential and community inclusion supports

Page 9: Service array formerly known as B3 supports: this section does not seem to be about B3 services at all. It is all about the mild/moderate boundary (see later). Plus it only addresses mental health conditions. It needs to also speak to persons with IDD who only have need for therapy/health services.

Populations/eligibles

1. Does this waiver change the challenging boundary management with respect to persons with **mild/moderate needs?** It appears that this in not addressed - other than by the goal of better coordination. This would been a wonderful chance to resolve this issue -- especially given that the MiHealthLink MME demonstration sites have changed that boundary. PLEASE reconsider the maintenance of this problematic issue... and IF you keep it, please make the MHPs behave more responsibly both on the front end (ie emerging MH needs) and more importantly on the back end as persons with more acute MH needs are stabilized and need to graduate from the PIHPs/CMHSPs as part of their personal pathway to recovery and to receive services in a more integrated setting.

2. One power point slide used the term **"new populations"** - what new ones do you think are out there in the Medicaid eligibles? (not the same as new persons in existing populations)

3. Please give consideration to how you describe the "sub-population" of **HSW persons**...there are over 3000 who look like HSW but cannot get in because of slot caps. This has created a problem boundary between HSW-C and DABs, especially as it relates to funding (see later). While you appear to be needing to provide protections for the current HSW persons, you are not providing such protections for these 3000 others who are also high need. Will this 1115 address this inequity after the first year transition? Will this continuance of using a description (ie C-waiver HSW) that essentially goes away with the ending of that waiver, **be replaced by a more appropriate sub-**

population description and eligibility criteria that addresses and includes ALL persons with I/DD with high needs?

4. **What is the plan for SEDW and DDCW/CWP "silos"?** The reality is that the services covered by those waivers is essentially the same as for the rest of the specialty services/supports. These were historically used to target some priority persons (eg DHS foster care cases and SEDW) and also to deem Medicaid eligibility for children that would not otherwise have qualified (who now occupy most of the DDCW slots).

5. **Page 14 - DDCW/CWP section.** Currently the DDCW has a service called case management that is not consistent with either definition of targeted case management or the reporting of that activity by the rest of the specialty services system. Will that be cleaned up with this waiver?? Will you consider using Supports Coordination like we do for HSW? Note - it is not even listed as part of the CWP array (presumably as it is a state plan benefit). Also with the CWP, does the PDN responsibilities change?

6. **Page 15 - SED section needs to be relabeled.** Clearly this does not apply to ALL SED eligibility -- just to those former SEDW children. Also please give consideration to using the definition of wraparound and encounter reporting that is used for all other wraparound services. This is very confusing and creates administrative inefficiencies.

7. **Page 17 - Array of services** - can we use this opportunity to clear up the dissonance between **"non-vocational ", "prevocational", and skill building** - though that last one does not appear to even be listed

8. Page 23 re self-direction. **THANKS** for allowing individuals to exercise choice about **self direction to include a single service**. This has been dismissed in the past as not part of the self-determination model and thus inhibited the use of self-determination particularly with adults with serious mental illness. I also want to put in a plea for FAMILY-CENTERED practices -- and thus give families more choice about who are providers for their child and family.

9. Will the 1115 address the problem **boundary with Home Help** (personal care state plan benefit in non-licensed settings) -- which has gotten even more challenging with ICOs managing that benefit for MHL enrollees?

Financing and Funding

1. SEDW and DDCW shift to pmpm -- appears to be shifting more risk to PIHPs. How will these pmpm be established? will they use a severity criteria? Will it use the current DDCW 75% budget approach -- which does not work for small numbers?

2. The use of the word "incentives" is mis-leading -- what is being described at least for now are in fact with-holds.

3. With-holds will effectively reduce capacity by 1% at a time when the system is under-funded and experiencing significant demands well beyond revenue increases. The money needs to be earned back MUCH faster than current with-holds/incentives so they can be ploughed back into services.

4. Savings construct needs to be fleshed out -- great idea but weak on details as to how it would work in practice between PIHPs and MHPs. The biggest challenge here will be how to get the savings earned by PIHP efforts back from the Health Plans. How does MDHHS intend to make that work?

5. Funding trends in the attachment on budget neutrality are a big problem as the cost demand trend (pmpm) is significantly under-funded given flattening eligibles, increased demands/new entries, increased demand as person age, and basic cost of business increases (eg Michigan's minimum wage increases let alone reasonable wages for these direct care staff). **We need PARITY in funding for cost increases with the Medicaid Health Plans.**

6. This 1115 waiver appears to add requirements, add services, add populations, but does not add additional funding to address these added costs (except for autism). Given inadequate funding increases - this is a recipe for disaster.

7. **FUNDING MODEL**: The over 200,000 persons served by the specialty services system would have been better served by using this opportunity to reshape the financing/funding model. The current model was developed in response to the BBA and the issues that Michigan and CMS had to resolve to accommodate this one-of-a-kind managed care program. It was developed quickly and unfortunately one feature was to separate out the HSW C-waiver funding and thus split persons with I/DD with high needs into those in the HSW and those who were not and blend those residual non-C-waiver persons in with the rest of I/DD as well as children with SED and adults with serious mental illness.
   This has **created inequities in how persons with I/DD are funded** as the persons who were not in the HSW c-waiver includes over 3000 persons who would qualify but cannot due to the c-waiver caps. Thus there are high need persons with I/DD funded by an enrolled member model (ie the c-waiver) and another 50% that are funded by a capitation/covered lives model. The latter significantly masks the needs of these persons.
   In addition now there is increased emphasis on the dual Medicare-Medicaid persons. Interestingly the PIHP system has had these MME persons in managed care since day 1 in October 1998, and thus is the only health care manager/provider that has managed their care within managed care constructs.

   The rate cell model should have been changed to reflect these dynamics of the underlying population -- ie created rate cells for MME vs non-MME and also refocused on needs/funding by population by separating I/DD from MH/SED within the DABs population. This would have provided a much better match to needs and been a much sounder actuarial base for ensuring the DHHS funding was targeted to the sub-populations of interest. This is a big LOST OPPORTUNITY.

   One remedy is to restate the protected population called HSW-C-waiver to include ALL adult persons with I/DD who would meet eligibility for this waiver

8. **FUNDING TREND: It is very unfortunate that this proposal limits cost increase for DABs to just 1.5%. This exacerbates the issue mentioned above about the residual C-waiver like persons in DABs.** With the flattening of eligibles, the system will experience increased penetration rate, and the persons who enter the system stay longer due to their level of needs. As the stay they age - and each of those life passages tends to increase their needs and thus demands/costs. Plus costs are increasing. **It is estimated that these three factors result in a cost demand impact on the system in the order of 6-9%. The projected 1.5% is woefully insufficient to meet the existing demand trends let alone increased requirements of this waiver and the HCBS rules implementation,**

   The only subpopulation that fares well under the funding trends is Autism which has a 2% pmpm cost trend factor, plus significant increases in enrollment. How can the state justify spending that much more (including approximately $20m in state match) while holding all other populations to a much tighter funding projection. This does not seem equitable.

MALA
MICHIGAN ASSISTED LIVING ASSOCIATION

February 1, 2016

Attention: Eric Kurtz
Michigan Department of Health and Human Services
Bureau of Community Health
Behavioral Health and Developmental Disabilities Administration
320 South Walnut Street, Lewis Cass Building, 5th Floor
Lansing, MI 48913

Re: Section 1115 – Pathway to Integration

Dear Mr. Kurtz:

Michigan Assisted Living Association (MALA) appreciates the opportunity to submit comments on Michigan's Section 1115 Waiver Proposal. Our nonprofit organization represents providers of residential and non-residential services for persons with disabilities. MALA members receive funding through the Specialty Services and Supports 1915(b/c) Waiver and other 1915(c) Home and Community-Based Waivers.

As a general comment, MALA supports the overall concept of seeking approval from the Centers for Medicare and Medicaid Services to combine several waivers under a single waiver authority. This approach should provide greater flexibility in the provision of quality services and enhance the integration of physical and behavioral health care.

MALA also supports the proposal's recommendation under Section IV.5 to "maintain the use of a managed care delivery structure using ten (10) recently procured PIHPs who contract for service delivery with forty-six (46) CMHSP's and other non-for-profit providers." Continuation of this current system makes sense based upon its long-standing commitment to quality services for persons with disabilities. This approach is essential to ensure continuity of services for these individuals as the state of Michigan moves forward with the Section 1115 Waiver.

Under Section IV.7, information is provided on the two options for participants choosing to directly employ workers which are the Choice Voucher System and Agency with Choice. MALA fully supports self-determination and maximum choice for individuals. We assume that such choice will continue to include the option for individuals not to directly employ workers but rather contract with providers for this purpose as referenced later in the proposal.

Under Appendix A, Long Term Service and Supports, extensive information is provided on the essential elements for person-centered planning and service plan development. MALA supports this emphasis on person-centered planning in the proposal.

Under Appendix A, we support the focus on choice in the MDHHS Self Determination Overview. For example, we agree with the statement that "Qualified providers chosen by the beneficiary, but who are not currently in the network or on the provider panel, should be placed on the provider panel."

Thank you again for the opportunity to submit comments on Michigan's Section 1115 Waiver Proposal. Please contact our organization if you have any questions regarding the comments provided above.

Sincerely,

Robert L Stein

ROBERT L. STEIN
General Counsel

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Shari Fitzpatrick, President

Sherri Boyd, Executive Director/CEO

February 1, 2016

To Whom It May Concern,

The Arc Michigan supports this State's proposal for an 1115 Demonstration Waiver, with qualifications. Our concerns which follow must be addressed.

Nothing in this proposal addresses the tremendous disparity which exists from one PIHP to another, between CMHSPs in the same PIHP, or even the discrepancy which exists from one Managed Care Provider Network (MCPN) to another under the Detroit Wayne Mental Health Authority. The practice of informal denials exist in some places where individuals and their families are told, "we don't do that here", while even in an adjoining county, the supports or services are readily available.

The quality of and even existence of a person-centered planning process is so variable as to be unconscionable Despite its existence in statute in Michigan for 20 years, despite a state mandate that it be an issue for local quality improvement projects for a number of years, and despite CMS efforts including the HCBS rules, many, many places do not follow even the State's guidelines for a person-centered planning process. Individuals and their supporters are seldom told of the availability of independent facilitation and some places deny that the option even exists.

The disparity of availability of arrangements that support self-determination (directing) is even greater. In some places the only services really offered are far more limited. The only options which will be supported are group homes or one's parent's home. The only options offered for supports during the day will frequently be some form of a congregate, segregated day wasting program. Any assurance, that the current array of supports and services will continue to be offered, remains somewhat empty, depending upon where, in Michigan, you live.

CMS must insist on a robust site review process. On page 29, the last preprint question and the answer on page 30: Current Single State Agency oversight is grossly insufficient. Site visits every two years, addressing current 1915(c) beneficiaries is way too infrequent and only looks at a sample of less than ¼ of the persons with developmental disabilities, and not those with mental illness at all. When NCI results indicate 60% of those with developmental disabilities served signify they want a job, while only 20% have that addressed in their plans, something is wrong.

As such, we cannot support the current paltry, infrequent site reviews nor could we support site visits from the PIHPs in charge of the CMHSPs or other providers. This must be a state process, free of the inherent conflicts of interest with the PIHPs. At a minimum, the

State process must address: the variance and lack of integrity in the Person-Centered Planning Process, those Individual Plans of Service which were not developed through a person-centered planning process or do not reflect the process, the wide disparity from one CMHSP or even PIHP in terms of how people are treated, the disparity of the supports and services offered, the evident conflicts of interests of many CMHSPs who provide services directly, and finally, the rampant ignoring of the real need for conflict free case management (supports coordination). After these problems we could get to the quality of life issues, which must be addressed. Again, not be the PIHPs or anyone who has a conflict of interest.

The Certification process and External Quality Reviews are weak, sorely lacking and absent any qualities of a robust evaluation. Any assurances provided are totally suspect. The previous discussion of disparities is one example of the lack of quality. Local or State efforts at quality improvement have failed to improve person-centered planning or uniformity of supports and services. Utilization of accreditation is as empty of a process as we could imagine. Depending on it has proved its uselessness.

We believe only frequent site visits by the single State Agency, which must include interviews with a significant number of those being served and their allies, has any hope of correcting the above problems. Some portion of the interviews should be longitudinal interviews over time, to test the progress being made on person's Plans of Service developed through a person-centered planning process. We would also hope that a mystery shopper program could be established to stop the informal denials and lack of full information provided to beneficiaries or potential beneficiaries.

The lack of specificity or even definition of Permanent Supportive Housing is a problem. We and CMS must assure that such an addition meets all of the requirements of the HCBS rules. We need assurance that this will not violate the principle of providing supports and services where people live, not places where people have to live to receive services.

Finally, the only definition for eligibility for persons with developmental disabilities contained in the proposal is that for those eligible for 1915(c) waiver services (eligible for ICF). While there are assurances about those currently served, including utilizing the 1915(b) waiver, we believe the definition in the Mental Health Code should also be included in the proposal.

Sincerely,

Sherri Boyd
Executive Director

Dohn Hoyle
Director of Public Policy

KCMHSAS

Memo

To: Michigan Department of Health and Human Services

From: Kathy Lentz
Kalamazoo Community Mental Health & Substance Abuse Services

Date: February 1, 2016

Re: Section 1115—Pathway to Integration Stakeholder Feedback

Thank you for the opportunity to provide feedback regarding Michigan's Section 1115 Waiver Proposal. The following comments and suggestions are provided:

1. Specialized Complex Care Managers (page 5)

    a. The use of "Specialized Complex Care Managers" for individuals considered "high utilizers" is referenced. This appears to be a type of Care Coordination; however, it is not clear whether this is conceptualized as a direct service, an administrative function or combination. Please expand on this function/role, including expectations.

2. Permanent Supportive Housing (page 9)

    a. Permanent Supportive Housing is listed as proposed added coverage. There is no definition of this service further reference. Please provide service definition as well as eligibility criteria.

3. Qualified Intellectual Disability Professional (QIDP) definition (page 33, 34)

    a. This definition is more stringent than the federal definition of QIDP. Michigan requires a licensure or working as QIDP prior to 2008. As we move further from 2008, fewer and fewer staff meet this qualification. Due to specific licensing rules in Michigan (or absence thereof), staff with Bachelor's Degrees in psychology and other human services degrees are excluded. We encourage the department to use this opportunity to examine the definition and ensure that qualified, competent professionals are not excluded.

b. The definition of "Supports Coordinator: QIDP (page 34) is more inclusive however it is not clear how the two definitions relate to each other. Can one be a "Supports Coordinator:QIDP" without being a "QIDP"?

c. Supports Coordinator Qualifications (page 91-92) specify that the individual must meet the Michigan definition of QIDP. This seems to contradict (b) above, as well as unnecessarily restricts pool of potential Supports Coordinators.

4. HCBS compliance

a. Statement regarding HCBS performance measures (page 48) implies that the HCBS final rule will be applied to all receiving services through 1115 waiver. Can this be confirmed? And if so, can a statement regarding any HCBS Transition time period would be helpful as there is a concern regarding the immediate applicability of the rule to all new waivers.

5. Pre-vocational and Skill Building Assistance Services (page 79-83)

a. The definitions are confusing, overly wordy and overlapping. Recommend that one definition be adopted, that includes and focuses on general skill acquisition to support goal of integrated, competitive employment.

b. Additionally, Supported Employment is not listed as a covered service. We hope this was inadvertent, since earlier it is clearly stated that services are not being reduced or eliminated.

6. Specialty Services/Therapies (page 84)

a. Massage therapy is listed as a covered service that is not available to people under age 21 who meet criteria for psychiatric level of care. Currently, this is a covered service for children's waiver, not adults. Is this expanding to be available to adults? If so, much additional clarification of benefit and eligibility criteria is needed.

Thank you for the opportunity to

February 1, 2016

UCP United Cerebral Palsy
of Michigan
Life without limits for people with disabilities

3496 Lake Lansing Rd., Ste 170
East Lansing, MI 48823
TEL 517.203.1200
TEL 800.828.2714
FAX 517.203.1203

ucp@ucpmichigan.org
www.ucpmichigan.org

KATHLEEN BROCKEL
Executive Director

Attention: Eric Kurtz
Michigan Department of Health and Human Services
Bureau of Community Health
Behavioral Health and Developmental Disabilities Administration
320 South Walnut St., Lewis Cass Building, 5th Floor
Lansing, MI 48913

RE: Section 1115 – Pathway to Integration

Dear Mr. Kurtz:

Thank you for the opportunity to comment on the Michigan 1115 – Pathway to Integration waiver proposal. United Cerebral Palsy of Michigan supports the state's goal with this waiver application to develop seamless, coordinated care for the individuals served under the new waiver. We certainly support expanded the use of peer supports and self determination arrangements and the creation of a robust evaluation system.

We request your attention to the following aspects of the waiver application:

1. The application should reconsider the threshold eligibility level for SUD service. P11: The application states, that among other eligibility criteria, services to the Substance Use Disorders is limited to those whose "emotional, behavioral and cognitive conditions" will not prevent the beneficiary from benefitting from this level of care. We are concerned that this might be too high a standard to include people with developmental disabilities who also have substance abuse disorders. Please clarify that people with developmental disabilities will not be excluded from SUD services if they need them.

2. The application should clarify that Home and Community Based Supports Services are available to 1915(b) participants. P 12 - 15: The application indicates that intensive home and community based supports and services are available to Hab and Children's waiver program participants. But 1915(b) waiver participants should also be eligible for these services. Please clarify in the application that 1915(b) participants can access and use home and community based services.

3. The application should provide for intermediate correction steps for PIHPs that are having difficulties rather than simply severing the contract and hiring outside the PIHP/CMHSP system. P 22: On section 5 e, the application states that the system will contract with the 10 PIHPs and will continue the current managed care delivery system but that the state can contract outside that delivery system if providers cannot meet service delivery, quality, financial and reporting requirements. This appears to be an all or nothing proposition. The state should include in the application steps for working with the PIHPs to correct problems. This would result in a better overall system and provide for some real improvements where needed, rather than a somewhat empty threat to simply just pull the whole contract. Please clarify in the application the correction steps that the state will implement with underperforming PIHPs.

4. We support the range of assistance that will be offered to waiver participants, but actual access to the services must be monitored. P23-24: The application includes a description of service positions within the PIHPs including supports coordinators, coordinator assistants and independent support brokers to help support self determination and the person centered planning process. Because Michigan has a history of disparity of access to these services, they should be monitored and evaluated in the overall project evaluation system to ensure that they are available and are used by individuals throughout the state.

5. The plan should monitor and evaluate the services from the perspective of actual participants. P 45 – 50. We applaud the state's interest in assessing the waiver services from the perspective of the participant. The application includes monitoring and evaluating best practices that are "relevant to the persons served" (p 45); monitoring performance measures that "reflect their goals and preferences" (p 47); and developing performance measures in compliance with the HCBS final rule, person-centered planning and conflict free case management (p 48). We believe that it is important to assess quality of life measurements and to track individuals over the long haul. Also, as noted above we are concerned about the current wide disparity of services from CMH to CMH around the state. The application should include a specific plan to address disparities for participants and to monitor the waiver services from the perspective of participants.

Thank you for the opportunity to provide these comments and request changes. We look forward to the department's response.

Sincerely,

Kathleen Brockel
Executive Director

Kurtz, Eric (DHHS)

From: Melvin Lester <mlester@mcc.edu>
Sent: Monday, February 01, 2016 8:55 PM
To: MDHHS-Pathway1115
Subject: Section 1115-Pathway to integration

I believe respite should be included as an alternative to hospitalization and (C.R.U) Crisis Residential Units. Because when I am in a crisis having the opportunity to speak with someone who is also living with a mental illness, and who can relate to what I am experiencing empowers me.

Sincerely Melvin Lester C.P.S.S

Kurtz, Eric (DHHS)

From: Monica Ortquist <mevans7768@gmail.com>
Sent: Monday, February 01, 2016 8:57 PM
To: MDHHS-Pathway1115
Subject: Section 1115 - Pathway to Integration

I feel a peer run respite would have helped me tremendously a few years ago when I didn't know where to turn. I know I didn't need to go into hospitalization but I needed care that I was not able to get from our local agency because I did not qualify for services. Using a peer respite center would have been so helpful to me at that time of crisis. During my prior hospitalizations all my goals were centered on medication and appointments. We were told you will feel better if you sleep only 8 hours a day,eat 3 balanced meals, and exercise daily. If you don't know what it's like to be in a depressive or manic state then telling someone this is like talking to a brick wall because we will immediately shut you out because we know you've never been where we are. I feel more at ease with someone who has gone through the same trials and tribulations I have to help me in setting goals. A peer would also be better equipped with other strategies and wellness tools to help me through my crises.
I also feel that self directed care is an area that could be advanced upon in the Mental Health community as it is in the Developmentally Disabled community. There have been great strides made in this area that the Mental Health community could benefit from for its consumers. The Developmentally Disabled community has shown a variety of treatments and services that are available for use with these monies that need to be shared in the Mental Health community.

--
Monica Ortquist
"Normal is a setting on your washing machine"

Kurtz, Eric (DHHS)

From: Zeller, Lynda (DHHS)
Sent: Thursday, January 21, 2016 9:20 PM
To: Kurtz, Eric (DHHS)
Subject: FW: Friends of DD Email Update, 1/21/2016 - Transition Plan for HCBS; Privatizing CMH; Medicaid Waivers...

In case you didn't see the notes from this advocate on the 1115

From: Jill Barker [mailto:jillrbarker@sbcglobal.net]
Sent: Thursday, January 21, 2016 3:57 PM
To: Jill Barker <jillrbarker@sbcglobal.net>
Subject: Friends of DD Email Update, 1/21/2016 - Transition Plan for HCBS; Privatizing CMH; Medicaid Waivers...

This is the Friends of DD Email Update for 1/21/2016. There is almost too much news to report and digest, so here are some tidbits to get you thinking and recent commentary on issues affecting people with developmental disabilities.

See The DD News Blog for regular posts on subjects of interest to people with developmental disabilities and their families.

Jill Barker
Friends of DD
The DD News Blog
Twitter: @DDNewsblog
Ann Arbor, MI
jillrbarker@sbcglobal.net

==========

Comments on the Revised State Transition Plan for Home and Community-Based Services due Friday, 1/22/2016

See The DD News Blog for the notice from the Michigan Department of Health and Human Services with links to relevant documents.

I have posted my comments on The DD News Blog, Part I & Part II. The gist of of my comments are that the state should interpret and implement the 2014 federal Home and Community-Based Services (HCBS) rule in a way that respects the individual differences and preferences of the people receiving Medicaid waiver services:

- Don't allow the HCBS rule to become an instrument for coercing people with disabilities and their families into accepting inadequate settings and living situations that they would otherwise reject in order save money for Medicaid funding agencies.
- Don't allow monitoring for compliance with the rule to become overly intrusive. The assessment of settings depends on subjective criteria for how integrated the setting is in the community and how often and to what extent the person with a disability spends time in proximity to people without disabilities. Monitoring what people do and who they associate with is not only intrusive, but could become an easy excuse to remove individuals from waiver programs as a cost-savings measure.

- Include the Person-Centered Plan that describes the needs and preferences of the individual to determine the appropriateness of the setting for the person with a disability and compliance with the HCBS rule.
- Don't let the opinions of third-party "stakeholders" supplant the judgment of the people with disabilities who are directly affected by the determination of compliance with the rule for a particular setting.

More information from the Coalition for Community Choice: Guidance for States Implementing the HCBS Rule

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Move to Privatize Michigan Mental Health Services by Lobbyists for Health Insurance Plans

From "HMOs seek mental health bids", Crain's Detroit Business, 1/17/2016

"A move is underway in Michigan to further privatize the public nonprofit mental health system by turning over $2.4 billion in state funding to Medicaid HMOs, some of which are owned by for-profit insurers.

"The Lansing-based **Michigan Association of Health Plans** has mounted a lobbying effort to gain state approval next year to bid for the potentially lucrative contracts that now are exclusively in the public health sector."...

"...officials for the **Michigan Association of Community Mental Health Boards** have warned state officials about the dangers that could face a vulnerable and needy population by allowing health plans to take over the state's mental health system.

"'This budget is pretty attractive to the health plans,' said Bob Sheehan, CEO of the mental health board association. 'They see that market, and they believe they can do quite well' financially.

"Sheehan said the health plans underestimate the difficulty in caring for a complex population and their plans' ability to earn high profit margins in behavioral health.

"'This is not a traditional market most health plans are used to serving,' Sheehan said. '(We) treat the more severe cases that involve the additional complexities of poverty, housing, employment, disease and environmental concerns.'..."

[We will be hearing much more about this in the months to come. JB]

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Michigan Dept. of Health and Human Services seeks approval for combining Medicaid Waivers under a new 1115 Demonstration Waiver

Here is the notice from the Dept. of HHS regarding the 1115 Waiver. This includes links to information about the Proposal, a summary of the waiver, and more.

A hearing on the waiver proposal will be held in Lansing:

January 28, 2016, Lansing Center, 10:00-11:30 a.m.
333 Michigan Avenue
Lansing MI 48933

[I hope to find out much more about this and will be attending the hearing in Lansing. JB]

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Does Closing Sheltered Workshops Increase Supported Employment for People with DD? Not Necessarily!

From The DD News Blog

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Next Washtenaw County CMH Townhall Meeting in March

The next WCCMH Townhall Meeting is scheduled for March 22, 2016 at the Learning Resource Center.

- Assistance in Finding Housing
- Collect Housing Application Materials
- Assist with Completing Housing Applications
- Assist with Subsidy applications/re-certifications
- Advocate on behalf of participant with landlords
- Negotiate master-lease and third-party payee
- Assist with Furniture Acquisition
- Purchase other household goods
- Assist with moving
- Tenant Education i.e. rights & responsibility
- Eviction Prevention including:
    - On-time payments
    - Conflict Resolution
    - Lease Requirements
    - Utilities Management
- Maintain landlord relationships
- Maintain Subsidy-provider relationships
- Make mental health beneficiaries aware of housing alternatives, including up to date data and navigation systems

Housing Case Management

- Develop Service Plans
- Monitor implementation and make necessary revisions
- Coordinate
    - Primary Care
    - Health Homes
    - Substance Use Treatment
    - Mental Health Providers
    - Vision Providers
    - Dental Providers
    - Hospital/Emergent Care
- Interventions
    - Crisis
    - Critical Time
    - Landlord Relationships
    - Law Enforcement Issues
    - Individual Counseling to de-escalate
- Motivational Interviews
- Trauma Informed Care
- Transport to appointments
- Assist with Entitlements

- Assist with Independent Living Skills
- Provide links to education, job training, etc.
- End of Life Plans
- Re-engagement

As you are aware, there have been discussions at the federal level on housing and homelessness. Centers for Medicare and Medicaid issued a bulletin in July of 2015, informing states that Housing and Urban Development (HUD) may discontinue funding where it is felt Medicaid should be paying for these services within supportive housing. While this may be accurate, and some of these services may be reflected in the current waivers and state plan, unless MDHHS mandates through adequate contract requirements tied to performance outcomes and sanctions/penalties, many PIHP's, Medicaid Health Plans, and their provider networks may will continue to do business as usual.

To truly apply for a Pathway to Integration Waiver, the discuss and clear delineation of "payor" between the Medicaid Health Plans responsibility for persons with mental illness and substance use disorders, and PIHP's, needs further definition and contractual mandates.

It is the hope of CHN and many providers throughout the State of Michigan that MDHHS, particularly Behavioral Health and Developmental Disabilities Administration (BHDDA), considers the comments from providers and incorporates them into the 1115 Waiver application. Equally important, we urge that BHDDA incorporates mandatory performance outcomes in future PIHP contracts in promoting supportive community integrated housing.

Sincerely,

Marc Craig
President

Association for Children's Mental Health

February 2, 2016

Eric Kurtz
Michigan Department of Health and Human Services
Bureau of Community Health
Behavioral Health/Developmental Disabilities Administration
320 South Walnut Street, Lewis Cass Building, 5th Floor Lansing, MI48913

RE: Comments by the Association for Children's Mental Health (ACMH) to *Pathways to Integration 1115 Waiver Application*

Dear Mr. Kurtz:

The Association for Children's Mental Health (ACMH) is the statewide family-run organization offering support, information and training, systems navigation, and advocacy for children and youth with emotional, behavioral, and/or mental health challenges and their families. ACMH is pleased to offer the following comments on the "Pathway to Integration" 1115 Medicaid Waiver Application.

1. ACMH supports the shift in payment arrangement for the SED waiver from fee for service to a managed care structure while recommending that children and families receive adequate notice and support in navigating potential service provision outcomes from this shift. This includes the possibility that children and families may lose their established service providers if the providers do not join the managed care organization under the new waiver.

2. ACMH supports the potential inherent in the 1115 for statewide expansion of the SED waiver and for expanded enrollment caps but would like an awareness of and sensitivity to the inconsistency in services and supports from PHIP to PHIP, CMH to CMH, and even provider to provider within existing networks. It is our hope that services be available, accessible, and appropriate regardless of where children and families live.

3. ACMH recommends that family-driven/youth-guided language be included in the waiver application in addition to the existing language around person-centered planning. This

language would be in alignment with family-driven/youth-guided policy adopted by MDHHS and would reflect the need for supported family involvement and voice in service plan development for children and youth.

4. ACMH recommends the addition of Youth Peer Support Services in Appendix B as a Long Term Service Benefit under the 115 waiver.

5. ACMH recommends that site review and quality assurance processes as outlined on pages 47-48 be examined and strengthened. Site reviews are an important component of this waiver and should reflect participation by recipients of services and their families.

6. ACMH applauds the provisions for home and community based services for children, youth and their families and encourages expansion of this services to include the mild and moderate population.

The Pathway to Integration Waiver Application is an important step in creating improved and enhanced services for children and youth and their families. ACMH appreciates this opportunity to provide comments. If there are questions or a need for further information, please feel free to contact me at 231-383-1593 or acmhjane@sbcglobal.net.

Sincerely,

Jane Shank

Jane Shank
Executive Director

AuSable Valley
Community Mental Health Authority

Joseph Stone, Board Chairperson
David L. Beck, Ed.D., LPC, Chief Executive Officer

January 26, 2016

Michigan Department of Health and Human Services
Behavioral Health and Developmental Disabilities Administration,
Bureau of Community Health
320 S. Walnut Street,
Lewis Cass Building, 5th Floor
Lansing, Michigan 48913

RE: Section 1115 – Pathway to Integration

Dear Sirs and Madams:

In respect to the published Section 1115 – Pathway to Integration proposal, I respectfully request your consideration of the following:

Section IV.5

That the State clearly describe how the risk to be mitigated by the application of conflict free case management rules can be addressed without adding another fiscal burden and unnecessary level of staffing to a system that is attempting to reduce health cost and reduce medical loss ratios. The capitated funding system, with clear limitations on Medicaid savings, limits on risk reserves, and the required return of lapsed dollars to MDHHS restricts any motivation to under serve and retain funds as the monies are not retained by the provider.

In addition, the active monitoring of services taking place in a robust utilization management system at the PIHP level, proper application of the Access Standards, Person-Centered planning, Grievance and Appeals processes, and focused performance measures provide methods and measures to ensure proper services, in the proper amounts delivered timely.

Finally, the absence of owners and shareholders who stand to experience personal financial benefit from unspent revenues protects against profiteering. If nothing else, propose that the rural northern 21 counties and the UP model this system as a rural demonstration and measure those results, in proportion to all other counties.

- That the state commit to the maintenance of effort related to all citizens currently on the Habilitation Support Waiver. Subsequently, all persons who meet the HSW criteria receive funding at the level of those currently enrolled in HSW.

- That historical funding patterns be eliminated and that a funding system be adopted that ensures that all eligible consumers have the opportunity to have all medically necessary treatment, in accordance with the Person-Centered Plan of Service, at the right time, right place, and at the proper intensity to meet needs.

Sincerely,

David L. Beck, Ed.D., LPC
Chief Executive Officer

Lapeer County Community Mental Health

1570 Suncrest Drive • Lapeer, MI 48446 • (810) 667-0500 • Fax: (810) 664-8728
a member of the Region 10 Mental Health Alliance

Serving Lapeer County Residents

FEB 02 2016

January 21, 2016

Eric Kurtz
Michigan Department of Health & Human Services
32 South Walnut Street
Lewis Cass Building, 5th Floor
Lansing, MI 48913

Re: Section 1115 – Pathway to Integration

Dear Mr. Kurtz:

Thank you for the opportunity to submit comments related to the Section 1115 Waiver submittal to the Centers for Medicare and Medicaid Services (CMS). Lapeer County Community Mental Health (LCCMH) is a department of Lapeer County and has a long history of collaboration with multiple community partners. We are deeply committed to improving the general health and well-being of all persons within our county. We provide many specialty services through evidence-based practices and person-centered planning for adults with severe and persistent mental illness, persons with intellectual and developmental disabilities, children with severe emotional disorders, including autism, and their families, and persons with co-occurring substance use disorders. We have also been actively engaged in the state sponsored integrated healthcare community training and have made enormous progress toward the goal of providing fully integrated healthcare for our community. We recently worked with the Hamilton Community Health Network to renovate a section of our main CMH Building to create a new FQHC for Lapeer County. We also partnered with Advanced Care Pharmacy to open services within our CMH facility. We have also included McLaren Lapeer Region Hospital and the Lapeer County Health Department in this partnership with the goal of developing a system of seamless, integrated healthcare, as one team. In addition to this effort, LCCMH recently opened a satellite office in Imlay City. We have co-located with Health Delivery, Inc. (FQHC), again with the goal of providing fully integrated healthcare in that part of the county.

Michigan Rehabilitation Services maintains an office within the CMH Building. This is part of an ongoing collaboration that includes an annual Certified Cash-Match Agreement. This partnership created a unique employment training project that helped save the County Park System and has helped on average about 30 persons served through CMH actively work toward competitive employment. LCCMH supports a DHHS worker onsite to actively work with our staff to encourage enrollment in the Healthy

CMS

Michigan Plan as well as regular Medicaid and other entitlement benefits. LCCMH is a core partner in the Lapeer County Community Collaborative and are central to many of the initiatives of that body of over 50 agencies focused on coordinating efforts to address social issues such as unemployment, homelessness, access to services, and nutritional awareness/obesity. Through our role with the Senior Coalition CMH also participates in many efforts to serve the elderly, including veterans. Most recently LCCMH was identified as one of 12 locations in the state awarded a Senior Reach Grant through the Blue Cross Health Endowment Fund and the Michigan Association of Community Mental Health Boards. LCCMH and its partners in the Community Collaborative also established a countywide Suicide Prevention Plan and actively participate in a multi-agency workgroup to educate the community and measure effectiveness of this effort.

As a county department, LCCMH has close ties to the County Sherriff's Department and the Lapeer County Court system. We provide ongoing jail diversion and jail treatment services. We are in the second year of the Lapeer County Mental Health Court, working with many community partners to reduce incarceration and hospital recidivism. We also trained a Sherriff Deputy to help our staff provide Mental Health First Aid. This allowed more effective training of law enforcement officers throughout the county. We have also utilized the Mental Health First Aid training to educate specific groups such as the community schools and the local clergy, as well as, the general public.

LCCMH is a strong supporter of utilizing Certified Peer Support Specialist and Parent Support Partners in most of the programs we offer. Our Harmony Hall Psychosocial Rehabilitation Clubhouse and the Golden Arrow Drop-In Center are two examples of programs actively using peer supports. The clubhouse and our InShape Program also partnered with the University of Michigan – Flint, School of Nursing to publish research related to the health benefits of the InShape Program. We have extended the concept of the InShape Program to provide services for persons with intellectual and developmental disabilities, persons with autism and children. In addition to this we have developed exercise groups that are open to graduates of the InShape Program, staff and the general community. These programs along with our community garden and walking trail all fit with the general theme of integrated health and wellness.

I provide this lengthy introduction to highlight many examples of ongoing efforts LCCMH has implemented that are consistent with the themes of the Section 1115 Waiver, "Pathway to Integration". We strongly support this path and are greatly encouraged by the repeated recognition of the publicly funded Michigan Mental Health system as a national leader, with a robust array of services. We applaud efforts to reduce multiple waivers into a single 1115 waiver that does not reduce services or harm individuals or communities in our state. Clearly integrated health care is a priority that LCCMH is in agreement with and actively working toward, however, it is important when trying to improve the overall health and well-being of our communities that our efforts not be restricted solely to a medical perspective. There are multiple examples listed above that are also important to the overall health and prosperity of our communities.

The 1115 Waiver submission mentioned the Certified Community Behavioral Health Centers and LCCMH is excited about this new opportunity to build upon the specialty services we currently provide by expanding services for veterans and their families, for persons with mild to moderate mental illness, and for persons with substance use disorders. We are very supportive of the concept of shared goals and outcomes with the Michigan Health Plans; however, we would like to see more focus on encouraging or requiring the MHPs to more actively engage in this partnering process. It is suggested that the State either removes some of the requirements on the PIHP/CMHSPs, (i.e., excessive documentation and reporting requirements), allowing them to competitively contract with MHPs or imposes the same standards on the MHPs and requires them to pay the full cost of services, to facilitate expanded services for persons with mild to moderate mental illness. The hypotheses sited in the 1115 Waiver – "the goal of this demonstration is to actually create a robust evaluation that tests both quality and cost outcomes between traditional MHPs and Michigan's Specialty Services" – appears to be too narrow in focus. It does a great job of highlighting medical costs and outcomes, but ignores broader community benefits. The publicly funded Community Mental Health System and the Michigan Mental Health Code was largely enacted upon the idea of strong local input and control. These concepts in a broad sense are consistent with the concepts of person-centered planning and self-determination at a community level. The very advanced Michigan Managed Care model was designed to preserve both individual and local ownership of the services provided, not driven by profits, but rather by the needs of the state's most vulnerable individuals and the community in which they live. The 1115 Waiver repeatedly highlights the need to build upon the outstanding performance of the PIHP/CMHSP system which we strongly endorse. It is our belief this system meets the spirit of the federal requirement for conflict-free case management and should be utilized to assist in attaining improved outcomes and cost reductions related to primary medical care.

We support the 1115 waiver submission and the State's profession to build upon "Michigan's long standing commitment to community supports and inclusion and to focus on the capability to function and the opportunity to achieve for persons with severe mental illness (SMI), substance use disorders (SUD), intellectual/developmental disabilities (I/DD) and children with severe emotional disturbances (SED)."

Please contact me if you have questions (810) 694-2817.

Sincerely,

Robert M Sprague

Dr. Robert M. Sprague, Chief Executive Officer

Lori C. Curtiss

Lori Curtiss, Chairperson LCCMH Board

moka We See the Individual in Everyone

February 1, 2016

Mr. Eric Kurtz
Michigan Department of Health and Human Services
Bureau of Community Health
Behavioral Health and Developmental Disabilities Administration
320 South Walnut Street, Lewis Cass Building, Fifth Floor
Lansing, MI 48913

Dear Mr. Kurtz,

I am writing in response to the opportunity to respond to Michigan's proposal to consolidate existing Medicaid waiver programs into one unified approach under the Section 1115 Waiver Rules.

From our perspective as a provider of mental health services under contract with several CMHSP's in western Michigan, we support the initiative to consolidate and streamline existing waiver programs into one program with the goals of facilitating the integration of physical and behavioral healthcare as well as pursuing improved quality through greater flexibility in program provision.

We have recommendations on three distinct themes:

THEME: We support the assurances that through this proposed plan "...Michigan is not reducing or limiting any benefits previously offered..." and in fact will be expanding certain services (with appropriate safeguards to ensure budget neutrality).

RECOMMENDATION
Ensure that resources are proactively directed to maintain access to and quality of existing services with particular attention paid to:

- Increased funding for direct support wages and fringes to improve recruitment and retention of high quality employees for these positions so critical to quality through strong relationships.
- Holding leadership within PIHP, CMHSP and provider networks accountable for the empowerment and forward progress of individuals toward greater independence (and less restrictive services) which would free up resources in support of the proposed expansion of services.

THEME: While review of large data often provides valuable insight into how well services are working across systems, it may not reflect or align with how services are experienced at the individual level.

RECOMMENDATION

Assure the "robust evaluation that tests both quality and cost outcomes between traditional Medicaid Health Plans (MHPs) and Michigan's Specialty Services System"[1] aligns with actual consumer outcomes and consumer experience (satisfaction)

- Identify specific demonstrable outcomes or performance measures which directly impact the experience of individuals receiving the services.
- Conduct external third-party satisfaction surveys
- Assess how satisfaction, based on quality measures, aligns or fails to align with overall data and use data for continuous quality improvement.

THEME: Conflict free case management is an important system wide initiative to avoid perceived or potential financial conflicts or self-referrals. However, preventing such conflicts may unnecessarily restrict individual choice, particularly for individuals considered high risk or high utilizers of services who require integrated, interdisciplinary and tightly coordinated care teams as promoted by CMS in health homes.

RECOMMENDATIONS:

- Acknowledge and support front line services which have achieved great success with individuals through integrated care teams.
- Identify and support other strategies to mitigate conflicts of interest in lieu of strict "firewalls."
- Consider the use of informed consent and disclosure statements to allow case managers to link and coordinate services on an interdisciplinary team within the same agency calling out the potential for self-referral but still supporting choice.

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[1] Pathways to Integration; Executive Summary. Hypothesis/Evaluation p. 2 http://www.michigan.gov/documents/mdhhs/Section_1115_Pathway_to_Integration_Waiver_Summary_508810_7.pdf

Thank you for the opportunity to comment on this important change in the evolution of the mental health system—a system with long and successful history and which we are proud to play a part.

Sincerely,

Thomas Zmolek
Executive Director

Tracey Hamlet
Director of Programs

Cc: MOKA Board of Directors