DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop: S2-26-12
Baltimore, Maryland 21244-1850

October 27, 2020

Kate Massey
Senior Deputy Director
Michigan Department of Health and Human Services (MDHHS)
100 South Capital Avenue
Lansing, Michigan 48909

Dear Ms. Massey:

On March 13, 2020, the President of the United States issued a proclamation that the Coronavirus Disease 2019 (COVID-19) outbreak in the United States constitutes a national emergency by the authorities vested in him by the Constitution and the laws of the United States, including sections 201 and 301 of the National Emergencies Act (50 U.S.C. 1601 et seq.), and consistent with section 1135 of the Social Security Act (Act) as amended (42 U.S.C. 1320b-5). On March 13, 2020, pursuant to section 1135(b) of the Act, the Secretary of Health and Human Services invoked his authority to waive or modify certain requirements of titles XVIII, XIX, and XXI of the Act as a result of the consequences of the COVID-19 pandemic, to the extent necessary, as determined by the Centers for Medicare & Medicaid Services (CMS), to ensure that sufficient health care items and services are available to meet the needs of individuals enrolled in the respective programs and to ensure that health care providers that furnish such items and services in good faith, but are unable to comply with one or more of such requirements as a result of the COVID-19 pandemic, may be reimbursed for such items and services and exempted from sanctions for such noncompliance, absent any determination of fraud or abuse. This authority took effect as of 6:00 PM Eastern Standard Time on March 15, 2020, with a retroactive effective date of March 1, 2020. We note that the emergency period will terminate, upon termination of the public health emergency (PHE), including any extensions.

In response to the section 1115(a) demonstration opportunity announced to states on March 22, 2020, in State Medicaid Director Letter (SMDL) #20-002,[1] on June 11, 2020, Michigan submitted a request for a section 1115(a) demonstration to address the COVID-19 PHE. CMS has determined that the state's application is complete, consistent with the exemptions and flexibilities outlined in 42 CFR 431.416(e)(2) and 431.416(g).[2] CMS expects

[1] See SMDL #20-002, "COVID-19 Public Health Emergency Section 1115(a) Opportunity for States," available at https://www.medicaid.gov/sites/default/files/Federal-Policy-Guidance/Downloads/smd20002-1115template.docx.
[2] Pursuant to 42 CFR 431.416(g), CMS has determined that the existence of unforeseen circumstances resulting from the COVID-19 PHE warrants an exception to the normal state and federal public notice procedures to expedite a decision on a proposed COVID-19 section 1115 demonstration or amendment. States applying for a COVID-19 section 1115 demonstration or amendment are not required to conduct a public notice and input process. CMS is also exercising its discretionary authority to expedite its normal review and approval processes to render timely

that states will offer, in good faith and in a prudent manner, a post-submission public notice process, including tribal consultation as applicable, to the extent circumstances permit. This letter also serves as time-limited approval of several of the requests which were included in the state's request. With this letter, these requests will be approved as an amendment under the "Michigan 1115 Pathway to Integration" section 1115(a) demonstration (Project Number 11-W-00305/5) and which are hereby authorized retroactively from March 1, 2020, through the date that is 60 days after the end of the PHE (including any renewal of the PHE).

CMS has determined that the COVID-19 Public Health Emergency amendment to the Michigan 1115 Pathway to Integration demonstration – including the flexibilities detailed in the enclosed Attachment F – is necessary to assist the state in delivering the most effective care to its beneficiaries in light of the COVID-19 PHE. The demonstration amendment is likely to assist in promoting the objectives of the Medicaid statute because it is expected to help the state furnish medical assistance in a manner intended to protect, to the greatest extent possible, the health, safety, and welfare of individuals and providers who may be affected by COVID-19.

In addition, in light of the unprecedented emergency circumstances associated with the COVID-19 pandemic and consistent with the President's declaration detailed above – and in consequence of the time-limited nature of this demonstration amendment – CMS did not require the state to submit budget neutrality calculations for this COVID-19 PHE amendment to the Michigan 1115 Pathway to Integration demonstration. In general, CMS has determined that the costs to the federal government are likely to have been otherwise incurred and allowable. Michigan will still be required to track demonstration expenditures and will be expected to evaluate the connection between those expenditures and the state's response to the PHE, as well as the cost-effectiveness of those expenditures. For similar reasons, and due to the highly limited scope of the changes under the amendment, CMS did not require revised special terms and conditions (STC).

Requests CMS is Approving at this Time

The state currently has expenditure authority to provide residential treatment for individuals with substance use disorder (SUD), and time-limited expenditure authority for 1915(i)-like services. The state has requested flexibilities related to the 1915(i) like services expenditure authority during the PHE.

This letter only addresses requests that CMS is approving at this time. Consistent with the flexibilities described in the SMDL #20-002 and additional flexibilities, CMS is approving the expenditures, with associated requirements, for individuals receiving 1915(i)-like home and community based (HCBS) services as described in Attachment F, starting March 1, 2020, and ending 60 days post-PHE.

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decisions on state applications for COVID-19 section 1115 demonstrations or amendments. CMS will post all section 1115 demonstrations approved under this COVID-19 demonstration opportunity on the Medicaid.gov website.

Monitoring and Evaluation Requirements

The state must submit an evaluation design to CMS within 60 days of the demonstration amendment approval. CMS will provide guidance on an evaluation design specifically for the expenditure authorities approved for the COVID-19 emergency, including any amendments. The state is required to post its evaluation design to the state's website within 30 days of CMS approval of the evaluation design, per 42 CFR 431.424(e).

The state will test whether and how the approved expenditure authorities affect the state's response to the public health emergency. To that end, the state will use research questions that pertain to the approved expenditure authorities. The evaluation will also assess cost-effectiveness by tracking administrative costs and health services expenditures for demonstration beneficiaries and assessing how these outlays affected the state's response to the public health emergency.

The state is required to submit a final report. The final report will consolidate monitoring and evaluation reporting requirements for this demonstration authority. The state must submit this final report no later than one year after the end of the COVID-19 section 1115 demonstration authority. The final report will capture data on the demonstration implementation, lessons learned, and best practices for similar situations. The state will be required to track separately all expenditures associated with this demonstration, including but not limited to, administrative costs and program expenditures. CMS will provide additional guidance on the structure and content of the final report. Should the approval period of these demonstration authorities exceed one year, for each year of the demonstration that the state is required to complete per the annual report required under 42 CFR 431.428(a), the state may submit that information in the Final Report.

Approval of this demonstration amendment is subject to the limitations specified in the flexibilities listed in Attachment F and the previously approved expenditure authorities and STCs. The state may deviate from its Medicaid state plan requirements only to the extent that the requirements have been specifically identified as not applicable for the demonstration as specified in the list of approved authorities. This approval is conditioned upon continued compliance with the previously approved STCs which set forth in detail the nature, character and extent of anticipated federal involvement in the project.

The award is subject to CMS receiving written acceptance of this award within 15 days of the date of this approval letter. Your project officer is Ms. April Wiley. Ms. Wiley is available to answer any questions concerning implementation of the state's section 1115(a) demonstration amendment and her contact information is as follows:

Centers for Medicare & Medicaid Services
Center for Medicaid and CHIP Services
Mail Stop: S2-25-26
7500 Security Boulevard
Baltimore, Maryland 21244-1850
Email: april.wiley@cms.hhs.gov

We appreciate your state's commitment to addressing the significant challenges posed by the COVID-19 pandemic and we look forward to our continued partnership on the Michigan 1115 Pathway to Integration section 1115(a) demonstration. If you have any questions regarding this approval, please contact Ms. Judith Cash, Director, State Demonstrations Group, Center for Medicaid and CHIP Services, at (410) 786-9686.

Sincerely,

Anne Marie Costello
Acting Deputy Administrator and Director

Enclosure

cc: Keri Toback, State Monitoring Lead, Medicaid and CHIP Operations Group

Attachment F- – Time-limited Expenditure Authorities and Associated Requirements for State's Response to COVID-19 Public Health Emergency (PHE)

These authorities are necessary to assist the state in delivering the most effective care to its beneficiaries in light of the COVID-19 PHE. The demonstration amendment is likely to assist in promoting the objectives of the Medicaid statute because it is expected to help the state furnish medical assistance in a manner intended to protect, to the greatest extent possible, the health, safety, and welfare of individuals and providers who may be affected by COVID-19. The expenditure authorities provided via this demonstration amendment assist the state in achieving these goals.

1. **Expedited Eligibility for Long-Term Care Services and Supports (LTSS).** Expenditures to allow for self-attestation or alternative verification of individuals' eligibility (income/assets) and level of care to qualify for LTSS. This authority allows an individual to self-attest to income or assets. The individual may remain eligible until such time that the state verifies that the individual has income or assets greater than what is allowable under the Medicaid state plan. The state may also accept self-attestation of level of care (LOC) requirements. The individual may receive the LTSS services up until the state verifies that the individual does not meet LOC requirements. This authority allows the state to: a) delay the need for income and asset verification for one year, and b) delay the need for a level of care assessment for one year.

2. **LTSS.** Expenditures for 1905(a) LTSS services for impacted individuals even if services are not timely updated in the plan of care, or are delivered in alternative settings for the period of the public health emergency. The State defines alternative settings as those which would have been otherwise-approvable via 1915(c), Appendix K (e.g. hotels, shelters, schools and churches).

3. **Home and Community-Based Services (HCBS) Rates.** Expenditures for the state to pay higher rates for 1915(i)-like HCBS providers for 1915(i)-like HCBS services provided in accordance with Section 1902(a)(30)(A) in order to maintain capacity to address the needs of individuals who require Medicaid services during the PHE. The amount of the increase in payment rates to providers and the effective time periods will be determined by the Michigan Department of Health and Human Services (MDHHS) and paid to the prepaid inpatient health plans (PIHP) for these populations. The rate increase will not exceed 50 percent of the currently approved rates.

4. **Functional Assessments.** Expenditures to allow the state to temporarily reduce or delay the need for states to conduct functional assessments to determine LOC for beneficiaries needing 1915(i)-like services. This authority allows the state to delay the need for a functional assessment and LOC determination for one year, and for reassessments to be delayed one year.

5. **Payment for Supports in Alternative Settings.** Expenditures to allow payment for Personal care, Community living, behavioral and communication supports (e.g., services to promote activities of daily living and instrumental activities of daily living), not

otherwise provided in that setting, to support individuals in an acute care hospital or short-term institutional setting, when MDHHS identifies that no other alternatives are available, and an institution or hospital is the only setting that service may be offered to meet an individual's health and safety needs. Services provided will not be duplicative of hospital or short-term institutional services provided in those settings.

6. **Person-Centered Planning.** Expenditures to allow for modification of the person-centered planning process. Person-Centered Service Plans that are due to expire within the next 60days require case management contact to the participant using allowable remote contact methods to verify with the participant or representative that the current assessment and services, including providers, remain acceptable and approvable for the upcoming year. The state will verify by obtaining electronic signatures/or electronic verification via secure email consent from service providers and the individual or representative, in accordance with the state's Health Insurance Portability and Accountability Act (HIPAA) requirements The state will ensure the service plan is modified to allow for additional supports/and or services to respond to the COVID-19 pandemic. The specificity of such services including amount, duration and scope will be appended as soon as possible to ensure that the specific service is delineated accordingly to the date it began to be received. The care coordinator must submit the request for additional supports/services no later than 30 days from the date the service begins.

7. **Telehealth.** Expenditures to allow for modifications of the following processes for telehealth:
   - Allow an extension for reassessments and reevaluations for up to one year past the due date.
   - Allow the option to conduct evaluations, assessments, and person-centered service planning meetings virtually/remotely in lieu of face-to-face meetings.
   - Allow an electronic method of signing off on required documents such as the person-centered service plan, consent for treatment, and releases of information.
   - Accept verbal/electronic consent documented by the PIHP or community mental health services program (CMHSP) as a method of signing off on required documents such as the person-centered service plan, consent for treatment, and releases of information with the understanding that written consent will be obtained as soon as feasible to validate consent.

8. **Quality Reviews.** Expenditures to suspend the collection of data for performance measures other than those identified for the Health and Welfare assurance and notes that as a result the data will be unavailable for this time frame in ensuing reports due to the circumstances of the pandemic.

9. **Incident Reporting.** Expenditures to allow for entry of incidents into the Incident Reporting System outside of typical timeframes in instances in which staff shortages due to COVID-19 occur, consistent with the states identified transition plan. Response to incidents will not be impacted.

10. **Evaluation Design.** The state must submit an evaluation design to CMS within 60 days of the demonstration amendment approval. CMS will provide guidance on an evaluation design specifically for the expenditure authorities approved for the COVID-19 emergency, including any amendments. The state is required to post its evaluation design to the state's website within 30 days of CMS approval of the evaluation design, per 42 CFR 431.424(e).The state will test whether and how the approved expenditure authorities affect the state's response to the public health emergency. To that end, the state will use research questions that pertain to the approved expenditure authorities. The evaluation will also assess cost-effectiveness by tracking administrative costs and health services expenditures for demonstration beneficiaries and assessing how these outlays affected the state's response to the public health emergency.

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CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

COVID-19 Section 1115(a) Demonstration Application Template

The State of Michigan, Department of Health and Human Services proposes emergency relief as an affected state, through the use of section 1115(a) demonstration authority as outlined in the Social Security Act (the Act), to address the multi-faceted effects of the novel coronavirus (COVID-19) on the state's Medicaid program.

I. DEMONSTRATION GOAL AND OBJECTIVES

Effective retroactively to March 1, 2020, the State of Michigan seeks section 1115(a) demonstration authority to operate its Medicaid program without regard to the specific statutory or regulatory provisions (or related policy guidance) described below, in order to furnish medical assistance in a manner intended to protect, to the greatest extent possible, the health, safety, and welfare of individuals and providers who may be affected by COVID-19.

II. DEMONSTRATION PROJECT FEATURES

A. Eligible Individuals: The following populations will be eligible under this demonstration. To the extent coverage of a particular service is available for a particular beneficiary under the State plan, such coverage will be provided under the State plan and not under demonstration authority.

Check to Apply	Population
	Current title XIX State plan beneficiaries
X	Current section 1115(a)(2) expenditure population(s) eligible for/enrolled in the following existing section 1115 demonstrations: • Michigan 1115 Behavioral Health Demonstration

B. Benefits: The state will provide the following benefits and services to individuals eligible under this demonstration. To the extent coverage of a particular service is available for a particular beneficiary under the State plan, such coverage will be provided under the State plan and not under demonstration authority.

Check to Apply	Services
X	Current title XIX State plan benefits
X	Others as described here: • Services per the 1115 SMI/SED Waiver Opportunity pertinent to COVID-19: o IMD services for SMI/SED for 30 days

C. Cost-sharing

Check to Apply	Cost-Sharing Description
	There will be no premium, enrollment fee, or similar charge, or cost-sharing (including copayments and deductibles) required of individuals who will be enrolled in this demonstration that varies from the state's current state plan.
X	Other as described here: Michigan will not impose cost sharing for testing services (including in vitro diagnostic products, and including test administration), testing-related services, and treatments for COVID-19, including vaccines, specialized equipment and therapies, for any quarter in which the increased FMAP is claimed.

D. Delivery System:

Check to Apply	Delivery System Description
	The health care delivery system for the provision of services under this demonstration will be implemented in the same manner as under the state's current state plan.
X	Other as described here: MDHHS will utilize the delivery system cited in Michigan's approved 1115 Behavioral Health Demonstration

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III. EXPENDITURE AND ENROLLMENT PROJECTIONS

A. Enrollment and Enrollment Impact.

State projects that approximately 300,000 individuals as described in section II will be eligible for the period of the demonstration. The overall impact of this section 1115 demonstration is that these individuals, for the period of the demonstration, will continue to receive HCBS or coverage through this demonstration to address the COVID-19 public health emergency.

B. Expenditure Projection.

The state projects that the total aggregate expenditures under this section 1115 demonstration is budget neutral.

In light of the unprecedented emergency circumstances associated with the COVID-19 pandemic and consistent with the President's proclamation that the COVID-19 outbreak constitutes a national emergency consistent with section 1135 of the Act, and the time-limited nature of demonstrations that would be approved under this opportunity, the Department will not require States to submit budget neutrality calculations for section 1115 demonstration projects designed to combat and respond to the spread of COVID-19. In general, CMS has determined that the costs to the Federal Government are likely to have otherwise been incurred and allowable. States will still be required to track expenditures and should evaluate the connection between and cost effectiveness of those expenditures and the state's response to the public health emergency in their evaluations of demonstrations approved under this opportunity.

IV. APPLICABLE TITLE XIX AUTHORITIES

The state is proposing to apply the flexibilities granted under this demonstration opportunity to the populations identified in section II.A above.

Check to Apply	Program
	Medicaid state plan
	Section 1915(c) of the Social Security Act ("HCBS waiver"). Provide applicable waiver numbers below:
X	Section 1115(a) of the Social Security Act (i.e., existing, approved state demonstration projects). Provide applicable demonstration name/population name below: • Michigan's 1115 Behavioral Health Demonstration
	Other: [*State to describe here*]

V. WAIVERS AND EXPENDITURE AUTHORITIES

A non-exhaustive list of waiver and expenditure authorities available under this section 1115 demonstration opportunity has been provided below. States have the flexibility to request additional waivers and expenditure authorities as necessary to operate their programs to address COVID-19. If additional waivers or expenditure authorities are desired, please identify the authority needed where indicated below and include a justification for how the authority is needed to assist the state in meeting its goals and objectives for this demonstration. States may include attachments as necessary. Note: while we will endeavor to review all state requests for demonstrations to combat COVID-19 on an expedited timeframe, dispositions will be made on a state-by-state basis, and requests for waivers or expenditure authorities in addition to those identified on this template may delay our consideration of the state's request.

A. Section 1115(a)(1) Waivers and Provisions Not Otherwise Applicable under 1115(a)(2)

The state is requesting the below waivers pursuant to section 1115(a)(1) of the Act, applicable for beneficiaries under the demonstration who derive their coverage from the relevant State plan. With respect to beneficiaries under the demonstration who derive their coverage from an expenditure authority under section 1115(a)(2) of the Act, the below requirements are identified as not applicable. Please check all that apply.

Check to Waive	Provision(s) to be Waived	Description/Purpose of Waiver
X	Section 1902(a)(1)	To permit the state to target services on a geographic basis that is less than statewide.
X	Section 1902(a)(8), (a)(10)(B), and/or (a)(17)	To permit the state to vary the amount, duration, and scope of services based on population needs; to provide different services to different beneficiaries in the same eligibility group, or different services to beneficiaries in the categorically needy and medically needy groups; and to allow states to triage access to long-term services and supports based on highest need.
X	Section 1902(a)(23)(A)	To permit the state to limit beneficiaries' free choice of providers based on urgency and in coordination with other public and private resources.
X	Section 1932(a)(3)	To enable the State to assign Demonstration participants to PIHPs based on geography and to permit participant choice of provider, but not plan.
X	Section 1902(a)(4)	Mandate beneficiaries into a single Prepaid Inpatient Health Plan.
X	42 CFR 441.301 and 42 CFR 441.540	To permit flexibility in the Person-Centered Planning Process and Plan.
X	42 CFR 441.535	Annual reassessments of level of care that exceed the 12-month authorization period will remain open and services will continue to allow enough time for the case manager to complete the annual reassessment.

B. Expenditure Authority

Pursuant to section 1115(a)(2) of the Act, the state is requesting that the expenditures listed below be regarded as expenditures under the state plan.

Note: Checking the appropriate box(es) will allow the state to claim federal financial participation for expenditures that otherwise would be ineligible for federal match.

Check to Request Expenditure	Description/Purpose of Expenditure Authority
X	Allow for self-attestation or alternative verification of individuals' eligibility (income/assets) and level of care to qualify for long-term care services and supports.
X	Long-term care services and supports for impacted individuals even if services are not timely updated in the plan of care or are delivered in alternative settings.
X	Ability to pay higher rates for HCBS providers in order to maintain capacity.
X	Allow states to modify eligibility criteria for long-term services and supports.
X	The ability to reduce or delay the need for states to conduct functional assessments to determine level of care for beneficiaries needing LTSS.
X	Other: Allow payment for personal, community living, behavioral and communication supports (e.g., services to promote ADLs and IADLs), not otherwise provided in that setting, to support individuals in an acute care hospital or short-term institutional setting, when MDHHS identifies that no other alternatives are available, and an institution or hospital is the only setting that service may be offered to meet an individual's health and safety needs. Services provided will not be duplicative of hospital or short-term institutional services provided in those settings.
X	Other: Modify processes for level of care evaluations or re-evaluations. MDHHS proposes to extend level of care determinations that will expire during the effective period of this 1115 waiver by twelve months for eligibility.
X	Other: Modify person-centered planning process by proposing to extend pre-existing person-centered services plans and their amendments during the effective period of this 1115 waiver by twelve months.
X	Other: Modifications of the following processes for telehealth: • Allow an extension for reassessments and reevaluations for up to one year past the due date. • Allow the option to conduct evaluations, assessments, and person-centered service planning meetings virtually/remotely in lieu of face-to-face meetings. • Allow an electronic method of signing off on required documents such as the person-centered service plan, consent for treatment, and releases of information • Accept verbal/electronic consent documented by PIHP/CMHSP, as a method of signing off on required documents such as the person-centered service plan, consent for treatment, and releases of information with the understanding that written consent will be obtained as soon as feasible to validate consent.
X	Other: Quality reviews—the state may suspend the collection of data for performance measures other than those identified for the Health and Welfare assurance and notes that as a result the data will be unavailable for this time frame in ensuing reports due to the circumstances of the pandemic.
X	Other: Allow for entry of incidents into the Incident Reporting System outside of typical timeframes in instances in which staff shortages due to COVID-19 occur, consistent with the states identified transition plan. Response to incidents will not be impacted.

VI. Public Notice

Pursuant to 42 CFR 431.416(g), the state is exempt from conducting a state public notice and input process as set forth in 42 CFR 431.408 to expedite a decision on this section 1115 demonstration that addresses the COVID-19 public health emergency.

VII. Evaluation Indicators and Additional Application Requirements

A. Evaluation Hypothesis. The demonstration will test whether and how the waivers and expenditure authorities affected the state's response to the public health emergency, and how they affected coverage and expenditures.

B. Final Report. This report will consolidate demonstration monitoring and evaluation requirements. No later than one year after the end of this demonstration addressing the COVID-19 public health emergency, the state will be required to submit a consolidated monitoring and evaluation report to CMS to describe the effectiveness of this program in addressing the COVID-19 public health emergency. States will be required to track expenditures and should evaluate the connection between and cost effectiveness of those expenditures and the state's response to the public health emergency in their evaluations of demonstrations approved under this opportunity. Furthermore, states will be required to comply with reporting requirements set forth in 42 CFR 431.420 and 431.428, such as information on demonstration implementation, progress made, lessons learned, and best practices for similar situations. States will be required to track separately all expenditures associated with this demonstration, including but not limited to administrative costs and program expenditures, in accordance with instructions provided by CMS. CMS will provide additional guidance on the evaluation design, as well as on the requirements, content, structure, and submittal of the report.

VIII. STATE CONTACT AND SIGNATURE

State Medicaid Director Name: Kate Massey
Telephone Number: 517-241-7882
E-mail Address: MasseyK4@michigan.gov

State Lead Contact for Demonstration Application: Jacqueline Coleman
Telephone Number: 517-241-1190
E-mail Address: ColemanJ@michigan.gov

Authorizing Official (Typed): Kate Massey

Authorizing Official (Signature): 
Date: 06/11/2020

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148 (Expires 03/31/2021). The time required to complete this information collection is estimated to average 1 to 2 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. Your response is required to receive a waiver under Section 1115 of the Social Security Act. All responses are public and will be made available on the CMS web site. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850. ***CMS Disclosure*** Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact Judith Cash at 410-786-9686.

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-25-26
Baltimore, Maryland 21244-1850

State Demonstrations Group

June 9, 2020

Robert Gordon
Director
Michigan Department of Health and Human Services
100 South Capitol Avenue
Lansing, MI 48909

Dear Mr. Gordon:

The Centers for Medicare & Medicaid Services (CMS) has approved the evaluation design for Michigan's section 1115 Behavioral Health Demonstration entitled, "Michigan's 1115 Behavioral Health Demonstration Waiver" (Project Number 11-W-00305/5), and effective through September 30, 2024. We sincerely appreciate the state's commitment to a rigorous evaluation of your demonstration.

CMS has added the approved evaluation design to the demonstrations Special Terms and Conditions (STC) as part of Attachment C. A copy of the STCs, which includes the new attachment, is enclosed with this letter. The approved evaluation design should now be posted to the state's Medicaid website within thirty days, per 42 CFR 431.424(c). CMS will also post the approved evaluation design as a standalone document, separate from the STCs, on Medicaid.gov.

Please note that an interim evaluation report, consistent with the approved evaluation design is due to CMS one year prior to the expiration of the demonstration, or at the time of the renewal application if the state chooses to extend the demonstration. Likewise, a summative evaluation report, consistent with this approved design, is due to CMS within 18 months of the end of the demonstration period.

We look forward to our continued partnership with you and your staff on your section 1115 Behavioral Health Demonstration. If you have any questions, please contact your CMS project officer, Mr. Thomas Long. Mr. Long may be reached by email at Thomas.Long@cms.hhs.gov.

Sincerely,

Andrea J Casart

Danielle Daly
Director
Division of Demonstration
Monitoring and Evaluation

Andrea J. Casart
Director
Division of Eligibility and Coverage
Demonstrations

cc: Keri Toback, State Monitoring Lead, CMS Medicaid and CHIP Operations Group

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-25-26
Baltimore, Maryland 21244-1850

State Demonstrations Group

June 5, 2020

Robert Gordon
Director
Michigan Department of Health and Human Services
100 South Capitol Avenue
Lansing, MI 48909

Dear Mr. Gordon:

Thank you to you and your staff for your work on the monitoring protocol for the substance use disorder (SUD) component of the Michigan's section 1115 Behavioral Health Demonstration (Project Number 11-W-00305/5). The SUD monitoring protocol submitted to the Centers for Medicare & Medicaid Services (CMS) on April 9, 2020 has been found to fulfill the requirements set forth in the Special Terms and Conditions (STC), specifically STC 19, and the State Medicaid Director Letter (SMD #17-003), "Strategies to Address the Opioid Epidemic."

The monitoring protocol is approved for the demonstration period through September 30, 2024 and is hereby incorporated into the demonstration STCs as Attachment E (see attached). Per 42 CFR 431.424(c), the approved SUD monitoring protocol should now be posted to your state's Medicaid website.

If you have any questions, please contact your CMS project officer, Mr. Thomas Long. Mr. Long is available to answer any questions concerning your section 1115 demonstration and may be reached either by phone at (410) 786 – 5019 or by email at Thomas.Long@cms.hhs.gov. We look forward to our continued partnership on the Michigan 1115 Behavioral Health demonstration.

Sincerely,

Andrea J. Casart
Director
Division of Eligibility and Coverage Demonstrations

cc: Keri Toback, State Monitoring Lead, CMS Medicaid and CHIP Operations Group

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CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

Robert Gordon
Director
Michigan Department of Health and Human Services
100 South Capitol Avenue
Lansing, MI 48909

SEP 2 7 2019

Dear Mr. Gordon:

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

For the reasons discussed below, the Centers for Medicare & Medicaid Services (CMS) is approving Michigan's (the "state") request for an amendment to its section 1115(a) demonstration titled, "Michigan 1115 Pathway to Integration" (Project Number 11-W-00305/5) (the "demonstration"), in accordance with section 1115(a) of the Act. With this approval, the demonstration will become effective from October 1, 2019 through September 30, 2024.

CMS's approval of this section 1115(a) demonstration is subject to the limitations specified in the attached expenditure authority, Special Terms and Conditions (STCs), and any supplemental attachments defining the nature, character, and extent of federal involvement in this project. The state may deviate from the Medicaid state plan requirements only to the extent those requirements have been specifically listed as not applicable to expenditures or individuals covered by expenditure authority.

Objectives of the Medicaid Program

As noted above, the Secretary may approve a demonstration project under section 1115 of the Act if, in his judgment, the demonstration is likely to assist in promoting the objectives of title XIX. The purposes of Medicaid include an authorization of appropriation of funds to "enabl[e] each State, as far as practicable under the conditions in such State, to furnish (1) medical assistance on behalf of families with dependent children and of aged, blind, or disabled individuals, whose income and resources are insufficient to meet the costs of necessary medical services, and (2) rehabilitation and other services to help such families and individuals attain or retain capability for independence or self-care." Act § 1901. This provision makes clear that an important objective of the Medicaid program is to furnish medical assistance and other services to vulnerable populations. But, there is little intrinsic value in paying for services if those services are not advancing the health and wellness of the individual receiving them, or otherwise helping the individual attain independence. Therefore, we believe an objective of the Medicaid program, in addition to furnishing services, is to advance the health and wellness needs of its beneficiaries, and that it is appropriate for the state to structure its demonstration project in a manner that prioritizes meeting those needs.

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

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

[1] States have considerable flexibility in the design of their Medicaid programs, within federal guidelines. Certain benefits are mandatory under federal law, but many benefits may be provided at state option, such as prescription drug benefits, vision benefits, and dental benefits. Similarly, states have considerable latitude to determine whom

the same token, such measures may also preserve states' ability to continue to provide the optional services and coverage they already have in place.

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

Background on Medicaid Coverage in Michigan

Michigan's Medicaid and CHIP programs provide health coverage to over 2.3 million individuals. The Medicaid program in Michigan includes non-mandatory populations, such as the medically needy and optional targeted low income children, in addition to the mandatory eligibility groups. The state also covers several categories of non-mandatory services, including prescription drugs, dental services, and vision benefits, in addition to mandatory services. In addition, on April 1, 2014, Michigan expanded its Medicaid program to include the ACA expansion population (adults with income up to and including 133 percent of the federal poverty level).

Extent and Scope of Demonstration

At the time of approval of the 1115 SUD demonstration, CMS stated its intent to continue to work with Michigan on the state's goals for expanded access to services, use of needs-based eligibility criteria, and streamlined program financing and management through use of appropriate authorities. Currently, Michigan authorizes a managed care arrangement with the Prepaid Inpatient Health Plans (PIHP) using 1915 authority called the "Managed Specialty Services and Supports Program". This arrangement allows the PIHP to perform eligibility evaluations and determinations for beneficiaries receiving 1915(b)(3) services. The state reported that its 1915(b) waiver will not be renewed, and submitted this amendment request seeking authority for the delivery system to be included in its 1115 SUD demonstration. Effective October 1, 2019, Michigan intends to transition most of the specialty behavioral health services and supports currently covered under section 1915(b)(3) authority to a section1915(i) authority initially

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their Medicaid programs will cover. Certain eligibility groups must be covered under a state's program, but many states opt to cover additional eligibility groups that are optional under the Medicaid statute. The optional groups include a new, non-elderly adult population (ACA expansion population) that was added to the Act at section 1902(a)(10)(A)(i)(VIII) by the Patient Protection and Affordable Care Act (ACA). Coverage of the ACA expansion population became optional as a result of the Supreme Court's decision in *NFIB v. Sebelius*, 567 U.S. 519 (2012). Accordingly, several months after the *NFIB* decision was issued, CMS informed the states that they "have flexibility to start or stop the expansion." CMS, *Frequently Asked Questions on Exchanges, Market Reforms, and Medicaid* at 11 (Dec. 10, 2012). In addition to expanding Medicaid coverage by covering optional eligibility groups and benefits beyond what the Medicaid statute requires, many states also choose to cover benefits beyond what is authorized by statute by using expenditure authority under section 1115(a)(2) of the Act. For example, recently, many states have been relying on this authority to expand the scope of services they offer to address SUD beyond what the statute explicitly authorizes.

pursuant to section 1115(a)(2) expenditure authority under this demonstration. In accordance with 1915(i)(1)(F) of the Social Security Act and 42 CFR 441.720 and 441.730, Michigan's PIHP will not be able to function in the same manner under this new authority due to not being a "separate agency of the state" nor will the state have sufficient time to move this currently delegated function back to the administration of a state agency. As a result, Michigan will be required to complete all evaluations and re-evaluations of beneficiaries enrolled in and/or seeking a 1915(i) State Plan service benefits by October 1, 2022, as stipulated in section VIII of the Special Terms and Conditions (STCs). After this date, beneficiaries will be covered under a section 1915(i) State Plan Amendment effective on that date. With the approval of this amendment request, the 1115 demonstration name will also be changed from *Michigan 1115 Pathway to Integration* to Michigan *1115 Behavioral Health* demonstration.

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

CMS assessed that the Behavioral Health demonstration amendment is likely to promote the objectives of Medicaid because it not only gives the state expenditure authority to provide services as part of a comprehensive approach to SUD service delivery for residents of IMD facilities, but it also allows the state to continue providing Medicaid coverage to beneficiaries receiving 1915 (b)(3) services. CMS also expects that the implementation of this amendment in Michigan is likely to assist in promoting the objectives of the Medicaid program as it is expected to improve health outcomes for Medicaid beneficiaries by increasing access to high quality opioid use disorder (OUD)/SUD care, expanding the OUD/SUD, and also preventing a disruption in 1915(b)(3) services being delivered to eligible beneficiaries.

Consideration of Public Comments

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

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

CMS did not receive any comments during the public comment period.

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

Other Information

CMS's approval of this demonstration is also conditioned upon compliance with these STCs and associated expenditure authorities that define the nature, character, and extent of anticipated federal involvement in this demonstration project. This award is subject to the state's written acknowledgement of the award and acceptance of the enclosed STCs.

Your CMS project officer is Mr. Thomas Long, who can be contacted to answer any questions concerning the implementation of this demonstration at thomas.long@cms.hhs.gov. Mr. Long's other contact information is as follows:

Mr. Thomas Long
Centers for Medicare & Medicaid Services
Center for Medicaid and CHIP Services
Mail Stop: S2-25-26
7500 Security Boulevard
Baltimore, MD 21244-1850

Official communications regarding demonstration program matters should be sent simultaneously to Mr. Thomas Long and to Mr. James Scott, Director, Division of Medicaid Field Operations North. Mr. Scott's contact information is as follows:

Mr. James Scott
Division of Medicaid Field Operations North
Regional Operations Group
Centers for Medicare & Medicaid Services
Richard Boling Federal Building
601 E. 12th St, Room 355
Kansas City, MO 64106-2808
Email: James.Scott1@cms.hhs.gov

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

Sincerely,

[redacted]

Calder Lynch
Acting Deputy Administrator and Director

Enclosures

cc: James Scott, Director, Division of Medicaid Field Operations North

CENTERS FOR MEDICARE & MEDICAID SERVICES
EXPENDITURE AUTHORITY

NUMBER: 11-W-00305/5

TITLE: Michigan 1115 Behavioral Health Demonstration

AWARDEE: Michigan Department of Health and Human Services (MDHHS)

Under the authority of section 1115(a)(2) of the Social Security Act (the Act), expenditures made by Michigan (the state) for the items identified below (which would not otherwise be included as matchable expenditures under section 1903 of the Act) shall, for the period April 5, 2019 through September 30, 2024, unless otherwise specified, be regarded as matchable expenditures under the state's Medicaid state plan.

1. **Residential Treatment for Individuals with Substance Use Disorder (SUD).** Expenditures for otherwise covered services furnished to otherwise eligible individuals who are primarily receiving treatment and withdrawal management services for substance use disorder (SUD) who are short-term residents in facilities that meet the definition of an institution for mental diseases (IMD).

2. **Time-Limited Expenditure Authority for 1915(i)-Like Services.** Expenditures for 1915(i)-like home and community based (HCBS) services provided to individuals starting October 1, 2019, and ending September 30, 2022. During this period, the state will develop and implement a framework for performing independent assessments of financial and functional eligibility. As of October 1, 2022, all individuals will receive 1915(i) services in the State Plan Amendment effective on that date.

3. **PrePaid Inpatient Health Plan (PIHP) Services.** Expenditures for all PIHP services including case management and health education services that are not available to other Medicaid beneficiaries to the extent that not all services for categorically needy individuals will be equal in amount, duration, and scope. The state will be required to ensure that all beneficiaries use a specific regional PIHP plan and to restrict disenrollment from them. The state is also granted the authority to restrict freedom of choice of provider for the demonstration eligible population.

CENTERS FOR MEDICARE AND MEDICAID SERVICES
SPECIAL TERMS AND CONDITIONS (STCs)

NUMBER: 11-W-00305/5

TITLE: Michigan 1115 Behavioral Health Demonstration

AWARDEE: Michigan Department of Health and Human Services (MDHHS)

I. PREFACE

The following are the special terms and conditions (STCs) for the "Michigan 1115 Behavioral Health Demonstration" section 1115(a) Medicaid demonstration (the "demonstration") to enable the Michigan (the "state") to operate this demonstration. The Centers for Medicare & Medicaid Services (CMS) has granted expenditure authorities authorizing federal matching of demonstration costs not otherwise matchable under section 1903 of the Social Security Act (the "Act"), which are separately enumerated. These STCs set forth conditions and limitations on those expenditure authorities, and describe in detail the nature, character, and extent of federal involvement in the demonstration and the state's obligations to CMS related to this demonstration. These STCs neither grant additional expenditure authorities, nor expand upon those separately granted. The STCs are effective as of April 5, 2019, through September 30, 2024, unless otherwise specified. The state expects to begin implementation October 1, 2019.

The STCs have been arranged into the following subject areas:

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

II. PROGRAM DESCRIPTION AND OBJECTIVES

On June 21, 2016, Michigan submitted an 1115 demonstration request entitled *Pathway to Integration*. The purpose of this demonstration was to allow Michigan to broaden the crucial component of residential substance disorder services in the state's existing network of SUD providers and SUD benefits to provide a broader continuum of care for beneficiaries seeking help with a SUD, including withdrawal management services in residential treatment facilities that meet the definition of an Institution for Mental Disease (IMD). Benefits under this demonstration were to be provided through a managed care delivery system. The state believed that offering a full continuum of SUD treatment and recovery supports based on American Society of Addiction Medicine (ASAM) criteria or other nationally recognized, SUD-specific program standards, would result in improved health outcomes and sustained recovery for this population.

This demonstration sought to accomplish these efforts by:

- Establishing an integrated behavioral health delivery system that included a flexible and comprehensive SUD benefit and the Michigan continuum of care;
- Enhancing provider competency related to the use of ASAM criteria or other nationally recognized, SUD-specific program standards, for patient assessment and treatment;
- Expanding the treatment continuum of residential care including medically necessary use of qualified residential treatment facilities regardless of the size of the facility, withdrawal management programming and medication assisted treatment and recovery;
- Expanding the use of recovery coach delivered support services; and
- Establishing coordination of care models between SUD providers, primary care and other behavioral health providers.

After careful review and consideration by CMS, the demonstration was approved on April 5, 2019. The expenditure authorities permitted by the demonstration will remain in effect until September 30, 2024.

At the time of approval of the 1115 SUD demonstration, CMS stated its intent to continue to work with Michigan on the state's goals for expanded access to services, use of needs-based eligibility criteria, and streamlined program financing and management through the use of the appropriate authorities. Michigan authorized a managed care arrangement with the Prepaid Inpatient Health Plans (PIHP) using 1915 authority called the "Managed Specialty Services and Supports Program". This arrangement allowed the PIHP to perform eligibility evaluations and determinations for beneficiaries receiving 1915(b)(3) services. However, the 1915(b) waiver

will not be renewed, and with this amendment request, the state is seeking authority for the delivery system be moved to the 1115 demonstration. Following CMS' guidance, effective October 1, 2019, Michigan intends to transition most of the specialty behavioral health services and supports currently covered under section 1915(b)(3) authority to the equivalent of a section 1915(i) State Plan benefit, initially through 1115(a)(2) expenditure authority under this demonstration. In accordance with 1915(i)(1)(F) of the Social Security Act and 42 CFR 441.720 and 441.730, Michigan's PIHP will not be able to function in the same manner under this new authority due to not being a "separate agency of the state" nor will the state have sufficient time to move this currently delegated function back to the administration of a state agency. Consequently, Michigan will complete all evaluations and re-evaluations of beneficiaries enrolled in and/or seeking 1915(i) State Plan benefits by October 1, 2022 as stipulated in section VIII. After this date, beneficiaries will be covered under section 1915(i) pursuant to a State Plan Amendment effective on that date. Upon approval of this amendment request, on September 27, 2019, the 1115 demonstration name will also be changed from *Michigan Pathway to Integration* to the *Michigan 1115 Behavioral Health* demonstration.

III. GENERAL PROGRAM REQUIREMENTS

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

2. **Compliance with Medicaid Law, Regulation, and Policy.** All requirements of the Medicaid program, expressed in federal law, regulation, and written policy, not expressly waived or identified as not applicable in the expenditure authority documents (of which these terms and conditions are part), apply to the demonstration.

3. **Changes in Medicaid Law, Regulation, and Policy.** The state must, within the timeframes specified in federal law, regulation, or written policy, come into compliance with any changes in federal law, regulation, or policy affecting the Medicaid program that occur during this demonstration approval period, unless the provision being changed is expressly waived or identified as not applicable. In addition, CMS reserves the right to amend the STCs to reflect such changes and/or changes of an operational nature without requiring the state to submit an amendment to the demonstration under STC 7. CMS will notify the state

30 calendar days in advance of the expected approval date of the amended STCs to allow the state to provide comment.

4. **Impact on Demonstration of Changes in Federal Law, Regulation, and Policy.**
    a. To the extent that a change in federal law, regulation, or policy requires either a reduction or an increase in federal financial participation (FFP) for expenditures made under this demonstration, the state must adopt, subject to CMS approval, a modified budget neutrality agreement for the demonstration as necessary to comply with such change. Further, the state may seek an amendment to the demonstration (as per STC 7 of this section) as a result of the change in FFP.
    b. If mandated changes in the federal law require state legislation, unless otherwise prescribed by the terms of the federal law, the changes must take effect on the day such state legislation becomes effective, or on the last day such legislation was required to be in effect under federal law, whichever is sooner.

5. **State Plan Amendments.** The state will not be required to submit title XIX state plan amendments (SPAs) for changes affecting any populations made eligible solely through the demonstration. If a population eligible through the Medicaid state plan is affected by a change to the demonstration, a conforming amendment to the appropriate state plan may be required, except as otherwise noted in these STCs. In all such instances, the Medicaid state plan governs.

6. **Changes Subject to the Amendment Process.** If not otherwise specified in these STCs, changes related to eligibility, enrollment, benefits, beneficiary rights, delivery systems, cost sharing, sources of non-federal share of funding, budget neutrality, and other comparable program elements must be submitted to CMS as amendments to the demonstration. All amendment requests are subject to approval at the discretion of the Secretary in accordance with section 1115 of the Act. The state must not implement changes to these elements without prior approval by CMS either through an approved amendment to the Medicaid state plan or amendment to the demonstration. Amendments to the demonstration are not retroactive and no FFP of any kind, including for administrative or medical assistance expenditures, will be available under changes to the demonstration that have not been approved through the amendment process set forth in STC 7, except as provided in STC 3.

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

a. A detailed description of the amendment, including impact on beneficiaries, with sufficient supporting documentation;
b. A data analysis worksheet which identifies the specific "with waiver" impact of the proposed amendment on the current budget neutrality agreement. Such analysis shall include total computable "with waiver" and "without waiver" status on both a summary and detailed level through the current approval period using the most recent actual expenditures, as well as summary and detail projections of the change in the "with waiver" expenditure total as a result of the proposed amendment, which isolates (by Eligibility Group) the impact of the amendment;
c. An explanation of the public process used by the state consistent with the requirements of STC 13; and,
d. If applicable, a description of how the evaluation design will be modified to incorporate the amendment provisions.

8. Extension of the Demonstration. States that intend to request a demonstration extension under sections 1115(e) or 1115(f) of the Act must submit extension applications in accordance with the timelines contained in statute. Otherwise, no later than twelve (12) months prior to the expiration date of the demonstration, the Governor or Chief Executive Officer of the state must submit to CMS either a demonstration extension request that meets federal requirements at 42 CFR 431.412(c) or a transition and phase-out plan consistent with the requirements of STC 9.

9. Demonstration Phase Out. The state may only suspend or terminate this demonstration in whole, or in part, consistent with the following requirements:

a. Notification of Suspension or Termination. The state must promptly notify CMS in writing of the reason(s) for the suspension or termination, together with the effective date and a transition and phase-out plan. The state must submit a notification letter and a draft transition and phase-out plan to CMS no less than six (6) months before the effective date of the demonstration's suspension or termination. Prior to submitting the draft transition and phase-out plan to CMS, the state must publish on its website the draft transition and phase-out plan for a 30-day public comment period. In addition, the state must conduct tribal consultation in accordance with STC 13, if applicable. Once the 30-day public comment period has ended, the state must provide a summary of the issues raised by the public during the comment period and how the state considered the comments received when developing the revised transition and phase-out plan.
b. Transition and Phase-out Plan Requirements. The state must include, at a minimum, in its transition and phase-out plan the process by which it will notify affected beneficiaries, the content of said notices (including information on the beneficiary's appeal rights), the process by which the state will conduct administrative reviews of Medicaid eligibility prior to the termination of the demonstration for the affected beneficiaries, and ensure ongoing coverage for eligible beneficiaries, as well as any community outreach activities the state will

undertake to notify affected beneficiaries, including community resources that are available.

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

d. Transition and Phase-out Procedures. The state must comply with all applicable notice requirements found in 42 CFR, part 431 subpart E, including sections 431.206, 431.210, 431.211, and 431.213. In addition, the state must assure all applicable appeal and hearing rights are afforded to beneficiaries in the demonstration as outlined in 42 CFR, part 431 subpart E, including sections 431.220 and 431.221. If a beneficiary in the demonstration requests a hearing before the date of action, the state must maintain benefits as required in 42 CFR 431.230. In addition, the state must conduct administrative renewals for all affected beneficiaries in order to determine if they qualify for Medicaid eligibility under a different eligibility category prior to termination as discussed in October 1, 2010, State Health Official Letter #10-008 and as required under 42 C.F.R. 435.916(f)(1). For individuals determined ineligible for Medicaid, the state must determine potential eligibility for other insurance affordability programs and comply with the procedures set forth in 42 CFR 435.1200(e).

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

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

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

10. Expiring Demonstration Authority. For demonstration authority that expires prior to the demonstration's expiration date, the state must submit a demonstration authority expiration plan to CMS no later than six (6) months prior to the applicable demonstration authority's expiration date, consistent with the following requirements:

a. Expiration Requirements. The state must include, at a minimum, in its demonstration authority expiration plan the process by which it will notify affected beneficiaries, the content of said notices (including information on the beneficiary's appeal rights), the process by which the state will conduct administrative reviews of Medicaid eligibility prior to the termination of the

demonstration authority for the affected beneficiaries, and ensure ongoing coverage for eligible beneficiaries, as well as any community outreach activities.

b. Expiration Procedures. The state must comply with all applicable notice requirements found in 42 CFR, part 431 subpart E, including sections 431.206, 431.210, 431.211, and 431.213. In addition, the state must assure all applicable appeal and hearing rights are afforded to beneficiaries in the demonstration as outlined in 42 CFR, part 431 subpart E, including sections 431.220 and 431.221. If a beneficiary in the demonstration requests a hearing before the date of action, the state must maintain benefits as required in 42 CFR 431.230. In addition, the state must conduct administrative renewals for all affected beneficiaries in order to determine if they qualify for Medicaid eligibility under a different eligibility category prior to termination as discussed in October 1, 2010, State Health Official Letter #10-008 and as required under 42 CFR 435.916(f)(1). For individuals determined ineligible for Medicaid, the state must determine potential eligibility for other insurance affordability programs and comply with the procedures set forth in 42 CFR 435.1200(e).

c. Federal Public Notice. CMS will conduct a 30-day federal public comment period consistent with the process outlined in 42 CFR 431.416 in order to solicit public input on the state's demonstration authority expiration plan. CMS will consider comments received during the 30-day period during its review of the state's demonstration authority expiration plan. The state must obtain CMS approval of the demonstration authority expiration plan prior to the implementation of the expiration activities. Implementation of expiration activities must be no sooner than fourteen (14) calendar days after CMS approval of the demonstration authority expiration plan.

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

11. Withdrawal of Expenditure Authority. CMS reserves the right to withdraw expenditure authorities at any time it determines that continuing the expenditure authorities would no longer be in the public interest or promote the objectives of title XIX. CMS must promptly notify the state in writing of the determination and the reasons for the withdrawal, together with the effective date, and afford the state an opportunity to request a hearing to challenge CMS' determination prior to the effective date. If expenditure authority is withdrawn, FFP is limited to normal closeout costs associated with terminating the expenditure authority, including services, continued benefits as a result of beneficiary appeals, and administrative costs of disenrolling beneficiaries.

12. Adequacy of Infrastructure. The state must ensure the availability of adequate resources for implementation and monitoring of the demonstration, including education, outreach, and enrollment; maintaining eligibility systems; compliance with cost sharing requirements; and reporting on financial and other demonstration components.

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

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

The state must also comply with the Public Notice Procedures set forth in 42 CFR 447.205 for changes in statewide methods and standards for setting payment rates.

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

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

IV. ELIGIBILITY AND ENROLLMENT

16. Eligibility Groups Affected by the Demonstration. Under the demonstration, there is no change to Medicaid eligibility. Standards for eligibility remain set forth under the state plan. All affected groups derive their eligibility through the Medicaid state plan, and are subject to all applicable Medicaid laws and regulations in accordance with the Medicaid state plan. All Medicaid eligibility standards and methodologies for these eligibility groups remain applicable.

V. SUBSTANCE USE DISORDER (SUD) PROGRAM

17. <u>Opioid Use Disorder/Substance Use Disorder Program.</u> Effective upon CMS' approval of the OUD/SUD Implementation Plan, the demonstration benefit package for Michigan Medicaid recipients must include OUD/SUD treatment services, including short term

residential services provided in residential and inpatient treatment settings that qualify as an Institution for Mental Diseases (IMD), which are not otherwise matchable expenditures under section 1903 of the Act. The state will be eligible to receive FFP for Michigan Medicaid recipients who are short-term residents in IMDs under the terms of this demonstration for coverage of medical assistance, including OUD/SUD benefits that would otherwise be matchable if the beneficiary were not residing in an IMD. Michigan must aim for a statewide average length of stay of 30 days in residential treatment settings, to be monitored pursuant to the OUD/SUD Monitoring Protocol as outlined in STC 19 below, to ensure short-term residential treatment stays. Under this demonstration, beneficiaries will have access to high quality, evidence-based OUD and other SUD treatment services ranging from medically supervised withdrawal management to on-going chronic care for these conditions in cost-effective settings while also improving care coordination and care for comorbid physical and mental health conditions. Such services will be delivered through the prepaid inpatient health plan (PIHP) delivery system.

The coverage of OUD/SUD treatment services and withdrawal management services during short-term residential and inpatient stays in IMDs will expand Michigan's current SUD benefit package available to all Michigan Medicaid recipients as outlined in Table 1. OUD/SUD treatment services and withdrawal management services approved through the state plan as well as expenditure authority to cover and provide FFP for such services for individuals residing in an IMD approved through this demonstration will be available to all Michigan Medicaid recipients who meet medical necessity criteria for services. Room and board costs are not considered allowable costs for residential treatment service providers unless they qualify as inpatient facilities under section 1905(a) of the Act.

Table 1: Michigan OUD/SUD Benefits Coverage with Expenditure Authority

OUD/SUD Benefit	Medicaid Authority	Expenditure Authority
Early Intervention Services	State plan (Individual services covered)	
Ambulatory Withdrawal Management	State plan	
Outpatient Services	State plan *(Individual services covered)*	
Intensive Outpatient Services	State plan *(Individual services covered)*	
Opioid Treatment Program Services	State Plan	Services provided to individuals in IMDs
Office Based Opioid Treatment Services	State Plan	Services provided to individuals in IMDs

Residential Treatment	State plan *(Individual services covered)*	Services provided to individuals in IMDs
Medically Supervised Withdrawal Management	State plan	Services provided to individuals in IMDs
Inpatient Services	State plan *(Individual Services covered)*	Services provided to individuals in IMDs
SUD Support Services	State plan *(Individual services covered)*	Services provided to individuals in IMDs

The state attests that the services indicated in Table 1 above, as being covered under Medicaid state plan authority are currently covered in the Michigan Medicaid state plan.

18. OUD/SUD Implementation Plan. The state must submit a OUD/SUD Implementation Plan within 90 calendar days after approval of the OUD/SUD program under this demonstration. The state may not claim FFP for services provided in IMDs until CMS has approved the SUD Implementation Plan. CMS is approving the OUD/SUD Implementation Plan concurrently with this demonstration. The approved OUD/SUD Implementation Plan appears as Attachment D and may be altered only with CMS approval. After approval of the OUD/SUD Implementation Plan, FFP will be available prospectively, not retrospectively. Failure to progress in meeting the milestone goals agreed upon by the state and CMS will result in a funding deferral. At a minimum, the OUD/SUD Implementation Plan will describe the strategic approach and detailed project implementation plan, including timetables and programmatic content where applicable, for meeting the following milestones which reflect the key goals and objectives of the OUD/SUD component of this demonstration program:

a. **Access to Critical Levels of Care for OUD and other SUDs:** Service delivery for new benefits, including residential treatment and withdrawal management, within 12-24 months of OUD/SUD program demonstration approval;

b. **Use of Evidence-based SUD-specific Patient Placement Criteria:** Establishment of a requirement that providers assess treatment needs based on SUD-specific, multidimensional assessment tools, such as the American Society of Addiction Medicine (ASAM) Criteria or other patient placement assessment and placement tools that reflect evidence-based clinical treatment guidelines within 12-24 months of OUD/SUD program demonstration approval;

c. **Patient Placement:** Establishment of a utilization management approach such that beneficiaries have access to SUD services at the appropriate level of care

and that the interventions are appropriate for the diagnosis and level of care, including an independent process for reviewing placement in residential treatment settings within 12-24 months of SUD program demonstration approval;

d. **Use of Nationally Recognized SUD-specific Program Standards to set Provider Qualifications for Residential Treatment Facilities:** Currently, residential treatment service providers must be a licensed organization, pursuant to the residential service provider qualifications described in the *State Administrative Rules for the Licensure of Substance Use Disorder Programs***.** The state will establish residential treatment provider qualifications in licensure, policy or provider manuals, managed care contracts or credentialing, or other requirements or guidance that meet program standards in the ASAM Criteria or other nationally recognized, SUD-specific program standards regarding in particular the types of services, hours of clinical care, and credentials of staff for residential treatment settings within 12-24 months of OUD/SUD program demonstration approval;

e. **Standards of Care:** Establishment of a provider review process to ensure that residential treatment providers deliver care consistent with the specifications in the ASAM Criteria or other nationally recognized SUD program standards based on evidence-based clinical treatment guidelines for types of services, hours of clinical care, and credentials of staff for residential treatment settings within 12-24 months of SUD program demonstration approval;

f. **Standards of Care:** Establishment of a requirement that residential treatment providers offer MAT on-site or facilitate access to MAT off-site within 12-24 months of SUD program demonstration approval;

g. **Sufficient Provider Capacity at each Level of Care including Medication Assisted Treatment for OUD:** An assessment of the availability of providers in the key levels of care throughout the state, or in the regions of the state participating under this demonstration, including those that offer MAT within 12 months of SUD program demonstration approval;

h. **Implementation of Comprehensive Treatment and Prevention Strategies to Address Opioid Abuse and OUD:** Implementation of opioid prescribing guidelines along with other interventions to prevent prescription drug abuse and expand coverage of and access to naloxone for overdose reversal as well as implementation of strategies to increase utilization and improve functionality of prescription drug monitoring programs;

i. **Improved Care Coordination and Transitions between levels of care:** Establishment and implementation of policies to ensure residential and inpatient facilities link beneficiaries with community-based services and supports following stays in these facilities within 24 months of SUD program demonstration approval.

19. OUD/SUD Monitoring Protocol. The state must submit a OUD/SUD Monitoring Protocol within 150 calendar days after approval of the OUD/SUD Demonstration. The OUD/SUD

Monitoring Protocol must be developed in cooperation with CMS and is subject to CMS approval. Once approved, the OUD/SUD Monitoring Protocol will be incorporated into the STCs, as Attachment E. At a minimum, the SUD Monitoring Plan Protocol must include reporting relevant to each of the program implementation areas listed in STC 18. The SUD Monitoring Protocol must specify the methods of data collection and timeframes for reporting on the state's progress on required measures as part of the general reporting requirements described in Section VIII of the demonstration. In addition, the SUD Monitoring Protocol must identify a baseline, and a target to be achieved by the end of the demonstration. Where possible, baselines must be informed by state data, and targets will be benchmarked against performance in best practice settings. CMS will closely monitor demonstration spending on services in IMDs to ensure adherence to budget neutrality requirements. Progress on the performance measures identified in the Monitoring Protocol must be reported via the quarterly and annual monitoring reports.

20. **Mid-Point Assessment.** The state must conduct an independent mid-point assessment by December 31, 2022. The state must require that the assessor must collaborate with key stakeholders, including representatives of MCOs, SUD treatment providers, beneficiaries, and other key partners in the design, planning and conducting of the mid-point assessment. The state must require that the assessment will include an examination of progress toward meeting each milestone and timeframe approved in the SUD Implementation Plan, and toward meeting the targets for performance measures as approved in the SUD Monitoring Protocol. The state must require that the assessment include a determination of factors that affected achievement on the milestones and performance measure gap closure percentage points to date, and a determination of selected factors likely to affect future performance in meeting milestones and targets not yet met and about the risk of possibly missing those milestones and performance targets. The state must require that the mid-point assessment also provide a status update of budget neutrality requirements. For each milestone or measure target at medium to high risk of not being met, the state must require that the assessor provide, for consideration by the state, recommendations for adjustments in the state's implementation plan or to pertinent factors that the state can influence that will support improvement. The state must require that the assessor provide a report to the state that includes the methodologies used for examining progress and assessing risk, the limitations of the methodologies, its determinations and any recommendations. The state must provide a copy of the report to CMS. The state must brief CMS on the report. For milestones and measure targets at medium to high risk of not being achieved, the state will submit to CMS modifications to the SUD Implementation Plan and SUD Monitoring Plan for ameliorating these risks subject to CMS approval.

21. **Deferral for Insufficient Progress Towards Milestones and Failure to Report Measurement Data.** If the state does not demonstrate sufficient progress on milestones, as specified in the Implementation Protocol, as determined by CMS, or fails to report data as approved in the Monitoring Protocol Monitoring Protocol, CMS will defer funds in the amounts specified in STC 40 and STC 41 for each incident of insufficient progress or failure to report in each reporting quarter.

22. OUD/SUD Evaluation Design. The draft Evaluation Design must be developed in accordance with Attachment A (Developing the Evaluation Design) of these STCs. The state must submit, for CMS comment and approval, the Evaluation Design to including the SUD program with implementation timeline, no later than one hundred eighty (180) days after the effective date of these STCs. Any modifications to an existing approved Evaluation Design will not affect previously established requirements and timelines for report submission for the demonstration, if applicable. The state must use an independent evaluator to develop the draft Evaluation Design.

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

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

23. SUD Health Information Technology (Health IT). The state must provide CMS with an assurance that it has a sufficient health IT infrastructure/"ecosystem" at every appropriate level (i.e. state, delivery system, health plan/MCO and individual provider) to achieve the goals of the demonstration—or it must submit to CMS a plan to develop the infrastructure/capabilities. This SUD Health IT Plan must be submitted to CMS within 90 days of the approval of the SUD program within this demonstration. The state's failure to submit the SUD Health IT Plan by this deadline may result in a funding deferral as provided by STC 21. The SUD Health IT Plan must detail the necessary health IT capabilities in place to support beneficiary health outcomes to address the SUD goals of the demonstration. The SUD Health IT Plan must also be used to identify areas of SUD health IT ecosystem improvement.

a. The SUD Health IT section of the SUD Implementation Plan must include implementation milestones and dates for achieving them (see Attachment [D]).
b. The SUD Health IT Plan must be aligned with the state's broader State Medicaid Health IT Plan (SMHP) and, if applicable, the state's Behavioral Health (BH) "Health IT" Plan.
c. The SUD Health IT Plan must describe the state's goals, each DY, to enhance the state's prescription drug monitoring program's (PDMP)[1].
d. The SUD Health IT Plan must address how the state's PDMP will enhance ease of use for prescribers and other state and federal stakeholders.[2] The SUD Health IT Plan must also include plans to include PDMP interoperability with a statewide, regional or local Health Information Exchange. Additionally, the SUD Health IT Plan must describe ways in which the state will support clinicians in consulting the PDMP prior to prescribing a controlled substance—and reviewing the patients' history of controlled substance prescriptions—prior to the issuance of a Controlled Substance Schedule II (CSII) opioid prescription.
e. The SUD Health IT Plan must, as applicable, describe the state's capabilities to leverage a master patient index (or master data management service, etc.) in support of SUD care delivery. Additionally, the SUD Health IT Plan must describe current and future capabilities regarding PDMP queries—and the state's ability to properly match patients receiving opioid prescriptions with patients in the PDMP. The state must also indicate current efforts or plans to develop and/or utilize current patient index capability that supports the programmatic objectives of the demonstration.
f. The SUD Health IT Plan will describe how the activities described in (a) through (e) above will support broader state and federal efforts to diminish the likelihood of long-term opioid use directly correlated to clinician prescribing patterns.[3]
g. In developing the SUD Health IT Plan, the state may use the following resources:
h. The state may use resources at Health IT.Gov (https://www.healthit.gov/playbook/opioid-epidemic-and-health-it/) in "Section 4: Opioid Epidemic and Health IT."
i. The state may also use the CMS 1115 Health IT resources available on "Medicaid Program Alignment with State Systems to Advance HIT, HIE and Interoperability" at https://www.medicaid.gov/medicaid/data-and-systems/hie/index.html. The state must review the "1115 Health IT Toolkit" for health IT considerations in conducting an assessment and developing its SUD Health IT Plan.
j. The state may request from CMS technical assistance to conduct an assessment and develop plans to ensure it has the specific health IT infrastructure with

[1] Prescription drug monitoring programs (PDMP) are electronic databases that track controlled substance prescriptions in states. PDMPs can provide health authorities timely information about prescribing and patient behaviors that contribute to the "opioid" epidemic and facilitate a nimble and targeted response.
[2] *Ibid*.
[3] Shah, Anuj, Corey Hayes and Bradley Martin. *Characteristics of Initial Prescription Episodes and Likelihood of Long-Term Opioid Use — United States, 2006–2015*. MMWR Morb Mortal Wkly Rep 2017;66.

regards to PDMP plans and, more generally, to meet the goals of the demonstration.

k. The state must include in its SUD Monitoring Protocol (STC 19) an approach to monitoring its SUD Health IT Plan which will include performance metrics provided by CMS or State defined metrics to be approved in advance by CMS.

l. The state must monitor progress, each DY, on the implementation of its SUD Health IT Plan in relationship to its milestones and timelines—and report on its progress to CMS in in an addendum to its Annual Reports (STC 31).

m. As applicable, the state must advance the standards identified in the 'Interoperability Standards Advisory—Best Available Standards and Implementation Specifications' (ISA) in developing and implementing the state's SUD Health IT policies and in all related applicable State procurements (e.g., including managed care contracts) that are associated with this demonstration.

   i. Where there are opportunities at the state- and provider-level (up to and including usage in MCO or ACO participation agreements) to leverage federal funds associated with a standard referenced in 45 CFR 170 Subpart B, the state must use the federally-recognized standards, barring another compelling state interest.

   ii. Where there are opportunities at the state and provider level to leverage federal funds associated with a standard not already referenced in 45 CFR 170 but included in the ISA, the state must use the federally-recognized ISA standards, barring no other compelling state interest.

VI. COST SHARING

24. Cost Sharing. Cost sharing imposed upon individuals under the demonstration is consistent with the provisions of the approved state plan.

VII. DELIVERY SYSTEM

25. General. The state must comply with the managed care regulations published under 42 CFR 438 unless explicitly waived.

26. Type of Managed Care. The state is authorized to operate a risk based Prepaid Inpatient Health Plan (PIHP) as defined under 42 CFR 438.2. One PIHP will operate in each geographical region designated by the state.

27. Contracts. No FFP is available for activities covered under contracts and/or modifications to existing contracts that are subject to 42 CFR 438 requirements prior to CMS approval of such contracts and/or contract amendments. The State will provide CMS with a minimum of 60 days to review and approve changes.

28. Enrollment. The State will mandatorily and passively enroll the following groups of beneficiaries into a PIHP:

a. Section 1931 Children and Related Populations are children including those eligible under Section 1931, poverty-level related groups and optional groups of older children;
b. Section 1931 Adults and Related Populations are adults including those eligible under Section 1931, poverty-level pregnant women and optional group of caretaker relatives;
c. Blind/Disabled Adults and Related Populations are beneficiaries, age 18 or older, who are eligible for Medicaid due to blindness or disability. Report Blind/Disabled Adults who are age 65 or older in this category, not in Aged;
d. Blind/Disabled Children and Related Populations are beneficiaries, generally under age 18, who are eligible for Medicaid due to blindness or disability;
e. Aged and Related Populations are those Medicaid beneficiaries who are age 65 or older and not members of the Blind/Disabled population or members of the Section 1931 Adult population;
f. Foster Care Children are Medicaid beneficiaries who are receiving foster care or adoption assistance (Title IV-E), are in foster-care, or are otherwise in an out-of-home placement; and
g. New adults.

29. Disenrollment and choice of providers. Beneficiaries cannot disenroll from the PIHP in their area. However, for specific services within the PIHP network, the beneficiary may choose from among a range of available network providers, and may change providers within the PIHP at any time. In addition, in some special circumstances, a beneficiary may wish to receive services from a provider that is part of another PIHP's provider network. In these situations, the PIHP may make arrangements to contract with that provider.

30. Transition Plan for Care Coordination. The state must develop a transition of care policy consistent with 438.62(b)(1). In the event the State intends to transition beneficiaries to an alternative delivery system, the State will timely inform CMS how the transition will comply with their transition of care policy.

VIII. TRANSITIONAL ELIGIBILITY FOR HCBS REQUIREMENTS

In order to come into compliance with CMS policy with regard to HCBS services covered under the State plan pursuant to section 1915(i), the state must meet the established transitional eligibility requirements as follows:

31. By November 1, 2019, the State will phase in the proposed tool to assess and evaluate beneficiaries against the 1915(i) HCBS State plan benefit needs-based eligibility criteria.

32. From June 1, 2020 through September 30, 2020, the State will provide technical assistance to all PIHPs on the 1915(i) HCBS State plan benefit needs-based eligibility packets and tools developed to assure individuals meet all the eligibility requirements.

33. From October 1, 2020 through January 1, 2021, the State will do the joint Application and Design (JAD) Sessions for requirements/design.

34. From January 1, 2021 through March 1, 2021, the State will phase in enrolled beneficiaries information packets to the online system with the state testing the eligibility capabilities and notifications.

35. From June 1, 2021 through July 1, 2021, the State will analyze the adequacy of administration needed to process information and to make eligibility determinations.

36. From September 1, 2021 through September 30, 2021, the State will finalize the process and requirements via manual revisions and training to all PIHP users.

37. From October 1, 2021 forward, the State will demonstrate full compliance in executing eligibility determinations for all individuals currently enrolled in or seeking 1915(i) HCBS State plan benefits to ensure all individuals receiving services will be determined eligible by the state on or before October 1, 2022. NOTE: PIHPs will no longer be responsible for determining needs-based criteria and eligibility for initial or re-evaluations.

38. The state will adhere to the all of the requirements, including quality monitoring and reporting, in accordance with the information specified in the approved 1915(i) HCBS State plan benefit which will become effective as of October 1, 2022.

IX. GENERAL REPORTING REQUIREMENTS

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

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

The following process will be used: 1) Thirty (30) days after the deliverable was due if the state has not submitted a written request to CMS for approval of an extension as described in subsection (b) below; or 2) Thirty days after CMS has notified the state in writing that the deliverable was not accepted for being inconsistent with the requirements of this agreement and the information needed to bring the deliverable into alignment with CMS requirements:

a. CMS will issue a written notification to the state providing advance notification of a pending deferral for late or non-compliant submissions of required deliverable(s).
b. For each deliverable, the state may submit to CMS a written request for an extension to submit the required deliverable that includes a supporting rationale for the cause(s) of the delay and the state's anticipated date of submission. Should CMS agree to the state's request, a corresponding extension of the deferral process can be provided. CMS may agree to a corrective action plan submitted by the state as an interim step before applying the deferral, if the state proposes a corrective action plan in the state's written extension request.
c. If CMS agrees to an interim corrective plan in accordance with subsection (b), and the state fails to comply with the corrective action plan or, despite the corrective action plan, still fails to submit the overdue deliverable(s) with all required contents in satisfaction of the terms of this agreement, CMS may proceed with the issuance of a deferral against the next Quarterly Statement of Expenditures reported in Medicaid Budget and Expenditure System/State Children's Health Insurance Program Budget and Expenditure System (MBES/CBES) following a written deferral notification to the state.
d. If the CMS deferral process has been initiated for state non-compliance with the terms of this agreement with respect to required deliverable(s), and the state submits the overdue deliverable(s), and such deliverable(s) are accepted by CMS as meeting the requirements specified in these STCs, the deferral(s) will be released.
e. As the purpose of a section 1115 demonstration is to test new methods of operation or service delivery, a state's failure to submit all required reports, evaluations and other deliverables will be considered by CMS in reviewing any application for an extension, amendment, or for a new demonstration.

41. Deferral of Federal Financial Participation (FFP) from IMD claiming for Insufficient Progress toward Milestones. Up to $5,000,000 in FFP for services in IMDs may be deferred if the state is not making adequate progress on meeting the milestones and goals as evidenced by reporting on the milestones in the Implementation Plan and the required performance measures in the Monitoring Protocol agreed upon by the state and CMS. Once CMS determines the state has not made adequate progress, up to $5,000,000 will be deferred in the next calendar quarter and each calendar quarter thereafter until CMS has determined sufficient progress has been made. The state is expected to meet the milestones by the end of the first two years of the SMI demonstration.

42. Compliance with Federal Systems Updates. As federal systems continue to evolve and incorporate additional 1115 demonstration reporting and analytics functions, the state will work with CMS to:
a. Revise the reporting templates and submission processes to accommodate timely compliance with the requirements of the new systems;
b. Ensure all 1115, T-MSIS, and other data elements that have been agreed to for reporting and analytics are provided by the state; and

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

43. Cooperation with Federal Evaluators. As required under 42 CFR 431.420(f), the state must cooperate fully and timely with CMS and its contractors' in any federal evaluation of the demonstration or any component of the demonstration. This includes, but is not limited to, commenting on design and other federal evaluation documents and providing data and analytic files to CMS, including entering into a data use agreement that explains how the data and data files will be exchanged, and providing a technical point of contact to support specification of the data and files to be disclosed, as well as relevant data dictionaries and record layouts. The state must include in its contracts with entities who collect, produce or maintain data and files for the demonstration, that they must make such data available for the federal evaluation as is required under 42 CFR 431.420(f) to support federal evaluation. The state may claim administrative match for these activities. Failure to comply with this STC may result in a deferral being issued as outlined in STC 40.

X. MONITORING

44. Monitoring Reports. The state must submit three (3) Quarterly Reports and one (1) compiled Annual Report each DY. The information for the fourth quarter should be reported as distinct information within the Annual Report. The Quarterly Reports are due no later than sixty (60 calendar days) following the end of each demonstration quarter. The compiled Annual Report is due no later than ninety (90 calendar days) following the end of the DY. The reports will include all required elements as per 42 CFR 431.428, and should not direct readers to links outside the report. Additional links not referenced in the document may be listed in a Reference/Bibliography section. The Monitoring Reports must follow the framework provided by CMS, which is subject to change as monitoring systems are developed/evolve, and be provided in a structured manner that supports federal tracking and analysis.

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

b. Performance Metrics – Per 42 CFR 431.428, the Monitoring Reports must document the impact of the demonstration in providing insurance coverage to beneficiaries and the uninsured population, as well as outcomes of care, quality and cost of care, and access to care. This may also include the results of beneficiary satisfaction surveys, if conducted, grievances and appeals. The required monitoring and performance metrics must be included in writing in the

Monitoring Reports, and will follow the framework provided by CMS to support federal tracking and analysis.

c. Budget Neutrality and Financial Reporting Requirements - Per 42 CFR 431.428, the Monitoring Reports must document the financial performance of the demonstration. The state must provide an updated budget neutrality workbook with every Monitoring Report that meets all the reporting requirements for monitoring budget neutrality set forth in the General Financial Requirements section of these STCs, including the submission of corrected budget neutrality data upon request. In addition, the state must report quarterly and annual expenditures associated with the populations affected by this demonstration on the Form CMS-64. Administrative costs should be reported separately.

d. Evaluation Activities and Interim Findings - Per 42 CFR 431.428, the Monitoring Reports must document any results of the demonstration to date per the evaluation hypotheses. Additionally, the state shall include a summary of the progress of evaluation activities, including key milestones accomplished, as well as challenges encountered and how they were addressed.

e. SUD Health IT - The state will include a summary of progress made in regards to SUD Health IT requirements outlined in STC 23.

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

a. The draft close-out report must comply with the most current Guidance from CMS.

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

c. The state must take into consideration CMS' comments for incorporation into the final close-out report.

d. The final close-out report is due to CMS no later than 30 calendar days after receipt of CMS' comments.

e. A delay in submitting the draft or final version of the close-out report may subject the state to penalties described in STC 21.

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

a. The purpose of these calls is to discuss any significant actual or anticipated developments affecting the demonstration. Examples include implementation activities, enrollment and access, budget neutrality, and progress on the evaluation.

b. CMS will provide updates on any amendments or concept papers under review, as well as federal policies and issues that may affect any aspect of the demonstration.

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

47. Post Award Forum. Pursuant to 42 CFR 431.420(c), within six (6) months of the demonstration's implementation, and annually thereafter, the state must afford the public with an opportunity to provide meaningful comment on the progress of the demonstration. At least 30 calendar days prior to the date of the planned public forum, the state must publish the date, time and location of the forum in a prominent location on its website. The state must also post the most recent annual report on its website with the public forum announcement. Pursuant to 42 CFR 431.420(c), the state must include a summary of the comments in the Monitoring Report associated with the quarter in which the forum was held, as well as in its compiled Annual Report.

XI. EVALUATION OF THE DEMONSTRATION

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

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

50. Draft Evaluation Design. The draft Evaluation Design must be developed in accordance with Attachment A (Developing the Evaluation Design) of these STCs. The state must submit, for CMS comment and approval, a draft Evaluation Design with implementation timeline, no later than one hundred eighty (180) days after the effective date of these STCs. Any modifications to an existing approved Evaluation Design will not affect previously established requirements and timelines for report submission for the demonstration, if applicable.

51. Evaluation Design Approval and Updates. The state must submit a revised draft Evaluation Design within sixty (60) days after receipt of CMS' comments. Upon CMS approval of the draft Evaluation Design, the document will be included as an attachment to these STCs. Per 42 CFR 431.424(c), the state will publish the approved Evaluation Design to the state's website within thirty (30) days of CMS approval. The state must implement the evaluation design and submit a description of its evaluation implementation progress in each of the Monitoring Reports, including any required Rapid Cycle Assessments specified in

theses STCs. Once CMS approves the evaluation design, if the state wishes to make changes, the state must submit a revised evaluation design to CMS for approval.

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

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

a. The interim evaluation report will discuss evaluation progress and present findings to date as per the approved evaluation design.
b. For demonstration authority that expires prior to the overall demonstration's expiration date, the Interim Evaluation Report must include an evaluation of the authority as approved by CMS.
c. If the state is seeking to renew or extend the demonstration, the draft Interim Evaluation Report is due when the application for renewal is submitted. If the state made changes to the demonstration in its application for renewal, the research questions and hypotheses, and how the design was adapted should be included. If the state is not requesting a renewal for a demonstration, an Interim Evaluation report is due one (1) year prior to the end of the demonstration. For demonstration phase outs prior to the expiration of the approval period, the draft Interim Evaluation Report is due to CMS on the date that will be specified in the notice of termination or suspension.
d. The state must submit the final Interim Evaluation Report 60 calendar days after receiving CMS comments on the draft Interim Evaluation Report and post the document to the state's website.
e. The Interim Evaluation Report must comply with Attachment B of these STCs.

54. Summative Evaluation Report. The draft Summative Evaluation Report must be developed in accordance with Attachment B of these STCs. The state must submit a draft Summative Evaluation Report for the demonstration's current approval period, October 1 2019 to September 30, 2024, within 18 months of the end of the approval period represented

by these STCs. The Summative Evaluation Report must include the information in the approved Evaluation Design.

a. Unless otherwise agreed upon in writing by CMS, the state must submit the final Summative Evaluation Report within 60 calendar days of receiving comments from CMS on the draft.
b. The final Summative Evaluation Report must be posted to the state's Medicaid website within 30 calendar days of approval by CMS.

55. State Presentations for CMS. CMS reserves the right to request that the state present and participate in a discussion with CMS on the Evaluation Design, the interim evaluation, and/or the summative evaluation.

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

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

XII. GENERAL FINANCIAL REQUIREMENTS UNDER TITLE XIX

58. Standard Medicaid Funding Process. The standard Medicaid funding process must be used during the demonstration. The state will provide quarterly expenditure reports through the Medicaid and CHIP Budget and Expenditure System (MBES/CBES) to report total expenditures for services provided under this demonstration following routine CMS-37 and CMS-64 reporting instructions as outlined in section 2500 of the State Medicaid Manual. The state will estimate matchable demonstration expenditures (total computable and federal share) subject to the budget neutrality expenditure limit and separately report those expenditures by quarter for each federal fiscal year on the Form CMS-37 (narrative section) for both the medical assistance payments (MAP) and state and local administrative costs (ADM). CMS will make federal funds available based upon the state's estimate, as approved by CMS. Within thirty (30) calendar days after the end of each quarter, the state shall submit the Form CMS-64 Quarterly Medicaid Expenditure Report, showing Medicaid expenditures made in the quarter just ended. If applicable, subject to the payment deferral process, CMS will reconcile expenditures reported on the Form CMS-64 quarterly with federal funding previously made available to the state, and include the reconciling adjustment in the finalization of the grant award to the state.

59. Extent of Federal Financial Participation for the Demonstration. Subject to CMS approval of the source(s) of the non-federal share of funding. CMS will provide FFP at the applicable federal matching rate for the demonstration as a whole for the following, subject to the limits described in Section XII:

a. Administrative costs, including those associated with the administration of the demonstration;
b. Net expenditures and prior period adjustments of the Medicaid program that are paid in accordance with the approved Medicaid state plan; and
c. Medical assistance expenditures and prior period adjustments made under section 1115 demonstration authority with dates of service during the demonstration extension period; including those made in conjunction with the demonstration, net of enrollment fees, cost sharing, pharmacy rebates, and all other types of third party liability.

60. Sources of Non-Federal Share. The state certifies that the matching non-federal share of funds for the demonstration is state/local monies. The state further certifies that such funds must not be used as the match for any other federal grant or contract, except as permitted by law. All sources of non-federal funding must be compliant with section 1903(w) of the Act and applicable regulations. In addition, all sources of the non-federal share of funding are subject to CMS approval.

a. The state acknowledges that CMS has authority to review the sources of the non-federal share of funding for the demonstration at any time. The state agrees that all funding sources deemed unacceptable by CMS must be addressed within the time frames set by CMS.
b. The state acknowledges that any amendments that impact the financial status of the program must require the state to provide information to CMS regarding all sources of the non-federal share of funding.

61. State Certification of Funding Conditions. The state must certify that the following conditions for non-federal share of demonstration expenditures are met:

a. Units of government, including governmentally operated health care providers, may certify that state or local monies have been expended as the non-federal share of funds under the demonstration.
b. To the extent the state utilizes certified public expenditures (CPE) as the funding mechanism for the state share of title XIX payments, including expenditures authorized under a section 1115 demonstration, CMS must approve a cost reimbursement methodology. This methodology must include a detailed explanation of the process by which the state would identify those costs eligible under title XIX (or under section 1115 authority) for purposes of certifying public expenditures.
c. To the extent the state utilizes CPEs as the funding mechanism to claim federal match for expenditures under the demonstration, governmental entities to which general revenue funds are appropriated must certify to the state the amount of

such state or local monies that are allowable under 42 CFR 433.51 to satisfy demonstration expenditures. If the CPE is claimed under a Medicaid authority, the federal matching funds received cannot then be used as the state share needed to receive other federal matching funds under 42 CFR 433.51(c). The entities that incurred the cost must also provide cost documentation to support the state's claim for federal match;

d. The state may use intergovernmental transfers (IGT) to the extent that such funds are derived from state or local monies and are transferred by units of government within the state. Any transfers from governmentally operated health care providers must be made in an amount not to exceed the non-federal share of title XIX payments.

e. Under all circumstances, health care providers must retain 100 percent of the reimbursement for claimed expenditures. Moreover, consistent with 42 CFR 447.10, no pre-arranged agreements (contractual, voluntary, or otherwise) may exist between health care providers and state and/or local government to return and/or redirect to the state any portion of the Medicaid payments. This confirmation of Medicaid payment retention is made with the understanding that payments that are the normal operating expenses of conducting business, such as payments related to taxes, including health care provider-related taxes, fees, business relationships with governments that are unrelated to Medicaid and in which there is no connection to Medicaid payments, are not considered returning and/or redirecting a Medicaid payment.

62. Program Integrity. The state must have a process in place to ensure that there is no duplication of federal funding for any aspect of the demonstration. The state must also ensure that the state and any of its contractors follow standard program integrity principles and practices including retention of data. All data, financial reporting, and sources of non-federal share are subject to audit.

63. Medicaid Expenditure Groups (MEG). MEGs are defined for the purpose of identifying categories of Medicaid or demonstration expenditures subject to budget neutrality, components of budget neutrality expenditure limit calculations, and other purposes related to monitoring and tracking expenditures under the demonstration. The Master MEG Chart table provides a master list of MEGs defined for this demonstration.

Table 2: Master MEG Chart

MEG	To Which BN Test Does This Apply?	WOW Per Capita	WOW Aggregate	WW	Brief Description

DAB	Hypo 1	X		X	Includes non-dual and dual eligible members who are enrolled in the disabled, aged, or blind (DAB) eligibility categories.
TANF	Hypo 1	X		X	Includes non-dual and dual eligible members who are enrolled in the Temporary Assistance for Needy Families (TANF) eligibility categories.
HMP	Hypo 1	X		X	Includes non-dual and dual eligible members who are enrolled in the Healthy Michigan Plan (HMP) eligibility categories.
HSW	Hypo 1	X		X	Includes members who are enrolled in the 1915 (c) Habilitation Supports Waiver (HSW) program.
SED	Hypo 1	X		X	Includes members who are enrolled in the 1915(c) Serious Emotional Disturbances (SED) Waiver program.
CWP	Hypo 1	X		X	Includes members who are enrolled in the 1915(c) Children's Waiver Program (CWP)
SUD IMD-DAB	Hypo 1	X		X	All expenditures for costs of medical assistance that could be covered, were it not for the IMD prohibition under the state plan, provided to individuals in the DAB eligibility category during a month in which the individual is a short-term resident in an IMD.
SUD IMD-TANF	Hypo 1	X		X	All expenditures for costs of medical assistance that could be covered, were it not for the IMD prohibition under the state plan,

					provided to individuals in the TANF eligibility category during a month in which the individual is a short-term resident in an IMD.
SUD IMD-HMP	Hypo 1	X		X	All expenditures for costs of medical assistance that could be covered, were it not for the IMD prohibition under the state plan, provided to individuals in the HMP eligibility category during a month in which the individual is a short-term resident in an IMD.

64. Reporting Expenditures and Member Months. The state must report all demonstration expenditures claimed under the authority of title XIX of the Act and subject to budget neutrality each quarter on separate forms CMS-64.9 WAIVER and/or 64.9P WAIVER, identified by the demonstration project number assigned by CMS (11-W-00305/5). Separate reports must be submitted by MEG (identified by Waiver Name) and Demonstration Year (identified by the two digit project number extension). Unless specified otherwise, expenditures must be reported by DY according to the dates of service associated with the expenditure. All MEGs identified in the Master MEG Chart as WW must be reported for expenditures, as further detailed in the MEG Detail for Expenditure and Member Month Reporting table below. To enable calculation of the budget neutrality expenditure limits, the state also must report member months of eligibility for specified MEGs.

a. Cost Settlements. The state will report any cost settlements attributable to the demonstration on the appropriate prior period adjustment schedules (form CMS-64.9P WAIVER) for the summary sheet line 10b, in lieu of lines 9 or 10c. For any cost settlement not attributable to this demonstration, the adjustments should be reported as otherwise instructed in the State Medicaid Manual. Cost settlements must be reported by DY consistent with how the original expenditures were reported.

b. Premiums and Cost Sharing Collected by the State. The state will report any premium contributions collected by the state from demonstration enrollees quarterly on the form CMS-64 Summary Sheet line 9D, columns A and B. In order to assure that these collections are properly credited to the demonstration, quarterly premium collections (both total computable and federal share) should also be reported separately by DY on form CMS-64 Narrative, and on the Total Adjustments tab in the Budget Neutrality Monitoring Tool. In the annual calculation of expenditures subject to the budget neutrality expenditure limit, premiums collected in the demonstration year will be offset against expenditures

incurred in the demonstration year for determination of the state's compliance with the budget neutrality limits.

c. Pharmacy Rebates. Because pharmacy rebates are not included in the base expenditures used to determine the budget neutrality expenditure limit, pharmacy rebates are not included for calculating net expenditures subject to budget neutrality. The state will report pharmacy rebates on form CMS-64.9 BASE, and not allocate them to any form 64.9 or 64.9P WAIVER.

d. Administrative Costs. The state will separately track and report additional administrative costs that are directly attributable to the demonstration. All administrative costs must be identified on the forms CMS-64.10 WAIVER and/or 64.10P WAIVER. Unless indicated otherwise on the Master MEG Chart table, administrative costs are not counted in the budget neutrality tests; however, these costs are subject to monitoring by CMS.

Member Months. As part of the Quarterly and Annual Monitoring Reports described in section IX, the state must report the actual number of "eligible member months" for all demonstration enrollees for all MEGs identified as WOW Per Capita in the Master MEG Chart table above, and as also indicated in the MEG Detail for Expenditure and Member Month Reporting table below. The term "eligible member months" refers to the number of months in which persons enrolled in the demonstration are eligible to receive services. For example, a person who is eligible for three months contributes three eligible member months to the total. Two individuals who are eligible for two months, each contribute two eligible member months, for a total of four eligible member months. The state must submit a statement accompanying the annual report certifying the accuracy of this information.

Table 3: MEG Detail for Expenditure and Member Month Reporting

MEG (Waiver Name)	Detailed Description	Exclusions	CMS-64.9 Line(s) To Use	How Expend. Are Assigned to DY	MAP or ADM	Report Member Months (Y/N)	MEG Start Date	MEG End Date
DAB	See Brief Description above	N/A	Standard lines by type of service	Date of service	MAP	Yes[4]	Oct. 1, 2019	Sep. 30, 2024

[4] SUD IMD-HMP Member Months are months of Medicaid eligibility during which the individual belonging to the Healthy Michigan Plan MEG is an inpatient in an IMD under terms of the demonstration for any day during the month and must be reported separately for each SUD IMD-HMP MEG, as applicable. SUD IMD-HMP Member Months must not be duplicative of member months reported under any other Michigan section 1115 demonstration

TANF	See Brief Description above	N/A	Standard lines by type of service	Date of service	MAP	Yes[5]	Oct. 1, 2019	Sept. 30, 2024
HMP	See Brief Description above	N/A	Standard lines by type of service	Date of service	MAP	Yes	Oct. 1, 2019	Sept. 30, 2024
HSW	See Brief Description above	N/A	Standard lines by type of service	Date of service	MAP	Yes	Oct. 1, 2019	Sept. 30, 2024
SED	See Brief Description above	N/A	Standard lines by type of service	Date of service	MAP	Yes	Oct. 1, 2019	Sept. 30, 2024
CWP	See Brief Description above	N/A	Standard lines by type of service	Date of service	MAP	Yes	Oct. 1, 2019	Sept. 30, 2024
SUD IMD-DAB	See Brief Description above	N/A	Standard lines by type of service	Date of service	MAP	Yes	Oct. 1, 2019	Sept. 30, 2024
SUD IMD-TANF	See Brief Description above	N/A	Standard lines by type of service	Date of service	MAP	Yes	Oct. 1, 2019	Sept. 30, 2024
SUD IMD-HMP	See Brief Description above	N/A	Standard lines by type of service	Date of service	MAP	Yes	Oct. 1, 2019	Sept. 30, 2024

e. Budget Neutrality Specifications Manual. The state will create and maintain a Budget Neutrality Specifications Manual that describes in detail how the state will compile data on actual expenditures related to budget neutrality, including methods used to extract and compile data from the state's Medicaid Management Information System, eligibility system, and accounting systems for reporting on the CMS-64, consistent with the terms of the demonstration. The Budget

[5] SUD IMD-TANF Member Months are months of Medicaid eligibility during which the individual belonging to the TANF MEG is an inpatient in an IMD under terms of the demonstration for any day during the month and must be reported separately for each SUD IMD-TANF MEG, as applicable. SUD IMD-TANF Member Months must not be duplicative of member months reported under any other Michigan section 1115 demonstration.

Neutrality Specifications Manual will also describe how the state compiles counts of Medicaid member months. The Budget Neutrality Specifications Manual must be made available to CMS on request.

65. Demonstration Years. Demonstration Years (DY) for this demonstration are defined in the Demonstration Years table below.

Table 4: Demonstration Years		
Demonstration Year 1	October 1, 2019- September 30, 2020	12 months
Demonstration Year 2	October 1, 2020- September 30, 2021	12 months
Demonstration Year 3	October 1, 2021- September 30, 2022	12 months
Demonstration Year 4	October 1, 2022- September 30, 2023	12 months
Demonstration Year 5	October 1, 2023 - September 30, 2024	12 months

66. Budget Neutrality Monitoring Tool. The state must provide CMS with quarterly budget neutrality status updates, including established baseline and member months data, using the Budget Neutrality Monitoring Tool provided through the Performance Metrics Database and Analytics (PMDA) system. The tool incorporates the "Schedule C Report" for comparing demonstration's actual expenditures to the budget neutrality expenditure limits described in section XI. CMS will provide technical assistance, upon request.[6]

67. Claiming Period. The state will report all claims for expenditures subject to the budget neutrality agreement (including any cost settlements) within two years after the calendar quarter in which the state made the expenditures. All claims for services during the demonstration period (including any cost settlements) must be made within two years after the conclusion or termination of the demonstration. During the latter two-year period, the state will continue to identify separately net expenditures related to dates of service during the operation of the demonstration on the CMS-64 waiver forms in order to properly account for these expenditures in determining budget neutrality.

[6] 42 CFR §431.420(a)(2) provides that states must comply with the terms and conditions of the agreement between the Secretary (or designee) and the state to implement a demonstration project, and §431.420(b)(1) states that the terms and conditions will provide that the state will perform periodic reviews of the implementation of the demonstration. CMS's current approach is to include language in STCs requiring, as a condition of demonstration approval, that states provide, as part of their periodic reviews, regular reports of the actual costs which are subject to the budget neutrality limit. CMS has obtained Office of Management and Budget (OMB) approval of the monitoring tool under the Paperwork Reduction Act (OMB Control No. 0938 – 1148) and in states agree to use the tool as a condition of demonstration approval.

68. Future Adjustments to Budget Neutrality. CMS reserves the right to adjust the budget neutrality expenditure limit:

a. To be consistent with enforcement of laws and policy statements, including regulations and letters, regarding impermissible provider payments, health care related taxes, or other payments, CMS reserves the right to make adjustments to the budget neutrality limit if any health care related tax that was in effect during the base year, or provider-related donation that occurred during the base year, is determined by CMS to be in violation of the provider donation and health care related tax provisions of section 1903(w) of the Act. Adjustments to annual budget targets will reflect the phase out of impermissible provider payments by law or regulation, where applicable.

b. To the extent that a change in federal law, regulation, or policy requires either a reduction or an increase in FFP for expenditures made under this demonstration. In this circumstance, the state must adopt, subject to CMS approval, a modified budget neutrality agreement as necessary to comply with such change. The modified agreement will be effective upon the implementation of the change. The trend rates for the budget neutrality agreement are not subject to change under this STC. The state agrees that if mandated changes in the federal law require state legislation, the changes shall take effect on the day such state legislation becomes effective, or on the last day such legislation was required to be in effect under the federal law.

c. The state certifies that the data it provided to establish the budget neutrality expenditure limit are accurate based on the state's accounting of recorded historical expenditures or the next best available data, that the data are allowable in accordance with applicable federal, state, and local statutes, regulations, and policies, and that the data are correct to the best of the state's knowledge and belief. The data supplied by the state to set the budget neutrality expenditure limit are subject to review and audit, and if found to be inaccurate, will result in a modified budget neutrality expenditure limit.

XIII. MONITORING BUDGET NEUTRALITY FOR THE DEMONSTRATION

69. Limit on Title XIX Funding. The state will be subject to limits on the amount of federal Medicaid funding the state may receive over the course of the demonstration approval. The budget neutrality expenditure limits are based on projections of the amount of FFP that the state would likely have received in the absence of the demonstration. The limit may consist of a Main Budget Neutrality Test, and one or more Hypothetical Budget Neutrality Tests, as described below. CMS' assessment of the state's compliance with these tests will be based on the Schedule C CMS-64 Waiver Expenditure Report, which summarizes the expenditures reported by the state on the CMS-64 that pertain to the demonstration.

70. Risk. The budget neutrality expenditure limits are determined on either a per capita or aggregate basis. If a per capita method is used, the state is at risk for the per capita cost of state plan and hypothetical populations, but not for the number of participants in the

demonstration population. By providing FFP without regard to enrollment in the for all demonstration populations, CMS will not place the state at risk for changing economic conditions. However, by placing the state at risk for the per capita costs of the demonstration populations, CMS assures that the demonstration expenditures do not exceed the levels that would have been realized had there been no demonstration.

71. Calculation of the Budget Neutrality Limit and How It Is Applied. To calculate the budget neutrality limits for the demonstration, separate annual budget limits are determined for each DY on a total computable basis. Each annual budget limit is the sum of one or more components: per capita components, which are calculated as a projected without-waiver PMPM cost times the corresponding actual number of member months, and aggregate components, which project fixed total computable dollar expenditure amounts. The annual limits will then be added together to obtain a budget neutrality limit for the entire demonstration period. The federal share of this limit will represent the maximum amount of FFP that the state may receive during the demonstration period for the types of demonstration expenditures described below. The federal share will be calculated by multiplying the total computable budget neutrality limit by appropriate Composite Federal Share.

72. **Main Budget Neutrality Test.** The Main Budget Neutrality Test allows the state to show that demonstration expenditure authorities granted have not resulted in increased costs to Medicaid, and that federal Medicaid "savings" have been achieved sufficient to offset the additional projected federal costs resulting from expenditure authority. The table below identifies the MEGs that are used for the Main Budget Neutrality Test. MEGs designated as "WOW Only" or "Both" are components used to calculate the budget neutrality expenditure limit. MEGs that are indicated as "WW Only" or "Both" are counted as expenditures against the budget neutrality expenditure limit. In addition, any expenditures in excess of limit from Hypothetical Budget Neutrality Tests count as expenditures under the Main Budget Neutrality Test. The Composite Federal Share for this test is calculated based on all MEGs indicated as "Both."

MEG	PC or Agg*	WOW Only, WW Only, or Both	TREND	DY1 - PMPM	DY2 – PMPM	DY3 – PMPM	DY4 – PMPM	DY5 – PMPM
DAB	**PC**	**Both**	**4.2%**	**$318.29**	**$331.50**	**$345.26**	**$359.59**	**$374.51**
TANF	**PC**	**Both**	**4.5%**	**$27.27**	**$28.50**	**$29.78**	**$31.12**	**$32.52**
HMP	**PC**	**Both**	**4.5%**	**$53.51**	**$55.92**	**$58.44**	**$61.07**	**$63.82**
HSW	**PC**	**Both**	**2.0%**	**$5,004.36**	**$5,104.45**	**$5,206.54**	**$5,310.67**	**$5,416.88**
SED	**PC**	**Both**	**0.0%**	**$2,117.84**	**$2,117.84**	**$2,117.84**	**$2,117.84**	**$2,117.84**
CWP	**PC**	**Both**	**0.0%**	**$3,547.20**	**$3,547.20**	**$3,547.20**	**$3,547.20**	**$3,547.20**
SUD-IMD-DAB	**PC**	**Both**	**4.4%**	**$1,657.57**	**$1,730.50**	**$1,806.64**	**$1,886.14**	**$1,969.13**

SUD-IMD-TANF	**PC**	**Both**	**4.8%**	**$842.82**	**$883.27**	**$925.66**	**$970.09**	**$1016.66**
SUD-IMD-HMP	**PC**	**Both**	**4.9%**	**$729.30**	**$765.03**	**$802.52**	**$841.84**	**$883.09**

73. Hypothetical Budget Neutrality. When expenditure authority is provided for coverage of populations or services that the state could have otherwise provided through its Medicaid state plan or other title XIX authority (such as a waiver under section 1915 of the Act), CMS considers these expenditures to be "hypothetical;" that is, the expenditures would have been eligible to receive FFP elsewhere in the Medicaid program. For these hypothetical expenditures, CMS makes adjustments to the budget neutrality test which effectively treats these expenditures as if they were for approved Medicaid state plan services. Hypothetical expenditures, therefore, do not necessitate savings to offset the otherwise allowable services. This approach reflects CMS's current view that states should not have to "pay for," with demonstration savings, costs that could have been otherwise eligible for FFP under a Medicaid state plan or other title XIX authority; however, when evaluating budget neutrality, CMS does not offset non-hypothetical expenditures with projected or accrued savings from hypothetical expenditures. That is, savings are not generated from a hypothetical population or service. To allow for hypothetical expenditures, while preventing them from resulting in savings, CMS currently applies a separate, independent Hypothetical Budget Neutrality Tests, which subject hypothetical expenditures to pre-determined limits to which the state and CMS agree, and that CMS approves, as a part of this demonstration approval. If the state's WW hypothetical spending exceeds the supplemental test's expenditure limit, the state agrees (as a condition of CMS approval) to refund the FFP to CMS.

74. Hypothetical Budget Neutrality Test 1: Substance Use Disorder Expenditures. The table below identifies the MEGs that are used for Hypothetical Budget Neutrality Test 1. MEGs that are designated "WOW Only" or "Both" are the components used to calculate the budget neutrality expenditure limit. The Composite Federal Share for the Hypothetical Budget Neutrality Test is calculated based on all MEGs indicated as "WW Only" or "Both." MEGs that are indicated as "WW Only" or "Both" are counted as expenditures against this budget neutrality expenditure limit. Any expenditures in excess of the limit from Hypothetical Budget Neutrality Test are counted as WW expenditures under the Main Budget Neutrality Test.

75. Composite Federal Share Ratios. The Composite Federal Share is the ratio that will be used to convert the total computable budget neutrality limit to federal share. The Composite Federal Share is the ratio calculated by dividing the sum total of FFP received by the state on actual demonstration expenditures during the approval period by total computable demonstration expenditures for the same period, as reported through MBES/CBES and summarized on Schedule C. Since the actual final Composite Federal Share will not be known until the end of the demonstration's approval period, for the purpose of interim

monitoring of budget neutrality, a reasonable estimate of Composite Federal Share may be developed and used through the same process or through an alternative mutually agreed to method. Each Main or Hypothetical Budget Neutrality Test has its own Composite Federal Share, as defined in the paragraph pertaining to each particular test.

76. Exceeding Budget Neutrality. CMS will enforce the budget neutrality agreement over the life of the demonstration approval period, which extends from October 1, 2019 to September 30, 2024. The budget neutrality limits calculated in STC 72 will apply to actual expenditures for demonstration services as reported by the state under section XIII of these STCs. Actual expenditures are from a state and federal basis, including managed care capitation payments for members enrolled in managed care programs and fee-for-service (FFS) claims for services or members carved out of MDHHS' managed care programs. If at the end of the demonstration period the budget neutrality limit has been exceeded, the excess federal funds will be returned to CMS. If the demonstration is terminated prior to the end of the demonstration period, the budget neutrality test will be based on the time period through the termination date.

77. Mid- Course Correction. If at any time during the demonstration approval period CMS determines that the demonstration is on course to exceed its budget neutrality expenditure limit, CMS will require the state to submit a corrective action plan for CMS review and approval. CMS will use the threshold levels in the tables below as a guide for determining when corrective action is required.

Table 9: Main Budget Neutrality Test Mid-Course Correction Calculations		
Demonstration Year	*Cumulative Target*	*Percentage*
DY 1	*Cumulative budget neutrality cap plus:*	*0.25 percent*
DY 2	*Cumulative budget neutrality cap plus:*	*0.25 percent*
DY 3,4, and 5	*Cumulative budget neutrality cap plus:*	*0 percent*

Table 10: Hypothetical Budget Neutrality Test Mid-Course Correction Calculations		
Demonstration Year	*Cumulative Target*	*Percentage*
DY 1	*Cumulative budget neutrality cap plus:*	*0.25 percent*
DY 2	*Cumulative budget neutrality cap plus:*	*0.25 percent*
DY 3,4, and 5	*Cumulative budget neutrality cap plus:*	*0 percent*

XIV. SCHEDULE OF STATE DELIVERABLES DURING THE DEMONSTRATION

Date	Deliverable	STC
30 days after approval date	State acceptance of demonstration STCs and Expenditure Authorities	Approval letter
150 days after approval date	OUD/SUD Monitoring Plan	STC 19
90 days after SUD program approval	OUD/SUD Implementation Plan	STC 18
90 days after SUD program approval	SUD Health IT Plan	STC 23
180 days after approval date	Draft Evaluation Design	STC 22
60 days after receipt of CMS comments	Revised Draft Evaluation Design	STC 22
30 days after CMS Approval	Approved Evaluation Design published to state's website	STC 22
December 31, 2022	Mid-Point Assessment	STC 20
One year prior to the end of the demonstration, or with renewal application	Draft Interim Evaluation Report	STC 53
60 days after receipt of CMS comments	Final Interim Evaluation Report	STC 53
18 months after the end of the demonstration	Draft Summative Evaluation Report	STC 54
60 calendar days after receipt of CMS comments	Final Summative Evaluation Report	STC 54
30 calendar days after approval of CMS comments	Approved Final Summative Evaluation Report published to state's website	STC 54
Monthly Deliverables	Monitoring Calls	STC 46
Quarterly Deliverables Due 60 days after end of each quarter, except 4th quarter	Quarterly Monitoring Reports	STC 44

Annual Deliverables -Due 90 days after end of each 4th quarter	Annual Reports	STC 44
30 calendar days after receipt of CMS comments	Final Close-out Operational Report	STC 45
60 calendar days after receipt of CMS comments	Final SUD Mid-point assessment	STC 20

ATTACHMENT A
Developing the Evaluation Design

Introduction

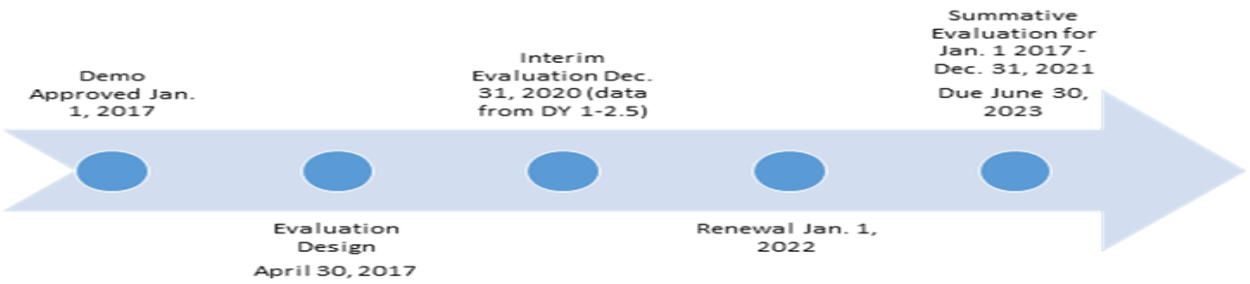
For states that are testing new approaches and flexibilities in their Medicaid programs through section 1115 demonstrations, evaluations are crucial to understand and disseminate what is or is not working and why. The evaluations of new initiatives seek to produce new knowledge and direction for programs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

Expectations for Evaluation Designs

All states with Medicaid section 1115 demonstrations are required to conduct an evaluation, and the Evaluation Design is the roadmap for conducting the evaluation. The roadmap begins with the stated goals for the demonstration followed by the measurable evaluation questions and quantifiable hypotheses, all to support a determination of the extent to which the demonstration has achieved its goals**.**

The format for the Evaluation Design is as follows:
General Background Information;
Evaluation Questions and Hypotheses;
Methodology;
Methodological Limitations;
Attachments.

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



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

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

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

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

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

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

5) Describe the population groups impacted by the demonstration.

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

1) Describe how the state's demonstration goals are translated into quantifiable targets for improvement, so that the performance of the demonstration in achieving these targets could be measured.

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

3) Identify the state's hypotheses about the outcomes of the demonstration:

4) Discuss how the evaluation questions align with the hypotheses and the goals of the demonstration;

5) Address how the research questions / hypotheses of this demonstration promote the objectives of Titles XIX and/or XXI.

C. Methodology – In this section, the state is to describe in detail the proposed research methodology.

The focus is on showing that the evaluation meets the prevailing standards of scientific and academic rigor, and the results are statistically valid and reliable, and that where appropriate it builds upon other published research (use references).

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

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

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

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

4) *Evaluation Measures* – List all measures that will be calculated to evaluate the demonstration. Include the measure stewards (i.e., the organization(s) responsible for the evaluation data elements/sets by "owning", defining, validating; securing; and submitting for endorsement, etc.) Include numerator and denominator information. Additional items to ensure:

   a. The measures contain assessments of both process and outcomes to evaluate the effects of the demonstration during the period of approval.

   b. Qualitative analysis methods may be used, and must be described in detail.

   c. Benchmarking and comparisons to national and state standards, should be used, where appropriate.

   d. Proposed health measures could include CMS's Core Set of Health Care Quality Measures for Children in Medicaid and CHIP, Consumer Assessment of Health Care Providers and Systems (CAHPS), the Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults and/or measures endorsed by National Quality Forum (NQF).

   f. Proposed performance metrics can be selected from nationally recognized metrics, for example from sets developed by the Center for Medicare and Medicaid Innovation or for meaningful use under Health Information Technology (HIT).

   g. Among considerations in selecting the metrics shall be opportunities identified by the state for improving quality of care and health outcomes, and controlling cost of care.

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

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

6) *Analytic Methods* – This section includes the details of the selected quantitative and/or qualitative measures to adequately assess the effectiveness of the demonstration. This section should:

   a. Identify the specific statistical testing which will be undertaken for each measure (e.g., t-tests, chi-square, odds ratio, ANOVA, regression). Table A is an example of how the state might want to articulate the analytic methods for each research question and measure.

b. Explain how the state will isolate the effects of the demonstration (from other initiatives occurring in the state at the same time) through the use of comparison groups.

c. A discussion of how propensity score matching and difference in differences design may be used to adjust for differences in comparison populations over time (if applicable).

d. The application of sensitivity analyses, as appropriate, should be considered.

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

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

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

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

1) When the state demonstration is:
   a. Long-standing, non-complex, unchanged, or
   b. Has previously been rigorously evaluated and found to be successful, or
   c. Could now be considered standard Medicaid policy (CMS published

regulations or guidance)

2) When the demonstration is also considered successful without issues or concerns that would require more regular reporting, such as:
    a. Operating smoothly without administrative changes; and
    b. No or minimal appeals and grievances; and
    c. No state issues with CMS-64 reporting or budget neutrality; and
    d. No Corrective Action Plans (CAP) for the demonstration.

E. Attachments

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

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

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

ATTACHMENT B
Preparing the Interim and Summative Evaluation Reports

Introduction

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

Expectations for Evaluation Reports

Medicaid section 1115 demonstrations are required to conduct an evaluation that is valid (the extent to which the evaluation measures what it is intended to measure), and reliable (the extent to which the evaluation could produce the same results when used repeatedly). To this end, the already approved Evaluation Design is a map that begins with the demonstration goals, then transitions to the evaluation questions, and to the specific hypotheses, which will be used to investigate whether the demonstration has achieved its goals. States should have a well-structured analysis plan for their evaluation. As these valid analyses multiply (by a single state or by multiple states with similar demonstrations) and the data sources improve, the reliability of evaluation findings will be able to shape Medicaid policy in order to improve the health and welfare of Medicaid beneficiaries for decades to come. When submitting an application for renewal, the interim evaluation report should be posted on the state's website with the application for public comment. Additionally, the interim evaluation report must be included in its entirety with the application submitted to CMS.

Intent of this Guidance

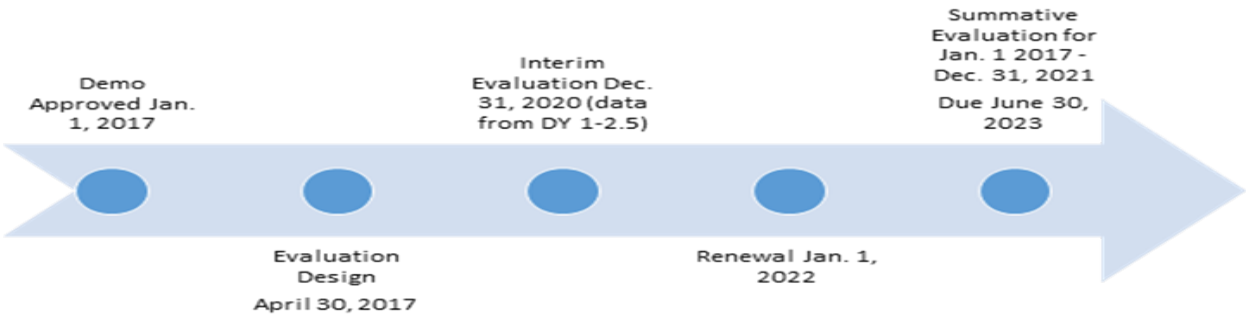
The Social Security Act (the Act) requires an evaluation of every section 1115 demonstration. In order to fulfill this requirement, the state's submission must provide a comprehensive written presentation of all key components of the demonstration, and include all required elements specified in the approved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

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

A. Executive Summary;
B. General Background Information;
C. Evaluation Questions and Hypotheses;
D. Methodology;
E. Methodological Limitations;
F. Results;
G. Conclusions;
H. Interpretations, and Policy Implications and Interactions with Other State Initiatives;
I. Lessons Learned and Recommendations; and
J. Attachment(s).

Submission Timelines

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



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

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

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

1) The issues that the state is trying to address with its section 1115 demonstration and/or expenditure authorities, how the state became aware of the issue, the potential magnitude of the issue, and why the state selected this course of action to address the issues.

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

3) A brief description of the demonstration and history of the implementation, and if the evaluation is for an amendment, extension, renewal, or expansion of, the demonstration;

4) For renewals, amendments, and major operational changes: A description of any changes to the demonstration during the approval period; whether the motivation for change was due to political, economic, and fiscal factors at the state and/or federal level; whether the programmatic changes were implemented to improve beneficiary health, provider/health plan performance, or administrative efficiency; and how the Evaluation Design was altered or augmented to address these changes.

5) Describe the population groups impacted by the demonstration.

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

1) Describe how the state's demonstration goals were translated into quantifiable targets for improvement, so that the performance of the demonstration in achieving these targets could be measured. The inclusion of a Driver Diagram in the Evaluation Report is highly encouraged, as the visual can aid readers in understanding the rationale behind the demonstration features and intended outcomes.

2) Identify the state's hypotheses about the outcomes of the demonstration;
    a. Discuss how the goals of the demonstration align with the evaluation questions and hypotheses;
    b. Explain how this Evaluation Report builds upon and expands earlier demonstration evaluation findings (if applicable); and
    c. Address how the research questions / hypotheses of this demonstration promote the objectives of Titles XIX and XXI.

D. Methodology – In this section, the state is to provide an overview of the research that was conducted to evaluate the section 1115 demonstration consistent with the approved Evaluation Design.

The evaluation design should also be included as an attachment to the report. The focus is on showing that the evaluation builds upon other published research (use references), and meets the prevailing standards of scientific and academic rigor, and the results are statistically valid and reliable.

An interim report should provide any available data to date, including both quantitative and qualitative assessments. The Evaluation Design should assure there is appropriate data development and collection in a timely manner to support developing an interim evaluation.

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

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

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

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

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

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

2) Based on the findings, discuss the outcomes and impacts of the demonstration and identify the opportunities for improvements. Specifically:

   a. If the state did not fully achieve its intended goals, why not? What could be done in the future that would better enable such an effort to more fully achieve those purposes, aims, objectives, and goals?

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

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

1. What lessons were learned as a result of the demonstration?

2. What would you recommend to other states which may be interested in implementing a similar approach?

F. Attachment - Evaluation Design: Provide the CMS-approved Evaluation Design

ATTACHMENT C:
Evaluation Design

University of Michigan Institute for Healthcare Policy and Innovation (IHPI)

Proposed Evaluation of Michigan's 1115 Behavioral Health Demonstration Waiver

Pursuant to Special Terms and Conditions 50-52 of Michigan's Approved 1115 Behavioral Health Demonstration Waiver

4-21-2020

Table of Contents

Michigan's Behavioral Health Demonstration Waiver - Evaluation Plan
Submitted to the Michigan Department of Health and Human Services
from the University of Michigan Institute for Healthcare Policy and Innovation (IHPI)
February 6, 2020

A. Background

The Centers for Medicare & Medicaid Services (CMS) approved Michigan's 1115 Demonstration Waiver amendment entitled: *Michigan's 1115 Behavioral Health Demonstration Waiver* (Project No I l-W-00305/5) on April 5, 2019, for the period of October 1, 2019, through September 30, 2024. As noted in the Special Terms and Conditions (STCs), the demonstration will allow Michigan to broaden the crucial component of residential substance disorder services (SUD) in the state's existing network of SUD providers and SUD benefits to provide a broader continuum of care for beneficiaries seeking help with a SUD, including withdrawal management services in residential treatment facilities that meet the definition of an Institution for Mental Disease (IMD). The benefits will continue to be provided through a managed care delivery system. The state and CMS expect that offering a full continuum of SUD treatment and recovery supports based on American Society of Addiction Medicine (ASAM) criteria or other nationally recognized, SUD-specific program standards, will result in improved health outcomes and sustained recovery for this population.

A.1 Overview of Michigan's behavioral health system

The Michigan Department of Health and Human Services' (MDHHS) Behavioral Health and Developmental Disabilities Administration (BHDDA), serves as the single state agency for mental health and SUD services. Through that designation, it is primarily responsible for the administration of behavioral health prevention, early identification, treatment, and recovery support services. BHDDA provides oversight to contracted Prepaid Inpatient Health Plans (PIHPs) and Community Mental Health Services Programs (CMHSPs) for the provision of specialty behavioral health supports and services. BHDDA's sister state agency, the Medical Services Administration (MSA), is also located within MDHHS, and functions as the State Medicaid Agency. MSA's primary responsibility is oversight of Michigan's Medicaid program. MSA manages comprehensive physical health services through Medicaid Health Plans (MHPs) including outpatient mental health services for individuals with mild to moderate behavioral health needs. MSA also oversees a fee-for-service benefit for office based opioid treatment providers outside the PIHP and MHP delivery systems.

In conjunction with MSA, BHDDA provides oversight of Medicaid-funded SUD services via the PIHP delivery system. BHDDA also oversees SUD appropriations, the Substance Abuse and Mental Health Services Administration's (SAMHSA) Substance Abuse Prevention and Treatment Block Grant, the SAMHSA Mental Health Block Grant, discretionary SAMHSA SUD grants, and other Medicaid-funded specialty supports and services. BHDDA carries out responsibilities specified in the Michigan Mental Health Code and the Michigan Public Health Code.

To achieve its charge, BHDDA contracts with regional PIHPs and local CMHSPs. PIHPs are public regional entities that serve as the state's publicly operated managed behavioral health plans for Medicaid-funded behavioral health specialty services and supports. PIHPs also serve as the department designated community mental health entity for substance use disorder prevention and treatment per the Mental Health Code. Ten regionalized PIHPs operate throughout the state and contract directly with MDHHS. All enrolled Medicaid beneficiaries are enrolled in a PIHP based on their county of residence. PIHPs, in turn, contract with SUD providers and CMHSPs to deliver public behavioral health services in Michigan. CMHSPs are publicly funded entities, created by county governments, that provide a comprehensive array of mental health services to meet local needs, regardless of an individual's ability to pay. CMHSPs provide Medicaid, state, block grant, and locally funded services to children with serious emotional disturbances, adults with serious mental illness, and children and adults with intellectual/developmental disabilities. CMHSPs provide these services either directly or through contracts with community-based providers. Some CMHSPs also contract to provide outpatient and other substance use disorder treatment services (residential, detoxification, and inpatient rehabilitation).

A.2 SUD/OUD burden and inadequate treatment options in Michigan

Michigan is experiencing a public health crisis related to SUD and OUD. The National Survey on Drug Use and Health (NSDUH) reported approximately 62,000 Michiganders had a past year pain reliever use disorder in 2017.[7] According to published raw data from the Michigan Automated Prescription System (MAPS), more than 11.4 million prescriptions for controlled substances were written in 2016 – an increase of roughly one million additional prescriptions from 2011, despite a slight decrease in Michigan's population over the same period.

The negative impact of SUD/OUD is evident in the substantial increase in hospitalization linked to opioids: from 2000 to 2011 Michigan's hospitalization rate increased from 9.2 to 20.4 per 10,000 residents.[8] Drug-related overdose deaths in Michigan increased from roughly 985 in 2005 to nearly 2,700 in 2017.[9] The 2017 overdose rate for Michigan was 27 deaths per 100,000, substantially higher than the national average of 21.6 per 100,000.

Several efforts have occurred to identify policy approaches to addressing SUD/OUD treatment needs. In August 2019, Governor Gretchen Whitmer created the Michigan Opioids Task Force, chaired by Dr. Joneigh Khaldun, chief medical executive for the State of Michigan.[10] The task

[7] SAMHSA National Survey on Drug Use and Health. 2016-2017 NSDUH State-Specific Tables. https://www.samhsa.gov/data/report/2016-2017-nsduh-state-specific-tables.

[8] Michigan Department of Community Health. Opioid-Related Hospitalizations in Michigan, 2000-2011. https://www.michigan.gov/documents/mdch/Opioid-Related_Hospit_2000-2011_05-31-13_427136_7_431273_7.pdf

[9] Centers for Disease Control and Prevention. National Center for Health Statistics: Drug Overdose Mortality by State. https://www.cdc.gov/nchs/pressroom/sosmap/drug_poisoning_mortality/drug_poisoning.htm

[10] Michigan Executive Order No. 2019-18. https://www.michigan.gov/whitmer/0,9309,7-387-90499_90705-505270--,00.html

force is charged with identifying the root causes of the opioid epidemic and implementing response actions to help Michiganders struggling with opioid addiction access the recovery services they need. The task force will also work to raise public awareness about the opioid epidemic and the resources available to those impacted by it. Task force membership includes representatives from key state agencies and departments. The work of this group will complement and extend the efforts of Former Governor Rick Snyder's Prescription Drug and Opioid Task Force that worked to address the state's burgeoning opioid crisis across five areas: prevention, treatment, regulation, policy and outcomes, and enforcement.[11] In 2013, CMS awarded Michigan a State Innovation Model (SIM) Design award that resulted in Michigan's "Blueprint for Health Innovation," which identified that lack of access to services for individuals with SUD and other behavioral health needs was a major driver of unnecessary hospital and emergency department utilization. More recently, MDHHS's engagement in the CMS Innovation Accelerator Program (IAP) for SUD aims to extend the state's comprehensive array of SUD/OUD and behavioral health treatment and, and to ensure more consistent use of industry-standard benchmarks to promote the use of evidence-based SUD services and strengthen SUD/OUD provider qualifications. MDHHS has also leveraged enhanced Medicaid authorities via the federal SUPPORT Act of 2018, including the Opioid Health Home currently implemented in PIHP Region 2. Even more recently, MDHHS applied for the Section 1003 SUD Demonstration Project with CMS to conduct a robust needs assessment and subsequent remediation initiatives to help increase SUD treatment capacity in Michigan.

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These efforts also have identified several problems with the availability of SUD/OUD services in the state. Although Michigan maintains a robust network of SUD providers and services, spanning from early intervention through inpatient withdrawal management services, the prohibition against Medicaid reimbursement for services provided to certain adults in an IMD setting creates a disjointed benefit package, particularly for withdrawal management services. Successfully treating Medicaid beneficiaries with severe SUD/OUDs requires access to these critical levels of care. Many beneficiaries will also require medication assisted treatment (MAT) to recover from addiction; these services are both clinically effective and cost effective, and they reduce the need for inpatient and detoxification services.[12] However, MAT is not currently consistently available in all regions of Michigan.

Residential treatment and withdrawal management for SUD/OUD also remains underutilized. A recent study found that individuals receiving residential treatment were three times more to complete treatment that those who received only outpatient treatment.[13] Withdrawal management is a critical component of early recovery from SUD/OUD. It serves several key

[11] Michigan Prescription Drug and Opioid Abuse Task Force. Report of Findings and Recommendations for Action. https://www.michigan.gov/documents/snyder/Presciption_Drug_and_Opioid_Task_Force_Report_504140_7.pdf

[12] Baser O, Chalk M, Fiellin DA, Gastfriend DR. Cost and utilization outcomes of opioid-dependence treatments. Am J Mgd Care 2011;17 Suppl 8: S235-48.

[13] Stahler GJ, Mennis J, DuCette JP. Residential and outpatient treatment completion for substance use disorders in the U.S.: Moderation analysis by demographics and drug of choice. Addictive Behaviors 2016; 58:129-35.

purposes including helping patients initiate abstinence, reducing withdrawal symptoms and preventing severe complications, and retaining the patient in treatment. Ongoing treatment is needed thereafter to maintain abstinence. Withdrawal management can take place in residential or outpatient settings depending on the substances used, the severity of dependence, and the presence of co-morbid conditions. Withdrawal management is vital to support and monitor patients in early stages of abstinence and is critical to preventing severe withdrawal symptoms including sometimes fatal complications. [14] However, residential SUD/OUD treatment and withdrawal management are not consistently offered/available across all regions of Michigan.

A.3. Other relevant contextual factors

The demonstration builds on the success of Michigan's Medicaid expansion program, the Healthy Michigan Plan (HMP). HMP provides full coverage, including behavioral health care, to adults with incomes at or below 133% of the Federal Poverty Level. The University of Michigan's HMP evaluation found that the number of uninsured adults has decreased substantially,[15] and that individuals enrolled in HMP report increased access to SUD-relevant services including primary care, behavioral health services, and prescription medication.[16]

A.4. Goals of the Medicaid 1115 substance use demonstration

As noted in the Special Terms and Conditions (STCs), the demonstration seeks to improve health outcomes and sustained recovery for beneficiaries with SUD/OUD by:

- Establishing an integrated behavioral health delivery system that includes a flexible and comprehensive SUD benefit and the Michigan continuum of care.
- Enhancing provider competency related to the use of ASAM criteria or other nationally recognized, SUD-specific program standards, for patient assessment and treatment
- Expanding the treatment continuum of residential care including medically necessary use of qualified residential treatment facilities, withdrawal management programming, and medication assisted treatment (MAT);
- Expanding the use of recovery coach-delivered support services; and
- Establishing coordination of care models between SUD providers, primary care and other behavioral health providers.

Michigan's revised implementation plan proposes specific strategies to accomplish the goals of the demonstration waiver. The implementation plan notes the current availability of services at all ASAM levels, but that efforts are needed to ensure that beneficiaries are assessed and

[14] Kosten TR, O'Connor PG. Management of drug and alcohol withdrawal. New Engl J Med 2003; 348:1786-95.

[15] Levy H, Buchmueller T. Healthy Michigan Plan Evaluation. Domain II – Reduction in the Number of Uninsured. https://www.michigan.gov/documents/mdhhs/Domain_II_-_Reduction_in_Number_of_Uninsured_647135_7.pdf

[16] Goold SD, Kullgren J, et al. Report on the 2016 Healthy Michigan Voices Enrollee Survey. https://www.michigan.gov/documents/mdhhs/2016_Healthy_Michigan_Voices_Enrollee_Survey_-_Report__Appendices_1.17.18_final_618161_7.pdf

recommended for treatment services according to evidence-based criteria. To this end, the state has established the expectation that all providers use an assessment tool that utilizes ASAM criteria. Initially, the state planned to require use of the GAIN-I (Global Assessment of Individual Needs - Initial)[17] as the standard for comprehensive assessment that supports clinical diagnosis, level of care placement, and treatment planning. However, the revised plan allows PIHPs to choose any assessment tool that utilizes ASAM criteria, such as the Level of Care Index (LOCI).[18] In addition, the state will establish and monitor the expectation that PIHPs will utilize the results of ASAM-based assessments and ASAM criteria to make authorization decisions for treatment services regarding length of stay, change in level of care, and discharge. For residential and withdrawal management services, PIHPs will be expected to use the six ASAM dimensions to guide decision-making for needed level of care, transitions in care, and discharge planning. The tentative timeline for implementation is for PIHPs to select their ASAM-based tools by September 30, 2020 (FY2020), and fully implement the ASAM-based assessment and treatment recommendations by October 1, 2021 (FY2022). The revised implementation plan offers the opportunity to compare outcomes for different ASAM-based tools, and to establish baseline rates prior to implementation of this strategy.

In addition, the state seeks to ensure all ASAM levels of care are available across PIHP regions and consistently offered and delivered. To this end, the state will validate the initial and ongoing qualifications of SUD providers to document their appropriate level of ASAM services and will use this information to assess availability across ASAM levels throughout the state. The implementation plan outlines several potential strategies that will be attempted to address deficiencies in availability.

Finally, the implementation plan proposes specific strategies to improve the coordination of care across levels of service and across settings.
The state's updated health information technology plan includes five key strategies.

1. The state will expand the cross-program use of the Master Person Index to enable greater precision in identifying high-need beneficiaries; the target implementation date is October 1, 2021.
2. The state will modify the existing care coordination platform, Care Connect 360, to allow expanded access to SUD claim/encounter information, including ADT messaging; the target implementation date for this modification is October 1, 2020.
3. The state will implement an electronic consent management system for data sharing. This system will be pilot tested in one region starting FY2021 and rolled out statewide by the end of the demonstration period.

[17] Dennis, M., Titus, J., White, M., Unsicker, J. & Hodkgins, D. (2002). Global Appraisal of Individual Needs (GAIN): Administration Guide for the GAIN and Related Measures. Bloomington, IL: Chestnut Health Systems.

[18] The LOCI is published by The Change Companies, www.changecompanies.net.

4. The state will implement a SUD residential bed registry within the context of a broader integrated crisis and access system. The registry will be pilot tested in one region starting FY2021 and rolled out statewide by the end of the demonstration period.
5. The state will develop a customer relationship management database to facilitate and track access to needed SUD treatment across providers and designated contractors; this database is currently in development and is expected to begin pilot testing in FY2021, and rolled out statewide by the end of the demonstration period.

The revised implementation plan clarifies that the evaluation will have an opportunity to establish baseline rates of health IT-focused outcomes prior to implementation of these strategies (See Table 1).

Table 1. Anticipated Timing of Implementation

	FY2019	FY2020	FY2021	FY2022	FY2023
ASAM-based tools for assessment & treatment recommendations		PIHP selection of assessment tools by the end of FY2020 Sept. 30 2020	Training and integration Oct. 1 2020- Sept.30 2021	Full implementation will take place by the beginning. of FY2022 Oct. 1. 2021- Sept. 30 2022	Oct. 1 2022- Sept. 30 2023
Health IT		Expansion of Care Connect 360	Master Person Index in place; Pilot test of electronic consent, bed registry, customer relationship management database	Full implementation	
EVALUATION PERIOD	Pre	Transitional	Transitional	Post	Post

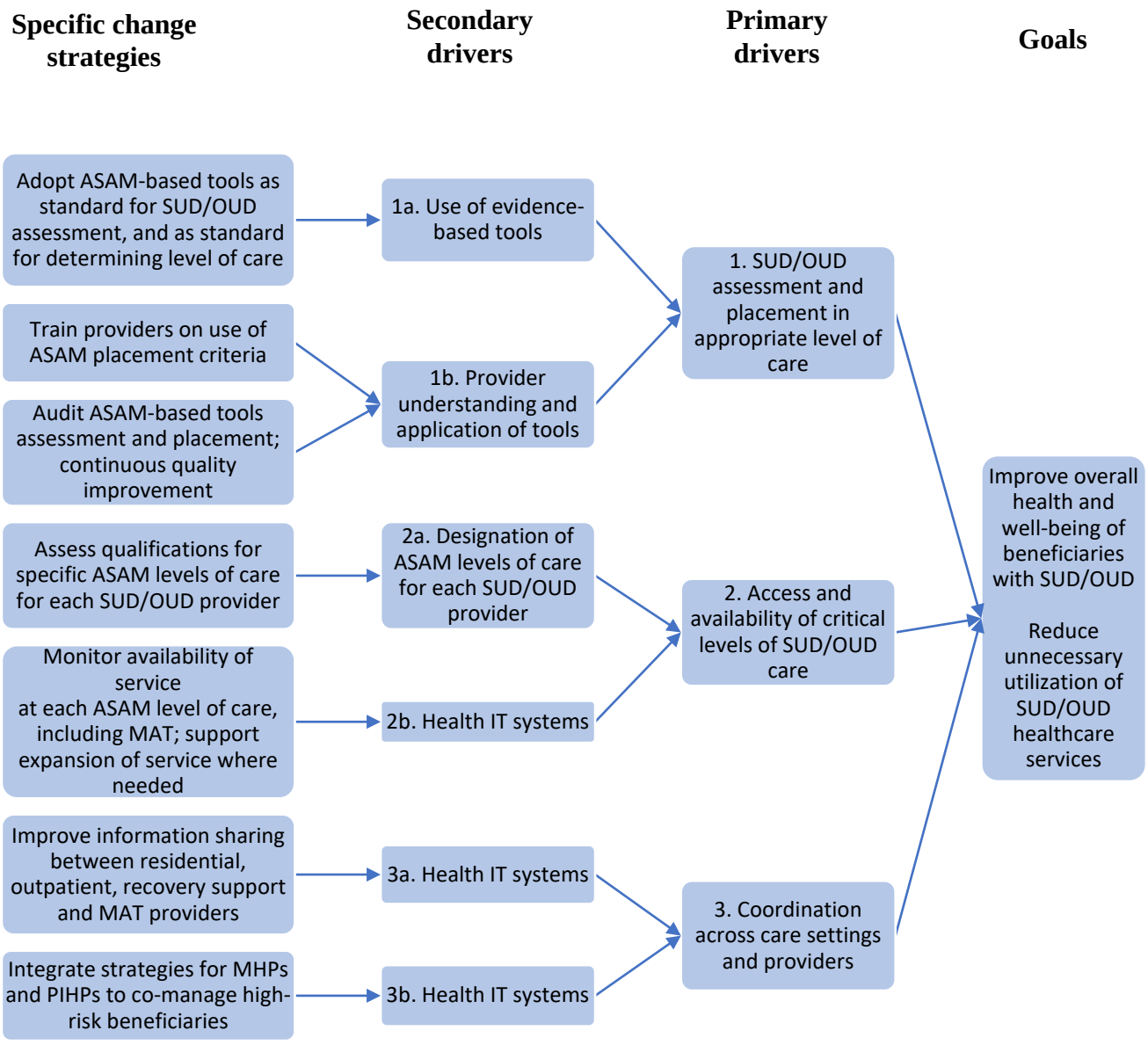
A.5. Population served by the demonstration

Medicaid eligibility will not change under the demonstration; standards for eligibility remain set per the state plan. The demonstration will also allow Medicaid beneficiaries ages 21- 64 to receive SUD/OUD treatment services in residential and inpatient treatment settings that qualify as an Institution for Mental Diseases (IMD).

B. Evaluation Overview

The driver diagram represents the broad goals of the demonstration and the key pathways through which the state will achieve those goals. Primary drivers are the broad mechanisms, while secondary drivers highlight key elements that support those broad mechanisms. The specific change strategies represent the key processes that the state will use to drive change.

Driver Diagram



C. Methodology

C.1. Evaluation design summary

This evaluation design responds to the requirements outlined in the Special Terms and Conditions (STCs) Section X. Evaluation of the Demonstration and related guidance in Attachment A: Developing the Evaluation Design. The evaluation design also reflects CMS's March 2019 guidance for Substance Use Disorder (SUD) Section 1115 demonstration projects.

We organize the hypotheses and key research questions for the evaluation into five sections that correspond to the main outcomes of interest highlighted in the STCs: (1) use of evidence-based standards to support SUD/OUD assessment and placement for care, (2) availability of and access to critical levels of SUD/OUD care, (3) coordination of care across settings, (4) overall impact on health and health services utilization, and (5) cost.

Table 2 outlines specific hypotheses, research questions, and evaluation methods. The mixed methods design incorporates both quantitative and qualitative data collection and analysis to answer key research questions and test hypotheses. We will use five sources of evaluation data:

1) MDHHS administrative data
2) Beneficiary surveys
3) State monitoring reports and PIHP audit data
4) Key informant interviews
5) Medicaid cost reports

We will employ a quasi-experimental evaluation design that is based on the expected timing of implementation for key waiver strategies (selection and adoption of ASAM-based tools; implementation of new health IT mechanisms) outlined in the state's revised implementation plan. For annual measures, we will use descriptive comparisons over time. For quarterly measured based on administrative data, we will use interrupted time series analysis to assess changes from pre-implementation (FY2017-FY2020) to transitional implementation (FY2021-FY2022)) to full implementation (FY2023-FY2024). For measures based on beneficiary surveys, the evaluation will compare pre-implementation results from Cohort 1 (those who receive SUD/OUD services in demonstration Year 1-2) against post- implementation results from Cohort 2 (those who receive SUD/OUD services in Year 4-5-). Specific measures, data sources, and analytic methods are outlined in Table 2.

CMS technical advisory guidance[19] on selection of comparison groups include: 1) a pre-intervention comparison group which would require prospectively collected data from prior to the start of the waiver intervention and/or 2) a Medicaid population from another state. Specifically, a SUD population with similar demographic characteristics, in another state

[19] https://www.medicaid.gov/medicaid/section-1115-demo/downloads/evaluation-reports/smi-sed-sud-1115-eval-guide.pdf

without those waiver flexibilities interventions described in Michigan. However, an external state comparison group is not feasible, since comparable datasets are not shared outside of the state due to the sensitivity of SUD privacy concerns as it relates to data sharing. Thus, an external comparison group from another state is outside the scope of the evaluation.

We will incorporate geographic comparisons in all evaluation analyses. This includes stratifying key results by PIHP region, adjusting for PIHP region in multivariate models, and establishing minimum participation targets for beneficiary surveys. These regional analyses will allow us to assess the consistency of outcomes across the diverse PIHP regions, compare outcomes related to PIHP-specific features (e.g., choice of ASAM-based assessment tool; participation in health IT pilot test), and to identify any differential impacts of the demonstration for specific regions.

Table 2. Table of Hypotheses & Research Questions for Evaluation of Michigan's Behavioral Health Demonstration Waiver

Evidence-Based Standards for Assessment and Placement

Hypothesis 1. Implementation of Michigan's Behavioral Health Demonstration Waiver will increase utilization of evidence-based standards for patient assessment and treatment placement. (Driver 1)

Linked Demonstration Goal:
Goal 2: Enhancing provider competency related to the use of ASAM criteria or other nationally recognized, SUD-specific program standards, for patient assessment and treatment

Primary research question 1: Does the proportion of beneficiaries assessed and recommended for placement using evidence-based standards increase over the demonstration period?
Subsidiary research question 1a: Are there differences by PIHP and by assessment tool (e.g., GAIN-I, LOCI) in provider utilization of evidence-based standards for assessment and treatment placement?
Subsidiary research question 1b: What are key barriers and facilitators to evidence-based SUD/OUD assessment and placement?

Measure Description	Steward	Numerator	Denominator	Data sources	Measurement Frequency	Analytic approach
OUTCOME: Proportion of beneficiaries with ASAM-consistent assessment	N/A	Number of beneficiaries deemed to have ASAM-consistent assessment	Number of beneficiary records audited	PIHP site visits and audits	Annual	Descriptive comparison over time, across PIHPs (frequencies, graphs)
OUTCOME: Proportion of beneficiaries with ASAM-consistent recommendation for treatment placement	N/A	Number of beneficiaries deemed to have ASAM-consistent recommendation for treatment placement	Number of beneficiary records audited	PIHP site visits and audits	Annual	Descriptive comparison over time, across PIHPs (frequencies, graphs)
PROCESS: Number of providers trained on selected assessment tool	N/A	Number of providers engaged in training on ASAM-based tools	N/A	PIHP site visits and audits	Annual	Descriptive comparison over time, across PIHPs (frequencies, graphs)
PROCESS: Experiences of PIHP administrators and SUD providers with implementation of ASAM-consistent tools	N/A	N/A	N/A	Key informant interviews		Qualitative analysis

Expanding Availability and Access to SUD/OUD Levels of Care

Hypothesis 2: Implementation of Michigan's Behavioral Health Demonstration Waiver will expand availability of critical levels of SUD/OUD treatment, including residential treatment, withdrawal management, and MAT. (Driver 2)

Linked Demonstration Goal:
Goal 1: Establishing an integrated behavioral health delivery system that includes a flexible and comprehensive SUD benefit and the Michigan continuum of care.

Primary research question 2: Does the number of qualified SUD providers increase over the demonstration period?

Subsidiary research question 2a: Are there differences by PIHP region in the number of qualified SUDD providers? Subsidiary research question 2b: What strategies are successful, and what are key barriers, to hiring and retaining SUD/OUD providers?						
Measure Description	**Steward**	**Numerator**	**Denominator**	**Data sources**	**Measurement Frequency**	**Analytic approach**
OUTCOME: SUD provider availability (all SUD; MAT)	N/A	Number of Medicaid-enrolled providers qualified to deliver SUD services; Subset who meet standards to provide buprenorphine or methadone as part of MAT	N/A	Provider enrollment database / state monitoring reports	Annual	Descriptive comparison over time, across PIHPs (frequencies, graphs)
OUTCOME: rate of SUD provider availability (all SUD; MAT)	N/A	Number of Medicaid-enrolled providers qualified to deliver SUD services; Subset who meet standards to provide buprenorphine or methadone as part of MAT	A) Total number of Medicaid beneficiaries B) Number of Medicaid beneficiaries with SUD diagnosis	Provider enrollment database/ administrative claims	Annual	Descriptive comparison over time, across PIHPs (frequencies, graphs)
OUTCOME: Primary care provider engagement in MAT	N/A	Number of primary care providers with at least one claim as rendering provider for MAT	N/A	Administrative claims	Annual	Descriptive comparison over time, across PIHPs (frequencies, graphs)
OUTCOME: Number of residential treatment beds for SUD	N/A	Number of beds licensed for SUD residential treatment	N/A	State licensing data	Annual	Descriptive comparison of annual number over time (frequencies, graphs)
PROCESS: Experiences with hiring and retaining SUD providers	N/A	N/A	N/A	Key informant interviews		Qualitative analysis

Hypothesis 3: Implementation of Michigan's Behavioral Health Demonstration Waiver will increase utilization of SUD treatment. (Driver 2 &3)
Linked Demonstration Goal: **Goal 1: Establishing an integrated behavioral health delivery system that includes a flexible and comprehensive SUD benefit and the Michigan continuum of care.** **Goal 3: Expanding the treatment continuum of residential care including medically necessary use of qualified residential treatment facilities, withdrawal management programming, and medication assisted treatment (MAT).**
Primary research question 3: Does utilization of SUD treatment increase over the demonstration period? **Subsidiary research question 3a: Are there differences by PIHP region in utilization of SUD treatment?** **Subsidiary research question 3b: What are key barriers and facilitators to beneficiary utilization of recommended SUD treatment?**

Measure Description	Steward	Numerator	Denominator	Data sources	Measurement Frequency	Analytic approach
OUTCOME: Initiation of alcohol and other drug abuse or dependence (AOD) treatment **-All AOD** **-Alcohol abuse or dependence** **-Opioid abuse or dependence** **-Other drug abuse or dependence**	NQF #0004	Number of beneficiaries who initiated treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter, or partial hospitalization within 14 days of the diagnosis	Number of beneficiaries with a new episode of AOD	Administrative claims	Quarterly	Interrupted time series; multivariable logistic regression models adjusting for PIHP region, beneficiary demographic and utilization characteristics
OUTCOME: Engagement of alcohol and other drug abuse or dependence (AOD) treatment **-All AOD** **-Alcohol abuse or dependence** **-Opioid abuse or dependence** **-Other drug abuse or dependence**	NQF #0004	Number of beneficiaries who initiated treatment who had two or more additional services with a diagnosis of AOD within 30 days of the initiation visit	Number of beneficiaries with a new episode of AOD	Administrative claims	Quarterly	Interrupted time series; multivariable logistic regression models adjusting for PIHP region, beneficiary demographic and utilization characteristics
OUTCOME: Any SUD treatment	N/A	Number of beneficiaries receiving any SUD treatment service, facility claim, or pharmacy claim	Total number of Medicaid beneficiaries	Administrative claims	Quarterly	Interrupted time series; multivariable logistic regression models adjusting for PIHP region, beneficiary demographic and utilization characteristics
OUTCOME: Residential SUD treatment	N/A	Number of beneficiaries receiving residential or inpatient SUD treatment	A) Total number of Medicaid beneficiaries B) Number of Medicaid beneficiaries with SUD diagnosis	Administrative claims	Quarterly	Interrupted time series; multivariable logistic regression models adjusting for PIHP region, beneficiary demographic and utilization characteristics
OUTCOME: Average length of residential SUD treatment	N/A	Total number of days of residential or inpatient SUD treatment	Number of residential or inpatient stays for SUD treatment	Administrative claims	Annual	Descriptive comparison over time, across PIHPs (frequencies, graphs)

OUTCOME: Withdrawal management	N/A	Number of beneficiaries receiving SUD withdrawal management services	A) Total number of Medicaid beneficiaries B) Number of Medicaid beneficiaries with SUD diagnosis	Administrative claims	Quarterly	Interrupted time series; multivariable logistic regression models adjusting for PIHP region, beneficiary demographic and utilization characteristics
OUTCOME: Medication assisted treatment (MAT)	N/A	Number of beneficiaries with a claim for MAT	A) Total number of Medicaid beneficiaries B) Number of Medicaid beneficiaries with SUD diagnosis	Administrative claims	Quarterly	Interrupted time series; multivariable logistic regression models adjusting for PIHP region, beneficiary demographic and utilization characteristics
PROCESS: Experiences of providers and PIHP administrators with facilitating residential treatment and withdrawal management	N/A	N/A	N/A	Key informant interviews	Qualitative analysis	Qualitative analysis
PROCESS: Access to Treatment	ECHO/ CAHPS	Number of beneficiaries reporting they always or usually got counseling or treatment as soon as they wanted.	Number of beneficiaries surveyed	Beneficiary surveys (initial, follow-up)		Comparison of Cohort 1 vs Cohort 2 (chi-square tests; multivariable logistic regression)
PROCESS: Barriers to Treatment	ECHO/ CAHPS	Number of beneficiaries reporting delays in counseling or treatment were a big problem	Number of beneficiaries surveyed	Beneficiary surveys (initial, follow-up)		Comparison of Cohort 1 vs Cohort 2 (chi-square tests; multivariable logistic regression)

Care Coordination and Transitions in Care

Hypothesis 4: Implementation of Michigan's Behavioral Health Demonstration Waiver will improve care coordination and transitions in care for beneficiaries with SUD/OUD. (Driver 3)

Linked Demonstration Goal:
Goal 4: Expanding the use of recovery coach-delivered support services
Goal 5: Establishing coordination of care models between SUD providers, primary care and other behavioral health providers.

Primary research question 4: Does care coordination for beneficiaries with SUD increase over the demonstration period?

Subsidiary research question 4a: Are there differences by PIHP region in care coordination? Subsidiary research question 4b: What strategies are successful to engage providers and beneficiaries in care coordination? What are key barriers?						
Measure Description	**Steward**	**Numerator**	**Denominator**	**Data sources**	**Measurement Frequency**	**Analytic approach**
OUTCOME: Follow-up after emergency department visit for alcohol or another drug dependence (FUA-AD)	NQF #2605	Number of beneficiaries who had a follow-up visit with a corresponding primary diagnosis for AOD within 7 days of the ED visit Number of beneficiaries who had a follow-up visit with a corresponding primary diagnosis for AOD within 30 days of the ED visit	Number of ED visits with a primary diagnosis of AOD abuse or dependent	Administrative claims	Quarterly	Interrupted time series; multivariable logistic regression models adjusting for PIHP region, beneficiary demographic and utilization characteristics
OUTCOME: Access to peer support	ECHO/ CAHPS	Number of beneficiaries who report being told about SUD treatment support options (e.g., peer support, 12-step programs)	Number of beneficiaries surveyed	Beneficiary surveys (follow-up)		Comparison of Cohort 1 vs Cohort 2 (chi-square tests; multivariable logistic regression)
OUTCOME: Access to assistance with arranging care	N/A	Number of beneficiaries who report getting as much help as they needed with arranging SUD care	Number of beneficiaries surveyed	Beneficiary surveys (follow-up)		Comparison of Cohort 1 vs Cohort 2 (chi-square tests; multivariable logistic regression)
OUTCOME: Adequate information sharing	N/A	Number of beneficiaries who report their outpatient providers always or usually know important information about their medical history	Number of beneficiaries surveyed	Beneficiary surveys (follow-up)		Comparison of Cohort 1 vs Cohort 2 (chi-square tests; multivariable logistic regression)
PROCESS: Number of unique users of Care Connect 360	N/A	Number of active users of Care Connect 360 in PIHPs, Medicaid Health Plans, and other settings	N/A	State health IT office	Annual	Descriptive comparison over time (frequencies, graphs)
PROCESS: Experiences of PIHP administrators and SUD providers with new health IT tools	N/A	N/A	N/A	Key informant interviews		Qualitative analysis

PROCESS: Experiences of primary care providers and ED staff with new health IT tools	N/A	N/A	N/A	Key informant interviews		Qualitative analysis

Hypothesis 5: Implementation of strategies to improve care coordination and transitions in care will result in increased duration of SUD/OUD treatment. (Driver 3)						
Linked Demonstration Goal: **Goal 4: Expanding the use of recovery coach-delivered support services** **Goal 5: Establishing coordination of care models between SUD providers, primary care and other behavioral health providers.**						
Primary research question 5: Does the duration of SUD/OUD treatment increase over the demonstration period? **Subsidiary research question 5a: Are there region differences by PIHP in SUD/OUD treatment duration?**						
Measure Description	**Steward**	**Numerator**	**Denominator**	**Data sources**	**Measurement Frequency**	**Analytic approach**
OUTCOME: Continuity of pharmacotherapy for OUD (short-term, medium-term, long-term)	NQF #3175	Number of beneficiaries with at least 90 days of continuous pharmacotherapy without a gap of more than 7 days Number of beneficiaries with at least 180 days of continuous pharmacotherapy without a gap of more than 7 days Number of beneficiaries with at least 270 days of continuous pharmacotherapy without a gap of more than 7 days	Number of beneficiaries with a diagnosis of OUD and at least one claim for an OUD medication	Administrative claims	Quarterly	Interrupted time series; multivariable logistic regression models adjusting for PIHP region, beneficiary demographic and utilization characteristics
OUTCOME: Continuation of counseling after SUD residential treatment	N/A	Number of beneficiaries who receive at least 2 outpatient counseling visits within 60 days after SUD residential treatment	Number of beneficiaries who receive SUD residential treatment	Administrative claims	Quarterly	Interrupted time series; multivariable logistic regression models adjusting for PIHP region, beneficiary demographic and utilization characteristics

PROCESS: Barriers to continuity of SUD care	N/A	Number of beneficiaries who report barriers to continuing MAT, counseling or other SUD treatment services	Number of beneficiaries surveyed	Beneficiary surveys (follow-up)		Comparison of Cohort 1 vs Cohort 2 (chi-square tests; multivariable regression)

Hypothesis 6: Implementation of care coordination strategies will increase the receipt of primary care services during or after SUD/OUD treatment. (Driver 3)

Linked Demonstration Goal:
Goal 5: Establishing coordination of care models between SUD providers, primary care and other behavioral health providers.

Primary research question 6: Does the proportion of beneficiaries with SUD/OUD who receive primary care services increase over the demonstration period?
Subsidiary research question 6a: What are barriers and facilitators to receipt of primary care?

Measure Description	Steward	Numerator	Denominator	Data sources	Measurement Frequency	Analytic approach
OUTCOME: Access to preventive/ ambulatory health services	HEDIS	Number of beneficiaries who had an ambulatory or preventive visit in the primary care setting	Number of beneficiaries with a diagnosis of SUD	Administrative claims	Annual	Descriptive comparison over time (frequencies, graphs)
OUTCOME: Receipt of primary care among individuals with comorbid medical conditions	N/A	Number of beneficiaries who had an ambulatory or preventive visit in the primary care setting	Number of beneficiaries with a diagnosis of SUD and evidence of a chronic medical condition	Administrative claims	Annual	Descriptive comparison over time (frequencies, graphs)
PROCESS: Usual source of primary care	NHIS	Number of beneficiaries who report a doctor's office or clinic as where they would go if sick or needed advice about their health	Number of beneficiaries surveyed	Beneficiary surveys (initial and follow-up)		Comparison of Cohort 1 vs Cohort 2 (chi-square tests; multivariable logistic regression)
PROCESS: Barriers to primary care	N/A	Number of beneficiaries who report barriers to receiving primary care services	Number of beneficiaries surveyed	Beneficiary surveys (initial and follow-up)		Comparison of Cohort 1 vs Cohort 2 (chi-square tests; multivariable logistic regression)

Hypothesis 7: Implementation of high-risk management strategies will result in decreased number of opioid fills among beneficiaries with OUD. (Driver 3)

Linked Demonstration Goal:
Goal 1: Establishing an integrated behavioral health delivery system that includes a flexible and comprehensive SUD benefit and the Michigan continuum of care.

Primary research question 7: Does the average number of opioid fills among enrollees with OUD decreased over the demonstration period?

Subsidiary research question 7a: What are unique barriers and facilitators to effective high-risk management?						
Measure Description	**Steward**	**Numerator**	**Denominator**	**Data sources**	**Measurement Frequency**	**Analytic approach**
OUTCOME: Average number of opioid prescriptions	N/A	Total number of filled opioid prescriptions	Number of beneficiaries with at least one filled opioid prescription	Administrative claims	Annual	Descriptive comparison over time (frequencies, graphs)
PROCESS: Experiences of PIHP and Medicaid health plan administrators with new high-risk management tool	N/A	N/A	N/A	Key informant interviews		Qualitative analysis

Health and Health Care Outcomes

Hypothesis 8: Implementation of the demonstration will improve the health and well-being of beneficiaries with SUD/OUD. (Driver 1, 2, & 3)						
Linked Demonstration Goal: **Goal 1: Establishing an integrated behavioral health delivery system that includes a flexible and comprehensive SUD benefit and the Michigan continuum of care.**						
Primary research question 8: Do beneficiaries with SUD/OUD report improved health and well-being over the demonstration period? **Subsidiary research question 8a: What are continued barriers to improved health and well-being?**						
Measure Description	**Steward**	**Numerator**	**Denominator**	**Data sources**	**Measurement Frequency**	**Analytic approach**
OUTCOME: Mental health status	ECHO/ CAHPS	Number of beneficiaries reporting Excellent or Very good mental health	Number of beneficiaries surveyed	Beneficiary survey (follow-up)		Comparison of Cohort 1 vs Cohort 2 (chi-square tests; multivariable regression)
OUTCOME: Overall health status	CDC Healthy Days	Number of beneficiaries reporting Excellent or Very good physical health				
OUTCOME: Health Limitations	CDC Healthy Days	Number of beneficiaries reporting 10+ days in the past month where poor physical or mental health prevented daily activities				
OUTCOME: Current employment	PRAPARE	Number of beneficiaries reporting their current work situation as employed				
OUTCOME: Current housing	PRAPARE	Number of beneficiaries reporting they currently have housing				

OUTCOME: Ability to accomplish objectives	ECHO/ CAHPS	Number of beneficiaries reporting their ability to accomplish things they want to do is much better or a little better				
OUTCOME: Overdose death rate	N/A	Number of beneficiaries with overdose death	Total number of Medicaid beneficiaries	State vital records	Annual	Descriptive comparison over time (frequencies, graphs)

Hypothesis 9: Implementation of the demonstration will decrease utilization of crisis care among beneficiaries with SUD/OUD. (Drivers 1, 2, and 3)

Linked Demonstration Goal:
Goal 1: Establishing an integrated behavioral health delivery system that includes a flexible and comprehensive SUD benefit and the Michigan continuum of care.

Primary research question 9: Do rates of crisis care for SUD/ODU decrease over the demonstration period?
Subsidiary research question 9a: Are there differences by PIHP region in utilization of crisis care for SUD/OUD?

Measure Description	Steward	Numerator	Denominator	Data sources	Measurement Frequency	Analytic approach
OUTCOME: Emergency department utilization for SUD	HEDIS*	Number of emergency department visits with a primary diagnosis of SUD	Number of member-months for all Medicaid beneficiaries (rate per 1,000 MM)	Administrative claims	Quarterly	Interrupted time series; multivariable Poisson regression models adjusting for PIHP region, beneficiary demographic and utilization characteristics
OUTCOME: Inpatient utilization for SUD	HEDIS*	Number of inpatient visits with a primary diagnosis of SUD	Number of member-months for all Medicaid beneficiaries (rate per 1,000 MM)	Administrative claims	Quarterly	Interrupted time series; multivariable Poisson regression models adjusting for PIHP region, beneficiary demographic and utilization characteristics
OUTCOME: All-Cause Readmission after SUD inpatient visit	HEDIS*	Number of subsequent inpatient visits within 30 days of an inpatient visit with a primary diagnosis of SUD	Number of inpatient visits with a primary diagnosis of SUD	Administrative claims	Quarterly	Interrupted time series; multivariable Poisson regression models adjusting for PIHP region, beneficiary demographic and utilization characteristics

Costs of the Demonstration

Hypothesis 10: Implementation of Michigan's Behavioral Health Demonstration Waiver will be sustainable for the Medicaid program with regard to costs. (Driver 1, 2, & 3)

Linked Demonstration Goal:
Goal 1: Establishing an integrated behavioral health delivery system that includes a flexible and comprehensive SUD benefit and the Michigan continuum of care.

Primary research question 10: Does the average total cost for beneficiaries with SUD/OUD change over the demonstration period?
Subsidiary research question 10a: Does average total cost differ by PIHP region or beneficiary characteristics?

Measure Description	Steward	Numerator	Denominator	Data sources	Measurement Frequency	Analytic approach
OUTCOME: Total SUD spending	N/A	Total dollars reported as spent on SUD, all sources	N/A	State cost reports	Annual	Descriptive comparison over time (frequencies; graphs)
OUTCOME: SUD spending for inpatient treatment, per member-month	N/A	Total paid amount for residential or inpatient treatment within IMDs	Total number of enrolled months for Medicaid beneficiaries	Administrative claims	Quarterly	Interrupted time series; multivariable linear regression models adjusting for PIHP region, beneficiary demographic and utilization characteristics
OUTCOME: MAT spending, per member-month	N/A	Total paid amount for SUD pharmacotherapy	Total number of enrolled months for Medicaid beneficiaries	Administrative claims	Quarterly	Interrupted time series; multivariable linear regression models adjusting for PIHP region, beneficiary demographic and utilization characteristics
OUTCOME: ED costs for SUD, per member-month	N/A	Paid amount for ED visits with a primary diagnosis of SUD	Total number of enrolled months for Medicaid beneficiaries	Administrative claims	Quarterly	Interrupted time series; multivariable linear regression models adjusting for PIHP region, beneficiary demographic and utilization characteristics
PROCESS: Proportion of PIHP spending by category	N/A	Dollars spent per category (e.g., detox, residential, outpatient, MAT, case	Total dollars spent	PIHP site visits and audits	Annual	Descriptive comparison over time (frequencies, graphs)

		management, recovery support)				

Institutional Review Board (IRB) Review and Data Use Agreement

The evaluation team anticipates that this evaluation will be exempt from the standard regulatory process, per the 2018 Common Rule (45 CFR 46.101(b)). Exemption category 5 states: *Research and demonstration projects that are conducted or supported by a Federal department or agency, or otherwise subject to the approval of department or agency heads (or the approval of the heads of bureaus or other subordinate agencies that have been delegated authority to conduct the research and demonstration projects), and that are designed to study, evaluate, improve, or otherwise examine public benefit or service programs, including procedures for obtaining benefits or services under those programs, possible changes in or alternatives to those programs or procedures, or possible changes in methods or levels of payment for benefits or services under those programs. Such projects include, but are not limited to, internal studies by Federal employees, and studies under contracts or consulting arrangements, cooperative agreements, or grants*. Per regulation, we will expect that the demonstration project will be included on the CMS list of research and demonstration projects, available on a publicly accessible CMS website, prior to commencing any activities involving human subjects.

We will submit the evaluation plan to the University of Michigan Medical School IRB to obtain final approval from the Director of the Human Research Protection Program (HRPP), per standard policy for Exemption 5 projects. In addition, we will submit the evaluation plan to the MDHHS IRB for approval, and to the MDHHS Compliance Office for a HIPAA Privacy Waiver. We will execute a project-specific Data Use Agreement that delineates the specific state data sources to be used for the project, and that outlines key privacy protections, based on existing protocols the evaluation team has used for other MDHHS projects.

C.2. Data sources, evaluation measures, and analytic approach

The evaluation data sources, measures and analytic approach are presented in Table 2 and described below.

C.2.1. State administrative data

Data source

Michigan offers a rich data environment to evaluate the impact of health policy changes. The backbone of the data environment is the state's Enterprise Data Warehouse. The Data Warehouse maintains individual-level, identifiable data for numerous programs within MDHHS, including:

- Medicaid enrollment files include individual eligibility for different benefit plans, enrollment start and end dates, contact information (address, phone, email), key demographic characteristics (gender, race/ethnicity), and third-party liability coverage.
- Medicaid administrative claims include service-level data on paid claims (fee-for-service) and encounters (managed care), with accompanying billing information (e.g., CPT and ICD-10 diagnosis codes, billing/rendering provider, paid amount) for inpatient, outpatient, pharmacy, durable medical equipment, dental, lab, and other services.

- Specialty behavioral health files include individual-level data on services provided through PIHPs and CMHSPs, including assessments and treatment recommendations.

The University of Michigan Institute for Healthcare Policy and Innovation (IHPI), including several members of the evaluation team, has a longstanding history of working with MDHHS on projects using data from the state Data Warehouse. MDHHS and the University of Michigan have a joint Business Associates Agreement in place to authorize direct access to the Data Warehouse via an existing secure portal; under this authorization, the lead analyst for this evaluation has extracted data directly from the Data Warehouse to use in a variety of projects, including prior evaluations of 1115 waiver demonstration projects. The lead analyst has led the development of internal protocols for extracting, processing and storing state data. MDHHS and the University of Michigan also execute project-specific Data Use Agreements, which outline the parameters of data access, level of identification, and data storage using file encryption, secure networks, multiple layers of password protection, and other strategies to ensure data privacy.

Regarding data quality, administrative claims and encounter data undergo regular and rigorous quality testing by MDHHS. The lead analyst employs internal processes to assess data completeness and consistency prior to creating variables or generating results based on administrative claims; she regularly communicates with MDHHS staff to raise data issues (e.g., apparent lag in data loading to the warehouse) and understand the expected timeframe in which MDHHS will make corrections.

We will also benchmark key evaluation outcomes against other sources, including the state's monitoring reports, ongoing quality measurement results for Michigan's Medicaid program, and the CMS Medicaid Adult Core Measure Set. In addition, Michigan's Medicaid program, along with two members of the evaluation team (Zivin, Clark) participates in the Medicaid Outcomes Distributed Research Network (MODRN)[20], a consortium of 12 states that are generating SUD-focused measures using a common data model. MODRN measures represent an additional option for benchmarking. A list of current MODRN measures and participating states is included with this revised evaluation plan.

Variables

We will extract and process data from the state Data Warehouse to generate outcome and predictor variables for evaluation analyses. These variables will include:

- Utilization-related variables will be based on counts of unique events (e.g., ED visits, prescription medication fill, inpatient stay). Diagnosis and procedure codes will be used to categorize the type of service (e.g., SUD treatment, primary care), to distinguish between subcategories of SUD (e.g., alcohol, opioid, other drugs), and to identify beneficiaries with co-occurring medical or behavioral conditions. We will use Place of service codes and

[20] https://www.academyhealth.org/MODRN

state specific PIHP and provider taxonomy codes will be used to distinguish the location of care. Claims processing for utilization-related variables will draw on specifications from established measures from the National Quality Forum (NQF), the Healthcare Effectiveness Data and Information Set (HEDIS), and the CMS Core Set of Adult Quality Measures for Medicaid. Specific utilization measures for the evaluation appear in Table 2. When appropriate, we will modify measures to focus on beneficiaries with SUD/OUD; for example, we will adjust HEDIS measures that typically are limited to individuals with continuous enrollment to use a standardized rate per enrolled month, due to lack of enrollment continuity for the SUD/OUD population. Importantly, we will modify criteria for key outcome measures to generate quarterly results, which we will use in our interrupted time series analysis.

- Enrollment-related variables will include enrollment continuity (e.g., number of months enrolled in Medicaid in the prior year) and enrollment disruptions (number and length of disruptions in enrollment in a specified period). Enrollment variables will be used in multivariate regression models.
- Demographic variables will include beneficiary age, race/ethnicity, geographic region PIHP, income level (% FPL), and health plan. Demographic variables will be used in multivariate regression models

Analytic approach

We will generate outcome measures based on administrative data for the demonstration period (FY2020-FY2024), as well as additional pre-demonstration years (FY2017 -FY2019) to extend our ability to appreciate trends over time. Prior to generating each subsequent year's measures, we will assess data completeness using established internal protocols.

For administrative claims measures produced annually (see Table 2), we will generate a descriptive comparison of results over time for the state overall, for each PIHP region, and for racial/ethnic subgroups; we will use these subgroup analyses to evaluate any differences in SUD treatment by race and by PIHP region.

For administrative claims measures produced quarterly (see Table 1), we will assess changes over time using an interrupted time series approach.

our interrupted time series models will reflect:

$$y = \alpha + \beta_1 time + \beta_2\, post + \beta_3\, post * time + \theta^T X + \varepsilon$$

Where y = outcome measure

time = quarters from beginning of the study

post = 1 for post-intervention and 0 for pre-intervention time periods.

X = Control variables

α = Intercept, pre-intervention

β_1 = Slope, pre-intervention

β_2 = Intercept (level) change, post-intervention

β_3 = Slope (trend) change, post-intervention
θ = vector of parameters corresponding to control variables
ε ~ N (0, σ^2)

For proportions, we will use the logit of the proportions (p) as outcomes in the interrupted time-series model:

$$logit(p) = \alpha + \beta_1 time + \beta_2\, post + \beta_3\, post * time + \theta^T X$$

To incorporate beneficiary-level demographic (e.g., age, gender, race/ethnicity) and clinical (e.g., number of ED visits in prior year) characteristics, we will
perform regression analyses that examines the change across years controlling for PIHP and beneficiary characteristics:

Binary outcomes (y), logistic regression analysis:

$$logit(p(y = 1|year, X)) = \alpha + \beta_1 * year + \theta^T X$$

Where X = Control variables
α = Intercept
β_1 = year effect
θ = vector of parameters corresponding to control variables

Count outcomes (y), Poisson regression analysis:

$$log((y|year, X)) = \alpha + \beta_1 * year + \theta^T X$$

We will use negative binomial regressions for count data with variability greater than what can be accounted for in Poisson regression. We will also examine interaction effects between year and beneficiary characteristics.

C.2.2. Beneficiary surveys

Data source

The evaluation team will conduct surveys of Medicaid beneficiaries with SUD/OUD to collect key patient-reported measures. The beneficiary surveys will be conducted in two cohorts that reflect the timing of key waiver strategies outlined in the state's revised implementation plan. Data collection for Cohort 1 will occur in FY2021 through early FY2022; this timeframe reflects the period prior to full implementation of the state's key strategies to improve SUD care, including ASAM-based assessment and treatment recommendations, and health IT improvements to support care coordination. Data collection for Cohort 2 will occur in the second half of FY2023 through FY2024; this timeframe reflects the period after implementation of these key strategies. Thus, comparison of beneficiary-reported outcomes from Cohort 1 (pre-implementation) vs Cohort 2 (post-implementation) will highlight the impact of the demonstration project on beneficiaries' SUD/OUD treatment experiences.

We will continue monthly sampling will continue until we achieve the target number of completed surveys.

Beneficiary surveys will consist of an initial survey, timed to occur approximately 2-3 months after the beneficiary begins SUD/OUD treatment, and a follow-up survey approximately 6 months later.

The initial survey will focus on the appropriateness and acceptance of treatment placement recommendations; access problems or other barriers to SUD/OUD treatment; support for transitions in SUD/OUD care and coordination between behavioral health and primary care providers; and mental and physical health status.

The follow-up survey will explore ongoing access to and compliance with treatment, including MAT, unmet needs and barriers to treatment, ongoing care coordination, mental and physical health status, and well-being (e.g., housing, employment).

To identify the eligible survey population, we will query the state data warehouse monthly during the survey period to identify individuals who received a new SUD/OUD diagnosis and/or comprehensive SUD assessment between 8 and 12 weeks prior, followed by initiation of residential or outpatient SUD treatment. Preliminary testing of this algorithm yielded an eligible population of roughly 2800-3200 unique beneficiaries each month. From each month's eligible population, we will select approximately 800 individuals for the survey sample according to a priori sampling frame based on age and geographic region; this is necessary to ensure adequate representation of beneficiaries in all PIHPs. We will require selected individuals to have complete data warehouse field for address and phone, and a preferred language of English, Spanish, or Arabic, which are the languages spoken by our interviewers.

Survey cohort and sample size

Our target for each cohort is 2,000 completed surveys for each Cohort (initial and follow-up), with at least 150 completed surveys in each PIHP region to ensure adequate representation across all areas of the state. Based on the evaluation team's recent experience conducting surveys of Medicaid beneficiaries for the state's Medicaid expansion evaluation, we estimate an initial survey participation rate of 40%, and a follow-up survey participation rate of 85%. Thus, for each Cohort, we will recruit 6,000 beneficiaries to achieve 2,000 completed (initial and follow-up) surveys.

For two-tailed hypothesis testing with Type I error of 5% ($p<0.05$), this sample size will provide 90% statistical power to detect a 5 percentage-point difference between Cohort 1 and Cohort 2 in the proportions of beneficiaries who report adequate access to SUD/OUD treatment, in the proportion who report receipt of care coordination and peer support services, and in the

proportion who report excellent/very good mental health status at the time of their follow-up survey.

Survey administration

We will build on strategies used successfully in the evaluation team's previous Medicaid-focused projects when conducting beneficiary survey administration. We will utilize a Computer Assisted Telephone Interviewing (CATI) system to administer the surveys; this system includes options for multi-modal survey administration for supplemental or follow-up questions (e.g., through web-based or text responses). Survey questions will be programmed into the CATI system, enabling for branching of survey items based on characteristics known prior to the survey and for responses given during the survey. The CATI system will integrate individual characteristics (e.g. gender, Medicaid health plan) to allow for tailored question wording. Interviewers will be trained on the survey instrument, including prompts and definitions, and appropriate response to questions about coverage or services.

We will mail sampled individuals an introductory packet containing a letter and brochure explaining the survey purpose, and a postage-paid postcard that can be used to indicate a preferred time/day for the interview or their refusal to participate. The letter will provide a toll-free number and email address for individuals who wish to indicate a preferred time/day for the interview or refusal to participate. For sampled individuals who do not refuse, interviewers will place phone calls between the hours of 9:00 AM and 8:30 PM. Non-respondents will receive two additional mailings with a brief letter and brochure encouraging participation.

Once we reach sampled individuals by phone, interviewers will explain the purpose of the project, emphasize the confidentiality of responses, and obtain agreement to participate. Interviewers will note that completion of the survey is voluntary and that only aggregate data will be reported. Interviewers will ask to record the interview; in recent telephone surveys with Medicaid beneficiaries, over 95% of respondents agreed to be recorded. We will mail a $25 gift card to individuals who complete the survey; individuals will indicate their preferred address for the gift card mailing. We will administer the incentives through the University of Michigan research incentive system, to allow for tracking and replacement of lost cards.

At the end of the survey, interviewers will ask if the respondent agrees to be re-contacted for follow-up surveys and interviews and, if yes, the preferred contact information to use. The incentive for survey completion will not be contingent upon agreement to be re-contacted.

We will monitor survey participation rates cross demographic groups (age, geographic region) to identify disparities in participation. If necessary, we will use other survey modalities (e.g., written survey, in-person interview) to allow for broad participation.

Measures

Outcome and process measures derived from beneficiary surveys are outlined in Table 1. Most items use existing validated items and scales in beneficiary surveys, including the Experiences of Care and Health Outcomes survey from the Consumer Assessment of Healthcare Providers and Systems (ECHO/CAHPS); the Center for Disease Control and Prevention's (CDC) Healthy Days survey; and the National Health Interview Survey (NHIS); and the Protocol for Responding to and Assessing Patients' Assets, Risks and Experiences (PRAPARE). When necessary, we will adapt survey wording to clarify meaning (e.g., use terms specific to Michigan Medicaid coverage; clarify which setting or provider type the question pertains to), as has been done successful in recent beneficiary surveys conducted by the evaluation team.[21,22]

The survey will include several open-ended questions to allow beneficiaries to describe their experiences in greater detail. Open-ended questions will explore barriers and facilitators to accessing SUD/OUD treatment, satisfaction with providers, unmet needs, and experiences of discrimination.

Regarding data cleaning and validation, trained research assistants will review recordings to verify the accuracy of coding and to categorize responses to open-ended questions. For quantitative variables, we will use logic checks to ensure that responses are within the allowable range. For open-ended questions, we will use qualitative analysis techniques to identify the key themes articulated in responses to open-ended questions. We will incorporate a summary of the key themes in the final report, including individual quotes to illustrate beneficiary experiences.

Analytic approach

Sample design and survey nonresponse will be handled through weights as well as adjustments to the weights. From the sample design, we will have base weights that account for potential over- or under-sampling based on the stratification. After the baseline survey, we will conduct a non-response bias analysis using data from Medicaid administrative files (e.g., demographic characteristics, enrollment continuity in past year) to examine nonresponse patterns. A response propensity score model will be developed with multiple predictors. Using the estimated response propensity scores, we will develop weighting classes that include both respondents and nonrespondents and compensate for the potential nonresponse bias by adjusting the base weights of respondents.

Furthermore, we will post-stratify our sample to match the group population. To minimize an undesirable effect of large weight variation that increases variability of estimates, the final

[21] Goold SD, Kullgren J, et al. Report on the 2016 Healthy Michigan Voices Enrollee Survey. https://www.michigan.gov/documents/mdhhs/2016_Healthy_Michigan_Voices_Enrollee_Survey_-_Report__Appendices_1.17.18_final_618161_7.pdf

[22] Clark SJ, Goold SD. Report on the Healthy Michigan Voices 2016-17 Survey of Individuals No Longer Enrolled in the Healthy Michigan Plan. https://www.michigan.gov/documents/mdhhs/HMV_No_Longer_Enrolled_2016-2017_Report.9.27.18_647095_7.pdf

weights will be prepared after weight trimming. A combination of the base weight, the nonresponse adjustment, and the post-stratification will project our respondents to the intended sample and to the target population.

For follow-up surveys, we will conduct non-response bias analyses using information from the frame as well as any surveys conducted previously and fit a response propensity score model. Similar to the baseline survey, we will make nonresponse adjustments and post-stratification.

Statistical Analysis

We will compare survey responses from Cohorts 1 and 2 to understand the extent to which implementation of key demonstration strategies is associated with improvements in beneficiaries' access to SUD/OUD treatment, receipt of care coordination and peer support, mental and physical health status, and well-being (e.g., employment, housing). All multivariable analyses will control for differences in beneficiary characteristics between the two cohorts.

First, we will perform unadjusted analyses, comparing categorical outcome variables for Cohort 1 vs Cohort 2 using the Chi-square test.

We will use multivariable regression to understand the differences in outcomes between cohorts controlling for differences in key demographic characteristics, including PIHP region, race/ethnicity, type of SUD diagnosis (OUD only; OUD + other SUD), co-occurring mental health condition or chronic medical condition, age, income, and continuity of Medicaid enrollment.

For binary outcome variables, we will use logistic regression analysis of the outcome variable on cohort indicator controlling for differences PIHP region and key beneficiary characteristics.

$$logit(p(y = 1|cohort, X)) = \alpha + \beta_1 * Cohort + \theta^T X$$

Where y = outcome measure

X = Control variables

α = Intercept

β_1 = Cohort effect

θ = parameters corresponding to control variables

For nominal outcome variables, with more than two response categories, we will use multinomial logit regression. There are J-1 (J=total # of categories) logistic regression models fit simultaneously compared to a selected reference outcome category.

$$log(p_j(cohort, X)/p_{Ref}(cohort, X)) = \alpha_j + \beta_{1j} * Cohort + {\theta_j}^T X$$

Where Outcome level *j* is compared with reference outcome level *Ref*

X = Control variables

α_j = Intercept for the jth logit

β_{1j} = Cohort effect on the jth logit
θj = parameters corresponding to control variables on the jth logit

C.2.3. State monitoring reports/PIHP audit data

Data source

Throughout the demonstration period, the state will collect and report on monitoring metrics, as required by CMS, in key areas such as assessment of need and qualification for SUD treatment services, access to critical levels of SUD/OUD care, provider capacity at critical levels of care, implementation of comprehensive treatment and prevention strategies, improved care coordination and transitions between levels of care, health outcomes, and spending.

In addition, throughout the demonstration project, the state will conduct routine PIHP site reviews that include review of clinical records to evaluation SUD treatment placement recommendations. Once each PIHP selects an ASAM-based assessment tool, the routine audits will determine appropriate application and fidelity to the ASAM assessment and placement criteria. Routine audits will also assess PIHP validation processes for network provider credentialing. We will conduct key informant interviews with state and PIHP officials; the key informant interviews will incorporate a review of monitoring data, along with key informant perspectives on barriers and facilitators to improvement.

Measures

Outcome and process measures derived from state monitoring reports and PIHP audit data are outlined in Table 2. Key outcome measures documented in monitoring reports include SUD provider capacity, fidelity to evidence based ASAM criteria for SUD assessment and treatment recommendations, number of beneficiaries receiving certain types of SUD services, overdose deaths, and use of health IT functionality to support care coordination.

Analytic approach

We will review monitoring reports and PIHP audit data to document progress toward full implementation of the demonstration. We will track key measures over time and conduct descriptive comparisons of measure progress across PIHPs.

In addition, we will highlight information from state monitoring reports and PIHP audits during key informant interviews (described below), to prompt informants to describe barriers and facilitators to success in the context of trends in key measures for the demonstration.

C.2.4. Key informant interviews

Data source

We will conduct key informant interviews with representatives from BHDDA, Medicaid, PIHPs, and SUD treatment providers. Interviews will include a review of monitoring and quality

improvement reports related to the demonstration, and discussion of barriers and facilitators to successful implementation and widespread adoption of key elements of the demonstration.

The evaluation team will develop structured interview protocols for each group key informants and will identify monitoring and quality improvement reports to review with each group. We will conduct baseline key informant interviews beginning in FY2020 and complete them in early FY2021; midpoint interviews in FY2022; and final interviews in FY2023. To the extent possible, we will interview the same individuals at each time point, to facilitate the option to "revisit" key informant perspectives from prior interviews.

Survey cohort & sample size

We will conduct key informant interviews with the following groups:

- State-level BHDDA officials (3-6 individuals) – selected from the group of BHDDA officials with responsibilities for implementation of the demonstration
- State-level Medicaid officials (3-5 individuals) – selected from the group of Medicaid involved in care coordination, policy review/change, or other elements of the demonstration
- PIHP regional officials (2-3 individuals per PIHP) – selected from the administrative leadership of each PIHP
- SUD providers (2-3 individuals in residential and 2-3 individuals in outpatient settings, for a total of 4-6 individuals per PIHP) – selected from the network of SUD/OUD providers with designated ASAM qualifications in each PIHP

Overall, we will interview 66-100 key informants at each time point. Interviews will be conducted in-person or by teleconference/webinar and are expected to last 30-45 minutes. Interviews may include more than one representative of a group. Participants will be asked for their permission to record the interview, to facilitate transcription of interview responses.

Measures

The structured interview protocols for the key informant interviews will include questions targeted to the individual's organizational roles and responsibilities.

For BHDDA officials, questions will include:

- Evidence-based assessment and placement: review of PIHP audit data, strategies to address deficiencies (e.g., additional training)
- Availability of SUD treatment: review of PIHP audits, strategies to address indicators of inadequate availability for certain regions and/or specific levels of care
- Utilization of SUD treatment services: review of quality improvement reports, discussion of areas of concern
- Health IT to support care coordination: update on implementation, barriers and facilitators

For Medicaid officials, questions will include:

- Utilization of primary care vs EDs for beneficiaries with SUD/OUD: review of quality improvement reports, discussion of strategies to address problematic trends
- Health IT to support care coordination: review data on use of health IT strategies by Medicaid health plans, barriers and facilitators
- Management of high-risk beneficiaries: update on co-management strategies, efforts to promote collaboration between Medicaid health plans and PIHPs

For PIHP officials, questions will include:

- Evidence-based assessment and placement: review of PIHP audit data, strategies to address deficiencies (e.g., additional training]
- Availability of SUD treatment: review of PIHP audits, strategies to address indicators of inadequate availability for certain regions and/or specific levels of care
- Utilization of SUD treatment services: review of quality improvement reports, discussion of areas of concern
- Health IT to support care coordination: update on use of health IT strategies to support transition across settings, collaboration with Medicaid health plans

For SUD providers, questions will include

- Availability of SUD treatment: barriers and facilitators to maintaining access, including hiring/retaining providers
- Utilization of SUD treatment services: barriers and facilitators to beneficiary initiation and continuation with treatment, including access to supportive services
- Health IT to support care coordination: use of and satisfaction with health IT strategies to support transition across settings,

Analytic approach

We will record and transcribe all interviews. Two evaluation team members will review each transcript to identify key themes, with a focus on identifying commonalities and differences across regions in the barriers and facilitators to implementation of key elements of the demonstration. Themes will be described in evaluation reports.

C.2.5. Program administrative cost data

Data source

Data sources for evaluation of cost data will include state cost reports for the Medicaid program and for the BHDDA (which includes services provided through state general funds, SAMHSA grants, and other non-Medicaid sources); we will supplement state cost reports with payment data linked to Medicaid administrative claims. Baseline costs will reflect the pre-demonstration period (state fiscal years 2017 and 2018).

Measures
Cost measures are outlined in Table 2 and will include total SUD spending and spending per member-month for specific cost drivers, including residential/inpatient treatment, medication assisted therapy, and emergency department visits.

Additionally, we will track PIHP spending by category (e.g., detox, residential, outpatient, MAT, case management, recovery support) reported in annual PIHP reporting to the state.

Analytic approach
Two broad measures – total SUD spending from all sources and PIHP spending by category – will be analyzed as descriptive comparisons across years, from FY2017 to FY2024. In particular, the analysis of PIHP spending patterns will highlight changes in the relative proportion of SUD spending devoted to certain types of services and suggest whether the demonstration project promotes greater consistency across PIHPs in the proportion of dollars spent in different treatment categories.

For cost measures derived from paid amounts on administrative claims (e.g., spending for SUD inpatient treatment, spending for MAT, ED costs for SUD), we will conduct an interrupted time series analysis. We will sum total paid amounts for each quarter from FY2017 through FY2023, along with total enrolled member-months. This analysis will estimate different linear effects in the pre-implementation period (FY2017-FY2020) through post-implementation (FY2021-FY2023). We will run separate models for SUD inpatient/residential treatment, medication assisted therapy, and ED visits with a primary diagnosis of SUD, and will report marginal effects and standard errors. We will use the following model:

$$\text{Costs } = \alpha + \beta_1 time + \beta_2\, post + \beta_3\, post * time + \theta^T X + \varepsilon$$

Where TIME is a quarterly count variable; POST is the indicator variable for whether the month occurred on or after implementation of key waiver strategies; and *X* include beneficiary age, gender, race, enrollment, and PIHP.

We will also perform multivariable linear regression analyses that examines the change in cost across years controlling for PIHP, beneficiary demographics and utilization characteristics:

$$Costs = \alpha + \beta_1 * year + \theta^T X$$

Where X = Control variables
α = Intercept
β_1 = year effect
θ = vector of parameters corresponding to control variables

C.3. Evaluation period, timeline and budget
The evaluation period will be for October 1, 2019, through September 30, 2025, which reflects the full demonstration period, with an additional year for final data analysis and reporting. Of

note, data from administrative claims and other routine state reporting sources will be available for FY2017-2018, allowed for an extended baseline period.

Table 3. Major evaluation reporting deliverables, as specified in the STCs, include the following:

Date	Deliverable
December 2022	Midpoint Assessment (will include baseline and midpoint key informant interviews, and baseline administrative and beneficiary survey data)
September 2023	Interim Report (will include baseline and midpoint key informant interviews, and baseline administrative and beneficiary survey data)
March 2026	Final Report (will include all evaluation results)

We provide an evaluation budget and timeline in the Appendix.

- **D. Methodological limitations**

Our proposed evaluation has several limitations.

The primary limitation is related an inability to attribute changes in outcomes to the activities undertaken in the demonstration. This limitation is in part due to the lack of a comparison group, as well as other SUD-related programmatic and policy changes occurring in Michigan during the time period of this demonstration project.

To address the lack of comparison group, we will analyze key evaluation outcomes using an interrupted time series design; this is the strongest available design option in the absence of a randomized controlled trial or matched control group. Our results may not be generalizable outside of Michigan although we will seek to benchmark results to other states with 1115 SUD waivers.

To address the potential impact of other changes in Michigan's SUD-focused policies and programs on the outcomes measured in this evaluation, we will document a broad range of SUD policy and program changes and note in evaluation reports how they may intersect with key outcomes. In addition, we will use key informant interviews to explore which policy and program changes represent key facilitators or barriers to improving SUD treatment.

Implementation of key elements of the demonstration is expected to be uneven across PIHP regions, including the use of single-region pilot tests for several health IT strategies. To address this likelihood, we will explore and describe regional differences in each of the five data elements (administrative data, beneficiary surveys, state monitoring reports/PIHP audits, key informant interviews, and cost reports). This will allow us to document any unevenness in

implementation, and to examine the extent to which uneven implementation is associated with evaluation process or outcome measures.

Gaining participation for the beneficiary survey will be challenging due to expected changes in beneficiary contact information, churn in Medicaid enrollment, and possible reluctance to provide sensitive information. We will employ methods used successfully in recent surveys of Michigan Medicaid beneficiaries, including multiple modes of recruitment, interviewer training on non-judgmental administration of survey questions, and use of gift cards as an incentive for participation. In addition, survey administration by telephone may not be appropriate for all beneficiaries; we will work with MDHHS officials to identify alternate mechanisms for participation, such as in-person interviews. In addition, we will employ a weighting scheme that utilizes demographic characteristics from the state data warehouse to compare survey participants to sampled non-participants, and to the eligible population for the survey.

A final limitation involves data completeness and reliability. Michigan has a long tradition of managed care for both medical and behavioral health benefits and has developed an excellent structure for administrative claims processing. As such, we feel confident in the completeness and reliability of most fields, including diagnosis and procedure codes, place of service and service type codes, billing and rendering provider identifiers, and pharmacy codes. Our greatest area of concern involves paid amounts. We will work with MDHHS officials to learn about their internal assessments of cost fields. In addition, our key informant interviews with PIHP administrators will include questions about the reliability of the paid amounts submitted with their administrative claims.

- **E. Evaluation Team**

Independent evaluator

The CMS approval of the Michigan's Behavioral Health Demonstration Waiver requires that the evaluation be designed and conducted by researchers who will meet the scientific rigor and research standards of leading academic institutions and academic journal peer review. The University of Michigan Institute for Healthcare Policy and Innovation is an interdisciplinary campus-wide institute at a premier public research university. The mission of the Institute is to improve the quality, safety, equity, and affordability of health care. The Institute includes more than 600 health services researchers from 14 schools and colleges across the university. IHPI faculty members and staff are national leaders in health services research, health economics, and population health with substantial experience conducting rigorous evaluations of access to care, quality of care, costs of care, and health outcomes. IHPI faculty members participating on the evaluation team have substantial experience in the evaluation of Medicaid demonstration programs and other state and federal policy initiatives.

The University of Michigan contracted with the MDHHS from 2014-2019 as the independent evaluator for the Healthy Michigan Plan 1115 Demonstration Waiver. As result of these previous relationships, MDHHS identified University of Michigan as a potential independent evaluator to conduct this demonstration evaluation and reached out to them. They held several preliminary meetings and discussions that led UM to develop a proposal for MDHHS, leading to their final selection to conduct the Demonstration evaluation.

The State attests that the relationship between the Contracting Party, the University of Michigan, shall be, and only be, that of an independent contractor and the Contracting Party shall not be construed to be an employee, agent, or in joint venture with, the State and/or agency. The University of Michigan attests that we will conduct a fair and impartial evaluation and prepare an objective Evaluation Report.

We have included a description of the core members of the team and certify that they do not have any conflict of interest in conducting this evaluation and that they will conduct a fair and impartial evaluation and prepare an objective Evaluation Report.

Evaluation team
The evaluation team includes three faculty leads who will guide all aspects of the proposed evaluation, including interacting with MDHHS, engaging with stakeholders, survey development and data collection, dissemination efforts, and ensuring responsiveness and on-time, high quality deliverables.

Anne Fernandez, PhD, MA, is Assistant Professor of Psychiatry, and the Clinical Program Director of two Michigan Medicine clinics, the University of Michigan Addiction Treatment Service and the Multi-Disciplinary Alcohol-Related Liver Disease Clinic. She is a licensed clinical psychologist and a clinical researcher with more than ten years of experience conducting research on substance and alcohol use disorders (SUD/AUD) and their treatments across a variety of settings and populations. She brings her extensive research and clinical expertise in addiction treatment and health outcomes to this project. Dr. Fernandez is the Principal Investigator (PI) of two grants focused on developing and improving treatment for substance use disorders. She is PI of an NIH-funded study to develop and pilot test a tailored pre-operative alcohol use intervention. She is also the PI of a precision health study that aims to prevent opioid misuse using machine learning-based risk prediction coupled with patient-centered early intervention. Her other areas of research focus on motivational interviewing, overdose, and polysubstance use. She has more than 30 peer-reviewed publications and expertise in both quantitative and qualitative methodologies.

Sarah J. Clark, MPH, is Research Scientist in the Department of Pediatrics, based in the Susan B. Meister Child Health Evaluation and Research (CHEAR) Center at the University of Michigan. Since joining the University of Michigan faculty in 1998, Ms. Clark has worked closely with

Michigan Medicaid and other units within the MDHHS on projects evaluating programs and policies, including co-leading the evaluation of the Healthy Michigan Plan. Her prior state projects have used a variety of methods, including analysis of Medicaid administrative data and primary data collection with Medicaid beneficiaries and providers. She collaborates with Dr. Zivin on a federally funded study to generate and track OUD measures across state Medicaid programs (Medicaid Outcomes Distributed Research Network). Ms. Clark has published more than 200 articles, including many related to analyses of Michigan Medicaid policies and programs. She supervises an experienced team of technical staff who will support the evaluation, including a call center for structured telephone interviews.

Kara Zivin, PhD, MS, MA, is Professor of Psychiatry at the University of Michigan Medical School, Professor at the School of Public Health, Faculty Affiliate at the Institute for Social Research, Research Investigator at the Department of Veterans Affairs (VA), and Senior Health Researcher at Mathematica Policy Research. Dr. Zivin has extensive experience in leading integrated physical and behavioral health care evaluations, including the Washtenaw County Community Mental Health (WCCMH) Health Home program. She served as a senior advisor and subject matter expert to CMS for the Comprehensive Primary Care initiative. She has led several analyses and evaluations for CMS contracts, including cost analyses of the Medicaid Emergency Psychiatric Demonstration, quality measure development for physical and mental health integration, and adaptation of substance use quality measures for use in Medicaid. She led a mixed methods pilot study of a change to an electronic health record default for opioid prescriptions for the Assistant Secretary for Planning and Evaluation (ASPE) within the U.S. Department of Health and Human Services. She led quantitative analyses of primary and behavioral health care integration sites for individuals with serious mental illness receiving physical health treatment in community mental health centers for the Substance Abuse and Mental Health Services Administration. Dr. Zivin served as the behavioral health committee chair for AcademyHealth, the preeminent health services research and policy organization. Dr. Zivin has been funded by multiple federal contracts and research grants and has over 150 peer-reviewed scientific publications.

The faculty leads will be supported by a technical staff experienced in Medicaid administrative claims data management and analysis, biostatistics, structured interviewing techniques, qualitative data analysis, cost analysis, policy analysis, and project management.

Appendix

REVISED EVALUATION BUDGET: Michigan 1115 Behavioral Health Demonstration

	10/1/2019 - 9/30/2020	10/1/2020 - 9/30/2021	10/1/2021 - 9/30/2022	10/1/2022 - 9/30/2023	10/1/2023 - 9/30/2024	10/1/2024 - 9/30/2025	10/1/2025 - 9/30/2026	TOTAL
	YEAR 1	YEAR 2	YEAR 3	YEAR 4	YEAR 5	YEAR 6	YEAR 7	
	Salary	Salary	Salary	Salary	Salary	Salary	Salary	
Subtotal	$47,824	$216,630	$262,184	$263,244	$262,865	$194,714	$97,277	$1,344,737
	Fringe	Fringe	Fringe	Fringe	Fringe	Fringe	Fringe	
Subtotal	$14,655	$61,377	$75,854	$76,090	$76,144	$59,838	$30,186	$394,155
	Supplies and Materials	Supplies and Materials	Supplies and Materials	Supplies and Materials	Supplies and Materials	Supplies and Materials	Supplies and Materials	
Subtotal	$398	$5,200	$5,200	$5,200	$5,200	$200	$200	$21,598
	Travel	Travel	Travel	Travel	Travel	Travel	Travel	
Subtotal	$553	$553	$553	$553	$553	$553	$0	$3,319
	Interviews and Surveys	Interviews and Surveys	Interviews and Surveys	Interviews and Surveys	Interviews and Surveys	Interviews and Surveys	Interviews and Surveys	
Subtotal	$150	$55,000	$56,000	$58,150	$50,500	$950	$150	$220,900
Total Directs	$63,590	$338,760	$399,792	$403,237	$395,261	$256,261	$127,813	$1,984,709
Total Indirects	$12,718	$67,752	79,958	$80,647	$79,052	$51,251	$25,563	$396,942

TOTAL	**$76,308**	**$406,512**	**$479,750**	**$483,884**	**$474,313**	**$307,506**	**$153,375**	**$2,381,650**

EVALUATION TIMELINE: Michigan 1115 Behavioral Health Demonstration

	Administrative data analysis	**Beneficiary Surveys (phone interviews)** 2000 per cohort (200 per PIHP)	**Key Informant Interviews**	**Deliverables**
10/1/19-9/30/20	Draft Data Use Agreements and obtain approvals Generate administrative measures for FY17 and FY18	Develop interview guide & protocol, finalize sampling plan	Develop interview guide Begin BASELINE key informant interviews	Finalize Evaluation Plan (response to CMS comments)
10/1/20-9/30/21	Generate administrative measures for FY19 Analyze pre-waiver data	Cohort 1 – administer Initial Surveys (baseline) and begin Follow up Surveys	Complete baseline key informant interviews Summarize baseline data	
10/1/21-9/30/22	Generate administrative measures for FY20	Cohort 1 – complete remaining Follow up Surveys Analyze Cohort 1 results	Conduct MIDPOINT key informant interviews Summarize midpoint data	MIDPOINT ASSESSMENT Due 12/31/2022
10/1/22-9/30/23	Generate administrative measures for FY21	Cohort 2 – administer Initial Surveys (baseline) and begin Follow up Survey	Conduct FINAL key informant interviews	INTERIM EVALUATION REPORT Due 9/30/23 Finalize interim report (respond to CMS comments)

10/1/23-9/30/24	Generate administrative measures for FY22	Cohort 2-complete remaining Follow-up Surveys Analyze Cohort 2 results	Analyze key informant data	
10/1/24-9/30/25	Generate administrative measures for FY23; analyze data trends over demonstration period			
10/1/25-9/30/26	Generate administrative measures for FY24; analyze data trends over demonstration period			SUMMATIVE EVALUATION REPORT due 3/31/26 Respond to CMS questions as needed

Medicaid Outcomes Distributed Research Network – Opioid Use Disorder Project (MODRN-OUD)

List of measures (March 2019)

#	Performance measure	Source
Identification, initiation, and engagement measures		
1	Initiation & engagement of alcohol and other drug dependence treatment (with sub-analysis of OUD)	NCQA-IET
2	Identification of alcohol and other drug services (with sub-analysis of OUD)	NCQA-IAD
3	Rates of medication-assisted treatment among enrollees with OUD	
Medication, treatment duration, counseling and monitoring		
4	Continuity of pharmacotherapy for OUD	NQF-3175
5	Urine drug screens for enrollees with pharmacotherapy for OUD	
6	Behavioral health counseling with pharmacotherapy for OUD	
Follow-up and general, preventive medical care		
7	Follow-up after Emergency Department visit for alcohol and other drug abuse or dependence (with sub-analysis of OUD)	NCQA-FUA-AD
8	Screening for HIV, HCV, HBV among enrollees with an OUD diagnosis	
9	PCP visits among enrollees with OUD diagnosis	
Opioid and benzodiazepine prescribing		
10	Any opioid fills among enrollees with OUD diagnosis	
11	Any benzodiazepine fills among enrollees with OUD diagnosis	
12	Use of opioids at high dosages in enrollees without cancer (not limited to OUD)	PQA
13	Multiple opioid prescribers and pharmacies in enrollees without cancer (not limited to OUD)	PQA
14	Concurrent use of opioids and benzodiazepines in enrollees without cancer (not limited to OUD)	PQA
Acute care use and overdose outcomes		
15	Emergency department use for SUD and OUD, per 1000 member months	
16	Inpatient hospitalizations for SUD and OUD, per 1000 member months	
17	Opioid and heroin poisoning overdose deaths among Medicaid enrollees	
Pregnancy and OUD/Neonatal Abstinence Syndrome (NAS)		
18	Number of children 0-12 months diagnosed with NAS at birth & in first year per 1,000 Medicaid-covered births	
19	Days in NICU for children 0-12 months diagnosed with NAS at birth hospitalization	
20	Percentages of children diagnosed with NAS receiving >= 1 and >=6 well-child visits in first 15 months	modified HEDIS

Current States Participating in MODRN-OUD

Delaware	Pennsylvania
Kentucky	Tennessee
Maryland	Virginia
Michigan	West Virginia

North Carolina
Ohio
Wisconsin

ATTACHMENT D:

State of Michigan
Michigan Department of Health and Human Services

Michigan's 1115 Behavioral Health Demonstration
Attachment D: Opioid/Substance Use Disorder Implementation Plan

(Revised April 2020)

Access to Critical Levels of Care for Opioid Use Disorder (OUD) and other Substance Use Disorders (SUD)

While Michigan has historically maintained a robust network of SUD providers and services spanning from early intervention through inpatient withdrawal management services, the 1115 waiver authority will permit the state to broaden the array of treatment services available and provide Medicaid coverage for the full American Society of Addiction Medicine (ASAM) care continuum, including residential and withdrawal management services in an IMD setting for adults age 21-64.

To effectuate a strong SUD network capable of delivering a comprehensive benefit consistent with ASAM Level of Care requirements, Michigan Department of Health and Human Services (MDHHS) is embarking on a process intended to enable the state to generate comprehensive and refreshable reports for future planning and decision-making. Through this work, MDHHS will develop a strategy to effectively utilize existing state-specific and other publicly available data to help achieve the following:

1. Ensure a Comprehensive Evidence-Based Benefit SUD Benefit
    - To guarantee a full continuum of evidence-based practices
    - To ensure use of evidence-based practices including Screening, Brief Intervention, and Referral to Treatment (SBIRT), withdrawal management, medication assisted treatment, care coordination, long-term recovery supports and services
    - To confirm service availability and use of services (e.g., short-term inpatient and short-term residential), including in IMDs

2. Ensure that SUD providers meet ASAM Program and Service Requirements
    - By establishing standards of care using ASAM criteria
    - By using ASAM standards to develop residential, withdrawal management, outpatient, early intervention and opioid treatment programs
    - By requiring all providers to meet ASAM level of care standards prior to participating in Medicaid

3. Ensure the Presence and Maintenance of a Strong SUD Provider Network
    - By developing and implementing a plan and strategy to ensure a sufficient network of providers across all ASAM levels
    - By ensuring that providers can deliver services consistent with ASAM criteria and provide evidence-based SUD practices
    - By ensuring that the provider network is robust in the event providers stop participating in Medicaid, are suspended or terminated

Michigan provides coverage for an extensive array of SUD treatment and recovery support services. Access to these services will be achieved within 18-30 months of the demonstration's approval. Table 1 below lists all the SUD services available under the waiver, including those newly covered under the 1115 waiver, delineated by the ASAM Level of Care. Recovery

Support Services are available to individuals regardless of ASAM care level. Unless otherwise noted, all services are available to adults and children/adolescents.

Table: 1

ASAM Level of Care	Service Title	Service Description	Provider / Practitioner Qualifications	Limits	Availability
SUD TREATMENT					
0.5 - Early Intervention					
	Screening, Brief Intervention, and Referral to Treatment (SBIRT)	Assessment and education for at-risk individuals. A face-to-face service for the purpose of identifying functional, treatment, and recovery needs and a basis for formulating the Individualized Treatment Plan.	Primary care providers payable under the state's managed care/ fee for service physical health care system.	NA.	Currently Available
	Early intervention services	Includes stage-based interventions for individuals with substance use disorders and individuals who may not meet the threshold of abuse or dependence but are experiencing functional/social impairment as a result of use.	Provider agency licensed and accredited as substance abuse treatment program. State approval for ASAM level of care. Clinical service provided by Substance Abuse Treatment Specialist (SATS) or Substance Abuse Treatment Practitioner (SATP) when working under the supervision of a SATS.	Services are not subdivided by the number of hours received during a week. The amount and type of services provided are based on individual needs based on the beneficiary's motivation to change and other risk factors that may be present.	Currently Available
Level 1 - Opioid Treatment Program (OTP)					
	Approved pharmacological support services	Oral medication administration, direct observation, physician evaluations, individual and person-centered assessments, nursing assessments, counseling and laboratory testing	Services must be provided under the supervision of a physician licensed to practice medicine in	Service limitations as indicated by state and federal requirements (e.g., physical	Currently Available

ASAM Level of Care	Service Title	Service Description	Provider / Practitioner Qualifications	Limits	Availability
		and access to primary care (approved for use of Methadone and/or Buprenorphine).	Michigan. Programs must meet applicable state licensure, CSAT certification, DEA licensure and accreditation requirements. State approval for ASAM level of care.	examination, laboratory tests, etc.).	
Level 1 - Outpatient Services					
	Psychiatric evaluation	Physician evaluation/exam	Psychiatrist or psychiatric mental health nurse practitioner.	Services provided as medically necessary.	Currently Available
	Assessment	A face-to-face service for the purpose of identifying functional, treatment, and recovery needs and a basis for formulating the Individualized Treatment Plan.	Provider agency licensed and accredited as substance abuse treatment program. State approval for ASAM level of care. Clinical service provided by Substance Abuse Treatment Specialist (SATS) or Substance Abuse Treatment Practitioner (SATP) when working under the supervision of a SATS.	ASAM level 1 Services from one to eight hours during a week. Less than 9 hours of service/week (adults); less than 6 hours/week (adolescents) for recovery or motivational enhancement therapies/strategies.	Currently Available
	Treatment planning	Activities associated with the development and periodic review of the plan of service, including	Provider agency licensed and accredited	Services provided as medically necessary.	Currently Available

ASAM Level of Care	Service Title	Service Description	Provider / Practitioner Qualifications	Limits	Availability
		all aspects of the person-centered planning process, such as pre-meeting activities, and external facilitation of person-centered planning. This includes writing goals, objectives, and outcomes; designing strategies to achieve outcomes (identifying amount, scope, and duration) and ways to measure achievement relative to the outcome methodologies; attending person-centered planning meetings per invitation; and documentation. Monitoring of the individual plan of service including specific services, when not performed by the case manager or supports coordinator, is included in this coverage.	as substance abuse treatment program. State approval for ASAM level of care. Clinical service provided by Substance Abuse Treatment Specialist (SATS) or Substance Abuse Treatment Practitioner (SATP) when working under the supervision of a SATS.		
	Therapy (Individual, Group, Family)	Individual - Face to face counseling services with the beneficiary; Group - Face-to-face counseling with three or more beneficiaries, and can include didactic lectures, therapeutic interventions/counseling, and other group activities; Family - Face-to-face counseling with the beneficiary and the significant other and/or traditional or nontraditional family members.	Provider agency licensed and accredited as substance abuse treatment program. State approval for ASAM level of care. Clinical service provided by Substance Abuse Treatment Specialist (SATS) or Substance Abuse Treatment Practitioner (SATP) when working under the supervision of a SATS.	Services provided as medically necessary.	Currently Available
	Counseling (Individual, Group)	An interpersonal helping relationship that begins with the client exploring the way they think, how they feel, and what they do, for the	Provider agency licensed and accredited as substance abuse	Services provided as medically necessary.	Currently Available

ASAM Level of Care	Service Title	Service Description	Provider / Practitioner Qualifications	Limits	Availability
		purpose of enhancing their life. The counselor helps the client set the goals that pave the way for positive change to occur.	treatment program. State approval for ASAM level of care. Clinical service provided by Substance Abuse Treatment Specialist (SATS) or Substance Abuse Treatment Practitioner (SATP) when working under the supervision of a SATS. Services can be provided by appropriately trained staff when working under the supervision of a SATS or SATP. A recovery coach or SUD peer specialist must be certified through an MDHHS-approved training program.		
	Didactics and education	Services that are designed or intended to teach information about addiction and/or recovery skills.	Provider agency licensed and accredited as substance abuse treatment program. State approval for ASAM level of care. Clinical service provided by Substance Abuse Treatment Specialist	Services provided as medically necessary.	Currently Available

ASAM Level of Care	Service Title	Service Description	Provider / Practitioner Qualifications	Limits	Availability
			(SATS) or Substance Abuse Treatment Practitioner (SATP) when working under the supervision of a SATS. Services can be provided by appropriately trained staff when working under the supervision of a SATS or SATP. A recovery coach or SUD peer specialist must be certified through an MDHHS-approved training program.		
	Crisis Intervention	A service for the purpose of addressing problems/issues that may arise during treatment and could result in the beneficiary requiring a higher level of care if intervention is not provided.	Clinical service provided by Substance Abuse Treatment Specialist (SATS) or Substance Abuse Treatment Practitioner (SATP) when working under the supervision of a SATS. Services can be provided by appropriately trained staff when working under the supervision of a SATS or SATP. A recovery coach or SUD	Services provided as medically necessary.	Currently Available

ASAM Level of Care	Service Title	Service Description	Provider / Practitioner Qualifications	Limits	Availability
			peer specialist must be certified through an MDHHS-approved training program.		
	Medication review	Evaluating and monitoring medications, their effects, and the need for continuing or changing the medication regimen. Medication review includes the administration of screening tools for the presence of extra pyramidal symptoms and tardive dyskinesia secondary to untoward effects of neuroactive medications.	A physician, physician assistant, nurse practitioner, registered nurse, licensed pharmacist, or a licensed practical nurse assisting the physician may perform medication reviews. Only an MD or DO, or a licensed physician's assistant or nurse practitioner under the supervision of a physician may prescribe medications.	Services provided as medically necessary.	Currently Available
	Laboratory Tests	Laboratory analysis of specimens to detect presence of alcohol or drugs.	Medicaid eligible and enrolled laboratory services providers.	Services provided as medically necessary.	Currently Available
Level 2.1 – Intensive Outpatient Services					
	Intensive Outpatient Services (IOP)	Includes assessment, counseling, crisis intervention, and activity therapies or education.	Provider agency licensed and accredited as substance abuse	Provided as 9 to 19 hours of structured programming per week	Currently Available

ASAM Level of Care	Service Title	Service Description	Provider / Practitioner Qualifications	Limits	Availability
		Outpatient services can include any variety of the covered services and are dependent on the individual needs of the beneficiary. The assessment, treatment plan and recovery support preparations are the only components that are consistent throughout the outpatient levels of care as each beneficiary must have these as part of the authorized treatment services.	treatment program. State approval for ASAM level of care. Clinical service provided by Substance Abuse Treatment Specialist (SATS) or Substance Abuse Treatment Practitioner (SATP) when working under the supervision of a SATS.	based on an individualized treatment plan. As a beneficiary's needs increase, more services and/or frequency/duration of services may be utilized if these are medically necessary.	
Level 2.5 – Partial Hospitalization Services					
	Partial hospitalization (Expanded Intensive Outpatient)	20 or more hours of service/week for multidimensional instability not requiring 24-hour care.	Provider agency licensed and accredited as substance abuse treatment program. State approval for ASAM level of care. Clinical service provided by Substance Abuse Treatment Specialist (SATS) or Substance Abuse Treatment Practitioner (SATP) when working under the supervision of a SATS.	Authorization for the partial hospitalization admission and continued stay includes authorization for all services related to that admission/stay, including laboratory, pharmacy, and radiology services.	Currently Available
Level 3.1 – Clinically Managed Low-intensity Residential Services					

ASAM Level of Care	Service Title	Service Description	Provider / Practitioner Qualifications	Limits	Availability
	Clinically Managed Low-Intensity Residential Services	The services are directed toward applying recovery skills, preventing relapse, improving emotional functioning, promoting personal responsibility, and reintegrating the individual in work, education, and family life. Treatment services are like low intensity outpatient services focused on improving the individual's functioning and coping skills in Dimension 5 and 6. Functional deficits found in this population may include problems in applying recovery skills to their everyday lives, lack of personal responsibility, or lack of connection to employment, education, or family life. The setting allows clients opportunity to develop and practice skills while reintegrating into the community. Services are inclusive of structured supervision within the 24-hour program, provided by available trained personnel; at least 5 hours of clinical service/week in which services are preparing individual for outpatient treatment.	Provider agency licensed and accredited as substance abuse treatment program. Clinical service provided by Substance Abuse Treatment Specialist (SATS) or Substance Abuse Treatment Practitioner (SATP) when working under the supervision of a SATS. Providers assessed by the state or its designee and confirmed to meet ASAM program level requirements for this level of care.	At least 5 hours per week of clinical services (Assessment; Episode of Care Plan- addressing treatment, recovery, discharge and transition across episode; interaction/ teaching to process skills and information adapted to the individual needs; includes alternative therapies, individual, group and family counseling, anger management, coping skills, recovery skills, relapse triggers, and crisis intervention); coordination and referral; medical evaluation and linkage to services; connection to next provider and medical services; preparation for next step. At least 5 hours of life skills and self-care per week.	Currently Available
Level 3.3 – Clinically Managed Population-specific High-Intensity Residential Services					
	Clinically Managed Population-specific High-Intensity	The program provides a structured recovery environment in combination with medium-intensity clinical services to support recovery.	Provider agency licensed and accredited	Not less than 13 hours per week of core services (Assessment; Episode of	Currently Available

ASAM Level of Care	Service Title	Service Description	Provider / Practitioner Qualifications	Limits	Availability
	Residential Services (Adult only)	Services may be provided in a deliberately repetitive fashion to address the special needs of individuals who are often elderly, cognitively impaired, or developmentally delayed. Typically, they need a slower pace of treatment because of mental health problems or reduced cognitive functioning. Treatment services are directed to provision of simple interventions to increase awareness and understanding of dangerous consequences of behavior and improving functioning and coping in Dimensions 4 and 5. The deficits for clients at this level are primarily cognitive, either temporary or permanent. Clients in this LOC have needs that are more intensive and to benefit effectively from services, they must be provided at a slower pace and over a longer period. The client's level of impairment is more severe at this level, requiring services be provided differently for maximum benefit to be received. Services are inclusive of structured supervision 24/7, provided by trained counselors to stabilize the multidimensional aspects of imminent danger. Services are offered within the less intense milieu and group treatment for those with cognitive or other impairments unable to use full active milieu or the therapeutic community as they prepare for outpatient treatment.	as substance abuse treatment program. Clinical service provided by Substance Abuse Treatment Specialist (SATS) or Substance Abuse Treatment Practitioner (SATP) when working under the supervision of a SATS. Providers assessed by the state or its designee and confirmed to meet ASAM program level requirements for this level of care.	Care Plan- addressing treatment, recovery, discharge and transition across episode; interaction/teaching to process skills and information adapted to the individual needs; includes alternative therapies, individual, group and family counseling, anger management, coping skills, recovery skills, relapse triggers, and crisis intervention); coordination and referral; medical evaluation and linkage to services; connection to next provider and medical services; preparation for next step. Not less than 13 hours per week of life skills and self-care services.	

ASAM Level of Care	Service Title	Service Description	Provider / Practitioner Qualifications	Limits	Availability
Level 3.5 – Clinically Managed High-Intensity Residential Services					
	Clinically Managed High-Intensity Residential Services	Services are inclusive of structured supervision within the 24-hour /7 day a week program, provided by available trained counselors who intervene to stabilize multidimensional aspects of imminent danger and other behaviors that are based in dysfunctional actions and require habilitation. Staff provide targeted interventions to rebuild social, psychological, educational/ vocational and employment limitations and support preparation and development for outpatient treatment. Clients must be able to tolerate and use full milieu or therapeutic community and began to address and make progress and improvements as they master life skills.	Provider agency licensed and accredited as substance abuse treatment program. Clinical service provided by Substance Abuse Treatment Specialist (SATS) or Substance Abuse Treatment Practitioner (SATP) when working under the supervision of a SATS. Providers assessed by the state or its designee and confirmed to meet ASAM program level requirements for this level of care.	Not less than 20 hours per week of core services (services (Assessment; Episode of Care Plan-addressing treatment, recovery, discharge and transition across episode); coordination and referral; medical evaluation and linkage to services; connection to next provider and medical services; preparation for next step. Not less than 20 hours per week of life skills and self-care services.	Currently Available

ASAM Level of Care	Service Title	Service Description	Provider / Practitioner Qualifications	Limits	Availability
Level 3.7 – Medically Monitored High-Intensity Inpatient Services					
	Medically Monitored High-Intensity Inpatient Services	Services are inclusive of structured supervision within the 24-hour/7 day a week program, provided by available trained counselors who intervene to stabilize multidimensional aspects of imminent danger and other behaviors that are based in dysfunctional actions and require habilitation. Programs provide a planned and structured regimen of 24-hour professionally directed evaluation, observation, medical monitoring and addiction treatment. The service, when clinically indicated, is an alternative to acute medical care provided by licensed health care professionals in a hospital setting. The skills of the interdisciplinary team and the availability of support services can accommodate withdrawal management	Provider agency licensed and accredited as substance abuse treatment program. Clinical service provided by Substance Abuse Treatment Specialist (SATS) or Substance Abuse Treatment Practitioner (SATP) when working under the supervision of a SATS. Providers assessed by the state or its designee and confirmed to meet ASAM program level requirements for this level of care. These services must be staffed 24-hours-per-day, seven-days-per-week by a licensed physician or by the designated representative of a licensed physician.	Not less than 20 hours per week of core services (services (Assessment; Episode of Care Plan-addressing treatment, recovery, discharge and transition across episode); coordination and referral; medical evaluation and linkage to services; connection to next provider and medical services; preparation for next step. Not less than 20 hours per week of life skills and self-care services.	Currently Available
4 – Medically Managed Intensive Inpatient Services					

ASAM Level of Care	Service Title	Service Description	Provider / Practitioner Qualifications	Limits	Availability
	Medically Managed Intensive Inpatient Services	Organized service delivered in an acute care inpatient setting. It is for patients whose acute biomedical, emotional, behavioral and cognitive problems are so severe that they require primary medical and nursing care.	A hospital providing medically managed intensive inpatient services is accredited and licensed and staffed 24/7 to provide licensed nursing and physician services to patients requiring access to a range of services including ancillary such as laboratory, x-ray, nutrition services) and specialty physician services. The staff are licensed and credentialed by the hospital and meet the accreditation standards related to practice within their licensures.	Service provided as medically indicated and through established medical protocols.	Currently Available
Level 1-WM – Ambulatory Withdrawal Management without Extended On-site Monitoring (Outpatient Withdrawal Management)					
	Ambulatory Withdrawal Management without Extended On-site Monitoring (Outpatient Withdrawal Management)	Ambulatory sub-acute detoxification without extended on-site monitoring for patients expected to demonstrate mild withdrawal with daily or less than daily outpatient supervision. Supervised monitoring of withdrawal occurs by personnel trained in SUD and withdrawal management during identified hours.	Provider agency licensed and accredited as substance abuse treatment program. Clinical service provided by Substance Abuse Treatment Specialist (SATS) or Substance	Initial length-of-stay authorizations may be for up to three days, with additional days authorized if there is clinical evidence that detoxification is not successful or complete and authorization	Currently Available

ASAM Level of Care	Service Title	Service Description	Provider / Practitioner Qualifications	Limits	Availability
		Services must have arrangements for access to licensed medical personnel as needed.	Abuse Treatment Practitioner (SATP) when working under the supervision of a SATS. Providers assessed by the state or its designee and confirmed to meet ASAM program level requirements for this level of care.	requirements continue to be met.	
Level 2-WM – Ambulatory Withdrawal Management with Extended On-site Monitoring (Outpatient Withdrawal Management)					
	Ambulatory Withdrawal Management with Extended On-site Monitoring (Outpatient Withdrawal Management)	Ambulatory sub-acute detoxification with extended on-site monitoring for patients expected to demonstrate moderate withdrawal with all day withdrawal management and support and supervision. Services must have arrangements for access to licensed medical personnel as needed. Patient has a supportive family or living situation at night.	Provider agency licensed and accredited as substance abuse treatment program. Clinical service provided by Substance Abuse Treatment Specialist (SATS) or Substance Abuse Treatment Practitioner (SATP) when working under the supervision of a SATS. Ambulatory detoxification services must be monitored by appropriately credentialed and licensed nurses.	Initial length-of-stay authorizations may be for up to three days, with additional days authorized if there is clinical evidence that detoxification is not successful or complete and authorization requirements continue to be met.	Currently Available

ASAM Level of Care	Service Title	Service Description	Provider / Practitioner Qualifications	Limits	Availability
			Providers assessed by the state or its designee and confirmed to meet ASAM program level requirements for this level of care.		
Level 3.2-WM – Clinically Managed Residential Withdrawal Management (Residential Withdrawal Management)					
	Clinically Managed Residential Withdrawal Management (Residential Withdrawal Management)	Detoxification management and monitoring of services to client determined to need moderate withdrawal, and 24-hour support to complete withdrawal supervision and increase likelihood of continuing treatment or recovery. This residential setting for detoxification emphasizes peer and social support for persons who warrant 24-hour support. Sub-acute detoxification provides supervised care to manage the effects of withdrawal from alcohol and/or other drugs as part of a planned sequence of addiction treatment. Detoxification is limited to stabilization of the medical effects of withdrawal and referral to ongoing treatment and/or support services. Services must have arrangements for access to licensed medical personnel as needed.	Provider agency licensed and accredited as substance abuse treatment program. Licensure as a sub-acute detoxification program is required. Clinical service provided by Substance Abuse Treatment Specialist (SATS) or Substance Abuse Treatment Practitioner (SATP) when working under the supervision of a SATS. Providers assessed by the state or its designee and confirmed to meet ASAM program level requirements for this level of care.	Initial length-of-stay authorizations may be for up to three days, with additional days authorized if there is clinical evidence that detoxification is not successful or complete and authorization requirements continue to be met.	Currently Available

ASAM Level of Care	Service Title	Service Description	Provider / Practitioner Qualifications	Limits	Availability
Level 3.7 WM – Medically Monitored Inpatient Withdrawal Management					
	Medically Monitored Inpatient Withdrawal Management	Services are inclusive of structured supervision within the 24-hour /7 day a week program, provided by available trained counselors who intervene to stabilize multidimensional aspects of imminent danger and other behaviors that are based in dysfunctional actions and require habilitation. The service is limited to stabilization of the medical effects of the withdrawal, and referral to necessary ongoing treatment and/or support services. The service, when clinically indicated, is an alternative to acute medical care provided by licensed health care professionals in a hospital setting.	Provider agency licensed and accredited as substance abuse treatment program. Clinical service provided by Substance Abuse Treatment Specialist (SATS) or Substance Abuse Treatment Practitioner (SATP) when working under the supervision of a SATS. These services must be staffed 24-hours-per-day, seven-days-per-week by a licensed physician or by the designated representative of a licensed physician. Providers assessed by the state or its designee and confirmed to meet ASAM program level requirements for this level of care.	Initial length-of-stay authorizations may be for up to three days, with additional days authorized if there is clinical evidence that detoxification is not successful or complete and authorization requirements continue to be met.	Currently Available

ASAM Level of Care	Service Title	Service Description	Provider / Practitioner Qualifications	Limits	Availability
Level 4 WM – Medically Managed Intensive Inpatient					
	Medically Monitored Inpatient Withdrawal Management	Severe, unstable withdrawal requiring 24-hour nursing care and daily physician visits. Inpatient medical acute detoxification services provided in a hospital setting must meet one of the following criteria as documented in the physician's orders and patient care plan: Vital signs, extreme and unstable; uncontrolled hypertension, extreme and unstable; delirium tremens, e.g., confusion, hallucinations, seizures or a documented history of delirium tremens requiring treatment; convulsions or multiple convulsions within the last 72 hours; unconsciousness; occurrence of SUD; with pregnancy, monitoring the fetus is vital to the continued health of the fetus; severe/complex medical conditions including insulin-dependent diabetes complicated by diabetic ketoacidosis; suspected diagnosis of closed head injury based on trauma injury; congestive heart disease, ischemic heart disease, or significant arrhythmia as examples of active symptomatic heart disease; suicidal ideation and gestures necessitating suicidal precautions as part of treatment; blood alcohol level 350 mg/dl with a diagnosis of alcohol abuse; blood alcohol level 400 mg/dl with diagnosis of alcohol dependence; active presentation of psychotic symptoms reflecting an urgent/emergent condition.	A hospital providing medically managed intensive inpatient services is accredited and licensed and staffed 24/7 to provide licensed nursing and physician services to patients requiring access to a range of services including ancillary such as laboratory, x-ray, nutrition services) and specialty physician services. The staff are licensed and credentialed by the hospital and meet the accreditation standards related to practice within their licensures. The inpatient unit must be staffed by physician and nursing personnel.	Service provided as medically indicated and through established medical protocols.	Currently Available
SUD SUPPORT SERVICES					

ASAM Level of Care	Service Title	Service Description	Provider / Practitioner Qualifications	Limits	Availability
	Recovery Supports	To support and promote recovery and prevent relapse through supportive services that result in the knowledge and skills necessary for an individual's recovery. Recovery programs are designed and delivered to and offer social, emotional, and/or educational supportive services to help prevent relapse and promote recovery.	Services can be provided by appropriately trained staff when working under the supervision of a SATS or SATP. A recovery coach or SUD peer specialist must be certified through an MDHHS-approved training program.	Available as medically necessary and appropriate (i.e., one to eight hours during a week; 9 to 19 hours in a week; 20 or more hours in a week.	Currently Available
	Peer Supports	To support and promote recovery and prevent relapse through supportive services that result in the knowledge and skills necessary for an individual's recovery. Peer recovery support programs are designed and delivered primarily by individuals in recovery (Recovery Coach) and offer social, emotional, and/or educational supportive services to help prevent relapse and promote recovery.	Services can be provided by appropriately trained staff when working under the supervision of a SATS or SATP. A recovery coach or SUD peer specialist must be certified through an MDHHS-approved training program.	Available as medically necessary and appropriate (i.e., one to eight hours during a week; 9 to 19 hours in a week; 20 or more hours in a week.	Currently Available
	Case Management	Referral/linking/coordinating/management of services - For the purpose of ensuring follow-through with identified providers, providing additional support in the community if primary services are to be provided in an office setting, addressing other needs identified as part of the assessment and/or establishing the beneficiary with another provider and/or level of care. This service may be provided individually or in conjunction with other services based on the need of the beneficiary.	Provider agency licensed and accredited as substance abuse treatment program. Clinical service provided by Substance Abuse Treatment Specialist (SATS) or Substance Abuse Treatment Practitioner (SATP) when working under	Available as medically necessary.	Currently Available

ASAM Level of Care	Service Title	Service Description	Provider / Practitioner Qualifications	Limits	Availability
			the supervision of a SATS. Services can be provided by appropriately trained staff when working under the supervision of a SATS or SATP. A recovery coach or SUD peer specialist must be certified through an MDHHS-approved training program.		

Use of Evidence-Based SUD Specific Patient Placement Criteria

One of the critical expectations that CMS set forth for 1115 demonstration waivers is a requirement that States use established standards of care in their design of the SUD benefit package, incorporating industry-standard benchmarks for defining medical necessity criteria, covered services, and provider qualifications. As previously indicated, Michigan has developed the continuum of SUD services using the treatment and recovery services for adolescents and adults recommended by the American Society of Addiction Medicine (ASAM).

To support the use of the ASAM criteria and aid in matching individuals with the appropriate level of care, Michigan is requiring its contracted Prepaid Inpatient Health Plans (PIHPs) and their SUD provider networks to use an assessment tool that utilizes the ASAM criteria. Some potential tools include, but are not limited to, the Global Appraisal of Individual Needs Initial Core (GAIN-I) assessment and the Level of Care Index (LOCI) assessment. Regardless of what tool is utilized, it must collect necessary information to provide a Diagnostic and Statistical Manual based diagnosis and recommend ASAM placement needs.

Pursuant to the STCs, MDHHS requires each PIHP to identify, select, and recommend to MDHHS an assessment tool for its region/SUD network within 18 months of the demonstration approval. Upon MDHHS review and approval, each PIHP must ensure the assessment tool is fully operational within 18-30 months of the demonstration's approval. After 30 months of the demonstration's approval, any assessment tool not approved will not be authorized for use. MDHHS is strongly encouraging and working with the PIHPs to implement a statewide solution for an assessment tool for the purposes of optimal efficiency and effectiveness in implementation, reliability of placements, and for evaluation rigor.

The PIHPs will continue to make authorization decisions for all treatment services regarding length of stay (including continued stay), change in level of care, and discharge based on the ASAM criteria. The PIHP will apply these decisions for both adolescents and adults. No predetermined limits of care will be established for these services. Access and continued involvement in a level of care will be based on individual need as determined through established medical necessity criteria.

The use of an ASAM assessment tool will allow the appropriate review and application of the ASAM dimensions and assist in matching the individual with a residential program that has been approved to provide the identified level of care. The PIHPs will also use the ASAM dimensions to establish the appropriate level of care for withdrawal management, outpatient and opioid treatment programs. This approach will solidify ASAM as the foundation of the entire SUD service system in Michigan.

For residential and withdrawal management services, PIHPs will use the six ASAM dimensions as a component of decision making for needed level of care. These are delineated below in Table 2:

Table 2:

Level of Care	Level 3.1	Level 3.3	Level 3.5	Level 3.7
Dimension 1 Withdrawal Potential	No withdrawal risk, or minimal/stable withdrawal; concurrently receiving Level 1-WM or Level 2-WM	Not at risk of severe withdrawal, or moderate withdrawal is manageable at Level 3.2-WM	At minimal risk of severe withdrawal. If withdrawal is present, manageable at Level 3.2-WM	At high risk of withdrawal, but manageable at level 3.7 WM and does not require the full resources of a licensed hospital
Dimension 2 Medical conditions and complications	None or very stable; or receiving concurrent medical monitoring	None or stable; or receiving concurrent medical monitoring	None or stable; or receiving concurrent medical monitoring	Requires 24-hour medical monitoring but not intensive treatment
Dimension 3 Emotional, behavioral, or cognitive conditions and complications	None or minimal; not distracting to recovery. If stable, a dual diagnosis capable program is appropriate. If not, a dual diagnosis-enhanced program is required	Mild to moderate severity; needs structure to focus on recovery. If stable, a dual diagnosis capable program is appropriate. If not, a dual diagnosis-enhanced program is required. Treatment should be designed to respond to any cognitive deficits	Demonstrates repeated inability to control impulses, or a personality disorder that requires structure to shape behavior. Other functional deficits require a 24-hour setting to teach coping skills. A dual diagnosis enhanced setting is required for the seriously mentally ill client	Moderate severity needs a 24-hour structured setting. If co-occurring mental health disorder present, requires concurrent mental health services in a medically monitored setting
Dimension 4 Readiness to change	Open to recovery but needs a structured environment to maintain therapeutic gains	Has little awareness and needs interventions available only at Level 3.3 to engage and stay in treatment; or there is high severity in this dimension but not in others. The client needs a Level I motivational enhancement program (Early Intervention)	Has marked difficulty engaging in treatment, with dangerous consequences; or there is high severity in this dimension but not in others. The client needs a Level I motivational enhancement program (Early Intervention)	Low interest in treatment and impulse control is poor, despite negative consequences; needs motivating strategies only safely available in a 24-hour structured setting
Dimension 5 Relapse, continued use, or continued problem potential	Understands relapse but needs structure to maintain therapeutic gains	Has little awareness and needs intervention only available at Level 3.3 to prevent continued use, with imminent dangerous consequences because of cognitive deficits o	Has no recognition of skills needed to prevent continued use, with imminently dangerous consequences	Unable to control use, with imminently dangerous consequences, despite active participation at less intensive levels of care
Dimension 6 Recovery/living environment	Environment is dangerous, but recovery achievable if Level 3.1	Environment is dangerous and client needs 24-hour structure to cope	Environment is dangerous and client lacks skills to cope outside of a highly structured 24-hour setting	Environment is dangerous and the patient lacks skills to cope outside of a highly structured 24-hour setting

Level of Care	Level 3.1	Level 3.3	Level 3.5	Level 3.7
	24-hour structure is available			

Use of Nationally Recognized SUD-Specific Program Standards to Set Provider Qualifications for Residential Treatment Facilities

An expectation for Michigan's 1115 Behavioral Health Demonstration is that the state implements a process to assess and demonstrate that residential providers meet ASAM criteria prior to participating in the Medicaid program. MDHHS ensures that providers meet key program requirements set forth by ASAM for each of the residential levels of care. Approximately 75 organizations provide the residential level of SUD treatment services in Michigan.

Currently, the State's laws and regulations that apply to organizations and practitioners rendering SUD services align with some of the ASAM program expectations. Michigan will maintain its robust process for ensuring the initial and ongoing qualification standards for individual providers of SUD treatment services. It utilizes state licensing, to ensure quality and competency of the provider network for publicly funded services based on educational and legal requirements for providing services as the initial standard.

State licensure for programs has four general categories that apply to:

1. Outpatient
2. Residential
3. Withdrawal Management (called sub-acute detoxification)
4. Opioid Treatment Programs (Methadone)

Additionally, any organization that provides SUD services for Medicaid beneficiaries must also be accredited by a national body. The following accreditation bodies are recognized in Michigan:

- The Joint Commission;
- Commission on Accreditation of Rehabilitation Facilities (CARF);
- American Osteopathic Association (AOA);
- Council on Accreditation of Services for Families and Children (COA);
- National Committee on Quality Assurance (NCQA); or
- Accreditation Association for Ambulatory Health Care (AAAHC).

The next level of standards is the credentialing of the individual clinical providers of services within each program. This includes the counselors, psychologists, social workers and medical staff along with their identified supervisors. In addition to having to meet professional licensing standards for education and experience to practice in the state, Michigan further delineates that an individual SUD provider must also be certified through the state board for the International Certification and Reciprocity Consortium (IC&RC). This certification ensures that individuals providing services in the publicly funded SUD service system have received additional experience and education in SUD treatment. The ongoing educational requirements that must be met in order to maintain that credential keeps knowledge current.

Michigan has set forth various treatment policies that establish additional guidance to providers and PIHPs regarding expectations for the structure of specific services and qualifications of providers. The policies on outpatient, residential, withdrawal management and opioid treatment programs are reflective of the ASAM requirements and delineate the criteria for levels of care within each respective area. These policies were effective for the fiscal year 18 contract the state has with the PIHPs for providing Medicaid services.

While the combination of licensing and policy guidance provides a firm foundation for providers to meet the program requirements set forth by ASAM, the State has taken an additional step to review providers against those requirements. After licensure and accreditation are established, each organization that is seeking to provide SUD treatment services (for adults and adolescents) must apply to the state to have an ASAM level assigned to their program. An application, in which the provider describes their program and submits policy evidence of compliance with ASAM, must be submitted for review. Based on the information submitted, the state will assign the appropriate ASAM level or reject the application. An organization is only able to join a PIHP network after a level has been assigned. The state has initiated and completed the initial ASAM designation enrollment process for early intervention, outpatient, residential, withdrawal management and opioid treatment programs. All PIHP contracted SUD treatment providers currently have an established ASAM level of care. A copy of the residential, withdrawal management and outpatient application instruments are in Attachment A.

The ASAM designation application process is always open, which allows new programs to apply so they may join a PIHP network. An online application process is being developed by the state to manage the assignment procedure. It is targeted to be available for use by the end of fiscal year 21 and moving forward. Until then, it will continue to be a manual, paper process. Michigan is working directly with national experts to provide training on the use of ASAM criteria. The training is targeted to providers to assist in overall education and program development. These trainings began in fiscal year 20 and will be complete in fiscal year 22

Standards of Care

The PIHPs are required to ensure that their providers and/or the intake agencies within their networks are all appropriately trained/educated in the application and use of ASAM. The frequency and duration of treatment services are expected to be guided by the ASAM criteria and individual need, not the designation of the provider program that may be conducting an assessment. PIHPs will provide evidence of initial training and ongoing training of providers during site reviews conducted by the state. Additionally, as part of quality monitoring during site reviews, clinical records will be reviewed to determine appropriate application and fidelity to ASAM processes. This quality monitoring will address the expectations that the assessment for all SUD services, level of care and length of stay recommendations has an independent third party reviewing and determining if the provider has the necessary competencies on the use of ASAM in the assessment process and determining an appropriate level of care. If the PIHP, or the state, determines during this monitoring that the provider is not using ASAM to make the appropriate level of care and length of stay decisions and recommendations, the state and PIHP will take the necessary corrective action.

The PIHP, through its contract with the state, is required to ensure an ongoing validation and re-validation processes for credentials of all providers in their network. Records must be maintained that show that any applicable licensure and certification are being maintained in good standing, the person is not excluded from Medicaid or Medicare participation and that criminal background checks are being made every other year. In addition to this, the PIHP also must ensure that any state licensing requirements surrounding scope of practice and supervision are being followed.

The contracts with the State require PIHPs to comply with the federal regulations to obtain, maintain, disclose, and furnish required information about ownership and control interests, business transactions, and criminal convictions as specified in 42 C.F.R. §455.104-106. In addition, the contract requires all PIHP ensure that any and all contracts, agreements, purchase orders, or leases to obtain space, supplies, equipment or services provided under the Medicaid agreement require compliance with 42 C.F.R. §455.104-106.

At the time of provider enrollment or re-enrollment in the PIHP's provider network, the PIHP is required to search the Office of Inspector General's (OIG) exclusions database to ensure that the provider entity, and any individuals with ownership or control interests in the provider entity (direct or indirect ownership of five percent or more or a managing employee), have not been excluded from participating in federal health care programs. Because these search activities must include determining whether any individuals with ownership or control interests in the provider entity appear on the OIG's exclusions database, the PIHP mandates provider entity disclosure of ownership and control information at the time of provider enrollment, re-enrollment, or whenever a change in provider entity ownership or control takes place.
The PIHP must notify the Division of Program Development, Consultation and Contracts, Behavioral Health and Developmental Disabilities Administration in MDHHS immediately if search results indicate that any of their network's provider entities, or individuals or entities with ownership or control interests in a provider entity are on the OIG exclusions database.

The MDHHS has responsibility and authority to make fraud and/or abuse referrals to the Office of the Attorney General, Health Care Fraud Division. Contractors who have any suspicion or knowledge of fraud and/or abuse within any of the MDHHS's programs must report directly to the MDHHS.

Sufficient Provider Capacity at Each Level of Care Including Medication Assisted Treatment for OUD

The ASAM enrollment work already completed by the state has established the initial provider capacity in the publicly funded system. The regional PIHPs can provide access to each ASAM Level of Care and the support services identified in Table 1. Residential treatment is available in all areas of the state. However, even with the use of IMD's, access to the more intensive level (3.7) has some limitations due to the geographic location of the program which may result in having to travel several hours to access this service from the rural areas of the state. Likewise, level 3.7-WM for withdrawal management, is in the same situation. There is access to this service however, getting to the program from a frontier or rural area may result in a significant amount of travel. The medically managed residential (4.0) and withdrawal management (4-WM)

levels of care, which are not a component of this 1115 Waiver, are more readily available due to these services being provided in a medical hospital setting. These services are being identified to demonstrate that the full ASAM Level of Care continuum is available in the state.

Opioid Use Disorder treatment has accessibility beyond just the Opioid Treatment Programs due to the availability of the Office Based Opioid Treatment services through primary care and other private practice practitioners. Many contracted providers work with these practitioners to provide the required treatment and support services that are not typically available in a primary care or other practice setting. Additionally, the state recognizes the importance of having medication assisted treatment available to address opioid abuse (and other substances when appropriate) in any level of care. PIHPs are required to ensure that their network providers support all avenues to an individual's recovery by providing access to medication assisted treatment when it is clinically appropriate. This access can be provided directly by a program or through an arrangement with another provider. In addition to providing access during treatment in a program, there must be appropriate arrangements for continuing treatment as part of the discharge and recovery plan for each beneficiary. Finally, MDHHS promulgated policy requiring its PIHPs to comply with network adequacy standards, including opioid treatment programs. This policy was activated in FY19.

The state has a commitment to ensure the SUD treatment needs of children and adolescents are met. Statewide, an estimated 127,000 (14%) youth aged 16-21 have a substance use disorder. Thirty-seven percent of those youth also had identified mental health concerns. 4% of adolescents (12-16) used pain relievers for nonmedical reasons. In 2018, a total of 2,591 substance abuse treatment admissions for youth were reported by publicly funded SUD programs.

Adolescents require different models of service than adults. As indicated in Table 1, adolescents that are enrolled in the Medicaid program and have or are at risk of a SUD will have access to early intervention, treatment and recovery services. Specifically, adolescents will have access to the following services:

- Early Intervention Services, including, but not limited to Screening, Brief Intervention, and Referral to Treatment (SBIRT).
- Outpatient Services including initiation services (assessment and treatment planning), individual, group and family therapy, crisis intervention services
- Intensive Outpatient Program and Partial Hospitalization
- Residential Services (3.1, 3.5 and 3.7)
- Inpatient Services (4.0)

Adolescents will also have access to the various Withdrawal Management Services set forth in the Continuum of Care Sections. When appropriate, older adolescents will also have access to SUD medications as part of the State's Medication Assisted Treatment approach.
While the current continuum reflects services that can be effective for treating adolescents with SUD, the state is aware that the current system of care reflects poor penetration rates for the

treatment of adolescents and transitional youth age. Only approximately 8% of those with an identified need are receiving SUD treatment services.

In response, the state has developed the Michigan Youth Treatment Improvement and Enhancement (MYTIE) initiative. This began with a two-year Planning project (SYT-P grant October 2015), and has extended an extra four years (SYT-I grant ending September 2021). MYTIE is guiding the state through the development and implementation of an effective continuum of care for transitional aged youth 16-21 years of age and their caregivers, with the goal of increased access to and improved quality of treatment and recovery support services. MYTIE has several goals, including:

- Establish state infrastructure that will increase service access, treatment and recovery support service use and quality for transitional youth aged 16-21;
- Establish partnerships with key stakeholders for the purpose of developing policies, expanding workforce capacity, disseminating age and developmentally appropriate evidence-based practices, and implementing financial mechanisms;
- Implementation of a statewide assessment tool to increase ease of transfer of services within the continuum of care and to reduce trauma caused by the recounting of historical traumatic events by the client;
- Identify issues and barriers that affect access and treatment of SUD and co-occurring disorders;
- Identify disparities that effect access to treatment;
- Promote the development of statewide family and youth support organizations;
- Develop a strategic plan to guide needed changes to the service delivery system.

Information regarding the MYTIE program and a description of current activities regarding the needs assessment and workforce development can be found at: http://www.michigan.gov/mdhhs/0,5885,7-339-71550_2941_4871_4877_77211---,00.html. Information from the gap's analysis in the MYTIE program will assist the State and PIHPs in their network development strategies, including age-appropriate recovery support services for adolescents.

Implementation of Comprehensive Treatment and Prevention Strategies to Address Opioid Abuse and OUD

Former Governor Rick Snyder created a Prescription Drug and Opioid Task Force in 2015 to address the growing prescription drug and opioid problem in Michigan. This work has been continued by current Governor Gretchen Whitmer. The task force reported the following information on the escalation of Michigan's problem.

According to published raw data from the Michigan Automated Prescription System (MAPS), more than 11 million prescriptions for controlled substances were written in 2016. This is roughly one million more prescriptions than were written in 2011, even though Michigan's population slightly decreased over the same time period.

Of the 11 million controlled substance prescriptions written in 2016, 10 million were for schedule II drugs. Schedule II drugs are classified by the U.S. Drug Enforcement Agency (DEA) as having a high potential for abuse and dependence. This compares with just four million schedule II prescriptions in 2011. This acute increase in schedule II prescriptions was due to the addition of Hydrocodone to the list of schedule II drugs in 2014.

The task force made recommendations under five areas: Prevention, Treatment, Regulation, Policy and Outcomes, and Enforcement. Many of the recommendations addressed the three critical areas set forth by the Secretary of Health and Human Services: provider education, increased access to Naloxone and strategies to increase Medication Assisted Treatment (MAT).

Prevention

1. Require additional training for all professionals who will be prescribing controlled substances, including training on the new CDC prescribing guidelines.
    a. State Targeted Response (STR) grant funds a project through the University of Michigan that has been offering training on the CDC prescribing guidelines.
    b. Medicaid is also tracking prescribing outliers and offering technical assistance and guidance to reducing the prescribing appropriately. (State Opioid Response {SOR} grant funded)

2. Development and maintenance of relationships among state and local agencies to provide necessary information regarding prescription drug abuse, prevention and treatment.
    a. Partnership for Success (PFS) funding provides resources to establish State and Community level infrastructure for Prevention Prepared Communities that includes the capacity to develop and implement data guided programming. PFS funds State and Community level Epidemiological Outcomes Workgroups charged with collecting, analyzing and reporting on morbidity, mortality, prevalence, incidence, trend and social indicator data need to identify the extent of prescription drug abuse and the need for prevention and treatment services at the State and Community levels.

3. Collaboration among local coalitions, pharmacies, health profession boards, state agencies and the DEA to increase the availability of prescription drop off bins.
    a. Collaboration among coalitions, pharmacies, DEA State and local law enforcement continues to occur in various Prepaid Inpatient Health Plan target communities funded by the PFS and other federal, state and local resources.

4. Review programs and parameters established within the Medicaid system as well as actions taken by other states to determine the best route forward to eliminate doctor and pharmacy shopping. Recommend looking at programs already in use in Tennessee and Washington.
    a. MDHHS employs a Benefits Monitoring System that flags Medicaid Beneficiaries that are pharmacy shopping and doctor shopping to acquire additional opioid prescriptions than legally prescribed. Beneficiaries that are flagged are contacted and limited to one pharmacy and one prescriber for opioid prescriptions.

5. Public awareness campaign to inform the public of the dangers of abuse, how to safeguard and properly dispose of medicines, publicize improper prescribing practices, and reduce the stigma of addiction. (www.michigan.gov/opioids)

Treatment

1. Pursue increased public awareness regarding the laws that limit civil and criminal liabilities for administering Naloxone.
    a. While Michigan has laws that limit civil and criminal liabilities for administering Naloxone, there has not been any major public campaigns to publicize the laws. Children's Services Agency staff are not allowed to carry it or be trained because of potential liability issues.

2. Explore the possibility of limited statutory immunity for low-level offenses involved in reporting an overdose and seeking medical assistance.
    a. Michigan has a Good Samarian Law which prevents drug possession charges against those that seek medical assistance in certain circumstances.

3. Explore ways for the State to increase access to care, including wraparound services and MAT, as indicated by national and state guidelines for treatment. In addition, the Task Force recommends that insurance companies consider providing health plans that cover the costs of MAT with reasonable quantity limits on medication used.
    a. The State Targeted Response (STR) and SOR grant both increase access to care, increase access to case management and peer services, and increase access to MAT through DATA 2000 waiver training and development of a SUD specific curriculum for medical schools.
    b. Initiation of an Opioid Health Home in a PIHP region to make treatment more assessible for Medicaid beneficiaries with an OUD. Look alike model being developed for Michigan's Upper Peninsula using SOR funding.

4. Explore ways to increase the number of addiction specialists practicing in Michigan.
    a. SOR project promoting the development of a curriculum specific to substance use disorders to be used in medical schools to prepare physicians entering the field.

5. Additional training for law enforcement in the area of recognizing and dealing with addiction for those officers who do not deal directly with narcotics regularly. The Task Force also recommends expansion of treatment courts as called for by former Governor Rick Snyder in his 2015 Criminal Justice Message, as well as expanding the courts' ability to create pilot programs for the use of MAT.
    a. There has been a significant increase in the number of Drug Courts implementing MAT programming. MDHHS has provided several trainings on the efficacy of MAT to Michigan Drug Court Professionals including judges.

6. Require a bona-fide physician-patient relationship as defined in Michigan law prior to prescribing controlled substances.

7. The State should review current best practice guidelines for reducing the development of neonatal abstinence syndrome (NAS) and consider pilot programs for the development of testing of pregnant women to reduce the risk of NAS caused by prescription drug and opioid abuse.
    a. The state and other entities are piloting several initiatives to identify pregnant women who are using opioids and connect them to any services needed including treatment and other supports.

Regulation

1. Consider legislation to better define and identify pain management practice for the purposes of licensing.

   Update regulations to delineate licensing for clinics (methadone) based on the population being treated. The State should consider a tiered system of licensing that regulates the functions and prescription capabilities of the clinics and their staff.

2. Recommend the establishment of an exemption from civil liability when a pharmacist is acting in good faith and has reasonable doubt regarding the authenticity of the prescription or believes the prescription is being filled for non-medical purposes.

3. Review the Michigan College of Emergency Physicians policy and then endorse a best practices policy that hospitals and doctors could use as a model.

4. Review the limitation of the sale of pseudoephedrine by pharmacies only.

Policy and Outcomes

1. Create an ongoing Prescription Drug and Opioid Task Force or Commission to evaluate the efficacy of current proposals and continually develop new solutions to address societal changes.

2. Add outcomes to the State Dashboard to track the success of efforts.

3. The State should consider mechanisms to ensure patient continuity of care during an abrupt closure of a medical practice to ensure that necessary treatments can continue without interruption.

4. Document law enforcement efforts with local coalitions and focus groups that have resulted in a reduction of prescription overdose deaths to determine if replication and expansion are possible and warranted.

Enforcement

1. Review the budgetary requirements for updating or replacing the Michigan Automated Prescription System (MAPS.) There should be mandatory registration in MAPS by all licensed prescribers to ensure all are registered when the updated or new system is brought online.
    a. The MAPS upgrades were completed with the new Appriss software. STR grant funds were used to help support the additional NarxCare portion of the Appriss program.

2. Allow broader access to MAPS for law enforcement purposes when investigating questionable business practices by prescribers.
    a. Requires legislation with is being reviewed.

3. Require enhanced licensing sanctions for health professionals that violate proper prescribing and dispensing practices.

The Department of Licensing and Regulatory Affairs which oversees all healthcare professional and healthcare organization licensure is actively involved in providing education about the use of opiate medications and pain management. Information regarding the activities, groups and educational materials can be found at the following website: http://www.michigan.gov/lara/0,4601,7-154-72600_72603_45947---,00.html .

To compliment and implement the recommendations of the Task Force, the former Governor, in June 2016, established the Prescription Drug and Opioid Abuse Commission (PDOAC). Consequently, the former Governor and a bi-partisan group of legislators announced a package of bills to combat opioid and prescription drug misuse which were signed into law in December of 2017. The legislation included:

- Prescribers documenting a bona-fide patient relationship prior to prescribing opioids;
- A seven-day prescribing limit for acute pain;
- The development of a prescription drug education curriculum in schools; and
- Mandated greater patient education requirements including a new consent form effective 2018

MDHHS is actively involved in statewide efforts to address the increasing use of both illegal and prescription opiates in conjunction with recommendations made by the Task Force and the implementation strategies provided by the PDOAC. In addition to ensuring that a variety of treatment and recovery support services are available, MDHHS, under the direction of the Single State Authority, is actively involved in supporting prevention activities around the state that are aimed at decreasing opiate use and providing education on the impacts of use. Some of these efforts include:

- Increase multi-system collaboration at state and community levels

- Assure and monitor PIHPs to develop and implement action plans for the prevention of prescription and over-the-counter drugs to prevent unintentional deaths from drug overdoses.
- Provide training to strengthen infrastructure to enhance substance use disorder prevention and mental health promotion at the community/coalition level.
- Promote to develop leadership structure combining MDHHS, Licensing and Regulatory Affairs, Law Enforcement and other stakeholders to oversee surveillance, intervention, education and enforcement to prevent illegal distribution and use of controlled substances.
- Secure federal discretionary funding to implement the activity listed above.

- Broaden statewide media messages
  - Promote the use of statewide media campaigns entitled: Stop Overdoses (www.michgan.gov/stopverdoses) and Do Your Part: Be the Solution to Prevent Prescription Drug Abuse (www.michigan.gov/doyourpart), that include information portals for parents, physicians, youth, educators and the general public interested in learning about prescription drug and opioid abuse.

- Broaden Rx/OTC drug abuse education and use of brief screenings in behavioral and primary health care settings
  - Ensure that public health approached to the delivery of early intervention such as SBIRT are implemented in behavioral and primary health care settings by providing funding and training
  - Ensure on-going surveillance to monitor data relevant to drug overdoses and deaths from drug overdoses

Michigan published Medication Assisted Treatment guidelines that are consistent with the federal guidelines and contain detailed guidance for treating people addicted to heroin and other opiates. The guidelines define mild, moderate and severe levels of addiction and then recommend appropriate medication and behavioral therapy that research has shown to be most effective for that level of addiction. These guidelines are considered best practice and have led efforts on changing how treatment should be delivered and viewed in Michigan during the implementation of the waiver.

Recent legislation has allowed Naloxone to be made available to first responders and law enforcement and it is being used in communities around the state. Additional legislation was passed to allow family members of those with opioid prescriptions to receive Naloxone as an additional way to prevent death from overdose.

Improved Care Coordination and Transitions Between Levels of Care

Care Transitions

Benefit management for SUD services has been the responsibility of the PIHPs since 2014. The PIHP employs utilization management for prior authorization and continued stay reviews which

include applying the ASAM criteria to identify the more appropriate individual treatment and support needs. Eligibility to receive services is based on medical necessity criteria that are outlined through currently established guidelines. These criteria were created for both behavioral health and developmental disabilities services and read as follows:

Medical Necessity Criteria
Mental health, developmental disabilities, and substance use disorder services are supports, services, and treatment:

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

The policy then further delineates how the medical necessity criteria are to be applied when determining the needs of an individual:

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

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

Consistent with parity rules, the benefits available in this demonstration will not have preset limits placed on them. There will be individual determination of medical and clinical necessity by qualified providers for each beneficiary for initial and ongoing care needs. The frequency and

duration of treatment services are expected to be guided by the ASAM criteria, which is a standardized process based on significant research evidence and application. As set forth in the Standards of Care discussion, PIHPs make authorization decisions (initial and continuing stay) regarding residential length of stay, change in LOC and discharge based on the ASAM criteria. PIHPs will continue to apply the ASAM criteria to both outpatient and residential services for adolescents and adults. In addition, PIHPs will make information regarding medical necessity and information regarding denials or changes in lengths of stay for residential services available to the client or the provider. The PIHP must disseminate all practice guidelines it uses to all affected providers and upon request to beneficiaries.

Care Coordination and Integration Models

MDHHS is committed to integrating physical and behavioral health care services for beneficiaries with behavioral health conditions and has been implementing several solutions to improve care coordination and care transitions to ensure warm hand-offs and successful engagement in treatment and transitions across levels of care, particularly for high-risk cohorts with complex care needs. This includes the implementation of Michigan's Opioid Health Home (OHH) under Section 1945 of the US Social Security Act. Michigan's OHH is predicated on the evidence-based collaborative care model and utilizes a multidisciplinary team to serve the whole-person. This includes primary, behavioral, and social services under the auspice of a recovery-oriented philosophy. Michigan implemented the OHH in one PIHP region in FY19 and is in the process of expanding the OHH several more regions at the beginning of FY21. Michigan will continue to work with stakeholders to develop a framework to evaluate successful care transitions to outpatient care, including hand-offs between levels of care within the SUD care continuum as well as linkages with primary care upon discharge.

In FY19, MDHHS was also awarded a five-year SAMHSA Promoting the Integration of Primary and Behavioral Health Care (PIPBHC) grant, which is predicated on integrating care between Community Mental Health Services Programs (CMHSPs) and Federally Qualified Health Centers (FQHCs). MDHHSs subgrantees indicated SUD as a focal point for integration, particularly in the context of assuring access to medication assisted treatment and overarching physical and behavioral health needs. Michigan also has several Certified Community Behavioral Health Care (CCBHC) expansion grantees, which primes Michigan as a potential expansion state should the CMS demonstration be augmented. This would further Michigan's vision to optimize its care integration/coordination for Medicaid beneficiaries with SUD.

Medicaid Health Plan (MHP) and Prepaid Inpatient Health Plan Coordination Agreement Requirements

MDHHS requires Medicaid Health Plans (MHP) and PIHPs to establish and implement coordination agreements with each other to better integrate services covered by MHPs and the PIHPs as well as provide incentives to support behavioral health integration. Managed care entities are also contractually required to collaborate and develop shared metrics to measure the quality of care provided to beneficiaries jointly served by MHPs and PIHPs.

MHPs and PIHPs have collaborated with MDHHS to establish a uniform process for identifying high-risk individuals and stratify populations as required under the MHP contract, which state in part that MHPs must work collaboratively with PIHPs to:

- Identify and coordinate the provision of services to shared members who have significant behavioral health issues and complex physical co-morbidities.
- Jointly create and implement a method for stratifying shared members who have significant behavioral health issues and complex physical co-morbidities.
- Jointly develop care management standards for providing care management services to shared members with significant behavioral health issues and complex physical co-morbidities based on patient needs and goals.
- Jointly develop and implement processes for providing coordinated complex care management services for shared members with significant behavioral health issues and complex physical co-morbidities.
- Jointly create a care management tool used by staff from each organization to document a jointly created care plan and to track contacts, issues, and services regarding shared members with significant behavioral health issues and complex physical co-morbidities.
- Hold case reviews at least monthly during which the care managers and other team members, including community health workers, pharmacists, medical directors and behavioral health providers, must discuss shared members with significant behavioral health issues and complex physical co-morbidities, and develop shared care management interventions.
- Work collaboratively with PIHPs, primary care providers, and MDHHS to develop and implement performance improvement projects involving shared metrics and incentives for performance.
- Report to MDHHS the results of shared metric performance incentive programs in a manner determined by MDHHS.

SUD Health IT Plan

See Michigan's Approved SUD Health IT Plan

Attachment A

- Document #1: MDHHS ASAM Residential Level of Care Designation Questionnaire
- Document #2: MDHHS ASAM Outpatient Level of Care Designation Application
- Document #3: MDHHS ASAM Withdrawal Management Level of Care Designation Application

MDHHS ASAM Residential Level of Care Designation Questionnaire

The Michigan Department of Health and Human Services (MDHHS) is required to designate the ASAM level of care for all licensed **residential treatment** facilities. In order to make this determination, the following questionnaire is required to be filled out for each licensed facility seeking to provide publicly funded services. The information provided and submitted with this questionnaire will allow MDHHS to assign an ASAM level for the program.

Program/Facility Name:

Facility Address:

City/State/Zip:

License Number:

Treatment Capacity:

Please indicate the ASAM Level being applied for:

- ☐ 3.1 Clinically Managed Low Intensity
- ☐ 3.3 Clinically Managed Population Specific High Intensity
- ☐ 3.5 Clinically Managed High Intensity
- ☐ 3.7 Medically Monitored Intensive Inpatient Services

Please indicate the population served by the program:

☐ Adolescent ☐ Adult

Please indicate which Pre-paid Inpatient Health Plan(s) the program is currently contracted with or planning to contract with to provide services: (check all that apply)

- ☐ Community Mental Health Partnership of Southeast Michigan
- ☐ Detroit Wayne Mental Health Authority
- ☐ Lakeshore Regional Entity
- ☐ Macomb County Community Mental Health Services
- ☐ Mid-State Health Network
- ☐ Northcare Network
- ☐ Northern Michigan Regional Entity
- ☐ Oakland County Community Mental Health Authority
- ☐ Region 10 Pre-paid Inpatient Health Plan
- ☐ Southwest Michigan Behavioral Health

SERVICE DELIVERY and SETTING

Please indicate the type of setting where services are provided.

1) ☐ Freestanding community setting.
2) ☐ Unit within a licensed health care facility.
3) ☐ Secure community setting in the criminal justice system.
4) On average, over the past 90 days, what percentage of residents were treated for moderate or severe substance use disorders: (Total must equal 100%)
    a. Without a co-occurring mental health disorder – %
    b. Combined with a co-occurring mental health disorder – %
    c. Combined with functional limitations that were primarily cognitive in nature? (For example: Traumatic Brain Injury, Dementia, Memory Problems) – %

SUPPORT SYSTEMS

Please select "yes" or "no" for each of the following questions:

1) Telephone or in-person consultation with physician and emergency services available 24/7? ☐Yes ☐No

2) Direct affiliations with other levels of care and/or close coordination for referrals to other services? ☐Yes ☐No

3) Ability to conduct and/or arrange for laboratory/toxicology tests or other needed procedures. ☐Yes ☐No

4) Ability to arrange for pharmacotherapy for psychiatric or anti-addiction medications. ☐Yes ☐No

5) Psychiatric/psychological consultation available as needed.
☐Yes ☐No

STAFF

Please select "yes" or "no" for each of the following questions:

1) Professional staff available on-site 24 hours a day.
☐Yes ☐No

2) Treatment team consists of medical, addiction and mental health professionals.
☐Yes ☐No

3) One or more clinicians available on site or by telephone 24 hours a day.
☐Yes ☐No

4) Please indicate program staff conducting each service.

Check all that apply on the following table:

License or Certification/	Individual Counseling	Group Counseling	Didactic/ Educational	COD Treatment	Medical RX
MD/DO	☐	☐	☐	☐	☐
LP/LLP/TLLP	☐	☐	☐	☐	☐
LMFT/LLMFT	☐	☐	☐	☐	☐
LPC/LLPC	☐	☐	☐	☐	☐
RN, NP, LPN	☐	☐	☐	☐	☐
PA	☐	☐	☐	☐	☐
LMSW/LLMSW	☐	☐	☐	☐	☐
LBSW/LLBSW	☐	☐	☐	☐	☐
CADC-M/CADC	☐	☐	☐	☐	☐
CAADC	☐	☐	☐	☐	☐
CCJP-R	☐	☐	☐	☐	☐
CCDP	☐	☐	☐	☐	☐
CCDP-D	☐	☐	☐	☐	☐
CCS-M	☐	☐	☐	☐	☐
CCS-R	☐	☐	☐	☐	☐
DP-S	☐	☐	☐	☐	☐
DP-C	☐	☐	☐	☐	☐

THERAPIES

Please describe the therapy services that are available:

1) Planned clinical program activities (professionally directed) hours per week:

2) Focus of counseling and clinical program activities:

3) Recovery support services available:

4) Involvement of family members and significant others?
☐Yes ☐No

5) Medication assisted treatment available?
☐Yes ☐No

6) Monitoring of medication adherence (for behavioral health and physical health)?
☐Yes ☐No

7) Use of random drug screens to monitor compliance?
☐Yes ☐No

8) Please attach a weekly schedule of services with the individual, group, educational and/or other treatment services labeled, in order to validate the service hours listed above. Please attach other programmatic documentation that will support the ASAM Level for which approval is being sought.

ASSESSMENT/ TREATMENT PLAN REVIEW

Does the program's assessment & treatment plan review include:

1) Individualized, comprehensive bio-psychosocial assessment utilized?
☐Yes ☐No

2) Individualized treatment plan, developed in collaboration with client and reflects client's personal goals?
☐Yes ☐No

3) Daily assessment of progress and treatment changes?
☐Yes ☐No

4) Physical examination by (MD/DO, PA, NP) performed as part of initial assessment/admission process?
☐Yes ☐No

5) Ongoing transition/continuing care planning?
☐Yes ☐No

I CERTIFY THAT THE INFORMATION PROVIDED REGARDING THE OPERATION OF THIS PROGRAM IS ACCURATE, TRUE, AND COMPLETE IN ALL MATERIAL ASPECTS. (Electronic signatures are acceptable)

AUTHORIZED INDIVIDUAL	TITLE	SIGNATURE	DATE

ENTER THE CONTACT INFORMATION OF THE PERSON THAT CAN BE REACHED FOR FOLLOW-UP IF NEEDED.

NAME	TITLE	EMAIL	TELEPHONE

MDHHS ASAM Outpatient Level of Care Designation Application

The Michigan Department of Health and Human Services (MDHHS) is required to designate the ASAM level of care for all licensed **outpatient treatment** programs. In order to make this determination, the following questionnaire is required to be filled out for each licensed program seeking to provide publicly funded services. The information provided and submitted with this questionnaire will allow MDHHS to assign an ASAM level for the program.

Program/Facility Name:

Facility Address:

City/State/Zip:

License Number:

Treatment Capacity:
(If Applicable)

Please indicate the ASAM Level being applied for (select only one):

- ☐ 0.5 Early Intervention
- ☐ 1 Outpatient Services
- ☐ 2.1 Intensive Outpatient Services
- ☐ 2.5 Partial Hospitalization Services

Please indicate the population served by the program:

☐ Adolescent ☐ Adult

Please indicate which Pre-paid Inpatient Health Plan(s) the program is currently contracted with (or planning to contract with for new programs) to provide services:
(check all that apply)

☐ Community Mental Health Partnership of Southeast Michigan
☐ Detroit Wayne Mental Health Authority
☐ Lakeshore Regional Entity
☐ Macomb County Community Mental Health Services
☐ Mid-State Health Network
☐ Northcare Network
☐ Northern Michigan Regional Entity
☐ Oakland County Community Mental Health Authority
☐ Region 10 Pre-paid Inpatient Health Plan
☐ Southwest Michigan Behavioral Health

SERVICE DELIVERY and SETTING

Please indicate the type of setting where services are provided.

☐ Behavioral health clinic/office-based program

☐ Primary care office/clinic

☐ Integrated care clinic (combined physical and behavioral health)

☐ Work sites

☐ School

☐ Community based

☐ Individuals home

On average, over the past 90 days, what percentage of clients with a substance use disorder were served **(Level 0.5 programs can skip this)**: (Total must equal 100%)

d. Without a co-occurring mental health disorder – %
e. Combined with a co-occurring mental health disorder – %

SUPPORT SYSTEMS

Please select "yes" or "no" for each of the following questions:

6) Does your program provide referral and linking to ongoing treatment?

☐Yes ☐No

7) Does your program provide referral for community social services?
☐Yes ☐No

8) Are emergency services available 24/7 outside normal program hours?
☐Yes ☐No

9) Does your program have direct affiliations with other levels of care and/or close coordination for referrals to other services?
☐Yes ☐No

10) Does your program have the ability to conduct and/or arrange for laboratory/toxicology tests or other needed procedures?
☐Yes ☐No

11) Does your program have the ability to arrange for pharmacotherapy for psychiatric or anti-addiction medications?
☐Yes ☐No

12) Are psychiatric and medical consultation available within 24 hours by phone and in person based on severity of condition (Level 1)?
☐Yes ☐No

13) Are psychiatric and medical consultation available within 24 hours by phone and 72 hours in person (Level 2.1)?
☐Yes ☐No

14) Are psychiatric and medical consultation available within 8 hours by phone and 48 hours in person (Level 2.5)?
☐Yes ☐No

STAFF

Please select "yes" or "no" for each of the following questions:

4) Do you employ trained personnel who are knowledgeable about substance use and addiction?
☐Yes ☐No

5) Is counseling/therapy provided by appropriately licensed and credentialed professionals?
☐Yes ☐No

6) Is there a generalist physician(s) and/or physician assistant(s) available?
☐Yes ☐No

7) Are nursing staff available?
☐Yes ☐No

8) Is the physician(s) or physician assistant specially trained in addiction medicine?
☐Yes ☐No

9) Are staff cross-trained in mental health, psychotropic medications and interactions with addictive substances?
☐Yes ☐No

7) Please indicate program staff conducting each service.

Check all that apply on the following table:

License or Certification/ Registration	Screening and/or Assessment	Individual Counseling Sessions	Group Counseling Sessions	Didactic/ Educational Sessions	COD Treatment Services	Medical RX
MD/DO	☐	☐	☐	☐	☐	☐
LP/LLP/TLLP	☐	☐	☐	☐	☐	☐
LMFT/LLMFT	☐	☐	☐	☐	☐	☐
LPC/LLPC	☐	☐	☐	☐	☐	☐
RN, NP, LPN	☐	☐	☐	☐	☐	☐
PA	☐	☐	☐	☐	☐	☐
LMSW/LLMS	☐	☐	☐	☐	☐	☐
LBSW/LLBSW	☐	☐	☐	☐	☐	☐
Occupational Therapist	☐	☐	☐	☐	☐	☐
Recreational Therapist	☐	☐	☐	☐	☐	☐
CADC-	☐	☐	☐	☐	☐	☐
CAADC	☐	☐	☐	☐	☐	☐
CCJP-R	☐	☐	☐	☐	☐	☐
CCDP	☐	☐	☐	☐	☐	☐
CCDP-D	☐	☐	☐	☐	☐	☐
CCS-M	☐	☐	☐	☐	☐	☐
CCS-R	☐	☐	☐	☐	☐	☐
DP-S	☐	☐	☐	☐	☐	☐
DP-C	☐	☐	☐	☐	☐	☐
Recovery	☐	☐	☐	☐	☐	☐
Specifically, trained staff	☐	☐	☐	☐	☐	☐

Specifically, trained staff explanation:

THERAPIES

Please describe the following in reference to the program:

9) Focus of program activities for the level of care requested in this application:

10) Recovery support services:

Please select "yes" or "no" for each of the following questions:

11) Individual therapy/counseling/psychotherapy provided?
☐Yes ☐No

12) Group therapy provided?
☐Yes ☐No

13) Family therapy provided?
☐Yes ☐No

a. If provided is there involvement of family members, guardians and significant others in the assessment, treatment and continuing care of the client?
☐Yes ☐No

14) Educational/didactic services provided?
☐Yes ☐No

15) Occupational therapy?
☐Yes ☐No

16) Recreational therapy available?
☐Yes ☐No

17) Medication management (SUD) available?
☐Yes ☐No

18) Medication management (mental health) available?
☐Yes ☐No

19) Monitoring of medication adherence (for behavioral health and physical health)?
☐Yes ☐No

20) Use of laboratory and toxicology services (on-site/consultation/referral)?

☐Yes ☐No

21) For **Levels 2.1 and 2.5** please submit a weekly schedule of services with the individual, group, educational and/or other treatment services labeled to verify the minimum number of hours of skilled treatment services for the level are available.

ASSESSMENT/ TREATMENT PLAN REVIEW

Indicate if the program's assessment & treatment plan review processes include the following?

6) Screening to rule in or out substance related addictive disorders?

☐Yes ☐No

7) Assessment of ASAM dimensional risk and severity of need performed prior to and throughout the process of delivering services?

☐Yes ☐No

8) Individualized, comprehensive bio-psychosocial assessment utilized?

☐Yes ☐No

9) Physical examination by (MD/DO, PA, NP) available for conditions as warranted based on physician approved protocols?

☐Yes ☐No

10) Individualized treatment plan, developed in collaboration with client and reflects client's personal goals?

☐Yes ☐No

11) Treatment plan reviews are conducted at specified times, as noted in the plan or with a frequency as determined by appropriately credentialed staff?

☐Yes ☐No

12) Documentation of mental health problems and relationship to substance use disorder?

☐Yes ☐No

13) Documentation of progress and treatment changes?

☐Yes ☐No

14) Ongoing recovery/continuing care planning?

☐Yes ☐No

I CERTIFY THAT THE INFORMATION PROVIDED REGARDING THE OPERATION OF THIS PROGRAM IS ACCURATE, TRUE, AND COMPLETE IN ALL MATERIAL ASPECTS. (Electronic signatures are acceptable)

AUTHORIZED INDIVIDUAL	TITLE	SIGNATURE	DATE

ENTER THE CONTACT INFORMATION OF THE PERSON THAT CAN BE REACHED FOR FOLLOW-UP IF NEEDED.

NAME	TITLE	EMAIL	TELEPHONE

MDHHS ASAM Withdrawal Management Level of Care Designation Application

The Michigan Department of Health and Human Services (MDHHS) is required to designate the ASAM level of care for all licensed **withdrawal management** treatment facilities. In order to make this determination, the following questionnaire is required to be filled out for each licensed facility seeking to provide publicly funded services. The information provided and submitted with this questionnaire will allow MDHHS to assign an ASAM level for the program.

Program/Facility Name:

Facility Address:

City/State/Zip:

License Number:

Treatment Capacity:

Please indicate the ASAM Level being applied for: (Select Only One)

☐ Level 1-WM – Ambulatory Withdrawal Management without Extended On-site Monitoring (Outpatient Withdrawal Management)

☐ Level 2-WM – Ambulatory Withdrawal Management with Extended On-site Monitoring (Outpatient Withdrawal Management)

☐ Level 3.2-WM – Clinically Managed Residential Withdrawal Management (Residential Withdrawal Management)
☐ Level 3.7-WM – Medically Monitored Inpatient Withdrawal Management (Residential Withdrawal Management)

Please indicate the population served by the program:
☐ Adolescent ☐ Adult

Please indicate which Pre-paid Inpatient Health Plan(s) the program is currently contracted with or planning to contract with to provide services: (check all that apply)
☐ Community Mental Health Partnership of Southeast Michigan
☐ Detroit Wayne Mental Health Authority
☐ Lakeshore Regional Entity
☐ Macomb County Community Mental Health Services
☐ Mid-State Health Network
☐ NorthCare Network
☐ Northern Michigan Regional Entity
☐ Oakland County Community Mental Health Authority
☐ Region 10 Pre-paid Inpatient Health Plan
☐ Southwest Michigan Behavioral Health

SERVICE DELIVERY and SETTING

Please indicate the type of setting where services are provided:

1) ☐ Client Home
2) ☐ Office or agency setting
3) ☐ Healthcare facility
4) ☐ Day hospital or residential type setting
5) ☐ Freestanding withdrawal management facility

Please indicate how services are provided in the program:

☐ Regularly scheduled services.
☐ Services delivered under physician approved policies and procedures or clinical protocols.

SUPPORT SYSTEMS

Please select “yes” or “no” for each of the following questions:

1) Available specialized psychological and psychiatric/clinical consultation and supervision.

☐Yes ☐No

2) Comprehensive medical history and physical examination completed as part of admission. ☐Yes ☐No

3) Affiliation with other levels of care, including other specialty substance use disorder treatment. ☐Yes ☐No

4) Ability to conduct and or arrange for laboratory/toxicology tests.
☐Yes ☐No

5) 24-hour access to emergency medical consultation services.
☐Yes ☐No

6) Ability to provide/assist with access to safe transportation services.
☐Yes ☐No

STAFF

Please select "yes" or "no" for each of the following questions:

1) Physicians and/or nurses present as needed. ☐Yes ☐No
2) Physicians and/or nurses readily available. ☐Yes ☐No
3) Physicians and/or nurses present at all times. ☐Yes ☐No
4) Counseling staff available or accessed through affiliation relationships.
☐Yes ☐No
5) Recovery coach/peer support staff available or accessed through affiliation relationships.
☐Yes ☐No

6) Please indicate program staff conducting each service. Check all that apply:

License or Certification/ Registration	Individual Counseling Sessions	Group Counseling Sessions	Didactic/ Educational Sessions	COD Treatment Services	Medical RX Services
MD/DO	☐	☐	☐	☐	☐
LP/LLP/TLLP	☐	☐	☐	☐	☐
LMFT/LLMFT	☐	☐	☐	☐	☐
LPC/LLPC	☐	☐	☐	☐	☐
RN, NP, LPN	☐	☐	☐	☐	☐
PA	☐	☐	☐	☐	☐
LMSW/LLMSW	☐	☐	☐	☐	☐
LBSW/LLBSW	☐	☐	☐	☐	☐
CADC-M/CADC	☐	☐	☐	☐	☐
CAADC	☐	☐	☐	☐	☐
CCJP-R	☐	☐	☐	☐	☐
CCDP	☐	☐	☐	☐	☐
CCDP-D	☐	☐	☐	☐	☐
CCS-M	☐	☐	☐	☐	☐
CCS-R	☐	☐	☐	☐	☐
DP-S	☐	☐	☐	☐	☐
DP-C	☐	☐	☐	☐	☐
Recovery Coach	☐	☐	☐	☐	☐

THERAPIES

Please describe the therapy services that are available:

1) Medication supported withdrawal management.
   ☐Yes ☐No
2) Self-administered withdrawal management medications.
   ☐Yes ☐No
3) Supervised self-administered withdrawal management medications.
   ☐Yes ☐No
4) Non-medication supported withdrawal management.
   ☐Yes ☐No
5) Education/didactics.
   ☐Yes ☐No
6) Involvement of family members and significant others.
   ☐Yes ☐No
7) Discharge/transfer planning.
   ☐Yes ☐No
8) Physician/nurse monitoring/management of intoxication and/or withdrawal.

☐Yes ☐No

9) Range of therapies available in group and/or individual format (cognitive, behavioral, medical).
☐Yes ☐No

10) Please submit a weekly schedule of services with the individual, group, educational and/or other treatment services labeled to verify what is reported above and attach other programmatic documentation that will support the ASAM Level being sought.

ASSESSMENT/TREATMENT PLAN REVIEW

Does the program's assessment and treatment plan review include:

1) Addiction focused history part of initial assessment and conducted or reviewed by physician. ☐Yes ☐No

2) Physical examination (by MD/DO, PA, NP) performed as part of initial assessment.
☐Yes ☐No

3) Biopsychosocial screening assessments used to determine level of care and to address treatment priorities in ASAM dimensions 2-6.
☐Yes ☐No

4) Interdisciplinary team available to participate in treatment and to obtain and interpret information regarding client needs.
☐Yes ☐No

5) Individual treatment plan, with problem identification for ASAM dimensions 2-6, with treatment goals and measurable objectives.
☐Yes ☐No

6) Daily assessment of progress and treatment changes.
☐Yes ☐No

7) Transfer/discharge planning beginning at point of admission.
☐Yes ☐No

8) Referral and linking arrangements for continuing care.
☐Yes ☐No

9) Medical assessments, using appropriate measures of withdrawal.
☐Yes ☐No

I CERTIFY THAT THE INFORMATION PROVIDED REGARDING THE

OPERATION OF THIS PROGRAM IS ACCURATE, TRUE, AND COMPLETE IN ALL MATERIAL ASPECTS. (Electronic signatures are acceptable)

AUTHORIZED INDIVIDUAL	TITLE	SIGNATURE	DATE

ENTER THE CONTACT INFORMATION OF THE PERSON THAT CAN BE REACHED FOR FOLLOW-UP IF NEEDED.

NAME	TITLE	EMAIL	TELEPHONE

ATTACHMENT E:
OUD/SUD Monitoring Protocol

1. Title Page for the State's SUD Demonstration or SUD Components of Broader Demonstration

The state should complete this Title Page as part of its SUD Monitoring Protocol. This form should be submitted as the title page for all Monitoring Reports. The content of this table should stay consistent over time.

a. State	*Michigan*
b. Demonstration name	*Michigan's 1115 Behavioral Health Demonstration*
c. Approval date for demonstration	*04/05/2019*
d. Approval period for SUD	*10/01/2019 – 09/30/2024*
e. Approval date for SUD, if different from above	*N/A*
f. Implementation date of SUD, if different from above	*N/A*
g. SUD (or if broader demonstration, then SUD - related) demonstration goals and objectives	*This demonstration will allow Michigan to broaden the crucial component of residential substance disorder services in the state's existing network of SUD providers and SUD benefits to provide a broader continuum of care for beneficiaries seeking help with a SUD, including withdrawal management services in residential treatment facilities that meet the definition of an IMD. The benefits will continue to be provided through a managed care delivery system. The state and CMS expect that offering a full continuum of SUD treatment and recovery supports based on American Society of Addiction Medicine (ASAM) criteria or other nationally recognized, SUD-specific program standards, will result in improved health outcomes and sustained recovery for this population.*

2. Proposed Modifications to SUD Narrative Information on Implementation, by Milestone or Reporting Topic

Summary of proposed modification	Related metric (if any)	Justification for modification
1. Assessment of Need and Qualification for SUD Services		
N/A	*3, 4, 5,*	*Michigan has no modification expectations for this topic.*
☐ The state has reviewed the corresponding prompts for narrative information in the SUD Monitoring Report Template and confirms that it will report the narrative information with the modifications described above.		
☒ The state has reviewed the corresponding prompts for narrative information in the SUD Monitoring Report Template and confirms that it will report the narrative information as requested (no modifications).		
2. Access to Critical Levels of Care for OUD and other SUDs (Milestone 1)		
N/A	*6, 7, 8, 9, 10, 11, 12, 36*	*Michigan has no modification expectations for Milestone 1.*
☐ The state has reviewed the corresponding prompts for narrative information in the SUD Monitoring Report Template and confirms that it will report the narrative information with the modifications described above.		
☒ The state has reviewed the corresponding prompts for narrative information in the SUD Monitoring Report Template and confirms that it will report the narrative information as requested (no modifications).		
3. Use of Evidence-based, SUD-specific Patient Placement Criteria (Milestone 2)		
N/A		*There are no CMS-provided metrics related to Milestone 2.*
☐ The state has reviewed the corresponding prompts for narrative information in the SUD Monitoring Report Template and confirms that it will report the narrative information with the modifications described above.		
☒ The state has reviewed the corresponding prompts for narrative information in the SUD Monitoring Report Template and confirms that it will report the narrative information as requested (no modifications).		
4. Use of Nationally Recognized SUD-specific Program Standards to Set Provider Qualifications for Residential Treatment Facilities (Milestone 3)		
N/A		*There are no CMS-provided metrics related to Milestone 3.*
☐ The state has reviewed the corresponding prompts for narrative information in the SUD Monitoring Report Template and confirms that it will report the narrative information with the modifications described above.		
☒ The state has reviewed the corresponding prompts for narrative information in the SUD Monitoring Report Template and confirms that it will report the narrative information as requested (no modifications).		
5. Sufficient Provider Capacity at Critical Levels of Care including for Medication Assisted Treatment for OUD (Milestone 4)		

Summary of proposed modification	Related metric (if any)	Justification for modification
N/A	*13, 14*	*Michigan has no modification expectations for Milestone 4.*
☐ The state has reviewed the corresponding prompts for narrative information in the SUD Monitoring Report Template and confirms that it will report the narrative information with the modifications described above.		
☒ The state has reviewed the corresponding prompts for narrative information in the SUD Monitoring Report Template and confirms that it will report the narrative information as requested (no modifications).		
6. Implementation of Comprehensive Treatment and Prevention Strategies to Address Opioid Abuse and OUD (Milestone 5)		
N/A	*15, 18, 19, 20, 21, 22*	*Michigan has no modification expectations for Milestone 5.*
☐ The state has reviewed the corresponding prompts for narrative information in the SUD Monitoring Report Template and confirms that it will report the narrative information with the modifications described above.		
☒ The state has reviewed the corresponding prompts for narrative information in the SUD Monitoring Report Template and confirms that it will report the narrative information as requested (no modifications).		
7. Improved Care Coordination and Transitions between Levels of Care (Milestone 6)		
N/A	*17*	*Michigan has no modification expectations for Milestone 6.*
☐ The state has reviewed the corresponding prompts for narrative information in the SUD Monitoring Report Template and confirms that it will report the narrative information with the modifications described above.		
☒ The state has reviewed the corresponding prompts for narrative information in the SUD Monitoring Report Template and confirms that it will report the narrative information as requested (no modifications).		
8. SUD Health Information Technology (Health IT)		
Please see detailed outline in part A	*Q1, Q2, Q3*	
☐ The state has reviewed the corresponding prompts for narrative information in the SUD Monitoring Report Template and confirms that it will report the narrative information with the modifications described above.		
☒ The state has reviewed the corresponding prompts for narrative information in the SUD Monitoring Report Template and confirms that it will report the narrative information as requested (no modifications).		
9. Other SUD-related Metrics		
N/A	*23, 24, 25, 26, 27, 28,*	*Michigan has no modifications for other SUD-related metrics.*

Summary of proposed modification	Related metric (if any)	Justification for modification
	29, 30, 31, 32, 33, 34, 35	
☐ The state has reviewed the corresponding prompts for narrative information in the SUD Monitoring Report Template and confirms that it will report the narrative information with the modifications described above.		
☒ The state has reviewed the corresponding prompts for narrative information in the SUD Monitoring Report Template and confirms that it will report the narrative information as requested (no modifications).		
10. Budget Neutrality		
N/A		*Michigan has no modifications for the budget neutrality.*
☐ The state has reviewed the corresponding prompts for narrative information in the SUD Monitoring Report Template and confirms that it will report the narrative information with the modifications described above.		
☒ The state has reviewed the corresponding prompts for narrative information in the SUD Monitoring Report Template and confirms that it will report the narrative information as requested (no modifications).		
11. SUD-Related Demonstration Operations and Policy		
N/A		*Michigan has no modifications for SUD-related demonstration operations and policy.*
☐ The state has reviewed the corresponding prompts for narrative information in the SUD Monitoring Report Template and confirms that it will report the narrative information with the modifications described above.		
☒ The state has reviewed the corresponding prompts for narrative information in the SUD Monitoring Report Template and confirms that it will report the narrative information as requested (no modifications).		
12. SUD Demonstration Evaluation Update		
N/A		*Michigan has no modifications for SUD demonstration evaluation.*
☐ The state has reviewed the corresponding prompts for narrative information in the SUD Monitoring Report Template and confirms that it will report the narrative information with the modifications described above.		
☒ The state has reviewed the corresponding prompts for narrative information in the SUD Monitoring Report Template and confirms that it will report the narrative information as requested (no modifications).		
13. Other Demonstration Reporting		
N/A		*Michigan has no modifications for other demonstration reporting.*
☐ The state has reviewed the corresponding prompts for narrative information in the SUD Monitoring Report Template and confirms that it will report the narrative information with the modifications described above.		

Summary of proposed modification	Related metric (if any)	Justification for modification
☒ The state has reviewed the corresponding prompts for narrative information in the SUD Monitoring Report Template and confirms that it will report the narrative information as requested (no modifications).		
14. Notable State Achievements and/or Innovations		
N/A		
☐ The state has reviewed the corresponding prompts for narrative information in the SUD Monitoring Report Template and confirms that it will report the narrative information with the modifications described above.		
☒ The state has reviewed the corresponding prompts for narrative information in the SUD Monitoring Report Template and confirms that it will report the narrative information as requested (no modifications).		

3. Acknowledgement of Budget Neutrality Reporting-

☒ The state has reviewed the Budget Neutrality workbook provided by the project officer and understands the expectations for quarterly and annual monitoring reports. The state will provide the requested budget neutrality information (no modifications).

4. Retrospective reporting

If a state's monitoring protocol is approved after its first quarterly monitoring report submission date, the state should report data to CMS retrospectively for any prior quarters of SUD demonstration implementation. States are expected to submit retrospective metrics data in the state's second monitoring report submission after monitoring protocol approval, or propose an alternative plan for reporting retrospectively on its SUD demonstration.

In the monitoring report submission containing retrospective metrics data, the state should also provide a general assessment of metrics trends from the start of the state's demonstration through the end of the current reporting period. The state should report this information in Part B of its report submission (Table 3: Narrative Information on Implementation, by Milestone and Reporting Topic). This general assessment is not intended to be a comprehensive description of every trend observed in metrics data (for example, unlike other monitoring report submissions, the state is not required to describe all metrics changes (+ or - greater than 2 percent). Rather, the assessment is an opportunity for states to provide context for its retrospective metrics data, to support CMS's review and interpretation. For example, consider a state that submits data showing an increase in the number of medication assisted treatment (MAT) providers (Metric #14) over the course of the retrospective reporting period. The state may decide to highlight this trend to CMS in Part B of its report (under Milestone 4) by briefly summarizing the trend and providing context that during this period, the state implemented a grant that supported training for new MAT providers throughout the state.

☐ The state will report retrospectively for any quarters prior to monitoring protocol approval as described above, in the state's second monitoring report submission after protocol approval.

☒ The state proposes an alternative plan to report retrospectively for any quarters prior to monitoring protocol approval: *Based upon MI's Covid-19 Declaration of Emergency we are requesting an alternative reporting plan for retrospectively to accomplish the response to help the epidemic. We are requesting to report all first-year data by 12/30/2020. The following reports will be reported together in 12/30/2020:* Narrative information for SUD DY1 Q1; Narrative information for SUD DY1 Q2; Other monthly and quarterly metrics for SUD DY1 Q1; Narrative information for SUD DY1 Q3; Other monthly and quarterly metrics for SUD DY1 Q2; Narrative and information for SUD DY1 Q4; Other monthly and quarterly metrics for SUD DY1 Q3.

5. Reporting SUD Demonstration Metrics and Narrative Information

The state should review the guidance in Appendix A of the instructions document in order to attest it will follow CMS's guidance on reporting metrics and narrative information, or propose any deviations. The state should complete Table A below to reflect its proposed reporting schedule for the duration of its SUD demonstration approval period.

☒ The state has completed the table below according to the guidance in Appendix A of the instructions document and attests to reporting metrics and narrative information in its quarterly and annual reports according as described.

☐ The state has reviewed Appendix A of the instructions document and completed the table below with the following deviations: *Michigan seeks CMS approval to submit all annual metrics in the first quarter of the subsequent demonstration year (e.g., for DY1, the annual metrics will be reported in DY2Q1). Michigan seeks this deviation to comport with its data run schedule for annual metrics calculated on a fiscal year measurement period. This aligns with Michigan's overarching performance monitoring reporting and defined data calculation schedules. Michigan also seeks to report the last demonstration year's annual metrics on February 28, 2025.*

Table A. Michigan's reporting in quarterly and annual monitoring reports

Dates of reporting quarter	Broader 1115 DY (if applicable) *	SUD DY	Report due (per STCs schedule)	Measurement period associated with SUD information in report, by reporting category
October 1, 2019- December 31, 2019	N/A	DY1 Q1	12/31/2020	• Narrative information for SUD DY1 Q1
January 1, 2020- March 31, 2020	N/A	DY1 Q2	12/31/2020	• Narrative information for SUD DY1 Q2 • Other monthly and quarterly metrics for SUD DY1 Q1
April 1, 2020- June 30, 2020	N/A	DY1 Q3	12/31/2020	• Narrative information for SUD DY1 Q3 • Other monthly and quarterly metrics for SUD DY1 Q2
July 1, 2020- September 30, 2020	N/A	DY1 Q4	12/31/2020	• Narrative information for SUD DY1 Q4 • Other monthly and quarterly metrics for SUD DY1 Q3
October 1, 2020- December 31, 2020	N/A	DY2 Q1	2/28/2021	• Narrative information for SUD DY2 Q1 • Other monthly and quarterly metrics for SUD DY1 Q4 • Annual metrics that are established quality measures for CY 2019 • Other annual metrics for SUD DY1
January 1, 2021- March 31, 2021	N/A	DY2 Q2	5/30/2021	• Narrative information for SUD DY2 Q2 • Other monthly and quarterly metrics for SUD DY2 Q1

Dates of reporting quarter	Broader 1115 DY (if applicable) *	SUD DY	Report due (per STCs schedule)	Measurement period associated with SUD information in report, by reporting category
April 1, 2021- June 30, 2021	N/A	DY2 Q3	8/31/2021	• Narrative information for SUD DY2 Q3 • Other monthly and quarterly metrics for SUD DY2 Q2
July 1, 2021- September 30, 2021	N/A	DY2 Q4	12/31/2021	• Narrative information for SUD DY2 Q4 • Other monthly and quarterly metrics for SUD DY2 Q3
October 1, 2021- December 31, 2021	N/A	DY3 Q1	2/28/2022	• Narrative information for SUD DY3 Q1 • Other monthly and quarterly metrics for SUD DY2 Q4 • Annual metrics that are established quality measures for CY 2020 • Other annual metrics for SUD DY2
January 1, 2022- March 31, 2022	N/A	DY3 Q2	5/30/2022	• Narrative information for SUD DY3 Q2 • Other monthly and quarterly metrics for SUD DY3 Q1
April 1, 2022- June 30, 2022	N/A	DY3 Q3	8/31/2022	• Narrative information for SUD DY3 Q3 • Other monthly and quarterly metrics for SUD DY3 Q2
July 1, 2022- September 30, 2022	N/A	DY3 Q4	12/31/2022	• Narrative information for SUD DY3 Q4 • Other monthly and quarterly metrics for SUD DY3 Q3
October 1, 2022-	N/A	DY4 Q1	2/28/2023	• Narrative information for SUD DY4 Q1 • Other monthly and quarterly metrics for SUD DY3 Q4

Dates of reporting quarter	Broader 1115 DY (if applicable) *	SUD DY	Report due (per STCs schedule)	Measurement period associated with SUD information in report, by reporting category
December 31, 2022				• Annual metrics that are established quality measures for CY 2021 • Other annual metrics for SUD DY3
January 1, 2023- March 31, 2023	N/A	DY4 Q2	5/30/2023	• Narrative information for SUD DY4 Q2 • Other monthly and quarterly metrics for SUD DY4 Q1
April 1, 2023- June 30, 2023	N/A	DY4 Q3	8/31/2023	• Narrative information for SUD DY4 Q3 • Other monthly and quarterly metrics for SUD DY4 Q2
July 1, 2023- September 30, 2023	N/A	DY4 Q4	12/31/2023	• Narrative information for SUD DY4 Q4 • Other monthly and quarterly metrics for SUD DY4 Q3
October 1, 2023- December 31, 2023	N/A	DY5 Q1	2/28/2024	• Narrative information for SUD DY5 Q1 • Other monthly and quarterly metrics for SUD DY4 Q4 • Annual metrics that are established quality measures for CY 2022 • Other annual metrics for SUD DY4
January 1, 2024- March 31, 2024	N/A	DY5 Q2	5/30/2024	• Narrative information for SUD DY5 Q2 • Other monthly and quarterly metrics for SUD DY5 Q1
April 1, 2024- June 30, 2024	N/A	DY5 Q3	8/31/2024	• Narrative information for SUD DY5 Q3 • Other monthly and quarterly metrics for SUD DY5 Q2

Dates of reporting quarter	Broader 1115 DY (if applicable) *	SUD DY	Report due (per STCs schedule)	Measurement period associated with SUD information in report, by reporting category
July 1, 2024-September 30, 2024	N/A	DY5 Q4	12/31/2024	• Narrative information for SUD DY5 Q4 • Other monthly and quarterly metrics for SUD DY5 Q3
July 1, 2024-September 30, 2024	N/A	N/A	2/28/2025	• Annual metrics that are established quality measures for CY 2022 • Other annual metrics for SUD DY4

*In this example, the state's SUD demonstration was added to its broader 1115 demonstration by amendment at the start of the broader 1115 demonstration's third demonstration year. States that do not have a broader 1115 demonstration (i.e., that have a SUD demonstration only) should delete this column.

**In this example, the state reports its established quality measures in the second quarterly report following the annual report because its demonstration year ends on 12/31; this lag allows adequate time for claims runout and other data completeness issues, as well as time to incorporate annual measure steward updates to specifications. States with demonstration years that end January 31 or February 28 should instead report established quality measures in the first quarterly report following the annual report. All other states should report established quality measures in the annual report.

	Medicaid Section 1115 SUD Demonstration Monitoring Protocol - Planned metrics																			
	State	Michigan																		
	Demonstration Name	Michigan's 1115 Behavioral Health Demonstration																		
	Submitted on	04/23/2020																		
			Standard information on CMS-provided metrics								**Baseline, annual goals, and demonstration target**			**Alignment with CMS-provided technical specifications**				**Initial reporting date**			
#	Metric name	Metric description	Milestone or reporting topic	Metric type	Reporting category	Data source	Measurement period	Reporting frequency	Reporting priority	State will report (Y/N)	Baseline Reporting Period (MM/DD/YYYY - MM/DD/YYYY)	Annual goal	Overall demonstration target	Attest that planned reporting matches the CMS-provided specification (Y/N)	Explanation of any deviations from the CMS-provided specifications (different data source, definition, codes, target population, etc.)	Dates covered by first measurement period for metric (MM/DD/YYYY - MM/DD/YYYY)	Name of first report in which the metric will be submitted (Format: DY1 Q1 report)	Submission date of first report in which the metric will be reported (MM/DD/YYYY)	State plans to phase in reporting (Y/N)	Explanation of any plans to phase in reporting over time
1	Assessed for SUD Treatment Needs Using a Standardized Screening Tool	Number of beneficiaries screened for SUD treatment needs using a standardized screening tool during the measurement period	Assessment of need and qualification for SUD treatment services	CMS-constructed	Other monthly and quarterly metric	Medical record review or claims	Month	Quarterly	Recommended	N										
2	Medicaid Beneficiaries with Newly Initiated SUD Treatment/Diagnosis	Number of beneficiaries with a SUD diagnosis and a SUD-related service during the measurement period but not in the three months before the measurement period	Assessment of need and qualification for SUD treatment services	CMS-constructed	Other monthly and quarterly metric	Claims	Month	Quarterly	Recommended	N										
3	Medicaid Beneficiaries with SUD Diagnosis (monthly)	Number of beneficiaries with a SUD diagnosis and a SUD-related service during the measurement period and/or in the 11 months before the measurement period	Assessment of need and qualification for SUD treatment services	CMS-constructed	Other monthly and quarterly metric	Claims	Month	Quarterly	Required	Y	10/01/2019 - 09/30/2020	Increase	Increase	Y		10/01/2019 - 12/31/2019	DY1 Q2 Report	05/30/2020	N	
4	Medicaid Beneficiaries with SUD Diagnosis (annually)	Number of beneficiaries with a SUD diagnosis and a SUD-related service during the measurement period and/or in the 12 months before the measurement period	Assessment of need and qualification for SUD treatment services	CMS-constructed	Other annual metric	Claims	Year	Annually	Required	Y	10/01/2019 - 09/30/2020	Increase	Increase	Y		10/01/2019 - 09/30/2020	DY2 Q1 Report	02/28/2021	N	
5	Medicaid Beneficiaries Treated in an IMD for SUD	Number of beneficiaries with a claim for residential or inpatient treatment for SUD in IMDs during the measurement period	Assessment of need and qualification for SUD treatment services	CMS-constructed	Other annual metric	Claims	Year	Annually	Required	Y	10/01/2019 - 09/30/2020	Increase	Increase	Y		10/01/2019 - 09/30/2020	DY2 Q1 Report	02/28/2021	N	
6	Any SUD Treatment	Number of beneficiaries enrolled in the measurement period receiving any SUD treatment service, facility claim, or pharmacy claim during the measurement period	Milestone 1	CMS-constructed	Other monthly and quarterly metric	Claims	Month	Quarterly	Required	Y	10/01/2019 - 09/30/2020	Increase	Increase	Y		10/01/2019 - 12/31/2019	DY1 Q2 Report	05/30/2020	N	
7	Early Intervention	Number of beneficiaries who used early intervention services (such as procedure codes associated with SBIRT) during the measurement period	Milestone 1	CMS-constructed	Other monthly and quarterly metric	Claims	Month	Quarterly	Required	Y	10/01/2019 - 09/30/2020	Increase	Increase	Y		10/01/2019 - 12/31/2019	DY1 Q2 Report	05/30/2020	N	
8	Outpatient Services	Number of beneficiaries who used outpatient services for SUD (such as outpatient recovery or motivational enhancement therapies, step down care, and monitoring for stable patients) during the measurement period	Milestone 1	CMS-constructed	Other monthly and quarterly metric	Claims	Month	Quarterly	Required	Y	10/01/2019 - 09/30/2020	Increase	Increase	Y		10/01/2019 - 12/31/2019	DY1 Q2 Report	05/30/2020	N	
9	Intensive Outpatient and Partial Hospitalization Services	Number of unique beneficiaries who used intensive outpatient and/or partial hospitalization services for SUD (such as specialized outpatient SUD therapy or other clinical services) during the measurement period	Milestone 1	CMS-constructed	Other monthly and quarterly metric	Claims	Month	Quarterly	Required	Y	10/01/2019 - 09/30/2020	Increase	Increase	Y		10/01/2019 - 12/31/2019	DY1 Q2 Report	05/30/2020	N	
10	Residential and Inpatient Services	Number of beneficiaries who use residential and/or inpatient services for SUD during the measurement period	Milestone 1	CMS-constructed	Other monthly and quarterly metric	Claims	Month	Quarterly	Required	Y	10/01/2019 - 09/30/2020	Increase	Increase	Y		10/01/2019 - 12/31/2019	DY1 Q2 Report	05/30/2020	N	
11	Withdrawal Management	Number of beneficiaries who use withdrawal management services (such as outpatient, inpatient, or residential) during the measurement period	Milestone 1	CMS-constructed	Other monthly and quarterly metric	Claims	Month	Quarterly	Required	Y	10/01/2019 - 09/30/2020	Increase	Increase	Y		10/01/2019 - 12/31/2019	DY1 Q2 Report	05/30/2020	N	
12	Medication Assisted Treatment	Number of beneficiaries who have a claim for MAT for SUD during the measurement period	Milestone 1	CMS-constructed	Other monthly and quarterly metric	Claims	Month	Quarterly	Required	Y	10/01/2019 - 09/30/2020	Increase	Increase	Y		10/01/2019 - 12/31/2019	DY1 Q2 Report	05/30/2020	N	
36	Average Length of Stay in IMDs	The average length of stay for beneficiaries discharged from IMD inpatient or residential treatment for SUD during the measurement period	Milestone 1	CMS-constructed	Other annual metric	Claims; State-specific IMD database	Year	Annually	Required	Y	10/01/2019 - 09/30/2020	**Stay Consistent**	**Stay Consistent**	Y		10/01/2019 - 09/30/2020	DY2 Q1 Report	02/28/2021	N	
13	SUD Provider Availability	The number of providers who were enrolled in Medicaid and qualified to deliver SUD services during the measurement period	Milestone 4	CMS-constructed	Other annual metric	Provider enrollment database; Claims	Year	Annually	Required	Y	10/01/2019 - 09/30/2020	Increase	Increase	Y		10/01/2019 - 09/30/2020	DY2 Q1 Report	02/28/2021	N	
14	SUD Provider Availability - MAT	The number of providers who were enrolled in Medicaid and qualified to deliver SUD services during the measurement period and who meet the standards to provide buprenorphine or methadone as part of MAT	Milestone 4	CMS-constructed	Other annual metric	Provider enrollment database; Claims; SAMHSA datasets	Year	Annually	Required	Y	10/01/2019 - 09/30/2020	Increase	Increase	Y		10/01/2019 - 09/30/2020	DY2 Q1 Report	02/28/2021	N	
15	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET-AD) [NCQA; NQF #0004; Medicaid Adult Core Set; Adjusted HEDIS measure]	Percentage of beneficiaries with a new episode of alcohol or other drug (AOD) AOD abuse or dependence who received the following: • Initiation of AOD Treatment—percentage of beneficiaries who initiated treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization, withdrawl, or MAT within 14 days of the diagnosis • Engagement of AOD Treatment—percentage of beneficiaries who initiated treatment and who had two or more additional AOD services or MAT within 34 days of the initiation visit The following diagnosis cohorts are reported for each rate: (1) Alcohol abuse or dependence, (2) Opioid abuse or dependence, (3) Other drug abuse or dependence, and (4) Total AOD abuse or dependence. A total of 8 separate rates are reported for this measure.	Milestone 5	Established quality measure	Annual metric that is an established quality measure	Claims	Year	Annually	Required	Y	1/1/2019 - 12/31/2019	Increase	Increase	Y		**01/01/2019-12/31/2019**	DY2 Q1 Report	02/28/2021	N	
18	Use of Opioids at High Dosage in Persons Without Cancer (OHD-AD) [PQA; NQF #2940; Medicaid Adult Core Set]	Percentage of beneficiaries age 18 and older who received prescriptions for opioids with an average daily dosage greater than or equal to 90 morphine milligram equivalents (MME) over a period of 90 days or more. Beneficiaries with a cancer diagnosis or in hospice are excluded.	Milestone 5	Established quality measure	Annual metric that is an established quality measure	Claims	Year	Annually	Required	Y	1/1/2019 - 12/31/2019	Decrease	Decrease	Y		**01/01/2019-12/31/2019**	DY2 Q1 Report	02/28/2021	N	
19	Use of Opioids from Multiple Providers in Persons Without Cancer [PQA; NQF #2950]	The percentage of individuals ≥18 years of age who received prescriptions for opioids from ≥4 prescribers AND ≥4 pharmacies within ≤180 days.	Milestone 5	Established quality measure	Annual metric that is an established quality measure	Claims	Year	Annually	Recommended	N										
20	Use of Opioids at High Dosage and from Multiple Providers in Persons Without Cancer [PQA; NQF #2951]	The percentage of individuals ≥18 years of age who received prescriptions for opioids with an average daily dosage of ≥90 morphine milligram equivalents (MME) AND who received prescriptions for opioids from ≥4 prescribers AND ≥4 pharmacies	Milestone 5	Established quality measure	Annual metric that is an established quality measure	Claims	Year	Annually	Recommended	N										
21	Concurrent Use of Opioids and Benzodiazepines (COB-AD) [PQA]	Percentage of beneficiaries age 18 and older with concurrent use of prescription opioids and benzodiazepines. Patients with a cancer diagnosis or in hospice are excluded.	Milestone 5	Established quality measure	Annual metric that is an established quality measure	Claims	Year	Annually	Required	Y	1/1/2019 - 12/31/2019	Decrease	Decrease	Y		**01/01/2019-12/31/2019**	DY2 Q1 Report	02/28/2021	N	
22	Continuity of Pharmacotherapy for Opioid Use Disorder [USC; NQF #3175]	Percentage of adults in the denominator with pharmacotherapy for OUD who have at least 180 days of continuous treatment	Milestone 5	Established quality measure	Annual metric that is an established quality measure	Claims	Year	Annually	Required	Y	1/1/2018 - 12/31/2019	Increase	Increase	Y		**01/01/2018-12/31/2019**	DY2 Q1 Report	02/28/2021	N	
16	SUB-3 Alcohol and Other Drug Use Disorder Treatment Provided or Offered at Discharge and SUB-3a Alcohol and Other Drug Use Disorder Treatment at Discharge [Joint Commission; NQF #1664]	SUB-3 rate: Patients who are identified with alcohol or drug use disorder who receive or refuse at discharge a prescription for FDA-approved medications for alcohol or drug use disorder, OR who receive or refuse a referral for addictions treatment. SUB-3a rate: Patients who are identified with alcohol or drug disorder who receive a prescription for FDA-approved medications for alcohol or drug use disorder OR a referral for addictions treatment.	Milestone 6	Established quality measure	Annual metric that is an established quality measure	Medical record review or claims	Year	Annually	Recommended	N										
17(1)	Follow-up after Emergency Department Visit for Alcohol or Other Drug Dependence (FUA-AD) [NCQA; NQF #2605; Medicaid Adult Core Set; Adjusted HEDIS measure]'	Percentage of ED visits for beneficiaries who have a principal diagnosis of AOD abuse or dependence and who had a follow-up visit with a corresponding principal diagnosis for AOD. Two rates are reported: - Percentage of ED visits for AOD abuse or dependence for which the beneficiary received follow-up within 7 days of the ED visit (8 total days). - Percentage of ED visits for AOD abuse or dependence for which the beneficiary received follow-up within 30 days of the ED visit (31 total days).	Milestone 6	Established quality measure	Annual metric that is an established quality measure	Claims	Year	Annually	Required	Y	1/1/2019 - 12/31/2019	Increase	Increase	**Y**		**01/01/2019-12/31/2019**	DY2 Q1 Report	02/28/2021	N	
17(2)	Follow-up after Emergency Department Visit for Mental Illness (FUM-AD) [NCQA; NQF #2605; Medicaid Adult Core Set; Adjusted HEDIS measure]'	Percentage of ED visits for beneficiaries who have a principal diagnosis of mental illness and who had a follow-up visit with a corresponding principal diagnosis for mental illness. Two rates are reported: - Percentage of ED visits for mental illness for which the beneficiary received follow-up within 7 days of the ED visit (8 total days). - Percentage of ED visits for mental illness for which the beneficiary received follow-up within 30 days of the ED visit (31 total days)	Milestone 6	Established quality measure	Annual metric that is an established quality measure	Claims	Year	Annually	Required	Y	1/1/2019 - 12/31/2019	Increase	Increase	**Y**		**01/01/2019-12/31/2019**	DY2 Q1 Report	02/28/2021	N	
Q1	PDMP Checking by Providers	Total number of Medicaid providers registered in Michigan's PDMP	Health IT	State-identified	Other annual metric	State PDMP Data	Year	Annually	Required	Y	10/01/2019 - 09/30/2020	Increase	Increase			10/01/2019 - 09/30/2020	DY2 Q1 Report	02/28/2021	N	
Q2	Consent Management	Total number of PIHP regions utilizing e-consent management for information sharing. There are 10 PIHPs (each is its own designated region) in Michigan.	Health IT	State-identified	Other annual metric	Provider Attestation	Year	Annually	Required	Y	10/01/2019 - 09/30/2020	Increase	Increase			10/01/2019 - 09/30/2020	DY2 Q1 Report	02/28/2021	N	
Q3	Care Management	Creation of a care coordination module with SUD data within Michigan's CareConnect 360, which is a repository of beneficiary claims/encounter/diagnostic information. Upon creation, the total number of PIHPs utilizing the care coordination module for quality management and planning purposes.	Health IT	State-identified	Other annual metric	Provider Attestation	Year	Annually	Required	Y	10/01/2019 - 09/30/2020	**Increase**	Increase			10/01/2019 - 09/30/2020	DY2 Q1 Report	02/28/2021	N	
23	Emergency Department Utilization for SUD per 1,000 Medicaid Beneficiaries	Total number of ED visits for SUD per 1,000 beneficiaries in the measurement period	Other SUD-related metrics	CMS-constructed	Other monthly and quarterly metric	Claims	Month	Quarterly	Required	Y	10/01/2019 - 09/30/2020	Decrease	Decrease	Y		10/01/2019 - 12/31/2019	DY1 Q2 Report	05/30/2020	N	
24	Inpatient Stays for SUD per 1,000 Medicaid Beneficiaries	Total number of inpatient stays per 1,000 beneficiaries in the measurement period	Other SUD-related metrics	CMS-constructed	Other monthly and quarterly metric	Claims	Month	Quarterly	Required	Y	10/01/2019 - 09/30/2020	Decrease	Decrease	Y		10/01/2019 - 12/31/2019	DY1 Q2 Report	05/30/2020	N	
25	Readmissions Among Beneficiaries with SUD	The rate of all-cause readmissions during the measurement period among beneficiaries with SUD.	Other SUD-related metrics	CMS-constructed	Other annual metric	Claims	Year	Annually	Required	Y	10/01/2019 - 09/30/2020	Decrease	Decrease	Y		10/01/2019 - 09/30/2020	DY2 Q1 Report	02/28/2021	N	
26	Overdose Deaths (count)	Number of overdose deaths during the measurement period among Medicaid beneficiaries living in a geographic area covered by the demonstration. States are encouraged to report the cause of overdose death as specifically as possible (for example, prescription vs. illicit opioids).	Other SUD-related metrics	CMS-constructed	Other annual metric	State data on cause of death	Year	Annually	Required	Y	10/01/2019 - 09/30/2020	Decrease	Decrease	Y		10/01/2019 - 09/30/2020	DY2 Q1 Report	02/28/2021	N	
27	Overdose Deaths (rate)	Rate of overdose deaths during the measurement period among adult Medicaid beneficiaries living in a geographic area covered by the demonstration. States are encouraged to report the cause of overdose death as specifically as possible (for example, prescription vs. illicit opioids).	Other SUD-related metrics	CMS-constructed	Other annual metric	State data on cause of death	Year	Annually	Required	Y	10/01/2019 - 09/30/2020	Decrease	Decrease	Y		10/01/2019 - 09/30/2020	DY2 Q1 Report	02/28/2021	N	
28	SUD Spending	Total Medicaid SUD spending during the measurement period.	Other SUD-related metrics	CMS-constructed	Other annual metric	Claims	Year	Annually	Recommended	N										
29	SUD Spending Within IMDs	Total Medicaid SUD spending on residential or inpatient treatment within IMDs during the measurement period	Other SUD-related metrics	CMS-constructed	Other annual metric	Claims	Year	Annually	Recommended	N										
30	Per Capita SUD Spending	Per capita SUD spending during the measurement period	Other SUD-related metrics	CMS-constructed	Other annual metric	Claims	Year	Annually	Recommended	N										
31	Per Capita SUD Spending Within IMDs	Per capita SUD spending within IMDs during the measurement period	Other SUD-related metrics	CMS-constructed	Other annual metric	Claims	Year	Annually	Recommended	N										
32	Access to Preventive/ Ambulatory Health Services for Adult Medicaid Beneficiaries with SUD (AAP) [Adjusted HEDIS measure]	The percentage of Medicaid beneficiaries with SUD who had an ambulatory or preventive care visit during the measurement period.	Other SUD-related metrics	Established quality measure	Annual metric that is an established quality measure	Claims	Year	Annually	Required	Y	1/1/2019 - 12/31/2019	Increase	Increase	Y		**01/01/2019-12/31/2019**	DY2 Q1 Report	02/28/2021	N	
33	Grievances Related to SUD Treatment Services	Number of grievances filed during the measurement period that are related to SUD treatment services	Other SUD-related metrics	CMS-constructed	Grievances and appeals	Administrative records	Quarter	Quarterly	Recommended	N										
34	Appeals Related to SUD Treatment Services	Number of appeals filed during the measurement period that are related to SUD treatment services	Other SUD-related metrics	CMS-constructed	Grievances and appeals	Administrative records	Quarter	Quarterly	Recommended	N										
35	Critical Incidents Related to SUD Treatment Services	Number of critical incidents filed during the measurement period that are related to SUD treatment services	Other SUD-related metrics	CMS-constructed	Grievances and appeals	Administrative records	Quarter	Quarterly	Recommended	N										
S.1	**Follow-up after Emergency Department Visit for Alcohol or Other Drug Dependence (FUA-AD)** **[NCQA; NQF #2605; Medicaid Adult Core Set; Adjusted HEDIS measure]b**	Percentage of ED visits for beneficiaries who have a principal diagnosis of AOD abuse or dependence and who had a follow-up visit with a corresponding principal diagnosis for AOD. Two rates are reported: - Percentage of ED visits for AOD abuse or dependence for which the beneficiary received follow-up within 7 days of the ED visit (8 total days). - Percentage of ED visits for AOD abuse or dependence for which the beneficiary received follow-up within 30 days of the ED visit (31 total days).	Other SUD-related metrics	State-identified	Other annual metric	Claims	Year	Annually	Recommended	Y	1/1/2019 - 12/31/2019	Increase	Increase	N	**Following careful review of the code sets used in this measure and the MDHHS reporting rules for SUD services, additional HCPCS codes were added to the list of qualified follow-up services: H0006, H0010, H0012, H0018 (except when reported with PO modifier), H0035, H0038 (except when reported with no modifier), H0049 and H0050.**	**01/01/2019-12/31/2019**	**DY2 Q1 Report**			
S.2	**Follow-up after Emergency Department Visit for Mental Illness (FUM-AD)** **[NCQA; NQF #2605; Medicaid Adult Core Set; Adjusted HEDIS measure]c**	Percentage of ED visits for beneficiaries who have a principal diagnosis of mental illness and who had a follow-up visit with a corresponding principal diagnosis for mental illness. Two rates are reported: - Percentage of ED visits for mental illness for which the beneficiary received follow-up within 7 days of the ED visit (8 total days). - Percentage of ED visits for mental illness for which the beneficiary received follow-up within 30 days of the ED visit (31 total days)	Other SUD-related metrics	State-identified	Other annual metric	Claims	Year	Annually	Recommended	Y	1/1/2019 - 12/31/2019	Increase	Increase	N	**Following careful review of the code sets used in this measure and the MDHHS reporting rules for SUD services, additional HCPCS codes were added to the list of qualified follow-up services: H0006, H0010, H0012, H0018 (except when reported with PO modifier), H0035, H0038 (except when reported with no modifier), H0049 and H0050.**	**01/01/2019-12/31/2019**	**DY2 Q1 Report**			
*There are no CMS-provided metrics related to milestone 2 or milestone 3.																				

Attachment D –SUD Health Information Technology (IT) Plan

Part 1: Overview and Table 1

Overview

The Michigan Department of Health and Human Services (MDHHS) SUD Health IT Plan attends to all requirements specified in STC 23 of Michigan's approved 1115 Waiver. This includes strategies to increase the utilization and functionality of the state's PDMP. Moreover, the SUD Health IT Plan aligns with the broader State Medicaid Health IT Plan (SMHP), particularly in the "to-be" section, which describes MDHHS' vision for the development, refinement, and application of HIT in Michigan. Specific areas where the SUD Health IT plan synchronizes with the broader SMHP includes the strategic goals to:

- Increase care coordination;
- Leverage electronic consent for data sharing purposes;
- Creation of a central repository of beneficiary resources.

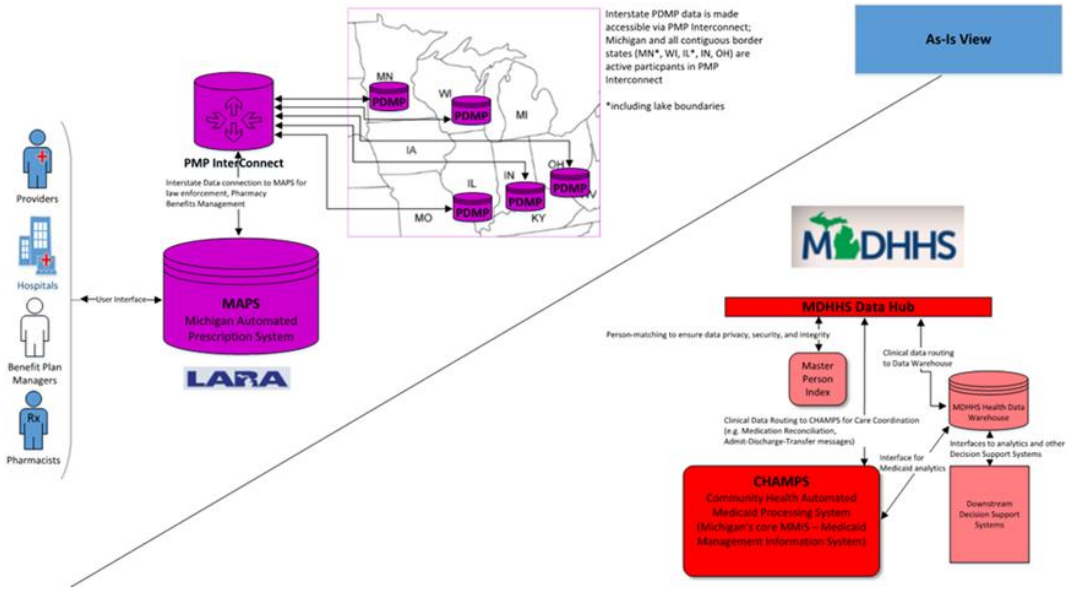
Current HIT/PDMP Ecosystem

MDHHS maintains a robust network of HIT/HIE systems to help execute its policies and programs. This includes the MDHHS Data Warehouse (a data repository for all programs and operations), the Community Health Automated Medicaid Payment System (CHAMPS) (Michigan's Medicaid Management Information System), and a statewide health information exchange (HIE) network. MDHHS also utilizes an innovative care coordination platform that integrates with the preceding systems, called Care Connect 360.

Michigan's PDMP, the Michigan Automated Prescription System (MAPS), is maintained by another state agency, the Department of Licensing and Regulatory Affairs (LARA). LARA utilizes its vendor Appriss to host MAPS. Although the PDMP data infrastructure is connected to the Appriss interstate PDMP network, it is maintained as a reporting and surveillance asset exclusive to LARA and its privacy policies. MDHHS does not have access to MAPS data. That said, MDHHS supports and encourages utilization of MAPS. In fact, MDHHS provided LARA with SAMHSA State Targeted Response resources to support an additional Appriss service called NarxCare, which sits on top of provider EHRs to provide quick access to the PDMP, including dashboarding and decision support tools to aid in clinical decision making and maximize appropriateness of controlled substance prescriptions.

Please refer to the following diagram for the technical "As-Is View" of Michigan's PDMP data ecosystem.

Figure 1 – PDMP Connection Diagram, courtesy of the MDHHS Medicaid Promoting Interoperability Section



SUD Health IT Plan Milestones

The SUD Health IT Plan components will afford MDHHS the opportunity to leverage real-time data to affect program policy and care coordination. First, it will create efficiencies by implementing standardized and electronic data sharing for consent management, diagnosis and treatment data, and payment information. The plan's components will also increase access to care through integrated access systems necessary to help beneficiaries and providers navigate treatment options most appropriate to a beneficiary's needs. Perhaps the greatest benefit is direct to providers prescribing controlled substances. In increasing access to the PDMP and its integrated supporting software, these enhancements will equip providers with a more comprehensive background of their patients. Specifically, the increase in the utilization of the PDMP and the clinical decision support tools embedded within NarxCare will allow providers understand the risks associated with prescribing controlled substances to high-risk beneficiaries and alter prescribing practices appropriately. The totality of the SUD Health IT Plan will lead to greater utilization of appropriate services through the sharing of more complete information, thereby leading to reductions in unnecessary prescriptions and subsequent increases in population health.

Specific milestones to be achieved by implementing the SUD Health IT Plan include:

1. Achieve statistically significant increases in PDMP online registrations and NarxCare integrations for Medicaid providers.
    - Measurement Year: FY20
    - Performance Years: (1) FY21, (2) FY22, (3) FY23…

2. Modify the current State's care coordination platform, Care Connect 360, to afford designated access to SUD claim/encounter information, including Admit-Discharge-Transfer (ADT) messaging (October 1, 2020)

3. Development of an SUD monitoring dashboard for the following elements:
    - Metrics requiring federal reporting (October 1, 2020)
    - Utilization of Master Person Index and Care Connect 360 to stratify high-need beneficiaries with an SUD and those at-risk of developing SUD (October 1, 2021)
        - Synchronization with homeless data
        - Synchronization with chronic condition data
        - Synchronization with available risk-scoring data
        - Synchronization with PDMP data (October 1, 2022)

4. Development of an e-consent management system for data sharing (October 1, 2021)

5. Development of a centralized and coordinated access system, including:
    a. A SUD residential bed registry in the context of the State's broader integrated crisis and access system (October 1, 2021)
    b. A Customer Relationship Management database for State, provider, and designated contractors to facilitate and track access to needed treatment (October 1, 2021)

Table 1: State Health IT / PDMP Assessment & Plan

Milestone Criteria	Current State	Future State	Summary of Actions Needed
5. Implementation of comprehensive treatment and prevention strategies to address Opioid Abuse and OUD, that is: *--Enhance the state's health IT functionality to support its PDMP; and* *--Enhance and/or support clinicians in their usage of the state's PDMP.*	*Provide an overview of current PDMP capabilities, health IT functionalities to support the PDMP, and supports to enhance clinicians' use of the state's health IT functionality to achieve the goals of the PDMP.*	*Provide an overview of plans for enhancing the state's PDMP, related enhancements to its health IT functionalities, and related enhancements to support clinicians' use of the health IT functionality to achieve the goals of the PDMP.*	*Specify a list of action items needed to be completed to meet the HIT/PDMP milestones identified in the first column. Include persons or entities responsible for completion of each action item. Include timeframe for completion of each action item*
Prescription Drug Monitoring Program (PDMP) Functionalities			
Establish connectivity between the state's PDMP and any statewide, regional or local health information exchange, including the MDHHS Data Warehouse	PDMP data does not flow into the MDHHS Data Warehouse	Synchronization of PDMP data with the MDHHS Data Warehouse for care coordination, program policy, and monitoring purposes	Responsible Party: MDHHS Behavioral Health and Developmental Disabilities Administration (BHDDA) Milestones: Leverage relationship with LARA to afford PDMP data access to the MDHHS Data Warehouse Timeframe: October 1, 2022
Enhanced "ease of use" for prescribers and other state and federal stakeholders	Current state of PDMP online registrations and NarxCare integrations unknown.	Greater utilization of PDMP and NarxCare for care coordination and clinical monitoring purposes.	Responsible Party: BHDDA Milestone: Statistically significant increases in all FYs from baseline. Timeframe: Measurement Year: FY20; Performance Years: (1) FY21, (2) FY22, (3) FY23…

Enhanced connectivity between the state's PDMP and any statewide, regional or local health information exchange	PDMP data does not flow into the MDHHS Data Warehouse	Synchronization of PDMP data with the MDHHS Data Warehouse for care coordination, program policy, and monitoring purposes	Responsible Party: BHDDA Milestone: Leverage relationship with LARA to afford PDMP data access to the MDHHS Data Warehouse Timeframe: October 1, 2022
Enhanced identification of long-term opioid use directly correlated to clinician prescribing pattern	Current state of PDMP online registrations and NarxCare integrations unknown.	Greater utilization of PDMP and NarxCare for care coordination and clinical monitoring purposes.	Responsible Party: BHDDA Milestone: Statistically significant increases in all FYs from baseline. Timeframe: Measurement Year: FY20; Performance Years: (1) FY21, (2) FY22, (3) FY23…
Current and Future PDMP Query Capabilities			
Facilitate the state's ability to properly match patients receiving opioid prescriptions with patients in the PDMP (i.e. the state's master patient index (MPI) strategy with regard to PDMP query)	PDMP data does not flow into the MDHHS Data Warehouse	Synchronization of PDMP data with the MDHHS Data Warehouse for care coordination, program policy, and monitoring purposes	Responsible Party: BHDDA Milestone: Leverage relationship with LARA to afford PDMP data access to the MDHHS Data Warehouse Timeframe: October 1, 2022

Use of PDMP – Supporting Clinicians with Changing Office Workflows / Business Processes			
Develop enhanced provider workflow / business processes to better support clinicians in accessing the PDMP prior to prescribing an opioid or other controlled substance to address the issues which follow	Current state of PDMP online registrations and NarxCare integrations unknown.	Greater utilization of PDMP and NarxCare for care coordination and clinical monitoring purposes.	Responsible Party: BHDDA Milestone: Statistically significant increases in all FYs from baseline. Timeframe: Measurement Year: FY20; Performance Years: (1) FY21, (2) FY22, (3) FY23…
Develop enhanced supports for clinician review of the patients' history of controlled substance prescriptions provided through the PDMP—prior to the issuance of an opioid prescription	Current state of PDMP online registrations and NarxCare integrations unknown.	Greater utilization of PDMP and NarxCare for care coordination and clinical monitoring purposes.	Responsible Party: BHDDA Milestone: Statistically significant increases in all FYs from baseline. Timeframe: Measurement Year: FY20; Performance Years: (1) FY21, (2) FY22, (3) FY23…
Master Patient Index / Identity Management			
Enhance the master patient index (or master data management service, etc.) in support of SUD care delivery.	Master Person Index and other risk-identifying information exists in the MDHHS Data Warehouse but is isolated from SUD data.	Providers will utilize a revamped care coordination module within Care Connect 360 to identify an prioritize outreach, treatment, and care management,	Responsible Party: BHDDA Milestone: Create new care coordination module in Care Connect 360 to allow PIHPs to support the provision and management of SUD care delivery. Timeframe: October 1, 2022
Overall Objective for Enhancing PDMP Functionality & Interoperability			

Leverage the above functionalities / capabilities / supports (in concert with any other state health IT, TA or workflow effort) to implement effective controls to minimize the risk of inappropriate opioid overprescribing—and to ensure that Medicaid does not inappropriately pay for opioids—and to increase care coordination.	PDMP data does not flow into the MDHHS Data Warehouse.	Synchronization of PDMP data with the MDHHS Data Warehouse for care coordination, program policy, and monitoring purposes	Leverage relationship with LARA to afford PDMP data access to the MDHHS Data Warehouse October 1, 2022

Part 2: Attestation Responses
MDHHS attests and assures that it has a sufficient health IT infrastructure/"ecosystem" at every appropriate level (i.e. state, delivery system, health plan/MCO, and individual provider) to achieve the goals of the demonstration. There is a caveat in that Michigan's PDMP is housed within LARA. Discussions are ongoing to increase data sharing between MDHHS and LARA, but currently PDMP data does not flow into the MDHHS Data Warehouse. As cited in the pertinent milestones in Table 1, it is anticipated this integration/data sharing will occur by FY23.

Part 3: Advancing Interoperability using Health IT Standards
MDHHS will include appropriate standards referenced in the ONC Interoperability Standards Advisory (ISA) and 45 CFR 170 Subpart B in subsequent PIHP contract amendments or Medicaid funded Health Plan re-procurements, such as:

- Electronic Prescribing – A Prescriber's Ability to Obtain a Patient's Medication History from a Prescription Drug Monitoring Program (Section II-I)
- "Direct" transport standards
- Documenting and Sharing Care Plans - Care Plan standards (CDA)
- Sending a Notification of a Patient's Admission, Discharge and/or Transfer Status to Other Providers - ADT Alerting and Messaging
- Clinical Quality Measurement and Reporting

Attachment A, Section II – Implementation Administration
Name and Title: Jon Villasurda, State Assistant Administrator, Office of the Deputy Director, BHDDA, MDHHS
Telephone Number: (517) 241-7193
Email Address: villasurdaj@michigan.gov

Attachment A, Section III – Relevant Documents
MCL 333.7333a;
http://www.legislature.mi.gov/(S(mfbvp1ld0o50hnp01xci213m))/mileg.aspx?page=getobject&objectname=mcl-333-7333a&query=on&highlight=7333a

Michigan's §1115 Waiver Proposal for to the Centers for Medicare and Medicaid Services US Department of Health and Human Services

State of Michigan
Rick Snyder Governor

Nick Lyon, Director
Michigan Department of Health and Human Services

I. Introduction

Michigan has a long-standing commitment to community supports and inclusion. The state continues to focus on enhancing systems capacity to further improve the functioning, capabilities, and recovery/resiliency for persons with Severe Mental Illness (SMI), Substance Use Disorders (SUD), Intellectual/Developmental Disabilities (I/DD), and Children with Serious Emotional Disturbances (SED)[1]. With this commitment and focus in mind, the State of Michigan is seeking approval from the Centers for Medicare and Medicaid Services (CMS) for a §1115 Demonstration Waiver that will **allow Michigan to establish a full continuum of Substance Use Disorder treatment services, based on the American Society of Addiction Medicine standards, and utilize residential treatment services in programs that meet the definition of an Institution for Mental Disease**

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

II. Program Description

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

In 2013, to better integrate behavioral health and SUD, MDHHS combined the former SUD CAs funding and service responsibility within ten (10) PIHPs. This multi-year effort has improved the effectiveness of the benefit design as well as the treatment and support services provided to individuals who have SUD. To further **those** efforts, MDHHS engaged the Centers for Medicare and Medicaid Services (CMS) Innovation Accelerator Program (IAP) for SUD to **assist in** further develop**ing** and improv**ing** ~~on~~ the state's comprehensive array of effective treatment and supports for persons with co-occurring disorders, and to ensure more consistent use of industry-standard benchmarks for refining medical necessity criteria, promoting the use of evidence-based services and strengthening provider qualifications and state oversight. The flexibilities permitted under a §1115 Waiver will also give the state expenditure authority for coverage of a broader array of residential services (regardless of facility size)**.**

[1]

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

The state of Michigan seeks to accomplish these efforts by:

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

2) Include the rationale for the §1115 Demonstration.

Michigan seeks to enhance the effectiveness of its SUD treatment and recovery system. The benefit design, service access, and quality enhancements proposed as part of this demonstration are intended to support **this effort**.

Through participation in the CMS IAP, the state has received technical assistance and exposure to national experts on a number of topics relevant to Michigan's goals to strengthen the continuum of SUD services throughout the state. While Michigan has historically maintained a robust network of SUD providers and services, the prohibition against Medicaid reimbursement for services provided to certain adults in an Institution for Mental Disease (IMD) setting has resulted in a disjointed benefit package and the inability to ensure access to needed services.

This waiver application seeks to remove treatment gaps through coverage of residential services, ensuring capacity to **all residential** ASAM levels **of care** and expanding statewide capacity for higher-end ASAM levels (i.e., **3.5 and** 3.7).

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

This proposal is not solely focused on cost savings, but rather on improving upon Michigan's robust coverage and service array, including the expanded use of peer recovery supports for persons with SUD, and SUD delivery reforms. The goal of this demonstration is to **establish a publicly funded SUD treatment system with a standardized access system that utilizes nationally recognized standards and evidenced based practices.**

Michigan will evaluate the impact of this new continuum by measuring the change in the number of people engaged in in recovery support services, the length of time in formal treatment, and improvement in overall physical health.

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

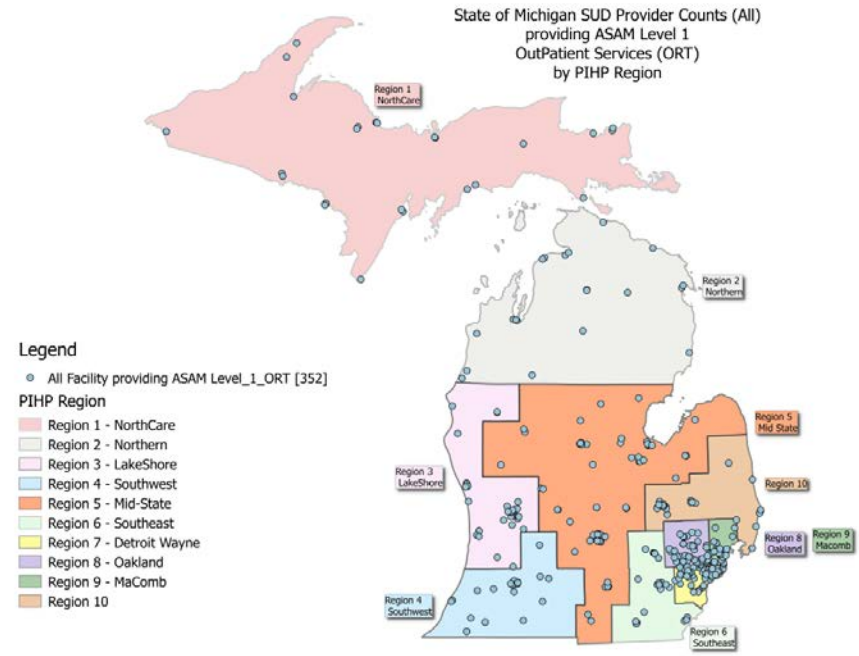
4. Describe where the 1115 Demonstration will operate, i.e., statewide, or in specific regions within the State. If the 1115 Demonstration will not operate statewide, please indicate the geographic areas/regions of the State where the 1115 Demonstration will operate.

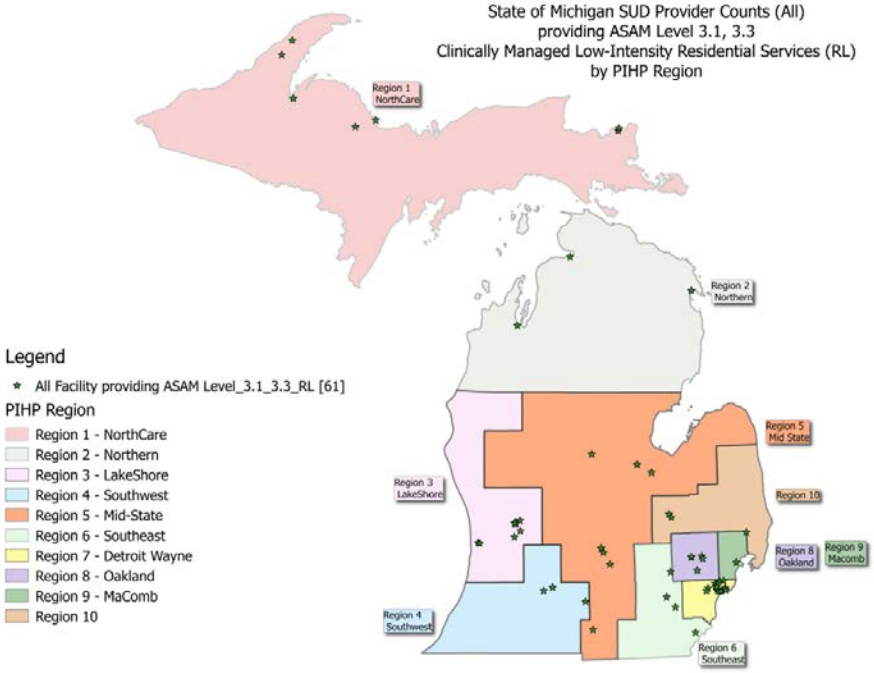
The Demonstration will operate statewide.

5. Include the proposed timeframe for the §1115 Demonstration

Michigan proposes to implement this §1115 Waiver on October 1, 201**9**. Demonstration Year (DY) 1, will focus on ensuring statewide capacity for ASAM level 3.1 and developing an approach for expanding provider and service capacity for ASAM levels up to and including **3.5 and** 3.

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





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

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

DY 2 will build off of the expan**sion of the** treatment continuum of residential care, outpatient withdrawal management, and medication assisted treatment for persons with SUD and **increase the overall access to care.**

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

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

III. Demonstration Eligibility

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

No eligibility changes will be affected by this demonstration.

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

No new eligibility changes will be affected by this demonstration.

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

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

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

Michigan is serving about 60,000 Medicaid beneficiaries in the current SUD service system. It is anticipated that Michigan could serve up to 70,000 individuals in the system set up through this demonstration.

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

Not Applicable

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

None.

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

Not Applicable.

IV. Demonstration Benefits and Cost Sharing Requirements

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

☐Yes ☒No (if no, please skip questions 3-7)

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

☐ Yes ☒No (if no, please skip questions 8-11)

There are no cost sharing requirements under this Demonstration.

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

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

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

Medical Necessity Criteria

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

- Necessary for screening and assessing the presence of substance use disorder; and/or
- Required to identify and evaluate substance use disorder; and/or
- Intended to treat, ameliorate, diminish or stabilize the symptoms of substance use disorder; and/or
- Expected to arrest or delay the progression of substance use disorder; and/or

- Designed to assist the beneficiary to attain or maintain a sufficient level of functioning in order to achieve his goals of community inclusion and participation, independence, recovery, or productivity.

Determination Criteria

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

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

Additional Eligibility Reforms

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

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

The Early Intervention level of care (0.5) is currently offered as a benefit and will continue to be included as part of this continuum with a more formal designation than it has now. The access systems are required to provide education and resource information as part of their programming already. This is consistent with ASAM expectations for individuals who are at risk

of developing a SUD yet there is not sufficient information to document a formal SUD diagnosis after an assessment has been completed. Similar to how SBIRT works, the individual will be able to return to the assessment center/component of a program for a set number of brief follow up visits for more education and information gathering to assist in determining if more intensive interventions are needed.

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

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

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

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

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

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

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

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

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

To support the use of the established medical necessity criteria, and make them more representative of "clinical necessity" that is needed for SUD treatment, the Six Dimensions of Multidimensional Assessment, part of the ASAM Criteria, will be incorporated into the assessment process for any individual seeking SUD related services. These dimensions include a detailed review of the following areas:

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

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

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

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

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

There are no premium amounts included in this Demonstration.

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

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

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

Cost sharing is not a component of this Demonstration.

V. Delivery System and Payment Rates for Services

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

☐Yes
☒ No

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

These changes will require PIHPs and their CMHSP providers to meet quality reporting requirements **and** develop and expand SUD provider systems. These linkages are intended to identify and provide education, prevention, and treatment of modifiable health risk factors, provide SBIRT for SUD at primary care settings, initiatives, provide incentives for increased access to primary care, and the coordinated tracking of "High Utilizers" of emergency department usage and hospital admissions/readmissions.

In order to **implement the** standardize**d** SUD assessment process and level of care criteria, there will be ongoing training and education on the application of the ASAM at all levels of SUD care. **Michigan has committed to use the Global Appraisal of Individual Needs – Initial (GAIN-I) SUD assessment instrument throughout the entire system. The GAIN instrument is normed with the ASAM criteria and will complement that transition.** The PIHPs will be required to ensure that their providers and/or the intake agencies within their networks are all appropriately trained/educated in the application and use **of the ASAM criteria and the GAIN-I**. PIHPs will provide evidence of initial training and ongoing training of providers during site reviews conducted by MDHHS. Additionally, as part of quality monitoring during MDHHS site reviews, records will be reviewed to determine appropriate application and fidelity to the established assessment and early intervention processes and to determine if the PIHP is appropriately monitoring providers and taking necessary corrective action.

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

- ☐ Managed care
- ☐ Managed Care Organization (MCO)

- ☒ Prepaid Inpatient Health Plans (PIHP)
- ☐ Prepaid Ambulatory Health Plans (PAHP)
- ☐ Primary Care Case Management (PCCM)
- ☐ Health Homes
- ☐ Other (please describe)

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

Multiple delivery systems are not being used for the delivery of the SUD benefit.

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

The Demonstration will use Medicaid PIHPs

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

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

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

   The managed care delivery system will be statewide

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

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

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

This §1115 Waiver will maintain the use of a managed care delivery structure using ten (10) PIHPs[2] who contract for service delivery with forty-six (46) CMHSP's and other non-for profit providers. As outlined in the table below, seven (7) of the PIHPs are formed by multiple CMHSP's (aka. Regional Entities) and three (3) are stand-alone PIHPs/CMHSPs.

CMHSP's/County/City	Type of program	Name of Entity
Pathways CMH **(Alger, Delta, Luce, Marquette) Copper Country CMH (Baraga, Houghton, Keewanaw, Ontonagon)** Hiawatha CMH **(Chippewa, Mackinac, Schoolcraft)** Northpointe CMH **(Menominee, Dickinson, Iron) Gogebic CMH**	**PIHP**	**Northcare Network**
AuSable CMH **(Oscoda, Ogemaw, Iosco) Central Wellness Network (Manistee, Benzie)** North Country CMH **(Antrim, Charlevoix, Cheboygan, Emmet, Kalkaska, Otsego)** Northern Lakes CMH **(Crawford, Grand Traverse, Leelanau, Missaukee, Roscommon, Wexford)** Northeast CMH **(Alcona, Alpena, Montmorency, Presque Isle)**	**PIHP**	**Northern Michigan Regional Entity**
Allegan CMH Muskegon CMH Network 180 **(Kent) Ottawa CMH West MI CMH (Lake, Mason, Oceana)**	**PIHP**	**Lake Shore Regional Entity**
Barry CMH Berrien CMH Kalamazoo CMH	**PIHP**	**Southwest Michigan Behavioral Health**

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

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

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

Although freedom of choice will continue to be waived, PIHPs will be required (as non-provider entities) to arrange Medicaid service contracts to ensure the independent

evaluation of eligibility, assessment, and the development of the Individual Plan of Service. Although model configuration may be optional (based on state approval), the independent evaluation of eligibly and assessment does not include the provision of emergency services that may result in a preliminary plan of service. For PIHPs who contract with CMHSPs, the PIHP will be required to monitor the CMHSP's self-referral and utilization patterns related to consumer choice and best value criteria.

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

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

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

Only state plan SUD services are included in this demonstration.

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

☐ Yes
☒ No

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

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

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

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

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

Quality based payments are not being utilized.

VI. Implementation of Demonstration

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

Upon submission and anticipated approval of October 1, 201**9** Michigan proposes to implement the benefit and spending authority effective October 1, 201**9**. Phase 1 of the demonstration will include the development of the demonstration based on CMS's timeframe to submit final evaluation. The **processes for the** enhancement of provider competency related to the use of ASAM criteria **and the GAIN-I assessment**, the expanded use of recovery coaches and the use of residential treatment facilities regardless of the size of the facility **are currently in place to prepare the system for the formal move to our proposed model**.

Phase 2 will build off of the expanding treatment continuum of residential care, outpatient withdrawal management, medication assisted treatment for persons with SUD

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

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

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

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

VII. Demonstration Financing and Budget Neutrality

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

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

VIII. List of proposed Waivers and Expenditure Authorities

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

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

- Proper and Efficient Administration
  §1902(a)(4)
  Rationale for Authority: Mandate beneficiaries into a single Prepaid Inpatient Health Plan
- Freedom of Choice
  §1902(a)(23)(A)
  To enable the State to restrict Demonstration participants to receive benefits through PIHPs and CMHSPs.
  Rationale for Authority: beneficiaries enrolled in the program must receive services through a PIHP

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

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

- Methods of Administration: Transportation §1902(a)(4), insofar as it incorporates 42 CFR 431.53

To enable the State to assure transportation to and from providers for the Demonstration participants.

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

- IMD Expenditure Authority

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

IX. Demonstration Administration

Name and Title: Jacqueline Coleman

Telephone Number: (517) 284-1190

Email Address: ColemanJ@michigan.gov

Appendix A

Substance Use Disorder Benefits and Service Array

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

Notes: These notes apply to the entire document.

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

Individual Assessments

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

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

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

Outpatient Care

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

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

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

Methadone Treatment

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

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

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

Withdrawal Management (Medically Monitored)

Service: Substance Use Disorder, Withdrawal Management (ASAM 3.7 WM)
Scope/Description: Alcohol and/or drug services; sub-acute withdrawal management; medically monitored residential withdrawal management

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

Limitations on the amount of service	Limitations on the duration of the service	Provider Category(s):	The service may be provided by a:	Description of allowable providers:
Per ☐ Day ☐ Week ☐ Month ☐ Year ☒ Other: ASAM 3.7-WM	_____Day(s) Week(s) Month(s) Other:	Individual (list types): ☒ Agency (list types of agencies): This may include Residential settings regardless of size that are within the definition of IMDs at 42 CFR 435.1010.	Legally Responsible Person Relative/Legal Guardian: N/A	Provider agency licensed and accredited as substance abuse residential withdrawal management program. Supervision by a licensed physician. Staffed 24-hours-per-day, 7 days a week by licensed physician or by a representative of a licensed physician.

Sub-Acute Withdrawal Management ~~Detoxification~~ (Clinically Monitored)

Service: Substance Use Disorder, Sub-Acute Withdrawal Management (ASAM 3.2-WM)
Scope/Description: Alcohol and/or drug services; sub-acute withdrawal management; clinically monitored residential withdrawal management; non-medical or social setting.

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

Limitations on the amount of service	Limitations on the duration of the service	Provider Category(s):	The service may be provided by a:	Description of allowable providers:
Per ☐ Day ☐ Week ☐ Month ☐ Year ☒ Other: ASAM 3.2-WM	_____Day(s) Week(s) Month(s) Other:	Individual (list types): ☒ Agency (list types of agencies): This may include Residential settings regardless of size that are within the definition of IMDs at 42 CFR 435.1010.	Legally Responsible Person Relative/Legal Guardian: N/A	Provider agency licensed and accredited as substance abuse residential withdrawal management program. Supervision by a licensed physician. Provided under the supervision of a substance abuse treatment specialist. Must have access to licensed medical personal.

Sub-Acute Withdrawal Management ~~Detoxification~~ (Ambulatory)

Service: Substance Use Disorder, Sub-Acute Withdrawal Management (Ambulatory) (ASAM 1-WM & ASAM 2-WM)
Scope/Description: Alcohol and/or drug services; ambulatory withdrawal management without and with extended on-site monitoring.

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

Limitations on the amount of service	Limitations on the duration of the service	Provider Category(s):	The service may be provided by a:	Description of allowable providers:
Per ☐ Day ☐ Week ☐ Month ☐ Year ☒ Other: ASAM 1-WM and 2-WM	_____Day(s) Week(s) Month(s) Other:	☒ Individual (list types): ☒ Agency (list types of agencies): This may include Residential settings regardless of size that are within the definition of IMDs at 42 CFR 435.1010.	Legally Responsible Person Relative/Legal Guardian: N/A	Provided under the supervision of a Substance Abuse Treatment Specialist. Must have arrangements for access to licensed medical personnel as needed. Appropriately certified licensed nurses must monitor ASAM level 2-WM ambulatory withdrawal management services.

Residential Services

Service: Substance Use Disorder, Residential Services (ASAM 3.1, 3.3, 3.5 & 3.7)
Scope/Description: Alcohol and/or drug services; short term residential (non-hospital residential treatment program).

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

Limitations on the amount of service	Limitations on the duration of the service	Provider Category(s):	The service may be provided by a:	Description of allowable providers:
Per ☐ Day ☐ Week ☐ Month ☐ Year ☒ Other: ASAM 3.1, 3.3, 3.5 and 3.7	_____Day(s) Week(s) Month(s) Other:	Individual (list types): ☒ Agency (list types of agencies): This may include Residential settings regardless of size that are within the definition of IMDs at 42 CFR 435.1010.	Legally Responsible Person Relative/Legal Guardian: N/A	Provider agency licensed and accredited as substance abuse treatment program. The clinical program must be provided under the supervision of a SATS with licensure as a psychologist, master's level social worker, licensed or limited-licensed marriage and family therapist.

Targeted Case Management

Service: Targeted Case Management

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

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

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

Appendix B

Long Term Service and Supports

Administration, Quality and Service Plan Development

Please complete this form if you indicated in Section III that the Demonstration will provide long term services and supports (LTSS).
Indicate the Population(s) that the following long-term services and support description applies to:
Enter Populations Here:

Administration of the Long Term Services and Supports Program
Will the LTSS component of the Demonstration be operated by one or more State agencies other than the Medicaid agency? ☐ Yes ☐ No
If yes, please provide the contact information of the key contacts at those agencies, including name, title, name of agency, address, telephone number, email address and fax number. Also describe the specific sub-population associated with the contact:
Do other State agencies, that are not part of the Single State Medicaid Agency, perform Demonstration operational and administrative functions on behalf of the Medicaid agency?
☐ Yes ☐ No
Do any contracted entities, including managed care organizations, perform Demonstration operational and administrative functions on behalf of the Medicaid agency or the waiver operating agency (if applicable)?
☐ Yes ☐ No
Do any local or regional non-state entities perform Demonstration operational and administrative functions?
☐ Yes ☐
No
If yes to any of the questions above, specify the types of State agencies, contracted entities and/or local/regional non-state entities and describe the specific functions that they perform. This includes individual enrollment, management of any enrollment or expenditure limits, level of care evaluation, review of service plans, prior authorization of services, utilization management, provider enrollment and agreements, rate methodologies, rules, policies and procedures, and quality assurance and improvement activities. Please describe how the Single State Agency oversees the performance of these non-State entities:

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

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

Level of Care to Qualify for the Program
This Demonstration is requested in order to provide LTSS to individuals who, but for the provision of such services, would require the following level(s) of care, the costs of which should be reimbursed under the approved Medicaid state plan:

Indicate and describe the level of care criteria for participants in the Long Term Services and Supports Demonstration program, such as hospital, nursing facility, ICF-MR, IMD-hospital, IMD-nursing facility, or needs-based criteria. Identify which entity performs the initial and subsequent level of care evaluations and the frequency of such reevaluations:

Individual Cost Limits
Do individual cost limits apply when determining whether to deny LTSS or entrance to the Demonstration to an otherwise eligible individual ☐Yes ☐No
If yes, indicate the type of cost limit that applies and describe any additional requirements pertaining to the indicated limit:

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

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

☐ **Cost Limit Lower Than Institutional Costs. The State refuses entrance to the Demonstration to any otherwise qualified individual when the State reasonably expects that the cost of LTSS furnished to that individual would exceed an amount specified by the State that is less than the cost of a level of care specified for the**

Demonstration. Specify the basis of the limit, including evidence that the limit is sufficient to assure the health and welfare of Demonstration individuals.

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

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

☐ Case Manager ☐ Social Worker
☐

Other (please describe, include qualifications)

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

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

☒ Administrative Staff ☒ Transport Staff

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

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

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

☐ Other (please describe)

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

Yes ☐
No ☒

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

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

☐ Administrative Staff ☐ Transport Staff

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

☐ Others (please describe)

Allowable Settings

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

☐ Yes ☒ No

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

Individual Rights

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

☐ Yes ☒ No

Quality Improvement Strategies

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

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

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

QAPIP Standards

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

mechanisms or procedures to be used for adopting and communicating process and outcome improvement.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

C. All unexpected* deaths of Medicaid beneficiaries, who at the time of their

deaths were receiving specialty supports and services, must be reviewed and must include:

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

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

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

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

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

The QAPIP must describe how the PIHP will analyze at least quarterly the critical incidents, sentinel events, and risk events (see below) to determine what action needs to be taken to remediate the problem or situation and to prevent the occurrence of additional events and incidents. MDHHS will request documentation of this process when performing site visits. MDHHS has developed formal procedures for analyzing the event data submitted through this system. This includes criteria and processes for Department follow-up on individual events as well as processes for systemic data aggregation, analysis and follow-up with individual PIHPs.

F. Risk Events Management

The QAPIP has a process for analyzing additional critical events that put individuals (in the same population categories as the critical incidents above) at risk of harm. This analysis should be used to determine what action needs to be taken to remediate the problem or

situation and to prevent the occurrence of additional events and incidents. MDHHS will request documentation of this process when performing site visits.

These events minimally include:

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

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

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

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

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

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

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

D. The organization insures the incorporation of consumers receiving long-term

supports or services (e.g., persons receiving case management or supports coordination) into the review and analysis of the information obtained from quantitative and qualitative methods.

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

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

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

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

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

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

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

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

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

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

XIV. The organization operates a utilization management program.

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

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

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

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

XV. The PIHP annually monitors its provider network(s), including any affiliates or sub-contractors to which it has delegated managed care functions, including service and support provision. The PIHP shall review and follow-up on any provider network monitoring of its subcontractors.

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

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

MDHHS Quality Management and Planning Site Review Process

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

In addition to the full biennial site review, the QMP Site Review Team members also conduct a follow-up review approximately 90 days after the issuance of the approved corrective action plan (CAP) to assess the status and effectiveness of the PIHPs implementation of their CAP.

A standard site review protocol is used at the time of each site visit. The protocol is used to record and document findings during the site review. The findings are sent to the PIHPs which are required to submit a CAP to MDHHS within 30 days. The CAP is reviewed and approved by MDHHS. The PIHP has 90 days after the CAP has been approved to provide evidence to MDHHS that all issues have been remediated. The remediation process continues until all concerns have been appropriately addressed.

If, during a QMP on-site visit, the site review team member identifies an issue that places a participant in imminent risk to health or welfare, the site review team would invoke an immediate review and response by the PIHP.

Appendix E

Public Notice Update with Attachments

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

Public Notice of Waiver Application

The MDHHS, BHDDA began discussions on the proposed §1115 waiver application to the Medical Care Advisory Council (MCAC) on 2/19/15. BHDDA staff, as regular members of the MCAC, continued to provide updates and receive input through their quarterly meetings in 2015 and 2016. BHDDA staff met with Tribal Health Centers as part of the Behavioral Health Communication Network on 4/15/15, 6-26-15, 7-16-15, 8-17-15, 10-14-15 and most recently 4-13-16. Although the §1115 Pathway to Integration Waiver application does not change the current relationship between the state and the Tribal Health Centers, as a result of these meetings the state has requested attendance from the regional PIHPs to assure proper service coordination and access to specialty services as needed. From September, 2015 through November, 2015, the BHDDA held four Sounding Board Workgroups with the Michigan Association of Community Mental Health Boards (MACMHB), the Michigan ARC and the Behavioral Health Advisory Council (BHAC). Membership included PIHPs, CMHSPs, invited advocates and family members. These sounding board workgroups allowed open discussion regarding Michigan's current behavioral health system and the planned initiatives to be included in Michigan's §1115 demonstration waiver application.

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

Michigan held two public hearings on the waiver application, one by webinar on 1-13-16 and one in person on 1-28-16 in Lansing Michigan. Combined attendance included over 150 participants from trade associations, family members' advocates, consumers and other

interested individuals. Common themes and responses along with all written comments and responses received is included as Appendix E, Attachment 2.

Attachment 1

Stakeholder Notice and Public Hearing

December 18, 2015

Dear Stakeholders and Interested Parties:

RE: Section 1115 Waiver - Pathway to Integration Proposal

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

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

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

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

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

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

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

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

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

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

We thank you in advance for your participation.

Sincerely,

Chris Priest, Acting Director
Medical Service Administration
Administration

Lynda Zeller, Director
Behavioral Health and Developmental Disabilities

Public Hearing PPT

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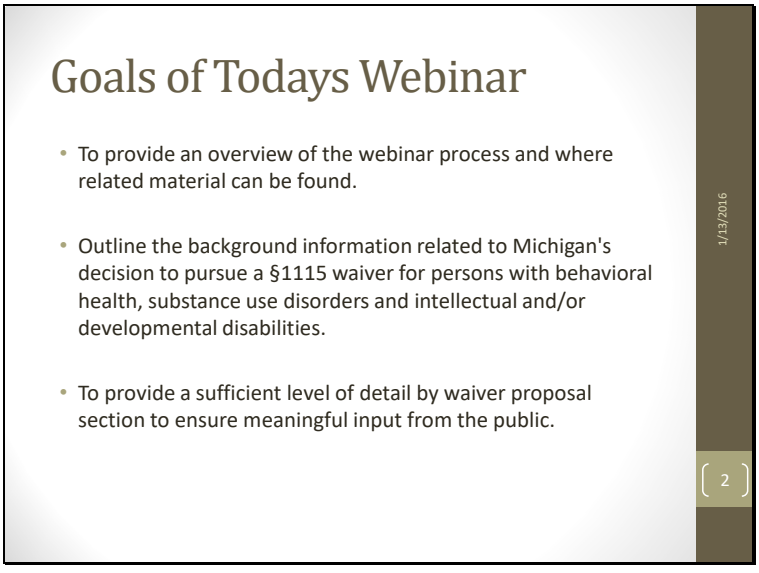

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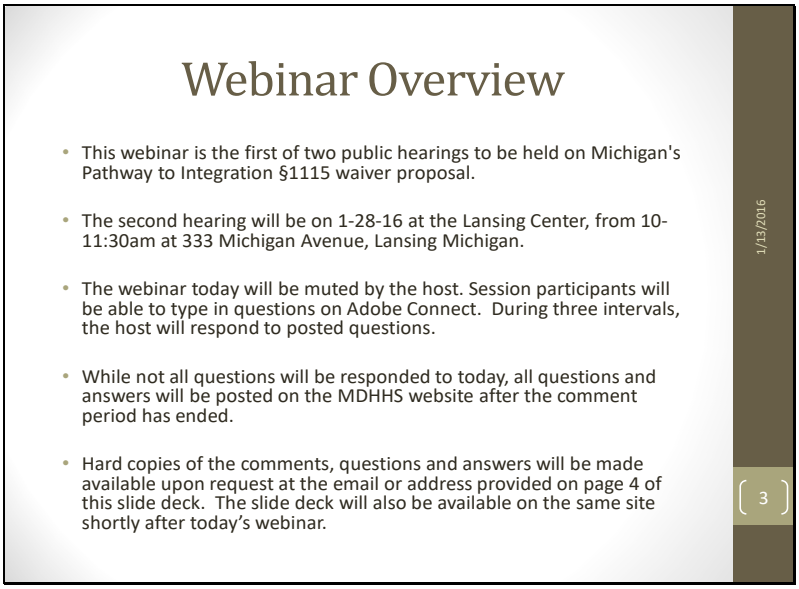

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Pathway to Integration Background

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

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The Desire and Need for Change

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

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Questions so far?

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Pathway to Integration Waiver Proposal

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

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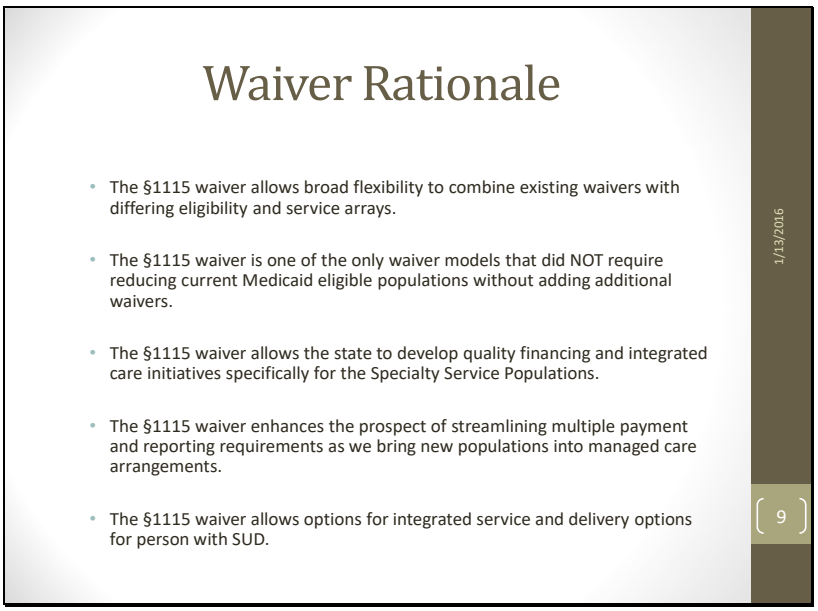

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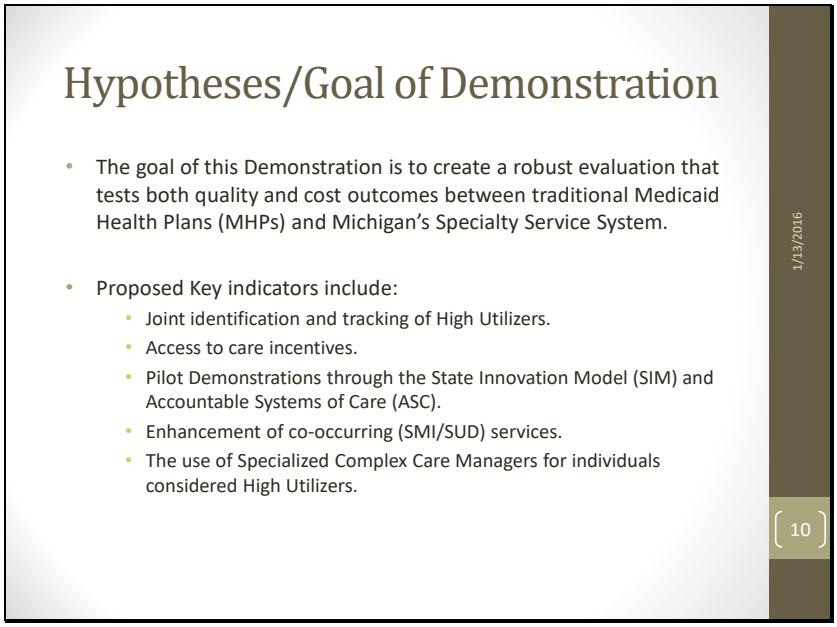

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Medicaid Eligibility

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

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Demonstration Benefits

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

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Questions so far?

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Delivery Systems and Reforms

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

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Delivery Systems and Reforms (cont.)

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

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Long Term Service and Supports & Self Direction

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

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Payments to Managed Care Entities

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

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Quality Based Supplemental Payments

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

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Implementation of the Demonstration

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

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List of Proposed Waiver & Expenditure Authorities

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

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

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

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

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List of Proposed Waiver & Expenditure Authorities

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

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List of Proposed Waiver & Expenditure Authorities

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

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Appendix A LTSS

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

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Appendix B LTSS

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

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Questions?

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Attachment 2

Common Themes and Written Comments Received

Common Themes and State Responses

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

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

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

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

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

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

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

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

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

Written Comments Received

(Please see separate PDF)