Summaries of Comments and Questions from Written feedback:

Name/Organization	Question(s)/Comments	Responses (as applicable)
Edwin M. LaFramboise Northern Michigan Community Mental Health Authority		Thank you for your questions and comments regarding Michigan's Pathway to Integration section 1115 waiver application.
	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.	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
	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?	The intent is only if the current managed care entity cannot meet the service delivery, quality, financial and reporting requirements to serve the beneficiaries within a given region.
	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.	It is the intent of MDHHS to maintain all service and supports to all enrolled HSW beneficiaries.
	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.	MDHHS will consider clarifications in future Medicaid Provider Manual updates.

	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	MDHHS will consider updates and/or clarification related to Good and Services in future Medicaid Provider Manual updates. Medicaid payments directly to family members will not be considered as part of this waiver application. Clarification regarding Supports Broker services may be considered as part of future Medicaid Provider Manual updates/revisions.
Elva Mills Chair, Sanilac County Community Mental Health Authority Region 10 PIHP Board Member	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	Thank you for your questions and comments regarding Michigan's Pathway to Integration section 1115 waiver application. The Pathway to Integration Waiver does NOT intend to undue the current managed care delivery system. The intent is only 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 managed care (PIHP) and local efforts to meet the waiver requirements.

	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.	
Jim Johnson Executive Director Sanilac County Community Mental Health Authority	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 (CFCSM). 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? 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. 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." **<u>Questions/Concerns</u>** 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? In Appendix A, under "Essential Elements for Person-Centered Planning and Service Plan Development", the request reads that "The following	Thank you for your questions and comments regarding Michigan's Pathway to Integration section 1115 waiver application. 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. This language only relates to the individual PIHP/managed care entities where performance effects or interferes with the delivery of beneficiary supports.

	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." **<u>Concern</u>** 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. **<u>Suggestion</u>** 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. **1)** 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." **<u>Question</u>** Does this mean that the topics of wellness, coordination,	The PCP s a process that leads to the development of the individual plan of service. The balance between consumer choice and reasonableness of location of the PCP development and service request 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. Additionally, the current PCP policy and process is being revised and will be reflected in this waiver application and the PIHP and CMHSP contracts.

	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. **2)** 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." **<u>Suggestion</u>** 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. **1)** 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." **<u>Suggestion</u>** I believe this should read that the QAPIP must be accountable to a Governing Body that is a **Regional Entity/PIHP** Board of Directors **2)** 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." **<u>Suggestion</u>**	Agreed

		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.	Primarily relates to persons receiving LTSS, but nearly all Specialty Service Populations have tendencies by nature to be vulnerable populations as you indicated. This should be defined by the PIHP.
	3)	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."	
		<u>Suggestion</u>	
		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.	All Specialty service and supports regardless of service delivery arrangement must meet medical necessity for the services authorized and delivered.
	4)	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."	
		<u>Question</u>	
		Doesn't the BBA give the organization the ability (and <u>responsibility</u>) 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?	BBA requires adequate provider network to meet the needs of the beneficiaries within a given geographic region. PIHP and CMHSP determine provider credentialing standards and qualifications regardless of delivery system arrangement.
		<u>Suggestion</u>	
		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. **5)** 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." **<u>Question/Suggestion</u>** 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).	Self-determination arrangements must be available and offered to all Specialty Service populations but if services such as ACT, ABA that are based on Evidence Based Services and described in the Medicaid manual cannot be modified based on the self-determination arrangement. As always beneficiary choice of provider when applicable should be considered.
Stephen Armstrong Chair, St. Clair County Community Mental Health Authority Region 10 PIHP Board Member	I applaud MDHHS's decision to implement the Section 1115 Waiver using the existing 10 PIHP agencies and regions. As a consequence of my two decades of experience helping to build the system through which behavioral and I/DD services are provided to individuals in St. Clair County and the Thumb Region, I recognize that the evolution of the current system was the result of the collective wisdom and good-faith efforts of scores of individuals from the statehouse, governor's office, your office, and persons like myself working at the PIHP and county levels. While no system is perfect, I believe the vast majority of	Thank you for your questions and comments regarding Michigan's Pathway to Integration section 1115 waiver application.

	organizations delivering services to individuals with mental illness and intellectual or developmental disabilities in the State of Michigan do so responsibly, both financially and in terms of the services they provide. Given current economic realities, it is understandable that the state hold organizations providing behavioral and I/DD services to the highest standards, in terms of service delivery, quality, financial and reporting requirements. However, I also believe it is important that each organization be evaluated on the basis of its own performance, and not the performance of other organizations. Therefore, I was concerned to read in section IV., 5., (d) that "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." The language appears ambiguous regarding scope: does it mean the state intends to contract outside the PHIP and CMHSP system on a case by case basis, or elect to do so on a statewide basis if it is concluded a portion of PHIPs and CMHSPs do not meet service delivery, quality, financial and reporting requirements? Abandoning the carefully constructed PHIP and CMHSP framework on the basis of the failure of a few PHIPs or CMHSPs to meet standards would be the proverbial "throwing the baby out with the bath water." Also, even in those instances where standards were not met, some period of remediation surely should be available before seriously disrupting service delivery to vulnerable community members with behavioral and I/DD issues? Finally, would it be possible to be more specific in terms of what degree of failure in each requirement alone or what combination of failures in multiple requirements (service delivery, quality, financial and reporting) would lead to the state contracting out of the PIHP and CMHSP system?	This language only relates to the individual PIHP/managed care entities where performance effects or interferes with the delivery of beneficiary supports.

Michigan Association of Community Mental Health Boards Comments on the Michigan's 1115 Waiver Application	**Overarching Themes** **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: o 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). o 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	Thank you for your questions and comments regarding Michigan's Pathway to Integration section 1115 waiver application. Currently Medicaid Health Plans (MHPs) are required to provide behavioral health services for licensure and parity purposes and in this case, that equates to the 20 outpatient visits as described in the Medicaid provider Manual. Better PIHPs and MHPs service coordination is part of the Pathway to Integration Waiver expectations. Since PIHPs and CMHSPs are currently both public entities, full risk contracting is not allowed. As part of the demonstration, MDHHS will look at shared saving models between MHPs and PIHPs as a way to partially address this issue.

	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: o co-location of behavioral health providers in primary care settings o co-location of primary care providers in behavioral healthcare settings o integrated treatment teams o electronic bridges between EMRs o shared data analytics systems and efforts o ease of movement across healthcare systems o high- utilizer focused collaborative efforts o integrated/coordinated person centered plans o imbedded pharmacies o efforts to address the social determinants of health o development of safety-net accountable systems of care **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.	We are seeking a discussion with CMS regarding allowances for specific populations.

	Recommend that the application address the need for increased access to community inpatient psychiatric beds and inpatient substance use disorder detoxification beds. **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:** **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	Inpatient psychiatric services are state plan service including medical detox. MDHHS has recognized the lack of access to needed psychiatric services and has multiple workgroups working on the issues. This is currently available at primary care settings. Use within the behavioral health system is being considered.

	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. **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: o 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) o 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 o the tools which MDHHS uses to ensure compliance with access, person-centered-planning, grievance and appeals, and other performance measures o the absence of owners or shareholders who would stand to benefit financially from unspent revenues **Section IV. 5 and Section V. 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;	Policy and definitions will be established by MDHHSA and the comment and recommendation will be forwarded to the CFCSM workgroup.

	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** **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: o Adults with serious mental illness o Children and adolescents with serious emotional disturbance o Adults with intellectual/developmental disabilities o Children and adolescents with intellectual/developmental disabilities o Adults with substance use disorders **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. **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.	Redefining actuarial rates by population maybe considered in future rate setting and/or waiver amendments.
	Section IV. 10.	
	Recommend that the incentives and withholds system should be outside of the actuarially sound rebasing process.	
	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.	Although the amounts and rates may be actuarially certified These incentives will be paid outside of the current actuarial process.
	Appendix A, Self Determination Overview	
	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."	
	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.	BBA requires adequate provider network to meet the needs of the beneficiaries within a given geographic region. PIHP and CMHSP determine provider credentialing standards and qualifications regardless of delivery system arrangement

Joseph P. Sedlock, MSA Chief Executive Officer Mid State Health Network	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	Thank you for your questions and comments regarding Michigan's Pathway to Integration section 1115 waiver application.

	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.	
COMMUNITY LIVING SERVICES, INC.'S	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. . 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?	Thank you for your questions and comments regarding Michigan's Pathway to Integration section 1115 waiver application. MDHHS will consider updates and/or clarification related to in future Medicaid Provider Manual updates. MDHHS is considering the expansion of goods and services but currently it only relates to individuals enrolled in the HSW program.

	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?	ABA/Behavioral Therapy will now be part of the Michigan State Plan and considered as part of the state Early and Periodic Screening Diagnostic and Treatment Program for children. This change does not affect funding.
	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'.	Complex Care Managers will need to be as close to the service delivery as possible but could be at either the plan or provider level. Individuals who meet the criteria as High Utilizers will be defined as part of the waivers overall demonstration.
	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?	Yes and where possible preventive interventions as applicable should be put in place to avoid unnecessary hospitalization or ED visits.
	• Will there be crisis residential locations available in all PIHPs for I/DD and what will they look like?	Crisis residential is only available for individuals with acute psychiatric symptomatology or disorders. This can and does include persons with I/DD who are also dually diagnosed.
	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.	Parental Income is waived for persons who qualify for the program.
	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.	Permanent Supportive Housing (PSH) has multiple definitions and will be finalized in the Medicaid manual after further input and consideration related to evidence based best practice (EBPs). The intent is to provide a set of flexible

	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?	services that support that maintain housing for all specialty service populations. Currently what is in the application? Fiscal Intermediary has never been an HSW service but HSW beneficiaries can access the service previously under the section 1915(b) and now under the 1115 as well. LTSS are a specific set up services as described by CMS but primarily relate to the former Section 1915(c) Waiver Supports. They will They will be included as part of the overall demonstration and negotiated as part of the PIHP contract.

	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?	They can be but not required.
	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	Medicaid beneficiaries will be notified by the state.
	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.	This will be taken under consideration.
	Page 48 • Define "conflict free case management" and what are the requirements around this term?	CFCSM is part of the Home and Community Based Setting Final Rules. CFCSM is defined and requires the state to establish conflict of interest standards for the assessments of functional need, independent evaluation and assessment in the person-centered service plan development process that apply to all individuals and entities, public or private. •Minimally, this must require that individuals are not: (1) Related by blood or marriage to the individual, or to any paid caregiver of the individual. (2) Financially responsible for the individual.

		(3) Empowered to make financial or health-related decisions on behalf of the individual. (4) Individuals who would benefit financially from the provision of assessed needs and services.
	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.	In order to be qualified, a provider must meet all o the provider qualifications for the service or support he or she is providing. No but does believe individuals should be served in the most independent and least restrictive settings. This is more related to certain bundled programs like Assertive Community Treatment, which has specific team models and evidence based practice. As best as possible, self-determination principals should be used whenever possible.
	Page 50 • Please describe the plan including relevant timelines to continue dialogue with stakeholders.	Formal stakeholder input concluded on 2-2-16 but continued stakeholder input and consideration will be provided throughout the waiver implementation process.
	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.	The Pathway to Integration Waiver does not include the MI-Choice Waiver.
	Page 55 • Define "Items necessary for life supports", what items are being contemplated? Does the term "life supports" refer to life in the community?	Community Treatment and Supports.
Melissa Essig Program and Services Manager		

Riverwood Center – Berrien Mental Health Authority	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	Thank you for your questions and comments regarding Michigan's Pathway to Integration section 1115 waiver application. These definitions are currently being revised and will be included as part of the final waiver application. Housing Assistance is a covered service but not considered a LTSS.

	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.	Transportation is not identified as a Long Term Service and Support but is a state plan service and covered as such under this section 1115. You input is appreciated and may be considered in future service and Medicaid Provider Manual Revisions. Non-Family Training will not be expanded at his time but could be considered in the future. No, PERS is a specific service as defined in the Medicaid Manual. We appreciate the recommendation but home help is not covered under this 1115 waiver proposal.
from Judith Taylor, Ph.D - longtime advocate for the public mental health services system in Michigan	**<u>Program Description Section</u>**	Thank you for your questions and comments regarding Michigan's Pathway to Integration section 1115 waiver application.

	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.	We concur that Michigan's historical progress is often overlooked and this is a point well taken. This statement is more related of the state's multiple integrated care initiatives and as they relate to this demonstration proposal.
	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.	Michigan is incorporating the requirements as outlined in the July 27, 2015 SMD# 15-003 for New Service Delivery Opportunities for Individuals with Substance Use disorders. Further details related to the expanded use of ASAM for all levels of SUD services will be detailed further in the final application.
	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?	The needs based criteria is related to the specialty services system. Although MHPs will continue to be required to provide services to persons with mild and moderate disorders, in order to better impact care coordination for populations considered High Utilizers, coordination between the MHPs and PIHPs will be monitored with increased contractual expectations.
	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	This could be considered and is as part of Michigan's HCBS transition plan, but the term for the purpose of this demonstration is related to the high usage of hospital ED and inpatient utilization of both psychiatric and medical care.
	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	This section describes the boundary issues between MHP and PIHPs for persons with mild and moderate disorders and

	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. **<u>Populations/eligibles</u>** 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?**	the eligibility for all Specialty Service and Supports outside of the former enrolled programs (HSW, SEDW, CWP). At this point in time it does not change the MHP requirements to provide a mental health benefit to persons with Mild and moderate disorders. There are no new populations besides the expansion of Autism services to children between the ages of 6-21. At this point in time the slot for enrollment will remain but consideration has been given to developing an I/DD specific rate cell to combine these populations currently receiving services.

	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).	These programs are still being used to deem Medicaid eligibility along with beneficiary access to specific services.
	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?	In order to maintain the array of services available to individuals enrolled in this program, Case Management will continue to be a covered service. Consistent use of terminology and service definition will be considered as part of the ongoing Medicaid Provider Manual revisions. PDN does not 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.	This will be taken into consideration.
	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	In order to maintain the full array of services within each of the sub-populations, these titles and definitions will continue to be used. There are efforts underway to modify the usage and clarify service definitions in future Medicaid Provider Manual revisions.
	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?	Personal Care in non-licensed settings will continue to be managed outside of this waiver proposal.
	<u>Financing and Funding</u>	
	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?	PM/PM rates will include the total historical cost of services provided including state general funds or other local contributions.
	2. The use of the word "incentives" is mis-leading -- what is being described at least for now are in fact with-holds. 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.	Currently these incentives are earned and timeliness of payment is being addressed.
	3. 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?	Currently the PIHPs and MHPs have joint incentive pools and the Pathway to Integration Waiver Demonstration intends to identify what services effect utilization and where saving acutely accrues.
	4. 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.**	Trends were based on current actuarial soundness.
	5. 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.	The only additional service being proposed at this time is the use of Permanent Supportive Housing, which is being offset by other utilization reductions in inpatient.

	6. **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.	Based on the state's ability to maintain budget neutrality these suggestions may be considered in future rate setting methodologies.
deborah monroe	Peer Respites need to be included, the research shows it's cost effective and it would decrease the use of psychiatric hospitalization services Michigan should be a model in the country.	Your input, comments and recommendations regarding MDHHS's Pathway to Integration Waiver are greatly appreciated. Peer Respite may be considered as part of the Permanent Supportive Housing (PSH) Model.
Jean Dukarski Certified Peer Support Specialist	Please consider my comments regarding S**ection 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.	Your input, comments and recommendations regarding MDHHS's Pathway to Integration Waiver are greatly appreciated. Peer Respite may be considered as part of the Permanent Supportive Housing (PSH) Model.
John Hales, cpss, crc	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	Your input, comments and recommendations regarding MDHHS's Pathway to Integration Waiver are greatly appreciated. Peer Respite may be considered as part of the Permanent Supportive Housing (PSH) Model.
Sara Lurie Chief Executive Officer Community Mental Health Authority of Clinton, Eaton, Ingham Counties	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.	Your recommendation is the exact intent based on contractual requirements and the PIHPs ability to meet BBA requirements. We are seeking a discussion with CMS regarding allowances for specific populations. Inpatient psychiatric services are state plan service including medical detox. MDHHS has recognized the lack of access to needed psychiatric services and has multiple workgroups working on the issues. The Pathway to Integration Waiver proposal does not have the ability or addresses the state General Fund allocations to CMHSPs.
Monica Ortquist	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	Your input, comments and recommendations regarding MDHHS's Pathway to Integration Waiver are greatly appreciated. Peer Respite may be considered as part of the Permanent Supportive Housing (PSH) Model.

	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.	
ROBERT L. STEIN General Counsel Michigan Assisted Living Association (MALA)	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	Thank you for your questions and comments regarding Michigan's Pathway to Integration section 1115 waiver application.

	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."	
Kathy Lents Kalamazoo Community Mental Health & Substance Abuse Services	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.	Care Coordination in the traditional sense is an administrative function and there are multiple models. For the Specialty Service populations and high utilizers, this group often needs much more coordination and intervention than normally provided as an administrative functions but can and will include both administrative and direct service functions. These functions may be carried out by Nurse/Nurse Practitioners who lead and coordinate care.

	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	Permanent Supportive housing is a set of services surrounding an individual to maintain housing. Further model definitions and requirements will be provided as part of the Medicaid Provider Manual updates and revisions upon waiver approval. These provider qualifications are being modified and final definitions will be included as part of the final waiver application.

	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	Please see the following link to the HCBS current transition plan. HCBS final rules apply to section 1115 LTSS. Prevocational and Skill Building Assistance are services basically separated by the former 1915(b)/(c) waiver authorities. In order to maintain consistency with regards to separating HSW services from other 191(b) waiver services the distinction will remain, but both service definitions are in the process of being updated and future consolidation may occur. Supported employment is not considered a LTSS. It is not being expanded to adults at this time.

	available to adults? If so, much additional clarification of benefit and eligibility criteria is needed.	
Melvin Lester C.P.S.S	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.	Your input, comments and recommendations regarding MDHHS's Pathway to Integration Waiver are greatly appreciated. Peer Respite may be considered as part of the Permanent Supportive Housing (PSH) Model.
Michelle Recovery Concepts	Hello I would like to speak about the need for Peer Respite 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.	Your input, comments and recommendations regarding MDHHS's Pathway to Integration Waiver are greatly appreciated. Peer Respite may be considered as part of the Permanent Supportive Housing (PSH) Model.
Jane Shank Executive Director Association for Children's Mental Health (ACMH)	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.	Your input, comments and recommendations regarding MDHHS's Pathway to Integration Waiver are greatly appreciated. Your comments/feedback and will take them into consideration.
Jill Gerrie Project Coordinator 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	Although independent facilitation is an option for PCP facilitation, it is up to the beneficiary to request this option.

	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	Revisions to the definition of Goods and Services may be considered as part of future Medicaid Provider Manual updates/revisions.

	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.	That is the intention. Your input, comments and recommendations regarding MDHHS's Pathway to Integration Waiver are greatly appreciated. Your comments and will consider your part of the final application.
Elizabeth W. Bauer, M.A.	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	ABA Behavioral Therapy is now a State Plan Service still paid through PIHPs. The Section 1915(i) waiver has been discontinued.

	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.	Your input, comments and recommendations regarding MDHHS's Pathway to Integration Waiver are greatly appreciated. MDHHS intends to maintain this long standing array of services that supports the Specialty Services populations and will continue to support the long history of community inclusion, which is only enhanced by the HCBS final rules. As part of the Pathway to Integration Waiver and its associated requirements related to LTSS, MDHHS intends to expand its current quality reporting and site review process to identify and address both of these concerns where they exist.

	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.	This waiver application does not change or effect a beneficiary FFS status or their participation in the MI-Health Link. MI-Health Link and enrolment into an ICO is voluntary.
	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.	Beneficiaries on the SED and Children's Waiver will receive notice regarding the change from the current FFS program to managed care for their Specialty Service and Supports.
	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,	The demonstration is targeting preventable high utilization of ED and Hospital utilization. LTSS is not a target of reduced utilization as part of the demonstration. Budget neutrality is a statewide not at the individual PIHP or provider level.

	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.	Again your comments and concerns are greatly appreciated and will be taken into consideration.

Kim Sibilsky Chief Executive Officer Michigan Primary Care Association	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	Your input, comments and recommendations regarding MDHHS's Pathway to Integration Waiver are greatly appreciated. The intent of this waiver is to raise the bar regarding integration between MHPs and PIHPs and to analyze the service and supports that impact the quality and

	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.	cost related to this Specialty Service Population. This waiver does not cover rates paid to providers by MHPs.
Carol Wallace, LBSW, MA, LPC Consultant for Peer Directed Support Michigan Department for Health and Human Services	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.	Your input, comments and recommendations regarding MDHHS’s Pathway to Integration Waiver are greatly appreciated. Advancement of Peer Respite services may be considered as part of the Permanent Supportive Housing (PSH) Model.