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

April 29, 2025

Megan Groen
Senior Deputy Director
Behavioral and Physical Health and Aging Services Administration
Michigan Department of Health and Human Services
400 S Pine Street, 7th Fl
Lansing, Michigan 48933

Dear Director Groen:

The Centers for Medicare & Medicaid Services (CMS) completed its review of Michigan's Final Report for the COVID-19 Public Health Emergency (PHE) amendment in Michigan's 1115 Behavioral Health Demonstration, formerly entitled "Pathway to Integration" (Project No. 11-W-00305/5), dated July 8, 2024. This report covers the demonstration period from January 1, 2019 to December 31, 2023. CMS determined that the Final Report, submitted on July 8, 2024 is in alignment with approval letter, and therefore, approves the state's Final Report.

In accordance with STCs #54(b) and 56, the approved Final Report may now be posted to the state's Medicaid website within 30 days. CMS will also post the Final Report on Medicaid.gov.

We appreciate the state's commitment to evaluating the COVID-19 PHE amendment under these extraordinary circumstances. We look forward to our continued partnership on in Michigan's 1115 Behavioral Health Demonstration. If you have any questions, please contact your CMS demonstration team.

Sincerely,

Danielle Daly
Director
Division of Demonstration Monitoring and Evaluation

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

Michigan 1115 Behavioral Health Demonstration:
COVID-19 Addendum
Evaluation Report

University of Michigan
Institute for Healthcare Policy and Innovation

July 8, 2024

Table of Contents

A. Executive Summary 1

B. General Background Information 5

C. Evaluation Questions and Hypotheses 7

D. Methodology 7

E. Methodological Limitations 11

F. Results 12

F.1. Primary research question 1: What changes in rates of HCBS initiation and utilization occurred during the COVID-19 PHE? 12

F.2. Primary research question 2: How did changes in initiation and utilization during the COVID-19 PHE compare to changes in initiation and utilization of other PIHP-administered services? 17

F.3. Primary research question 3: In what ways did the PHE impact HCBS service providers? 22

F.4. Primary research question 4. What strategies or adaptations were most effective in achieving the essential goals of the demonstration project? 35

F.5. Primary research question 5. How did HCBS-related expenditure patterns change during the PHE? 37

G. Conclusions 41

H. Interpretations, Policy Implications. and Interactions with Other State Initiatives 42

I. Lessons Learned and Recommendations 43

J. Attachments 43

LIST OF ABBREVIATIONS

BHDDA	Behavioral Health and Developmental Disabilities Administration
CDC	Centers for Disease Control and Prevention
CLS	Community Living Supports
CMHSP	Community Mental Health Services Provider
CMS	Centers for Medicare & Medicaid Services
CPT	Current Procedural Technology
CWP	Children's Waiver Program
CY	Calendar year
FFCRA	Families First Coronavirus Response Act
HCBS	Home- and Community-Based Services
HCPCS	Healthcare Common Procedure Coding System
HIPAA	Health Insurance Portability and Accountability Act
HSW	Habilitation Services Waiver
ICD-10	International Statistical Classification of Diseases and Related Health Problems, 10th revision
LARA	Department of Licensing and Regulatory Affairs
LOC	Level of care
MDHHS	Michigan Department of Health and Human Services
NPI	National Provider Identifier
PHE	Public Health Emergency
PIHP	Prepaid Inpatient Health Plans
SED	Waiver for Children with Serious Emotional Disorder
STC	Special Terms and Conditions
STP	Statewide Transition Plan
SUD	Substance Use Disorder

A. Executive Summary

A.1. Summary of Demonstration and Evaluation

On March 13, 2020, the President of the United States issued a proclamation that the Coronavirus Disease 2019 (COVID-19) outbreak constitutes a national emergency. In response, the Secretary of Health and Human Services invoked his authority pursuant to section 1135 of the Social Security Act to waive or modify certain requirements of titles XVIII, XIX, and XXI, 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 was retroactively effective on March 1, 2020.

To assist Michigan in delivering the most effective care to its beneficiaries in light of the COVID-19 public health emergency (PHE), CMS approved the COVID-19 PHE amendment to the Michigan 1115 Behavioral Health Demonstration, authorized retroactively from March 1, 2020, through 60 days after the PHE ended on May 11, 2023.[1] The demonstration amendment aimed to ensure that sufficient health care items and services are available to meet the needs of Medicaid beneficiaries, 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. With those goals in mind, CMS approved an array of expenditure authorities, including:

- Increased payment rates to home- and community-based services (HCBS) providers to maintain capacity
- Expedited eligibility and payment for long-term supports and services
- Relaxed timelines for functional assessments and level of care determinations
- Payment for HCBS in alternative settings
- Use of verbal consents to verify person-centered service plans
- Use of telehealth for evaluations, assessments, and service planning
- Suspension of some data collection requirements for quality reviews
- Flexibility around incident reporting requirements

A.2. Summary of Evaluation

This evaluation examined whether and how the approved expenditure authorities affected the state's response to the PHE, tracked administrative costs and health services expenditures for demonstration beneficiaries, and assessed how these outlays affected Michigan's response to the PHE, to address five specific evaluation questions:

1. What changes in rates of HCBS initiation and utilization occurred during the COVID-19 PHE?
2. How did changes in initiation and utilization of HCBS during the PHE compare to changes for other services administered through the Prepaid Inpatient Health Plans (PIHPs)?
3. In what ways did the PHE impact HCBS providers?
4. What strategies or adaptations were most effective in achieving the essential goals of the demonstration?
5. How did HCBS-related expenditure patterns change during the COVID-19 PHE?

[1] https://www.hhs.gov/about/news/2023/02/09/letter-us-governors-hhs-secretary-xavier-becerra-renewing-covid-19-public-health-emergency.html

The evaluation plan, approved by CMS on May 10, 2021,[2] is based on a mixed-methods approach, including analysis of state administrative data and collection of qualitative data through key informant interviews. The full approved evaluation design is included as Attachment A to this report.

Contextual Factors

Contextual factors affecting the state's implementation of the demonstration amendment included the impact of increased Medicaid funding provided during the COVID PHE by US Congress to states through Section 6008 of the Families First Coronavirus Response Act (FFCRA). One condition of receipt of FFCRA funds was a maintenance of effort requirement that prohibited states from terminating most Medicaid beneficiaries' coverage until the end of the PHE, which led to a dramatic increase in Medicaid enrollment. The Michigan Department of Health and Human Services (MDHHS) resumed conducting Medicaid eligibility renewals on a rolling, monthly basis after passage of the federal Consolidated Appropriations Act of 2023, with the expectation that the resumption of renewal process would extend through June 2024. Thus, roughly half of Medicaid beneficiaries would have completed the resumed renewal process at the end of this evaluation period.

Another contextual factor was the March 2022 reorganization of the state's behavioral health administration,[3] such that the functions previously administered by the Behavioral Health and Developmental Disabilities Administration (BHDDA) was shifted to different divisions within MDHHS, with unclear implications for the demonstration amendment.

A final contextual factor of note was the state's ongoing effort to comply with federal HCBS settings requirements for programs offering Medicaid HCBS, which aim to ensure integration into the community of individuals who receive HCBS.[4] In response to these requirements, MDHHS developed a Statewide Transition Plan (STP), which received final CMS approval in March 2023, [5] to outline the process for Michigan Medicaid waiver programs to come into compliance. Implementation of the demonstration amendment was complicated by the need to also make progress on STP activities, such as conducting HCBS provider site assessments, particularly in an environment where achieving community integration was counter to PHE behaviors (e.g., social distancing).

Data Sources and Methodological Limitations

The main sources of data for the evaluation are state administrative data and qualitative data from key informant interviews. Specific evaluation measures, analytic methods, and methodological limitations are described in detail in the main report by data source.

A.3. Results and Interpretations

Analysis of administrative data found that overall, HCBS initiation and utilization for the 1915(i)-like population declined slightly across the evaluation period. However, among beneficiaries who received HCBS, number of days with services and month-to-month continuity returned to pre-PHE levels. The

---

[2] www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/mi-covid-19-evaluation-design-approval.pdf

[3] https://www.michigan.gov/mdhhs/inside-mdhhs/newsroom/mdhhs-realigns-to-improve-coordination-of-behavioral-health-services-farah-hanley-appointed-chief-d

[4] See 79 Fed. Reg. 2948 (Jan. 16, 2014), available at https://www.gpo.gov/fdsys/pkg/FR-2014-0116/pdf/2014-00487.pdf; see also 42 CFR Parts 430, 431, et. al.

[5] www.michigan.gov/mdhhs/-/media/Project/Websites/mdhhs/Assistance-Programs/Health-Care-Coverage/Michigan_STP_Final_Approval_Letter.pdf

number of HCBS providers decreased by about 10% from the pre-PHE period, with a slight increase in the ratio of beneficiaries per HCBS provider. Use of telehealth for HCBS delivery was highest in the initial months of the PHE and then steadily declined. Utilization of HCBS varied by PIHP. In comparison, overall initiation utilization of SUD treatment services through the PIHP/CMHSP system showed similar patterns as HCBS; among those receiving SUD treatment services, average number of days and month-to-month continuity was lower than for HCBS.

HCBS expenditures increased in October 2020, statewide and for each PIHP, consistent with implementation of premium pay and other strategies to support HCBS providers. This likely contributed to the increased proportion of overall expenditures attributable to HCBS.

Overall, trends in administrative data support the effectiveness of the demonstration authorities in supporting HCBS providers and ensuring the availability of HCBS for beneficiaries.

Key informants described implementation of strategies to maintain stability of the HCBS provider network in each PIHP/CMHSP, including flexibility to modify contracts and offer supplemental payments to provider organizations. Key informants also described implementation of statewide policies to offer premium pay wage increases for direct care workers, highlighting administrative inconsistencies and reporting burdens that limited their effectiveness.

Many PIHP/CMHSP administrators and HCBS providers noted that staffing issues became more pronounced in 2021, which impacted services to beneficiaries in a variety of ways. Additionally, they expressed concern for the future that as staff turned over, new hires generally had less education and work experience, which could impact the quality of services delivered to consumers. Key informants had mixed views on modified training and certification requirements; while online trainings expedited the time from hire to delivering HCBS, an online experience does not provide a comparable learning environment.

To facilitate delivery of services at the outset of the PHE, key informants lauded telehealth as an effective mechanism to maintain connections while keeping consumers, families and HCBS providers safe. However, key informants agreed that HCBS are best delivered in person, and that telehealth should be limited to certain situations, service types, and/or frequency. Most PIHPs and CMHSPs began encouraging return to in-person HCBS delivery in March 2021, in conjunction with the state directive that telehealth should be the consumer's (not staff's) preference. Some key informants tied the October 2021 drop in HCBS providers to no longer being able to do case management via telehealth; trends in administrative data support this hypothesis.

PIHP and CMHSP administrators and HCBS providers agreed that verbal consent was an effective strategy to obtain expedited services, particularly at the outset of the PHE. As staffing shortages continued, the option of verbal consent was useful from an administrative sense. Other demonstration authorities were deemed effective but infrequently used due to demand or limited staffing.

Looking to the future, PIHP and CMHSP administrators and HCBS providers agreed that permanent increases in wages for direct care workers was the key to returning to prior staffing levels. Many recommended efforts to enhance the professionalization of the HCBS workforce; continued but limited use of telehealth to support HCBS administration; and efforts to reduce the administrative burden on HCBS providers, including strategies to minimize inconsistencies across PIHPs.

A.4. Recommendations

Based on results of this evaluation, we recommend that the state work with partners across state agencies to pursue efforts to support the HCBS workforce through a multi-pronged effort of advocating for wage increases, supporting training opportunities and career pathways, and expanding the use of family caregivers.

The COVID-19 PHE was the impetus to find innovative ways to deliver HCBS. We also recommend that the state support these new developments. Specifically, we encourage the state to seek stakeholder input to define the parameters for a limited use of telehealth for HCBS delivery and an expanded use of telehealth, including digital engagement via smartphones, to support HCBS administration.

Finally, we encourage the state to understand the impact of the current administrative inconsistencies across PIHPs in HCBS contracting and reporting, and seek ways to reduce administrative burdens for HCBS providers.

B. General Background Information

B.1. Overview and History of the Demonstration and Public Health Emergency Addendum

On March 13, 2020, the President of the United States issued a proclamation that the Coronavirus Disease 2019 (COVID-19) outbreak constitutes a national emergency. In response, the Secretary of Health and Human Services invoked his authority pursuant to section 1135 of the Social Security Act to waive or modify certain requirements of titles XVIII, XIX, and XXI, 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 was retroactively effective on March 1, 2020.

To assist Michigan in delivering the most effective care to its beneficiaries in light of the COVID-19 public health emergency (PHE), CMS approved the COVID-19 PHE amendment to the Michigan 1115 Behavioral Health Demonstration on October 27, 2020,[6] authorized retroactively from March 1, 2020, through 60 days after the PHE ended on May 11, 2023.[7] Approval of this demonstration amendment is subject to the limitations specified in the flexibilities listed in Attachment F of the CMS approval letter (Expenditure authorities granted under the Section 1115 COVID Demonstrations) and the previously approved expenditure authorities and Special Terms and Conditions (STCs).

B.2. Population Groups Impacted by the Demonstration

Medicaid beneficiaries receiving home- and community-based services (HCBS) during the COVID-19 PHE.

B.3. Goals of the Demonstration

The demonstration amendment aimed to ensure that sufficient health care items and services are available to meet the needs of Medicaid beneficiaries, 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. With those goals in mind, CMS approved an array of expenditure authorities, including:

- Increased payment rates to HCBS service providers to maintain capacity
- Expedited eligibility for long-term services and supports
- Relaxed timelines for functional assessments and level of care (LOC) determinations
- Payment for HCBS delivery in alternative settings
- Use of verbal consents to verify person-centered service plans
- Use of telehealth for evaluations, assessments, and service planning
- Suspension of some data collection requirements for quality reviews
- Flexibility around incident reporting requirements

CMS also approved nearly identical flexibilities for the state's 1915(c) waivers through the Emergency Preparedness and Response Appendix K.[8]

---

[6] www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/mi-pathway-integration-cms-covid19-amend-appvl-10272020.pdf

[7] https://www.hhs.gov/about/news/2023/02/09/letter-us-governors-hhs-secretary-xavier-becerra-renewing-covid-19-public-health-emergency.html

[8] https://www.michigan.gov/mdhhs/Approval_Letter__MI_0169_0438_4119_Appendix_K_3102021_signed.pdf

B.4. Relevant Contextual Factors

After the federal government declared the COVID-19 PHE, the US Congress provided increased Medicaid funding to states through Section 6008 of the Families First Coronavirus Response Act (FFCRA). States had to meet several conditions to receive FFCRA funds, including a maintenance of effort requirement that prohibited states from terminating most Medicaid beneficiaries' coverage until the end of the PHE. Consistent with continuous coverage requirement, MDHHS paused redeterminations of eligibility; beneficiaries were not required to submit proof or attestations of income eligibility during the PHE.[9] This federal policy change, along with an influx of newly eligible adults, led to a dramatic increase in Medicaid enrollment. Following passage of the federal Consolidated Appropriations Act of 2023, MDHHS resumed conducting Medicaid eligibility renewals on a rolling, monthly basis, with the expectation that the resumption of the renewal process would extend through June 2024. Thus, at the end of this evaluation period, roughly half of Medicaid beneficiaries would have completed the resumed renewal process.

Another contextual factor was the March 2022 reorganization of the state's behavioral health administration.[10] Prior to that change, the Behavioral Health and Developmental Disabilities Administration (BHDDA) had responsibility for policy, finance, and communication with Prepaid Inpatient Health Plans (PIHPs) around HCBS and other behavioral health services. With the reorganization, BHDDA functions and staff were assigned to different administrations and divisions within MDHHS.

The final contextual factor was the state's ongoing effort to comply with federal HCBS settings requirements for programs offering Medicaid HCBS.[11] These requirements aimed to ensure that individuals who receive HCBS are an equal part of the community and have the same access to the community as people who do not receive Medicaid waiver services. In response to the new requirements, MDHHS developed a Statewide Transition Plan (STP) to outline the transition process for Michigan Medicaid waiver programs to come into compliance. The STP received initial CMS approval in August 2017 and final approval in March 2023.[12] A major part of the STP involves working with PIHPs and Community Mental Health Services Providers (CMHSPs) to assess individual HCBS provider compliance with the requirements and to establish corrective action plans where needed. If a provider is unable to come into compliance, then individuals served by that provider must be transitioned to a compliant setting. As recognized by CMS in its most recent deadline extension, the COVID PHE impacted states' ability to conduct STP-related activities, such as doing site-specific assessments and evaluating the level of individuals' community integration. For PIHPs, CMHSPs, and HCBS providers, implementation of the flexibilities provided by the COVID-19 PHE demonstration amendment was further complicated by the need to make progress on STP activities, particularly in an environment where achieving community integration was counter to PHE behaviors (e.g., social distancing).

---

[9] Medical Services Administration Bulletin (MSA 20-37): COVID-19 Response: Suspending All Medicaid Renewals, August 2020, https://www.michigan.gov/MSA_2037Eligibility.pdf

[10] https://www.michigan.gov/mdhhs/inside-mdhhs/newsroom/mdhhs-realigns-to-improve-coordination-of-behavioral-health-services-farah-hanley-appointed-chief-d

[11] See 79 Fed. Reg. 2948 (Jan. 16, 2014), available at https://www.gpo.gov/fdsys/pkg/FR-2014-0116/pdf/2014-00487.pdf; see also 42 CFR Parts 430, 431, et. al.

[12] www.michigan.gov/mdhhs/-/media/Project/Websites/mdhhs/Assistance-Programs/Health-Care-Coverage/Michigan_STP_Final_Approval_Letter.pdf

C. Evaluation Questions and Hypotheses

This evaluation examined whether and how the approved expenditure authorities affected the state's response to the PHE, tracked administrative costs and health services expenditures for demonstration beneficiaries, and assessed how these outlays affected Michigan's response to the PHE, to address five specific evaluation questions:

1. What changes in rates of HCBS initiation and utilization occurred during the COVID-19 PHE?
2. How did changes in initiation and utilization of HCBS during the PHE compare to changes for other services administered through the PIHPs?
3. In what ways did the PHE impact HCBS providers?
4. What strategies or adaptations were most effective in achieving the essential goals of the demonstration?
5. How did HCBS-related expenditure patterns change during the COVID-19 PHE?

D. Methodology

D.1. Evaluation Design

The evaluation plan, approved by CMS on May 10, 2021,[13] is based on a mixed-methods approach, including analysis of state administrative data and collection of qualitative data through key informant interviews. These data sources are described in detail below.

The evaluation design (see Attachment A) was deemed exempt by the University of Michigan Medical School Institutional Review Board under Exemption 5 as an evaluation of a government health program. The evaluation plan was also determined to be exempt by the MDHHS Institutional Review Board, with approval of a Health Insurance Portability and Accountability Act (HIPAA) Privacy Waiver for the use of protected health information.

D.2. Data Sources, Target and Comparison Populations, Evaluation Period, Evaluation Measures, and Analytic Approach

The evaluation used state administrative data and qualitative data from key informant interviews; a description of and methods for each of these data sources is described below.

D.2.1. State Administrative Data

Data source

Administrative data were extracted from the State of Michigan's Enterprise Data Warehouse by an authorized member of the evaluation team under the authority of a Business Associates Agreement between MDHHS and the University of Michigan. Specific data elements included Medicaid enrollment history, including benefit plan, and Medicaid paid administrative claims for all services, including those provided through the specialty behavioral health system (PIHPs and CMHSPs), with accompanying billing information (e.g., HCPCS, CPT and ICD-10 diagnosis codes, billing/rendering provider, paid amount). Data processing, encryption and storage were conducted in accordance with established data security protocols.

This data source was used to examine evaluation questions 1, 2, 3, and 5.

[13] www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/mi-covid-19-evaluation-design-approval.pdf

Target and Comparison Populations

The target population was Medicaid beneficiaries receiving 1915(i)-like HCBS through the PIHP/CMHSP system of care under the 1115 waiver demonstration. To identify our target population, we first conducted monthly identification of all beneficiaries age 0-64 who received HCBS (defined under evaluation measures below). We then used monthly benefit plan fields to exclude beneficiaries enrolled in the Children's Waiver Program (CWP), Habilitation Services Waiver (HSW), and Waiver for Children with Serious Emotional Disorder (SED), as they are authorized through 1915(c) waivers. We also excluded the MI Choice waiver because it is administered through the Medicaid physical health benefit and the MI Health Link integrated care program and therefore claims for this dual-eligible population would be incomplete. The remaining beneficiaries constituted our target 1915(i)-like population.

The comparison population was Medicaid beneficiaries who received SUD treatment services through the PIHP/CMHSP system of care.

Evaluation Period

The evaluation period was January 2019 to December 2023.

Evaluation Measures

To identify HCBS, we reviewed the state's PIHP/CMHSP Encounter Reporting charts for FY2019 through FY2022 to identify HCPCS and revenue codes authorized for the 1915(i)-like population. Specific procedure codes are listed in Attachment B. We used modifiers to assign HCBS to either in-person or telehealth delivery mode.

We defined the following evaluation measures for the target population, as described below:

- <u>Initiation of HCBS</u>: the proportion of beneficiaries with at least one paid claim with an HCBS procedure code in the month, among Medicaid beneficiaries 0-64 years who did not have an HCBS procedure code in the prior 12 months
- <u>Utilization of HCBS</u>: the proportion of beneficiaries with at least one paid claim with an HCBS procedure code in the month, among all Medicaid beneficiaries 0-64 years
    - Also calculated for delivery of HCBS via telehealth
- <u>Average number of days with HCBS</u>: the total number of days with at least one HCBS procedure code, divided by the number of beneficiaries utilizing HCBS in that month
- <u>Median number of days with HCBS</u>: among beneficiaries utilizing HCBS in the month, the most common number of days with HCBS
- <u>Continuity of HCBS</u>: the proportion of beneficiaries utilizing HCBS in the prior month who continued HCBS utilization (i.e., had at least one HCBS paid claim in the month)
- <u>Number of HCBS providers</u>: the unique number of providers of HCBS in the month, based on rendering provider National Provider Identifier (NPI)
- <u>Beneficiaries per provider</u>: the number of beneficiaries in the target population (CWP, HAB, SED), divided by the number of rendering HCBS providers in the month
- <u>HCBS expenditures</u>: the total paid amounts for HCBS procedure codes, among beneficiaries with at least one paid claim for HCBS in the month
- <u>Overall expenditures</u>: the total paid amount for all Medicaid services, among beneficiaries with at least one paid claim for HCBS in the month
- <u>Proportion of expenditures attributed to HCBS</u>: the month's HCBS expenditures divided by the overall expenditures

Comparison – Substance Use Disorder (SUD) Treatment Services: We defined SUD treatment services as those delivered in the specialty behavioral system of care, using PIHP/CMHSP procedures codes consistent with our recent Mid-Point Assessment[14] for the state's 1115 Behavioral Health Demonstration. Specific procedure codes are listed in Attachment B.

We defined the following evaluation measures for the comparison population, as described below:

- Initiation of SUD treatment: the proportion of beneficiaries with at least one paid claim with an SUD treatment procedure code in the month, among Medicaid beneficiaries 0-64 years who did not have an SUD treatment procedure code in the prior 12 months
- Utilization of SUD treatment: the proportion of beneficiaries with at least one paid claim with an SUD treatment procedure code in the month, among all Medicaid beneficiaries 0-64 years
    - Also calculated for SUD treatment delivered via telehealth
- Average number of days with SUD treatment: the total number of days with at least one SUD treatment procedure code, divided by the number of beneficiaries utilizing SUD treatment in the month
- Median number of days with SUD treatment: among beneficiaries utilizing SUD treatment in the month, the most common number of days with SUD treatment
- Continuity of SUD treatment: the proportion of beneficiaries utilizing SUD treatment in the prior month who continued SUD treatment utilization (i.e., had at least one SUD treatment paid claim in the month)

Analytic methods

Our quasi-experimental evaluation design was based on comparing trends in service initiation and utilization over time (before, during, and after the PHE). For the measures listed above, we generated monthly statewide results, presented graphically; the graphs have markings to show the start and end of the COVID-19 PHE. We also generated stratified results by PIHP region to examine the explore the variability in trends across the diverse PIHP regions; however, we do not present stratified results for HCBS initiation, as cells sizes were less than 5 for some PIHPs.

Our evaluation plan called for examination of situations where outcomes decreased by ≥10% three months in a row. However, we did not identify any such situations.

Methodologic limitations

The evaluation plan did not call for statistical analysis of trends across time; instead, the analysis of administrative claims focused on demonstrating monthly trends across time, with attention to large changes in outcome measures, as well as to the time for decreases in service levels to resolve. Similarly, the evaluation plan included a general comparison service category, SUD treatment, and did not outline specific statistical comparisons. In addition, PIHP-specific outcomes were generated to describe the variation across regions, with no intention to conduct statistical comparisons.

We deviated from the approved evaluation plan in the measurement of HCBS and SUD treatment volume. The evaluation plan called for analysis of units of service; however, these are not standard across all HCBS and SUD treatment service. Therefore, to assess trends in volume of services we substituted average and median number of days with at least one service. In addition, we added a

[14] https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/mi-behavioral-health-accepted-mid-point-assessment.pdf

measure to describe service delivery via telehealth. To supplement the description of HCBS provider trends, we added a measure of average beneficiaries per HCBS provider.

Determination of what constitutes HCBS is open to interpretation, made difficult because there is no standardized list of HCBS procedure codes across states.[15] Results may have differed with the inclusion or exclusion of certain codes.

Finally, we present monthly data through December 2023. Because the billing and reimbursement process can be delayed, it is possible that data for the months at the end of calendar year (CY) 2023 may be incomplete due to administrative claims lag.

D.2.2. Qualitative Data

Data source

Our design evaluation plan calls for conducting key informant interviews with representatives PIHPs and HCBS providers, with the goal of describing their experiences with retaining HCBS providers and providing HCBS services during the PHE. The qualitative data from key informant interviews provides context to quantitative data.

Two evaluation team members conducted interviews with MDHHS officials, PIHP and CMHSP administrators, and representatives from HCBS provider organizations; CMHSP interviews were added because some PIHPs indicated they delegated administrative of HCBS services to the CMHSPs in their regions. We used structured interview protocols for each group of key informants, with ad hoc follow-up questions to clarify responses. Generally, interviews with PIHP and CMHSP officials lasted 60-90 minutes, while interviews with HCBS providers lasted 30-60 minutes.

Interviews were conducted via teleconference and recorded with the approval of all participants. We transcribed each interview.

This data source is used to examine evaluation questions 3 and 4.

Target and comparison populations/Study population

Our target population was state (MDHHS) and regional (PIHP and CMHSP) officials involved in administering HCBS benefits, and HCBS providers. We conducted interviews with two MDHHS officials, administrators in eight PIHPs and four CMHSPs, and representatives from 24 HCBS providers. The HCBS providers varied in size, with the number of staff reported ranging from 19 to 1,000, with a relatively even distribution across providers: 29% less than 100 staff, 25% 100-249, 29% 250-500, and 17% more than 500. The number of contracting PIHPs among these providers ranged from 1 to 10, with an average of 3 PIHPs. Most providers offered some type of residential or Community Living Supports (CLS) services, with several offering vocational/skills building services. Characteristics of the HCBS providers are presented in Attachment Table C-1.

Evaluation period

Key informant interviews were conducted between March and August 2022.

---

[15] V. Peebles, & A. Bohl. (2013). *The HCBS Taxonomy: A New Language for Classifying Home- and Community-Based Services*. Baltimore, MD: Centers for Medicare & Medicaid Services. Available: https://www.cms.gov/Research-Statistics-Data-and-Systems/Computer-Data-and-Systems/MedicaidDataSourcesGenInfo/Downloads/MAX_IB19_Taxonomy.pdf

Evaluation measures

Interviews with state officials focused on the application of and communication about the flexible authorities outlined in the waiver, and their views on the effectiveness of these efforts.

Interviews with PIHP and CMHSP officials explored challenges and facilitators to retaining HCBS providers during the PHE, facilitators and barriers to ensuring beneficiary access to care planning and HCBS during the PHE, unresolved or ongoing challenges, perspectives on which demonstration flexibilities or changes were most effective in retaining HCBS providers and facilitating HCBS delivery, and recommendations for additional strategies or adaptations.

Interviews with representatives of HCBS provider organizations explored challenges and facilitators to retaining staff, facilitators and barriers to ensuring beneficiary access to care planning and HCBS during the PHE, unresolved or ongoing challenges, perspectives on which demonstration flexibilities or changes were most effective in retaining HCBS providers and facilitating HCBS delivery, and recommendations for additional strategies or adaptations.

Interview guides can be found in Attachment C.

Analytic methods

We used contemporaneous notes and interview transcriptions to conduct thematic analysis of interviews with each subgroup of key informants, using a grid to document information for each participant. We identified major themes and subthemes, comparing themes across subgroups to highlight areas of concordance and disagreement.

Methodologic limitations

Key informant interviews with PIHP/CMHSP administrators included only 8 of 10 PIHP regions, due to staff turnover or lack of availability. Interviews with HCBS providers reflected all ten PIHP regions with regard to contracting and service areas. While all participating HCBS providers served the 1915(i)-like population, some comments may have pertained to other populations, such as the 1915(c) waivers.

Interviews were conducted in 2022 and reflect experiences to that point. Some key informants had been in their positions throughout the evaluation period and could offer an historical perspective on the administration and delivery of HCBS; others were hired more recently so they could not provide the history or rationale for certain decisions or processes. Given the chaotic nature of the early months of the PHE, it seems likely that key informants would not remember all details of their experiences related to the demonstration authorities.

Although we assured confidentiality, some key informants may have limited their comments to avoid being viewed as critical of state decisions. Nonetheless, we found that interviewees were very candid, sharing both challenges and successes of efforts to implement the demonstration authorities.

Finally, we chose quotes that reflected common views and situations. However, selected quotes cannot represent the full range of experiences or perspectives of all key informant interview participants.

E. Methodological Limitations

Methodological limitations are listed under each data source.

F. Results

F.1. Primary research question 1: What changes in rates of HCBS initiation and utilization occurred during the COVID-19 PHE?

Data sources used: Administrative data

Results

Initiation of HCBS

Initiation of HCBS dropped at the outset of the PHE, with a bump around October 2020. Subsequently, initiation stayed relatively stable throughout the evaluation period, never returning to pre-PHE levels.

Figure 1-1. Initiation of HCBS among beneficiaries 0-64 who had no HCBS in the prior 12 months

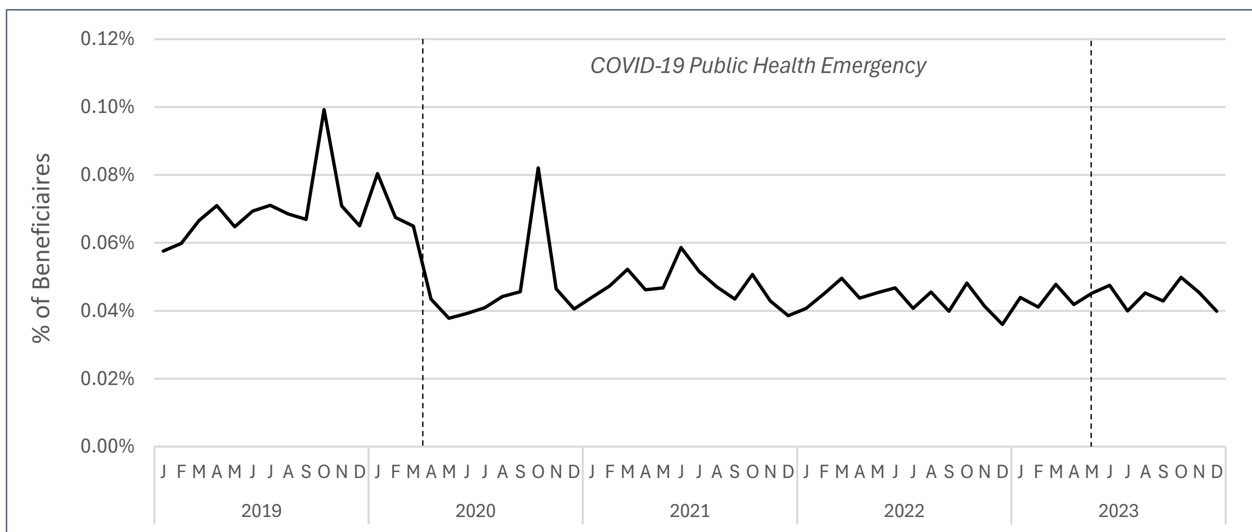
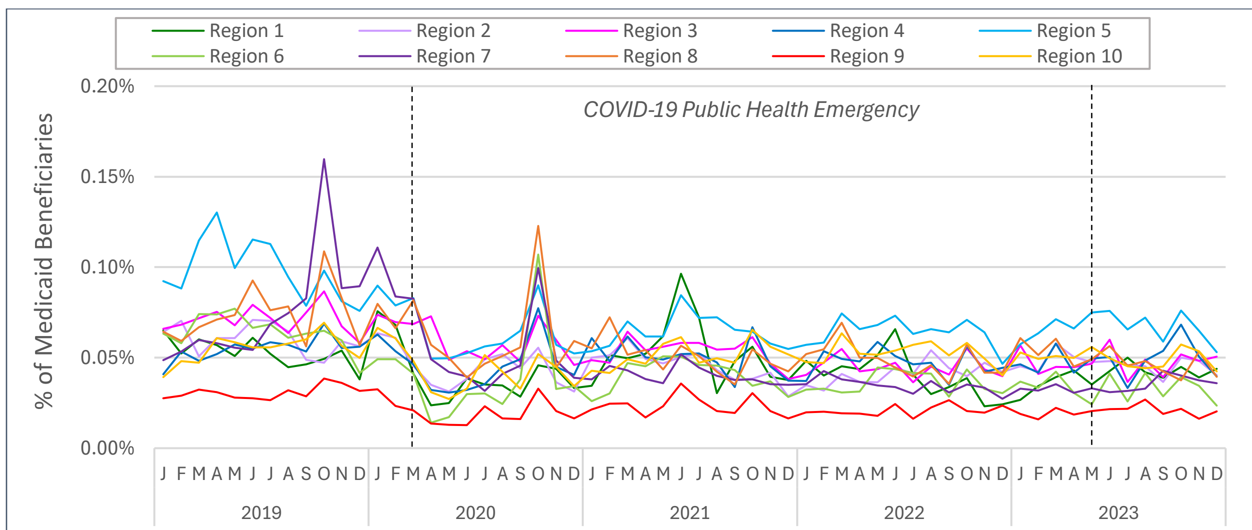


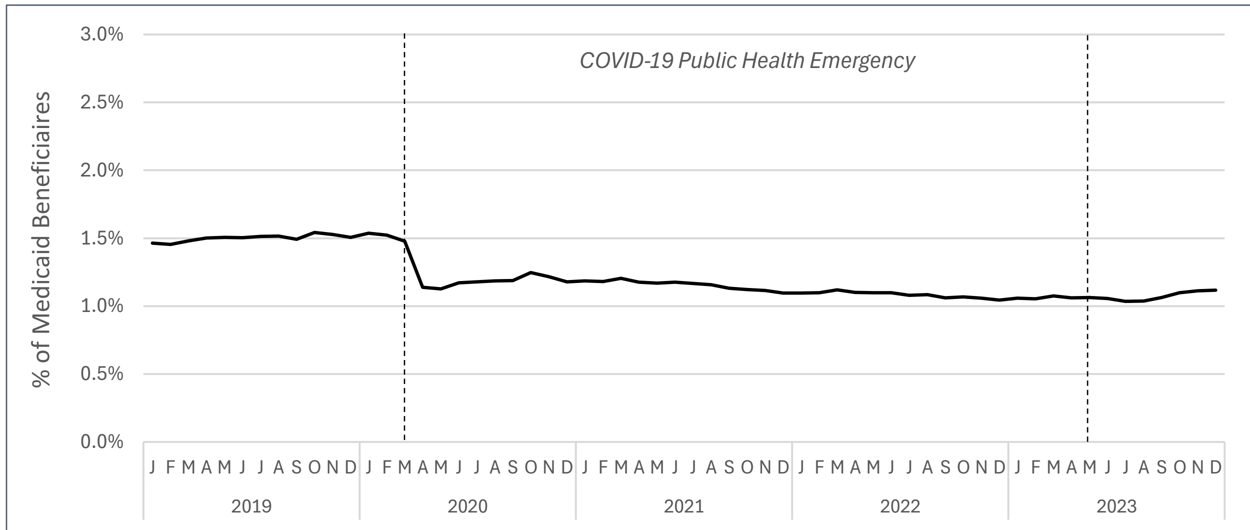
Figure 1-1a. Initiation of HCBS among beneficiaries 0-64 who had no HCBS in the prior 12 months, by PIHP



Utilization of HCBS

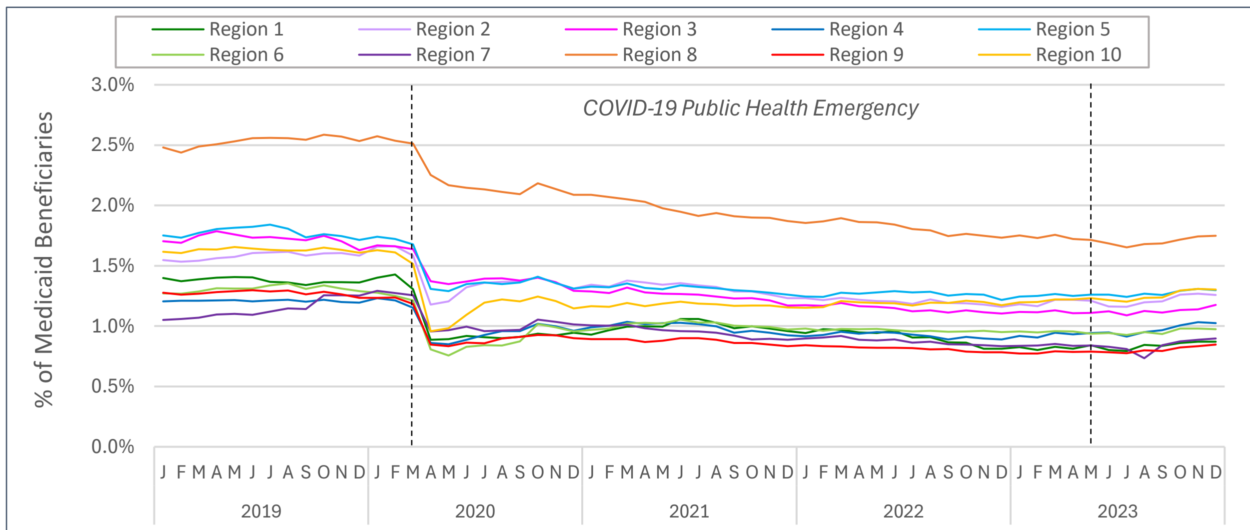
Overall, the proportion of all Medicaid beneficiaries who received at least one HCBS dropped at the outset of the PHE and continued to decline slightly through the remainder of the PHE. Utilization of HCBS began to increase in 2023 but did not return pre-PHE levels by the end of the evaluation period (Figure 1-2).

Figure 1-2. Utilization of HCBS: Proportion of beneficiaries age 0-64 with ≥1 HCBS in the month



Levels of HCBS utilization pre-PHE varied across PIHPs; all experienced a drop at the outset of the PHE and remained below pre-PHE levels for the duration of the evaluation period (Figure 1-2a).

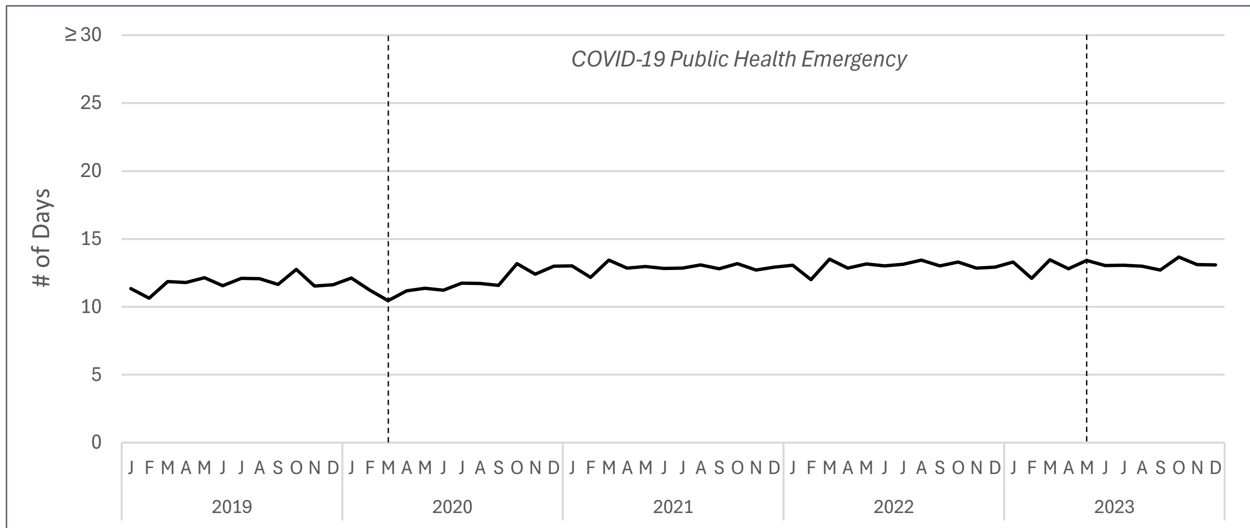
Figure 1-2a. Utilization of HCBS: Proportion of beneficiaries age 0-64 with ≥1 HCBS in the month, by PIHP



Volume of HCBS

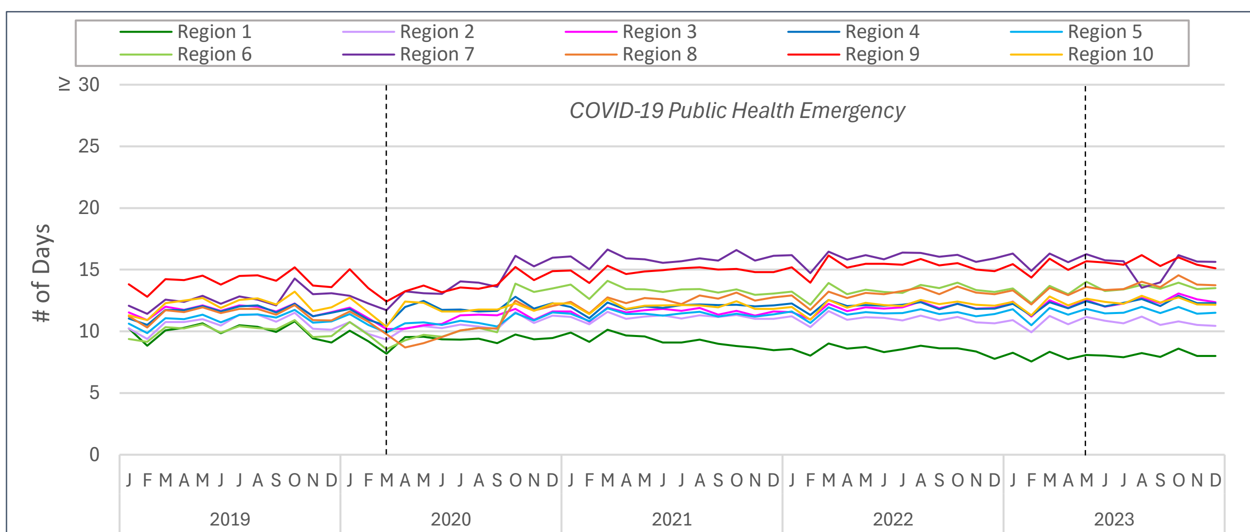
Among beneficiaries who received at least one HCBS in the month, the average number of days decreased slightly at the start of the PHE, and then increased in October 2020 and remained steady through the rest of the evaluation period (Figure 1-3).

Figure 1-3. Average number of days with HCBS in the month, among beneficiaries with any HCBS



Average number of days with HCBS was similar across PIHPs in the pre-PHE period (Figure 1-3a). All PIHPs saw a drop in average number of days in the first month of the PHE; some demonstrated increases throughout the first year of the PHE, while others did not increase over the rest of the PHE. At the end of the evaluation period, most PIHPs had returned to pre-PHE levels, except for one outlier region.

Figure 1-3a. Average number of days with HCBS in the month, among beneficiaries with any HCBS, by PIHP



Among beneficiaries who received at least one HCBS in the month, the median number of service days dropped at the outset of the PHE, then returned to pre-PHE levels within one year (Figure 1-4). There was a wide range across PIHPs in median days with HCBS in the pre-PHE period; most followed a similar pattern of a drop in the early phases of the PHE, recovering to pre-PHE levels within one year (Figure 1-4a).

Figure 1-4. Median number of days with HCBS in the month, among beneficiaries with any HCBS

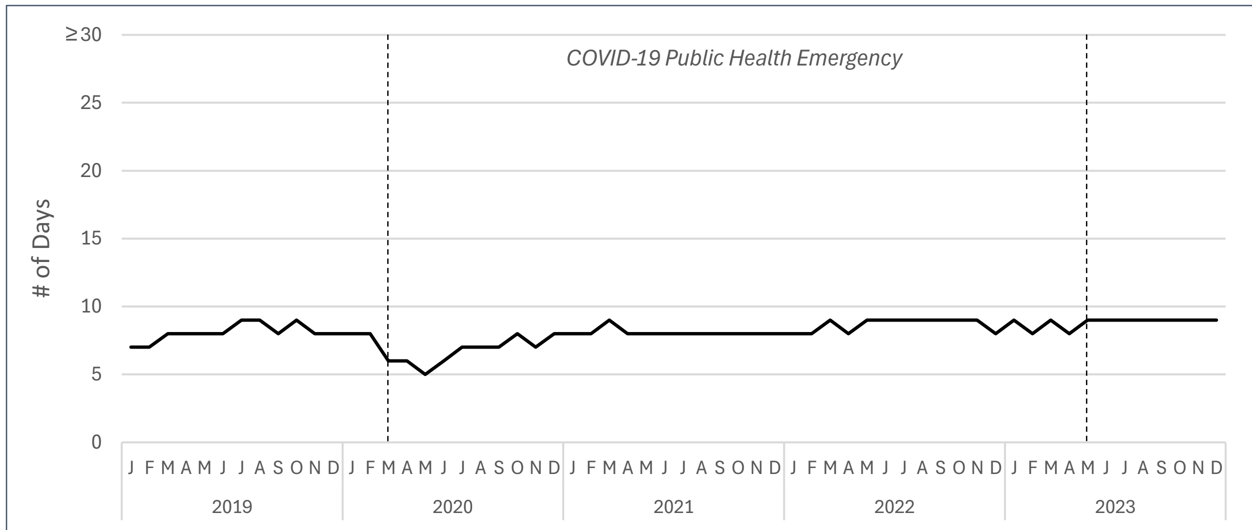
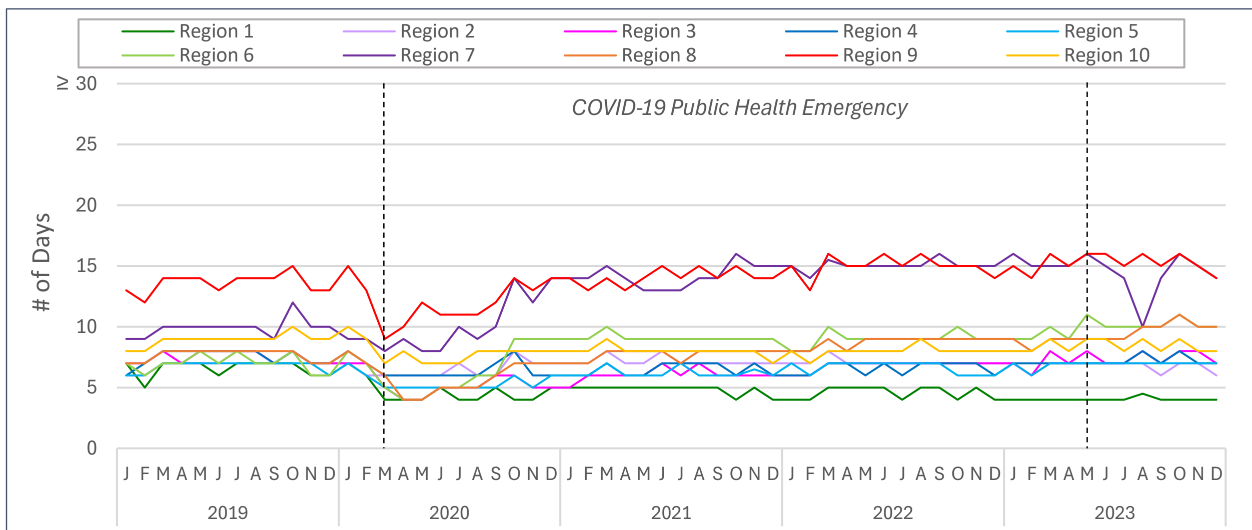


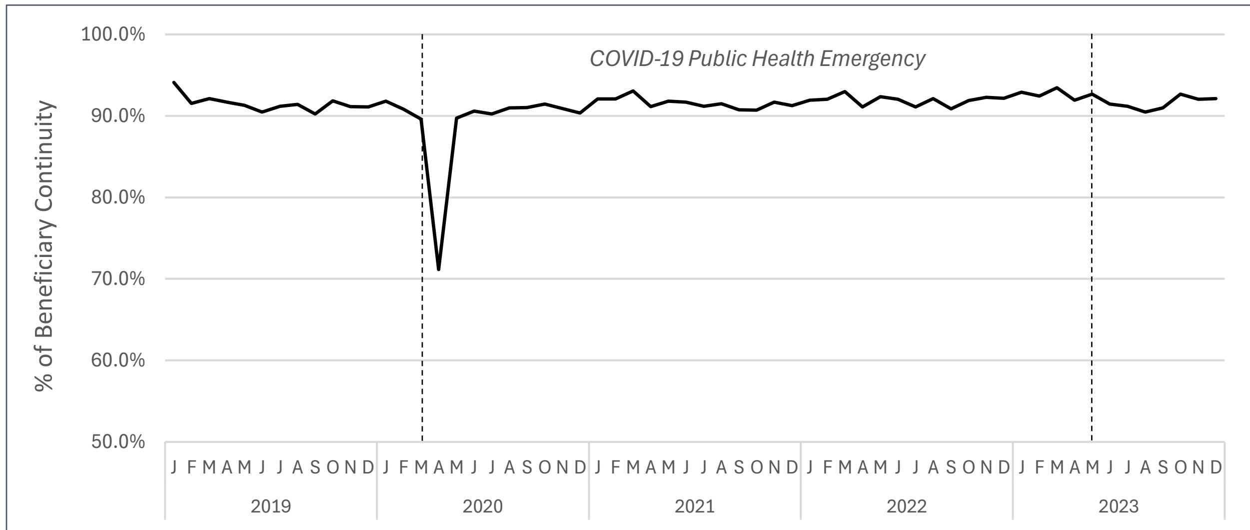
Figure 1-4a. Median number of days with HCBS services, among beneficiaries with any HCBS, by PIHP



Continuity of HCBS

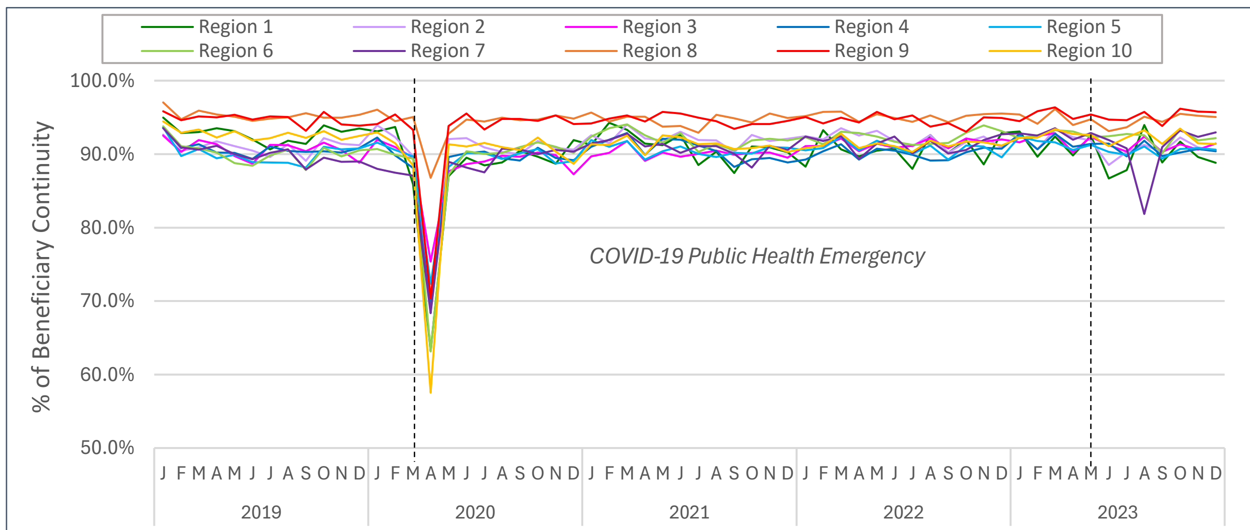
Prior to the PHE, roughly 90% of HCBS recipients had month-to-month continuity. At the outset of the PHE, continuity plunged to roughly 70%, but rebounding to prior levels within two months and remained stable through the remainder of the evaluation period (Figure 1-5).

Figure 1-5. Month-to-month continuity of HCBS: Proportion of HCBS utilizers with at least one HCBS service in the following month



Continuity patterns were similar across PIHPs, although the degree of the early-PHE plunge differed across PIHPs (Figure 1-5a).

Figure 1-5a. Month-to-month continuity of HCBS: Proportion of HCBS utilizers who also had at least one HCBS service in the following month, by PIHP



Summary of response to primary research question 1

Across several measures, HCBS utilization declined at the outset of the PHE, and began to increase within a few months. Overall initiation and utilization did not return to pre-PHE levels. However, among those served, number of days served and month-to-month continuity rebounded to pre-PHE levels by the end of the evaluation period. Utilization measures stratified by PIHP showed the same general patterns, with some PIHPs demonstrating higher or lower levels.

F.2. Primary research question 2: How did changes in initiation and utilization during the COVID-19 PHE compare to changes in initiation and utilization of other PIHP-administered services?

Data sources used: Administrative data

Results

Initiation of SUD treatment

Statewide, initiation of SUD treatment through the PIHP/CMHSP system was relatively consistent in the pre-PHE period, then declined at the outset of the PHE and remained below earlier levels (Figure 2-1). However, patterns varied considerably by PIHP, as did the range in the proportion of beneficiaries with SUD treatment initiation (Figure 2-1a).

Figure 2-1. Initiation of SUD treatment through the PIHP/CMHSP system, among beneficiaries age 0-64 who had no SUD treatment services in the prior 12 months

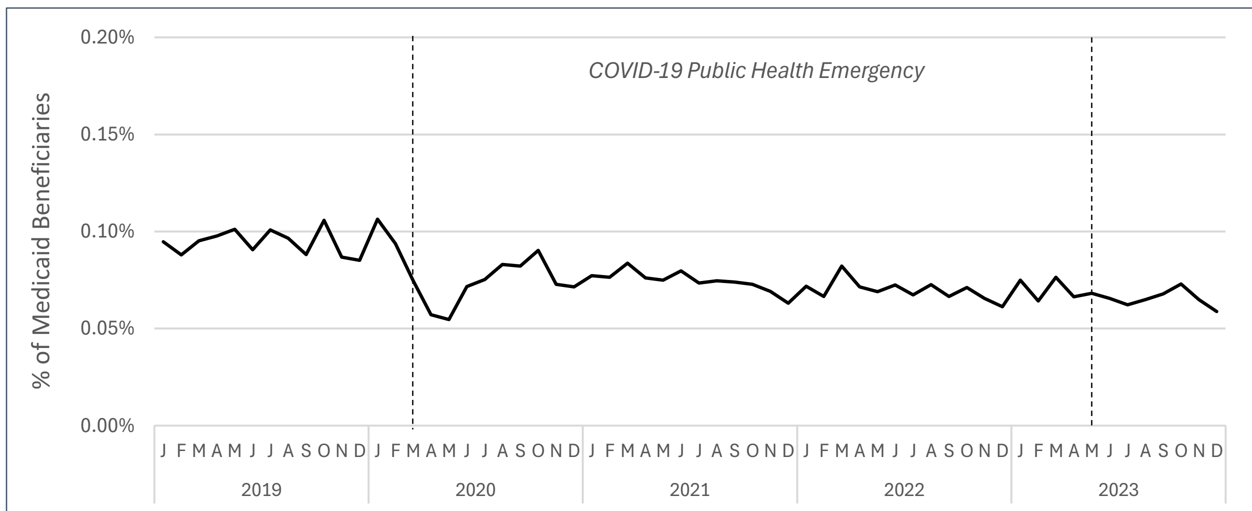
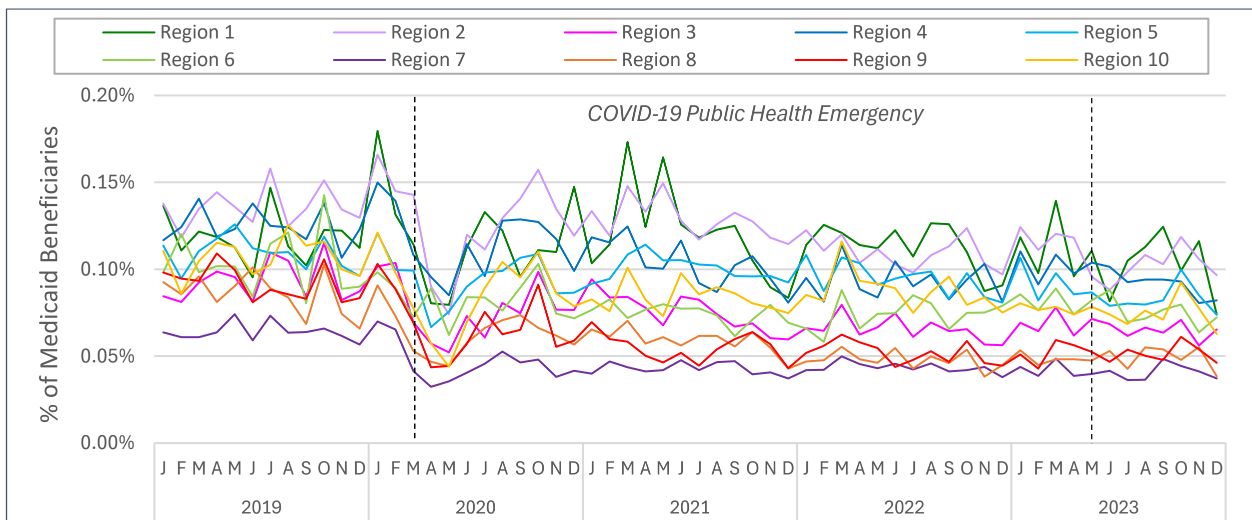


Figure 2-1a. Initiation of SUD treatment through the PIHP/CMHSP system, among beneficiaries age 0-64 who had no SUD treatment services in the prior 12 months, by PIHP



Utilization of SUD treatment

Statewide, utilization of SUD treatment through the PIHP/CMHSP system showed a slight and steady decline across the evaluation period (Figure 2-2). This pattern was consistent across most PIHPs, with one exception (Figure 2-2a).

Figure 2-2. Utilization of SUD treatment through the PIHP/CMHSP system: Proportion of beneficiaries age 0-64 with at least one SUD treatment service in the month

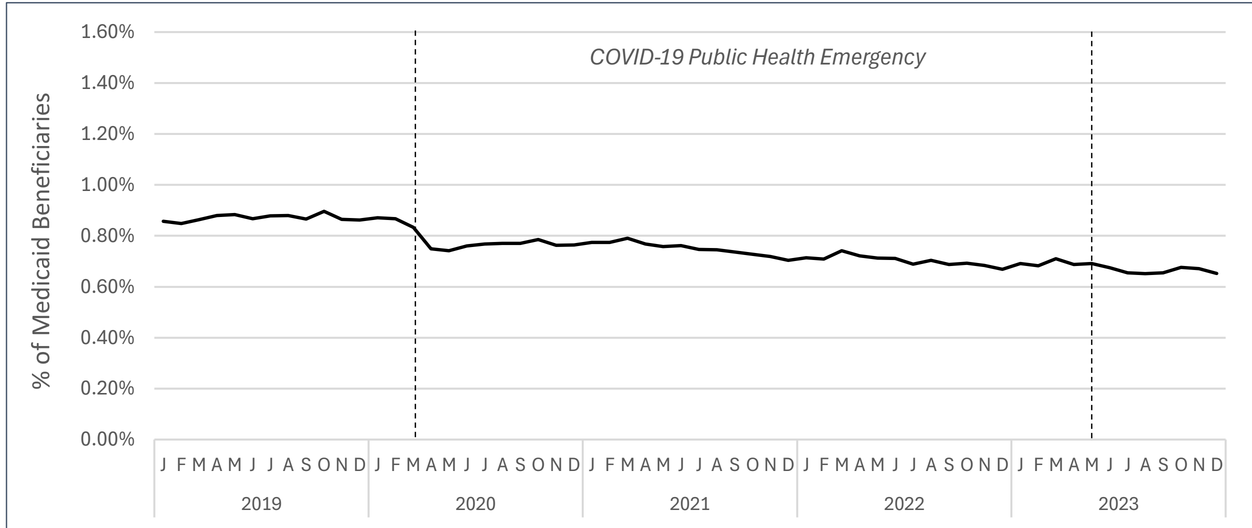
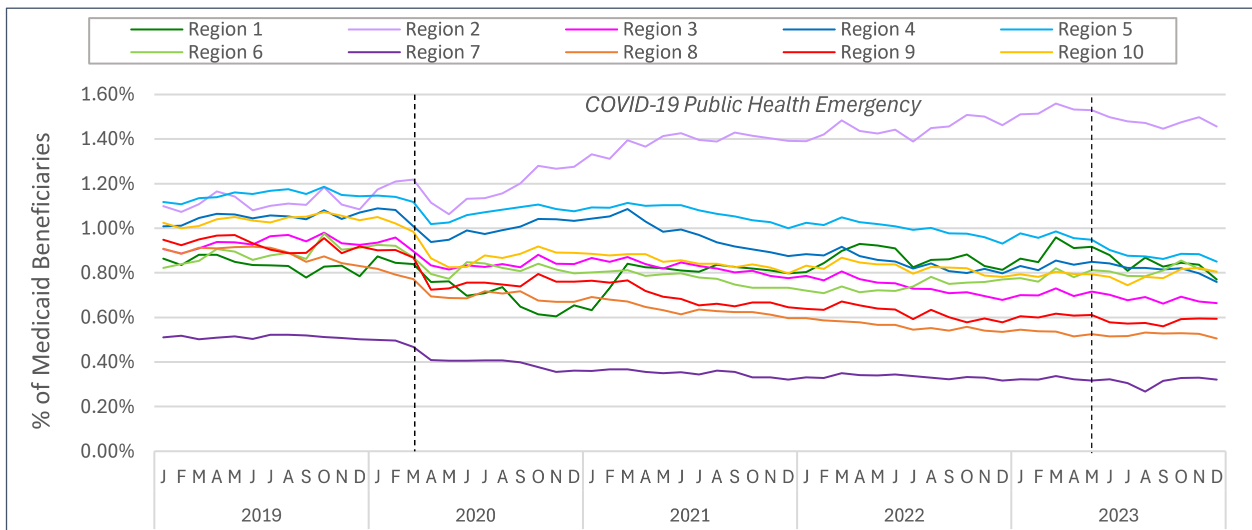
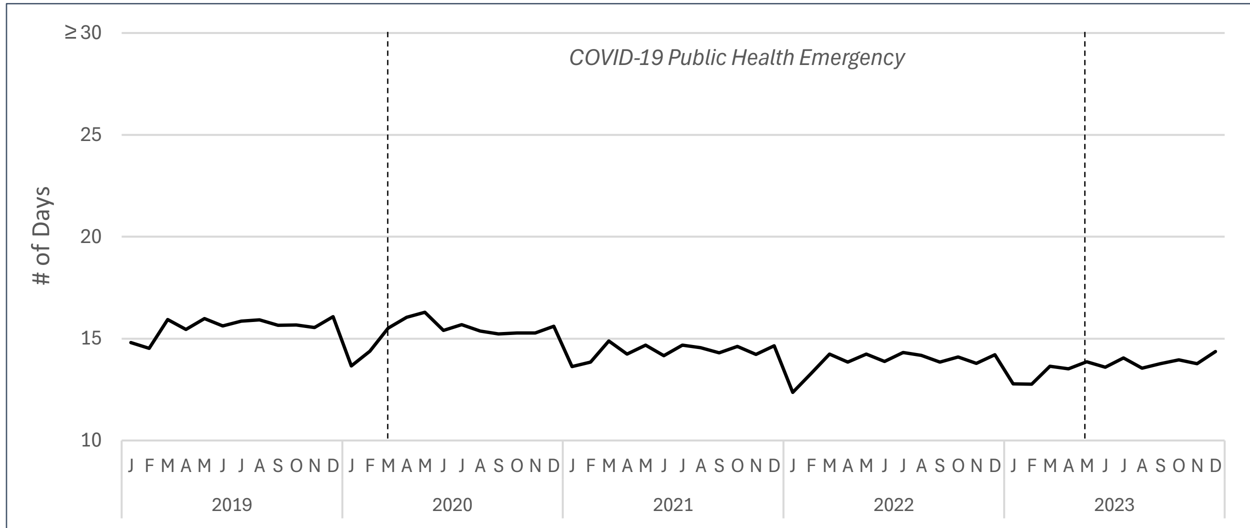


Figure 2-2a. Utilization of SUD Treatment through the PIHP/CMHSP system: Proportion of beneficiaries age 0-64 with at least one SUD treatment service in the month, by PIHP



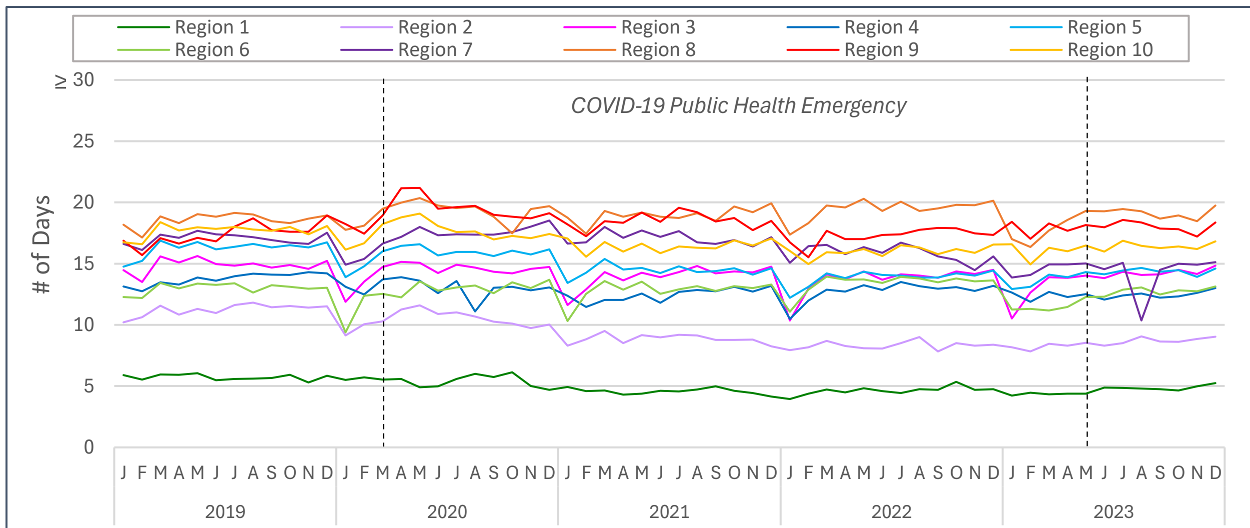
Volume of SUD treatment
The average number of days with SUD treatment demonstrated an annual dip each January, with levels for the remaining months never reaching the prior year, resulting in a slight decline across the evaluation period (Figure 2-3).

Figure 2-3. Average number of days with SUD treatment services, among beneficiaries with any SUD treatment service through the PIHP/CMHSP system in the month



Shown by PIHP (Figure 2-3a), average days with SUD treatment generally followed the same pattern, with wide ranges of starting points.

Figure 2-3a. Average number of days with SUD treatment services, among beneficiaries with any SUD treatment service through the PIHP/CMHSP system in the month, by PIHP



Statewide, the median number of days with SUD treatment showed a more pronounced decline (Figure 2-4) though the range and trends varied widely by PIHP (Figure 2-4a).

Figure 2-4. Median number of days with SUD treatment services, among beneficiaries with any SUD treatment service through the PIHP/CMHSP system in the month

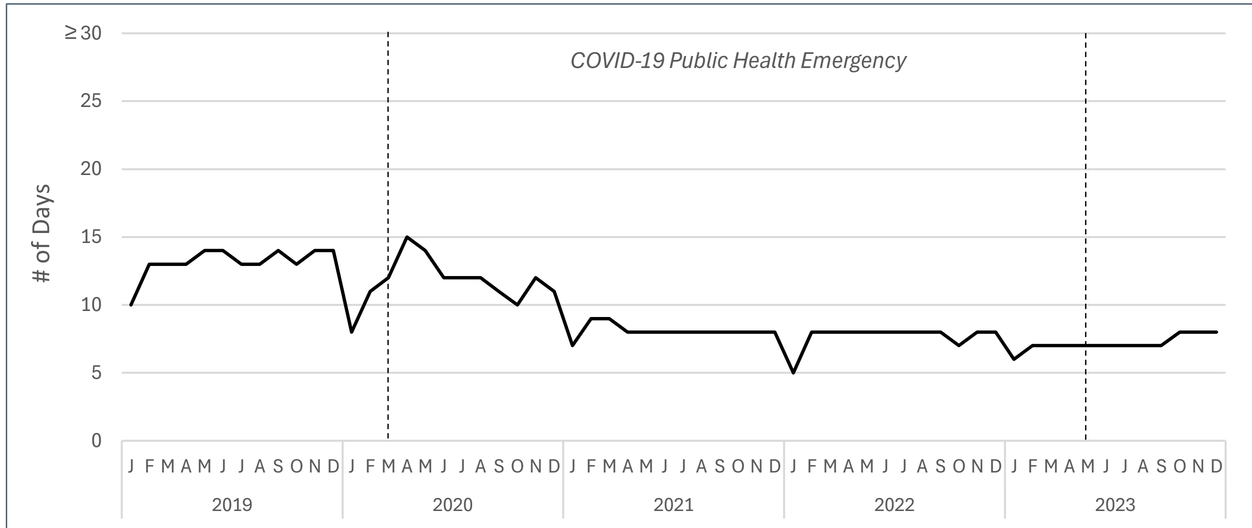
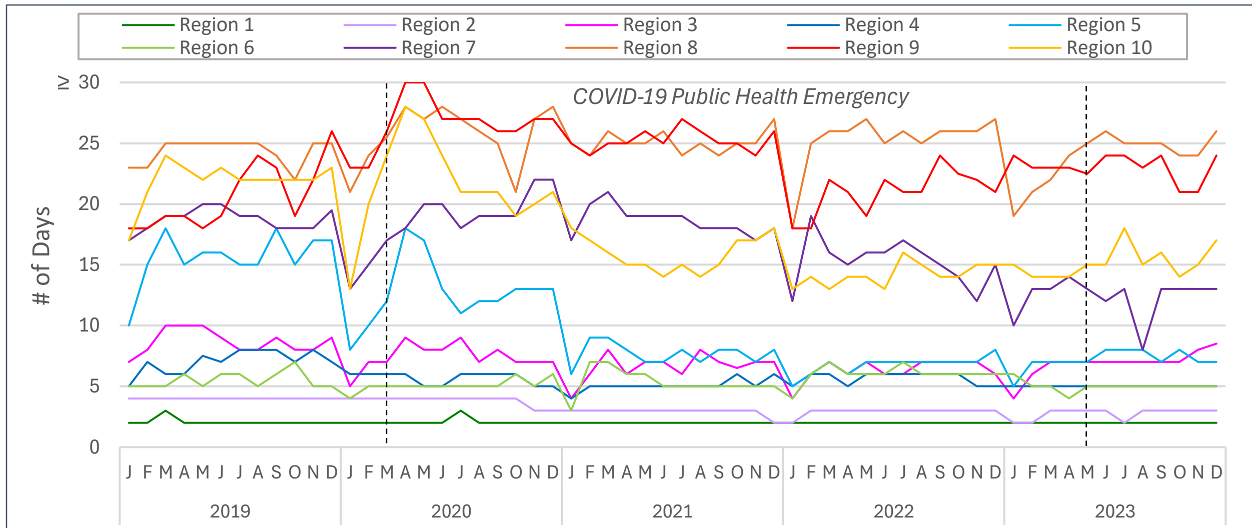


Figure 2-4a. Median number of days with SUD treatment services, among beneficiaries with any SUD treatment service through the PIHP/CMHSP system in the month, by PIHP



Continuity of SUD treatment
Statewide, after a dip at the outset of the PHE, month-to-month continuity of SUD treatment in the PIHP/CMHSP system remained 80-85%, at or above the level pre-PHE (Figure 2-5). However, month-to-month SUD treatment continuity varied widely by PIHP (Figure 2-5a).

Figure 2-5. Month-to-month continuity of SUD treatment services: Proportion of SUD treatment utilizers with at least one SUD treatment in the following month

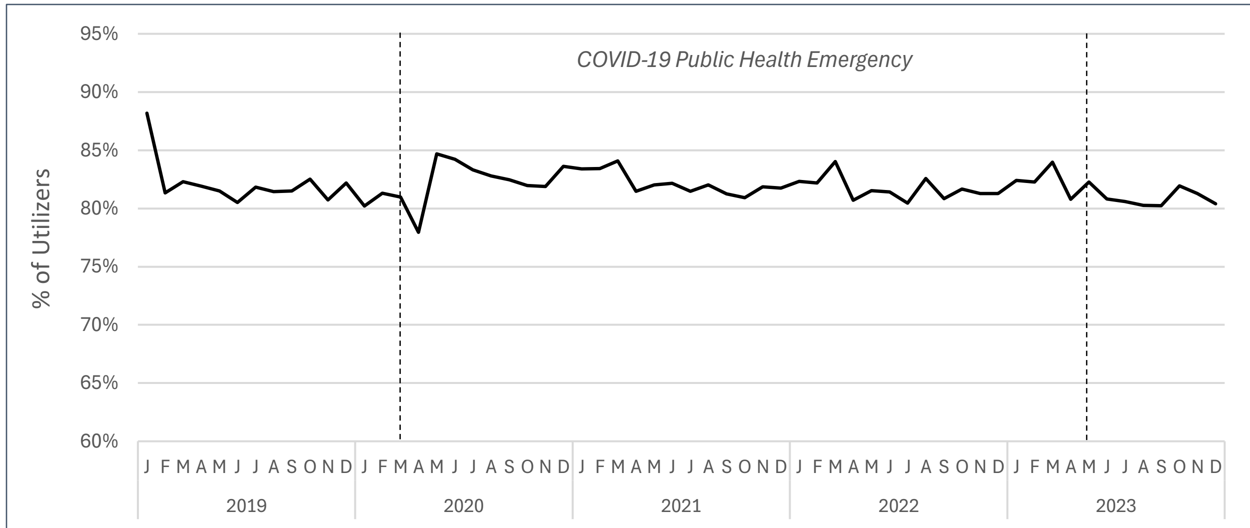
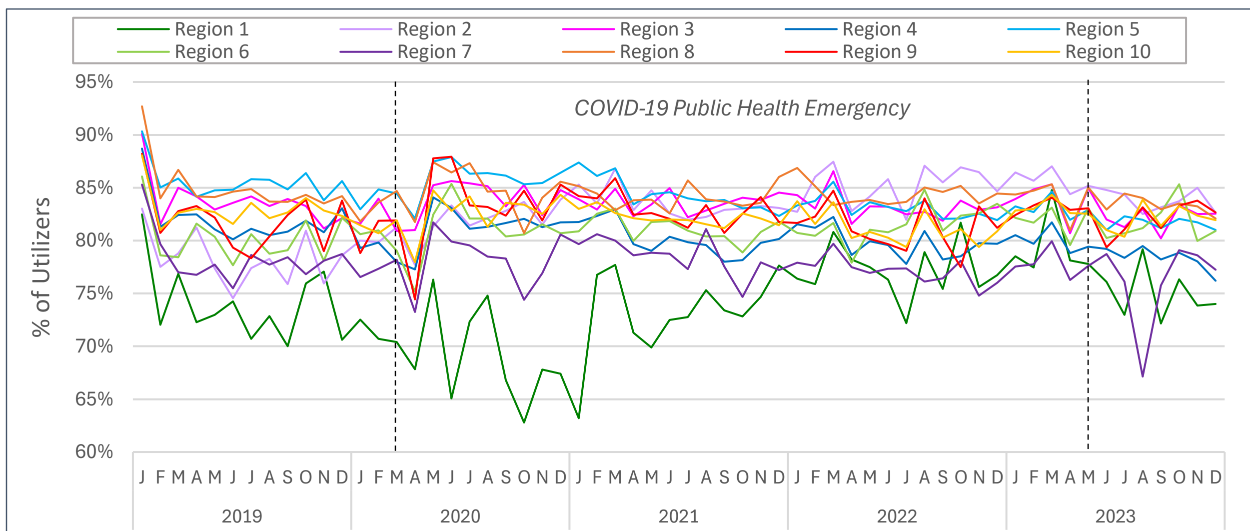


Figure 2-5a. Month-to-month continuity of SUD treatment services: Proportion of SUD treatment utilizers with at least one SUD treatment service in the following month, by PIHP



Summary of response to primary research question 2
Overall initiation and utilization of SUD treatment through the PIHP/CMHSP system showed patterns similar to HCBS, with decreases at the outset of the PHE, never returning to pre-PHE levels. Among those receiving SUD treatment, days of service and month-to-month continuity decreased at the start of the PHE; unlike HCBS, they did not return to pre-PHE levels by the end of the evaluation period.

F.3. Primary research question 3: In what ways did the PHE impact HCBS service providers?

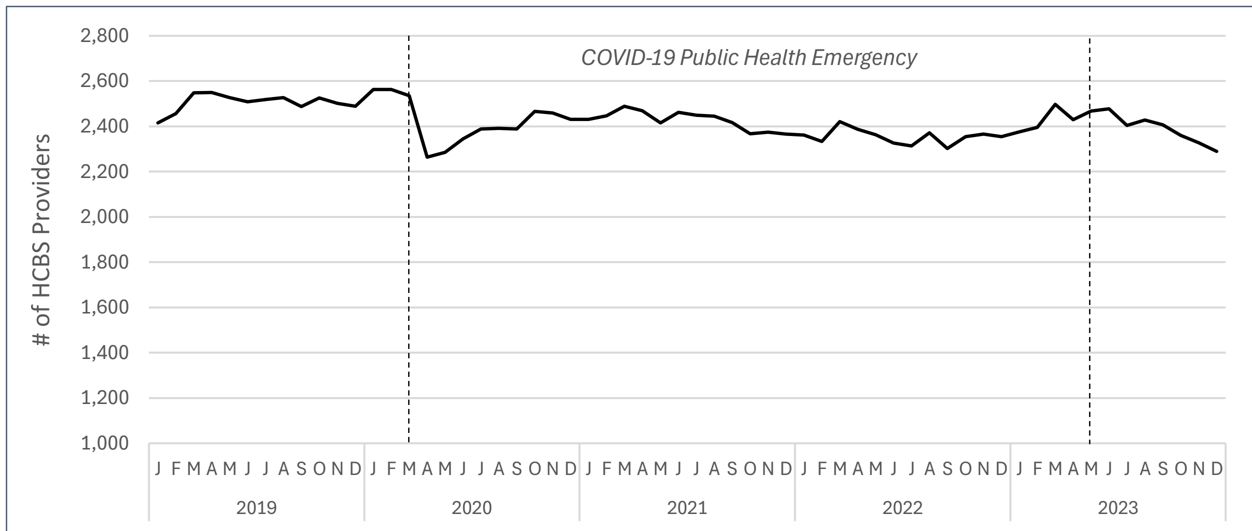
Data sources used: Administrative data, key informant interviews

Results

Number of HCBS providers

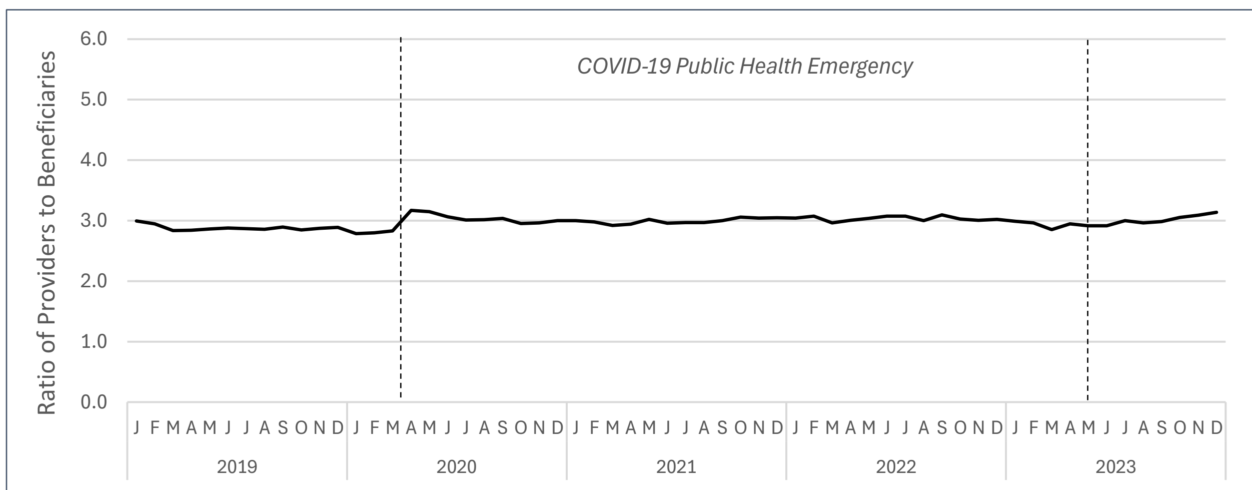
The number of providers with at least one paid HCBS encounter dropped in the first month of the PHE but reversed that trend within two months (Figure 3-1). In 2021, the number of providers began a small but steady decline, with a small rebound near the end of the PHE. As of the end of the evaluation period, the number of HCBS providers had declined by about 10% from pre-PHE levels.

Figure 3-1. Number of providers delivering at least one HCBS in the month



As shown in Figure 3-2, the average number of beneficiaries per HCBS provider increased slightly at the start of the PHE, remaining relatively stable throughout the evaluation period.

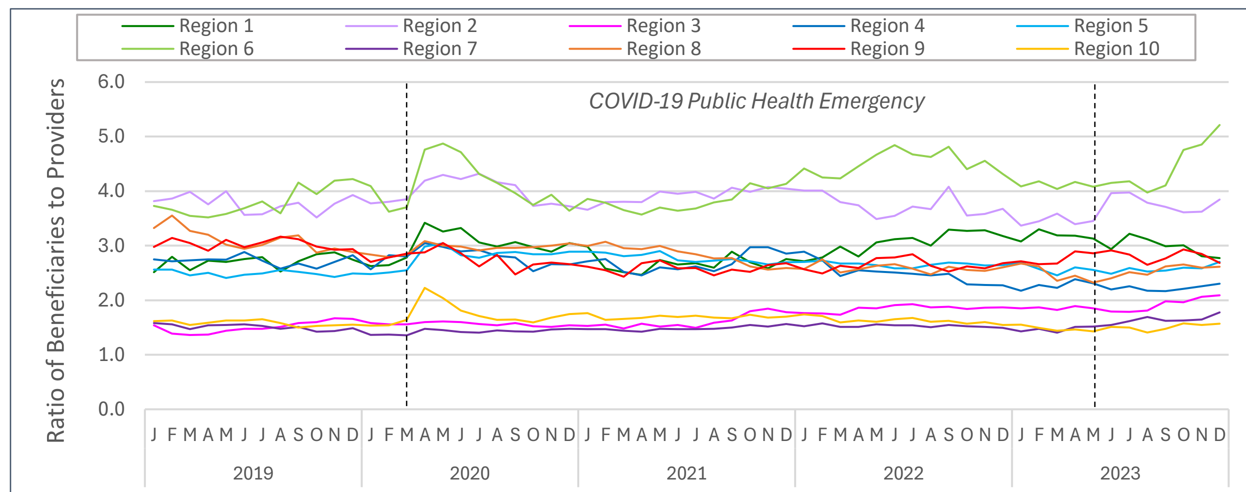
Figure 3-2. Average number of HCBS utilizers per HCBS provider*



**Providers who were reimbursed for at least one HCBS in the month*

The ratio of beneficiaries per HCBS provider was quite variable across PIHPs, with some demonstrating more pronounced changes at the outset of the PHE (Figure 3-2a).

Figure 3-2a. Average number of HCBS utilizers per HCBS provider,* by PIHP



*Providers who were reimbursed for at least one HCBS service in that month

Challenges and facilitators to retaining HCBS providers

The onset of the COVID-19 pandemic caused an abrupt change for HCBS providers. Some patients and families declined services in their home because they not want to risk face-to-face contact.

> *I know that some families did not want people in their homes. They just didn't have the confidence that they could protect their vulnerable child or adult, or themselves. And we had a lot of caretakers that became ill... And some consumers couldn't be compliant with the masking and the social distancing, because of their disability or their mental health needs. They just didn't understand that concept and couldn't comply, and that was challenging. – State official*

Staff also feared for their own safety. Many faced new burdens caring for sick family members or caring for children because schools were closed. Large group services, such as day programs and skill building programs, were suspended due to the Governor's "Stay Home, Stay Safe" order.[16]

> *Initially, there were the challenges of nobody knows what to do...direct care staff are terrified of the implications for them and for their consumers. Some providers who were doing large group services had to close temporarily until they could assess and create a structure that met all the standards, all the new rules, all the new executive orders. Then obviously they would have to stop and shift when there was a different executive order or state directive. – PIHP administrator*

> *With our skill building program, we did downsize significantly, and that was a direct result of COVID. We were the largest provider of skill building services when COVID hit. We actually had three different locations where we were providing services to about 300 customers. When COVID hit, we closed our doors. We had to. – HCBS provider*

---

[16] https://content.govdelivery.com/attachments/MIEOG/2020/03/23/file_attachments/1408152/EO%202020-21%20Stay%20Home,%20Stay%20Safe.pdf

Network stability. To ensure that provider organizations could remain financially viable, the state requested network stability plans and encouraged PIHPs to use existing flexibilities to support HCBS provider organizations.

> *We called the PIHPs up and said, "You need to assure the department that you have stability plans in place." Which meant, basically, we need you to tell us that you will do what you need to do to stabilize your provider network during this PHE and tell us what you're doing. And they had to report up on a regular basis, what their plan was... We weren't dictating to them what they needed to do for that part. They told us and we approved their plans. – State official*

PIHPs operationalized their stability efforts in a variety of ways.

> *Immediately, I'm talking within 24 hours of the world shutting down, we switched all of our providers to cost reimbursed contracts so that they knew that any allowable Medicaid expense would be covered, and they could really then just focus on the provision of services and not worrying about financial risk or the contract. They were reimbursed their normal per diem rates, but then also did report to us on a monthly basis any cost outside of that that, and we then reimbursed. So, if they were paying additional overtime or had COVID related expenses, we then covered those expenses. – PIHP administrator*

> *The State gave us guidance on how to stabilize our providers, but that was more related to decreased utilization.. So we were looking at the base period, which would have been the beginning of FY20, which was October through February. and then we analyzed any requests that came in for March through September. Like if they were 10,000 units a month, and then they dropped to 6,000 units a month, we were giving the providers money to bring them back up to what their average utilization had been. To the degree possible, we kept the funding consistent for providers when they were having issues with the utilization. – PIHP administrator*

> *In our region, for specialized residential, the providers were to direct those individual requests to their contracted CMH. So, if a member needed additional staffing, or they weren't in the community as much because everything was closed and so then the provider had to take on more staffing, they should direct that to the CMH who pays for that member. And as far as I know, they were providing the supporting documents or rationale to get higher rates. We did take a position that we didn't cover for projected revenues that were unrealized. If you said, 'Hey, we usually make $200,000 in a year. We want $200,000,' we said no. You have to provide us with your program costs, and we will be sure that those are covered through that cost arrangement. – PIHP administrator*

Premium pay. To address staffing shortages due to the COVID-19 pandemic, in May 2020, MDHHS instituted a temporary hourly wage increase (referred to as "premium pay") for direct care workers providing certain services, including HCBS.[17]The initial increase, which was retractive to April 1, 2020, was initially a $2.00 per hour supplement to direct care worker wages (to be recorded separately from base pay) and a $0.24 per hour increase for agencies to cover the additional costs to implement this increase. Premium pay was renewed periodically throughout the PHE, and increased to $2.25 per hour for direct care workers (and $0.27 per hour for agencies) in March 2021, and $2.35 per hour ($0.29 per hour) in October 2021.

Key informants identified several challenges with premium pay. First, some key informants felt the initial parameters were too narrow.

> *There are certain parameters that were put on those dollars. You had to have a face-to-face service in order to pay these premium dollars out… For instance, some CLS workers, to help out individuals that are*

[17] https://www.michigan.gov/mdhhs/-/media/Project/Websites/mdhhs/Folder4/Folder8/Folder3/Folder108/Folder2/Folder208/Folder1/Folder308/Numbered_Letter_L_20-28.pdf

too afraid to leave their house, would do a grocery pickup and drop it off and do a little wave through the window. That's not an encounterable service. But we've had staff that are out in the field, trying to help the consumers that are served, but really not getting quote, unquote credit for it, if you will. And also not a face-to-face service, but also being put at risk going into public, going to the grocery store, doing things like that. So, I think it was a little too restrictive on those parameters. – PIHP administrator

The guidance we got was that it was for billable time only, and the reality of life is that there is a lot of non-billable time for people... And there was no funding provided for overtime. We have a staffing shortage, so now providers have to pick up the extra 1.5X on every overtime ... It needs to be for every hour, it needs to include overtime, it needs to include the other non-billable hours, vacation time, for the direct care workers to really be like, this is making me want to stay. – PIHP administrator

Second, although state officials described attempts to have a consistent approach across programs under different state authorities, some PIHPs and HCBS providers felt there were inconsistencies.

We said, let's have a consistent approach for how we're going to leverage the flexibility... We worked with our MSA – our medical services administration – because we share 1915(c) waivers across the two administrations. [MSA has} MI Choice and MI Health Link, in addition to our three behavioral health waivers... And in those three authorities, we said the same thing – that we want to use the premium pay or hazard pay flexibility. – State official

The guidance that the MDHHS has provided with premium pay is not consistent between different parts of the department. The guidance that is given by BHDDA was different than what was given to Home Help, which is different than what was given to the AAAs doing adult aging services, which was different than what was given to the MI Choice. So we have multiple different implementations, from the same department, which in some instances crosses different payers, but ends up impacting the same providers. That has been a problem from the premium pay perspective. – PIHP administrator

Third, some HCBS providers felt the administrative burden for the premium pay was too cumbersome.

[The PIHP] has made the premium pay almost impossible to get. You have to get it after the fact. You have to turn it in, and you have to list every single hour that every single person worked. It has to match the amount of units that you billed, and it goes through an approval process. And they made us pull it from their daily rates and put it in what they call an FY 22 payment, a separate payment on their paycheck, or they wouldn't pay us. – HCBS provider

I'm still working on trying to get the information to turn in. I have not received the $2.35 for January, February, March, April, May, or June because I'm still working on trying to gather the information to get to them so that they'll pay me the amount of money that I need. They've made it so hard to do. You have to you have to list every employee by name, you have to list their total hours for the month, their, and it has to, and then it has to match how many units you bill. And if it doesn't match how many units you bill, they're kicking it back. – HCBS provider

By far the most common and emphatic complaint from HCBS providers was the inconsistent administration of premium pay across different PIHPs and/or CMHSPs.

In some of our counties our rates included the DCW payout so in our per diem and our specialized, it was included in that. And in our issue of H2105 billing, the CLS billing, the unit billing, they also included it, and it was done automatically; when we billed, we got paid. It was great. One county did not do that for a couple years; we had to send invoices to get paid. And especially not to get payment until we invoiced and then they would have to match it up and their turnaround time was awful. So yeah, that was tough. – HCBS provider

No, they did not do it the same way. Just to clarify how we are paid in general; we contract with a CMH for personal care and community living supports. Those two codes equal a per diem rate for each of our homes. So some CMHs would want to know the COVID rate – that's the per diem – so we would basically

tack on an additional per diem, and that ranged based on the rate and the home and location. But some [CMHs] did not want it per diem, they wanted it per month. Some [CMHs] didn't want it at all, they were going to ask it at the end of every quarter. It really ranged... it does make back-end processes extremely challenging. – HCBS provider

We have to submit separate reporting to [PIHP A] and separate reporting to [CMHSP PIHP B] to get them to reimburse us for that $2.35 for the appropriate hours that were staffed. It's just tough, because we're sharing staffing between counties. – HCBS provider

State officials learned about and attempted to address the inconsistencies.

What we've heard is that the process seemed to be somewhat inconsistent. For example, we had reports that some regions were paying out quarterly versus paying out in real time. We said: "Nope, you can't do that. You've got to pay out in real time." And they said: "Well, the providers' not invoicing us, so we can't pay out until we get an invoice." So, we were working through some of that. - State official

Some PIHP and CMHSP administrators recognized that there were inconsistencies across regions.

We're very strict, we're very policy and procedure oriented. When they implement these direct care wage increases, they'll give some criteria, but not always. And we're implementing it one way, [PIHP Q] is implementing it another. Providers are all getting their pass-through, but we're requiring additional documentation, this one might not be. Then we look like the bad guy, and then the providers are upset with us, and then it creates turmoil and frustration. So, I would say the state really needs to consider the position that they put us in when they don't give parameters or expectations. – PIHP administrator

One of the things we tried to be careful about was not stressing the system out by doing an exorbitant amount of auditing but trying to make sure we had a pulse on things. – PIHP administrator

We got nothing but appreciation from providers related to how we handled it -- that they didn't have to worry and go through a lot of hoops to get payment, which was the last thing they really had time for during that time period. We have a model with our providers where we expect you to do all things appropriately and we go back and retroactively test those things. So, it's not necessarily a requirement to jump through all the hoops ahead of time. – PIHP administrator

In some cases, the inconsistencies across PIHPs and/or CMHSPs created potential disparities between staff within the same HCBS provider organization.

Some of the PIHPs are 6 to 9 months behind. One of the PIHPs bundled into a cost settlement procedure, didn't tell us they were going to do that. That's not adequately funded. First off, when we were able to pay based on company's resources. Many of the PIHPs didn't pay a premium pay until 6 to 9 months later, so we were fortunate — we were able to pay it contemporaneously, so staff in the counties that were 6 to 9 months behind weren't just sitting, waiting. We paid it... so our staff didn't feel any weirdness. – HCBS provider

As the PHE continued in 2021, HCBS staffing challenges worsened.

And I wouldn't even say that we were like in a staffing crisis in 2020. We did not experience that until 2021. When everyone really experienced the shortage. If we were at 35 to 40% turnover regularly, we were inching closer to 50% turnover.... In some locations our turnover was closer to 60%. So it just it was frightening. – HCBS provider

We lost 10 homes. What's interesting is that happened in 2021, not 2020, so it's like they could make it through the first wave, and then they couldn't recoup enough. The staff never came back that they thought would come back. – PIHP administrator

We spent thousands and thousands on advertising, and I don't know what it ends up costing per person, but it's the only avenue we have for recruiting. The staffing shortage is absolutely critically backbreaking. – HCBS Provider

People will leave for minimal, more money, different flexibility. The market is the employees' market; lots of options. I am struggling with filling positions because the direct support level is competing with Walmart and McDonalds and retail and all kinds of positions that have very little risk and liability for the same pay or better pay with far less responsibility. – HCBS Provider

PIHPs and CMHSPs expanded their options to help HCBS provider organizations recruit and retain staff. Many HCBS providers expressed great appreciation for these additional efforts. At the same time, the administrative challenges or limitations of these efforts, as well as the inconsistencies across PIHPs, sometimes forced them to use internal funds to supplement these well-intended strategies.

Over the last year, especially FY 21 is when we started to see this issue with staffing, so for FY22 what we've done is we have this special grant that we're doing too that's specific to more around stabilizing providers related to staffing issues; and so we've offered a pot of money for providers to actually apply for that money, so if there was an HCBS provider that needed it, they would go through their CMHs just to apply for the money. – PIHP administrator

I think what truly unfolded for me was some of the CMH entities went above and beyond the premium pay for retention and recruitment. – HCBS Provider

There are like six initiatives right now going on, a temporary increase, there's some funding for advertisement, we tripled our referral bonus for staff, there's a sign-on, there's a retention bonus...We would typically not do those things, because it would just be an added administrative burden for us. Let's say that in county X, we serve two people from there, across our company; is it beneficial for us if we just serve two consumers across our company, to take whatever this additional money is, then we're going to have to micro manage and micro administer the proportional amount that the house got? A lot of the things made sense if you are an in-county provider and every consumer at AFC home A is from that. You can easily piece and parse that money out. But it doesn't make a lot of sense if you're an out of county provider and it's one consumer and a 10-bed house and you've got 10 other counties that you work with. At some point we just had to balance, is this even worth it to take this extra money? – HCBS provider

[CMHSP A] gives us a little bit of extra money at the end of a quarter, but they don't tell you what to do with it. And in my world, my company, if it isn't spelled out, it's going to my bottom line to help what's costing me money. So, it needs to be, it needs to be clear and concise and say 'staff retention'. Because when they tell me I can post it to overtime, I'm going to post it to overtime. I'm not going to give that to the staff, because my overtime is astronomical. – HCBS provider

When [PIHP X] gave us an extra dollar, we had to implement it across the board, and we're not being reimbursed for that extra dollar from [PIHP Y] or [PIHP Z] at all. So, we just have to scrounge up the money somehow and figure out how that's going to work. Because we can't give one person a raise for only a percentage of their hours, and we can't give it to one staff and not another. That's a great way for us to break faith with our team and lose great caregivers. They have to know that they're being treated fairly. So, that has been a struggle. We're super, super appreciative of [PIHP X]'s extra dollar, and so I would never complain that it has caused a little bit of a problem elsewhere, but that is a little bit of a complexity. – HCBS provider

Some key informants described the uncertainty of the provider stabilization payments as limiting their effectiveness.

To say past 10-1-22 we'll sustain this? We don't know. We don't even know our budget till after we sign our contracts, so it's hard to project out a rate increase. So, we've done this provider stability and while the providers are like that's great, it gets us through that month, it doesn't give them the security to say

> *I’ll have it next month and next month and next month. So as they're hiring staff today, they don't know what they're going to have 10-1-22. So yes, the funding we've had has been helpful. Has it helped every way? No. The Medicaid world does not have enough money to attract people to work with us rather than Starbucks. – HCBS provider*

Facilitators and barriers to ensuring beneficiary access to care planning and HCBS

As noted above, the onset of the COVID-19 pandemic caused both consumers and HCBS staff to be concerned about safety. Some consumers or their families declined services. Many staff got sick themselves or needed to care for a sick family member or supervise children home from school.

> *I’ve been doing, working this position, enrolling people in HSW… We have a standard, we have to fill our slots in a certain percentage, and this has been the hardest time in keeping our slots full. We had a lot of people disenroll, the families just disenrolled people from services altogether. The guardians would pull people from CMH services completely because they didn't want them to be involved in any kind of service due to COVID. – PIHP administrator*

> *And the other thing is the vaccinations. Either families are requiring staff be vaccinated, and the staff are hesitant to, or individuals aren't being vaccinated but they want their staff to be vaccinated. So, we're seeing different implications of that and it's delaying service provision or the ability to find staff. – State official*

Staffing shortages also impacted delivery of services across different HCBS settings and types.

> *Once the skill building programs were given permission to open back up, they couldn't get the staff back in, and then we have very small numbers that could kind of leak in for services, and that just kind of bleeds into a whole other problem where you were serving 100 people with your staff, the way we had it before COVID, you only have a few staff that want to come back to work, now you can only serve 20 people. How do you pick out of the hundred who gets to come back? So, then you have rights violations happening... – PIHP administrator*

> *Residential: they really struggled with staffing, probably the most because the most staff are needed...I can't just go find more people to work in the network. Residential closed a lot of homes and the more of them close with staff can go to other homes, that does help that provider, but then we have persons displaced and not getting the services that they need, or having to go back home, perhaps with family members. – PIHP administrator*

Telehealth. Telehealth was consistently cited as a facilitator of beneficiary access to HCBS. At the outset of the PHE, the state issued guidance that expanded the types of services that could be offered via telehealth. HCBS providers, as well as PIHP and CMHSP administrators, utilized telehealth in a variety of ways.

> *The biggest one that we leveraged was telehealth. That made the most difference in maintaining services for people. And so much so, that we adopted the telehealth codes post-PHE. We already have a code list approved ready to go when the PHE ends, because we think it's going to just be ingrained in the way you provide service now. – State official*

> *It was a very quick and essential shift, allowing telehealth. And I think it definitely has changed the landscape in service delivery. It has been helpful in making services more widely available, especially for individuals who may not want to physically come into the office. – PIHP administrator*

> *Almost every single one of our appointments was done via Zoom or phone calls. That was very, very helpful at the times when we did have like one less staff a day or didn't have the means for transportation to get everybody where they needed to be. That really freed up a lot of our resources, so we weren’t constantly sending people on the road. That was an extremely helpful tool. – HCBS provider*

We were distributing laptops and other resources to our network of providers, for persons served as well, to actually access services. So, that is something that we have been very proud of, I think, to offer. A one point, we were even offering some internet connectivity for those persons who were receiving services in addition to those iPads that we have issued throughout the network... We did receive a grant that allowed us to purchase, I think it was, 600 iPads, so that helped a lot, and those came with a year of internet access. And so, we've also been able to continue that for individuals, and it does give better access to services, especially still given not only the pandemic, but also transportation issues we struggle with here. – PIHP administrator

Early on in the pandemic, case managers were grabbing tablets that the agency had, driving to the consumers house, knocking on their door, setting the tablet down, sitting out in the car, and then connecting in the car while the person was in their house on that tablet to do their service. – PIHP administrator

[Telehealth] has revolutionized the admission process, and the access piece in a way I just can't explain to you. – HCBS provider

Sometimes it can be very disruptive for the individuals that we're supporting to physically get in the car go to the doctor's office, wait in a doctor's office, and then be seen and transition back home…Sometimes when you see behavioral escalations, it can be around those things, so I would say telehealth has been overwhelmingly positive for us. – HCBS provider

I don't know how we ever functioned without it. It became an essential part of our business model, and our staff very quickly adjusted to technology and the whole concept. – HCBS provider

However, many key informants were hesitant about delivering HCBS via telehealth.

I've struggled with telehealth for community living services. If they're needing that type of help, are you really able to budget with them over the phone, and cook with them, and clean with them, and teach them how to do their laundry? And a lot of the reasons that they have staff helping with those things is because they're not able to do it safely. So do you have someone now that's trying to use a stove while I'm on the phone going 'now click the button'? But if they do something that could sustain an injury to them, the person on the phone, they're not right there to help them get out of the home or do something or put a Band-Aid on and clean up a wound. So, I wasn't a huge supporter of that. – PIHP administrator

I think telehealth is a great option for some of the adults doing outpatient therapy. Where I've seen it almost completely fail is with the kiddos doing home-based services. So, even though there's an ability to bring the family together, the children aren't able to really engage to the level where it's appropriate, … it's high acuity; a lot of them aren't going to sit still in front of a monitor and be like, 'Okay, let's go through this activity.' … It's a hands-on, high needs, high intense kind of therapy intervention. – PIHP administrator

For the CLS stuff, you cannot really do that by telehealth… so we really could not put our limited resources into trying to develop some telehealth for a day program. – HCBS provider

Functional assessments are being almost solely done remotely still. The assessors have gotten pretty creative, but still it is not, it's lost in translation if you can't directly observe something. But on the other hand, it has allowed for a larger capacity of people to be seen. Because our SIS assessors, for example, cover all eight counties. They can complete more assessments if they do them remotely rather than driving two hours round trip. – PIHP administrator

Analysis of administrative data showed that in the early months of the PHE, nearly half of beneficiaries had a telehealth HCBS service (Figure 3-3); within a few months, the use of telehealth began to decline, and was around 20% at the time of the key informant interviews. In comparison, delivery of SUD treatment via telehealth showed the same early increase at the outset of the PHE but declined much more gradually (Figure 3-4).

Figure 3-3. Mode of delivery of HCBS: Proportion of beneficiaries receiving telehealth HCBS services, among those with any HCBS in the month

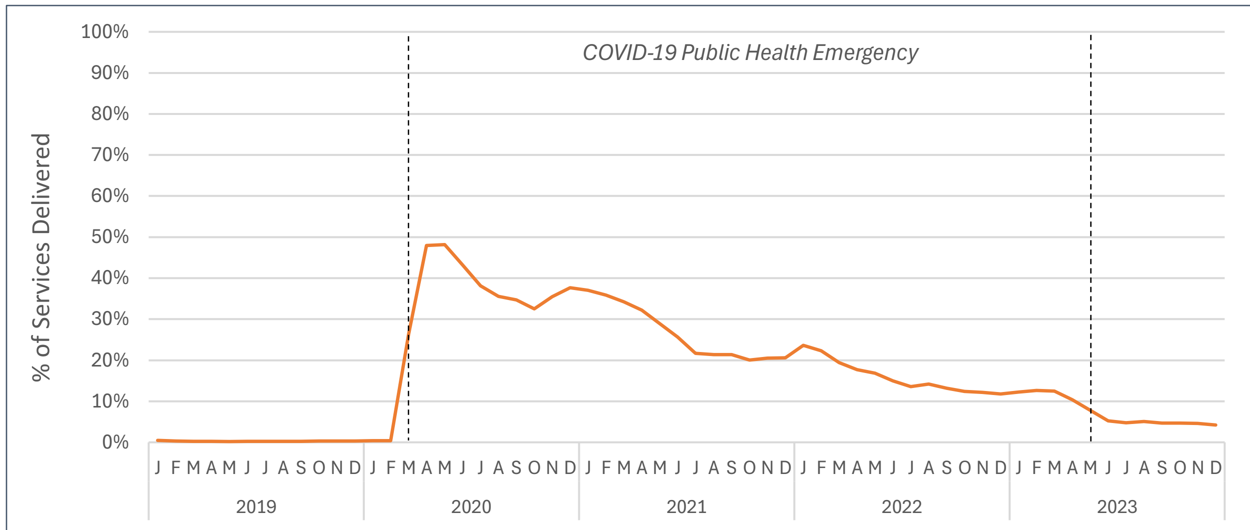
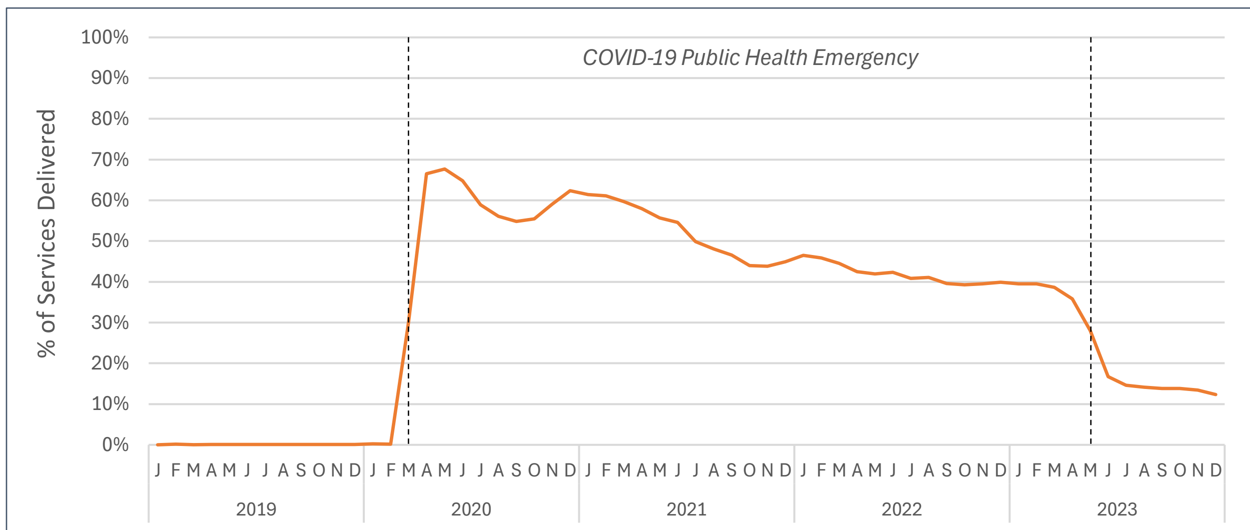


Figure 3-4. Proportion of beneficiaries receiving telehealth SUD treatment, among beneficiaries who received any SUD treatment service through the PIHP/CMHSP system in the month



This trend is consistent with statements from PIHP and CMHSP administrators about their efforts to encourage the transition from telehealth to face-to-face HCBS.

> *We've already encouraged everything to be face to face. As soon as that state mandate came out, where it said, 'you have to ask the person if they want their services face to face, like you need to be offering, you can't just assume,' we really flipped back to face-to-face at that point, if not before then. – PIHP administrator*

> *The challenges are that the ongoing telehealth is not to benefit the consumers … I guess the nicest way I can say it is it's being manipulated a little bit. And I don't think it's driven by the consumer need. I think it's driven by the clinician's desire to do telehealth. There are probably some guardrails that need to be*

reinforced for how it is used and how it is presented to members. First and foremost, we have to consider the client's needs and desires. Are they truly asking for it or are we trying to make it easier on staff? Which, again, is a double-edged sword, too. People need to keep their staff happy. We're in a staffing crisis. So, there's a fine balance, but still, the client comes first. So, I'd be really clear on messaging. 'This is one of several options available to you.' – PIHP administrator

I had to send out a friendly directive reminder to give people the choice, that the transition included not saying 'you will be telehealth.' The transition includes saying 'you now have the choice, which one do you want?' and making sure that was that choice was given to people. For the most part, what I found is providers really wanted to go back to face to face services as much as possible and are willing to, just because there's a different relationship, there's a different seeing of the whole person, and there's a different rapport that you have when you can meet with somebody face to face so. Most providers were interested in returning to the new normal while still giving the people the choice if they wanted telehealth.' – PIHP administrator

Other flexibilities. The state made modifications to HCBS staff training requirements, including changing some training from in-person to online, and extending the timeframe from requiring completion before starting to allowing 30-90 days to complete. However, state officials noted that PIHPs and CMHSPs were not required to allow those modifications, nor was the state's licensing agency.

A lot of the training-related flexibilities have been utilized to get staff on board assisting and addressing the staffing crisis that we are facing. The PIHP and CMHP still have their own requirements. So, even if a flexibility was offered, they may not take advantage of it or take full advantage of it... I think, from their standpoint, it was to still ensure that quality services are being provided. The other thing was, we did see a disconnect somewhat between licensing requirements and if there were professional credentialing requirements – how are those being relaxed and were they consistently being relaxed along the same lines as what we were relaxing? If, for example, a staff worked in a group home, the group home licensing rules might have an expectation of staff getting certain training, TB test, criminal history, background checks – things that they weren't going to waive, necessarily. But some flexibilities did occur for licensing as well, but perhaps not in line with all the ones that we allow. – State official

Modifying the training programs, allowing for online trainings when appropriate, and leniency when it comes to the face-to-face trainings… was greatly appreciated, and I hope that's something that continues. – HCBS provider

Most of the training had to go to virtual. That has worked out tremendously, they should have done that 10 years ago. – HCBS provider

Allowing verbal consents for care planning was another strategy that key informants viewed as helpful, particularly given the staffing shortage.

We did use the verbal consent flexibilities for a while, though those are pretty much gone away. But that was very helpful in the beginning when we were just trying to complete plans of service and assessments and various services. – PIHP administrator

[Verbal consent] was a big help because a lot of the individuals receiving the more intense HCBS services have parents that are elderly and they felt very unsafe, they didn't want to interact with anybody. So, to be able to mail them things or have their verbal consent, that was a big benefit for them. I think that was great and we should have that flexibility. We're in an electronic world, so I think that that was some good things, too, is it pushes our world where we need to get caught up and not be so rudimentary with... You know Medicaid has a lot more rules than the rest of the world, and I think this helped us to see, 'we can do things a little different and they can still be successful.' – PIHP administrator

We have several CMHs that cover five counties or more, you know, so that's a large geographic area-- and limited case managers. So, that kind of gives them the flexibility where instead of driving to see

everybody, if they have just a change or an addendum to make, that they can telehealth and check in and say, 'we're doing this and that.' So, I think that's a big flexibility that I would, I would like to see continue. – PIHP administrator

While the state authorized the relaxation of timelines for re-evaluations and assessments, the PIHP administrators varied in their willingness to offer that.

Our clinical and quality division were monitoring those like they normally would to ensure that they're getting done. We sustained our audits for the majority of the time, and we backed off here and there depending on how the providers were responding to us doing those. We did them virtually. But, from that standpoint, they can't not do the person-centered plan on time because that impacts the authorizations which affects billing. – PIHP administrator

We didn't, to my knowledge, relax any of the deadlines. We still expected our staff to make sure that all their reports, their person-centered plans, all those things were still done in a timely manner. Other than maybe a blip at the very beginning, the first week or two of the pandemic, but after that, with use of telehealth, we were able to be really creative and make sure that we could to continue to provide good service. – PIHP administrator

PIHP and CMHSP administrators were aware of other flexibilities, such as increased limits for private duty nursing (PDN) and delivery in alternate settings. However, these were used infrequently, either due to low demand or to lack of staff.

I don't know that we use a lot of alternative settings. When we talk about like the HAB waiver, which is the most vulnerable, the largest population that we work with, we may have used a couple nursing homes for a period of time in order to meet that need. So it wasn't a huge, it's not something we use a lot, but we did use it a couple times. – PIHP administrator

We need more PDN nurses. – PIHP administrator

Beyond the demonstration authorities, many key informants felt positive about their efforts to work together to address this unprecedented challenge.

Our adult foster care and homes for the aged really got hit hard. So much so that, we created a special webinar series that we started two years ago, and I continue to facilitate. And over 200 attendees come still to those webinars, where we bring public health in - emergency public health folks, the MSA, BHDDA. Everybody comes together and provides the – this group information about how to stay safe, how to keep their staff safe, and how to keep the people that they serve safe in those facilities. – State official

Unresolved or ongoing challenges related to care delivery for providers

At the time of key informant interviews, a major unresolved challenge was the uncertainty about how long the PHE would continue. PIHP and CMHSP administrators described preparing HCBS providers for when the PHE – and with it the demonstration authorities – would end. At the time key informant interviews were conducted in 2022, most key informants believed the PHE would be ending soon.

Our team has point people called waiver coordinators that we connect with the PIHPs, and of course they are tracking the PHE end date. We get calls like "is it coming soon?" It is a regular part of our standing agenda with the PIHPs, where we're saying to them, "Get ready, you should already get your processes in place." We're getting concerns from them about "if you turn things back on and flexibilities go away but our workforce has not returned, we're not going to be compliant." – State official

The main thing they're worried about right now, frankly, is that MSA is going to turn on the Medicaid eligibility process again, because it's been suspended for two years, where people didn't have to prove

their income or anything to stay on Medicaid. And that when it flips on again, it's going to put a lot of people off the Medicaid eligibility roles. – State official

My work is mostly in the recertification paperwork, to make sure people who are on the waivers maintain their waiver. There's been many cases that have gone delinquent, lapsed beyond the time. And that's what I'm really worried about, that it's going to continue to be lapsed, it's going to continue to have difficulties. People are still having trouble getting into see their doctor to get certain forms completed. People are still having difficulty getting out to homes and getting signatures. And then there's just a lack of staff at the CMHs so they're having to carry larger caseloads and in doing so, some of the stuff gets to me later than it should. – PIHP administrator

Several PIHP administrators were doubtful that some HCBS provider organizations could remain financially viable without ongoing support.

The kid system still remains on cost reimbursed, as does the residential system. And primarily that's just related to staffing. For residential specifically, staffing has gotten not much better if not worse since things started to open back up. So, until we get it to a level where they can live within the rates the model is built on, or we have to adjust the rates to accommodate the different levels of overtime and such going forward. – PIHP administrator

The vocational network is still really operating not at full capacity. Vocational providers are often serving people with very medically, behaviorally complex conditions in facilities, so there's a lot of health considerations in terms of if they're able to staff or have people there at full capacity. There's been a lot of parents and guardians that have really made decisions not to send their family member back at this point, just because they don't necessarily feel ready. So, I think it might be a little bit longer before we really see that network operating at full capacity again. – PIHP administrator

Several contextual factors also created ongoing challenges. A few PHIP administrators noted that the reorganization of BHDDA was causing some challenges in getting guidance.

Throughout all of this, we have sought the directions of the department or MDHHS…they have had some changes, like the change in their acronym and their staffing…from my perspective that's having an impact on the guidance that is being shared or consistency or us trying to recall directives or guidance that was previously shared or in the last couple of years. It's looking different.. – PIHP administrator

The state's looming deadline to fully implement the Statewide Transition Plan weighed on the minds of several PIHP and CMHSP administrators as an increased burden for HCBS providers.

For the home and community based rural - the final rural transition, we're currently doing video reviews. The travel is out of the picture so we're able to do more, we're not impeding on privacy, and it's hard to have extra individuals walking through your home. But on the other side, it's really hard for us to ensure that all of the HCBS standards are met when you're just looking at someone taking their phone or computer through a home. For sure we're missing things by not being able to be out in the settings. I do agree, telehealth was wonderful, but we didn't have eyes on in-homes for a really long time, so we're also having to do some extra work that we thought we had already done two years ago. We're kind of having to reteach providers and supports coordinators about the final rule.– PIHP administrator

Some of the complexities that are coming up now, with the impact on staffing and availability of beds. And it is worrisome because we know someone can't live in a setting or receive these HCBS, they can't use Medicaid funding after March of 2023 if the setting or program isn't HCBS compliant. So we're trying to bust it out with the network, trying to make sure every setting is compliant, but it is a little tricky. We want to make sure everyone is safe and placed appropriately, but there aren't a ton of options... I think it just going keep getting more and more difficult ... in the coming 10 months before that March 2023 deadline. – PIHP administrator

More generally, the increased administrative burden due to the PHE was a frustration for many key informants at both the PIHP level and at the HCBS provider level.

> *I would say that there is actually more reporting... across all the initiatives… Is it meaningful? I don't know. We send [the state] a lot of information, understanding what we send is really key. But there seems to be more and more of an administrative burden and load, whether it's a PIHP, the CMH, and even with the substantial amount of reporting requirements that they are continuing to put on our provider network. It really creates instability all around, frankly. It's a really big administrative lift, especially when you're trying to recruit individuals that have the knowledge and expertise that they need in understanding Medicaid in general, because this is a pretty nuanced system...and there's been quite a few code changes… with financial and billing but definitely a clinical component, with understanding what modifier is what now or what kind of authorizations need to be made. We've had to have a significant amount of electronic medical record changes. So, anytime there's stuff like that, especially when we're worried about staff turnover and making sure that we have people coming in, and there just was a significant push out of all this frankly unnecessary admin load. – PIHP administrator*

> *We've run legitimately 3 or 4 marathons since COVID started. And so, it kind of settled down, and now the people, the auditors and stuff, are coming out of their basements and now we're into our 4th marathon... to respond to audits. I'm working in the office, I'm working midnights at a group home, and [the PIHP] wants to know why so and so's this or that happened. Are you kidding me? Come out of your basement. Come out of your living room. Put your clothes on and come work with us, and then you can put the screws to us. – HCBS provider*

> *It would've been helpful to have a little more guidance from the department... I recognize that the pandemic was not anticipated, I recognize that we were trying to juggle a lot of things all at once, but a little but more of a coordinated effort of what we should be doing at the front end of this would've been helpful rather than having ten different PIHPs and in some instances, 46 different CMHs running in different directions on how are we gonna address this. Cause the reality is that we have providers that split over geographic boundaries, and so it is confusing to the providers, it's difficult to set up programs in a vacuum and not know am I setting up a program over here that's going to duplicate what another CMH or PIHP is doing? – PIHP administrator*

> *I would put in the plug for really taking a look from across the system, what our expectations are for paperwork and documentation requirements, and make sure that the things that we're requiring are not duplicative and are necessary and useful for the person's services and for the documentation from a Medicaid point of view. What are the things that we're requiring that can be pre-populated within a system so that people aren't asking the same questions multiple times. Are there things being requested by the department, by whoever is overseeing quality management, but then very similar items are being requested from the contracts team? – PIHP administrator*

> *The administrative burden directly translates to dollars wasted, dollars, and any money I have to spend on administrative work, I can't spend on staff wages and things like that. We want less money spent on admin, and the more duplicative, inconsistent reporting we have to do, the more time we could be spending on coaching our team and on the really important stuff that I think actually translates to quality care. – HCBS provider*

> *It's always difficult when we have to operate as a reaction...Anytime that we can have a solid plan in place and know how to move forward instead of it being a complete business disruption, that's always preferred. It's definitely helpful to be able to know how this is going to roll out far before we have to actually react and be able to do what's needed clinically and even administratively if we need to make modifications to our electronic medical record systems because of these changes. It's not just an easy flip of the switch. Being able to have this all pre-determined and worked on as a collaboration is always beneficial to everybody, even the state. – PIHP administrator*

We've really seen significant loss of clinical staff. So, anything that can be done -- within reason, of course-- to lessen the structure around paperwork and reporting requirements, and allow the focus to be on getting services to people, is appreciated. In the kids' network in particular, there's been a lot of discussion about struggles with meeting the home-based requirements and staff just being so burned out because their caseloads are higher than they should be. And then there's a very strict face-to-face requirement within the Medicaid model-- and there's a reason for that, it's what that model calls for, so I'm not trying to minimize that at all. But the challenge and the balance for the clinicians has been hard. – PIHP administrator

Unfortunately, at the same time, the State was refining some of their processes with the feds and recertification got infinitely harder. They were really looking at everything and going over with it with a fine-tooth comb. So we had a lot of extra stuff we had to do, and then the pandemic hit. They relaxed some things and it helped, but not greatly because there were all these other regulatory things that we had to do at the same time... a lot of the case managers left and so that knowledge base is gone... now you're working with people who are less skilled writing these plans and they're not meeting the muster for what needed to happen for MDHHS to get them recertified. – PIHP administrator

Summary of response to primary research question 3

Telehealth was broadly utilized statewide to facilitate HCBS, particularly during the early months of the PHE, to maintain connections between providers and beneficiaries. However, due to the nature of some HCBS (e.g., skills building, community living services), telehealth could not substitute for in-person service delivery. At the time of the key informant interviews, most PIHPs and HCBS providers had transitioned back to face-to-face HCBS delivery.

F.4. Primary research question 4. What strategies or adaptations were most effective in achieving the essential goals of the demonstration project?

Most effective demonstration flexibilities or changes

Overall, key informants felt that financial supports – including stabilization arrangements and premium pay – were the most effective toward ensuring access to HCBS services. However, they recognized that both strategies had aspects that limited their effectiveness. The vast majority of key informants felt that premium pay or other increases to direct care worker pay needed to be extended beyond the PHE, and increased to a higher rate. An encouraging step occurred after interviews were conducted, when the hourly wage increase for direct care workers was extended beyond the PHE and increased to $3.20 per hour ($0.40 per hour), along with guidance that it should be applied to direct care worker's indirect/administrative time and overtime.[18]

Key informants viewed telehealth as an essential tool which was very effective for connecting with beneficiaries during the initial months of the PHE; administrative data confirm that telehealth comprised a substantial portion of HCBS in those months. Key informants generally supported the continued but limited use of telehealth to deliver HCBS, with greater support for administrative use. Verbal consent was viewed as very effective in expediting access to services, and key informants view that as a flexibility that could continue.

Both HCBS providers and PIHP and CMHSP administrators felt that modifications to staff training and certification requirements were effective in streamlining new hires, which was particularly important

---

[18] https://www.michigan.gov/mdhhs/-/media/Project/Websites/mdhhs/Assistance-Programs/Medicaid-BPHASA/2024-L-Letters/Numbered-Letter-L-24-29-DCW.pdf

given the high turnover rates. Many key informants felt that many of the training modifications could continue past the PHE.

PIHP and CMHSP administrators deemed other demonstration authorities to be effective but used less frequently, either due to demand or to limited staffing.

Finally, despite the challenges, several key informants noted that state officials were effective in communicating and guiding them during a difficult time.

> *I just think that flexibility had to become much more of the norm during the pandemic, especially in the very early goings, when we were trying to keep track of all of the executive orders that were coming out, and information from the CDC and other groups, that were trying to synthesize all this together to give guidance to our region... The State was very, very concerned with providing actionable, reasonable answers that did their best to uphold the standards and the expectations of the state, but also conveyed that sense of flexibility that absolutely had to go with a pandemic situation. So overall, I felt it was good. – PIHP administrator*

Recommendations for additional strategies or adaptations

In addition to wage supports, several key informants felt that efforts to enhance the professionalization of HCBS staff would yield a more capable workforce that would remain with provider organizations and grow in their career pathway. This includes both a higher wage level as well as training requirements and a career pathway that reflect the growing complexity of their responsibilities.

> *Adding $2 to everybody doesn't help. If somebody was already at $17 and now they are at $19, and someone else was at $10 now they are at $12, that's not as helpful, from a staffing perspective…Realistically, we need to be talking about a minimum standard wage for caregivers. If we want people that are qualified, that are willing to stick it out to give care and not go to McDonald's or Walmart, we need a $17-$20 minimum caregiver wage. – HCBS provider*

> *Professionalizing this workforce would transform this field. Like really professionalize it, and we could hold people accountable. And I don't mean that in a punitive way, but the way that this field is structured…It's shocking, what we are asking direct service providers at entry level with nothing but a high school diploma to do - the medications they dispense and administer. It's kind of shocking that this field is so far behind with the credentialing. And it's really a disservice. – HCBS provider*

> *One of the things we were looking at… is, 'What can we do for that direct care worker position to help promote this kind of work?' and 'Can there be something that maybe is not tied directly to a provider, but to the profession?' And promote that so that younger people in high school that maybe aren't automatically college bound can see that there's a career path, like it is as a CNA. And have things by the state to promote a direct support professional as a true occupation and maybe even a career path. And that that way, something promoted across the state could help us. Is it a short-term fix? No, but it's actually looking at the long game. – HCBS provider*

> *When I think about the system and the stability of the system, I also think about the importance of having people who have the knowledge base in the history of the system to really make significant change. And one of the things that is really concerning for me is seeing providers who have been in this system for a long time, who have an expertise, who are some of our highest performing providers, who have stayed with us and done amazing work and loved on the people that we serve and they're retiring because they're so incredibly burnt out. And just the fears around the loss of the knowledge base in the in the last of the skill set with that is a great concern for me. – PIHP administrator*

> *The direct care worker has to be on top of it, has to be able to know what to recognize, has to be able to look back at a care plan or a treatment plan that may not be as fleshed out as they used to be because of the turnover that the CMHs are having. So, there's just an awful lot that's expected of our direct care*

workers. And so, it's something where I think that position needs to be professionalized because it's so much more that the job's expected to do. That's our crisis right now. -HCBS provider

Several PIHP administrators commented that they came to realize the importance of monitoring the HCBS provider capacity and felt they would continue beyond the PHE.

That information is still pretty new to us, but we are able to see all of our home and community-based providers that are added into power B-I using data behind the scenes – CHAMPS, LARA, those kinds of things – and pull into this dashboard. So, while we don't exactly know what their capacity is, we at least know who within our region is using these providers and have individuals placed there. – PIHP administrator

We started it during COVID. As an organization, we're looking at tracking our capacity, our network adequacy in a better format, so it kind of fell together at the same time. For residential, it's a little more concrete and you know how many homes you have contracted and how many beds are in each home, so you can kind of get an idea. – PIHP administrator

Key informants strongly recommended efforts to reduce the administrative burden on HCBS providers, including strategies to minimize inconsistencies in administrative processes across PIHPs. However, they varied in their comfort with having the state be more directive.

We like the flexibility of not having state directives that tell us how it has to be done, because I think that every situation is different, but some minimums or guidance is always helpful to point to. – PIHP administrator

I would like the guidance to come from state and then be followed up on as it trickles to the PIHP. If there is guidance, it needs to be from the state, then it needs to be monitored to be sure each PIHP hasn't twisted it to their own benefit. – HCBS provider

Summary of response to primary research question 4

Key informants viewed the demonstration authorities as effective in maintaining provider stability and in facilitating access to HCBS. Looking to the future, key informants agreed that permanent increases in wages for direct care workers was the key to returning to prior staffing levels. Other recommendations included efforts to enhance the professionalization of the HCBS workforce; continued but limited use of telehealth to support HCBS administration; and efforts to reduce the administrative burden on HCBS providers, including minimizing inconsistencies across PIHPs.

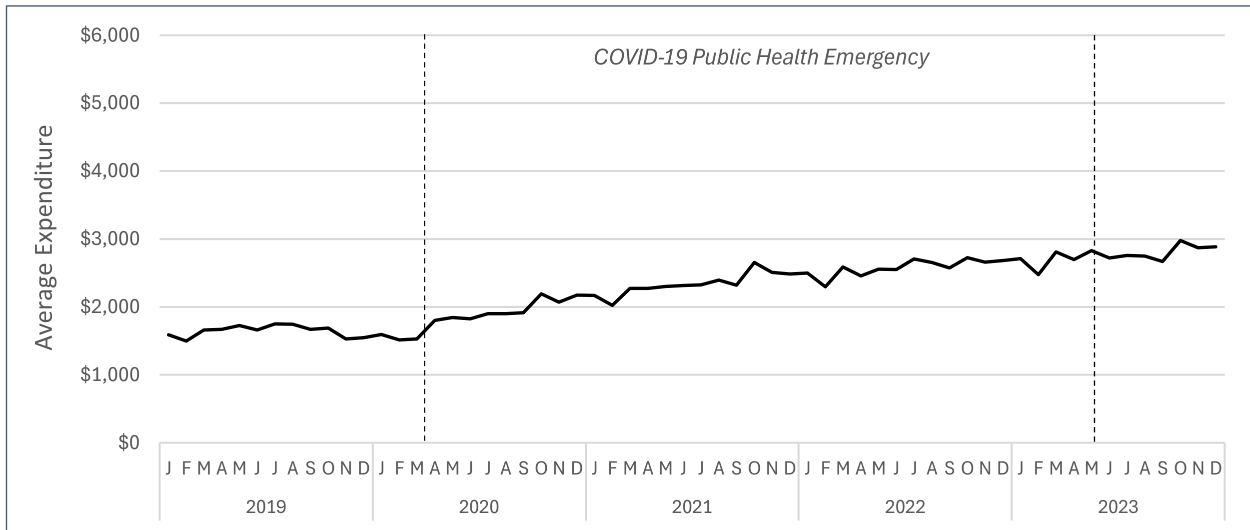
F.5. Primary research question 5. How did HCBS-related expenditure patterns change during the PHE?

Data sources used: Administrative data

Results

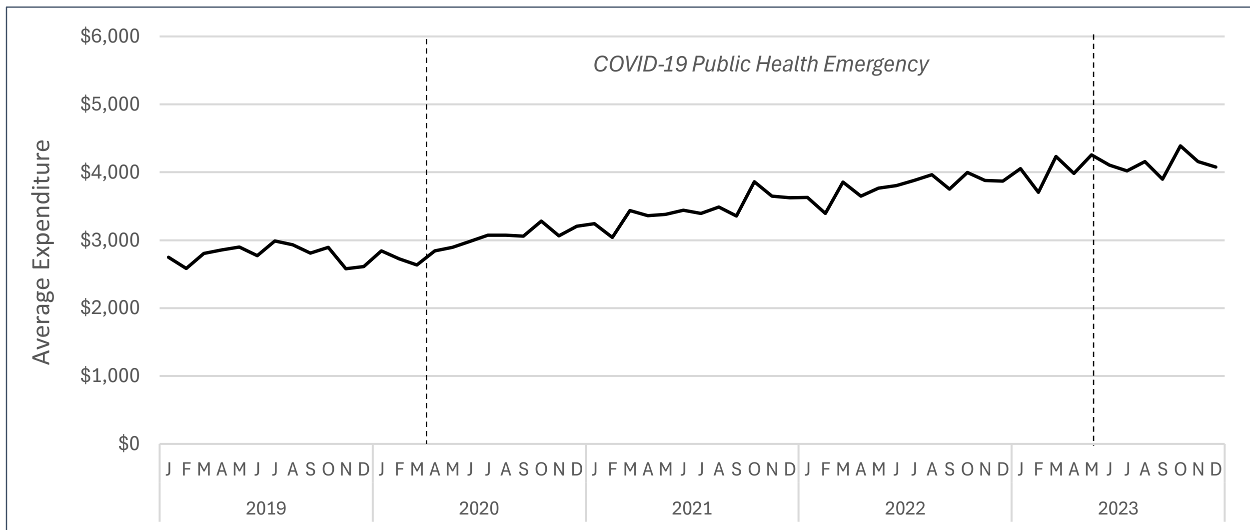
As shown in Figure 5-1, average HCBS expenditures were generally stable in the pre-PHE period; beginning with the start of the PHE, there was an incremental increase in HCBS expenditures through the remainder of the evaluation period.

Figure 5-1. Average HCBS expenditures, among beneficiaries receiving any HCBS service in the month



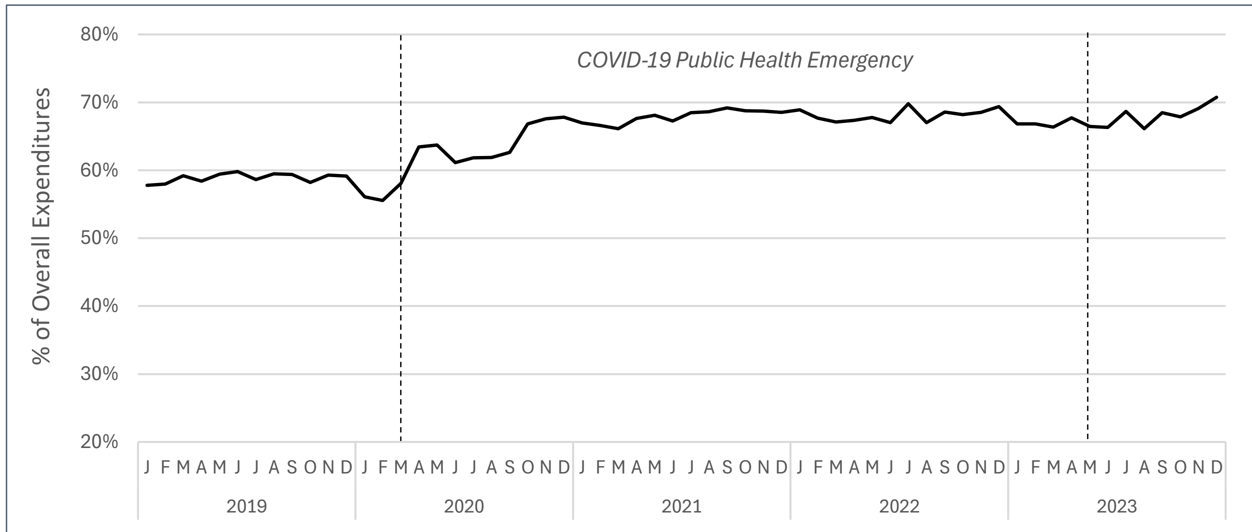
Similarly, overall Medicaid expenditures among beneficiaries with HCBS utilization increased incrementally over the evaluation period, with no dramatic month-to-month change (see Figure 5-2).

Figure 5-2. Average overall expenditures, among beneficiaries receiving any HCBS service in the month



The proportion of overall Medicaid expenditures attributable to HCBS was below 60% in the pre-PHE period; by October 2020 the proportion had increased to nearly 70% and remained at this level through the rest of the evaluation period (see Figure 5-3).

Figure 5-3. Proportion of overall expenditures attributable to HCBS, among beneficiaries receiving any HCBS service in the month



Shown by PIHP, HCBS expenditures (Figure 5-1a), overall expenditures for HCBS utilizers (Figure 5-2a), and proportion of overall expenditures attributed to HCBS (Figure 5-3a) were generally similar to statewide patterns but with pronounced variation for certain PIHPs.

Figure 5-1a. Average HCBS expenditures, among beneficiaries receiving any HCBS service in that month, by PIHP

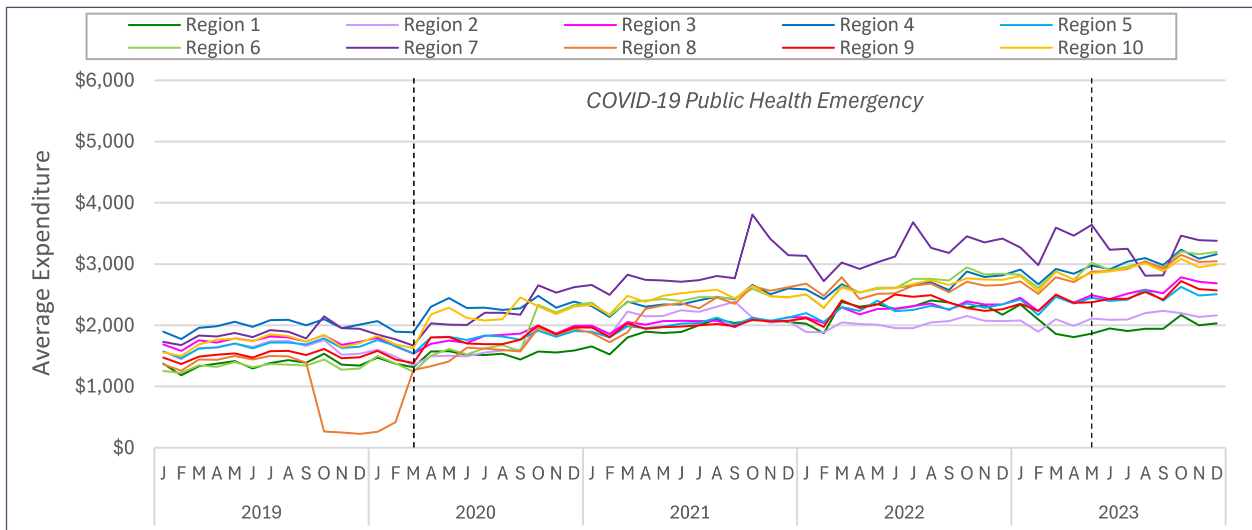


Figure 5-2a. Average expenditure for all services, among beneficiaries receiving any HCBS service in that month, by PIHP

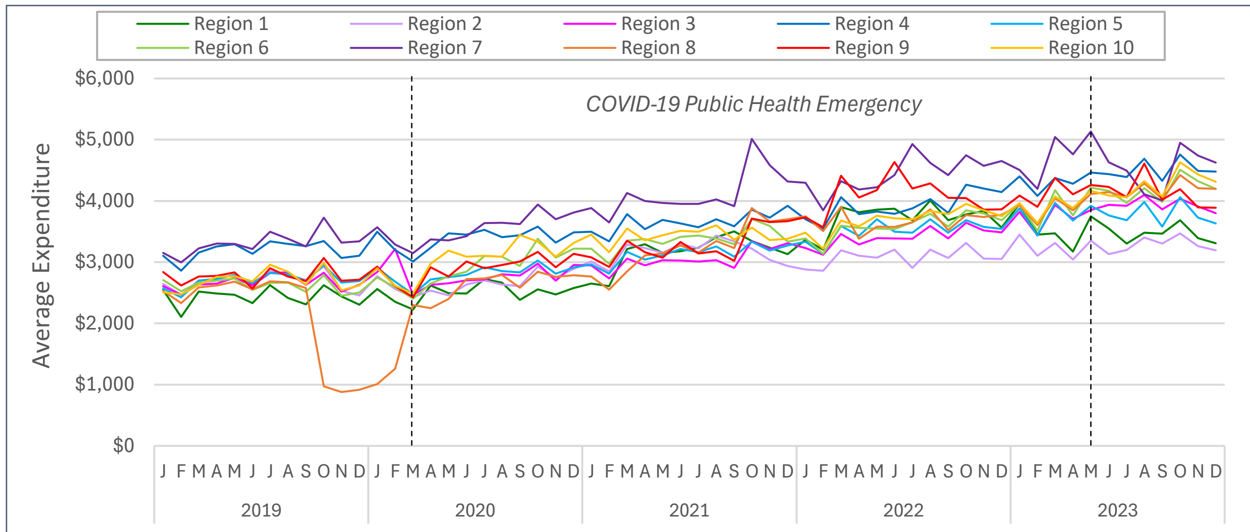
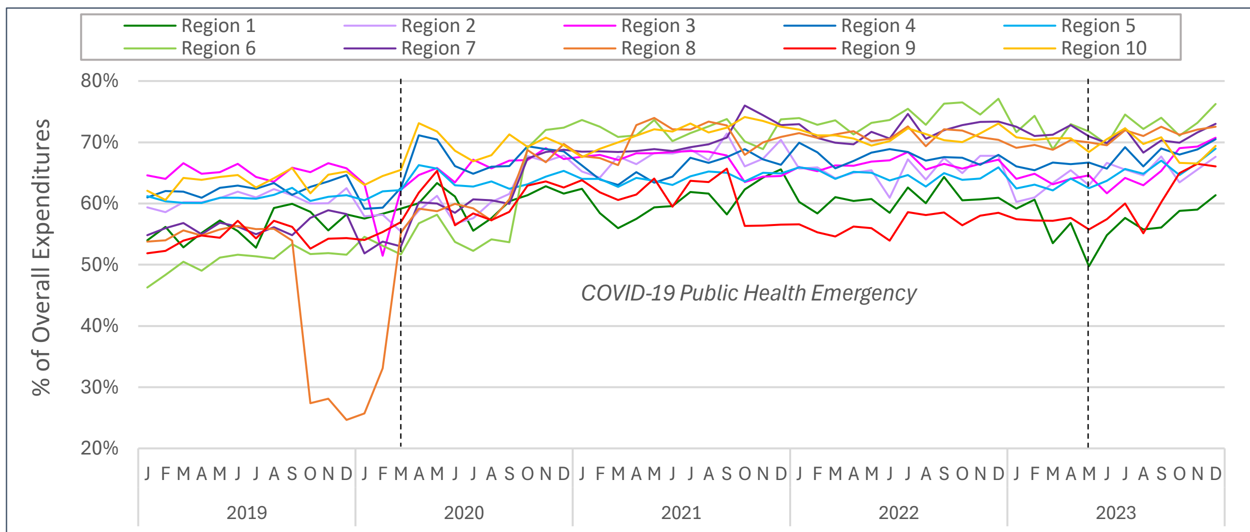


Figure 5-3a. Proportion of overall expenditures attributable to HCBS, among beneficiaries receiving any HCBS service in the month, by PIHP



Summary of response to primary research question 5

Statewide and for each PIHP, HCBS expenditures increased in October 2020, consistent with implementation of premium pay and other strategies to support HCBS providers. This likely contributed to the increased proportion of overall expenditures attributable to HCBS.

G. Conclusions

Analysis of administrative data found that overall, HCBS initiation and utilization for the 1915(i)-like population declined slightly across the evaluation period. However, among beneficiaries who received HCBS, number of days with services and month-to-month continuity returned to pre-PHE levels. The number of HCBS providers decreased by about 10% from the pre-PHE period, with a slight increase in the ratio of beneficiaries per HCBS provider. Use of telehealth for HCBS delivery was highest in the initial months of the PHE and then steadily declined. Utilization of HCBS varied by PIHP. In comparison, overall initiation utilization of SUD treatment services through the PIHP/CMHSP system showed similar patterns as HCBS; among those receiving SUD treatment services, average number of days and month-to-month continuity was lower than for HCBS.

HCBS expenditures increased in October 2020, statewide and for each PIHP, consistent with implementation of premium pay and other strategies to support HCBS providers. This likely contributed to the increased proportion of overall expenditures attributable to HCBS.

Overall, trends in administrative data support the effectiveness of the demonstration authorities in supporting HCBS providers and ensuring the availability of HCBS for beneficiaries.

Key informants described implementation of strategies to maintain stability of the HCBS provider network in each PIHP/CMHSP, including flexibility to modify contracts and offer supplemental payments to provider organizations. Key informants also described implementation of statewide policies to offer premium pay wage increases for direct care workers, highlighting administrative inconsistencies and reporting burdens that limited their effectiveness.

Many PIHP/CMHSP administrators and HCBS providers noted that staffing issues became more pronounced in 2021, which impacted services to beneficiaries in a variety of ways. Additionally, they expressed concern for the future that as staff turned over, new hires generally had less education and work experience, which could impact the quality of services delivered to consumers. Key informants had mixed views on modified training and certification requirements; while online trainings expedited the time from hire to delivering HCBS, an online experience does not provide a comparable learning environment.

To facilitate delivery of services at the outset of the PHE, key informants lauded telehealth as an effective mechanism to maintain connections while keeping consumers, families and HCBS providers safe. However, key informants agreed that HCBS are best delivered in person, and that telehealth should be limited to certain situations, service types, and/or frequency. Most PIHPs and CMHSPs began encouraging return to in-person HCBS delivery in March 2021, in conjunction with the state directive that telehealth should be the consumer's (not staff's) preference. Some key informants tied the October 2021 drop in HCBS providers to no longer being able to do case management via telehealth; trends in administrative data support this hypothesis.

PIHP and CMHSP administrators and HCBS providers agreed that verbal consent was an effective strategy to expedite services, particularly at the outset of the PHE. As staffing shortages continued, the option of verbal consent was useful from an administrative sense. Other strategies deemed effective but infrequently used included HCBS delivery in alternate settings, relaxed timelines for assessments and LOC determinations, and expanded authorization for PDN or respite.

Looking to the future, PIHP and CMHSP administrators and HCBS providers agreed that permanent increases in wages for direct care workers was the key to returning to prior staffing levels. Many recommended efforts to enhance the professionalization of the HCBS workforce; continued but limited use of telehealth to support HCBS administration; and continued monitoring of the stability and capacity of HCBS provider organizations. Key informants strongly recommended efforts to reduce the administrative burden on HCBS providers, including strategies to minimize inconsistencies in administrative processes across PIHPs.

H. Interpretations, Policy Implications. and Interactions with Other State Initiatives

Efforts to support HCBS providers and ensure access to HCBS during the COVID-19 PHE overlapped with implementation of the Statewide Transition Plan to comply with federal HCBS settings requirements. This created a challenge in which PIHPs recognized that HCBS providers were stretched beyond capacity, yet they still had to ensure compliance with the Final Rule. This limited PIHP options to minimize the administrative burden on HCBS provider organizations.

Issues surrounding the HCBS workforce are not unique to Michigan; both key informants in this evaluation and national reports[19] have identified wages, training, and recruitment/retention as key issues. The development and implementation of effective strategies will require collaboration across agencies and branches of government. For example, wage increases may require legislative action, supported with changes to Medicaid reimbursement rates. Efforts to professionalize the workforce, including training requirements and career ladders, will require cooperation between the state Department of Licensing and Regulatory Affairs (LARA), HCBS providers, and PIHP/CMHSP administrators to ensure that training and career pathways are accessible, meaningful, and incorporated into reimbursement models. Expanding the workforce through enhanced use of family caregivers will require substantive input from all stakeholders to ensure that policies and procedures are not administratively burdensome.

This evaluation highlights the issue of variation in administrative requirements across PIHPs and CMHSPs. While Michigan's specialty behavioral health system authorizes PIHPs and CMHSPs to establish administrative processes, the impact on HCBS providers is concerning, particularly when most provider organizations contract with multiple PIHPs and/or CMHSPs. In addition, some key informants identified discrepancies between waiver programs administered through the Medical Services Administration versus those through the PIHP/CMHSP system. The reorganization of the former BHDDA may offer an impetus to review and clarify policies and programmatic guidance, with the goal of greater uniformity.

Finally, the ability of individuals to receive HCBS relies on their ongoing Medicaid coverage. With the end of COVID PHE and the resumption of Medicaid eligibility redeterminations, it is likely that some HCBS recipients may lose coverage due to administrative issues (e.g., incorrect address, inability to complete the redetermination documentation). Ongoing efforts are needed to minimize administrative disenrollments in this vulnerable population.

---

[19] MACPAC Issue Brief. State Efforts to Address Medicaid Home- and Community-Based Services Workforce Shortages. March 2022. https://www.macpac.gov/publication/state-efforts-to-address-medicaid-home-and-community-based-services-workforce-shortages/

I. Lessons Learned and Recommendations

Based on results of this evaluation, we recommend that the state work with partners across state agencies to pursue efforts to support the HCBS workforce through a multi-pronged effort of advocating for wage increases, supporting training opportunities and career pathways, and expanding the use of family caregivers.

The COVID-19 PHE was the impetus to find innovative ways to deliver HCBS. We also recommend that the state support these new developments. Specifically, we encourage the state to seek stakeholder input to define the parameters for a limited use of telehealth for HCBS delivery and an expanded use of telehealth, including digital engagement via smartphones, to support HCBS administration. We also encourage the state to explore new strategies for delivering skills-building HCBS, including efforts described in this report.

Finally, we encourage the state to consider HCBS providers as a single statewide network, rather than ten regional networks that are separate for administrative purposes but overlapping for service delivery. A unified approach may allow state and regional officials to gain a more accurate sense of HCBS provider capacity, and to understand the impact of the current inconsistencies across PIHPs in administration of HCBS benefits.

J. Attachments

A. Approved Evaluation Design for COVID-19 Addendum to 1115 Behavioral Health Demonstration
B. Procedure Codes Used to Identify HCBS and SUD Treatment
C. Key Informant Interview Guides and Characteristics

Report Authors
Sarah Clark, Anne Cowan, Lisa Cohn, Natalie Krammer, Sara Schultz, Lindsey Ewing

Attachment A: Approved Evaluation Design for COVID-19 Addendum to 1115 Behavioral Health Waiver

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

May 10, 2021

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

Dear Ms. Massey:

The Centers for Medicare & Medicaid Services (CMS) has approved the evaluation design for the COVID-19 amendment in Michigan's section 1115 demonstration entitled, "Michigan 1115 Pathway to Integration" (Project Number 11-W00305/5), and effective through the date that is sixty calendar days after the public health emergency expires. We sincerely appreciate the state's commitment to efficiently meeting the requirement for an evaluation design stated in the demonstration's Special Terms and Conditions (STC), especially under these extraordinary circumstances.

The approved evaluation design may 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 on Medicaid.gov.

Please note that, in accordance with Attachment F of the STCs, a final report, consistent with the approved evaluation design, is due to CMS one year after the end of the COVID-19 section 1115 demonstration authority.

We look forward to our continued partnership with you and your staff on the Michigan 1115 Pathway to Integration COVID-19 amendment. If you have any questions, please contact your CMS project officer, Mr. Thomas Long, who may be reached by email at Thomas.Long@cms.hhs.gov.

Sincerely,

Danielle Daly -S Digitally signed by Danielle Daly -S Date: 2021.05.10 10:28:43 -04'00'

Danielle Daly
Director
Division of Demonstration Monitoring and Evaluation

Andrea J. Casart -S Digitally signed by Andrea J. Casart -S Date: 2021.05.10 16:27:58 -04'00'

Andrea Casart
Director
Division of Eligibility and Coverage Demonstrations

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

Covid-19 Addendum

Section 1. Introduction and Background

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. On March 13, 2020, 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. The emergency period will terminate, upon termination of the public health emergency (PHE), including any extensions.

To assist Michigan in delivering the most effective care to its beneficiaries in light of the COVID-19 PHE, CMS approved the COVID-19 PHE amendment to the Michigan 1115 Pathway to Integration Demonstration on October 27, 2020, authorized retroactively from March 1, 2020, through 60 days after the end of the PHE (including any renewal of the PHE). Approval of this demonstration amendment is subject to the limitations specified in the flexibilities listed in Attachment F (Expenditure authorities granted under the Section 1115 COVID Demonstrations) and the previously approved expenditure authorities and Standard Terms and Conditions (STCs). The demonstration amendment will likely promote the objectives of the Medicaid statute by helping Michigan furnish medical assistance to protect the health, safety, and welfare of individuals and providers affected by COVID 19.

As noted in attachment F of the approval letter, the demonstration approves time-limited expenditure authority and requirements for the state of Michigan to enable the state to deliver the most effective care during the PHE to beneficiaries receiving Home and Community Based Services (HCBS). The demonstration amendment aims to help the state achieve the following goals:

- Expedited eligibility for Home and community-based Long-Term Care Services and Supports (LTSS) and delivery in alternative settings
- Increase payment rates to HCBS service providers to maintain capacity to address the needs of beneficiaries during PHE
- Temporary changes to requirements for functional assessments
- Payment for Supports in Alternative Settings
- Modifications to Person-Centered Planning
- Increased use of telehealth for evaluations, assessments, and service planning as well as consent processes
- Suspension of some data collection requirements for quality reviews
- More flexible Incident Report requirements

The Michigan Department of Health and Human Services (MDHHS) will test whether and how the approved expenditure authorities affected Michigan's response to the PHE using evaluation questions that pertain to the approved expenditure authorities. The evaluation will also track administrative costs and health services expenditures for demonstration beneficiaries and assess how these outlays affected Michigan's response to the PHE.

Section 2. Evaluation Overview

This evaluation will test whether and how the approved expenditure authorities affected the state's response to the PHE by investigating the specific evaluation questions:

Evaluation Questions:

1. What changes in rates of HCBS initiation and utilization occurred during the COVID-19 PHE?

2. How did changes in initiation and utilization of HCBS during the PHE compare to changes for other services administered through the PIHPs?

3. In what ways did the PHE impact HCBS providers?

4. What strategies or adaptations were most effective in achieving the essential goals of the demonstration?

5. How did HCBS-related expenditure patterns change during the COVID-19 PHE?

Section 3. Methodology

3.1 Evaluation Design Summary

We propose an evaluation design consistent with evaluation design recommendations and requirements outlined in the "COVID-19 PHE Medicaid Section 1115 Demonstration: Guidance for Monitoring and Evaluation Final Report" document. We will use a quasi-experimental evaluation design based on comparing trends in service initiation and utilization over time (before and during the PHE). We will also employ a mixed methods design that incorporates both quantitative and qualitative data collection and analysis to answer key evaluation questions. We will stratify results by Prepaid Inpatient Health Plan (PIHP) region, and adjust for PIHP region in multivariable models. These regional analyses will allow us to assess the consistency of outcomes across the diverse PIHP regions and to identify any differential impacts of the demonstration for specific regions.

The State will track separately all expenditures associated with the COVID-19 Demonstration, including but not limited to, administrative costs and program expenditures. We will examine expenditure patterns specific to HCBS and for all services (total expenditures) among the population of beneficiaries who receive HCBS, and calculate the proportion of total expenditures attributable to costs. We hypothesize that total and HCBS-specific expenditures will decrease during the PHE but that the proportion of total expenditures attributable to HCBS will remain relatively constant.

3.2. Data sources, evaluation measures, and analytic approach

The evaluation data sources, measures, and analytic approach appear in Table 1.

Table 1. Research Questions for Evaluation of Michigan's COVID-19 PHE Amendment of the Michigan 1115 Pathway to Integration Demonstration

Question 1. What changes in rates of HCBS initiation and utilization occurred during the COVID-19 PHE?				
Measures	Data Sources	Numerator	Denominator	Analytic Approach
Initiation of HCBS (monthly) before and during PHE	Administrative Claims	Number of beneficiaries with any new HCBS claim who did not have an HCBS claim in the prior 12 months	Total number of eligible beneficiaries	Descriptive monthly trends over time (Jan 2019 through end of PHE), statewide and by PIHP region
Utilization of HCBS (monthly) before and during PHE	Administrative Claims	Number of beneficiaries with any HCBS claim in current month	Total number of eligible beneficiaries	Descriptive monthly trends over time (Jan 2019 through end of PHE), statewide and by PIHP region
Volume of HCBS claims (mean and median) per HCBS user	Administrative Claims	Total number of HCBS claims per individual beneficiary in current month	Total number of eligible beneficiaries	Descriptive monthly trends over time (Jan 2019 through end of PHE), statewide and by PIHP region
Continuity of HCBS (monthly): Proportion of prior month's HCBS users who continued HCBS service	Administrative Claims	Number of beneficiaries who had an HCBS claim in current month	Number of beneficiaries who had an HCBS claim in previous month	Descriptive monthly trends over time (Jan 2019 through end of PHE), statewide and by PIHP region

Question 2. How did changes in initiation and utilization of HCBS during the PHE compare to changes in initiation and utilization of other PIHP-administered services (such as substance use disorder; SUD)?				
Measures	Data Sources	Numerator	Denominator	Analytic Approach
Initiation of other PIHP services (monthly)	Administrative Claims	Number of beneficiaries with any new SUD claim who did not have an SUD treatment claim in the prior 12 months	Total number of eligible beneficiaries	Descriptive monthly trends over time (Jan 2019 through end of PHE), statewide and by PIHP region; **comparison with parallel HCBS measure**
Utilization of Other PIHP Services (monthly)	Administrative Claims	Number of beneficiaries with any SUD treatment claim in current month	Total number of eligible beneficiaries	Descriptive monthly trends over time (Jan 2019 through end of PHE), statewide and by PIHP region; **comparison with parallel HCBS measure**
Utilization of Other PIHP Services (monthly)	Administrative Claims	Total number of SUD treatment claims per individual beneficiary in current month	Total number of eligible beneficiaries	Descriptive monthly trends over time (Jan 2019 through end of PHE), statewide and by PIHP region; **comparison with parallel HCBS measure**
Continuity of Other PIHP Services (monthly)	Administrative Claims	Number of beneficiaries who had an SUD treatment claim in current month	Number of beneficiaries who had an SUD claim in previous month	Descriptive monthly trends over time (Jan 2019 through end of PHE), statewide and by

				PIHP region; **comparison with parallel HCBS measure**
Question 3. In what ways did the PHE impact HCBS service providers?				
Measures	Data Sources	Numerator	Denominator	Analytic Approach
Total number of providers for HCBS	Administrative Claims	n/a	n/a	Descriptive monthly trends over time (Jan 2019 through end of PHE), statewide and by PIHP region
Challenges and facilitators to retaining HCBS providers	Key informant interviews	n/a	n/a	Qualitative Analysis
Facilitators and barriers to ensuring beneficiary access to care planning and HCBS services during the PHE	Key informant interviews	n/a	n/a	Qualitative Analysis
Unresolved or ongoing challenges related to care delivery during the PHE for providers	Key informant interviews	n/a	n/a	Qualitative Analysis

Question 4. What strategies or adaptations were most effective in achieving the essential goals of the demonstration?				
Measures	Data Sources	Numerator	Denominator	Analytic Approach

Which demonstration flexibilities or changes were most effective in retaining HCBS providers and facilitating HCBS delivery during the PHE?	Key informant interviews	n/a	n/a	Qualitative Analysis
What additional strategies or adaptations would you recommend	Key informant interviews	n/a	n/a	Qualitative Analysis

Question 5. How did HCBS-related expenditure patterns change during the COVID-19 PHE?				
Measures	Data Sources	Numerator	Denominator	Analytic Approach
Average expenditures for HCBS, per beneficiary (monthly)	Administrative Claims	Total paid amounts for all HCBS claims in month	Number of beneficiaries with any HCBS claim in month	Descriptive monthly trends over time (Jan 2019 through end of PHE), statewide and by PIHP region
Average expenditures for all services, per beneficiary with HCBS (monthly)	Administrative Claims	Total paid amounts for all services, among beneficiaries with any HCBS claim in month	Number of beneficiaries with any HCBS claim in month	Descriptive monthly trends over time (Jan 2019 through end of PHE), statewide and by PIHP region
Proportion of total expenditures attributable to HCBS (monthly)	Administrative Claims	Total paid amounts for all HCBS claims in month	Total paid amounts for all services, among beneficiaries with any HCBS	Descriptive monthly trends over time (Jan 2019 through end of PHE),

			claim in month	statewide and by PIHP region

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.

3.2. Data Sources

Qualitative Data
We will conduct key informant interviews with representatives from HCBS and PIHP regions. Interviews will include a review of the principal challenges and responses associated with engagement with beneficiaries and ability to provide access to care during this PHE. The goal is to give context to quantitative data analysis and identify which flexibilities were most effective in achieving the goals of the demonstration and what challenges remain.

State administrative data
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
- Administrative Program Records include PIHP Community Mental Health Service Programs demographic and cost data reports sent the state (908s and 905s)

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.

<u>Variables</u>
We will extract and process data from the state Data Warehouse to generate outcome and predictor variables for evaluation analyses. These variables will include:
- <u>Initiation-related variables</u> will include the presence of a new procedure code for any beneficiary who did not have an HCBS or LTSS procedure code in the 12 months prior.
- <u>Utilization-related variables</u> will include counts of unique events. We will use diagnosis and procedure codes to categorize the type of service. We will use Place of service codes and 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. We will modify criteria for key outcome measures to generate quarterly results, which we will use in our analysis.
- <u>Expenditure-related variables</u> will include paid amounts linked to fee-for-service claims, managed care encounters, and pharmacy services.
- <u>Demographic variables</u> will include beneficiary age, race/ethnicity, geographic region PIHP, income level (% FPL), and health plan.

3.3. Analytical Approach

We will generate outcome measures based on administrative data for 24 months prior to the start of the COVID-19 PHE period through the end of the PHE period. This will allow us to appreciate trends over time.

We will generate monthly measures of HCBS utilization, including:
#/% of beneficiaries with any HCBS
#/% of beneficiaries with new HCBS
Volume (mean # units) per HCBS user
#/% of HCBS users with an HCBS gap of ≥28 days

We will generate these monthly measures for the state overall, for each PIHP region, and for demographic subgroups (age, Medicaid benefit program). We will assess the extent to which decreases of ≥10% in HCBS utilization observed for 3 continuous months are reversed in the subsequent quarter.

3.4. Timeline

Table 2. EVALUATION TIMELINE: Michigan COVID-19 PHE Medicaid Section 1115 Demonstration Waiver

	Administrative data analysis	Administrative program record data analysis	Key Informant Interviews	Deliverables
FY21 Q1				Finalize Evaluation Plan - due to CMS 12/27/20
FY21 Q2	Draft Data Use Agreements and obtain approvals	Identify programmatic data from PIHP reports to MDHHS	Develop interview guide and protocol	

FY21 Q3	Develop programming code for measures based on administrative claims	Obtain programmatic data for FY2020	Begin conducting key informant interviews Make adjustments to interview guide as needed	
FY21 Q4	Generate monthly administrative measures through Dec 2020	Analyze FY2020 programmatic data	Continue key informant interviews Iterative qualitative analysis of interviews	
Potential extension of PHE	Generate monthly administrative measures from Jan 2021 through the end of the PHE period	Obtain programmatic data for FY2021	Iterative qualitative analysis of interviews	
1 year + 60 days after end of PHE	Summarize monthly measures; compare HCBS vs SUD treatment service trends	Summarize programmatic data; use information to supplement interpretation of administrative claims and key informant interviews	Summarize key informant interview data	Final report - due to CMS one year after the state's COVID-19 related waiver and expenditure authorities expire

Section 4. Methodological Limitations
Our proposed evaluation has several limitations. The primary limitation is related to 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. Given the nation-wide, unplanned nature of the

PHE no comparison group is readily available. Qualitative data collection will help provide explanatory context and insight into quantitative findings; however, sampling for qualitative interviews is not statistically representative of the population and findings lack generalizability. Implementation of key elements of the demonstration is expected to be uneven across PIHP regions. To address this likelihood, we will explore and describe regional differences in each of the three data elements (administrative data, program data, and key informant interviews). This will allow us to document any differences in implementation, and to examine the extent to which implementation differences are associated with evaluation process or outcome measures.

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, paid amounts for both fee-for-service and managed care encounters, billing and rendering provider identifiers. Our greatest area of concern involves accurately identifying changes in utilization of HCBS due to beneficiaries (or their families) being uncomfortable being in close proximity to care providers during the PHE. This could result in differential changes in initiation, utilization, and continuity of HCBS compared to SUD treatment services. To address this challenge, we will include questions of key informants to understand their experiences with beneficiaries suspending or refusing services due to COVID precautions.

ATTACHMENT B: Procedure Codes for HCBS and SUD Treatment Services

Target Group - HCBS Procedure Codes, by group

Community Living Supports
H2015
H2016
T2036
T2037

Enhanced Medical Equipment & Supplies
T2028
T2029
S5199
E1399
T2039

Enhanced Pharmacy
T1999

Environmental Modifications
S5165

Family Training
S5111
S5110
G0177
T1015

Fiscal Intermediary Services
T2025

Goods and Services
T5999

Housing Assistance
T2038

Non-Family Training
S5116

Overnight Health and Safety Supports
T2027

Out of home Non-Vocational Habilitation
H2014

Out of home Prevocational Service
T2015

Personal Emergency Response System
S5160
S5161

Private Duty Nursing
S9123
S9124
T1000

Respite Care
T1005
H0045
S5150
S5151
T2036
T2037

Skill Building
H2014

Supported Employment
H2023

Assertive Community Treatment
H0039

Clubhouse
H2030

Home Based Services
H0036
H2033

Personal Care in Licensed Specialized Residential Setting
T1020

Comparison Group - SUD Treatment Services Procedure Codes

80305	G0397	H0047
80307	G0466	H0048
90791	G0467	H0049
90792	G0470	H0050
90832	G2067	H2011
90834	G2068	H2015
90837	G2074	H2027
90839	G2076	H2034
90846	G2077	H2035
90847	G2078	H2036
90849	H0001	Q3014
90853	H0002	S0215
96372	H0003	S0280
97810	H0004	S0281
97811	H0005	S9976
99201	H0006	T1001
99202	H0010	T1007
99203	H0012	T1009
99204	H0015	T1012
99205	H0018	T1013
99211	H0019	T1016
99212	H0020	T1017
99213	H0022	T1023
99214	H0023	T1040
99215	H0025	T2001
99241	H0032	T2002
99408	H0033	T2003
A0100	H0038	T2004
A0110	H0043	T2038

Attachment C: Key Informant Interview Guides and HCBS Provider Characteristics

Interview Guide: BHDDA officials involved in oversight of HCBS

Interview Guide: PIHP officials involved in administration of HCBS

Interview Guide: HCBS provider leadership involved in administration of HCBS

Attachment Table C-1. Characteristics of the HCBS providers interviewed

Interview Guide: BHDDA officials involved in oversight of HCBS

The COVID PHE waiver allowed for substantial flexibility related to HCBS, including process changes and payment changes. In this interview, I'm going to ask about how you rolled out these changes with PIHPs and HCBS service providers, what you heard from PIHPs and service providers about whether they had adequate flexibility, and finally, where we're at now, as we near the end of the PHE.

PART I. Let's talk about the roll-out of the payment changes. According to the CMS waiver approval notice, these were increased payment rates to HCBS service providers and payment for supports in alternative settings.

a) What do you recall about the roll-out of these payment changes with PIHPs? Did PIHPs have broad latitude on how they implemented these changes, or did BHDDA give parameters?

b) How were these payment changes communicated to HCBS service providers: exclusively through the PIHPs, or did BHDDA also have a role?

c) How consistently do you think these payment changes were implemented across the PIHPs? What were the likely areas of inconsistency?

d) Do you think the payment changes were adequate to allow PIHPs to maintain HCBS provider capacity? Did PIHPs ask for any other flexibilities around payment?

PART II. Let's talk about the process changes. According to the CMS waiver approval notice, these include:

- Expanded eligibility for LTSS
- Changes to requirements for functional assessments, person-centered planning, incident reports
- Suspension of some data collection requirements for quality reviews
- Expanded use of telehealth for evaluations, assessments, service planning and consent

a) What do you recall about the roll-out of these process changes with PIHPs? Did you direct PIHPs to allow any HCBS provider to use these expanded flexibilities, or was it on a case-by-case basis?

b) How were these process changes communicated to HCBS service providers: exclusively through the PIHPs, or did BHDDA also have a role?

c) How consistently do you think these process changes were applied across the PIHPs? What were the likely areas of inconsistency?

d) Which process changes were most effective in retaining HCBS providers while ensuring that beneficiaries received care planning and HCBS services? Were there other strategies that PIHPs suggested that you could not implement?

e) In what ways did BHDDA change its processes for monitoring PIHP performance related to HCBS? Were there any areas of concern, particularly for beneficiary access?

Part III. Looking ahead.

a) Was there a point at which BHDDA encouraged PIHPs to have HCBS providers start returning to the "usual" processes? Did some PIHPs start doing this on their own?

b) Right now, are most PIHPs and HCBS providers still relying on the COVID PHE flexibility? In which areas?

c) Do you anticipate push-back from PIHPs or HCBS providers with the return of "usual" policies and procedures?

d) Are there any process or payment changes that you would like to be able to maintain past the PHE, if that were possible?

e) Have you returned to "usual" BHDDA monitoring of PIHP performance related to HCBS?

f) Anything else you'd like to share about HCBS processes and payment?

Part IV. The evaluation plan approved by CMS calls for interviews with officials in each PIHP to get their perspectives on the COVID PHE process and payment changes for HCBS.

a) Will you share a list of key staff in each PIHP, and their contact information?
b) Would you be willing to send an email encouraging their participation in these interviews?

Interview Guide: PIHP officials involved in administration of HCBS
Michigan's COVID Public Health Emergency waiver allowed for substantial flexibility related to HCBS, including some changes around payments to providers, as well as process changes in use of telehealth, timing of assessments and care planning, and some quality review measures.

In this interview, we'll talk about how well this flexibility allowed your PIHP to retain HCBS providers and facilitate their ability to provide services despite the challenges of COVID. And we'll discuss your current thinking as we near the end of the public health emergency.

PART I. Big picture.

a) In general, how do you monitor your HCBS provider capacity (e.g., # of providers, # of beneficiaries served)? How has provider capacity changed over the course of the COVID PHE?
b) What were the biggest challenges for HCBS providers at the start of the pandemic?

PART II. Let's talk about the increased payment rates to HCBS service providers during the COVID PHE.

a) Were HCBS providers willing and able to provide the information you needed to justify payment levels?

b) Were the payment changes adequate to maintain HCBS provider capacity – in other words, were you able to meet the financial needs of your HCBS providers? Did you lose any HCBS providers?

c) Looking back, do you wish you had done anything differently regarding implementation of the increased payment rates? Do you wish the state had done anything differently?

d) Are HCBS providers still relying on the increased payment rates? Are they worried about their ability to retain staff without the increased rates?

PART III. Let's talk about the process changes in the COVID PHE waiver, which include:

- Relaxation of timeframes for completion of functional assessments, person-centered planning, incident reports
- Expanded use of telehealth for evaluations, assessments, service planning and consent
- Expanded eligibility for LTSS / payment for supports in alternative settings

a) How well did the process changes allow you to ensure that beneficiaries received the HCBS they needed during COVID?
    - What worked well, and what did not work well, for HCBS providers?
    - What worked well, and what did not work well, for beneficiaries?

b) How did you monitor whether beneficiaries were able to receive care planning and HCBS services during the PHE? When you had concerns, how did you address them?

c) Looking back, do you wish you had done anything differently regarding implementation of telehealth and other COVID PHE flexibilities? Do you wish the state had done anything differently?

d) Was there a point at which you started encouraging HCBS providers to start returning to the "usual" processes? Are most HCBS providers still relying on the flexibilities?

e) Do you anticipate push-back from HCBS providers with the return of "usual" policies and procedures?

Part IV. Looking ahead

a) As we look to the eventual end of the COVID PHE, what process or payment changes would be helpful to continue? How would you describe the rationale for doing so?

b) Anything else you'd like to share about HCBS processes and payment?

Part V. The evaluation plan approved by CMS calls for interviews with HCBS providers to get their perspectives on the COVID PHE process and payment changes.

a) Are there HCBS providers that you recommend we include in these interviews? If yes, would you be willing to send us their name and contact information, and/or send them an email encouraging their participation in these interviews?

Interview Guide: HCBS provider leadership involved in administration of HCBS
Michigan's COVID Public Health Emergency waiver allowed for flexibility related to HCBS, including some options around payments to providers, use of telehealth, timing of assessments, case management and reporting.

The University of Michigan is conducting an evaluation of how the state of Michigan and its partners managed services for individuals receiving 1915(i) -like in home services and community-based services during the COVID public health emergency. The evaluation includes key informant interviews with officials at the state and at each PIHP region.

As a next step, we're talking with a sample of HCBS providers to understand their perspectives on retaining staff and providing HCBS services through the COVID PHE.

We would like to record the interview, to make sure we have accurate information. The recording would be only for our University of Michigan team. We will not share any of your information with any PIHP or with the state. Our written summary will not identify any provider or agency names. Do we have your permission to record?

PART I. First, we'd like to get a little information about your organization.

- What HCBS services do you provide?
- Which CMHSPs and/or PIHPs do you contract with?
- About how many staff do you currently have?

PART II. Let's talk about payment for HCBS services.

a) Were you offered the option to get premium pay or any other increase in pay rate for your staff?

- Were the increased payment rates adequate to retain staff?
- Anything that didn't work well?
- [if the provider contracts with multiple PIHPs or CMHSPs]: Did each PIHP and/or CMHSP implement the increased payment rates the same way? If not, what differed?

b) Were you offered any other payment flexibilities, like advanced payment?

- Were the payment flexibilities adequate to retain staffing and keep your business financially viable?
- Anything that didn't work well?
- [if the provider contracts with multiple PIHPs or CMHSPs]: Did each PIHP and/or CMHSP implement the payment flexibilities the same way? If not, what differed?

PART III. Another area of flexibility involved changes in processes, like being able to use telehealth to deliver some services and doing electronic consents.

a) How did your staff and clients adapt to using telehealth for case management, HCBS services, and electronic consents?
   [if the provider contracts with multiple PIHPs or CMHSPs]: Did each PIHP and/or CMHSP implement telehealth options the same way? If not, what differed?

b) Did the option to use telehealth help you retain staff?

c) Did you have any concerns about use of telehealth – either for clients or for staff? How did you address those concerns?

d) Were there any other ways in which PIHPs allowed you flexibility during the COVID PHE? [if yes] Was that flexibility helpful in retaining staff and delivering services?

PART IV. Looking ahead.

a) What's your current situation in terms of being able to hire and retain staff?

b) Overall, what payment strategies (from the state, the PIHPs or CMHSPs) are most effective in helping you retain staff and ensure that clients get the HCBS they need?

c) Overall, what process strategies (from the state or the PIHPs) are most effective in helping you retain staff and ensure that clients get the HCBS they need?

d) Do you have any advice to the state or the PIHPs as the COVID public health emergency comes to an end?

Anything else you'd like to share about HCBS processes and payment?

Thanks so much for talking with us today!

Attachment Table C-1. Characteristics of the HCBS providers interviewed

Provider	# of Staff	# of PIHPs*	Types of Services		
			Residential[#]	CLS	Vocational / Skills Building
A	250-500	2	✓	✓	
B	≥500	6	✓	✓	
C	250-500	10	✓		
D	250-500	3	✓	✓	✓
E	100-249	3	✓	✓	
F	<100	1		✓	✓
G	100-249	4	✓		
H	250-500	1	✓		
I	250-500	2		✓	
J	<100	3	✓		
K	250-500	5	✓	✓	✓
L	≥500	2	✓	✓	
M	100-249	1	✓	✓	
N	250-500	1	✓	✓	
O	<100	3	✓	✓	
P	100-249	3	✓	✓	
Q	<100	2	✓	✓	
R	<100	1	✓		
S	<100	1		✓	✓
T	≥500	3	✓	✓	✓
U	100-249	4	✓		
V	<100	1	✓		
W	≥500	1	✓	✓	
X	100-249	7	*Supports coordination/case management only*		

** number of PIHP regions contracting for HCBS services*

[#] *includes licensed and unlicensed residential, specialized residential (e.g., adult foster care, assisted living)*